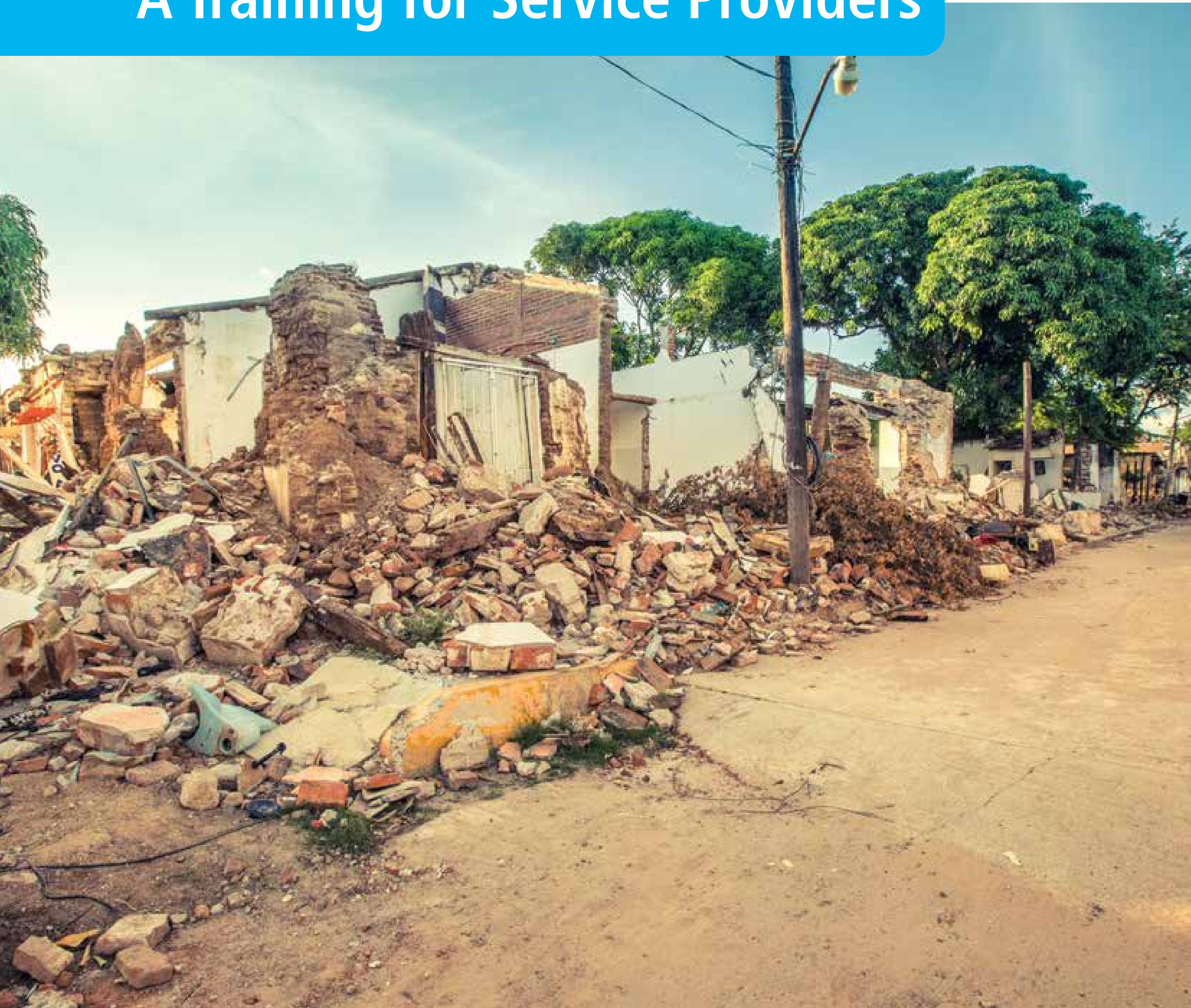
Inter-Agency Working Group on
Reproductive Health in Crises

International
Planned Parenthood
Federation

Sexual and reproductive health in emergencies

An introduction to the Minimum Initial Service Package (MISP)

A Training for Service Providers



IPPF/Jon Spaull

Acknowledgements

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

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

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

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

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

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List of Acronyms

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

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

A note on Terminology

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

Disaster, Emergency or Crisis

A disaster is defined as a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts (UNDRR).

The term emergency is sometimes used interchangeably with the term disaster, as, for example, in the context of biological and technological hazards or health emergencies, which, however, can also relate to hazardous events that do not result in the serious disruption of the functioning of a community or society (UNGA A/71/644).

A crisis is an unstable or crucial time or state of affairs in which a decisive change is impending especially: one with the distinct possibility of a highly undesirable outcome (Meriam Webster).

There are many definitions of 'disaster', 'emergency' or 'crisis'. In the context of this training when 'disaster', 'emergency' or 'crisis' is mentioned, it is the definition given under disaster that is being referred to. In this training, 'emergency' and 'crisis' are used interchangeably.

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

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

IPPF prefers the term SRHR as it emphasizes the importance of SRH as a basic human right.

In this training we will reference SRH, SRHR, and RH interchangeably. We will have to reference RH at certain points as this is the terminology used within some RH in Crises tools and guidelines. Where there is no particular need to talk about RH we will default to SRHR which is IPPF language.

The Minimum Initial Service Package (MISP)

The Minimum Initial Service Package for sexual and reproductive health in emergencies *defines which SRH services are most important in preventing morbidity and mortality, while protecting the right to life with dignity in humanitarian settings*. The MISP was first articulated in the 1999 guidance document Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. Since that time, the MISP has undergone a series of revisions which have included technical updates and re-prioritisation. The most current version of the MISP is found in the 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, referenced throughout this manual as IAFM 2018 (http://iawg.net/wp-content/uploads/2018/11/IAFM-web.pdf). This manual serves as the authoritative source for SRH programming in humanitarian settings and is based on guidelines issued by key international organisations including the World Health Organization (WHO). It will provide the technical contents of this training.

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

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

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

SRH / RH Coordinator ... Focal Point ... Officer

According to the 2009 Health Cluster Guide[1], the assignment of an 'RH area focal point agency', working under the Health Cluster Coordinator, should be discussed and agreed upon within the Health Cluster.

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

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

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

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

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

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

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[1] This manual is currently being revised. Watch out for it at this link http://www.who.int/health-cluster/resources/publications/hc-guide/en/

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

Signal functions[2] are used for monitoring emergency obstetric care (life-saving emergency interventions performed by skilled providers to manage the majority of maternal complications in pregnancy, childbirth and postpartum period).

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

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

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

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

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

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

Purpose and Structure of the Manual

This Facilitators Manual will take you through the various steps necessary to facilitate a training workshop on sexual and reproductive health in emergencies and the MISP for SRH for service providers.

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

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

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

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

This manual accompanies the PowerPoint Slide Deck titled *Sexual and Reproductive Health in Emergencies: Training for Service Providers*. In addition to covering the six objectives and the other priority activity of the MISP for SRH, it also covers topics such as fundamental principles of SRH programming in humanitarian settings, inclusion and adolescent SRH; and logistics and monitoring which are considered important for implementation of the MISP for SRH and are also addressed in the IAFM.

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

⚠ **Note to facilitators** boxes are included throughout the manual. These contain suggestions on how to make the session more interactive, links to additional information or resources, or strategies to contextualise information on that slide. It is not intended that every note should be implemented.

'Matrix' work will be undertaken throughout the training. At various points, participants will be asked to add information to **matrices**, based on the MISP for SRH objective being addressed at the time.

The purpose of these matrices is to:

- Recap 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

- Help plan for future capacity development needs.

By the end of the training, participants should have a more complete picture of the MISP for SRH, their role as service providers in implementing the MISP for SRH, resources to support this work, and contextual realities. The matrices can then be built on and adapted for future preparedness activities.

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

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

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

IPPF/Alana Holmberg

Objectives of the Training

At the close of the workshop, all participants should:

1. Explain why it is important to address sexual and reproductive health in emergencies.
2. Define key terminology & concepts for providing sexual and reproductive health services in emergencies.
3. Demonstrate a clear understanding of the objectives and activities prescribed by the MISP for SRH and the skills needed to deliver these.
4. Identify challenges and solutions to delivering SRH service in emergencies.
5. Identify the competencies service providers need and the key role they must play to ensure the delivery of activities prescribed by the MISP for SRH.

This training is intended to provide a clear overview of the MISP objectives and supportive elements. It is not a training that will provide the skills needed to implement the MISP for SRH. At the end of each objective are links to resources and training packages that participants can explore if they want more knowledge and skills on particular objectives.

IPPF/Isabel Corthier

Planning and Conducting the Training

The intended audience for this workshop is national/ local health staff from the public system, non-government health service providers or supportive actors (such as IPPF Member Associations). Participants must be clinical and be in a position to support the implementation of sexual and reproductive health services during emergencies. They too are expected to be certified in the MISP for SRH online module.

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

Inviting Participants

This workshop will require careful planning, particularly when it comes to making sure the right people attend. What is important is that those invited to attend the workshop for service providers is that they have training and qualifications in the delivery of general and/or sexual and reproductive health services. Service providers must also be in a **position** to **implement** the knowledge and skills developed during the training. The purpose of this training is to build knowledge and practical skills in the delivery of services prescribed by the MISP for SRH and as such, participants should be in a position to integrate these knowledge and skills into their work roles as service providers.

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

This may require inviting and reminding with sufficient time to ensure they can participate.

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

Participants are expected to be certified in the MISP Distance Online Learning Module (http://iawg.net/minimum-initial-service-package/) before attending the training.

Adaptation to local contexts

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

> *Each country, region or community has a different context … and they have different causes or symptoms of that issue. Being aware of this context is essential for effective communication, and it will help you make your case more relevant, legitimate and powerful (UNAIDS, 2014)*[3] .

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

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

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

Contextualisation of the training materials and content is important to show that the MISP for SRH is a priority in any emergency setting. While this contextualisation is encouraged throughout the manual, it must be stressed that the **MISP for SRH is an evidenced-based life-saving set of priority activities and as such, all MISP objectives, activities and other priority should be covered in the training**.

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

Completion of the training

It is important to recognise the efforts of participants who commit time and energy to the training.

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

Notes on Facilitators, Facilitation and Training Skills

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

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

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

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

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

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

- When facilitating different objectives, technical experts for the different fields can enrich the training with examples and help respond to various questions.

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

Remember: as a Facilitator, you are an SRH advocate. It is of critical importance that the delivery of this training supports and promotes sexual and reproductive rights, and clearly explains that the services identified within the MISP are necessary within humanitarian action and beyond. Women, girls, men and boys and others in all their diversity all have a right to these services regardless of any bias or personal beliefs of service providers, programme managers, or facilitators running this training. It is imperative that potential personal biases of facilitators and/or participants do not undermine the key messaging in this training.

Key resources for all participants

In addition to the various documents listed throughout the manual, provide all participants with a copy of the **entire IAFM 2018**. Also provide the MISP for SRH Cheat Sheet and related advocacy documents (available at www.IAWG.net or on the accompanying USB).

Key resources are provided on the accompanying USB however it is good to check the websites regularly for updates or latest materials.

IPPF/Kathleen Prior

Agenda

Day 1: Sexual & Reproductive Health in Emergencies

Session 1.1	**Introduction to sexual & reproductive health in emergencies**
Length	3 hours
Overview	This session will welcome participants to the training for service providers and provide an introduction to the importance of addressing sexual and reproductive health in emergencies. Key terminology and concepts to take forward through the remainder of the training will also be discussed and defined.
Methodology	Pre-test Interactive presentation Video presentation Group work
Materials	Pre-test PowerPoint Presentation Video: SRH in emergencies/ Audiovisual equipment Participant Handouts & Group Work Supplies

Break

Session 1.2	**Inclusion: Leaving no one behind**
Length	1½ hours
Overview	This session will provide participants with an understanding of inclusion, intersectionality, vulnerability and capacity, and the fundamental principles for SRH programming in humanitarian settings. The frameworks discussed during this session will be applied throughout the training.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts & Group Work Supplies

Short Break

Session 1.2 (continued)	**Adolescent sexual & reproductive health & rights in emergencies**
Length	1 hours
Overview	This session will require participants to consider the particular needs and strengths of adolescents in humanitarian settings. The role of service providers in ensuring that services are responsive to adolescents' diverse needs will also be discussed.
Methodology	Interactive presentation Role Play
Materials	PowerPoint Presentation Participant Handouts & Role Play Supplies

Break

Session 1.3	**MISP Objective 1: Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP for SRH**
Length	1 hours
Overview	This session will provide participants with an understanding of global and national coordination mechanisms for sexual and reproductive health in emergencies.
Methodology	Interactive presentation Game
Materials	PowerPoint Presentation

Day 1 Close

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

Session 2.1	**MISP Objective 2: Prevent sexual violence & respond to the needs of survivors**
Length	5 hours (allowing participants a short break when needed)
Overview	This session will develop service providers' knowledge and skills in preventing sexual violence and responding to the needs of survivors in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Video presentation Group Work Role Play Discussion
Materials	PowerPoint Presentation Video: GBV in emergencies/ Audiovisual equipment Participant Handouts and Group Work/ Role Play Supplies

Break

Session 2.2	**MISP Objective 3: Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs**
Length	3 hours
Overview	This session will develop service providers' knowledge and skills in preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts & Group Work Supplies

Day 2 Close

Day 3: The Minimum Initial Service Package continued, Logistics and M&E

Session 3.1	**MISP Objective 4: Prevent excess maternal & newborn morbidity & mortality**
Length	2½ hours
Overview	This session will develop service providers' knowledge and skills in preventing excess maternal and newborn morbidity and mortality in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Group Work Discussion
Materials	PowerPoint Presentation Participant Handouts and Group Work Supplies

Break

Session 3.2	**MISP Objective 5: Prevent unintended pregnancies**
Length	1½ hours
Overview	This session will develop service providers' knowledge and skills in preventing unintended pregnancies in emergencies, with a focus on how the MISP for SRH addresses this serious SRH concern.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts & Group Work Supplies

Short Break

Session 3.3	**MISP Objective 6: Plan for comprehensive SRH services integrated into primary health care as soon as possible**
Length	45 minutes
Overview	This session will provide participants with an understanding of the importance of planning for comprehensive SRH services to be integrated into primary care as soon as possible, and the utility of the health systems building blocks.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts and Group Work Supplies

Break

Session 3.4	**MISP Other priority: Safe Abortion Care to the Full Extent of the Law in Emergencies**
Length	1 hour 15 minutes
Overview	This session will explore the importance of providing safe abortion care, to the full extent of the law, in humanitarian emergencies, and context-specific laws and resources. Challenges and enablers to providing safe abortion care will be considered.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts and Group Work Supplies

Short Break

Session 3.5	**Logistics & Assessment, Monitoring & Evaluation**
Length	45 minutes
Overview	This session will develop service providers' knowledge and skills in logistics, assessment, monitoring and evaluation of SRH programs in emergencies.
Methodology	Interactive presentation Group Work
Materials	PowerPoint Presentation Participant Handouts and Group Work Supplies

Break

Session 3.6	**Next steps & follow up**
Length	90 minutes
Overview	This session will allow participants to practically apply their newly developed knowledge and skills to planning for next steps in preparedness and response.
Methodology	Group Work Post-test
Materials	Participant Handouts & Group Work Supplies Post-test

Training Close

Guide for Facilitators

Day 1

Introduction to Sexual & Reproductive Health in Emergencies

Session 1.1 3 hours

Overview

This session will welcome participants to the training for service providers and provide an introduction to the importance of addressing sexual and reproductive health in emergencies. Key terminology and concepts to take forward through the remainder of the training will also be discussed and defined.

Methodology

- Pre-test
- Interactive presentation
- Video presentation
- Group work

Materials

- Pre-test
- PowerPoint Presentation
- Video: SRH in emergencies/ Audiovisual equipment
- Participant Handouts & Group Work Supplies

Slide #1: Day 1: Sexual & Reproductive Health in Emergencies

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Day 1: Sexual & Reproductive Health in Emergencies

Training for Service Providers

Welcome your participants to 'Sexual and reproductive health in emergencies: Training for Service Providers'.

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

Key Messages

- This training is one of three developed by IPPF and supported by IAWG. As well as this training for service providers, there is a workshop for policy makers and a training package for program managers. These are available to you if useful and relevant in your context.
- Sincere appreciation goes to the Australian Government for its continuous support of the SPRINT Initiative, which these manuals would not be possible without.

Note to facilitators Introduce your organization as relevant. You are also welcome to add your institution's logo on the slide deck.

Slide #2: Introductions

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Introductions

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

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

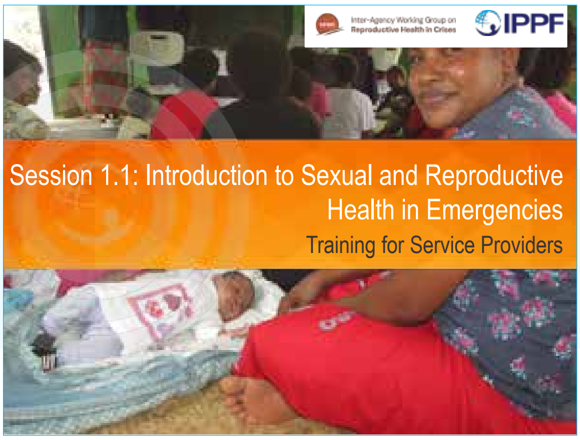
Note to facilitators Administer the pre-test when participants have finished introductions and/or the icebreaker exercise. Allow 15-20 minutes for participants to complete the test. After this time, collect tests and inform participants that you will discuss results later in the day or by tomorrow at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

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

Slide #3: Session 1.1

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

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



Session 1.1: Introduction to Sexual and Reproductive Health in Emergencies

Training for Service Providers

Slide #4: Learning Objectives

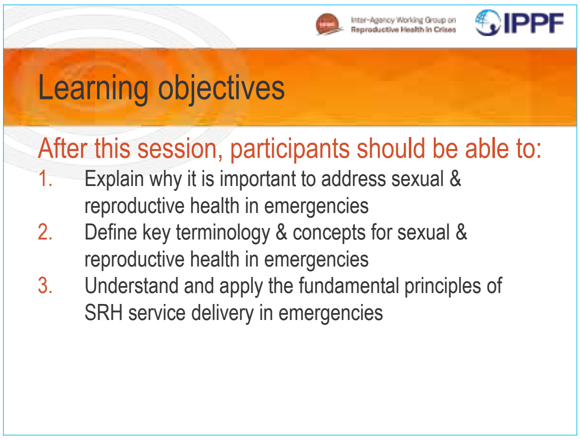
Key Messages

- There are three learning objectives for session 1.1

  1. Explain why it is important to address sexual and reproductive health in emergencies

  2. Define key terminology and concepts for sexual and reproductive health in emergencies

  3. Understand and apply the fundamental principles of SRH service delivery in emergencies



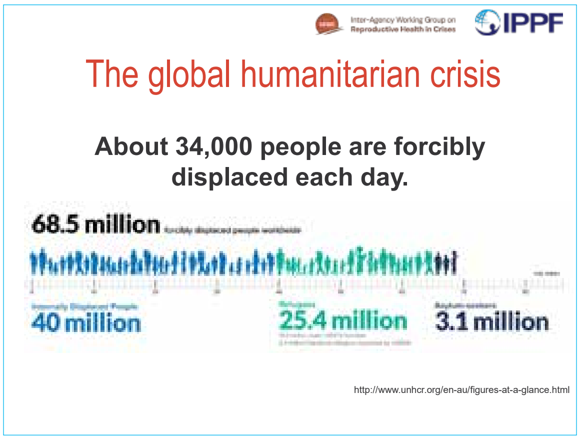
Learning objectives

After this session, participants should be able to:

1. Explain why it is important to address sexual & reproductive health in emergencies
2. Define key terminology & concepts for sexual & reproductive health in emergencies
3. Understand and apply the fundamental principles of SRH service delivery in emergencies

Slide #5: The global humanitarian crisis

Key Messages



The global humanitarian crisis

About 34,000 people are forcibly displaced each day.

http://www.unhcr.org/en-au/figures-at-a-glance.html

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

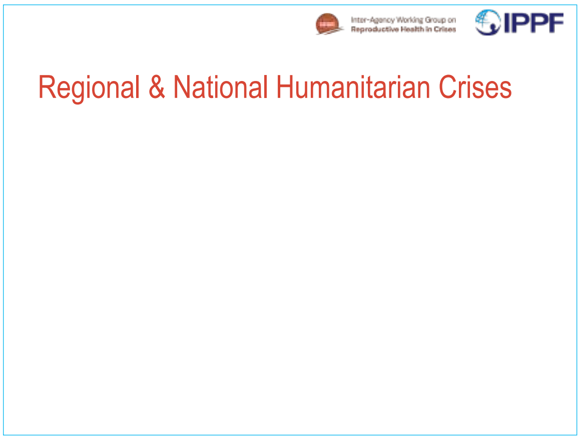
Note to facilitators Consider including information about regional, national, or setting-specific humanitarian issues.

Link For further statistics or updates, visit:

- http://www.unhcr.org/en-au/figures-at-a-glance.html
- https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/10/B-WDR-2018-EXECSUM-EN.pdf

Slide #6: Regional and national humanitarian crises

Provide information on the scope and type of humanitarian crises in your region and/ or country on this slide. It is important that your participants appreciate the scale of humanitarian crises and see that they are relevant to your context.



Regional & National Humanitarian Crises

Slide #7: Causes of the global humanitarian crisis

Key Messages

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

Causes of the global humanitarian crisis

- Natural hazards
- Climate change
- Armed conflict
- Political repression
- Complex emergencies
- Epidemics
- Famine
- Technological hazards
- Combination of the above

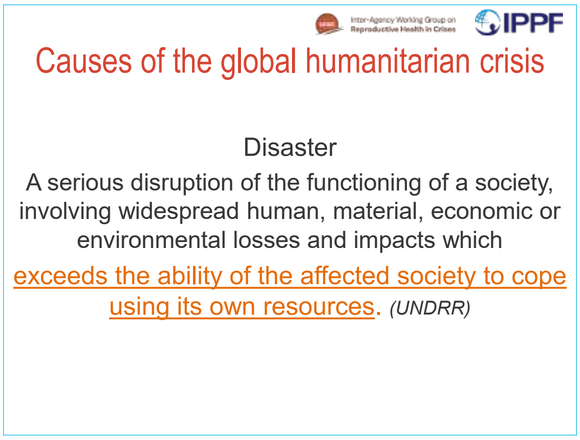
Note to facilitators Consider including information about regional, national, or setting-specific causes of humanitarian crises in your setting. You could also ask participants for their experience with various emergencies in your context.

For more information and definitions of hazards, visit:

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

Slide #8: Causes of the global humanitarian crisis

Key Messages



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Causes of the global humanitarian crisis

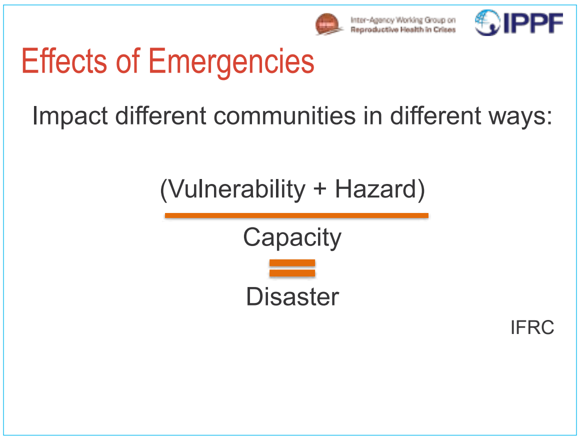
Disaster

A serious disruption of the functioning of a society, involving widespread human, material, economic or environmental losses and impacts which exceeds the ability of the affected society to cope using its own resources. *(UNDRR)*

- This definition from UNDRR will guide our understanding of disaster throughout this training.
- There are many definitions of 'disaster', 'emergency' or 'crisis'. In the context of this training when 'disaster', 'emergency' or 'crisis' is mentioned, it is the definition given on this slide that is being referred to. In this training, 'emergency' and 'crisis' are used interchangeably.

Slide #9: Effects of emergencies

Key Messages



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Effects of Emergencies

Impact different communities in different ways:

$$\frac{(\text{Vulnerability} + \text{Hazard})}{\text{Capacity}} = \text{Disaster}$$

IFRC

- Emergencies affect people in different ways. Vulnerability of the affected population, the magnitude of the hazard, and the capacity of individuals, households, communities and wider systems to cope with or resist a threat influence whether a hazard will become a disaster, and the impact that disaster may have on affected populations.
- This equation is a useful way to think about the variables which determine the real impact of hazards on an affected community. For the purposes of this training, 'disaster' refers to events arising from both natural and human induced hazards.
- Vulnerability in this context "can be defined as the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard. The concept is relative and dynamic. Vulnerability is most often associated with poverty but it can also arise when people are isolated, insecure and defenceless in the face of risk, shock or stress" (https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/).
- Hazard- refers to the triggering event and its magnitude.

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

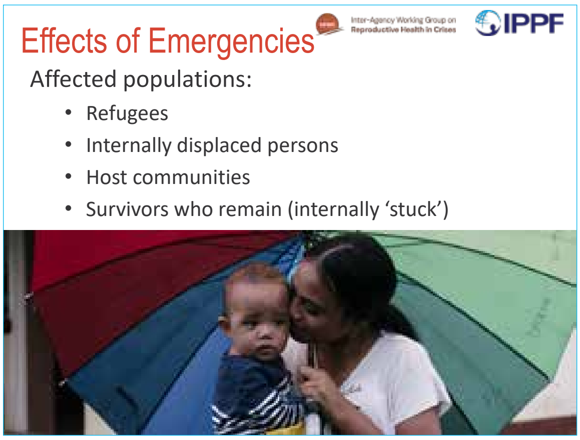
- Service providers who have the appropriate skills and experience form an important part of this capacity to address the SRH needs of people affected by crises, and thus help to reduce vulnerability.

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

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

Slide #10: Effects of emergencies

Key Messages



Effects of Emergencies

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Affected populations:

- Refugees
- Internally displaced persons
- Host communities
- Survivors who remain (internally ‘stuck’)

- Various populations are affected by emergencies:

- Refugees: people who have been forced to flee their homes by conflict or persecution. They are unwilling or unable to avail themselves of the protection of their own government and must seek protection in another country” (UNHCR).

- Internally Displaced Persons or IDPs have not crossed an international border to safety but have remained inside their home countries. Even if they have fled for similar reasons as refugees, IDPs legally remain under the protection of their own government (UNHCR).

- Host communities include populations in the region/area to which refugees or internally displaced persons flee.

- Affected populations who remain as they are unable or unwilling to leave the affected area (internally 'stuck' populations). This inability or unwillingness to leave may be due to poverty, the geographic limits of the affected area (remote, island or other areas), the scale of the hazard, insecurity or hazards in surrounding zones, and/or the continuation of some services within the affected area (such as in urban areas affected by disasters).

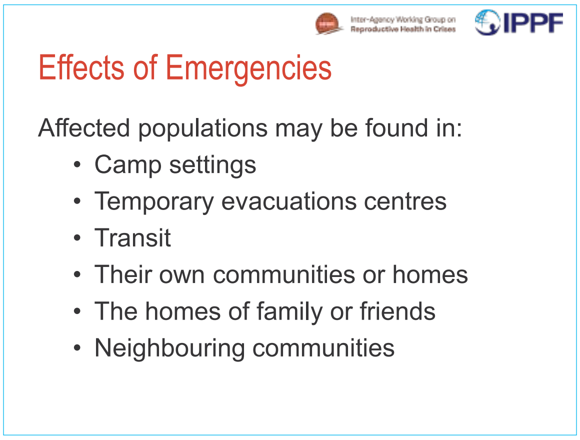
Note to facilitators For more information and definitions of affected groups, visit:

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

Slide #11: Effects of emergencies

Key Messages

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



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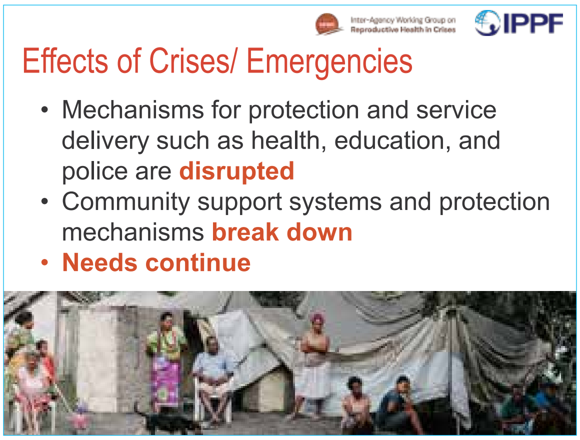
Effects of Emergencies

Affected populations may be found in:
- Camp settings
- Temporary evacuations centres
- Transit
- Their own communities or homes
- The homes of family or friends
- Neighbouring communities

Slide #12: Effects of emergencies

Key Messages

- The process of displacement results in changes to social structures and systems. For example:
  - Families and communities are separated and there may be a breakdown in societal structures, during displacement.
  - Mechanisms for protection and service delivery such as health, education, and police are disrupted.
  - Community support systems and protection mechanisms break down.



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Effects of Crises/ Emergencies
- Mechanisms for protection and service delivery such as health, education, and police are **disrupted**
- Community support systems and protection mechanisms **break down**
- **Needs continue**

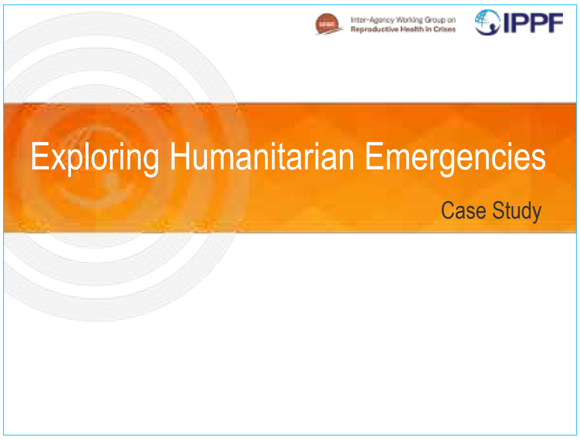
- Existing power dynamics (based, for example on age or gender) may become more prominent during a crisis and underserved groups can have less access to information and services. These may include marginalized populations who normally face barriers to accessing appropriate information and services such as people living with disabilities, ethnic minorities, LGBTQIA individuals, and others.
- The need for sexual and reproductive health information and services do not stop because of a crisis.

IPPF/Kathleen Prior

Slide #13: Exploring Humanitarian Emergencies: case study

Case Study

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

Case Study

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.

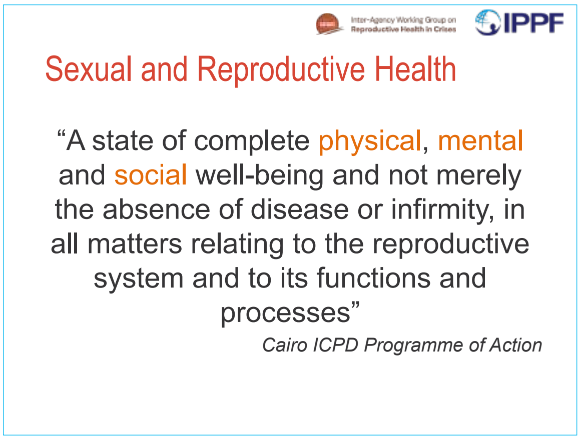
Materials

Participant Handout #1.

Slide #14: Sexual and reproductive health

Key Messages

- The definition given on this slide was created at the International Conference on Population and Development held in Cairo in 1994. Stress the holistic nature of this definition.
- This was the first time that SRH was defined as a right and a matter of choice for individuals.
- SRH is not merely the absence of disease or infirmity.
- Refugee and internally displaced persons rights, including adolescents, were explicitly recognised in the ICPD Programme of Action.



Sexual and Reproductive Health

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes"

Cairo ICPD Programme of Action

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

Slide #15: Effects of Emergencies on SRHR

Key Messages

- In humanitarian settings, it is essential to provide SRH services. Morbidity and mortality related to SRH is a significant global public health issue and those in humanitarian settings often face heightened risks and additional barriers to SRH services. Research from around the world has shown that conflict-affected and displaced populations are at increased risk of:
  - Rape and sexual violence
  - Early, child, and forced marriage
  - Human trafficking
  - Unintended pregnancy

Effects of Emergencies on SRHR

Increased risk of:

- Rape and sexual violence
- Early, child, and forced marriage
- Human Trafficking
- Unintended pregnancy
- Unsafe abortion
- Complications during pregnancy and delivery
- STI and HIV acquisition

Women and girls most affected

  - Unsafe abortion

- In any crisis-affected population, approximately 4% of the total population will be pregnant at any given time. Of these pregnant women and girls, approximately 15% will experience an obstetric complication such as obstructed or prolonged labour, pre-eclampsia/ eclampsia, infection or severe bleeding. The WHO estimates that 9% to 15% of newborns will require lifesaving emergency care (IAFM 2018). The first day of life is the highest risk for newborns.

- The lack of access to information, services and supplies combined with high population density and increased risk of sexual violence can increase risk of unintended pregnancy, unsafe abortion, and STI/HIV transmission.

- The inability to reach health facilities or skilled workers, and increased risk of malnutrition and communicable diseases during crisis can make delivery unsafe and increase risk of pregnancy complications. Indeed, when health services are disrupted or impossible to access, complications in pregnancy/childbirth can quickly become deadly.

- Crisis situations can lead to an increase in risk-taking behavior which increases risk of having unintended pregnancies and contracting STIs and HIV infection.

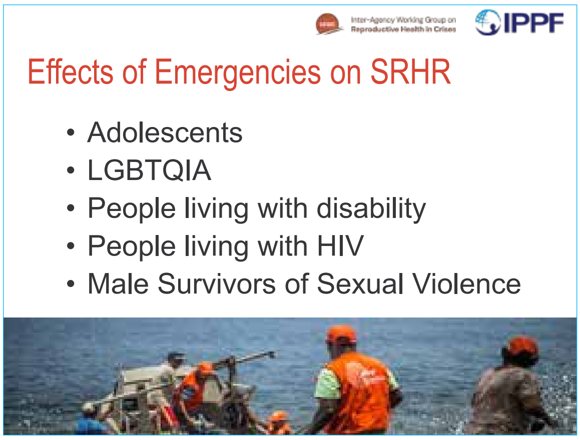
⚠ **Note to facilitators** Ask participants why they think women and girls are at particular risk in humanitarian settings and facilitate a brief discussion. For more information on this, visit:

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

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

Slide #16: Effects of Emergencies on SRHR

Key Messages



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Effects of Emergencies on SRHR

- Adolescents
- LGBTQIA
- People living with disability
- People living with HIV
- Male Survivors of Sexual Violence

- Emergencies impact people in all their diversity. It is therefore important to consider the specific SRH needs of all populations.

- Adolescents are often forgotten during humanitarian crises but are at increased risk of threats to their sexual and reproductive health during emergencies. They are also a resilient and resourceful group who should be engaged with in a meaningful way.

- LGBTQIA individuals face a variety of risks and present with divergent sexual and reproductive health needs during emergencies. It is important to engage with LGBTQIA self-help or rights groups and make sure that service provision points are respectful of diversity.

- People living with disabilities and their carers have specific, and often increased, risks and sexual and reproductive health needs during emergencies.

- Male survivors of sexual violence- Entrenched social, cultural and religious norms, including taboos around sexual orientation and masculinity, may stigmatize male survivors, evoke feelings of shame, and prevent men and adolescent boys from reporting incidents or seeking services. It is important that multisectoral services are available to all survivors (Guidelines on Integrating Gender Based Violence Interventions in Humanitarian Action https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf).

- The above groups can face discrimination- both intended and unintended- from service providers. It is therefore important to link with the populations and their representative organisations to learn how to best meet SRH needs.

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

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

Key Messages

What is the Minimum Initial Service Package (MISP)?

- A set of priority SRH activities to be implemented at the onset of a crisis
- A package including coordination, services and supplies
- Defines which SRH services are most important in saving lives
- Minimum initial response
- Sphere standards

- In response to the clear need for sexual and reproductive health services in humanitarian emergencies, the international community developed a set of minimum standards for response- the Minimum Initial Service Package or MISP for SRH.
- The MISP defines which SRH services are most life-saving, while protecting the right to life with dignity, particularly for women and girls, in humanitarian settings.
- All services should be in place within 48 hours of the onset of an emergency and progress to comprehensive SRH services within 3-6 months, or earlier.
- The services included in the MISP are based on well-documented evidence of SRH needs in humanitarian settings and World Health Organization normative standards. Thus, we do not need an in-depth needs assessment to tell us which SRH services to implement. However, some initial situational, demographic and health information is needed to optimize delivery of the MISP.
- It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. Even where other components of SRH care are available, we should ensure that the MISP services are first implemented and available to all as they are most life-saving. As soon as possible, humanitarian stakeholders should expand services towards comprehensive SRH service delivery. Planning for comprehensive SRH services is included as Objective 6 of the MISP for SRH.
- The MISP is considered a package as it outlines the services, supplies and coordination needed to implement the MISP objectives.
- The MISP for SRH is the standard within the humanitarian sector. Priority activities of the MISP are integrated into the SRH components of the health standard in the Sphere Minimum Standards in Humanitarian Response.

Note to facilitators It can be useful to write what the 'MISP' stands for on a flip chart and link each of the above points to the acronym.

In addition, make sure that participants are familiar with the Sphere Standards and Handbook.

Sphere standards help humanitarian workers determine the minimum level of quality in humanitarian aid, providing both a description of what's required, quantitative indicators to help determine if these are met, and guidance notes as to how agencies should work with communities in 4 key sectors: water and sanitation, health, food security, and shelter. The Sphere Handbook is one of the most widely known and internationally recognised sets of common principles and universal minimum standards in humanitarian response.

For more information on the Sphere Standards, refer participants to the following resource: https://www.spherestandards.org/about/

Slide #18: The MISP for SRH

Key Messages

- The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) developed the MISP as part of the Inter-Agency Field Manual and Reproductive Health in Crises (IAFM). The most recent version was released in November 2018.

- An extensive evaluation process has resulted in the 6 objectives and one additional priority activity of the MISP for SRH, as shown on this slide.

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MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH (MISP for SRH)

PREVENT MORTALITY, MORBIDITY AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

1. Ensure the health cluster identifies an organisation to lead the MISP for SRH
2. Prevent sexual violence and respond to the needs of survivors
3. Prevent and reduce morbidity and mortality due to HIV and other STIs
4. Prevent excess maternal and newborn morbidity and mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH services integrated into primary health care as soon as possible

Ensure that safe abortion care is available, to the full extent of the law, in health centres and hospitals.

Slide #19: The continuum of an emergency

Key Messages


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The continuum of an emergency

- This slide shows the continuum of an emergency. **The MISP for SRH should be implemented from DAY 1 of the crisis**. This includes planning for more comprehensive services.
- The emergency continuum may run from emergency to post-emergency phase, but it is also possible that the post-acute and rehabilitation phases may become unstable and once again become acute.
- More comprehensive SRH services should then be built on the MISP and integrated into primary health care as soon as possible (because it is a right) as we aim for durable solutions.
- Preparedness is key to ensure a timely and effective SRH response when a crisis occurs. Preparedness helps to ensure that the MISP can be implemented at the onset of a crisis.

Slide #20: Sexual and reproductive health in emergencies

Key Messages


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Sexual and Reproductive Health in Emergencies

The Inter-agency Working Group on Reproductive Health in Crises (IAWG)
- Inter-agency coalition
- Works to expand and strengthen access to sexual and reproductive health services in humanitarian crises

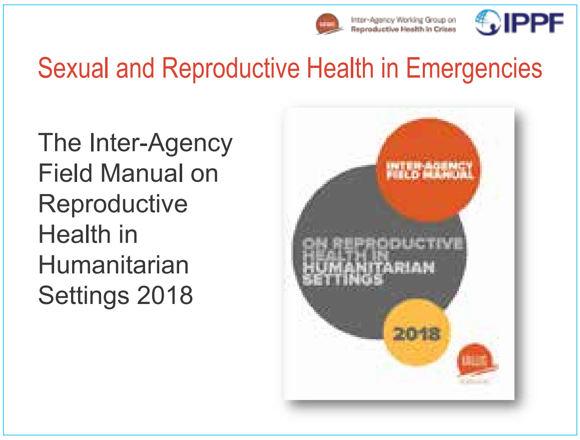
Join IAWG! http://iawg.net/

- The IAWG for RH in crisis is a broad-based, highly collaborative coalition representing United Nations, government, non-governmental, research, and donor organisations. Founded in 1995 and formerly known as the IAWG on Reproductive Health in Refugee Situations, the IAWG for RH in Crises works to expand and strengthen access to quality SRH services for people affected by conflicts, natural disasters and public health emergencies. The IAWG for RH in Crises is currently led by a 19-member Steering Committee comprising United Nations agencies and non-governmental humanitarian, development, research, and advocacy organisations. It had more than 2,800 individual members from 450 agencies in 2018.

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

Slide #21: Sexual and reproductive health in emergencies

Key Messages



Sexual and Reproductive Health in Emergencies

The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings 2018

- The MISP is contained within the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.
- This manual serves as the authoritative source for SRH programming in humanitarian settings.
- It provides much of the content of this training and will be a key reference document for your learning.
- Additional tools and resources related to MISP implementation are available on the IAWG website (www.IAWG.net) and will be references throughout the training.

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

IPPF/Kathleen Prior

Slide #22: Video: SRH in emergencies

Video Presentation

The video presentation will provide participants with important contextual information and allow an opportunity for engagement with the realities of sexual and reproductive health needs in humanitarian emergencies.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Video: SRH in emergencies

Time

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

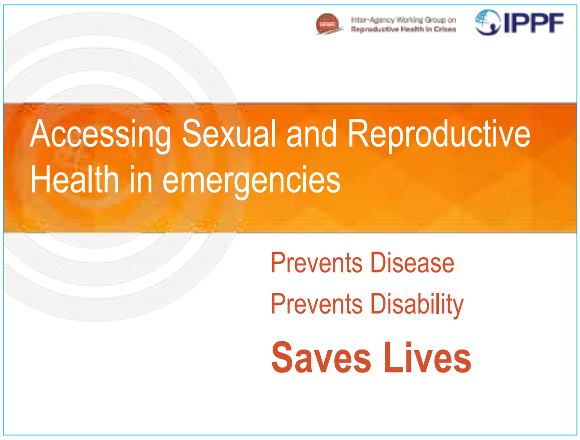
Process

- Choose a video that is most relevant to your context. The following are suggestions only. They are provided on the USB but many other options are available online.
- Project the chosen video.
- Video Discussion (optional): After showing the video, facilitate a large group discussion that addresses the following questions:
  1. What does video tell us about SRH in emergencies?
  2. What do you see as the SRH priorities at the outset of a humanitarian emergency?
  3. What do you see as the facilitators and barriers to implementing those priorities?
- As is best practice for group work, call first on a woman to respond to the questions.

Materials

- Access to chosen video and projecting equipment.
- Suggested videos (included on the USB):
  - Women & War
  - MISP in India
  - Planning Sexual & Reproductive Health before Emergencies
- IPPF Humanitarian Slideshow

Slide #23: Stories of accessing SRH in emergencies: group work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Accessing Sexual and Reproductive Health in emergencies

Prevents Disease
Prevents Disability
Saves Lives

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

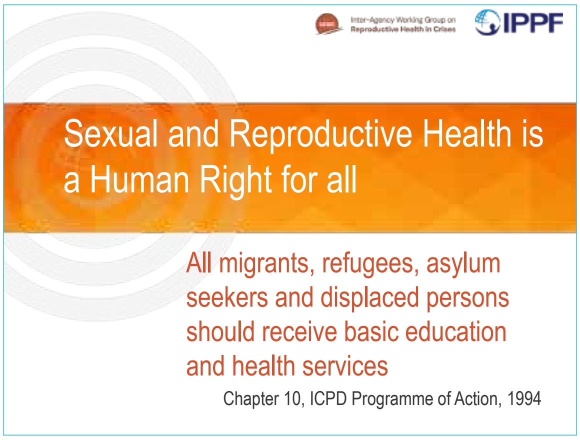
- Participant Handout #2 if using option 3 (above).

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

- Prevents disease
- Prevents disability
- Saves Lives

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

Key Messages



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Sexual and Reproductive Health is a Human Right for all

All migrants, refugees, asylum seekers and displaced persons should receive basic education and health services

Chapter 10, ICPD Programme of Action, 1994

- As well as being lifesaving, access to sexual and reproductive health is a human right and, like all other human rights, it applies to refugees, internally displaced persons, and others living in humanitarian settings.
- To realize this right, affected populations must have access to SRH information and services so they are free to make informed choices about their health and well-being.
- The global political community has made progress, especially in addressing the gravity of sexual violence in armed conflict. The United Nations Security Council Resolutions 1325, 1820, 1888, and 1889 on Women, Peace, and Security affirm the unique needs, perspectives, and contributions of women and girls in conflict settings. The Security Council has recognized sexual and reproductive health, with Resolution 1889 explicitly referencing the need to ensure women and girls' access to SRH services and reproductive rights to achieve better socioeconomic conditions in post-conflict situations. The Human Rights Council also adopted texts on maternal mortality in 2016.

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

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

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

Key Messages

Sexual & Reproductive Health is a Human Right for All

- All countries have signed up to various international protocols such as the Convention on the Rights of the Child, the Sustainable Development Goals (specifically SDGs 3 and 5), and the Sendai Framework of Action for Disaster Risk Reduction (specifically priority 3).

- Ensuring the provision of SRH services even in times of emergency is critical in order to maintain the achievements and gains made during stable time and uphold national commitments.

Slide #26: Humanitarian principles

Key Messages

Humanitarian Principles

Humanity Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings	**Neutrality** Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature
Impartiality Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.	**Independence** Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

- As just discussed, SRH is a right that should be upheld in emergencies. In addition to this, work in humanitarian contexts is guided by the humanitarian principles.

- There are four humanitarian principles which must guide all action in this field, including the work of health service providers. These are humanity, neutrality, impartiality and independence.

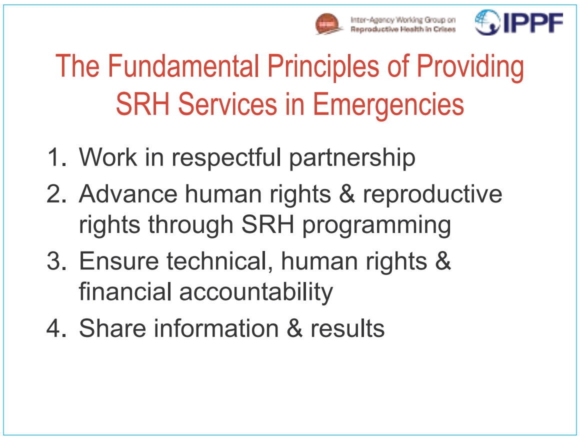
- While agencies in humanitarian work may have different roles and responsibilities, they are expected to be guided by these common humanitarian principles.

- These principles have evolved from ICRC in late 19th century and were adopted by the United Nations in General Assembly Resolutions 46/182 and 58/114, officially to guide action in all humanitarian settings. They apply to all actors working in humanitarian settings.

Note to facilitators Ask different participants to read each humanitarian principle out loud. Facilitate a brief discussion on questions/comments. Ask participants if they recognise situations in their context where these are important guiding principles.

Slide #27: The fundamental principles of providing SRH services in emergencies

Key Messages



The Fundamental Principles of Providing SRH Services in Emergencies

1. Work in respectful partnership
2. Advance human rights & reproductive rights through SRH programming
3. Ensure technical, human rights & financial accountability
4. Share information & results

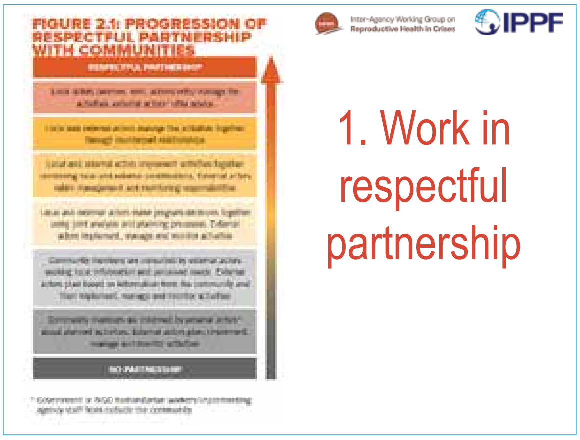
- The fundamental principles are an expression of values and practices, that should underpin service delivery in humanitarian settings. They are at once both operational and aspirational (IAFM 2018).

- The fundamental principles discussed in the session should remain with all participants and serve as an overarching framework for approaching the clinical aspects of service provision for the MISP for SRH as the training progresses.

- The fundamental principles outlined on the slide were developed through extensive consultation with stakeholders in the humanitarian and sexual and reproductive health sectors. They serve as both a guide for action and underpin the identity and purpose of the IAWG's work to prevent mortality, morbidity and disability in crisis-affected populations- the ultimate goals of the MISP for SRH.

Slide #28: Work in respectful partnership

Key Messages



1. Work in respectful partnership

- The first fundamental principle outlined in the IAFM is for all stakeholders to work in respectful partnership.

- Partnership is a respectful way of organizing working relationships that values collaboration and joint decision making over hierarchy in order to achieve a desired result, in this case, improvements in SRH coverage and quality (IAFM 2018).

- Partnerships can be between organisations, including government agencies, and local and international NGOs.

- Communities can also be a full partner in SRH programming, usually through village health committees and other service delivery organisations, groups for LGBTQIA people, supportive faith-based organisations, or other local groups (IAFM 2018).

- The figure included on the slide shows that working in respectful partnership is an intentional process and that partnerships between humanitarian agencies and local communities evolve over time (IAFM 2018).

Note to facilitators Ask participants how they feel it may be possible to work in partnership with all of these groups in humanitarian settings?

Facilitate a brief discussion, using the following points (from IAFM 2018). Write a summary of key points from the discussion on a flipchart. You can display the flipchart for the remainder of the training and remind participants of the importance of this fundamental principle throughout.

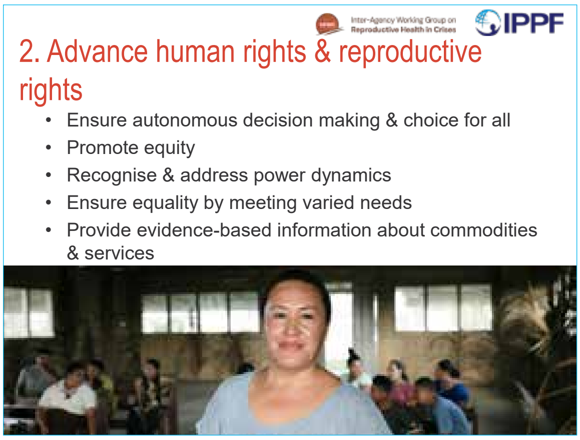
Work in respectful partnership by:

- Engaging in respectful and meaningful partnership for a diversity of perspectives from a broad group of stakeholders (including government, international and local NGOs, community-based organisations (CBOs), and community beneficiaries);
- Acknowledging that partnerships vary greatly from one type of partner to another;
- Openly discussing respective goals. Coordination will improve efficiency in communication, decision-making, response and use of resources, and viable outcomes;
- Using culturally-sensitive approaches to identify both challenges and strategic opportunities for advancing SRH.

Remind participants that they should keep the importance of working in partnership in mind as they proceed through the training. See IAFM 2018 page 12 for more information on developing respectful partnerships.

Slide #29: Advance human rights and reproductive rights

Key Messages



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2. Advance human rights & reproductive rights

- Ensure autonomous decision making & choice for all
- Promote equity
- Recognise & address power dynamics
- Ensure equality by meeting varied needs
- Provide evidence-based information about commodities & services

- International human rights are a set of global obligations that govern how states treat the people under their jurisdiction with a goal of ensuring the equal dignity, freedom, and well-being of all people. Human rights are universal; they apply to all individuals by virtue of their being human (IAFM 2018).
- Reproductive rights are a set of recognized human rights. As discussed previously, the 1994 International Conference on Population and Development (ICPD) set out a framework for the realization of reproductive rights that has since been reaffirmed.
- Service providers can help people achieve their inherent human rights and reproductive rights by reducing inequalities and organizing programs that benefit everyone. How this may be done will be addressed in session 1.2 Inclusion: Leaving No One Behind.

Note to facilitators Ask participants how they feel it may be possible to advance human rights and reproductive rights in humanitarian settings.

Facilitate a brief discussion, using the following points (from IAFM 2018). Write a summary of key point on a flipchart. Display the flipchart for the remainder of the training and remind participants of the importance of this fundamental principle throughout.

Actions to advance human and reproductive rights include:

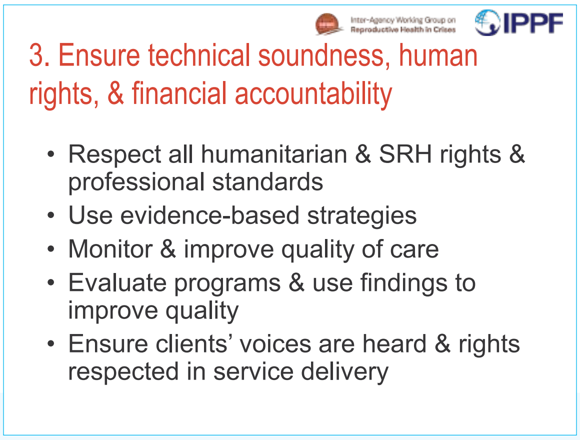
- Ensuring autonomous decision-making and choice by all clients with regard to services and commodities;
- Promoting equity with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g., rural/urban), religion, ethnic group, social group, and other characteristics;
- Recognising and addressing power dynamics and ensuring no force, coercion, discrimination, or violence/ mistreatment/ disrespect/ abuse in health services;
- Ensuring quality by meeting clients' varied SRH needs and ensuring that services are affordable or free, accessible to all, adequate given the cultural or crisis context, and of high quality;

Click to reveal these points as answers on the slide.

Slide #30: Ensure technical soundness, human rights & financial accountability

Key Messages

- Accountability is the process of holding individuals and organisations responsible for performance according to set standards and principles. In crisis settings, we must abide by humanitarian standards as well as professional medical, public health, legal and financial; accounting standards.



3. Ensure technical soundness, human rights, & financial accountability

- Respect all humanitarian & SRH rights & professional standards
- Use evidence-based strategies
- Monitor & improve quality of care
- Evaluate programs & use findings to improve quality
- Ensure clients' voices are heard & rights respected in service delivery

Note to facilitators Remind participants of the humanitarian principles discussed earlier. Reiterate their importance as a framework to guide all action in humanitarian settings.

Ask participants how they feel it may be possible to ensure technical soundness, human rights, and financial accountability in humanitarian settings.

Facilitate a brief discussion, using the following points (from IAFM 2018). Write a summary of key point on a flipchart. Display the flipchart for the remainder of the training and remind participants of the importance of this fundamental principle throughout.

Actions to ensure technical, human rights, and financial accountability include:

- Respecting all humanitarian and sexual and reproductive health and rights professional standards;
- Using evidence-based and evidence-informed strategies in designing, implementing and evaluating programs;
- Monitoring and improving the quality of care;
- Evaluating programs and using findings to improve the program;
- Ensuring clients' voices are heard and rights are respected in service delivery.

Click to reveal these points as answers on the slide.

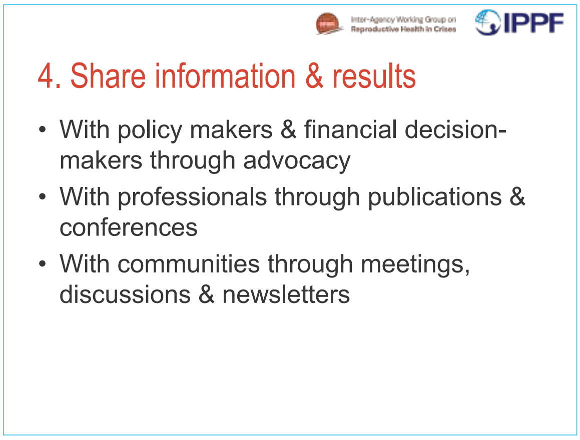
See IAFM 2018 page 13 for more information on developing respectful partnerships.

Where possible, source and present sexual and reproductive health and rights professional standards from your setting.

Slide #31: Share information & results

Key Messages

- Sharing information and results promotes ownership of programs by stakeholders and also helps other program learn from successes and failures.
- The information that is shared will vary by audience.
- Information should be shared with policy and financial decision-makers through advocacy; professionals through journal publications and conferences; and communities through meetings, discussion, and newsletters.



4. Share information & results

- With policy makers & financial decision-makers through advocacy
- With professionals through publications & conferences
- With communities through meetings, discussions & newsletters

Note to facilitators Ask participants to briefly relate any experience they have with sharing information with the varied audiences outlined on the slide.

Ask the group how they feel it may be possible to share information and results with these different groups in humanitarian settings.

Facilitate a brief discussion, using the following points (from IAFM 2018). Write a summary of key point on a flipchart. Display the flipchart for the remainder of the training and remind participants of the importance of this fundamental principle throughout.

To share information and results, DO:

- Hold community meetings to discuss results from local sites and seek their feedback (open and anonymous fora);
- Involve local health and civil authorities early and regularly in the program to promote understanding and ownership;
- Inform national and regional policymakers of summary results, successes and challenges in the program;
- Post summary results and lessons on your organisation's and other websites and social media to inform workers in other countries;
- Publish results in professional journals to inform donor, advocacy, program and research colleagues; and
- Maintain regular discussion with these groups.

Slide #32: Challenges to providing SRH services in emergencies: self care

Key Messages

- Explain that we will now briefly look at the specific challenges to providing SRH services in humanitarian settings and strategies for overcoming these challenges.

Challenges to delivering SRH services in Emergencies

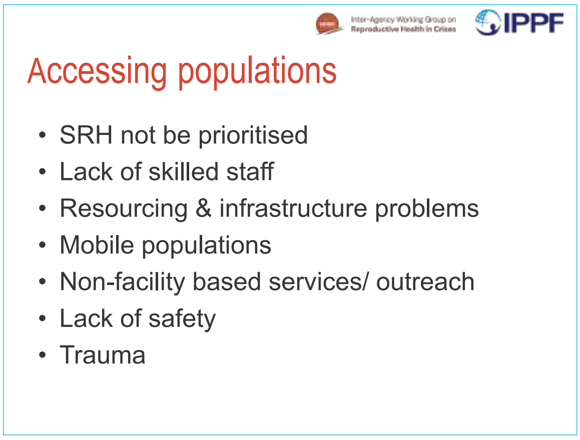
1. Accessing populations
2. Care for service providers

Note to facilitators As a group, brainstorm some of the challenges that participants have faced or believe they may face in trying to deliver SRH information and services in humanitarian contexts.

When the key issues mentioned in the following slides have been covered, allow a few minutes for participants to share stories of overcoming these challenges, or encourage participants to think strategically about how this might be done. This will be built upon in the section to follow.

Slide #33: Challenges to providing SRH services in emergencies: accessing populations

Key Messages



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Accessing populations

- SRH not be prioritised
- Lack of skilled staff
- Resourcing & infrastructure problems
- Mobile populations
- Non-facility based services/ outreach
- Lack of safety
- Trauma

- As well as the challenges to applying fundamental principles discussed above, a number of practical challenges may also arise for your service provider participants in their work for SRH in emergencies.

- Humanitarian emergencies present unique challenges for the delivery of health services. The following points can commonly affect the delivery of services:

  - SRH may not be prioritized by emergency management and health mechanisms. Acute Injury/ displacement and the rush for health resources may redirect attention to the most distracting health concerns +/- the health care provider might also be experiencing a lack of shelter WASH, etc

  - There may be a lack of skilled staff due to weak health systems before the crisis or displacement as a result of the crisis; Health care providers may also experience a lack of shelter, access to WASH and other services experienced by the general population.

  - Resourcing and infrastructure may be problematic, reducing access to health care and commodities, lack of WASH, breakdown in infrastructure (including roads and means of transportation);

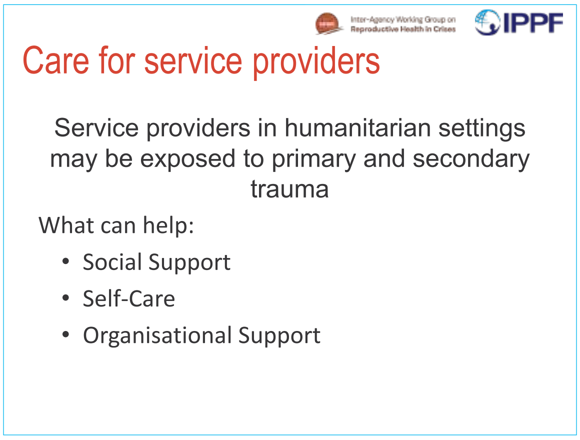
  - Populations may be mobile or in overcrowded conditions;

  - Services may need to be delivered in settings outside the health facility, in remote areas, or in a camp setting which might be in an urban area or a more rural area. Health service outreach may be a critical component of service providers work in these contexts;

  - There may be a lack of safety and security for service providers and affected populations. There may be curfews, and a lack of police and law enforcement. Breakdown or separation of family and community may also make the environment unsafe. Services will need to be delivered to people who are displaced and traumatized, possibly from a different area or different country. There are specific challenges to this.

Slide #34: Challenges to providing SRH services in emergencies: care for service providers

Key Messages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Care for service providers

Service providers in humanitarian settings may be exposed to primary and secondary trauma

What can help:

- Social Support
- Self-Care
- Organisational Support

- One important challenge to consider is that service providers working in humanitarian settings may be exposed to trauma. This may be primary trauma caused by direct dangers to workers, or secondary trauma, through exposure to the suffering of others. It is vitally important that service providers are supported to work in the challenging conditions of humanitarian settings.
- A number of protective factors have been identified as helpful. These include:
  - Social support: service providers should "stay connected to existing support networks of friends and family, and try to form support networks with peers and colleagues in the field. Connecting with people who have been through a similar experience can help provide practical assistance with solving problems or sharing coping strategies, as well as provide some comfort that [the service provider] is not alone" (Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf)
  - Self-Care: service providers may "experience some guilt at making conscious efforts to protect [their] own wellbeing in the face of such overwhelming humanitarian need. However, remember that people who look after themselves will be in a better psychological and physical condition to do what needs to be done" (Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf). Provide your participants with some of the following suggestions for self-care:
    - "Take some time each day to pause and reflect on your experiences, whether by writing in a journal, debriefing with a manager, or talking informally with a colleague. Part of sustaining yourself is about locating yourself in the work and reflecting on its impact" (Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf)
    - "Review your expectations, and focus on what is realistic to achieve within this complex environment. Try to refrain from viewing limited outputs as a direct result of your knowledge and skills. It is not the time to start questioning your abilities while you are in the field" (Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf).

  - "Know your own signs of stress and monitor your own wellbeing. Seek help if you are struggling to cope, e.g. by reaching out to a manager or colleague, accessing confidential in-field counselling sessions via your organisations, or pursuing further psychosocial counselling or support…" (Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf).

- Organisations can also help reduce the impact of trauma on their staff by (from Mandala Staff Support http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf):
  - Ensuring staff are well-briefed on what to expect in their role and working conditions;
  - Check-in with staff regarding role and workload;
  - Acknowledge efforts;
  - Managers model good self-care;
  - Enable and enforce appropriate breaks and work hours;
  - Provide confidential counselling and critical incident support.

Note to facilitators Provide participants with resources on support and self-care relevant to your context. Some possible resources may include:

- http://www.mandalastaffsupport.org/wp-content/uploads/2017/12/Humanitarian-Response-Bangladesh-Final.pdf
- https://www.antaresfoundation.org/filestore/si/1164337/1/1167964/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf?etag=4a88e3afb4f73629c068ee24d9bd30d9

Slide #35: Challenges to delivering services in emergencies

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Challenges to delivering services in emergencies

Group Work

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

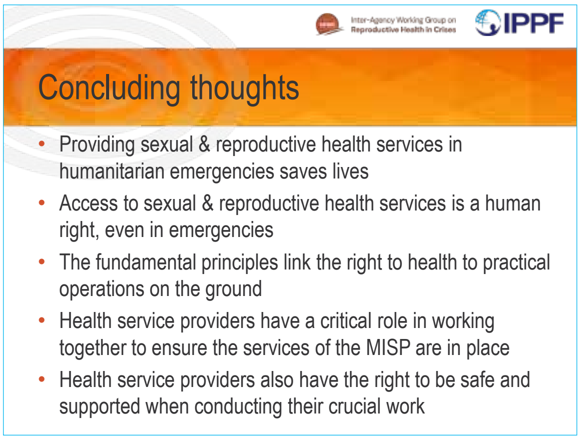
- Flexible and adaptable service delivery models are need in emergency response.
- Quality and human rights are still essential in the delivery of services during emergencies.

- It is essential to consider the well-being of staff and volunteers providing services.
- Planning for these challenges in preparedness can help facilitate more effective response

Slide #36: Concluding thoughts

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

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



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Concluding thoughts

- Providing sexual & reproductive health services in humanitarian emergencies saves lives
- Access to sexual & reproductive health services is a human right, even in emergencies
- The fundamental principles link the right to health to practical operations on the ground
- Health service providers have a critical role in working together to ensure the services of the MISP are in place
- Health service providers also have the right to be safe and supported when conducting their crucial work

IPPF/Peter Caton

Day 1 continued

Inclusion: Leaving no one behind

Session 1.2 1 ½ hours

Overview

This session will provide participants with an understanding of inclusion, intersectionality, vulnerability and capacity, and the fundamental principles for SRH programming in humanitarian settings. The frameworks discussed during this session will be applied throughout the training.

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #37: Session 1.2: Inclusion: Leaving no one behind

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

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Session 1.2: Inclusion: Leaving no one behind

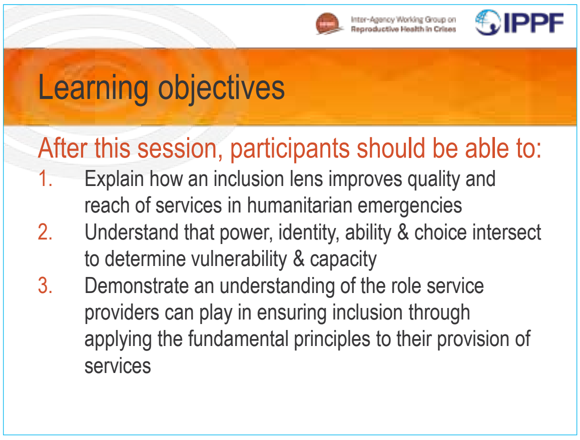
Training for Service Providers

Slide #38: Learning objectives

Key Messages

- There are three learning objectives for session 1.2:

  1. Explain how an inclusion lens improves quality and reach of services in humanitarian emergencies.
  2. Understand that power, identity, ability & choice intersect to determine both vulnerability & capacity.
  3. Demonstrate an understanding of the role service providers can play in ensuring inclusion through applying fundamental principles to their provision of services.



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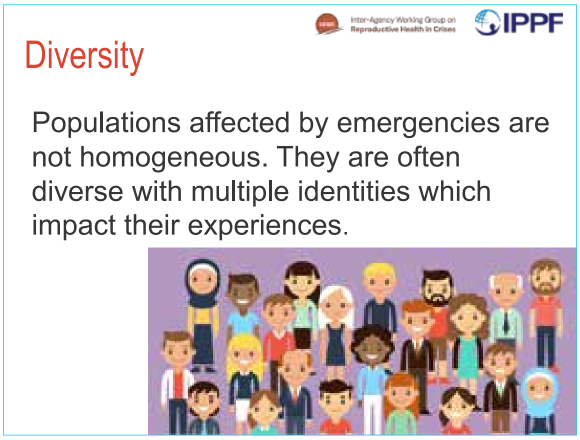
Learning objectives

After this session, participants should be able to:

1. Explain how an inclusion lens improves quality and reach of services in humanitarian emergencies
2. Understand that power, identity, ability & choice intersect to determine vulnerability & capacity
3. Demonstrate an understanding of the role service providers can play in ensuring inclusion through applying the fundamental principles to their provision of services

Slide #39: Diversity

Key Messages



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Diversity

Populations affected by emergencies are not homogeneous. They are often diverse with multiple identities which impact their experiences.

- Populations affected by crises are not homogeneous. It is vital that program managers and service providers acknowledge, understand and respect the diversity found in affected populations.

- Diversity involves any dimension that can differentiate groups and people from one another. Diversity may include consideration of such aspects as age, gender, ethnicity, religion, disability, sexual orientation, educational attainment, and country of origin.

- A full understanding of diversity helps to identify the factors that increase a person's vulnerability.

- In this session of the training, we will focus on better understanding the complexities of diversity and interactions with vulnerability in order to improve the delivery of acceptable and effective SRH services in crises. It is only through this understanding that service providers and program managers can meet needs and make the most out of the diversity in the communities they seek to serve and in the people they work with.

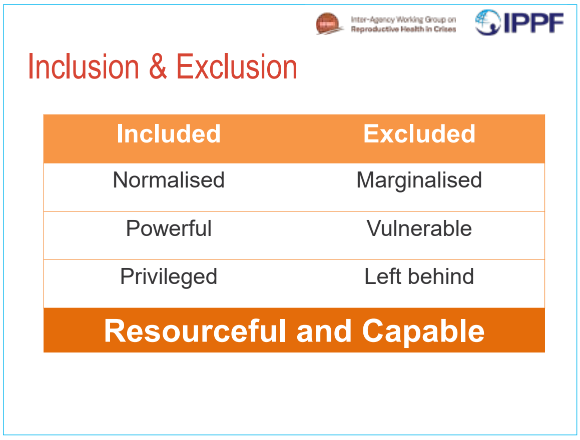
Slide #40: Inclusion & exclusion

Note to facilitators Ask participants to think about the definitions of diversity discussed above and consider who in their context fits in the left-hand column 'included', and who fits in the right-hand column 'excluded'. They can provide answers from stable or emergency settings.

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

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

Key Messages



Inclusion & Exclusion

Included	Excluded
Normalised	Marginalised
Powerful	Vulnerable
Privileged	Left behind
Resourceful and Capable	

- Remind participants that it is important to recognize and understand aspects of diversity in the populations they seek to provide services for. An important part of this is knowing who is often included and who is often excluded from accessing acceptable services, and from the processes of health decision making.

- "In every human population some people are marginalised and as a result are often 'voiceless' within their communities and more vulnerable to crises" (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook)

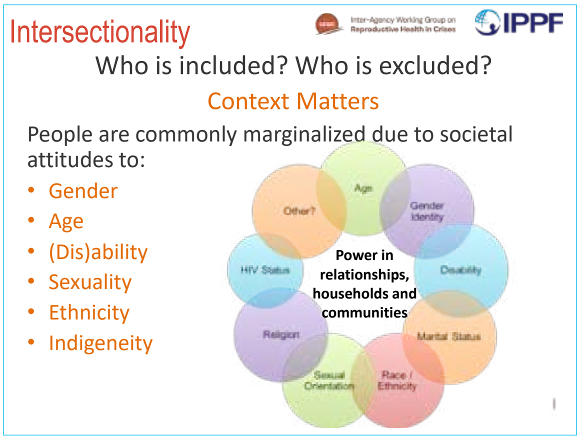
- "One of the basic principles of effective participation is the representation of affected populations and the creation of spaces for participation. Working only with existing leaders and organised groups can reinforce the marginalisation of those who are not represented in these organisations and those who are not organised" (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook).

- Marginalised and underserved groups might not be organized. Importantly, established humanitarian actors must take the time to identify such potential partnerships.

- In this session, we will look further into inclusive humanitarian programming that works to identify marginalized groups, ensure that their exclusion is not exacerbated by either the crisis or the crisis response, engage their resources, and actively contribute to the development of capacities in crises and beyond.

Slide #41: Intersectionality

Key Messages



Intersectionality

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Who is included? Who is excluded?

Context Matters

People are commonly marginalized due to societal attitudes to:

- Gender
- Age
- (Dis)ability
- Sexuality
- Ethnicity
- Indigeneity

- In every society, individuals and groups are accorded differential status and power, leading to the exclusion and marginalization of certain groups. It is now well-recognised in humanitarian contexts that certain groups of individuals may be more at risk of protection concerns than others (e.g. adolescent girls, persons with disabilities, LGBTQIA persons).

- Intersectionality refers to the fact that individual identities are made up of multiple attributes such as sex, age, gender identity, disability, race/ethnicity, religion, bodily diversity, and sexual orientation, and other factors including family structure and marital status. These **all intersect (as per the diagram on the slide)** to impact the range of resources and opportunities individuals can access, their vulnerability to risks, and their capacity to respond to protection concerns.

- It is important that service providers understand, acknowledge and respect the aspects of diversity they may engage with in their work. It is also vitally important to understand that **no one person is just one of these characteristics**.

- Service providers should also consider the diversity of their own medical teams. Diverse teams can improve accessibility of services by making communities feel more comfortable to come forward.

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

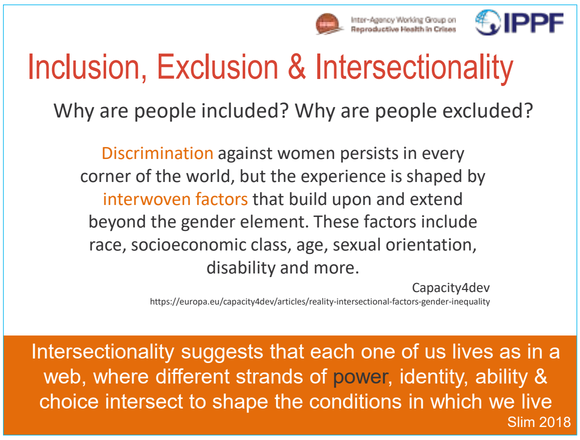
Note to facilitators Ensure that participants have a clear understanding of the key terms presented on this slide.

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

It may also be useful to provide examples to illustrate the complexity that is in all of our identities and how this connects to our vulnerabilities and capacities. An example may be the status of a married versus an unmarried adolescent in the eyes of their community, and how this determines her/ his/ their vulnerability, needs and capacities. Ask participants to revisit the fundamental principles of providing SRH services in emergencies and highlight how these support inclusion of people in all their diversity.

Slide #42: Inclusion, exclusion and intersectionality

Key Messages


Inclusion, Exclusion & Intersectionality

Why are people included? Why are people excluded?

Discrimination against women persists in every corner of the world, but the experience is shaped by interwoven factors that build upon and extend beyond the gender element. These factors include race, socioeconomic class, age, sexual orientation, disability and more.

Capacity4dev
https://europa.eu/capacity4dev/articles/reality-intersectional-factors-gender-inequality

Intersectionality suggests that each one of us lives as in a web, where different strands of power, identity, ability & choice intersect to shape the conditions in which we live
Slim 2018

- As an example, allow participants to read through the description of factors that intersect to result in discrimination against women.
- The quote focuses on discrimination against women but we have seen that discrimination happens differently to women, the intersectional approach allows us to understand which women, in all their diversity, are most vulnerable, as well as identifies their capacities.
- Intersectionality, as defined on the slide, emphasizes the complexity of human identity and power and how the many factors which make each person who they are combine and interact to contribute to their access to power and resulting opportunities.
- The inclusion/ exclusion continuum is a dynamic, multi-dimensional process resulting from unequal power relationships at individual, household and community levels, and influencing an individual’s access to resources, capabilities and rights.

Slide #43: Intersectionality


Intersectionality

Group Work

This activity will help participants understand the concept of “intersectionality” and identities and learn how different identities hold levels of power and marginalisation.

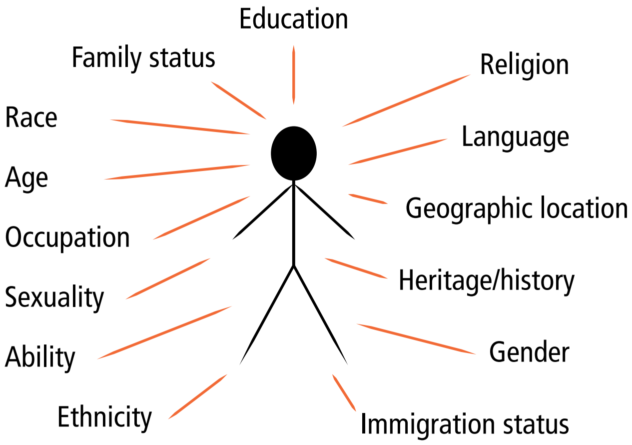
Time

25 minutes

Process

- Ask each person to take five minutes and put together a stick figure chart with 10 identities. See picture below. While they are also putting together this picture, ask them to highlight any identities that they think give them power and any that negatively affect them or have negative connotations from others (e.g. marginalization). Participants can describe the identity of someone they know in their community if they are not comfortable with sharing their own. It can help to use different colours to distinguish between identities of power and marginalisation.

- Then in groups of two ask them to take 10-15 minutes to share and discuss their identities, why they chose them and any experiences they'd like to share with their partner.



- As a group, ask each pair to share one identity that gives them power and one identity that has negatively impacted them in their life or work.

Materials

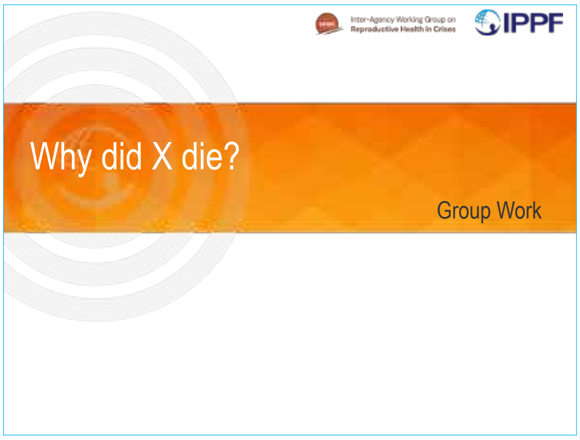
Pieces of paper and different colour pens for individuals to draw.

Key Messages

- People have multiple identities and during emergencies, these may affect their power and vulnerability.
- In different spaces, individuals may have decided to choose another identity (e.g. if they were outside of their country, they might say "national identity" or if they were among adults they might say "young".)
- It is important to be mindful that some identities might be private and individuals may not wish to share these which should be respected.

Slide #44: 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):



Why did X die?

Group Work

- 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

- **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.

- 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.

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

Materials

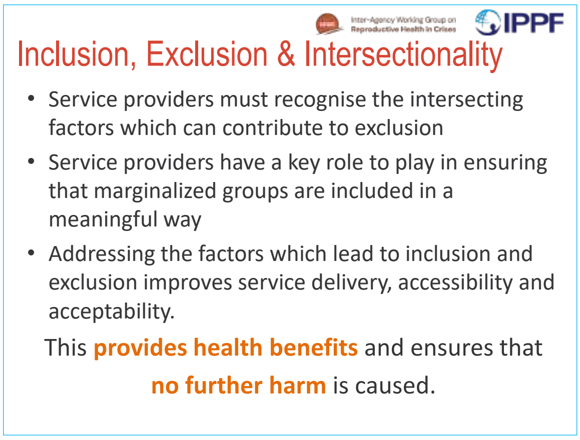
Copies of Participant Handout # 4

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

Slide #45: Inclusion, exclusion & intersectionality

Key Messages



Inclusion, Exclusion & Intersectionality

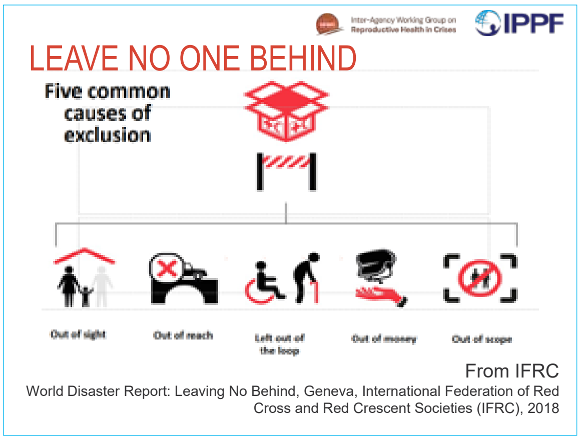
- Service providers must recognise the intersecting factors which can contribute to exclusion
- Service providers have a key role to play in ensuring that marginalized groups are included in a meaningful way
- Addressing the factors which lead to inclusion and exclusion improves service delivery, accessibility and acceptability.

This **provides health benefits** and ensures that **no further harm** is caused.

- We have seen the impact that unequal power relations can have on access to resources and opportunities for marginalized populations.
- It's also important to consider what can be done about this in humanitarian settings and in preparedness and development.
- Service providers must recognise and address the intersecting factors which can contribute to exclusion.
- Service providers have a key role to play in working with program managers to ensure that marginalized groups are included in a meaningful way at all stages of the emergency management cycle- from preparedness, to response and recovery.
- Being mindful of and addressing the factors which lead to inclusion and exclusion improves service delivery, accessibility and acceptability. This both provides health benefits and ensures that no further harm is caused.

Slide #46: Leave no one behind

Key Messages



From IFRC
World Disaster Report: Leaving No Behind, Geneva, International Federation of Red Cross and Red Crescent Societies (IFRC), 2018

- This slide from IFRC (World Disaster Report: Leaving No Behind, Geneva, International Federation of Red Cross and Red Crescent Societies (IFRC), 2018) provides a summary of the five main reasons that people are excluded (according to IFRC research) and to keep in mind when planning programs:
  - Out of sight- people who may not have the documentation needed to be registered or to access various services;
  - Out of reach- humanitarian assistance fails to reach due to limited humanitarian presence and access e.g. physical barriers around terrain, climate and lack of infrastructure;
  - Left out of the loop- older people and people with disabilities are often not getting the assistance they need in crisis contexts;

  - Out of money- underfunded emergencies both rapid and slow onset crises as well as chronic complex emergencies; and
  - Out of scope- people that are often not considered the concern of the humanitarian community, and rarely feature in humanitarian appeals e.g. irregular migrants.
- Service providers have an important role in ensuring that all people, particularly marginalised individuals, are not out of sight, out of reach, or left out of the loop.

Slide #47: Fundamental principles

Key Messages

- An important way to ensure that we leave no one behind when providing SRH services in humanitarian settings is by following the fundamental principles outlined earlier today.
- These are further elaborated on the reverse of the MISP for SRH Cheat Sheet.

Fundamental Principles

1. Work in respectful partnership
2. Advance human rights & reproductive rights through SRH programming
3. Ensure technical, human rights & financial accountability
4. Share information & results

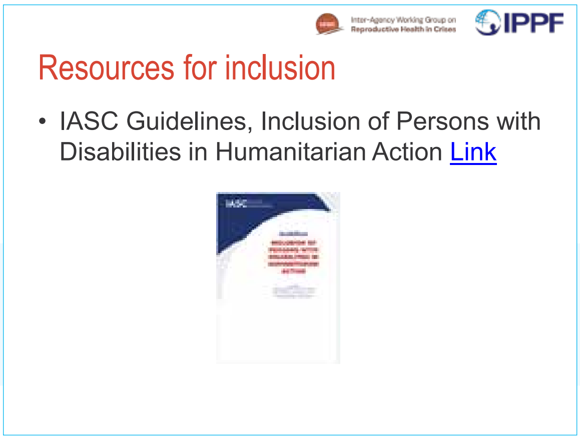
Note to facilitators Ask participants to look through the Fundamental Principles outlined on the reverse of the MISP for SRH Cheat Sheet. Allow a few minutes to read through these and remind participants that these were covered in the first session of day 1. Facilitate a brief discussion with participants about what they can do in their roles as service providers to not leave anyone behind.

Ask for training participants with experience in providing health services (SRH and/or broader) in humanitarian settings to provide examples of their work towards inclusion if possible.

Slide #48: Resources

This slide contains a list of resources your participants can engage with to increase their understanding of inclusion, intersectionality and fundamental principles in humanitarian settings.

Note to facilitators Add to this slide with context-specific resources as able.



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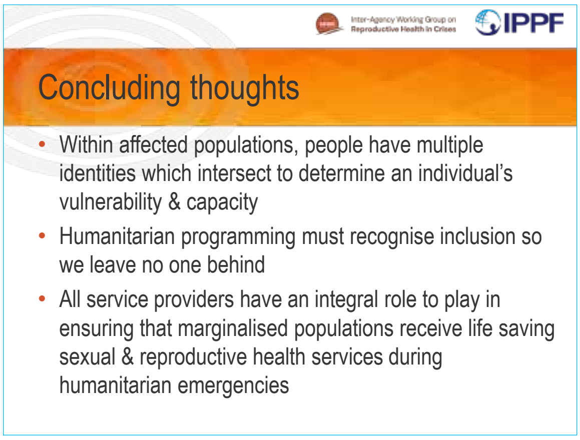
Resources for inclusion

- IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action Link

Slide #49: Concluding thoughts

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

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



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Concluding thoughts

- Within affected populations, people have multiple identities which intersect to determine an individual's vulnerability & capacity
- Humanitarian programming must recognise inclusion so we leave no one behind
- All service providers have an integral role to play in ensuring that marginalised populations receive life saving sexual & reproductive health services during humanitarian emergencies

Day 1 Session 1.2 continued

Adolescent Sexual & Reproductive Health & Rights in Emergencies

Session 1.2 continued 1 hours

Overview

This session will require participants to consider the particular needs and strengths of adolescents in humanitarian settings. The role of service providers in ensuring that services are responsive to adolescents' diverse needs will also be discussed.

Methodology

- Interactive presentation
- Role play

Materials

- PowerPoint Presentation
- Participant Handouts
- Role Play Supplies

Slide #50: Adolescent SRHR

Key Messages

- For the rest of this session we will focus on the specific needs of one marginalized community- adolescents, who often make up a significant portion of affected populations.

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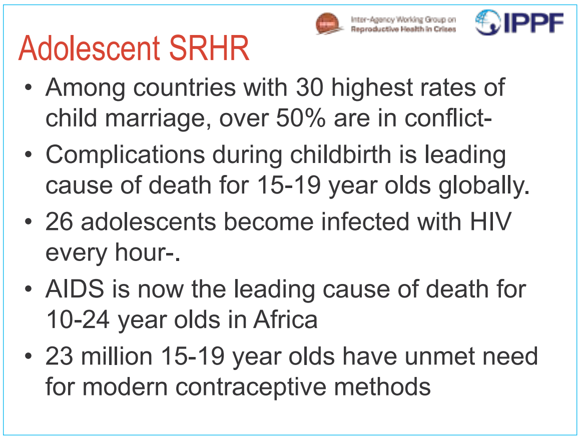
Adolescent Sexual & Reproductive Health & Rights in Emergencies

Slide #51: Adolescent SRHR

Key Messages

- As seen in the statistics represented on this slide, adolescents are in need of sexual and reproductive health services:
  - Dire health consequences are associated with early marriage and early child bearing. Complications during childbirth is the leading cause of death for 15-19 year olds globally.
  - AIDS is now the leading cause of death among young people aged 10-24 years in Africa (AVERT 2018).
  - Unmet need for family planning is highest amongst 15-19 year olds (UNFPA 2012)
  - As with any population, SRH needs do not stop for adolescents in emergency situations. Despite this, these needs are being neglected in humanitarian programming. From 2009-2012 proposals for ASRH through humanitarian funding streams constituted less than 3.5% or all health proposals. Most were unfunded.
  - Adolescent SRH care in emergencies is not just needed, it is a right. The SRH of young people is protected by international law.



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Adolescent SRHR

- Among countries with 30 highest rates of child marriage, over 50% are in conflict-
- Complications during childbirth is leading cause of death for 15-19 year olds globally.
- 26 adolescents become infected with HIV every hour-.
- AIDS is now the leading cause of death for 10-24 year olds in Africa
- 23 million 15-19 year olds have unmet need for modern contraceptive methods

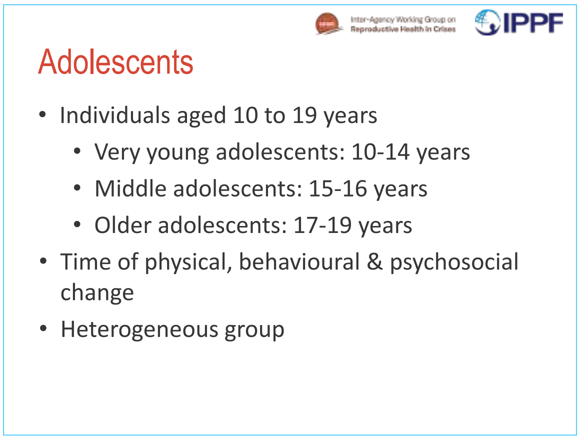
Slide #52: Regional and national context

This slide has been left blank for you to provide regional and/or national information on adolescent sexual and reproductive health and rights. It is important for your participants to have a good understanding of the state of ASRHR in your region and/or country.

Regional and national context

Slide #53: Adolescent SRH

Key Messages



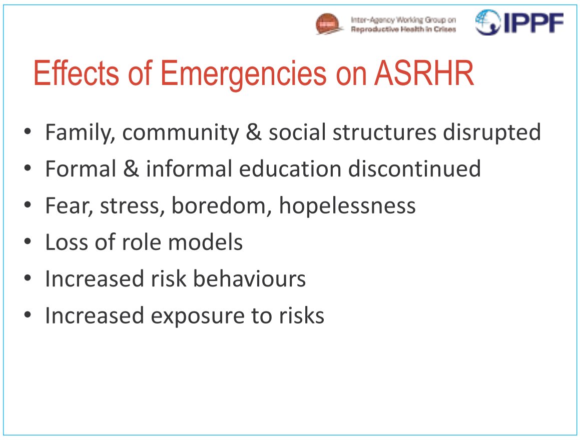
Adolescents

- Individuals aged 10 to 19 years
  - Very young adolescents: 10-14 years
  - Middle adolescents: 15-16 years
  - Older adolescents: 17-19 years
- Time of physical, behavioural & psychosocial change
- Heterogeneous group

- Definitions of the different stages of adolescents include very young, middle and older girls and boys.
- Adolescence is a period of biological, physical, and cognitive changes and is accompanied by unique sexual and reproductive health (SRH) needs.
- Adolescents are not a heterogeneous group. It is important for program managers and service providers to recognize that adolescents' "needs vary by age, sex, education, marital status, local and cultural context, gender, gender identity, bodily identity, sexual orientation, and disability status" (IAFM 2018).
- "Sub-groups have unique needs and risks. Design and implementation of all programming, including provision of health services and behavior change communication strategies, should be tailored to their specific needs and be age and sex appropriate" (IAFM 2018). It may not be feasible to identify the unique needs of sub-groups of adolescents and work with them in the timeframe of the MISP for SRH. However, it is important to do so as soon as possible and ensure this approach is taken in comprehensive SRH programming.
- It is important for program managers and service providers to collect sex and age disaggregated data to best represent the needs and demands of adolescent sub-groups.

Slide #54: Effects of emergencies on adolescent SRH

Key Messages


Effects of Emergencies on ASRHR

- Family, community & social structures disrupted
- Formal & informal education discontinued
- Fear, stress, boredom, hopelessness
- Loss of role models
- Increased risk behaviours
- Increased exposure to risks

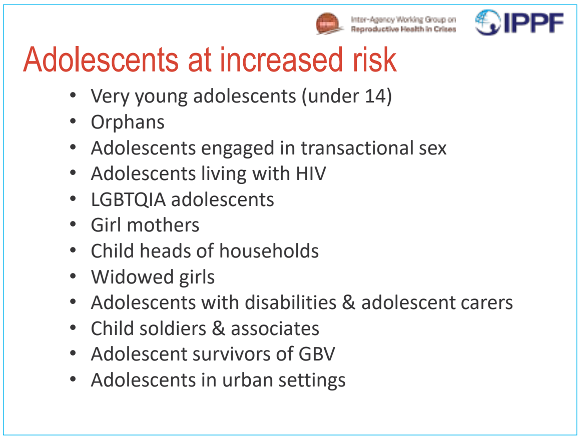
- "Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse, and exploitation. These factors can disrupt protective family and social structures, peer networks, schools, and religious institutions and can greatly affect the ability of adolescents to protect themselves and practice safe SRH behaviors. Their new environment can be violent, stressful, and/or unhealthy. Adolescents (especially adolescent girls) who live in crisis settings are highly vulnerable to sexual coercion, exploitation, and violence, and may engage in high-risk or transactional sex for survival" (IAFM 2018).

- "At a critical and vulnerable time of life, crisis may dramatically shift the individual's view on life. It may lead to increased risk-taking, such as violence, substance use, and/or unsafe sexual activity" (IAFM 2018).

Note to facilitators For more detail on the increased risks to adolescents in emergencies, see IAFM 2018 Chapter 6: Adolescent Sexual & Reproductive Health.

Slide #55: Adolescents at increased risk

Key Messages


Adolescents at increased risk

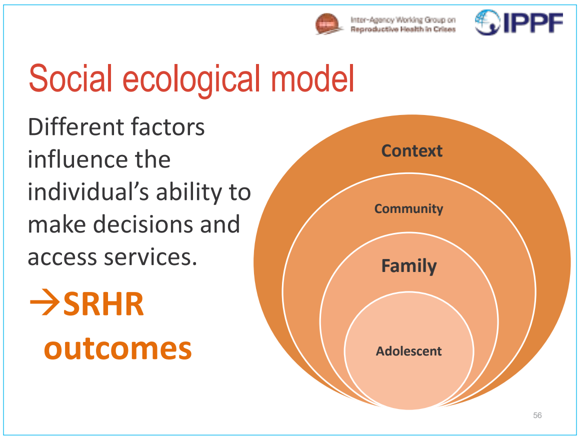
- Very young adolescents (under 14)
- Orphans
- Adolescents engaged in transactional sex
- Adolescents living with HIV
- LGBTQIA adolescents
- Girl mothers
- Child heads of households
- Widowed girls
- Adolescents with disabilities & adolescent carers
- Child soldiers & associates
- Adolescent survivors of GBV
- Adolescents in urban settings

- Service providers should consider the needs of especially vulnerable adolescents.

- Especially vulnerable adolescents including LGBTQIA individuals, young people living with HIV, orphans, separated/unaccompanied young people, survivors of SV, former child soldiers, adolescents heading households, adolescents with disabilities, pregnant adolescents and adolescent mothers, and young girls who are at increased risk of sexual exploitation.

Slide #56: Social ecological model

Key Messages



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Social ecological model

Different factors influence the individual's ability to make decisions and access services.

→SRHR outcomes

56

- Adolescents are surrounded by important influences and it is critical to acknowledge and work with these in order to create an environment which enables and supports access to SRH information and services.

- The social ecological model shown on this slide illustrates the ecosystem in which adolescents are situated. There are different factors that can hinder or enable young people's sexual and reproductive health. For example, the adolescent's immediate surroundings (parents, siblings, peers etc.), may be supportive of the adolescent accessing SRH services, but the adolescent may be very shy. Or the adolescent may want to seek help but there may be no services available for them to access. The combination of all of these factors will contribute to the SRH outcomes of the adolescent (adapted from: ASRHR in Humanitarian Settings https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf).

- Individual factors, family factors, community factors and contextual factors all have a role to play. For example, school-based comprehensive sexuality education promotes positive development; it is possible to work with parents to promote positive, stable emotional connections with their adolescent children; and community initiatives can reduce early marriages and support youth to seek for health services.

- There are promising approaches to build protective factors and address risk factors at all of these levels. For example, at the individual level by building individual assets; at the relational level by working with parents and peers; at the community level by challenging and changing community norms; and at the societal level by formulating and applying enabling laws and policies, and increasing investment.

- It is important that these promising approaches are adapted to the realities of different contexts, using a multilevel approach.

Slide #57: Adolescent-friendly services

Key Messages

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Adolescent-friendly Services

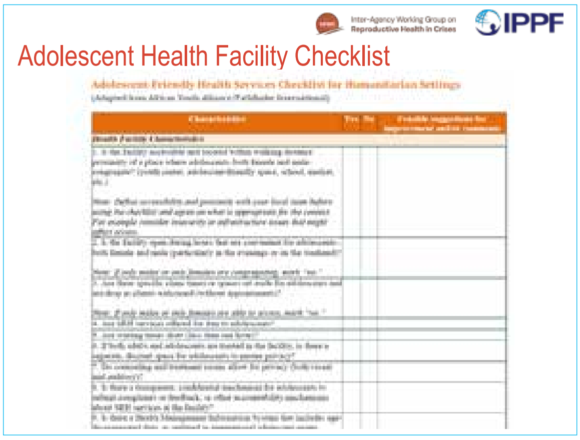
- Adolescents face barriers to accessing SRH information & services:
  - Individual Barriers
  - Socio-cultural Barriers
  - Structural Barriers
- ASRH services must be:
  - Acceptable
  - Accessible
  - Affordable
  - Appropriate
  - Equitable
  - Effective
  - Efficient

- Adolescents face a number of barriers to accessing SRH information and services, even in stable settings. Some of these barriers include lack of knowledge about SRH issues, lack of information about available services and where they are located, insecurity, limits to freedom of movement, physical barriers, cultural norms, lack of privacy and confidentiality, and a lack of same-sex SRH healthcare providers.
- It is also important to remember that these barriers will differ for different groups of adolescents and from culture to culture.
- To overcome these barriers, program managers should work to ensure that adolescent SRH services are acceptable, accessible, affordable, appropriate, equitable, effective and efficient.

Slide #58: Adolescent Health Facility Checklist

Note to facilitators Provide participants with a copy of the Adolescent Health Facility Checklist for them to refer to during your presentation of this slide. See Participant Handout #18 in Program Managers Manual.

Key Messages



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Adolescent Health Facility Checklist

- One of the main ASRH facility tools we have is the Adolescent Health Facility Checklist (currently being updated).
- This tool is used to assess how responsive the clinic or facility is in meeting the SRH needs of adolescents.
- There are three main sections of this checklist: the characteristics of the health facility, the characteristics of the service provider, and the characteristics of the programs/services provided at the health facility.

- The supervisor/manager will fill out the checklist and check yes or no for each question. There is space for providing comments, as some questions are difficult to provide an easy yes or no response. This space is also useful for writing recommendations or next steps in response to the observation.

- Some of the examples of responsive SRH services or activities that programs can implement and track using this checklist include:

    - Involve adolescents in program design & implementation

    - Hire youth in community health programs

    - Meaningful participation of adolescents in design and implementation of the health services.

    - Engage adolescents in supervision activities of health services

    - Strengthen referrals between the facility and other adolescent services that might be available in the area (schools, youth centers, girl friendly spaces, child friendly spaces, etc.)

⚠ **Note to facilitators** Now that participants have been given a chance to look through the checklist and listen to your explanation, highlight the important role for them, as service providers, in ensuring that their services are acceptable and accessible for adolescents. Facilitate a discussion using the following questions:

- Are there any questions on the checklist that you find confusing?

- Are there questions you would add?

- How could you use this information?

- Is there anything you could do in preparedness to support adolescent friendly facilities?

Slide #59: Adolescent SRH in humanitarian emergencies: role play

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Adolescent SRHR in Humanitarian Emergencies

Role Play

(Adapted from: The IAWG ASRHiE training package for frontline workers (draft).

This activity will allow participants to see the barriers experienced by adolescents when seeking SRH services and discuss elements of providing adolescent-friendly and inclusive services.

Time

30 minutes

Process

- Ask for two volunteers from the group. Take the volunteers aside and separately explain to one volunteer that s/he will play the role of the health provider and the other will play the role of an adolescent. Have them read the following scenario to themselves:

  A scared, pregnant adolescent girl is seeking information on where to find contraception and is unsure which method they prefer to use. The service provider asks many personal questions, such as is the adolescent married, why are they seeking contraception now, and do their parents know that they are here. The service provider explains only a few contraceptive options—pill and condoms—and uses judgmental words when talking to the adolescent about contraception, such as telling them that they should not be engaging in sex until they are married.

- Have the two volunteers act out the scenario and instruct the rest of the participants to observe the role-play as they will provide feedback after the session. Let the volunteers role-play for about 10 minutes (or sooner if they finish earlier).

- For the next 20 minutes, facilitate a discussion about the exercise. Here are some prompts you can use for the discussion:

  - What are some positive attributes of the counselor?

  - What did you observe of the adolescent? Is this true of young patients that come seeking SRH services?

  - Ask the person playing the role of the adolescent, what made them feel comfortable or uncomfortable about the session?

  - Ask the person playing the role of the service provider, how did the counseling make them feel? Would they have changed their counseling?

Materials

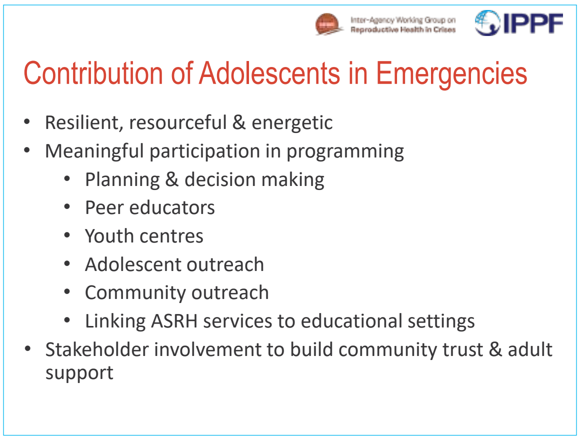
A copy of the scenario for both role players

Key messages

- Ensure privacy and confidentiality (auditory & visual)
- Allocate more time than usual
- Be respectful of the client's choices, culture, religion, and sexuality
- Listen actively and show interest
- Be attentive to the client's questions and specific needs
- Use clear language the client can understand
- Avoid one-way communication and ask open-ended questions
- Avoid judgmental attitudes and behaviors—don't lecture, scold, or tell the adolescent what he/she should do
- Provide unbiased, evidence-based information/resources to ensure the adolescent has the full choice of all available methods

Slide #60: Contribution of adolescents in emergencies

Key Messages



Contribution of Adolescents in Emergencies

- Resilient, resourceful & energetic
- Meaningful participation in programming
  - Planning & decision making
  - Peer educators
  - Youth centres
  - Adolescent outreach
  - Community outreach
  - Linking ASRH services to educational settings
- Stakeholder involvement to build community trust & adult support

- Adolescents can play an important role in response. For example, they can serve as first responders in emergencies through activities such as assisting health providers as volunteers and community-based distributers. They can expand access to quality SRH services for the wider community as well as for their peers at the community level, support referral services from other sectors to health.
- For this to happen, program managers must work to meaningfully engage with adolescents before, during and after emergencies.
- "Understanding the cultural context and creating a supportive environment is critical to advancing SRH services for adolescents, as they may be affected by community values regarding ASRH…Community members, including parents, guardians, teachers, health care providers, and religious leaders, must be consulted and involved in developing programs with and for adolescents" (IAFM 2018 page 113).

Note to facilitators A number of stories and videos of adolescents contributing to ASRH programs during humanitarian response are available online. If time permits and you feel it is appropriate, source one of these stories or videos and present it to your participants here.

As an example, a short video which shows the contribution of youth volunteers in Indonesia can be found at: https://www.youtube.com/watch?v=aZKSRZCh1Us

Other useful resources include CARE's Community Scorecard for ensuring adolescent-friendly services (an example of which can be found in the IAFM in relation to CARE's work in Democratic Republic of Congo: IAFM 2018 page 111).

Slide #61: Things to keep in mind when engaging adolescents

Key Messages

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Things to keep in mind when Engaging Adolescents

1. Policy for engaging volunteers under the age of 18
2. Orientation to your agency's ways of working
3. Clear selection criteria for adolescent and youth volunteers
4. Communication terms of engagement of adolescent and youth volunteers
5. **What else?**

https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf

Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings

- The *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* is a useful resource and contains information and guidance on engaging with adolescents and things to consider in humanitarian response (Some of these are mentioned on the slide). It is designed to accompany the IAFM and contains a number of useful tools to encourage meaningful adolescent participation.

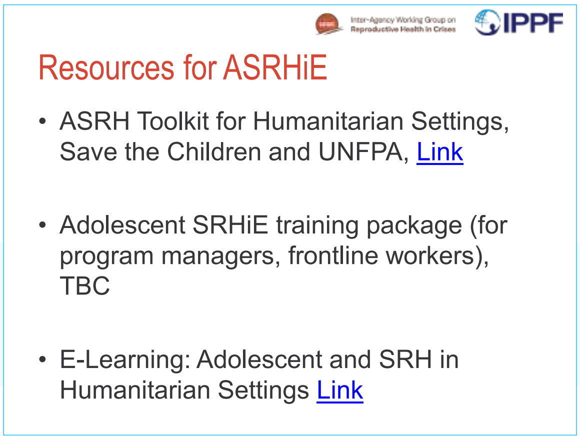
Note to facilitators For more details on what to consider when working with adolescents see the: Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings available at: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf.

Please note that the toolkit was in the process of being updated at the time of writing this manual. Check for an updated version before facilitating the training.

Slide #62: Resources

This slide contains a list of resources your participants can engage with to increase their knowledge and skills in adolescent sexual and reproductive health and rights in humanitarian settings.

Note to facilitators Add to this slide with context-specific resources as able.



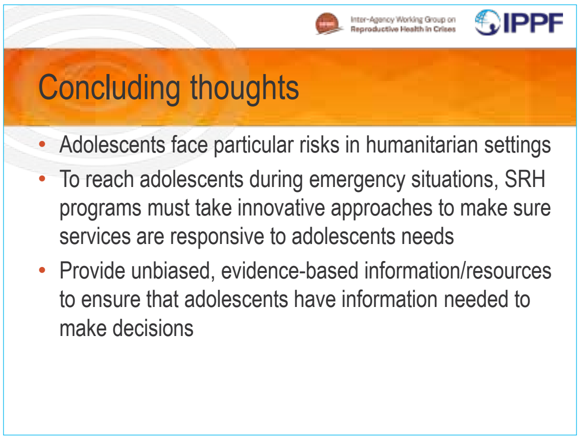
Resources for ASRHiE

- ASRH Toolkit for Humanitarian Settings, Save the Children and UNFPA, Link
- Adolescent SRHiE training package (for program managers, frontline workers), TBC
- E-Learning: Adolescent and SRH in Humanitarian Settings Link

Slide #63: Concluding thoughts

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

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



Concluding thoughts

- Adolescents face particular risks in humanitarian settings
- To reach adolescents during emergency situations, SRH programs must take innovative approaches to make sure services are responsive to adolescents needs
- Provide unbiased, evidence-based information/resources to ensure that adolescents have information needed to make decisions

Day 1 continued

MISP Objective 1: Ensure the health sector/ cluster identifies an organization to lead implementation of the MISP

Session 1.3 1 hour

Overview

This session will provide participants with an understanding of global and national coordination mechanisms for sexual and reproductive health in emergencies.

Methodology

- Interactive presentation
- Game

Materials

- PowerPoint Presentation

Slide #64: Section 1.3: MISP Objective 1: Ensure the Health Sector/ Cluster Identifies an Organization to Lead Implementation of the MISP

Welcome your participants back from their break and explain that you will now move on to the objectives of the MISP for SRH. You will begin with MISP Objective 1: Ensure the health sector/ cluster identifies an organization to lead implementation of the MISP.

Session 1.3: MISP Objective 1: Ensure the Health Sector/ Cluster Identifies an Organisation to Lead Implementation of the MISP

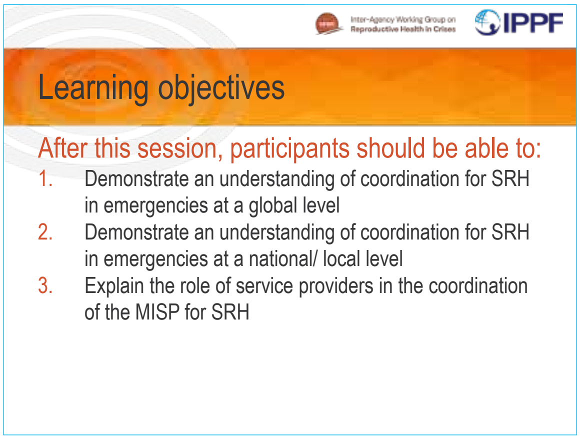
Training for Service Providers

Slide #65: Learning objectives

Key Messages

- There are three learning objectives for session 1.3:

  1. Demonstrate an understanding of coordination for SRH in emergencies at a global level
  2. Demonstrate an understanding of coordination for SRH in emergencies at a national/ local level
  3. Explain the role of service providers in the coordination of the MISP for SRH



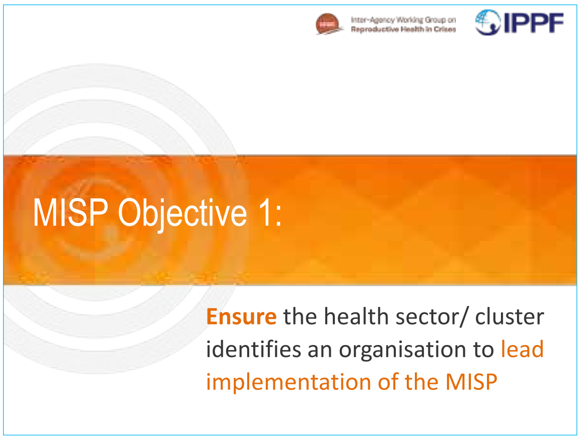
Learning objectives

After this session, participants should be able to:

1. Demonstrate an understanding of coordination for SRH in emergencies at a global level
2. Demonstrate an understanding of coordination for SRH in emergencies at a national/ local level
3. Explain the role of service providers in the coordination of the MISP for SRH

Slide #66: MISP Objective 1

Key Messages



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MISP Objective 1:

Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP

- The first objective of the MISP for SRH is to ensure that the health sector/ cluster identifies an organisation to lead implementation of the MISP.
- This is critical to ensure that the life-saving components of the MISP for SRH are made available to all people affected by humanitarian emergencies.
- Service providers should have a working understanding of the various coordination mechanisms which are in place to support their work, and be able to recognize gaps and advocate for the inclusion of SRH as necessary.

Slide #67: The importance of effective coordination: game

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The Importance of Effective Coordination

Game

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

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

Time Restrict this activity to 10 minutes.

Example of a possible coordination game:

Process

- Give each participant a number. Ask them to write this number on two papers (pad size)
- Participants are asked to scrunch their papers into two balls
- Request participants to stand in a circle
- Place an empty box in the center of the circle made by participants
- Ask the participants to place/throw one ball with their number in the box

- Now play music for 15 seconds or the facilitator should count 1-15, and ask all participants to find the paper ball containing their number within 15 sec.
- Give them one – two minutes and count how many participants were successful in finding their own ball.
- Now repeat all of the above and ask participants to place their second paper ball in the empty box. This time, instruct them to help each other in finding their right numbers. Again, count the participants who can get the paper ball with their number back.

Materials

Box; paper and pens

Key Messages

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

We do, however, encourage you to use an activity you are familiar with, and which is culturally applicable and acceptable.

Slide #68: Coordination improves

Key Messages

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Coordination improves

- Efficiency
- Effectiveness
- Speed of response
- Strategic decision making
- Problem solving

- The ‘soft skills’ of coordination are vital for successful implementation of the MISP for SRH.
- Coordination of reproductive health within the health sector/cluster and with other relevant sectors/clusters can improve efficiency, effectiveness and speed of response, enable strategic decision-making and problem solving and help avoid gaps and duplication in services.
- Coordination will help to deliver a standard package of life-saving SRH services throughout an area, making good quality SRH care accessible to all.
- Coordination can generate a multiplier effect that results in expanded coverage and efficient use of resources and can compensate for any single agency’s limited expertise, staff, resources or range of activities.

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

Slide #69: Effective coordination involves

Key Messages

Effective Coordination involves

- Clear roles & responsibilities
- Information management & sharing
- Trust
- Communication
- At and between all levels

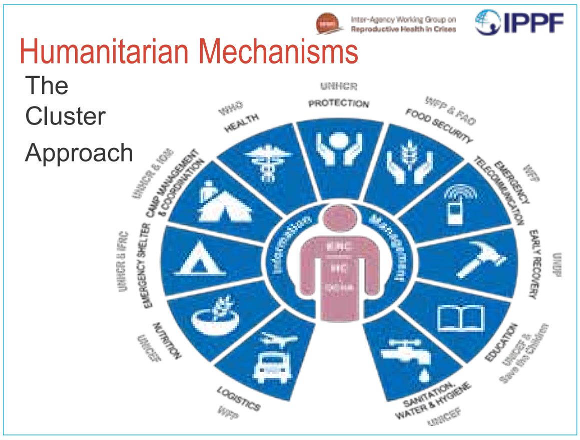
Common goals & purpose:

No organisation can implement the MISP alone

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

Slide #70: Global coordination mechanisms

Key Messages



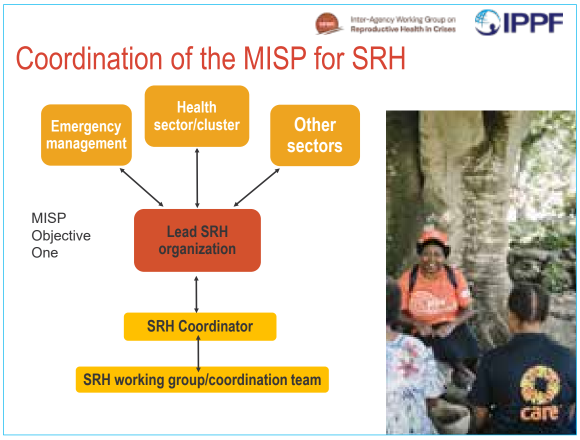
Humanitarian Mechanisms

The Cluster Approach

- As part of Humanitarian Reform in 2005, the "Cluster System" was established to ensure coordination per sector-area (i.e. there is a health cluster, a shelter cluster, an education cluster etc.). This diagram represents the global cluster mechanism.
- For the purposes of this training, the most important clusters are:
    - Health: led by World Health Organization. SRH is a direct part of the Health Cluster and SRH lead agencies participate in the Health Cluster.
    - Protection: led by UNHCR. The protection cluster also has 4 focus areas called Areas of Responsibility (AoRs). One of these sub-clusters is the GBV AoR. This is very important for the implementation of the MISP and is led by UNFPA.
- During an emergency a Health Cluster/national equivalent will usually be established and an SRH lead agency appointed to establish a sub cluster/working group to coordinate SRH activities.
- There will also need to be coordination with the GBV AoR and GBV Cluster coordinators may be appointed.

Slide #71: MISP Objective 1: Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP

Key Messages



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Coordination of the MISP for SRH

Emergency management

Health sector/cluster

Other sectors

MISP Objective One

Lead SRH organization

SRH Coordinator

SRH working group/coordination team

- Using the diagram on the slide explain each of the main components of MISP Objective 1: **Ensure** the health sector/ cluster identifies an organisation to lead implementation of the MISP

- From the beginning of the response, in every humanitarian emergency, the health sector or health cluster (whichever is operational in your context) must identify a lead SRH organization.

- This organisation can be the Ministry or Department of Health, a United Nations Agency such as UNFPA, or an international or local NGO.

- The nominated organisation should be the one which has the greatest capacity to fulfil this role. They must then immediately dedicate a full-time SRH coordinator.

- Advocacy will often be required to ensure that an SRH agency and/or coordinator is appointed. It is vital that these mechanisms are in place as the health cluster or sector can often focus on a range of health-related areas to the exclusion or sidelining of SRH.

- The **SRH Coordinator** will provide operational and technical support to health partners and facilitate coordinated planning with all involved sectors/ clusters to ensure the prioritization of SRH and the effective provision of MISP services. These stakeholders include organisations and individuals within the health sector/ cluster and other related sectors/ clusters (such as emergency management, social welfare, protection etc.) and affected populations.

- **Service providers** have a key role to play in providing timely and accurate information to enable the SRH Coordinator and working group to be effective, to make decisions based on needs, overcome challenges and to develop funding proposals. While service providers may not attend coordination meetings, their input from the field is vital for effective coordination.

- **Community groups** also have an important role to play in coordination to ensure voices or marginalized communities are heard and their assets and resources are drawn upon effectively in response.

Note to facilitators If participants are interested in learning more about the role of the SRH Coordinator, point them to the Terms of Reference for this position included in the IAFM 2018 (page 20).

Slide #72: Exploring coordination in context: presentation

Exploring Coordination in Context:

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

If this is not possible, make sure to source this information yourself and use this opportunity to make these mechanisms clear to participants.

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Exploring Coordination In Context

Time

20 minutes

Process

- Allow a representative from your national disaster management organization or other relevant actor to present relevant contextual information to training participants. This should include:
  - Over-arching disaster management/ coordination mechanisms
  - Where SRH sits within these mechanisms
  - What this means for service providers.
- If you are not able to engage an appropriate speaker, make sure to provide this information yourself. It is very important that service providers see where they sit within emergency management and health mechanisms, and are aware of what they can expect and how they may contribute.
- The follow blank slides provides a space for you to include this information.

Slide #73: Regional and national context

This slide has been left blank for you to provide your participants with important information about humanitarian health and protection coordination mechanisms in your region and/or at a country level. Provide this information through the lens of how these mechanisms impact the work of health care providers in ensuring information and services are available, acceptable, accessible and of good quality.


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Regional and national contexts

Slide #74: Coordination between service providers

Key Messages

- A critical component of coordination for service providers is working with other cadre within their health delivery points and working in collaboration with other service delivery points or organisations to ensure that each activity under each Objective of the MISP for SRH is made available to affected populations in emergencies.

- Remind participants that one organization can not implement the MISP for SRH alone.

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Coordination between service providers

- Working with other providers:
  - Other health workers & cadre
  - Within and between health facilities
  - With the common goal of ensuring all activities of the MISP for SRH are implemented

One Organisation CAN'T do it all!

Note to facilitators Ask participants to brainstorm the health personnel who would be required so that all activities of the MISP for SRH could be made available to people in humanitarian emergencies in their context. Explain that this will be further elaborated on as they work through the Objectives of the MISP for SRH, but together, they can provide a preliminary list of health cadre. Write answers on a flipchart.

Next ask participants where these health personnel may be found and write a list of suggested organisations and health service delivery points/ types relevant to the context.

Finally, ask participants to brainstorm non-medical organisations or groups that might be useful for reaching out to affected populations so they are aware of available health services.

Remind participants of the importance of coordination and working to ensure that respectful partnerships at all levels of health service planning and delivery.

Keep these flipcharts for use throughout the remainder of the training.

Slide #75: Concluding thoughts

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

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

Day 1 Close

Concluding thoughts

- The first objective of the MISP for SRH is to ensure the health sector/ cluster identifies an organization to lead implementation of the MISP for SRH
- Effective coordination is important to ensure the efficiency, effectiveness and timeliness of the SRH response
- Service providers have an important role to play in providing timely and accurate information to enable the SRH Coordinator and working group to be effective, to make decisions based on needs, and to develop funding proposals

IPPF/Victoria Milko

Day 2

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

Session 2.1 5 hours

Overview

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

Methodology

- Interactive presentation
- Video presentation
- Group Work
- Role Play
- Discussion

Materials

- PowerPoint Presentation
- Video: GBV in emergencies/ Audiovisual equipment
- Participant Handouts
- Group Work/ Role Play Supplies

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

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

Day 2: The Minimum Initial Service Package (MISP)

Training for Service Providers

Slide #2: Day 1 Review

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

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

Day 1 Review

Introduction, Inclusion and MISP Objective 1

Slide #3: MISP objectives

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

MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH (MISP for SRH)

PREVENT MORTALITY, MORBIDITY AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

1. Ensure the health cluster identifies an organisation to lead the MISP for SRH
2. Prevent sexual violence and respond to the needs of survivors
3. Prevent and reduce morbidity and mortality due to HIV and other STIs
4. Prevent excess maternal and newborn morbidity and mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH services integrated into primary health care as soon as possible

Ensure that safe abortion care is available, to the full extent of the law, in health centres and hospitals.

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

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

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

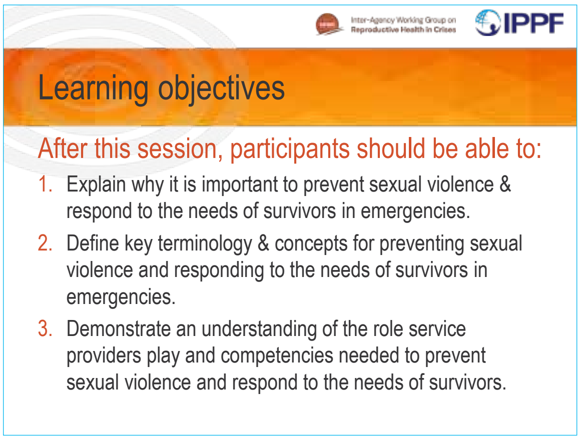
Training for Service Providers

Slide #5: Learning objectives

Key Messages

- There are three learning objectives for session 2.1:

  1. Explain why it is important to prevent sexual violence & respond to the needs of survivors in emergencies.
  2. Define key terminology & concepts for preventing sexual violence and responding to the needs of survivors in emergencies.
  3. Demonstrate an understanding of the role service providers play and competencies needed to prevent sexual violence and respond to the needs of survivors.



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Learning objectives

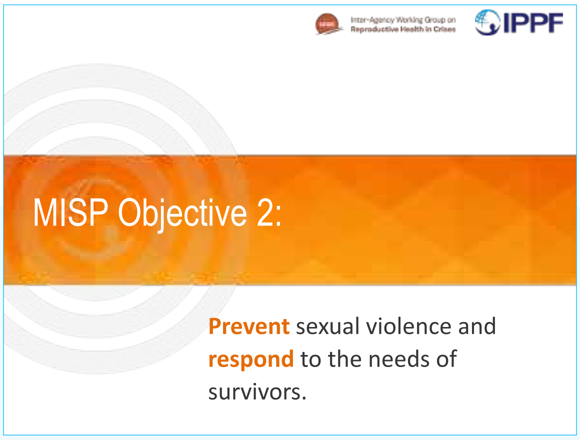
After this session, participants should be able to:

1. Explain why it is important to prevent sexual violence & respond to the needs of survivors in emergencies.
2. Define key terminology & concepts for preventing sexual violence and responding to the needs of survivors in emergencies.
3. Demonstrate an understanding of the role service providers play and competencies needed to prevent sexual violence and respond to the needs of survivors.

Slide #6: MISP objective

Key Messages

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



MISP Objective 2:

Prevent sexual violence and **respond** to the needs of survivors.

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

Slide #7: Video presentation: GBV in emergencies

Video Presentation

The video presentation will provide participants with important background information and allow an opportunity for engagement with the impact of gender based violence in emergencies. A video that provides an overview of GBV in crises is provided in the presentation (available at https://youtu.be/lEDzl1dFGzk), or you may choose one impactful in your setting. Some additional suggested videos are listed below and provided on the USB, but others are available online. It should be noted that if you select a different video, the discussion questions may also need to be adapted.

Time

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

Process

- Explain to participants that the video may contain graphic or content that is distressing, particularly for some participants.
- Project the given video or choose a video more relevant to your context.

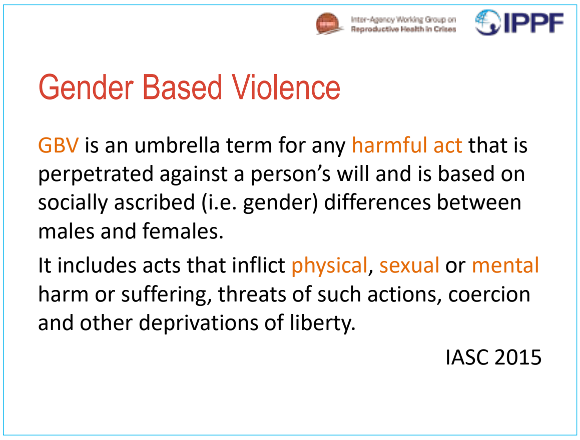
- At the close of the video, ask participants some broad questions about what they have just watched. These could include:
    - What factors increased the risk of sexual violence in the context shown in the video?
    - What were/ may be some barriers to seeking care in the setting shown in the video?

Materials

- Projecting equipment
- Suggested videos (included on USB):
- Our Bodies, Their Battleground- IRIN (now New Humanitarian)
- Iraqi Refugees in Jordan- Women's refugee commission

Slide #8: Gender based violence

Key Messages



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Gender Based Violence

GBV is an umbrella term for any harmful act that is perpetrated against a person's will and is based on socially ascribed (i.e. gender) differences between males and females.

It includes acts that inflict physical, sexual or mental harm or suffering, threats of such actions, coercion and other deprivations of liberty.

IASC 2015

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

Slide #9: Gender based violence in emergencies

Key Messages

- Gender based violence is amongst the greatest health and protection challenges individuals, families and communities face during humanitarian emergencies (IASC 2015).
- Gender based violence takes many forms in emergencies, as shown in the examples included on the slide.
- As the situation stabilizes, humanitarian emergencies may also provide a window of opportunity to transform unequal gender relations and shift harmful gender norms.

Gender Based Violence in Emergencies

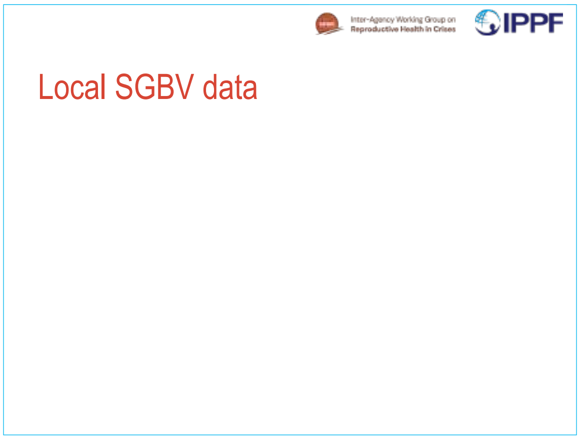
- In Liberia, 32.6% of male combatants & 55% of displaced women experienced sexual violence
- 1/3 of women with disabilities interviewed in post-conflict Northern Uganda experienced GBV and several had children as a result of rape
- Intimate partner violence increases after natural disasters (e.g. United States, Canada, Australia, New Zealand, after 2004 tsunami)

IASC 2015

Slide #10: Local SGBV data

Key Messages

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

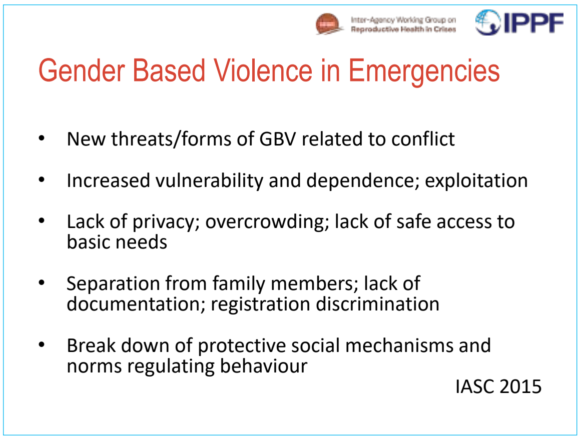


Local SGBV data

Objective 2

Slide #11: Gender based violence in emergencies

Key Messages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Gender Based Violence in Emergencies

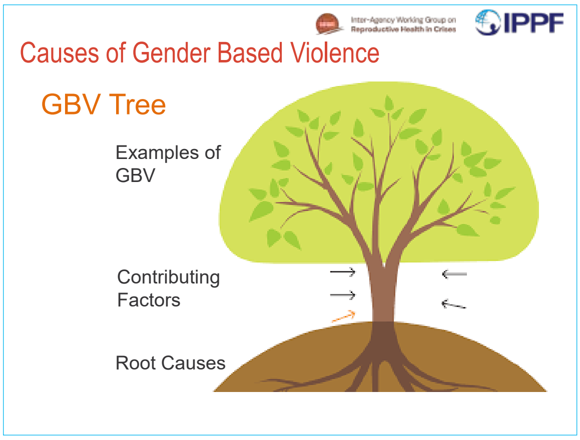
- New threats/forms of GBV related to conflict
- Increased vulnerability and dependence; exploitation
- Lack of privacy; overcrowding; lack of safe access to basic needs
- Separation from family members; lack of documentation; registration discrimination
- Break down of protective social mechanisms and norms regulating behaviour

IASC 2015

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

Slide #12: Causes of gender based violence

GBV Tree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Causes of Gender Based Violence

GBV Tree

Examples of GBV

Contributing Factors

Root Causes

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

Time

10 minutes.

Process

- If time permits break group into two, to work on problem trees, each.
- Distribute post-it notes to the group.
- Show the slide and ask if anyone has seen or used a problem tree before.
- Explain that this is a blank problem tree. It shows a 'problem' (the tree) as being constructed of:
  - The roots: denote underlying or root causes of GBV;
  - The trunk: represents the problem and contributing factors;

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

- Ask participants to write examples of root causes, contributing factors and examples of GBV on separate post-it notes and place these on the blank problem trees.

- Facilitate a brief discussion about the participants' work, highlighting similarities and difference across their problem trees and explaining that the next slide will show an example GBV tree.

Materials

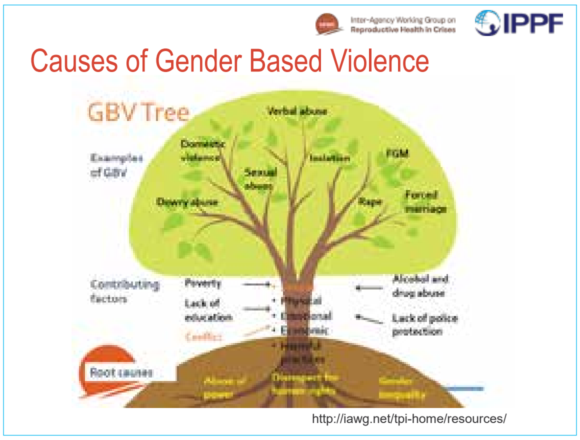
- Two or more flipcharts (depending on the number of participants) with a blank problem tree drawn on each, Markers

- Post-it notes

Note to facilitators Be mindful of persons with disabilities and their carers, LGBTQIA individuals, sex workers and other priority populations when presenting the problem tree.

Slide #13: Causes of gender based violence

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



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Causes of Gender Based Violence

http://iawg.net/tpi-home/resources/

Key Messages

- The root causes of all forms of GBV lie in societal attitudes towards and practices of gender discrimination - the roles, responsibilities, limitations, privileges and opportunities afforded to an individual according to gender.

- Contributing factors are those that perpetuate GBV or increase the risk of GBV, and influence the type and extent of GBV in any setting. Contributing factors do not cause GBV although they are associated with some acts of GBV. War, displacement, and the presence of armed combatants are all contributing factors, but all soldiers do not rape civilian women. Poverty is a contributing factor, but not all poor women and girls will be sexually exploited. Many contributing factors can be eliminated or significantly reduced through prevention activities.

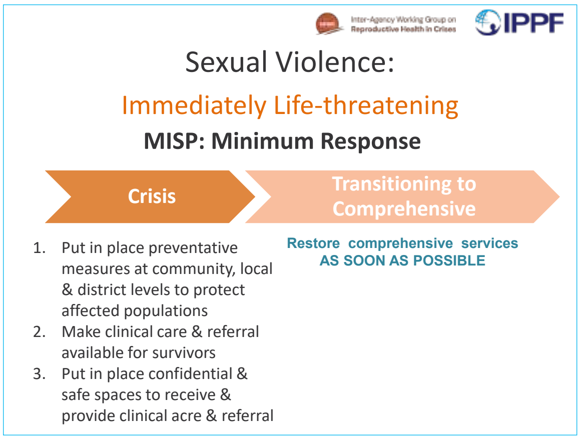
- Addressing the root causes through prevention activities requires sustained, long term action with change occurring slowly over a long period of time. Many contributing factors can be eliminated or significantly reduced through prevention activities.

- Remind participants that the MISP for SRH is to be implemented at the onset of a humanitarian crisis and it therefore addresses immediately life-threatening sexual violence. Work to address the root causes, contributing factors and other symptoms of GBV should be addressed at a minimum when transitioning to comprehensive and in preparedness and recovery efforts.

Link For more on the contributing factors and root causes of gender based violence in emergencies, see IASC (2019) *The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming* https://www.unfpa.org/minimum-standards

Slide #14: MISP focuses on sexual violence

Key Messages



Inter-Agency Working Group on Reproductive Health in Crises
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Sexual Violence:

Immediately Life-threatening

MISP: Minimum Response

Crisis

Transitioning to Comprehensive

1. Put in place preventative measures at community, local & district levels to protect affected populations
2. Make clinical care & referral available for survivors
3. Put in place confidential & safe spaces to receive & provide clinical acre & referral

Restore comprehensive services AS SOON AS POSSIBLE

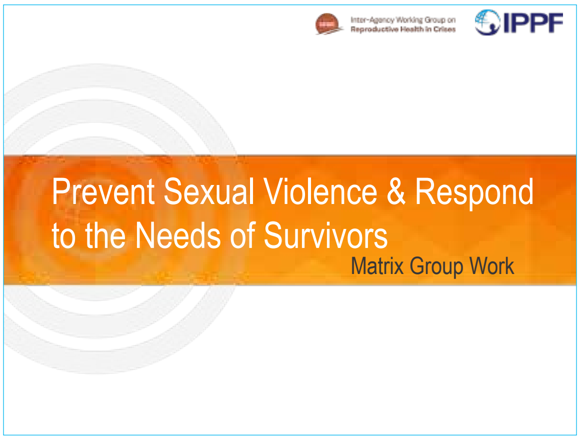
- GBV in all its forms is an issue in crisis settings. However, agencies agree that preventing sexual violence and responding to the needs of survivors is the minimum intervention that needs to take place in the early phase of an emergency health response because of the immediately life-threatening impact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

- Incidents of rape and other forms of sexual violence often increase in emergencies.

- The activities under MISP Objective 2 include both prevention and response. We will start with prevention and then move on to response.

Slide #15: Matrix group work: MISP for SRH objective 2

Time



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Prevent Sexual Violence & Respond to the Needs of Survivors

Matrix Group Work

10 minutes.

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.

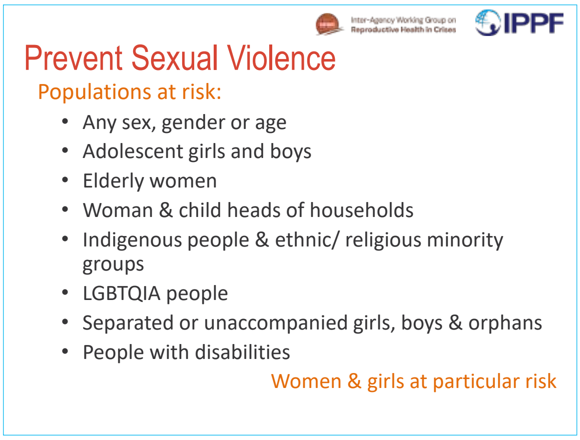
Materials

- Participant Handout #5
- MISP for SRH Cheat Sheet

Slide #16: Prevent sexual violence

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

Key Messages



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Prevent Sexual Violence

Populations at risk:

- Any sex, gender or age
- Adolescent girls and boys
- Elderly women
- Woman & child heads of households
- Indigenous people & ethnic/ religious minority groups
- LGBTQIA people
- Separated or unaccompanied girls, boys & orphans
- People with disabilities

Women & girls at particular risk

- Most reported cases of sexual violence among crisis-affected communities- and in most settings around the world- involve male perpetrators committing violent acts against females. It is important to remember that perpetrators may be known to the survivor and in many instances are family members or intimate partners.

- However, men and boys may also be at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture.

- While all women in crisis-affected settings are susceptible to sexual violence, adolescent girls are exceptionally vulnerable as they are often targeted for sexual exploitation and rape.

- Women and girls with disabilities, and particularly women and girls with psychosocial, hearing and intellectual disabilities, are at higher risk of sexual violence and other forms of GBV. Repeated and regular rape by multiple perpetrators is the most common form of GBV reported. (*IASC guidelines -inclusion of persons with disabilities in humanitarian action*, 149)

- In addition, sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community- including the fathers, brothers, husbands and sons of the survivor. It is important to recognize that anyone can be a survivor of sexual violence (women, girls, boys and men of all ages) and to ensure that services are available and accessible to all.

Slide #17: The MISP for SRH Objective 2

Key Messages

- Remind participants of the three activities under MISP Objective 2.

MISP for SRH Objective 2 Activities:

- Work with other clusters especially the protection or gender based violence sub-cluster to put in place **preventive measures at community, local and district levels including health facilities** to protect affected populations, particularly women and girls from sexual violence
- Make **clinical care and referral** to other supportive services available for survivors of sexual violence
- Put in place **confidential and safe spaces** within the health facility to receive and provide survivors of sexual violence with appropriate clinical care and referral

Slide #18: Prevent sexual violence

Key Messages

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

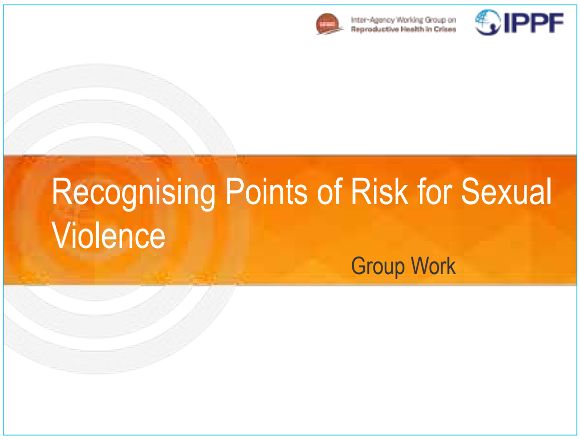
Prevent Sexual Violence

MISP

Work with other clusters/ sectors (protection, GBV) to put in place preventive measures at community, local & district levels including health facilities

Slide #19: Recognising points of risk for sexual violence: Case study

An important aspect of preventing sexual violence is recognizing points of risk and addressing these through service provision. This activity is to enable participants to recognise points of risk for sexual violence in the case study introduced on day 1 of the training.



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Recognising Points of Risk for Sexual Violence

Group Work

Time

10 minutes.

Process

- Ask participants to look back at their case studies from yesterday. As a group, review the case study and discover and discuss any potential points of specific risk for sexual violence. In addition to this, ask participants to identify the existence of any protective factors in the case study.
- At the close of the discussion, ask participants who might be responsible in their setting for preventing sexual violence by addressing these points of risk in emergencies. These can be added to their matrix (Participant Handout #5) and noted on a flipchart so that these organisations can be referred to and added throughout the session.

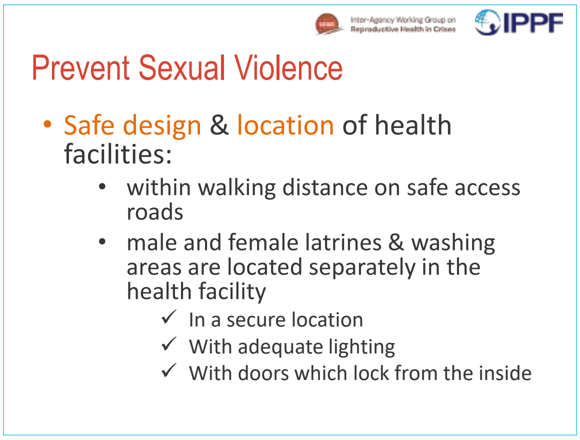
Materials

Participant Handouts #1 and #5

⚠ **Note to facilitators** Explain to participants that identifying and addressing points of risk for sexual violence can not be done by any one agency. Other sectors, agencies, health facilities and responsible individuals must be involved in addressing these points of risk at community, local and district levels. Service providers have a direct contribution to ensuring that their practices and places of work are safe, but prevention requires coordination between agencies.

Slide #20: Prevent sexual violence: safe design and location of health facilities

Key Messages



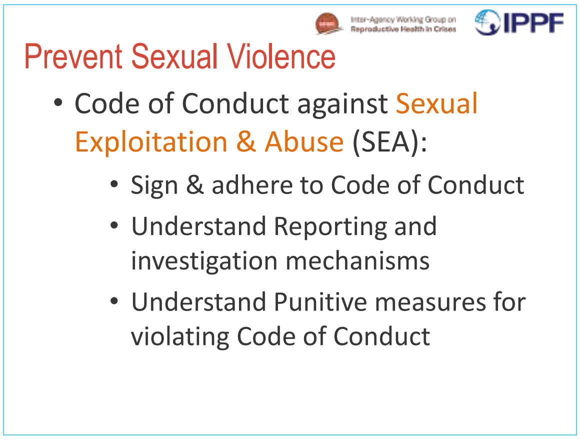
Prevent Sexual Violence

- Safe design & location of health facilities:
  - within walking distance on safe access roads
  - male and female latrines & washing areas are located separately in the health facility
    - ✓ In a secure location
    - ✓ With adequate lighting
    - ✓ With doors which lock from the inside

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

Slide #21: Prevent sexual violence: Code of conduct against SEA

Key Messages



Prevent Sexual Violence

- Code of Conduct against Sexual Exploitation & Abuse (SEA):
  - Sign & adhere to Code of Conduct
  - Understand Reporting and investigation mechanisms
  - Understand Punitive measures for violating Code of Conduct

- In emergencies, health providers and other providers of assistance are in a position of power as communities are in need. There have been some instances where providers of assistance have exploited their position of power and abuse, including forms of GBV, have occurred.
- The involvement of humanitarian workers, including those working to provide health services, in acts of sexual exploitation and abuse is a violation of the responsibility of all involved to do no harm and to protect people affected by crises.

- One way to guard against sexual exploitation and abuse is through an enforceable code of conduct.

- All health workers and other facility staff must sign and abide by a Code of Conduct against sexual exploitation and abuse (SEA). Most agencies will have their own policies and codes of conduct for preventing sexual exploitation and abuse.

- A Code of Conduct (CoC) against sexual exploitation and abuse (SEA) is a set of agency guidelines that promote respect by staff of the agency for fundamental human rights, social justice, human dignity and respect for the rights of women, men, adolescents and children. The CoC also informs staff that their obligation to show this respect is a condition of their employment

- Codes of conduct and reporting mechanisms on SEA (which ensure whistle blower protection) must be in place, as well as relevant investigative measures to enforce the codes of conduct. An enforceable CoC is a critical component of humanitarian accountability to beneficiaries.

- Codes of Conduct and the prevention of Sexual Exploitation and abuse systems are often part of a HR mechanisms, not specific to SRH. However, links to GBV/ SV referral systems and services are important to those affected

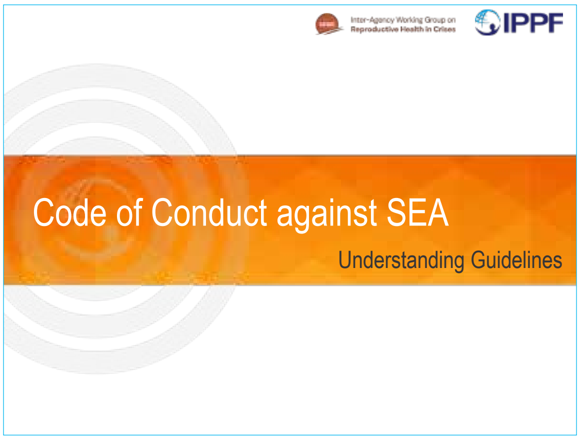
Note to facilitators Ask participants for their experience with Codes of Conduct against Sexual Exploitation and Abuse. Are these in place in their agencies/ clinics/ facilities? Are they in place for standard settings and/ or are special provisions made for emergencies? If not, ask participants why they think this may be and whether they will take steps to address this with agency/ clinic/ facility managers when they return to work.

For more information on the prevention of sexual exploitation and abuse, refer participants to:

- https://www.unocha.org/protection-against-sexual-exploitation-and-abuse-psea

- Red Cross NGO Code of Conduct

Slide #22: Code of conduct against SEA



Code of Conduct against SEA

Understanding Guidelines

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

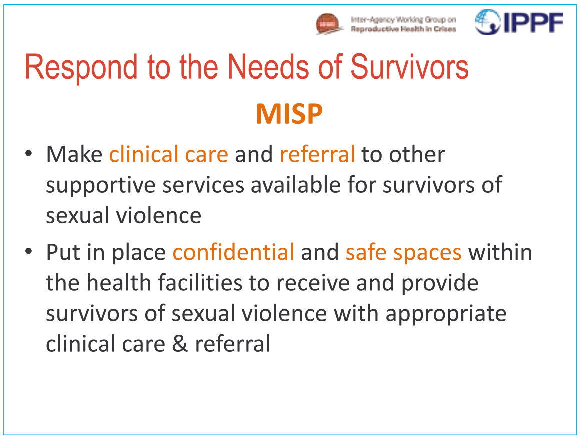
- Ask participants to look at the sample codes of conduct provided on Participant Handout #6.
- Allow participants time to read through the documents and answer the following questions (also included on Participant Handout #6):
  - What principles are common to the documents?
  - How do these principles 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

Slide #23: Respond to the needs of survivors: MISP

Key Messages



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Respond to the Needs of Survivors

MISP

- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care & referral

- We are now moving from preventing sexual violence in emergencies to responding to the needs of survivors.
- The MISP for SRH outlines two components for responding to the needs of survivors of sexual violence:
  - Make clinical care and referral to other supportive services available for survivors of sexual violence; and
  - Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.
- We will now look at each of these aspects in some detail.

Slide #24: Respond to the needs of survivors

Key Messages

Respond to the Needs of Survivors

Inter-Agency Working Group on Reproductive Health in Crises IPPF

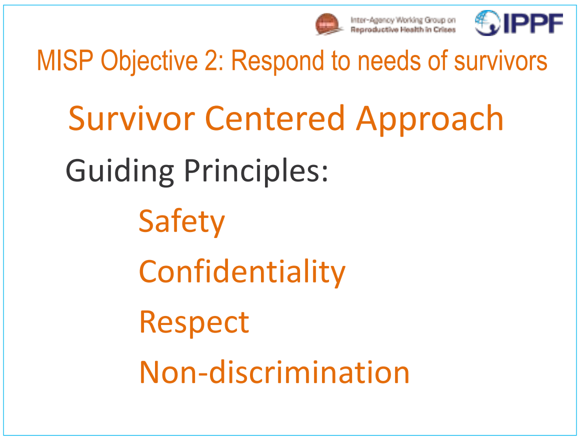
- To develop an appropriate response to sexual violence, it is important to understand the possible consequences of sexual violence.
- Programming to address sexual violence can be grouped into four main areas: health, psychosocial, safety/security, and legal/ justice.
- Sexual violence, especially rape, has a huge impact on people's health. It goes beyond the individual survivor's physical health, where the consequences can range from relatively minor injuries to severe injuries that lead to death or permanent disability, sexually transmitted infections (STIs)/AIDS, pelvic inflammatory disease, infertility, chronic pain syndromes, unwanted pregnancy, unsafe and complicated abortion, pre-term labor, and low birth weight (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).
- Many survivors will suffer psychological ill health, including: post-traumatic stress disorder, depression, suicide, anxiety/fear, feelings of inferiority, inability to trust, or sexual dysfunction (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).

- Sexual Violence, therefore, also has a large impact on the social health of the community in terms of increased health care costs and increased legal and security costs, losses in women's income potential, interrupted education of adolescents, alcohol abuse, rejection and isolation of survivors, homicide, and delayed community reconciliation and reconstruction (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).

- The health sector is one of the key actors in providing care for sexual violence survivors and preventing many of these consequences (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).

Slide #25: Survivor centred approach

Key Messages



MISP Objective 2: Respond to needs of survivors

Survivor Centered Approach

Guiding Principles:

Safety
Confidentiality
Respect
Non-discrimination

- To ensure the clinical needs of survivors of sexual violence are met and to follow the survivor-centred approach, services must be delivered in a way that ensures safety: confidentiality, respect and non-discrimination.

- A survivor-centered approach means that all those who are engaged in programming to prevent and address violence against women and men, prioritize the rights, needs and wishes of the survivor.

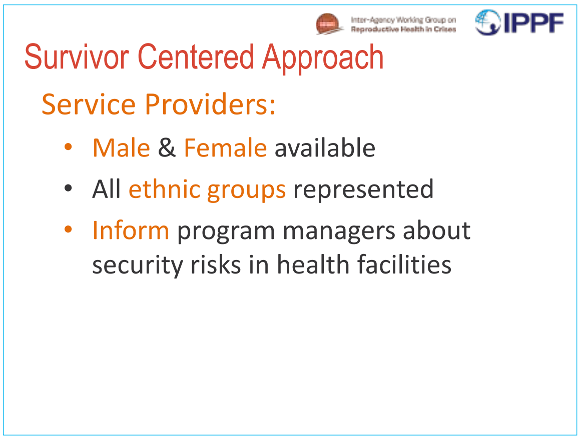
- Essentially, a survivor-centered approach applies a human rights-based approach to designing and developing programming that ensures that survivors' rights and needs are first and foremost.

- The survivor-centered approach aims to create a supportive environment in which the survivor's rights are respected and she/he is treated with dignity and respect. The approach helps to promote the survivor's recovery and her/his ability to identify and express needs and wishes, as well as to reinforce her/his capacity to make decisions about possible interventions (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).

- The survivor centred approach must be applied to all people who require care. To ensure that this is so, service providers, staff at facilities, clinic and program managers must take into special consideration the needs of adolescents, male survivors, persons with disabilities, LGBTQIA individuals, people who engage in sex work and ethnic and religious minorities.

Slide #26: Survivor centred approach

Key Messages



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Survivor Centered Approach

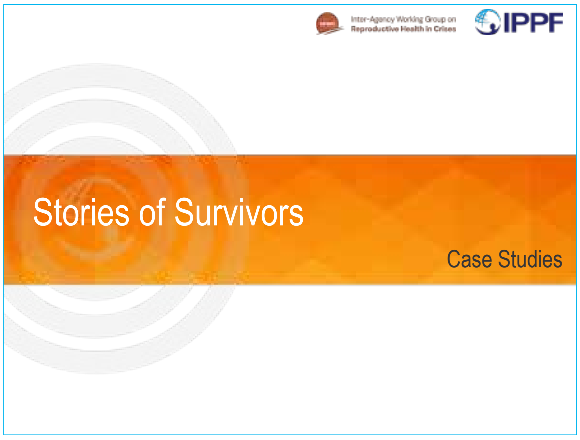
Service Providers:

- Male & Female available
- All ethnic groups represented
- Inform program managers about security risks in health facilities

- Preventing sexual violence also requires the availability of a choice of providers, with both male and female service providers available. Community health workers, program staff, interpreters and other key workers must also represent diversity for accessibility and acceptability.
- All staff must adhere to the guiding principles of safety, confidentiality, respect and non-discrimination.
- Ensuring accessibility and acceptability of health services, including sexual and reproductive health services, also requires ensuring that all ethnic subgroup languages are represented among service providers, or that male and female interpreters are available.
- Service providers should inform program and facility managers about any security or safety concerns they may have for themselves or their patients.

Note to facilitators This is a good opportunity for participants to reflect on work practices and service provision in their own settings. Ask participants what they think are the particular issues for different populations in their settings (standard and/or emergency contexts, depending on the experience of participants). Ask participants if they think all survivors attend their clinics. Why or why not? Who may find it most difficult to attend? What might accessible and acceptable services look like for survivors?

Slide #27: Stories of Survivors



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Stories of Survivors

Case Studies

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 two 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 two 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 of the stories by themselves.
- When they have finished reading, ask participants to discuss with the person next to them or in small groups:
    - The situation which made the survivor vulnerable to sexual violence
    - The care seeking behaviour of the survivor
    - 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

Slide #28: Referral mechanisms for survivors


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Referral Mechanisms for Survivors

Role Play

The aim of this activity is for participants to develop a deep understanding of the need for the guiding principles of survivor-centred care. Facilitators should adapt the story and characters to fit the context(s) of their participants.

Time

25 minutes.

Process

- Begin by reminding participants of the guiding principles in responding to the needs of survivors and explaining that these also relate to referral mechanisms for survivor care. Ask participants to keep in mind the stories of survivors they have just discussed as they move into this exercise.

- Explain to participants that we will look at referral for further intervention and care for survivors later in this session, but have included this activity here to bring to the fore the importance of maintaining a survivor centred approach at all times.

Option 1

- Ask for a volunteer to play the part of a 17 year old survivor of SV. Put them in the middle of the circle.

- Distribute name tags for the other roles to volunteers. Tell them that they will be in the role of the person noted on their name tag.

- Ask the volunteers to stand in a circle, fairly close together around the survivor. Ask the remaining participants to stand outside the circle so that they can easily see the activity.

- Explain that the ball of yarn represents the journey of a 17 year old girl who was raped.

- Once everyone is in place start reading the story. Ask the survivor to hold on to a piece of the string and pass the rest to the next person mentioned in the story and so on. Each Actor who receives the ball of string will wrap it around a finger and then pass the ball to the next Actor as instructed.

- Let the activity speak for itself, unfolding before participants' eyes. Do not describe it or explain its purposes before completing the activity.

Story

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

- Mother takes girl to Community Leader

- Community Leader refers the girl to the TBA
- TBA helps, but the girl needs more health intervention and TBA refers girl to the Midwife
- Midwife calls in the Doctor
- Doctor administers treatment and sends girl back to Midwife
- Midwife refers the girl to the Community Services Worker
- Community Services Worker provides emotional support and contacts the UNHCR Community Services Officer for assistance
- UNHCR Community Services Officer talks with the girl and discovers the girl wants to involve the police—refers the girl to the UNHCR Protection Officer
- UNHCR Protection Officer meets the girl, takes her back to the Doctor for a few more questions
- Doctor sends the girl back to the UNHCR Protection Officer
- UNHCR Protection Officer refers the girl to the Police
- Police contact the Doctor
- Doctor contacts Mother
- Mother takes girl to UNHCR Protection Officer
- UNHCR Protection Officer refers girl to a Lawyer
- Lawyer contacts Police
- Police contact Prosecutor to have him speak with the survivor
- Prosecutor discusses with Lawyer
- Lawyer discusses with Prosecutor
- Prosecutor calls the Doctor about the survivor to get information about the medical exam. Doctor asks to see the survivor again because she forgot to examine something
- The Doctor refers the survivor to a Social Worker
- The Social Worker then contacts the Police to give them some new information
- The Police contact the UNHCR Protection Officer to report the incident
- The Protection Officer contacts the mother to ask questions
- The Mother asks the survivor additional questions

- The survivor goes to talk with the Community Leader because she is confused about the process
- The Community Leader contacts the Prosecutor and the Judge to find out the status of the case
- They refer the Community Leader to the Police
- The Police refer the Leader to the UNHCR Protection Officer

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

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

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

Actors should let go of the string and let it drop to the floor. Leave the red stringy chaotic mass sitting on the floor for all to see. Explain that Standard Operating Procedures (SOPs) are an important instrument to ensure that this scenario doesn’t happen.

Option 2 (variation of Option 1)

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

Key Messages

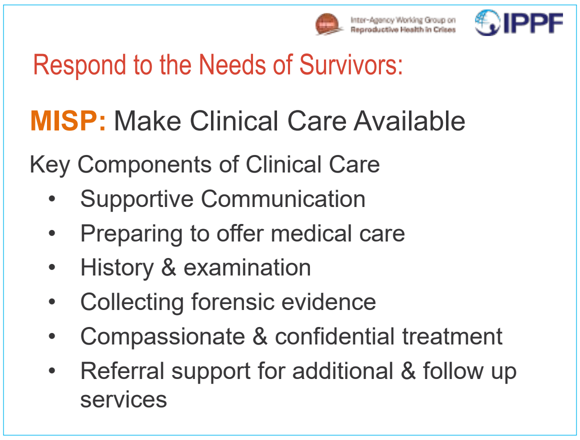
- SOPs are important to stop this scenario happening.
- In most refugee/IDP contexts, the SV survivor has to interact with a vast number of resources and contacts that are often not well trained and not well coordinated. This can be very daunting and confusing to the survivor and may discourage incident reporting or negatively impact the survivor. It is important to set up a clear response system and to have someone act as a case manager for the survivor, helping her to navigate the system.

- Explain that roles and responsibilities can be divided into the nature/scope of the services provided by each organization. Referrals should be clearly defined to prevent unnecessary "back and forth" of the survivor which only delays medical attention and worsens his/her situation (as shown in thread game). A reporting mechanism should be in place in order to monitor the incidence of sexual violence and its trend for more targeted programs.

- Displaced communities should be a part of the SOPs and be aware of the response mechanisms in place for them. Community can be involved in peer-to-peer awareness on human rights, especially women's rights, establishing women committees, facilitating women support groups for survivors, engaging the women groups in identification of survivors, etc. Women and girls who are survivors of sexual violence should know where they can go to receive the necessary attention, assistance, support and care.

Slide #29: Respond to the needs of survivors: Make clinical care available

Key Messages



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Respond to the Needs of Survivors:

MISP: Make Clinical Care Available

Key Components of Clinical Care
- Supportive Communication
- Preparing to offer medical care
- History & examination
- Collecting forensic evidence
- Compassionate & confidential treatment
- Referral support for additional & follow up services

- The MISP for SRH dictates that those working for SRH in emergencies must make clinical care available. The following session is an overview of the clinical management of rape based on the IAFM (2018) MISP chapter (Chapter 3). Resources for more in-depth training on the clinical management of rape (including the eight steps) will be provided at the end of the session.

- The key components of this clinical care include:

    - Supportive communication
    - Preparing to offer medical care
    - History and examination
    - Collecting forensic evidence
    - Compassionate and confidential treatment
    - Following specific guidelines for children and adolescents.

- Each of these will be explored in detail below.

Slide #30: Respond to the needs of survivors: LIVES

Key Messages

Supportive Communication – Job Aid

Learn to listen with your

Eyes – giving her your undivided attention

Ears – truly hearing her concerns

Heart – with caring and respect

- A health care provider may be the first or only person a survivor ever approaches and the quality of the care provided can have short and long-term impacts on the well-being of the survivor and the survivor's willingness to disclose (IAFM 2018).

- Service providers (including those who are not working in facilities equipped to provide clinical care for survivors of sexual violence) must be prepared to provide the first-line of support, which include empathetic listening and validation, identifying the survivors immediate emotional, psychological and physical needs, and identifying available support services (IAFM 2018). To support these discussions, it is important that there is a space that facilitates privacy and confidentiality.

- Service providers can use the acronym LIVES to help guide their work in providing first-line support to survivors. In this acronym, the letters stand for the following

  - **L:** listen closely, with empathy and no judgement.

  - **I:** inquire about their needs and concerns.

  - **V:** validate their experiences. Show you believe and understand.

  - **E:** enhance their safety.

  - **S:** support them to connect with additional services.

- This guidance comes from the UN's Health Care for Women Subjected to Intimate Partner Violence (2019) https://www.who.int/reproductivehealth/publications/violence/VAW_infographics/en/).

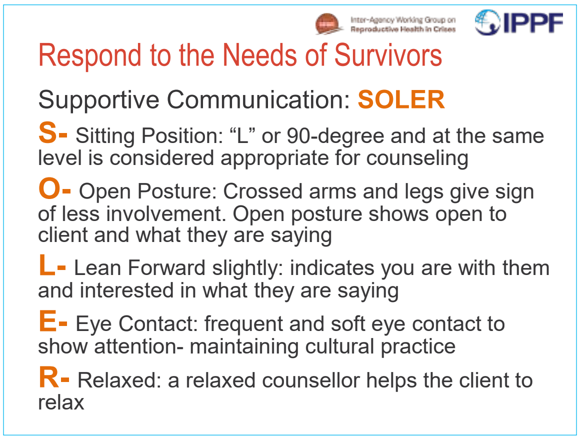
- Although LIVES is aimed at survivors of intimate partner violence (who are also at increased risk during emergencies) it provides useful guidance for dealing with all survivors including male and LGBTQIA survivors during response.

- Enhancing Safety (E) can be difficult at the onset of large scale responses however coordination with other agencies and member of the protection cluster can help find solutions.

Note to facilitators Encourage participants to add this aspect of responding to the needs of survivors of sexual violence to their matrix for this session.

Slide #31: Respond to the needs of survivors: SOLER

Key Messages



Respond to the Needs of Survivors

Supportive Communication: **SOLER**

S- Sitting Position: "L" or 90-degree and at the same level is considered appropriate for counseling

O- Open Posture: Crossed arms and legs give sign of less involvement. Open posture shows open to client and what they are saying

L- Lean Forward slightly: indicates you are with them and interested in what they are saying

E- Eye Contact: frequent and soft eye contact to show attention- maintaining cultural practice

R- Relaxed: a relaxed counsellor helps the client to relax

- As mentioned above, the survivor's healing process should begin from the first visit to the clinic. This may be the first and only point of contact for survivors. The LIVES approach provides a method for doing this.

- Supportive communication is an important part of the LIVES approach and service providers must extend compassionate and confidential support to the survivor through communication that is accurate, clear, non-judgmental, and involves empathetic listening without pressuring the survivor to respond (IAFM 2018). It is very important that service providers never say or do anything that would blame the victim for what has happened.

- One method of supportive communication is the SOLER approach that describes actions to make a survivor more comfortable in a clinical setting. In this acronym:

    - 'S' is for the sitting position of the service provider. An "L" or 90-degree position at the same level as the survivor is considered appropriate for the provider;

    - 'O' stands of open posture. This is to remind the service provider that crossed arms and legs may be a sign of less involvement. An open posture can show that the counselor is open to the survivor and to what she, he or they have to say.

    - "L" indicates that the provider may lean forward when listening to their client. A slight inclination may indicate that the service provider is 'with' the survivor and is interested in what they are saying.

    - "E" is for eye contact, an important and culturally specific consideration in ensuring survivor comfort. The SOLER method suggests that frequent and soft eye contact may make the survivor feel that the provider is being attentive. In this instance, the counselor should not make as frequent eye contact during initial meetings but should increase this as rapport is established.

    - "R", the final component of the SOLER approach is to recommend that the provider appears relaxed in their interaction with the survivor. It is suggested that this will help the survivor to feel relaxed and allow the provider to think, focus and understand their client.

Note to facilitators Be sure to adjust the information on the slide to fit the cultural context of your participants and the people they are working with. Many of these instructions for providing a comfortable and safe environment for the survivor are dependent on the socio-cultural background of the survivor and service provider. If you are unsure what would best support a survivor in being comfortable with a service provider in your participants' context(s), use this as an opportunity for discussion and make a note of any important considerations on a flipchart for later reference.

Slide #32: Supportive communication

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Supportive Communication

Role Play

(Adapted from UNFPA CMR Training package)

This activity will allow participants to practice supportive communication. This is an important skill for service providers to demonstrate when responding to the needs of survivors of sexual violence.

Time

15 minutes.

Process

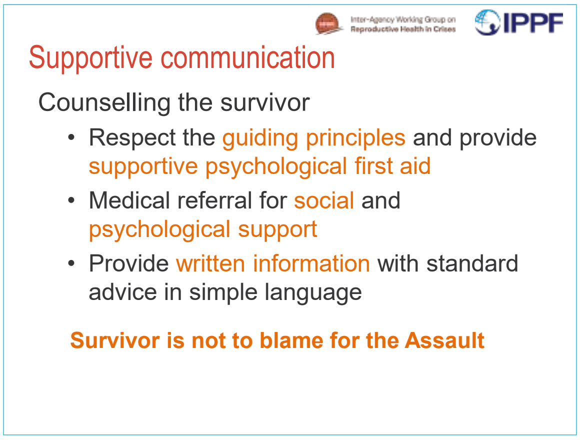
- Ask participants to turn to their neighbour and form pairs, deciding who will speak first and who will listen first.
- Ask the first speaker to recall a challenging situation in their life and take 5 minutes to describe it to their partner.
- After five minutes, instruct participants to switch roles so that the second speaker now recalls a challenging situation in their life.
- After both participants have had a chance to tell their stories, ask them to discuss the following questions (you may write them up on a flipchart if it aids discussion):
    - Did your partner adhere to the LIVES approach?
    - What did your partner do to show that they were listening attentively to you?
    - What did your partner NOT do or say?
    - How closely did your partner follow the suggestions of the SOLER (or other culturally appropriate) approach?
    - How did you feel afterwards?

Key Messages

Remind participants of the following key points:

- Effective communication and listening happens through a combination of verbal and non-verbal skills
- Effective communication makes the speaker feel heard.
- Violence survivors are often silenced by abusers, family members and others in the community – and even health care providers.
- By contrast, active and supportive listening allows survivors to be heard – an important step towards healing.

Slide #33: Supportive communication



Supportive communication

Counselling the survivor

- Respect the guiding principles and provide supportive psychological first aid
- Medical referral for social and psychological support
- Provide written information with standard advice in simple language

Survivor is not to blame for the Assault

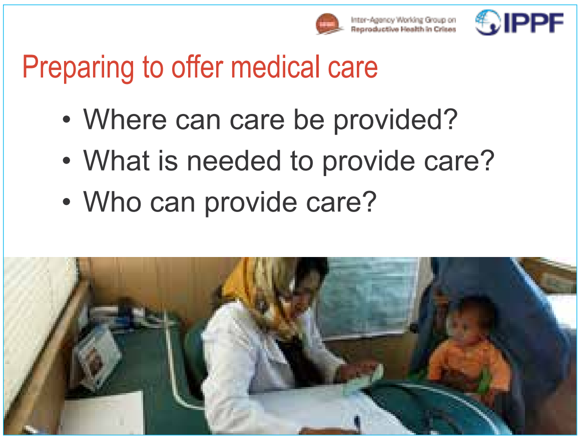
- For patient interaction, it is important to remember to Listen closely, with empathy and no judgement; Inquire about needs and concerns; Validate their experiences; Enhance their safety; and Support them to connect with services. Remind participants that the attitude and behavior of service providers can be a very real barrier to survivors receiving the care that they need.
- Refer participants to Box 10.7 of the IAFM (p203) for some important key messages when dealing with survivors of Sexual Violence.
- Each of these action steps is closely linked to the guiding principles for responding to the needs of survivors of sexual violence and to the fundamental principles of health programming in humanitarian emergencies.

Note to facilitators Provide participants with information on further training they may undertake on supportive communication for survivors of sexual violence. These training courses may be locally available or online. International resources include:

- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/
- WHO Preventing Intimate Partner Violence Course https://www.who.int/violence_injury_prevention/capacitybuilding/courses/intimate_partner_violence/en/

Slide #34: Preparing to offer medical care

Key Messages



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Preparing to offer medical care

- Where can care be provided?
- What is needed to provide care?
- Who can provide care?

- The health care service and providers must prepare to respond to the needs of survivors. Ideally, this action will be accomplished before the onset of a humanitarian crisis.

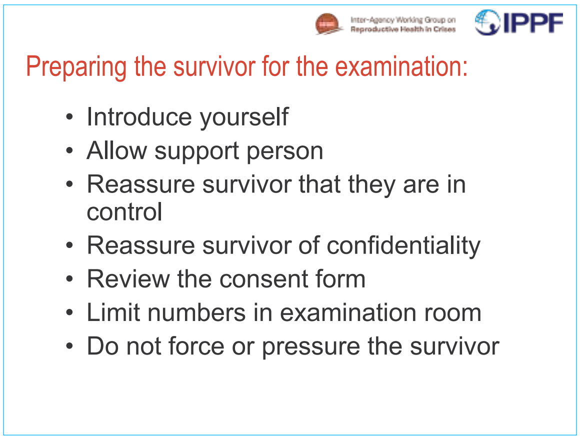
- In understanding the role of different cadre of service providers in humanitarian settings, it is important to consider where care can be provided, what is needed to provide care, and who can provide different aspects of care for survivors. Health care providers should be trained to provide the care outlined by the MISP and have the appropriate equipment and supplies to do so.

- The questions outlined on the slide are important to contextualise the response. Different countries will have different laws and/or protocols that determine where certain services are provided, the resources which are needed to provide this care, and the scopes of practice and skill mix of different health care providers.

- These are key questions to be addressed by service providers, program managers and other health support staff to ensure that the services provided for survivors in the MISP for SRH are available, accessible and acceptable.

Slide #35: Preparing the survivor for the examination

Key Messages



Preparing the survivor for the examination:

- Introduce yourself
- Allow support person
- Reassure survivor that they are in control
- Reassure survivor of confidentiality
- Review the consent form
- Limit numbers in examination room
- Do not force or pressure the survivor

- The second preparatory action is to prepare the survivor for the examination.

- A person who has been raped has experienced trauma and may be in an agitated or depressed state. She often feels fear, guilt, shame and anger, or any combination of these. The health worker must prepare her and obtain her informed consent for the examination, and carry out the examination in a compassionate, systematic and complete fashion (from Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1).

- The health and well-being of the survivor is the main priority for the examination.

- Following the guiding principles of safety, confidentiality, respect, and non-discrimination is key, and respectful introduction by the service provider is an important first step to this.

- Allow the survivor to choose a trusted person to be present at the examination if he or she so desires. For children, this may be their (non-offending) guardian, or where they are not available, a trained support person; the survivor should always be able to choose the sex of the support person and this is obligatory for children. Inform the survivor that the person is there to give the survivor support, but only at the survivor's request (IAFM 2018).

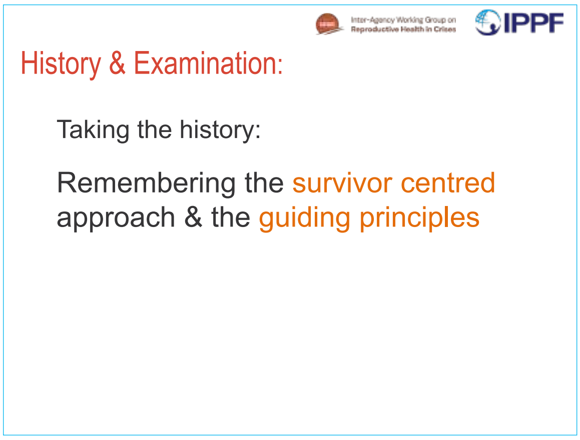
- The survivor should be assured that she or he is in control, does not have to talk about anything she or he is uncomfortable with, and can stop the process at any time. It is the survivor's right to decide whether to be examined and to refuse any part of the exam (IAM 2018).

- A history and thorough medical examination are conducted after the survivor understands and consents to each step.

⚠ **Note to facilitators** Encourage participants to add who responds to survivors of sexual violence to their matrix for this session.

Slide #36: History & examination

Key Messages



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History & Examination:

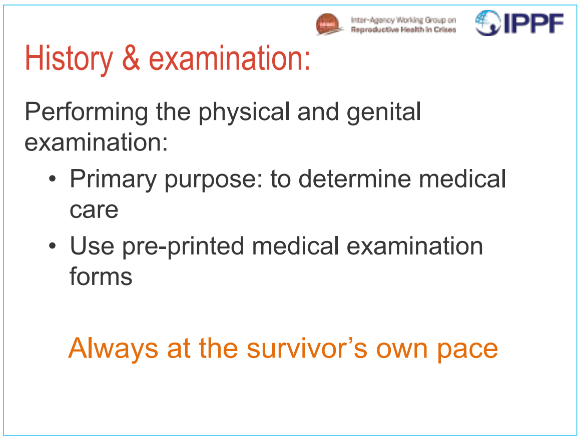
Taking the history:

Remembering the survivor centred approach & the guiding principles

- It is imperative that service providers remember the guiding principles and survivor-centred approach when taking the history.
- History taking should include (IAFM 2018):
  - Questions about the assault limited to what is needed for medical care (e.g., type of penetration, injuries) and, where appropriate, the collection of samples for forensic evidence. Do not ask the survivor to repeat information that is already noted on a referral form.
  - General medical information.
  - Medical and gynaecological history for women and girls.
  - Assessment of mental state, by asking how the survivor is feeling and noting the survivor's emotions during the exam.

Slide #37: History & examination

Key Messages



Inter-Agency Working Group on Reproductive Health in Crises IPPF

History & examination:

Performing the physical and genital examination:

- Primary purpose: to determine medical care
- Use pre-printed medical examination forms

Always at the survivor's own pace

- The primary purpose of the history and examination is to determine the clinical care that is needed. History-taking and the examination are to be done at the survivor's own pace (IAFM 2018).
- In taking the history, service providers should limit questions about the assault to what is needed for medical care (such as type of penetration and any injuries); general medical information; medical and gynaecological history (for women and girls); and an assessment of the survivor's mental state by asking how they are feeling and noting emotions.
- Allow the survivor to ask questions and agree to or refuse any aspect of the examination and treatment at any time.
- Preprinted history and examination forms should guide the process and all findings should be thoroughly documented.

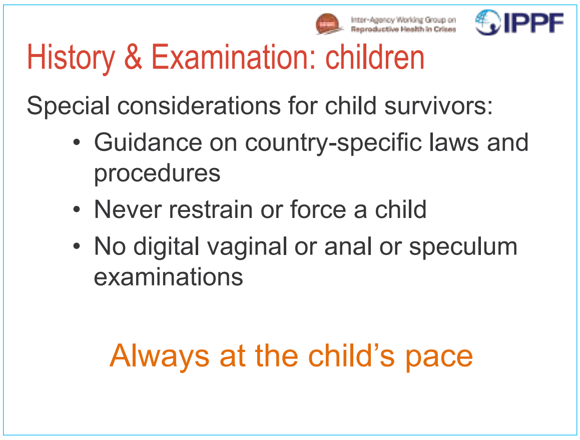
Note to facilitators Provide participants with a standard pre-printed history and examination form from your context. If none are available, access the standard history and examination form provided in the World Health (2004) Organisation’s Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1

Allow participants time to read through the form and ask any questions they may have.

Work with participants to pull out the essential skills needed for history-taking and examination and encourage them to add this aspect of responding to the needs of survivors of sexual violence to their matrix for this session.

Slide #38: History & examination: children

Key Messages



History & Examination: children

Special considerations for child survivors:

- Guidance on country-specific laws and procedures
- Never restrain or force a child
- No digital vaginal or anal or speculum examinations

Always at the child's pace

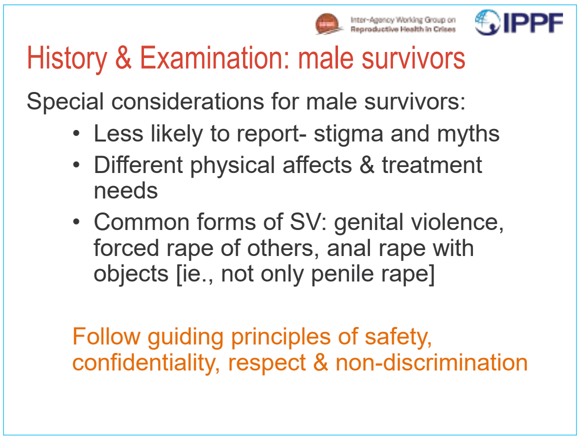
- Service providers should ensure special considerations are made when examining and providing treatment to child survivors of sexual violence.
- SRH coordinators should inform service providers of guidance on country-specific laws with regard to the age of consent for treatment, the professional who can give legal consent for clinical care if a parent or guardian is the suspected offender, and mandatory reporting requirements and procedures when service providers suspect, or are informed of a case of child abuse.
- With adequate preparation, most children will be able to relax and participate in the examination. It is possible that the child is in pain and cannot relax for this reason. If you suspect the child is in pain, then give simple pain relief first, such as paracetamol, and wait for this to take effect.
- A child should never be examined against his or her will, regardless of age, unless treatment is vital. Never restrain and force an unwilling child to complete an examination. If the child cannot be calmed down and treatment is vital, only then may an examination be performed by a trained provider with the child under sedation, using diazepam or promethazine hydrochloride (from Clinical Management of Sexual Violence Survivors: Facilitator's Guide https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf).
- Digital vaginal or anal or speculum examinations should not be conducted in children unless absolutely necessary. In those cases, children should be referred to a specialist (IAFM 2018).
- Protocols showing appropriate drug dosages must be posted or easily available to service providers (IAFM 2018).

Note to facilitators Allow participants time to add any relevant information on providing care to child survivors to their original matrix (Participant Handout #5).

Provide participants with information on resources they might access to increase their own capacity to provide treatment to child survivors of sexual violence in emergencies (such as IAWGs Training Partnership Initiative's S-CORT resources, available at http://iawg.net/tpi-home/).

Slide #39: History & examination: male survivors

Key Messages



History & Examination: male survivors

Special considerations for male survivors:

- Less likely to report- stigma and myths
- Different physical affects & treatment needs
- Common forms of SV: genital violence, forced rape of others, anal rape with objects [ie., not only penile rape]

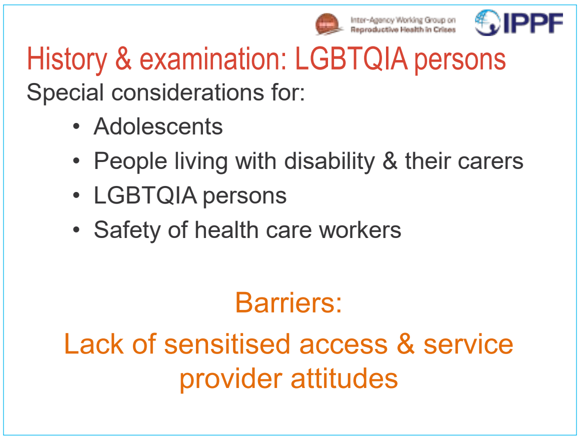
Follow guiding principles of safety, confidentiality, respect & non-discrimination

- Male survivors are less likely to report an incident of sexual violence because of shame, criminalization of same sex relationships, and negative or homophobic provider attitudes.
- Destructive myths around male survivors can also also exist such as male rape survivors become gay
- Often providers & survivors don’t recognize genital violence, forced rape of others, etc, as sexual violence
- It is critical that service providers follow the guiding principles of safety, confidentiality, respect and non-discrimination with male survivors just as they do with all survivors.

Note to facilitators Allow participants time to add any relevant information on providing care to male survivors to their original matrix (Participant Handout #5).

Slide #40: History & examination: LGBTQIA persons

Key Messages



History & examination: LGBTQIA persons

Special considerations for:

- Adolescents
- People living with disability & their carers
- LGBTQIA persons
- Safety of health care workers

Barriers:

Lack of sensitised access & service provider attitudes

- Service providers have a responsibility to ensure that special consideration is given to the needs of survivors from other specific populations, including adolescents, people with a disability and their carers, LGBTQIA persons and for the safety of themselves and their colleagues.

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

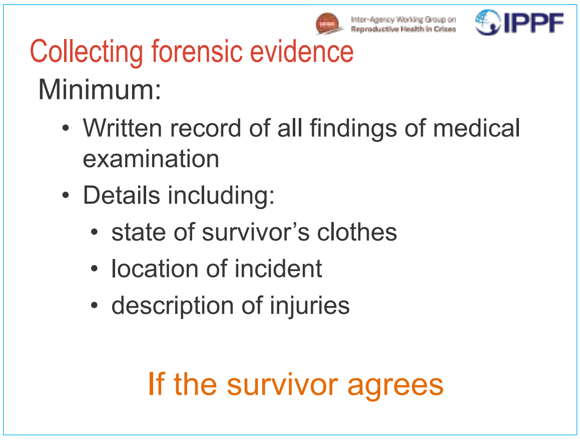
Remind participants that considerations for male and LGBTQIA survivors are important. Negative and homophobic provider attitudes are a main barrier to care, as are destructive myths such as male rape survivors become gay. Another barrier at the service provision level is when providers and survivors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

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

Remind participants that the attitudes of service providers are key- they can facilitate a survivor's path to having their health care needs met, or they can be an insurmountable barrier.

Slide #41: Collecting forensic evidence

Key Messages



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Collecting forensic evidence

Minimum:

- Written record of all findings of medical examination
- Details including:
  - state of survivor's clothes
  - location of incident
  - description of injuries

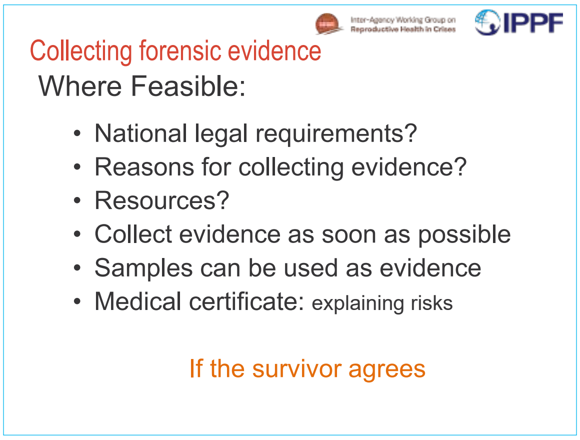
If the survivor agrees

- The next step in responding to the clinical needs of sexual violence survivors is the collection of forensic evidence.
- A non-specialised health care provider should, at a minimum, keep a careful written record of all findings during the medical examination that can support the survivor's story, including the state of the survivor's clothes, location of the incident, and a detailed description of any injuries. The medical chart is part of the legal record and a summary of it can be submitted as evidence (with the survivor's consent) if the case goes to court. It must be kept confidential in a secure place (IAFM 2018).

Note to facilitators Updated guidelines from WHO/UNFPA on the Clinical Management of Rape (CMR) provide more guidance on the collection of evidence given contextual difficulties. Refer to most recent guidelines before facilitating this section to provide your participants with latest updates.

Slide #42: Collecting forensic evidence

Key Messages



Collecting forensic evidence

Where Feasible:

- National legal requirements?
- Reasons for collecting evidence?
- Resources?
- Collect evidence as soon as possible
- Samples can be used as evidence
- Medical certificate: explaining risks

If the survivor agrees

- In addition to this minimum collection of evidence, trained health care providers can collect further forensic evidence

- Different countries and locations have different legal requirements and different facilities (laboratories, refrigeration etc.) for performing tests on forensic materials. National and local resources and policies should determine if and what evidence should be collected and by whom (from Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1).

- In crisis settings, various aspects of an existing system comprised of health and social services, forensic medicine, forensic lab services, police/ investigative services, and the legal system could be compromised due to a lack of qualified personnel or insufficient/ damaged facilities, equipment, supplies, and resources (IAFM 2018).

- Clinical management of survivors takes priority over the medico-legal process. However, if the survivor agrees, the exam and forensic evidence can be collected together. (IAFM 2018).

- Evidence should be collected as soon as possible after the incident. Documenting injuries and collecting samples within 72 hours can help to support the survivor's story. If the survivor presents more than 72 hours after the incident, the amount and type of evidence that can be collected will depend on the situation (Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1).

- Samples can include injury evidence, clothing, foreign material, hair, sperm/ seminal fluid, DNA, blood or urine.

- Health care providers should systematically offer a medical certificate to the survivor with a clear explanation of risks in keeping this document. Depending on the law applicable in the setting, this form may be used for legal purposes, such as redress or asylum. Two copies of the document are made. One copy is kept locked away at the health facility or by the program manager. The other copy is provided to the survivor if she or he wants it after careful counseling of the risk of further violence if the document is found in the survivor's possession. These documents should be provided free of charge. The survivor is the only one who decides when and how to use the medical certificate (IAFM 2018).

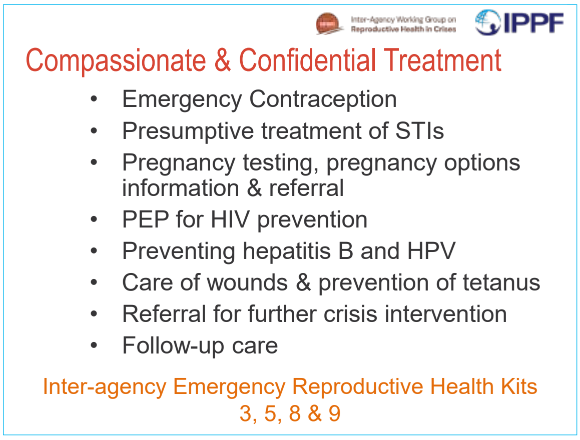
Note to facilitators Provide participants with information on national laws and protocols for the collection and processing of forensic evidence. Make clear to participants what is available in standard settings, what is required by law and who is able to collect such evidence.

Reiterate that these resources may not remain available in humanitarian settings . Explain to participants that it is often challenging to collect and store evidence, and ensure no cross contamination at the onset of an emergency. Investing time and limited resources into doing so should be carefully planned and weighed up against other priorities in the acute phase.

Encourage participants to add this aspect of responding to the needs of survivors of sexual violence to their matrix for this session.

Slide #43: Compassionate & confidential treatment

Key Messages



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Compassionate & Confidential Treatment

- Emergency Contraception
- Presumptive treatment of STIs
- Pregnancy testing, pregnancy options information & referral
- PEP for HIV prevention
- Preventing hepatitis B and HPV
- Care of wounds & prevention of tetanus
- Referral for further crisis intervention
- Follow-up care

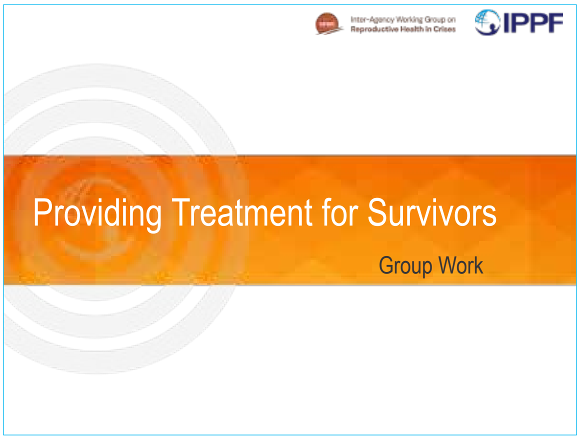
Inter-agency Emergency Reproductive Health Kits 3, 5, 8 & 9

- The IAFM 2018 outlines treatment for survivors of sexual violence in humanitarian settings as including: emergency contraception; presumptive treatment of STIs; pregnancy testing, pregnancy options information and referral; preventing HIV transmission; preventing hepatitis B and HPV; care of wounds and prevention of tetanus; referral for further crisis intervention; and follow-up care.
- Treatment can be started without examination if that is the survivor's choice. Treat life-threatening complications and refer to higher-level health facilities if appropriate (IAFM 2018).
- All treatment should follow the guiding principles for responding to the needs of survivors of sexual violence, and the fundamental principles of programming in humanitarian settings.

Note to facilitators Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants. Advise participants to keep the booklet open as you go through the treatment slides.

Let participants know the next few slides will go into detail about the different treatment options on the slide. Participants can find more detailed information between p 28-34 of the IAFM. After going through this section you may want to give participants some time to revisit their matrix for the session.

Slide #44: Providing treatment for survivors: Group Work



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Providing Treatment for Survivors

Group Work

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, and less time spent on areas familiar to participants.

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

Time

30 minutes

Process

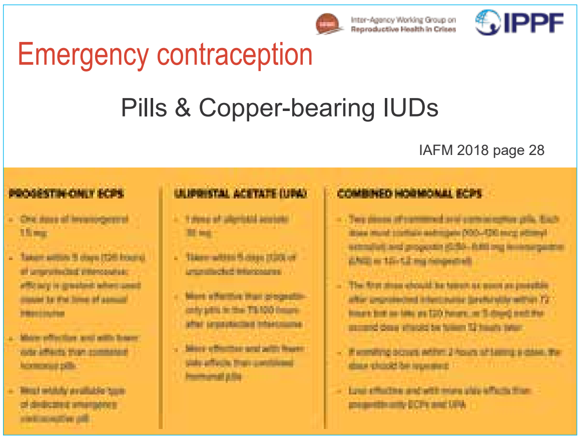
- Advise participants that the subject matter may be upsetting and they can take a break at any time throughout the exercise.
- Divide participants into two groups.
- Ask participants to look at Participant Handout #8 and work through the case studies and treatment decisions as a group. Group 1 to review 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 in the instructions on the Participant handout.

Materials

Participant Handout #8

Slide #45: Emergency Contraception

Key Messages



Emergency contraception

Pills & Copper-bearing IUDs

IAFM 2018 page 28

PROGESTIN-ONLY ECPS

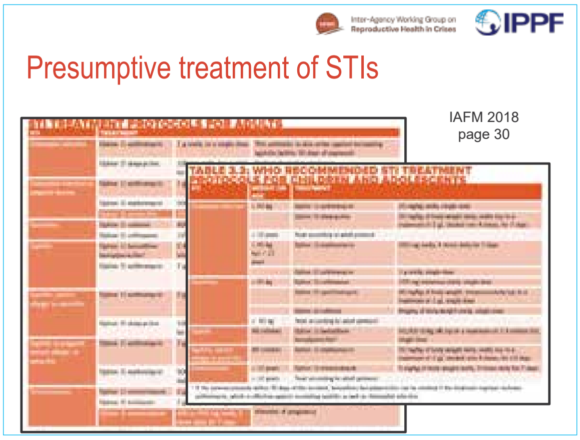
ULIPRISTAL ACETATE (UPA)

COMBINED HORMONAL ECPS

- "Emergency contraception (EC) can prevent unintended pregnancies after sexual violence. EC should be provided as soon as possible to a sexual violence survivors or within 120 hours after the rape.
- There are multiple regimens of emergency contraceptive pills (ECPs) that can be used, including those indicated on the slide.
- A copper bearing IUD can also be inserted in medically eligible women through to 5 days after unprotected sex, including sexual violence. Effective form of post coital contraception that that will prevent more than 99% of expected pregnancies (p29 IAFM)
- Service providers should provide counselling on both options to allow for informed and voluntary choice. Counselling should include information on risk, benefits, side effects and complications.

Slide #46: Presumptive treatment of STIs

Key Messages



Presumptive treatment of STIs

IAFM 2018 page 30

STI TREATMENT PROTOCOLS FOR ADULTS

TABLE 3.3: WHO RECOMMENDED STI TREATMENT PROTOCOLS FOR CHILDREN AND ADOLESCENTS

- Service providers should provide survivors with "antibiotics to presumptively treat gonorrhea, chlamydial infection, and syphilis, as warranted and if desired. If other STIs are prevalent in the area (such as trichomoniasis or chancroid), give presumptive treatment for these infections as well. (IAFM 2018 p30).
- The shortest course available should be given.
- Where an IUD has been inserted make sure to give full STI treatment. (IAFM,29)

Slide #47: Pregnancy testing and options information

Key Messages

Pregnancy Testing & Options Information

Pregnancy testing, pregnancy options information & safe abortion care/ referral for safe abortion care, to the full extent of the law

- Pregnancy testing at initial presentation but do not withhold EC if testing not available
- Additional testing at 2 week and 1 month follow-up if possible
- Accurate information about pregnancy options
- Safe abortion care or referral to the full extent of the law

IAFM 2018
Page 31

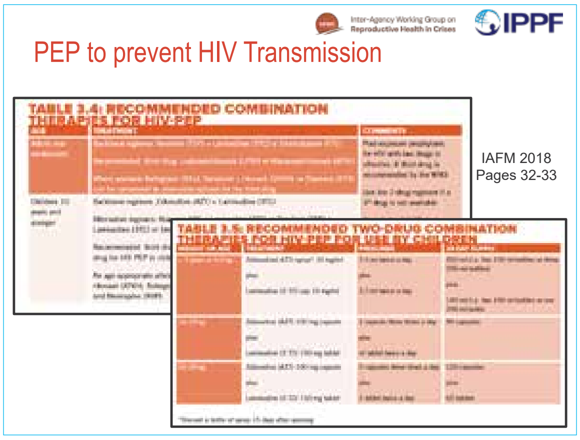
- Service providers should provide pregnancy testing at the time of the initial presentation but should not withhold emergency contraception if pregnancy testing is not available. Additional pregnancy testing should be made available at the 2 week and 1 month follow-up visits where possible.

- Survivors should be provided with "accurate information about pregnancy options, including continuing the pregnancy and parenting, continuing the pregnancy and placing the child for adoption, and having an abortion, as applicable, and non-biased counseling to facilitate informed decision making" (IAFM 2018 p31).

- "If the survivor is pregnant as a result of sexual violence and an abortion is desired, provide safe abortion care or a referral for hat care, to the full extent of the law. Women can seek post-rape care any time after the event.

Slide #48: PEP to prevent HIV transmission

Key Messages



PEP to prevent HIV Transmission

IAFM 2018
Pages 32-33

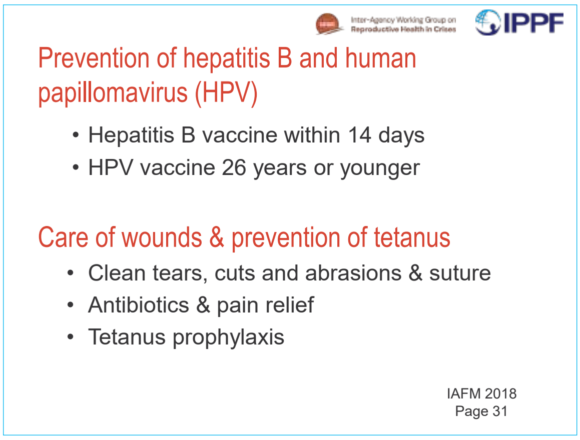
- Service providers should offer and initiate post-exposure prophylaxis (PEP) "as early as possible for all individuals with an exposure that has potential for HIV transmission. The likelihood of HIV transmission after sexual violence can be reduced through the prompt administration of PEP" (IAFM 2018 p32).

- "PEP must be initiated as soon as possible and no later than 72 hours following exposure and continued for 28 days. Studies suggest that PEP is more effective the sooner it is initiated" (IAFM 2018 p32).

- "Although PEP is ideally provided within 72 hours of exposure, people may not be able to access services within this time. Provide other relevant post-rape care and refer clients presenting after 72 hours for voluntary HIV counseling and testing services, as appropriate" (IAFM 2018 p32).

Slide #49: Prevention of hepatitis B & HPV & care of wounds & prevention of tetanus

Key Messages



Prevention of hepatitis B and human papillomavirus (HPV)

- Hepatitis B vaccine within 14 days
- HPV vaccine 26 years or younger

Care of wounds & prevention of tetanus

- Clean tears, cuts and abrasions & suture
- Antibiotics & pain relief
- Tetanus prophylaxis

IAFM 2018
Page 31

- Service providers should "provide hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. A total of 3 doses are needed, the second dose 4 weeks after the first, and the third dose 8 weeks after the second dose" (IAFM 2018 p33).

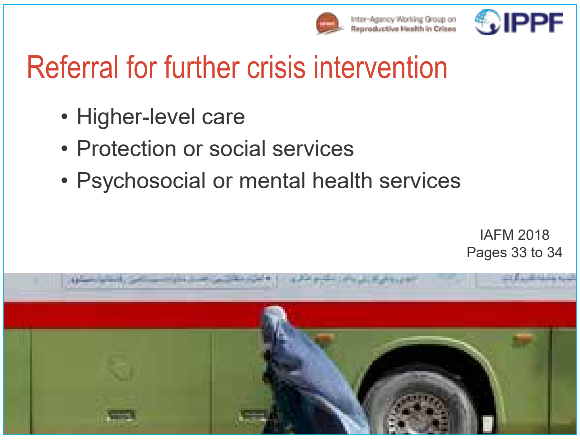
- "Consider providing the HPV vaccine to anyone age 26 or younger, unless the survivor has been fully vaccinated. In most cases, a total of 3 doses need to be given over a 6-month period" (IAFM 2018 p33).

- Service providers should "[c]lean any tears, cuts, and abrasions and suture clean wounds within 24 hours. Do not suture dirty wounds. Consider giving appropriate antibiotics and pain relief if there are large unclean wounds" (IAFM 2018 p33).

- "Give tetanus prophylaxis if there are any breaks in skin or mucosa and the survivor is not vaccinated against tetanus, or the vaccination status is uncertain. Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year" (IAFM 2018 p33).

Slide #50: Referral and follow-up care

Key Messages



Referral for further crisis intervention

- Higher-level care
- Protection or social services
- Psychosocial or mental health services

IAFM 2018
Pages 33 to 34

- With the survivors consent or upon their request, service providers should offer referral to a hospital in case of life-threatening complications or where clinical needs can not be met at the health facility level; and to protection or social services in cases where the survivor does not have a safe place to go when they leave the health facility.

- Survivors may also be referred to psychosocial or mental health services where these are available. Service providers and managers should liaise with GBV and protection focal points to identify such services in their setting, keeping in mind that this might involve services offered by affected populations, women's centres, and other support groups.

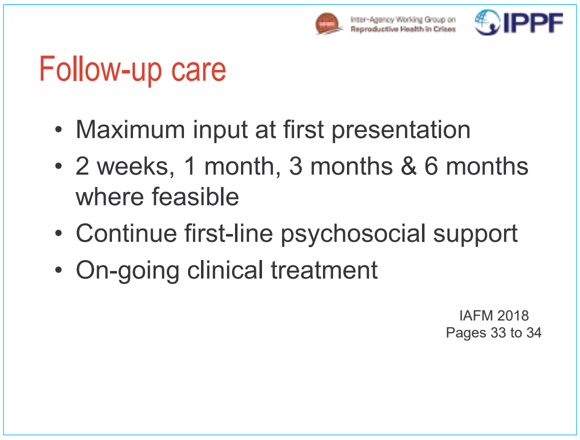
- All survivors should be offered a referral to the community focal point for gender-based violence, if one exists.

- In instances where there is no GBV focal point available in your area, the IASC "How to support survivors of gender-based violence when a GBV actor is not available in your area" Pocket Guide (herein IASC Pocket Guide) is a useful document to make broadly available to humanitarian practitioners on the frontline who are not specialists.

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

Slide #51: Follow-up care

Key Messages



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Follow-up care

- Maximum input at first presentation
- 2 weeks, 1 month, 3 months & 6 months where feasible
- Continue first-line psychosocial support
- On-going clinical treatment

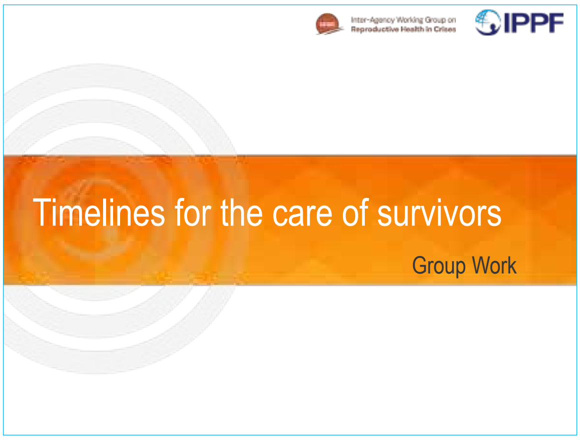
IAFM 2018
Pages 33 to 34

- Service providers should assure the survivor that they may return to the health facility at any time if they have questions or other health problems.

- In emergency settings, it is possible that the survivor cannot or will not return to the health facility for follow up. It is important, therefore, to provide maximum input during the first visit as this may be only contact the survivor has with medical and psychosocial help. This maximum input should include the clinical treatment and services outlined above, sanitary items, referral information to take home, and ideally a change of clothes.

- "If feasible, follow-up care is recommended at 2 weeks, 1 month, 3 months, and 6 months following the incident" (IAFM 2018 p34). This can support things such as monitoring and treatment of wounds, follow-up vaccinations (tetanus, hepatitis B, HPV), support adherence to STI prophylaxis or treatment including PEP, provide HIV testing at 3 months and 6 months, and inform survivors of pregnancy status and options.

Slide #52: Timelines for the care of survivors



Timelines for the care of survivors

Group Work

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

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

Time

30 minutes

Process

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

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

Materials

- Participant Handout #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

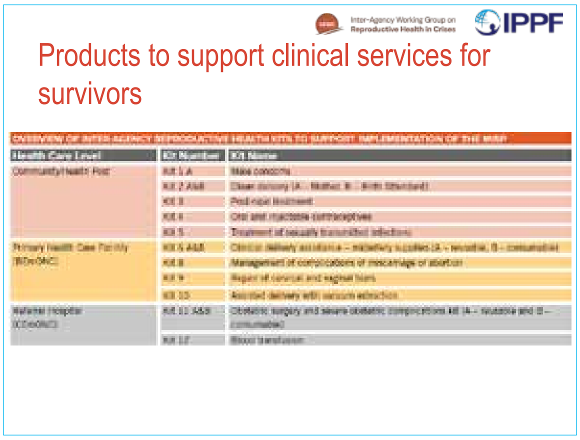
Key Discussion points

- 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 #9 which provides a summary of treatment timelines.

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

Slide #53: Products to support clinical services for survivors

Key Messages



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Products to support clinical services for survivors

OVERVIEW OF INTER-AGENCY REPRODUCTIVE HEALTH KITS TO SUPPORT IMPLEMENTATION OF THE MISP		
Health Care Level	**Kit Number**	**Kit Name**
Community/Health Post	Kit 1 A	Male condoms
	Kit 2 A&B	Clean delivery (A – Mother; B – Birth Attendant)
	Kit 3	Post-rape treatment
	Kit 4	Oral and injectable contraceptives
	Kit 5	Treatment of sexually transmitted infections
Primary Health Care Facility (BEmONC)	Kit 6 A&B	Clinical delivery assistance – midwifery supplies (A – reusable; B – consumable)
	Kit 8	Management of complications of miscarriage or abortion
	Kit 9	Repair of cervical and vaginal tears
	Kit 10	Assisted delivery with vacuum extraction
Referral Hospital (CEmONC)	Kit 11 A&B	Obstetric surgery and severe obstetric complications kit (A – reusable and B – consumable)
	Kit 12	Blood transfusion

- Program and clinic managers will need to ensure the availability of commodities and equipment to support the clinical care for survivors of sexual violence.

- Program and clinic managers can work in the preparedness phase to support the pre-positioning of appropriate supplies to implement clinical care for survivors of sexual violence. These may include medical drugs, equipment, and administrative supplies. Health care providers can liaise closely with program and clinic managers to provide input on necessary supplies and their use.

- Commodities and equipment to support the implementation of clinical services for survivors are available in the reproductive health kits shown on the slide. These may be ordered if necessary by program managers to support the response in the acute phase of the emergency.

Note to facilitators If available, provide participants with copies of the Reproductive Health Kit books and allow them some time to look through the content of the kits for this MISP component.

If not available, ask participants to look at the kit descriptions on the MISP for SRH Cheat Sheet. Facilitate a brief discussion about the contents of the kits, which supplies and equipment they are familiar with, and how these differ from those they use in their current practice.

Slide #54: Respond to the needs of survivors

Key Messages

- The next activity under the second objective of the MISP for SRH is to put in place confidential and safe spaces within health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

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Respond to the Needs of Survivors:

MISP: Put in place confidential & safe spaces

within health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

- Safety & Confidentiality
- Availability of information
- Compassion & non-discrimination

- Safety of survivors must be a critical consideration in both choosing the location of health facilities, and in planning how services are delivered within the facility. Facilities should be located in safe places, with adequate lighting, sex-separated washing and latrine facilities and within easy access to main roads and settlements. Engaging with the affected population, particularly marginalized communities in the setting up of facilities is valuable.

- In consultation with program managers, service providers should consider the need for security personnel at facility entrances.

- Facilities must have private non-stigmatizing examination rooms.

- The confidentiality of individuals who provide information about sexual violence must be maintained at all times and they must give consent before their information is documented (IAFM 2018). All information should be kept in locked storage and be not attributable to individuals.

⚠ **Note to facilitators** If time permits, ask participants to brainstorm ways that safety and confidentiality may be optimised for survivors and health care providers in their context. Provide an example of women friendly tents as one option for this important work.

Slide #55: Respond to the needs of survivors

Key Messages

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MISP: Put in place confidential & safe spaces

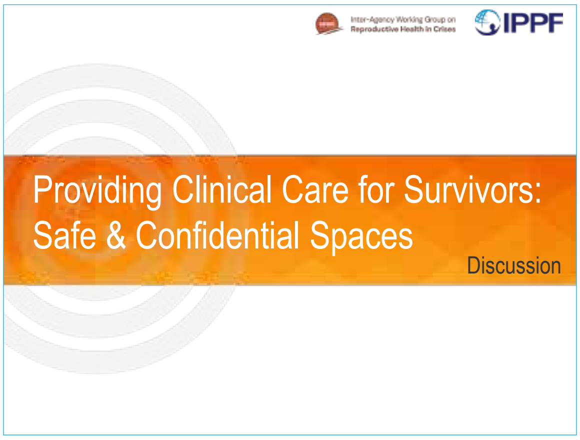
- Culturally acceptable
- Giving special consideration to vulnerable groups

- As mentioned above, the survivor's healing process begins from the first visit to the clinic. This may only be true if available care maintains confidentiality and safety, and is provided in a way that is appropriate to the socio-cultural background of the survivor.

- Special considerations will need to be given when providing care to vulnerable groups. The next part of this session will work through the special needs of children, male survivors, persons with disabilities, LGBTQIA individuals, people who engage in sex work and ethnic and religious minorities.

Note to facilitators Ask participants what confidential and safe spaces for receiving and providing care to survivors of sexual violence might look like in their setting. Allow a few minutes to discuss this with their table groups and ask participants to add to their matrix (Participant Handout #5) any additional resources or actions needed to ensure these spaces.

Slide #56: Providing clinical care for survivors: safe & confidential spaces



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Providing Clinical Care for Survivors: Safe & Confidential Spaces

Discussion

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 two 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

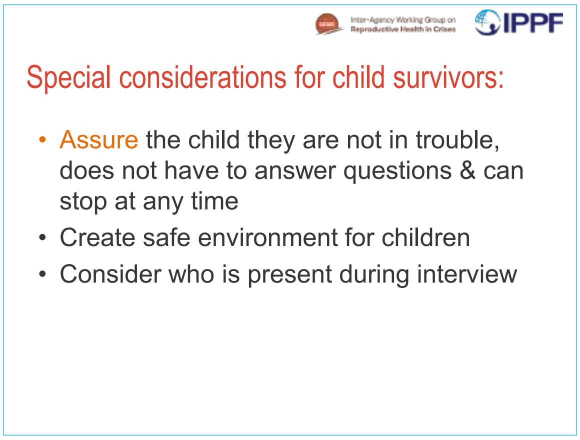
- Participant Handout #10
- Items as depicted in pictures

Solutions/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.

Slide #57: Special consideration for child survivors

Key Messages



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Special considerations for child survivors:

- Assure the child they are not in trouble, does not have to answer questions & can stop at any time
- Create safe environment for children
- Consider who is present during interview

- Briefly remind participants of the special considerations that should be taken for child survivors of sexual violence. To create a safe environment for children, service providers should "take special care in determining who is present during the interview and examination (remember that it is possible that a family member is the perpetrator of the abuse). It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present" (from Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1).

- Service providers should always introduce themselves to the child, sit at eye level and maintain eye contact. The child should always and continually be assured that she or he is not in any trouble. It is a good idea to start by asking a few questions about neutral topics before taking the history and conducting the examination. Service providers should always be patient and go at the child's pace through history taking, examination and treatment (from Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1).

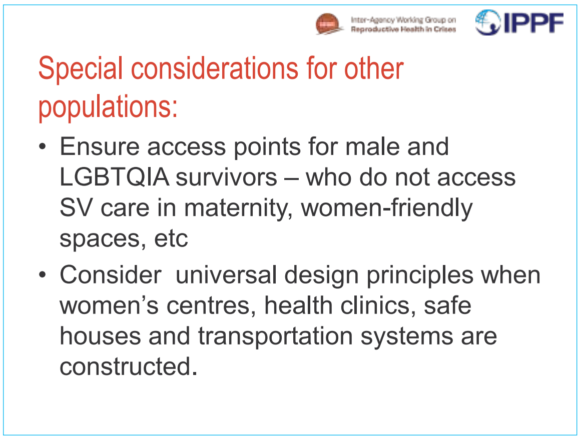
Note to facilitators Provide participants with information on national consent and mandatory reporting laws and protocols if they exist.

Remind participants that the fundamental principles of sexual and reproductive health programming in humanitarian settings discussed earlier in the training apply equally to children. If time permits, take a moment to reflect on these as a group and reiterate the importance of applying them to child survivors of sexual violence.

For more on ensuring confidential and safe spaces for child survivors of sexual violence, direct participants to Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (https://apps.who.int/iris/bitstream/handle/10665/43117/924159263X.pdf;jsessionid=F5B1121EC25BA7D7C4FEB0EA07B09186?sequence=1.

Slide #58: Special considerations for other populations

Key Messages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Special considerations for other populations:

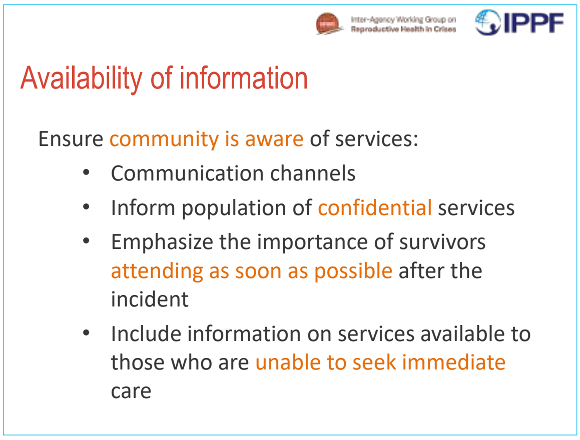
- Ensure access points for male and LGBTQIA survivors – who do not access SV care in maternity, women-friendly spaces, etc
- Consider universal design principles when women's centres, health clinics, safe houses and transportation systems are constructed.

- Briefly remind participants that other specific populations also require special considerations to ensure that there are appropriate confidential and safe spaces within health facilities where they can be received and provided with appropriate clinical care and referral.
- Note male or LGBTQIA survivors will not likely access services in maternity, women-friendly spaces, etc where they are likely to stand out or feel uncomfortable.
- In order to for women and girls with disabilities to access confidential and safe GBV care services principles of universal design should be considered in the construction of health facilities.

Note to facilitators The IASC guidelines on Inclusion of persons with disabilities in humanitarian Action, July 2019 provides more information on GBV considerations for people living with disabilities in acute and protracted emergencies. For more information see https://interagencystandingcommittee.org/system/files/2019-11/IASC%20Guidelines%20on%20the%20Inclusion%20of%20Persons%20with%20Disabilities%20in%20Humanitarian%20Action%2C%202019.pdf .

Slide #59: Availability of information

Key Messages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Availability of information

Ensure community is aware of services:

- Communication channels
- Inform population of confidential services
- Emphasize the importance of survivors attending as soon as possible after the incident
- Include information on services available to those who are unable to seek immediate care

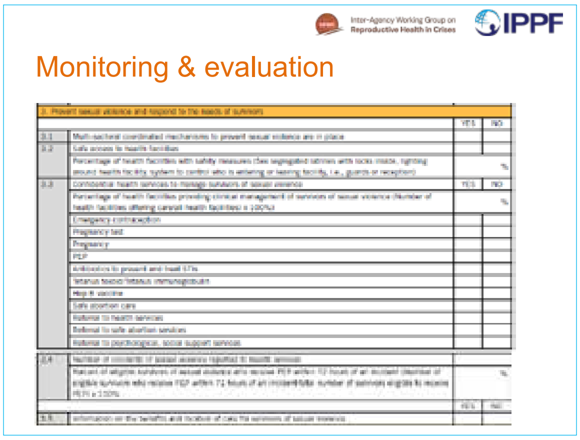
- The community must also have access to appropriate information that these services are available, the location of the services and their hours of operation.
- Service providers should work with program managers to inform the community about the importance of seeking immediate medical care following sexual violence, as highlighted in the earlier exercise.
- Affected populations should know that services are confidential and available to all people, regardless of age or marital status.

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

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

Slide #60: Monitoring & evaluation

Key Messages



Monitoring & evaluation

- Monitoring and evaluation are important components of ensuring the quality of services provided. For all monitoring and evaluation, and particularly for sexual violence, it is critically important that confidentiality is maintained and any data is de-identified.

- The MISP Checklist provides a useful tool for monitoring and evaluating the sexual violence objective of the MISP, and further indicators are included in the IAFM 2018.

- Indicators that should be collected at the health-facility level include (from IAFM 2018 p208):
  - Number of reported cases of sexual violence reported to health services (per month);
  - Timing of EC provision (percentage of eligible rape survivors presenting to the health services within 120 hours who receive EC);
  - Timing of PEP provision (percentage of eligible rape survivors who present to the health services within 72 hours and receive PEP);
  - Number of women and girls who receive safe abortion care (SAC) to the full extent of the law.

- Indicators to measure annually:
  - Number of health workers trained in providing clinical care to survivors of sexual violence.

- The MISP for SRH checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. The presence of staff with capacity to provide care to survivors should also be considered, as should opportunities for developing capacity and task-sharing.

Note to facilitators Another important tool that you may wish to introduce to your participants is the Gender Based Violence Information Management System. The GBVIMS enables those providing services to GBV survivors to effectively and safely collect, store, analyse and share data related to the reported incidents of GBV.

It can be found at https://resourcecentre.savethechildren.net/library/gender-based-violence-information-management-system-gbvims

Slide #61: Sharing & using data

Key Messages

Sharing & using data

- Coordinate data collection
- Align tools and data collection methods
- Ensure privacy, confidentiality & safety
- Avoid blaming and being judgemental

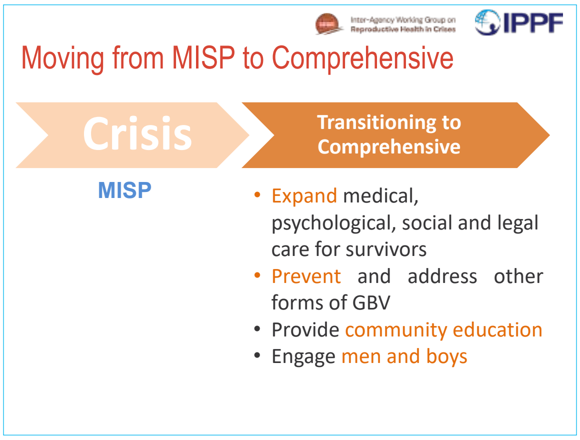
Use your findings to improve your service delivery & quality of care

- To make best use of data collected during clinical service delivery, it is important to ensure that data collection tools and methods are aligned and coordinated amongst facilities and across organisations.
- Privacy, confidentiality and safety must remain the first concern when sharing data. All data must be de-identified and unable to be attributed to any individual in any way.
- When results of an evaluation are available, it is important to regard any negative findings as an opportunity to improve the delivery of critical life-saving services, rather than judging or blaming individuals or organizations for the outcomes.
- Most importantly, efforts for monitoring and evaluation come to nothing if findings are not used to improve service delivery.

Slide #62: Moving from MISP to comprehensive

Key Messages

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



Moving from MISP to Comprehensive

Crisis

MISP

Transitioning to Comprehensive

- Expand medical, psychological, social and legal care for survivors
- Prevent and address other forms of GBV
- Provide community education
- Engage men and boys

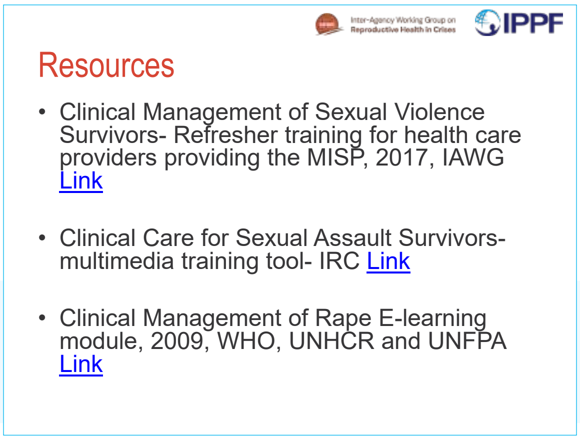
Note to facilitators Ask participants to look again at the first column of their matrix for this session (Participant Handout #5). Facilitate a group discussion around which of the components of expanded care for survivors of sexual violence were included at the start of the session compared to those on the slide. Ask participants to reiterate how these compare to the services provided for in the MISP and ensure that all areas covered during this session are mentioned.

Slide #63: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their capacity to prevent sexual violence and respond to the needs of survivors in humanitarian settings.

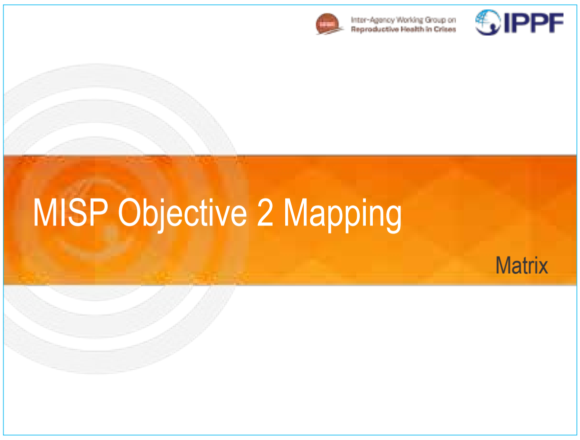
Note to facilitators Add to this slide with context-specific resources as able.



Resources

- Clinical Management of Sexual Violence Survivors- Refresher training for health care providers providing the MISP, 2017, IAWG Link
- Clinical Care for Sexual Assault Survivors- multimedia training tool- IRC Link
- Clinical Management of Rape E-learning module, 2009, WHO, UNHCR and UNFPA Link

Slide #64: MISP Objective 2: Mapping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MISP Objective 2 Mapping

Matrix

Participants will spend some time reviewing the entries they have made to their matrix for this MISP for SRH Objective and add any further information as needed.

Time

20 minutes

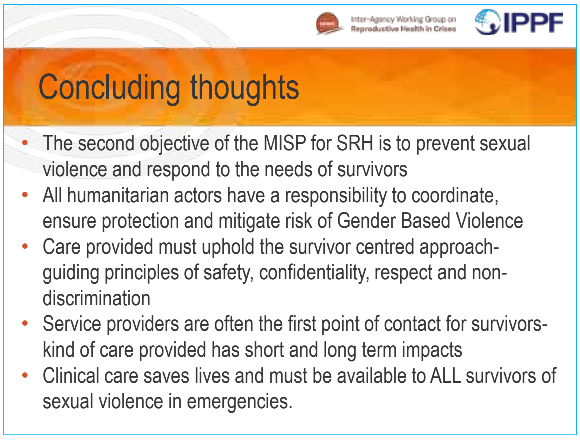
Process

- Ask participants to return to their matrix for this objective of the MISP for SRH.
- In pairs or groups, participants should review and compare the entries they have made during the session and add any information that is missing.
- When this is done, ask participants to work (again in pairs or groups) to identify any gaps and priorities for action to fill these gaps.

Materials

Participant Handout #5

Slide #65: Concluding thoughts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Concluding thoughts

- The second objective of the MISP for SRH is to prevent sexual violence and respond to the needs of survivors
- All humanitarian actors have a responsibility to coordinate, ensure protection and mitigate risk of Gender Based Violence
- Care provided must uphold the survivor centred approach- guiding principles of safety, confidentiality, respect and non-discrimination
- Service providers are often the first point of contact for survivors- kind of care provided has short and long term impacts
- Clinical care saves lives and must be available to ALL survivors of sexual violence in emergencies.

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

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

Day 2 continued

MISP Objective 3: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs

Session 2.2 3 hours

Overview

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

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #66: Session 2.2: MISP Objective 3: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs

Welcome your participants back from their break and explain that you are now moving on to MISP for SRH Objective 3: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs.

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Session 2.2: MISP Objective 3:Prevent the Transmission of an Reduce Morbidity and Mortality due to HIV and Other STIs
Training for Service Providers

Slide #67: Learning objectives

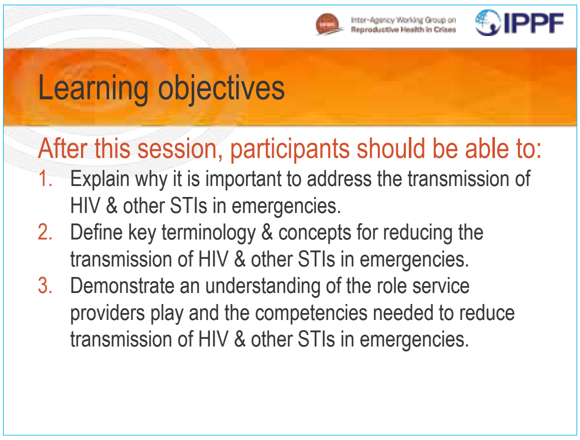
Key Messages

- There are 3 learning objectives for session 2.2:

  1. Explain why it is important to address the transmission of HIV & other STIs in emergencies.

  2. Define key terminology & concepts for reducing the transmission of HIV & other STIs in emergencies.

  3. Demonstrate an understanding of the role service providers play and the competencies needed to reduce transmission of HIV & other STIs in emergencies.



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Learning objectives

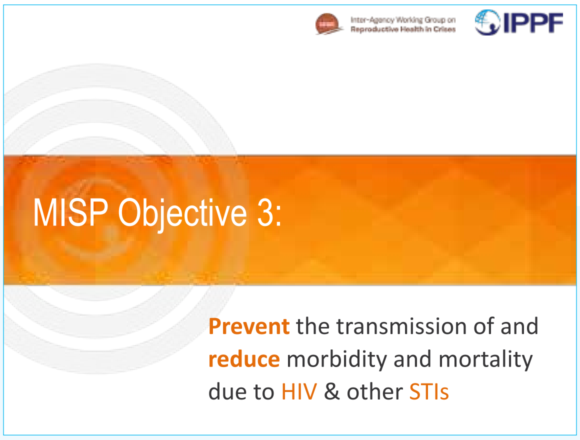
After this session, participants should be able to:
1. Explain why it is important to address the transmission of HIV & other STIs in emergencies.
2. Define key terminology & concepts for reducing the transmission of HIV & other STIs in emergencies.
3. Demonstrate an understanding of the role service providers play and the competencies needed to reduce transmission of HIV & other STIs in emergencies.

Slide #68: MISP objective 3

Key Messages

- The third MISP Objective is to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.

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

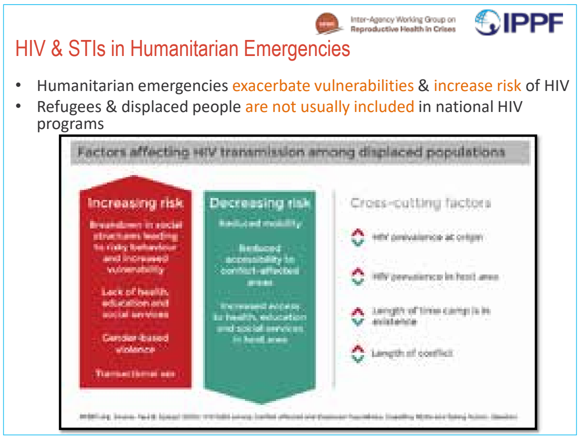


MISP Objective 3:

Prevent the transmission of and **reduce** morbidity and mortality due to HIV & other STIs

Slide #69: HIV & STIs in humanitarian emergencies

Key Messages



HIV & STIs in Humanitarian Emergencies

- Humanitarian emergencies exacerbate vulnerabilities & increase risk of HIV
- Refugees & displaced people are not usually included in national HIV programs

- HIV transmission in humanitarian settings is complex and is dependent on the dynamic interaction of a variety of factors. This includes HIV prevalence and vulnerability of some groups within the population in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement, and the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees) (IAFM 2018).

- The characteristics that define a complex emergency, such as conflict, mass displacement, loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV (IAFM 2018).

- As indicated on the slide, this increased vulnerability occurs through the breakdown of social structures; reduced access to HIV prevention, treatment and care services; exacerbated inequalities and stigmatization of PLWHIV; and an increase in GBV.

- In addition to this, refugees and internally displaced people are not usually included in national HIV programs, meaning that prevention and treatment services may not reach them.

Slide #70: Local HIV and STI situation

Key Messages

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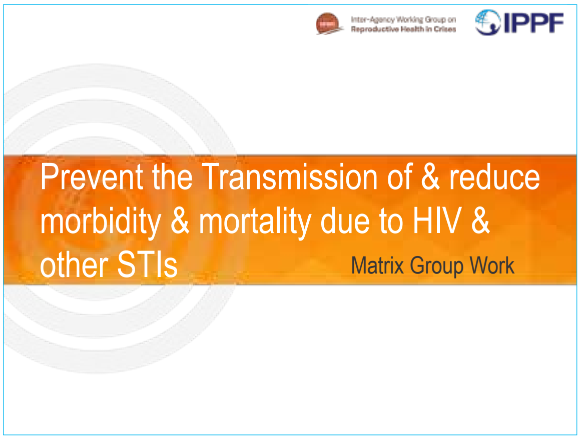
Local HIV and STI data

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

Slide #71: Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs: matrix

Matrix Group Work



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Prevent the Transmission of & reduce morbidity & mortality due to HIV & other STIs

Matrix Group Work

Time

10 minutes.

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.

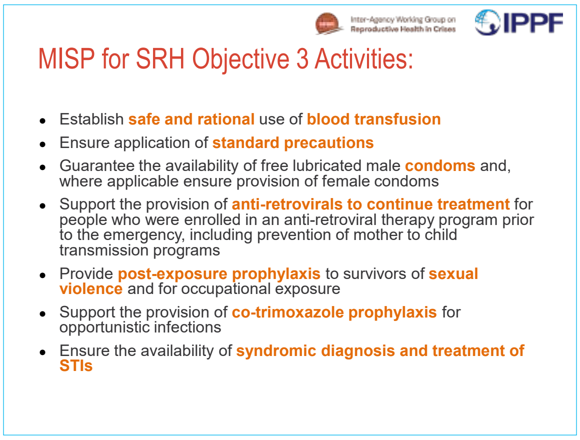
- Encourage participants to work in groups (such as table groups) to brainstorm and engage their existing knowledge and experience of this objective, filling in aspects of the matrix as they are able at this stage. Remind participants that they will have the opportunity to add to the matrix throughout and at the end of the session.

Materials

- Participant Handout #11
- MISP for SRH Cheat Sheet

Slide #72: MISP for SRH Objective 3 Activities

Remind participants of the seven activities under MISP Objective 3.



MISP for SRH Objective 3 Activities:

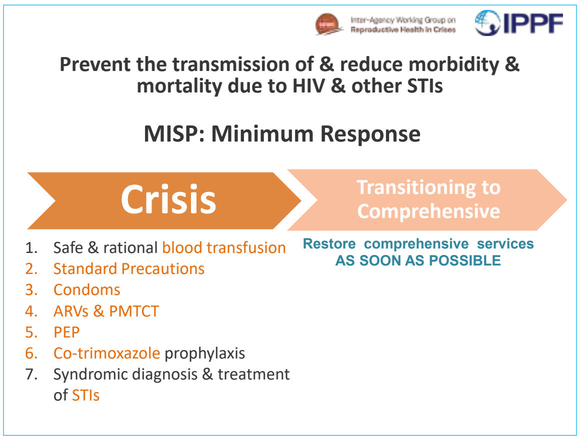
- Establish **safe and rational** use of **blood transfusion**
- Ensure application of **standard precautions**
- Guarantee the availability of free lubricated male **condoms** and, where applicable ensure provision of female condoms
- Support the provision of **anti-retrovirals to continue treatment** for people who were enrolled in an anti-retroviral therapy program prior to the emergency, including prevention of mother to child transmission programs
- Provide **post-exposure prophylaxis** to survivors of **sexual violence** and for occupational exposure
- Support the provision of **co-trimoxazole prophylaxis** for opportunistic infections
- Ensure the availability of **syndromic diagnosis and treatment of STIs**

Slide #73: Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs

Key Messages

- Remind participants that we are now going to look at priority activities for preventing the transmission of & reducing morbidity & mortality due to HIV & other STIs in humanitarian settings as they are prescribed by the MISP for SRH.

- The MISP for SRH must be implemented as a minimum in every humanitarian emergency. There are 7 activities under Objective 3 of the MISP for SRH.



Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs

MISP: Minimum Response

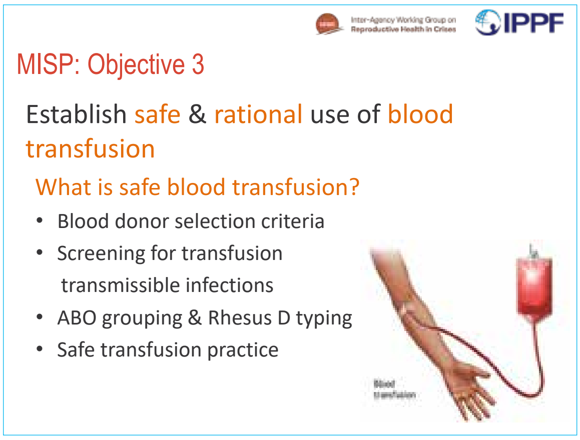
1. Safe & rational blood transfusion
2. Standard Precautions
3. Condoms
4. ARVs & PMTCT
5. PEP
6. Co-trimoxazole prophylaxis
7. Syndromic diagnosis & treatment of STIs

Restore comprehensive services AS SOON AS POSSIBLE

Slide #74: Establish safe & rational use of blood transfusion

Key Messages

- The first activity under MISP for SRH Objective 3 is to establish safe and rational use of blood transfusion.
- Safe blood transfusion includes collecting blood only from voluntary, unpaid blood donors at low risk of acquiring TTIs and developing stringent blood donor selection criteria (IAFM 2018).
- All blood must be screened for at least HIV 1 and 2, hepatitis B, hepatitis C, and syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine status (IAFM 2018).
- ABO grouping and Rhesus D typing and, if time permits, cross-matching should be conducted. Women of reproductive age should only be transfused with appropriate Rhesus type blood (IAFM 2018).
- Service providers must ensure safe transfusion practice at the bedside and safe disposal of blood bags, needles and syringes.



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MISP: Objective 3

Establish safe & rational use of blood transfusion

What is safe blood transfusion?

- Blood donor selection criteria
- Screening for transfusion transmissible infections
- ABO grouping & Rhesus D typing
- Safe transfusion practice

Slide #75: What is rational blood transfusion

Key Messages

- Rational blood transfusion is the second component of the first activity under MISP for SRH Objective 3.
- Rational blood transfusion includes:
  - Only transfusing blood in life-threatening circumstances and when there is no other alternative;
  - Using medicines to prevent or reduce active bleeding (e.g., oxytocin and misoprostol);
  - Using blood substitutes to replace lost volume, such as crystalloid-based substitutes (Ringer’s lactate, normal saline) wherever possible (IAFM 2018).

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MISP: Objective 3

What is rational blood transfusion:

- Transfusion only in life-threatening circumstances
- Appropriate clinical use of blood
- Use of alternatives & medicines to reduce bleeding & minimise unnecessary transfusions

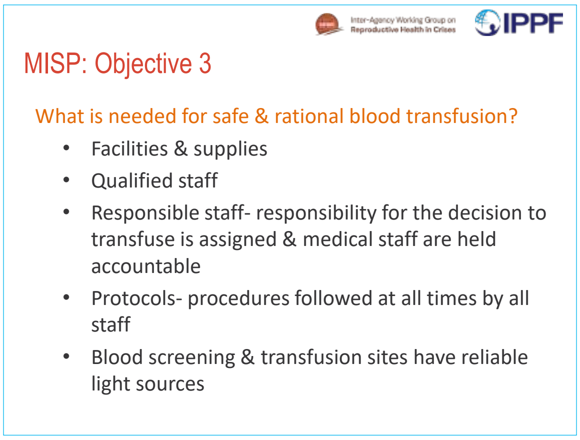
Note to facilitators This is a good opportunity to provide participants with national guidelines on safe and rational blood transfusion if available.

Ask participants to add this information to their matrix (Participant Handout #11), including who is able to conduct blood transfusion in their setting.

If participants would like more information on HIV testing of donated blood and linking to services, refer them to IAFM 2018 Chapter 11.

Slide #76: What is needed for safe & rational blood transfusion?

Key Messages



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MISP: Objective 3

What is needed for safe & rational blood transfusion?

- Facilities & supplies
- Qualified staff
- Responsible staff- responsibility for the decision to transfuse is assigned & medical staff are held accountable
- Protocols- procedures followed at all times by all staff
- Blood screening & transfusion sites have reliable light sources

- To establish safe and rational blood transfusion, service providers and program managers can work together to ensure that:
  - Referral-level hospitals have sufficient supplies;
  - Staff have appropriate knowledge of safe transfusion practices and have access to supplies to reduce the need for blood transfusion;
  - Safe donors are recruited. Safe donors can be selected through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety. Voluntary donors should be recruited and service providers should not request staff to donate blood;
  - Standard operating procedures and protocols for blood transfusion are in place, known and adhered to by service providers;
  - Responsibility for the decision to transfuse is assigned and medical staff are held accountable;
  - Waste products are safely disposed; and
  - Sites where blood is screened and where transfusion is performed have reliable light sources. To minimize the risk of errors, service providers should avoid blood transfusion at night as much as possible, unless sufficient lighting is available (IAFM 2018).

Note to facilitators As an optional discussion, you may ask participants to strategise for when supplies, qualified staff, safe donor practices and blood screening are not in place in humanitarian settings. Prompt participants to think about what may be done before an emergency to strengthen safe and rational blood transfusion practices before and emergency occurs, and who they may advocate to in emergencies to help establish safe transfusion practices (MoH, UN Agencies, other humanitarian agencies such as International Committee of the Red Cross).

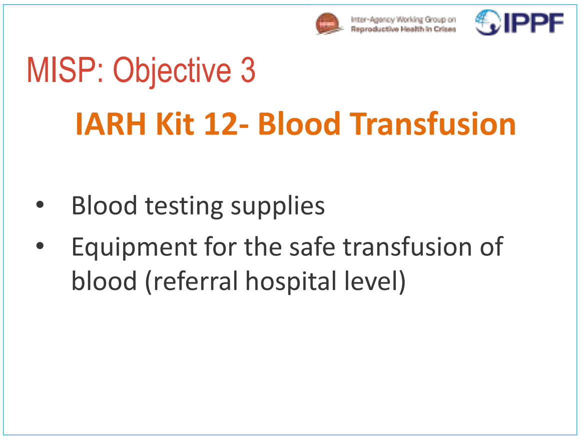
Ask participants to add these organisations as partners on their matrix (Participant Handout #11).

Also ensure that participants clearly understand that service providers must not administer blood that has not been screened.

Slide #77: IARH KIT 12- Blood Transfusion

Key Messages

- Supplies to support safe and rational blood transfusion are found in the Inter-agency Emergency Reproductive Health Kit Number 12 for referral level hospitals.
- To perform safe blood transfusions after testing for HIV, syphilis, hepatitis B and C, this kit should be used only by a trained laboratory technician with access to basic laboratory facilities. The kit includes blood testing supplies (for blood-group, rhesus status, HIV, hepatitis B and C, syphilis), and equipment for the safe transfusion of blood.



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MISP: Objective 3

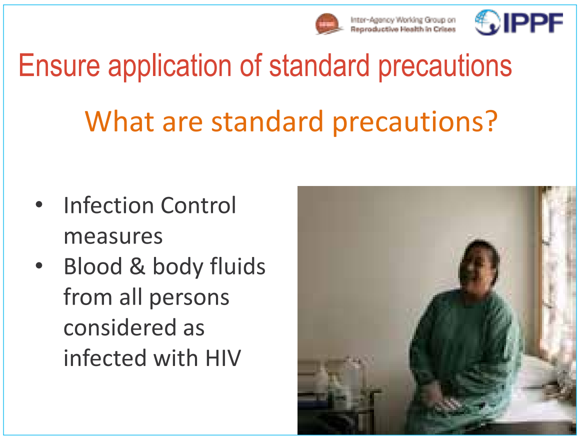
IARH Kit 12- Blood Transfusion

- Blood testing supplies
- Equipment for the safe transfusion of blood (referral hospital level)

Note to facilitators Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #78: Ensure application of standard precautions

Key Messages



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Ensure application of standard precautions

What are standard precautions?

- Infection Control measures
- Blood & body fluids from all persons considered as infected with HIV

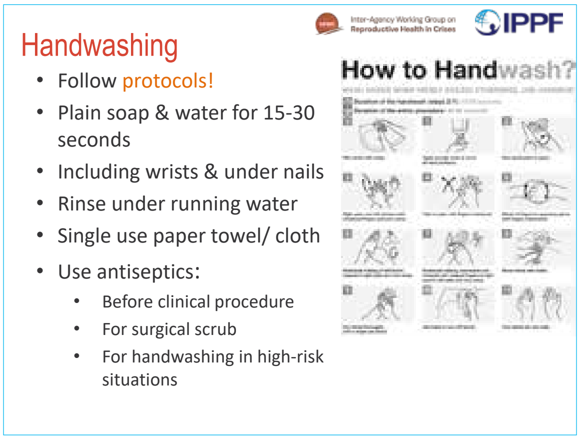
- The second activity under MISP for SRH Objective 3 is to ensure the application of standard precautions.

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

- In addition to commodities for standard precautions that may be available locally, Inter-agency Emergency Reproductive Health Kits 2,4,6,8,9 and 11 contain supplies for standard precautions.

Slide #79: Handwashing

Key Messages



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Handwashing

- Follow protocols!
- Plain soap & water for 15-30 seconds
- Including wrists & under nails
- Rinse under running water
- Single use paper towel/ cloth
- Use antiseptics:
  - Before clinical procedure
  - For surgical scrub
  - For handwashing in high-risk situations

- The first standard precaution is frequent hand washing.

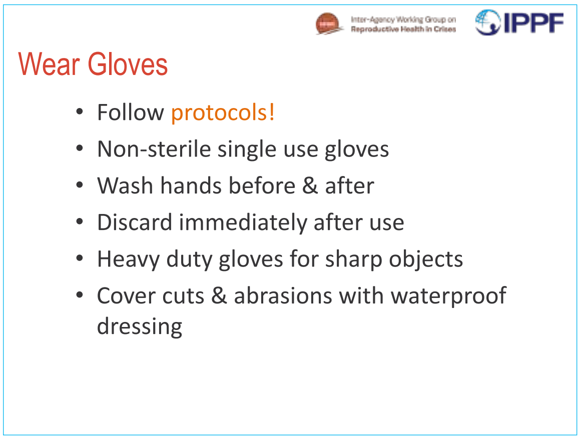
- Service providers and clinic staff must wash hands with soap and water before and after all patient contact. Hands should be washed vigorously for at least 30 seconds, including wrists and under nails, then rinsed under running or poured water.

- Protocols for hand washing should be posted, understood and adhered to by all clinic staff. An example protocol is included on the slide and is available at https://www.hha.org.au/component/jdownloads/send/5-local-implementation/76-poster-who-2?Itemid=0

Note to facilitators Singing Happy Birthday twice is roughly the equivalent of 30 seconds. Invite participants to stand up and choose a partner. Tell them that they are going to role play hand washing. One participant washes their hands with imaginary soap, while the other pours the imaginary water. Both of them sing Happy Birthday twice. If necessary, demonstrate correct hand washing to reinforce good practice or correct any errors noted.

Slide #80: Wear gloves

Key Messages



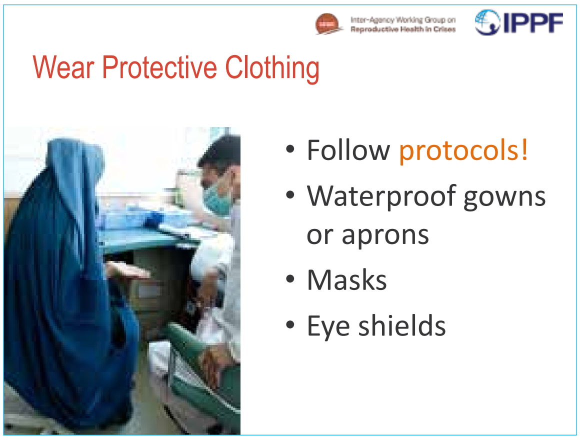
Wear Gloves

- Follow protocols!
- Non-sterile single use gloves
- Wash hands before & after
- Discard immediately after use
- Heavy duty gloves for sharp objects
- Cover cuts & abrasions with waterproof dressing

- The next standard precaution is to wear non-sterile single use gloves for all procedures where contact with blood or other potentially infected body fluids is anticipated.
- Service providers and clinic staff must wash hands before putting on and after removing gloves.
- Gloves must be discarded immediately after use.
- Staff handling materials and sharp objects must wear heavy duty gloves and cover any cuts and abrasions with a waterproof dressing.
- Service providers and clinic staff should never reuse or re-sterilize single use gloves as they can become porous (IAFM 2018).
- Protocols for wearing gloves should be posted, understood and adhered to by all clinic staff.

Slide #81: Wear protective clothing

Key Messages



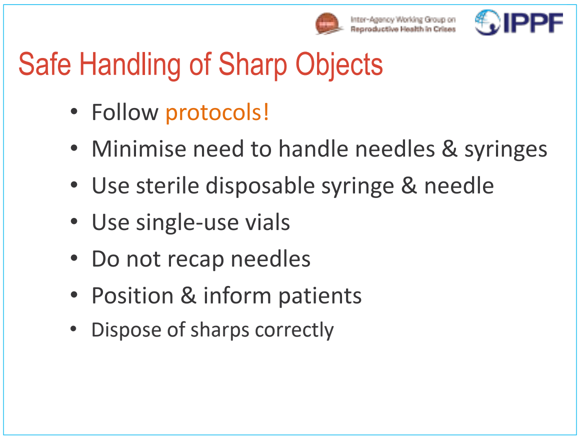
Wear Protective Clothing

- Follow protocols!
- Waterproof gowns or aprons
- Masks
- Eye shields

- The third standard precaution is to wear protective clothing, such as waterproof gowns or aprons, where blood or other body fluids might splash.
- Service providers and other clinic staff must wear masks and eye shields where there is a possibility of exposure to large amounts of blood (IAFM 2018).
- Protocols for wearing protective clothing should be posted, understood and adhered to by all clinic staff.

Slide #82: Safe handling of sharp objects

Key Messages



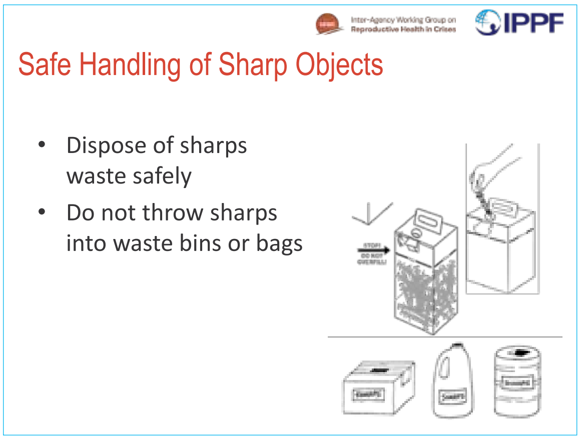
Safe Handling of Sharp Objects

- Follow protocols!
- Minimise need to handle needles & syringes
- Use sterile disposable syringe & needle
- Use single-use vials
- Do not recap needles
- Position & inform patients
- Dispose of sharps correctly

- the safe handling of sharp objects is the next standard precaution. This can be respected through:
  - Minimising the need to handle needles and syringes;
  - Using a sterile disposable syringe and needle for each injection;
  - Setting up the work area where injections are given to reduce the risk of injury;
  - Using single-dose vials rather than multi-dose vials. If multi-dose vials are used, avoid leaving a needle in the stopper. Once opened, store multi-dose vials in a refrigerator;
  - Not recapping needles;
  - Positioning and informing patients correctly for injections;
- Protocols for handling sharp objects should be posted, understood and adhered to by all clinic staff.

Slide #83: Safe handling of sharp objects

Key Messages



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Safe Handling of Sharp Objects

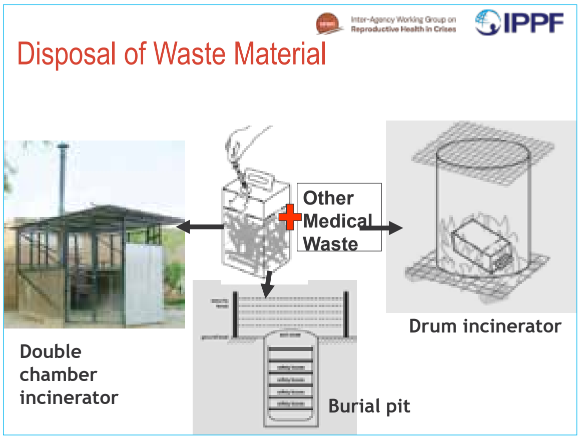
- Dispose of sharps waste safely
- Do not throw sharps into waste bins or bags

- The next standard precaution ensures that needles and sharps are disposed of safely. This involves:
  - Disposing needles and sharps in puncture- and liquid-proof safety boxes.
  - Do not fill sharps containers to more than ¾ full. Overloaded sharps containers are a needle stick injury risk.
  - Ensuring puncture-resistant containers for sharps disposal are readily available, close at hand, and out of reach of children.
  - Sharp objects should never be thrown into ordinary waste bins or bags.

Note to facilitators Ask participants to brainstorm what alternative containers could be used if medical-issue sharps boxes are not available. Follow this up with questions about how these containers should be labelled and sealed.

Slide #84: Disposal of waste material

Key Messages



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Disposal of Waste Material

Other Medical Waste

Double chamber incinerator

Burial pit

Drum incinerator

- Service providers and/or clinic managers and other staff should burn all medical waste in a separate area, preferably within the health facility grounds.
- Items that still pose a threat, such as sharp objects should be buried in a covered pit at least 10 meters from a water source.

Slide #85: Disposal of Waste Material

Key Messages

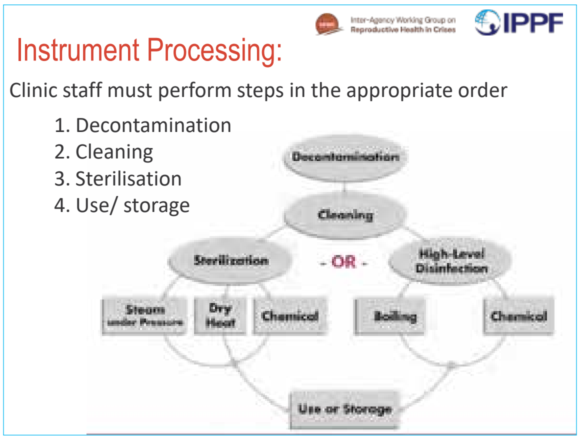
Disposal of Waste Material

Note to facilitators Ask participants to take 1 minute to work in pairs and assess the appropriateness of this burial pit for sharps.

- Note that the fence and cover are both missing.
- The pit should be 1- 2 meters wide, 2-3 meters deep and lined with a substance of low permeability.
- The bottom of the pit should be at least 2 metres above ground water.
- For more information on burial and other methods of wate disposal, see the WHO Safe management of wastes from health care activities, edited by Y. Chartier et al. – 2nd ed. 2014. https://www.who.int/water_sanitation_health/publications/wastemanag/en/

Slide #86: Instrument processing

Key Messages



Instrument Processing:

Clinic staff must perform steps in the appropriate order

1. Decontamination
2. Cleaning
3. Sterilisation
4. Use/ storage

- A further standard precaution is to ensure that instruments are processed correctly. This should be done in the following order:
  - First, decontaminate instruments to kill viruses (HIV and hepatitis B) and make items safer to handle;
  - Second, clean instruments to remove debris before sterilization or high-level disinfection (HLD);
  - Next, sterilize (eliminates all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. HLD (through boiling or soaking in a chlorine solution) may not eliminate spores;
  - Finally, items must be used or properly stored immediately after sterilization (IAFM 2018).
- For housekeeping, spills of blood or other body fluids must be promptly and carefully cleaned up with a 0.5% chlorine solution.

Note to facilitators Single use devices are not to be sterilised and reused.

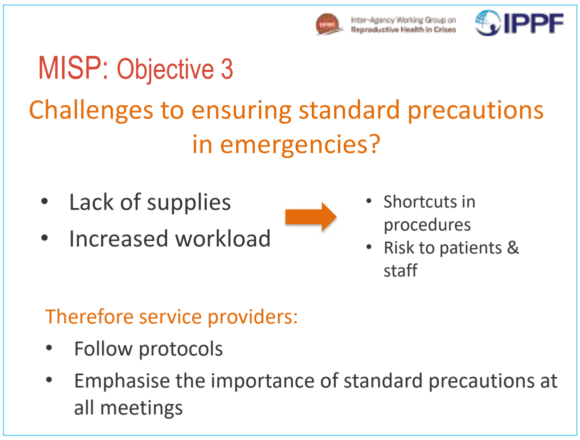
Different instruments require different levels of processing depending on their use. Provide participants with information on relevant country protocols for your setting.

A good guide can be found at: https://www.engenderhealth.org/wp-content/uploads/imports/files/pubs/qi/ip/ip-ref-eng-new.pdf

Slide #87: Challenges to ensuring standard precautions in emergencies

Key Messages

- There are a number of challenges to ensuring standard precautions in emergency settings.
- In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected (IAFM 2018).



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MISP: Objective 3

Challenges to ensuring standard precautions in emergencies?

- Lack of supplies
- Increased workload

- Shortcuts in procedures
- Risk to patients & staff

Therefore service providers:

- Follow protocols
- Emphasise the importance of standard precautions at all meetings

- Service providers must respect standard precautions at all times and closely adhere to protocols.
- Service providers can also emphasise the importance of standard precautions at all meetings, both within health facilities and to partner organisations.

Slide #88: Standard precautions

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

Time

45 minutes

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Standard Precautions

Group Work

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.

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).

Key Messages

- Standard precautions are meant to reduce the risk of transmission of blood borne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions, which are to be used, as a minimum, in the care of all patients (WHO)

Note to facilitators Ask participants to add information on respecting standard precautions to their matrix (Participant Handout #11).

Slide #89: Occupational exposure

Key Messages

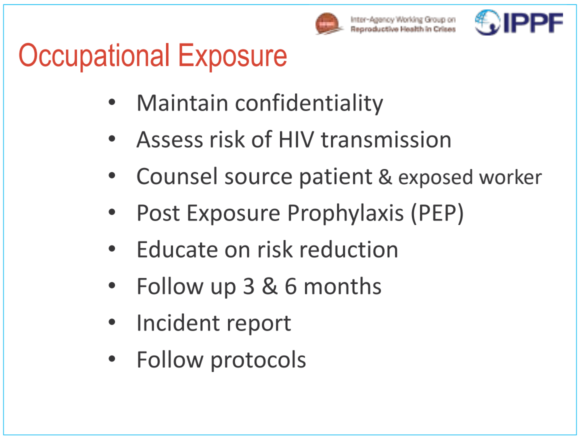
- It is possible for occupational exposure to occur, despite standard precautions being put in place.
- First aid procedures following occupational exposure, such as those outlined on the slide, should be posted in relevant workplaces and all staff should be informed of how to access treatment for exposure.

Occupational Exposure

Slide #90: Occupational exposure

Key Messages

- When occupational exposure does occur, it is important to:
    - Maintain confidentiality at all times;
    - Assess the risk of HIV transmission in case of occupational exposure: the type of exposure (percutaneous injury, mucous membrane splash, etc.), the type of exposed material (blood, other body fluids etc.). and the likelihood of HIV infection of the source patient;
    - Counsel the source patient regarding HIV testing and conduct an HIV test if consent is obtained;
    - Provide counseling for the exposed worker on the implications of the exposure, the need for PEP, how to take it, and what to do in case of side effects;
    - Take a medical history and conduct an exam of the exposed worker only after informed consent, recommend HIV voluntary counseling and testing, and provide PEP where appropriate. HIV test is not required (neither for the source patient nor the health care worker) before prescribing PEP;
    - Educate on risk reduction through review of the sequence of events and advise the exposed worker to use condoms to prevent secondary transmission during the next 3 months;
    - Provide HIV voluntary counselling and testing at 3 and 6 months after the exposure, whether or not the exposed worker received PEP;



Occupational Exposure

- Maintain confidentiality
- Assess risk of HIV transmission
- Counsel source patient & exposed worker
- Post Exposure Prophylaxis (PEP)
- Educate on risk reduction
- Follow up 3 & 6 months
- Incident report
- Follow protocols

  - Complete an incident report (IAFM 2018).

- Protocols for incidents of occupational exposure should be posted, understood and adhered to by all clinic staff.

> **Note to facilitators** Ask participants to add information on addressing occupational exposure to their matrix (Participant Handout #11). If participants would like further information on responding to occupational exposure, direct them to page 39 of the IAFM 2018.

Slide #91: Guarantee availability of free condoms

Key Messages

Guarantee availability of free condoms

- Lubricated male condoms
- Female condoms if already used by population

- The third activity under MISP for SRH Objective 3 is to guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.

- Condoms are key protection methods to prevent transmission of HIV, other STIs, and unplanned pregnancy.

- Free lubricated condoms and, where applicable, female condoms, must be available and promoted from the earliest days of a humanitarian response. They should be made available in health facilities and in locations in communities that are easily accessible. Working with community groups and marginalized populations is important to identify which locations are considered safe and accessible.

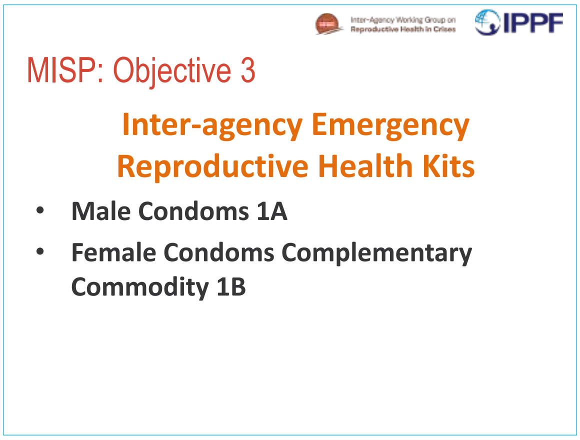
- Condom supply in humanitarian contexts should focus on the type of condom used in the local context (IAFM 2018).

> **Note to facilitators** This is a good opportunity to ask a willing participant to do a demonstration of male and female condoms for the group. Asking a confident participant to provide this demonstration will ensure that everyone has the correct knowledge of these important commodities, and will allow questions or observation from service providers who are less familiar, or not confident to ask questions.

Slide #92: Inter-agency Reproductive Health Kits

Key Messages

- Condoms are available as part of the Inter-agency Emergency Reproductive Health Kits
- Kit 1A provides lubricated male condoms that should be made available at community and at all health service delivery levels.
- Female condoms are included as a complementary commodity (Kit 1B). These should be provided where they are already in use by the target population.



MISP: Objective 3

Inter-agency Emergency Reproductive Health Kits

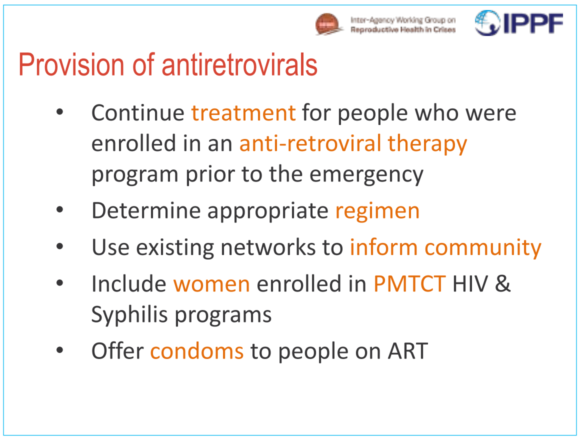
- **Male Condoms 1A**
- **Female Condoms Complementary Commodity 1B**

> **Note to facilitators** Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #93: Provision of antiretrovirals

Key Messages

- The fourth activity under MISP for SRH Objective 3 is to support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an antiretroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT of HIV and Syphilis programs.
- Continuation of ARVs for those already on treatment is a priority because sudden disruption of ARVs can cause deterioration of individual health (by allowing opportunistic infection and immune-deficiency progression), potential transmission (due to viral rebound), and development of ARV resistance (IAFM 2018). Testing is not a priority during the acute phase.
- If service providers are not providing ART treatment, they must be aware of where it is available and the referral system in place.



Provision of antiretrovirals

- Continue treatment for people who were enrolled in an anti-retroviral therapy program prior to the emergency
- Determine appropriate regimen
- Use existing networks to inform community
- Include women enrolled in PMTCT HIV & Syphilis programs
- Offer condoms to people on ART

- To determine who has been on treatment, program managers and service providers may examine health records or patient cards, ensuring that confidentiality is safe-guarded (IAFM 2018).

- Where possible, existing networks of people living with HIV can be useful to disseminate information about the availability of ART for continuation of treatment. With program managers, ensure that focal points are identified (primarily health care providers or PLWHIV networks) and that the community is informed about how to reach focal points that will help them to get their treatment and care (IAFM 2018).

- Service providers can use patients' treatment cards to determine the appropriate regimen. Many experienced patients can also identify which regimen they are using (IAFM 2018).

- People on ART should also be offered condoms.

⚠ **Note to facilitators** Ask participants how the national system operates in stable settings and how this translates to ART supply in emergency situations. Facilitate a brief discussion and provide any clarification needed for your context.

Also ask participants to think back to the work they completed on inclusion and discuss how they can work with peer networks to ensure that those on ART continue access. Ask the group to share any experiences they may have had of challenges and strategies to overcome these.

Ask participants to add information on supporting the provision of antiretrovirals to their matrix (Participant Handout #11). If participants would like further information on provision of antiretrovirals, direct them to pages 40- 41 of the IAFM 2018.

Slide #94: Provide PEP

Key Messages

- The fifth activity under MISP for SRH Objective 3 is to provide PEP to survivors of sexual violence as appropriate and for occupational exposure.

- Provision of PEP to survivors of sexual violence is part of providing compassionate and confidential treatment, as outlined in session 2.1.

- PEP treatment protocols for occupational exposure are the same as those for survivors of sexual violence (IAFM 2018).

Provide Post Exposure Prophylaxis (PEP)

- Occupational Exposure
- After Sexual Violence
- IARH KIT 3- Post Rape Treatment

- Supplies for post-exposure prophylaxis after occupational exposure can be found in inter-agency Emergency reproductive Health Kit 3 (post-rape treatment kit).

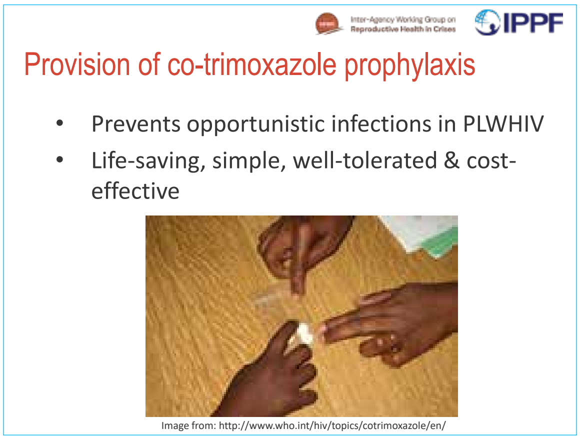
Note to facilitators Ask participants to add information on providing PEP to their matrix (Participant Handout #11). If participants would like further information on provision of PEP, direct them to pages 41- 42 and Tables 3.4 and 3.5 of the IAFM 2018.

Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #95: Provision of co-trimoxazole prophylaxis

Key Messages

- The sixth activity under MISP for SRH Objective 3 is to support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.



Provision of co-trimoxazole prophylaxis

- Prevents opportunistic infections in PLWHIV
- Life-saving, simple, well-tolerated & cost-effective

Image from: http://www.who.int/hiv/topics/cotrimoxazole/en/

- Co-trimoxazole prophylaxis is a life-saving, simple, well-tolerated, and cost-effective intervention for people living with HIV. It should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy care. Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery (IAFM 2018).

- Co-trimoxazole prophylaxis is an antibiotic used to prevent pneumocystis pneumonia and toxoplasmosis in adults and children with HIV, as well as other infectious and parasitic diseases, demonstrating significant benefits in regions affected by malaria (IAFM 2018).

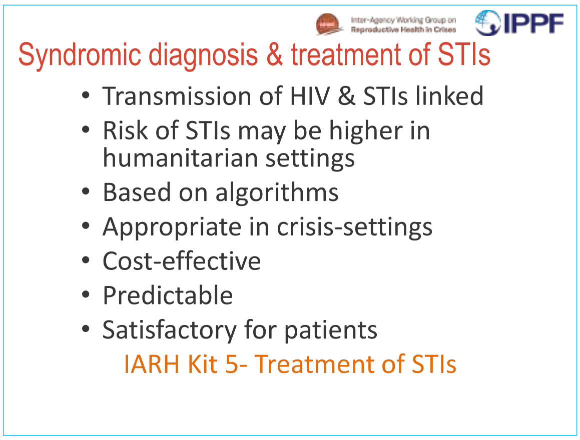
- Dosage of co-trimoxazole is as follows (for more information on this, consult the IAFM 2018 p42):
  - For infants below 6 months or < 5 kg (100 mg sulfamethoxazole/20 mg trimethoprim)
  - For children 6 months–5 years or 5-15 kg (200 mg/40 mg)
  - For children 6–14 years old or 15–30 kg (400 mg/80 mg)
  - For anyone over 14 years or >30 kgs (800 mg/160 mg)

Note to facilitators Ask participants to add information on supporting the provision of co-trimoxazole to their matrix (Participant Handout #11). If participants would like further information on the provision of co-trimoxazole, direct them to page 42 of the IAFM 2018 and guidance from WHO at https://www.who.int/hiv/topics/cotrimoxazole/en/ .

Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #96: Syndromic diagnosis & treatment of STIs

Key Messages



Syndromic diagnosis & treatment of STIs

- Transmission of HIV & STIs linked
- Risk of STIs may be higher in humanitarian settings
- Based on algorithms
- Appropriate in crisis-settings
- Cost-effective
- Predictable
- Satisfactory for patients

IARH Kit 5- Treatment of STIs

- The seventh and final activity under MISP for SRH Objective 3 is to ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

- The transmission of HIV and other STIs are closely linked. Certain STIs facilitate the transmission of HIV, such as STIs producing ulcers in the genital area, and those associated with discharge, such as chlamydia or gonorrhea. On the other hand, the weakened immune system of people living with HIV, in particular those who do not have access to ARVs, cam make people more susceptible to become infected with STIs. The presence of HIV also increases the severity of symptoms for some STIs (such as genital herpes) (IAFM 2018).

- The syndromic treatment of STIs is a method built from algorithms (decision trees) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols (IAFM 2018).

- The approach is particularly relevant at the onset of a crisis where people are less likely to come for follow-up visits and where access to laboratories might be difficult, impossible or expensive (IAFM 2018).

- Syndromic management is cost-effective, satisfactory for patients, predictable (easing procurement and training), and has a strong public heath base and impact (IAFM 2018).

- Supplies the syndromic treatment of STIs are included as Inter-agency Emergency reproductive Health Kit 5.

- Included in this kit are medicines based on patient presentation, male and female condoms, treatment guidelines for sexually transmitted and other reproductive tract infections, and a wallchart on the syndromic treatment of STIs.

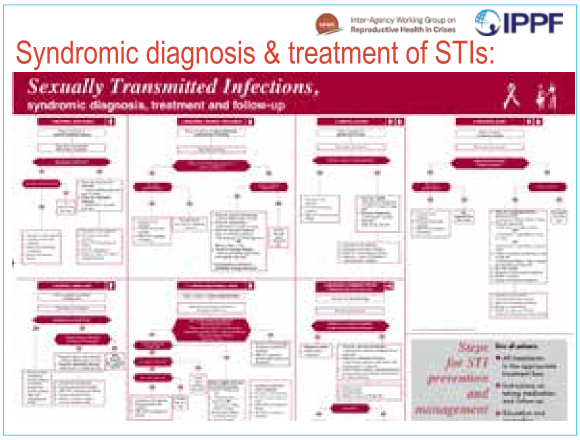
Note to facilitators Depending on your country context, it may be a good to present some information on STI rates to explain the scope and gravity of the situation to participants.

Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #97: Syndromic diagnosis & treatment of STIs 3

Key Messages

- It is important that algorithms or decision trees for the syndromic diagnosis and treatment of STIs are adapted to fit the context.
- This adaptation should be based on the prevalence of STIs in the population; local etiology of the syndromes; antimicrobial susceptibility in the region; the availability of drugs; and social and behavioural practices.


Inter-Agency Working Group on Reproductive Health in Crises
IPPF
Syndromic diagnosis & treatment of STIs:
Sexually Transmitted Infections, syndromic diagnosis, treatment and follow-up
Steps for STI prevention and management

Note to facilitators Provide participants with algorithms or decision trees from your context. Ask participants to add information on syndromic diagnosis and treatment of STIs to their matrix (Participant Handout #11).

Slide #98: 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.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Syndromic Diagnosis & Treatment of STIs: Adapting Algorithms
Group Work

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

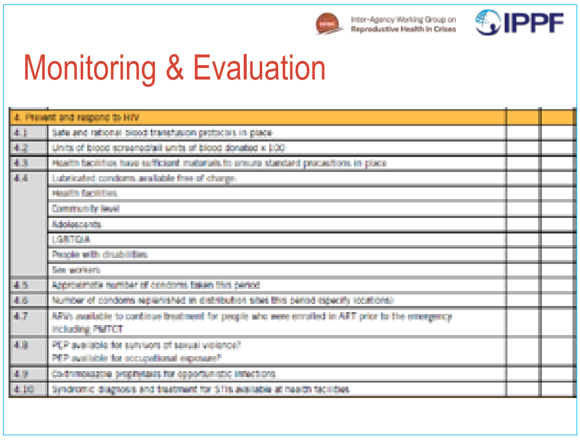
- STI algorithm wall chart- 1 for each group of 5-6 (Available in resources folder). Print A3 or larger.
- Post-it notes for each group
- Participant Handout #13 or an alternative national protocol from your context.

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.

Slide #99: Monitoring & evaluation

Key Messages



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Monitoring & Evaluation

4. Prevent and respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		
4.4	Lubricated condoms available free of charge		
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	People with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period (specify locations)		
4.7	ARVs available to continue treatment for people who were enrolled in ART prior to the emergency including PMTCT		
4.8	PEP available for survivors of sexual violence? PEP available for occupational exposure?		
4.9	Cotrimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		

- The MISP checklist provides a useful tool for monitoring and evaluating the HIV and other STIs objective of the MISP.
- Some priority indicators include (from IAFM 2018 p239):
  - The percentage of donated blood units screened for HIV in a quality assured manner.
  - Percentage of HIV positive pregnant women receiving ART to reduce the risk of mother-to-child transmission.
  - Percentage of people living with HIV receiving ARVs (according to national protocol).

- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. Partnerships with organisations working with PLHIV and mechanisms that coordinate national HIV programmes should also be established in the preparedness phase. These relationships will also support the collection of data to inform MISP implementation and the development of protocols.

- The presence of staff with the capacity to provide HIV and other STI services should also be considered, and mapping and rostering conducted prior to the onset of an emergency.

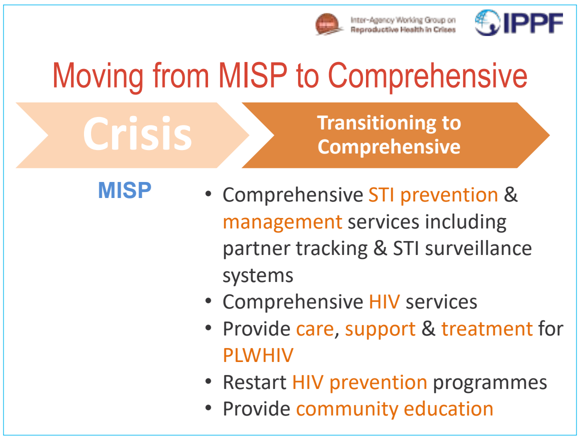
Slide #100: MISP: Moving from MISP to comprehensive

Key Messages

- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.

- It is critical to provide comprehensive services as soon as possible.

- Comprehensive HIV and STI care includes: HIV voluntary counseling and testing, partner tracking and STI surveillance systems; providing care, support and treatment for PLHIV; and expanding community education programmes.



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Moving from MISP to Comprehensive

Crisis

Transitioning to Comprehensive

MISP

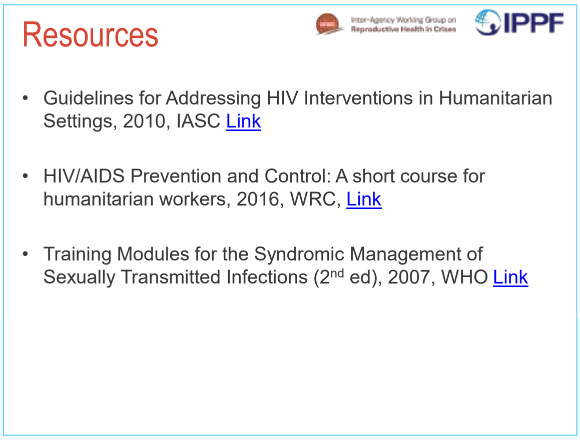
- Comprehensive STI prevention & management services including partner tracking & STI surveillance systems
- Comprehensive HIV services
- Provide care, support & treatment for PLWHIV
- Restart HIV prevention programmes
- Provide community education

Note to facilitators Ask participants to look again at their matrix and compare the columns they have filled out on the provision of services in standard settings as compared to those outlined in the MISP. Briefly discuss the differences and emphasise again that the MISP prioritises the most life saving interventions. If participants are interested in learning more about comprehensive HIV and other STI programming, refer them to the IAFM 2018 Chapter 11: HIV.

Slide #101: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their capacity to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs in humanitarian settings.



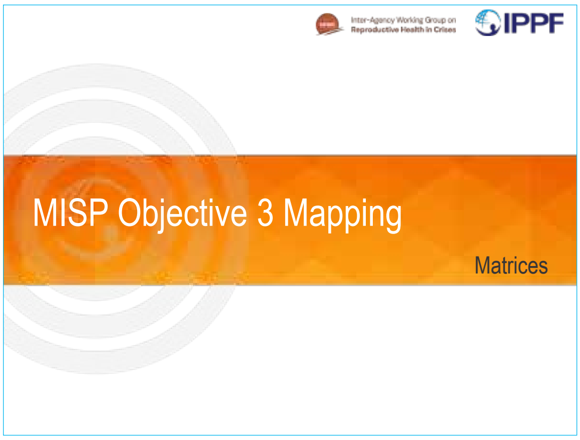
Resources

- Guidelines for Addressing HIV Interventions in Humanitarian Settings, 2010, IASC Link
- HIV/AIDS Prevention and Control: A short course for humanitarian workers, 2016, WRC, Link
- Training Modules for the Syndromic Management of Sexually Transmitted Infections (2nd ed), 2007, WHO Link

Note to facilitators Add to this slide with context-specific resources as able.

Slide #102: MISP Objective 3: Mapping

Participants will spend some time reviewing the entries they have made to their matrix for this MISP for SRH Objective and add any further information as needed.



MISP Objective 3 Mapping

Matrices

Time

20 minutes

Process

- Ask participants to return to their matrix for this objective of the MISP for SRH.
- In pairs or groups, participants should review and compare the entries they have made during the session and add any information that is missing.
- When this is done, ask participants to work (again in pairs or groups) to identify any gaps and priorities action to fill these gaps. This information should be added to final column of the matrix and include consideration of pressing needs at individual skill, organisational, interagency and community levels.

Materials

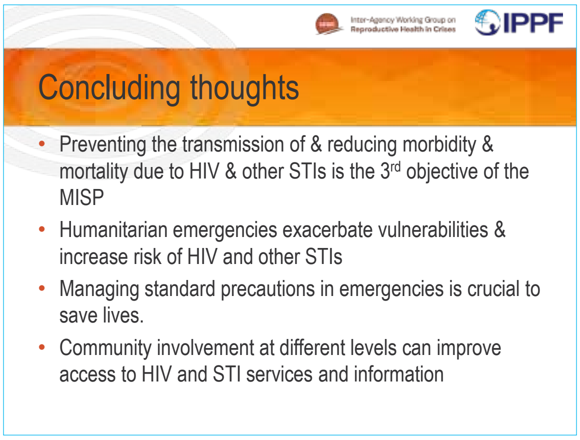
Participant Handout #11

Slide #103: Concluding thoughts

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

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

Day 2 Close



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Concluding thoughts

- Preventing the transmission of & reducing morbidity & mortality due to HIV & other STIs is the 3^{rd} objective of the MISP
- Humanitarian emergencies exacerbate vulnerabilities & increase risk of HIV and other STIs
- Managing standard precautions in emergencies is crucial to save lives.
- Community involvement at different levels can improve access to HIV and STI services and information

Day 3

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

Session 3.1 2 ½ hours

Overview

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

Methodology

- Interactive presentation
- Group Work
- Discussion

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

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

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


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Day 3: The Minimum Initial Service Package (MISP)

Training for Service Providers

Slide #2: Day 2 Review

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

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


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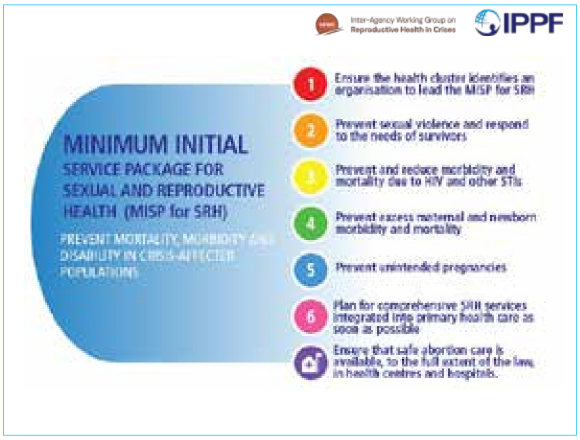
Day 2 Review

MISP Objectives 2 & 3

Slide #3: MISP objectives

Remind participants that we are now focusing on the objectives of the MISP.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MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH (MISP for SRH)

PREVENT MORTALITY, MORBIDITY AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

1. Ensure the health cluster identifies an organisation to lead the MISP for SRH
2. Prevent sexual violence and respond to the needs of survivors
3. Prevent and reduce morbidity and mortality due to HIV and other STIs
4. Prevent excess maternal and newborn morbidity and mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH services integrated into primary health care as soon as possible

Ensure that safe abortion care is available, to the full extent of the law, in health centres and hospitals.

Slide #4: Session 3.1: MISP Objective 4: Prevent Excess Maternal & Newborn Morbidity & Mortality

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

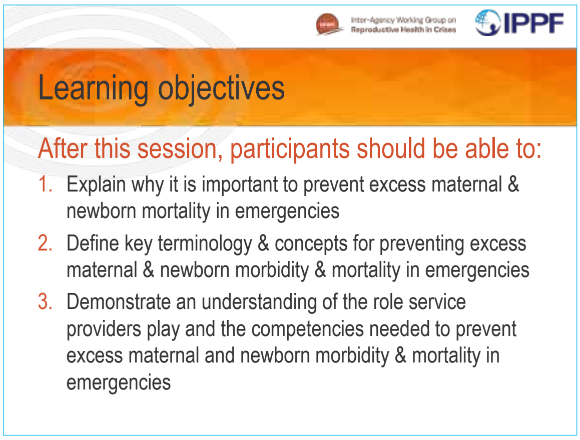
Session 3.1: MISP Objective 4: Prevent Excess Maternal & Newborn Morbidity & Mortality
Training for Service Providers

Slide #5: Learning objectives

Key Messages

- There are three learning objectives for session 3.1

  1. Explain why it is important to prevent excess maternal & newborn mortality in emergencies.
  2. Define key terminology & concepts for preventing excess maternal & newborn morbidity & mortality in emergencies.
  3. Demonstrate an understanding of the role service providers play and the competencies needed to prevent excess maternal and newborn morbidity & mortality in emergencies.



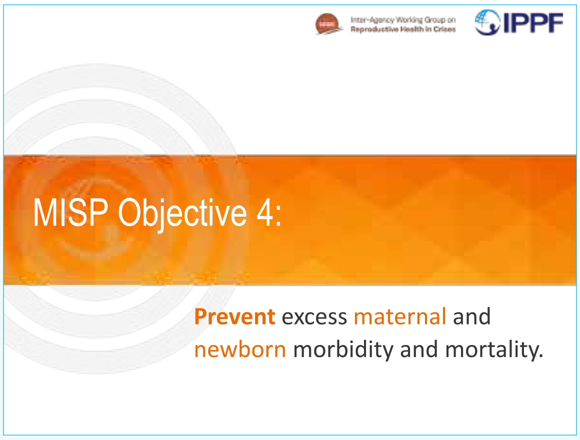
Learning objectives

After this session, participants should be able to:

1. Explain why it is important to prevent excess maternal & newborn mortality in emergencies
2. Define key terminology & concepts for preventing excess maternal & newborn morbidity & mortality in emergencies
3. Demonstrate an understanding of the role service providers play and the competencies needed to prevent excess maternal and newborn morbidity & mortality in emergencies

Slide #6: MISP Objective 4

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



MISP Objective 4:

Prevent excess maternal and newborn morbidity and mortality.

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

Slide #7: Maternal & newborn health in emergencies

Key Messages

Maternal & Newborn Health in Emergencies

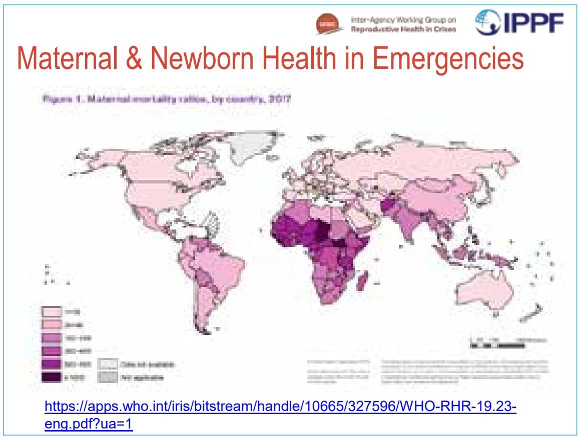
More than 500 women & girls die in emergency settings every day due to complications arising from pregnancy & childbirth

UNFPA 2018

- "Every woman has the right to decide whether or when she will become pregnant, and the right to give birth safely and live free from violence. Yet every day, millions of women and girls whose lives have been upended by wars, conflicts or natural disasters are denied these rights. When we speak of leaving no one behind and reaching the furthest behind first, there can be no more compelling example of exactly whom we are speaking about. More than 500 women and girls die in emergency situations every day from complications due to pregnancy and childbirth. Sexual and gender-based violence also increase in such settings, with devastating – and often deadly – consequences. The unprecedented frequency, intensity and scope of humanitarian emergencies in the past year has dramatically amplified these risks for millions of women and girls" (Dr Natalia Kanem UNFPA Executive Humanitarian Action. 2018 Overview. P3)

Slide #8: Maternal & newborn health in emergencies

Key Messages



Maternal & Newborn Health in Emergencies

Figure 1. Maternal mortality ratios, by country, 2017

https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?ua=1

- This map shows rates of maternal mortality by country. Darker colours represent higher rates of maternal mortality.

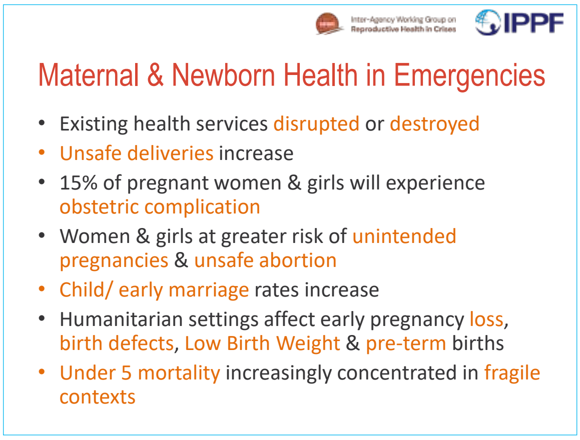
- According to estimates by WHO, UNICEF, UNFPA and the World Bank Group, the Maternal Mortality Ratio (MMR) "in the world's least developed countries (LDCs) is high, estimated at 415 maternal deaths per 100 000 live births, which is more than 40 times higher than that for MMR in Europe, and almost 60 times higher than in Australia and New Zealand. In the world's LDCs, where an estimated 130 000 maternal deaths occurred in 2017, the estimated lifetime risk of maternal death was 1 in 56" (Trends in Maternal Mortality 2000 to 2017 https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?ua=1).

- In addition to this, 15 countries considered 'very high alert' or 'high alert' on the Fragile States Index had MMRs in 2017 ranging from 31 (Syrian Arab Republic) to 1150 (South Sudan)"

- Almost all of these deaths could have been prevented.

Slide #9: Maternal & newborn health in emergencies

Key Messages



Maternal & Newborn Health in Emergencies

- Existing health services disrupted or destroyed
- Unsafe deliveries increase
- 15% of pregnant women & girls will experience obstetric complication
- Women & girls at greater risk of unintended pregnancies & unsafe abortion
- Child/ early marriage rates increase
- Humanitarian settings affect early pregnancy loss, birth defects, Low Birth Weight & pre-term births
- Under 5 mortality increasingly concentrated in fragile contexts

- Humanitarian emergencies disrupt and sometimes destroy health services, increasing vulnerability for pregnant women, newborns and children.

- Unsafe deliveries often increase in these settings as skilled maternal and newborn care providers become unavailable.

- Emergencies also expose women and girls to greater risk of unintended pregnancies and unsafe abortion practices.

- Growing evidence shows that child, early and forced marriage rates increase in crisis settings, including after natural disasters or during conflict (https://www.girlsnotbrides.org/resource-centre/child-marriage-in-humanitarian-crises/). Child marriage is often accompanied by early and frequent pregnancy which results in higher maternal morbidity and mortality rates (https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/ChildMarriage.aspx).

- Humanitarian emergencies affect early pregnancy loss, birth defects, low birth weight and pre-term birth (https://reliefweb.int/report/world/maternal-newborn-and-child-health-emergency-settings).

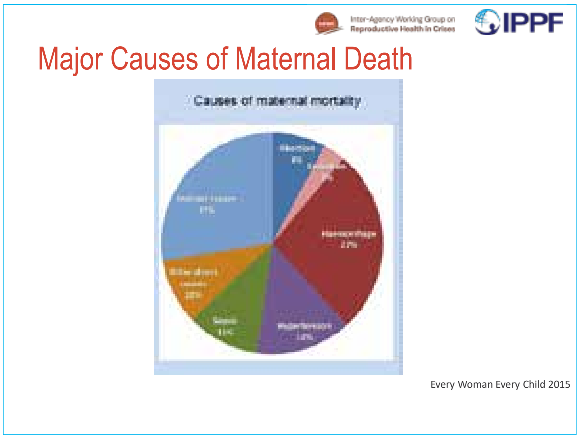
- Under 5 mortality is becoming geographically concentrated in fragile contexts and demographically concentrated in the newborn period (https://reliefweb.int/report/world/maternal-newborn-and-child-health-emergency-settings).

Slide #10: Major causes of maternal death

Key Messages

- Most maternal and newborn deaths occur around the time of labour, delivery, and in the immediate post-partum phase. This is why the MISP focuses on care at time of delivery and immediately post-partum and does not include ante-natal care or pre-natal care.

- The leading causes of maternal death are haemorrhage, hypertension, sepsis and complications of unsafe abortion.



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Major Causes of Maternal Death

Every Woman Every Child 2015

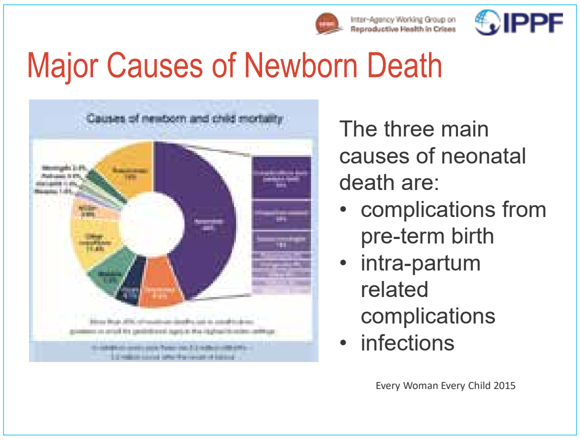
- Many of these causes are preventable or could be managed by skilled providers with adequate resources at the facility level.

Slide #11: Major causes of newborn death

Key Messages

- The three main causes of neonatal death are complications from pre-term birth, intra-partum related complications and infections.

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



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Major Causes of Newborn Death

The three main causes of neonatal death are:

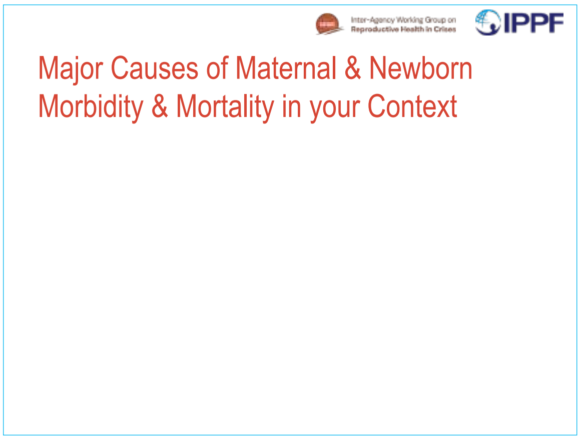
- complications from pre-term birth
- intra-partum related complications
- infections

Every Woman Every Child 2015

Slide #12: Major causes of maternal & newborn death

Key Messages

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



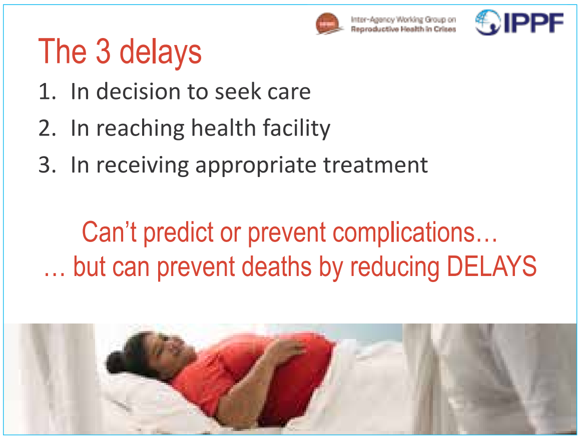
Major Causes of Maternal & Newborn Morbidity & Mortality in your Context

Slide #13: The 3 delays

Key Messages

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

  1. decision to seek care
  2. time to reach the health facility
  3. time to receive appropriate care at the facility



The 3 delays

1. In decision to seek care
2. In reaching health facility
3. In receiving appropriate treatment

Can't predict or prevent complications…
… but can prevent deaths by reducing DELAYS

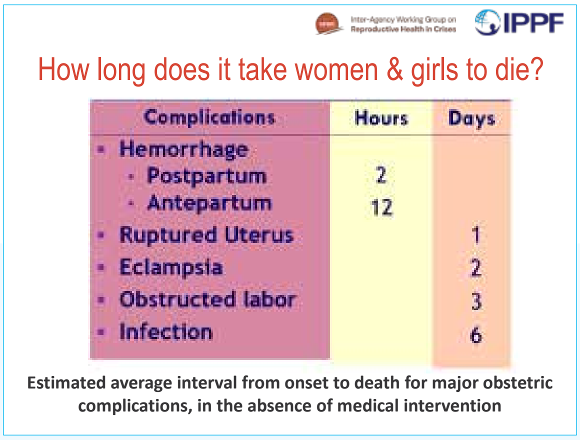
Note to facilitators Ask participants to spend a few minutes with their table groups discussing the following questions:

- What are some reasons women and girls may face these delays in your setting?
- What might contribute to more delays in a crisis?

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

Key Messages

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



How long does it take women & girls to die?

Complications	Hours	Days
• Hemorrhage		
• Postpartum	2	
• Antepartum	12	
• Ruptured Uterus		1
• Eclampsia		2
• Obstructed labor		3
• Infection		6

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

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

Strategies might include:

Delay 1: Inform traditional birth attendants (TBAs), women, girls and men about danger signs that need emergency treatment. Involving TBAs in early recognition and timely referral of women with obstetric emergencies.

Delay 2: Improve MISP-referral system, including communication capacity and transport mechanism. Implement community finance and transport schemes. Ensure provision of, clean delivery kits for when the second delay cannot be overcome.

Delay 3: Ensure facilities have the right staff and equipment.Improve coverage of EmOC to meet the minimum requirement (e.g.,four basic and one comprehensive EmOC facilities for every 500,000 people). Improve quality of EmOC,clients' satisfaction and 24/7 coverage. Improve utilization of EmOC services by reducing barriers and ensuring equitable access.

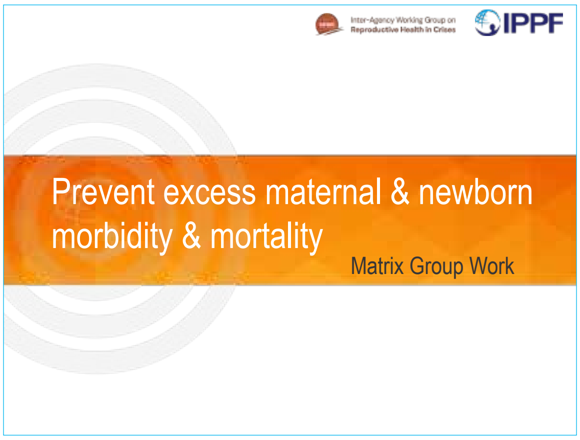
Slide #15: Maternal & newborn health: matrix

Matrix Group Work

Time

10 minutes.

Process



Prevent excess maternal & newborn morbidity & mortality

Matrix Group Work

- 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.

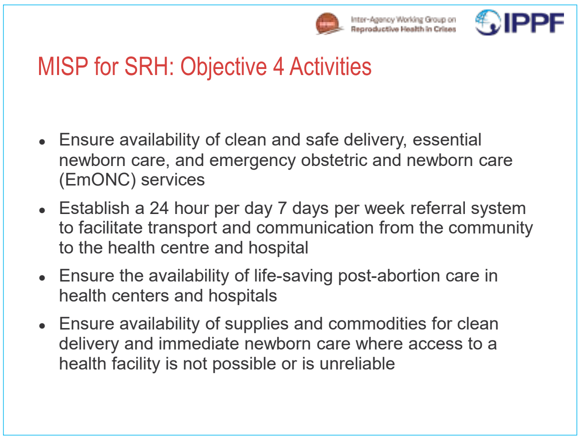
Materials

- Participant Handout #14

- MISP for SRH Cheat Sheet

Slide #16: Priority Activities of MISP Objective 4

Remind participants of the four activities under MISP Objective 4.



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MISP for SRH: Objective 4 Activities

- Ensure availability of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services
- Establish a 24 hour per day 7 days per week referral system to facilitate transport and communication from the community to the health centre and hospital
- Ensure the availability of life-saving post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable

Slide #17: MISP Objective 4- Minimum Response

Key Messages

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Maternal & Newborn Health

MISP: Minimum Response

Crisis

Transitioning to Comprehensive

- Availability & accessibility of EmONC:
  CEmONC (referral hospital level) &
  BEmONC (health facility level)
- 24/7 referral system
- Post-Abortion Care
- Supplies for clean delivery & immediate newborn care

Restore comprehensive services AS SOON AS POSSIBLE

- Due to the ongoing and often increased threats to maternal and newborn health in emergency situations, the 4th life-saving objective of the MISP is for maternal and newborn health.

- The evidence-informed activities that support this objective include the availability and accessibility of Emergency Obstetric and Newborn Care (EmONC), with CEmONC available at referral hospital level and BEmONC at health facility level, a referral system that is available 24 hours a day, 7 days a week, post-abortion care services, and supplies for clean delivery and immediate newborn care.

- MISP for SRH interventions focus on the time of birth because most maternal and neonatal deaths occur around the time of labor, delivery, and the immediate postpartum period (IAFM 2018).

- It is for this reason that antenatal and post natal care are NOT part of the MISP for SRH.

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

Slide #18: Ensure availability & accessibility

Key Messages

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Ensure availability & accessibility of:

- clean & safe delivery
- essential newborn care
- emergency obstetric & newborn care services at different levels

- The first activity of MISP for SRH Objective 4 is to ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services. This includes:

  - At referral level hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC);

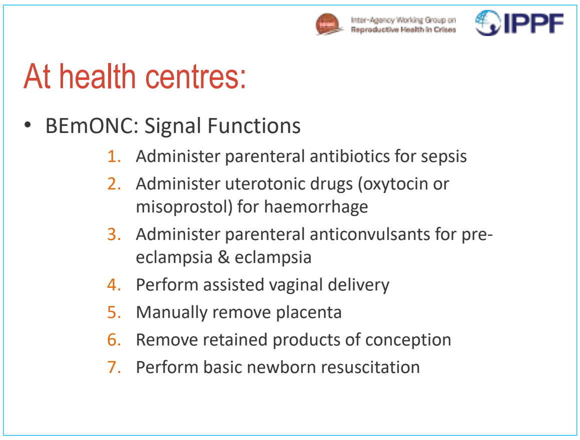
  - At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC);

- At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

Note to facilitators As this information is not on a slide, consider writing up the three components on the flip chart CEmONC, BEmONC and clean delivery kits so people can have this as a reference throughout.

Slide #19: At health centres

Key Messages



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At health centres:

- BEmONC: Signal Functions
    1. Administer parenteral antibiotics for sepsis
    2. Administer uterotonic drugs (oxytocin or misoprostol) for haemorrhage
    3. Administer parenteral anticonvulsants for pre-eclampsia & eclampsia
    4. Perform assisted vaginal delivery
    5. Manually remove placenta
    6. Remove retained products of conception
    7. Perform basic newborn resuscitation

- As specified in the MISP for SRH, basic obstetric and newborn care (BEmONC) should be made available at the health facility level to address the main complications of childbirth, including newborn complications (IAFM 2018).

- Signal functions are key medical interventions that are used to treat the direct obstetric complications that cause the vast majority of maternal deaths around the globe. Following signal functions helps to reduce the 3rd Delay discussed earlier.

- BEmONC must be available 24 hours a day, 7 days a week. For BEmONC, there are seven signal functions:

    1. Administer parenteral antibiotics for treatment of sepsis;

    2. Administer uterotonic drugs (i.e., parenteral oxytocin or misoprostol tablets) for treatment of postpartum haemorrhage;

    3. Administer parenteral anticonvulsants to manage preeclampsia and eclampsia (i.e., magnesium sulfate);

    4. Perform assisted vaginal delivery (e.g., vacuum extraction, forceps delivery;

    5. Manually remove placenta;

    6. Remove retained products of conception (e.g., manual vacuum, aspiration, misoprostol for treatment of incomplete abortion);

    7. Perform basic neonatal resuscitation (e.g., with bag and mask).

Note to facilitators The signal functions include treatment of complications from unsafe and/or incomplete abortion. This will be looked at in more detail below.

For now, ask participants to include information to their matrix (Participant Handout #14) on who in their setting has the clinical skills and supplies required for BEmONC. Consider sharing if available context-specific information on the use of misoprostol for postpartum haemorrhage and removal of the retained products of conception.

Slide #20: Inter-agency Emergency Reproductive Health Kits

Key Messages

- Inter-agency Reproductive Health Kits 8, 9 and 10 contain materials to support basic emergency obstetric care at the health centre or hospital level.

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Inter-agency Reproductive Health Kits

- Kit 8: Management of miscarriage & complications of abortion
- Kit 9: Suture of tears (cervical & vaginal) & vaginal examination
- Kit 10: Vacuum extraction delivery

Note to facilitators Allow participants some time to look through the Inter-agency Emergency Reproductive Health Kit booklet if available, and to ask any questions.

Slide #21: At health centres

Key Messages

- Approximately two-thirds of infant deaths occur within the first 28 days of life. The majority of these deaths are preventable by initiating essential actions that can be taken by health workers, mothers, or other community members (IAFM 2018).
- Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation. About half of those that have difficulty initiating breathing require resuscitation (IAFM 2018).

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At health centres:

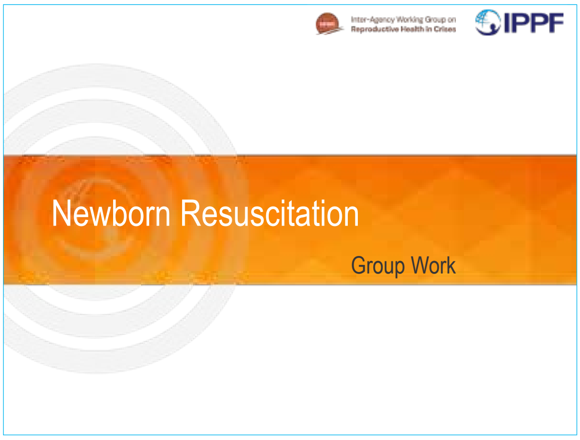
- Essential Newborn Care:
    - Labor monitoring using partograph
    - Newborn resuscitation
    - Manage signs of infection
    - Skin to skin contact
    - Support immediate breastfeeding
    - Provide basic prematurity & LBW care
    - Recognise danger signs & refer

Inter-agency Emergency Reproductive Health Kit 11 contains some supplies for newborn resuscitation

- Newborn care is part of the continuum of care for mother and baby. In humanitarian settings, essential newborn care to be provided at the community health centre level includes:

  - Labor monitoring using a partograph: the partograph can be a useful tool for monitoring labour and detecting maternal or fetal complications. If complications are detected, relevant EmONC interventions or referral are critical to saving the lives of both the mother and the baby. The partograph helps detect complications so service providers know what other newborn care is required;
  - Newborn resuscitation: service providers should be prepared for newborn resuscitation at every birth including drying, clearing airway as needed, stimulation, and bag and mask ventilation;
  - Managing signs of possible serious bacterial infections in newborns, including diagnosing, classifying, providing first dose of antibiotics, and referring to a hospital as soon as possible (IAFM 2018);
  - For pre-term and LBW/ small newborns where babies and mothers are clinically stable, service providers should initiate skin to skin contact, support immediate breastfeeding, and refer to a hospital as soon as possible.

Slide #22: Newborn resuscitation



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Newborn Resuscitation

Group Work

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

  - 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

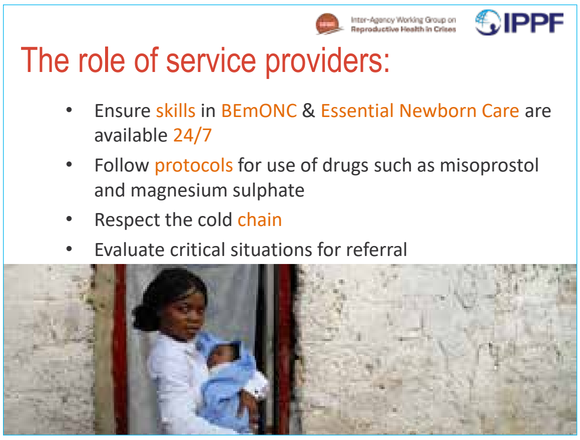
- For a baby who is not breathing and does not responds to tactile stimulation, a bag and mask should be used to assist the baby breathe. (See New born Health in Humanitarian Settings Field Guide, 2018, IAWG)

Note to facilitators Ask participants to add this information to their matrix (Participant Handout #14). Make sure to emphasise the importance of them thinking strategically about clinical skills required for essential newborn care at the health facility level, who in their settings is able to perform these clinical tasks, possible partnerships in humanitarian emergencies, and gaps in capacity and resources to fill these gaps.

If participants would like more information on the clinical skills required for essential newborn care at the health facility level in humanitarian emergencies, refer them to IAFM 2018 pages 44-47, the TPI checklist (http://iawg.net/tpi-home/resources/), and share videos from the Healthy Newborn Initiative, easily found online.

Slide #23: The role of service providers

Key Messages



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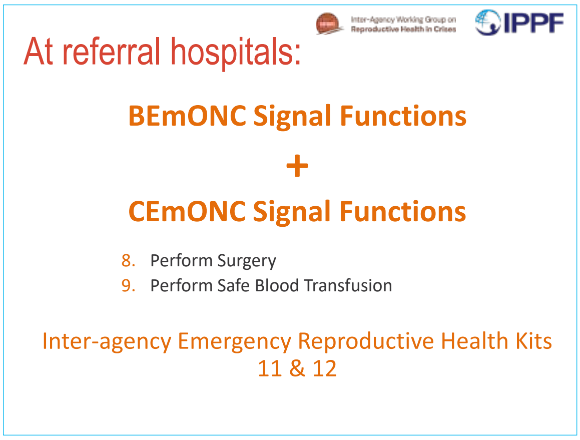
The role of service providers:

- Ensure skills in BEmONC & Essential Newborn Care are available 24/7
- Follow protocols for use of drugs such as misoprostol and magnesium sulphate
- Respect the cold chain
- Evaluate critical situations for referral

- To ensure the availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care at health facility level, service providers have a key role in:
    - Ensuring their own and others' capacity in BEmONC and essential newborn care, and that these skills are available 24 hours a day, 7 days a week;
    - Following protocols for the use of drugs such as misoprostol and magnesium sulfate;
    - Respecting the cold chain at all times; and
    - Evaluating critical situations for possible referral.

Slide #24: At referral hospitals

Key Messages



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At referral hospitals:

BEmONC Signal Functions

+

CEmONC Signal Functions

8. Perform Surgery
9. Perform Safe Blood Transfusion

Inter-agency Emergency Reproductive Health Kits 11 & 12

- As well as ensuring basic emergency obstetric and newborn care are available at health facility level, it is critical that skilled medical staff and supplies for the provision of comprehensive emergency obstetric and newborn care are available and accessible at the referral hospital level.
- CEmONC consists of the 7 signal function defined for BEmONC and adds the 2 further signal functions of:
    1. Perform surgery (e.g., caesarean section): caesarean surgery may be necessary when vaginal birth could pose a risk to the woman or baby- for example due to prolonged labor, fetal distress, or because the fetus has an abnormal presentation or position.
    2. Perform safe blood transfusion observing universal infection prevention precautions: as discussed during Day 2: Session 2.
- Supplies to support CEmONC are included in Inter-agency Emergency Reproductive Health Kits 11 (Referral level kit for reproductive health) and 12 (Blood transfusion kit).

Note to facilitators Ask participants to add this information to their matrix (Participant Handout #14). Make sure to emphasise the importance of them thinking strategically about clinical skills required for comprehensive emergency obstetric and newborn care at the referral hospital level, who in their settings is able to perform these clinical tasks, possible partnerships in humanitarian emergencies, and gaps in capacity and resources to fill these gaps.

Slide #25: At referral hospitals

Key Messages

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At referral hospitals:

Newborn Care:

Essential Newborn Care

+

- Space for newborn resuscitation in labour ward
- Provide newborn resuscitation & continue to manage newborns with respiratory distress
- Establish Kangaroo Mother Care Unit

- In a similar way to the addition of signal functions 8 and 9 to form comprehensive emergency obstetric and newborn care, newborn care at the referral hospital level includes the aspects discussed for essential newborn care and adds to these with:
  - Ensuring space for newborn resuscitation in the labor ward and capacity and supplies to provide bag and mask ventilation;
  - Addressing intrapartum complications and provide newborn resuscitation as for essential newborn care and continue to manage newborns in respiratory distress;
  - Establish Kangaroo Mother Care (KMC) Unit for babies and mothers that are clinically stable, support immediate breastfeeding, and follow WHO guidelines for pre-term infants, including management of serious signs of bacterial infection in newborns (IAFM 2018).

Note to facilitators Provide participants with further information on Kangaroo Mother Care (see below) if needed:

(From IAWG 2017 Newborn Health in Humanitarian Settings https://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide/)

Kangaroo mother care (KMC) is one of the most promising ways to save preterm and low birth weight (LBW) babies in all settings. This form of care, initiated in health facilities, involves teaching health workers and caregivers how to keep newborns warm through continuous, 24 hours per day, skin-to-skin contact on the mother or caregiver's chest.

Not much is needed to start KMC other than designated beds with infection and access control and access to extra care if complications arise.

Health workers should counsel mothers and families with stable small babies to initiate KMC as soon as possible after birth, particularly in the absence of intensive neonatal care.

This might be a good chance to ask an experienced participant to demonstrate the steps of Kangaroo Mother Care. As they do so, talk through the instructions provided below.

If no one in the group is experienced in Kangaroo Mother care, a facilitator could demonstrate each step.

- The environment where KMC is practiced should be kept warm, above 25 degrees C if possible

Positioning

- Dress baby in only socks, nappy, and hat
- Place baby between mother's breasts, in vertical position, with head turned to side, slightly extended to protect airway
- Flex hips in frog position
- Flex arms
- Wrap/tie baby securely with cloth to mother

Feeding

- Mother provides exclusive breastfeeding 2 to 3 hourly, and on-demand
- If baby unable to latch/suckle, feed expressed breastmilk with cup or spoon

Duration

- LBW and premature babies should remain in KMC for at least 20 hrs/day (with mother or surrogate) until baby no longer tolerates KMC positioning
- Mother should sleep in a half-sitting position, with baby tied in KMC
- If baby needs to be out of KMC position, care should be taken to keep baby warm

Follow-up

- Mother and baby should be sent home in KMC position with counselling prior to discharge and follow-up monitoring as clinically indicated

Instruct participants that they can visit www.who.int/maternal_child_adolescent/documents/9241590351/en/ to download WHO's Kangaroo Mother Care: A Practical Guide.

Slide #26: The role of service providers

Key Messages

The role of service providers:

- Ensure skills in CEmONC & Newborn Care are available 24/7
- Follow protocols for safe blood transfusion
- Respect the cold chain
- Providing non-judgemental services for all

- To ensure the availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care at referral hospital level, service providers have a key role in:
  - Ensuring their own and others' capacity in CEmONC and essential newborn care, and that these skills are available 24 hours a day, 7 days a week;
  - Following protocols for safe blood transfusion;
  - Respecting the cold chain at all times and working with managers to ensure the availability of supplies; and
  - Providing non-judgmental services for all.

Note to facilitators Ask participants to add this information to their matrix (Participant Handout #14). Make sure to emphasise the importance of them thinking strategically about clinical skills required for newborn care at the referral hospital level, who in their settings is able to perform these clinical tasks, possible partnerships in humanitarian emergencies, and gaps in capacity and resources to fill these gaps.

If participants would like more information on the clinical skills required for essential newborn care at the health facility level in humanitarian emergencies, refer them to IAFM 2018 pages 44-47.

Slide #27: At community level

Key Messages

- One of the priority activities of Objective 4 is to: Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable

- Where this is not possible, the provision of clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries is suggested by the MISP for SRH for when access to a health facility is not possible.

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At community level:

- Promote skilled attendance where possible
- Provide clean delivery kits (2A & 2B) & newborn kits to visibly pregnant women & birth attendants

- "Clean, safe delivery and newborn care kits should be made available to all visibly pregnant women to improve birth practices when access to a health facility is not possible. Distributions can be done at registration sites or via community health workers where there is a network established. At a minimum, kits should include 1 sheet of clean plastic for the women to deliver on (noting she should assume birth position of choice), a bar of soap, a pair of gloves, 1 new razor blade to cut the umbilical cord, 3 pieces of string to tie the cord, 2 pieces of cotton cloth (1 to dry and the other to cover the baby), and 1 tube of 7.1% chlorhexidine digluconate antiseptic gel for clean cord care" (IAFM 2018 p170).

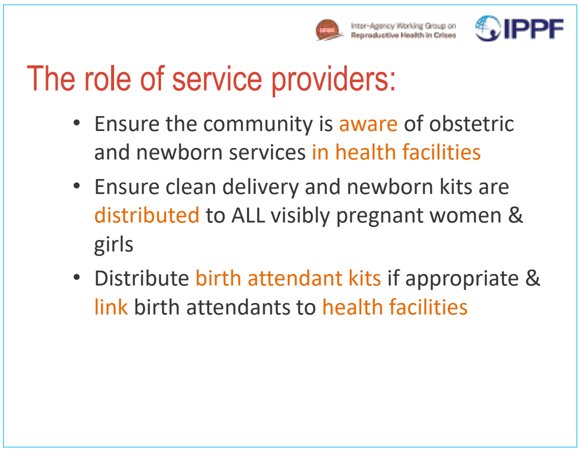
- Clean delivery kits for birth attendants may also be distributed and these include all of the items listed above, together in a shoulder bag with the additions of a flashlight, gloves, apron and wet weather protection.

- "In settings with national protocols for advanced distribution of misoprostol tablets for PPH prevention, this essential life-saving commodity should be included in the kits. Decades of research have proven the safety and efficacy of using misoprostol as a prophylactic uterotonic to reduce post-partum hemorrhage when taken immediately after birth of a newborn. The World Health Organization recommends the administration of misoprostol by community health workers and lay health workers where skilled birth attendants are not present and oxytocin is not available." (IAFM 2018 p170).

- "In all settings, context-appropriate instructional materials should be provided in all kits. At the time of distribution, women should be provided with essential information on kit contents, use, and danger signs" (IAFM 2018 p170).
- Two kinds of clean delivery kits are provided in the Inter-agency Emergency Reproductive Health Kits. Kit 2A is for individual delivery and consists of a bag, plastic, approximately 18 X 28cm, snap-lock fastening, for disposal of placenta, containing the following items:
    - Toilet soap bar,
    - Plastic drawsheet approximately 100cm x 100cm,
    - Razor blade, single-edged and disposable,
    - Umbilical tape, 3mm x 15 cm,
    - Cotton cloth/ towel, and
    - Single use gloves.
- 2B is for use by birth attendants and includes:
    - Shoulder bag,
    - Gloves,
    - Rechargeable flashlight,
    - Protective, reusable, plastic apron, and
    - Wet weather poncho
- Newborn kits are complementary kits provided by UNICEF. They include a baby blanket (50x75cm), Polyester fleece, newborn cap (cotton), newborn romper suit (cotton), baby socks (size extra small), and a small cotton towel. In some contexts, newborn kits may include chlorhexidine digluconate gel, 7.1% (delivering 4% base), 10cc; Tetracyline hydrochloride 1% (for eye care).

Slide #28: The role of service providers

Key Messages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The role of service providers:

- Ensure the community is aware of obstetric and newborn services in health facilities
- Ensure clean delivery and newborn kits are distributed to ALL visibly pregnant women & girls
- Distribute birth attendant kits if appropriate & link birth attendants to health facilities

- Service providers have a key role to play in supporting this activity of the MISP for SRH Objective 4 by working with communities to make sure they are aware of obstetric and newborn services in health facilities.

- Service providers should also work with local organisations to ensure that clean delivery and newborn kits are distributed.

- Engaging with birth attendants through kit delivery is an opportunity to link these providers to more formal health facilities

Note to facilitators If time permits, allow participants a few minutes to strategise on how it might be possible to make sure communities are aware of obstetric and newborn services available in health facilities. Participants can then add this information, together with notes on what is necessary to ensure all visibly pregnant women and girls are provided with clean delivery kits to their matrix for this session.

Slide #29: Clean delivery kits


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Clean Delivery Kits

Group Work

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.

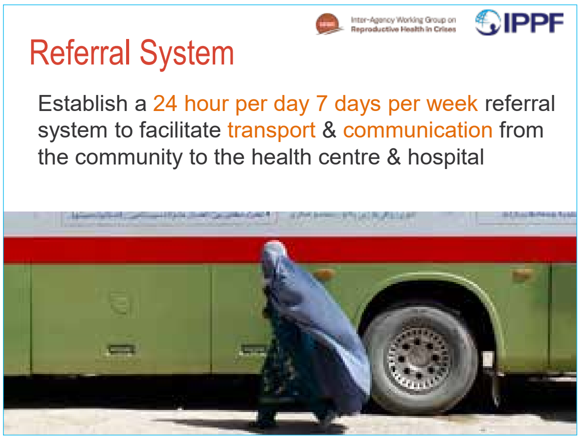
Remind participants that this meets the final activity of Objective 4 of the MISP for SRH: ensuring availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable.

Slide #30: Referral system

Key Messages

- The second key activity under MISP Objective 4 is to establish a referral system for the management of maternal and newborn complications.

- The referral system includes means of communication and transport. Both of these components must be available at all times and the referral system is to be established as soon as possible after the onset of the crisis.



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Referral System

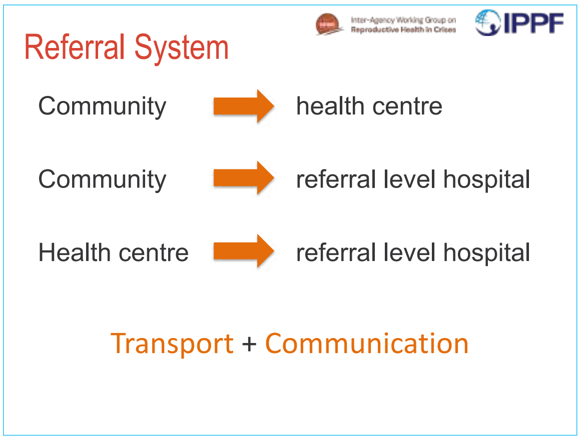
Establish a 24 hour per day 7 days per week referral system to facilitate transport & communication from the community to the health centre & hospital

Slide #31: Referral system

Key Messages

- Under Objective 4: A 24 hour per day 7 days per week referral system to facilitate transport and communication from the community to the health centre and hospital should be established.

- It is to help ensure that women, girls and newborns who need emergency care are referred from the community to a health centre where they can access BEmONC.



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Referral System

Community ➡ health centre

Community ➡ referral level hospital

Health centre ➡ referral level hospital

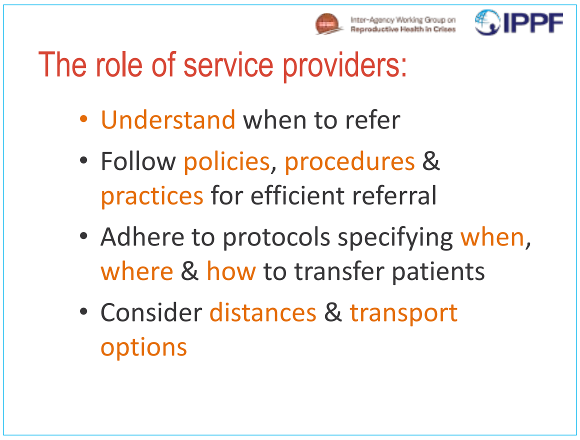
Transport + Communication

- Patients with obstetric complications and newborn emergencies that can not be managed at the health centre must be stabilized and transported to a hospital with CEmONC services.

- This is a critical component in reducing the second delay. Service providers need to know how to access referral systems and be aware of the EmONC services provided at different health facilities so that timely care decisions can be made.

Slide #32: The role of service providers

Key Messages



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The role of service providers:

- Understand when to refer
- Follow policies, procedures & practices for efficient referral
- Adhere to protocols specifying when, where & how to transfer patients
- Consider distances & transport options

- Service providers can support the referral system by:
  - Understanding when to refer and where skilled staff and supplies are located;
  - Ensuring that referral mechanisms are clearly visible in all health facilities and are shared with any outreach workers who may need to refer;
  - Following policies, protocols and practices in health centres and referral hospitals;
  - Adhering to protocols which include when, where and how to refer patients with obstetric and newborn emergencies.
  - Considering distances from the affected community to functioning health centres and hospitals, and transport and communication options for referral. Means of communication are an important link to skilled staff when it is not possible to reach other facilities, or for use during the journey.

Slide #33: The role of service providers

Key Messages

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The role of service providers
Inform communities:

- When & where to seek emergency care
- Messages in multiple formats & languages
- Distribute messages through multiple channels
- Use illustrative brochures & IEC materials

- To address the first delay (in the decision to seek care), service providers should also work with local healthworkers and organization to "inform communities when and where to seek emergency care for complications of pregnancy and childbirth. Messages should be shared in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (with women's, LGBTQIA, and PWD groups) and other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines)" (IAFM 2018 p47).
- "Meet with and inform community leaders, traditional birth attendants, and others to distribute illustrative brochures or undertake other creative information, education, and communication (IEC) approaches" (IAFM 2018 p47).

Note to facilitators The IEC materials on this slide are available from www.iawg.net and can be adapted to different contexts. Ask participants if they know of any similar materials already available in their contexts. These can then be added to their matrix for this objective.

Slide #34: Post-abortion care

Key Messages

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Post-Abortion Care

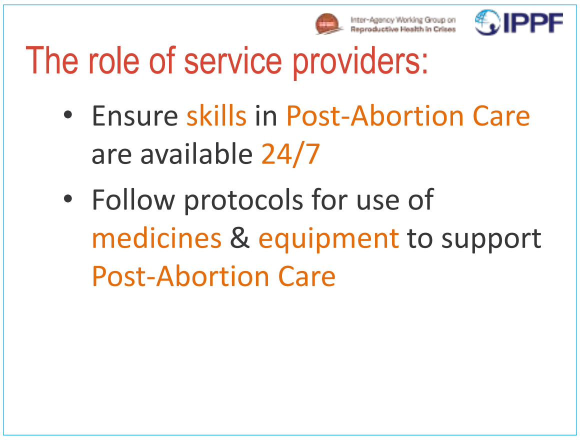
Ensure the availability of life-saving post-abortion care in health centres & hospitals

- Rapid assessment of all women presenting for care
- Stabilisation for haemorrhagic or septic shock
- Stabilisation for heavy vaginal bleeding
- Directed physical exam & concurrent treatment
- Tetanus prophylaxis
- Referral to higher level service

- Another activity under Objective 4 is to ensure the availability of life-saving post-abortion care in health centres and hospitals.
- Post-abortion care is always legally available as an essential part of BEmONC.
- "Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects women, girls, families and entire communities…Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion" (IAFM 2018 p48).
- Post-abortion care (PAC) is the global strategy to reduce death from unsafe and spontaneous abortion.
- Clinical service providers in health centres and hospitals should perform the series of interventions displayed on this slide.
- Highlight to service providers that this list is the minimum requirement for post-abortion care in emergencies.

Slide #35: The role of service providers

Key Messages


The role of service providers:

- Ensure skills in Post-Abortion Care are available 24/7
- Follow protocols for use of medicines & equipment to support Post-Abortion Care

- As with each aspect of preventing excess maternal and newborn death in humanitarian settings, service providers have a key role to play in ensuring life-saving post-abortion care services are in place.
- This can be done by ensuring skills in post-abortion care are available 24 hours a day, 7 days a week. Mapping of capacities and strategizing for partnerships with other skilled service providers and organisations is an important part of this, both in the preparedness and response phases.
- Service providers should follow protocols for the use of medicines and equipment to support post-abortion care.

Note to facilitators This is a good opportunity to provide participants with context specific information on post-abortion care. It is also important to reiterate that post-abortion care is life saving and always legal.

Ask participants to add this information to their matrix (Participant Handout #14).

Slide #36: Providing post-abortion care


Providing Post-Abortion Care

Discussion

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

Time

20 minutes

Process

- Ask participants to work through the discussion questions on the 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.

Slide #37: Quality & respectful maternal and newborn care in humanitarian settings

Key Messages

Quality & Respectful Maternal & Newborn Care in Humanitarian Settings

ALL WOMEN HAVE A RIGHT TO A POSITIVE CHILDBIRTH EXPERIENCE THAT INCLUDES:

- Respect and dignity
- A companion of choice
- Clear communication by maternity staff
- Pain relief strategies
- Mobility in labour and birth position of choice

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

- Right to be free from harm & ill-treatment
- Right to information, informed consent & refusal
- Right to privacy & confidentiality
- Right to be treated with dignity & respect
- Right to equality & equitable care
- Right to health care
- Right to liberty, autonomy, self-determination & freedom from coercion

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

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

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

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

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

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

- The right to liberty, autonomy, self-determination, and freedom from coercion

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

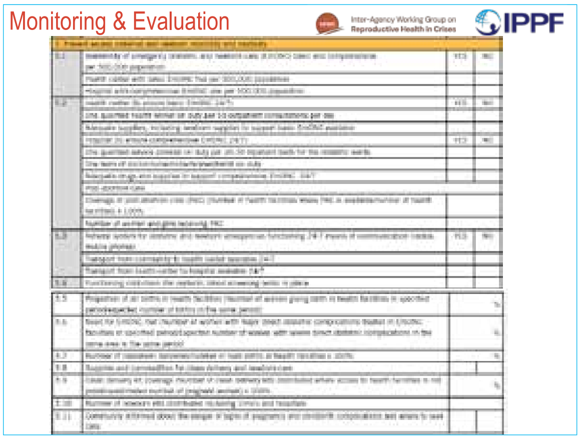
For more information on respectful maternal and newborn care, visit

https://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf

https://reliefweb.int/report/world/rmc-not-luxury-case-respectful-maternity-care-humanitarian-settings

Slide #38: Monitoring & evaluation

Key Messages



Monitoring & Evaluation

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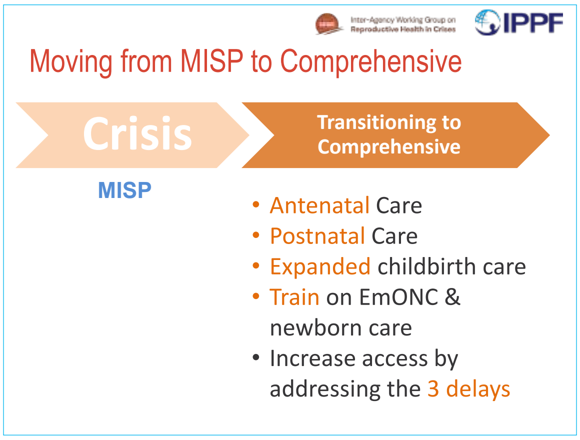
- The MISP checklist provides a useful tool for monitoring and evaluating the maternal and newborn health objective of the MISP.
- Priority indicators include:
    - Availability of emergency obstetric and newborn care (basic and comprehensive) per 500,000 population.
    - Proportion of all births in health facilities.
    - Need for EmONC met (number of women with major direct obstetric complications treated in EmONC facilities in specified period/ Expected number of women with severe direct obstetric complications in the same area in the same period).
- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. The presence of staff with the capacity to provide maternal and newborn care at the 3 levels detailed in the MISP (community, health centre and referral level hospital) should also be considered, and mapping and rostering conducted prior to the onset of an emergency.
- It is important to review staffing structure, roles, responsibilities, protocols and scopes of practice to map who is able to contribute what during an emergency. This will also highlight gaps in capacity and provide opportunities to work on developing capacity.

Slide #39: Moving from MISP to comprehensive

Key Messages

- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.
- It is critical to provide comprehensive services as soon as possible.
- For the maternal and newborn health objective of the MISP, this includes providing antenatal and postnatal care. It also entails the expansion of childbirth care, training new workers on EmONC and working to comprehensively address the 3 delays.
- Strong systems and programs in place before an emergency minimize the impact of hazards on sexual and reproductive health when a crisis hits. Steps to building comprehensive maternal and newborn health services should, therefore, be taken in the preparedness phase.



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Moving from MISP to Comprehensive

Crisis

Transitioning to Comprehensive

MISP

- Antenatal Care
- Postnatal Care
- Expanded childbirth care
- Train on EmONC & newborn care
- Increase access by addressing the 3 delays

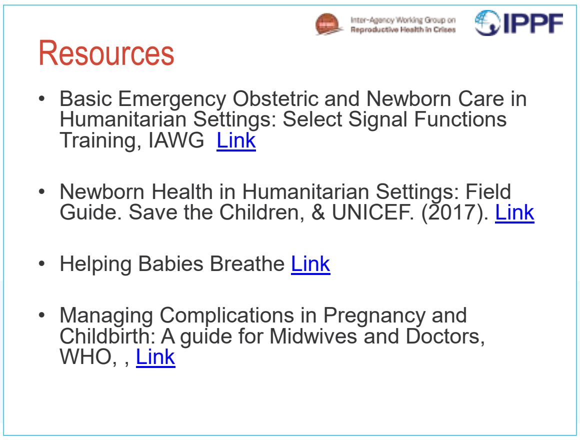
Note to facilitators Ask participants to look again at their matrix and compare the columns they have filled out on the provision of services in standard settings as compared to those outlined in the MISP. Briefly discuss the differences and emphasise again that the MISP prioritises the most life saving interventions.

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

Slide #40: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase your knowledge and skills to prevent excess maternal and newborn morbidity and mortality in humanitarian settings.



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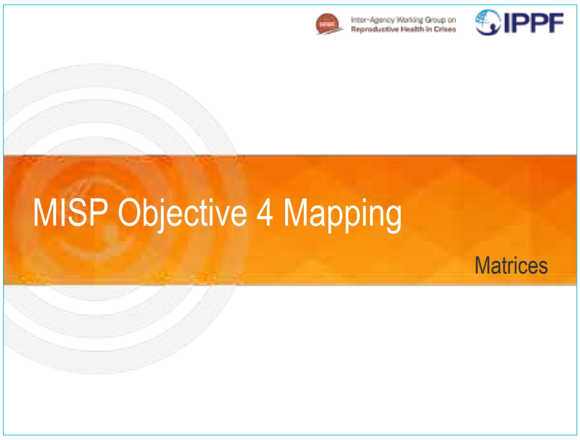
Resources

- Basic Emergency Obstetric and Newborn Care in Humanitarian Settings: Select Signal Functions Training, IAWG Link
- Newborn Health in Humanitarian Settings: Field Guide. Save the Children, & UNICEF. (2017). Link
- Helping Babies Breathe Link
- Managing Complications in Pregnancy and Childbirth: A guide for Midwives and Doctors, WHO, , Link

Note to facilitators Add to this slide with context-specific resources as able.

Slide #41: MISP Objective 4: Mapping



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MISP Objective 4 Mapping

Matrices

Participants will spend some time reviewing the entries they have made to their matrix for this MISP for SRH Objective and add any further information as needed.

Time

20 minutes

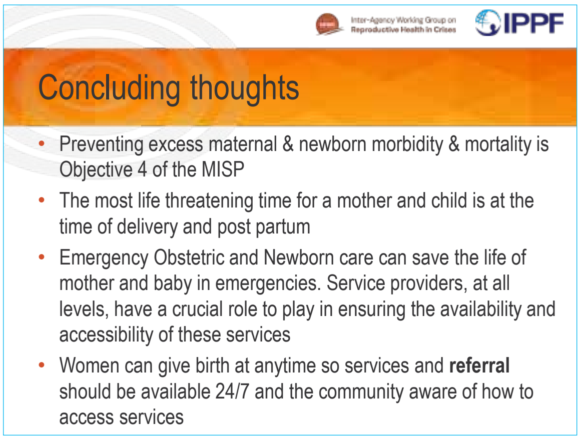
Process

- Ask participants to return to their matrix for this objective of the MISP for SRH.
- In pairs or groups, participants should review and compare the entries they have made during the session and add any information that is missing.
- When this is done, ask participants to work (again in pairs or groups) to identify any gaps and priorities action to fill these gaps. This information should be added to final column of the matrix and include consideration of pressing needs at individual skill, organisational, interagency and community levels.

Materials

Participant Handout #14

Slide #42: Concluding thoughts



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Concluding thoughts

- Preventing excess maternal & newborn morbidity & mortality is Objective 4 of the MISP
- The most life threatening time for a mother and child is at the time of delivery and post partum
- Emergency Obstetric and Newborn care can save the life of mother and baby in emergencies. Service providers, at all levels, have a crucial role to play in ensuring the availability and accessibility of these services
- Women can give birth at anytime so services and **referral** should be available 24/7 and the community aware of how to access services

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

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

Day 3 continued

MISP Objective 5: Prevent Unintended Pregnancies

Session 3.2 1 ½ hours

Overview

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

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #43: Session 3.2: MISP Objective 5: Prevent Unintended Pregnancies

Welcome your participants back and explain that you will now move on to Objective 5- addressing the prevention of unintended pregnancies in emergencies.

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Session 3.2: MISP Objective 5: Prevent Unintended Pregnancies

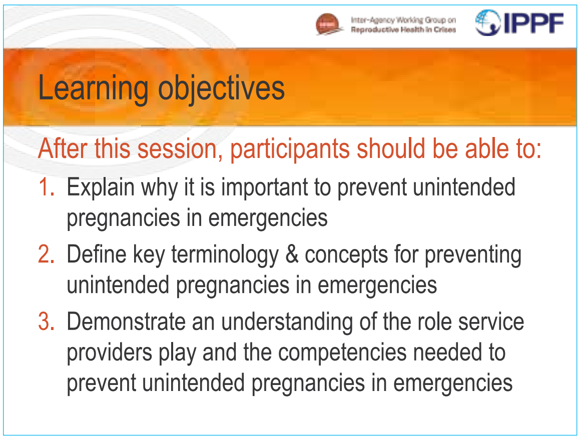
Training for Service Providers

Slide #44: Learning objectives

Key Messages

- There are three learning objectives for session 3.2

  1. Explain why it is important to prevent unintended pregnancies in emergencies
  2. Define key terminology & concepts for preventing unintended pregnancies in emergencies
  3. Demonstrate an understanding of the role service providers play and the competencies needed to prevent unintended pregnancies in emergencies



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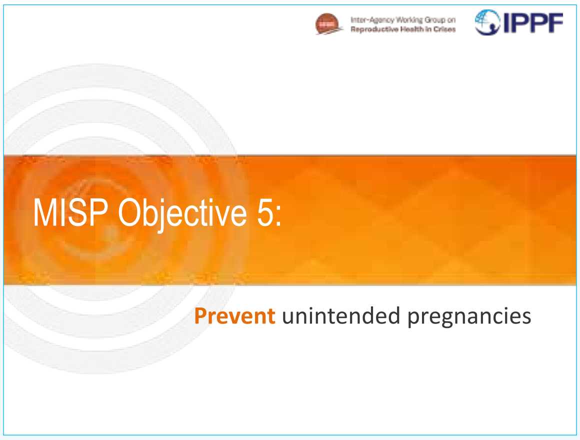
Learning objectives

After this session, participants should be able to:

1. Explain why it is important to prevent unintended pregnancies in emergencies
2. Define key terminology & concepts for preventing unintended pregnancies in emergencies
3. Demonstrate an understanding of the role service providers play and the competencies needed to prevent unintended pregnancies in emergencies

Slide #45: MISP Objective 5

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

Prevent unintended pregnancies

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

Slide #46: Preventing unintended pregnancies in humanitarian emergencies

Key Messages


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Preventing Unintended Pregnancies in Humanitarian Emergencies

- Making contraceptive services available is a life-saving humanitarian intervention
- Contraception is one of the most effective ways to prevent maternal death
- Access to contraception improves women's economic, educational & employment outcomes
- It is possible to provide family planning services in even the most challenging of settings, and demand is strong

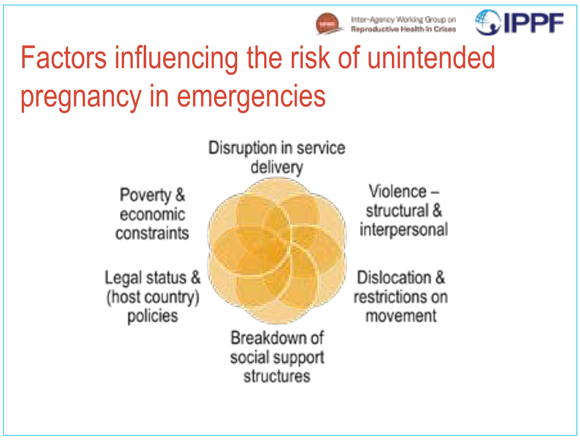
- At the onset of an emergency it is important to ensure contraceptive services are available to prevent unintended pregnancies.
- Contraception is one of the most effective ways to prevent maternal death. "It is estimated that if unmet need for contraception were fulfilled, an additional 104, 000 maternal deaths could be prevented- a 29% reduction in global maternal mortality" (https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf).
- Making a range of long-acting reversible and short-acting methods of contraception available is a life-saving intervention in humanitarian settings. It is also empowering and cost-effective but a gap in the provision of contraception during emergency response remains due to a lack or prioritization and funding.
- "Strong evidence demonstrates that family planning services can and should be integrated into each stage of humanitarian interventions, from preparedness, to response and recovery" (https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf).

Note to facilitators If participants are interested in learning more about providing contraception in emergencies, encourage them to explore Family Planning Saves Lives and Promotes Resilience in Humanitarian Contexts: http://iawg.net/wp-content/uploads/2017/07/Family-planning-white-paper-complete-spread-in-US-LETTER-WEB.pdf

Slide #47: Factors influencing the risk of unintended pregnancy in emergencies

Key Messages

- Access to contraception decreases during emergencies as health systems are compromised.
- New barriers to access come at a time when many people's desire and need for birth spacing and pregnancy prevention increase. Evidence shows that many recently displaced couples have no desire to become pregnant for two or more years.



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Factors influencing the risk of unintended pregnancy in emergencies

Disruption in service delivery

Poverty & economic constraints

Violence – structural & interpersonal

Legal status & (host country) policies

Dislocation & restrictions on movement

Breakdown of social support structures

- Additionally, the loss of social structure and protective mechanisms during emergencies increase the risk of forced sex, risk-taking behaviours, and exposure to high-risk situations, highlighting the critical role of the availability of contraception.
- The factors on this slide are amongst those which place thousands of women and girls at risk of unintended pregnancy, unsafe abortion, and related morbidity and mortality.

Slide #48: Prevent unintended pregnancies: matrix

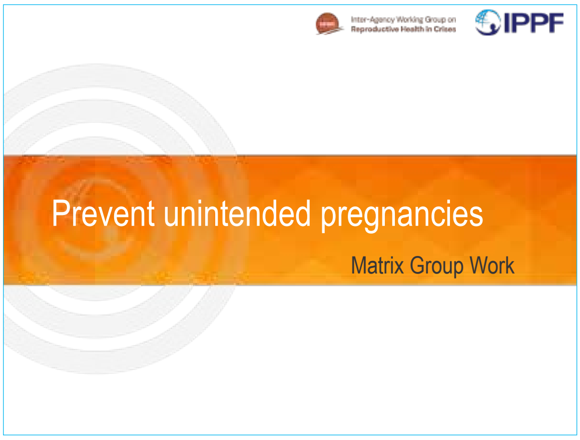
Matrix Group Work: MISP for SRH Objective 5

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.



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Prevent unintended pregnancies

Matrix Group Work

- 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 Cheat Sheet

Slide #49: Prevent unintended pregnancies

Key Messages

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Prevent Unintended Pregnancies

MISP: Minimum Response

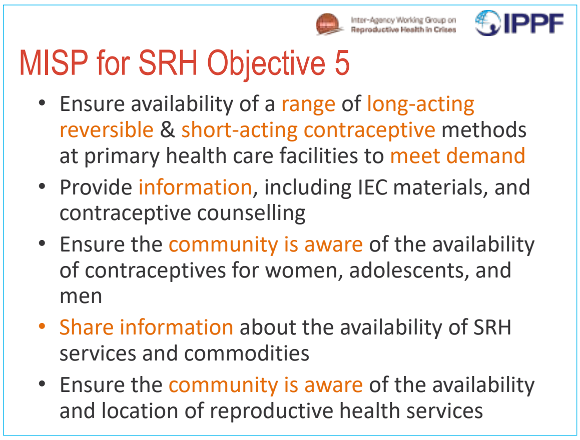
- Ensure availability of a range of long-acting reversible & short-acting contraceptive methods at primary health care facilities to meet demand
- Provide information & contraceptive counselling
- Ensure community is aware of availability

Restore comprehensive services AS SOON AS POSSIBLE

- Due to the life-saving nature of contraceptive provision in emergency situations, the 5th objective of the MISP is for the prevention of unintended pregnancies. This objective was added in the 2018 revision.
- The evidence-informed activities that support this objective include ensuring the availability of a range of long-acting reversible and short-acting contraceptive methods to meet demand, provision of information and contraceptive counselling to users, and ensuring that the community is aware of services.
- These activities form an absolute minimum of response during a crisis. They should be expanded and comprehensive family planning services made available as soon as possible.

Slide #50: MISP for SRH Objective 5

Key Messages



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MISP for SRH Objective 5

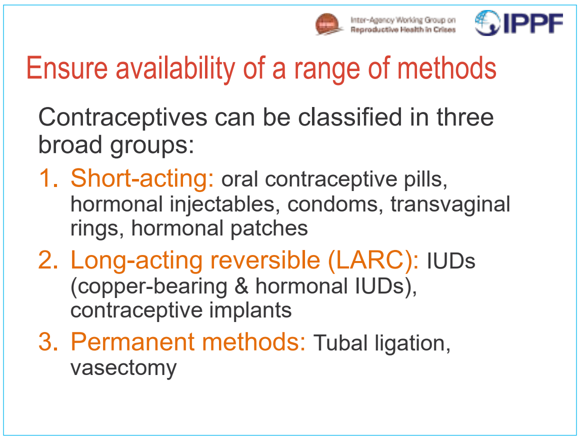
- Ensure availability of a range of long-acting reversible & short-acting contraceptive methods at primary health care facilities to meet demand
- Provide information, including IEC materials, and contraceptive counselling
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men
- Share information about the availability of SRH services and commodities
- Ensure the community is aware of the availability and location of reproductive health services

- Five activities are listed under Objective 5 of the MISP for SRH.
- These are:
  - Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female (where already used) condoms and emergency contraception) at primary health care facilities to meet demand
  - Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
  - Ensure the community is aware of the availability of contraceptives for women, adolescents, and men
  - Shares information about the availability of SRH services and commodities

- Ensure the community is aware of the availability and location of reproductive health services

Slide #51: Prevent unintended pregnancies in humanitarian emergencies

Key Messages



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Ensure availability of a range of methods

Contraceptives can be classified in three broad groups:

1. Short-acting: oral contraceptive pills, hormonal injectables, condoms, transvaginal rings, hormonal patches
2. Long-acting reversible (LARC): IUDs (copper-bearing & hormonal IUDs), contraceptive implants
3. Permanent methods: Tubal ligation, vasectomy

- The MISP for SRH requires the availability of a range of long-acting reversible and short-acting contraceptive methods at primary health care facilities to meet demand. As explained in the IAFM (2018), “[a] range of oral contraceptives, hormonal injectables and implants, IUDs, male and female condoms and emergency contraceptive pills should be available immediately to meet demand in the affected population where providers are trained and skilled to provide, and in the case of long-acting reversible contraceptive, remove the method” (p50).

- To clarify some of these terms, contraceptives can be classified under three broad groups, depending on their duration of action. These are represented on the slide with examples given of each type. Note that the MISP for SRH focuses on short-acting and long-acting reversible methods, not permanent methods.

- Long Acting Reversible contraceptive methods include hormonal IUDs, non-hormonal IUDs and implants. They are safe and can be used by women of all ages, including youth.

- All forms of contraception should be provided on a confidential basis and without requiring the consent of a partner, parent, relative or other caregiver in line with the law of the country.

- “Emergency contraception should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual” (IAFM 2018 p51).

Slide #52: Prevent unintended pregnancies in humanitarian emergencies

Key Messages

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


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Contraceptive methods

Slide #53: Rumours and Misconceptions vs. Facts and Realities of LARCs


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Rumours and Misconceptions vs. Facts and Realities of LARCs

Group Work

(Adapted from *LARC Learning Resource Package Jhpiego* http://resources.jhpiego.org/resources/Modular_LARC_LRP).

This activity will allow participants to increase their knowledge 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.

Materials

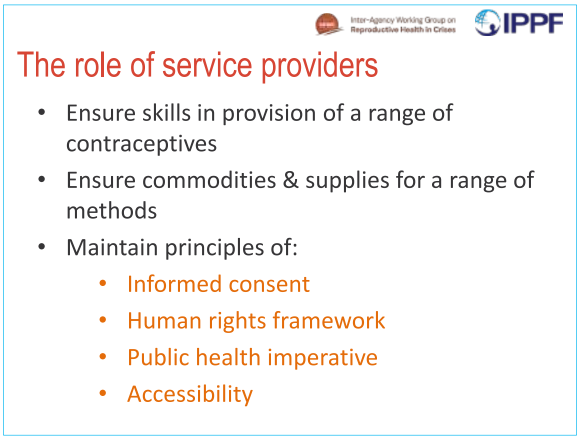
Participant Handout #19 cut into cards. One colour for facts and realities and one for Rumours and Misconceptions.

Key Messages

- Long Acting Reversible Contraceptives (LARCs) can be provided safely and effectively in emergency settings.

Slide #54: The role of service providers

Key Messages



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The role of service providers

- Ensure skills in provision of a range of contraceptives
- Ensure commodities & supplies for a range of methods
- Maintain principles of:
  - Informed consent
  - Human rights framework
  - Public health imperative
  - Accessibility

- Service providers can support the 5th MISP Objective, first by ensuring their competency in the provision of family planning services so that contraceptives may be provided from the onset of the crisis.
- It is also important that service providers play their role in stock management and ordering to ensure that there are enough commodities and supplies available to provide a range of methods.
- Service providers must also understand and adhere to the principles of contraception programming including:

Note to facilitators Make sure that participants are familiar with the principles outlined on the slide. Ask questions of the room to ensure a good understanding, using the following information to inform your discussion:

Informed consent:

- Women, couples, and families have a right to determine the timing and size of their families, regardless of their displaced status or living in a fragile context;
- Every contraceptive client has the right to information, confidentiality, and privacy and to be able to voluntarily choose a contraceptive method;

Human rights framework:

- Coercing people to use a contraceptive method is unacceptable and in violation of international human rights law;

Public health imperative:

- A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy

Accessibility:

- Design contraceptive services so that they are accessible and convenient;
- Condoms should be available at community and health facility levels and all contraceptive clients counselled on dual protection against STIs and HIV and pregnancy;
- Emergency contraception should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual;

Ask participants to look at page 130 of the IAFM 2018 and use the questions listed under "Assess Local Capacity" to complete sections of their matrix.

Slide #55: WHO medical eligibility criteria wheel for contraceptive use

Key Messages

WHO Medical Eligibility Criteria
Wheel for Humanitarian Settings

- There are many different types of contraceptive products that can be offered by providers in humanitarian contexts.
- The World Health Organization's Medical Eligibility Criteria (MEC) for Contraceptive Delivery in Humanitarian Settings provides evidence-based guidance regarding who can use contraceptive methods safely, and how these may be used safely and effectively. It also includes a checklist for users on how to be reasonably certain that a woman is not pregnant, as well as a clear graphic that compares the effectiveness of different contraceptive methods. A section is also included on how to approach the provision of care to women who may have been subjected to sexual violence.
- At the facility, the MEC wheel can be used as a practical tool during counselling and method decision-making together with a woman. A woman who has actively chosen a method based on quality information is more likely to use it consistently and correctly (IAFM 2018).

Note to facilitators If you have the wheels available, you can distribute so people can become familiar with how it works or alternatively, ask a participant who is familiar with the tool to do so. For more information on the MEC, direct participants to:

https://www.who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/

An app is also available. For more information on this, visit:

https://www.who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/

If you would like to include an activity which utilises the MEC wheel for decision making, see the TPI SCORT on LARCS- Activity 1.1. (http://iawg.net/tpi-home/)

Slide #56: Contraceptive supplies and commodities

Key Messages

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Contraceptive supplies & commodities

- In-country supplies and commodities
- Inter-Agency Reproductive Health Kits (RH Kits)

RH Kits through 2018

Block 1
RH Kit 1A: Male condoms
RH Kit 1B: Female condoms
RH Kit 3: Post-rape
RH Kit 4: Oral and injectable contraception

Block 2
RH Kit 7: IUD

RH Kits beginning 2020

Community health post
Kit 1A: Male condoms
Kit 3: Post-rape
Kit 4: Oral and injectable contraceptives

Complementary commodities
Kit 1B: Female condoms
Kit 4: DPMA-SC
Kit 7A: IUD
Kit 7B: Contraceptive implant

- Reliable and sustainable supplies of contraceptives need to be available to support this MISP Objective.
- In-country supplies and commodities and engagement with/ strengthening of supply chains is important prior to an emergency and, to meet Objective 6 of the MISP, planning to integrate comprehensive SRH services into primary health care.
- Commodities are available in RH Kits to be ordered as required at the onset of an emergency.
- Complementary commodities can be ordered according to the enabling environment and capacities of health care providers.

Note to facilitators Guidance on the inter-agency Emergency Reproductive Health Kits was being revised at the time of writing this manual. Please ensure you source the most up-to-date information on kit contents and use from iawg.net before presenting this information to your participants.

Slide #57: Access to information

Key Messages

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Access to information

- Provide information/ IEC materials and contraceptive counselling
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men
- Share information about availability of SRH services & commodities
- Ensure community is aware of availability & location of reproductive health services

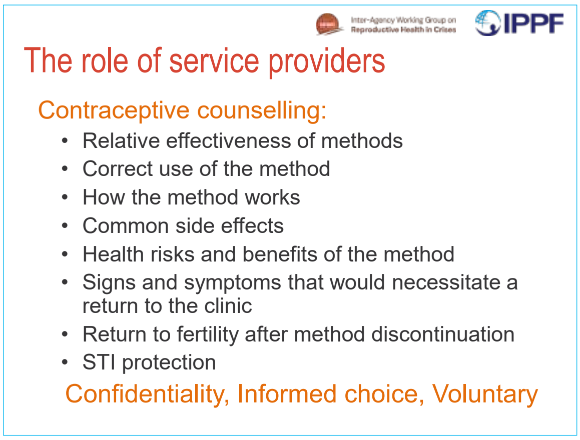
- The next activity under MISP for SRH Objective 5 is to provide information, including information, education, and communication (IEC) materials, and, as soon as possible, ensure contraceptive counseling that emphasizes informed choice, effectiveness, and supports client privacy and confidentiality.

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

- Objective 5 of the MISP for SRH also asks providers and managers to ensure the community is aware of the availability of contraceptives for women, adolescents, and men; and to share information about the availability of SRH services and commodities, and the location of reproductive health services.

Slide #58: The role of service providers

Key Messages



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The role of service providers

Contraceptive counselling:

- Relative effectiveness of methods
- Correct use of the method
- How the method works
- Common side effects
- Health risks and benefits of the method
- Signs and symptoms that would necessitate a return to the clinic
- Return to fertility after method discontinuation
- STI protection

Confidentiality, Informed choice, Voluntary

- As soon as possible, service providers should provide contraceptive counseling as this forms an essential component of volunteerism and informed choice. Informed choice includes a consideration of:
  - Relative effectiveness of methods;
  - Correct use of the method;
  - How the method works;
  - Common side effects;
  - Health risks and benefits of the method;
  - Signs and symptoms that would necessitate a return to the clinic;
  - Return to fertility after method discontinuation; and

  - STI protection.

- High quality counseling ensures clients are informed about their chosen method and fosters longer continuation.

- Being in a humanitarian setting is not a reason to cut corners on this quality aspect of service provision; on the contrary, investing in this integral part of quality contraceptive services helps to lay the foundation for high-quality services that are critical to establishing trust with clients and facilitating longer term service delivery interventions (IAFM 2018).

- Good counseling skills follows all of the following basic principles:
  - Non-judgemental
  - Maintain respect for choices & dignity
  - Provide full explanation & evidence-based responses
  - Ensure confidentiality and provision of contraception without consent of partner or parent
  - Ensure availability of emergency contraception irrespective of age, marital status, religion, race/ethnicity, whether sex was consensual
  - Communication: open interactive dialogue

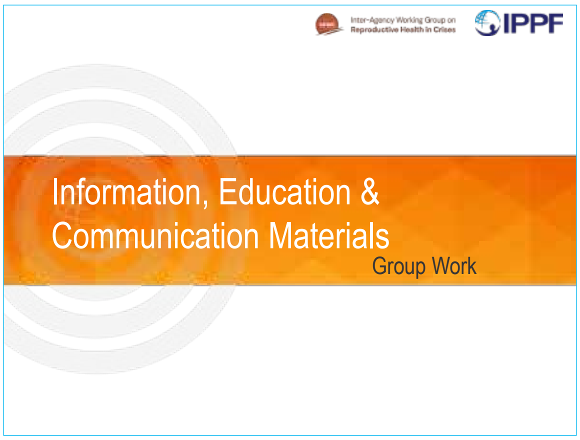
⚠ **Note to facilitators** Ask participants to add this information to their matrix (Participant Handout #18). Make sure to emphasise the importance of them thinking strategically about skills required for contraceptive counselling, who in their settings is able to perform these tasks, possible partnerships in humanitarian emergencies, and gaps in capacity and resources to fill these gaps.

Slide #59: Information, Education & Communication materials

This activity will allow participants to reflect on the importance of providing contraceptive information and services in humanitarian settings and to strategise to ensure the community is aware of available services.

Time

15 minutes.



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Information, Education & Communication Materials

Group Work

Process

- Ask participants to consider how they might highlight the importance of contraceptives to populations (or a specific population) in their context and inform them of where to go for these services in an emergency. This might be based on experience, a hypothetical event or the case study provided on Day 1 of the training (Participant Handout #1).

- If there are good IEC resources available in your setting, provide these to your participants and ask them to critically appraise them for use in humanitarian settings. Then ask participants to strategise on the best methods or channels for distributing these IEC materials in standard and humanitarian settings.

- If no good IEC materials are available in your setting, ask participants to work with their table group to develop a basic IEC poster, flier or infographic containing relevant information on contraceptive services.

- Remind participants of the importance of understanding health and general literacy levels, culturally appropriate images and clarity of message.

- Next, ask participants to discuss and strategise on the best methods or channels for distributing these IEC materials in standard and humanitarian settings.

Materials

Flipcharts and markers (per table group)

Key Messages

- Service providers have an important role to play in ensuring access to information and services by:

    - Ensuring the community is aware of where and how to seek access to contraception, including unmarried and adolescent community members. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms and pictures);

    - Engaging community leaders to disseminate information about the availability of contraceptive services and conducting community outreach;

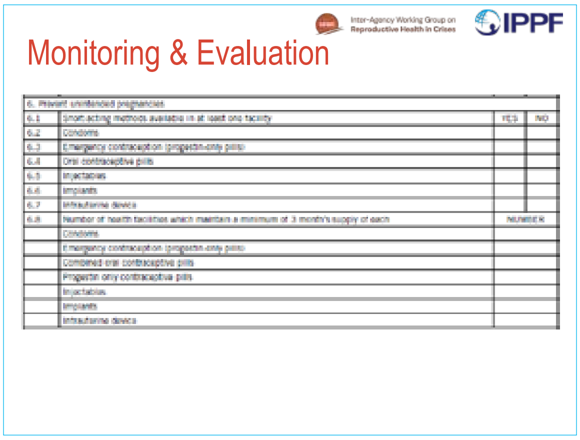
    - IEC materials should be used in the acute phase to create basic awareness about availability of contraceptive services. Where possible, it is important to use existing IEC materials, which can include posters, fliers in local languages with locally-appropriate images, and radio messages. These should be distributed through appropriate channels;

    - Responding to misinformation and method discontinuation;

    - Ensuring the community is aware of the availability and location of all reproductive health services.

Slide #60: Monitoring & evaluation

Key Messages



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Monitoring & Evaluation

6. Prevent unintended pregnancies			
6.1	Short-acting methods available in at least one facility	YES	NO
6.2	Condoms		
6.3	Emergency contraception (progestin-only pills)		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine device		
6.8	Number of health facilities which maintain a minimum of 3 month's supply of each	NUMBER	
	Condoms		
	Emergency contraception (progestin-only pills)		
	Combined oral contraceptive pills		
	Progestin only contraceptive pills		
	Injectables		
	Implants		
	Intrauterine device		

- The MISP check list once again provides a useful tool for monitoring and evaluating Objective 5 of the MISP.

- Some key indicators for this objective that are relevant to the MISP for SRH include:

  - Number of clients who begin using a contraceptive method, by method (IUD, implants, tubal ligation, vasectomy, oral contraceptive pill, injectables, condoms, emergency contraception).

  - Percentage of contraceptive clients also counseled about STIs.

  - Number of contraceptive service delivery points that had no stock-outs (for more than 1 day) of methods in previous month.

- It may not be possible to collect this information from the onset of crisis but to consider if and how as the emergency progresses.

- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. These relationships will also support the collection of data to inform MISP implementation and the development of protocols.

- The presence of staff with the capacity to provide a range of contraceptive methods should also be considered, and mapping and rostering conducted prior to the onset of an emergency. Any gaps should be addressed through additional capacity building, and support provided.

Note to facilitators Go through the checklist and ask participants for any questions on monitoring and evaluating this objective of the MISP for SRH.

Slide #61: Moving from MISP to comprehensive

Key Messages

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


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Moving from MISP to Comprehensive

Crisis

Transitioning to Comprehensive

MISP

- Assessing needs
- Managing supply chain
- Ensuring availability of providers & facilities
- Social behaviour change
- Community outreach & involvement
- IEC
- Working with specific populations
- Advocacy

Note to facilitators Ask participants to look again at their matrix and compare the columns they have filled out on the provision of services in standard settings as compared to those outlined in the MISP. Briefly discuss the differences

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

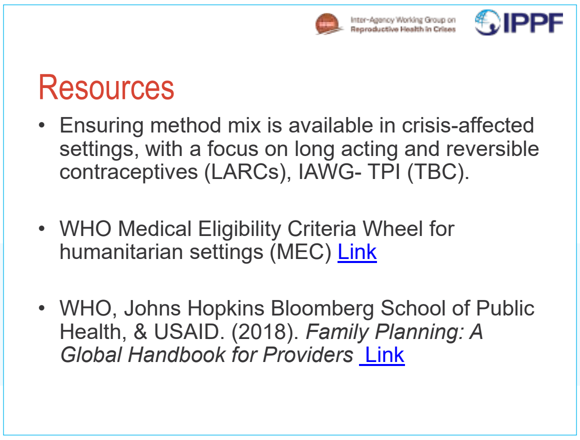

IPPF/Kathleen Prior

Slide #62: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their capacity to prevent unintended pregnancies in humanitarian settings.

Note to facilitators Add context-specific resources available to this slide.



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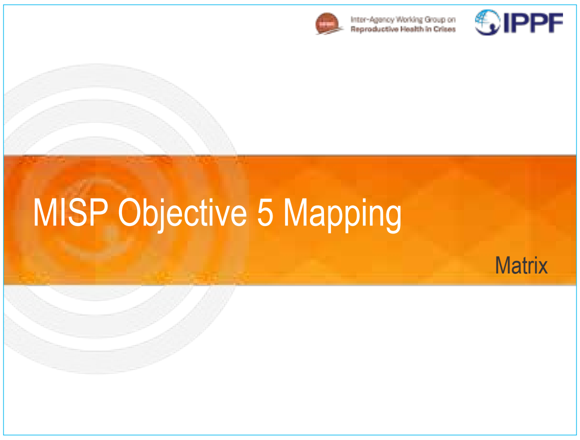
Resources

- Ensuring method mix is available in crisis-affected settings, with a focus on long acting and reversible contraceptives (LARCs), IAWG- TPI (TBC).
- WHO Medical Eligibility Criteria Wheel for humanitarian settings (MEC) Link
- WHO, Johns Hopkins Bloomberg School of Public Health, & USAID. (2018). *Family Planning: A Global Handbook for Providers* Link

Slide #63: MISP Objective 5: Mapping



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MISP Objective 5 Mapping

Matrix

Participants will spend some time reviewing the entries they have made to their matrix for this MISP for SRH Objective and add any further information as needed.

Time

20 minutes

Process

- Ask participants to return to their matrix for this objective of the MISP for SRH.
- In pairs or groups, participants should review and compare the entries they have made during the session and add any information that is missing.
- When this is done, ask participants to work (again in pairs or groups) to identify any gaps and priorities action to fill these gaps. This information should be added to final column of the matrix and include consideration of pressing needs at individual skill, organisational, interagency and community levels.

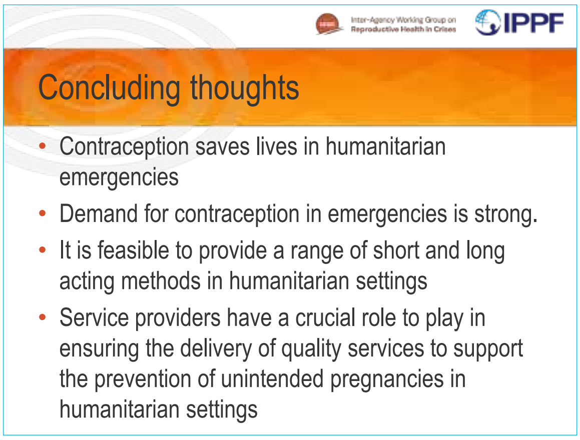
Materials

Participant Handout #18

Slide #64: Concluding thoughts

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

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



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Concluding thoughts

- Contraception saves lives in humanitarian emergencies
- Demand for contraception in emergencies is strong.
- It is feasible to provide a range of short and long acting methods in humanitarian settings
- Service providers have a crucial role to play in ensuring the delivery of quality services to support the prevention of unintended pregnancies in humanitarian settings

Day 3 continued

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

Session 3.3 45 minutes

Overview

This session will provide participants with an understanding of the importance of planning for comprehensive SRH services to be integrated into primary care as soon as possible, and the utility of the health systems building blocks.

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #65: Session 3.3: MISP Objective 6: Plan for Comprehensive SRH Service Integrated into Primary Health Care

This session will look at transitioning towards comprehensive SRH programming.

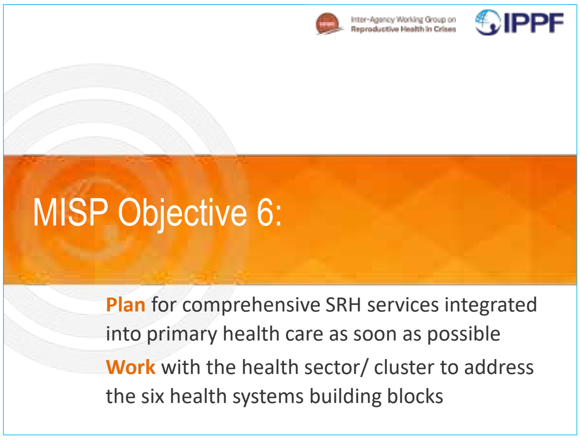
Session 3.3: MISP Objective 6: Plan for Comprehensive SRH Service Integrated into Primary Health Care

Training for Service Providers

Slide #66: MISP Objective 6

Key Messages

- The 6th Objective of the MISP is to plan for comprehensive SRH services integrated into primary health care as soon as possible and to work with the health sector/ cluster to address the six health systems building blocks.



MISP Objective 6:

Plan for comprehensive SRH services integrated into primary health care as soon as possible

Work with the health sector/ cluster to address the six health systems building blocks

Slide #67: Comprehensive SRH services

Key Messages

Comprehensive SRH services

- Sustain, improve & expand MISP services
- Address comprehensive SRH as soon as possible
- Through protracted crises, recovery & reconstruction

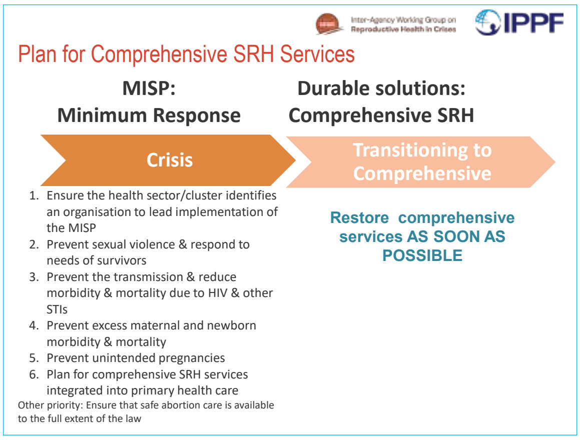
- Using the diagram to explain the following:
    - "The MISP is designed to form the starting point for SRH programming. It was developed based on well-documented evidence of SRH needs in humanitarian settings, and therefore, the four "clinical service delivery" components of the MISP …can be put in place without an in-depth SRH needs assessment among the affected population. Even in settings where other service components of SRH are provided, such as an antenatal care or safe abortion care, it is important to ensure that the MISP objectives are also implemented, as they are high priority actions" (IAFM 2018 p52).
    - "When planning for the delivery of comprehensive SRH, the clinical services put in place as part of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction. After the situation stabilizes and while preparing for comprehensive SRH services, plan to obtain input from the community on the initial response in order to identify gaps, successes, and avenues for improvement" (IAFM 2018 p52).
    - Ensuring that vulnerabilities and capacities are addressed in humanitarian settings will enable better access to services, an increased opportunity for marginalized people to have a voice in decision-making, build the capacity of these groups for action post-crisis, and minimize the chance of exacerbated vulnerabilities and further harm.
    - Note that crises seldom take a linear path from emergency, stability, recovery to development. They are often complex with ongoing and varying degrees of improvement and deterioration. The provision of SRH services must take into account the non-linear trajectory of a crisis.

⚠ **Note to facilitators** At this stage, it can be helpful to show a slide of the six building blocks (see pg 178 of the Program Manager Manual) to discuss key considerations when transitioning to comprehensive services.

Slide #68: Plan for comprehensive SRH services

Key Messages

- Remind participants of the transition between the MISP for SRH and more comprehensive SRH services. This transition has been discussed for each of the objectives of the MISP and should be reiterated now.
- As the training moved through the MISP for SRH Objectives, examples of comprehensive services were given for each. More information on comprehensive SRH activities can be found in the IAFM 2018 chapters by information and service area.



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Plan for Comprehensive SRH Services

MISP:
Minimum Response

Durable solutions:
Comprehensive SRH

Crisis

Transitioning to Comprehensive

1. Ensure the health sector/cluster identifies an organisation to lead implementation of the MISP
2. Prevent sexual violence & respond to needs of survivors
3. Prevent the transmission & reduce morbidity & mortality due to HIV & other STIs
4. Prevent excess maternal and newborn morbidity & mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH services integrated into primary health care

Other priority: Ensure that safe abortion care is available to the full extent of the law

Restore comprehensive services AS SOON AS POSSIBLE

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

At the end of the discussion, choose one or two of the MISP objectives. Ask participants what services would be included when implementing comprehensively vs the onset of crisis. Highlight the differences between what is in the MISP and what should be built upon the MISP for comprehensive programming. Participants may wish to refer to their matrices they have been completing throughout the training.

Slide #69: 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

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Transitioning to Comprehensive SRH:
3 Month Update to Case Study

Group Work

- 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.

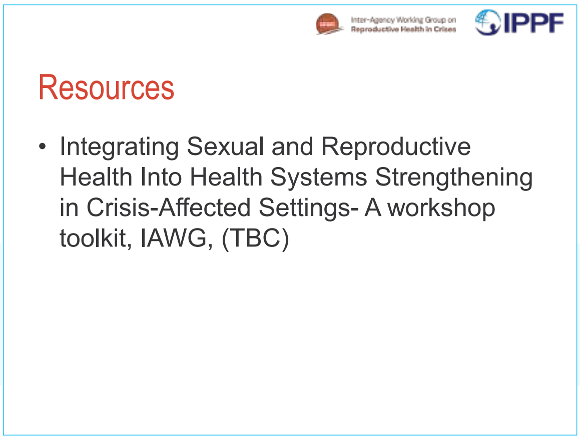
- Transition planning: Consider how to transition to stable supply system not reliant on kits; opportunity to consider capacity development needs; data collected in emergencies is important to use in planning for where supplies, facilities and staff should be, based on need.

Slide #70: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their capacity to build towards comprehensive SRH services.

Note to facilitators Add to this slide with context-specific resources as able.



Resources

- Integrating Sexual and Reproductive Health Into Health Systems Strengthening in Crisis-Affected Settings- A workshop toolkit, IAWG, (TBC)

Slide #71: Concluding thoughts

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

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

Concluding thoughts

- It is important to plan for comprehensive SRH services to be integrated into primary health care as soon as possible.
- The health systems building blocks provide a useful framework for transitioning to comprehensive SRH services.
- There are opportunities to build back better through humanitarian response.
- Planning for comprehensive SRH services begins from day one

Day 3 continued

MISP Other priority: Safe Abortion Care to the Full Extent of the Law in Emergencies

Session 3.4 1 ¼ hour

Overview

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

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #72: Session 3.4: MISP Other priority: Safe Abortion Care

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

This topic can be sensitive for some, so remind participants that the ground rules, including that of respectful interaction, must be maintained throughout.

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Session 3.4: MISP Other Priority:
Safe Abortion Care
Training for Service Providers

Slide #73: Learning objectives

Key Messages

- There are three learning objectives for session 3.4

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

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

  3. Strategise to ensure the availability of safe abortion care, to the full extent of the law, in health centres and hospital facilities.

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Learning objectives

After this session, participants should be able to:

1. Explain why it is important to ensure that safe abortion care is available, to the full extent of the law, in health centres and hospital facilities.
2. Define key terminology, context-specific laws & concepts for ensuring safe abortion care in humanitarian emergencies.
3. Strategise to ensure the availability of safe abortion care, to the full extent of the law, in health centres and hospital facilities.

Slide #74: MISP Other priority activity

Key Messages

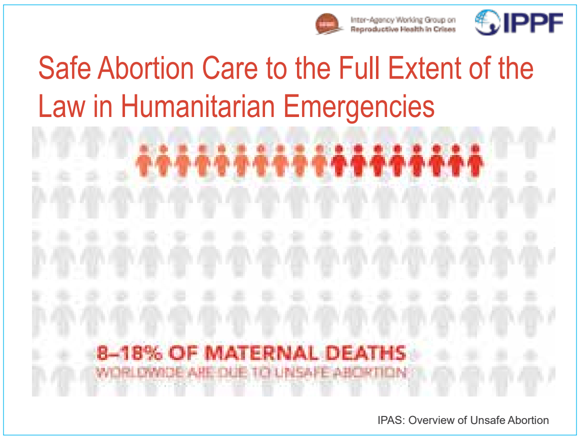
MISP Other Priority Activity:

It is important to ensure that safe abortion care is available, to the full extent of the law, in health centres & hospital facilities

- Access to safe abortion care, to the full extent of the law, in health centres and hospital facilities is defined as an 'other priority activity' in the IAFM 2018.
- As explained in the IAFM (2018), "… the SRH Coordinator, health program managers, and service providers should ensure that safe abortion care is available at the onset of a crisis when capacity already exists. When existing capacity is not present, SAC should be made available once implementation of the MISP priority activities is underway, ideally within 3 months after the onset of an emergency, if not sooner" (p147).

Slide #75: Safe abortion care to the full extent of the law in humanitarian emergencies

Key Messages



Safe Abortion Care to the Full Extent of the Law in Humanitarian Emergencies

8–18% OF MATERNAL DEATHS WORLDWIDE ARE DUE TO UNSAFE ABORTION

IPAS: Overview of Unsafe Abortion

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

Slide #76: Safe abortion care to the full extent of the law in humanitarian emergencies

Key Messages

Safe Abortion Care to the Full Extent of the Law in Humanitarian Emergencies

- Safe Abortion Care saves lives
- There IS a need for Safe Abortion Care in humanitarian settings
- Medical care for abortion is not a difficult procedure
- Many donors do fund abortion care
- Abortion is prohibited only in very few countries

- Evidence demonstrates that access to safe abortion for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality.

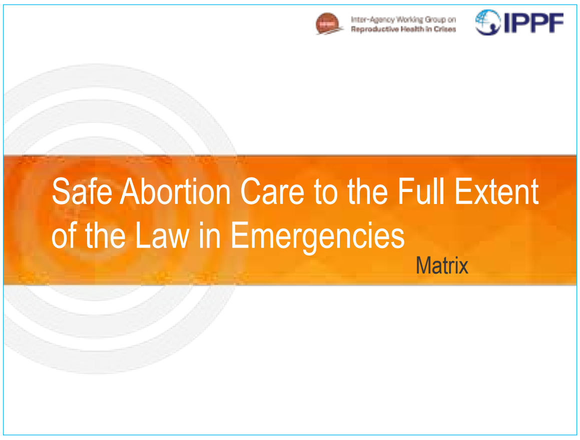
- Medical care for abortion is not a difficult procedure.

- Global data indicate that unsafe abortion is present in countries where safe abortion care is not accessible to all women and girls and that the need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of SAC for women who are raped in crises; international human rights law supports access to SAC across all settings” (IAFM 2018 p60).

- While abortion is restricted in many places, it is only completely prohibited in very few: Dominican Republic, El Salvador, Nicaragua, Vatican City, Holy See and Malta.

Slide #77: Safe abortion care to the full extent of the law: matrix

Matrix Group Work



Safe Abortion Care to the Full Extent of the Law in Emergencies

Matrix

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).

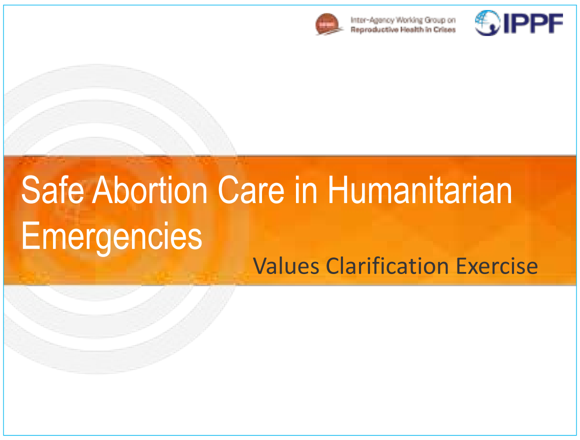
- Start with the section on laws regarding safe abortion care in the participants' context(s). Facilitate a brief discussion on participants' understanding of laws and protocols. You may use the Centre for Reproductive Rights World's Abortion Laws resources and maps as a guide to provide the correct information to the group (available at https://reproductiverights.org/worldabortionlaws).

Materials

Participant Handout #21.

Slide #78: Safe abortion care to the full extent of the law in humanitarian emergencies

Safe Abortion Care in Humanitarian Emergencies: Values Clarification Exercise



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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.

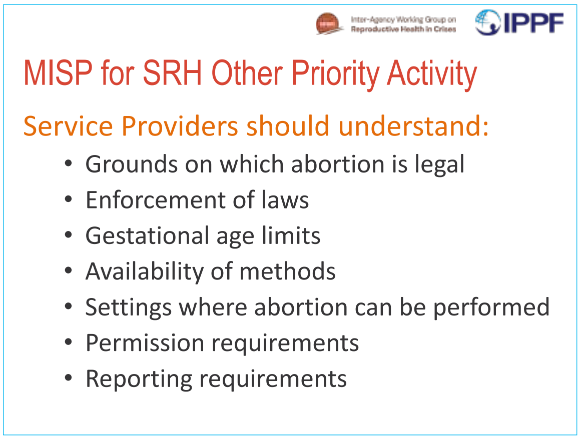
Materials

- Participant Handout #22 Parts A & B
- Copies of national and organisational laws and policies regarding safe abortion care

Slide #79: Safe abortion care to the full extent of the law in humanitarian emergencies

Key Messages

- Program managers and service providers have a responsibility to understand relevant laws and look for entry points to provide these life-saving services in humanitarian contexts.
- In many countries, induced abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest (IAFM 2018).



MISP for SRH Other Priority Activity

Service Providers should understand:

- Grounds on which abortion is legal
- Enforcement of laws
- Gestational age limits
- Availability of methods
- Settings where abortion can be performed
- Permission requirements
- Reporting requirements

- Programs should identify the conditions under which national policies, signed international agreements and international humanitarian and human rights law permit the provision of SAC (ISFM 2018).
- The slide shows important legal aspects which should be considered by program managers and service providers.

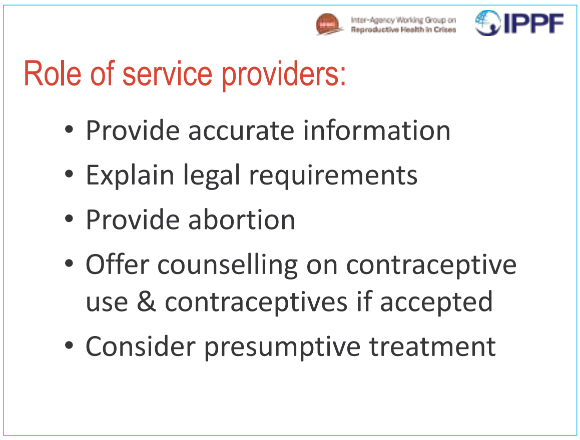
Note to facilitators It is very important for you to provide context-specific information on all legal aspects outlined in the slide. Provide participants with as much detail on this as possible while also reiterating the importance of safe abortion care to the full extent of the law as a life saving intervention in humanitarian settings.

Allow participants time to add this information to their matrix (Participant Handout #21). Ask participants if these laws still stand in emergencies.

Slide #80: Role of service providers

Key Messages

- In most settings safe abortion care is legally permissible for some or all reasons and capacity exists to provide and/or refer women to SAC services. If the woman chooses an abortion, health care workers should:
    - Provide medically accurate information about abortion services in a form women can understand and recall;



Role of service providers:

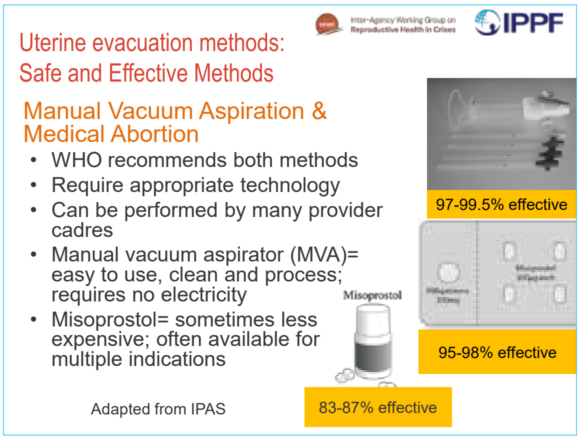
- Provide accurate information
- Explain legal requirements
- Provide abortion
- Offer counselling on contraceptive use & contraceptives if accepted
- Consider presumptive treatment

  - Explain any legal requirements for obtaining safe abortion care;
  - Provide medical abortion, with mifepristone/ misoprostol if available or misoprostol-alone if mifepristone is unavailable, vacuum aspiration, dilation and evacuation, or induction procedures as recommended by WHO;
  - provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method;
  - Consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of STIs (IAFM 2018).
- Supplies to support manual vacuum aspiration (MVA) and misoprostol alone for post-abortion care are included in the Inter-Agency RH Kit for managing complications of miscarriage and abortion. These supplies can also be used for safe abortion care. The mifepristone/ misoprostol regimen is the global gold standard for medication abortion and should be provided in settings where mifepristone is registered and available (IAFM 2018).

Note to facilitators This may be a good opportunity to discuss or share information on the Safe Abortion Care regime in your context.

Slide #81: Uterine evacuation methods: safe and effective procedures

Key Messages



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Uterine evacuation methods:
Safe and Effective Methods

Manual Vacuum Aspiration & Medical Abortion

- WHO recommends both methods
- Require appropriate technology
- Can be performed by many provider cadres
- Manual vacuum aspirator (MVA)= easy to use, clean and process; requires no electricity
- Misoprostol= sometimes less expensive; often available for multiple indications

Adapted from IPAS

- Manual vacuum aspiration and medication abortion are the abortion methods recommended by the WHO. These methods can be safely and effectively performed in the first trimester by trained mid-level providers at the primary health care level. Neither requires electricity, running water, or sophisticated equipment.
- The WHO recommends manual vacuum aspiration (MVA) and medical abortion with mifepristone + misoprostol as the primary methods in the first trimester. Where mifepristone is not available, misoprostol can also be used by itself.
- All of these methods are appropriate in crisis settings for these reasons.
- MVA and medical abortion are not complicated to provide. They do not require running water. They do not require electricity or sophisticated equipment. And they can be done by many provider cadres such as nurses, midwives and clinical officers with no difference in effectiveness and complication rates compared to doctors.

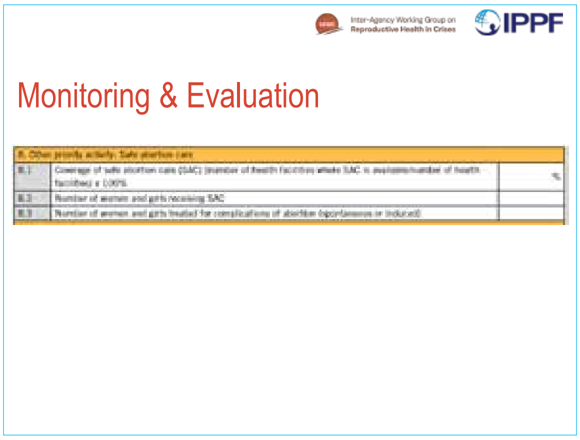
- MVA and medical abortion can be provided in a health center, in any facility that provides Basic Emergency Obstetric and Newborn Care or other similar services, and certainly in hospitals.
- MVA and misoprostol are currently already available in the Inter-agency Emergency Reproductive Health Kit labeled for the management of miscarriage and complications of abortion.
- Mifepristone will soon be available to order through the UNFPA RH kit system as an additional commodity where it is approved in country.

Note to facilitators It may be a good idea to demonstrate or display the supplies needed for safe abortion care if you have access to the medicines and equipment for manual vacuum aspiration and medication abortion.

IPPF/Hannah Maule-ffinch

Slide #82: Uterine evacuation methods: safe and effective procedures

Key Messages



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Monitoring & Evaluation

8. Other priority activity: Safe abortion care		
8.1	Coverage of safe abortion care (SAC) (number of health facilities where SAC is available/number of health facilities) x 100%	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	

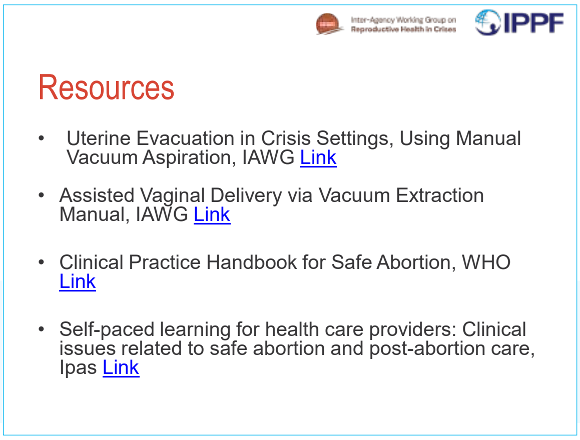
- The MISP check list once again provides a useful tool for monitoring and evaluating the other priority activity of the MISP.
- It may not be possible to collect this information from the onset of crisis but to consider if and how as the emergency progresses.
- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. These relationships will also support the collection of data to inform MISP implementation and the development of protocols.
- The presence of staff with the capacity to provide safe abortion care should also be considered, and mapping and rostering conducted prior to the onset of an emergency. Any gaps should be addressed through additional capacity building, and support provided.

Note to facilitators Go through the checklist and ask participants for any questions on monitoring and evaluating this objective of the MISP for SRH.

Slide #83: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their capacity to ensure safe abortion care to the full extent of the law in humanitarian settings.



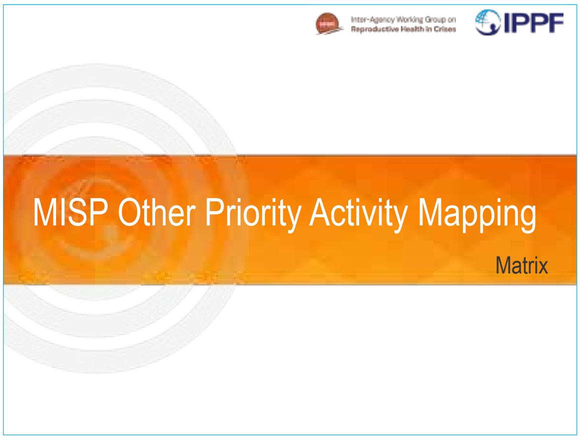
Resources

- Uterine Evacuation in Crisis Settings, Using Manual Vacuum Aspiration, IAWG Link
- Assisted Vaginal Delivery via Vacuum Extraction Manual, IAWG Link
- Clinical Practice Handbook for Safe Abortion, WHO Link
- Self-paced learning for health care providers: Clinical issues related to safe abortion and post-abortion care, Ipas Link

Note to facilitators Add to this slide with context-specific resources as able.

Slide #84: MISP Other priority activity: Mapping

Participants will spend some time reviewing the entries they have made to their matrix for this MISP for SRH Objective and add any further information as needed.



MISP Other Priority Activity Mapping

Matrix

Time

20 minutes

Process

- Ask participants to return to their matrix for this objective of the MISP for SRH.
- In pairs or groups, participants should review and compare the entries they have made during the session and add any information that is missing.
- When this is done, ask participants to work (again in pairs or groups) to identify any gaps and priorities action to fill these gaps. This information should be added to final column of the matrix and include consideration of pressing needs at individual skill, organisational, interagency and community levels.

Materials

Participant Handout #21

Slide #85: Concluding thoughts

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

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

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Concluding thoughts

- The MISP lists access to Safe Abortion Care as a sexual and reproductive health priority
- Trained Mid level cadre can provide Safe Abortion Care and save lives
- It is feasible and necessary to ensure that Safe Abortion Care is available, to the full extent of the law, in health centres and hospital facilities during emergencies

Day 3 continued

Supporting MISP Implementation: Logistics & Assessment, Monitoring and Evaluation

Session 3.5 45 minutes

Overview

This session will develop service providers' knowledge and skills in logistics, assessment, monitoring and evaluation of SRH programs in emergencies.

Methodology

- Interactive presentation
- Group Work

Materials

- PowerPoint Presentation
- Participant Handouts
- Group Work Supplies

Slide #86: Session 3.5: Supporting MISP Implementation

This session will look at cross cutting mechanisms to support MISP implementation.


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Session 3.5: Supporting MISP Implementation

Training for Service Providers

Slide #87: Supporting the MISP for SRH

We will examine the logistics necessary to support the MISP for SRH and assessment, monitoring and evaluation of MISP implementation


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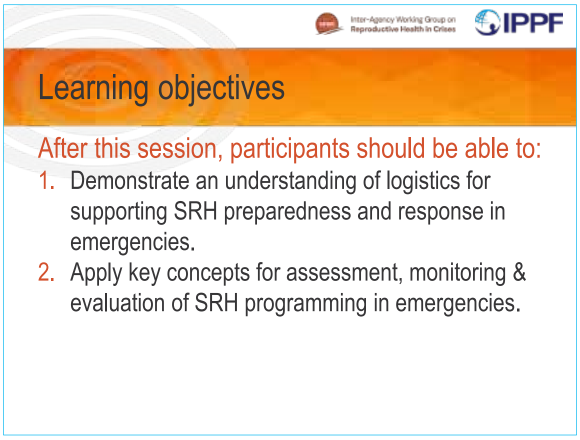
Supporting the MISP for SRH

1. Logistics
2. Assessment, Monitoring & Evaluation

Slide #88: Supporting the MISP for SRH

Key Messages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Learning objectives

After this session, participants should be able to:

1. Demonstrate an understanding of logistics for supporting SRH preparedness and response in emergencies.
2. Apply key concepts for assessment, monitoring & evaluation of SRH programming in emergencies.

- There are two learning objectives for session 3.5- one for logistics and one for the separate section on assessment, monitoring and evaluation

  1. Demonstrate an understanding of logistics for supporting SRH preparedness and response in emergencies;

  2. Apply key concepts for assessment, monitoring and evaluation for SRH programming in emergencies.

Slide #89: Logistics

Key Messages

- In the first part of this session, we will look at the logistics necessary for supporting the implementation of the MISP for SRH.
- This session is designed as an introduction to logistics necessary to support the MISP.
- We will look at products, essential program information and briefly at supply chain management.

Logistics

1. Products
2. Essential Program Information
3. Supply Chain Management

Slide #90: The 6 'RIGHTS' of logistics

Key Messages

- This slide shows the 6 principles, or 'rights' of logistics. These include the right goods in the right quantities, in the right condition, delivered to the right place at the right time, for the right cost.
- As explained in the IAFM (2018), "[a] strong supply chain is a critical component of sexual and reproductive health (SRH) service delivery. When SRH supplies – from contraceptive methods, to antibiotics for sexually transmitted infections, to medicines that prevent maternal death and basic supplies for small and sick newborns – are not available, SRH services cannot be effective. In short, no product, no program" (p69).
- We will work through some of these principles in the following presentation.

The 6 'RIGHTS' of logistics

The **RIGHT** goods
In the **RIGHT** quantities
In the **RIGHT** condition
Delivered
To the **RIGHT** place
At the **RIGHT** time
For the **RIGHT** cost

No product, no program

Slide #91: Products to support MISP implementation

Key Messages

Products to Support MISP Implementation

- Reproductive Health Kits

In-country supplies to meet demand?

- Local procurement
- Pre-positioning of equipment & supplies

- The first ‘right’ involves products, goods or commodities.

- Inter-agency Emergency Reproductive Health (IARH) Kits are one possible source of SRH goods for humanitarian response. The purpose of these kits is to speed up the provision of appropriate SRH services in emergencies. As they are not context specific or comprehensive, organisations should not depend solely on the Inter-agency Emergency reproductive Health Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP for SRH to comprehensive SRH.

- As well as these kits, however, SRH agencies should determine whether it is possible to obtain SRH supplies locally to meet the SRH needs of affected populations. “When supplies are not already in-country, agencies will often procure IARH Kits from the Procurement Services Branch of the United Nations Population Fund (UNFPA). The IARH Kits can also be procured from regional warehouses where they have been pre-positioned” (IAFM 2018 p72)

- Not every context will require procurement of IARH Kits, or all of the available kits. This will be context specific and depend on what was available pre-emergency, and the extent to which facilities are affected by the crisis.

- Agencies and program managers should coordinate with clusters and other agencies to ensure SRH supplies are part of the health cluster/ sector core commodity pipeline.

Note to facilitators This is a good opportunity to provide participants with information on any pre-positioning of supplies in-country or regionally.

If participants are interested in further information about IARH Kits, refer them to IAFM 2018 Chapter 3: The MISP

Slide #92: Products to support MISP implementation

Key Messages

- The Inter-agency Emergency Reproductive Health Kits are categorized by level of service delivery. They contain SRH supplies for the relevant number of people for each level, for 3 months, after which further needs should be calculated based on monthly consumption.
- The Inter-agency Emergency Reproductive Health Kits are based on assumptions of which facilities have the capacity to deliver specific services.
- Further supplies should be ordered through the usual supply systems of the ministry or organization implementing the services. Kits can be re-ordered, if needed, but this is not recommended. They are meant to implement services where none exist at all.

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Products to Support MISP Implementation

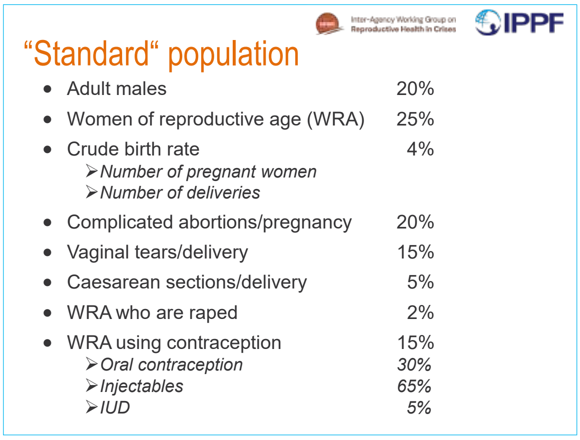
- Reproductive Health Kits

1. Community Level/ Health Post:
   10,000 people for 3 months
2. Primary Health Care Facility:
   30,000 people for 3 months
3. Referral Hospital Level:
   150,000 people for 3 months

Slide #93: Standard population

Key Messages

- Supplies in the Kits are calculated for a 'standard' population with the assumptions listed on the slide (i.e. 20% adult males, 25% women and girls of reproductive age (WRA), etc.).
- There is therefore no need to re-do these calculations when ordering the supplies.
- The only information required when ordering is the number of affected people and the distribution of health services and staff that this population has access to.



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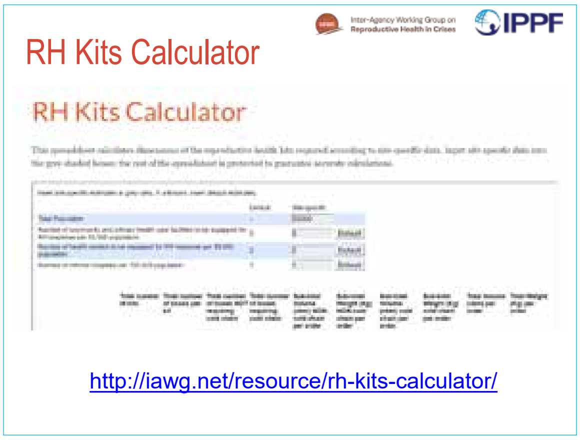
"Standard" population

• Adult males	20%
• Women of reproductive age (WRA)	25%
• Crude birth rate	4%
➢ *Number of pregnant women*	
➢ *Number of deliveries*	
• Complicated abortions/pregnancy	20%
• Vaginal tears/delivery	15%
• Caesarean sections/delivery	5%
• WRA who are raped	2%
• WRA using contraception	15%
➢ *Oral contraception*	*30%*
➢ *Injectables*	*65%*
➢ *IUD*	*5%*

Slide #94: RH kits calculator

Key Messages

- An online RH Kits Calculator is available through the link provided on this slide. This spreadsheet calculates reproductive health kits required according to site-specific data.
- Important to note is that if site-specific data is not available, the standard population figures outlined on the previous slide can be used for calculations.


RH Kits Calculator

RH Kits Calculator

http://iawg.net/resource/rh-kits-calculator/

Slide #95: Kit 3

Key Messages

- This is an example of an RH Kit- in this case Post-rape treatment kit (Kit 3), designed for use at the health facility level.
- It is important for service providers to be familiar with the items in each kit, how they may be used and by whom. The matrix work conducted throughout this training should assist with this.


Kit 3: Post-rape treatment (health facility)

Slide #96: Kit 6

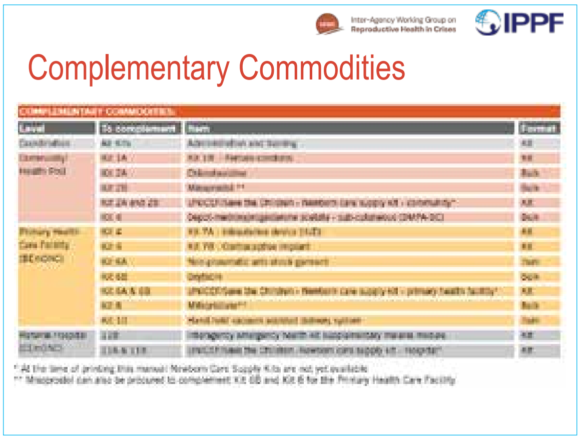
Key Messages

- This slide shows the contents of the BEmONC clinical delivery kit to be used at health facility level.
- It is important to establish and maintain the cold chain for this kit. As with all kits, it is important for service providers to be familiar with the items in each kit, how they may be used and by whom. The matrix work conducted throughout this training should assist with this.


Kit 6: Clinical delivery (health facility)

Slide #97: Complementary commodities

Key Messages



Complementary Commodities

- As well as the IARH Kits, there are a series of ‘complementary commodities’ kits.
- “Complementary commodities are disposable and consumable items that can be ordered under specific circumstances to complement the main kits:
    - Where providers or the population are trained to use the commodity
    - Where the supplies were accepted and used prior to the emergency
    - In protracted or post-emergency settings, (although effort must be directed to procuring from more stable procurement channels); and
    - Where the use of the supplies is allowed to the fullest extent of the national law” (IAFM 2018).
- Complementary Commodities in kits are procured based on the same catchment populations as the standard kits. Complementary Commodities in BULK can be procured for a population of 10,000 or a multiple of 10,000 people.
- “Complementary Commodities with specific agency names can be ordered through the respective organizations including:
    - Interagency Emergency Health Kit Supplementary Malaria Module – WHO
    - UNICEF/Save the Children Newborn Care Supply Kits – UNICEF
- Additionally, it is important to keep in mind that other pre-packaged emergency medical kits for various interventions (Non-Communicable Diseases (NCD), Cholera, Severe Acute Malnutrition (SAM), etc.) can be procured from other partner organizations or may have been brought in by health partners already” (IAFM 2018 p59).

Slide #98: Other supplies

Key Messages

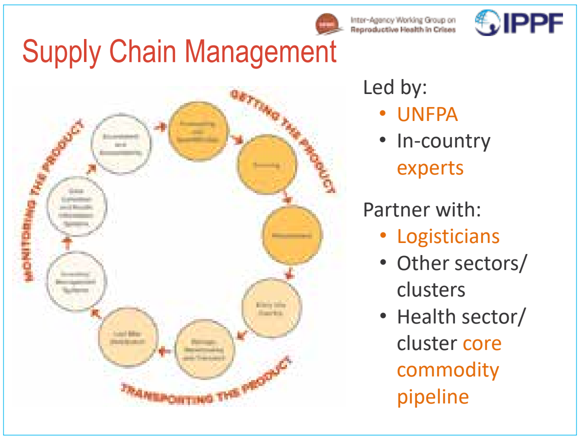
- Other Supplies:
  - Culturally appropriate hygiene or dignity Kits

- Other supplies to be distributed during the SRH response include hygiene or dignity kits.
- These are not part of the MISP as they are not immediately life-saving, but provide important basic supplies so that affected populations, particularly women and girls, can continue engaging with daily activities.
- UNFPA have devised a standard dignity kit (picture on slide) but generally it is best if these are adapted to local cultural needs.
- Hygiene supplies are important products for the population but should not be implemented in lieu of the life saving components of the MISP.

Note to facilitators Ask participants what they believe would be appropriate in hygiene kits for women in their context.

Slide #99: Supply chain management

Key Messages



Supply Chain Management

Led by:
- UNFPA
- In-country experts

Partner with:
- Logisticians
- Other sectors/ clusters
- Health sector/ cluster core commodity pipeline

- Supply chain management for SRH supplies in humanitarian contexts are generally led by UNFPA, national government and other experts.
- "Establishing effective supply chains requires people to engage with each other across the entire supply management system, including the logistician, the procurement officer, the customs agent, the provider in the clinic, the facility's pharmacy manager, and the end user" (IAFM 2018 p76).
- Supply chain management is the flow and processes involved from getting the product to its distribution an monitoring. It can be divided into three stages as per the diagram: Getting the product; providing the product and monitoring the product.

- Service providers make an important contribution through their knowledge of system and consumption before response and in identifying consumption patterns and needs to inform planning for comprehensive services.

Slide #100: Monitoring the Product

Key Messages

Monitoring the Product

- Service Providers should maintain simple and effective inventory systems for supplies and stock

- Service providers have an important role in monitoring the consumption and distribution of commodities and related supplies

- During the acute response phase having simple systems to regularly monitor inventory levels of stock, expiration dates and product specifications is important to prevent unnecessary stock outs.

- Service providers should be supported to understand the type of data they need to collect including how often they need to collect, reordering systems, stock losses and when they are in danger of stock outs, given the additional challenges of procuring stock in emergencies.

- It is important that service providers feed the data and information they collect on stock and supplies to program manages to improving efficiency of supply chain management including better forecasting.

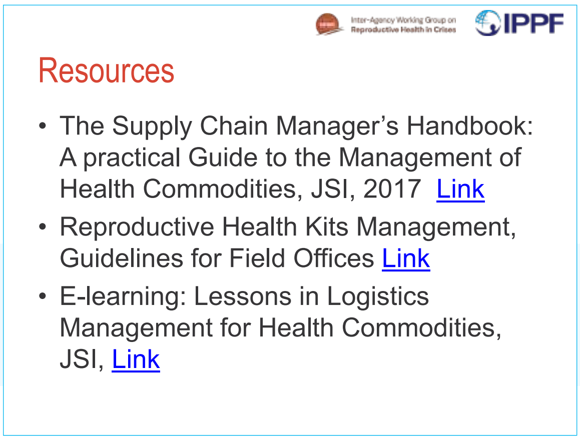
Note to facilitators For more information on last-mile delivery, see IAFM 2018 p81

Slide #101: Resources

Key Messages

- This slide contains a list of resources your participants can engage with to increase their knowledge of logistics in humanitarian settings.

Note to facilitators Add to this slide with context-specific resources as able.



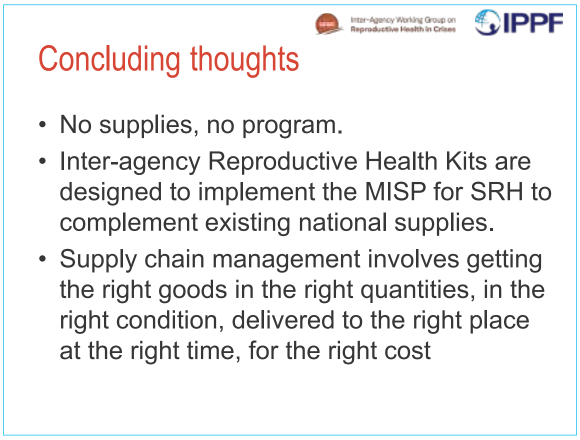
Resources

- The Supply Chain Manager's Handbook: A practical Guide to the Management of Health Commodities, JSI, 2017 Link
- Reproductive Health Kits Management, Guidelines for Field Offices Link
- E-learning: Lessons in Logistics Management for Health Commodities, JSI, Link

Slide #102: Concluding thoughts

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

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



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Concluding thoughts

- No supplies, no program.
- Inter-agency Reproductive Health Kits are designed to implement the MISP for SRH to complement existing national supplies.
- Supply chain management involves getting the right goods in the right quantities, in the right condition, delivered to the right place at the right time, for the right cost

Slide #103: Supporting the MISP for SRH: assessment, monitoring & evaluation

Key Messages

- In the second part of this session, we will look at assessment, monitoring and evaluation of the MISP for SRH.
- This session is designed as an introduction to these important components and we will look at each in turn.

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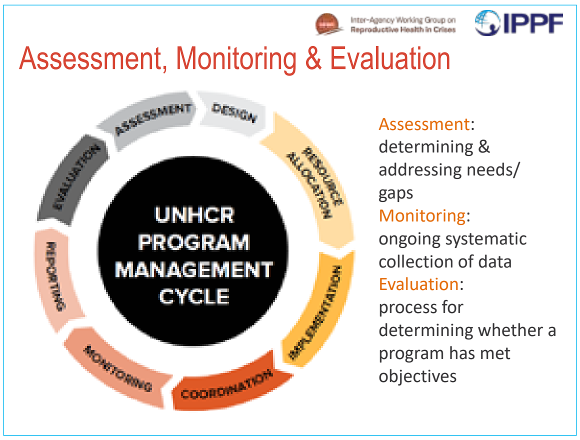
Supporting the MISP for SRH

1. Logistics
2. Assessment, Monitoring & Evaluation

Slide #104: Assessment, monitoring & evaluation

Key Messages

- Key terms for this process can be defined as follows (from IAFM 2018 p93):
  - Assessment: is a process for determining and addressing needs or 'gaps' between current conditions and desired conditions and contributors to those gaps.



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Assessment, Monitoring & Evaluation

Assessment: determining & addressing needs/ gaps

Monitoring: ongoing systematic collection of data

Evaluation: process for determining whether a program has met objectives

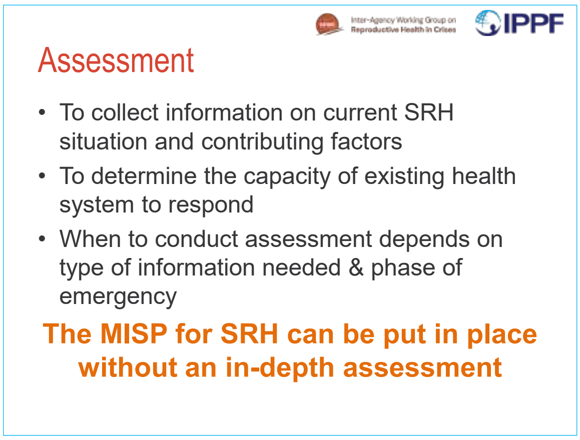
  - Monitoring: is the on-going, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of program milestones and objectives.

  - Evaluation: Is a process for determining whether a program has met expected objectives and/ or the extent to which changes in outcomes can be attributed to the program.

- The UNHCR program management cycle shown on this slide is a useful way of visualizing these processes. It shows a feedback loop and the important role data can play throughout a humanitarian response in informing, monitoring, and evaluating SRH programming.

Slide #105: Assessment

Key Messages



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Assessment

- To collect information on current SRH situation and contributing factors
- To determine the capacity of existing health system to respond
- When to conduct assessment depends on type of information needed & phase of emergency

The MISP for SRH can be put in place without an in-depth assessment

- The purpose of assessment is to identify the SRH needs of the population and contributing factors and to determine the capacity of the existing health system to respond to those needs. Assessments can be undertaken throughout the life of a program to evaluate its progress towards achieving objectives (IAFM 2018 p94).

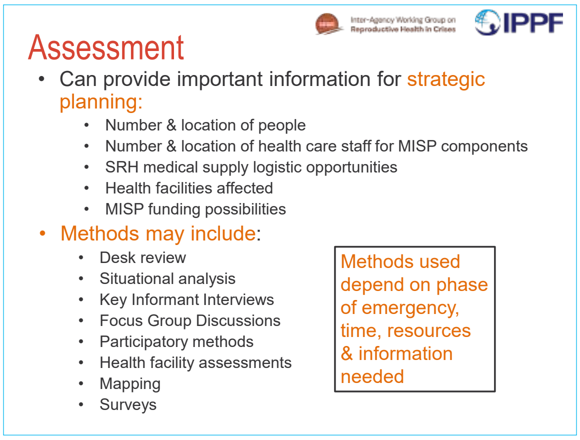
- When to conduct an assessment depends on the type of information needed and the phase of the emergency.

- At the beginning stages of a crisis, many people may want to assess the community which can cause disruption. Consider where possible working with other SRH actors to collect the information needed and avoid duplication.

- Gender, age, ethnicity, and social status diversity should be considered when putting together assessment teams to improve chances of collecting information from the affected population. For example, in some cultures, it may be inappropriate for a man to ask a married woman questions about her reproductive history (IAFM 2018 p94).

Slide #106: Assessment

Key Messages



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Assessment

- Can provide important information for strategic planning:
  - Number & location of people
  - Number & location of health care staff for MISP components
  - SRH medical supply logistic opportunities
  - Health facilities affected
  - MISP funding possibilities
- Methods may include:
  - Desk review
  - Situational analysis
  - Key Informant Interviews
  - Focus Group Discussions
  - Participatory methods
  - Health facility assessments
  - Mapping
  - Surveys

Methods used depend on phase of emergency, time, resources & information needed

- Some types of assessments, such as situational analyses and rapid assessments are often conducted during the acute phase of a humanitarian crisis when time and resources may be limited. Desk assessments may be used in the acute phase to avoid duplication of effort and can also be used throughout the emergency. Other methods that require more resources, such as surveys or some participatory methods, may be more appropriate in later phases of an emergency (IAFM 2018 p94) when planning for more comprehensive programming.

- The MISP calculator mentioned earlier is available to help in the calculation of reproductive health statistics necessary for the implementation of the MISP for SRH. It enables you to input site specific data.

Note to facilitators Key terms to explain methods of assessment are included below:

- Rapid assessments: “At the onset of the humanitarian response, humanitarian partners carry out an initial rapid assessment. While the causes of the most important SRH-related morbidity and mortality are already addressed by the MISP and do not need to be assessed at the onset of the humanitarian response, there is nonetheless important information to be gathered with a rapid assessment to ensure appropriate strategic planning” (IAFM 2018 p94). This information must include: “the number and location of people needing access to minimum SRH services; the number and location of health-care staff providing, or capable of providing, the service components of the MISP; SRH medical supply logistic opportunities; and MISP funding opportunities” (IAFM 2018 p94).

- Desk review: a review of secondary data sources on existing SRH information for the affected population should be conducted. This information could include demographic and health survey data; routine surveillance or health facility data; availability of SRH services, their location and functionality; and national strategic plans and/or UN Development Assistance Framework. These data will be available from government organisations, UN agencies and NGOs (IAFM 2018 p95).

- Situational analysis: “should be conducted to understand the legal, political, cultural, and socio-economic context of the locale and how this might impact the SRH needs and availability of services for affected populations” (IAFM 2018 p95). This should also include an understanding of how different subpopulations might be differently affected.

- Key informant interviews: may be used to generate qualitative data from a range of individuals. They can be used to collect views of "pre-existing conditions and SRH practices, the current situation, changes in practice since the onset of the emergency, adequacy of current SRH services, and priority SRH needs of the population" (IAFM 2018 p95).

- Focus group discussions: "are particularly useful in generating information representative of a specific sub-group in the population, such as women of reproductive age or adolescent males" (IAFM 2018 p95).

- Participatory methods: aim to "make the assessment process as inclusive as possible of the target communities. Community organisations led by members of the affected population and informal groups of different subpopulations within the affected population should be engaged and involved throughout the process" (IAFM 2018 p95). Community members may be involved in all stages of the assessment process, including design, data collection, analysis and dissemination.

- Health facility assessments: are inventories "of the places where health care is provided and the types and quality of services provided at these sites" (IAFM 2018 p95).

- Mapping: "can often be done in conjunction with the health sector/ cluster to include health facility assessments. Mapping of relevant stakeholders and service providers includes both those currently providing SARH services to affected populations and those who potentially could..." (IAFM 2018 p95).

- Surveys: "can be useful for gathering population-based information from a sample that can be representative of the larger population of interest" (IAFM 2018 p96).

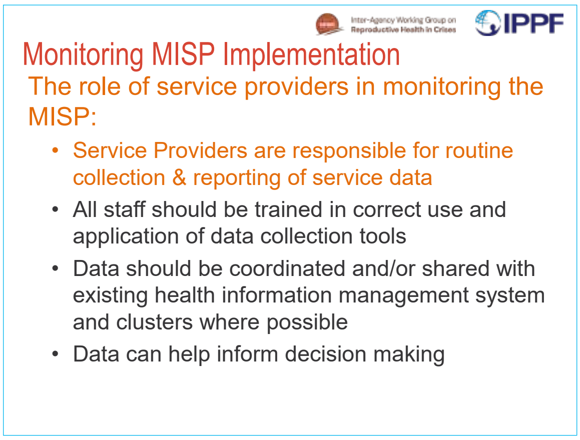
Slide #107: Monitoring MISP implementation

Key Messages

- Service providers have an important role to play in ensuring MISP service delivery is effectively monitored.

- At the onset of the emergency, weekly monitoring should be implemented, and once services are established, an agreed upon, routine monitoring and evaluation should be put in place. This is to understand progress towards quality MISP for SRH and more comprehensive services are available as possible.

- Service providers should also ensure that any gaps and/or overlaps in service delivery are discussed in with program or facility managers and that representatives discuss any issues at SRH and other coordination meetings.



Monitoring MISP Implementation

The role of service providers in monitoring the MISP:

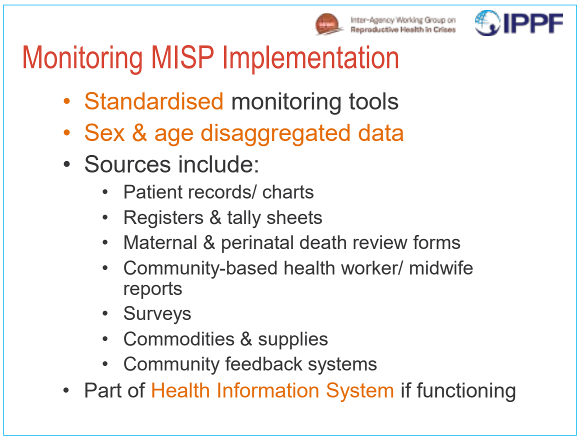
- Service Providers are responsible for routine collection & reporting of service data
- All staff should be trained in correct use and application of data collection tools
- Data should be coordinated and/or shared with existing health information management system and clusters where possible
- Data can help inform decision making

- Where they are in existence or still functioning after an emergency, data should be coordinated and/or shared with existing health information management system and clusters to provide a complete picture of the SRH needs

- It is also important to ensure confidentiality when sharing data.

Slide #108: Monitoring MISP implementation

Key Messages



Monitoring MISP Implementation

- Standardised monitoring tools
- Sex & age disaggregated data
- Sources include:
  - Patient records/ charts
  - Registers & tally sheets
  - Maternal & perinatal death review forms
  - Community-based health worker/ midwife reports
  - Surveys
  - Commodities & supplies
  - Community feedback systems
- Part of Health Information System if functioning

- All health partners should use the same monitoring tools to ensure that data are standardized, of good quality and comparable across programs and locations.

- If functioning, health data can be collected as part of the national Health Information System. Where such a system does not exist or has been interrupted by the emergency, "the health sector/cluster will implement an emergency monitoring system in order to support program management and coordination." (IAFM 2018 p99).

- Sex, age and data on disabilities should always be collected from health facility and community-based sources to enable disaggregated analysis. Sex, age and ideally disability disaggregated data is vital for monitoring as it allows more specific, and therefore more effective programming.

- Sources of routine data can include (from IAFM 2018 p99):

  - Individual patient records and charts;

  - Daily registers and tally sheets;

  - Maternal and perinatal death review forms;

  - Community-based health workers/ midwife reports;

  - Weekly and/or monthly reporting forms;

  - Repeated surveys;

  - Commodities/ supplies.

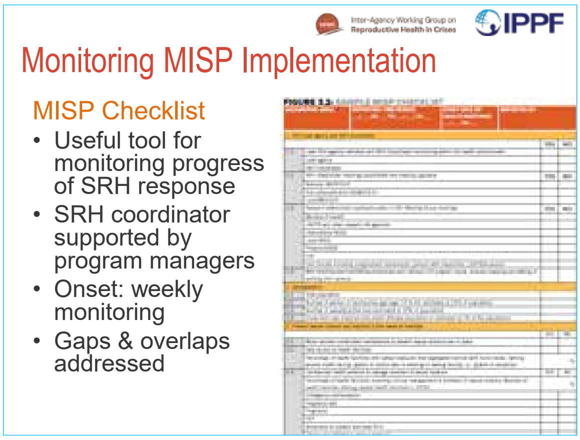
  - Community feedback systems

Note to facilitators For more information on the importance of sex, age and disability disaggregated data, refer participants to:

- SADD: The devil is in the detail: or are they? (360 Degrees) https://360degreesaccess.org/saddd-the-devil-is-in-the-detail-or-are-they/
- Mainstreaming Gender into Data Analysis and Advocacy (UN Women) http://asiapacific.unwomen.org/en/focus-areas/humanitarian-action-and-disaster-risk-reduction/mainstreaming-gender-into-data-analysis-and-advocacy

Slide #109: Monitoring MISP implementation

Key Messages



Monitoring MISP Implementation

MISP Checklist
- Useful tool for monitoring progress of SRH response
- SRH coordinator supported by program managers
- Onset: weekly monitoring
- Gaps & overlaps addressed

- The MISP checklist provides a useful tool for monitoring the progress of the SRH response in humanitarian settings.
- The SRH Coordinator, supported by program managers, should implement the MISP checklist. "In some cases, this may be done by verbal reporting from SRH managers and/or through observation visits" (IAFM 2018 p61).
- At the onset of the emergency, weekly monitoring should be implemented, and once services are established, an agreed upon, routine monitoring and evaluation should be put in place. This is to understand progress towards quality MISP and more comprehensive services are available as possible.
- Service providers should also ensure that any gaps and/or overlaps in service delivery are discussed in SRH and other coordination meetings and strategies developed to overcome these.
- Where they are in existence or still functioning after an emergency, data should be coordinated and/or shared with existing health information management systems.

Note to facilitators Remind participants that they have been consulting the MISP checklist throughout the training. Ask them to look once again at their copy of the MISP checklist and briefly review the indicators included under each MISP for SRH objective. After they have done this, ask them to look for more details on SRH indicators and tools for monitoring available in the individual IAFM (2018) chapters.

Slide #110: MISP Checklist: Group Work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Monitoring

Group Work

Time

20 minutes

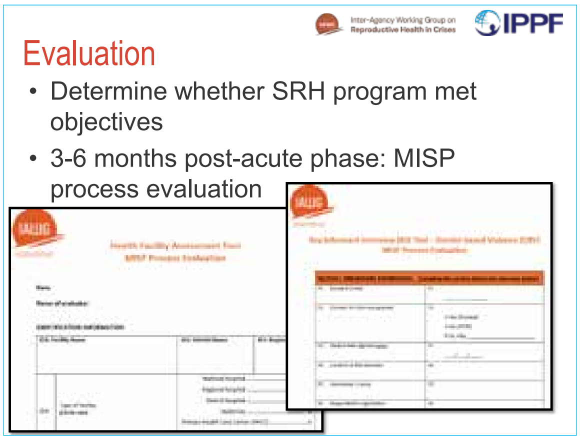
Process

- Divide participants into three groups
    - Group 1. Quality of Services (consider technical standards/SOPs/Guidelines);
    - Group 2. Accessibility of Services (satisfaction of population; accessibility by marginalised populations; barriers to accessing services; SADD data)
    - Group 3. Health Data (what type of information about services is feasible to collect, type of contraceptives; deliveries with attendants etc)
- Give each group 10 minutes to brainstorm strategies to collect this type of information during emergency response. Ask participants to think of existing systems/tool that might help them to do this (e.g. MISP checklist; FGDs etc).
- After 10 minutes, ask group to share one key strategy they discussed

Materials

Flip charts and markers for each group

Slide #111: Evaluation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Evaluation

- Determine whether SRH program met objectives
- 3-6 months post-acute phase: MISP process evaluation

Key Messages

- Evaluation supports our understanding of if and how programs met defined objectives. "It compares program activities and services (outputs) with benefits (outcomes) and public health impact (goals)" (IAFM 2018 p100).

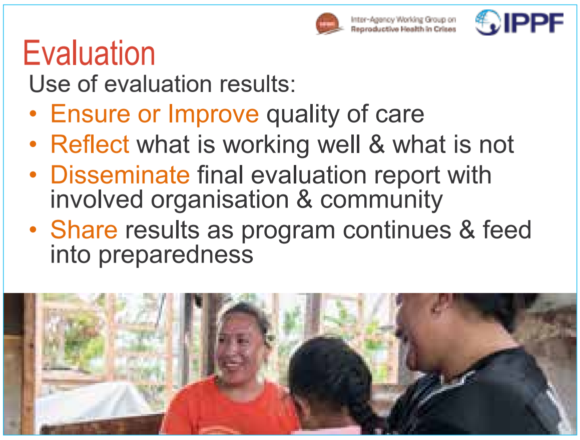
- Evaluations need a sufficient amount of time so that they can measure program outputs and impacts. “Therefore, evaluations are not appropriate in acute situations where assessments and monitoring can provide feedback on emergency actions. However, 3 to 6 months post-acute phase, a comprehensive package of MISP process evaluation tools are available” (IAFM 2018 p101). Samples of these are shown on the slide.

- Evaluation also provides insight into coverage and whether any populations have been left out in the response.

Note to facilitators The MISP for SRH process evaluation tools are available at: http://iawg.net/resource/misp-process-evaluation-tools-2017/

Slide #112: Evaluation

Key Messages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Evaluation

Use of evaluation results:
- Ensure or Improve quality of care
- Reflect what is working well & what is not
- Disseminate final evaluation report with involved organisation & community
- Share results as program continues & feed into preparedness

- Evaluation results are used to improve program planning and design. They should, therefore, reflect both what is working well and what is not.

- The final evaluation report should be shared with all stakeholders, including the Ministry of Health, health cluster, involved organisations, and the community. It can be useful for advocacy, learning and resource mobilization purposes.

- Feedback should be provided to service providers and program managers “as the program continues and not just at the end to ensure that issues identified in the evaluation are dealt with promptly before they become problems or risks” (IAFM 2018 p101).

Slide #113: Key concepts

Key Messages

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Key Concepts

- Privacy
- Confidentiality
- Security
- Identifiable information
- Patient-identifiable data

- It is important that considerations of privacy, confidentiality, security, identifiable and patient-identifiable data are made throughout the assessment, monitoring and evaluation cycle.
- "Privacy risks in data collection relate to identifiability or participants and the potential harms they, or groups to which they belong, may experience from the collection, use and disclosure of personal information- particularly sensitive SRH information" (IAFM 2018 p102).
- To safeguard against this, a number of key concepts should inform and guide the assessment, monitoring and evaluation process at all times. These include (from the IAFM 2018 pages 101 to 103).
  - Privacy: an individual's right to be free from intrusion or interference by others.
  - Confidentiality: the obligation of an individual or organization to safeguard entrusted information.
  - Security: measures used to protect information. Security includes physical, administrative and technical safeguards.
  - Identifiable information: where researchers seek to collect, use, share and access different types of information or data about participants, they are expected to determine whether the information or data proposed in research may reasonably be expected to identify an individual.
  - Patient-identifiable data: refer to any personal data that can be used directly or indirectly to identify an individual.

⚠ **Note to facilitators** Refer participants to pages 102-103 of the IAFM 2018 for more on these important concepts.

Slide #114: Concluding thoughts

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

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

Concluding thoughts

- Assessment, monitoring and evaluation help us:
  - Understand and quantify needs
  - Ensure effective and efficient use of resources
  - Identify programmatic barriers and enablers
  - Provide accountability and transparency to donors, beneficiaries, and other stakeholders
- Privacy, confidentiality, security and identifiable data must be considered in assessment, monitoring and evaluation processes

Next Steps & Follow Up

Session 3.6 90 minutes

Overview

This session will allow participants to practically apply their newly developed knowledge and skills to planning for next steps in preparedness and response.

Methodology

- Group Work
- Post-test

Materials

- Participant Handouts
- Group Work Supplies
- Post-test

Slide #115: Session 3.6: Next Steps

This session will look at next steps and evaluate participants' learning during the training.

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Session 3.6: Next Steps

Training for Service Providers

Slide #116: Matrices and final presentations

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Matrices and Final Presentations

Group Work

This activity will allow participants to consolidate their learning and finalise mapping of resources for MISP for SRH service delivery in their context.

Time

30-45 minutes

Process

- Ask participants to revisit the matrices they have been building throughout the training.
- Give five minutes to participants to revise and consolidate their various matrices as individuals.
- Give participants 20 minutes to discuss their matrices and identify priority actions which they would like to take forward to help improve MISP preparedness. Emphasise that without preparedness, MISP implementation at the time of response can be very difficult.
- Use the remaining 20 minutes to share key discussion points and brainstorm how participants can address some of the priorities and gaps they have identified. Encourage participants to continue this discussion beyond the trainings.
- Facilitators should try and capture this information as it can be useful for follow up.

Materials

- Matrices (Participant handouts: 5,11,14,18,21).
- Flipcharts for each table group (multiple sheets).

Slide #117: Follow up

- Encourage all participants to keep in touch through social media, email groups or other appropriate methods and promise that you will share these photographs (and any others taken during the training) as a first step to establishing a service providers for MISP community of practice.
- Ensure that participants have your contact details and know who they can reach out to with any questions or concerns.

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Follow Up

Slide #118: Close

Note to facilitators Before closing, administer the post-test and evaluation. This is the same test provided on the first day of the training. Allow participants 20 minutes to answer the questions and evaluation. Collect answer sheets and then work through the questions and field any additional questions or comments.

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Close

Next Steps

Day 3 & Training Close

This is an opportunity to celebrate the achievements of your participants. Plan for a closing ceremony and/or presentation of certificates in line with cultural preferences.

Annex 1: Facilitation & Training Skills

For your session to be successful:

- Be prepared, and have extensively reviewed all of the training materials, notes, exercises and links before the training starts
- Know what the learning outcomes are that they want the learners to achieve for every sentence, phrase, exercise, session and period of learning.
- Constantly focus on the learners, and adapt the pace to the needs of the group, whilst recognising that time keeping is critical. Training should always start and finish on time.
- Adopt a position with their learners of guide and facilitator of learning and not the fountain of all knowledge and request the learners to accept an equal responsibility for their own learning.
- Enable the learners to generate self-motivation for the learning and provide clear input explaining the subject being covered and how to apply it.
- Reflect on their own performance, tracking the responses from the learners and then assessing these responses in order to generate improvements to future sessions.

Adult Learning Principles

There are six generally understood characteristics of adult learning[4] which are important for trainers to understand:

1. Autonomous and self-directed
2. Accumulated a foundation of experiences and knowledge
3. Goal orientated
4. Relevance orientated
5. Practical
6. Need to be shown respect

Common concerns for New Trainers

Public Speaking

Tips:

- Everyone gets nervous about public speaking, the only difference is that some people are more experienced, or can hide their nervousness more. But it is very normal to be nervous!
- Be prepared: make sure you have read through the materials and facilitator notes a few times and are very familiar with the content; this will help reduce nervousness.

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[4] Identified by Malcolm Knowles, a pioneer in the field of adult learning, in 1970

- Take a deep breath before starting. Normally, the first few minutes are the most difficult and then it becomes easier.
- Enjoy! If participants can see that you are passionate and engaged in the course, they will be too.

Having participant ask difficult questions that you don't know the answer to

Tips:

- Sincerity shows. If you don't know the answer, admit it and work together with the participants to decide where, collectively, you might find the answer to this.
- Remember: being a facilitator does not make you the font of all knowledge.

Controlling the room

Tips:

- Occasionally there will be a participant that is deliberately disruptive and undermining. If this happens, always remain calm. Try to adopt an open listening style and try not to get too defensive. If questions and interruptions are hostile, deflect them back to the group to answer which will often help calm the situation.
- Sometimes people read emails, don't engage, are late back from lunch or breaks etc. It is important to remember that this is adult learning, and adults generally do not respond well to being treated like children. Assertive is always better than aggressive. Try to keep calm, and explain to participants that not engaging or being late is detrimental to the whole group. Ask the group to come up with ideas for how this behaviour should be addresses.

Remember: the more times you facilitate training or orientation, the better it will get. After each training, reflect on what went well and what could have gone better, and document this to ensure continual learning and improvement. Share your reflections with others. Consider engaging with the IAWG Community of Practice (CoP) for this. Advocate internally for a facilitator CoP forum to share experiences.

Annex 2: Using this manual to conduct a Training of Trainers

The purpose of this training package is to increase the knowledge and skills for the MISP for SRH among key individuals and agencies with responsibility for collaboratively planning and managing SRH programs during crisis situations. If it is decided that there is a gap in training capacity on MISP for SRH (for service providers) in your setting, it is possible to use this manual to conduct a training of trainers (ToT) course.

When deciding to conduct a ToT, the objectives of training others to train using the curriculum contained in this manual must be very clear.

- Will ToT participants then be engaged to roll-out trainings in their own contexts (nationally, sub-nationally, or more locally)?
- Who will the participants at their trainings be?
- Are there more appropriate trainings for these potential participants (such as service provider or clinical skills trainings)?

If it becomes clear that a ToT is needed, the following section will provide guidance on preparing, conducting and following up after a SPRINT ToT.

Goal and objectives of conducting a ToT

The goal of the ToT is to provide new trainers with the knowledge, skills and experience necessary to conduct a Training for service providers on the Minimum Initial Service Package for Sexual and Reproductive Health using this manual.

On completion of the ToT, participants should demonstrate:

- Working knowledge of the contents of this manual and accompanying resources;
- Effective instructional methods, based on adult learning principles, to deliver the contents of the training;
- Willingness and ability to fulfil all responsibilities of a SPRINT trainer (pre-, during, and post-training).

ToT Participant selection

ToT participants should already have some experience in training and/or adult education, as well as knowledge and experience of SRH and/or humanitarian response to build on. Potential trainees will need to demonstrate their availability for involvement in future training events. It may be necessary for ToT facilitators to confirm this with supervisors or advocate for availability before the ToT begins.

Using this manual to conduct a ToT

This facilitator's manual contains materials and resources necessary for conducting the Training for service providers on the Minimum Initial Service Package for Sexual and Reproductive Health. If you plan to conduct a ToT you need to factor additional time in the agenda. Consider at least half a day to full additional day for this so the content is not rushed.

Resources needed to adapt this manual for use in a ToT include:

- Resources on adult learning and facilitation (source externally);
- Trainer competency checklists (for use by ToT facilitators- source externally).

For training skills to be assessed, participants will need to demonstrate their capacity by facilitating a segment of the training course. To this end, ToT facilitators will need to provide ToT participants with training resources well ahead of the scheduled workshop and assign sections to facilitate or co-facilitate.

During the ToT it is important for ToT facilitators to be open, approachable and provide support and guidance to ToT participants during their presentation sessions. Facilitators should complete a trainer competency checklist for all participants and provide constructive feedback in one-on-one interviews at the close of the training day. It is also important to engage participants in planning for future trainings at this time.

After the ToT, it is important that ToT facilitators work closely with ToT participants to plan future training courses.

It may be necessary for ToT facilitators to continue their mentoring role, and this may extend to co-facilitating trainings with ToT participants until their confidence and competence increases.

IPPF/Ellena Ashley Williams

Our sincere appreciation extends to the Australian Government for their commitment in safeguarding the rights and dignity of persons living in crises, particularly of women and girls.

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