THE IMPORTANCE OF PREPAREDNESS FOR AN EFFECTIVE SEXUAL & REPRODUCTIVE HEALTH RESPONSE IN EMERGENCIES

INSIGHTS FROM FIJI & TONGA

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Photo Credit: IPPF/Rob Rickman/Fiji

ABOUT THIS REPORT

This report describes the findings of a study that examined how IPPF SPRINT-supported capacity development and preparedness activities facilitated the Sexual and Reproductive Health (SRH) response to Cyclone Winston in Fiji and Cyclone Gita in Tonga. It identifies the different approaches to capacity development and response in the two settings and provides recommendations for future preparedness and response efforts and investment in line with the objectives of the Minimum Initial Service Package for Sexual and Reproductive Health (MISP).

BACKGROUND

A lack of access to sexual and reproductive health (SRH) services and information is a leading cause of morbidity and mortality amongst displaced women and girls of reproductive age. Emergencies exacerbate pre-existing gender inequities in access to reproductive and sexual health care because of stigma, discrimination, and legal barriers.

The Minimum Initial Service Package (MISP) for SRH defines the essential services that are "most important in preventing morbidity and mortality, while protecting the right to life with dignity, particularly among women and girls, in humanitarian settings" (IAWG, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings 2018).

To meet the demand for SRH services in humanitarian contexts, investment in capacity development and other preparedness activities has increasingly focused on improving the skills and engagement of key stakeholders, including program managers, service providers and policy makers, to implement lifesaving components of the MISP for SRH. This requires a strategic approach to developing human resource capacity and ensuring supportive structures are in place at both organizational and broader levels. In line with this, the Australian Government funded SPRINT Initiative was launched in 2008 to strengthen capacity and address organizational and structural impediments to effective SRH response in humanitarian contexts. This program is led by the International Planned Parenthood Federation (IPPF) in collaboration with Member Associations (MAs) including the Reproductive and Family Health Association of Fiji (RFHAF) and the Tonga Family Health Association (TFHA), as well as other national and international partners.

This study aimed to identify the capacity development and preparedness efforts in Fiji pre cyclone Winston (2016) and in Tonga prior to cyclone Gita (2018) and explore key factors that influenced the type, scope and timeliness of the response to SRH.

> Our people are emotionally invested and care because they've been caring for individuals and families for decades. And after seeing them devastated by a cyclone, if (they) are in a position to help, they will. But they need the knowledge and that knowledge can be provided through training and support.
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> ~ study respondent

Photo Credit: IPPF/Rob Rickman/Fiji

METHODS

This study comprised a desk review, a survey, and interviews with key stakeholders. First, a detailed review of available documents provided important background information on the SRH and emergency management contexts of each country, and preparedness and response activities for Cyclones Winston and Gita. The desk review further informed the mixed methods research which followed. Key stakeholders were interviewed or provided their insights through an online survey, and all text responses were thematically analysed to aid in our understanding of the comparative impact of different preparedness activities on the SRH response in our two contexts of interest.

FINDINGS

The sexual and reproductive health response to tropical cyclones Winston & Gita

A sexual and reproductive health response was launched in response to both Tropical Cyclone Winston in Fiji and Tropical Cyclone Gita in Tonga. The scope of these responses differed, however, and the summary table below provides detail on activities achieved in relation to the MISP for SRH as they stood in 2016 and 2018.

MISP (2016 & 2018) Objective & Activities	Fiji Response: Winston	Tonga Response: Gita
Objective 1: **Ensure health cluster/sector identifies agency to LEAD implementation of the MISP.**		
Activity 1: RH Officer in place	√	√
Activity 2: Meetings to discuss RH implementation held	√	√
Activity 3: RH Officer reports back to the health cluster/ sector	√	√
Activity 4: RH kits and supplies available and used	√	√
Objective 2: **Prevent Sexual Violence and assist survivors**		
Activity 1: Protection system in place especially for women and girls	Somewhat: monitoring done; information sessions conducted	√
Activity 2: Medical services and psychosocial support available for survivors	Services and referral available	√
Activity 3: Community aware of services	√	√
Objective 3: **Reduce the transmission of HIV**		
Activity 1: Safe and rationale blood transfusion in place	-	-
Activity 2: Standard precautions practices	During medical missions	During medical missions
Activity 3: Free condoms available	√	√
Objective 4: **Prevent excess maternal and neonatal mortality and morbidity**		
Activity 1: EmONC services available	√	√
Activity 2: 24/7 referral system established	Referral (at time of medical mission)	√
Activity 3: Clean delivery kits provided to birth attendants and visibly pregnant women	√	√
Activity 4: Community aware of services	√	√
Objective 5: **Plan for comprehensive RH services, integrated into primary health care**		
Activity 1: Background data collected	√	√
Activity 2: Sites identified for future delivery of comprehensive RH	-	√
Activity 3: Staff capacity assessed and trainings planned	-	√
Activity 4: RH equipment and supplies ordered	-	-
Additional Priorities:		
Continue family planning	√ & new users	√ & new users
Manage symptoms of STIs	√	√
Continue HIV care and treatment	-	√
Distribute hygiene kits and menstrual protection materials	√	√

IPPF/Alana Holmberg/Tonga

FIJI

IPPF SROP and the Reproductive and Family Health Association of Fiji (RFHAF) led a program for implementing the MISP in the Northern and Western parts of Fiji after Tropical Cyclone Winston with surge support from IPPF East, South East Asia & Oceania Region (ESEAOR) and the Solomon Islands Member Association. This work was undertaken in collaboration with government agencies and locations were assigned to the RFHAF/ IPPF team during early national-level coordination meetings. The SPRINT program provided funding to support a phased implementation of the MISP for SRH in these locations and two IPPF staff-members' deployment to support the response.

Early work in the response phase included the facilitation of a half-day MISP and coordination training by an experienced trainer from the IPPF ESEAOR office in Kuala Lumpur, and collaboration with partners through several different cluster meetings. A Family Health Sub-cluster was established and health services teams were able to provide services during the initial stages of the emergency response. The establishment of a sub-cluster focused on SRH was seen as an essential step for facilitating coordination and implementation of the MISP, and the response to Tropical Cyclone Winston was the first time this sub-cluster had been put in place. It was reported that its early implementation was due to the IPPF SROP and MA representatives' advocacy efforts, guided by individuals deployed from the regional office for surge-capacity. This, together with the delegation of responsibility to RFHAF and IPPF SROP was regarded as an impressive achievement by a number of respondents.

The RFHAF/IPPF SPRINT team provided one of the earliest medical interventions for affected communities. The aim of these missions was to ensure access to the information and services outlined in the MISP for SRH. In addition to this, hygiene and dignity kits were distributed to women and girls of reproductive age.

TONGA

The Tongan Government, through the National Emergency Management Office, led the Health, Nutrition, Water, Sanitation and Hygiene Cluster, which supports public health broadly, sexual and reproductive health, child and WASH-related activities. In addition to this, Tonga's Ministry of Internal Affairs led the Safety and Protection Cluster which included in its remit, the identification and mitigation of risks of violence against women and children. Within these structures, the Tongan Ministry of Health made an official request to the Tonga Family Health Association (TFHA) to facilitate SRH services and education to communities affected by Tropical Cyclone Gita.

The response from TFHA and partners was decided after an assessment of SRH needs and gaps in communities affected by the cyclone. This was the first emergency response by the Member Association and the first time IPPF had responded to an emergency in Tonga. The work of TFHA was supported by the IPPF Pacific Humanitarian team and the IPPF Humanitarian Hub based in Bangkok. The response was focused on the objectives and activities of the MISP and included the provision of essential services to 938 women, men and young people from 95 affected communities, and a further 3742 non-SRH services to 1,693 individuals. Dignity kits were delivered to women and girls, and other supplies including contraceptives and medicines were distributed.

> **'80% of your response lies in how prepared you are. And being prepared doesn't just mean that you have clinicians trained, or the resources prepositioned, it's about being part of a national support network... we need to have those linkages to national level. We need to have those policies in place, we need to have the buy in from the key ministries...and I think we need to have partnerships- these play a great deal in the preparedness needs. And definitely capacity building at the Member Association level not just for the clinical or program staff but for youths engaged, at the board level for governance and so people are clear about what their role is and how that contributes to the bigger, broader picture of meeting people's SRH needs '**
>
> ~ study respondent

THE ROLE OF CAPACITY DEVELOPMENT

Across the two contexts there were differences in capacity development activities undertaken prior to the crises caused by Tropical Cyclones Gita and Winston and this impacted the speed and scope of the response.

While there had been Pacific regional SPRINT training in the spring of 2008, MISP training in Fiji in 2016 was early in its development. More investment in regular MISP and Gender-Based Violence training updates was notable in Tonga.

The initial response to Tropical Cyclone Winston in Fiji was compromised by a lack of in-country capacity to implement the MISP, and insufficient knowledge and experience of humanitarian emergency coordination mechanisms. Despite these challenges, adaptations were made to capitalize on the motivation, existing capabilities, position and relationships of those involved. A 'crash-course' training was facilitated by surge staff from IPPF and this, together with the advocacy and relationship building efforts, ongoing support, guidance and mentoring was regarded as critical to the broadly effective MISP response that was achieved in Fiji.

These capacity-related barriers to timely and comprehensive response were largely absent in Tonga. The response team in Tonga had been supported by concerted capacity development efforts prior to the crisis and they generally felt confident in their ability to meet the SRH needs of communities affected by Tropical Cyclone Gita, and to work effectively with disaster response mechanisms.

This study showed that exposure to training on the MISP for SRH before a crisis, together with knowledge of and engagement with organisations and mechanisms for coordination can help to enable a timely and effective response, although adaptations to bridge capacity gaps can be made. This research also, however, revealed that a broader set of factors influenced the type, scope and timeline of the response across both settings.

BEYOND TRAINING: IDENTIFYING & ADDRESSING BARRIERS & FACILITATORS TO THE RESPONSE

Training as a strategy for capacity development had an important role to play in supporting the response in both contexts- both the more comprehensive training efforts seen in Tonga, and the 'crash-course' and mentoring approach adopted in Fiji. This study found, however, that a raft of other factors operating on environmental, organisational, training and individual levels, influenced the breadth, depth and timeliness of the response. These are captured in figure 1 and described below.

On a broad environmental level, damage and destruction of infrastructure and challenges in reaching remote or isolated communities was noted. Appeals from communities that responders meet non-SRH health and welfare needs were reported as a challenge, but the willingness to meet these requests was noted as important for acceptance of the response. Socio-cultural considerations at a community level, such as following approach protocols were also noted as important to facilitate support. At the government level, relationships and engagement with platforms for coordination were regarded as essential for the response- whether these were existing prior to the crisis as seen in Tonga, or built during the response through "hard work and extra effort" (Study Respondent: Fiji) as they were in Fiji.

Factors at an organisational level also influenced the SRH response in both contexts. The support of management and program staff in IPPF Member Associations and regional bodies, and the role of the IPPF Humanitarian Hub teams in Bangkok and Suva, and the regional and sub-regional offices as sources of technical support and guidance was widely appreciated. Broadly, however, a lack of capacity or availability of staff was noted in both contexts, and this provided the additional challenge of one person having to assume multiple roles.

The challenge of insufficient staff, or staff with insufficient training was overcome to a degree in both contexts through collaboration with government and other sources of personnel, though gaps remained, particularly in relation to the second MISP objective. Preparedness and positioning of SRH and dignity kit supplies were reported as crucial for a timely response. In Tonga, TFHA was able to access clinical buffer stock and these were complemented by supplies provided by the Ministry of Health. In Fiji, supplies were provided by the government pharmacy without charge, and initial delays caused by communication processes were overcome through relationships facilitated by cluster meetings.

Figure 1: Barriers & Facilitators to an effective SRH response

This study also found that the position or status of an agency or association, both in relation to government functions and regional players, and in terms of their standing amongst other organisations, influenced their capacity for immediate response. TFHA had pre-existing relationships with key government organisations, and RFHAF needed to establish these during the response period. In addition to this, it was noted that the number of players within the field differed across these contexts, and that this influenced each organisation's engagement with coordination mechanisms.

In relation to training, this study found differences between activities undertaken across the contexts, with concerted efforts reported in Tonga, and little MISP training prior to Tropical Cyclone Winston in Fiji. It was found that these differences had a role to play in the type, scope and timing of each SRH response. Importantly, however, adaptations were made to accommodate capacity deficits and while these may not have been able to bridge the gap in MISP-related knowledge and skills entirely, they did contribute to the implementation of a broadly effective response.

The half-day training and ongoing mentoring and advice was seen as indispensable by Fiji responders who had received no prior training or training some time ago. This training, though brief, provided a foundation for the response and this was built upon through the processes of mentoring and feedback. In both settings, it was clear than an essential approach for increasing the capacity of individuals, organisations and their networks, was through 'learning by doing'. This process of developing capacity through the process of implementation was regarded as crucial, and knowledge and skills built in this way have been applied to preparedness efforts and subsequent humanitarian response.

The engagement, motivation and connections of SPRINT-supported individuals and teams was regarded as a key driver of an effective response. This was seen in the determination to overcome obstacles in Tonga and Fiji and the commitment to dedicate long hours and "heavy work" (Study Respondent). This passion and commitment were highly regarded, but there was caution from study participants that this not be taken for granted as stress, trauma and overwork were reported in both contexts.

For many involved in the response, the MISP for SRH was regarded as novel and an opportunity to learn and contribute. More than this, however, passion, experience, knowledge, position in and commitment to local communities were seen as laying the foundation of all efforts to meet the SRH needs of those affected by Tropical Cyclones Winston and Gita.

RECOMENDATIONS FOR WAYS FORWARD

This study found that differences in the preparedness efforts in Fiji and Tonga prior to Tropical Cyclones Winston and Gita influenced the type, scope and timeliness of the sexual and reproductive health response. It found that key actions in preparedness allowed the response team in Tonga to take clear and directed action, engage with established coordination partners and platforms, and implement a more comprehensive SRHiE response. We also discovered, however, that adaptability and flexibility, together with the use of a different approach to training and capacity development- a 'crash-course' followed by mentoring and support- and motivated and engaged staff allowed responders from Fiji to provide many of the SRH and broader health services needed by affected communities. Across both contexts, study respondents highlighted the importance of learning by doing, of building capacity through the process of implementation.

Preparation was regarded as key for any response, and it was found that any preparedness efforts must take account of the myriad factors that influence the type, scope and timeliness of an SRH response. In this research, it was clear that across both contexts, factors operating on individual, training, organisational and the broader environmental level worked to either support or impede the effective implementation of MISP-related activities. Each level of factors requires careful consideration and action in preparedness, and participants noted that this work has been a focus of efforts by IPPF Humanitarian and the Pacific Hub since Cyclones Winston and Gita.

IN SUMMARY THEN, KEY FINDINGS FROM THIS RESEARCH HIGHLIGHT THE IMPORTANCE OF:

- Preparedness, which was regarded as key for any response. A component of action for preparedness should include regular, on-going training that is relevant and contextualised.
- Understanding, addressing and preparing for the myriad of factors that may support or undermine an effective sexual and reproductive health response in emergencies.
- Flexibility, adaptability and different approaches to capacity development in response. 'crash-course' training followed by mentoring and support can be used to engage and guide staff. The importance of learning by doing and of engaging and developing capacity through the process of supported implementation was highlighted.
- Access to platforms for coordination and relationships with key national and international players. Individual and organisational position and relationships were noted as important to open doors, gain access to coordination mechanisms, engage with the community, and access opportunities to advocate for sexual and reproductive health and rights in emergencies.
- Employing buttressing strategies to support capacity development efforts and optimise the application of knowledge and skills to action, including the institutionalisation of the MISP into policy and practice, and maintaining the humanitarian hub for support.

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