Participant Handout #1 Instructions

Case Study

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

Time

15-20 minutes

Process

Divide participants into groups of 3-5.

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

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

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

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

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

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

Materials

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

Participant Handout #1

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

Situation Report

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

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

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

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

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

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

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

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

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

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

Reproductive Health Indicators for Gammalpha

(Most figures date from the last DHS 2015)

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

Participant Handout #1

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

Situation Report

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

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

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

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

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

1 Source: National Red Cross Society and local government official

2 Source: Local government official

3 Source: National Red Cross Society

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

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

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

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

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

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

Participant Handout #1

Reproductive Health Indicators For GAMMA

(Most figures date from the last DHS 2010)

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

Participant Handout #2 Instructions

Stories of Accessing SRH in Emergencies

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

Time

20 minutes

Process

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

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

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

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

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

After 5 minutes or so, ask each small group or pair to discuss their story and how they feel it highlights the need for SRH in crisis

Materials

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

Participant Handout #2

Stories of accessing SRH in emergencies: group work

1. Epi

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

2. Amelia

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

3. PNG Highlands Earthquake

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

Participant Handout #3 Instructions

Power Walk

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

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

Time

20 minutes

Process

1. Ask 2 participants to volunteer to be the characters Alieva or Amina and stand in the front of room. Option: if the group is large, add 'mother', 'sister', 'father', 'aunt' and/or 'brother who are also mentioned in the scenarios.

2. Provide the rest of the group with slips of paper describing different scenarios experienced by each character (Participant Handout #3).

3. Ask the group to read out what is on their paper one by one.

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

4. Encourage discussion throughout. If needed, try these key questions to facilitate discussion on whether each girl should move forward or backward:

   What are the good and bad things that are happening in this scenario for the girl?
   What skills, capacities and assets are they developing?
   What opportunities are they missing?
   What kind of power exists in the relationships around them? (e.g., power over/power within/ power to/power with)
   How does this affect their vulnerability or resilience?
   What power dynamics are happening here? How will you address these dynamics?
   When a disaster happens in this community, who will access services? Who may not?

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

Materials

Participant Handout #3

Participant Handout #3

Power Walk

Taken from: A training module for GBV practitioners in humanitarian settings

Character 1: Scenarios

1. Alieva

Alieva is 15 years old. She was born with a disability – she has difficulty moving, and was slow to develop her speech. The doctors said that Alieva would never go to school, and so she spends most of her time inside the house. A cyclone has passed through the community where Alieva lives however, the house where she lives remains intact.

2. Alieva

Alieva's mother helps her with daily care, like washing and going to the toilet. Her father recently left the family, and now Alieva's mother needs to leave Alieva and her younger sister in order to access disaster relief information and services. Alieva's younger sister must stay at home to help her with things when their mother goes out for meetings.

3. Alieva

Alieva's mother now has a job and can access disaster relief. Alieva is home alone most of the day, and different relatives and people in the community need to come throughout the day to help her go to the toilet or have lunch. Sometimes her rlatives are late, and when Alieva complains they sometimes get angry with her and refuse to take her outside. Alieva likes being outside in her wheelchair, and will talk to anyone who stops to say "hello."

4. Alieva

Alieva's sister and another neighbor have started taking Alieva to attend a group a local women's center that provides activities to support the community as part of disaster response. The social workers spend time talking to Alieva – when she is ready, they organize transportation so the three girls can travel together to the center. Alieva looks forward to these days being around the other girls, and is hoping to learn more about computers.

5. Alieva (FINAL)

One day you meet with the girls to identify the activities they would like to do at the center. Alieva doesn't speak at this meeting and all the other girls want hairdressing. They all say that Alieva will enjoy this, as they can all do her hair for her – she can be the client, and doesn't need to stand up to do that.

Participant Handout #3

Character 2: Scenarios

1. Amina

Amina is 16 years old. She finished her primary education, but has missed a lot of her secondary school because a cyclone has passed through her community and her family members are always asking her to undertake different chores. Her aunty has been encouraging her to do some classes, so she can get a job one day.

2. Amina

Amina has a lot of friends from primary school. They support each other by accessing disaster relief services and keeping each other informed. They meet sometimes in the shops and talk a lot on the phone. Some of her friends are going to the center to learn accounting, and Amina would like to join them. Her friends give her lots of information that she shares with her parents, and they say it is OK for her to go, as long as she is able to continue her other work.

3. Amina

Amina has learned a lot at the center and now has many more friends. Her brothers sometimes take away her phone to prevent her from talking to these friends. The other girls at the center sometimes have the same thing happen, and they discuss different ways to talk to their families about this.

4. Amina (FINAL)

Amina has passed her accounting course and wants to find work. The teachers at the center give her some different ideas of places to look for work and how the recruitment processes work. Amina talks to her aunty – she also works and has a lot of experience. Amina's aunty supports her when she discusses this idea with her family.

Tools for Inclusion

Note This activity should only be conducted if time permits.

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

The Gender with Age Marker (GAM) is a tool which, based on a code, provide an automatic and objective calculation of the quality of humanitarian programming. The IASC GAM codes programs and projects on a 0-4 scale, based on responses to questions about 12 key gender quality measures.

Participant Handout #4 Instructions

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

Time

40 minutes

Process

Share handout with participants.

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

Option 1

1. If internet is available: access: https://iascgenderwithagemarker.com/en/home/ . Go to "Access the Marker" and click on the "Play with the Marker"

2. In plenary, fill out the different questions asked. Some sections will need some language added ("analysis based on etc"). It may be useful to have that language pre-prepared and cut and pasted in as the test proceeds. The purpose of going through the tool in plenary is to illustrate the type of questions we need to ask of ourselves as we design programs.

3. Go through the exercise until a score is provided. Open up a discussion on how target groups need to participate in design of our programs. Mention that the tool does not adequately add a disability component and is something that needs to be integrated. (Note that upcoming IASC Guidelines on Disability Inclusion will facilitate this)

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

Option 2

Ask participants to look at the Gender with Age Marker Health Tip Sheet (Participant Handout #4).

In small groups, ask participants to consider:

Which of the tips may be feasible in the early stages of an emergency?

Do you already collect/use this information- what are the sources for this information in your country?

What would be needed to implement these tips in emergency programming?

Then ask the group to feed back key points to the plenary.

Materials

Internet access and projecting equipment or

Participant Handout #4

GENDER EQUALITY MEASURES IN HEALTH

This Tip Sheet offers interventions, guiding questions and an example of how 4 Key Gender Equality Measures (GEMs) support gender equality in Health projects and programs. It should be read together with the GAM Overview. The IASC GAM identifies and codes projects based on the extent to which key programming elements are consistently present in proposals and implemented projects. Four steps (GEMs) are assessed in the design phase, and twelve GEMs are reviewed in monitoring.

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

HEALTH interventions can make assistance responsive and fair by:

- Describe the specific priorities, needs of and the dynamics that affect women and men, girls and boys in different age groups for emergency health services;
- Design activities to address the needs, roles and power dynamics at home and in the community that might deprive groups of equal access to health services;
- Locate the types of health services based on the needs expressed by girls, boys, men and women in different age groups, including adolescent girls and boys and older women and men; and
- Record and compare the different health results for women and men, girls and boys in comparable age groups. Review activities where there are project problems, including barriers.

QUESTIONS TO INSPIRE ACTION

Needs Analysis Set	Gender Analysis	What are the health trends by gender & age group? How does the crisis affect respective abilities to access health and rehabilitation services? Are there RHS services and appropriate clinical management of rape? How do cultural beliefs and practices regarding pregnancy, childbirth, care of the sick, body disposal, washing, water use, cooking and hygiene affect the health of women and girls compared to men and boys?
	Sex and Age Disaggregated Data (SADD)	Are pathologies seen in similar rates in different gender and age groups? How do project access rates vary by gender and age? Are there disproportionate disease or death rates in certain groups? If so, why?
	Good Targeting	Should the intervention be for everyone or do certain groups need targeting? How do gender and age affect ability to access project services? What efforts are made to ensure people with disabilities can access the project?
Adapted Assistance Set	Tailored Activities	Are facilities designed so that people who need them can access safely confidentially? (e.g. handrails, non-stigmatizing entrances) Are mobile outreach services used to enable access for those with physical or cultural restrictions on mobility? Are maternal health activities designed for women of all ages, including very young women? Do men and boys of all ages have equal opportunities for capacity-development on personal and family health?
	Protect from GBV Risks	Is poor health contributing to early marriage or transactional sex? Is the Minimum Initial Services Package available? Is there a referral pathway?
	Coordination	Does the project fit with the cluster response plan & complement other clusters' actions? Is the gender analysis and data shared?
Adequate Participation Set	Influence on Project	Are diverse women, girls, boys, men of appropriate ages equally involved in the project design, implementation and review? Are women and men meaningfully and fairly involved in decision-making groups such as health committees? Are there equal opportunities to engage as volunteers?
	Feedback	Are there feedback mechanisms? Confidential, safe and responsive complaints channels?
	Transparency	Is everyone given information about the project and how to access services in ways they can understand? Are campaigns adapted and relevant to the different concerns of different gender and age groups?

Review Set		
	Benefits	Are targets and indicators disaggregated by sex and age? Is assistance provided to those who need it most? Do men and women receive assistance fairly?
	Satisfaction	Are men and women in different age groups asked about their satisfaction? Are they equally satisfied?
	Project Problems	Do affected people identify barriers or unintended negative consequences? Are they different depending on gender or age? Do women talk with women, and men with men? Are there plans to improve the project?

GENDER MAINSTREAMING, OR A TARGETED ACTION?

Some Health interventions target actions to address specific discrimination or gaps resulting from gender norms and expectations (Targeted Actions or T). For example, a project recognizing the risks of childbirth attended by unskilled traditional birth attendants seeks to improve women's knowledge, skills, and employment potential by providing training for local midwifes, and in consultation with the community establishes a savings cooperative for payment of their incentives. Other health interventions, such as construction of a CHC, aim to serve everyone, and provide services and facilities to equally accommodate the needs and preferences of both male and female users (Gender Mainstreaming, or M.)

EXAMPLE OF GOOD GENDER EQUALITY PROGRAMMING IN WASH

(GAM Code 4(T) – can you work out why? See the GAM Overview)

Key GEM A: Gender Analysis
The needs, roles and dynamics of women, girls, boys and men in different age groups are understood.

HIV/AIDS and access to health care were proving to be a significant challenge among women in Uganda. There is significant discrimination against people with HIV/AIDS, particularly women of reproductive age. There is a "cycle of HIV transmission" driven by high rates of new HIV infections in adolescent girls and young women from men (on average 8 years older). Many of these men were also partners of similarly-aged women, who also have HIV.

→

Key GEM D: Tailored Activities
How did the project address the Gender Analysis?

The Health Empowerment and Livelihoods (HEAL) project combined HIV prevention training, testing and counselling with savings and business-enterprise coaching and life skills training, helping young women secure access to higher earnings and increasing overall levels of confidence and self-esteem.

→

Key GEM J: Benefits
What benefits do affected groups gain in this example?

HEAL found that engaging local leaders and men made women more likely to participate in savings groups and less likely to fear repercussions. This engagement helped the wider community to see benefits of women's participation in savings groups for the family and the community. In an evaluation, project implementers Act4Africa found a 25% reduction in men and women reporting high-risk sexual behaviour compared with the project baseline. By the end of the project, the majority (80%) testing HIV positive were taking up healthcare referrals compared with only 48% at the start.

↑ ↑ ↑

Key GEM G: Influence on Projects

How women, girls, boys and men in different age groups were involved in decisions in this example:
HEAL consulted with young women (18-25 years) as well as local community leaders, authorities and men about their issues, how to set up the project and what the project achieved. HEAL also arranged for a bank representative to go to villages and speak to women and men directly about the project.

Using Gender Equality Measures in projects or cluster programs leads to better quality programming, responsive to gender and age issues.

GOOD TO GO? Apply the IASC Gender with Age Marker to your proposal or project.
RESOURCES? Refer to iascgenderwithagemarker.com

Participant Handout #5 Instructions

SRH Coordinator Terms of Reference

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

Time

10 minutes

Process

Provide participants with copies of the SRH Coordinator Terms of Reference from IAFM 2018 (pages 20-21).

Allow some time for participants to read through these guidelines and then bring participants back to the group.

Facilitate a guided discussion with the group about the roles and responsibilities of the SRH Coordinator, making sure to highlight the importance of the coordination principles discussed above (clear roles and responsibilities, information and management sharing, trust, communication, common goals and purpose, and respectful partnerships).

Materials

Participant Handout #5

Participant Handout #5

Sexual & reproductive health coordinator terms of reference

The SRH Coordinator is responsible for supporting health sector/cluster partners to implement the MISP and plan for the provision of comprehensive SRH services.

The SRH Coordinator's role is to:

- Coordinate, communicate, and collaborate within the health, GBV, and HIV cluster/ sectors/ actors and actively participate in health and other inter-sectoral coordination meetings, providing information and raising strategic and technical issues and concerns
- Host regular SRH coordination meetings at national and relevant sub-national/regional and local levels with all key stakeholders, including MOH, local and international NGOs including development organizations working on SRH, relevant UN agencies, civil society groups, intersectoral (protection, GBV, HIV) representatives, and community representatives from often marginalized populations such as adolescents, organizations of PWDs and LGBTQIA organizations to facilitate implementation of the MISP
- Compile basic demographic and SRH information of the affected populations to support MISP advocacy, implementation and planning for comprehensive SRH service delivery
- Identify, understand, and provide information about the elements of national and host country policies, protocols, regulations, and customary laws that:
  - Support SRH services for the affected population
  - Create barriers and restrict access to SRH services
- With health, GBV, and HIV coordination mechanisms, support a mapping exercise/ situation analysis of existing SRH services (including specialized local service providers that are already working with sub-populations such as LGBTQIA individuals and those engaged in sex work), and identify SRH program needs, capacities, and gaps and conduct a planning exercise in coordination with all relevant stakeholders for effective, efficient, and sustainable SRH services
- Support health partners to seek SRH funding through humanitarian planning processes and appeals including the flash appeals process (Central Emergency Response Fund (CERF) and Country-based Pooled Funds (CBPFs) and the Humanitarian Response Plan, in coordination with the health sector/cluster
- Provide technical and operational guidance on MISP implementation, as well as orientation for health partners on the MISP, RH Kits, and other resources
- Support coordinated procurement and distribution of RH Kits and supplies and plan for long-term sustainable SRH procurement and distribution systems

The SRH Coordinator works within the context of overall health sector/cluster coordination mechanism to obtain and use information:

- Ensure MISP services are monitored to ensure quality and sustainability. Utilize the MISP checklist to monitor services
- Ensure regular communication among all levels and report back on key conclusions and challenges requiring resolution to the overall health coordination mechanism
- Collect and apply service delivery data, analyze findings, identify solutions to service gaps, and plan for the provision of comprehensive SRH services
- Facilitate planning meetings with all stakeholders to identify synergies, needs, gaps, and opportunities, to support establishment of client-centered comprehensive SRH services as soon as possible and within 3-6 months of the onset of the emergency

Participant Handout #6 Instructions

Mapping Coordination in Context

If time allows:

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

Time

25 minutes

Process

Break group into smaller groups

Provide each group with a copy of Participant Handout #6.

Allow participants 15 minutes to discuss and fill in the template. At the end of 15 minutes, facilitate a brief discussion and allow participants to share information on the involved organisations, how they function and coordinate, and to suggest contacts and follow up activities as appropriate.

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

Materials

Participant Handout #6

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.

General Humanitarian Coordination in your context

Lead Responsible Organisation	Supporting Organisations	Mechanisms for Coordination

Coordination of the MISP in your context

MISP	Lead Responsible Organisation	Supporting Organisations	Mechanisms for Coordination
Objective 1			
Objective 2			
Objective 3			
Objective 4			
Objective 5			
Objective 6			
Other SRH Priority			

Participant Handout #7 Instructions

Cluster Coordination

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

Time

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

Process

1. Ask for 9 volunteers and assign each person a different role (try to identify those who have had some experience in coordination meetings before). See Participant Handout #7 for suggested name plates/ role cards.

E.g.

- 1 person should be allocated the role of WHO Health Cluster Coordinator.
- 1 person should be allocated the role of UNFPA country coordinator.
- 1 person should be allocated the role of Ministry of Health Representative.
- 1 person should be the IPPF Program Manager.
- Other people should choose to represent other organisations (either local organisations such as disabled persons organisations, LGBTQIA organisations, women's groups, faith-based groups etc.; youth- based organisations; and international NGOs such as CARE, Save the Children, Médecins Sans Frontières / Doctors without Borders).

2. Read out the following instructions to the group:

It is the day after the emergency described in your case study occurred. The local IPPF MA/ other organisation have called UNFPA or Ministry of Health or WHO to find out when the first cluster meeting will take place. There is a Health Cluster Meeting taking place today.

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

3. Give participants a couple of minutes to review their roles and think about how they want to play their characters. Will they be dictatorial, will they understand SRH etc. See guide.

4. The other participants can act as observers.

5. Allow up to 25 minutes for the role play, and then facilitate 15 minutes a discussion consider:

- What was going on in the meeting? Who was leading? what were the priorities (ask

observers)
- Did people seem supportive of SRH? Ask the actors (e.g. MoH)
- Ask IPPF/UNFPA how they felt trying to convince others?
- Ask participants what they think worked- was there potential for collaboration
- Ask what could be done in preparedness to improve coordination in response

Key Messages

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

Materials

Participant Handout #7

Scenario from Participant Handout #1

Participant Handout #7

Coordination Name Plates

Instructions: Print each of the following roles on half a page and the text upside down on the other half. (See example at the end of this document).

When the paper is folded in half on the dotted line, the audience can see the title and the participant can see the instructions.

Humanitarian Officer – UNFPA

GBV Coordinator - UNFPA

You are trying to establish a SRH Working Group with other SRH actors to make sure that SRH needs are addressed properly and that MISP is properly implemented. You know others in the Health Sector Group have not heard of the MISP so you are trying explain its importance.

Emergency Coordinator – MoH

Emergency Coordinator – MoH

You are leading the first Health Cluster Meeting. In two hours you have to report to the inter sector meeting which is being run by the National Disaster Relief Office. You have to share the Health Response Plan. From the health Cluster meeting you want to know what resources and support different agencies can offer the government response. You are mainly worried about preventing any additional deaths and disease like diarrhoea and respiratory infections. You are not familiar with SRH and don't think it is life saving but could be convinced.

Health Coordinator – WHO

Health Coordinator – WHO

You are the co lead of the Health Cluster and your role is to support the MoH health response. You just arrived in country after the Cyclone hit and are not familiar with the country context. You are relying on others organisations to help identify the priorities

Humanitarian Coordinator- IPPF

Humanitarian focal point – IPPF

You have worked in Gammalpha for a long time on SRH and are aware that maternal mortality and contraceptive uptake is low. You know that the situation is likely to worsen because of the break down in health facilities and lack of staff. You are trying to convince the health cluster with UNFPA of the importance of SRH being integrated into the response and that you staff and facilities can support. No one else has heard of you though so you have to explain all the time who you are.

Health Officer – Red Cross/Crescent

Health Officer – Red Cross/Crescent

You are supporting basic primary health care services in all affected districts as well as outreach clinics in the camp. You having seen a few cases of Sexual Violence coming forward but have heard there is a lot more but you don't have the capacity to address this. You want to know which actors are working on this so you can refer.

Health Officer – MSF

Health Officer – MSF

MSF has been running services since the crisis started. Working in some of the most remote areas. Your supplies are running low and you want to know when the ports will re open as you have a shipment waiting. You are not interested in coordinating.

Water & Sanitation Officer – OXFAM

Water & Sanitation Officer – OXFAM

You think the priority issue is water and sanitation to stop any disease outbreak. Anytime anyone starts talking about other topics you keep trying to bring back the focus to water and sanitation. You are ready to start digging latrines/toilets and set up water distribution

Food Security & Nutrition Specialist – WFP

Food Security & Nutrition Specialist – WFP

You are really worried about food running out and the impact this will have on malnutrition which already appears to be a problem. You don't think SRH is a priority at this stage of the emergency and every time it is raised you question why we are talking about this when addressing nutrition I the bigger priority.

Programme Officer – CBM

Programme Officer – CBM

You have heard from your community outreach officers that many people living with disability are not able to access the health services because the information on the health services and opening hours are inaccessible and it is expected that community members have to get to the facilities themselves. You want to know what is being done to make services more inclusive. You are new to humanitarian work and people are talking over you. You had to travel far to be here.

Water & Sanitation Officer
OXFAM

Water & Sanitation Officer – OXFAM

You think the priority issue is water and sanitation to stop any disease outbreak. Anytime anyone starts talking about other topics you keep trying to bring back the focus to water and sanitation. You are ready to start digging latrines/toilets and set up water distribution

Humanitarian Coordinator

UNFPA

Humanitarian Coordinator – UNFPA

You are trying to establish a SRH Working Group with other SRH actors to make sure that SRH needs are addressed properly and that MISP is properly implemented. You know others in the Health Sector Group have not heard of the MISP so you are trying explain its importance.

Emergency Coordinator
MoH

Emergency Coordinator – MoH

You are leading the first Health Cluster Meeting. In two hours you have to report to the inter sector meeting which is being run by the National Disaster Relief Office. You have to share the Health Response Plan. From the health Cluster meeting you want to know what resources and support different agencies can offer the government response. You are mainly worried about preventing any additional deaths and disease like diarrhoea and respiratory infections. You are not familiar with SRH and don't think it is life saving but could be convinced.

Health Coordinator
WHO

Health Coordinator – WHO

You ae the co lead of the Health Cluster and your role is to support the MoH health response. You just arrived in country after the Cyclone hit and are not familiar with the country context. You are relying on others organisations to help identify the priorities

Humanitarian focal point

IPPF

Humanitarian focal point – IPPF

You have worked in Gammalpha for a long time on SRH and are aware that maternal mortality and contraceptive uptake is low. You know that the situation is likely to worsen because of the break down in health facilities and lack of staff. You are trying to convince the health cluster with UNFPA of the importance of SRH being integrated into the response and that you staff and facilities can support. No one else has heard of you though so you have to explain all the time who you are.

Red Cross/ Red Crescent

Health Officer

Health Officer – Red Cross/Crescent

You are supporting basic primary health care services in all affected districts as well as outreach clinics in the camp. You having seen a few cases of Sexual Violence coming forward but have heard there is a lot more but you don't have the capacity to address this. You want to know which actors are working on this so you can refer.

Health Officer
MSF

Health Officer – MSF

MSF has been running services since the crisis started. Working in some of the most remote areas. Your supplies are running low and you want to know when the ports will re open as you have a shipment waiting. You are not interested in coordinating.

Food Security & Nutrition Specialist WFP

Food Security & Nutrition Specialist – WFP

You are really worried about food running out and the impact this will have on malnutrition which already appears to be a problem. You don't think SRH is a priority at this stage of the emergency and every time it is raised you question why we are talking about this when addressing nutrition I the bigger priority.

Christian Blind Mission

Programme Officer

Programme Officer – CBM

You have heard from your community outreach officers that many people living with disability are not able to access the health services because the information on the health services and opening hours are inaccessible and it is expected that community members have to get to the facilities themselves. You want to know what is being done to make services more inclusive. You are new to humanitarian work and people are talking over you. You had to travel far to be here.

Participant Handout #8 Instructions

Code of Conduct against Sexual Exploitation and Abuse:

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

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

Time

15 minutes.

Process

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

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

   What principles are common to the documents?

   How do these principles relate to sexual exploitation and abuse?

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

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

Materials

Participant Handout #8

Participant Handout #8

Sample Codes of Conduct

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

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

1. Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
2. Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
3. Exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes the exchange of assistance that is due to beneficiaries.
4. Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
5. Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
6. Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

2. IAFM 2010

Sample Code of Conduct

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

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

Commitment to [ORGANIZATION] Code of Conduct

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

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

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

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

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

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

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

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

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

I may face disciplinary sanctions.

Employee’s name, function and signature, date

Manager’s name and signature, date

Participant Handout #9 Instructions

Coordination with Other Humanitarian Sectors

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

Time

25 minutes.

Process

1. Ask participants to think again about the points of risk for sexual violence in their case studies which they identified earlier in the session.
2. Divide participants into 2 groups. The first group will play the role of SRH Coordinators. The second will be divided between the other relevant sectors/ clusters.
3. Give participants **in the first group** a copy of the IASC Health TAG Excerpt. Allow them time to read through and identify what they will be seeking through the GBV working group meeting with other stakeholders in reference to their discussion on points of risk for sexual violence.
4. Ask participants **from the second group** to take a role card identifying them as a representative of one of the other relevant sectors/ clusters and ask them to brainstorm potential priorities for each of these representatives.
5. After approximately 10 minutes, convene the GBV working group meeting and ask group one to address each representative in turn and ask them how they might contribute to the prevention of sexual violence, based on the points of risk for sexual violence identified earlier in their case study. Group one should ensure that each action outlined for each sector in the IASC Health Tag Excerpt is discussed.

Participants from the second group should push for their other priorities, compelling the SRH Coordination team to engage advocacy messages discussed on the first day and at the start of this session.

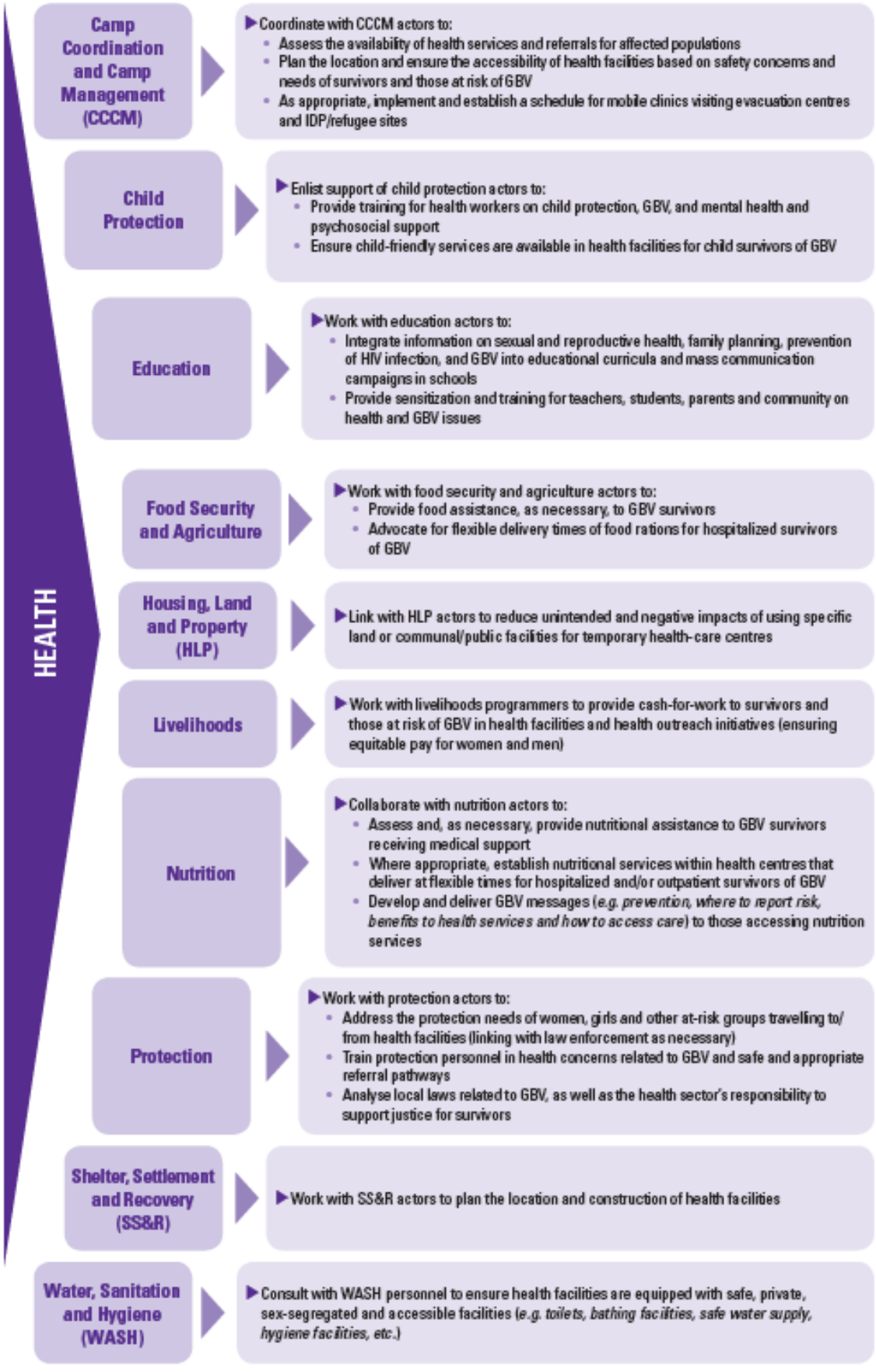
At the close of the role play, facilitate a brief discussion with the group to ensure that advocacy messages and proposed strategies for coordination are on track.

Materials

Participant Handouts #1 & #9

Participant Handout #9

IASC Health Tag Excerpt



Participant Handout #9

Role Cards for Coordination Role Play

Coordinator: UNOCHA	**Education Specialist: UNICEF**
Protection Officer: UNHCR	**Health Officer: Red Cross/ Red Crescent**
Water & Sanitation Officer: OXFAM	**Food Security & Nutrition Specialist: World Food Program**
Legal Advisor: CARITAS	**Camp Coordination & Camp Management: Norwegian Refugee Council**

Participant Handout #10 Instructions

Providing Clinical Care for Survivors: Guiding Principles

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

Time

10 minutes.

Process

1. Divide participants into four groups (such as by table) and give one copy of Participant Handout #10 to each group.
2. Explain the pictures: entrance sign, files, medicines, and latrine.
3. Ask the groups to take 2 minutes to work on the following question:
   As a program manager, you are evaluating a clinic that provides care to survivors of sexual violence. Give your comments and recommendations.
4. Have a reporter for each group share findings and facilitate a discussion based on the solutions below.
5. Alternatively, you can set this up as a role play based on the pictures if have time.

Materials

Participant Handout #10

Solutions

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

Key message for participants

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

Participant Handout #10

Providing Clinical Care for Survivors of Sexual Violence: Guiding Principles

Timelines for the Care of Survivors

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

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

Time

30 minutes

Process

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

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

Key Discussion points

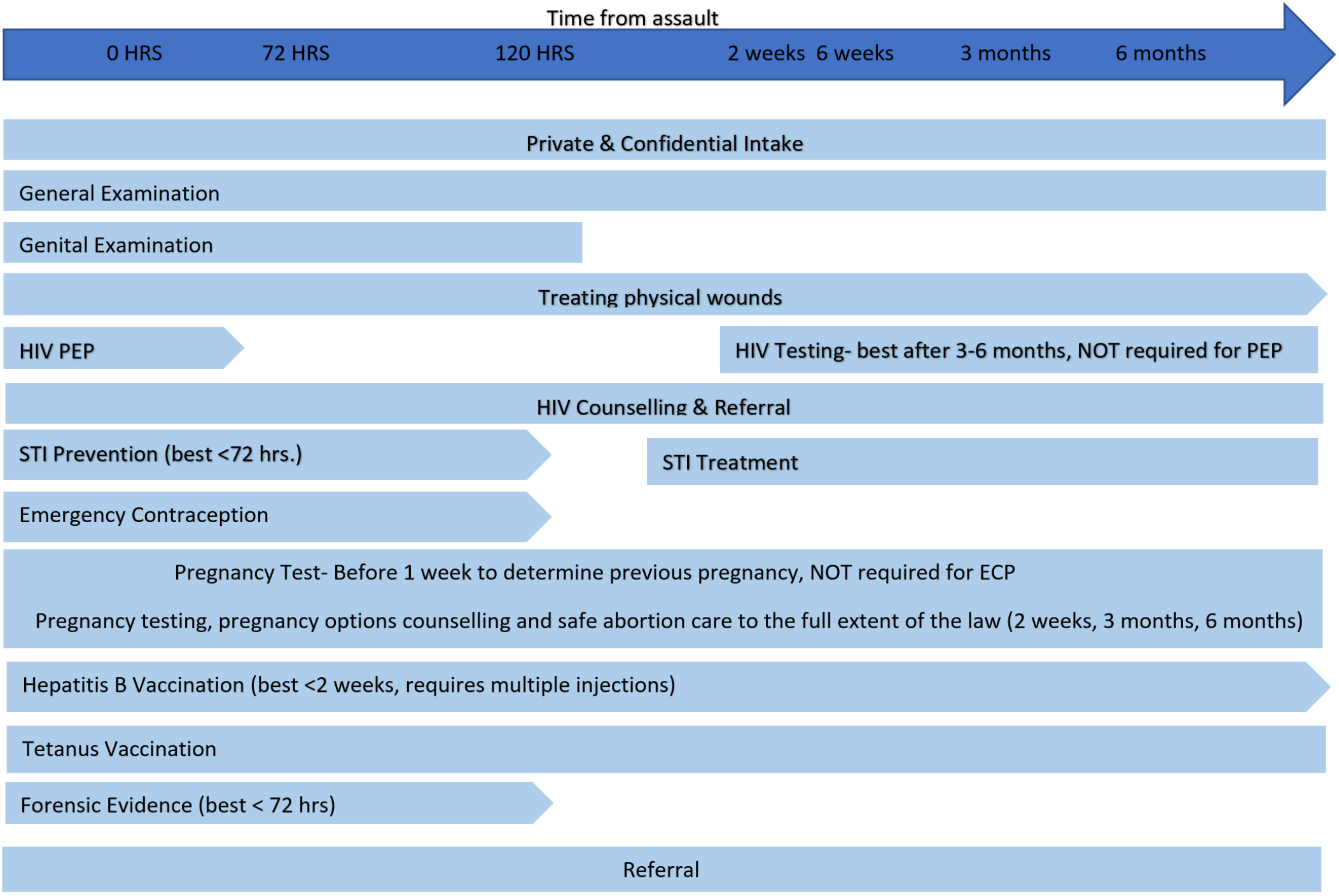
- CMR treatment should be available and accessible to all survivors soon as possible. The reality is that many survivors present many days, weeks or even months after the event and not all survivors wish to receive all treatments at the same time. It is important to understand which interventions have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

Materials

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

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

Solution: Timelines for the Care of Survivors



Participant Handout #12 (A & B) Instructions

Standard Precautions

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

Time

45 minutes

Process

The following 2 Group Work activities are designed to be conducted at the same time. Divide participants into 2 groups. One group will undertake **Group A Standard Precautions: Health Post** while the other group conducts **Group Work B Standard Precautions: Challenges & Strategies**.

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

Group Work A Standard Precautions: Health Post

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

Procedure

In a corner of the training room, set up a nurses' station where the items listed below are displayed (some of them inappropriately, as not to respect standard precautions). The hotel or training centre will have panels and curtains that you can use to build your station. Be creative and the participants will have fun learning!

Instruct participants that they are conducting an inspection of the health post.

A facilitator may take the role of a nurse or other service provider staffing the health post.

Participants should conduct an inspection and be encouraged to give feedback directly to the 'service provider' as well as noting comments on the Participant Handout #12 (Part A).

Also encourage participants to consult the IAFM, pages 37 and 38 for more on the breaches of standard precautions they are witnessing.

Materials for Group Work A Standard Precautions: Health Post

1 Sign 'Nurses' Station'
1 Wall protocol on safe injections
1 Mask
1 Apron
1 Pair of rubber gloves
1 Bucket
1 Mop
1 Injection table: Box of gloves; Needle in vial; Uncapped used syringe; Kidney basin
1 Water dispenser & soap
1 Nurse's table: Burn box full of syringes; Stethoscope; Blood pressure cuff; Trash can with recapped syringe inside; 5 Patient's files.
Participant Handout #12 (Part A)

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

Group Work B Standard Precautions: Challenges & Strategies

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

Procedure

Ask participants to work through the questions on their worksheet as a group.

Encourage them to discuss, outline obstacles and strategise as a group to overcome these obstacles.

Materials for Group Work B Standard Precautions: Challenges & Strategies

Participant Handout #12 (Part B)

Participant Handout #12 A

Standard Precautions

Participant Handout #12A: Health Post

You are conducting a supervisory visit to a health post:

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

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

Notes

Participant Handout #12B: Challenges & Strategies

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

1. Identify 3 challenges to implementing standard precautions in your setting as it is now.
2. Identify 3 challenges to implementing standard precautions in your setting in the event of a crisis.
3. Discuss some strategies to overcome these challenges. How would you implement these strategies during a crisis?
4. In the event that your area is cut off from supply routes because of the crisis, and you are therefore unable to restock health posts with official supplies, suggest some simple, practical measure which could be taken as a first step using existing or local resources (remember- staff are resources too!).

Notes

Condoms: Ordering & Distribution

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

Time

20 minutes

Process

Provide participants with copies of Participant Handout #13 and ask them to work through the discussion questions and calculations.

At the close of 15 minutes, ask participants to report back on their discussion in relation to the case study and calculations using the key messages below.

Materials

Participant Handout #13

Solutions

Do not order female condoms for emergencies if the population has not been exposed to them.

Condoms can be made available in many ways, but you must be creative and take cultural sensitivities into consideration.

Program managers and health clinic staff should discuss with young men and women (separately) and ask them where the best place to pick up condoms would be if people need them. Male condoms (and if available, female condoms) should be available to adolescents free-of-charge at distribution points located in places that are discreet and convenient to access. Program managers and clinic staff should engage selected adolescents in the community to help identify adolescent-friendly distribution points and inform others that condoms are available. In addition, condoms should be offered to any person (regardless of sex, age or marital status) who requests them or who presents to the health facility with symptoms of STIs.

Some examples are: making condoms available at registration sites; providing them in the non-food item distribution; putting them out during the food distribution, put supplies in the latrines, in schools, in clinics, through community leaders, community health workers or TBAs.

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

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

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

Answer

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

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

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

14,400 x 3 months = 43,200 condoms

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

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

Participant Handout #13

Ordering Condoms

1. How would you ensure that condoms are available for women, men and adolescents in the acute phase of a crisis in your setting?

2. How would you make the community aware that condoms are available during the acute phase of a crisis?

3. How would you monitor the uptake of condoms?

4. Using the formula below, calculate how many condoms you would need to order for a population of 30 000 people for 3 months.

Formula

Assume 20% of the population are sexually active men.

20% of them use condoms

Each condom user needs 12 condoms per month.

Add 20% to allow for wastage

Notes

Participant Handout #14 Instructions

Providing Post Abortion Care

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

Time

20 minutes

Process

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

At the close of 15 minutes, take 5 minutes to ask participants to report back on their discussion. Give constructive feedback using the solutions below.

Materials

Participant Handout #14

Solutions

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

Participant Handout #14

Providing Post-Abortion Care

Discuss these questions with your group:

1. What is Post-Abortion Care?
2. What services does it include?
3. Is it against the law?
4. How can these services be coordinated? How can we ensure that women have access to them? Think about referral within health facilities and between health facilities at different levels.
5. What other SRH health services should be available to women who present for post-abortion care?

Notes

Contraception in Humanitarian Emergencies

Participants will explore case studies to highlight the importance of providing contraception to prevent unintended pregnancies in emergencies. These case studies are from *Family planning saves lives and promotes resilience in humanitarian contexts* available at: https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf

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

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

Time

25 minutes

Process

Ask participants to read through the case studies provided in Participant Handout #15.

When they have read through these, as a group, ask participants to point out some good practices and some challenges in providing family planning which were discussed in the case studies.

Note these challenges and good practices on a flipchart to refer to in the coming session.

Allow some time for a general discussion and ask participants whether these good practices and challenges would apply to their setting.

Finally, explain to participants that you are now going to work through the activities prescribed by the MISP to support the prevention of unintended pregnancies and as you do, they should keep in mind the good practices and challenges discussed here.

Materials

Participant Handout #15

Flipchart and markers

Contraception in Humanitarian Emergencies

Case Studies From: *Family planning saves lives and promotes resilience in humanitarian contexts* available at: https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf

Case Study 1

Early investment: family planning in acute crisis MISP response BORNO STATE, NIGERIA

Following a recent escalation of violence in northeast Nigeria, the International Rescue Committee (IRC) launched an emergency health response in Borno state, which hosts the highest number of internally displaced people nationally. The conflict destroyed infrastructure and severely limited access to services, with only 35% of the primary health care clinics functioning and a lack of skilled staff and medical supplies. The IRC initiated MISP services in August 2016 and established the only clinic providing comprehensive reproductive health services in the Bakassi IDP camp. The IRC also supports four government primary health care facilities within the Maiduguri Metropolitan Council-Jere area, with a particular focus on family planning services, post abortion care, clinical care for sexual assault survivors and delivery care. Additionally, the IRC has established comprehensive reproductive health services in Konduga and Monguno through reproductive health clinics, supporting a total population of 291,767 in all of Borno State. Between January and March 2017, across all supported sites, the IRC served a total of 3,474 family planning clients. 69% (2,398) of these clients were new FP acceptors, 14.4% (346) of whom selected a long-acting reversible contraceptive method.

Participant Handout #15

Case Study 2

Building back better 2015 NEPAL EARTHQUAKE

On 25 April 2015, a major earthquake struck central Nepal, devastating parts of the country. Almost one-third of the population and 43% of the country's health infrastructure were impacted. Within hours of the earthquake, CARE mounted a rapid emergency response to provide lifesaving services to people in three of the worst affected districts of Nepal: Gorkha, Sindhupalchowk, and Dhading. CARE partnered with UNFPA to implement the MISP in these intervention districts. CARE planned and coordinated its response through the Reproductive Health sub-cluster and the Association of International NGOs in Nepal (AIN). CARE worked with government authorities, local NGOs and Female Community Health Workers to deliver community based SRH services, including family planning, through mobile camps in 20 locations in two districts. In addition, CARE distributed essential medicines, supplies and equipment to health facilities to ensure the delivery of MISP services. CARE's emergency response ensured that women had full access to a wide range of modern contraceptive methods by supporting the delivery of short- and long acting reversible contraceptive (LARC) methods to the affected population through mobile reproductive health camps and static primary health facilities. The response in these three crisis locations strengthened the health system beyond pre-crisis standards, leaving the communities better served and more resilient as a result of the response.

Case Study 3

Strengthening health systems for family planning service delivery in chronic instability YEMEN

Continued armed conflict, population displacement, and a rise in infectious diseases has eroded the already fragile health care system in Yemen, where 10.3 million people are in acute need of humanitarian assistance. Save the Children, in partnership with the Ministry of Health, is providing family planning services as part of its emergency health response strategy in the governorates Hodeida and Lahj. Save is currently supporting 16 health facilities, including four hospitals and 12 health centres. Since 2013, these 16 health facilities, which serve 507,000 people, have provided family planning services to 37,347 new acceptors (first time to the facility and/ or method); 21% have accepted LARCs. The programme provides competency-based training and follow-up support for trainees. By April 2017, 60 health care workers had received competency-based clinical training, including family planning counselling and provision of short-acting and LARCs. In this context, the humanitarian response is meeting both immediate needs due to instability and long term health system and capacity needs of the country overall.

Participant Handout #16 Instructions

Transitioning to Comprehensive SRH

3 Month Update to Case Study

This activity asks participants to develop a transition plan for the health cluster based on a 3 month update to the case study introduced on day 1 of the training (Participant Handout #1).

Time

20 minutes

Process

Break participants into small groups

Remind participants of the case study they have been working with throughout the training and explain that it is now 3 months after the event.

Provide each group with the update notes relevant to their case study (Gammalpha or Gammaland). Handout #16.

Alternatively, participants could be provided with a context-specific case study to discuss how transition planning was done after a recent crisis in their setting.

Ask participants to work in groups, using the health systems building blocks as a guide, to prepare a brief transition plan to be presented to the Ministry of Health and Emergencies.

Explain to participants that part of transition planning is to note the strengths and assets that have been identified and can be built upon as they plan for comprehensive SRH services/ recovery.

Ask groups to share back one or two key points from their plan and facilitate a discussion on key considerations. Volunteers can pretend to be MoH to be more interactive

Materials

Participant Handouts #1 & #16

Participant Handout #16

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

Situation Report

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

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

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

- The camps near Brew remain the largest. Although people are now living in tents the area has become over crowded with more people from the smaller islands moving there.
- There are reports that members of the surrounding community are becoming upset by the number of handouts that people in the camps continue to receive
- The ports, communication and electricity have been restored, and Oxfam has rebuilt the sanitation infrastructure including latrines.
- Hospitals in Brew and Tarki are now fully functional. The smaller health centres continue to run but often face stock out of basic supplies, particularly since the supplies from the initial Interagency Reproductive Health Kits have run out.
- Many of the international agencies that arrived at the onset of the emergency are starting to pull out as their emergency funding runs out.
- Through the protection cluster GBV actors have set up an informal referral system sharing phone number of relevant actors- there is still some confusion though around when cases have to be reported to the police.
- Service providers have been reporting that women have really preferred the implant methods, more than expected but there is a shortage of skilled staff to meet demand. This has been made more challenging as only nurses are allowed to provide implants according to the national guidelines.
- Gammalpha has committed to the meeting the sustainable development goals and has a large programme supporting MNCH programmes

TABLE 3.6: HEALTH SYSTEM BUILDING BLOCKS

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

Table 3.6 From IAFM 2018

Participant Handout #16

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

Situation Report

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

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

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

- The camps in Beta province remain the largest displacement sites of this response. Although more than half of approximately 100,000 people have been living in these camps even before this conflict, the local populations are now restricting their access to food and other necessities. Most NGOs are focusing their efforts on Beta due to the lack of safety measures in Alpha.
- The hospitals are fully functional but they often face stock outs of basic supplies, due to disruption in the local supply chains and a shortage of in country vendors. Most of the commodities that were distributed from the initial Interagency Reproductive Health Kits have run out.
- Health service providers are reporting feeling overwhelmed by the number of the SV cases they are seeing, including types of cases they have not seen before. They were last trained 4 years ago.
- FGDs have been conducted with women to better understand the low demand for contraceptives. A common theme found was the need for permission from male partners first.
- In Beta province the emergency referral system for EMONC and CEMONC services is operating but only really in the day time, the lack of lighting and volunteers makes it difficult to operate in the evenings
- Cluster members have been feeding into the Health Information Management system but not all service points and many find there is no place for the RH data they are collecting.
- Gammalpha has committed to the Sustainable Development Goals and the 2030 Agenda for humanity- 'leave no one behind' and wants to ensure plans are in line with these agendas.

TABLE 3.6: HEALTH SYSTEM BUILDING BLOCKS

HEALTH SYSTEMS BUILDING BLOCK	WHEN PLANNING FOR COMPREHENSIVE SRH SERVICES, COLLABORATE WITH ALL STAKEHOLDERS TO
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Table 3.6 From IAFM 2018

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 #17 to each participant. Ask participants to work through Part A of Participant Handout #17, checking each statement that applies regarding their personal beliefs. Highlight that this is confidential and that there are no right or wrong answers.

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

- What were your reasons for providing or supporting access to the provision of safe abortion care?
- What people and life experiences have influenced these reasons?

Step 3

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

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

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

Step 4

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

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

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

- Please discuss what you interpret as your professional responsibilities with regard to safe abortion care.
- Please discuss what you interpret as your organisation's responsibilities with regard to

safe abortion care.
- What are some ways we can maintain our personal beliefs about abortion, while adhering to our professional responsibilities?

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

Materials:

Participant Handout #17 Parts A & B

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

Participant Handout #17

Safe Abortion Care in Humanitarian Emergencies: Values Clarification Exercise

Participant Handout #17 Part A

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

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

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

- ☐ All women should have access to safe abortion care.
- ☐ Many women seeking safe abortion care are not able to receive it.
- ☐ Refugees and displaced women have a disproportionate need for safe abortion care.
- ☐ I am committed to preventing women's deaths and disabilities due to unsafe abortion.
- ☐ My agency has a medical responsibility to provide safe abortion care.

Participant Handout #17 Part B

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

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

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

- ☐ My agency's staff have a responsibility to provide information to pregnant women about their pregnancy options, including abortion.
- ☐ My agency's staff have a responsibility to provide safe abortion care or support the provision of safe abortion care in a discreet manner.
- ☐ My agency's staff have a responsibility to refer women who request abortion to appropriate safe abortion care.
- ☐ My agency's staff have a responsibility to provide safe abortion care or support provision of safe abortion care to women who meet legal indications in that country.
- ☐ My agency's staff have a responsibility to provide safe abortion care or support the provision of safe abortion care to any woman who requests it.
- ☐ My agency's staff have a responsibility to be leaders in providing safe abortion care to refugees and displaced people.
- ☐ My agency's staff have no responsibilities to women with regard to safe abortion care.

Final small group discussion questions:

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

Participant Handout #18 Instructions

Adolescent SRH in Humanitarian Emergencies: Identifying Good Practice

This activity will allow participants to apply the Adolescent-Friendly Checklist to a case study of family planning for adolescents (based on a protracted setting). Alternatively feel free to use a case study from your context or an acute setting.

Time

20 minutes

Process

Part 1

Provide participants with a copy of Participant Handout #18 and allow them time to read through with their group, identifying aspects of good practice for providing SRH services to adolescents in emergencies. Participants may use the copy of the Adolescent-Friendly Checklist also included in Participant Handout #18 to check off any positive characteristics described in the case study.

After people have shared their comments facilitate a brief discussion on what they think would be particular challenges or approaches that could be used in their context to deliver quality adolescent services.

Materials

Participant Handout #18

Participant Handout #18

Adolescent Sexual and Reproductive Health in Emergencies: Identifying Good Practice

Case Study: Taken from: *Adolescent Sexual & Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services* available at: https://www.unfpa.org/sites/default/files/resource-pdf/AAASRH_good_practice_documentation_English_FINAL.pdf

Family Planning Services - Raise Project Colombia

Location Pacific Coast, Colombia

Type of program Mobile outreach and youth-led peer education

Target age group 10-24 years

Setting Semi-rural, Pacific Coast Region

Crisis Four decades of armed conflict and human rights abuses by armed groups have caused massive internal displacement within Colombia. With an estimated 2-5 million people internally displaced within Colombia, the country currently hosts one of the largest IDP populations globally.

Program Background In Colombia, Profamilia has worked for over 25 years to deliver comprehensive SRH services for all persons, and specifically youth. Programs directed towards IDPs within Colombia started in 1995 with the national government's creation of the National Program for Comprehensive Attention to the Population Displaced by Violence. In the late 1990s Profamilia, with support from the Reproductive Health Response in Crises (RHRC) Consortium (then Reproductive Health for Refugees Consortium), launched programs directed towards promoting SRH services among IDPs. In the early 2000s, the SRH program began targeting IDP adolescents and youth. Profamilia pooled knowledge of best practices from its 22 years of experience working with this age group to develop a health outreach and youth-led peer education model for this crisis-affected region.

Program model Profamilia's program delivered youth-friendly SRH care and education to crisis-affected adolescents through clinics, mobile health brigades and community education. Clinics: Six health clinics located within the coastal region most affected by conflict and displacement, were supported to provide comprehensive SRH services: Buenaventura, Cali (including Aguablanca), Pasto, Quibdo, Popayan and Tumaco. Services included, but were not limited to, family planning, STI counseling and treatment, deliveries and antenatal care. Appointments were not necessary to receive care, and, when possible, transportation was arranged to bring patients to and from the clinic for procedures. Transportation was provided through Profamilia's services or community networks and support systems developed by Profamilia.

Mobile health brigade Each clinic deployed no more than one mobile health brigade that could deliver the full range of SRH services to all Colombians. The outreach worker, who was hired and trained by Profamilia from within the communities reached by the brigades, first identified the needs of the community and then coordinated with the Profamilia clinic to deliver these services. The outreach worker collaborated with the community to identify available space for the health personnel to use: ideally a church, school or health facility. The mobile health brigade consisted of one doctor, one nurse and one outreach worker. They traveled to the communities by public transportation, transportation provided by the community they were going to or by renting transportation. The brigades also carried with them all materials necessary, including surgical equipment needed to perform operations when a surgical unit is donated.

Community education Youth educators provided education and sensitization on ASRH to their peers. Profamilia recruited youth who were already living in the communities they wanted to serve. Parents and youth were informed of the training content and requirements for peer educators. Adolescents and youth between the ages of 13 and 25 who were perceived to have leadership skills were recruited from schools and other community settings. They attended a 120-hour training, which was broken into three hour training sessions a day over the course of two months. Trainings included content on SRH; development of presentation and facilitation skills through theater and recreational activities; and follow-up training and supervision. Adolescents actively participated in the development of educational and training materials. After completing their training requirement, peer educators identified opportunities for outreach and education within their communities. Profamilia provided adolescents with their own set of educational materials which included a packet of informational brochures covering a broad range of ASRH topics. While no formal compensation was provided, peer educators received organizational T-shirts and hats.

Program hours Clinics were open daily from 8:00 to 19:00 in order ensure after-school hours. Mobile clinics and community outreach had no set hours or schedules, as outreach was determined by community needs and interest.

Monitoring and evaluation National standards and Profamilia's institutional protocols were applied to the clinics, mobile units and community outreach. Baseline data was collected at the start of the program and each clinic had established committees that handled monthly evaluations and feedback. Yearly evaluation surveys were administered by the national office in Bogota.

Challenges faced and solutions developed

Retention of peer educators School, work and family commitments prohibited some peer educators from continuing to participate in the peer education program.

- Peer educator trainings were reduced from four hours a day to three hours a day to better accommodate youth attention spans and their daily responsibilities. A flexible outreach schedule allowed peer educators to balance their educational activities with work, school and home life. There was no weekly or monthly requirement of hours for peer educators to complete, allowing peer educators to identify opportunities and schedule events based on the needs of their communities. Peer educators led educational activities by themselves or with others depending on the needs of the community and

mobility of the peer educators.

Adult objection to ASRH Adults feared that introducing SRH knowledge would cause adolescents to initiate sexual relationships at a younger age.

- Profamilia established ties with community leaders and schools to educate adults on the importance of family planning education for adolescents. Adults recognized the need for these services in their communities and showed little resistance to the actual implementation of program activities.

Unpredictability of working in active conflict zones Medical providers and outreach staff encountered problems reaching their target population, following up with patients and following through with their planned outreach activities due to insecurity.

- Neutral zones, such as schools and community centers, were identified to provide security for adolescents traveling between conflict zones.
- A number of communication strategies (peer education, word of mouth, liaisons with community leaders, radio announcements and brochures) were used to ensure that the maximum number of people was informed of their rights.
- Staff understood the importance of and implemented new outreach plans when met with obstacles such as finding a new population to reach or providing services that do not require the use of electricity.
- Program teams said that they placed a high value on flexibility when recruiting new staff, stating that "you have to have the capacity and capability to adapt while implementing." This was especially important for doctors who were brought on to join the program. Rather than focusing on the situation being stable, they ensured that their teams were comfortable with the lack of predictability when implementing.
- The creation of personal ties within the community enabled an informal follow-up process to occur between Profamilia and the clients they served.

Lack of medical personnel Regions affected by conflict frequently struggle with human resource challenges. In the Pacific Coast region, clinics did not always have adequate medical staff to sufficiently staff the mobile units.

- Because Profamilia is such a large health service organization, it has been able to leverage staff from its other sites nearby to support clinics and mobile units.
- Profamilia provided referrals to other community health centers that had the specialized services sought by community members.
- Established transportation ties also facilitated client transport to and from the main Profamilia health clinic in the event that medical personnel were unable to travel to the community.

Vast distances require budget considerations Significant budgetary commitments may be needed if a project aims to provide transportation to clients and outreach workers in an attempt to improve access.

- Working with communities and creating linkages with partners help create local transportation options for clients to travel to and from health clinics.
- Profamilia was careful to allow for and prioritize the costs of this activity. However, it recognizes that this may not be a possibility for many programs.

Staff training and sensitivity Profamilia invested heavily in staff recruitment and staff sensitivity training, as well as comprehensive initial and annual update trainings to peer educators. This investment was believed to be an important factor contributing to quality, staff adaptability and community sensitivities.

Confidentiality Clinics and mobile units were marketed as providing general family medicine to reduce anxiety and stigma for youth wanting to receive services from Profamilia. Youth, regardless of age, did not need parental consent for family planning services.

Community trust With 25- plus years working in the field, Profamilia has created a name that people trust and respect. It hires outreach workers and trains peer educators from within the communities they wish to serve, which further reinforces their commitment to representing and serving community members. Limited paperwork and autonomy of youth to consent to services reduced barriers to health care access and allowed clients to easily reach the services they wish to receive.

Adolescent-centered approach Adolescents are not just beneficiaries of the program; they contributed to the design and implementation. Adolescents were consulted during the peer education training about what lessons and approaches to teaching appear most useful and sensitive for their peers. Additionally, the varying needs of adolescents, by age group and other sub-populations were acknowledged and specific attempts were made to address their differing needs.

****Data collection activities** A total of seven in-depth interviews were conducted with program staff in Cali and Aguablanca (the national director, four program staff and two clients). Two focus groups were conducted: one with the peer educators and another with clients who received services. Interviews were conducted by an outside consultant who also provided direct observations from the program. Interviews and FGDs took place between August 19 and September 25, 2012.

Participant Handout #18

ASRH Health Facility Checklist

Characteristics	Yes	No	Feasible suggestions for improvement and/or comments
Health Facility Characteristics			
1. Is the facility accessible and located within walking distance proximity of a place where adolescents–both female and male–congregate? (youth center, adolescent-friendly space, school, market, etc.) *Note: Define accessibility and proximity with your local team before using the checklist and agree on what is appropriate for the context. For example consider insecurity or infrastructure issues that might affect access.*			
2. Is the facility open during hours that are convenient for adolescents– both female and male (particularly in the evenings or on the weekend)? *Note: If only males or only females are congregating, mark "no."* *Please verify hours of school for adolescents and facility hours*			
3. Are there specific clinic times or spaces set aside for adolescents and are drop in clients welcomed (without appointments)? *Note: If only males or only females are able to access, mark "no."*			
4. Are SRH services offered for free to adolescents?			
5. Are waiting times short (less than one hour)?			
6. If both adults and adolescents are treated in the facility, is there a separate, discreet space for adolescents to ensure privacy?			
7. Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
8. Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback, or other accountability mechanisms about SRH services at the facility?			

9. Is there a Health Management Information System that includes age-disaggregated data, as outlined in international adolescent group standards (e.g. data broken out by different age groups: 10-14, 15-16, and 17-19 years old)? *Note: Ask for the monthly health facility reports submitted to the MoH/NGO or other entity that operates the facility.*			
10. A. Is the staff collecting data on people living with disabilities? *Note: this can be done using the Washington Group Questions (www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/).* B. Is the clinic accessible for those with disabilities (e.g. have a wheelchair ramp)? *Note: A person with disability is defined as a person who has a physical or mental impairment that substantially limits one or more major life activity. For example, does the facility have ramps or other aids to ensure mobility for disabled people, including adolescents within the facility services?*			
11. Do the SRH services enable young men to access services? *For example, are SRH services available outside of the maternity ward?*			
12. Are male condoms available to both young men and young women, including in discreet locations, such as bathrooms? *Note: Select no if male condoms are only available to boys or only available to girls. Or if male condoms are only available from providers directly.*			
At minimum: Answer "yes" to questions 4, 7, 8, 9, and 12.			
Provider Characteristics			
1. In the last year, have all service providers been trained on how to provide SRH services to adolescents, which includes non-judgmental attitudes, empathic language, active listening, and age-appropriate counseling?			

2. In the last year, have all staff members (receptionist, security guards, community health workers, cleaners, etc.) been oriented to providing confidential, adolescent-friendly services?			
3. Based on your observations during this visit, do staff members demonstrate respect for adolescents and their choices?			
4. Based on your observations during this visit, do the providers ensure the clients' privacy? (if yes, state how they ensure privacy in the comments section)			
5. Based on your observations during this visit, do the providers ensure the clients' confidentiality?			
6. Do the providers set aside sufficient time for client-provider interaction, including ensuring all of the client's questions are fully answered?			
7. Are there both male and female providers available to provide SRH services at this facility?			
8. In the last year, have health providers been assessed using quality standard checklists?			
At minimum: Answer "yes" to questions 3 and 7.			
Program Characteristics			
1. Do adolescent representatives join monthly HF staff meetings, if they exist?			
2. Are community mobilization activities on ASRH linked to the health facilities (CHWs, youth volunteers, etc.)?			
3. Are adolescents involved in quality improvement or supervision activities?			
4. Are adolescents involved the design or implementation of feedback mechanisms? *For example, do adolescents help with collecting or reporting complaint feedback for the facility?*			
5. Can adolescents be seen for all SRH services in the facility without the consent of their parents or spouses? *Note: These services include all forms of contraception, post-abortion care, STI/HIV screening and treatment, MCH services, and SGBV.*			

6. Is there written guidance visible at the health facility that adolescents do not require parental[KS11] consent to receive SRH services?			
7. Does the facility have the commodities for at least three contraceptive methods (including one long-acting method)? *For example, are SRH commodities, including family planning methods, available at education centers, safe spaces, bathrooms, and other places youth congregate?*			
8. Are modern contraceptive methods and counseling offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in comments section. *Note: modern contraceptive methods include condoms, emergency contraception, pills, injectables, implants, and IUDs.*			
9. Are STI treatment and prevention services offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in comments section.			
10. Are HIV counseling and testing services offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in comments section.			
11. Are ante- and post-natal care services offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in comments section.			
12. Are maternal delivery care services offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in comments section.			
13. Are post-abortion care services offered to adolescents at this facility? If yes, please provide how many adolescent clients have received services in the last 3 months in the comments section.			
14. Are there written guidelines for providing adolescent-specific health services in the facility?			

15. Are there SRH educational materials, posters, or other job aids/information education communication materials tailored to an adolescent audience? How are these distributed? *For example, are adolescents featured in the posters or flipbooks used for health education?*			
16. Are there functional referral mechanisms in place between health and child protection services, including MHPSS for GBV cases? *For example, does the facility use referral cards specifically for adolescents?*			
17. Are there functional referral mechanisms in place between health services and education?			
18. Are there functional referral mechanisms in place between health and nutrition services?			
19. Are there functional referral mechanisms in place between health and MHPSS services?			
20. Are there functional referral mechanisms in place between health and LGBTIQ+ organizations?			
21. Are there functional referral mechanisms in place between health and PLWD organizations?			
At minimum: ■ Program should include adolescents in at least one component of the program cycle (design, implementation, evaluation): relates to questions 1, 2, 3, 4 (at minimum should have answered "yes" to one of the four questions). ■ Answer "yes" to questions 7, 8, 9, 12, 13, 15, and 16.			

Source: Adapted from African Youth Alliance/Pathfinder International

Logistics Exercise: Group Work

There are two exercises in this Group Work. Depending on available time and group size, facilitators can select one part or split the group into two, and do the activities simultaneously.

Part 1

The first part of the logistics exercise will allow participants to strategise on overcoming challenges in supply chain management in humanitarian settings. It relies on the experience of participants and their previous involvement in providing services in humanitarian contexts. The experience level of participants should be considered when deciding whether to conduct this part of the logistics exercise.

Time

30 minutes

Process

- Divide the group into 3 (or multiples of 3, depending on the size of the group). Assign each group one of the three major steps in supply chain management, reminding them that for every major step in the supply chain, there are three sub-steps:

  Group 1: Getting the product: forecasting; sourcing; and procurement;

  Group 2: Transporting the product: entry into country; storage, warehousing and transport; and last mile distribution;

  Group 3: Monitoring the product: inventory management systems; data collection and health information systems; and assessment and accountability.
- Ask the groups to use their experience/ strategise based on their knowledge, to explain how they may overcome challenges for each sub-step during the preparedness, acute response, and transition to comprehensive SRH phases.
- Ask participants to write their responses on flipcharts.
- At the close of 20 minutes, ask participants to present their results and elicit questions and comments from the group.

Materials

Flip charts and markers for each group.

Part 2

The second part of the logistics exercise is a way for participants to apply the key principles of logistics discussed during this session.

Time

60 minutes

Process

Divide participants into groups of 5 to 8 people.

Distribute copies of Participant Handout #19 and ask participants to refer once again to the case study introduced on day 1 of the training (Participant Handout #1).

Explain the exercise (instructions are on the handout), stressing that each group needs to present their work on flip charts at the end of the exercise.

Let the groups start the exercise on their own.

Facilitate the group work and by gentle probing and constructive feedback, ensure that the groups keep to the allocated time as to address all the questions required.

After 40 minutes of group work, take 20 minutes for presentation. Each group will take turn to present their work and receive your feedback (in total, 5-10 minutes per group depending on the number of groups).

Materials

Participant Handout #19

Flip charts and markers for each group

Case study introduced on Day 1 of the training (Participant Handout #1).

The following answers will help you to facilitate and provide guidance during and after Part 2 of the logistics exercise.

1. Which assessments need to be made?

None, except an estimate of the number of affected population and an assessment of the location of health care facilities and staff.

2. Which priority RH interventions will you put in place immediately?

The components of the MISP

3. Which Kits will you order and how many?

The handout 'RH Indicators for___' is aimed to confuse participants.

Clue: there is no need for calculating Kits based on these DHS indicators, but they can be used to compare the affected population with the "standard" population assumptions used to calculate the supplies in the Kits. They also give an indication of what not to order (low use of IUDs, and no exposure to female condoms).

The RH Kits are already pre-calculated based on population assumptions. These assumptions can be found on the last page of the Inter-Agency RH Kits Manual.

4. How much will this cost?

Use the UNFPA revised price list to make the calculations.

5. Calculate your storage requirement (in cubic meter)

Note: 1 extra cubic meter is needed for staff to move around the Kits. Kits should not be stacked more than 2 meters high.

Inform participants that the following resources for calculating RH kit needs are also available:

1. MISP Calculator: A spreadsheet which calculates the reproductive health statistics necessary for the implementation of the MISP (Minimum Initial Service Package).

2. RH Kits Calculator: A spreadsheet which calculates dimensions of the reproductive health kits required according to site-specific data.

Both of these resources are available at:

http://www.iawg.net/resources/calculator.html

For more information on the RH kits and to keep up to date with changes to guidance and kit contents, the coordination team should consult:

http://www.iawg.net/resources/rhkits.html

Participant Handout #19

Logistics exercise

Your Job This morning in the inter-agency emergency coordination meeting you were given the briefing contained in your Case Study (Participant Handout #1) and you were asked to take on SRH coordination. You are now holding a meeting with health NGOs to discuss putting in place the most essential sexual and reproductive health interventions for affected populations. Use the information provided in your case study and the price list below to plan and coordinate your response.

Discuss next steps

1. Which assessments need to be made?

2. Which priority SRH interventions will you put in place immediately?

3. Which Kits will you order and how many, assuming the influx of refugees stops after one month?

4. How much will this cost?

5. Calculate your storage requirement (in cubic meters)

6. Make a distribution plan:

   What (Kit) goes **Where** (which place), for **Whom** (implementing partners) and **How** (what form of transport)? (Make a table)

7. Drawing a map may be helpful. Brainstorm and write down your conclusions on a flipchart.

UNFPA

REVISED PRICE LIST RH KITS

Revised: 18 January, 2008

NAME	KIT NOs.	Unit Price US$	Remarks
Administration and Training Kit	Kit No.0	160	
Male Condom Kit	Kit No.1A	405	
Female Condom Kit	Kit No.1B	545	
Clean Delivery Kit - Individual	Kit No.2A	450	
Clean Delivery Kit - for Birth Attendants	Kit No.2B	110	
Rape Treatment Kit	Kit No.3A	90	
Post Exposure Prophylaxis for HIV, incl Treatment for Children Kit	Kit No. 3B	880	PEP for HIV for treatment of 30 adults and 8 children
Oral and Injectable Contraception Kit	Kit No.4	540	
STD Drug Kit	Kit No.5	400	
Clinical Delivery Assistance Kit	Kit No.6	900	
Intra Uterine Device Kit	Kit No.7	250	
Mgt.of Complication of Miscarriage Kit	Kit No.8	895	
Suture of Cervical and Vaginal Tears Kit	Kit No.9	380	
Vacuum Extraction Kit	Kit No.10	145	
Referral Level Kit A - Reusable Equipment	Kit No.11A	250	
Referral Level Kit B - Drugs & Disposable equipment	Kit No.11B	3,690	
Blood Transfusion Kit	Kit No. 12	1,350	
Freight Charges			
Subtotal in US $			
5% HANDLING COST			
Grand total			

David Smith
Chief Procurement Services Branch

Orders placed after January 18, 2008 will be quoted on the prices listed here.

Mapping & Planning

This activity will allow participants to consolidate their learning from the previous 4 days and discuss concrete steps to take their work as program managers for sexual and reproductive health in emergencies forward.

Time

1 hour to 90 minutes

Process

- Provide participants with Participant Handout #20 and briefly go through the contents of the template. Ask participants if they have any questions.
- Depending on the audience, you may want to break participants into small groups.
- Give participants a good amount of time to work together to complete the mapping and discuss which actions they would like to prioritise.
- Explain to the group that the mapping is an opportunity to identify what exists in their current system to help prepare for MISP implementation and identify what gaps remain. Emphasise that without preparedness MISP implementation at the time of response can be very difficult.
- Participants should be encouraged to think about how they can work together to follow up on the gaps identified.
- Let participants know they will have a chance to share some key actions and priorities at the end of the activity.
- For ideas on preparedness activities refer participants to the list of suggested activities at end of template
- Circulate around the room to ensure that the mapping and planning is progressing, to answer any further questions, and to encourage participants to think about practical, concrete steps they can take.

Materials

Participant Handout #20 (electronically)

Mapping & Planning*

	Current status	Gaps	Activities to address gaps	Focal Point	Challenges & Strategies	Resources Required
Objective 1: **Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP** -SRH Coordinator nominated -Regular meetings -Reporting mechanisms -Mapping & analysis of SRH services -Information sharing -Community awareness						
Objective 2: **Prevent sexual violence & respond to the needs of survivors** -Preventive measures -Clinical care & referral for survivors -Confidential & safe spaces						

Objective 3: **Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs** -Safe & rational blood transfusion -Standard precautions -Condoms available -ARVs for continuing users -PEP -Co-trimoxazole -Syndromic diagnosis & treatment of STIs						
Objective 4: **Prevent excess maternal & newborn morbidity & mortality** -Availability & accessibility of EmONC -Community awareness -Clean delivery kits -24/7 referral system -Post-abortion care -Supplies & commodities						

Objective 5: **Prevent unintended pregnancies** -Range of contraceptive methods available -IEC materials -Community awareness						
Objective 6: **Plan for comprehensive SRH services integrated into primary care as soon as possible** -Plan for comprehensive SRH services -Address 6 health system building blocks						
Other SRH Priority Activity: **Safe abortion care to the full extent of the law, in health centres and hospital facilities**						

*See MISP for SRH Cheat Sheet and IAFM 2018 for the full list of activities

Participant Handout #20

Mapping & Planning: Suggested Preparedness Activities

Preparedness activities can include (not exhaustive- adapt for context):

Coordination

- Integrate humanitarian topics into existing SRH technical working groups, or if need establish an SRH WG to support preparedness and response activities
- SRH actors to undertake active engagement in humanitarian coordination mechanisms
- Support integration of MISP and SRH components into humanitarian Disaster Management plans and guidance, including health and protection specific plans
- Conduct joint advocacy with other SRH actors to sensitise relevant government/ humanitarian actors on importance of SRH services in crises.
- Coordinate with Community Based Organistions (CBOs) working with marginalised groups such as women and girls, person living with disabilities, youth groups or LGBTIQA+ to identify opportunities in capacity development for preparedness and response activities
- Coordinate with private sector and business industry to identify opportunities for response support e.g. commodities, transportation etc
- Collaborate with existing midwife nurse/nursing/medical school to support humanitarian response capacity building needs

Service Delivery

- Maintain up to date list of SRH providers
- Establish a training and capacity development plan to support health providers deliver MISP services e.g. conduct refresher courses
- Review policies on task shifting to meet emergency needs
- Assess availability of SRH supplies and equipment (can use IARH kit list as a guide)- ensure supplies are included on approved essential medicines list
- Strengthen supply chains including identification of storage, prepositioning and last mile delivery points and actors
- Adapt/translate existing IEC materials on MISP objectives for different levels of literacy/ ability
- Develop/Review referral pathways for the various MISP Objectives- ensure linkages between communities and facilities
- Ensure staff are aware and trained on referral systems
- Review/Adapt SRH policies/guidelines for emergency contexts
- Review Health Information Systems for inclusion of key SADD and SRH data
- Identify funding opportunities to support SRH preparedness and response activities

General-Institutional

- Establish Contingency funds for response
- Adapt institutional policies for emergency response (e.g. finance, procurement and HR)
- Develop emergency preparedness and response plans that integrate SRH
- Establish emergency response teams/integrate SRH focal points into emergency teams
- Conduct action review of response to strengthen preparedness activities

Pre- and Post-Test

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

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

1. The MISP for SRH objectives and other priority activities include:

    a. Prevent sexual violence and respond to survivors
    b. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
    c. Prevent excess maternal and newborn morbidity and mortality
    d. Prevent unintended pregnancy and ensure safe abortion care is available, to the full extent of the law.
    e. All of the above

2. The SRH Coordinators role is to:

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

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

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

4. If you suspect that a staff member is violating the protection against Sexual Exploitation and Abuse (SEA) Core Principles, what should you do?

    a. Investigate to see if the staff member is in violation
    b. Speak to the staff member and tell him/her to stop
    c. Report the staff member to your supervisor or protection against SEA Focal Point

5. Condoms can be made available at:

    a. Health facilities
    b. Food and non-food distribution points
    c. Latrines
    d. Popular bars or coffee shops in urban areas
    e. All of the above

6. Which are the minimum requirements for infection control?

   a. Safe handling of sharp objects
   b. Wearing protective clothing
   c. Disposal of waste material
   d. Frequent hand washing
   e. All of the above

7. Where should BEmONC and/or CEmONC services be made accessible?

   a. In referral hospitals
   b. In health centers
   c. At the community level
   d. a and b

8. Who should be involved in the program planning and implementation of MISP for SRH services and CSRH services?

   a. LGBTQIA groups
   b. Persons with disabilities
   c. Adolescents
   d. Community Leaders
   e. SRH Coordinators

9. What 3 things should be emphasized to ensure quality of care when providing contraception?

   a. Confidentiality
   b. Privacy
   c. Informed Choice
   d. Approval from family members/partner

10. An effective referral system should have transport options available only during clinic operational hours

    a. True
    b. False

11. Which are core components/building blocks of the health system?

    a. Health Information System
    b. Health Workforce
    c. Advocacy
    d. Service Delivery
    e. Community awareness
    f. a, b and d
    g. All of the above

12. What can be done to facilitate access to SAC to the full extent of the law?

a. Provide SAC through health facilities staffed by willing providers
b. Offer technical support and resources to qualified medical personnel already providing abortion services
c. Distribute information and commodities for safe medication abortion
d. Identify and refer to providers and organizations that have capacity
e. All of the above

13. Adolescents have the right to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice

True

False

14. It is 2 weeks after a natural disaster, the health coordination meetings have been established, however the SRH coordination meetings have not started, what should you do?

a. Wait a little longer, once the health activities are established, the health cluster/sector will focus on SRH
b. Advocate to the health cluster for immediate initiation of separate SRH meetings
c. Attend the nutrition coordination meetings
d. Both A and C

15. Your organization is having logistical challenges and significant delays receiving supplies into the country. Given this reality, what can you do to address this situation?

a. Contact UNPFA and/or the logistics cluster to see if they can support you.
b. Follow procurement process to obtain medications and supplies locally
c. Discuss during the SRH and Health cluster/sector coordination meeting.
d. All of the above

ANSWER KEY: Pre- and Post-Test

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

1. The MISP for SRH objectives and other priority activities include:

    a. Prevent sexual violence and respond to survivors
    b. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
    c. Prevent excess maternal and newborn morbidity and mortality
    d. Prevent unintended pregnancy and ensure safe abortion care is available, to the full extent of the law.
    e. **All of the above**

Why is this correct: The MISP for SRH objectives and other priority activities include: prevent sexual violence and respond to survivors, prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs, prevent excess maternal and newborn morbidity and mortality; and prevent unintended pregnancy and ensure safe abortion care is available, to the full extent of the law. Hence E is the correct answer.

2. The SRH Coordinators role is to:

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

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

3. If a survivor does not feel comfortable with an examination and refuses to have one, the health provider should explain that treatment and medication can only be provided after an exam

    True

    False

Why is this correct: In the answers: A survivor's rights, needs and wishes should be prioritized and respected. Treatment and medication can be provided without an exam. Hence, the answer is false.

4. If you suspect that a staff member is violating the protection against Sexual Exploitation and Abuse Core Principles (SEA), what should you do?

    a. Investigate to see if the staff member is in violation
    b. Speak to the staff member and tell him/her to stop

c. **Report the staff member to your supervisor or protection against SEA Focal Point**

Why is this correct: If you suspect that a staff member is violating the protection against SEA Core Principles, you should report the staff member to your supervisor or protection against SEA Focal Point. Hence, C is the correct answer.

5. Condoms can be made available at:

   a. Health facilities
   b. Food and non-food distribution points
   c. Latrines
   d. Popular bars or coffee shops in urban areas
   e. **All of the above**

Why is this correct: Condoms can be made available at: health facilities, food and non-food distribution points, latrines and popular bars or coffee shops in urban areas. Hence, E is the correct answer.

6. Which are the minimum requirements for infection control?

   a. Safe handling of sharp objects
   b. Wearing protective clothing
   c. Disposal of waste material
   d. Frequent hand washing
   e. **All of the above**

Why is this correct: Safe handling of sharp objects, wearing protective clothing, disposal of waste material and frequent hand washing are all minimum requirements for infection control. Hence, E is the correct answer.

7. Where should BEmONC and/or CEmONC services be made accessible?

   a. In referral hospitals
   b. In health centers
   c. At the community level
   d. a and b

Why is this correct: BEmONC services should be accessible at the health facility level, and CEmONC services should be accessible at the referral hospital level. Therefore D is the correct answer.

8. Who should be involved in the program planning and implementation of MISP for SRH services and CSRH services? (Choose all that are correct)

   a. **LGBTQIA groups**
   b. **Persons with disabilities**
   c. **Adolescents**
   d. **Community Leaders**
   e. **SRH Coordinators**

Why is this correct: LGBTQIA groups, PWD, Adolescents, Community leaders and the SRH Coordinator should all be involved in the program planning and implementation of MISP for SRH services and CSRH services. Hence the correct answers are A, B, C, D, and E.

9. What three things should be emphasized to ensure quality of care when providing contraception?

   a. **Confidentiality**
   b. **Privacy**
   c. **Informed Choice**
   d. Approval from family members/partner

Why is this correct: Confidentiality, privacy and informed choice should be emphasized to ensure quality of care when providing contraception. Hence, A, B, and C are the correct answers.

10. An effective referral system should have transport options available only during clinic operational hours

    a. True
    b. False

Why is this correct: Referral systems should function 24/7

11. Which are core components/building blocks of the health system?

    a. Health Information System
    b. Health Workforce
    c. Advocacy
    d. Service Delivery
    e. Community awareness
    f. **a, b and d**
    g. All of the above

Why is this correct: Health information system, health workforce, service delivery, medical commodities, finance and governance and leadership are the six WHO health system building blocks. Hence F is the correct answer.

12. What can be done to facilitate access to SAC to the full extent of the law?

    a. Provide SAC through health facilities staffed by willing providers
    b. Offer technical support and resources to qualified medical personnel already providing abortion services
    c. Distribute information and commodities for safe medication abortion
    d. Identify and refer to providers and organizations that have capacity
    e. **All of the above**

Why is this correct: Providing SAC through health facilities staffed by willing providers, offering technical support and resources to qualified medical personnel already providing abortion services, distributing information and commodities for safe medication abortion and identifying and referring women to providers and organizations that have capacity are ways to facilitate SAC, to the full extent of the law. Hence E is the correct answer.

13. Adolescents have the right to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice

    True

    False

Why is this correct: Adolescents have the right to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice.

14. It is two weeks after a natural disaster, the health coordination meetings have been established, however the SRH coordination meetings have not started, what should you do?

    a. Wait a little longer, once the health activities are established, the health cluster/sector will focus on SRH
    b. **Advocate to the health cluster for immediate initiation of separate SRH meetings**
    c. Attend the GBV coordination meetings to get more information on sexual violence
    d. Both A and C

Why is this correct: From the beginning of the response in each humanitarian setting, the health sector or cluster must identify a lead SRH organization. If SRH coordination meetings have not started, organizations should advocate to the health cluster for immediate initiation of separate SRH meetings.. Hence B is the correct answer.

15. Your organization is having logistical challenges and significant delays receiving supplies into the country. Given this reality, what can you do to address this situation?

    a. Contact UNPFA and/or the logistics cluster to see if they can support you.
    b. Follow procurement process to obtain medications and supplies locally
    c. Discuss during the SRH and Health cluster/sector coordination meeting.
    d. **All of the above**

Why is this correct: If your organization is having logistical challenges and/or significant delays receiving supplies into the country, you can contact UNPFA and/or the logistics cluster to see if they can support you, follow your procurement process to obtain medications and supplies locally and discuss the issue during the SRH and Health cluster/sector coordination meeting. Hence D is the correct answer.

Evaluation

Participant Feedback Form

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

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

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

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

Evaluation

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

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

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

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

a. Confident to support MISP implementation

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

c. Not comfortable at all to support MISP implementation

d. Other (please describe)_____

Evaluation

Any other comments?

Evaluation

Logistics

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

Evaluation

Staying in touch

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

1 2 3 4 5 6 7 8 9 10

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

email ◯ Facebook Messenger ◯ Google Hangout ◯

GroupMe ◯ iMessage ◯ Slack ◯

Viber ◯ WeChat ◯ WhatsApp ◯

Other please list:

_____

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

a. Yes ◯ b. No ◯

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

_____

_____

_____

_____

_____

Thank you!

Learner Profile Template

This form should be sent to participants before the training. It can help with selection and to better adapt training for participant backgrounds and expectations.

Participant Information Form

Minimum Initial Service Package (MISP) for Reproductive Health in Crises: A Course for SRH Program Managers

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

Learner Profile Template

1. What expectations do you have of the training?

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

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

4. Special requirements or learning considerations?

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

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