India: Be Prepared

Focussing on women and children during natural disasters

Prepare To Save Lives!

Minimum Initial Service Package for Sexual and Reproductive Health in Disasters

A Course for SRH Coordinators

FACILITATOR'S MANUAL

UNFPA

Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Disasters:
A Course for SRH Coordinators: Facilitator's Manual

The MISP Manual has been formulated jointly by the National Disaster Management Authority (NDMA) and the United Nations Population Fund (UNFPA) in consultation with various stakeholders, academic experts and specialists in the concerned subject and officials from the Ministries and Department of Government of India and State Governments.

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UNFPA, the United Nations Population Fund, is an international development agency committed to delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

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Minimum Initial Service Package (MISP)

The MISP Initiative

In recent years, the global community has made great strides in developing standards for addressing the needs of populations in humanitarian settings. Many of these standards and recent guidelines such as the Sphere Humanitarian Charter and Minimum Standards in Humanitarian Response incorporate Sexual and Reproductive Health (SRH). While there is progress in the global mandate, not much progress has been made in fully implementing SRH services in the countries during humanitarian situations.

In response to the increased vulnerability of populations affected by disasters, the international community designed a package of priority SRH activities to be put in place during a disaster: Minimum Initial Service Package (MISP).

The MISP for Reproductive Health is a set of priority activities to be implemented at the beginning of the humanitarian response. MISP consists of life saving interventions and is designed to reduce morbidity and mortality, particularly among women and girls.

Although the name might imply that MISP is a package of supplies or commodities, it is actually a **strategy,** that includes **coordination, SRH services** (of which reproductive health commodities are an essential part) and **planning**.

The acronym “MISP” means:

Minimum: Basic, limited SRH services

Initial: for use in a disaster, without site specific in-depth SRH needs assessment

Services: Reproductive health care for population

Package: Coordination and planning, supplies and activities

Need for MISP – Minimum Initial Service Package

MISP for SRH saves lives, if implemented at the onset of a disaster. Neglecting Sexual and Reproductive health in disasters has serious consequences:

- Preventable maternal and infant deaths
- Unwanted pregnancies and subsequent unsafe abortions
- Spread of sexually transmitted infections including Human Immunodefeciency Virus (HIV)/Acquired Immune Defeciency Syndrome (AIDS)

MISP for Sexual and Reproductive Health is a coordinated set of priority activities designed to:

- Prevent and manage consequences for sexual violence
- Prevent excess neo-natal and maternal morbidity and mortality, including FP and safe abortion
- Address the needs of adolescents
- Reduce HIV transmission
- Plan for comprehensive SRH services in the early days and weeks of a disaster

MISP also includes a kit of equipment and supplies to complement a set of priority activities that must be implemented in the early days and weeks of a disaster in a coordinated manner by trained staff. Thus, it is a cluster of Reproductive Health services to meet the **minimum requirements** in a disaster situation with the expectation that comprehensive services will be provided as soon as the situation permits. MISP can be implemented **without a "Needs Assessment",** since documented evidence already justifies its use.

MISP was developed by Inter-Agency Working Group (IAWG) on Reproductive Health and countries are expected to include MISP as an integral component of their Preparedness Plans.

UNFPA globally has been collaborating with partners since 2007 on integrating Reproductive Health Programmes in Disasters and Post Disaster, with the goal to increase access and information on SRH to populations surviving disasters and living in post disaster situations, by enhancing capacity building on SRH coordination, advocacy and service provision efforts. Experience has shown that inter-agency coordination is crucial for advocacy to policy makers, capacity building of key institutions, policy change and service implementation.

Goal of MISP

The goal of MISP is to reduce mortality, morbidity and disability among populations affected by disasters, particularly women and girls.

Objectives of MISP

- To identify organisations and individuals to facilitate the coordination and implementation of MISP
- Prevent and manage the consequences of sexual violence by:
  - Ensuring systems are in place to protect affected population, particularly women and adolescent girls from sexual violence
  - Ensure medical services, including psycho-social support are available for survivors of sexual violence
- Reduce HIV transmission by:
  - Enforcing respect for universal precautions against HIV/AIDS
  - Guaranteeing the availability of free condoms
  - Safe blood transfusion

- Prevent excess maternal and neo-natal mortality and morbidity by:
  - Providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries
  - Providing midwife delivery kits to facilitate clean and safe deliveries at the health facility
  - Initiating the establishment of a referral system to manage obstetric emergencies
- Plan for provision of comprehensive SRH services and integrate into PHC as the situation permits by:
  - Collecting basic background information
  - Identifying sites for future delivery of comprehensive SRH services
  - Assessing staff and identifying training protocols
  - Identifying procurement channels and assessing monthly drug consumption

Scope of MISP in India

Reproductive health interventions for community affected by natural disasters require special knowledge and skills. Displaced women and young girls experience elevated risks from pregnancy, childbirth, rape and escalated spread of HIV/AIDS and other health problems. Studies have also reported adverse reproductive health outcomes following disasters, including early pregnancy loss, premature delivery, still births and delivery-related complications. Women and girls also often confront discrimination and gender based violence in the aftermath of disasters. Pregnant and lactating women may not have access to necessary health care and food supplements.

The MISP programme is significant as it would enable India to have trainers who could roll out state and district training programmes, advocate for the inclusion of SRH in state and district disaster management plans and health plans and work to integrate and implement Reproductive Health services as a standard in disaster response.

To build the technical capacity in humanitarian response, United Nations Population Fund (UNFPA) in partnership with National Disaster Management Authority (NDMA) is providing technical assistance to integrate MISP in humanitarian settings.

A mechanism of UNFPA supported training programmes will be made sustainable through Government supported training and by accrediting Government officials in facilitating the programmes. These trainings would lead to trained MISP professionals – Master Trainers, as well as, help in responding to SRH needs during disasters, in coordination with other key agencies. The Master Trainers will then carry out state and district level training.

The overall goal of the MISP Initiative can be achieved by increasing access to SRH information and services for persons affected by disaster. The MISP initiative aims to achieve its goal through achieving a set of objectives, together with its partners. This includes:

- Increasing state and district capacity to implement the MISP for SRH during disaster
- Data bank of trainers/trainings
- Strengthening coordination of SRH stakeholders and activities
- Responding in a timely and effective manner to SRH needs in disaster
- Enhancing access to comprehensive SRH information and services for affected populations
- Integrating MISP in state and district disaster management plans and health plans

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सत्यमेव जयते

Vice Chairman
National Disaster Management Authority
Government of India

Message

India's unique geo-climatic conditions make it vulnerable to a host of disasters. Each disaster in its trail leaves behind suffering, especially for women and children, some of which can be alleviated to an extent by relief and rehabilitation measures, but leave behind indelible scars in terms of the loss of precious lives.

As envisaged in the Disaster Management Act 2005, the National Disaster Management Authority (NDMA) since its inception has been prioritising the critical areas for strengthening efforts on disaster management in the country. With the paradigm shift from the erstwhile response centric approach to the holistic management of disaster, NDMA embarked upon the task of formulating guidelines and SOPs with the purpose of enhancing capacities on prevention, mitigation and preparedness.

Reproductive Health (RH) issues including Gender Based Violence (GBV) during disasters had been an area which was unfortunately not addressed adequately in the past. It thus became imperative for NDMA to formulate a Manual so as to institutionalise a standard process for enhancing the capacities of stakeholders, thereby enabling them to be able to appropriately respond to the special needs of women, children and adolescents.

I am happy to state that NDMA has evolved this MISP Manual (India version) with the strong support from UNFPA, which will be the base document for capacity building interventions in the area of Reproductive Health in Emergency Situations in India.

I am confident that the MISP Manual for Sexual and Reproductive Health in Disasters will be of enormous value to the various stakeholder groups involved in the provision of services for Reproductive Health. I look forward to the interventions suggested getting integrated into the State and District Disaster Management Plans and Health Plans.

I am pleased to place on record my deep appreciation to all those who have contributed for this pioneering work in steering the process of formulation of this Manual.

New Delhi
3rd May 2013

(M.SHASHIDHAR REDDY)

सत्यमेव जयते

Member
National Disaster Management Authority
Government of India

Message

The National Disaster Management Act in 2005 led to a paradigm shift in the Government's approach with respect to dealing with issues in disaster management from rescue, relief and recovery to Prevention, Mitigation and Preparedness (PMP).

It is now recognised that morbidity, mortality and the long term health impact of disasters can be significantly reduced by adopting PMP strategies. Recognising the gravity of risks posed by natural and man-made disasters on the reproductive health sector, National Disaster Management Authority, (NDMA), GoI launched efforts to address issues pertaining to reproductive health in crisis situations/emergencies in India.

NDMA, with technical support from UNFPA, has prepared this training Manual for MISP (Minimum Initial Service Package) to address reproductive health and gender issues in disasters. The global MISP Facilitator Manual has been adapted for use in India. The Manual is for a four day training programme to address issues related to Sexual and Reproductive Health, Sexual and Gender Based Violence, Maternal and Neo-Natal Health, Family Planning (FP), Adolescent Sexual and Reproductive Health and STIs & HIV/AIDS in crisis situations. The Manual also sheds light on the use of data in Disaster Management and on Coordination and Action Planning for RH in disasters.

MISP aims at enhancing the capacities of disaster managers to effectively prevent and respond to Reproductive Health/Sexual Health needs in humanitarian settings.

The Manual will be shared with State governments, so that MISP training is integrated in state and district training programmes on disaster preparedness.

I would like to express my sincere gratitude to Shri. Shashidhar Reddy, Hon'ble Vice Chairman, NDMA for his guidance and continuous support at all times in taking the agenda forward on addressing needs with respect to Reproductive Health in crisis situations.

We value UNFPA's technical support especially Ms. Frederika Meijer, Country Representative, UNFPA and Mr. Anders Thomsen, Deputy Country Representative, UNFPA in facilitating adaptation of the Manual for use in India as well as office bearers at NDMA Secretariat for rendering technical guidance for the roll out of the Programme.

Finally, I appreciate the contribution of the participants of the TOTs for their feedback to the contents of the Manual. MISP, implemented through the use of this Manual, would make an important contribution in strengthening our response to address RH issues in crisis situations on a more proactive basis

April 2013

Dr. Muzaffar Ahmad
Member, NDMA

Foreword

Women form the backbone of families and communities. When emergencies strike, their important contributions become even more vital. But in times of crisis, the particular strengths and vulnerabilities of women are often overlooked. This Disaster Management Manual would ensure that women's reproductive health needs are met, that gender based violence is prevented, and young people have access to reproductive health services to safeguard against reproductive health infections such as HIV, prevent unplanned pregnancies and unsafe abortion.

To achieve these aims, UNFPA has lent technical expertise to NDMA to respond to reproductive health challenges in the wake of disasters. This Manual combines India's year long experience in disaster management and preparedness with UNFPA's global technical expertise in the roll-out of the MISP - a tested methodology which enables responders to take action without delay.

Disasters can change life in an instant, destroying homes and communities, often leaving families and individuals without basic necessities, from food and water to hygiene supplies, contraceptives and medical care. In the aftermath, pregnancy-related deaths and sexual violence soar. It is estimated that in any displaced population and at any given point, almost 4% of the population is pregnant, of which, 15% women experience obstetric complications, risking their lives. Reproductive health services, including prenatal care, assisted delivery, and emergency obstetric care, are often unavailable. Many women lose access to family planning services, exposing them to unwanted pregnancy in perilous conditions. And young people become more vulnerable to HIV infection and sexual exploitation.

With the launch of the MISP Manual, family planning, safe abortion and young people's specific needs would factor in emergency-response in the country. The Manual would also help in data collection to allow for appropriate, effective and efficient relief.

UNFPA congratulates NDMA, Government of India on this important step towards prevention and preparedness in disasters. This effort launches the integration of a reproductive health focus when preparing for and responding to disasters in the country. With this Manual in place, the way has been paved to ensure that districts and states have MISP integrated in every disaster management plan, in every standard operating procedure and in every department's plan document and budget.

New Delhi
April 2013

Ms. Frederika Meijer
UNFPA Representative

Acknowledgement of Contributions

The MISP Facilitator Manual is based on the inputs received from a variety of persons during the wide consultations organised. The list is long however their contributions are well acknowledged and recognised as an important part of the process of formulation.

The Manual would not have been possible without the contributions of the following in particular:

1. Partnership established between NDMA and UNFPA to prepare a Training Manual for MISP (Minimum Initial Service Package) that will address Reproductive Health and Gender issues in Disasters.
2. This Manual would not have been a reality in the absence of the International Facilitator Manual: A course for SRH coordinators, which was an AusAID initiative managed by International Planned Parenthood Federation, East, South East Asia and Oceania Region (IPPF ESEAOR). The contents of this Facilitator Manual are derived from sources developed by members of the Inter Agency Working Group on SRH in Crisis situation, the contributors being Dr. Wilma Doedens, Ms. Carol El-Sayed and Dr. Tran Nguyen Toan.
3. Dr. Muzaffar Ahmad, Member, NDMA for taking the lead in this intervention and for his initiative, guidance and continuous support at all times in the process of adaptation and finalisation of this Manual. A special mention for the consistent efforts of Ms. Naghma Firdaus, Senior Specialist, NDMA, for her technical support and facilitation in this endeavour of adaptation and finalisation of this Manual.
4. UNFPA for providing technical support in adaptation and finalisation of this Manual, especially at a time when the occurrence of natural disasters is on the increase with rapid climate change and global warming. In particular, Ms. Frederika Meijer, UNFPA Representative and Mr. Anders Thomsen, UNFPA Deputy Representative for their invaluable contributions. Further, the technical contribution, support and commitment of Ms. Shachi Grover, UNFPA Programme Officer, Humanitarian Response and Disaster Management, in conceptualising the content and her untiring involvement in the process to bring out the Manual in its present shape requires a special mention.
5. The authors - Dr. Ramji Adkekar, Dr. Itinderpal Singh Bali, Dr. Shripad Kamat, Mr. Kartikeyan Mishra, Ms. Sujata Sathpathy for taking time out from their regular assignments and contributing in revising this Manual.
6. The wealth of knowledge, experience and guidance from Dr. Shakti Kumar Gupta, Head of Department Hospital Administration and Dr. Sudhir Gupta, Additional Professor, Forensic Medicine and Toxicology from All India Institute of Medical Sciences, which ensured that the Manual is technically sound.
7. Ministry of Health and Family Welfare, National AIDS Control Organisation for their support and inputs provided in the formulation process. The State Government of Goa for their cooperation and support in providing the opportunity to pre-test the MISP Manual.

National Disaster Management Authority **United Nations Population Fund**

List of Acronyms

AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labour
ANC	Ante Natal Care
AR	Administrative Record
ARSH	Adoloscent Reproductive and Sexual Health
ART	Anti-retroviral Therapy
ASHA	Accredited Social Health Activists
ATI	Apex Training Institute
AusAID	Australian AID
BCC	Behaviour Change Communcation
BEmONC	Basic Emergency Obstetrics and Neonatal Care
CBR	Crude Birth Rate
CCNC	Cabinet Committee on Natural Calamities
CCS	Cabinet Committee on Security
CEDAW	Convention on the Elimination of all Forms of Violence against Women
CES	Coverage Evaluation Survey
CHW	Community Health Workers
CMC	Crisis Management Committee
CMG	Crisis Management Group
CMR	Crude Mortality Rate
CPR	Contraceptive Prevelance Rate
CRF	Calamity Relief Fund
DDMA	District Disaster Management Authority
DDMC	District Disaster Management Committee
DEVAW	Declaration on the Elimination of all Forms of Violence against Women
DLHS	District Level Household Survey
DPM	Disaster Programme Management
EC	Emergency Contraception
EmOC	Emergency Obstetric Care
FAO	Food & Agriculture Organisation
FGD	Focus Group Discussion
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender-based Violence
GIS	Geographic Information System
GoI	Government of India
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
HMIS	Health Management Information System
HTP	Harmful Traditional Practices
IAG	Inter-Agency Groups
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crisis Situations
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICTC	Integrated Counselling and Testing Centre
IDP	Internally Displaced Persons
IDRN	India Disaster Resource Network
IEC	Information, Education and Communication
IFRC	International Federation of Red Cross/Red Crescent Societies
IOM	International Organisation for Migration
IPC	Indian Penal Code
IPPF ESEAOR	International Planned Parenthood Federation of East, South East Asia and Oceania Region
IUD	IntraUterine Device
IV	Intravenous
MISP	Minimum Initial Service Package (for RH)
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MSM	Men having Sex with Men
MVA	Manual Vacuum Aspiration

M&E	Monitoring & Evaluation
NACO	National AIDS Control Organisation
NCC	National Cadet Corps
NCCF	National Calamity Contingency Fund
NCMC	National Crisis Management Committee
NDMA	National Disaster Management Authority
NDRF	National Disaster Response Force
NEC	National Executive Committee
NFHS	National Family Health Survey
NGO	Non Government Organisation
NIDM	National Institute of Disaster Management
NNMR	Neo-natal Mortality Rate
NSS	National Service Scheme
NYK	Nehru Yuva Kendra
OCP	Oral Contraceptive Pills
PAC	Post-Abortion Care
PEP	Post Exposure Prohpylaxis
PFA	Platform for Action
PHC	Primary Health Care
PHCW	Primary Health Care Workers
PLHA	People Living with HIV/AIDS
PMP	Prevention, Mitigation and Preparedness
PMTCT	Prevention of mother-to-child transmission [of HIV]
PNC	Post Natal Care
PPH	Postpartum Hemorrhage
QOC	Quality of Care
RBM	Result Based Management
RH	Reproductive Health
RHRC	Reproductive Health for Refugees Consortium
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SDMA	State Disaster Management Authority
SDRF	State Disaster Response Force
SE	Sexual Exploitation
SGBV	Sexual Based Gender Violence
SIDM	State Institute of Disaster Management
SIHFW	State Institute of Health and Family Welfare
SOP	Standard Operating Procedure
SRH	Sexual & Reproductive Health
SRS	Sample Registration System
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SV	Sexual Violence
TBA	Traditional Birth Attendant
TTI	Transfusion-Transmissible Infections
UN	United Nations
UNDMT	United Nations Disaster Management Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office of High Commissioner for Human rights
UTI	Urinary Tract Infection
VAW	Violence against Women
VCT	Voluntary Counselling and Testing
VHND	Village Health and Nutrition Day
WCD	Women and Child Development
WFP	World Food Programme
WHO	World Health Organization
WRA	Women of Reproductive Age

MISP Training

Introduction

This Manual will take you through the various steps needed to facilitate the training on the MISP for Sexual and Reproductive Health during Disaster. The MISP is a Sphere Standard.

The training is part of the MISP Initiative launched by NDMA in collaboration and partnership with UNFPA and aims to increase SRH services and information for persons affected and living in disaster situation.

NDMA with the technical support of UNFPA has played an integral role in the adaptation of the International Facilitator Manual for use in India.

Goal and Learning Outcomes of the Training

The overall goal of the training is to increase the coordination skills of Sexual and Reproductive Health (SRH) Coordinators or Managers. Upon completion of this training, participants should be able to:

1. Advocate for SRH in emergencies
2. Apply core concepts and techniques provided in the MISP
3. Apply coordination skills for the implementation of the MISP
4. Produce an action plan to integrate SRH into emergency preparedness plans, e.g. Disaster Management Plans and Health Plans

Who is the Four Day Training for?

The training is intended for SRH Coordinators from local and national governmental institutions and other organisations such as UN agencies and NGOs working in the area of health, including SRH, emergency preparedness, disaster management and situations of forced displacement. This training can also be used as an advocacy tool to mainstream SRH into disaster preparedness plans and disaster responses. Throughout the sessions, information that can be used to advocate for SRH in disaster will be highlighted by this symbol. (alongside)

Advocacy

Who is the Manual for and How should it be Used?

The Manual is intended to guide Master Trainers and Trainers, persons from agencies, organisations or governments who provide training on SRH in disasters and who are familiar with the concepts. This Manual provides step-by-step direction through each day of the training, including materials required. The training sessions should be used alongside the following key documents:

- *2006 Minimum Initial Service Package for Reproductive Health in Crisis Situations: A Distance Learning Module*. **Ensure that participants complete the online MISP Distance Learning Module prior to attending the training** (http://misp.rhrc.org/), as the course is based on the premise that participants have basic knowledge of RH in emergencies
- *MISP 'Cheat Sheet'*
- *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review* (www.iawg.net/resources/field_manual.html)
- *Inter-agency Reproductive Health Kits for Crisis Situation*

The attached CD-ROM contains the MISP manual, all the PowerPoint presentations, handouts, key reference documents and advocacy films. (www.iawg.net/resources/field-manual.html)

While using this Facilitator's Manual will ensure that training sessions follow the same overall structure, facilitators **need to customise** the contents, examples and training materials to suit the local context/ data and the profile of participants. This Manual is not designed to develop competencies in clinical skills for health care providers. It is intended to provide information, resources and coordination skills necessary to facilitate the integration of the MISP into emergency preparedness plans and humanitarian responses.

Structure of the Manual

This Manual is structured for four day training on MISP for SRH in Disasters targeting SRH Coordinators:

- Day 1-Morning: Overview of SRH in Disasters and Coordination (these sessions can be specifically used as an advocacy tool for SRH in disasters)
- Day 1-Afternoon: Sexual and Gender Based Violence (SGBV)
- Day 2-MNH – Maternal and New Born Health including Adolescents Sexual and Reproductive Health, Safe Abortion Care and FP
- Day 3-HIV and Sexually Transmitted Infections (STI)
- Day 4-SRH Logistics and Supplies, Data in Disaster Management, Monitoring in Disasters and Action Planning

Session Outline

Each session opens with a work plan that outlines the following:

- Length and overview of the session
- Learning outcomes identifying the main Learning Objectives
- Training methods and materials needed for the different sessions

Each session ends with a summary of key messages that facilitators need to emphasise. Other key messages are signaled by this symbol for facilitators to focus on.

Emphasise

Guiding Principles

A set of guiding principles applicable to both individuals and programmes involved in SRH in disaster are incorporated into this Manual:

- Multi-sectoral and coordinated approach among agencies in relation to SRH in disaster
- Integration of SRH into primary health care from the early stage of a disaster and beyond
- Age, gender and diversity mainstreaming approach in all activities
- Rights and community-based approaches to health and SRH services and programmes
- Attention to groups with special needs
- Ensure participation of concerned persons and communities
- Accountability through monitoring and evaluation
- Staff development and training
- Adequate quality of care
- Commitment to collaborative relationships
- Ongoing commitment to mainstream SRH into disaster responses
- Ensure safety, confidentiality, respect and non-discrimination towards persons affected by disasters and their families regardless of age, sex, ethnicity, nationality, culture, religion, political opinion, disability, etc.

Logistics

Read the Manual at least one month before the training. Preparation is the key to success of any training. Arranging logistics well in advance allows you to focus your efforts on training content during the session and ensures a smooth flow during the training.

Checklist for Meeting Room

- Meeting room space should be adequate for the number of participants and group work stations
- Table and chairs arranged in bistro style (preferably circular tables)
- Laptop and printer
- LCD projector
- Flipchart paper, markers or white boards or blackboard and chalk
- Training bags and folders (refer to the introduction session of Day 1 for more details)
- Materials for each session (read and follow carefully the instructions outlined at the beginning of each session)
- Table to set material and readings for display
- Tape or tack-it to hang posters or papers on wall
- Pens and notebooks
- Staplers, scissors, hole punch
- Water, coffee and tea readily available in the room or nearby
- Specific materials for group work stations as indicated under the various sessions

Translation of Materials

You may wish to translate key training documents into your local language. Key documents are the MISP Facilitator Manual, MISP Distance Learning Module, MISP 'Cheat Sheet' and Participants' Handouts.

Selection of Participants

It cannot be emphasised enough that the right mix of participants ensures both successful training as well as outcomes. Therefore, great care should be given to the selection of participants. Effective coordination of SRH in disasters requires collaboration of stakeholders from different agencies. We encourage you to train a mix of participants that can include government representatives from Health Ministry/Department of Women and Child, Revenue, Police, UN agencies, NGOs, Civil Society and service providers who are working in the area of SRH and/or disasters.

Your Role as Facilitator

Sharing training responsibilities with other facilitators not only decreases your workload but also enriches the training with different perspectives. If you are working in a team, agree together on a **Lead Facilitator** who will ensure coordination throughout the training.

Facilitators should have facilitation and communication skills, as well as the ability to present and convey ideas. SRH technical skills and/or coordination experience in SRH in disasters would be an asset. As a facilitator, your role is to make the material easy for participants to learn. Avoid lecturing as you are not there to teach or enforce, but to guide and facilitate the exchange of knowledge and experiences among groups. As this training focuses on SRH Coordination, make a point to allow as many **group works and discussions** as possible (in pairs, three's and four's). This will help establish collaborative relationships that are crucial for successful coordination work during the training and in the field. To reflect the importance of and need for exchanging experiences, skills and knowledge to become effective SRH Coordinators, the course is structured around many group work stations and group discussions. Build on this interactive template to adapt the sessions to the group dynamics and create or improvise as needed additional occasions for group works and discussions.

Some Tips

In preparation for each day:

- Revise the PowerPoint presentations. **Rehearse in advance the animations in the slides.** For key group discussions, the icon on the right will remind you to STOP first, facilitate the group discussion, before clicking to show the proposed answers.
- Study the background readings as necessary
- Divide responsibilities and sessions among lead facilitator and co-facilitators
- Prepare the group work stations the evening before

Group Discussion

During the Course of a Session

- Be punctual and time conscious: start on time, ensure that participants return on time from breaks and try to end on time. Ask a participant to volunteer time keeping. Write warning cards for 'ten minutes' 'five minutes', and 'stop' for the time keeper to show to the facilitator
- Establish rapport, project warmth, actively listen and encourage participation
- Address participants by name (work to learn them from the beginning)
- Emphasise key messages during and at the end of each session
- Show genuine interest and enthusiasm
- Maintain impartiality and flexibility - be open to comments and respect people and their opinions
- Go with the training agenda and prevent groups from wasting time
- Engage participants with body language, facial expressions, eye contact and varying tonality (as culturally appropriate)
- Be responsive to the group's needs
- Identify silent or withdrawn participants and engage them
- Use regular energisers facilitated by participants
- Avoid being defensive
- Remain positive, confident and open!

At the end of a session and before starting a new session:

- Invite participants to link the information they received to their national/state/district action plan (see below)
- Debrief, debrief and debrief: 'Are there any questions or comments?'

Suggested Further Reading

www.thelearningweb.net/chapter10/page36.html
www.experiential-learning-games.com/
http://ezinearticles.com/?Honey-and-Mumford-Learning-Styles&id=155849

Action Plan

The key outcome of the MISP training is to produce a collective action plan to integrate SRH into State and Districts Disaster Management Plans and Health Plans.

The participants will receive a copy of the draft during the first session of Day-1. The training will provide daily opportunities to collectively draft/refine the Action Plan and agree on roles and responsibilities to carry out its implementation. This will mean that as participants move through the training, facilitators need to encourage them to reflect on the information received daily and consider its relevance to the tasks, roles and responsibilities proposed in the State and District Action Plans.

Day 4 will allow participants to synthesise all the information received during the course, and collectively brainstorm and finalise their Action Plans.

Agenda

Day 1 Morning – MISP Overview and Coordination	
Time	**Session**
0930 – 1000	Registration
1000 – 1045	Welcoming Remarks and Opening Introduction of Participants Participants' Expectations Logistics and Ground Rules
1045 – 1100	**Tea Break**
1100 – 1115	MISP Pre-test and Feedback
1115 – 1245	Overview of SRH interventions in Disasters and Introduction to MISP
1245 – 1315	Introduction to Institutional Mechanisms and Coordination for SRH in Disasters
1315 – 1400	**Lunch**
Day 1 Afternoon – Sexual and Gender-Based Violence (SGBV)	
1400 – 1450	Introduction to Gender and SGBV: Sexual Violence: Barriers to Care and Support and Guiding Principles
1450 – 1550	Medical Services for Rape Survivors
1550 – 1600	**Tea Break**
1600 – 1700	Group Work: 1: Referral Mechanism for Rape Survivors 2: Inter-Agency Coordination for SGBV
1700 – 1730	Action Plan Review and Discussions
Day 2 Morning – Maternal and New Born Health (MNH)	
Time	**Session**
1000 – 1030	Review of Day 1
1030 – 1145	Maternal and Newborn Health in Disasters and Post-Disaster Situations
1145 – 1300	Adolescence Reproductive and Sexual Health, Safe Abortion Care, Breastfeeding and Comprehensive Care
1300 – 1400	**Lunch**
Day 2 Afternoon – FP in Disasters	
1400 – 1500	Family Planning in Disasters
1500 – 1515	**Tea Break**
1515 – 1630	Group Work: 1: Clean Delivery and Immediate Newborn Care 2: Post Abortion Care 3: Quality of Care in MNH
1630 – 1700	Action Plan Review and Discussions

Day 3 Morning – HIV and STI	
Time	**Session**
1000 – 1030	Review of Day 2
1030 – 1145	Preventing HIV/STIs in Disasters
1145 – 1200	**Tea Break**
1200 – 1300	Planning for Comprehensive STI and HIV Programming
1300 – 1400	**Lunch**
Day 3 Afternoon – Group Work Station on HIV and STI	
1400 – 1600	Group Work: 1: Standard Precautions 2: Condoms 3: STI Syndromic Approach
1600 – 1615	**Tea Break**
1615 – 1700	Action plan review and discussions
Day 4 Morning – Action Planning	
Time	**Session**
0930 – 0945	Review of Day 3
0945 – 1115	SRH Supplies and Logistics
1115 – 1130	**Tea Break**
1130 – 1300	Data, Monitoring and Evaluation
1300 – 1400	**Lunch**
Day 4 Afternoon	
1400 – 1530	Completion of Action Plans
1530 – 1545	**Tea Break**
1545 – 1615	Post-test and Feedback - Q & A
1615 – 1630	Review of Participants Expectations
1630 – 1645	Evaluation of Training/Feedback
1645 – 1730	Closing

SRH/MISP in Disasters: Overview

Learning Outcomes

By the end of the morning, participants should be able to:

1. Define a Disaster and explain why SRH and the MISP are important in disasters
2. Outline the objectives and activities of the MISP Initiative
3. Describe the tools, resources and coordination mechanisms at the national, state and district level to implement the MISP

Session Plan

Day 1 Morning – MISP Overview and Coordination	
Time	**Session**
0930 – 1000	Registration
1000 – 1045	Welcoming Remarks and Opening Introduction of Participants Participants' Expectations Logistics and Ground Rules
1045 – 1100	**Tea Break**
1100 – 1115	MISP Pre-test and Feedback
1115 – 1245	Overview of SRH Interventions in Disasters and Introduction to MISP
1245 – 1315	Introduction to Institutional Mechanisms and Coordination for SRH in Disasters
1315 – 1400	**Lunch**

Notes:

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Introductions, Expectations, Logistics and Ground Rules

Length
45 minutes

Overview	This session opens the 4-day training. After welcoming remarks, participants will introduce themselves and state their expectations from the course before setting the ground rules.
Learning outcomes	By the end of the session, participants should: ● Be familiar with fellow participants and facilitators ● Have stated their expectations and be aware of whether these may or may not be met in the training ● Have agreed on ground rules ● Know where relevant facilities are and who to contact for any logistics and administrative issues
Preparation	● Ensure that participants are informed in advance to come between 9.30 and 10.00 a.m. to register and pick up their training bag ● Ensure that name tags and participants' folders are ready ● Place coloured cards on each table so that participants can write down their expectations for the training ● Write and display the main learning outcomes of the training on a flip chart: *Upon completion of the training, participants should be able to:* ◆ Advocate for SRH in disasters ◆ Apply core concepts and techniques provided in the MISP ◆ Apply coordination skills for the implementation of the MISP ◆ Produce an action plan to integrate SRH into national/state/district disaster management and health plans ● Copy PowerPoint presentation handouts for each participant (print PowerPoint handouts 6 slides per page in 'grayscale'. Print recto verso if possible. Apply this to all PowerPoint handouts throughout the four days)
Materials	● Flip charts or white boards and markers ● Pins or tape to display materials on the wall ● Coloured cards ● Name tags ● Training bags containing: ◆ Folder with: ➢ Agenda ➢ List of participants ➢ List of acronyms ➢ Separators for each section (1. MISP and Coordination, 2. SGBV, 3. MNH, 4. HIV/STIs, 5. SRH supplies, 6. Data Management, Monitoring and Evaluation in Disaster Management 7. Action Planing) ➢ PowerPoint handouts ➢ Action planning matrix ➢ Handouts for group work stations ➢ Evaluation form *(Do not include the pre and post-tests!)* ◆ Pen and notebook ◆ MISP 'Cheat Sheet' ◆ SRH Kits booklet ◆ MISP Distance Learning Module ◆ Inter-Agency Field Manual on RH in Humanitarian Settings ◆ Optional: IASC HIV Guidelines, IASC GBV Guidelines, Clinical Management of Rape Survivors ◆ CD
Methodology	Interactive format

Process

1. Welcome all participants as they arrive. Invite them to sit wherever they would like, but encourage them to mix with other teams.

2. While waiting for all participants to arrive, ask those who are already present to write down one main expectation on the coloured cards (i.e. what they would like to get out of the training).

3. **Opening:** Invite the head of the organisation hosting the event (or others as necessary) to give opening remarks (suggested time: 10 minutes maximum).

4. **Introductions:** Get participants to take a maximum of 15 seconds to stand and introduce themselves to the large group, by name, function and organisation. One of the facilitators can break the ice and start by saying 'My name is (name) and I am a (function) in (organisation). Alternatively use a game for introduction.

5. **Expectations:** Invite participants to complete writing their main expectation for the course on the coloured cards.

6. A co-facilitator collects the cards, groups and displays them by similar expectations on the wall.

7. Read out the main expectations to all participants.

8. Present the overall learning outcomes of the training course and use these to respond to the expectations, stating clearly which are and which aren't likely to be addressed. Keep learning outcomes and expectations displayed on a wall of the training room for the remainder of the workshop as you will need to come back to these on the last day.

9. **Agenda:** Invite participants to open their folder at the agenda of the training and review the agenda together.

10. **Logistics:** Explain where the relevant facilities are (washrooms, restaurant, break out rooms etc.), and introduce the person dealing with administration issues (travel expenses if relevant, TA/DA, etc.)

11. **Ground rules**: Brainstorm with the group on ground rules for the training, such as allowing others to speak, no side discussions, punctual arrival for sessions, mobile phone on silent mode, etc. Each batch of participants will have their own ground rules that are culturally specific. Therefore, be wary of dominating the discussion with your own suggestions if the group is shy. Encourage them to speak freely, a basic ground rule to any workshop. Write agreed ground rules on a flip chart and display them for the rest of the training.

12. To make it more interesting and participatory, brainstorm with participants on ground rules for facilitators as well (such as no use of acronyms, speaking clearly, finishing on time, etc). This will help break the ice and remove perceived 'authoritative' barriers.

Pre-Test

Length
15 minutes

Overview	Participants' answers to the pre-test will allow you to gauge some of the gaps in their knowledge of the MISP, which you can address during the course.
Learning outcomes	By the end of the session, participants should be able to: • Identify gaps in their knowledge of the MISP
Preparation	Copy the pre-test (make sure not to include it into the participants' folder) and blank answer sheets on separate pages for each participant (no recto verso, as participants will keep the pre-test questions).
Materials	Flip charts or white boards and markers
Methodology	Test (multiple choice questions) and feedback

Process

1. Explain that the purpose of the pre-test is to help the facilitators understand better the learning needs of participants and to assess the impact of the training. Inform the participants that a post-test will be done at the end of the training for the same purpose. Stress that the test is anonymous.
2. Distribute the pre-test with the blank answer sheets (see below).
3. Inform participants that they have 10 minutes to complete the 10 questions of the pre-test. Instruct participants to report their answers on the answer sheet without putting their name on it.
4. After 10 minutes, collect the answer sheets.
5. To help break the ice between participants, ask them to work in groups of three or four and to take two minutes to discuss the question that each found the most challenging.
6. Quickly review each question and answer with the whole group. Facilitate questions and answers as time allows.
7. At the end of this session, a co-facilitator marks the test, calculates the mean score and summarises areas of strength and weakness, so that facilitators can emphasise accordingly during the training. You may want to post the mean score on a wall for all participants to see. (Pre-Test solutions can be found in the Post-Test session, **on page 211.**

Pre-Test

Participants' handout

*Please note that multiple choice questions may have **more than one** correct answer.*

1. **A flood in Bihar has recently displaced tens of thousands of people and approximately 500 persons are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority SRH activities you immediately undertake?**

   a. Ensuring survivors of domestic violence have access to psychosocial services
   b. Providing clean delivery Kits to all visibly pregnant women and birth attendants to support clean deliveries
   c. Ensuring blood for transfusion is safe
   d. Ensuring safe access to cooking fuel

2. **When should the MISP be implemented?**

   a. In the first days of an emergency situation
   b. Once approval from NDMA has been given
   c. Once early mortality rates have stabilised
   d. After the displaced population has been settled into camps

3. **The activities of a SRH Coordinator facilitating the implementation of the MISP include:**

   a. Training/retraining staff to provide comprehensive SRH services
   b. Ensuring the presence of a same-sex, same-language health worker or chaperone during any medical examination of a survivor of sexual violence
   c. Adapting and introducing simple forms for monitoring MISP activities
   d. Ensuring the provision of FP services

4. **What health and demographic data should the SRH Coordinator determine/estimate after the MISP is in place?**

   a. Malnutrition rate
   b. Number of sexually active men
   c. Crude birth rate
   d. Age-specific mortality rate

5. **What type of services should be offered to a rape survivor?**

   a. Clinical services
   b. Additional food rations for her extended family
   c. Protection for her physical safety
   d. Psychosocial care

6. **Which of the following is a way that does not help to prevent sexual violence in a disaster situation?**

   a. Involve women in the distribution of materials and supplies
   b. Ensure that women have their own individual registration cards
   c. Communal bathing facilities for both men and women
   d. Involve women in the decision-making process regarding the layout of the site/camp

7. **What are the requirements of a referral-level facility for comprehensive obstetric care?**

    a. Child health care
    b. Safe blood transfusion
    c. Antenatal care
    d. Medical staff that can perform c-sections available 24 hours a day, seven days per week

8. **You are a newly assigned SRH Coordinator and have recently arrived in a disaster situation. What are some of the first RH activities that you carry out?**

    a. Ensure SRH coordination meetings are established
    b. Co-host trainings on HIV/AIDS
    c. Discuss supply needs with NDMA and other agencies
    d. Coordinate community outreach on STI prevention

9. **You are coordinating the implementation of the MISP and are trying to ensure that emergency obstetric care is available in the camp clinic. What activities do you undertake?**

    a. Ensure qualified staff at the camp clinic is available only during the day to stabilise the patient with basic emergency obstetric care
    b. Ensure qualified physicians are available at the referral hospital
    c. Establish a communication system to consult qualified providers for guidance on referrals
    d. Establish trainings for medical staff on safe motherhood

10. **You have tried to procure clean delivery Kits, but logistical challenges have significantly delayed the arrival of these supplies. Given this reality, what can you do to address this situation?**

    a. Contract with a local agency to produce Kits
    b. Procure Kit contents locally and assemble on site
    c. Order supplies from another source and wait until they arrive
    d. Discuss during the SRH coordination meeting where to procure supplies

Pre-Test Answer Sheet

Do not put your name

Participants' handout (to be collected)

*Please note that multiple choice questions may have **more than one** correct answer.*

1.
a
b
c
d

2.
a
b
c
d

3.
a
b
c
d

4.
a
b
c
d

5.
a
b
c
d

6.
a
b
c
d

7.
a
b
c
d

8.
a
b
c
d

9.
a
b
c
d

10.
a
b
c
d

Overview of SRH Interventions in Disasters

Length
30 minutes

Overview	This session introduces SRH in disasters. The presentation can be used as an advocacy and awareness raising tool targeting decision makers, medical students, etc. It starts by defining SRH and its role in the different phases of disaster. It then introduces the MISP. Relevant legal international human rights frameworks are also addressed
Learning outcomes	See below
Preparation	• Ensure that PowerPoint presentation handouts are copied • Ensure that MISP Cheat Sheets are copied, if hard copies are not available
Materials	• Markers and flip charts or white boards • MISP Cheat Sheet
Methodology	Interactive presentation

1 Process

- Read the learning outcomes and explain that this presentation can be used as an advocacy tool to raise the awareness of policy-makers and service providers on the necessity of implementing SRH in disasters.

Learning Outcomes

By the end of the session, you should be able to:

- Define disaster and explain why SRH and the MISP are important in disasters
- Describe the components of the MISP
- Know where to access key tools and resources to support implementation of SRH in disasters

1

2

- Start with some definitions to set a common ground of understanding.
- 1st bullet point: Explain that there are many definitions of “disaster”. In the context of this training, highlight that when you talk about ”disaster”, you refer to the simplest form/ definition.
- 2nd bullet point: Emphasise on urgent action and need for using additional resources.
- 3rd bullet point: This is a definition that health NGOs and WHO use to determine the acute phase of disaster. To put it in perspective, explain that the CMR (Crude Mortality Rate) in stable situations varies between 0.2 and 0.3/10,000/ day.

You are not talking about slow onset disaster (such as global warming).

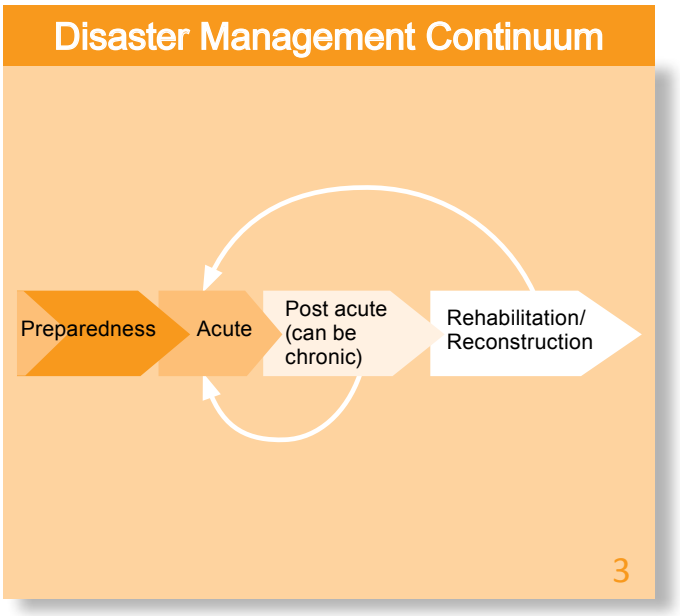
What is Disaster?

- A serious disruption of the functioning of a society, causing widespread human, material, economic or environmental losses which exceed the ability of the affected society to cope using its own resources
- A threatening condition that requires an urgent action
- Acute phase: CMR > 1/10,000/Day

2

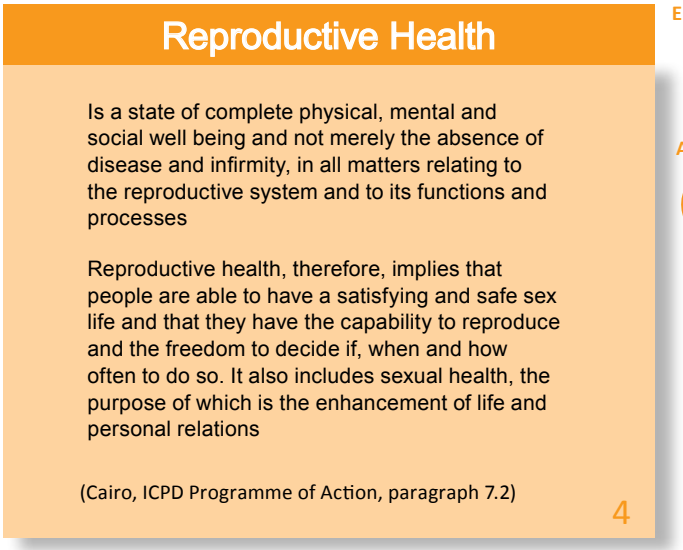
3

- There is no agreement on the definitions or on the time limit of the different disaster phases. These phases are however used to plan programmes. The post-acute and rehabilitation phase may be unstable and once again become acute.



4

- In the next three slides, you will introduce the definition of RH and international human rights frameworks related to RH.
- Before you show the definition on the slide, ask participants: "What is the definition of RH?" Take a minute to jot down suggestions from the audience on a flip chart.
- Click to show the definition of RH created at the International Conference on Population and Development (ICPD) in Cairo in 1994. (India is a signatory) This was the first time that RH was defined as a right and a matter of choice for individuals.
- Explain that some say RH and others SRH. In the training, both terms will be used interchangeably.
- In India the term used is RCH, where C denotes CHILD. However this training programme is limited to RH/SRH.



Emphasise

Advocacy

5
- Some conventions and human rights instruments support ICPD.
- Do not read the whole slide. Point that India is signatory to these conventions.

International Mandates & Policies Addressing RH Rights and Services

- Universal Declaration of Human Rights, 1948
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979
- Programme of Action, International Conference on Population and Development, Cairo 1994
- Platform of Action, Fourth World Conference on Women, Beijing, 1995
- CEDAW & Declaration on the Elimination of all Forms of Violence against Women (DEVAW)
- Convention on All Forms of Rational Discrimination
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Rights of the Child
- UN Security Council Resolutions 1325, 1820, 1308, 1888, 1889*
- Reports of the UN Special Rapporteurs on (1) Advocacy Against Women and (2) Rights to Health

*www.un.org/womenwatch/directory/women_and_armed_conflict_3005.htm

5

6
- Explain that ICPD Cairo also sets out the right to SRH for displaced persons.

Right to SRH

Advocacy

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

Chapter 10, ICPD Programme of Action, 1994

6

7
- This is an important advocacy message. Explain that SRH needs continue and, as a matter of fact, often increase during disasters. For instance, the absence of law and order, commonly seen in disaster situations, may, together with men's loss of power and status and the loss of income for women who find themselves responsible for the household, lead to sexual violence, rape, sexual abuse, and exchanging sex for food or protection. In disasters, there often is an increase in demands on the health systems, but insufficient supplies

SRH Needs Continue... in fact, Increase during Disaster

- Risk of sexual violence may increase during social instability
- STIs/HIV transmission may increase in areas of high population density
- Lack of FP increases risks associated with unwanted pregnancy
- Malnutrition and epidemics increase risks of pregnancy complications
- Childbirth occurs on the wayside during population movements
- Lack of access to comprehensive emergency obstetric care increases risk of maternal death

7

to assure standard precautions against the transmission of HIV/STI. Furthermore, the system of provision of safe blood supplies may break down, whereas there may be a greater need for blood transfusions.

- 4th bullet point: Malnutrition can lead to anemia, which increases the risk of post-partum hemorrhage. An example of epidemics is Hepatitis E, which increases the risk of miscarriage.
- 5th bullet point: Give the example of pregnant woman in Tsunami who had to climb a tree to escape the flood waters and who had to deliver her baby in the tree without any assistance or supplies.

8

- Ask participants: 'So, why should we provide SRH services in disasters?'
- Briefly facilitate feedback and click to show answer and explain that ICPD Programme of Action defined SRH as a matter of right and that people continue to have SRH needs even in disasters.

Why SRH Services for Populations in Disasters?

Advocacy

Sexual and Reproductive Health is:

- a human right
- a bio-psycho-social health need

8

9 Introduction of IAWG:

- Explain that in 1995, in response to the problems identified in humanitarian settings and in response to the ICPD Programme of Action, a group of more than 30 UN agencies, NGOs, international academic and donor institutions formed the IAWG on SRH in Refugee Situation now called humanitarian settings. The group's main tasks are to advocate for, organise and facilitate SRH services in humanitarian situations.

Inter-Agency Working Group on SRH in Refugee Situations (IAWG)

Formed in 1995: over 30 UN, NGO, Academic, Donors

- Minimum Initial Service Package (MISP) SRH
- Inter-Agency Field Manual (IAFM)
  - The MISP
  - Comprehensive RH
- RH Kits

 Safe Motherhood

 Gender-based Violence

 Family Planning

 STI/HIV

9

WHO is the technical standard setting agency for this group. Over the years, the group has developed several tools. It started with MISP for SRH in disasters, which was developed in 1995 and is described in the Inter-Agency Field Manual (show the book and mention that the MISP is explained in the next session).

10

- Ask participants to list a few challenges. Discuss and show slide.
- It was based on these challenges, that the goal and objectives of the MISP Initiative were formulated.

11

- In addition, many guidelines have been published globally on SRH in emergencies and are freely available online. Click to show slide.
- Guidelines are available in the CD attached to the manual.

12

- Explain how the four-day training is structured.
- Wrap up the session and allow questions and answers as time permits.

Introduction to the MISP

Length
1 hour

Overview	This session introduces the MISP Initiative.
Learning outcomes	By the end of the session, participants should be able to: • Describe the MISP training for SRH Coordinators within the context of the MISP Initiative and IAWG
Preparation	• Ensure that PowerPoint presentation handouts are copied
Materials	• Markers and flip charts or white boards • Audio visual material which is being used • Action planning matrix
Methodology	Interactive presentation

1 Process

- Explain that the MISP Initiative was created based on some of the needs highlighted in the Disaster Situations globally.

Learning Outcomes of the MISP Training

Upon completion of the training, participants should be able to:

- Advocate for MISP in disasters
- Apply core concepts and techniques provided in the MISP
- Apply coordination skills for the implementation of the MISP
- Produce an action plan to integrate RH into the state and district disaster management plan and health plans

1

2 Introduction to MISP

- Explain that during the disaster, there is chaos and you cannot put in place all the components of comprehensive SRH. You have to limit the interventions to life saving SRH activities.
- The IAWG argues that a minimum of SRH services should be part of the primary health care measures in early disasters, and as such, define the MISP.
- Explain the slide from bottom up, starting with "Package". Stress that package does not mean a box that one can open, but refer to a **strategy** that includes coordination/planning, SRH supplies and activities.
- Explain that 'MISP' is a loosely associated acronym that stands for… **(read the slide).**

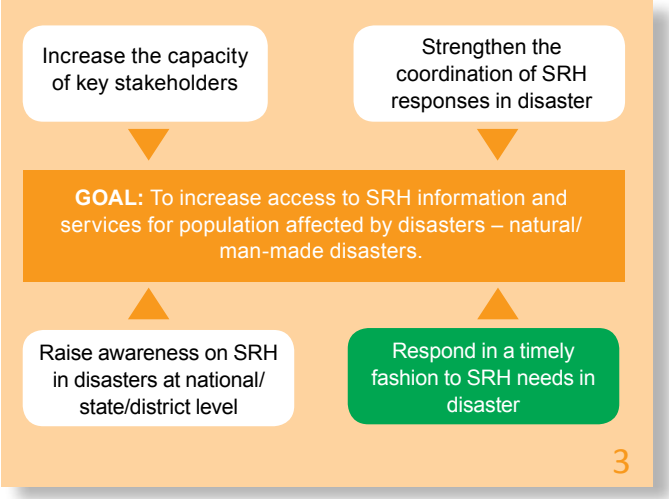
What is MISP?

Minimum	• basic, limited reproductive health
Initial	• for use in emergency, *without site specific need assessment*
Service	• services to be delivered to the population
Package	• supplies (e.g. RH kit) and activities • coordination and planning

2

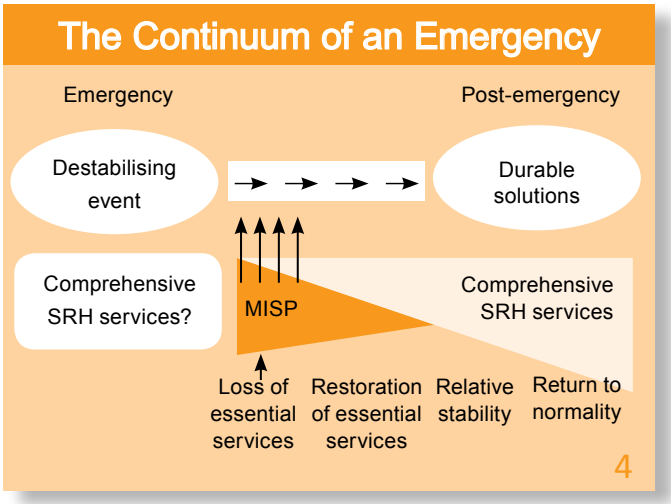
3

- Explain that the MISP training aims at fulfilling the first three objectives (Capacity building, Coordination and Awareness raising which will lead to effective response during disasters).
- Click to show slide.



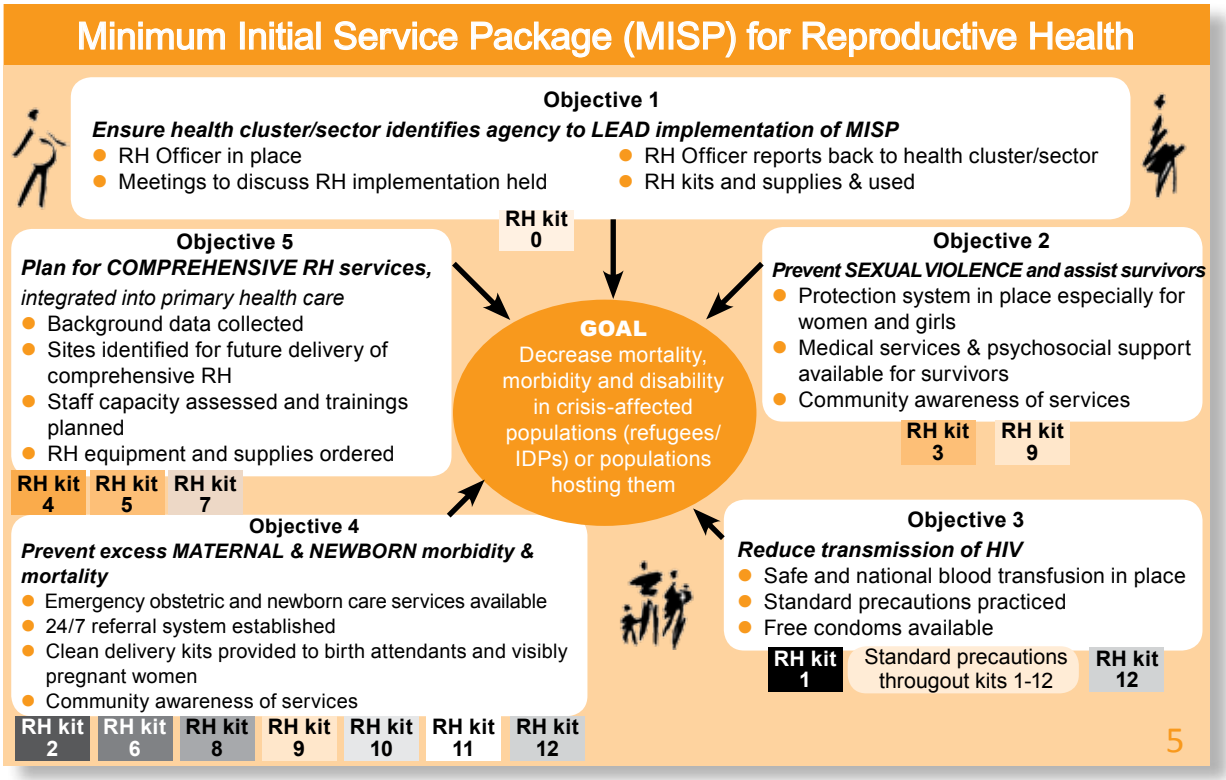
4

- Explain the role of the MISP in the continuum of a disaster. SRH Coordinators should plan for comprehensive SRH information and services as soon as the situation allows.
- In the next slides you will review the different components of the MISP.



5

- Invite the participants to take their MISP Cheat Sheet and explain that the following discussion is summarised on the Cheat Sheet.



6 • Now you will briefly discuss the activities for each of the objectives (keep the discussions short as you will go into detail of each of the MISP components during the rest of the training).

Objectives of the MISP

- Identify SRH Coordinator
- Prevent and manage the consequences of sexual violence
- Reduce HIV/STI transmission
- Reduce excess neo-natal and maternal morbidity and mortality
- Plan for comprehensive RH services and integrate MISP into primary health care as soon as possible

6

7 • 1st bullet point: Ask participants 'Who can be a SRH Coordinator?' Allow feedback from participants. Click to show answer and explain that an organisation is usually appointed (Health, Revenue, WCD, NGO). But the organisation needs to recruit an individual to take on this task.

• 2nd bullet point: Ask participants 'What activities would you plan to prevent sexual violence?' Allow feedback from participants, then ask 'What needs to be in place to manage the consequences of sexual violence (rape)?' Allow feedback and click to show answers.

Components of the MISP

- Identify a SRH focal point/coordinator
  - Organisation
  - Individual
- Prevent and manage the consequences of sexual violence
  - Plan camp design
  - Medical response (EC, STI/HIV prevention)
  - Inform the community
  - Protection of at risk groups

7

8 • Repeat the same process with the rest of the MISP objectives, always reminding people that the situation they are planning for is chaotic and they only have the possibility to implement minimum life-saving interventions.

Components of the MISP

- Reduce HIV transmission
  - Standard precautions
  - Free condoms
  - Safe blood tranfusion
- Reduce excess newborn and maternal morbidity and mortality
  - Provide Emergency Obstetric and Newborn Care Services (EmONC)
    - Basic EmONC in primary health care facilities
    - Comprehensive EmONC in referral hospitals
  - Referral system (transport/communication) for Emergencies
  - Clean home deliveries

8

9

- Planning for comprehensive SRH services includes planning for all the components that you discussed earlier.
- 1st check sign: For the planning of such services, background information on health data of the displaced people should be collected from their district and from sources such as the Health Department, etc.
- 2nd check sign: Suitable sites for further delivery of comprehensive SRH services must be identified to ensure security, accessibility, privacy and confidentiality, access to water and sanitation, appropriate space and aseptic conditions.
- 3rd check sign: Planning for and providing quality training is only possible after the situation has stabilised.
- Last check sign: It is important to set up reliable SRH commodities supply line as soon as possible.
- Show the MISP Cheat Sheet once more and remind participants that they can review the MISP objectives on the front side of the Cheat Sheet.

Components of the MISP

- Plan for comprehensive SRH services, integrated into PHC
  - Collect background information
  - Identify suitable sites
  - Staff capacity assessed and trainings planned
  - SRH equipment and supplies ordered
- **Plan to integrate SRH in health system reconstruction**

Health systems building blocks	Plan for comprehensive SRH services, e.g.
Service delivery	• Identify SRH needs • Identify suitable sites for SRH service delivery
Health workforce	• Assess staff capacity and train
Health information system	• Include SRH information in HIS
Medical commodities	• Support/strengthen RH commodity supply lines
Financing	• Identify SRH financing possibilities
Governance, leadership	• Review RH-related laws, policies, protocols

9

10

- 1st bullet point: Experience has shown that it is important to meet the FP needs of continuing users (e.g. people who are using a FP method but who no longer have access to it).
- 2nd bullet point: Menstrual protection allows women to fully participate in community life and look after their family. The contents of the hygiene kits/dignity kits will be discussed in detail on the last day. The components mentioned here are those that have been provided by UNFPA in the past in collaboration with NDMA following the disaster in Bihar–Koshi, Andhra Pradesh and Karnataka floods, etc.

Provide Other Important Supplies

- Meet pre-existing FP Needs
  - **Basic FP methods to meet spontaneous demand**
- Meet needs for menstrual protection
  - **"Hygiene" or "Dignity" kits**

(One Saree with blouse, salwar kameez with dupatta for adolescent girls, two panties, thirty sanitary napkins, two washing soaps, two bathing soaps, one comb, two packets of safety pins, two boxes of sindoor and an old newspaper)

10

11

The MISP and Sphere:

- Explain that the MISP is recognised as a health standard in the Humanitarian Charter and Minimum Standards in Humanitarian Response (a useful advocacy argument to convince the detractors of SRH in disasters).

Health Standard

Advocacy

People have access to the Minimum Initial Service Package (MISP) to respond to their reproductive health needs

11

12

- Stress that this training is not about a top-down approach and explain the different bullet points.
- 6th bullet point: This refers to the daily reflection and work on the action plan.

Core Values of the MISP Training

- Commitment to ***collaborative relationships***
- Positive ***sharing*** of experiences
- ***Empowerment*** of all participants as coordinators
- ***Open and constructive*** peer feedback
- Nurturing of ***reflective and continuous learning*** within and beyond the program
- Awareness of the important ***role and responsibilities*** and ongoing ***commitment*** of the participants to mainstream SRH into disaster response

12

13

- Earlier the challenges of SRH were discussed. This is about the MISP and its implementation.
- Explain that an evaluation in 2004 in many countries showed that the MISP was not well implemented in the field.
- 1st check sign: The MISP was not well known, therefore the Online Distance Learning Module, and this MISP Advocacy Module were designed to improve awareness.
- 2nd check sign: People are often not aware which SRH components are crucial to life-saving. For instance, skilled delivery care will prevent more deaths than antenatal care.
- 3rd check sign: Even in the most traditional societies, some people know and use condoms.

Challenges in Implementing the MISP

- **2004 Global Evaluation: MISP not well implemented**
  - Not known
  - Other priorities (ANC > delivery care)
  - Perceived inappropriate (condoms)
  - Difficult (24 hr access, referral, post-rape care)
  - Lack of coordination
  - Lack of timely planning for comprehensive RH
- **Logistic challenges**
  - Distribution of kits; in-country transport, storage and distribution
  - National capacity to manage post-crisis comprehensive RH commodity security to move from “push” to “pull” supply systems

13

14

- Explain that the MISP has been implemented more or less successfully in many disaster settings around the world since 1996. Some of the lessons learned are summarised here.
- 1st and 2nd bullet points: These justify the need to build a pool of RH Coordinators. This is another reason why this training on SRH coordination has been developed.

Lessons Learned

- Identify an appropriate ***Coordinator***
- ***Transparent collaboration*** facilitates implementation!
- ***Prevention of sexual violence*** requires a concerted effort, sensitivity and staff preparation
- ***People use condoms*** during an emergency
- ***Clean delivery kits*** provide essential supplies for deliveries outside health facilities
- ***Logistics preparedness*** is essential for prompt use of RH Kits
- Satisfactory implementation requires ***pre-planning***.

14

Lessons Learned

- ***'Do not wait for an emergency to address the MISP'***
- ToTs and in-country roll-out trainings along with technical assistance can effectively build the capacity of humanitarian actors

- Coordination among UN agencies, NGOs and implementing partners is achievable and can improve the SRH response
- SRH coordinators/focal points are essential to move MISP forward
- *Must have strong advocacy and coordination skills*
- Continuous advocacy for MISP can change attitude of policy makers and implementing agencies
- Essential to make funding available immediately for implementing partners
- Onsite technical assistance for MISP implementation can help translate training into practice

15

- Last bullet: Stress the need to bridge the gap between immediate relief and development.

What's Innovative about the MISP

- First national initiative to address SRH in disasters through capacity building
- Integrating of MISP in state and district disaster management plans and health plans
- ***Inter-Agency collaborative approach***
- NDMA will expand its development agenda to embrace SRH in disaster
- Bridging the gap between immediate **relief** and **development**

→ *continuum between disaster and development*

15

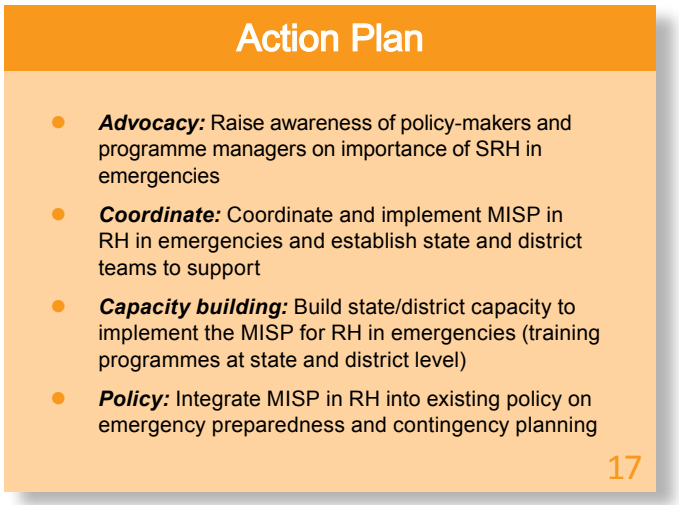
16

- Wrap up the session with the key messages and allow questions and answers as time permits.

17

Action Plan

- Explain the general format of the action plan matrix and how it reflects the different themes addressed during this training and that are needed to mainstream SRH in disasters (Coordination, MNH, SGBV, HIV/STIs, etc.).
- Emphasise that this is a key document that forms a red thread throughout the whole training. At the end of each day, there will be time for participants to individually and collectively reflect on the information acquired daily, integrate this into the state and district disaster and health plan and contribute additional ideas on how to refine (or develop) it.



Suggested Further Reading

- MISP for Reproductive Health in Crisis Situations: A Distance Learning Module, New York: Women's Commission, 2006, available at http://misp.rhrc.org/content/view/22/36/lang,english/
- Reproductive Health in Refugee Situations - an Inter-Agency Field Manual, UNHCR, 1999, available at http://www.iawg.net/resources/iawg_Field%20Manual_1999.pdf
- Humanitarian Charter and Minimum Standards in Disaster Response, The Sphere Project, 2004 Edition, available at www.sphereproject.org

Suggested Preparedness Activities

Participants' handout

Preparedness activities can include:

I. Coordination:

a. Raising awareness of partners in health and other sectors and working with them to ensure preparedness (i.e. talk to the partners responsible for water and sanitation, to ensure that they consider prevention of SGBV in their activities, etc.).
b. Ordering supplies to ensure the implementation of all components of the MISP, or making arrangements to order supplies as soon as the disaster hits.
c. Finding safe storage space (that will not be affected by the disaster) and managing supplies with expiry dates.
d. Making clear arrangements with partners on ultimate destination and in-country transport of supplies.
e. Developing or adapting protocols and IEC materials.
f. Translation, printing and safe storage of materials.
g. Setting up a core coordination group (at national/state/district level) and structures.
h. Collecting SRH data on the affected population: population size, women of reproductive age, men of reproductive age, adolescents (boys/girls), crude birth rate, ANC coverage, age-specific mortality rate, sex-specific mortality rate, lactating women, STI and HIV prevalence, CPR, FP method mix, etc.
i. Identifying national health (SRH) response mechanism.

II. Build national capacity to implement the MISP for SRH in disaster:

a. Conducting MISP training and identifying lead facilitators and co-facilitators.
b. Identifying potential agencies/organisations in country to participate.
c. Identify specific training needs to strengthen implementation of MISP components.
d. Arranging for logistics such as invitations, transportation, venue, material for workshop, etc.
e. Follow-up with agencies and organisations after the training.

III. Prevention and management of the consequences of sexual violence:

Prevention

a. Careful site planning of displacement camps, in consultation with persons of concern, especially women.
b. Ensuring female staff members are included in registration, security, food distribution, other sections, etc.
c. Setting up latrines, hygiene and water points to be accessible and safe and have proper lighting.
d. Ensuring house-hold fuel collection methods are safe.
e. Ensuring that displaced women have individual registration cards, food ration cards etc.
f. Identifying persons/groups with special needs who could be at a higher risk for sexual violence such as female headed households, unaccompanied and separated children, women at risk, single women, persons living with disabilities, elderly etc. and determining their special protection and assistance needs.
g. Ensuring confidentiality and impartiality in access to services (non-judgmental).

Response

h. Identifying lead agency and partners to set up Standard Operating Procedures (SOPs) or protocols with partners and agencies for identification, response and referral of sexual violence survivors for the necessary assistance (agreeing on definition of concepts, reporting formats, referrals etc.).
i. Ensuring that survivors of sexual violence have access to health services.
j. Coordinating mechanisms for appropriate psychosocial support.
k. Ensuring 24/7 access to services, private consultation spaces, and conditions and reporting mechanisms obliging staff to maintain confidentiality.
l. Ensuring physical safety of survivors.
m. Appointing staff trained on SV prevention and response mechanisms.

IV. Reducing maternal and newborn mortality and morbidity:

a. Distributing clean delivery Kits.
b. Making sure that midwifery Kits are available at health centres.
c. Appointing skilled staff.
d. Provide for safe abortion care facilities.
e. Include the needs of adolescent population.
f. Make provision for FP services.
g. Establishing a functioning obstetric emergency referral system.

V. Reducing transmission of HIV and other STIs:

a. Ensuring condoms are available and accessible.
b. Ensuring staff will comply with standard precautions and have easy access to protocols.
c. Ensuring blood transfusion is rational and safe (protocols, rapid HIV and other screening tests).
d. Appointing health workers who can effectively apply standard precautions.

VI. Plan for provision of comprehensive SRH services:

a. Collecting SRH data (segregated by age and sex): SRH mortality, HIV/STI prevalence, contraceptive prevalence, etc.
b. Identifying appropriate sites for future delivery of comprehensive SRH services.
c. Identifying training needs on technical, cultural, ethical religious and legal aspects of SRH and gender awareness.
d. Putting in place a logistics management information system for equipment/supplies for comprehensive SRH services.

Disaster Preparedness/Contingency Planning for Future Scenario

Together with your team, identify a likely future disaster for which you will integrate SRH into the disaster preparedness plans. Please select a Chairperson, a note taker and a presenter.

Expected disasters, most likely future scenario		
State/District		
Area expected to be affected by disaster		
Nature of expected disaster	*e.g., earthquake, flood etc.*	
Expected number of affected persons		
National/state policies	Is there a disaster management plan/health plan in your state/district? Yes/No	
	If yes, are sexual and reproductive health issues addressed in these plans? Yes/No	
	SRH component *e.g. HIV/STI, maternal health, sexual violence etc.* (if applicable)	List key stakeholders

Coordinated Action Planning for Integrating Sexual and Reproductive Health into Disaster Preparedness and Contingency Plans

State/District :_____

Affected area :_____ Team Members :_____

MISP	Examples of steps	Activities required for preparedness (see separate sheet)	Focal person (name)	Key actors (can be agencies)	Challenges	Resources needed	Timeframe
I. Coordination: Coordinate and implement MISP/SRH in disasters and establish teams to support the Coordinator	1. Ensure that Coordinator is in place and functioning within the health coordination structure						
	2. Ensure that SRH focal points are available in the field/on site or have access to affected populations						
	3. Make available material for implementing the MISP						
	4.						
II. Integrate SRH into existing disaster management plans and health plan: Build capacity to implement the MISP for SRH in disasters	1. Identify existing management plans						
	2. Conduct MISP trainings						
	3.						

MISP	Examples of steps	Activities required for preparedness (see separate sheet)	Focal person (name)	Key actors (can be agencies)	Challenges	Resources needed	Timeframe
III. **Sexual Violence:** Prevent sexual violence and provide assistance to survivors	1. Ensure that prevention and response mechanisms are in place to protect affected persons from sexual violence						
	2. Ensure that medical services, including psychosocial support, are available for survivors						
	3.						
IV. **Maternal and newborn mortality and morbidity:** Prevent excess death and illness among mothers and newborns	1. Provide clean delivery Kits to visibly pregnant women and birth attendants						
	2. Provide midwifery Kits to health facilities						
	3. Establish a functioning 24/7 obstetric emergency referral system						
	4. Provide for safe abortion care facilities						
	5. Include the needs of adolescent population						
	6. Make provision for FP services						
	7. RH Kits/Dignity Kit						
	8.						

MISP	Examples of steps	Activities required for preparedness (see separate sheet)	Focal person (name)	Key actors (can be agencies)	Challenges	Resources needed	Timeframe
V. HIV and other STIs: Reduce the transmission of HIV/STIs	1. Ensure that standard precautions are in place						
	2. Ensure availability of condoms						
	3. Ensure safe blood transfusion						
	4.						
VI. Plan for comprehensive SRH services: Integrate comprehensive SRH care into primary health care services	1. Collect basic background information						
	2. Assess staff and identify training needs						
	3. Identify procurement channels and assess monthly drug supplies						
	4.						
VII. Plan for Data in disaster	1. Collect basic data required during different phases of disasters						
	2. Establish indicators for monitoring of MISP						
	3.						

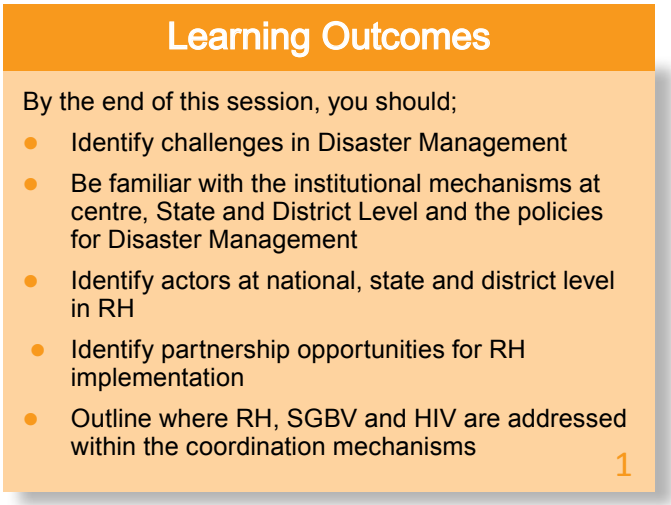
Institutional and Coordination Mechanisms for SRH in Disasters

Length
30 minutes

Overview	This session introduces coordination mechanism of SRH in disasters, describes key funding mechanisms and outlines where RH, SGBV and HIV can be addressed within coordination mechanisms
Learning outcomes	See below
Preparation	• Ensure that PowerPoint presentation handouts are copied • The concepts in this session are complex and may require you to study the material carefully in advance (refer to suggested further reading at the end of this session) • Video film on disaster
Materials	Markers, flip charts or white boards and a video film on disaster and its challenges
Methodology	Interactive presentation

1 Process

- Explain that this session introduces the DM Act and National Policy on DM.
- SRH coordinators need to be familiar with the national institutional framework and mechanisms available in order to effectively work in disasters.



2

- *Audio-Visual Aid : Through a Video reflect on coordination challenges and mechanisms of Inter-Agency response.*
- Show video and engage participants in discussion.
- Ask participants: 'What are the challenges you have encountered with coordination in disasters?'
- Briefly facilitate feedback and click to show proposed answers.

3

- Ask if anyone is familiar with the term NDMA, SDMA, DDMA, NIDM etc.
- Click to show slide.

Who are the Overall Partners?

- National Disaster Management Authority (NDMA)
- Central Ministries – Health, Women & Child Development, etc.
- State and District Disaster Management Authorities (SDMAs, DDMAs)
- State Health Departments and related line departments
- Other I/National relief agencies including the UN
- NGOs
- Community/local population affected by disaster

3

4

- Ask participants "What were the earlier mechanism for DM in India"?
- Discuss and show slide on paradigm shift.

Paradigm Shift

- Government appointed HPC on Disaster Management
- Shift in orientation from relief centric to a multidisciplinary, multi-sectoral holistic approach
- Eleventh Five Year Plan (2007-2012) outlined a multi-pronged strategy for total risk management for sustainable development
- States advised to have Plan Schemes for Disaster Management

Result was

- A national roadmap on Disaster Management
- Development of Disaster Management Framework
- Enactment of Disaster Management Act 2005

4

5

- The next few slides will give information on NDMA and other institutional frameworks at state and district level. Ask participants about the DM Act 2005.
- Discuss and show slide.

National Disaster Management Authority

- Headed by Prime Minister with other members, not exceeding nine, to be nominated by PM
- PM has designated one of the members as Vice-Chairperson, NDMA
- Recommends provision of fund for mitigation
- Provides support to other countries affected by major disasters as determined by the Central Government

5

6
- Ask participants about the roles and responsibilities of NDMA.
- Discuss and show slide.

National Disaster Management Authority

- Approves National Plan
- Lays down policies on Disaster Management – preparedness, prevention, mitigation
- Provides Technical Guidance in relief/response
- Approves plans prepared by the Ministries and departments of Government of India in accordance with National Plan
- Lays down guidelines to be followed by the state authorities in drawing up the state plan
- Coordinates the enforcement and implementations of the policy and plan for Disaster Management

6

7
- Explain the legislative powers of the DM Act 2005 in the slide.

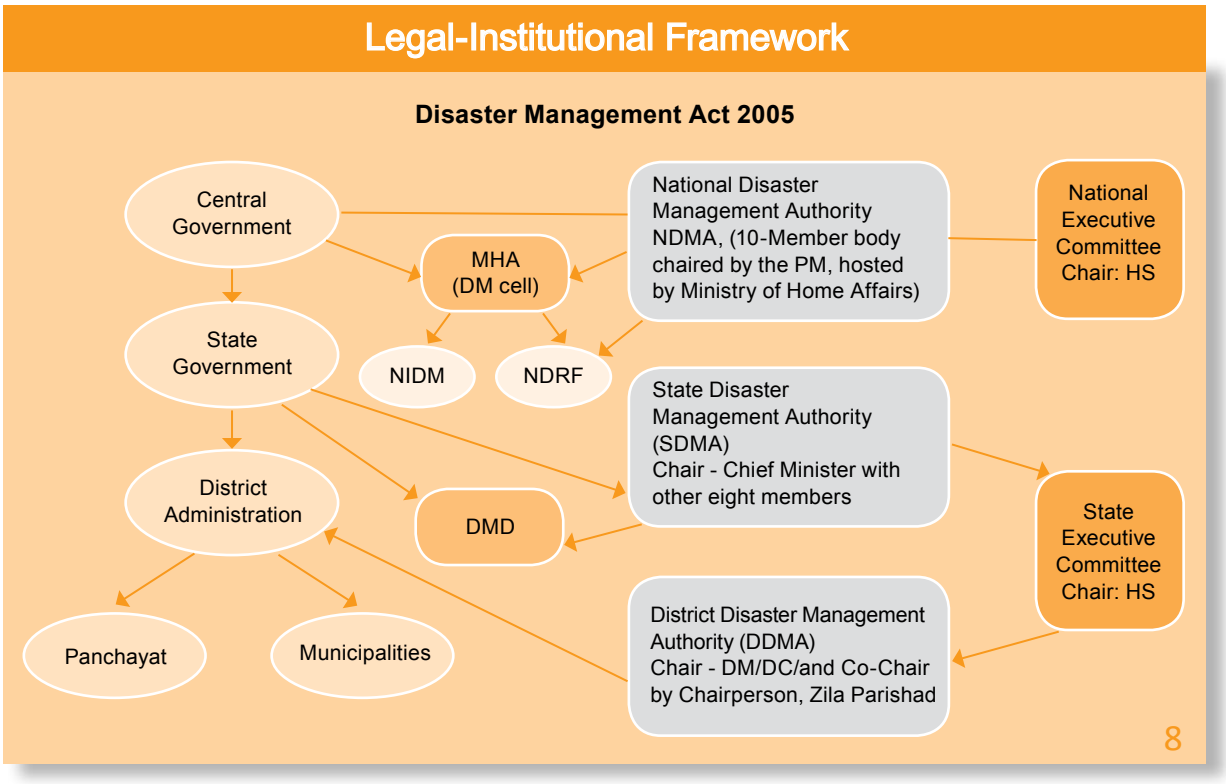
Central Legislation-The Disaster Management Act, 2005

The Act provides for: -

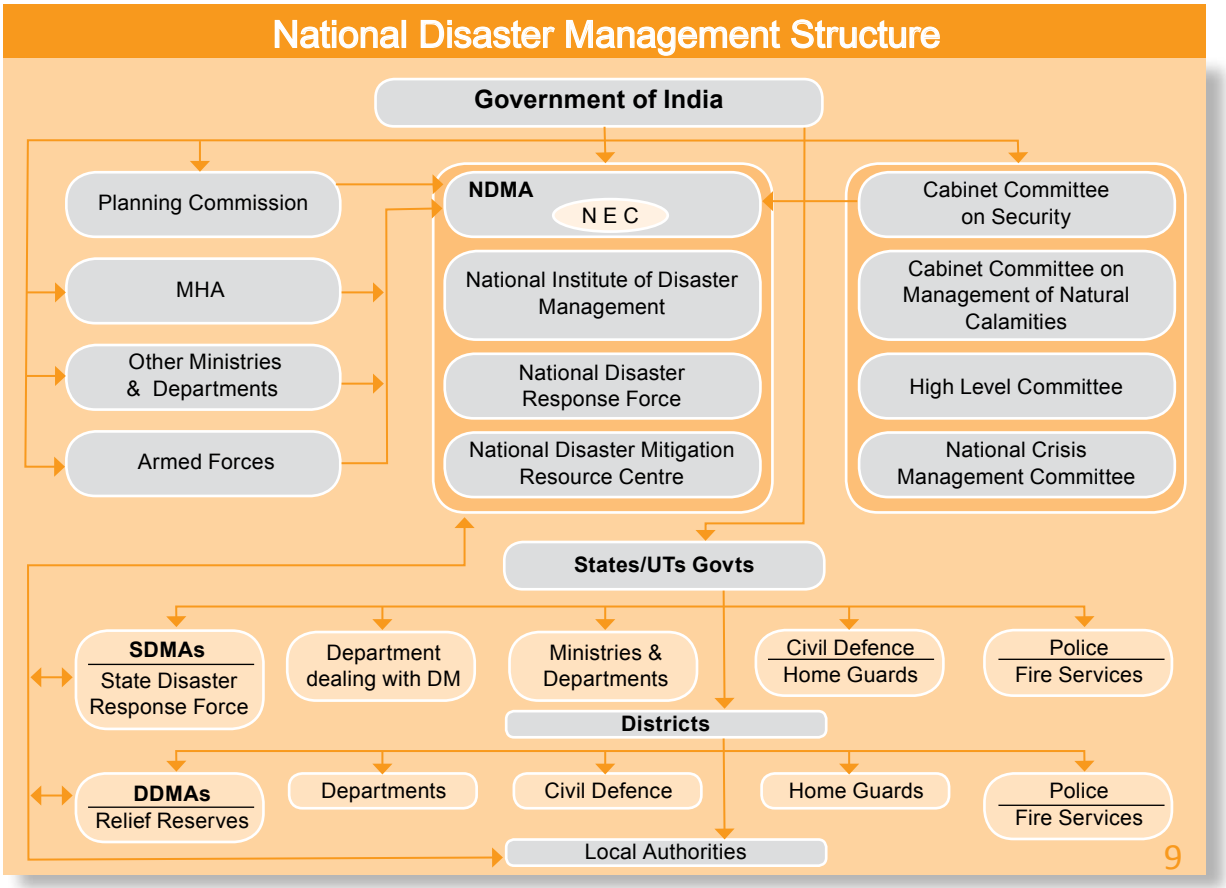
- Constitution of Disaster Management Authorities at National, State and District levels
- Role of local authorities (Panchayati Raj Institutions and Municipalities) in disaster management strengthened
- Puts in place Disaster Management plans at national, state and district level
- Constitution of a National Disaster Response Force
- National Fund for Disaster Response and National Mitigation
- Similar Funds to be constituted at State and District level.
- Mitigation Funds for projects exclusively addressing mitigation at National, State and District level

7

8 • Ask participants "Are you familiar with the institutional framework for Disaster Management?" Discuss and click to show slide.



9 • Discuss the DM structure and show slide.



10 • Show slide and discuss National Policy on Disaster Management (refer to suggested readings).

National Policy on Disaster Management

- National Policy on Disaster Management formulated and approved in 2009
- Lays down the roadmap/ directions for all government endeavours

10

11 • Ask participants to link the disasters with the nodal ministries in charge. Discuss and show slide.

Role of Central Ministries and Departments

- Disaster Management; a multi-disciplinary process, all Central Ministries and Departments have key role in the field of Disaster Management
- Nodal Ministries and Departments of GoI address specific disasters as assigned to them as:

(i) Drought	- Ministry of Agriculture
(ii) Epidemics & Biological Disaster	- Ministry of Health
(iii) Chemical Disaster	- Ministry of Environment
(iv) Nuclear Accidents & Leakages	- Dept. of Atomic Energy
(v) Railway Accidents	- Ministry of Railways
(vi) Air Accidents	- Ministry of Civil Aviation
(vii) Natural Disasters & Civil Strife	- Ministry of Home Affairs

11

12 • 1st bullet point: Cabinet Committee on Natural Calamities functions at the apex level and reviews the various disasters.
• 2nd bullet point: Cabinet Committee on Security looks after matters relating to Nuclear, Biological & Chemical Emergencies.
• 3rd bullet point: National Crisis Management Committee headed by the Cabinet Secretary reviews and monitors disasters situations on a regular basis, and gives directions to any ministry, department or organisation for specific action.

Coordinating Mechanism at National Level

- Cabinet Committee on Natural Calamities (CCNC)
- Cabinet Committee on Security (CCS)
- National Crisis Management Committee (NCMC)
- National Executive Committee (NEC)
- Crisis Management Group (CMG)
- Nodal Ministries
- National Disaster Management Authority (NDMA)
- National Disaster Response Force (NDRF)
- National Institute of Disaster Management (NIDM)

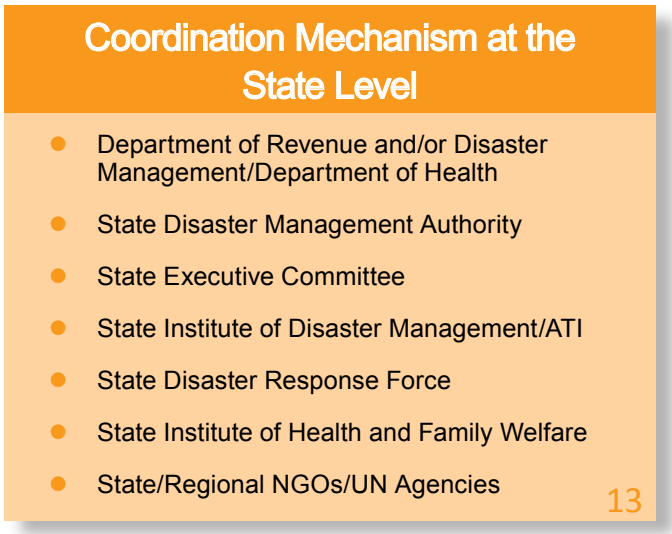
12

needed to meet the emergency situation.

- 4th bullet point: National Executive Committee enjoys extensive powers and functions, including laying down guidelines and giving directions to the concerned ministries and departments.
- 5th bullet point: Crisis Management Group functions under the chairmanship of Central Relief Commissioner in the Ministry of Home Affairs; it reviews the annual contingency plans of various ministries and departments and measures required for dealing with disasters. It also coordinates the activities of Union Ministries and State Governments, and obtains information from nodal officers of different ministries.
- 6th bullet point: The Ministry of Home Affairs has the nodal responsibility for response in disasters. Management of any disaster/crisis/emergency situations is collective. The nodal ministries have the responsibility to take lead when specific such scenarios arise.
- 7th bullet point: National Disaster Management Authority operates under the chairmanship of the Prime Minister and is responsible for laying down policies, plans and guidelines. NDMA renders effective guidance towards prompt response to disasters to stakeholders concerned.
- 8th bullet point: National Disaster Response Force is a specialised force with state of the art equipment and training to respond to various disasters.
- 9th bullet point: National Institute of Disaster Management is responsible for training, capacity building, research and documentation on different aspects of Disaster Management.

13

- 1st bullet point: Department of Revenue/Disaster Management/ Health: Are apex departments for DM at state level and may vary from state to state. In some states the Secretary of health is holding charge for DM as well which provides opportunity for coordination.
- 2nd bullet point: SDMA: In accordance with the DM Act 2005, all states are mandated to constitute SDMA. Presently, SDMAs are functional in few states.
- 3rd bullet point: SEC: Apex committee which guides/directs concerned departments in the state on matters pertaining to DM.
- 4th bullet point: State Institute of Disaster Management (SIDM)/Apex Training Institute (ATI): Are apex training institutions for DM in state and may vary from state to state. In the absence of SIDMs, ATIs are performing this function.



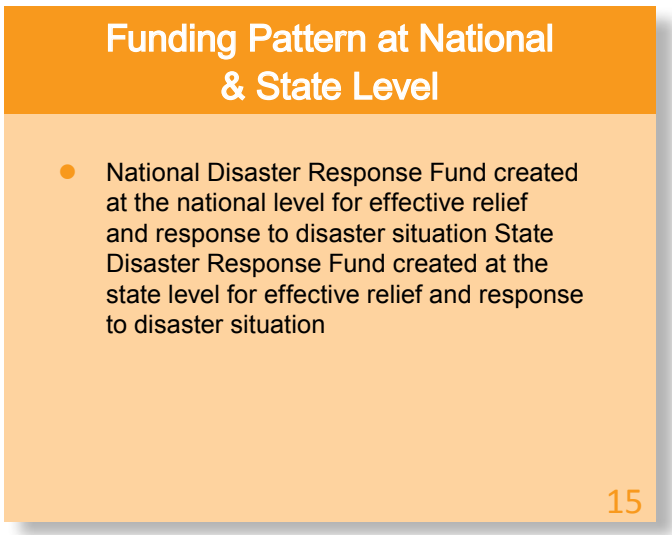
- 5th bullet point: SDRF: Are being established at the state level (Sikkim, Bihar and Andhra Pradesh).
- 6th bullet point: SIHFW: Nodal Training institution at state level for health.
- 7th bullet point: NGOs: Refers to state level NGOs working in the area DM/ health.

14

- 1st bullet point: DDMA (as an authority looks into the prevention, mitigation, preparedness as well as relief and response matters) works under the chairmanship of the District Collector and has a committee established at a district level (DDMC).
  The actual implementation of relief operations is under the mandate of Revenue and Disaster Management Department.
- Immediate rescue and relief is naturally the responsibility of the local and district administration, which is closest to the affected population. Same holds true for rehabilitation. District Collector exercises coordination and supervision over all the departments in the district.
  DDMC acts as the district planning, coordinating and implementing body for disaster management.
- 2nd bullet point: NGOs serve as a human resource of organised, trained and active volunteers, and have a very extensive reach. They can be instrumental in community mobilisation and awareness generation/capacity building in the pre-disaster phase, even in areas not accessible to local governments, and also during the post-disaster phase of relief and rehabilitation to ensure the provision of relief material to the victims. (Not all NGO functionaries) are volunteers, there is a difference between NGOs and VOs).
- 3rd bullet point: The Civil Defence and Home Guards play a role in search and rescue operations and relief services, minimising damage to the property and other supporting activities. Since the corps is derived from the local community, their participation makes community participation an important ingredient of disaster management at the district level.
- 4th bullet point: Community participation is also ensured through volunteers of NCC, Scouts, NSS, NYK etc.
- 5th bullet point: Community is the first responder in any disaster situation.

15

- Ask participants to mention the funding resources available for DM interventions. Discuss and show slide.
- These are aimed at the post-disaster activities of relief and rehabilitation, and do not cover either pre-disaster prevention, mitigation and preparedness, nor long-term reconstruction works, which have to be funded separately from the budgets of the concerned departments of the State or Union Government.



16

- Inform participants about new funding initiatives for DM.

Disaster Management Act, 2005 provides for setting up of a National Disaster Mitigation Fund, which will ensure quality of infrastructure, capacity building and a culture of prevention and safety thereby addressing the pre-disaster aspect of Disaster Management.

New Funding Initiative

- National Disaster Mitigation Fund for projects exclusively for the purpose of mitigation of disasters

16

17

- Show slide to inform participants on Emergency Operation Centres.

Emergency Operation Centres

- State-of-the-art **Emergency Operation Centres** established in Ministry of Home Affairs for data, video and audio up-linking with all State, District and remote areas
- EOCs set up in all State, Union Territory and District headquarters
- **India Disaster Resource Network (IDRN)** web-enabled, centralised inventory of resources established - www.idrn.gov.in
- Over 80,000 records from 565 districts across country is uploaded

17

18

- Show slide to explain the role and functions of NIDM which is the apex training institution under the DM Act.

National Institute of Disaster Management

Core mandate of the NIDM under the Act:

- Provide assistance in national level policy formulation on disaster management
- Formulate and implement comprehensive human resource development plan on disaster management
- Develop training modules and undertake research and documentation work on disaster management
- Mainstream disaster management in education
- Network with research and training institutions at national and international level

18

19

- Discuss with participants the structure and location of NDRFs in India. You may also brief the participants on the establishment of SDRFs.

National Disaster Response Force

- 11 battalions of National Disaster Response Force raised,
  - Two each from CRPF, CISF, BSF & ITBP raised and equipped.
  - 2 Bns are being raised
- Each battalion to consist of 18 Specialist Response Teams besides other support staff
- Each SRT to have 45 persons comprising:
  - 4 Search & Rescue Teams
  - 1 Medical Support Team
  - 1 Technical Support Team and
  - 1 Dog Squad
- Each battalion to have one Diving and one Water Rescue Team
- Four of these battalions to specialise on Nuclear Biological and Chemical (NBC) disasters

19

20

- Ask participants if they are familiar with the Government's initiative in DM which may have linkages to SRH/ MISP interventions. Discuss and show slide.

Initiatives of Government

- DM in Medical education (curriculum in emergency health management and nursing courses finalised in consultation with IMC)
- CBDRM
- Cyclone Risk mitigation
- ERM
- DM in school education
- Incident Command System

20

21

- Explain that there are several SRH partnerships that SRH Coordinators can tap into. e.g. United Nations Disaster Management Team (UNDMT), National AIDS Control Organisation (NACO), Inter Agency Groups (IAGs) working under the auspices of SPHERE at district/state national level.

State the mechanisms on ground which facilitates inter-agency communication and coordination concerning health matters at the national, state and district levels.

RH Partnerships at Various Levels

- Ministry of Health & Family Welfare, Ministry of Women and Child Development
- National Aids Control Organisation (NACO), Police, Social Justice and Empowerment
- Inter Agency Groups (IAGs) under SPHERE
- Other possible collaboration during disasters

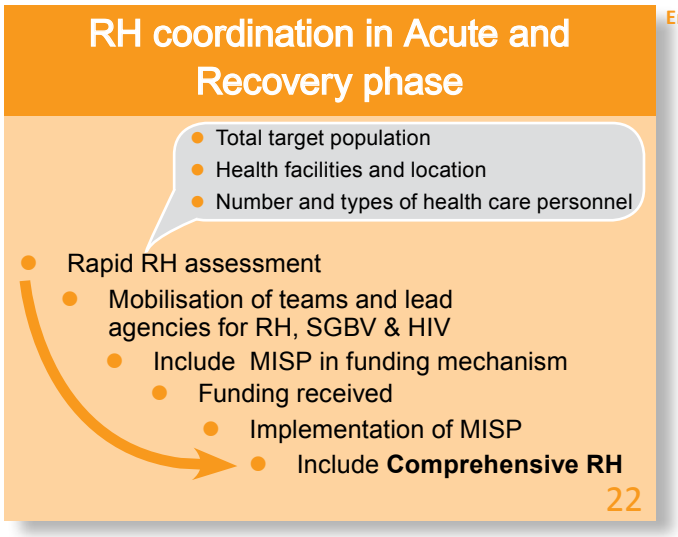
  Community based Organisations hygiene kits

  Government stockpiling/pre-positioning, distribution
- United Nations Disaster Management Team (UNDMT)

21

22

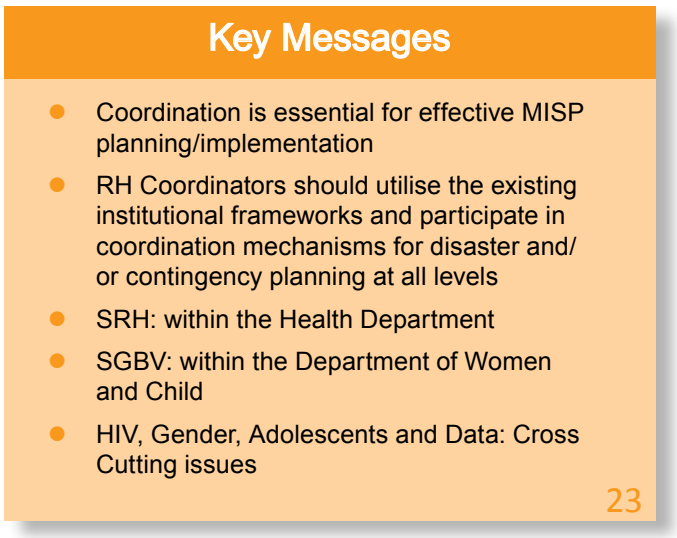
- This slide summarises the sequence of events and where MISP and comprehensive SRH can be included in the operational mechanisms. Explain that other resource mobilisation tools can comprise of strategy documents and action plans of the involved agencies.
- Emphasise that MISP does not require a needs assessment.
- Rapid RH assessment: stress that SRH Coordinators only need to know an estimate of the following:
  - Total target population,
  - Number of health facilities and their location,
  - Number and types of health care staff.



Emphasise

23

- Wrap up the session with the key messages and allow questions and answers as time permits.



Suggested Further Reading

- National DM Act 2005
- National Policy on DM 2009

(i) Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review: http://www.who.int/reproductivehealth/publications/emergencies/field_manual/en

(ii) Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations : Distance Learning Manual: http://misp.rhrc.org/index.php?option=com_content&view=article&id=3&Itemid=112

Sexual and Gender-Based Violence (SGBV)

Learning Outcomes

By the end of the Session, the trainees would be able to:

1. Define gender, distinguish it from sex and describe the gender base of socialisation process
2. Explain concepts and types of SGBV
3. Get sensitised to the magnitude of risk of the problem of SGBV in disaster situation
4. Discuss its causes, contributing factors and consequences of SGBV
5. Identify obstacles that women face in accessing support services
6. Identify the roles and responsibilities of service providers in supporting survivors of SGBV
7. Discuss the responses required to tackle SGBV in disaster situation in an Action Plan to integrate MISP in preparedness plan

Session Plan

Day 1 Afternoon - Sexual and Gender-Based Violence (SGBV)	
Time	**Session**
1400 – 1450	Introduction to Gender and SGBV Sexual Violence: Barriers to Care and Support and Guiding Principles
1450 – 1550	Medical Services for Rape Survivors
1550 – 1600	**Tea Break**
1600 – 1700	Group Work: 1. Referral Mechanism for Rape Survivors 2. Inter-Agency Coordination for SGBV
1700 – 1730	Action Plan Review and Discussions

Notes:

Introduction to Gender and SGBV Issues

Length
50 minutes

Overview	This session introduces the basic concept of Gender, Sex, Gender Violence issues with an informal interaction with the participants and includes the following key headings: Understand sex and gender issues;Define SGBV; Identify different forms of violence across the life span of a woman; SGBV and human rights; Indian legislation/laws and SGBV; Prevalence of SGBV: Indian data; Root cause analysis: Problem tree
Learning outcomes	By the end of the session, participants would be able to: ● Explain the concepts of Sex, Gender, SGBV and India specific data on SGBV. ● Identify the human rights, legal frameworks and root causes underlying SGBV and guiding principles when working with rape survivors
Preparation	Ensure that Action Plans are copied along with suggested preparedness activities, and poster on SGBV in Humanitarian Situation as available.
Materials	● Audio visual material: computer with projector ● Markers and flip charts or white boards
Methodology	Interactive session, Group discussion (Problem tree)

1 Process

Explain the learning outcomes.

Read the learning outcomes of the session: stressing that you will not address detailed clinical issues which will be addressed in the next session. However, practical information relevant for SRH coordinators will be highlighted.

Learning Outcomes

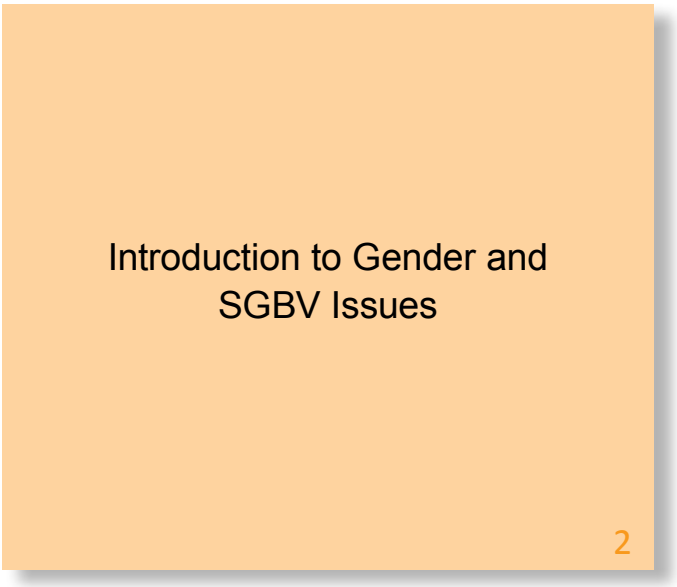
In this session the participants would be able to:

1. Define Gender, and sexual violence
2. Describe different forms of gender violence and its consequences
3. Explain the link between SGBV and violation of human rights
4. Outline root causes, risk factors and consequences of SGBV
5. Highlight that prevention and response to SGBV requires coordinated, multi-sectoral action
6. List down and ensure respect for the Guiding Principles

1

2 Participants' understanding of the concept of gender is essential for the module. The following is one quick exercise at the end of which one can verify and reinforce participants' knowledge of the difference between sex and gender.

1. Start the session by an interactive opening. Ask a question to know the participants views on difference between Sex and Gender.
2. Proceed to group work to understand this difference.
3. Divide the participants into four groups. Instruct them that this is a group work. The groups are given topics to work on: a) I want to be a man, b) I want to be a woman, c) I don't want to be a man and d) I don't want to be a woman. In the meanwhile when the groups are busy in group work, draw four boxes on the white board/flip chart and write the heading of each group work on each box.
4. As the groups share their work, jot down the answers in the respective boxes.
5. Request participants to identify points which are specific to a particular Sex. Discuss the remaining points as Gender and link it to sexual and gender violence.



Group Discussion

Note: SGBV, including sexual violence, is perpetrated primarily by males against women and girls. Men and boys are also vulnerable to sexual violence, particularly when they are subjected to torture and/or detention. Nevertheless, the majority of survivors of sexual violence are females. Therefore, for the sake of simplification, the Manual will often refer to survivors as females.

It is difficult to be 100% gender-sensitive: we are almost all influenced by gender in our ideas and actions.

3 • Emphasise on common terminologies and definitions provided by IASC guidelines.

Definitions

- Sex is biological i.e. innate physical characteristics that we are born with
- Gender is social i.e. characteristics that are learned gradually and can change over time

Gender refers to widely shared ideas and expectations (norms) concerning women and men; on how men and women should behave differently in the same situations; the different roles, social status, economic and political power of women and men in the society

3

4 • 1st bullet point: Explain that different acronyms are used by different organisations. It does not matter which acronym you use, we are all talking about the same thing.
- 2nd bullet point: Explain that there is no consensus on definitions.
- 3rd and 4th bullet points: These are examples of working definition for SGBV programming in disaster/ emergencies. Invite participants to read the definitions for themselves and ask: 'What are the key terms and concepts in both definitions?' (person's will, difference between males and females, different forms of violence, etc.).

Definitions

- No common terminology among Humanitarian agencies: SGBV, GBV, VAW
- No consensus on definitions
- IASC definition for GBV/SGBV: 'An umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females'
- There are also different types or forms of violence; (1) sexual: (2) physical; (3) harmful tradition practices (4) socio-economic; and (5) emotional and psychological
- UNHCR definition
  … gender-based violence that is directed against a person on the basis of gender or sex, it includes acts that inflict physical, mental or sexual harm or suffering, threats of such act, coercion and other deprivation of liberty…

4

5 • Invite participants to read for themselves the definition of Sexual Violence from the IASC GBV Guidelines.

Definition of Sexual Violence: *IASC Guidelines*

- Includes at least: rape/attempted rape, sexual abuse and sexual exploitation
- Is " any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work."
- Takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion

5

6 **Violence:** The World Health Organization (WHO) defines violence as "The intentional use of physical force or power, threatened or actual against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (World Health Organization, Geneva 2002).

Violence against Women: The Beijing Platform for Action (PFA) defines violence against women as "any gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".

Gender-based Violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and criminal acts in national laws and policies.

Sexual Violence: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work". (WHO, 2002).

Survivor/Victim: A person who has experienced gender-based violence is a survivor/victim. The terms "victim" and "survivor" can be used interchangeably.

Definition: Violence, Sexual Violence

- **Violence** refers to acts of aggression or intimidation, the use of force or threat which has physical, mental and social consequences for the victim. When a woman experiences violence on the basis of her gender or gender + caste, gender + religion (e.g. dowry death, rape of dalit women, rape of women from opposite religions during communal riots, sati, domestic violence, etc)
- **Sexual Violence:** 1) **lateral**-in form of harassment, molestation, and rape - when it is directed towards women from same apparently same class, (e.g. rape in marriage/sexual violence by intimate partner, wife beating, wife swapping, etc) 2) **vertical** when violence is directed towards women from lower caste/class

6

"Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.

Rape/Attempted Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Any penetration is considered rape. Efforts to rape someone which do not result in penetration are considered attempted rape.

Sexual Abuse is the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

Sexual Exploitation is any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another.

7 • Explain different forms/types of SGBV and the different forms of violence in the life span of a female which can be divided into six phases: before birth till death/old age.

Forms of Violence: *Life Span Experience of Women*

Phase	Shifting & changing nature and type of gender violence
Pre Birth	Sex-selective abortion (female foeticides), battered during pregnancy, Coerced pregnancy
Infancy	Infanticide, emotional & physical abuse, differential access to basic rights (food, medical care, etc)
Childhood	Child marriage, sexual abuse by family members &known people + strangers, differential access to basic rights (education)

7

Forms of Violence: *Life Span Experience of Women*

Phase	The Shifting & changing nature and type of gender violence
Adolescence early youth	Violence during courtship, economically coerced sex (e.g. for school fees, food), sexual harassments and abuse more with adolescents with disability), trafficking, honour killing, acid throwing
Reproductive age	Sexual violence (even can lead to death) in intimate partnership (within or outside marriage), forced pregnancies, sexual harassment at workplace, abuse of widows including forced marriage or sex by family members), rape, forced sex worker, property grabbing, dowry death, sati pratha, domestic violence, polyandry, public stripping & parading, rape by upper caste people, mob violence against women visiting late night parties/pubs
Elderly	Abuse of widows, physical and psychological violence by immediate family member. Property grabbing, differential access to basic right (food, medical care, staying with family), with hunting

7

8

- Correlate India's as well as International perception of SGBV and how it ensures equal rights to each citizen. Explaining SGBV from a human rights perspective sensitises the participant in a better and positive way.
- 1st, 2nd and 3rd bullet points: Explain that we are all born with human rights wherever and whoever we are. No one gives us human rights nor can they be taken away. We cannot enjoy some rights while being denied of others. A denial of one right, leads to many other rights being denied. Emphasise that all acts of SGBV are violations of fundamental human rights.

Human Rights

Advocacy

- "All human beings are born free and equal in dignity and rights" (Universal Declaration of Human Rights)
- Human rights are universal, inalienable, indivisible, interconnected and interdependent
- As per constitution of India, everyone is entitled to all the rights and freedoms, without distinction of any kind, such as race, gender, religion, political opinion, etc.
- Prevention of and response to gender based violence is directly linked to the protection of human rights

8

9 SGBV and Human Rights

- Ask participants: 'What human rights are violated when SGBV occurs?'
- Briefly facilitate feedback, click and show the answer (do not read all of them).

Highlight that SGBV violates many human rights principles and the law provisions are to protect the human rights by preventing it through punitive measures.

SGBV Human Rights

Advocacy

SGBV violates a number of human rights principles:

- Life, liberty and security of the person
- Freedom from torture or cruel, inhuman, or degrading treatment or punishment
- Freedom of movement, opinion, expression and association
- Enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and its dissolution
- Equality, including to equal protection under the law, even during war
- Human dignity and physical integrity
- Be free from all forms of discrimination
- Equality in the family
- The highest attainable standard of physical and mental health

9

10

- Indian scenario of SGBV: Reported data of Government of India, 2011 is the official proof of the number of incidences and rate of prevalence of such incidents.
- Ask participants if such forms of violence occur in their states and if yes what is their view on the prevalence. (Government data is proof of such incidences and shows their rate of prevalence. After this, show the CRB crime maps and ask participants to read the slide for themselves).

Sexual Violence in India

- First time included questions on sexual violence
  - Ever married women
  - All women (regardless of marital status)
- Women aged 15-49 — 8.5%
  - Currently married — 10.1%
  - Women age 15-19 — 5%
  - Before age 15 — 12%
  - Divorced/separated/widow — 25% (2.5 times higher than currently married women)
  - Rural — 10%
  - Urban — 6%

(Sample size 83,703 women)

Source: NFHS3

10

11

- This slide explains the constitutional rights and laws on SGBV in India.

Rights and Laws on SGBV in India

1. The Crimes under the Indian Penal Code (IPC)	2. The Crimes under the Special & Local Laws (SLL)
i. Rape (Sec. 376 IPC) ii. Kidnapping & Abduction for specified purposes (Sec. 363 – 373 IPC) iii. Homicide for Dowry, Dowry Deaths or their attempts (Sec. 302/304-B IPC) iv. Torture – both mental and physical (Sec. 498-A IPC) v. Molestation (Sec. 354 IPC) vi. Sexual Harassment (Eve Teasing) (Sec. 509 IPC) vii. Importation of girls (upto 21 years of age) (Sec. 366-B IPC)	i. Immoral Traffic (Prevention) Act, 1956 ii. Dowry Prohibition Act, 1961 iii. Indecent Representation of Women (Prohibition) Act, 1986 iv. Sati Prevention Act, 1987

11

12

- Mention that SGBV happens in all societies and cultures and is often exacerbated in disasters.

Figures at a Glance-2011

Sl. No.	Crime Heads	Cases Reported	% Total IPC Crimes	Rate of Crime	Charge Sheeting Rate	Conviction Rate
4	Rape	24206	1.0	2.0	93.8	26.4
B) Crime Against Women (IPC+SLL)						
1	Kidnapping & Abduction of Women & Girls	35565	1.5	2.9	73.0	28.1
2	Molestation	42968	1.8	3.6	96.5	27.7
3	Sexual Harassment	8570	0.4	0.7	96.4	45.8
4	Cruelty by Husband and Relatives	99135	4.3	8.2	94.4	20.2
5	Importation of Girls	80	0.0	0.0	82.4	7.8
	Total Crime Against Women (IPC+SLL)	228650	9.8	18.9	92.0	26.9

Source: NCRB, 2011

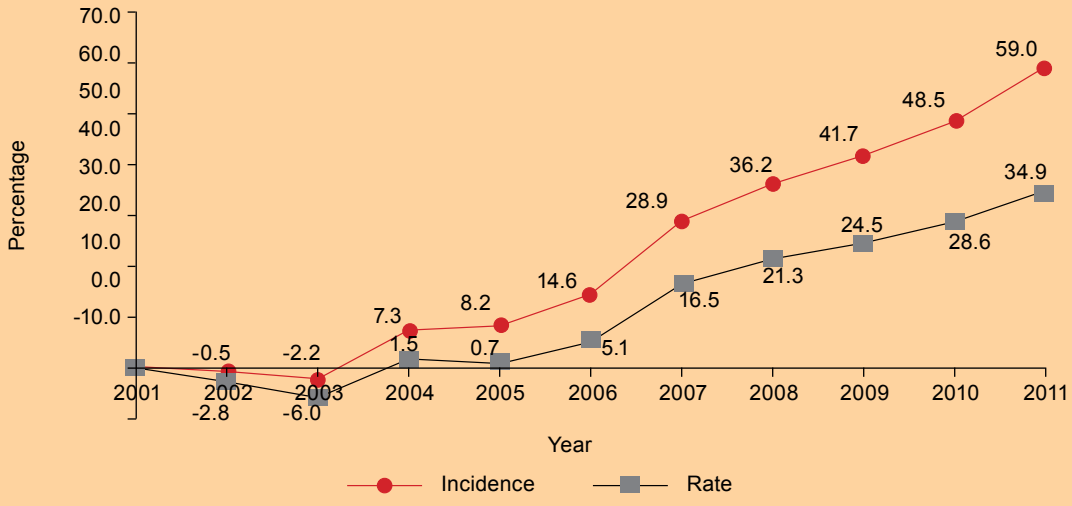
12

13

The participants should be encouraged to discuss any issue that is relevant to this topic.

1. In India, almost 20 -70% of the women interviewed were talking about their abuse for the first time (Multi-country research-WHO).
2. Majority of the women consider violence by men/wife beating as normal. So they do not come forward to report such incidences.
3. According to the Indian Penal Code (IPC), violence against women has increased [rape by 69%; molestation by 24% and sexual harassment by 86% during the period 1995-99].
4. The Supreme Court has approved the doctors to examine the case at the earliest even before the police are involved to avoid delay of examination of the survivor so that the evidence is not lost (Satyasundaram 2002).

Incidence & Rate of Crime Against Women Percentage Change from 2001



13

14

- Here is some data on the incidence and rate of human trafficking.

Human Trafficking

INCIDENCE	RATE
2010 : 3,422	2010 : 0.3
2011 : 3,517	2011 : 0.3

- 2.8% increase in human trafficking incidence was observed in 3,517 cases in 2011 as compared to 3,422 in 2010
- Percentage distribution of Immoral Trafficking (69.2%), Procurement of Minor Girls (24.5%), Selling of Girls for Prostitution (3.2%) and Importation of Girls (2.3%) and Buying of Girls for Prostitution (0.8%) were observed
- 122.2% of increase of cases of 'Importation of Girls' was reported during 2011 over 2010

14

15

- Not to forget that for every case reported against children there are a hundred, which are not reported.

Crime against Children

INCIDENCE	RATE
2010 : 26,694	2010 : 2.3
2011 : 33,098	2011 : 2.7

- An increase of 24.0% was reported in incidence of crime against children in 2011 over 2010

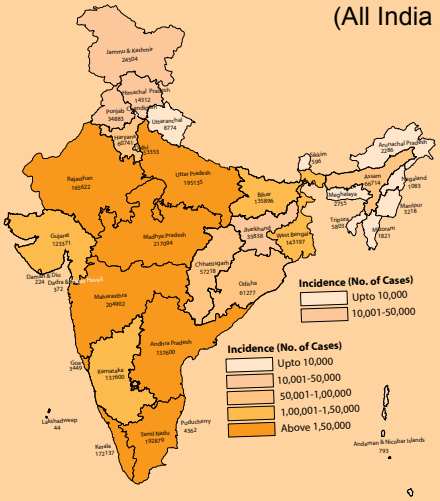
15

16

- Accentuate or reiterate the fact that SGBV is a human right issue.
- Show slide and explain the rate and incidence for the year 2010.

Incidence of IPC Crime During 2010

(All India 2325575)



16

17 • Slide will show the incidence and rate of crime against women in 2010-11.

Crime against Women

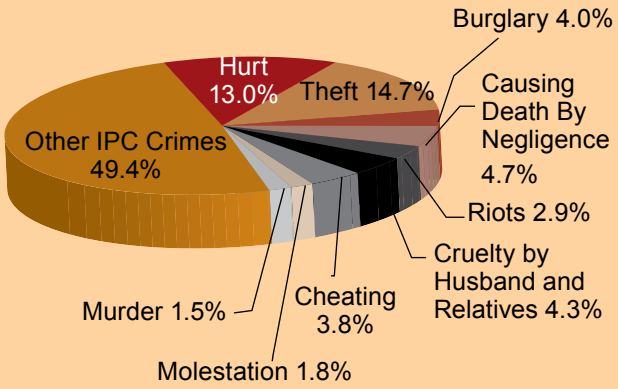
INCIDENCE	RATE
2010 : 2,13,585	2010 : 18.0
2011 : 2,28,650	2011 : 18.9

- West Bengal reported 12.7% of total such cases in the country (29,133 out of 2,28,650). Tripura reported the highest crime rare (37.0) as compared to the National average rate of 18.9
- The proportion of IPC crimes committed against women towards total IPC crimes has increased during last 5 years from 8.8% in the year 2007 to 9.4% during the year 2011

17

18 • This slide is a distribution of IPC crimes in 2011.

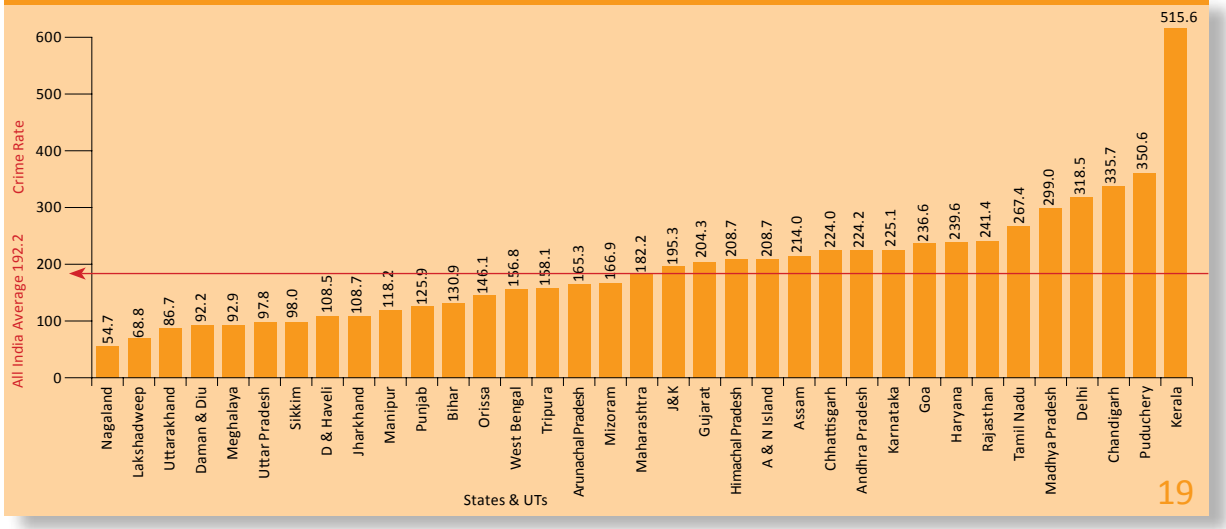
Percentage Distribution of IPC Crimes during 2011



18

19 • Ask the participants to read the figure for their respective state and have a brief dialogue on it. Highlight that the data refers to the **reported cases** only.

State-wise IPC Crime Rate during 2011



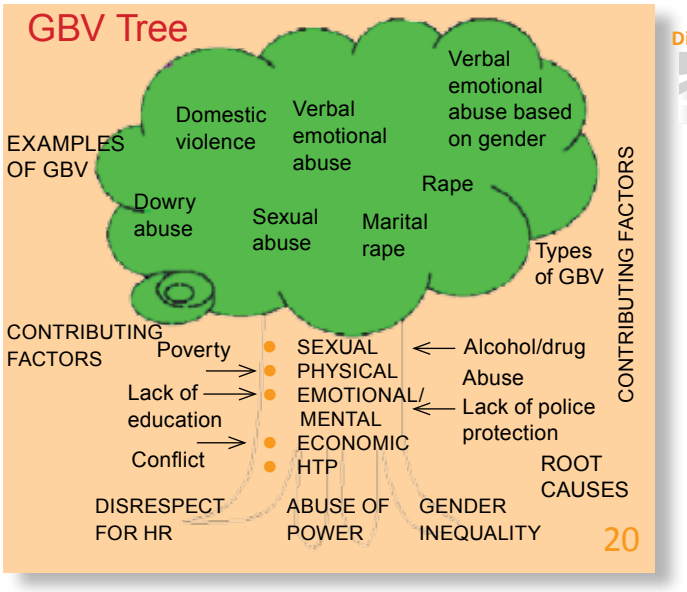
19

20 Causes, Risk factors and Consequences of SGBV.

Group Discussion

Do not show the next slide. Move the flip chart with the tree drawing in front of the participants.

a. Explain that this is the SGBV tree. It has roots, a trunk and branches. The branches represent examples of SGBV, the trunk represents contributing factors, while the roots signify the underlying or root causes.
b. Ask the group to give some examples of SGBV. Stop the discussion when you have five to eight examples. Write the appropriate examples in the branches of the tree. Some examples might be: rape, domestic violence, sexual exploitation, etc.
c. Write the following types of violence on the tree trunk and point out where the examples given before fall: Sexual/Physical/Emotional-Mental-Social/Economic/Harmful Traditional Practices.
d. Explain that in order to design effective SGBV programming, we must understand the contributing factors and underlying causes of SGBV.
e. Ask participants for examples of causes and contributing factors. Write them in the appropriate areas of the tree. Continue until you have elicited the majority of items listed in the slide below.



Contributing factors

Physical: Domestic violence, assault and other physical violence.

Emotional: Verbal, emotional abuse, humiliation, discrimination, denial of opportunities, spouse confinement.

Economic: Can be a component of any of the above.

Harmful Traditional Practices (HTP): Early/forced marriage, honour killings, dowry abuse, widow ceremonies, punishment to women for crimes against culture, denial for education, food for girls due to gender role expectations.

Key Discussion Points (for the facilitator to consider)

- The root causes of all forms of SGBV lie in the society's attitudes towards women and practices of gender discrimination - the roles, responsibilities, limitations, privileges, and opportunities accorded to an individual on the basis of their gender. Addressing the root causes through prevention activities requires sustained, long term action with change occurring slowly over a long period of time.
- Contributing factors are factors that perpetuate SGBV or increase risk of SGBV, and influence the type and extent of SGBV in any setting. Contributing factors do not cause SGBV although they are associated with some acts of SGBV. Some examples: alcohol/drug abuse is a contributing factor—but all alcoholics/drug addicts do not beat their wives or rape women.
- Disasters, wars, displacement, migration and the presence of armed combatants are all contributing factors, but all soldiers do not rape civilian women.
- Poverty is a contributing factor, but not all poor women and girls will be sexually exploited or will resort to sex work.
- *Many contributing factors can be eliminated or significantly reduced through prevention activities.*

Some Myths and Realities about GBV

Myths	Realities
SGBV happens only to poor and marginalised women	SGBV happens among people of all socio-economic, educational and racial profiles
SGBV is not common in industrialised countries	Even in developed countries such as the US, one in three women report being physically, sexually abused by their partner
Men cannot control themselves. Violence is simply a part of their nature	Male violence is not genetically based, it is perpetuated by a model of masculinity that permits and even encourages men to be aggressive
Victims of gender based violence provoke the abuse through their inappropriate behaviour	Blaming the victim is precisely the kind of attitude that has the potential to cause harm to a survivor of violence
Most women are abused by strangers. Women are safe when they are home	Studies consistently show that most women who experience GBV are abused by people they know; often the perpetrators are those they trust and love

Attitudes

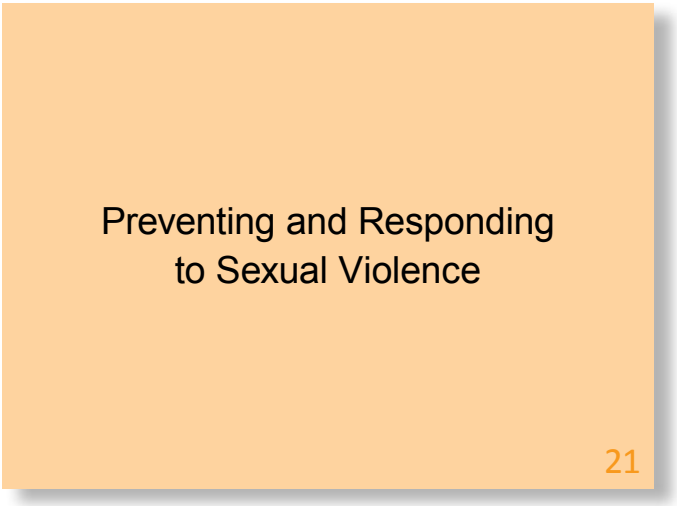
Gender-based violence is justified by social and cultural norms as well as attitudes and beliefs by both men and women across many societies. Such common attitudes include:

1. Notion that men have the right to control wives' behaviour and to 'discipline' them:
   "If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings." (a husband in India)
2. Notion that there are 'just' causes for violence:
   "If I have done something wrong…, nobody should defend me. But if I haven't done something wrong, I have a right to be defended." (a woman in Mexico)
3. Blaming the victim for the violence received:
   Saying that girls and women who are raped "asked for it" because of the way they were dressed.

Source: WHO TEACH-VIP, 2005

21

- Explain that you will now briefly discuss inter-agency coordination for the prevention of and response to SV.



22

- Explain that Sexual Violence (SV) is highlighted because, although SGBV in all its forms is an issue in disasters, agencies agree that preventing and responding to SV is the **minimum intervention** that needs to be in place in the early phase of disasters because of the immediate life-threatening impact of SGBV. For the rest of the sessions we will therefore focus on SV (other SGBV interventions must follow as the situation stabilises).
- According to WHO report, GVB accounts for more deaths and disability than cancer, malaria, traffic injuries or war put together among women aged 15-44 years.

Why Focus on Sexual Violence in Disasters?

- SV is immediately life threatening
- SV has serious negative consequences at all levels
- Effective response to SV can prevent further violence
- Prevention and response to SV is a minimum standard in humanitarian (SPHERE & MISP)

22

23

- Explain that you will now briefly discuss inter-agency coordination for the prevention of and response to sexual violence.
- Explain the contents of the slide.
- Invite participants to open the matrix poster from their IASC GBV guidelines. Explain the structure of the guidelines.

IASC Guidelines for GBV Interventions in Humanitarian Settings

Contents

- Best "sectoral" practices presented in a framework to facilitate coordination and information sharing
- Document and resources on CD

Purpose

- To enable the delivery of the minimum required multi-sectoral response to SV in emergency situations

Target audience

- Authorities, personnel and organisations working in emergency settings

23

Key discussion points explaining the structure of the IASC Guidelines:

- The document is built around the Matrix. The rows in the matrix represent 10 sectors or over-arching functions and the columns represent the three response phases recognised in the humanitarian response.
- The division of the sectors is based on the chapters in the Sphere standards, which are widely recognised as the minimum standards of humanitarian response in emergencies.
- The three response phases are the preparedness, the minimum prevention and response, and comprehensive response.
- The numbers in the middle column outline an essential activity to prevent or respond to SV. These activities must be in place at the same time. As the situation evolves more comprehensive activities can be added depending on the setting.
- Each of the bullet points in the minimum response phase corresponds to a chapter in the guidelines. These chapters are called “Action Sheets”.
- Implementation details are available in resource documents referenced throughout the guidelines and included in the CD-ROM in the back of the guidelines.
- The Matrix is a very useful tool for inter-sectoral coordination.

24 Explain that you will now talk about prevention of SV. Stress that in order to do effective programming to prevent SV, it is important to understand the contributing factors in each of the sectors (point to the GVB Tree).

Preventive activities:

1. Careful site planning of displacement camps, in consultation with persons of concern, especially women.
2. Ensuring that female staff members are included in registration, security, food distribution, other sections, etc.
3. Setting up latrines, hygiene and water points to be accessible and safe and they should have proper lighting.
4. Ensuring that house-hold fuel collection methods are safe.
5. Ensuring that displaced women have individual registration cards, food ration cards etc.
6. Identifying persons/groups with special needs who could be at a higher risk for sexual violence such as female headed households, unaccompanied and separated children, women at risk, single women, persons living with disabilities, elderly etc. and determining their special protection and assistance needs.
7. Ensuring impartiality in access to services.

Prevention

To prevent sexual violence you need to know **root** causes and risk factors that put people at risk in every sector

- Food
- Protection
- Education
- Water Sanitation
- Camp management
- Community groups
- Health
- Community Services
- Police/Security

24

25
- 2nd bullet point: Ask participants to name some consequences of SV for each of the areas. For example:
  - Health: STI, unwanted pregnancies.
  - Psycho-social: Depression, social isolation.
  - Safety/security: Repeated rapes.
  - Legal/justice: Impunity.

Response

- To develop an appropriate response to sexual violence you need to understand the possible **consequences** of sexual violence
- Programming to address consequences can be grouped into four main areas:
  - Health
  - Psycho-social
  - Safety/security
  - Legal/justice

25

26

- Stress that in responding to the needs of rape survivors in all four areas, the guiding principles must be applied. Ask participants "What are the guiding principles''.
- Wait until participants mention the four principles and show the slide.

Guiding Principles in Responding to Sexual Violence

- Safety
- Confidentiality
- Respect
- Non-discrimination

26

Emphasise

Key Messages: Guiding Principles

Safety: Ensure the physical safety of the survivor

Confidentiality:

- The entire staff signs a code of conduct to respect confidentiality. This should be backed up by reporting mechanisms and punitive measures in case of breach.
- Share information with others only if survivor gives consent, or in emergencies, to save lives.
- Wherever possible, maintain anonymity of survivor and others involved in the incident.
- Keep all written information locked and secure.

Respect: be guided by respect for the wishes, rights and the dignity of the survivor:

- Conduct interviews in private settings.
- Be a good listener; do not judge; be compassionate.
- Be patient; do not press for more information if she/he is not ready.
- Ask only relevant questions.
- Avoid requiring her to repeat the story in multiple interviews.
- Reassure her that it was not her fault.

Non-discrimination:

- Provide all women (married or unmarried), girls, men and boys with access to services.
- Ensure same-sex interviewers, including: interpreter, doctor, police officer, protection officer, community service worker, others.

27

- Ask participants to whom the services must be addressed. Discuss and show slide.

Access to Sexual Violence Prevention and Response for All

Includes

- Adolescents
- Men
- Sex Workers
- Other marginalised groups

27

Group Discussion

28 Group Work

Conduct Group Work Station 1: Referral Mechanism for Rape Survivor (refer to page 77-81).

After the game ask participants to mention a few barriers to care and support.

Do you think all rape survivors can access medical care?

Discuss and show slide.

Barriers to accessing medical care after rape:

1. Rape survivors are stigmatised and blamed for the rape.
2. Health care providers consulted by rape survivors should respect confidentiality. Nobody should find out that the survivor came to seek health care services. Yet this is often not the case.
3. The rapist may threaten to harm the rape survivor if she tells about the rape to anyone.
4. Survivors may be reluctant to seek health care services because they feel the provider may also show no respect and blame them.

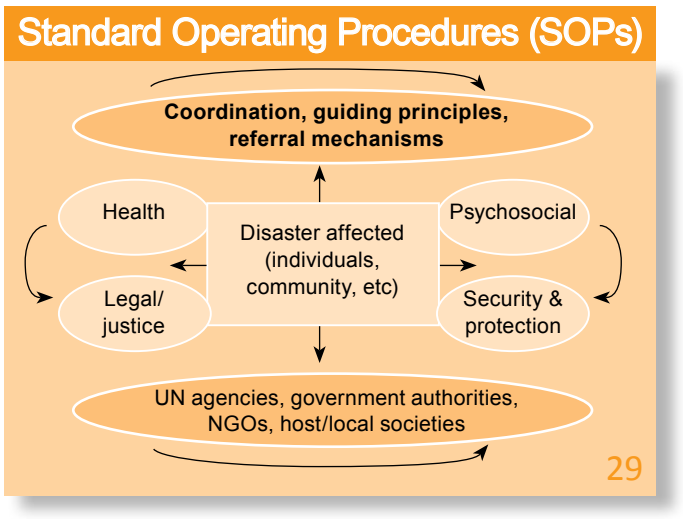
In most humanitarian situations, the rape survivor has to interact with a vast number of services. This can be very daunting and confusing to the survivor and may discourage her/him to seek care. Remember the importance of establishing inter-agency Standard Operating Procedures (SOPs) for care and referral of rape survivors. It is good practice to appoint a trained care manager (community or social worker) who can be offered to the survivor to support her/him and assist with the referral process.

Ask participants for solutions. This will gradually move the discussion to the next sub- topic of need for SOPs.

Group Discussion

29

- Explain that SOPs are an agreement among agencies outlining the roles and responsibilities when responding to SV.



30

- 4th bullet point: The SOPs lists the focal points in each of these sectors.
- Last bullet point: SOPs facilitate the response to SV at camp or community level, whereas the IASC GBV Guidelines are a tool for coordinating prevention and response at the inter-agency level.

Content of SOPs

- Definition of SGBV, its categories and key concepts
- Guiding Principles
- Roles and Responsibilities in terms of prevention and response
- Health, legal/justice, community, women's group implementing and operational partners, police, the government
- Reporting and referral mechanism
- Co-ordination, monitoring, and evaluation mechanisms
- SOPs put in place at camp/community level

30

31

Discuss the advantages of having SOPs in place in context of the web game and show the slide.

You may ask participants to identify lead agency and partners to set up SOPs or protocols for identification, response and referral of sexual violence survivors for the necessary assistance (agreeing on definition of concepts, reporting formats, referrals, etc.).

- Ensure that survivors of sexual violence have access to health services.
- Coordinate mechanisms for appropriate psycho-social support.
- Ensure 24/7 access to services, private consultation spaces, and conditions and reporting mechanisms obliging staff to maintain confidentiality.
- Ensure physical safety of survivors.
- Appoint staff trained on SV prevention and response mechanisms.

Advantage of SOPs

- Enhance *coordination* between partners by clarifying roles and responsibilities
- Facilitate a *common and agreed understanding* of what needs to be done and how it should (common definitions, reporting, monitoring)
- Facilitate *effective communication*
- Ensures *timely and quality response* to survivors

31

32

- Wrap up the session with the key messages and allow questions and answers as time permits.

Key Messages

- Sexual Violence is a violation of human rights
- Discrimination and gender inequality are root causes of SGBV
- A multi-sectoral and coordinated approach to sexual violence is important to prevent and respond to consequences of sexual violence
- Guiding principles should be observed at all times when responding to sexual violence

32

Medical Services for Rape Survivors

Length
60 minutes

Overview	This session offers an overview of the medical response to rape survivors. It highlights practical information relevant for SRH Coordinators
Learning outcomes	See below
Preparation	• Ensure that PowerPoint presentation handouts are photocopied • Ensure that participants have the Clinical Management of Rape Survivors (2004), and make sure you have studied it in advance
Materials	Markers and flip charts or white boards
Methodology	Interactive presentation

1 Process

- Read the learning outcomes of the session, stressing that you will not address detailed clinical issues but highlight practical information relevant for SRH Coordinators.
- 3rd bullet point: Show the book entitled 'Clinical Management of Rape Survivors' (available in the CD attached to the Manual).

Learning Outcomes

By the end of this session, you should be able to:

- Describe the essential components of the clinical management of rape survivors
- Implement an appropriate clinical care setting for rape survivors
- Know the key tools that support implementation of clinical management of rape survivors

1

2

- Refer to the legal definition. World-wide all definitions agree that rape is an act of sexual intercourse without consent.
- 4th bullet point: Ask audience to give examples, which may include (IASC Guidelines):
  - Rape of an adult female.
  - Rape of a minor (male or female), including incest.
  - Gang rape, if there is more than one assailant.
  - Marital rape, between husband and wife.
  - Male rape, sometimes known as sodomy (but women can also be victims of sodomy).

Definition of Rape

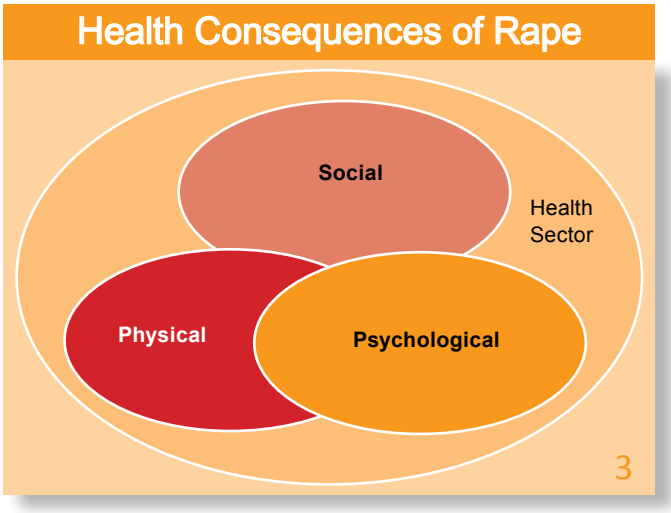
- An act of sexual intercourse without the survivors consent
- Any penetration is considered rape
- ''Attempted'' rape is an effort to rape someone which does not result in penetration

(Give Examples)

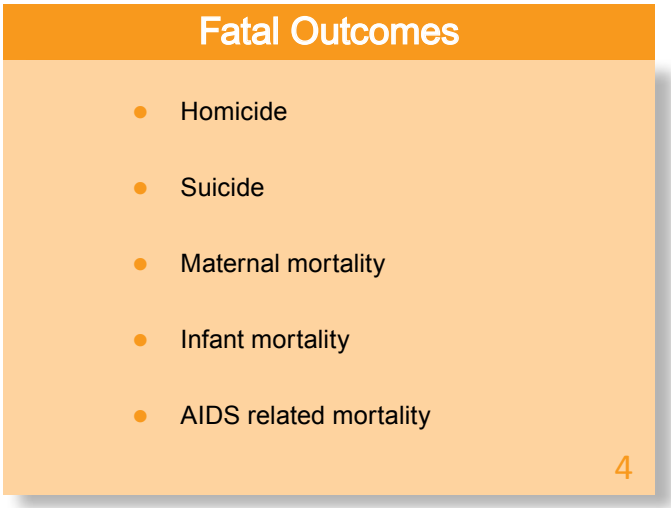
2

3 Click to show the Physical bubble, and ask audience to give examples of physical consequences of rape, such as: from relatively minor injuries to severe injuries, leading to permanent disabilities or death, STIs or HIV/AIDS, Pelvic Inflammatory Diseases (PID), infertility, chronic pain syndromes, unwanted pregnancy, unsafe and complicated abortion, pre-term labour and low birth weight.

- Repeat with Psychological bubble: Post-Traumatic Stress Disorder (PTSD), depression, suicide, anxiety/ fear, feelings of inferiority, inability to trust, or sexual dysfunction.
- Repeat the same process with Social bubble: Increased health care costs and increased legal and security costs, losses in women's income potential, interrupted education of adolescents, alcohol abuse, rejection and isolation of survivors, homicide, and delayed community reconciliation and reconstruction.
- Stress that all three dimensions are addressed to a certain extent by the health sector response. Therefore, the SRH Coordinator needs to ensure that health sector response is coordinated with other sector responses, as discussed in the previous session.



4 • Ask participants to mention the fatal outcomes. Discuss and show slides.



5
- Ask participants to mention the psychological consequences. Discuss and show slides.

Psychological Consequences

Mental Illness of survivors that requires medical intervention

- Post Traumatic Stress
- Depression
- Anxiety
- Phobias/Panic disorders
- Eating disorder
- Sexual Dysfunction
- Low self esteem
- Substance abuse

5

6 Explain the slide

- Click to show bullet point 1: The core role of the health sector is to provide clinical care for individual survivors of SV, who present to the health care setting. Other responsibilities of the health sector are to collect forensic evidence and referral of the survivor for further care if needed.
- Click to show bullet point 2: Collaborating with other sectors to prevent SV and to prevent stigmatisation and discrimination of survivors is also a role of the health sector.

Role of the Health Sector

- Respond to sexual violence:
  - Provide clinical care
  - Collect forensic evidence
  - Refer for further crisis intervention
- Prevent sexual violence and stigmatisation, in collaboration with other sectors

6

7 **Group Work:**

- Divide participants into four groups (by tables) and give one picture per group (explain the pictures: entrance sign, files, medicines, and latrine). Ask the groups to take two minutes to work on the following question and have a reporter share the group's findings: 'As SRH Coordinators, you are evaluating a post rape clinic. Give your comments and recommendations'.
- Facilitate feedback from participants
  - Entrance sign: Does not ensure confidentiality and safety, limited opening hours.
  - Files: Names should be coded and files put in a locked cabinet.
  - Medicines: Should be better organised with drugs in a separate cabinet.

Group Discussion

7

- Latrine: It is important to have access to latrines but male and female latrines should be separate.

8

- Summarise the previous exercise. Ask participants: 'So, what do you need to ensure when you set up a post-rape clinic?'
- Briefly facilitate feedback, click to show the answers and highlight points that were not mentioned by participants.
- 3rd bullet point: Private room with all equipment ready, so that the service provider does not need to walk in and out to look for things. The room should also have easy access to latrines and running water.
- Last bullet: Make sure that clothes of different colours and patterns are available for rape survivors who had their clothes torn apart during the incident (providing the same clothes for rape survivors will increase the risk of stigmatisation because rape survivor will be identified by their clothes).

The treatment will be directed at the relief of pain and repair of tissue damage. In the case of pregnant woman, special attention must also be paid to the foetus. The health care providers should also counsel the members of the in-laws' household and her own household. The health provider should:

1. Try to understand the severity of physical damage and trauma.

Clinic Setup

- Provide 24/7 services
- Ensure access for adolescents
- Private consultation area
- Secure, lockable file cabinet
- Don't let the survivor wait
- Ensure all equipment is ready
- Explain everything, obtain consent for everything!
- Patient information leaflets
- Provide new clothes when needed

8

2. Encourage patients to tell everything but without coercion or any pressure.
3. Ensure confidentiality and privacy [Private consultation area].
4. Respect the views and perceptions-Explain everything, obtain consent for everything.
5. Do not be judgmental.
6. Treat and manage the patients in an empathetic way.
7. Start treatment as soon as possible-Don't let the survivor wait.
8. Treat according to severity of damage.
9. Assist to make a plan for the protection and safety of the injured parties-secure, lockable file cabinet.

(Source: *Training Module on the Management of Violence against Women,* Government of Bangladesh, and UNICEF, 2000)

9

- 1st bullet point: Refer again to the guiding principles. One way to ensure confidentiality is to have all staff (including support staff) sign a code of conduct, which is backed up by reporting mechanisms.
- 2nd bullet point: Ideally the health care provider is of the same sex as the survivor and speaks her language. If the provider is not of the same sex as the survivor, ensure that there is a trained chaperone. Also allow the survivor to have one trusted support person in the room with her. Avoid having too many people in the room. Police officers should not be in the examination room.

Preparation of Staff

- Ensure confidentiality: all staff sign code of conduct
- Same sex/language trained staff, 1 support person
- Ensure trained staff are employed and have correct information
- Prepare and translate all protocols and forms

9

- 3rd bullet point: Whereever possible, make sure female health workers are recruited to provide post-rape care.

10

- Explain that the medical management consists of three key elements.
- Explain that the next slides will focus on the first two bullets points.

Medical Management of Rape Survivors

- **Provide clinical care:**
  - History
  - Examination
  - Treatment
  - Counselling
- **Collect forensic evidence**
- **Refer for further crisis intervention**

10

11

- 1st bullet point: The majority of survivors do not tell anyone about the rape. In coming to you and telling you what has happened, she is demonstrating her trust in you. Do not betray this trust. The first step to recovery is often your reassurance that she did not deserve to be raped, that the incident was not her fault and that it was not caused by her behaviour or manner of dressing. This requires awareness of the provider's own feelings and preconceptions.
- 2nd bullet point: She may have reported to the police or community services already. Carefully read any documentation that she brings along and do not make her tell her story again, unless it is absolutely necessary.

Clinical Care

Emphasise

History and examination

- Compassionate and non-judgmental
- Survivors own pace, no unnecessary repeating
- Explain everything you are going to do
- Do not do anything without consent
- Follow History and Examination forms
- Document everything thoroughly

11

12

- Stress that the primary objective of the examination is to determine the medical care that needs to be given. However, forensic evidence may also be collected to help the survivor pursue legal redress.
- While reading out the points in the left column Stress that evidence is collected during the examination.
- Click to show the reasons as to why we collect evidence (left column). Ask participants what kind of evidence would be useful for issues mentioned in each of the bullet points:

Medical Management: Forensic Evidence

Forensic evidence is collected during the clinical examination

- To confirm recent sexual contact
- To show that force or coercion was used
- To possibly identify the assailant
- To corroborate the survivor's story

Types of evidence that can be collected

- **Medical documentation**
  - Injuries
  - Presence of sperm (<72 hours)
  - State of clothes
- Clothes
- Foreign materials
- Foreign hairs?
- DNA analysis?
- Blood or urine for toxicology testing?

12

- To confirm recent sexual contact: Sperm.
- Force or coercion: Wound, bruises, trauma.
- To identify assailant: DNA (not a possibility in most settings).
- Story corroboration: Document findings that support her report of events.

- Click to show the right column: Medical documentation (documenting findings during examination) is often the only type of evidence that can be collected in emergency settings, and therefore is very important.
- Other types of evidence that can be collected are:
  - Taking torn clothes (take it only if you can provide replacement clothing).
  - Foreign material: Such as soil, leaves, grass on clothes or body or in hair.
  - DNA, foreign hair and toxicology testing is usually not available. SRH Coordinators should be aware of the limitations of the setting and inform providers accordingly.

13

- Last bullet point: The chain of evidence is maintained by:
  - Correct collection of evidence.
  - Correct labelling (with anonymous code).
  - Correct storage and transport (to conserve samples).
- Hand-over document with signatures of the responsible persons to avoid risk of manipulation.

Medical Management: Forensic Evidence

- Findings should ALWAYS be documented
- Other evidence is ONLY collected IF
  - Timing is appropriate (<72 hours?)
  - Local possibilities for analysing samples
  - Government policies are respected
  - Consent is obtained
  - The chain of evidence can be maintained

13

14

- 1st bullet point: Stress that life threatening complications should be treated first.
- Click to show the 2nd bullet point: Ask participants 'What are the STIs you want to prevent?'
- Click to show the answer: Stress the usage of local treatment protocols. Where possible, prescribe the shortest oral treatment.
- There is growing evidence that one gram of Azithromycin will prevent incubating syphilis as well as chlamydia. However, be aware that established syphilis cannot be treated by Azithromycin.
- Click to show the 3rd bullet point: Ask participants 'What is Post-Exposure Prophylaxis (PEP)?'and then 'What is the timing for the administration of PEP?' (72 hours).
- Click to show the answer: Write **72 hours** on the flip chart to stress the short time period during which rape survivors can benefit from PEP. If rape survivors come to the clinic after 72 hours, it is too late for PEP and referral for Voluntary Counselling and Testing (VCT) is needed 3-6 months after the incident, if the survivor wants to know her HIV status.

Clinical Care: Treatment

- Treat life threatening complications first
- STI Prevention
  - Syphilis, Chlamydia, gonorrhea (other infections if common)
  - Use local treatment protocols
  - Hepatitis B vaccination, if indicated
- Prevent HIV transmission (PEP)
  - If incident **<72 hours** and risk of transmission
  - **Zid ovudine** (AZT) + Lamuvidine (3CT) for 28 days

14

Emphasise

15

- 1st bullet point: Emphasise that testing is not a requirement before giving PEP.
- 2nd bullet point: Stress that the sooner the first PEP dose, the more beneficial it is.
- 3rd and 4th bullet points: Give seven day supply, schedule a visit on day six to assess the patient and to give the rest of the supply (21 days). If the follow-up visit on the sixth is not feasible, service providers should then dispense the full supply (28 days).
- Last bullet point: When the person is repeatedly assaulted, consider other crisis interventions and offering durable protection.

Considerations when Supplying PEP

Emphasise

- HIV testing is **not a requirement** for supplying PEP if survivor presents< 72 hours of rape, but: **first dose the sooner the better**
- Provide one-week, then three-week supply but: **full supply if the survivor can not return**
- Schedule return visit one day prior to last dose
- For recurrent exposures requiring repeat PEP: **Crisis intervention, Offer protection**

15

16

- If the menstrual history is not clear, rule out an existing pregnancy with a pregnancy test (best option) or a checklist if no pregnancy test is available (checklist on page 12 of the Clinical Management of Rape Survivors).
- 1st bullet point: Ask 'How many days after the incident can you prevent the pregnancy with Emergency Contraception (EC) pills?' (five days: stress that it is no longer 72 hours as recommended in previous guidelines).

Then ask 'What other method can be used?' (Intrauterine Device (IUD).

- Click to show the answer: EC pills: ***facilitators must study Annexure 11 of the Clinical Management of Rape Survivors*** so that they can give the appropriate information. Levonorgestrel (the preferred EC method) is included in RH Kit 3 (rape treatment).

Clinical Care: Treatment

Emphasise

- **Prevent Pregnancy**
  - 5 days
  - Preferred: levonorgestrel 1.5 mg single dose
  - Or: ethinylestradiol 10 mcg + levonorgestrel 0.5 mg,
  - Two doses 12 hours apart (Yuzpe)
- **Injury Care**
  - Clean and treat wounds
  - Provide tetanus prophylaxis and vaccination
- **Refer for higher level care if needed**

16

17

- Explain to participants that the education of survivors on their treatment plan needs to take into account the listed bullet points.
- 2nd and 3rd bullet points: Stress that VCT is recommended at baseline and three months, and that condom use is recommended until HIV status is determined.
- 4th bullet point: If a pre-existing pregnancy is diagnosed, then it is not a result of the rape. The survivor needs to be reassured and referred for early antenatal care, as potential pregnancy complications due to the rape need to be monitored (miscarriage, infections, early labour, etc.).
- 5th bullet point: Counsel on the available options: Keeping the pregnancy, adoption, safe abortion if legal, or abortion in another country, etc. If she chooses to keep the pregnancy, refer for early antenatal care. Social support is also needed as mothers with children born as a result of rape maybe stigmatised by the community. It is important to give early support to the mother and child and find solutions in case the child is neglected.

Clinical Care: Treatment Counselling

- Effectiveness of drugs, importance of adherence, side effects
- VCT recommended at baseline and 3 months
- Use condoms until 3 months after rape (or until HIV Status is determined)
- Too late for EC, or pregnancy as result or rape?
- Counsel survivor on all option
- Follow up visit at 1 week, 6 week, 3 months
- Return at any time if problems

17

18

- 2nd bullet point: As a first step to psychological support of the survivor, the provider must be compassionate, supportive, non-judgmental and aware of his/her own taboos and pre-conceptions.
- Last bullet point: The provider needs to refer all cases to community or social services (but should not force her to go). *Facilitators must study pages 26 and 27 of the Clinical Management of Rape Survivors* so that they can give the appropriate information.

Medical Management

Mental health care

- Most survivors will with trauma within their own culture and support systems
- At the ***health care setting:***
  - Respectful, confidential, non-judgmental care
  - Supportive listening, do not force taking at first visit
  - ***Refer*** to trained community focal point for *on going*
  - Psychological support

18

19

- Remind participants of the **guiding principle of Safety.**
- 5th bullet point: Stress that the survivor needs to give her/ his consent before sharing any information on the case.
- 6th bullet point: Share information only with actors providing assistance to survivors.

Medical Management: Safety Considerations

Mental health care

- Make sure survivor has a safe place to go to (refer)
- All files must be stored in secure locked cabinet
- Use codes (not names) on documents that are shared
- Reports or statistics made public should have **all** potentially identifying information removed
- Share only necessary and relevant information, **only if requested and agreed** by the survivor
- Only actors providing assistance
- Consider safety of staff

19

20

- Medical care of a survivor includes preparing a medical certificate or a police form. It is a confidential medical document that the service provider can hand over to the survivor.
- 3rd bullet point: Stress that the medical certificates often the only material evidence available.
- Last message: Stress that the survivor has the sole right to decide whether and when to use the medical certificate.

Medical Certificate

Emphasise

- Legal requirement
- Confidential medical document
- Often only material evidence available
- Completed by health care provider
- 1 copy to survivor, I copy locked with file
- Hand over ***with consent*** of survivor to
  - legal services
  - organisations with protection mandate

20

21

- The clinical management of children has some issues that needs special attention. **Facilitators must study Care for Child Survivors** (page 32 onward) of the ***Clinical Management*** of Rape Survivors so that they can give the appropriate information.
- The child should be given the choice in deciding who they want as a support person in the room during the examination.

Legal Issues

- Mention that it is obligatory to report cases of child abuse. SRH Coordinators need to be familiar with applicable legislation and should obtain a sample of the national child abuse protocol as well as information on police and court proceedings.
- Consent: There may be specific laws that determine as to who can give consent for minors. Normally it is the parent or legal guardian, ***unless he or she is the suspected offender***. In that case, a representative from the police, community support services or the court may sign the form.
- Health workers who have to deal with a lot of child abuse should get specific training.

Special Considerations: Children

Emphasise

- **Legal issues**
  - Trained health care workers
  - Find out state specific laws:
    - Reporting
    - Consent
- **Clinical Care**
  - Safe environment (beware of repeated abuse)
  - Adapt interview; slow, no leading questions
  - Never force examination
  - No digital vaginal, anal or speculum examination in young children
  - Appropriate drug dosage and forms
  - Emergency contraception even in Pre-pubertal girls!

21

22

- **Facilitators *must study Special Considerations for Men (page 28) of the Clinical Management of Rape Survivors*** so that they can give appropriate information.
- Last bullet point: Explain that while the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

Special Consideration: Men

- Male surivors are less likely than women to report the incident, because of:
  - Extreme embarrassment
  - Shame
  - Criminalisation of same sex-relationships
  - Slownesss of institutions and health workers to recognise the extent of the problem
- Psychological trauma and after-effects similar to women

22

23

- Explain that informing the community is essential for an adequate uptake of the services, and should address the ***what, why, where and when.***
- 2nd bullet point: Emphasise the 72 hours period.
- 3rd bullet point: Stress that the community needs to understand that PEP is not a treatment of AIDS, but helps prevent the transmission of HIV.

Inform the Community

- Provide information to community leaders, women's groups, adolescents, on prevention of sexual violence and where to get care
- Emphasise that to receive optimum care, survivors must report < 72 hrs
- Give correct information on available services (i.e PEP prevents transmission of HIV; it is **not treatment of AIDS**)
- Develop talking points to ensure all staff deliver the same message
- Use different media (radio, posters, leaflets) to disseminate your message

23

24

- Wrap up session with key messages and allow questions and answers as time permits.

Key Messages

- Guiding principles in medical management of rape survivors: *safety, confidentiality, respect non discrimination*
- Provide 24/7, confidential services that include at least
  - prevention of pregnancy (<5 days), STIs, and HIV transmission (<72 hours)
  - detailed documentation
  - referral for further crisis intervention
- Ensure staff have treatment protocols, forms, and supplies
- Coordinate confidential referral procedures between health, psychosocial, police, and legal services

24

25 • **Optional PEP Discussion:** The following slides may be useful for a discussion on PEP, which can be controversial in various settings. Tackle these slides if participants are interested and if time allows. Otherwise, offer this discussion to those who are interested during the breaks or at the end of the day.

PEP Discussion (optional)

25

26 • Explain that this shows the HIV transmission risk per consensual sexual contact, and that survivors who are vaginally raped (receptive vaginal) or anally raped (receptive anal) are at higher risk of infection.

PEP Discussion
Why PEP for Rape Survivors?

Exposure	HIV transmission risk [per consensual sexual contact]
Receptive vaginal	< 0.1% - 1%
Receptive anal	1-3 %
Insertive vaginal	< 0.1 %
Insertive anal	0.1 -1 %
Receptive oral	?
Needle stick	0.3 %

26

27 • Ask participants to discuss in pairs: '**Why** is the risk of HIV transmission increased in the case of rape?' and invite reporting after 30 seconds. Briefly facilitate feedback and click to show answers.

PEP Discussion
Why PEP for Rape Survivors?

Increased risk of HIV transmission with rape

- Multiple assailants
- Perpetrator unknown
- Genital trauma
- Anal penetration

27

28

- Ask participants: 'Is the HIV test result needed before starting PEP?'
- Then ask participants: 'What happens if you give PEP to someone who is already HIV-positive?'
- Briefly facilitate feedback and click to show answer and stress that it is possible for the HIV-positive individual to develop some drug resistance but this will disappear within six months. There will be no change in the natural history of the infection.
- Ask participants: 'Can PEP increase the risk of resistant virus in the community?'
- Facilitate feedback and click to show answer and explain that rape survivors are usually HIV-negative. By keeping survivors free from HIV infection, PEP actually reduces the transmission of HIV in the community.
- Last message: Emphasise that VCT is recommended prior to PEP but is not a pre-requisite.

PEP Discussion: Is HIV Test Result Needed before Starting PEP?

- PEP for already HIV-positive individual?
  - No benefit, no harm
  - Some resistance possible after PEP;
  - But disappears ≤ 6 month
  - No change in natural history of infection
- Increased risk of resistant virus in community?
  - PEP usually provided to HIV negative survivors
  - PEP will reduce transmission of HIV
- HIV VCT recommended, but not a pre condition

28

29

- Explain that there is no evidence for the superiority of three drugs over two. The two drug regime avoids serious side effects, the need for high-tech follow up and high costs.
- Providers should not give PEP to perpetrators. In case the suspected perpetrator is caught and the survivor is known to be HIV positive, it is not the role of the service provider to take care of the perpetrator. Above all, the provider needs to respect the survivor's confidentiality and therefore cannot disclose her status without her consent. In addition, the perpetrator must admit that he was responsible for the rape and the time frame needs to be less than 72 hours.
- Fake survivors: Some providers believe that there may be HIV positive people who do not have access to antiretroviral and who present the story that they were raped so as to receive PEP, hoping that this can cure AIDS. Community information needs to be clear to dispel such misconceptions.

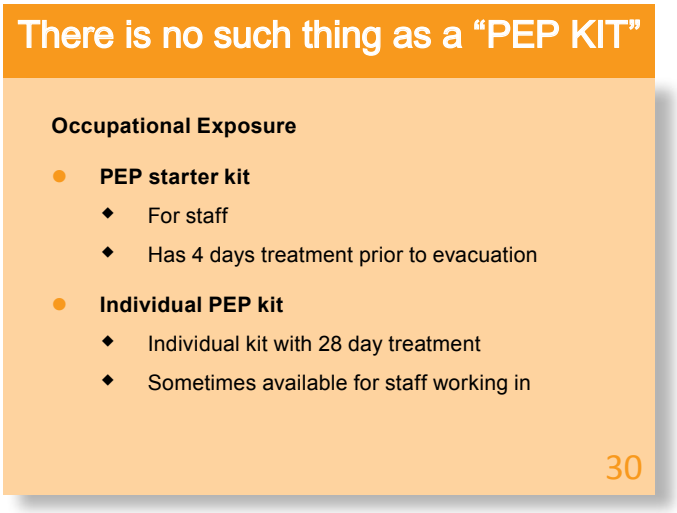
PEP Discussion

- **Two or three drugs?**
  - No consensus
  - No evidence that 3 drugs are more effective than 2
  - More side effects, less compliance
  - Possible dangerous complications
  - More high-tech follow-up needed
  - Increased cost ++
- **Other Points**
  - PEP for perpetrators if rape survivor known to be HIV positive"?
  - FAKE survivors?

29

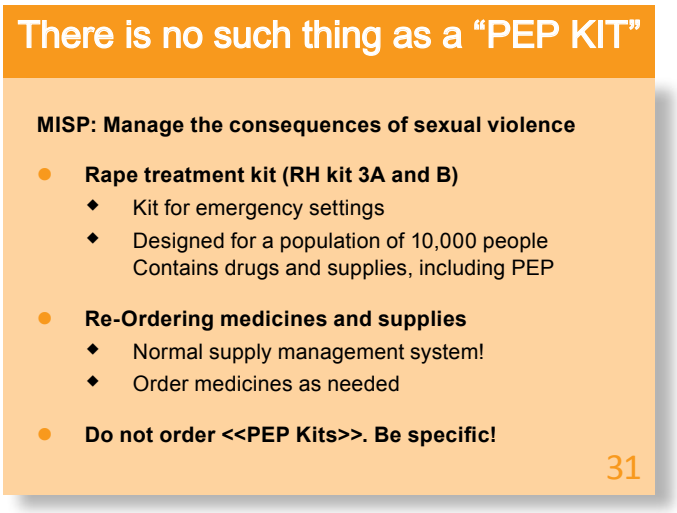
30

- The term 'PEP Kit' is confusing and should not be used. PEP is included in different types of kits.
- Click to show 'Occupation Exposure' and explain that UN agencies and some NGOs have PEP starter Kits or individual PEP Kits in the context of occupation exposure for their own staff.
- Click to show the different types of Kits.



31

- Explain that in the context of the MISP, PEP is part of managing the consequences of Sexual Violence together with EC and STI prevention.
- Click to show information on the rape treatment Kit.
- Click to show 'Reordering Medicines and Supplies': Insist that SRH Coordinators should follow the normal supply management system when re-ordering, especially when supplies are low and RH Kits should not be reordered.
- Click to show last message and insist that SRH Coordinators need to be specific in their Kit ordering.



Suggested Further Reading

Introduction to Gender and SGBV Issues

- Training Manual: Facilitator's Guide, Inter-Agency and Multi-sectoral Prevention and Response to GBV in populations affected by armed conflict, JSI/RHRC, 2004, available at http://www.rhrc.org/resources/gbv/gbv_manual/gbv_manual_toc.html

Medical Services for Rape Survivors

- Clinical Management of Rape Survivors, WHO/UNHCR, 2004, Geneva, available at http://www.rhrc.org/pdf/Clinical_Management_2005_rev.pdf
- Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, UNHCR, 2003, Geneva, available at http://www.rhrc.org/pdf/gl_sgbv03.pdf

SGBV Group Work Stations

Length
1 Hour

Overview	The group work stations will address: 1. Referral mechanisms for rape survivors (25 minutes) 2. Inter-Agency coordination for SGBV (25 minutes)
Learning outcomes	By the end of the session, participants should be able to: • Remember the importance of establishing Inter-Agency Standard Operating Procedures (SOPs) for care and referral of rape survivors • Use the IASC GBV Matrix as a tool for planning and follow-up
Preparation	• Ensure participants' worksheets for these stations are copied (if possible copy page 2 at the back of page 1) and staple all of them together • For other copies and preparation activities, see below • A facilitator is assigned to each station to set it up and facilitate it • The three stations need to be set up the evening before in different physical spaces or with enough distance between them so that groups do not disturb each other • If possible, assign a time keeper to inform each group to start wrapping up their work five minutes before the end of each session
Materials	See below
Methodology	Facilitated group work

1 Process

1. Ensure participants have their worksheets for the work stations.
2. Divide participants into two-three groups (try using a game to do so).
3. Facilitate the group work and, by gentle probing and constructive feedback, ensure that the group addresses key discussion points.
4. At the end of the sessions, bring participants together in large group and take five minutes to debrief.

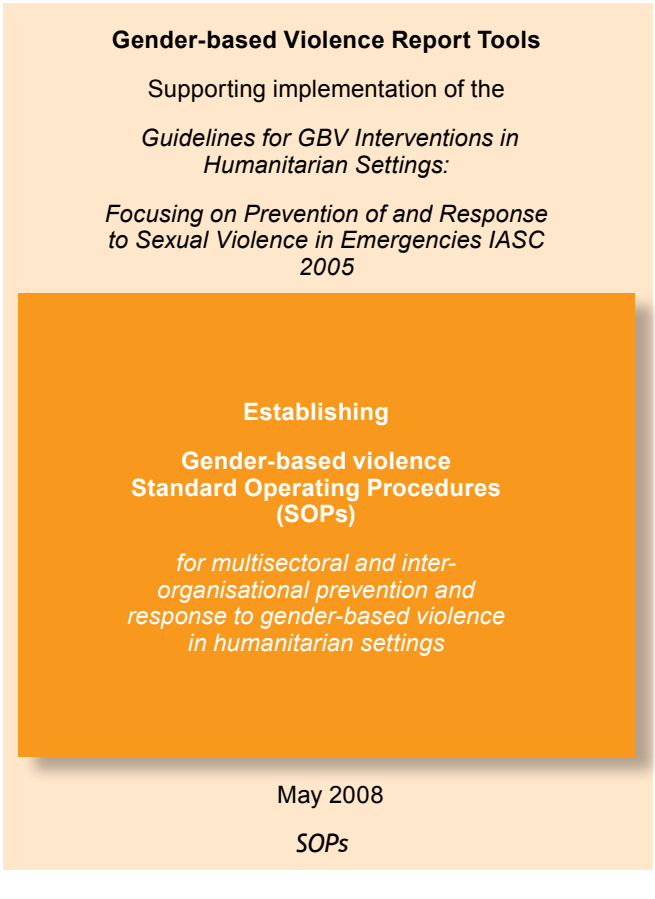
SGBV - Group Work Station 1: Referral Mechanisms for Rape Survivors

25 Minutes

(Adapted from Facilitator's Guide, Inter-Agency and Multisectoral Prevention and Response to GBV in Population Affected by Armed Conflict, JSI/RHRC, 2004)

Checklist

X	Number	Item	Comments
	1	Wool ball (red or similar colour)	
	1	Facilitator's instructions	
	1/role	Name tag stickers: Survivor Mother Community Leader TBA (Traditional Birth Attendant) ANM/ASHA Doctor Judge Police Lawyer Prosecutor Social Welfare Officer Women Commission Representative Women Protection Officer	• Make them yourself (three sets would be advisable) • If possible, collect the name tags after each group and use them again for the following group
	1/person	Standard Operating Procedures (SOP)	In CD-ROM



"Rape survivor" standing in the middle of the group circle and holding threads

SGBV - Group Work Station 1

Referral Mechanisms for Rape Survivors

Participants' Worksheet (Page 1 of 2)

10 Minutes

1. Conduct exercise

- Draw roles (those who do not have a role are observers)
- Follow the case narrative as told by the facilitator

15 Minutes

2. Facilitate a group discussion, using some of the following triggers:

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

Notes:

SGBV - Group Work Station 1

Referral Mechanisms for Rape Survivors

Participants' Worksheet (Page 2 of 2)

Key Discussion Points

- In most disaster situations, the rape survivor has to interact with a vast number of services. This can be very daunting and confusing to the survivor and may discourage her/him to seek care.
- Remember the importance of establishing Inter-Agency SOPs for care and referral of rape survivors.
- It is a good practice to appoint a trained care manager (community or social worker) who can be offered to the survivor to support her/him and assist with the referral process.

GBV - Group Work Station 1

Referral Mechanisms for Rape Survivors

Facilitator's Instructions

1. Ask for volunteers and distribute the name tags to the appropriate number of people. Tell them that they will be in the role of the person noted on their name tag.
2. Seat the volunteers in a circle, chairs fairly close together. Ask the remaining participants to stand outside the circle so that they can easily see the activity.
3. Explain that the ball of yarn represents a 20 year old girl who was raped.
4. Standing outside the circle, give the ball to mother and explain that the girl has told her mother about the incident.
5. Instruct mother to hold the end of the string firmly, do not let go, and throw the ball to the person you tell her.
6. Tell the story below, of what happens to this girl. Each time an actor is involved, the ball of string is tossed across the circle to that actor. Each actor who receives the ball will wrap it around a finger and then toss the ball to the next actor as instructed.

7. **Story**:
   A 20 year old girl was raped in a flood affected area while she had gone to release herself. The area did not have electricity and hence she was unable to see anyone's face. She tells her mother.
   - Mother takes girl to TBA
   - TBA refers the girl to the ANM
   - ANM helps, but the girl needs more health intervention and ANM refers girl to the Doctor
   - Doctor administers treatment and informs the police
   - Girl is send back to ANM/ASHA
   - ANM provides emotional support and refers the girl to the women protection officer
   - Women Protection Officer meets the girl, takes her back to the Doctor for a few more questions
   - Doctor sends the girl back to the Women Protection Officer
   - Women Protection Officer refers the girl to the Police
   - Police contact the Doctor
   - Doctor contacts mother
   - Mother takes girl to Women Commission Representative
   - Women Commission representative refers girl to a Lawyer
   - Lawyer contacts Police
   - Police contact Prosecutor to have him speak with the survivor
   - Prosecutor discusses with Lawyer
   - Prosecutor calls the Doctor about the survivor to get information about the medical examination
   - Doctor asks to see the survivor again because she forgot to examine something
   - The Doctor refers the survivor to a Social Welfare Officer
   - The Social Welfare Officer then contacts the Police to give them some new information
   - The Police contact the Social Welfare Officer to report the incident
   - The Social Welfare Officer contacts the mother to ask questions
   - The mother asks the survivor additional questions
   - The survivor goes to talk with the Community Leader because she is confused about the process
   - The Community Leader contacts the prosecutor and the Judge to find out the status of the case
   - They refer the Community Leader to the Police
   - The Police refer the Leader to the Social Welfare Officer
8. Stop the game when every actor has taken part in at least two communication exchanges regarding the case. There will be a large red web in the centre of the circle, with each actor holding parts of the string.

9. Pause to look at the web. **Ask some questions** to generate discussion:
   - What do you see in the middle of this circle?
   - Was all of this helpful for the survivor? Traumatic?
   - Can a situation like this happen in your setting?
   - What could have been done to avoid making this web of string?
   - Observers: How many times did the girl have to repeat her story?
   - Actors: How many times did you talk with the survivor—or with others about her? Do you remember the details?
10. Actors should let go of the string and let it drop to the floor. Leave the red stringy chaotic mass sitting on the floor for all to see.
11. **Hand out the sample Standard Operating Procedure Manual**. Take a few moments to go through it, highlighting the fact that these kinds of procedure manuals must be developed with the entire inter-agency team (as indicated on the cover). It will NOT work for one organisation to write procedures for others to follow.

Key Discussion Points

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

SGBV - Group Work Station 2
Inter-Agency Coordination for SGBV

25 Minutes

Checklist

X	Number	Item	Comments
	1/role	'Name' plates: ● Coordinator - Collector ● Protection Officer ● Education Officer ● Health Officer ● Water & Sanitation Officer ● Food Security & Nutrition Specialist ● Legal Advisor ● Shelter and Site Planning Officer ● Representatives from NGOs, e.g. Oxfam, Care, Red Cross ● Representatives from UN agencies e.g. UNICEF, UNFPA, WHO ● Observer (2 sets)	Make them yourself
	1/person	Scenario Case study Barmer	See below
	1/person	Matrix of interventions to prevent and respond to SGBV in humanitarian settings (IASC Guidelines	See below

Inter Agency Coordination for SGBV: Stakeholders with their name plates

SGBV - Group Work Station 2
Inter-Agency Coordination for SGBV

Participants' Handout

Case Study (Barmer, Rajasthan)

(adapted from the Sprint Facilitator Manual Course)

Report

Barmer in Rajasthan witnessed floods after 400 years, therefore people staying over there did not have the experience of floods for years and generations together. The sudden cloudburst resulted in 170mm rainfall, which shattered the unprepared population with hundreds of deaths and damage to property and livestock. Even the administration took time to handle the emergency situation.

Survivors are living in temporary shelter they have made from grass, branches, and some banana leaves. Drinking water is obtained from the Tapti River not far from the camp, however there are problems with this water source. Reports indicate that there are poor sanitation provisions for the survivors. NGOs have been asked by the district administration to dig latrines and set up water distribution points.

Cooking fuel is a problem, but there are forests one km away, where women go to get firewood. The survivors are supplied with some food supplies, but these have been exhausted. The local community and various organisations have been trying to help out, but this is clearly not enough and district administration has initiated a food pipeline programme by taking help from neighbouring villages.

Health problems in the province include malaria, cholera, measles, tuberculosis, HIV, meningitis, diarrhea, respiratory infections and skin conditions. Although no surveys have been completed, it appears that malnutrition may be a significant problem. There is an increase in trauma cases due to persons coming in with war wounds and there are reports of rapes and abductions of women, girls and boys and girls by armed men. Obstetrical complications are common, and although the maternal mortality ratio is not known, it is thought to be high.

There are health centres and health posts scattered around the three districts of Barmer village. The district hospital is in the city of Barmer (50 km from the temporary shelter camp).The closest hospital is 20 kilometres away in Bikaner. Being the only hospital in the vicinity,it is affect by an influx of survivors and demand for its services. A training of Primary Health Care Workers (PHCW) was undertaken in Barmer several years ago, but not as many as needed have been trained. Some TBAs received training about 10 years ago. Several organisations like Red Cross and MSF are providing limited health services for survivors of this enormous flood. There is already a major shortage of drugs and supplies that is looming.

Transport in the area is not possible by road as they were severely damaged in many connecting main highways. Only one train a day comes to the nearest village in Bikaner. The nearest airport is in Jaipur, which is 800 kilometres away. All of these are problematic at times. Roads around Barmer are subject to reduction in inundation after flooding, and access to some areas may be cut off for several days.

Your job

This morning in the Inter-Agency emergency coordination meeting you were given the above briefing and you were asked to represent your agency in a GBV coordination meeting. You are now holding this meeting with GBV focal points from health and other sectors, to discuss putting in place the most essential interventions to prevent and respond to SV of the flood survivors in Barmer.

Conduct the meeting, using the IASC GBV coordination matrix as a planning tool.

SGBV - Group Work Station 2

Inter-Agency Coordination for SGBV

Participants' Worksheet (Page 1 of 2)

10 Minutes

1. Set up of the exercise

This is a role-play exercise based on an imaginary refugee scenario:

- Take a name plate with a role
- Read the case study for yourself
- Review the minimum prevention and response column of the IASC GBV matrix

25 Minutes

2. Conduct a GBV coordination meeting, acting your assigned role and discussing the following issues:

- Which priority interventions are needed to prevent and respond to SV in the scenario?
- Which actor is responsible for which activity?
- By when should the activity be completed?

Notes:

SGBV - Group Work Station 2

Inter-Agency Coordination for SGBV

Participants' Worksheet (Page 2 of 2)

Key Discussion Points

- The GBV Matrix is a useful coordination tool
- It can be adapted to your setting
- Use your working GBV matrix as a record of planning and follow-up

SGBV - Group Work Station 2: Inter-Agency Coordination for SGBV Participants' Handout

Matrix of interventions to prevent and respond to SGBV in humanitarian settings

	Functions & Sectors	**Minimum Prevention and Response in an Emergency** (to be conducted even in the midst of emergency)	Activities in your setting	Responsibility of	Timeline
1	Coordination	1.1 Establish coordination mechanisms and orient partners 1.2 Advocate and raise funds 1.3 Ensure Sphere standards are disseminated and adhered to			
2	Assessment and monitoring	2.1 Conduct coordinated rapid situation analysis 2.2 Monitor and evaluate activities			
3	Protection (legal, social and physical)	3.1 Assess security and define protection strategy 3.2 Provide security in accordance with needs 3.3 Advocate for implementation of and compliance with international instruments and seek accountability/redress			
4	Human Resources	4.1 Recruit staff in a manner that will discourage SEA 4.2 Disseminate and inform all partners on codes of conduct 4.3 Implement confidential complaints mechanisms 4.4 Implement SEA focal group network			

	Functions & Sectors	**Minimum Prevention and Response in an Emergency** (to be conducted even in the midst of emergency)	Activities in your setting	Responsibility of	Timeline
5	Water and Sanitation	5.1 Implement safe water and sanitation programmes			
6	Food security and Nutrition	6.1 Implement safe food security and nutrition programmes			
7	Shelter and Site Planning, and Non-Food Items	7.1 Implement safe site planning and shelter 7.2 programmes 7.2 Ensure that survivors/victims of sexual violence have safe shelter 7.3 Implement safe fuel collection strategies 7.4 Provide sanitary materials to women and girls			
8	Health and Community Services	8.1 Ensure women's access to basic health services 8.2 Provide SV related health services 8.3 Provide community-based psychological and social support for survivors/victims			
9	Education	9.1 Ensure girls' and boys' access to safe education			
10	Information, Education & Communication	10.1 Inform community about sexual violence and the availability of services 10.2 Disseminate information on International Humanitarian Law to arms-bearers			

Action Plan Review and Discussions

Length
30 minutes

Overview	This session will allow the master trainers to present the action plan they worked on during the Training of Trainers, and to engage all participants to reflect on its relevance
Learning outcomes	By the end of this session, participants should be able to: • Outline elements of the plan related to coordination and SGBV • Assess the relevance of the proposed activities and discuss alternatives as needed
Preparation	Ensure that national plans worked on by master trainers are copied along with 'Suggested Preparedness Activities'
Materials	Markers and flip charts or white boards
Methodology	Self-reflection and group discussion

1 Process

1. The handouts of the draft action plan should have been distributed to participants during the first session in the morning ('Suggested Preparedness Activities' and the national plan as proposed by the master trainers).
2. Explain again the general format of the Action plan and how it reflects the different themes addressed during this training and that are needed to mainstream SRH in crises (Coordination, SGBV, MNH, HIV/STIs, etc.).
3. Stress again that this is a very important exercise that will be carried out at the end of each day. Participants will apply the information that they learn each day to reflect on the action plan. This matrix will allow participants to agree on roles and responsibilities of each organisation and individual to advance the agenda of SRH in crises in the country.
4. Review the proposed activities under coordination and SGBV with the whole group. Ask participants in groups of three or four take 30 minutes to reflect on their relevance and brainstorm on new ideas.
5. Explain that participants will have more time on day 3 to share their thoughts and comments on the national plan. They will spend two hours discussing, fine tuning and agreeing on the action plan and ways forward.
6. Bring the national planning session to an end and take 10 minutes to debrief the day with the whole group.
7. Close the day by thanking participants. Ensure that you have identified volunteers to do the review of day 1 for tomorrow's first session.
8. Inform participants that you will be available for further questions and comments after the end of the session.

Remaining happy trainers

At the end of the day, make sure you take time to:

- Debrief your day among co-facilitators to identify strengths and weaknesses, so that the team can find ways to improve for the rest of the training
- Set up the room and prepare sessions for day 2
- Exercise, eat, relax, and sleep plenty!

Breaking the Ice

Our experience has shown that organising an informal dinner with all participants at the end of day 1 helps break the ice further between participants and facilitators. Propose the idea to the group and make sure that those who will join you understand the time and venue. Have fun!

Maternal and Newborn Health (MNH)

Learning Outcomes

By the end of the morning, participants should be able to:

1. Identify key components of maternal and newborn health services needed in disaster
2. Identify strategies for setting up referral mechanisms (transportation, communication, support of referral hospitals)
3. Plan for comprehensive MNH programme services
4. Identify the needs of adolescent population
5. Provide for safe abortion care services
6. Discuss the role of FP in disaster and post disaster situations

Session Plan

Day 2: Maternal and Newborn Health	
Time	**Session**
1000-1030	Review of Day 1
1030-1145	Maternal and Newborn Health in Disaster and Post Disaster Situations (Tea will be served during session)
1145-1300	Adolescent Reproductive and Sexual Health (ARSH), Safe Abortion Care, Breastfeeding and Comprehensive care
1300-1400	**Lunch**
1400-1500	Family Planning in Disasters
1500-1515	**Tea Break**
1515-1630	Group Work: Clean Delivery and Immediate Newborn Care Post Abortion Care Quality of Care in MNH
1630-1700	Action Plan Review and Discussion

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Review of Day 1

Length
30 minutes

Overview	This session will allow participants to review key messages of Day 1
Learning outcomes	By the end of this session, participants should be able to recall key points from Day 1
Preparation	Invite two or three volunteers at the end of Day 1 to prepare this session
Materials	As needed by the volunteers
Methodology	As planned by the volunteers. Encourage them to make it fun and interactive

Notes:

Maternal and Newborn Health in Disaster and Post-Disaster Situations

Length
2 hour and 30 minutes

Overview	These sessions give an overview of why maternal and newborn health (MNH), safe abortion, breastfeeding and ARSH are essential components in disaster and post disaster situations
Learning outcomes	See below
Preparation	Ensure that PowerPoint Presentation handouts are copied
Materials	Markers and flip charts or white boards
Methodology	Interactive Presentation

1 Process

Review the learning outcomes. Stress on Advocacy of MNH services is necessary.

- Ask participants to take their MISP Cheat Sheet and refer to objective 4.
- Explain that you will start with MNH in disasters including ARSH, Safe Abortion and Breastfeeding and proceed to post-disaster settings, before addressing selected MNH topics relevant to coordination, if time allows. FP will be covered in a separate session.

Learning Outcomes

By the end of the session, you should be able to:

1. Identify key issues of maternal and newborn health services needed in disaster
   - Advocacy for MNH services in disasters
   - The three delays
   - Basic and Comprehensive Emergency Obstetrics and Neonatal Care (BEmONC and CEmONC)
2. Identify strategies for setting up referral mechanisms (transportation, communication, support of referral hospitals)
3. To understand the needs of Adolescents and the necessity of providing Safe Abortion care
4. Plan for comprehensive MNH programme services
   - Antenatal and Postnatal Care
   - Traditional Birth Attendants (TBAs)

1

2

- Explain that MNH is a continuum of care.
- Stress that Antenatal Care (ANC) and Postnatal Care (PNC) are not part of the MISP as you will explain later.

Maternal and Newborn Health (MNH)

Emphasise

Continuum promoting healthy mothers and babies through:
Care during pregnancy
(Antenatal Care - ANC)
Pitfalls: ANC not part of MISP!

Care at the time of delivery, including emergency obstetrics

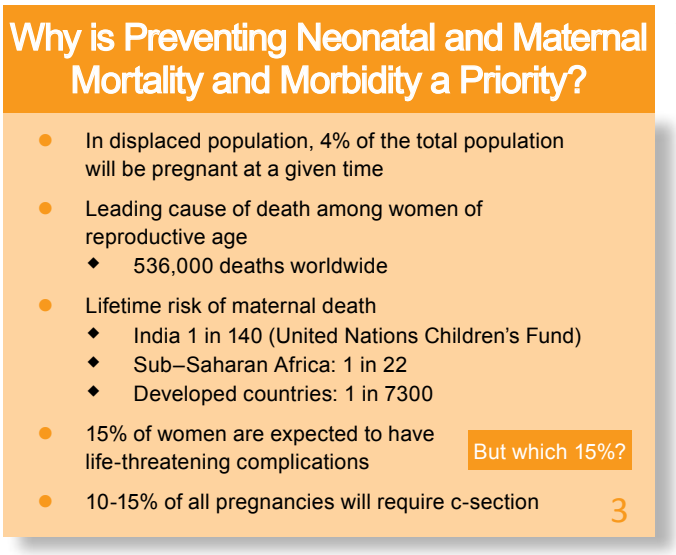
MISP

Care after delivery
(Postnatal Care - PNC)
Not part of MISP

2

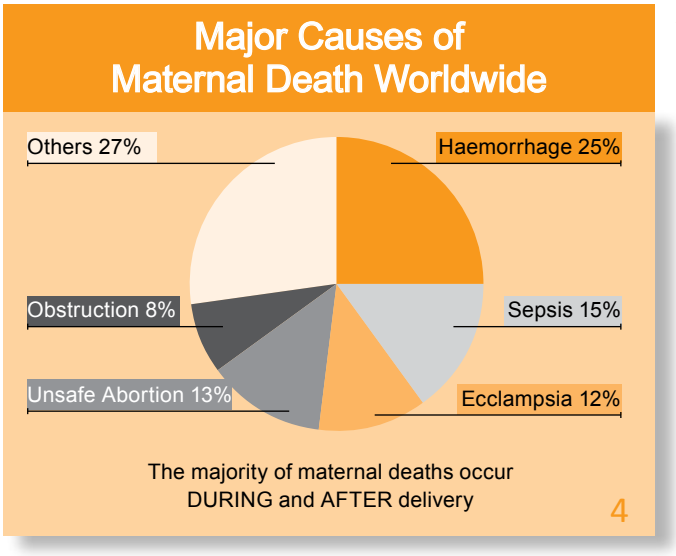
3

- Ask participants: 'Why is preventing newborn and mother deaths and diseases a priority?' - Briefly facilitate feedback and click to show the numbers.
- 4th bullet point: Emphasise that even with good ANC, it is difficult to predict which women will develop life-threatening complications. The majority of life-threatening complications develop in pregnant women without identified risk factors. (Therefore ANC is not part of the MISP).



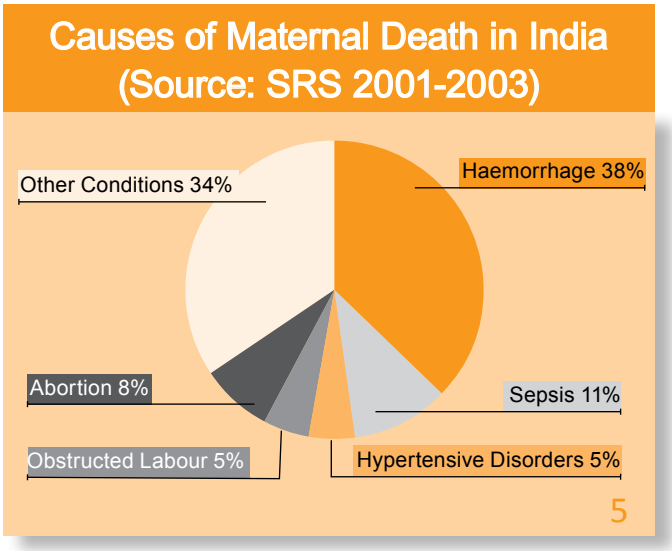
4

- Ask participants: 'Why do women die?'
- Briefly facilitate feedback and click to show the pie chart.
- Emphasise that the majority of maternal deaths occur **during and immediately after delivery.** Therefore MISP focuses on **delivery care** to prevent those deaths, and not on ANC or PNC.



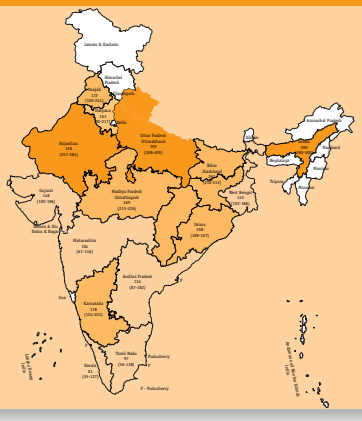
5

- Ask the participants whether there are specific reasons in India which may differ worldwide. Causes of maternal mortality should also be highlighted as it may differ worldwide.
- Discuss the local causes based on the experiences of the various participants.



6 • Explain the differences in various parts of the countries with the help of the Map of India highlighting the difference in the Maternal Mortality Ratios (MMR) in various states of the country.

Maternal Mortality Ratio (MMR) Along With 95% Confidence Interval, India and States, 2007-2009



6

7 • State level health statistics have to be emphasised when regional training programmes are conducted.
• This is a sample of various important population statistics at state level to impress upon the participant the health status in their state. ***Facilitator to change the information in the slide depending on the state.***

Health Status in Bihar

Indicator	Value	Year	Source
IMR	48 per 1000 live births	2010	SRS
USMR	64 per 1000 live births	2010	SRS
MMR	305 per 100,000 live births	2010	Annual Health Survey (AHS)
Home deliveries (not attended by any skilled SBA)	68% 46.1%	2007-2008 2009	DLHS 3, UNICEF, Coverage Evaluation Survey
Lifetime risk of maternal death (India)	1 in 170	2010	WHO, UNICEF, UNFPA & the World Bank

7

8 • Discuss the various health statistics at district level. The example is from Sitamarhi district. However, similar statistics could be found in other districts where the training is conducted. Facilitator to include relevant data from the districts, thereby leading to greater understanding as well as involvement of the participants.

Health Status in Sitamarhi

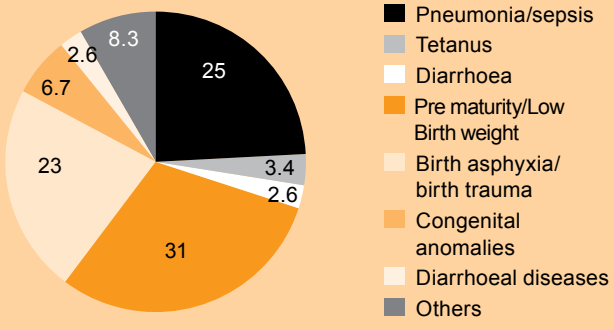
Indicator	Value	Year	Source
IMR	67 per 1000 live births	2010	Annual Health Survey
USMR	106 Per 1000 live births	2010	Annual Health Survey
Home deliveries (not attended by any skilled SBA)	78.3%	2007-2008	DLHS -III

8

9 Causes of Neonatal Mortality Worldwide.

- Ask participants: 'Why do newborns die?'- Briefly facilitate feedback and click to show and explain the causes.
- Briefly discuss the causes and explain that nearly 85% of all newborn deaths are caused by Newborn Infection, Prematurity/Low Birth Weight and Birth Asphyxia/ Birth Trauma.

Causes of Neonatal Mortality Worldwide



(Source: WHO, global burden of disease 2004 update, 2008)

9

Advocacy

10

- Explain the slide and impress upon the participant on the urgency of initiating MISP in Disasters as 32% of deaths occur on the first day, 50% of deaths in first three days and 71% in first week.

Primary causes of deaths on Day 0 (i.e. day of birth) are Birth Asphyxia or injury constituting 31% of the total deaths and Pre-term Delivery constituting 26% of the deaths. 50% of all neonatal deaths due to Sepsis or infection occur in first week(Bulletin of WHO, 2006, 84(9) page 706). Therefore, Emphasise should be placed on early intervention which will improve the survival rates.

MNH: Mortality Statistics

Globally, 9 to 40 babies out of every 1000 born die in the pre-natal period

- 25% birth asphyxia
- 25% birth injuries
- Prematurity, low-birth weight
- Hypothermia
- Infections (sepsis, tetanus, syphilis, pneumonia)

India: 35 per 1000; Rural 39 and Urban 23

(SRS, Registrar General, India)

10

Advocacy

11

- Explain that three delays are described as major contributors to mother/newborn mortality:
  1. Delay in identifying the complication and deciding to seek help.
  2. Inefficient or no transportation, no money for transportation, curfews/security barriers, etc.
  3. Absence or lack of trained staff, lack of drugs or other materials, costs.

Can't predict or prevent complication…….. but can prevent deaths by reducing DELAY:

The Three Delays

1. In decision to seek care
2. In reaching health facility
3. In receiving appropriate treatment

Group Work

In the context of your site, what are some reasons Women might experience these delays?

- *Restricted movement and access to clinics*
- *Decision-making not in the women's hands*
- *Lack of female health care providers*

11

Group Discussion

In a disaster, the SRH Coordinator can address delays two and three to a certain extent.

- Ask participants to take two minutes to work in a group: 'What are some reasons owing to which women might experience these delays in your setting?'
- Take one minute to facilitate reporting and click to show proposed answers.

12

- Explain why it is life-saving to act quickly, especially in case of post-partum haemorrhage.

Advocacy

How Long Does it Take to Die?

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

Complications	Hours	Days
• Haemorrhage,		
◆ Post-partum,	2	
◆ Ante-partum,	12	
• Ruptured Uterus,		1
• Eclampsia		2
• Obstructed labour		3
• Infection		6

12

13

- Group Work: Ask participants to take three minutes to work by table and assign a delay to each group. Take two minutes to facilitate the reporting and click to show the proposed answers.
- Note that the usage of clean delivery kits at home or during displacement in case access to a health facility is not possible, aims to prevent sepsis and tetanus in mothers and newborns.

Group Discussion

The Three Delays: What Can be Done in Your Setting?

1. Delay in the decision to seek care:
   Teach TBAs, women, men about the complications that need emergency treatment **NOT PART OF THE MISP**
2. Delay in reaching health facility:
   - ◆ Initiate establishment of 24/7 referral system to manage EmONC (Emergency Obstetrics and Neonatal Care)
   - ◆ Communication system (radio, mobile phone, medical record) Establishment of telemedicine system
   - ◆ Transportation (stretchers, vehicle, security, transport at night)
   - ◆ Clean delivery kits distributed to all visibly pregnant women incase 2nd delay cannot be overcome and women need to deliver outside the health facility
3. Delay in receiving appropriate care at the health facility:
   - ◆ Equip health centres and hospitals
   - ◆ Train health workers in emergency obstetric procedures

Kits
6,8,9,10,11,12

13

14

- Show the participants the slide on the Indian scenario.

Indian Scenario

- As per UN estimates MMR:230: nearly 63,000 maternal deaths annually
- More than 73 percent deliveries in institution
- Conditional cash transfer scheme to promote institutional deliveries (JSSK scheme)
- Referral transport service
- Training of existing nurse mid wives in SBA: And of Doctors in EmONC and Life saving Obstetric Anesthesia: task Shifting
- Maternal Death Reviews in place
- Birth Preparedness and Complication readiness plans
- Up gradation of facilities to BeONC and CemONC

14

15

- Continue the group work by asking participants to take two minutes to address the above question.
- Take one minute to facilitate reporting and click to show the proposed answers.
- Note that BEmONC will be explained here below.

Referral Mechanisms: Challenges and Solutions

Group Discussion

What if ensuring 24/7 referral services may not be possible due to disruption in infrastructure of in the area?

- Ensure that staff qualified in basic EmONC are available at all times at the primary health care level to stabilise patients with basic EmONC
- Establish system of communication (radio) to communicate with more qualified personnel for medical guidance and support

15

16

- Explain that to address the third delay, it is useful to follow priority interventions called 'signal functions' outlined in BEmONC. BEmONC is performed at the health-centre level to address or stabilise before referring the main complications of childbirth as well as newborn problems.
- Stress that EmONC must be available 24 hours a day, seven days a week.

Basic Emergency Obstetric and Neonatal Care

(BEmONC)

At Primary health centres (1 per 30,000 people) 24x7 PHCs can have BEmONC facilities

Provided by midwives and nurses

1. Administer parenteral antibiotic
2. Administer parenteral uterotonic drugs (oxytocin, Tab. Misoprostol (600mcg),
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulphate – MgSO4)
4. Perform manual removal of placenta
5. Perform removal of retained products of conception (MVA - Manual Vacuum Aspiration, D&C dilatation & curetage)
6. Perform assisted vaginal delivery, e.g. vacuum
7. Newborn resuscitation using bag and mask

Kit 6

Kit 8

Kit 10

Kit 9

16

17 CEmONC

- Emphasise that in the early phase of a disaster, SRH Coordinators need to ensure that qualified staff, medicines, equipment, and supplies are in place.
- As per the Indian norms, there should be one CEmONC facility for every five lakh population or for every four BEmOC centres.

Comprehensive EmONC (CEmONC)

At First Referral Unit with Operating Theater
(3-4 per District, in addition to identified private sector facilities - 150,000 -200,000 people)

Provided by team of doctors, anesthetists, midwives and nurses

BEmONC (steps 1-7), plus

8. Perform surgery (Cesarean section, laparotomy for ectopic pregnancy, anesthesia)
9. Perform safe blood transfusion

Kit 11

Kit 12

17

18

- Summarise the key MNH activities in disaster situations.
- Last bullet point: Explain that this will be addressed in the following slides.

Key Messages: MNH in Disaster Situations

- Establish assured referral transport systems
- Identify and supply referral level care facilities (CEmONC)
- Ensure supplies in adequate quantities at health Facilities (BEmONC)
- Clean delivery kits (Home deliveries in case access to Health facilities not possible)
- Plan for antenatal care (ANC) and postnatal care (PNC) integrated into primary health care (PHC) services as soon as possible

18

19

- Explain that you will now address planning for MNH in post-disaster situations, which includes prenatal care, PNC and basic monitoring and evaluation for MNH.

Maternal and Newborn Health Post Disaster/Stabilised Situations

19

20

- Emphasise the importance of postnatal care to avert maternal and newborn deaths. FP will be discussed in details later.

Postnatal Care (PNC)

Up to 50% of maternal deaths occur after delivery
Up to 50% of newborn deaths occur in the first 24 hours

- Postpartum visit within 24 - 48 hours
- Mother
  - General condition, sepsis
  - Breasts
  - Lochia, state of perineum
  - Discuss nutrition, hygiene, breastfeeding
  - Supply iron, folate
  - Post-partum FP: counselling and services

20

21

- Note on Umbilicus Care: There is new evidence regarding the use of 4% chlorhexidine in community based settings in Nepal and its association with the decrease in neonatal mortality. (Mullany et al, 2006).
- Use of 10% povidone Iodine can also be used with good results (African journal of Microbiological Research April 2012).

Postnatal Care (PNC)

- Baby
  - General condition, warmth
  - Breastfeeding on demand
  - Weight
  - Umbilicus care
  - Discuss well child services: immunisations, growth monitoring

21

22

- Explain that the primary objectives of ANC(pregnancy) is to identify and treat/manage pre-existing health problems and complications arising during pregnancy and to provide health promotion and disease prevention.
- The first visit should happen within the first 12 weeks and registration; while the second visit within 14 to 26 weeks; the third visit between 28-34 weeks and the last visit between 36 weeks and term.

Antenatal Care (ANC): 4 antenatal visits recommended

- Assess maternal health, including history and clinical signs
- Detect and manage complications
- Make a micro birth plan
- Give counselling (nutrition, clean delivery, FP)
- Reinforce prevention activities (syphilis, tetanus, malaria, anaemia, iodine deficiency, STIs, etc.)

WHO – UNICEF 2003 Antenatal care in developing countries – promises, achievements and missed opportunities

22

23

- Without going into the clinical details outlined in each column, explain that even though ANC can help assess maternal risk factors and detect and manage complications, every pregnancy faces risks (remember the 15% of life-threatening complications). In other words, the majority of pregnant women who deliver with life threatening complications do not have risk factors.

Emphasise

ANC

Assess maternal risk factors

- Poor obstetric history
- Strikingly short stature
- Maternal age < 15 years
- Grand multiparous or nulliparous
- Size-date discrepancy
- Unwanted pregnancy
- Extreme social disruption/deprivation
- Multiple gestation
- Abnormal lie/ presentation

Prevent, detect and manage

- Anaemia
- Hypertensive disorders
- UTI (urinary tract infections)
- Vaginal bleeding
- Syphilis
- Pre-term labour
- STI/HIV/AIDS
- Malaria and intestinal parasites
- Serious medical conditions

BUT: Every Pregnancy Faces Risks!

23

24

- Explain that continuity of the MISP package is important and it is on this framework we are to build up the Comprehensive Programme.
- Ask the participants about the existing model of service delivery in ANC and PNC in their region and ask as to how they would want to integrate the same in the MISP for providing the continuum of care.

Comprehensive MNH Services

- Sustain MNH activities of the MISP
- Provide quality antenatal care at VHNDs/SCs/PHCs
- Provide postnatal care as per protocols
- Home visits by ASHAs on pre defined days
- Have Skilled Birth attendants(Mid-wives, Nurses, Doctors) at identified facilities
- Increase access to basic and comprehensive EMONC
- Set up processes for maternal death and near Miss Review

24

25

- Explain that this section will focus on the specific needs of adolescent population.
- Social economic and environmental realities for young people today mean that they are one of the largest group of marginalised and excluded.
- Adolescence is a transitional stage of physical and psychological human development between puberty and legal adulthood.

Adolescent Reproductive and Sexual Health Services

25

26

- Ask the participants on the specific medical needs and pregnancy related complications among adolescents. Take two minutes to facilitate discussion on the same.
- Explain that the problems of the adolescents are to be addressed specifically in any society.
- For young people the biological onset of adolescent phase brings out not only changes in their bodies but also gives rise to new vulnerabilities to human rights issues, particularly in the arenas of sexuality, marriage and child bearing. Lots of girls are coerced into unwanted sex or marriage and also face high risk of unwanted pregnancies, unsafe abortions, STIs an HIV and childbirth.
- Safe passage from adolescents into adulthood is the **right** of every child. SRH and fulfilment of associated human rights are at the very heart of adolescents' transition into adulthood.
- Leading causes of mortality and morbidities among **girls and young women in age group 15-24 are complications of pregnancy unsafe abortion and childbirth.**
- Fully engaged, educated, healthy and productive adolescents and youth can break multi-generational poverty; they are resilient in face of personal and societal threats and can contribute to the strengthening of communities.

Why to Address Adolescents?

Advocacy

- Pregnancy : leading cause of death for adolescent girls in developing countries
- <16:immature pelvises, which can be too small for a baby to pass through birth canal=can result in obstructed labour
- 15-19 years of age are twice as likely to die during pregnancy and childbirth than women 20 and older
- <15 are 5 time more at risk of death during pregnancy and childbirth than 20 and older
- More likely to have spontaneous abortion, premature births and stillbirths than older mothers
- Infants of adolescents mother are 50%more likely to die during their first year of life than born to mothers in their twenties

26

- Disaster affected adolescents and youth are poor, perhaps have one or no parent, could be married to older or abusive men, work in unsafe occupations or are commercially sexually exploited, engage in high risk behaviours, violence and exploitation. Barriers that complicate their access to resources include discrimination because of their age, gender or inequities in the society (on grounds of poverty, ethnicity, health and pregnancy status, marital status or sexual orientation).
- **Health services must be readily available** to help prevent and manage major causes of death and ill health in adolescents and youth; unsafe sex and related risks of pregnancy, childbirth, STIs including HIV, violence and mental ill health.

27

- It has been seen that the needs of adolescent population are usually not addressed.
- Adolescents should be considered at risk and their special needs must be met even when framing the BEmONC and CEmONC.

Interventions Targeting Adolescents

Emphasise

Acute emergencies, ensure:

- Adolescent-friendly EmONC in place
- Engagement of traditional birth attendants (TBAs) or community health workers (CHWs) in identification and referral of pregnant adolescents

As the situation stabilises, ensure:

- Pregnant adolescents are aware of the risks of pregnancy and know where to access MNH services
- Develop birth plans
- Discuss FP options in antenatal care and supply post-partum FP
- Establish infant care support groups
- Provide mental health and psychosocial support
- Education programmes allow adolescent mothers to stay in school

27

28

- Ask participants why abortion should be addressed in disasters. Facilitate discussion and click to show the slide below.

Safe Abortion Care

28

29

- The need for providing safe abortion care services in disaster settings is of utmost importance as it is can decrease morbidity and mortality among the survivors.

During Disasters

Advocacy

Why Abortion Services in Disasters?

Higher rates of spontaneous abortions
High rates of sexual violence
Decision to postpone pregnancies

High rates of unwanted and high risk pregnancies

Disruption of FP services and safe abortion services

High rates of unsafe abortions

High rates of maternal and child mortality

A Reproductive Right

29

30

- Ask participants about the abortion scenario in their regions. Get a feedback on the same.
- Organise a short discussion on the changes they foresee in disaster settings.

India

- 6.7 million abortions take place annually
- 4 million out of them are performed illegally
- For every safe abortion, there are eleven illegal abortions taking place*
- "In India, two thirds of all abortions take place outside the authorised health services by unauthorised, often unskilled providers"

(Source: DLHS Survey 2007- 2008)

30

31

- Explain that abortion care services should be complete and include referral services. Cases that are reported late may have severe problems, and hence may require treatment in a referral facility.

Safe Abortion Care in Disasters

Safe Abortion Care

- Essential counselling services
- Clinical assessment
- Investigation facilities
- Medical and surgical procedure of abortion upto 12 weeks
- Referral and Transportation for safe abortion services and management of complications
- Management of abortion complications, Second trimester abortion services, blood transfusion services, screening for HIV and HBV

Post Abortion Care

- Recognition of abortion complications
- Emergency management of complications
- FP services
- Links to comprehensive reproductive health services

31

32

- If time allows, address some of the following MNH topics according to the participants' interests.

Maternal and Newborn Health Topics Relevant to Coordination

32

33

- Note that HIV in disaster settings will be addressed during the HIV/STI sessions.
- Explain that since this is a rapidly-evolving field, SRH Coordinators should frequently check for updates when establishing or coordinating PPTCT programming.
- Explain the four-prong approach:
- Point 1: This can be addressed by IEC (Information, Education and Communication) and BCC (Behaviour Change and Communication) campaigns.
- Point 2: This can be addressed by ensuring access to FP information and services.
- Point 3: Explain the different interventions and their corresponding risk of HIV transmission without intervention. Maintenance of confidentiality of the user and knowledge of prevalence of HIV in a community is of utmost importance.

PMTCT: Prevention of Mother to Child Transmission UNICEF/WHO/UNAIDS "4-prong" Approach

1. Preventing HIV infection in young people and women of childbearing age
2. Preventing unwanted pregnancy among women with HIV infection
3. Preventing transmission of HIV from an infected mother to her infant:

Risk of transmission during pregnancy without intervention: 5-10%	> Anti-retroviral (ARV)
Risk in labour & delivery: 15-20%	> ARV & caesarean section
Risk in breastfeeding: 5-15%	> Alternative feeding

4. Provision of care and support to HIV-infected women, their infants, and their families

33

34

- 2nd bullet point: Even if breastfeeding increases mother-to-child transmission of HIV, explain that in disaster/post-disaster and low-resource settings, HIV positive women should exclusively breastfeed, unless replacement feeding is 'AFASS' (Acceptable, Feasible, Affordable, Sustainable, Safe) (Flash heating: as soon as the water comes to a boil, the bottle is removed and allowed to cool.)
- Last bullet point: Wet nursing is where an infant is breastfed by a woman other than his/her mother. Wet nursing maybe considered in communities where this option is accepted. It is not recommended as it has many constraints: the wet-nurse must understand and agree to the implications of HIV testing and counselling, as she will need HIV testing before wet-nursing and six to eight weeks after starting.

Breastfeeding

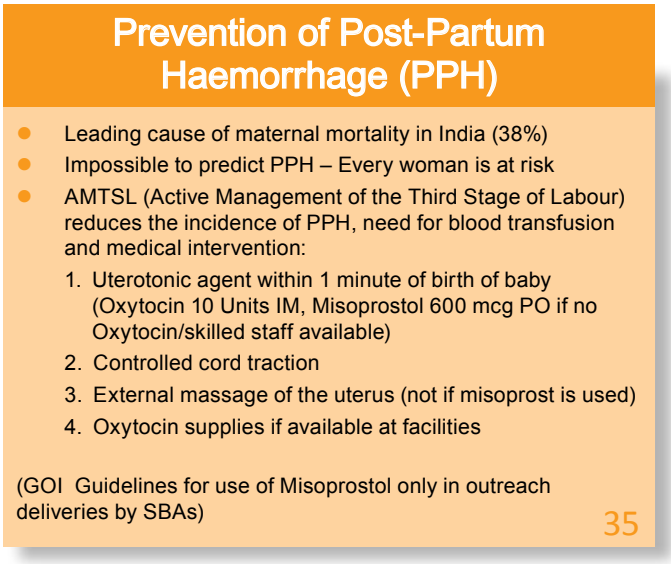
- HIV negative women: exclusive breastfeeding → 6 months
- HIV positive women:
  - **Exclusive breastfeeding** → 6 months unless replacement feeding acceptable, feasible, affordable, sustainable and safe - 'AFASS' depending on individual circumstances, health status of woman, local situation, availability of health services, counselling and support.
  - **Field based** flash heating of breast milk under study
- Wet nurse: if culturally accepted, needs HIV counselling and testing before wet-nursing and 6-8 weeks after starting. Education on HIV prevention also required

(Source: guidance on infant and HIV in emergencies: UNHCR 2006)

34

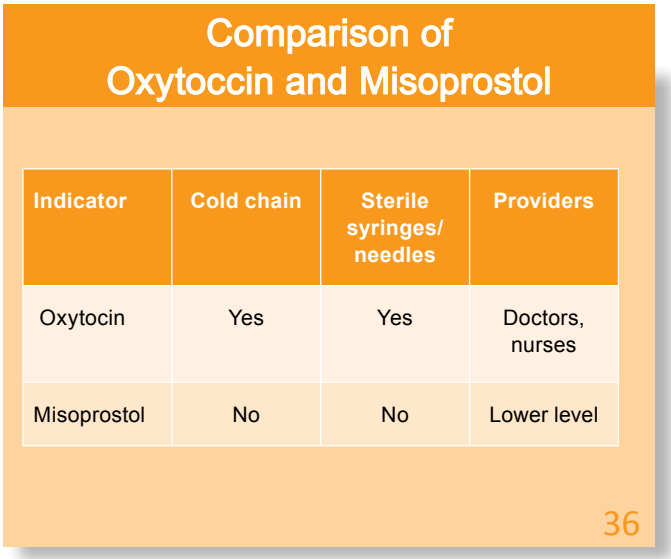
35

- 2nd bullet point: Stress that it is impossible to predict PPH on the basis of risk factors. Every woman is potentially at risk. Furthermore, once PPH occurs, there is very little time to employ life-saving interventions, assuming they are even available at all. All of us are aware of the critical lack of skilled providers and resources. In severe/catastrophic hemorrhage, a woman can literally bleed out in a matter of minutes, which is why prevention is critical in reducing maternal mortality due to postpartum hemorrhage.
- 3rd bullet point: Explain that the current standard of care for prevention of PPH is Active Management of the Third Stage of Labour (AMTSL). SRH Coordinators need to ensure that staff qualified in providing AMTSL and relevant supplies are in place.



36

- Table: Explain that for PPH prevention and treatment, misoprostol 600mcg can be used if there is no other alternative such as oxytocin (gold standard). Explain the advantages of misoprostol over oxytocin (no cold chain, no injection, low-level provider). Note that WHO does not recommend the use of misoprostol for the prevention of PPH (2007 Recommendations for the Prevention of Postpartum Hemorrhage). However it states that in the absence of active management of the third stage of labour, a uterotonic drug (oxytocin or misoprostol) should be offered by a health worker trained in its use for prevention of PPH. (Strong recommendation, moderate quality evidence).
- Explain that oxytoccin has reduced efficacy when exposed at room temperature. However, this is limited. Therefore, stress that when there is no other uterotonic available, oxytocin should not be discarded even if the cold chain was not maintained. Use of Carboprost 250 mcg should be preferred where cold chain is maintained. This is a rapidly evolving field. Check updates at www.pphprevention.org and www.who.int.



37

- Explain that in disaster settings access to skilled birth attendants may be severely constrained and TBAs may be the first to report during the onset of a disaster. It may be necessary to utilise TBAs or other community health workers who might be providing maternal and newborn care outside of the formal healthcare system.
- 4th bullet point: Stress that TBAs, either trained or untrained, cannot be considered as skilled providers. However, they often hold a special position in the lives and esteem of women and should be treated with respect as partners in efforts to reduce maternal and newborn mortality.
- Last 2 bullet points: If TBAs are identified in a community, they should be supported and oriented in such activities.

Traditional Birth Attendants (TBAs)

- It is not necessary to train TBAs and midwives before providing them with clean delivery kits
- Delivery kits to reach pregnant women without delay
- TBAs **should not** be encouraged to perform technical midwifery tasks
- WHO no longer recommends training **new** TBAs
- Orientation of **existing** TBAs on the following tasks should wait until the situation has stabilised:
  - Educating women and families on danger signs, timely referral, nutrition, hygiene, breastfeeding support, FP, etc.
  - Distribution of iron, folate, vitamin A, intermittent preventive treatment for malaria

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Suggested Further Reading

- Managing Newborn Problems: a guide for doctors, nurses and midwives, WHO, 2003, available at: http://www.who.int/reproductive-health/publications/mnp/mnp.pdf
- Managing Complications of Pregnancy and Childbirth: a guide for midwives and doctors, WHO, 2005, available at: http://www.who.int/reproductive-health/impac/mcpc.pdf

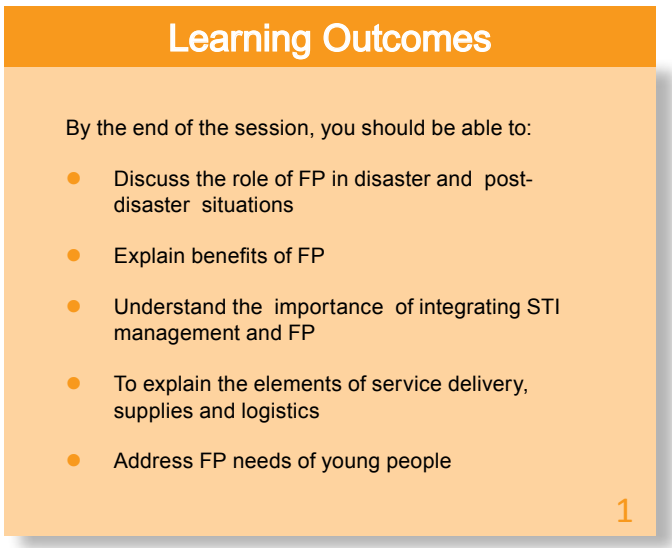
Family Planning Services in Disaster Situations

Length
1 hour

Overview	This session reviews the principles of providing family planning services in disaster settings. Emergency contraception was discussed in SGBV session
Learning outcomes	See below
Preparation	Copies of power point presentations, group work papers
Materials	Power point presentation, samples of contraceptives
Methodology	Interactive discussion, group work

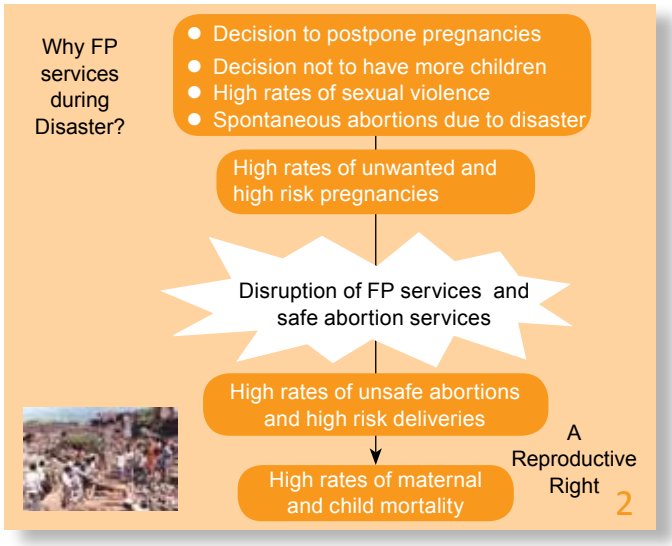
1 Process

Explain the learning outcomes. Remind participants that emergency contraception was addressed under SGBV.



2

- Ask participants: 'Why is FP important for women, families and communities?'
- Briefly facilitate feedback and click to show proposed answers.
- Explain that where birth rates are high, over 30% of maternal deaths and nearly 10% of childhood deaths can be avoided by the use of FP. FP decreases poverty and hunger and contributes to women's empowerment, education, and economic stability.



3
- Ask participants to explain the family planning situation in India in normal conditions emphasising that there is no data for disaster situations. Briefly facilitate discussion and click to show.
- Explain that permanent methods of female contraception have preference among the married couples in India. Public Sector is a major source of all contraceptives Contraceptive offered in MISP should be of similar mix as in public sector.

Family Planning Situation in India

- The contraceptive prevalence rate for currently married women in India is 56%
- Female Sterilisation - 85% of all modern contraceptive methods used
- The most common spacing methods are condoms and the rhythm method, each used by 5 per cent of currently married women
- 71% per cent of modern contraceptive users obtained their method from a public sector source
- Unmet need for family planning among currently married women is 13 percent but in adolescents it is 27%
- 13 % married and 9% unmarried girls reported current use of modern contraceptive methods

(The above data refers to normal situation and as there is no data available during disasters)

3

4
- Ask participants: 'Why is FP important in disasters for women, families and communities?'
- Briefly facilitate feedback and click to show proposed answers.
- Protecting human rights and providing people with essential FP services in disasters is a priority.

Why Family Planning ?

Advocacy

- Is a Human Right
- Saves women's lives, preserves their health
- Saves children's lives
- Offers women more choices
- Encourages adoption of safer sexual behaviour

4

5
- Explain that there is a large unmet need for effective FP services even in normal conditions which increases manifold in disaster situations when the health services are disrupted.
- Ask participants to guess the percentage of unintended pregnancies and induced abortions worldwide.
- Access to contraception is integral to efforts to reduce recourse to abortion. Click to show proposed answers.

Family Planning Scope of Unplanned Pregnancy

Advocacy

- 40% pregnancies worldwide are unintended
- 22% pregnancies worldwide end in induced abortions
- Large unmet needs for effective FP services

(Source: World Health Report 2005: Make every mother and child count)

5

6
- Ask participants to name some benefits of FP for women, their children and family.
- Importance of FP to achieve MDG 5 to improve maternal health cannot be overstated.
- Availability of contraception and dual protection are also important ways to reduce potential HIV infection.
- Briefly facilitate feedback and click to show proposed answers.

Benefits of Family Planning

Advocacy

For women

- Averting unwanted pregnancies would prevent at least 1 in 4 maternal deaths: most cost effective intervention

For children

- Adequate spacing (>2 years) can prevent 1 in 4 infant deaths

For families

- Planning births permits controlled use of household resources

6

7
- As part of advocacy message for FP, explain the 4 toos coming from lack of FP.
- Maternal mortality in India is high. The reasons for this high mortality are many. Childbearing beginning in early age and continued till old age, too many pregnancies, less than three years gap in two pregnancies are some of the major causes of this high mortality.

Family Planning – the 4 toos

Advocacy

- too young
- too old
- too many
- too close together

Example: women giving birth between 15- 19 are five times more likely to die in childbirth than women aged 19-24

7

8
- Experience has shown that providing basic contraceptive methods such as oral pills and injectables for continuing users is essential from the beginning of any disaster.
- SRH Coordinators should adapt to the situation at hand and make decisions based on opportunities to provide basic FP methods within the MISP and start planning for comprehensive FP programming whenever possible.

Subject area	Minimum(MISP) RH services	Comprehensive RH services
Family Planning	Make contraceptives available according to the needs of the community	• Source and procure contraceptive supplies • Offer sustainable access to a range of contraceptive methods • Provide staff training • Provide community IEC (Information, Education and Commutation)

8

9

- Divide the four questions among the participants' tables and give three minutes for group work.

Issues and concerns regarding FP services during disasters may include:

- Desire to continue FP methods used before the onset of disaster.
- Some women desire not to get pregnant in the unstable situation because they have to flee again.
- Separation of families.
- Pressure on women to give birth to replenish population.
- Desire to replace children who have died or missing.
- FP services to special populations like adolescents.
- PLHIVs: Community may not be comfortable with providing FP services to these sections and there may be a resistance in service delivery.
- Lack of FP leads to an increase in unwanted pregnancies and possibly unsafe abortions.

Group Discussion

- What are some of the issues and concerns regarding Family Planning in Disaster settings?
- Is there a problem of unintended pregnancy in Disaster settings and why?
- What are the community attitudes towards Family Planning?
- What are the patterns of contraceptive use in Disaster settings?

9

Emphasise

Group Discussion

- FP service delivery points: Community may want to have the contraceptives available near their camp/place of stay.
- FP service cost: People may need services free of cost or at highly subsidised rate since during disaster their financial status may be affected adversely.

10

- Ask participants to name some FP methods.
- Click to show the different methods. Explain that the RH Kits contain three-month injectables, combined Oral Contraceptive Pills(OCP), Intra-Uterine Devices(IUD), condoms and Emergency Contraceptive Pills(ECP).
- Stress again that FP methods should be made available for continuing users or people who spontaneously request FP.
- Explain that condoms and emergency contraception should be free and immediately available in the earliest phases of an emergency (through other components of the MISP, such as with Kit 3, rape treatment). Stress that there should be no restrictions on access to ECP (i.e. it should be available to everyone) or other requirements such as physical examination.
- Explain that some newer contraceptive are available under private sector and these can be used in disasters.

Current Family Planning Methods Available in India in Public and Private Health Sector

Public Sector

- Temporary (spacing) methods
- Oral contraceptives
  - Combined oral pills
  - Emergency contraceptive pills
- Intrauterine Device (IUDs)
  - Cu T 380 A (10 years)
- Condoms male
- Permanent methods
- Sterilisation
  - Male
  - Female

Private Sector

- Injectable contraceptives DMPA
- Progesterone only pills
- Centchroman pills
- Intrauterine Device (IUDs)
  - Cu 375/250,
  - IUS LNG
- Combined vaginal ring
- Barrier methods like sponge, caps
- Spermicides

10

11 • Briefly compare some of the methods.

Contraceptive Methods Comparison Chart

More effective
Less than 1 pregnancy per 100 women in one year

Less effective
About 30 pregnancies per 100 women in one year

	How to make your method most effective
Implant, Vasectomy, Female Sterilisation, IUD	After procedure, little or nothing to do or remember **Vasectomy:** Use another method for first three months
Injectables, LAM, Pills, Patch, Ring	**Injections:** Get repeat injections on time **LAM (for six months):** Breastfeed often, day and night **Pills:** Take a pill each day **Patch, ring:** Keep in place, change on time
Male Condoms, Female Condoms, Diaphragm, Sponge, Fertility-Awareness Based Methods	**Condoms, diaphragm, sponge:** Use correctly every time you have sex **Fertility-awareness based methods: Abstain or use condoms on fertile days.** Newest methods (Standard Days Method and Two Day Method) may be the easiest to use
Withdrawal, Spermicide	**Withdrawal, spermicide:** Use correctly every time you have sex

Source: WHO 2006 (17), adapted with permission

11

12 **GROUP WORK:** Barriers to FP services in disaster (Give five minutes for discussion and five minutes for presentation).

- Make three groups of participants.
- Ask them to discuss barriers to FP services in disasters and possible solutions at three levels.

Barriers to FP services in Disaster (GE)

Group Discussion

Barriers	Possible solutions
Physical/Structural	
Bureaucratic/Administrative	
Cultural and individual	

12

13

- Have a round of discussion on contraceptive services for men and youth. Stress that SRH Coordinators should do their utmost to guarantee access to FP services for men and young people.
- Men Participation: Male partners should also be involved in FP programme design and implementation. Services should be planned so that they are culturally appropriate and accessible to the user.
- Access to Youth: Explain some of the points that make a service delivery point youth friendly. Adolescents and young people form a significant proportion of the population and are particularly vulnerable in disaster settings; not only are they displaced from their home, but they may also be separated from family and societal support mechanisms at a crucial time during their transition from childhood to adulthood. Adolescents in disaster settings may face violence, poverty, sexual abuse and exploitation. SRH coordinators should ensure FP access for adolescents and young people.

Access to Family Planning Services for Men and Adolescents

Men

- Access to services and information
- Encourage adoption/support of partner's choice

Access for youth

- Appropriate opening times
- Access for unmarried people
- Provide services in combination with other youth activities-clubs
- Provide comprehensive information-IEC
- Providing respect and confidentiality

13

14

- Briefly review methods to avoid both pregnancy and STIs. It is important for young people to know and have access to both condoms and other forms of FP methods for dual protection.
- Discuss the importance of effective Implementation of FP services during disasters through integration with STI services.
- Stress the importance for SRH coordinators to integrate STI management into FP.

Integrate STI Management in FP Services

- Discuss STI with all clients at each visit
  - Risk assessment
- Enquire if symptoms (in client or partner)
  - Treat using syndrome approach
  - Arrange for treatment of partner
- Screen for STIs
- Encourage dual protection!
  - Condoms
  - Method of choice plus condoms
- Beware IUD use in areas of high STI prevalence
- No spermicides if at risk of HIV

14

15 • Explain that providing FP services is not enough. SRH coordinators should ensure quality of care for the services provided. It is important to consider protocols, service provider capacity and training, logistics and supplies.

Quality of Family Planning Programmes

- **Method mix: provide choice to clients to address their contraceptive needs**
  - No excuse for running out of supplies
- **As many outlets as possible**
  - Health centres
  - Social Marketing/Private sector
  - Community Based Depot holders such as ASHAs and AWWs
- **Informed Decision Making**
  - Communication aids
  - Offer full information about procedures
- **Accessible Facilities**
  - Accessible to men, women adolescents
  - Private room(audio and visual privacy)
  - Equipment/supplies for infection prevention
  - Replenishment of supplies

15

16 • FP should be of high quality and contraceptive procurement should be from a reliable source. The distribution mechanism must also be ensured. SRH coordinator should link programme procurement mechanism to national or agency supply systems. Stock outs must be avoided at all costs.

Quality of Family Planning Programmes

- **Trained Personnel**
  - Technical competence and counselling skills
  - Protocols and guidelines
- **Monitoring, Evaluation and Information System**
  - Supportive Supervision
  - Drop outs
  - Method switching
  - Major complication
  - Failure rate
- **Integration with other RH programme components:**
  - ANC, PNC, PAC and STI
  - ICTC for HIV testing

16

17 • Ask participant to list some challenges that are faced during FP service delivery.
• Click to show slide and follow with a small contraceptive quantity calculation exercise.

Challenges

- Not a prioritised issue during Disasters
- Limited resources
- Lack of awareness among community about FP methods
- No male involvement in FP

17

18
- Ask participant to calculate quantities of contraceptives needed for the population for three months.
- Show the answers to the exercise.

Exercise

Group Discussion

	Basic population data	50000
1	20% of population are adult male	
2	20% of population are sexually active adult male	
3	12 male condoms per person per month	
4	25% are women aged 15-49 years	
5	15% of women aged 15-49 years use contraception of which:	
6	60% use oral contraceptives	
7	25% use injectable contraceptives	
8	15% use an IUD	

18

Solutions

Group Discussion

	Basic population data	50000
1	20% of population are adult male	10000
2	20% of population are sexually active adult male	2000
3	12 male condoms per person per month	24000
4	25% are women aged 15-49 years	12500
5	15% of women aged 15-49 years use contraception of which:	1875
6	60% use oral contraceptives	1125
7	25% use injectable contraceptives	468.75
8	15% use an IUD	281.25

18

19
- Wrap up the session with key messages and allow questions as time permits.

Key Messages

- Ensure basic FP supplies available for continuing users
- Provision of FP services during disasters helps reduce teenage pregnancy and maternal and child mortality as well as unsafe abortions
- Ensure a reliable supply of a variety of contraceptive methods to choose from
- Ensure access for young people/adolescents
- Integrate FP services with PAC, Post natal care and STI management
- Focus on Quality of Care

19

20 • Show the participants the resources which will be of help to the trainer to conduct their programmes.

Suggested Further Reading

- WHO Family Planning Cornerstone, Family Planning – a Global Handbook for Providers, 2007, available at www.fphandbook.org
- Resource List for Adolescent Reproductive Health Programming in Conflict Settings, available at www.rhrc.org/pdf/ARH%20Master%20Resource%20List%20Dec06.pdf

MNH Group Work Stations

Length
1 hour
15 minutes

Overview	The group work stations will address: 1. Clean delivery and immediate newborn care (25 minutes) 2. Post-abortion care (25 minutes) 3. Quality of care (QOC) in MNH (25 minutes)
Learning outcomes	By the end of the session, participants should be able to: ● Apply the contents of the clean delivery Kit for immediate newborn care ● Plan the distribution of delivery Kits to disasters ● Discuss the impact of unsafe abortion in disasters situations ● Describe elements of Post-abortion Care (PAC) services ● List major causes of death and disability in mothers and newborns ● Discuss the relevance of QOC in preventing the third delay
Preparation	● Ensure participants' worksheets for these stations are copied (if possible copy page 2 at the back of page 1) and staple all of them together ● For other copies and preparation activities, see below ● A facilitator is assigned to each station to set it up and facilitate it ● The three stations need to be set up the evening before in different physical spaces or with enough distance between them so that groups do not disturb each other ● If possible, assign a time keeper to inform each group to start wrapping up their work five minutes before the end of each session
Materials	See below
Methodology	Facilitated group work

Process

1. Ensure participants' have their worksheets for the three stations.
2. Divide participants into three groups (try using a game to do so).
3. Assign each group to a station.
4. Facilitate the group work and by gentle probing and constructive feedback, ensure that the group addresses key discussion points.
5. After 20 minutes of group work, take five minutes to allow each group to rotate to the next station.
6. At the end of the three sessions, bring participants together in large group and take five minutes to debrief.

MNH - Group Work Station 1

Clean Delivery Kits and Immediate Newborn Care

25 Minutes

Checklist

X	Number	Item	Comments
	1	Baby doll	To be procured locally
	1	Clean delivery Kit	Distributed during ToT

Suggested Further Reading

Managing newborn problems: A guide for doctors, nurses and midwives, WHO, 2003, available at www.who.int/reproductivehealth/publications/mnp/index.html

Clean delivery kit and baby doll

Contents of Clean Delivery Kit:

- Soap
- Pair of gloves
- Plastic Sheet
- Cotton cloth to wipe the baby
- Razor blade (for cutting the umbilical cord)
- Cord ties or clamps

Note: The kits designed for home use are easy to use and convenient, especially when deliveries are performed by women who are not trained as birth attendants. The primary focus is clean cord care and keep the baby warm to prevent hypothermia.

Participants' Worksheet

1. Demonstration and practice of immediate newborn care using the clean delivery Kit

5 Minutes

Steps in immediate newborn care

- Be sure that attendants use gloves or wash hands with soap and water before the delivery
- Keep delivery room warm
- Dry the baby, remove the wet cloth and wrap the baby in a dry, warm cloth. Keep the head covered. Delay bathing for at least six hours
- Clamp and use a clean (preferably sterile) instrument to cut the umbilical cord
- Keep the baby with the mother to ensure warmth and frequent breastfeeding
- Help mother with the first breastfeeding (within one hour after birth)
- Clean baby's eyes immediately after birth
- Pay attention to frequent hand washing by anyone handling the baby
- Encourage Kangaroo Mother Care. (Skin-to-skin contact; exclusive breastfeeding; and medical, emotional, psychological and physical support of mother and baby without separating them)

Continuing postnatal care

- Keep the baby with the mother
- Clean the cord with soap and water and keep it dry. Do not cover the cord with any bandage or cloth
- Tell the mother what danger signs to look for in the condition of the cord and in her baby. Be sure she knows when and where to go for help
- Take the baby to the health centre at six weeks for immunisations
- Advise the mother to give her child nothing but breast milk for the first six months and to continue breastfeeding up to two years or longer

2. Exercise: Order clean delivery Kit

10 Minutes

Use the CBR (4%) to calculate the supplies and services needed for a population of 10,000 for three months to ensure pregnant women have a safe delivery

3. Facilitate a group discussion, using some of the following triggers

5 Minutes

- To whom do you plan to distribute the clean delivery Kits in your setting?
- What are the challenges in distributing the clean delivery Kits in your setting?
- How can you assemble the clean delivery Kits locally?

_____

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Key Messages

- Approximately two-thirds of infant deaths occur within the first 28 days. The majority of these deaths are preventable by initiating essential actions that can be taken by health care workers, mothers or other community members.
- Clean delivery Kits need to be distributed to all visibly pregnant women (six-nine months), even in flight, for use by birth attendant or herself. It should be emphasised that at the very least, women should receive supportive care during childbirth and should never be left unattended. Clean delivery Kits can be procured or assembled locally.

Solution to Exercise: Order Clean Delivery Kit

CBR =	4% per year
10'000 x 0.04 =	400 births per year
400 x 0.25 (3 months are 25% of 1 year) **=**	100 births in a three-month period
Order	One RH Kit 2, Part A which contains 200 clean delivery packages to be used by women. This is sufficient for more than a three-month period.

MNH - Group Work Station 2

Post-abortion Care

25 Minutes

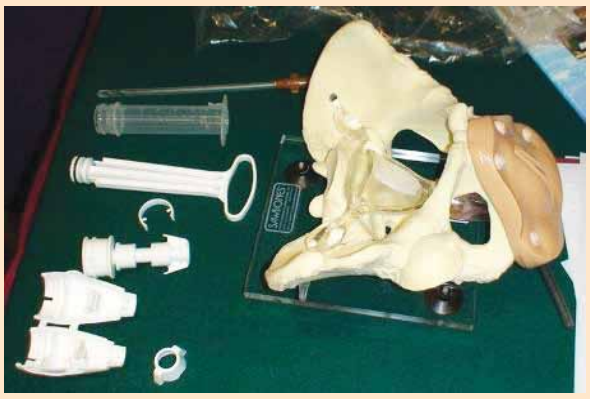
Checklist

X	Number	Item	Comments
	1	Pelvic model	Optional
	1	Ipas MVA Plus	Optional, try to source locally or if not available, show picture.
	1	Set of Easygrip cannulae	Optional, try to source locally.
	1	Set of basic instruments	Optional, try to source locally.
	1	• Speculum	
	1	• Vaginal retractor	
	1	• Forceps	

Suggested Further Reading

- Centre for Reproductive Rights: www.reproductiverights.org
- IPAS (resources on MVA and comprehensive abortion care): www.ipas.org
- Safe abortion: Technical and policy guidance for health systems, WHO, 2003 available at www.who.int/reproductive-health/publications/safe_abortion/

MVA and Pelvic Model



Participants' Worksheet (Page 1 of 2)

1. MVA demonstration (Kit 8):

5 Minutes

Application on pelvic model, dismantlement and reassembling of MVA. (If MVA not available, proceed to point 2)

2. Facilitate a group discussion, using some of the following triggers:

20 Minutes

- What is the difference between PAC and abortion?
- Why is PAC so important in situations of forced migration?
- At what levels of service (community, health post, health centre, referral hospital) can PAC be provided in this situation?
- What kinds of services can be provided at each level?
- What other SRH health services should be available to women who present for PAC?
- How can these services be coordinated? How can we ensure that women have access to them? (How can they be coordinated within large facilities such as the referral hospital? How can they be coordinated between levels?)

Notes:

MNH - Group Work Station 2

Post-abortion Care

Participants' Worksheet (Page 2 of 2)

Key Messages

- Unsafe abortion is a major contributor to maternal morbidity and mortality. Up to 15% of pregnancy-related deaths worldwide are due to unsafe abortion, and in some countries, deaths due to unsafe abortion may be responsible for up to 45% of all maternal deaths.
- UNFPA estimates that 25-50% of maternal deaths in disaster settings may be related to unsafe abortion*.
- Contraceptive failure as a result of disrupted use during flight, interruption of health services, rape and sexual violence place women and adolescent girls at particular risk of unintended pregnancy and unsafe abortion.
- Abortions will occur despite restrictive legislation. Settings with restrictive abortion laws have higher rates of maternal mortality due to unsafe abortion. This is even further magnified in disaster.
- Deaths from abortion complications are avoidable. Governments, UN agencies, and humanitarian organisations have an obligation to ensure that health services are able to respond to complications from unsafe abortion.
- PAC is the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. The elements of PAC include:
  - Emergency management of incomplete abortion and potentially life-threatening complications
  - Post-abortion FP counselling and services
  - Linkages between post-abortion emergency services and other SRH care services
- PAC involves all levels of service, including education in the community about prevention of unsafe abortion.
- Post-abortion services should include treatment and/or referral for:
  - STIs
  - Voluntary counselling and testing for HIV
  - Services following sexual violence
  - Family Planning
  - Antenatal care
  - Nutrition

* United Nations Population Fund, *Reproductive health for refugees and displaced persons,* in the State of the World's Population, New York: UNFPA 1999.

MNH - Group Work Station 3
Quality of Care (QOC) in MNH

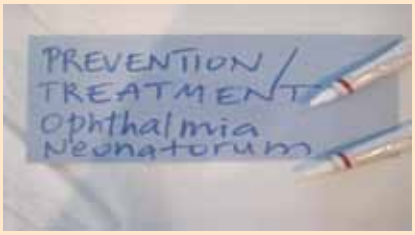
25 Minutes

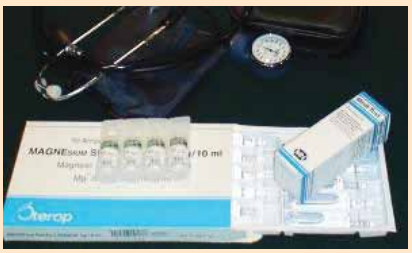
Checklist

For all the clinical items, try to procure locally or if not possible, print and show pictures

X	Number	Item	Comments
	1	Blood pressure cuff	
	1	Urinary protein test strips	
	1	Magnesium sulphate, injectable	
	1	Calcium gluconate, injectable	
	1	Oxytocin	
	1	IV fluids, saline 0.9%	
	1	Tetracyclin eye ointment	
	1	Vacuum extractor	
	1	Kiwi cup and/or vacuum extractor	
	1	Amoxicillin 250 mg, tablets	
	1	Metronidazole 250 mg, tablets	
	1	Thermometer	
	1	Ferrous sulfate 200 mg and Folic acid 25 mg	
	1	Gynecological long cuff glove for manual removal of placenta	
	3	Set of cards with the following diagnostics (One diagnostic per card): ● Pre-eclampsia ● Prevention/treatment of Postpartum Hermorrhage (PPH) ● Prevention/treatment of Ophthalmia Neonatorum ● Prolonged labour ● Endometritis ● Manual removal of the placenta ● Anemia	

Note: this is a session that requires careful timing. You may want to have two co-facilitators for this station.





Suggested Further Reading

CARE (2002) Moving from Emergency Response to Comprehensive Reproductive Health Programme - A modular Training Series, 4.56 – 4.60, available at www.rhrc.org/resources/FinManual_toc.html

Participants' Worksheet (Page 1 of 2)

1. Practice: Match (pictures of) supplies/equipment with their medical indications (as indicated on the cards).

10 Minutes

Supplies/equipment	Medical indications
Blood pressure cuff Urinary protein test strips Magnesium Sulphate, injectable, 10 ml Calcium Gluconate, injectable, 10 ml, 100 mg/ml ***What is missing?***	
Oxytocin, 10 IU/ml ***What are the logistics issues to bear in mind?***	
Intravenous fluids (saline 0.9%, plasma expander)	
Tetracycline eye ointment	
Vacuum extractor Kiwi cup	
Amoxicillin 250 mg, tablets Metronidazole 250 mg, tablets Thermometer	
Ferrous sulphate 200 mg and Folic acid 25 mg	
High cuff gynecological gloves	

2. Facilitate a group discussion, using some of the following triggers:

15 Minutes

- What are the elements of QOC?
- What are possible indicators of QOC in MNH services?
- How does QOC relate to the third delay?
- What are the challenges in implementing quality MNH services at your referral health facility?
- What type of training do the service providers at your health facility need?
- How are you going to respond to the identified training needs?

Notes:

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Participants' Worksheet (Page 2 of 2)

Supplies/equipment	Medical indications
Blood pressure cuff Urinary protein test strips Magnesium Sulphate, injectable, 10 ml Calcium Gluconate, injectable, 10 ml, 100 mg/ml ***What is missing?*** ➔ *Answer 'Diazepam vials'. Diazepam 5 mg/ml, 2 ml, is not included because of import licensing requirements. This drug should be purchased locally*	Pre-eclampsia/eclampsia (hypertension in pregnancy, causing headache, troubled vision, body swelling, abdominal pain and leading to convulsion and death)
Oxytocin, 10 IU/ml ***What are the logistics issues to bear in mind?*** ➔ *Cold Chain*	Prevention/treatment of Postpartum Hemorrhage (PPH)
Intravenous fluids (saline 0.9%, plasma expander)	PPH
Tetracycline eye ointment	Prevention/treatment of Ophthalmia Neonatorum
Vacuum extractor Kiwi cup	Prolonged labour
Amoxicillin 250 mg, tablets Metronidazole 250 mg, tablets Thermometer	Endometritis (infection of the uterus)
Ferrous sulphate 200 mg and Folic acid 25 mg	Anemia
High cuff gynecological gloves	Manual removal of the placenta

Key Messages

Quality of care means health care that provides what clients need - respect, understanding, fairness, accurate information, competence, convenience, and results.

Elements in QOC include:

- **Availability** - The services exist and there are no legal, procedural, or logistical barriers restricting their availability;
- **Access** - The services are convenient, affordable and respectful;
- **Acceptability** of services - The services conform to socio-cultural norms of the community, respect clients' concerns;
- **Organisation of care** - Integration of SRH services into primary health care; referral systems; continuity of care;
- **Technical competence** - Quantity and quality of staff; standards and protocols for care; supervision;
- **Facilities and supplies** - Appropriate technologies; logistics; and
- **Client rights** - Privacy; confidentiality; informed consent; respect; courtesy; safety.

Quality should be measured from the perspective of the manager, the provider and the client or community. Possible indicators include:

- The percentage of facilities equipped with appropriate equipment, supplies, and physical structure (specification of 'appropriate' to be defined for each case) [Source of information: supervisory checklist, assessed quarterly]
- Percentage of providers who follow clinical/technical protocols, offer information and use educational materials [Source of information: Supervisor's observation with checklist]
- The percentage of clients who report that they feel respected, are treated with courtesy and get the information they want. [Source of information: Exit interviews].

HIV and STIs

Learning Outcomes

By the end of the session, participants should be able to:

1. Explain the link between HIV transmission, STIs and Sexual Violence and their relevance in disaster settings
2. Identify appropriate strategies for effective implementation and maintenance of Standard Precautions
3. Identify strategies to ensure access to free condoms in disaster settings
4. Identify strategies to ensure rational and safe blood transfusion
5. Plan for syndromic STI management in comprehensive SRH services, including strategies for contact tracing
6. Outline the importance of the IASC guidelines for HIV interventions

Session Plan

Day 2 Afternoon HIV & STIs	
1000 – 1030 1030 – 1145	Review of Day 2 Preventing HIV/STIs in Disaster
1145 – 1200	**Tea Break**
1200 – 1300	Planning for Comprehensive STI and HIV Programming
1300 – 1400	**Lunch**
1400 – 1600	Group Work: 1. Standard Precautions 2. Condoms 3. STI Syndromic Approach
1600 – 1615	**Tea Break**
1615 – 1700	Action Plan Review and Discussions

Notes:

Review of Day 2

Length
30 minutes

Overview	This session will allow participants to review key messages of Day 2
Learning outcomes	By the end of this session, participants should be able to recall key points from Day 2
Preparation	Invite two or three volunteers at the end of Day 1 to prepare this session
Materials	As needed by the volunteers
Methodology	As planned by the volunteers. Encourage them to make it fun and interactive

Notes:

Preventing HIV/STIs in Disaster

Length
1 hour
15 minutes

Overview	This session discusses the challenges of introducing HIV and STI prevention measures during a disaster. It provides an overview of the links between HIV, STI and SGBV and also outlines coordination mechanisms related to HIV. It also introduces inter-agency coordination tools
Learning Outcomes	See below
Preparation	• Ensure that PowerPoint presentation handouts are copied • Post the HIV and SGBV coordination matrix on the wall if available
Materials	• IASC HIV Guideline and Poster • Markers and flip charts or white boards
Methodology	Interactive presentation

1 Process

Read the learning outcomes of the session, stressing that you will not address detailed clinical issues but will highlight practical information relevant for SRH Coordinators.

Learning Outcomes

By the end of the session you should be able to:

- Describe the link between HIV transmission, STIs and SV
- Explain the importance of ensuring that universal precautions are implemented in all health care settings
- Apply the measures to be taken after an occupational incident
- Identify strategies to ensure access to free condoms in disaster
- Reinforce the rational use of blood and strategies to ensure safe blood transfusion
- Explain the use of the IASC HIV matrix as a coordination tool

1

2

- Explain this is in normal situation. There is no data available for Disaster Situation.

HIV/AIDS Scenario In India

NACO 2006 ESTIMATES

- Between 2 to 3.1 million – average 2.5 million (50% of previous estimate of 5.2 million)
- Prevalence in general population 0.36%
- More men are positive than women
  - Prevalence rate in adult women 0.29%
  - Prevalence rate in adult men 0.43%
- (100 PLHAs – 61 men and 39 women)
- 88% of all infections are in 15-49 age group (prime working group)

Source: NACO

2

3 • Explain the slide on prevelance of HIV among different populations.

HIV/AIDS Prevalence

HIV/AIDS prevalence among different population (2008 -09)

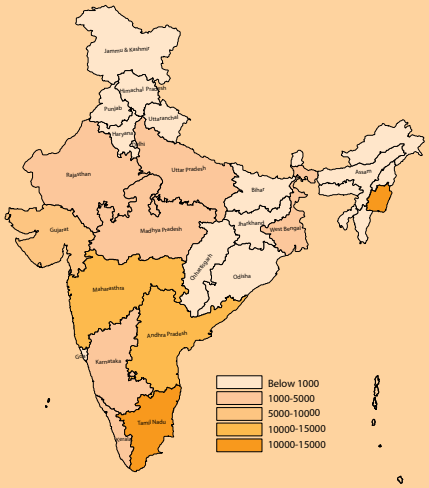
IDUs	9.2
MSM	7.4
FSW	4.9
ANC population	0.49
STD population	2.5

- 3.8% of all HIV infections are in children under 15 years
- 118 districts have HIV prevalence of more than 1% among women attending ante-natal clinics

3

4 • Ask participants what is the latest data in India. Facilitate feedback for one minute and click to give answers.

India: HIV (AIDS) Cases



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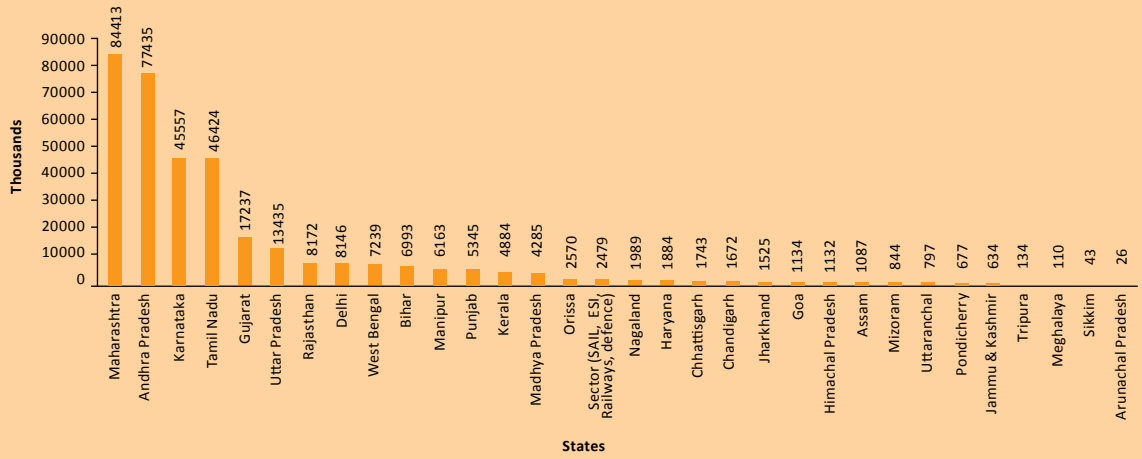
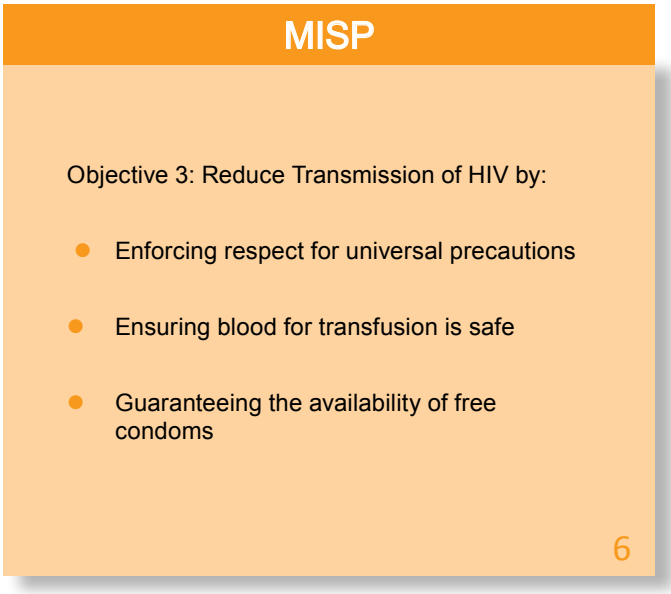
5 • Click Slide and show the participants state wise data.
• Trainer may add slides on the particular state/district using latest data.

Analysis of AIDS Patients in Corresponding States in August 2010

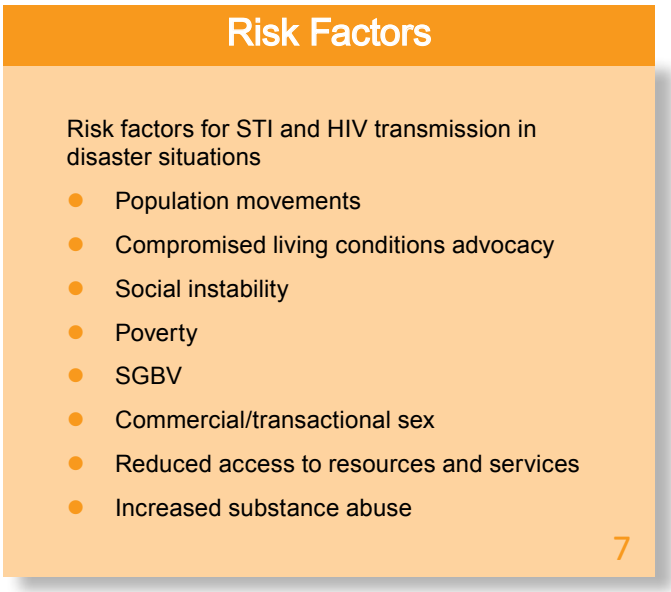


5

6
- Ask participants: 'Can you name the activities that should be given priority to reduce the transmission of HIV, as outlined in the MISP?'
- Briefly facilitate feedback and click to show answer (refer to the MISP Cheat Sheet) and explain that the presentation will address each of the three items.



7
- Ask participants: 'Can you name some risk factors for STI and HIV transmission in disaster situations?'
- Briefly facilitate feedback and click to show proposed answers. (Background information for facilitators).
- Population movements and migration are recognised as important risk factors for the transmission of STIs and HIV. Spread of STIs may result from sexual interaction between populations with different STI prevalence, for example, between displaced and host communities, returnees and home communities, urban and rural populations, or among displaced populations from different geographical areas or cultures.
- Social instability arising out of disruption of family and social structures as well as the psychological trauma of conflict and displacement may result in changes in sexual behaviour. Lack of work, educational and recreational opportunities, and the accompanying boredom and frustration, further contribute to risky sexual behaviour. Young people are particularly at risk.
- Poverty leads to increased economic vulnerability of women and unaccompanied minors in disaster situations that may result in survival sex, involving commercial sex or the bartering of sex for basic commodities and shelter.
- Commercial sex trade may flourish in disaster situations, with an influx of commercial sex workers from other areas.
- Reduced access to health services: disaster may disrupt curative services and prevention programmes. Access to condoms may also become limited, while several health facilities may also be destroyed. High workloads, shortages of trained staff and lack of supplies may result in risky health care practices, such as neglect of standard precautions, unsafe



Advocacy

injections and unscreened blood transfusions. Disaster-related injuries may result in an increased need for blood transfusions. Where health services remain functional, access may be limited because of insecurity, lack of transport or lack of money.

- Increased substance abuse: disaster has been associated with increased use of alcohol and drugs. Risks include both those associated with injecting drug use as well as risky sexual behaviour under the influence of drugs or alcohol.

8

- Ask participants: 'What is the link between the transmission of STIs and HIV?'
- Facilitate feedback for one minute in the large group and click to give answer and explain each bullet one by one. There is a clear link between STIs and HIV in that:
  - Certain STIs facilitate the transmission of HIV: a person with ulcers in the genital area is much more likely to contract and transmit HIV. STIs associated with discharge, such as Chlamydia or Gonorrhea can also facilitate the transmission of HIV because the discharge contains a high number of white blood cells, which is a source of HIV.
  - The presence of HIV can make people more susceptible to become infected with an STI. HIV weakens the body's immune system.
  - The presence of HIV increases the severity of some STIs (for instance Herpes).

Advocacy

STI and HIV: The Link

- Unprotected sex increases the risk of both STIs and HIV
- The presence of STIs facilitates transmission of HIV-10 times depending on type of STI-Easy access point
  - Open ulcers; broken skin (syphilis and herpes)
  - Discharge; increased presence of white bloodcells

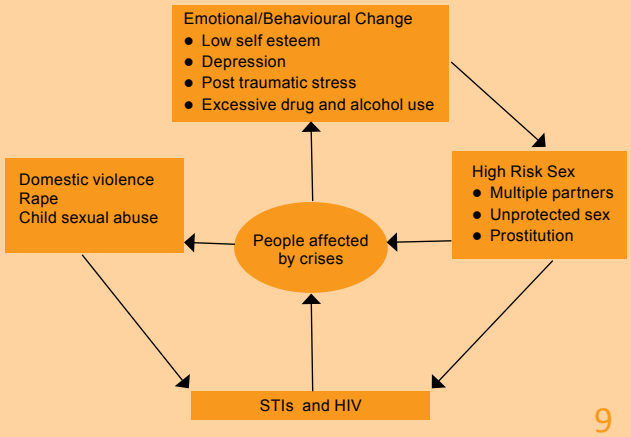
  (chlamydia, gonorrhoea and trichomonas)
- HIV can make people more susceptible to STIs
- HIV increases the severity of some STIs

8

9

- Ask participants: 'Now thinking back to our SGBV session, what are the possible links between SV and STIs/ HIV transmission in disaster.
- Facilitate discussion for one minute in the large group, and click to show a possible model. Do not spend a long time on this slide.

Possible Links Between Sexual Violence, STIs and HIV in Disaster



9

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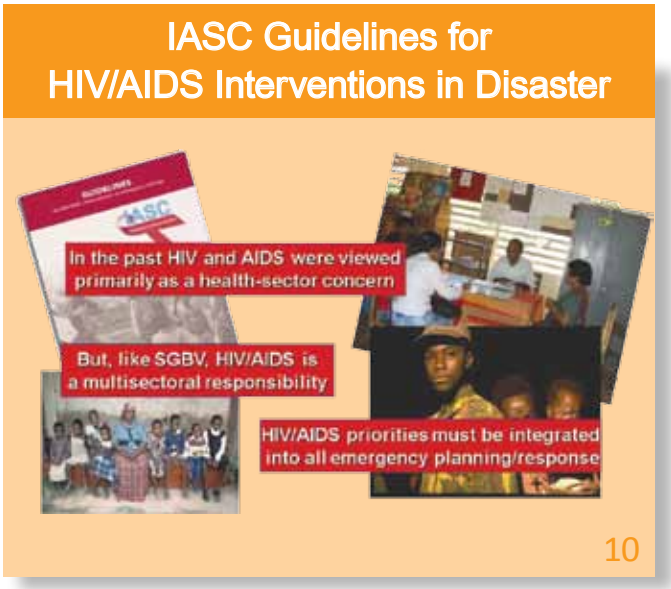
- In view of what was just discussed, the IASC developed guidelines for HIV/AIDS interventions in disaster settings. Like GBV, HIV prevention and response must also be mainstreamed throughout the sectors and this requires a multisectoral approach in disaster settings. The IASC HIV guidelines are similar to the GBV guidelines. The matrices are parallel and many of the sector activities in the minimum response column are the same in both guidelines (show both matrices).
- Group work (five minutes): ask participants to form a group at each table. Divide up the "sectors" among the tables. Give one group the water/sanitation sector, the other group food and nutrition sector and lastly, shelter and site planning sector. Divide the other sectors among the other groups. Each group should compare the minimum response activities (middle column) of the assigned sectors in both HIV and GBV matrices. Participants should also determine whether the activities are similar and if not, where do they differ.
- Take two minutes to facilitate feedback from the different groups. (For the facilitator: the minimum response activities in both matrices are very similar. Notable differences are that the GBV matrix has a "sector" called "Human Resources" that outlines measures to prevent Sexual Exploitation and Abuse (SEA). The corresponding "sector" in the HIV guidelines is "HIV in the Workplace", which deals with protecting staff from HIV-related discrimination and provision of PEP. In the HIV matrix, SEA is an activity under the Protection Sector. The Health Sector in both matrices is different in that HIV prevention activities (MISP) are mentioned in the HIV matrix, but not in the GBV matrix (apart from medical services for rape survivors). The IEC "sector" in the GBV matrix (which is BCC in the HIV matrix) has an additional human rights related activity. Despite these differences, in smaller response operations, both matrices can be merged for more effective coordination.
- Often, especially in greater disasters, a HIV Coordinator as well as a GBV and a SRH Coordinator will be appointed. It is very important to agree on a division of responsibilities and accountability between these three people, as well as the Health Coordinator. All should participate in the regular health coordination meetings, in order to identify and address gaps and overlaps between the general health, SRH, GBV and HIV/AIDS interventions. In reviewing and adapting the matrices from both guidelines, a site-specific coordination matrix can be developed to ensure effective working relations and find practical solutions to overcome the challenges.



Group Discussion

11

- Explain that you will now review universal precautions, now called 'Standard' Precautions.

Ensure Adherence to Standard (Universal) Precautions

11

12

- Ask participants: 'What are standard precautions?'
- Briefly facilitate feedback and click to show first bullet point.
- Ask participants: 'So this means that we have to be very careful with blood from HIV patients?' Wait for the answer and click to show second bullet point.
- 2nd bullet point: Stress that one should consider blood and all body fluids as infected with HIV.

What are Standard (universal) Precautions?

Emphasise

- Simple infection control measures that reduce the risk of transmission of the blood borne pathogens *through exposure to blood or body fluids* among patients and health care workers
- Blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person

12

13

- Explain that the different figures refer to non-disaster situations. In disaster, the situation may be worse due to the lack of reinforcement of standard precautions. (This a 2000 WHO estimate).

HIV Transmission in Health Care Settings

Advocacy

About 5% of new HIV infections in the world are caused by unsafe injections (incl. unsafe blood & occupational exposures)

21 million Hep B; 2 million Hep C; 260 000 HIV infections/year

causing

49 000 Hep B; 24 000 Hep C; 210 000 HIV deaths

40% of the global burden of Hepatitis B and C among health workers is caused by occupational exposure

Technical Guidance for Round 8 Global Fund HIV Proposals, Broad Area: Prevention, Service Delivery; Area: Blood Safety and Universal Precautions. UNAIDS/WHO, 2 April 2008

13

14

- Ask participants: 'Can you name the activities that are part of standard precautions?'
- Take one minute to facilitate feedback and click to show answers and emphasise the message at the bottom:
  The importance for SRH Coordinators to have the supplies available and the protocols should also be in place.

Standard Precautions

- Wash hands
- Wear gloves for contact with body fluids, non-intact skin and mucous membranes
- Wear mask, eye protection, gown, if blood or other body fluids might splash
- Cover cuts and abrasions with a waterproof dressing
- Handle needles and sharps safely
- Dispose needles and sharps in puncture- and liquid-proof safety boxes
- Process instruments correctly
- Clean up spills of blood or other body fluids promptly and carefully
- Dispose of contaminated waste safely

(SRH coordinators must ensure availability of supplies and protocols)

14

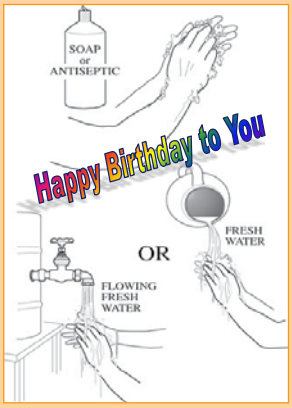
15

- Stress that hand washing is the single most important measure for infection prevention.
- Share the following tip: 15 seconds corresponds approximately to singing 'Happy Birthday to you' once.
- Invite participants to stand up and choose a partner. Tell them that they are going to role- play hand washing. One participant washes one's hands with an imaginary soap, while the other pours the imaginary water. Both of them sing 'Happy Birthday'. Then reverse roles.

Hand Washing

Group Discussion

- Hand washing is the *most important measure* for infection prevention
- Plain soap and water is effective
- Wash hands vigorously for at least 15 seconds, including wrists and under nails
- Rinse under poured or running water



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16

- Explain the slide, stressing under the 1st bullet point antiseptics are to be used for skin and mucous membranes. The word 'antiseptics' is often confused with 'disinfectants', which will be explained later on.
- 2nd bullet point under 'Use': High risk situations include protection in susceptible persons (newborn, immuno suppressed persons) or before invasive procedures.
- Antiseptics included in the Reproductive Health kits are povidone iodine and chlorhexidine gluconat.

Antiseptics

What are antiseptics?

- Chemical agents that reduce microorganisms on *skin and mucus membranes* without irritation or damaging tissues

Use

- Before clinical procedure
- For surgical scrub
- For hand washing in high-risk situations

Antiseptics in the kits

- Povidone iodine
- Chlorhexidine gluconate

16

17

- Ask participants: 'What do health care workers need to do to make injections safe?'
- Briefly facilitate feedback and click to show the answers and highlight points that were not mentioned.

Safe Injections

- Minimise the need to handle needles and syringes
- Use a sterile disposable syringe and needle for each injection
- Handle syringes and needles safely
- Set up work area to reduce the risk of injury
- Use single-dose vials rather than multi-dose vials
- If multi-dose vials used, avoid leaving a needle in the stopper
- Once opened, store multi-dose vials in refrigerator
- Do not re-cap needles
- Position and warn patients correctly for injections
- Practise safe disposal of all medical sharps waste

17

18

- Explain the slide and highlight that the incineration of the containers may be an issue in disaster settings.

Disposing of Sharps

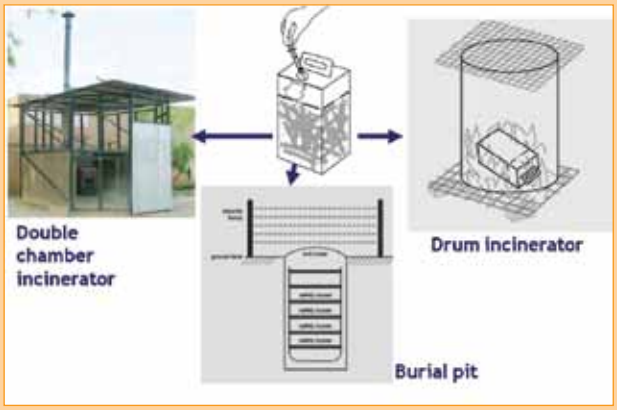
- Dispose off needles and syringes immediately after use in a puncture-resistant sharps-disposal container
- Do not fill the containers more than *three-quarters* full
- Incinerate sharps-disposal containers

18

19

- Explain the different methods of waste management in disasters.

Waste Management



19

20 • Ask participants to take one minute to work in pairs: 'As SRH Coordinators, how would you assess the appropriateness of this burial pit for sharps?' (Fence and cover are missing).

Group Discussion

Example of Burial Pit

20

21 • Explain the slide. This slide outlines the first aid measures to be taken by health care workers after an occupational exposure. Stress that SRH coordinators must ensure that these measures are posted in all settings where sharps are handled and that staff are made aware of them.

Occupational Exposure: First Aid

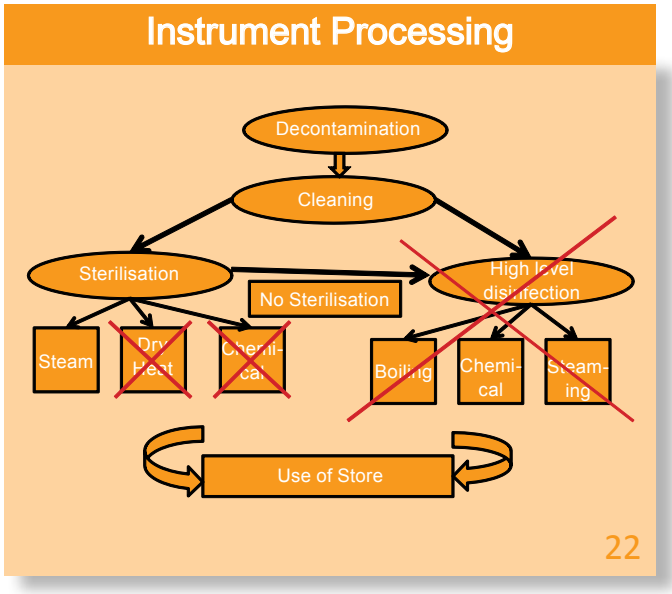
- Injury with a used needle or sharp instrument and broken skin
  - Do not squeeze or rub
  - Wash immediately using soap and water or chlorhexidine gluconate solution
  - Do not use strong solutions; bleach or iodine may irritate the wound
- Splash of blood or body fluids on unbroken skin
  - Wash the area immediately and do not use strong disinfectants
- Splash in the eye
  - Moisten the exposed eye immediately with water or normal saline
  - Tilt the head back and have a colleague pour water or normal saline
  - Do not use soap or disinfectant on the eye
- Splash in the mouth
  - Spit the fluid out immediately
  - Rinse mouth thoroughly with water or saline. Repeat several times
  - Do not use soap or disinfectant in the mouth
- Report the incident and take PEP if indicated

21

22

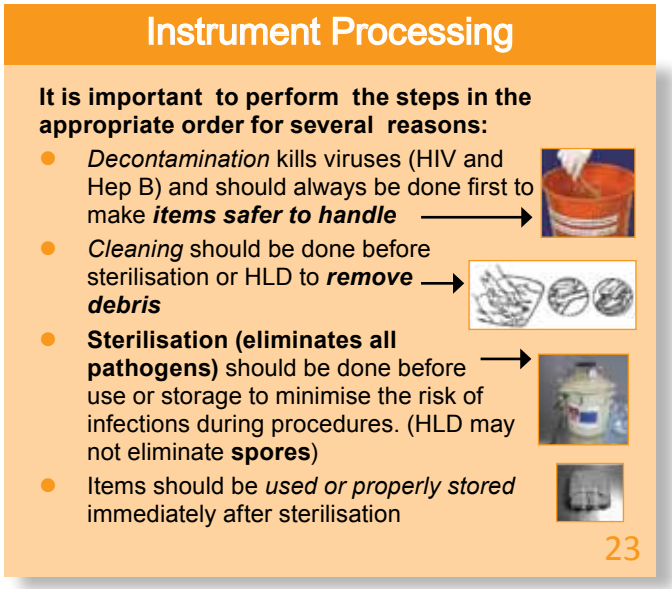
Explain that the four steps of instrument processing consist of:

- Decontamination,
- Cleaning,
- Sterilisation (when not feasible use High Level Disinfection (HLD)) and
- Immediate use or storage of sterilised equipment
- Stress that sterilisation using steam (autoclave) is the gold standard. Sterilisation with dry heat or chemical sterilisation (with glutaraldehyde for instance) is no longer recommended. SRH Coordinators may consider HLD with chlorine in disaster settings until sterilisation equipment is available.



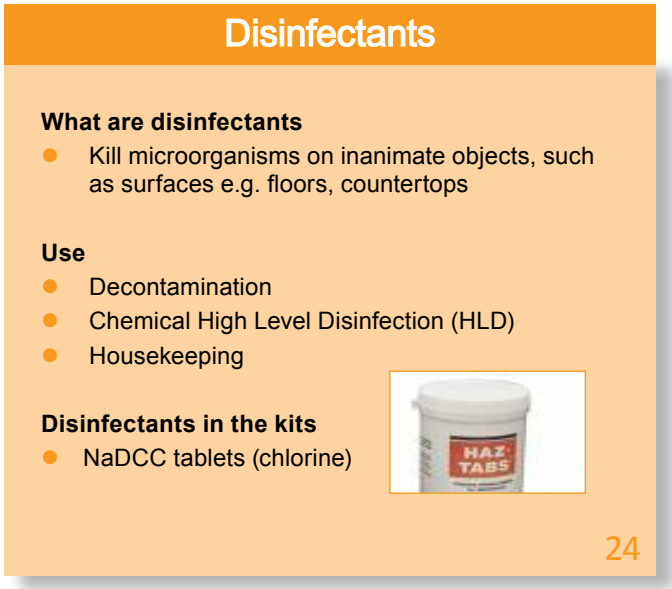
23

- Explain slide, highlighting the underlined information.
- Sterilisation: Stress that it is the gold standard as HLD may not eliminate spores such as tetanus spores.



24

- Explain the slide, stressing that disinfectants, unlike antiseptics, are not for use on skin but are used for decontamination or HLD.



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- 2nd bullet point: Wrapped instruments need a longer autoclaving time (30 minutes).
- Last bullet point: Small autoclaves are widely distributed to the smaller health posts in disaster settings, usually with a stove that runs on kerosene or another fuel. One of the main barriers to staff using the autoclave is lack of fuel. SRH Coordinators need to take this into account and discuss with clinic staff to put a strategy in place ensuring a sustainable fuel supply for sterilisation (making someone responsible, ensuring petty cash for this purpose, record book). Autoclaving is a process that needs careful attention and timing in order to be effective. SRH Coordinators need to ensure that a poster with appropriate steps is posted near the autoclave and verify that the process is adhered to during all field-visits. Relevant staff supervisors must be reminded to include a checklist on correct autoclaving and autoclave maintenance in their supervision activities.

Emphasise

Autoclaving

- Autoclaving should be the main form of sterilisation
- All viruses including HIV, are inactivated by autoclaving for **20 minutes** at 121-131 °C (**30 minutes** if instruments in wrapped packs)
- More practical to use a small autoclave several times a day than to use a large machine once
- At the end of the procedure, the outside of the packs of instruments should have no wet spots, which may indicate that sterilisation has not occurred

SRH Coordinators must ensure: fuel supply, autoclaving protocols and maintenance are in place

25

26

- Explain the slide and stress that Glutaraldehyde is toxic.

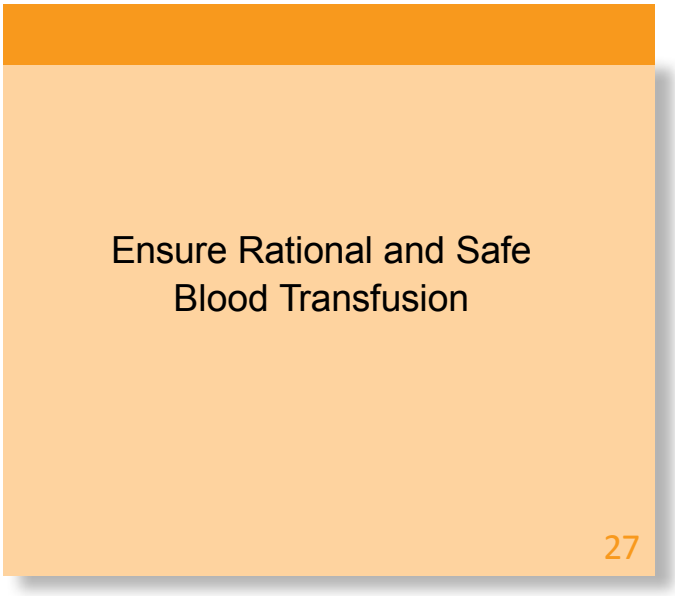
Not Recommended

- Dry heat sterilisation:
  electricity dependent and time-consuming
- Chemical sterilisation:
  time consuming, glutaraldehyde is toxic
- Boiling instruments:
  fuel consuming
- Storing instruments in liquid antiseptic:
  ineffective
- “Flaming” instruments:
  ineffective

26

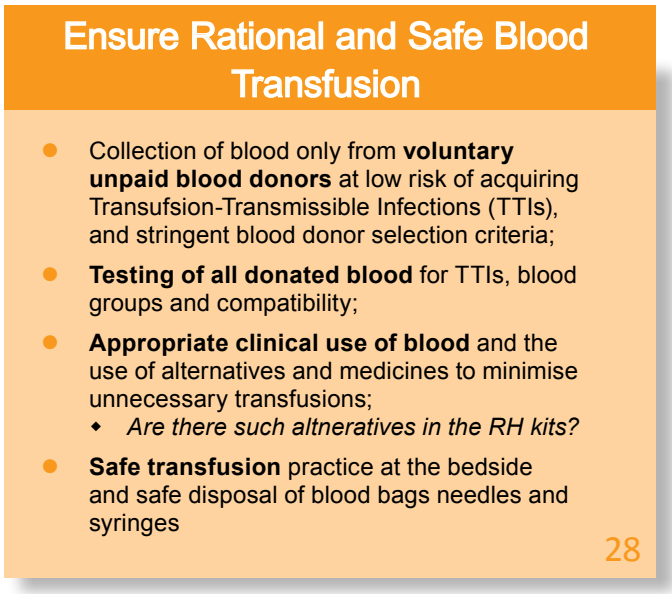
27

- Explain that you will now address the second activity under MISP objective 3: Ensuring rational and safe blood transfusion, which can be a critical issue in disaster settings.



28

- Ask participants: 'What do you think rational and safe blood transfusion means?' Prompt them by asking about 'rational' and 'safe' separately.
- Take one minute to facilitate feedback and click to show bullet points and explain.
- 2nd bullet point: Transfusion-transmitted infections (TTIs) include HIV, Syphilis, Hepatitis B and Hepatitis C. Malaria should be tested in endemic areas. Staff should be made aware that the purpose of the tests is to screen the blood and not the donor status. One positive HIV test result is not enough to make a diagnosis. Therefore, test results should not be divulged to the donor. For this, VCT services with different testing strategies are needed.
- 3rd bullet point: Ask participants to take one minute to discuss in pairs the possible alternatives to blood and medicines to manage bleeding. The RH Kits contain sodium chloride (NaCl) and plasma expanders as fluid replacement alternatives and oxytocin to prevent and manage post-partum hemorrhage.



Group Discussion

29

- 1st bullet point: Highlight that SRH Coordinators should ensure that blood donors come from a low-risk and non-remunerated pool.

Emphasise

Blood Donors

- Safest blood donors are ***voluntary***, ***non-remunerated*** blood donors from ***low-risk populations***
- Family/replacement and paid donors are associated with a significantly higher prevalence of Transfusion-Transmissible Infections (TTIs) but provide more than 50% of the blood collected

29

30

- 2nd bullet point: Stress that SOPs for blood transfusion are key to ensure that blood transfusion is rational and safe.
- 5th bullet point: The technician who conducts the tests and the service provider who administers the blood transfusion need a reliable light source.

SRH Coordinators Must

- Ensure that staff knows ways to reduce the need for blood transfusion along with required supplies
- Put Standard Operating Procedures (SOPs) for blood transfusion in place
- Inform staff on protocols and ensure that procedures are followed at all times
- Keep copies of SOPs in a central location, as well as at the place where each procedure is performed, so they are available for easy reference
- Avoid blood transfusion at night as much as possible
- Assign responsibility and hold medical staff accountable
- Ensure safe donors
- Ensure laboratory facilities have sufficient supplies

30

31

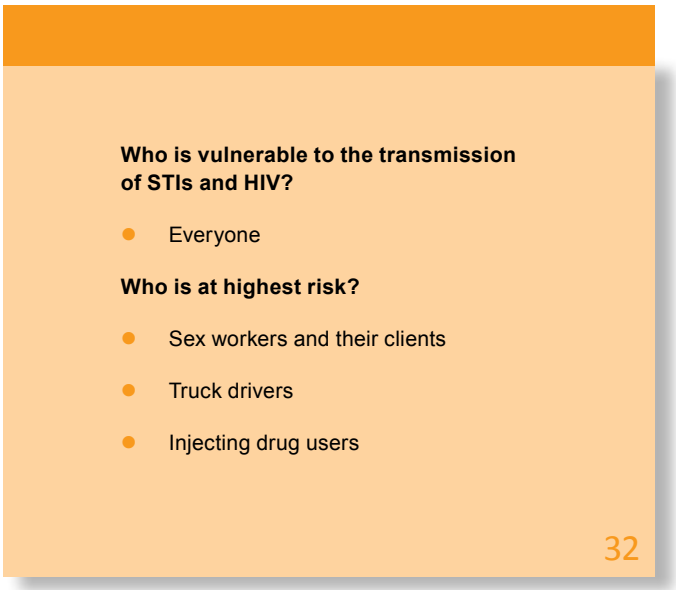
- We will now look at the third activity of objective 3, which will be availability of free condoms.

Guarantee Availability of Free Condoms

31

32

- Ask participants: 'Who is vulnerable to the transmission of STIs and HIV?', to which the answer is everyone.
- Ask participants: 'Who is at the highest risk?' Facilitate feedback for few seconds and click to show answer.
- All people are vulnerable to HIV infection, particularly single women and unaccompanied girls, as also are the armed forces, humanitarian workers, and people who (are forced to) trade sex for favours, goods or money. Being vulnerable to HIV does not necessarily mean that people are a 'high risk group'. Risk factors increase a person's chance of being infected with HIV. Risk factors for HIV include behaviours such as injecting drug use, unprotected casual sex and multiple concurrent partners over a period of time with low and inconsistent condom use.



33

- Explain that condoms have been addressed in the MNH section, however, these are mentioned here again as they are a key method of protection against HIV and other STIs. Even though the entire population will not be knowledgable about them, experience shows that some part of it does use condoms, even in the most traditional societies. Therefore condoms should be available in accessible, private areas from the earliest days of an emergency so that anyone who is familiar with them, both the affected populations and humanitarian staff, has access to them. Condoms should also be made available where young people congregate. Sufficient supplies should be ordered immediately.
- 2nd bullet point: Alongside providing condoms on request, field staff should make sure that the community is aware that condoms are available and where they can be obtained.

- 4th bullet point: Do not conduct condom awareness campaigns during the chaotic acute phase of disaster. This is not a priority and could be offensive to the population if it is not well prepared. Consult the local staff about how condoms can be made available in a culturally sensitive way: they can either be widely distributed with non-food items, or be put out in bars, latrines and other public places. Condoms should be made available in health

facilities and should be provided when treating STIs.

- 7th bullet point: Stock cards should be used to monitor distribution. On the cards it should be noted how many (boxes) of condoms have been placed where. The distribution places should be visited every week or every two weeks and the uptake should be monitored. The condoms must be replaced as and when needed. Note that monitoring distribution number is not the same as knowing the usage rate. For the latter a behavioural surveillance study would have to be conducted in the post-acute phase.

34

- Explain the slide, stressing that these services should be included whenever possible. If not possible, a referral system should be put in place.
- 1st bullet point: Syndromic STI treatment should be included whenever possible.
- 2nd bullet point: Antiretroviral medicines (ARVs) should be made available for those who were already taking it. Usually ART programmes are coordinated by the Health or HIV Coordinator.

Emphasise

Although not in the MISP, it is important to:

- Make treatment available for patients presenting with STI symptoms as part of routine clinical services
- Make first-line ARVs available for patients who were enrolled in ART programmes

34

35

- In terms of MISP indicators for HIV and STI programming, explain the different bullet points.
- Last bullet point: Highlight that in disasters, making condoms available is a priority and condom distribution is more important than considerations about actual use.

Indicators

- % health facilities with sufficient supplies for universal precautions, such as disposable injection materials, gloves, protective clothing and safe disposal containers for sharp objects
- % referral level hospitals with sufficient HIV tests to screen blood
- Estimate of condom distribution: Number of condoms distributed in a specified time period

35

36

- 1st bullet point: Engender Health provides a self-study guide on infection prevention.
- Tip for facilitators: For more information on waste management go to www.healthcarewaste.org

For More Information

www.engenderhealth.org/ip/index.html

www.who.int/bloodsafety/en/

www.healthcarewaste.org

36

37

- Wrap up session with key messages and allow questions and answers as time permits.

Key Messages

- SGBV and the transmission of HIV and STIs are linked
- The MISP objectives are part of both the IASC HIV and the IASC GBV guidelines
- All health care settings should apply the full range of universal precautions from the onset of the humanitarian response
- Safe working practice protocols, first aid information for occupational exposure, and PEP should be available to staff working in health care settings
- Condom distribution strategies need to be adapted to the situation in order to make them accessible
- All blood for transfusion must be tested for TTIs

37

Planning for Comprehensive STI and HIV Programmes

Length
60 minutes

Overview	This session discusses the syndromic approach to STI case management and outlines the key components of comprehensive care programs and priority interventions for PLHIV
Learning outcomes	See below
Preparation	Ensure that PowerPoint presentation handouts are copied
Materials	Markers and flip charts or white boards
Methodology	Interactive presentation

1 • Read the learning outcomes of the session, stressing that you will not address detailed clinical issues but will highlight practical information relevant for SRH Coordination.

Learning Outcomes

By the end of the session, you should be able to:

- Appreciate the public health burden of STIs and the importance of STI prevention and control programmes in post-disaster settings
- Identify the features of the syndromic approach to diagnosis and treatment of STIs
- Describe different strategies for partner management
- Outline the principles of HIV programming in post-disaster settings

1

2 • STIs are a common and serious problem worldwide. WHO estimates that globally, more than 340 million new cases of syphilis, gonorrhea, chlamydia and trichomoniasis occur every year in men and women between 15-49 years. In East and Southeast Asia, an estimated 48 million people have a curable STI at any one time, and 151 million people are newly infected with a curable STI every year (figures from 1999).

Global Burden of STIs

2

3 • The above data refers to normal settings. There is no data available in disaster situation (Facilitators to pudate data as and when available).

STI/RTI in India

- STI/RTI service provision is an important strategy for prevention of HIV under NACP-3 and RCH-2 of NRHM
- Episodes treated
  - 2007-2008 2.6 million
  - 2008-2009 6.6 million
  - 2009-2010 8.2 million
- Rate similar in rural and urban areas
- Only half of general population suffering STI seek treatment

3

4 • Explain the inverse pyramid and how the number of individuals eventually cured is much smaller than all the people who are infected with STIs. The next slides will explain some of the reasons behind this public health issue.

STIs: A Public Health Problem

All people infected with STIs

Aware of symptoms or being a contact

Seek treatment

Correct diagnosis

Correct treatment

Comply with treatment

Cured

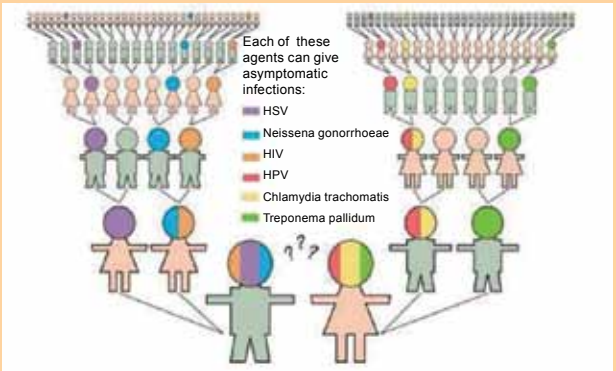
Partners cured

4

5 • Show slide and explain how two individuals can spread infections with unprotected sexual intercourse.

STIs: A Public Health Problem

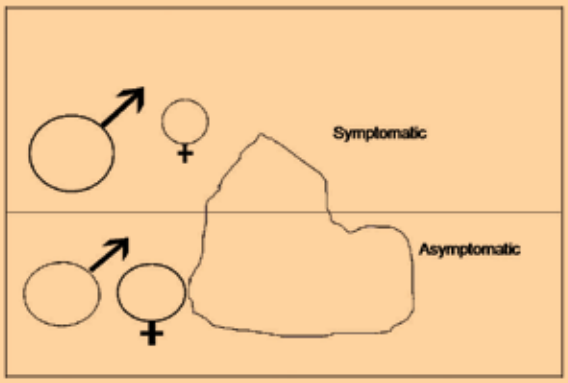
Risk of acquiring STDs in two individuals contemplating unprotected sexual intercourse



5

6 • Explain the iceberg analogy: There are more asymptomatic individuals (especially women) than symptomatic ones. This explains why many people may not be aware of having a STI.

Sexually Transmitted Infections



6

7 • Ask participants: 'What may be the factors related to spread of STIs?'
• Briefly facilitate feedback and click to show proposed answers and highlight the points not mentioned by participants.

Factors Related to the Spread of STI

- Lack of Information
- Condoms not available
- Sexual abuse and violence
- Increased alcohol and IV drug use
- Sex work
- Migration work

7

8 • Ask participants: 'Can you name some consequences of STIs?' Facilitate feedback for one minute.
• Click to show proposed answers and highlight the social and economic consequences.

Consequences of STIs

Ascending Infections
- Endometritis
- Salpingitis
- PID
- Peri Hepatitis
- Epididymitis
- Infertility

Pregnancy
- Ectopic pregnancy
- Abortions/still births
- Pre term delivery
- Premature rupture of membrane
- Post-partum infections

Other
- Blindness in infants
- Extensive organ and tissue destruction in children
- Vaginal, cervical,anal and liver cancer
- Heart and cerebral diseases

Social and economic
- Stigma and conflict
- Financial burden due to cost of treatment
- Loss of life and productivity

8

9

- Ask participants: 'What are the different steps in managing a person with a STI?'
- Take few seconds to facilitate feedback and click to show the answers.

STI Case Management

- Early diagnose of the STI(s)
- Antimicrobial treatment for the syndrome
- Education of the patient
- Condom supply
- Counselling
- Partner notification and management

9

10

- There are three different ways to diagnose a STI: Clinical diagnosis (the provider diagnoses the pathogen by examining the patient's signs and symptoms), laboratory tests (swabs are taken and sent to the laboratory for identification of the causative pathogen), or syndromic approach. Click to show the disadvantages of the first two methods.
- Ask participants: 'What is syndromic approach?' Click to show the next slide.

How can we Best Diagnose a STI?

Diagnosis	Disadvantages
Clinician diagnosis (etiological)	• Not sensitive/specific • Cannot detect mixed infections
Laboratory diagnosis (tests)	• They are not reliable, inexpensive, simple to use tests • Results not available within a short time
Syndromic approach	• Details in next slide...

10

11

- Explain what a syndromic approach means.

Syndromic Approach

- Approach that uses algorithms **(flowcharts)** based on **syndromes** (patient symptoms and clinical signs) to arrive at treatment **decisions**, which use antibiotics that **work in the region**

11

12
- Ask participants: 'Can you name STIs that can cause genital ulcers?'
- Briefly facilitate feedback and click to show answers.
- Repeat the process with urethral and vaginal discharge.

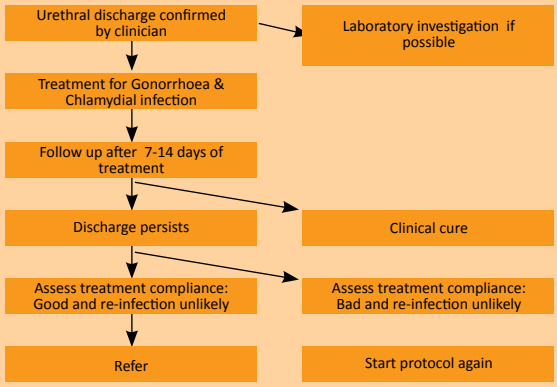
Examples of STI Syndromes

Syndrome	STIs/RTIs
Genital ulcer	• Syphilis • Herpes • Chancroid • Granuloma inguinale • Lymphogranuloma venerum
Urethral discharge	• Gonorrhea • Chlamydia
Vaginal discharge	• Bacterial vaginosis • Yeast infection • Trichomoniasis • Gonorrhoea • Chlamydia

12

13
- Explain this simple example for Urethral Discharge.

Urethral Discharge in Males: Syndromic Diagnosis



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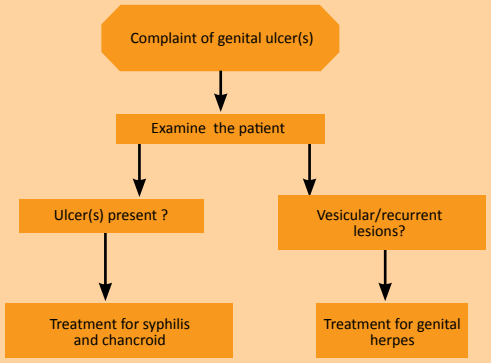
14
- Explain this example of a simple algorithm (flowchart with boxes and arrows) for the genital ulcer syndrome.

Genital Ulcers: Syndromic Diagnosis



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- Ask participants: 'What are the advantages of the syndromic approach?' Click to show answers.
- Syndromic case management offers many benefits in post-disaster situations for the prevention and control of curable STIs. It enables **trained first-line service providers** to diagnose a STI syndrome and treat patients 'on the spot' without waiting for the results of time-consuming and expensive laboratory tests. By offering treatment to the patient's first visit, it helps to prevent the further spread of STIs. Repeat the process with the disadvantages.

STI Syndromic Case Management

Advantages

- Faster treatment
  - ↓ in transmission
  - ↓ in complications
- Cost saving (No expensive lab tests)
- Client satisfaction
- Standardisation
  - Diagnosis & treatment
  - Supplies management
  - Training
  - Monitoring and Surveillance

Disadvantages

- Over diagnosis
  - ↑ in treatment cost
  - ↑ risk of SE
  - ↑ risk domestic violence
- Not good for screening

15

16

- 3rd bullet point: Explain that the antibiotics selected to treat STI syndromes must be tested to ensure that certain pathogens in the region (mainly Neisseria Gonorrhea or Hemophilus Ducreyi, the cause of chancroid) have not become resistant to certain antibiotics over time. The adaptation of syndromic algorithms should be undertaken by the authorities, in collaboration with research institutes.

Algorithms Need to be Adapted

Depending on

- Prevalence of STIs in the population
- Local etiology of the syndromes
- Antimicrobial susceptibility in the region
- Availability of drugs
- Social and behavioural practices

16

17

- Now that you have explained how to identify a syndrome, explain that comprehensive case management of a patient with STIs includes a number of other steps.
- After syndromic diagnosis and treatment, the management of STI patients also includes patient education and counselling (about the infection, how STIs are transmitted, risky sexual behaviours and how to reduce risks), partner management, and the provision of condoms.

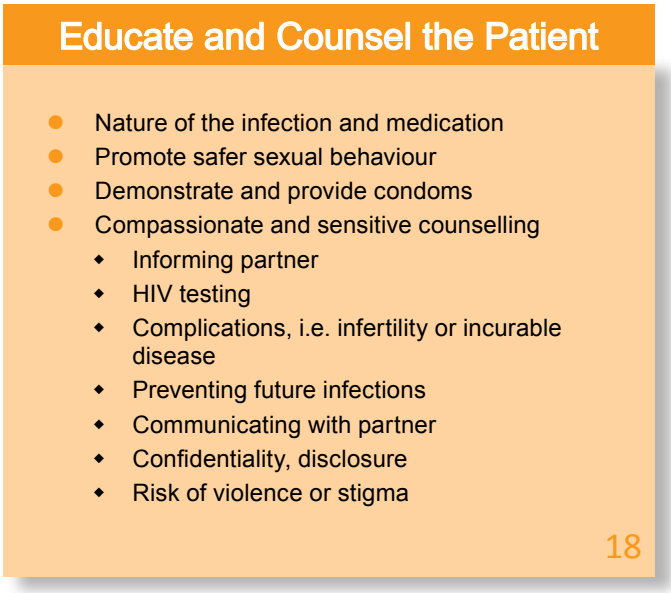
Comprehensive STI Case Management (2)

- Identify the syndrome
- Antibiotic treatment for the syndrome
  - High efficacy (at least 95%)
  - Low cost
  - Few side effects
  - No anti-microbial resistance
  - Single oral dose
  - No contraindication
  - Available at first point of contact (including private sector)
- Education and counselling of the patient
- Condom supply
- Partner notification and management

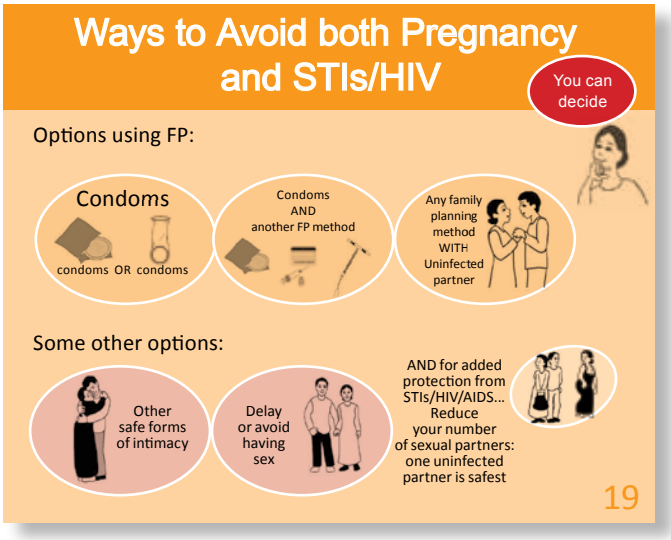
17

18• Two-minute group work: Ask participants to form pairs at their table. One person plays the service provider giving STI counselling to the other person who will play the patient.

- Recall participants, take one minute to ask them to give you feedback on what they discussed in their counselling session and click to show the information to be discussed with the patient.



19• Explain ways to avoid both pregnancy and STIs and that condoms play a central role. Discussing 'dual protection' (using condoms plus another FP method) is particularly important when counselling young people.



20

- 1st and 2nd bullet points: Explain in detail.
- 3rd bullet point: Ask participants 'In your experience how can we best contact partners of STI patients?'
- Briefly facilitate feedback and click to show answers
  The purpose of partner management is to treat as many of the patient's sexual partners as possible. There are two approaches to contacting sexual partners:
  1) By the patient: This is known as **patient referral**;
  2) By a service provider: This is known as **provider referral.**
- Due to the expenses of provider referral and the perceived threat to patient confidentiality, the more practical and workable option is patient referral. This is also the approach recommended by WHO.
- Ask participants: 'From how far back should we contact an STI patient's sexual partners?'

Partner Management

- Respectful, voluntary, confidentially, non-coercive
- In order to be successful in limiting the transmission of STIs, we need to treat:
  - all sexual partners
  - for the same STI
  - any new STI identified
- How can we notify partners?
  - patient informs partner verbally
  - patient informs partner by coded card
  - health worker visits the partner
  - health facility sends letter advising to seek care
  - patient is given additional medication to take home

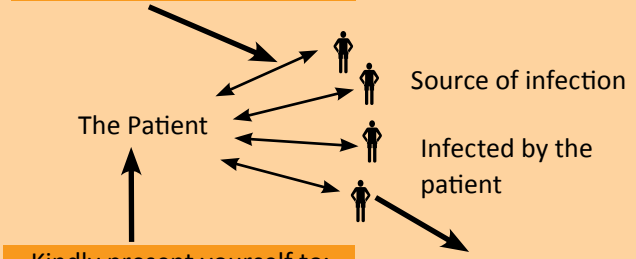
20

21

- All partners from the last two months should be contacted.
- Lower box: Explain that this is an example of a patient referral method with a coded card that the patient will give to sexual partner(s) from the past two months.
- The code at the bottom of the card (ABC) refers to the syndrome that the initial patient (or 'index patient') presented with.

Partner Management

Contacts over past 2 months



Kindly present yourself to:
R. No. 62, District Hospital,
Tel: 234 56 834
Opening hours Mon, Wed, Fri
9.00am – 3.00 pm

Date Referral ABC

When partner(s) present(s): treat immediately with same regimen as for index patient

21

22 • Ask participants: 'As SRH Coordinators, now that we have seen the key components of comprehensive STI case management, what are the elements of quality of care that should be part of an STI programme?'
- Briefly facilitate feedback and click to show answers and highlight points not raised by participants.

Quality of Care in STI Programme

- Available, accessible, affordable, appropriate
- STI management protocols
- Trained health workers (technical and counselling)
- Adequate and regular supply of effective STI drugs
- Confidential contact tracing system
- Monitoring & supervision of clinics
- In-service training

22

23 • Explain that STI programming should be part of a larger public health package including the different bullet points.
- Highlight that the aim of STI prevention and care programmes is to:
  1. Interrupt the transmission of STIs
  2. Prevent development of diseases and complications in individual patients and their partners.
- Reduce the risk of HIV infection.

The Public Health Package

- Promote safer sex
- Condom programming
- Public awareness of STIs
- Comprehensive STI case management at first contact
- Provide specific services for populations at risk
  - Sex workers
  - Adolescents
  - Military
  - Prisoners
- Early detection of infections
- Integrate STI prevention and care into other services

23

24 • Remind participants that STI management should be integrated into Family Planning (as discussed in the FP session), Adolescent Health Care and Maternal and Newborn Health services.
- 3rd bullet point: During pregnancy, a syphilis infection can spread through the placenta and infect the foetus. Up to 40% of syphilitic pregnancies end in spontaneous abortion, stillbirth or perinatal death. This is particularly serious when the maternal infection is untreated during the first 20 weeks of pregnancy.

Integrated STI Management

- **Integrate STI management in FP services**
  - Discuss STI with all clients at each visit
  - Screen for STIs if warranted
  - Encourage dual protection!
- **STI management in adolescent health care services**
- **Integrate STI management in mother and newborn health services**
  - STI risk assessment for all clients in ANC
  - Syphilis screening in ANC (syphilis 40% pregnancy loss)
  - Ophthalmia neonatorum prophylaxis in PNC (1% tetracycline ointment or 1% silver nitrate)

24

25• Principles: Explain that if the host population has access to a particular HIV service then displaced communities should also have access to it.

Comprehensive HIV Programming

Principles: in post-disasters, aim to integrate programming for displaced populations and host community. Aim for services to be similar to those the host community has.

Interventions:

- Initiate or expand HIV awareness and BCC activities
- Set up VCT services
- Ensure prevention of mother-to-child transmission - PMTCT (4 prongs, including ARVs)
- Strengthen care, support and treatment for PLHIV:
  - Prevention and management of OI
  - Home-based care, including palliative care
  - Highly Active Antiretroviral Treatment (HAART)
- Surveillance (biological and behavioural)

25

26• According to ARV policy:

- 1st bullet point: Continuation of ARVs for people already on HAART is a priority and should be ensured as soon as possible in a disaster response.
- 2nd bullet point: Initiation of ART programmes should be planned for and included in the post-acute phase response if the minimum criterias are in place.

(Refer to Antiretroviral Medication Policy for Refugees, January, 2007).

ARV Policy

- Continuity of ART is a priority
- Initiate if minimum criteria in place
  - Availability of resources
  - Sufficiently trained persons
  - Protocols
  - Confidentiality
  - Supervision
  - 2 months of funding
  - Local population has access

26

27• Wrap up session with key messages and allow questions and answers as time permits.

Key Messages

- The syndromic approach is an appropriate way to diagnose and treat STIs in post-disaster settings
- Syndromic approach algorithms need to be adapted to the country situation
- Do not forget partner management
- STI management should be part of a larger public health package and integrated into FP, adolescents and MNH services
- In acute phase: essential HIV interventions (MISP and IASC guidelines)
- In post-acute phase: services similar to those the host community has (make sure minimum in place!)

27

Suggested Further Reading

- Sexually Transmitted and Other Reproductive Tract Infections, A guide to essential practice, WHO, 2005
- Guidelines for the Management of Sexually Transmitted Infections, WHO, 2001
- Training Modules for the Syndromic Management of Sexually Transmitted Infections, 2nd Edition, WHO, 2007 (7 modules plus Trainer's Guide), available at: http://www.who.int/reproductive-health/stis/training.htm
- HIV/AIDS Prevention and Control, A short course for humanitarian workers. Facilitator's Manual developed by the Women's commission for refugee Women and Children on behalf of the Reproductive Health Response in Conflict Consortium, 2004, available at: http://www.rhrc.org/resources/sti/hivaidsmanual/

(i) www.int/reproductive health/publication/mngt stis/index.html
(ii) www.who.int/reproductive_health/topics/rtis/syphilis/en
(iii) www.who.int/hiv/pub//mtct/advice/en/index.html
(iv) www.who.int/hiv/pub/guidelines/pmtct guide

HIV/STI Group Work Stations

Length
2 hours

Overview	The group work stations will address: 1. Standard precautions (40 minutes) 2. Condoms (40 minutes) 3. STI Syndromic Approach (40 minutes)
Learning outcomes	By the end of the session, participants should be able to: • Assess the implementation of standard precautions at a service delivery point • Explain how access to free condoms can be ensured in disaster settings • Calculate condom supplies • Describe the importance of adapting the STI syndromic approach to national guidelines
Preparation	• Ensure participants' worksheets for these station are copied (if possible copy page 2 at the back of page 1) and staple all of them together • For other copies and preparation activities, see below • A facilitator is assigned a station each to set it up and facilitate it • The three stations need to be set up the evening before in different physical spaces or with enough distance between them so that groups do not disturb each other • If possible, assign a time keeper to inform each group to start wrapping up their work five minutes before the end of each session
Materials	See below
Methodology	Facilitated group work

Process

1. Ensure participants have their worksheets for the three stations
2. Divide participants into three groups (try using a game to do so)
3. Assign each group to a station
4. Facilitate the group work and by gentle probing and constructive feedback, ensure that the group addresses key discussion points
5. After 30 minutes of group work, take 10 minutes to allow each group to rotate to the next station
6. At the end of the three sessions, bring participants together in large group and take five minutes to debrief

HIV/STIs - Group Work Station 1: Standard Precautions

40 Minutes

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

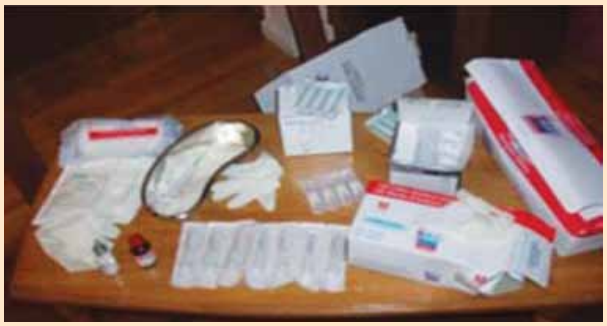
In a corner of the training room, set up a nurses' station where the following items are displayed (some of them inappropriately, so as not to respect the standard precautions). The hotel or training centre will have panels and curtains that you can use to build your station. Be creative and the participants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

(If setting up the station is not possible, project the PowerPoint presentation containing pictures of the station for participants to comment.)

Checklist

X	Number	Item	Comments
	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	
	1	Box of gloves	
	1	Needle in vial	
	1	Uncapped used syringe	
	1	Kidney basin	
	1	Water dispenser & soap	
	1	Nurse's table	
	1	Burn box full of syringes	
	1	Stethoscope	
	1	Blood pressure cuff	
	1	Trash can with recapped syringe inside	
	5	Patients file	

Handwashing Station



Injection Table

HIV/STI - Group Work Station 1

Standard Precautions

Participants' Worksheet (Page 1 of 1)

1. 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 component	Your comment
Hand washing set-up	
Safe use of needles	
Safe disposal of needles	
Standard Precaution protocols displayed	
House keeping	

Standard Precautions: Reinforcing standard precautions.

HIV/STIs - Group Work Station 2
Condoms

40 Minutes

Checklist

X	Number	Item	Comments
	1	Penis model	
	1	Pelvis model	Optional
	1/person	Male condom	
	1/person	Female condom	
	1/person	Male and female condom instructions	Available with the Health Department Resource : CD on Demonstration of use of Female Condom (http://india.unfpa.org/?publications=6616)

HIV/STI - Group Work Station 2

Condoms

Participants' Worksheet (Page 1 of 2)

25 Minutes

1. Condom Demonstration

Take turns in demonstrating how to use male and female condoms
Alternatively show the film on female condom (http://india.unfpa.org/?publications=6616)

2. Discuss the following

15 Minutes

- How would you ensure that condoms are available during a disaster situation?
- How would you monitor the uptake of condoms?
- Using the formula below, **calculate** how many condoms you would need to order for a population of 30 000 people for three months

1. Assume 20% of the population are sexually active men.
2. 20% of them use condoms.
3. Each condom user needs 12 condoms per month.
4. Add 20% to allow for wastage.

Notes:

_____

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HIV/STI - Group Work Station 2

Condoms

Participants' Worksheet (Page 2 of 2)

Key Messages

- Do not order female condoms for disaster if the population has not been exposed to them.
- Condoms can be made available in many ways, but SRH Coordinators must be creative and take cultural sensitivities into consideration. They 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.
- Some examples include making condoms available at registration sites; providing them in the non-food distribution; putting them out during the food distribution, putting supplies in the latrines, in schools, in clinics, through community leaders, community health workers or TBAs.
- SRH Coordinators 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.
- Important to keep track of how many condoms are distributed. Weekly check has to be conducted to evaluate the number of condoms 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

HIV/STIs - Group Work Station 3: STI Syndromic Approach

40 Minutes

Checklist

For all the clinical items, try to procure locally or if not possible, print and show pictures.

X	Number	Item	Comments
	1/5 person	STI syndromic wall chart	
	60	Post-its	
	1/person	Contact cards	

Adapting the STI syndromic poster

HIV/STI - Group Work Station 3

STI Syndromic Approach

Participants' Worksheet (Page 1 of 2)

40 Minutes

1. Explanation of Exercise

Review the STI wall poster.

The acute phase of the emergency is over and you have to **adapt** the STI syndromic poster to the national protocol (below).

Write the appropriate national syndromic treatment on stickers and stick them in the correct place on the wall poster.

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

2. Discuss

- What key messages would you give to the patients?

3. Examine the sample contact cards and discuss:

- How would you improve/adapt these contact cards?
- How are the contact cards used?

Kindly present yourself to:

Name of clinic and address

Opening hours:
Monday 9.00 am – 3.00 pm
Tuesday 9.00 am – 3.00 pm
Wednesday 9.00 am – 3.00 pm
Friday 9.00 am – 1.30 pm

Date :

Referral: ABC

Key Messages

- The aim of STI prevention and care programmes is to:
  - Interrupt the transmission of sexually transmitted infections
  - Prevent development of diseases, complications and sequelae in individual patients and their partners
  - Reduce the risk of HIV infection
- The STI antibiotics in the RH Kit 5 are not specific to a region. It is important to adapt the syndromic treatment choices to national protocols and available anitbiotics.
- Patient counselling to include:
  - Nature of the infection
  - Medication compliance
  - Promote safer sexual behaviour to prevent future infections
  - Demonstrate and provide condom (for 3 months, until confirmatory HIV testing)
  - Informing partner
  - HIV testing
  - Complications, i.e. infertility or incurable disease
  - Communicating with partner
  - Confidentiality, disclosure
  - Risk of violence or stigma

National Plan Review and Discussions

Length
45 minutes

Overview	This session will allow the master trainers to continue their presentation of the action plan they worked on during the Training of Trainers and to engage all participants to reflect on its relevance.
Learning outcomes	By the end of this session, participants should be able to: ● Outline elements of the national plan related to MNH and HIV/STIs ● Assess the relevance of the proposed activities and discuss alternatives as needed
Preparation	Participants should already have the national plan worked by master trainers and 'Suggested Preparedness Activities'
Materials	Markers and flip charts or white boards
Methodology	Self-reflection and group discussion

Process

1. Ask participants to take their handouts ('Suggested Preparedness Activities' and the national plan as proposed by the master trainers).
2. Review the proposed activities under MNH and HIV/STIs with the whole group. Ask participants in groups of three or four to take 30 minutes to reflect on their relevance and brainstorm on new ideas.
3. Bring the national planning session to an end and take 10 minutes to debrief the day in large group.
4. Close the day by thanking participants. Ensure that you have identified volunteers to do the review of day 2 for tomorrow's first session.
5. Inform participants that you will be available for further questions and comments after the end of the session.

Remaining happy, trainers at the end of the day should take time to:

- Debrief your day among co-facilitators to identify strengths and weaknesses, so that the team can find ways to improve for the rest of the training
- Set up the room and prepare sessions for day 3
- Exercise, eat, relax, and sleep plenty!

SRH Supplies and Logistics

Learning Outcomes

By the end of the day, participants should be able to:

1. Order SRH Kits by being familiar with RH Kits booklet and plan for storage and distribution
2. Conduct basic monitoring and evaluation for the MISP implementation and outline existing needs assessment tools to plan for comprehensive SRH
3. Clarify roles and responsibilities for implementing the MISP at the national level
4. Complete and present action plan to integrate the MISP into disaster management plan and health plans

Session Plan

Day 4 Action Planning	
Time	**Session**
930-945	Review of Day 3
945-1115	SRH Supplies and Logistics
1115-1130	**Tea Break**
1130-1300	Data, Monitoring and Evaluation
1300-1400	**Lunch**
1400-1530	Completion of Action Plans
1530 – 1545	**Tea Break**
1545 – 1615	Post-test and Feedback Q&A
1615 – 1630	Review of Participants Expectations
1630 – 1645	Evaluation of Training/Feedback
1645 – 1730	Closing

Notes:

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Review of Day 3

Length
15 minutes

Overview	In this session participants will review key messages of day 3
Learning outcomes	By the end of this session, participants should be able to : ● Recall key points from Day 3
Preparation	Invite two or three volunteers at the end of the day 3 to prepare this session
Materials	As needed by the volunteers
Methodology	As planned by the volunteers: Encourage volunteers to make it fun and interactive

Notes:

SRH Supplies and Logistics

Length
1 hour and
30 minutes

Overview	After reviewing the basics of the RH kits (30 minutes), participants will embark onto a comprehensive logistics exercise (60 minutes) that will allow them to put into practice the information received from the first three days of the training
Learning Outcomes	See Below
Preparation	• Ensure that Powerpoint presentation handouts are copied • Ensure that the Case Study Bihar Floods is copied (three pages)
Materials	• MISP cheat sheet • RH Kits booklet • Calculator • Markers and flip chart or marker for each group (five-eight individuals)
Methodology	Interactive presentation and group exercise

1 Process

Read the learning outcomes of the session and explain that participants will have the opportunity to synthesise all the information of the previous sessions and demonstrate coordination skills through a case scenario.

Learning Outcomes

By the end of the session, you should be able to:

- Be familiar with the contents and supplies of the Inter-Agency RH Kits/RH Kit Booklets
- Assemble the kit locally
- Organise storage and distribution plans
- Adhere to the objectives of MISP package

1

2

Explain that apart from the MISP and the Inter-Agency Field Manual, the IAWG also designed the RH Kits for emergency situations. The Kits contains the medical supplies and drugs to put in place the MISP, **without having to do an in-depth need assessment** first. The contents of the Kits are regularly revised by the IAWG, under the technical guidance of WHO. The Kits are assembled and stockpiled by UNFPA throughout the world.

There is an ongoing effort from NDMA in consultation with the Ministry of Health and Family Welfare to make these Kits locally, stockpile the same and make it available through their own supply chain management system by adapting the IAWG RH kit booklet to the Indian context.

Inter-Agency Working Group on RH in Crises (IAWG)

- Minimum Initial Service Package (MISP)
- Inter-Agency Field Manual and other guidelines
- ***Inter-Agency RH Kits for Emergency Situations***

2

3 • Ask participants to look at the back side of their MISP cheat sheet where there is a summary of the RH Kits.

Explain Blocks 1, 2 and 3, their respective facility level and population coverage. The 12 Kits are divided into three blocks. Each block has a number of kits designed for a different level of health service delivery and contains RH supplies for the relevant number of people for each level, for three months, after which further needs should be calculated based on monthly consumption. Further supplies should be ordered through the usual supply systems of the ministry or organisation implementing the services. You can re-order the Kits, if needed, but this is not recommended. They are meant to implement services where none exist at all.

A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with four-six indoor/ observation beds. It acts as a referral unit for six sub-centres and refers cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.

(Source: (IPHS) For Primary Health Centres 2006)

Inter-Agency RH Kits for Disaster Situations

- **Block 1 (Kits 0 to 5)**

  Sub centre health care/health centre level
  10,000 people for three months
- **Block 2 (Kits 6 to 10)**

  Primary Health centre level or referral level
  30,000 people for three months
- **Block 3 (Kit 11 and 12)**

  District Hospital Referral level
  150,000 people for three months

3

4 • Explain that the supplies in the Kits are calculated for a 'standard' population, with these assumptions (i.e. 20% adult males, 25% WRA, etc.). Therefore there is no need to redo these calculations when ordering the supplies. SRH coordinators only need to know the number of affected people and the distribution of health services and staff that this population has access to.

'Standard' Population

Adult males	20%
Women of Reproductive Age (WRA)	25%
Crude birth rate	4%
Number of pregnant women	
Number of deliveries	
Complicated abortions/pregnancy	20%
Vaginal tears/delivery	15%
Caesarean sections/delivery	5%
WRA who are raped	2%
WRA using contraception	15%
Oral contraception	*30%*
Injectables	*65%*
IUD	5%

4

5 • Explain that Block 1 contains six Kits and is designed for the above interventions.

RH Kits for Disaster Situations

Block 1

Sub-Centre/Health Centre level 10,000 people for three months

Kit	
0	Administration/training supplies
1 A&B	Condoms (A/male & B/female)
2 A&B	Clean delivery (A/individual & B/attendant)
3 **A**	**Post-rape treatment (EC/STI prevention)**
B	**Post-rape (PEP)**
4	Oral and injectable contraception
5	Treatment of STIs

5

6 • This is a picture to illustrate one of the Kits (Kit 3: Treatment of rape survivors).

• Ask participants to take one minute to open their RH Kit, booklet and examine the contents of Kit 3 A and B.

Kit 3: Rape Treatment Kit

6

7 • Explain that Block 2 contains five Kits and is designed for the above interventions.

• Ask participants to review the contents in the RH Kit Booklet.

RH Kits for Disaster Situations

Block 2

Primary Health centre level or referral level 30 000 people for 3 months

Kit	
6	**Delivery (Health Facility)**
7	IUD insertion
8	Management of complications of abortion
9	Suture of cervical and vaginal tears
10	**Vacuum extraction**

7

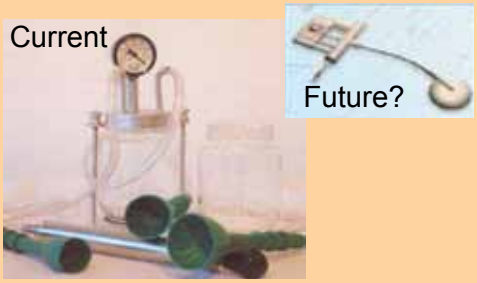
8 • This is a picture to illustrate Kit 6. Many of the Kits consist of more than one box. For instance Kit 6 consists of five boxes, of which one is a cold-chain box with oxytocin.

Kit 6: Clinical Delivery (Health Facility)

8

9 • This is a picture to illustrate Kit 10. The Kiwi Omni Cup is a preferred instrument.

Kit 10: Vacuum Extraction for Delivery



9

10 • Explain that Block 3 contains two Kits for the referral level and is designed for the above interventions.

RH Kits for Disaster Situations

Block 3

District Hospital/Referral level
150 000 people for three months

Kit	
11 A	Surgical (reusable equipment)
B	Surgical (consumable items and drugs)
12	***Blood transfusion***

10

11

- This is a picture to illustrate Kit 12.

Kit 12: Blood Transfusion

11

12

- 1st bullet point: Explain that hygiene supplies should be need and culture specific to the community. Therefore, there are no hygiene supplies in the RH Kits. Agencies need to consult the community about their needs (for instance using focus group discussions) and assemble such hygiene supplies locally.
- 2nd bullet point: Ask participants 'What would you include in hygiene kits for women?' (three minutes group work by table).
- Take two minutes to facilitate feedback. Click to show proposed items and highlight those not yet mentioned. Large underwears are more practical as women can amend them to smaller sizes. Emphasise that the affected women should be inquired about their needs. In Bihar, India, women asked for 'Sindoor' so that they can get respect and as it would provide dignity within the community.
- 3rd bullet point: Ask participants 'What would you include in hygiene kits for men?'
- Facilitate an immediate feedback. Click to show proposed items and highlight those not yet mentioned
- Show slide on Dignity Kits provided in India by NDMA/UNFPA.

Hygiene Supplies

- **No "global" kit, community specific**
- **For women:**
  - Sanitary supplies for 3 months
  - Underwear (3 large)
  - Soap, soap powder, toothpaste, toothbrush,
  - Aspirin
  - Bucket for washing
  - What else? **ASK!**
- **For men**
  - Shaving supplies, soap, toothbrush, toothpaste
  - Condoms
  - What else? **ASK!**

12

Emphasise

Dignity Kits

- Contents of Dignity Kits supplied by UNFPA in partnership with NDMA during disaster, consists of the following:
  - one saree with blouse
  - salwar kameez with dupatta for adolescent girls
  - two panties
  - thirty sanitary napkins
  - two washing soaps
  - two bathing soaps
  - one comb
  - two packets of safety pins
  - two boxes of sindoor and
  - an old newspaper

12

13 • 1st bullet point: The cold chain is needed for instance for oxytocin (Kit 6, 8, 11) and blood screening tests (Kit 12).

Local Logistic Issues

- Observing the cold chain (when necessary)
- Distribution plan
- Transport
- Storage/Warehousing (Colour codings)
- Coordinating with local partners (MOH, NGOs , Army, Red Cross, other government departments and UN agencies)

13

14 • This picture illustrates the large size of an RH Kits order (in Sri Lanka after the tsunami). It also demonstrates the colour coding on the different RH Kits. The light green marked boxes are in kit 11B, which has 35 boxes.

RH Kits at Sri Lanka Airport

14

15 • This picture illustrates an example of a distribution plan mapped out in detail.

Distribution Plan

15

16 • The pictures illustrate different ways to transport the Kits to the health facilities. The picture on the left shows a large-scale distribution operation in Sri Lanka with the Army doing the logistics. While, the picture on the right shows a doctor from UNFPA delivering RH Kits while on a technical support mission in the camps in Eastern Chad.

Transport

16

17 • This is an example of warehouse balance sheet to track the status of the RH kits.

Sample of Ware House Sheet

Sample of Ware Sheet

To :
From : Quantity Received in (Boxes)
Cc :

Date -	31/12/05	21/2/06					
			Total Received	Total Release	Balance	Location	Comments
Kit 0	0	4	4	2	2	Warehouse 2	
Kit 1A	30	48	78	29	49	Warehouse 1	1 broken has 8 Packets
Kit 1B	1	2	3	0	3	Warehouse 1	Quantity release in pieces (400 PCS), 2 cartons partly damage
Kit 2A	0	660	660	632	28	Warehouse 2	1 carton is broken
Kit 2B	2	13	15	11	4	Warehouse 1	
Kit 3	0	15	15	9	6	Warehouse 2	
Kit 4	0	24	24	15	9	Warehouse 1& 2	In warehouse 14 boxes. 8 in warehouse 1 & 6 in warehouse 2
Kit 5	0	35	35	34	1	Warehouse 1	
Kit 6	0	94	94	80	14	Warehouse 2	
Kit 7	2	2	4	2	2	Warehouse 1 & 2	1 box in warehouse 1, 2 boxes in warehouse 2
Kit 8	3	19	22	11	11	Warehouse 2	
Kit 9	3	10	13	13	0		
Kit 10	5	1	6	0	6	Warehouse 1	
Kit 11A		6	6	5	1	Warehouse 2	
Kit 11B	97	163	260	259	1	Warehouse 1 & 2	64 in warehouse 2
Kit 12		11	11	10	1	Warehouse 1 & 2	1 box in warehouse 1 & 3 boxes in ware house 2
Total	143	1107	1250	1112	138		
Kit 1B	740	1040	1780	400	1380	Warehouse 1	Amounts in Pieces

Signature : ----------
Date : ----------

Signature : ----------
Date : ----------

17

18 • Explain the different steps and functions of the different stakeholders.

RH Kits – Who does What

- First: Determine needs and make a distribution plan
- Contact State level Disaster Management Cell/ Dept. of H&FW
- Procure from Warehouses
- Funding: Central Government, NGO's own funds
- Supply Chain Management Systems: Public and Private agencies
- Transportation arrangements

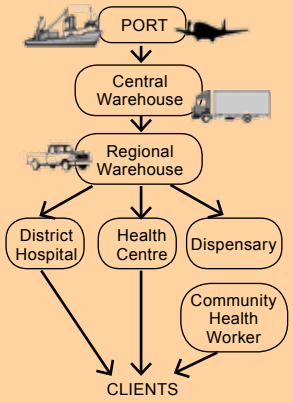
Supplies to be transported ***within 48 hours***

18

19 • First bullet point: Emphasise that reordering RH Kits after the crisis is not recommended. As soon as possible, supplies should be procured through local channels.

Long Term Recovery

- Do not re-order kits
- Develop/ strengthen a logistics supply chain for medical supplies
- Join or build onto existing systems



19

Emphasise

20 • Proceed with the group work: logistics exercise (1 hour).

Resources

- Essential List of RH Medicines (WHO)
- UNICEF supplies catalogue; http://www.unicef.org/supply/index.html
- John Snow Inc; http://deliver.jsi.com/dhome/topics/supplychain/logistics

20

21 Logistics Exercise Process

1. Divide participants into groups of 5-8 people.
2. Distribute the participants' handouts.
3. Explain the exercise (instructions are on the handout 'Case Study Bihar Floods'), stressing that each group needs to present their work on flip charts at the end of the exercise.
4. Let the groups start the exercise on their own.
5. Facilitate the group work and by gentle probing and constructive feedback, ensure that the groups keep to the allocated time so as to address all the questions required.
6. After 20 minutes of group work, take 20 minutes for presentation. Each group will take turns to present their work and receive your feedback (in total, five minutes per group depending on the number of groups).

Answers to some discussion points (refer to next page: Case Study Bihar Floods).

1. Which assessments need to be made?
   - None, except an estimate of the number of affected people 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 Bihar" 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.

Logistics Exercise (Group Work)

- Which assessments have to be made?
- Which interventions will you put in place immediately?
- Which kits will you order and how many (for three months)?
- Make a distribution plan (consider implementing partners and in-country storage and transport needs)
- PARTNERSHIPS!

21

Example of Logistics Plans

Logistics Exercise

Participants' Handout (page 1 of 3)

Case Study (Bihar Floods)

(adapted from the ICRC HELP course)

Report

The worst affected districts following the recent flooding on Kosi River included Supaul, Araria, Purnia, Katihar, parts of Khagaria and northern parts of Bhagalpur, as well as adjoining regions of Nepal. An unknown number of people from low lying areas have fled to the upper lying areas of district of Saharsa. At least 20,000 displaced people have created a settlement near the village of Patherghat, about 34 km from the border from Saharsa District, in a remote region of Madhepura. At the present time, according to the State Disaster Management Authority, who are coordinating the humanitarian response, there are still upto 1000 flood affected persons coming each day into the area. The displaced population is utilising overwhelming resources as they settle down in Madhepura district. Unable to deal with their needs, the Bihar government has requested assistance from the Central Government. At the same time the Bihar Government has brought in the machinery to plug in the leak at various embankments of the Kosi River.

The flood affected persons are living in temporary shelter they have made from grass, branches and some banana leaves. Water is obtained from the river not far from the camp, but there are problems with this water source. Reports indicate that there are poor sanitation provisions for the affected population and Oxfam has been requested to dig latrines and set up water distribution points.

Cooking fuel is a problem, but there are some woods one km away, where women go to get firewood. The displaced population brought with them some food supplies, but these have been exhausted. The local community and various organisations have been trying to help out, but this is clearly not enough and the World Food Programme (WFP) has initiated a food pipeline on request by the State Government.

Health problems in the province include malaria, cholera, measles, tuberculosis, HIV, meningitis, diarrhoea, respiratory infections and skin conditions. Although no surveys have been completed, it appears that malnutrition may also be a significant problem. There is an increase in trauma cases due to persons coming in with injuries and there are reports of rapes and abductions of women, girls and boys. Obstetrical complications are common, and although the maternal mortality ratio is not known, it is thought to be fairly high.

There are health centres and health posts scattered around the Madhepura district. The district hospital is in the city of Madhepura (50 km from the camp) and there are smaller hospitals in the towns of Ramnagar, Saur Bazar and Sonbarsa. The hospital at Saur Bazar is the closest (20 km) and so far seems to be the most affected by the influx and demands for services. A training of Primary Health Care Workers (PHCW) was undertaken several years ago, but not as many as needed have been trained. Some TBAs received training about 10 years ago. Several organisations are starting limited health services (Indian Red Cross, Indian Medical Association, Rotary Organisation etc.). Already a major shortage of drugs and supplies is looming. Even though transportation is possible by road, rail and air, it is many times problematic owing to factors such as flooding. In times like these, roads around Saur Bazar may get cut off for several days.

Your Job

This morning in the inter-agency emergency coordination meeting you were given the above briefing and you were asked to take on RH coordination. You are now holding a meeting with health NGOs to discuss putting in place the most essential sexual and reproductive health intervention for the refugees in Madhepura district.

Before your meeting you found some RH indicators for the Bihar population on the internet (see attached sheet).

Discuss the next few steps:

1. Which assessments need to be made?
2. Which priority RH interventions will you put in place immediately?
3. Which Kits will you order and how many?
4. Make a distribution plan: What (Kit) goes where (which place).

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

Logistic Exercise: Participants discuss the case study and make presentation

Logistics Exercise

Participants' Handout (page 2 of 3)

Reproductive Health Indicators for Bihar

Basic Demography Indicator

Total population	82, 900 ,000
Sex Ratio (F:1000 M)	9 19
% of women who are aged 15 - 49	2 4. 6 %
Percentage <5 years of age	1 %
Total fertility rate (per woman)	3.9
Safe Motherhood indicators	
Crude birth rate (per 1000 population)	28.9
Neonatal mortality rate (0 - 4 weeks) (per 1000 live births)	11.00 (estimated range: 9.00 12.00)
Maternal mortality ratio (per 100.000 live births)	312
Lifetime risk of maternal death	NA
Unsafe abortion	
Anemia in pregnant women	9% (rural)
	22% (urban)
STDs, including HIV/AIDS	11.7 % (rural)
	18.7 % (urban)
Adults living with HIV/AIDS (%)	
Men reporting (15- 49) reporting arthritis in last year (%)	
Family planning indicators	
Contraceptive prevalence (all methods) (% of women 15 - 49)	1 5 % (1 9 95)
Contraceptive method mix	
Condom	10 %
Pill	7%
Injection	1 %
IUD	10 %
Female sterilisation	20%
Traditional methods	52%

Data Management, Monitoring and Evaluation in Disaster Management

Learning Outcomes

By the end of the session participants should be:

- Able to identify the different types, sources and importance of data for monitoring and evaluation of disaster management programmes
- Familiar with human right approaches in data collection
- Able to understand Indicators and their use
- Familiar with the basics of Result Based Management (RBM)
- Familiar with the process of assessment, monitoring and evaluation in Disaster Programme Management (DPM)
- Able to identify the data needs in the different phases of disasters

Session Plan

Time	Session
1130-1230	Data, Sources, Types, RBM, Indicators
1230-1245	Group Work
1245-1300	Data Needs during Different Phases of Disasters

Notes:

Data Management, Monitoring and Evaluation in Disasters

Length
1 hour and
30 minutes

Overview	This session reviews Data Management , Monitoring and Evaluation in Disasters
Learning outcomes	See below
Preparation	Ensure that PowerPoint presentation and handouts are copied for distribution. Ensure that group work sheets are ready.
Materials	Audio Visual Material
Methodology	Interactive presentation

1 Process

Read the learning outcomes of this session. Explain that this is to sensitise the participants on basics of Data and Data Management in Disasters.

Learning Outcomes

By the end of the session you should be able to:

- What is Data and its importance
- Identify sources of Data and the types of Data
- Human Right approaches in Data collection
- Basics of RBM
- Indicators and Types of Indicators
- Data needs during different phases of Disasters
- Familiar with the process of Assessment, Monitoring and Evaluation in Disaster

1

2

- All of us frequently use the term 'Data'. Ask the participants, "What is data? Is it so important? If yes, Why?" Discuss and show the slide.
- Data is essential for the success of any programme. It is used for planning, implementation and evaluation of the programmes. Similarly, data is also necessary for the planning, service delivery and evaluation of services during disasters.

What is Data?

Data

- Is collection of facts
- May be values or measurements
- Can be observations or just description of things

2

3 • Ask the participants to list some **sources.** Briefly facilitate feedback and then click to show the proposed answer.

Sources of Data

- Grouped into two MAIN categories:
  - Primary
  - Secondary

3

4 • Ask participants to define what are **primary sources** of data and list some of the sources. Briefly facilitate feedback and click to show the answer.

Primary Sources of Data

- Data or information collected directly by project personnel or any external agency
- The users of the data are the same as those who have collected first hand information from the field
- Collected through the following means:
  - Surveys-Interviewing the respondents using questionnaire mode
  - Focus Group Discussions (FGDs)
  - Case studies
  - In-depth interviews and observations

4

5 • Ask participants to define what are **secondary sources** of data and to list ways of collecting them. Briefly facilitate feedback and click to show the answer.

Secondary Sources of Data

- Generated by one person and used by many others
- Reports published by researchers; if analysed by those who have not directly collected the information
- Collected through the following means:
  - Census
  - Household survey:
    - National Family Health Survey
    - District Level Household Survey
    - Annual Health Survey
  - Sample Registration System (SRS)
  - Administrative Records at District/State level
  - Geographic Information System (GIS)

5

6 • Ask the participants what are the **types of data**. Briefly facilitate feedback and click to show the proposed answer.

Types of Data

- Qualitative
- Quantitative

6

7 • Ask participants to explain **Qualitative Data**. Briefly facilitate and show answer.

Qualitative Data

- Structured individual interviews and in-depth discussions (FGDs) with individuals, service providers, communities, NGOs, etc.
  - Availability
  - Access
  - Coverage
  - Quality

7

8 • Ask participants to explain **Quantitative Data**. Briefly facilitate and show answer.

Quantitative Data

- Is numerical information (numbers)
  - Incidence
  - Prevalence
  - Morbidity
  - Mortality
  - No. of pregnant women, no. of breastfeeding women, no. of adolescent girls etc

In disaster through aerial method, enumeration or profiling, rapid data collection

8

9

- Ask the participants what are **Human Right Approaches** in data collection? Click to show the proposed answer and explain the approaches:

Bullet 1: Participatory: If the data collection is participatory then people know about validity of the data, believe in the data and respond positively to it.

Bullet 2: Transparency in decision making: During disasters, it is the duty of the government to take care of the victims. To provide all the support within time and as per the requirement. Therefore, it is mandatory to take transparent decisions.

Bullet 3: Non discrimination: ***Emphasise on*** Equity and Equality.

Bullet 4: Explain Accountability: To promote, protect and fulfill Human Rights in the process of collection, analysis and reporting information.

Human Right Approaches in Data Collection

- Participatory
- Transparency in decision making
- Non discrimination
- Accountability

9

10

- Ask the participants what do they understand by the term **'Indicator'**?
- Briefly facilitate feedback and click to show proposed answer.

Indicator

- "An indicator is a measure of an event or condition. It is a **marker of performance** and can be used to track progress in the performance"
- **Indicators** are an essential part of a Monitoring and Evaluation system because they are what we measure and/or monitor. Through the indicators we can ask and answer questions such as:
  - Who?
  - How many?
  - How often?
  - How much

10

11 • Ask the participants as to why **Indicators** are important. Briefly facilitate discussion and click to show the proposed answer.

Use of Indicators

- Indicators are important for:
  - Programme Management
  - Policy
  - Advocacy
  - Monitoring and Evaluation

11

12 • Ask the participants what are the various **types of Indicators**? Briefly facilitate feedback and click to show proposed answer.

Types of Indicators

- Input Indicator
- Process Indicator
- Output Indicator
- Outcome Indicator
- Impact Indicator

12

13 • Ask the participants what do they understand by **Input Indicator**? Briefly facilitate feedback and click to show the proposed answer.

Input Indicator

Refers to the resources invested in a programme and includes financial, technological and human resources:

- Staff
- Funds
- Facilities
- Supplies
- Resource persons

13

14 • Ask the participants what do they understand by **Process Indicator**? Briefly facilitate feedback and click to show proposed answer.

Process Indicator

Refers to the activities and used to monitor day to day work that would lead to achievement of outputs:

- Training
- Organisation of Village Health Nutrition Day
- No of people contacted
- No of counselling sessions

14

15 • Ask the participants what do they understand by **Output Indicator**? Briefly facilitate feedback and click to show the proposed answer.

Output Indicator

- Measures the immediate achievements of the project/programme.
- Useful to monitor the results of the project on a regular basis:
  - Trained staff, volunteers
  - Vaccination of pregnant ladies
  - Condom availability
  - Knowledge of STI/HIV prevention among youth

15

16 • Ask the participants what do they understand by **Outcome Indicator**? Briefly facilitate feedback and click to show the proposed answer.

Outcome Indicator

- Measures short term and mid-term achievements
- Are measured during Evaluation and cannot be monitored regularly:
  - Behaviour change (correct and consistent usage)
  - STI trends
  - Attitude change

16

17 • Ask the participants what do they understand by **Impact Indicator**? Briefly facilitate feedback and click to show the proposed answer.

Impact Indicator

- Measures the achievement of Programme
- Measures the long term development impact that the activity (policy Goal) contributes to at the national or sub-national level
- Impacts refer to changes in the (health) status of the population:
  - Maternal Mortality Ratio
  - Neo-natal Mortality Rate
  - Proportion of births among those under 18 years
- Are important to keep health–care interventions focused over the mid-term and long-term period
- Not useful for monitoring as they are expensive to measure, it may take years to get measurable effects, influenced by multiple factors

17

18 • Ask the participants what do they understand by the term **Result Based Management** and click to show the proposed answer.

Result Based Management (RBM)

- A broad management strategy aimed at achieving improved performance and demonstrable results
- Results are the collection of outputs and outcomes resulting from an intervention or activity

18

19 Ask the participants about the different **levels of results**. Facilitate discussion and click to show the proposed answers:

- Different levels of results seek to capture the different development changes.
- Results are linked together into what is commonly referred to as the results chain.

Different Levels of Results

RBM has three levels of results:

- Goals
- Outcomes
- Outputs

19

20 • Ask the participant what a **Goal** is and how to formulate it. Facilitate discussion and quickly click to show the proposed answer.

Different Levels of Results

GOAL

- Are specific end results desired or expected to occur as a consequence, at least in part of the intervention or activity
- Questions to ask when formulating the goals:
  - What are we trying to achieve?
  - Why are we working on this problem?
  - What is our overall goal?

20

21 • Ask the participant what an **Outcome** is and how to formulate one. Facilitate discussion and quickly click to show the proposed answer.

Different Levels of Results

OUTCOME

- Short-term and intermediate changes due to effects of an intervention or activity's outputs
- Questions to ask when formulating outcomes:
  - Where do we want to be at the end of the programming cycle?
  - What are the most immediate things we are trying to change?
  - What are the things that must first be in place in order for us to achieve our goals and have an impact?

21

22 • Ask the participants what they understand by **Output** and how to formulate an Output. Facilitate discussion and click to show the proposed answers.

Different Levels of Results

OUTPUT

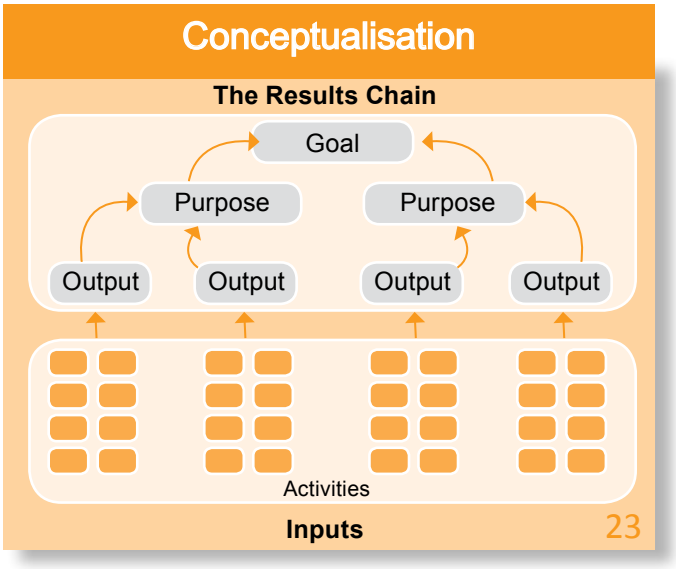
- Are changes in skills or abilities, or the availability of new products and services, produced by an intervention or activity
- Questions to ask when formulating outputs:
  - What are the things that need to be produced or provided through programmes in order for us to achieve our short-to-medium-term results?

22

23 Ask participants what they understand by **Result Chain**?

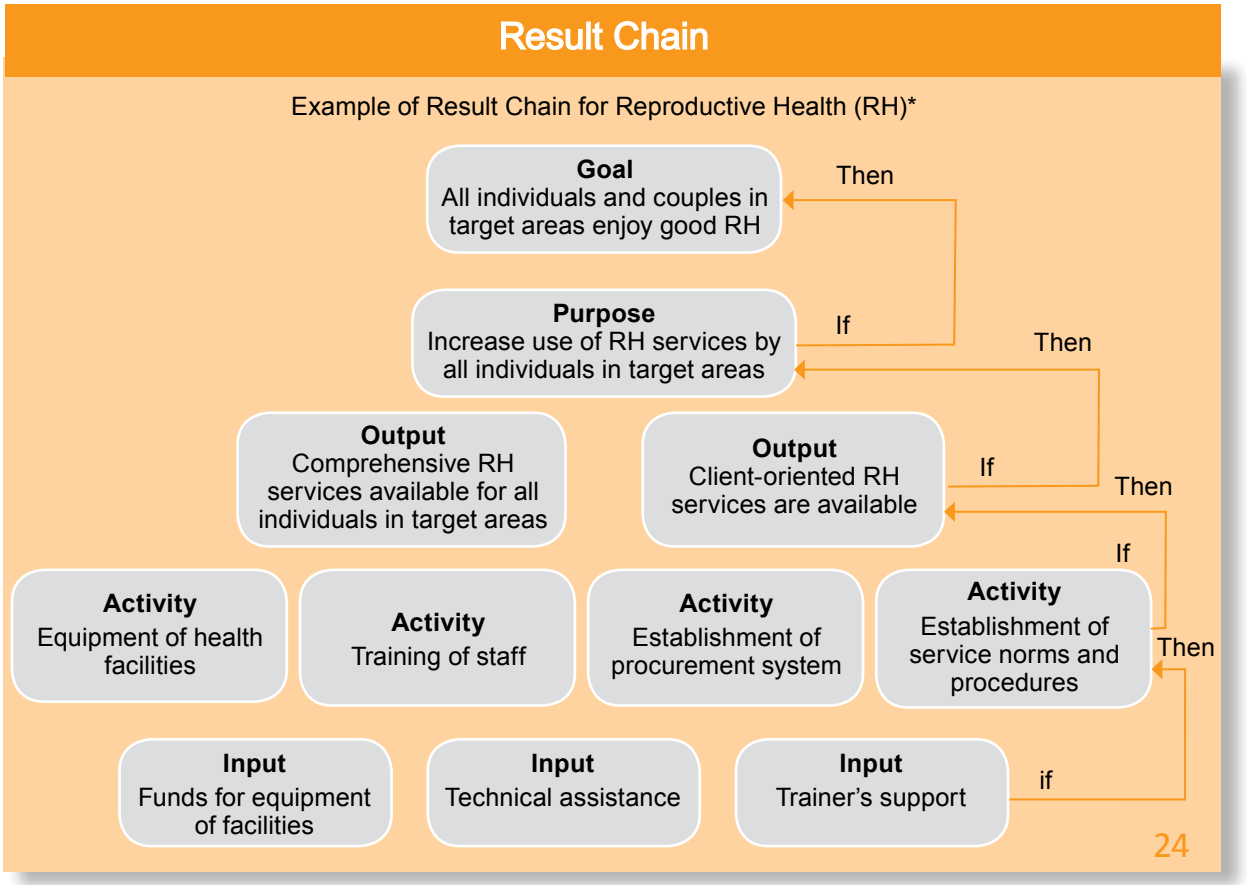
Explain: Result is a describable or measurable change in a state that is derived from a cause and effect relationship. Result = Change; Cause ⟶ Effect

Results chain shows the logical link between activities and the results that may be expected to occur over period of time. The cause and effect relationship is a central element of RBM.



24 Explain the participants the importance of Input, Activity, Output and Outcome in achieving the goal. If you do not have inputs, an activity cannot be performed.

If an activity is not performed one does get the output and when output is not achieved, then it will not contribute to the outcome and finally it will not contribute to achieving the desired goal.



25 • Ask the participants what they understand by the term **Assessment**. Facilitate discussion and click to show the proposed answers.

Assessment

- Assessment is a process to determine and address needs (gaps) between current condition and desired condition

Though MISP does not require a needs assessment, this is for the comprehensive RH service provision

25

26 • Ask the participants what they understand by the term **Initial Rapid Assessment**. Click to show the proposed answer. **MISP does not require NEEDS ASSESSMENT.**

Initial Rapid Assessment

- Ascertains number and location of people needing access to minimum RH service
- Number and location of health care staff providing, or capable of providing MISP component
- RH medical supply logistic opportunities
- MISP funding possibilities

26

27 • Explain to the participants some of the **tools used for Assessment.**

Tools for Assessment

- Review of existing information
- Key informant interviews and FGD
- Health facility assessment
- Rapid surveys

27

28 Ask the participants what is **Monitoring** and what are **Monitoring Tools**? From where can one get these tools?

Click to show the proposed answer

Ongoing, systematic collection and analysis of data as the project progresses is a measure towards the achievement of objectives.

- Aims to measure whether planned activities are being realised or not and how well are services being provided.
- Routine tracking of the key elements of programme/project performance.
- Assesses inputs and outputs of project activities achieved through a variety of information collection system including record keeping, regular reporting, surveillance system, facility observation, client surveys, etc.

Monitoring

- Concerned with Progress
- Routine tracking of key elements of project performance
- Usually assesses inputs and outputs of project
- Conducted regularly or at pre-specified intervals by those responsible for programme implementation
- Enables improvement in plans and corrective action
- Achieved through a variety of information collection systems
- Record keeping, regular reporting surveillance systems, facility observation, client survey etc

28

29

- Ask the participants what are the various elements involved in monitoring.
- Click to show slide.

Monitoring Involves

- Establishing key indicators: To judge the progress of project activities
- Setting up system: To collect information relating to these key indicators
- Collecting and recording information: As and when the project activities take place
- Analysing information: To derive key indicators and track the progress
- Using information: To inform day to day management decisions
- Providing feedback: About bottlenecks and providing direction to improve project implementation

29

30

- Ask the participants what is **Evaluation** and why it is essential? Click to show the proposed answer.
- Process to determine whether programme has met the expected objectives.
- Extent to which changes in outcomes can be attributed to programme.

Evaluation

- Aims to assess programme performance
- Episodic assessment of the extent to which changes in targetted results that can be attributed to programme intervention
- A process to determine whether the programme has met the expected objectives
- Application of research procedure to assess(inputs, processes outputs and outcome/impact) and provide learnings to improve
- When: Throughout the life of the programme implementation, not necessarily at the end. Can be qualitative or quantitative.

30

31

- Ask the participants what are the various elements involved in evaluation.
- Click to show slide.

Evaluation Involves

- What the project/programme intended to achieve
  - What difference did it make?
  - What impact did it have?
  - Is the programme towards what it wanted to achieve?
- Looks at the strategy of the programme
  - Did it have strategy?
  - Was it effective?
  - Did the strategy work?
  - If not, why?
- Look at how the project functioned
  - Was there efficient use of resources
  - Opportunity cost
  - Sustainable
  - Implication for stakeholders

31

32

- Ask the participants what are the phases/levels of evaluations. Discuss and show slide.

Phases/Levels of Evaluation

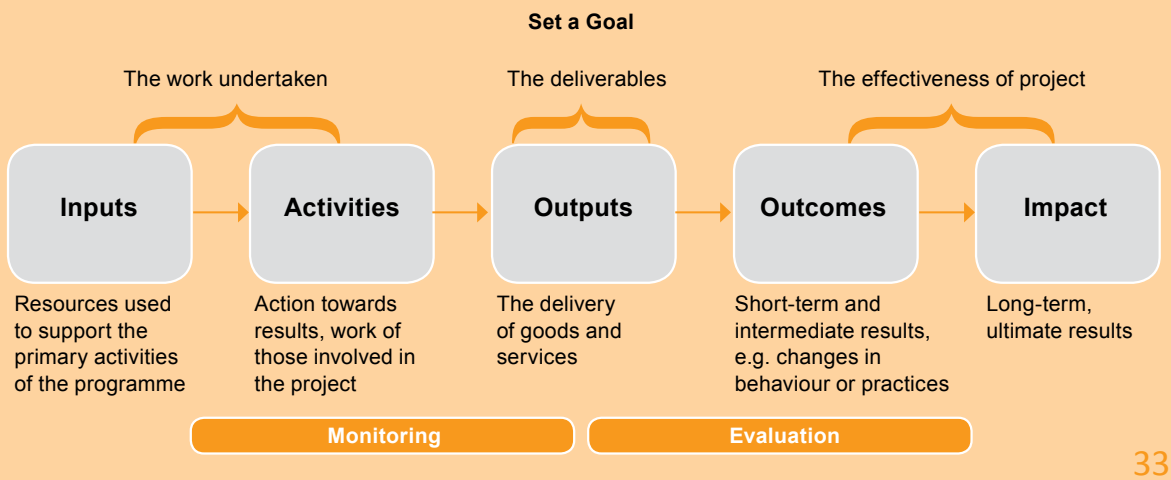
PROCESS
OUTPUT
OUTCOME

E.g.
Contraceptive Use – Outcome
Reduction in unwanted Pregnancy (Proxy out come)
% of births attended by Special Birth Attendents (SBA) - Output

32

33 • Explain to the participants what is Input, Activity and Output, Outcome and Impact, besides elucidating which of the indicators can be monitored and which can be evaluated.

Sequencing of Monitoring and Evaluation on Hierarchy of the Indicators



33

34 • Explain that you will touch upon M&E for MNH. SRH Coordinators must monitor and evaluate all implemented interventions. The extent of M&E will depend on the resources available and the phase of the disaster. For instance in the acute phase, the situation is chaotic and M&E is limited to only a few objectives to ensure that the MISP is in place.

Objectives of MISP

- Identify SRH lead agency and SRH Officer
- Collect Demographics
- Prevent sexual violence and respond to the needs of survivors
- Reduce the transmission of HIV
- Reduce excess maternal and newborn morbidity and mortality
- Planning for transition to comprehensive RH services

34

35 • Ask participants to look at their MISP Cheat Sheet and remind them that M&E should take place as soon as possible and that it is a part of the activities given under objective 5 (Plan for Comprehensive SRH Services, integrated into Primary Health Care).

Plan for Comprehensive SRH Services, Integrated into Primary Health Care

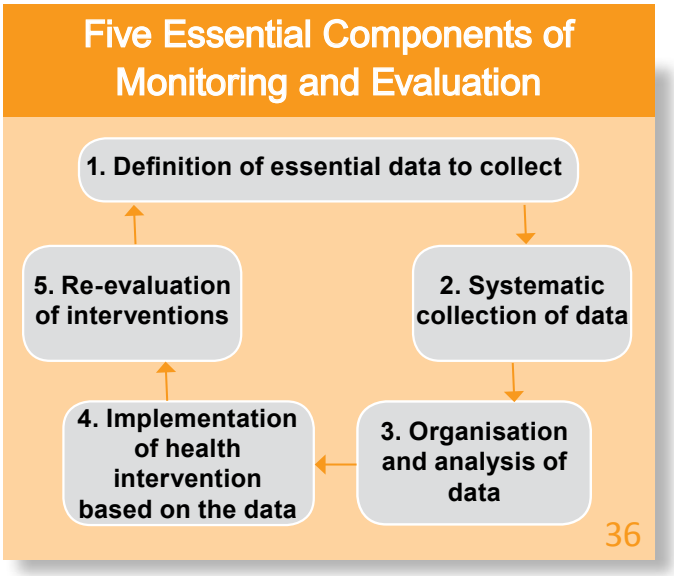
- Baseline SRH information and Monitoring and Evaluation
- Identify sites for future delivery of comprehensive SRH
- Assess staff and identify training protocols
- Procurement channels

35

36

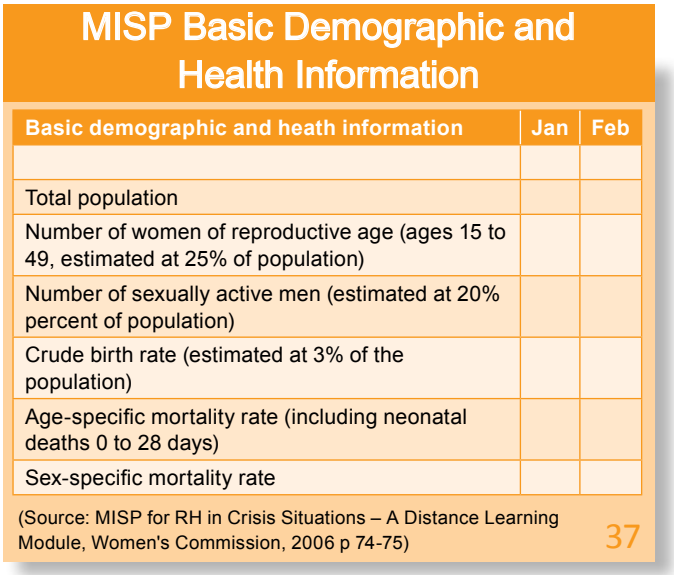
- Explain the importance of the M&E cycle: M&E should feedback into interventions.
- Point 2: Stress that collecting data needs to be sensitive and confidential, especially when dealing with investigating cases of maternal deaths or sexual violence.

Emphasise



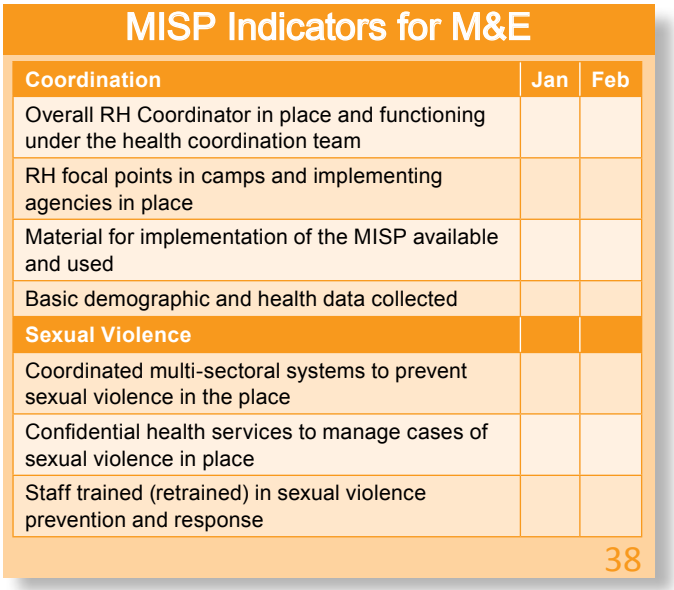
37

- Explain that the MISP has a basic template for reporting MISP related activities including basic demographic and health information.
- Invite participants to open the MISP Distance Learning Module in Appendix A.
- Participants should try to obtain latest data as and when updated.



38

- Explain that these indicators are straightforward and mirror the activities under each of the MISP objectives.
- As a summary of the MISP, quickly review the indicators shown in the slide for coordination and sexual violence.



39 • Show slide with indicators for HIV transmission and maternal and neo-natal mortality and morbidity.

MISP Indicators for M&E

HIV Transmission		
Sufficient materials in place for practice of universal precautions by trained, knowledgeable health workers		
Condoms procured and made available		
Blood for transfusion consistently screened		
Maternal and Neonatal Mortality and Morbidity		
Clean delivery kits available and distributed		
Calculate the number of clean delivery packages needed to cover for birth for 3 mo. (estimated population x 0.3 x 0.25)		
Midwife kits available at the health centre		
Referral hospital assessed and supported for adequate number of qualified staff, equipment and supplies		
Referral system for obstetric emergencies functioning 24/7		

39

40 • The next slide gives indicators for planning comprehensive RH services.

MISP Indicators for M&E

Planning for Comprehensive RH		
Basic background information collected		
Sites identified for future delivery of comprehensive RH services		
Staff assessed, training protocols identified		
Procurement channels identified and monthly drug consumption assessed		

40

41 • Explain that SRH Coordinators should monitor the MISP indicators as a minimum standard in the acute phase.

(Refer to http://iawg.net/resoures/misp-implementation)

MISP Monthly Data Collection

Monthly data collection		
Number of condoms distributed		
Number of clean delivery packages distributed		
Number of sexual violence cases reported in all sectors		
Number of health facilities with supplies for universal precautions		
Basic demographic and health data collected		

41

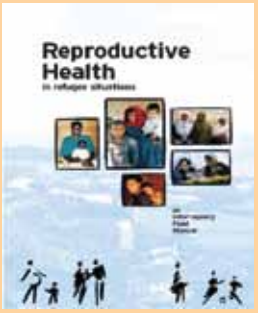
42

- If available, invite participants to open the **Inter-Agency Field Manual on RH** at the indicated pages and briefly introduce each tool.
- Explain that participants will have the opportunity to familiarise themselves with the tools in the group exercise.

Other Tools

1. SRH indicators for early phase: p.100
2. SRH indicators for stabilised phase: p.101 (safe motherhood)
3. SRH reference rates and ratios: p.110
4. Estimating number of pregnant women in a population: p.111
5. Monthly SRH report format: p.113
6. Summary of SRH indicators: p.116

pp100 – 116



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- Explain that, as the situation stabilises, the Process Indicators (depends upon the local available indicators which can easily be incorporated into the M&E process) are used to monitor the above standards for Emergency Obstetric Care. The first two indicators are relevant to programming at the national level. The last four can be used for monitoring safe motherhood services in disaster settings.

In other words,

- At least 15% of pregnant women develop obstetric complications
- Between 5 and 15% of all births require a caesarean section

The Ideal

- 100% of women who develop a complication should be treated in a health facility offering the essential obstetric care
- Less than 1% of these complications should lead to death

M&E: Process Indicators

M&E: Process Indicators

UN Process Indicator	Definition	Recommended level
National Level		
1. Amount of EmOC services available	Number of facilities that provide EmOC	Minimum: One comprehensive EmOC facility for every 500,000 people Minimum: Four basic EMoC facilities per 500,000 people
2. Geographical distribution of EmOC facilities	Facilities proving EmOC well-distributed at sub-national level	Minimum: 100% of sub-national areas have the minimum acceptable numbers of basic and comprehensive EmOC facilities
3. Proportion of all births in EmOC facilities	Proportion of all births in the population that take place in EmOC facilities	Minimum: 15%
4. Met need for EmOC services	Proportion of women with obstetric complications treated in EmOC facilities	At least 100% [Estimated as 15% of expected births. See Q9.]
5. Cesarean sections as a percentage of all births	Cesarean deliveries as a proportion of all birth in the population	Minimum 5% Maximum 15%
6. Case fatality rate	Proportion of women with obstetric complications admitted to a facility who die	Maximum 1%

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- As was discussed on Day 1, ask the participants about the different phases of disaster in terms of Preparedness, Response and Recovery.
- Explain the data which is required during different phases of the disaster and ways of obtaining the required data. Click to show the proposed answer.

Data Needs During Preparedness Phase

Data	Sources
• Number of households and average household size (Age and sex disaggregated data)	• Census/DLHS/NFHS
• Population size by locality	• Same as above
• Population density by administrative unit and total size of population at risk	• Administrative records/ HMIS
• Sex ratio	• NFHS/Census/HMIS
• Number of health facilities	• HMIS/AR
	• Facility survey

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- The next few slides will show the data required in the Preparedness, Response, Chronic and Recovery phases of disasters.

Data Needs During Preparedness Phase

contd.

Data	Sources
• Distance and accessibility of health facilities	• HMIS/AR
• Number and quality of heath personnel	
• Number of health facilities offering specific services (BEmOC and CEmOC)	
• Transportation facilities	• Administrative sources
• Number of NGOs and other stakeholders capable of working during disasters	• Administrative sources
• Communication facilities/ options	• Administrative sources

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Data Needs During Preparedness Phase

contd.

Data	Sources
Health problems and priorities	• NFHS/DLHS/SRS/ CES/HMIS
• Number of births	
• Number of pregnant women	
• Number of deaths by age and sex	
• Life expectancy	
• Knowledge of contraception	
• Contraceptive prevalence	
• Vaccination coverage	
• Nutritional status of children and pregnant women	
• Knowledge of HIV/AIDS	
• Prevalence of HIV/AIDS	
• Number of people living with HIV/AIDS	

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Data Needs During Response Phase

Data	Sources
• Number of service providing centres • Proportion of service delivery points in the affected zone • Number of service providers in the affected zone by type of facility (Doctor, ANM, ASHA) • Tradition and customs in the affected zone • Perception of the role of men and women • Cultural habits	• Administrative source/ Rapid survey • Rapid survey • Surveys

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Data Needs During Chronic Phase

Data	Sources
• Estimated number of persons affected by crisis • Causes and itinerary of displacements • Human capacity/skills by sector/ occupation • RH needs, inside and outside camps ◆ Number of women of reproductive age ◆ Number of pregnant women ◆ Number of pregnant women with complications	• Administrative records • Rapid assessment • Survey • HMIS/Survey/ Rapid assessment reports

48

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Data Needs During Recovery Phase

Data	Sources
• Population size and distribution by administrative unit ◆ Percentage change in population by locality ◆ Change in population density by administrative unit ◆ Number of households ◆ Change in average household size • Age-sex structure of the population for identification of various categories, especially, the vulnerable groups ◆ Sex ratio ◆ Proportion of women of reproductive age ◆ Population structure by age and sex	• Census/ Administrative records/HMIS • SRS/DLHS/ NFHS/CES

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Data Needs During Recovery Phase

Data	Sources
Health problems and priorities • Number of births • Number of pregnant women • Number of deaths by age and sex • Life expectancy • Knowledge of contraception • Contraceptive prevalence • Vaccination coverage • Nutritional status of children and pregnant women • Knowledge of HIV/AIDS • Prevalence of HIV/AIDS • Number of people living with HIV/AIDS	• NFHS/DLHS/ SRS/CES/ HMIS

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- Knowing the level of maternal and neonatal mortality is not enough, we need to understand the **underlying factors.**

Monitoring Impact

Knowing the level of maternal and neonatal mortality is not enough, we need to understand the underlying factors

- MMR: Maternal Mortality Ratio
- NMR: Newborn Mortality Ratio
- Incidence of obstetric complications
- Modalities
  - Verbal autopsies
  - Facility-based maternal deaths review
  - Confidential enquiries
  - Review of "near misses"
  - Clinical audit

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Suggested Further Reading

1. Guidelines on Data Issues in Humanitarian Crisis Situation by UNFPA
2. Use of Data for Planning and Monitoring of Development Programmes by IIPS, Mumbai and UNFPA
3. MISP for Reproductive Health in Crisis Situation, a distance learing module by UNFPA

Data Management, Monitoring and Evaluation in Disaster Management

Group Work

15 Minutes

Facilitators Instructions

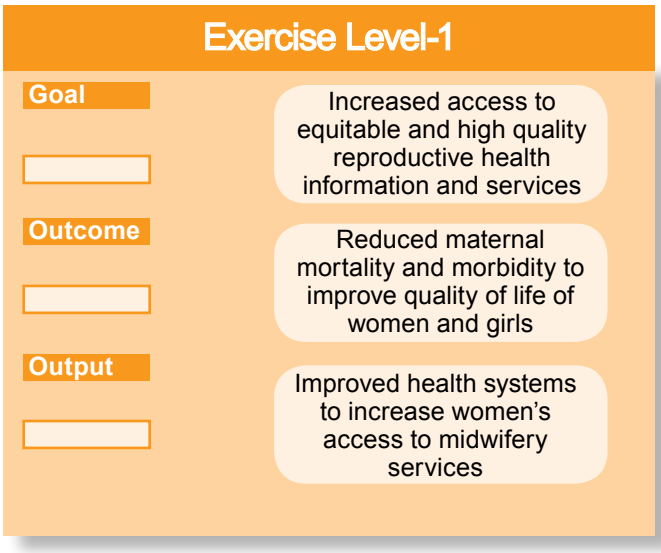
- Divide the participants into three groups. (Try using a game to do so)
- Ensure that each group gets a worksheet
- Allot each group one of the following exercises:
  - Exercise level -1
  - Exercise level -2
  - Exercise level -3

- ***Group work*** — 10 Minutes
- ***Presentation of group work*** — 5 Minutes

Keep samples of answers ready to share after group work

Exercise level-1

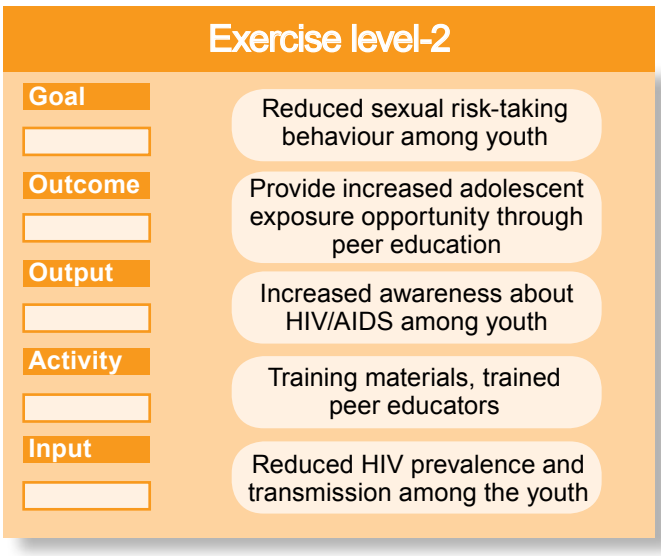
- Explain that exercise level -1 contains Goal, Outcome and Output indicators and examples of the same but not in the same order. You need to identify the correct example for Goal, Outcome and Output from the given options.



Group Discussion

Exercise level -2

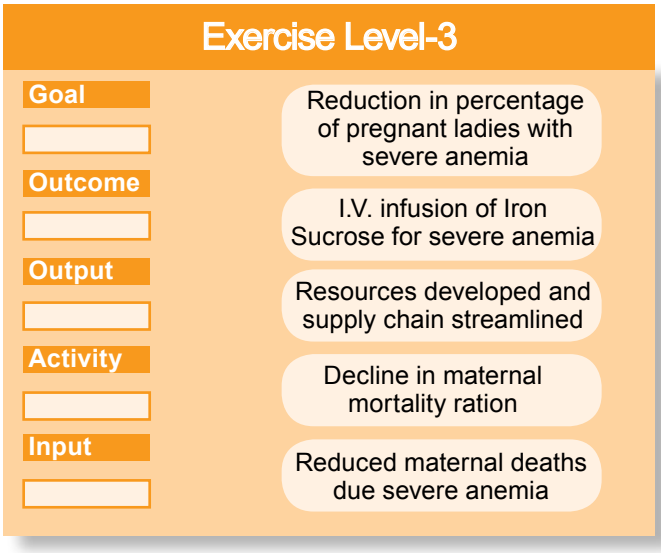
- Explain that exercise level -2 contains Goal, Outcome, Output, Process and Input indicators and examples of the same but not in the same order. You need to identify the correct example for Goal, Outcome, Output, Process and Input from the given options.



Group Discussion

Exercise level -3

- Explain that exercise level -3 contains Goal, Outcome, Output, Process and Input indicators and examples of the same but not in the same order. You need to identify the correct example for Goal, Outcome, Output, Process and Input from the given options.



Group Discussion

Click to show answers for Exercise Level 1.

Answers on Levels of Results…1

Goal

Reduced maternal mortality and morbidity to improve quality of life of women and girls

Outcome

Increased access to equitable and high quality reproductive health information and services

Output

Improved health systems to increase women's access to midwifery services

Click to show answers for Exercise Level 2.

Answers on Levels of Results…2

Goal

Reduced HIV prevalence and transmission among the youth

Outcome

Reduced sexual risk-taking behaviour among youth

Output

Increased awareness about HIV/AIDS among youth

Provide increased adolescent exposure opportunity through peer education

Activity

Training materials, trained peer educators

Click to show answers for Exercise Level 3.

Answers on Levels of Results…3

Goal

Decline in maternal mortality ratio

Outcome

Reduced maternal deaths due severe anemia

Output

Reduction in percentage of pregnant ladies with severe anemia

Activity

I.V. infusion of Iron Sucrose for severe anemia

Input

Resources developed and supply chain streamlined

Action Planning

Country Action Planning

Length
1 hour
30 minutes

Overview	This session will allow participants and master trainers to finalise the country action planning
Learning Outcomes	By the end of the session, participants should be able to: ● Outline elements of the national plan related to the planning of comprehensive SRH services ● Have a shared coordination vision among agencies ● Document what changes are needed in order to integrate SRH into crises, and who will be the focal person for each of the activities
Preparation	Participants should refer back to the national plan that they worked on for the first two days along with the 'Suggested Preparedness Activities'
Materials	Flip charts and markers
Methodology	Self-reflection and group discussion

Process

1. Ask participants to take their handouts ('Suggested Preparedness Activities' and the national plan as proposed by the master trainers).
2. Review the proposed activities under Comprehensive SRH with the whole group. Ask participants to take few minutes to reflect on its relevance.
3. Facilitate the discussion.
4. Now that all participants have addressed each of the sections, ask them to take one hour to re-examine the whole country action plan so as to agree on a focal person, resources needed and implementation timeframe for each of the activity. Remember that the key to successful implementation of your country action plan is to have a dedicated person to drive each of the activities.
5. Facilitate the plenary discussion. Try to get the team come to an agreement for the country action plan.

MISP Post-Test

Length
30 minutes

Overview	Participants' answers to the post-test will allow you to gauge the progress of the participants in their knowledge of the MISP. The session will also provide the last opportunity for participants to ask questions or discuss any issues
Learning Outcomes	By the end of the session, participants should be able to: ● Assess their progress in their knowledge of the MISP
Preparation	Ensure that the post-test (do not include in the participants' folder) and blank answer sheets are copied on separate pages. (no recto verso, as participants will keep the questions)
Materials	Markers and flip charts or whiteboards
Methodology	Test (multiple choice questions), feedback and group discussion

Process

1. Explain that the purpose of the post-test is to help the facilitators better assess the impact of the training.
2. Distribute the post-test with the blank answer sheets (see below).
3. Inform participants that they have 20 minutes to complete the 20 questions of the post-test. Instruct participants to report their answers on the answer sheet without putting their name on it.
4. After 20 minutes, collect the answer sheets.
5. Quickly review each question and answer with the whole group.
6. Facilitate questions and answers on the post-test and any other issues as time allows.
7. While you address questions and answers, ask your co-facilitator to mark the test and calculate the mean score. Solutions can be found hereafter.
8. Write down the mean score of the pre and post-test on a flip chart. Comment on the progress made by participants and congratulate them.

Post-Test

Participants' Handout (page 1 of 2)

Please note that multiple choice questions may have **more than one correct answer**

1. **A flood in Bihar has recently displaced tens of thousands of people and approximately 500 refugees are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority SRH activities you immediately undertake?**

   a. Ensuring survivors of domestic violence have access to psychosocial services
   b. Providing clean delivery Kits to all visibly pregnant women and birth attendants to support clean deliveries
   c. Ensuring blood for transfusion is safe
   d. Ensuring safe access to cooking fuel

2. **When should the MISP be implemented?**

   a. In the first days of a crisis situation
   b. Once approval from UNFPA has been given
   c. Once early mortality rates have stabilised
   d. After the displaced population has been settled into camps

3. **The activities of an SRH Coordinator facilitating the implementation of the MISP include:**

   a. Training/retraining staff to provide comprehensive RH services
   b. Ensuring the presence of a same-sex, same-language health worker or chaperone during any medical examination of a survivor of sexual violence
   c. Adapting and introducing simple forms for monitoring MISP activities
   d. Ensuring the provision of FP services

4. **What health and demographic data should the SRH Coordinator determine/estimate after the MISP is in place?**

   a. Malnutrition rate
   b. Number of sexually active men
   c. Crude birth rate
   d. Age-specific mortality rate

5. **What type of services should be offered to a rape survivor?**

   a. Clinical services
   b. Additional food rations for her extended family
   c. Protection for her physical safety
   d. Psychosocial care

6. **Which of the following is a way that does not help to prevent sexual violence in a crisis situation?**

   a. Involving women in the distribution of materials and supplies
   b. Ensuring that women have their own individual registration cards
   c. Communal bathing facilities for both men and women
   d. Involving women in the decision-making process regarding the layout of the site/camp

7. What are the requirements of a referral-level facility for comprehensive obstetric care?

a. Child health care
b. Safe blood transfusion
c. Antenatal care
d. Medical staff that can perform C-sections to be available 24 hours per day, seven days per week

8. **You are a newly assigned SRH Coordinator and have recently arrived in an emergency situation. What are some of the first SRH activities that you carry out**?

a. Ensure SRH coordination meetings are established
b. Co-host trainings on HIV/AIDS
c. Discuss supply needs with NDMA and other agencies
d. Coordinate community outreach on STI prevention

9. You are coordinating the implementation of the MISP and are trying to ensure that emergency obstetric care is available in the camp clinic. What activities will you undertake?

a. Ensure qualified staff at the camp clinic is available only during the day to stabilise the patient with basic emergency obstetric care
b. Ensure qualified physicians are available at the referral hospital
c. Establish a communication system to consult qualified providers for guidance on referrals
d. Establish trainings for medical staff on safe motherhood

10. You have tried to procure clean delivery Kits but logistical challenges have significantly delayed the arrival of these supplies. Given this reality, what can you do to address this situation?

a. Contract with a local agency to produce Kits
b. Procure Kit contents locally and assemble on site
c. Order supplies from another source and wait until they arrive
d. Discuss during the RH coordination meeting where to procure supplies

11. The code of conduct against sexual exploitation and abuse applies to:

a International NGO staff
b. Local humanitarian staff
c. UN personnel
d. Individuals contracted from the host population

12. Which situation puts women at risk of sexual violence?

a. Men distributing food and other goods
b. Well-lighted paths to nearby latrines
c. Lack of fuel available in or near settlement/camp
d. Most, but not all, protection officers being female

13. What is NOT a MISP-related service for women and girls who survive sexual violence?

a. Psychosocial care
b. Antenatal care
c. Ensured physical safety
d. Access to emergency contraception and post-exposure prophylaxis

14. Condoms can be made available at?

a. Health facilities
b. Food distribution points
c. Community service offices
d. Latrines

15. Which of the following activities should be undertaken in order to ensure safe blood transfusion?

a. Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases
b. Avoid blood transfusions for non-serious medical conditions
c. Select donors from the displaced community
d. Ensure sufficient HIV and other tests and supplies for screening blood where needed

16. Which is a requirement for infection control?

a. Facilities for frequent hand washing
b. Safe handling of sharp objects
c. Cleaning, disinfecting and sterilising medical equipment
d. Disposal of medical waste by burning materials and burying sharp objects outside the grounds of the health facility

17. Clean delivery Kits should be provided to all women over 20 years of age.

True
False

18. Approximately what proportion of the displaced population will be pregnant at a given time?

a. 25 %
b. 20 %
c. 15 %
d. 4 %

19. Female condoms are available in the Inter-Agency SRH Kits.

True
False

20. For what time period are the SRH Kits designed for use?

a. 1 month
b. 3 months
c. 6 months
d. 1 year

Post-Test Answer Sheet

Do not put your name

Participants' handout (to be collected)

*Please note that multiple choice questions may have **more than one** correct answer.*

1.
a
b
c
d

2.
a
b
c
d

3.
a
b
c
d

4.
a
b
c
d

5.
a
b
c
d

6.
a
b
c
d

7.
a
b
c
d

8.
a
b
c
d

9.
a
b
c
d

10.
a
b
c
d

11.
a
b
c
d

12.
a
b
c
d

13.
a
b
c
d

14.
a
b
c
d

15.
a
b
c
d

16.
a
b
c
d

17.
True
False

18.
a
b
c
d

19.
True
False

20.
a
b
c
d

Pre and Post-Test Solutions

*Please note that multiple choice questions may have **more than one correct answer.***

1. **A flood in Bihar has recently displaced tens of thousands of people and approximately 500 refugees are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority SRH activities you immediately undertake?**

   a. Ensuring survivors of ***domestic*** violence have access to psychosocial services
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   d. Ensuring safe access to cooking fuel

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3. **The activities of an SRH Coordinator facilitating the implementation of the MISP include:**

   a. Training/retraining staff to provide comprehensive RH services (***planning for***)
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20. For what time period are the SRH Kits designed for use?

a. 1 month
b. 3 months
c. 6 months
d. 1 year

Review of Participants' Expectations

Length
15 minutes

Overview	This short session will help you validate your training and see whether participants have met the course's Learning Objectives and their own expectations
Learning Outcomes	By the end of the session, participants should be able to: ● Describe whether they have achieved the Learning Objectives of the training
Preparation	● Prepare a PowerPoint presentation with: ◆ The general learning outcomes for the whole training (day 1 presentation): ● Upon completion of the training, participants should be able to: ◆ Advocate for SRH in crises ◆ Apply core concepts and techniques provided in the MISP ◆ Apply coordination skills for the implementation of the MISP ◆ Produce an action plan to integrate SRH into national emergency preparedness plans ● The summary of participants' expectations [Alternative: Review the flip charts where the above were posted] ● Write in big letters on separate A4 pages: 0%, 50%, 60%, 70%, 80%, 90% and 100% ● Place the different % proportionally along an imaginary line in the room
Materials	Markers and flip charts or white boards
Methodology	Interactive format

Process

1. Review the learning outcomes and participants' expectations.
2. Ask participants to stand up. Explain the imaginary line and the different percentages.
3. Ask participants: 'How would you grade your ability to advocate for SRH in crises? Place yourself along the line'.
4. Allow participants to move along the line. Observe, take note and invite comments from participants.
5. Ask participants: 'How would you grade your ability to apply core concepts and techniques provided in the MISP? Place yourself along the line'.
6. Allow participants to move along the line. Observe, take note and invite comments from participants.
7. Repeat the process with:

'How would you grade your ability to apply SRH coordination skills to implement the MISP? Place yourself along the line'.

'How would you grade your ability to advance the integration of SRH into national emergency preparedness plans? Place yourself along the line'.

8. Facilitate comments and impressions from participants as time allows.

Evaluation of the Training

Length
15 minutes

Overview	Participants will complete an anonymous evaluation form addressing the different aspects of the training course. This will allow the training team to reflect on strengths and weaknesses of the course and improve for the following trainings
Learning outcomes	By the end of the session, participants should be able to: ● Provide objective and anonymous feedback on the whole course
Preparation	Ensure that evaluation forms are copied
Materials	None
Methodology	Written evaluation

Process

1. Distribute the evaluation forms.
2. Inform participants to take 10 minutes to fill the evaluation form. This is anonymous and will allow the training team to assess the quality of the whole course and find ways to improve subsequent trainings.
3. Collect the evaluation forms after 10 minutes.
4. Ensure that the whole training team takes time at the end of the training to review the evaluation forms and debrief together.

Training Evaluation Form (Participants' handout, page 1)

Thank you for taking the time to complete this evaluation form. Your feedback will assist us in assessing the effectiveness of this training and help us improve the planning and organisation of future trainings.

Please indicate your choice according to the following rating for the entire training:

1 – Unsatisfactory 3 – Good

2 – Fair 4 – Excellent NA – Not Applicable

No	Item	Rating					Any comments?
1.	Achievement of training objectives	1	2	3	4	NA	
2.	Materials distributed	1	2	3	4	NA	
3.	Facilitation of training	1	2	3	4	NA	
4.	Time frame allocated for the training programme	1	2	3	4	NA	
5.	Opportunities for sharing and participation	1	2	3	4	NA	
6.	What did you learn from this training						
7.	Was this training relevant to your work?	☐ Yes	If yes, how will you use it?				
		☐ No	If no, please explain.				
8.	Which three sessions were the most beneficial? List in order of priority. Please comment on how to improve them.						
9.	Which three sessions were the least beneficial? List in order of priority. Please comment on how to improve them.						

(Participants' handout, page 2)

No	Item	Rating					Any comments?
LOGISTICS							
10.	Accommodation	1	2	3	4	NA	
11.	Food	1	2	3	4	NA	
12.	Travel arrangements	1	2	3	4	NA	
13.	Meeting arrangements	1	2	3	4	NA	
14.	Administrative support	1	2	3	4	NA	
15	Any other comments/suggestions for future trainings:						

Thank you for your feedback!

Feedback Form

The Facilitator's Manual is a living document. Have you used it? If so, help us improve the document by sharing with us your comments and feedback. Thank you!

MISP Overview and Coordination

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SGBV

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Maternal and Newborn Health

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HIV and STIs

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Logistics

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Data

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Action Planning

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Other

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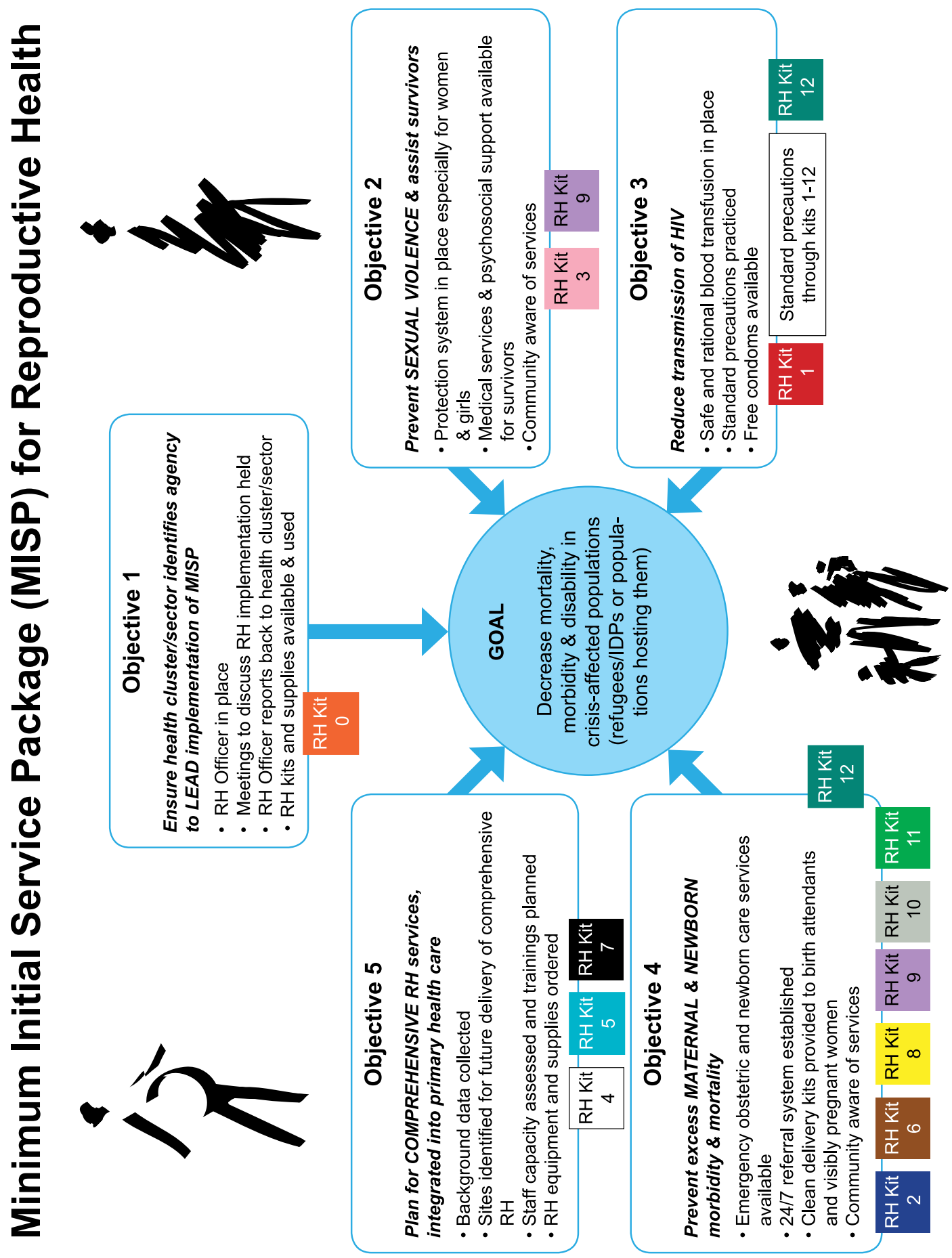
Closing

Length
30 minutes

Overview	This session will allow you to celebrate participants' efforts and work.
Learning Outcomes	Not applicable
Preparation	Prepare this session according to your customs and culture and to suit your training budget. Participants may appreciate the following: • Training Certificate • CD-ROM with training presentations and key resources • Group picture
Materials	As needed
Methodology	Try to have a mix of official and fun time. This is your celebration!

Notes

Annexure: MISP Cheet Sheet



	CRISIS	POST-CRISIS
	Crude mortality rate >1 death/10,000/day	Mortality returns to level of surrounding populations
SUBJECT AREA	**MINIMUM (MISP) RH SERVICES**	**COMPREHENSIVE RH SERVICES**
FAMILY PLANNING	• Provide contraceptives, such as condoms, pills, injectables and IUDs, to meet demand	• Source and procure contraceptive supplies • Provide staff training • Establish comprehensive family planning programs • Provide community education
GENDER-BASED VIOLENCE	• Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters • Provide clinical care for survivors of rape • Inform community about services	• Expand medical, psychological, social and legal care for survivors • Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting, • Provide community education • Engage men and boys in GBV programming
MATERNAL AND NEWBORN CARE	• Ensure availability of emergency obstetric and newborn care services • Establish 24/7 referral system for obstetric and newborn emergencies • Provide clean delivery packages to visibly pregnant women and birth attendants • Inform community about services	• Provide antenatal care • Provide postnatal care • Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care • Increase access to basic and comprehensive emergency obstetric and newborn care
STIs, INCLUDING HIV, PREVENTION & TREATMENT	• Ensure safe and rational blood transfusion practice • Ensure adherence to standard precautions • Guarantee the availability of free condoms • Provide syndromic treatment as part of routine clinical services for patients presenting for care • Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible	• Establish comprehensive STI prevention and treatment services, including STI surveillance systems • Collaborate in establishing comprehensive HIV services as appropriate • Provide care, support and treatment for people living with HIV/AIDS • Raise awareness of prevention, care, treatment services of STIs

The RH Kit is designed for use for a 3-month period for a varying population number and is divided into three "blocks" as follows:

Block 1: Six kits to be used at the community and primary health care level for 10,000 persons / 3 months

KIT NUMBERS	KIT NAME	COLOR CODE
Kit 0	Administration	Orange
Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
Kit 3	Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	STI	Turquoise

Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at the community and primary care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months

KIT NUMBERS	KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Abortion	Yellow
Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction for Delivery (Manual)	Grey

Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months

KIT NUMBERS	KIT NAME	COLOR CODE
Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

NOTE: Agencies should not depend solely on the Inter-agency RH Kits and should plan to integrate the procurement of MISP/RH supplies in their routine health procurement systems.

RESOURCES:

- ► Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual: http://www.iawg.net/resources/field_manual.html
- ► MISP Distance Learning Module: http://misp.rhrc.org
- ► SPRINT Facilitator's Manual for SRH Coordination: www.ippfeseaor.org/en/Resources/Publications/SPRINTFacilitatorsManual.htm
- ► UNFPA/Save the Children Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings: A companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: www.unfpa.org/public/publications/pid/4169
- ► RHRC Monitoring and Evaluation Toolkit: www.rhrc.org/resources/general_fieldtools/toolkit/
- ► CDC RH Assessment Toolkit for Conflict-Affected Women: http://www.cdc.gov/reproductivehealth/Refugee/RefugeesProjects.htm
- ► Inter-agency Working Group on Reproductive Health in Crises: www.iawg.net
- ► Reproductive Health Response in Crises (RHRC) Consortium: www.rhrc.org www.rhrc.org/resources/rhrkit/pdf

Notes

Notes

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