Building National Resilience for Sexual and Reproductive Health: Learning from Current Experiences

Research. Rethink. Resolve.

The Women's Refugee Commission improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

Acknowledgements

Cover photo: A group of adolescent girls standing with a village preparedness plan which they drew during community-based DRR trainings. © Rizwan Baig, Muslim Aid; and UNFPA

Contents

Acronyms & Abbreviations

ANC	Antenatal care
DoH	Department of Health
DRR	Disaster risk reduction
EC	Emergency contraception
EDRM-H	Emergency and Disaster Risk Management for Health
EECA	Eastern Europe and Central Asia
EmOC	Emergency obstetric care
GBV	Gender-based violence
HERA	Health Education and Research Association
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IDP	Internally displaced person
IEC	Information, education and communication
IMC	International Medical Corps
IPPF	International Planned Parenthood Federation
LHV	Lady health volunteer
MISP	Minimum Initial Service Package
MoH	Ministry of Health
NDMA	National Disaster Management Authority
NGO	Nongovernmental organization
NHEPRN	National Health Emergency Response Network
PEP	Post-exposure prophylaxis
PNC	Postnatal care
R-FPAP	Rahnuma Family Planning Association of Pakistan
RH	Reproductive health
SOP	Standard operating procedure
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
ToT	Training of trainers
UNFPA	United Nations Population Fund
UNISDR	United Nations International Strategy on Disaster Reduction
WFP	World Food Program
WHO	World Health Organization
WRC	Women's Refugee Commission

Executive Summary

In disasters, women face increased health and protection risks, resulting in the critical need for sexual and reproductive health (SRH) services. Since 1997, the Minimum Initial Service Package (MISP) has been the standard of care for SRH in humanitarian settings. Recent disasters have shed many lessons around humanitarian response, including the promise that preparedness efforts can have for a timely and adequate SRH response during crises. A multisectoral and multidisciplinary health emergency and disaster risk management system further protects public health and reduces morbidity, mortality, and disability associated with emergencies. This has been recognized in recent global frameworks and commitments, including the *Sendai Framework for Disaster Risk Reduction 2015-2030;* the *Global Strategy for Women's, Children's and Adolescent Health*; and the *Sustainable Development Goals*. All of these frameworks provide a facilitative environment for integrating SRH into the United Nations International Strategy for Disaster Reduction's *Thematic Platform for Emergency and Disaster Risk Management for Health.*

In 2015, the Women's Refugee Commission (WRC) collected examples of efforts to integrate SRH within emergency and disaster risk management for health (EDRM-H), exploring achievements, challenges, and reflections, in the Eastern Europe and Central Asia (EECA) region, Macedonia, and Pakistan. Main conclusions included:

- The process of assessing MISP readiness in the EECA region facilitated **coordination among diverse stakeholders** and identified gaps and recommendations for collective action, with **built-in accountability and experience-sharing opportunities across countries in the region.**

- Persistent advocacy and a multisectoral approach in Macedonia led to **policy setting at the national level and forging of partnerships** to prepare for a more coordinated MISP response.

- Reflections from recent emergency responses within a pre-existing RH working group in Pakistan allowed for national- and provincial-level preparedness planning, as well as a **district-level pilot to develop and implement SRH preparedness plans with community involvement.**

Common challenges across case studies included:

- **Lack of awareness, presence of culturally grounded assumptions or sensitivities, and lack of standard operating procedures (SOPs) at the policy level around SRH needs and priorities in emergencies.**

- **Lack of coordination among relevant departments and organizations** prior to coming together on a common agenda to address SRH as part of EDRM-H.

- **Weaknesses of existing primary health care systems**—especially for sexual violence prevention and response—led to limitations in existing health preparedness and response plans.

- **Limited engagement of community members,** particularly at-risk groups.

- **Limited financing for SRH preparedness,** especially for actual implementation of action plans.

Learning regarding SRH inclusion within disaster risk management systems remains nascent. However, these case studies offer early learning that can inform work on this topic moving forward. Most importantly, **efforts to integrate SRH into EDRM-H appear to take a non-linear path, based on opportunities, honest reflection and iterative processes.** Further, where response capacity is overwhelmed in spite of preparedness efforts, **adaptability and flexibility** become important ingredients for continuous improvement. Based on learning, **advocacy, coordination and partnerships, capacity-building, leadership, ownership, inclusion of community and at-risk groups, resilient primary health care systems, and financing** appear to be critical for countries to successfully integrate SRH into EDRM-H at all levels.

More initiatives that strengthen **community capacity are needed, as well as evidence and tools to support this focus.** A strong evidence-base of best-practices can prevent SRH from being sidelined from preparedness and empowerment activities at the community level, laying the groundwork for optimal response when crises occur.

Introduction

In 2014, 80 million people were in need of humanitarian assistance, of which the overwhelming majority were women and children.[1] Sixty percent of preventable maternal deaths and 53 percent of under-five deaths take place in settings of conflict, displacement, and natural disasters.[2] Of the countries least likely to reach the Millennium Development Goals (MDGs) for women's and children's survival, more than 80 percent have experienced a recent conflict, recurring natural disasters, or both.[3] Gender disparities are apparent both in the immediate loss of life during a natural disaster, as well as the longer-term impacts of emergencies.[4] In the 2004 Asian Tsunami, nearly four women died for every one man.[5] In Myanmar, women represented an estimated 61 percent of fatalities after Cyclone Nargis hit in 2008.[6] Conflicts also have a disproportionate impact on women and girls, including changing gender roles, risks of violence, exploitation and abuse and compromised, access to essential health services.[7]

Gender differences in disasters have been found to be closely linked to economic and social rights pre-crisis. According to a study by Neumayer and Plümper, examining 141 countries from 1981 to 2002, in contexts where the socioeconomic status of women was high, men and women died in roughly equal numbers during and after disasters. Conversely, where the socioeconomic status of women was low, more women died than men, or women died at a younger age.[8] Gender may impact women's ability to access warning systems, or they may not be trained in survival skills.[9] Gender roles and household expectations may also prevent women from fleeing to safety if they feel the need to stay behind to look after their children, or feel uncomfortable leaving without a male escort.[10]

1   United Nations, Every Woman Every Child, Abu Dhabi Declaration (New York. 2015).
2   Ibid.
3   Ibid.
4   Kristina Peterson, "From the Field: Gender Issues in Disaster Response and Recovery," *Natural Hazards Observer*, no. 5, vol. 21, Special Issue on Women and Disasters (1997).
5   Oxfam International, "The Tsunami's Impact on Women," *Oxfam Briefing Note,* (March 2005).
6   The World Bank Group, "Gender and Climate Change 3 Things You Should Know" (2011). http://wrc.ms/1RFGymN
7   Inter-Agency Standing Committee, *"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," IASC Gender Handbook in Humanitarian Action* (December 2006). http://www.who.int/hac/network/interagency/news/gender_handbook_draft/en/
8   Eric Neumayer and Thomas Plümper, "The Gendered Nature of Natural Disasters: The Impact of Catastrophic Events on the Gender Gap in Life Expectancy, 1981-2002," *Annals of the Association of American Geographers,* no. 97, vol. 3 (2007).
9   Irene Dankelman et al., *Gender, Climate Change and Human Security: Lessons from Bangladesh, Ghana and Senegal* (Women's Environment and Development Organization, May 2008).
10 World Bank. "Gender, Disasters and Climate Change."

Sexual and reproductive health (SRH) is a significant public health concern in all communities, including in times of conflict and natural disaster. Approximately four percent of a total population will be pregnant at a given time.[11] Of these pregnant women, 15 percent will experience an obstetric complication, such as obstructed or prolonged labor, pre-eclampsia/eclampsia, sepsis, ectopic pregnancy, or complications of abortion, requiring access to emergency obstetric services.[12] The World Health Organization (WHO) additionally estimates that 9 to 15 percent of newborns require lifesaving emergency care.[13]

Women and girls face risks of sexual violence, exploitation, and abuse in conflicts and in the wake of natural disasters, which can lead to unplanned pregnancies, unsafe

---

11 United Nations Population Fund, *State of the World Population 2002: people, poverty and possibilities* (New York. 2002). http://www.unfpa.org/sites/default/files/pub-pdf/swp02eng.pdf

12 United Nations Children's Fund, United Nations Population Fund, and World Health Organization, *Guidelines for Monitoring the Availability and Use of Obstetric Services* (New York. October 1997). http://www.childinfo.org/files/maternal_mortality_finalgui.pdf

13 Inter-Agency Working Group on Reproductive Health in Crises (IAWG), *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review* (Geneva. 2010). Hereafter IAWG Field Manual. http://www.who.int/reproductivehealth/publications/emergencies/field_manual/en/

Women and Adolescent girls of Union Council Pir Kot District Jhang, Punjab on a transit walk
© UNFPA/Muslim Aid, Jyang District, Pakistan

abortions, and sexually transmitted infections (STIs).[14] Conflict and displacement can further increase people's desire and need for family planning, while they simultaneously increase barriers to access family planning services.[15] The disruption of family and social support structures can pose particular challenges for adolescents, who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices.[16] Overall, Swatzyna and Pillai have found that armed conflict and natural disasters are associated with a reduction in women's SRH outcomes in developing countries.[17]

Since 1997, the Minimum Initial Service Package (MISP) for Reproductive Health has been the standard of care for SRH in humanitarian settings.[18] The MISP is a coordinated set of priority interventions aimed to prevent and respond to sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality, and plan for the provision of more comprehensive services as the situation permits. The MISP is a Sphere standard,[19] one of a set of minimum standards in core areas of humanitarian assistance, and a core recommended health response in the early stages of a crisis.

Recent disasters have given rise to many lessons around humanitarian response, including the promise that preparedness efforts can have for timely and appropriate SRH interventions during crises. Implementation of the MISP requires funding, effective coordination, skilled providers, supplies, equipment, and support. Learning shows that communities can and should be more involved in emergency response;[20] civil society groups need to understand the humanitarian system in order to access it;[21] communities must be better informed of available services;[22] and SRH services available before a crisis are more likely to be available after the crisis, as was the case with

---

14 Ibid.

15 IAWG, Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings (Geneva. 2010). http://www.iawg.net/IAWG_%20FP%20Statement_Final.pdf

16 Ibid.

17 Ronald J. Swatzyna and Vijayan Kumara Pillai, "The Effects of Disaster on Women's Reproductive Health in Developing Countries," *Global Journal of Health Science*, no. 4, vol. 5 (April 2007).

18 IAWG *Field Manual.*

19 The Sphere Project, *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response*, (UK. Practical Action Publishing, 201). http://www.sphereproject.org/handbook/

20 Paul Knox Clarke and Alice Obrecht, "Briefing Paper Four: Good Humanitarian Action is led by the state and builds on local response and capacities wherever possible," *Global Forum Briefing Papers,* (ALNAP, 2015).

21 Paul Knox Clarke and Alice Obrecht, "Briefing Paper Two: Good Humanitarian Action meets the priorities and respects the dignity of crisis-affected people," *Global Forum Briefing Papers,* (ALNAP, 2014).

22 Ibid.

HIV care and treatment in Kenya in 2008,[23] Haiti in 2010,[24] and Nepal in 2015.[25] The 2012-2014 global evaluation of SRH in humanitarian settings conducted by the Inter-agency Working Group (IAWG) on Reproductive Health in Crises additionally showed that, despite a growing awareness of the MISP as a standard,[26] gaps continued to exist around its full implementation at the field level.[27]

A multisectoral and multidisciplinary health emergency and disaster risk-management system protects public health and reduces morbidity, mortality, and disability asso-ciated with emergencies through effective prevention, preparedness, response, and recovery measures.[28] For the past decade, the United Nations International Strategy for Disaster Reduction's (UNISDR) *Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters*[29] has guided global dialogue, and has encouraged international and national stakeholders increasingly to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies.

Supportive Frameworks and Fora

Since the *Hyogo Framework*, other frameworks and international commitments have further contributed to a facilitative environment for integrating SRH into EDRM-H.

Sendai Framework for Disaster Risk Reduction 2015-2030

In March 2015, the *Sendai Framework for Disaster Risk Reduction 2015-2030* was adopted by member states at the United Nations World Conference on Disaster Risk Reduction in Sendai, Japan. The framework calls for increased attention to resilience, and identifies health, specifically SRH, as a critical aspect of strengthening individual

23 Women's Refugee Commission, *Reproductive Health Coordination Gap, Services Ad hoc: Minimum Initial Service Package (MISP) Assessment in Kenya,* (New York. September 2008). http://wrc.ms/MISP-KENYA

24 Women's Refugee Commission, *Priority Reproductive Health Activities in Haiti 2011: An inter-agency MISP assessment* conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission, (New York. February 2011). http://wrc.ms/MISP-HAITI

25 Women's Refugee Commission, *Evaluation of the Minimum Initial Services Package (MISP) of Repro-ductive Health Services for Crisis-affected Persons in Kathmandu and Sindhupalchowk Districts, Nepal,* (New York. pending).

26 Sarah, K. Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review," *Conflict and Health*, no. 9, suppl. 1 (March 2015). http://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-9-S1-I1

27 Sandra Krause et al., "Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package," *Conflict and Health* 2015, no. 9, suppl. 1 (February 2015). http://wrc.ms/1SkCQfG

28 World Health Organization, *Integrating sexual and reproductive health into health emergency and disaster risk management* (Geneva. October 2012). http://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf

29 United Nations Office for Disaster Risk Reduction, *Hyogo Framework for Action: Building the resilience of nations and communities to disaster* (Geneva. 2007). https://www.unisdr.org/we/inform/publications/1037

and community resilience.[30] Priority 3 reads:

Priority 3. Investing in disaster risk reduction for resilience

*29. Public and private investment in disaster risk prevention and reduction through structural and non-structural measures are essential to enhance the economic, social, **health** and cultural resilience of persons, communities, countries and their assets, as well as the environment…*

National and local levels

30. To achieve this, it is important to:

*i. Enhance the resilience of national health systems, including by integrating disaster risk management into primary, secondary and tertiary health care, especially at the local level; **developing the capacity of health workers in understanding disaster risk and applying and implementing disaster risk reduction approaches in health work;** promoting and enhancing the training capacities in the field of disaster medicine; and **supporting and training community health groups in disaster risk reduction approaches in health programmes,** in collaboration with other sectors, as well as in the implementation of the International Health Regulations (2005) of the WHO.[31]*

*j. Strengthen the design and implementation of inclusive policies and social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including **maternal, newborn and child health, sexual and reproductive health,** food security and nutrition, housing and education towards the eradication of poverty, to find durable solutions in the post disaster phase and to empower and assist people disproportionately affected by disasters.[32]*

Based on the *Sendai Framework*, the UN Population Fund's (UNFPA's) *The State of World Population 2015: Shelter from the storm: A transformative agenda for women and girls in a crisis-prone world*[33] recognizes the critical need to address SRH as part of preparedness efforts for response, recovery, and resilience. The report notes that women and adolescents must remain at the center of community preparedness and at the core of the transition from crisis to development.

---

30 United Nations Office for Disaster Risk Reduction, *Sendai Framework for Disaster Risk Reduction 2015-2030* (Geneva. 2015). http://www.unisdr.org/we/coordinate/sendai-framework

31 Ibid.

32 Ibid.

33 United Nations Population Fund, *The State of World Population 2015: Shelter from the storm: A transformative agenda for women and girls in a crisis-prone world* (New York. 2015). https://www.unfpa.org/sites/default/files/sowp/downloads/State_of_World_Population_2015_EN.pdf

Every Woman Every Child

The United Nations Secretary General's *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*,[34] which aims to transform societies for women, children and adolescents everywhere, includes preparedness as essential to building health-system resilience. Preparedness also intersects with SRH in the *Global Strategy's* action areas for humanitarian assistance in the context of fragile states. Excerpts follow.

Health system resilience

Prepare all parts of the health system to cope with emergencies.

> *Strengthen emergency preparedness capacities at all levels in accordance with the International Health Regulations, in areas such as legal and institutional frameworks for multisector emergency management; human resources and medical supplies and equipment for emergency response; information management systems for surveillance, risk communication and emergency management; financing and social protection; and service delivery to provide continuity of essential health services and management of mass casualties in crises.* **Underpinning all of these aspects of preparedness is the ability of the health system to ensure the availability of essential health services.**

Humanitarian and Fragile Settings

Support use of health risk assessments, human rights and gender-based programming to better protect the specific needs of women, children and adolescents in humanitarian settings.

> *Use a gender perspective when assessing risk and mapping community safety. In partnership with civil society and communities,* **build multi-hazard risk assessment and disaster risk reduction, including emergency preparedness**, *into country plans and budgets for women's, children's and adolescents' health.* **Ensure that the Minimum Initial Service Package includes up-to-date evidence-based interventions**. *Deliver comprehensive packages that meet the unique, context-specific needs of women, children and adolescents in the full range of humanitarian, disaster, outbreak and conflict situations. Empower and support civil society actors to access populations where government actors cannot do so.[35]*

---

34 http://www.who.int/life-course/partners/global-strategy/en/

35 United Nations, Every Woman Every Child, *The Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030): Survive, Thrive, Transform (New York. 2015). http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

Sustainable Development Goals

The Sustainable Development Goals highlight the need to reduce SRH-related morbidity and mortality and ensure access to SRH services under Goal 3, as well as eliminate violence against women and girls under Goal 5. Goal 3 also includes the importance of EDRM-H to building health-system resilience.

Goal 3: Ensure healthy lives and promote well-being for all at all ages

- *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.*

- *By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.*

- *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of RH into national strategies and programmes.*

- ***Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.***

Goal 5: Achieve gender equality and empower all women and girls

- *Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.*

- *Ensure universal access to SRH and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.[36]*

---

36 United Nations, *Sustainable Development Goals: 17 Goals to Transform our World* (New York. 2015). http://www.un.org/sustainabledevelopment/sustainable-development-goals/

United National International Strategy for Disaster Reduction (UNISDR) Thematic Platform for Health

To date, numerous efforts have been documented at the global, regional, district, and community levels to integrate SRH into EDRM-H efforts and improve response capacity. The WRC has advocated for the integration of SRH into disaster risk management for health since 2010. That year, in collaboration with the World Health Organization (WHO), the WRC established a reproductive health (RH) working group within the UNISDR Thematic Platform for Emergency and Disaster Risk Management for Health. The WRC continues to facilitate activities of the working group, which includes the International Planned Parenthood Federation (IPPF) South Asia Region's Sexual and Reproductive Health Programme in Crisis and Post Crisis Situations (SPRINT) Initiative, UNICEF, the UNFPA, the International Federation of the Red Cross, CARE, and the International Medical Corps (IMC). IPPF's SPRINT Project, in particular, has contributed greatly to building the capacity of national governments and providers to provide MISP services in emergencies.

Mobile clinic providing SRH care for emigrants in Kumanovo (North Macedonia)
© Health Education and Research Association in Macedonia

Tools

A number of tools have been developed to integrate SRH into EDRM-H activities.

UNISDR RH Working Group Tools

Guided by the *Hyogo Framework for Action* and now the *Sendai Framework*, the UNISDR RH working group has attempted to operationalize the mainstreaming of SRH into EDRM-H activities. Thus far, the group has developed a fact sheet,[37] policy brief,[38] and a tool to guide SRH integration in EDRM-H at the national level.[39] These tools advocate for the need to address SRH within EDRM-H, as well as how to do so. The national monitoring tool is currently being piloted.

MISP Readiness Assessment Tool

The IAWG Eastern European and Central Asia region developed the "MISP Readiness Assessment tool" in 2013 to assess the extent to which a country is ready to develop and implement an adequate intervention to meet SRH needs in emergencies. Based on the Pan American Health Organization's Health Sector Self-Assessment for disaster risk reduction (DRR) tool[40] as well as the MISP cheat-sheet,[41] and piloted in four EECA countries, the tool is designed for use by a country team of national SRH stakeholders, including the Ministry of Health (MoH), the National Disaster Management Agency (NDMA), UN agencies, the Red Cross Red Crescent National Societies, nongovernmental organizations (NGOs), and other civil society partners. Main outputs of this readiness assessment are an analysis of a country's readiness to respond to SRH needs in an emergency, and its establishment of a sound basis for the development of practical action plans for essential partners involved in SRH in that country. Applied at regular intervals, the assessment is additionally meant to serve as an internal tool for SRH national partners to monitor the evolution of their readiness to provide MISP services.

---

37 World Health Organization, *Disaster Risk Management for Health Fact Sheets: Sexual and Reproductive Health* (Geneva. 2011). http://www.who.int/hac/events/drm_fact_sheet_sexual_and_reproductive_health.pdf

38 World Health Organization, *Integrating sexual and reproductive health into health emergency and disaster risk management* (Geneva. 2012). http://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf?ua=1

39 United Nations Office for Disaster Risk Reduction, *Integrating Sexual and Reproductive Health (SRH) into Emergency and Disaster Risk Management for Health: Building resilient communities and reproductive health systems: National Monitoring Tool,* (Geneva. DRAFT).

40 Pan-American Health Organization, *Health Sector Self-Assessment Tool for Disaster Risk Reduction* (Washington. 2010). http://wrc.ms/PAHO-DRR

41 IAWG, MISP Cheat Sheet: Minimum Initial Service Package (MISP) for Reproductive Health (Geneva. 2010). http://wrc.ms/MISP-cheatsheet

Community Preparedness for Reproductive Health and Gender

In 2014-15, UNFPA Philippines and the WRC developed, adapted, and refined a community-based curriculum, *Facilitator's Kit: Community Preparedness for Repro-ductive Health and Gender.*[42] The curriculum provides a framework for a three-day training to build community capacity to prepare for and respond to risks and ineq-uities faced by women and girls during emergencies. The WRC developed this curriculum through eight training events conducted across six natural disaster and conflict-affected settings in the Philippines. The revised curriculum has been piloted in two more settings in the Philippines, in collaboration with EngenderHealth and the Hauirou Commission.

Methodology

The WRC identified case-studies of efforts to integrate of SRH within EDRM-H in order to explore:

- What have organizations done to integrate SRH into EDRM-H, and what frame-work and/or tools have been used in this process?

- What are the successes that show that SRH has been integrated into EDRM-H, and what has led to these successes?

- What are the constraints or challenges faced in integrating SRH into EDRM-H, and how were these overcome?

- What are the key lessons learned when integrating SRH into EDRM-H?

- What continues to be needed to ensure effective SRH preparedness and response in emergencies at the national, subnational, and community levels?

The WRC selected three settings for the case studies that represented variations in global geography and in levels of programmatic integration of SRH into EDRM-H, identifying them in consultation with the UNISDR RH working group: the EECA region, to serve as a regional case study; Macedonia, for a national-level study of SRH integration; and Pakistan, for examination of provincial- and district-level SRH integration. Across their respective levels, the studies highlighted that:

- The process of assessing MISP readiness in the EECA region facilitated **regional**

---

42 Women's Refugee Commission and UNFPA, *Community Preparedness: Reproductive Health and Gen-der: A Facilitator's Kit for a 3-day Training Curriculum* (New York. 2015). http://wrc.ms/DRR_facilitator_kit

learning and coordination among diverse stakeholders and identified gaps and recommendations for collective action.

- Persistent advocacy and a multisectoral approach in Macedonia led to **policy setting at the national level and forging of partnerships** to prepare for a more coordinated MISP response.

- Reflections from recent emergency responses within a pre-existing RH working group in Pakistan allowed for national and provincial level preparedness planning, as well as a **district-level pilot to develop and implement SRH preparedness plans.**

While the literature shows the need to include and empower communities in EDRM-H efforts, few community-based SRH and EDRM-H efforts were available for evaluation and documentation. Hence, it was important for this good-practices documentation to examine efforts through to the district level.

Information for the case studies was drawn from key informant interviews with representatives of coordinating disaster management systems (MoH and DRR Departments); relevant coordinating bodies for health, including UN agencies; and international and national implementing partners providing SRH services. Existing work plans and reports from respective RH coordination bodies were also reviewed.

The learning from this exercise will be used to advocate for the integration of SRH into EDRM-H efforts at the national, subnational, district, and community levels. The report is expected to inform the work of the UNISDR RH sub-working group and other international, regional, and national efforts.

Limitations

Innovative efforts to integrate SRH into EDRM-H may have existed, especially at the local level, about which the WRC was not aware and thus did not include among its case studies. Among those that WRC did select, despite best intentions and extensive outreach, not all relevant stakeholders for each case study could be consulted. Further, interviews were limited to policy makers and implementing agencies, without verification by community representatives on interviewees' observations or perspectives on SRH-related preparedness activities and/or subsequent humanitarian responses. Hence, this report is a reflection of interviewees' reported practice and activities, with an emphasis on gathering learning from iterative processes of improvement and action.

Case Study I: Assessment of National-level Integration of SRH into EDRM-H in 18 Countries in the Eastern European and Central Asia Region

Background to relevant EDRM-H infrastructure

EDRM-H Infrastructure	Fully accomplished (of 18 countries)
National level	See below
National Platform for DRR	14
National emergency preparedness plan for health	See below*
National emergency response plan for health	12
Lead agency identified for health for emergencies	6
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	3
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health	See above*
Existence of an SRH coordination group	14
SRH focal points appointed at national and/or subnational levels	5
Integration of EDRM-H and/or preparedness in the UNFPA Country Program	Not assessed
SRH risk assessment undertaken	2
Subnational level	
Subnational Platform for DRR	14
Subnational emergency preparedness plan	See below*
Subnational emergency response plan	11
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	Not assessed
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health	Not assessed
Existence of an SRH coordination group	Not assessed
SRH risk assessment undertaken	Not assessed
Community level	
Existence of an SRH coordination group	Not assessed
SRH risk assessment undertaken	Not assessed

Most countries have one plan for preparedness and response at the national and subnational levels and one plan for MISP preparedness and response.

October 2014 EECA regional forum.   © Kristina Puzarina, IPPF Eastern European Network

What has the EECA Region accomplished?

Policy advocacy

In 2011, at the IAWG annual meeting in Istanbul, Turkey, the EECA regional IAWG was formed, comprising 18 countries. The regional group has met annually to develop a common work plan for the following year. During the first regional IAWG forum in 2012, participants came with a clear recommendation on the necessity of a needs-assessment tool for the crisis preparedness phase. In follow-up, in 2013, the EECA region prioritized the development of a MISP readiness assessment tool.

Composed of 38 indicators and 42 questions, the assessment tool primarily focuses on the national health disaster response and disaster management plans. For each MISP objective, the tool captures the number of indicators fully achieved; the number of indicators partially achieved; and the number of indicators not achieved. The MISP tool builds on and complements the UNISDR EDRM-H national monitoring tool[43] and is user friendly for countries and partners that are unfamiliar with the MISP or have had no recent humanitarian experience.
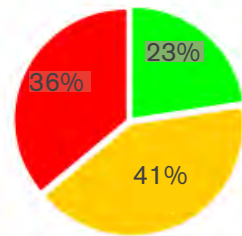
43 United Nations Office for Disaster Risk Reduction. See note 39.

In 2014, country teams conducted the MISP assessment with the support of a technical consultant. Among the 18 assessed countries,[44] findings specific to **health disaster response planning showed:**

🟥 # of indicators not fulfilled   🟨 # of indicators partially fulfilled   🟩 # of indicators fulfilled
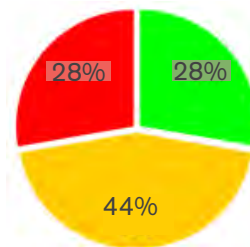
Objective 1: Coordination of the MISP and DRR

In 2014, 13 of 18 countries were found to have health disaster coordination. Seven of 18 countries had a nonformalized SRH working group, and 11 countries had no SRH working group.
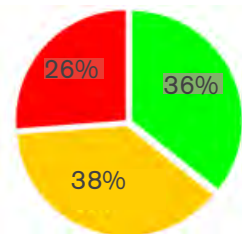
36% / 23% / 41%

Objective 2: Prevention of and Response to Sexual Violence

Lack of knowledge on nonmedical structures and networks to prevent and respond to sexual violence was apparent at national and subnational levels. More than half (55 percent) of the assessed countries had some sexual violence prevention and response services integrated into their health disaster response plans, while the remaining 45 percent had no related services in their health disaster response plans.
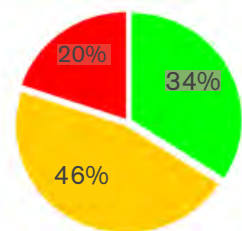
28% / 28% / 44%

Objective 3: Reduction of HIV

Seventy percent of the countries had portions of the required HIV-related services integrated into their health disaster response plans. Twenty-three percent had no such services in their plans.

26% / 36% / 38%

Objective 4: Prevention of excess maternal and newborn morbidity and mortality

Fifteen of 18 countries had emergency obstetric and newborn care included in their health disaster response plans. Of those, 10 countries included provision for post-abortion care. Eight countries had a list or map of existing referral systems that were available on a 24 hour, 7 days a week basis.

20% / 34% / 46%

Objective 5: Planning for comprehensive SRH

Only five countries had SRH indicators in their health information systems. Plans to

---

44 The 18 countries: Albania, Bosnia and Herzegovina, Serbia, Kosovo, Macedonia, Armenia, Azerbaijan, Georgia, Turkey, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, Bulgaria, Moldova, Romania, Ukraine

use the MISP checklist or measure MISP-related indicators from the onset of the response were also limited.

Additional priority objectives of the MISP

Eight countries included the provision of contraceptive services in their health disaster response plans. While seven out of 18 countries included HIV services in their response plans, none mentioned STI services.

Overall, the integration of priority SRH services in health disaster response plans was fair across the region; it was best for maternal and newborn health and least good for provision of STI services. The exercise further showed weaknesses in pre-existing health policy and infrastructure, especially services to respond to the medical needs of survivors of sexual violence, as well as comprehensive services to address pregnancy complications and HIV. Where pre-existing services were weak or non-existent, response plans mirrored those limitations.

Implementing the preparedness action plan

Countries that undertook the MISP readiness exercise went on to develop action plans with emphasis on coordination, and with focus on specific indicators. On average, each country team prioritized activities for five indicators. The action plans were reviewed within the EECA region in October 2015 to assess implementation. While only seven of 18 countries had a non-formalized SRH working group in 2014, 14 countries reported establishing SRH coordination mechanisms in 2015.

Targeting systemic change, countries have begun implementing activities to improve the integration of MISP services in their health disaster response plans and key policies.

- In Macedonia, the SRH working group developed an SRH chapter for its revised national health preparedness plan, and advocacy is underway to integrate HIV prevention in crisis situations into the country's new National HIV Strategy.

- In Serbia and Armenia, SRH in crises was integrated into their respective National Plans of Action for Disaster Risk Reduction.

- Turkmenistan's MISP action plan, including a section on GBV, was approved by the MoH and included in its national emergency response plan.

- In Kosovo, advocacy was conducted to include SRH indicators in the health facilities where a new health information system is being piloted.

- Kazakhstan has drafted regulations around protective systems to prevent sexual

violence in its refugee camps.[45]

Several countries have also focused on developing or adapting information, education, and communication (IEC) materials to their contexts. Most countries have begun to examine how to increase the availability of trained human resources for MISP implementation:

- In Kyrgyzstan, SRH in crises will be integrated into the Kyrgyz Medical Continuous Post Graduate Training Institute for all health care providers from 2016.

- In Armenia, an online course on SRH in crises for health care providers is being developed within the new mandatory credit system for the professional development of medical staff.

- Uzbekistan has included national STI protocols into its MISP training curriculum.

- Serbia has implemented three trainings for health providers on identifying and treating survivors of GBV.

- In Turkey, 13 trainings led to over 280 service providers being trained on the MISP, of whom 52 were Syrians working in northern Syria, among other conflict-affected locations. Turkey has also begun thematic trainings, including five emergency obstetrics care trainings for 175 service providers. Fourteen of the trainees are Syrian providers.

Responding to new emergencies

The MISP readiness assessment tool and subsequent action planning took place at an opportune time, with the unfolding of the European refugee and migrant crisis. While the quality of responses has reportedly varied across countries, Macedonia has rolled out a coordinated response (see the Macedonia case study). The UNFPA EECA regional office and the Serbia country office have responded through a number of initiatives, including the provision of specific mobile medical equipment to Presevo, Vranje, Dimitrovgrad, Bosilegrad, Belgrade, and Sid, and the distribution of SRH-related IEC materials. Given that most migrants/refugees are transiting through Serbia, it is distributing dignity kits that include underwear, sanitary pads, hand-washing supplies, toothpaste, and wet wipes. The overall response in Serbia has reportedly been well coordinated, per a detailed WHO/IOM health capacity assessment.[46] In Turkey, based on the capacity built through focused trainings, the

---

45 UNFPA. See footnote 33.
46 World Health Organization, *Serbia: assessing health-system capacity to manage sudden large influxes of migrants: Joint report on a mission of the Ministry of Health of Serbia and the WHO Regional Office for Europe with the collaboration of the International Organization for Migration* (Geneva. 2015). http://www.

country team, including the MoH, is responding by establishing counseling units, translating and distributing IEC materials on maternal newborn health, hygiene, and GBV, and distributing family planning supplies. UNFPA is also implementing a cross-border response through its Gaziantep office that focuses on SRH and GBV.

Despite preparedness efforts, implementing actions around MISP Objective 2, to prevent and respond to sexual violence, has reportedly been difficult across countries. Sensitivities around sexual violence, limited survivor reporting, and lack of trained staff, as well as the lack of registered post-exposure prophylaxis or emergency contraceptive products, appear to be contributing to this challenge. HIV testing and anti-retroviral therapy (ART) interventions have also been difficult to implement, with a number of countries more heavily focused on dignity kits, due to the short stays of the population in transit.

For Macedonia, Serbia, and Turkey, in particular, common challenges that have been identified include language barriers between the migrant/refugee community and responding staff, and the need to provide IEC materials in local languages. There is also recognition of the need for qualified female health providers as necessary to increasing demand for, and use of, SRH services, and of the importance of improving and increasing community-based interventions.

Among other observations, in Macedonia the existence of a coordination team has facilitated progress immensely. Turkey's crisis response appears to be less based on the MISP readiness exercise and action planning than in the other EECA countries, since it actions were being implemented for an extended period previously. For Serbia, the response has been heavily needs-based,[47] with it thus being unclear to what degree implemented activities have been based on the action-planning exercise.

We should be optimists. We should always be positive.

Stakeholder working in the EECA region

---

euro.who.int/__data/assets/pdf_file/0010/293329/Serbia-Assessment-Report-en.pdf

47 UNHCR, MoH Republic of Serbia and UNFPA, *Field assessment and analysis of service provision to migrants, refugees and asylum seekers with regard to their sexual and reproductive health* (New York. 2015).

What challenges did the EECA region face, and how did the region overcome them?

Lack of consideration and awareness of SRH in emergencies: Initially, SRH was not well understood or seen as a priority in preparedness activities.

- The MISP readiness exercise helped raise awareness among the country teams around the MISP and its significance, and showed that the commitment of the MoH, Ministry of Interior, and other agencies is crucial. In total, more than 90 organizations participated from the 18 countries, including from the MoHs, UNFPA, the IPPF Member Association, and other civil society partners. This partnership has helped build accountability into the process and strengthen inter-agency collaboration around cross-cutting MISP indicators.

Difficulties obtaining accurate information and data: Across countries, response plans were not always precise or used inconsistent terminology. Government response plans were also at times confidential. Lack of cooperation and transparency in other sectors, as well as lack of records and documentation at the central and local levels, additionally contributed to this challenge.

- When the Ministry of Interior and disaster management agencies became involved, the country teams were able to access more information around EDRM-H than that pertaining solely to SRH. Engaging DRR bodies was key, as was persistence to ensure this engagement.

Limited response coordination: Limited coordination within country responses, especially among actors that were not familiar with the MISP, and changes in focal persons throughout the process, contributed to difficulties making progress.

- Where countries worked well in teams and came to a common understanding of what preparedness was and how it should be achieved for SRH, coordination improved dramatically. It was important to **involve actors beyond the SRH sector** to contribute to planning. **Organizing MISP training of trainers (ToT) by country teams** and not by individuals also helped ensure the process was not dependent on any one person. **Encouragement** helped to identify champions, as well as foster interactions among countries. Country teams have reportedly found the EECA IAWG annual forums helpful in harnessing commitment since they can engage with teams beyond their own.

Difficulties in prioritizing activities: Between the assessment process itself and action planning, countries were more enthusiastic about the assessment, since prioritization of actions proved more challenging. In some instances, teams also struggled

to develop action plans with SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) indicators, activities, and outcomes.

- Having the right people with the right knowledge helped in many instances. Teams were encouraged to balance short-term and long-term goals with specific actions, and begin with achievable outcomes. That way, they could observe that preparedness is feasible and build on preliminary accomplishments.

Difficulties in implementing action plans: With few financial resources, implementation of action plans raised challenges. Further complicating the picture, communications among certain UN agencies in some countries was inconsistent and, in countries where government buy-in was limited, partners were reluctant to move forward. Lack of SOPs for the MISP also prevented some countries from taking meaningful steps to implement their national action plans.

- Some of the national governments have demonstrated tremendous goodwill and commitment to working with United Nations and civil society actors to address gaps and implement activities from their action plans. From 2011 to 2013, the EECA regional IAWG recognized the need for capacity-building on specific topics and agreed to cover a thematic focus at every annual forum. In 2014, the regional IAWG held a one-and-a-half-day capacity-building session on adolescent SRH, and in 2015 the session was on GBV. This regional approach to capacity-building has been a helpful factor in strengthening capacity across countries.

Why was the EECA region successful?

Beyond the results of each MISP readiness assessment, **the process itself offered opportunities for different stakeholders to work together and bring in more partners, as well as gain buy-in from the government.** Countries felt the exercise helped strengthen their knowledge and awareness around the MISP standards, as well as raise the importance of preparedness. The MISP readiness tool offered SRH and DRR actors the chance to collaborate for the first time in collecting related data and developing a shared document with concrete recommendations and actions. Dialogue among stakeholders further allowed for the exchange of knowledge and experience, as well as understanding around the cross-cutting aspects of the MISP and related opportunities for inter-agency cooperation.

The EECA region positioned itself at the forefront of attempts to address SRH integration in EDRM-H, and continues to be a main leader . Among countries that are spearheading action planning and implementation, factors contributing to achievements included:

- **Endorsement by the MoH** for integrating SRH into EDRM-H efforts.

- **Commitment of partners** to working together as partners, even with a limited budget. The ability of country teams to work well in concert, as well as the presence of strong and committed individuals, was critical.

- **Existence of a strong regional IAWG,** which had been functioning since the regional network was established at the 2011 IAWG meeting in Istanbul. This forum, currently led by the UNFPA EECA regional office and IPPF European Network, was and continues to be the engine driving developments. The EECA regional IAWG secured a dedicated budget to develop the MISP readiness tool and hired a technical consultant to work with each of the countries. Technical support was critical to advancing the process.

- **Training of country teams that included government actors**. This way, **stakeholders are accountable to each other** and processes are less prone to stalling from staff turnover .

- **Preparedness was on the agenda of the UNFPA country offices,** which gave UNFPA reason to actively lead and participate in activities at both the regional and national levels.

- **Ability to address underlying pre-existing issues of importance in the region,** such as maternal newborn health and family planning. The MISP readiness assessment provided opportunities for countries to strengthen weaker policies and services of interest, and align themselves with an international standard of care prior to an emergency.

What were the critical lessons learned?

The MISP readiness tool offered lessons around the importance of the planning process itself to building a cohesive network to address SRH preparedness capable of generating a more robust response. Other learning included:

- Making sure stakeholders **use a common language and have the same understanding of SRH and DRR. Training on basic action-planning is also important,** so that teams are able to develop a feasible schedule of actions, prioritizing those activities at the beginning that appear to have more easily achievable outcomes to build momentum.

- The **establishment of a fully functioning terms of reference (ToR) for an SRH working group** is critical in all cases, but especially where focal point turnover is

high, it is important that roles be fulfilled regardless of individual. ToRs can also be used to secure buy-in from stakeholders, including the government.

- **Engaging non-traditional actors, such as emergency departments, as well as related sectors, including GBV.** Where challenges exist to engaging certain actors, it is important to consider tailored strategies that will be effective. For example, in a context where UNFPA has a good working relationship with the MoH, it is well-positioned to try to work through the MoH to reach non-collaborative actors.

- **A budget is needed to continue to bring people together at the country level, to strengthen emergency preparedness**. Resources are also necessary for regional consultation, as country teams have expressed that the annual forum is very useful for driving progress, as they are then also accountable to each other.

What are next steps for the EECA region?

Next steps for the region were determined at the EECA regional forum in October 2015. The 2016 EECA action plan includes:

- **Updating National Readiness Action Plans for 2015-16,** including actions to improve SRH coordination and address at least one indicator from the other MISP objectives.

- **Strengthening coordination and partnerships through the development of an SRH working group ToR template that countries can use and adopt,** as well as sharing learning from real-time responses, including the ongoing migrant/refugee crisis.

- **Developing a regional pool of experts** to support capacity-building.

- **Facilitating knowledge sharing through collecting and cataloging IEC materials and making them available,** including for linguistic minorities.

- **Conducting advocacy to strengthen preparedness in the region,** including through translating and disseminating fact sheets in local languages and advocating for MISP inclusion in national contingency plans.

When emergencies strike in the future, country teams are positioned to conduct their own evaluations using the MISP checklist, to examine preparedness and how it is addressed.

Case study II: Integration of SRH into EDRM-H at the National Level in Macedonia

Background to relevant EDRM-H infrastructure

EDRM-H Infrastructure	✓ Yes X No
National level	
National Platform for DRR	✓
National emergency preparedness plan for health	✓
National emergency response plan for health	✓
Lead agency identified for health for emergencies	✓
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	X
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health	In process
Existence of an SRH coordination group	✓
SRH focal points appointed at national and/or subnational levels	✓
Integration of EDRM-H and/or preparedness in the UNFPA Country Program	✓
SRH risk assessment undertaken	Partial
Subnational level (not relevant for Macedonia as a small country)	
Subnational Platform for DRR	X
Subnational emergency preparedness plan	X
Subnational emergency response plan	X
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	X
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health	X
Existence of an SRH coordination group	X
SRH risk assessment undertaken	X
Community level	
Existence of an SRH coordination group	X
SRH risk assessment undertaken	X

What has Macedonia accomplished?

Policy advocacy

As part of the regional initiative, in January 2014, Macedonia implemented the MISP readiness tool at a national workshop. The tool provided an opportunity for the SRH sub-working group, led by the MoH and the National Institute for Public Health, to develop its action plan. Stakeholders included the Health Education and Research Association (HERA – an IPPF member association), the Macedonia Red Cross, the University Clinic for Obstetrics and Gynecology, and UNFPA. In rolling out the action plan, the SRH working group prepared an SRH chapter on crisis situations for the 2009 *National Preparedness Plan for the Health Sector* that is currently undergoing revision by the MoH and WHO. The inclusion of the SRH chapter in the national preparedness plan will better legitimize, and mandate, preparedness around SRH. The SRH chapter is five pages, and references the UNISDR policy statement on inte-grating SRH into DRR and the WRC's *MISP Distance Learning Module.* The chapter is divided into main content and annexes, of which the SRH preparedness action plan an annex. The SRH working group is also developing SOPs for addressing HIV, STIs, and GBV in emergency contexts.

Implementing the preparedness action plan

The SRH working group implemented multiple trainings of key stakeholders to improve their capacity around the MISP, in line with the action plan. Those trained include staff from the National Institute of Public Health, Centers of Public Health, health facilities, including obstetrics and gynecology clinics, the National Crisis Management Center, the Red Cross, and the Regional Crisis Management Center.

The SRH working group also advocated for improving data collection systems during emergencies. At present, an MoU is being discussed for signature with the Crisis Management Center and the National Institute of Public Health to collect and share SRH-related data via the Crisis Management Center's database, which maps health facility capacity as well as sex- and age-disaggregated service data. Such informa-tion would help regional and local Centers of Public Health better understand SRH capacity by region, and be an important resource for first responders, who rely on such information to respond adequately to emergencies. Disaggregated data would also help with service planning, providing information on the need for more compre-hensive services. Indicators were taken from IAWG standards and include:
- # of pregnant women
- # of sexually active men
- referral systems for emergency obstetric care (EmOC), etc.

The Crisis Management Center and the National Institute of Public Health agreed on a communications plan, and have identified coordinators at the regional level.

Responding to new emergencies

Early in 2015, eastern Macedonia experienced flooding. Members of the SRH working group, with representatives from the Center for Public Health and the Crisis Management Center, requested funds from UNFPA to implement the MISP. The working group procured dignity kits and implemented other activities.

Learning from this response has since been applied to Macedonia's latest influx of migrants/refugees, who are traveling primarily from Afghanistan, Iraq, and Syria, and who have been granted a 72-hour window to enter, register, and exit the country.[48] While the large influx has overwhelmed capacity, SRH sensitization reportedly helped partners to rapidly implement a minimum package of SRH services. UNFPA provided an initial 500 dignity kits to women migrants/refugees. UNFPA and the MoH have been supporting HERA to provide mobile outreach that includes pregnancy care and STI treatment. Hospitals have also been responding with 24 hour, seven days a week access to SRH, including EmOC. The MoH issued an order to health facilities to provide free health services, including MISP-related SRH services. The MoH, UNFPA, and HERA jointly conducted a rapid assessment of health facilities along the migrant/refugee route, identifying the needs of the health system in responding to the crisis. The national coordination body for migrant care also confirmed SRH as a health priority. For its part, the media have highlighted an example of a safe delivery by a migrant woman, demonstrating initial advocacy successes.[49]

What challenges did Macedonia face, and how did it overcome them?

EDRM-H as a topic: EDRM-H was initially challenging to discuss, since there were concerns that there would be resistance or negative repercussions if there was talk of some kind of impending "crisis."

- The SRH working group focused on **natural disasters as an entry point**, as it was less challenging to discuss than other types of humanitarian crises, thus leaving people more open to preparedness planning.

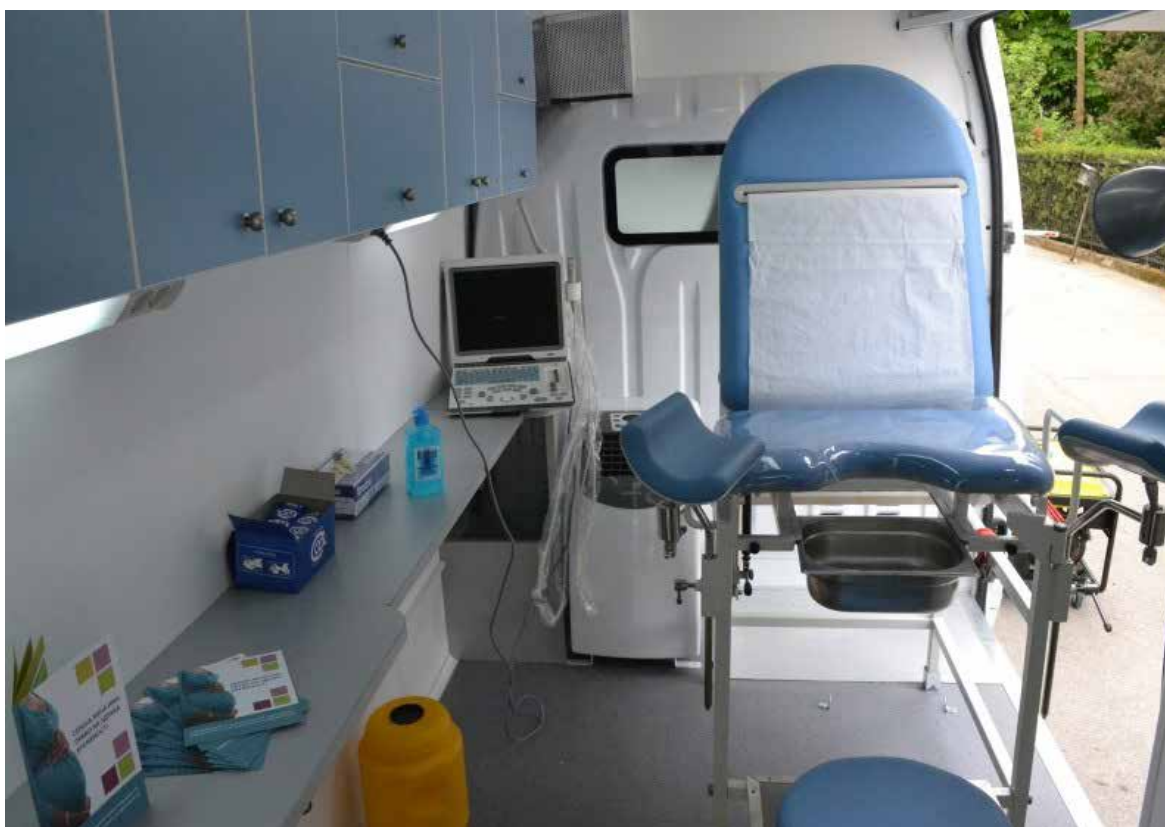- **SRH as a topic:** With a conservative government, SRH was initially challenging to discuss.

---

48 This information was gathered in June 2015. The situation has subsequently changed.
49 Activities are as of September 2015.

It is important not to criticize the government and other stakeholders, since no one likes to be criticized. Instead, it is much more effective if constructive proposals are developed to address gaps.

Stakeholder working in Macedonia

- Maternal newborn health and the fact that 4 percent of the total population would be pregnant each year proved to be a positive entry point for discussions around SRH. Additionally, family planning was framed in the context of human rights, rather than on lowering the total fertility rate or decreasing the number of children. The SRH working group also highlighted the ways in which SRH, and specifically delaying adolescent pregnancy and ensuring appropriate birth spacing, would help to reduce newborn death, an issue of concern for the government. The SRH working group ensured inclusion of sexual violence and STIs/HIV by stressing the added risks of both during emergencies. In general, the working group empha-sized **points and approaches that were already of interest** to the government, which helped with receptivity.

Mobile gynecological clinic, Macedonia © HERA

Financing SRH in preparedness efforts: In Macedonia, not every plan is able to command a budget.

- The SRH working group **focused on low-cost, high-impact activities,** including policy advocacy, training, and development of partnerships. Further, the Minister appointed existing staff who were willing to participate and move the agenda forward, thus eliminating the need for additional staff costs. UNFPA provided funds for the MISP trainings.

Why was Macedonia successful?

- The **MISP readiness tool identified gaps in SRH preparedness, and the action planning process yielded concrete next steps with responsible agencies.**

- The SRH working group was, and continues to be, led by a highly respected and charismatic coordinator, with active involvement from various institutional stake-holders at the highest levels. The **leadership, motivation, and hard work of members was critical, as was the senior level they represented, as they were in a position to foster change.** The SRH working group also benefited from the fact that Macedonia is a small country and colleagues knew each other well.

- Taking an **intersectoral and multisectoral approach facilitated buy-in from the government.** The Committee on Health and the Environment is fully on board, and the Deputy Minister attended an IAWG EECA regional meeting in Istanbul.

- **Seeking collaboration with other agencies was key to success.** The working group joined efforts with the WHO to revise the *National Preparedness Plan for the Health Sector*. This has facilitated recognition of the SRH working group's advocacy, with the MoH appreciating that a**dvocacy has been coordinated and synchronized.**

- There was **excellent cooperation among UN organizations in Macedonia.**

- The **SRH working group used the MISP checklist in real time,** first in the 2015 flooding, and more recently as Macedonia's preparedness efforts continue to be tested in the current crisis.

What were the critical lessons learned?

- **"Selling SRH for preparedness" is an art.** When the MISP was discussed in workshops, the SRH working group received good questions, including how the government would institutionalize the standards in practice. The questions trig-

gered new ideas and strategies for the working group to incorporate moving forward.

- **Staffing is important.** An SRH working group benefits from members who are influential, in positions of decision-making at the highest levels, and highly motivated.

- **NGOs are the engine**. In addition to the government, NGOs must be involved, as must the Red Cross and other international agencies.

> *We need NGOs as engines, since they move the agenda forward.*
>
> Stakeholder working in Macedonia

- **Financing is a long-term challenge.** DRR donors are international, which presents a potential risk for sustainability. It is important to establish private-sector partners to shore up resources for SRH preparedness.

- **Effective emergency response is conditioned by level of preparedness.** Challenges around responding to the migrant/refugee crisis have included ensuring adequate stocks of RH supplies (inter-agency RH Kits), and understanding the possible needs of migrants in advance. Since the working group had prepositioned dignity kits in the wake of the earlier flood response, those have been readily available for the migrant/refugee response. Similar efforts could be made with other RH supplies. Having SOPs in place has mitigated confusion during the more recent crisis by clarifying responsibilities of specific actors.

What are next steps for Macedonia?

Post-exposure prophylaxis (PEP) is currently not a part of Macedonia's post-rape care policy. PEP is only indicated for use by health providers in health care settings. As of September 2015, as per national policy, only one health facility in the country was equipped to provide medical care for survivors of sexual assault. While the SRH working group has not so far prioritized advocacy in the current action plan around enhancing access to PEP, due to low HIV prevalence and other country priorities around HIV funding, this gap has been recognized.

Critical next steps include the continued implementation of the action plan. Some key activities are:

- Develop RH Kits for use in emergencies.

- Establish a focal point for SRH at the national and regional levels for better chan-

nels of communication.

- Pilot the Crisis Management Center's database that integrates SRH data.

- Train additional providers and build community capacity on the MISP and how to use MISP Kits.

Other opportunities are available to take a rights-based approach and to be more inclusive of at-risk groups, such as adolescents and persons with disabilities. The inclusion of at-risk groups is an area that the working group is actively aiming to address, especially looking at adolescents, as no sexuality education is available in schools in Macedonia.

Vinojug Transit centre in front of mobile gynecological clinic.   © HERA

Case study III: Provincial- and District-level Integration of SRH into EDRM-H in Pakistan

Background to relevant EDRM-H infrastructure

EDRM-H Infrastructure	✓ Yes X No
National level	
National Platform for DRR	✓
National emergency preparedness plan for health	✓
National emergency response plan for health	✓
Lead agency identified for health for emergencies	✓
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	X
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health	X
Existence of an SRH coordination group	✓
SRH focal points appointed at national and/or subnational levels	Some
Integration of EDRM-H and/or preparedness in the UNFPA Country Program	✓
SRH risk assessment undertaken	X
Subnational level (provincial/regional)	
Subnational Platform for DRR	✓
Subnational emergency preparedness plan (same as response plan)	✓
Subnational emergency response plan (same as preparedness plan)	✓
Integration of minimum services of SRH as described in the MISP in the *response* plan(s) for health	See line below
Integration of minimum services of SRH as described in the MISP in *preparedness* plan(s) for health (SOPs)	7
Existence of an SRH coordination group	X
SRH risk assessment undertaken	X
Community level (Jhang District)	
Existence of an SRH coordination group	✓
SRH risk assessment undertaken	✓

What has Pakistan accomplished?

Policy advocacy

The 2005 earthquake highlighted Pakistan's vulnerability to disaster risks and motivated the government to take a more proactive preparedness approach.[50] In 2006, it developed the National Disaster *Management Ordinance* and a *National Disaster Risk Management Framework (2007 to 2012)* that outlined a comprehensive national DRR agenda. These instruments were later replaced by the 2010 *National Disaster Management Act* (NDMA) and the 2013 *DRR Policy*.[51] The current disaster risk management system outlines the involvement of government and communities at all levels in planning and preparedness, and defines the roles and responsibilities of the provincial and district arms/chapters (see Figure 1, page 34). This system maintains a supportive environment for work on SRH within the existing DRR structures.

Pakistan has integrated a gender perspective in DRR through NDMA's Gender and Child Cell, which has a mandate to ensure that sensitivity to these groups is reflected in disaster-management practices. The 2014 *National Policy Guidelines on Vulnerable Groups in Disasters* recommends women's participation at all levels of the disaster management system. It also highlights the needs of displaced women and acknowledges the impact of their limited mobility on all aspects of DRR.[52]

The National Health Emergency Preparedness and Response Network (NHEPRN), under the Ministry of National Health Services, has been the authority responsible for leading health-related emergency response and disaster risk management since its enactment in 2007. NHEPRN chairs the Reproductive Health Working Group (RHWG) at the federal level, with UNFPA as co-chair. The RHWG dates to 2013 and is a revitalization of in the health cluster that was formed under the 2010 flood response, with those roots positioning it to raise SRH issues within the humanitarian country team architecture.

Since 2014, NHEPRN has successfully organized 20 RHWG meetings, and has developed a ToR and annual work plan in consultation with members.[53] Members

---

50 National Disaster Management Authority, Government of Pakistan, National Disaster Risk Management Framework (Islamabad. 2007). http://www.ndma.gov.pk/Docs/National.Framework_Full.pdf
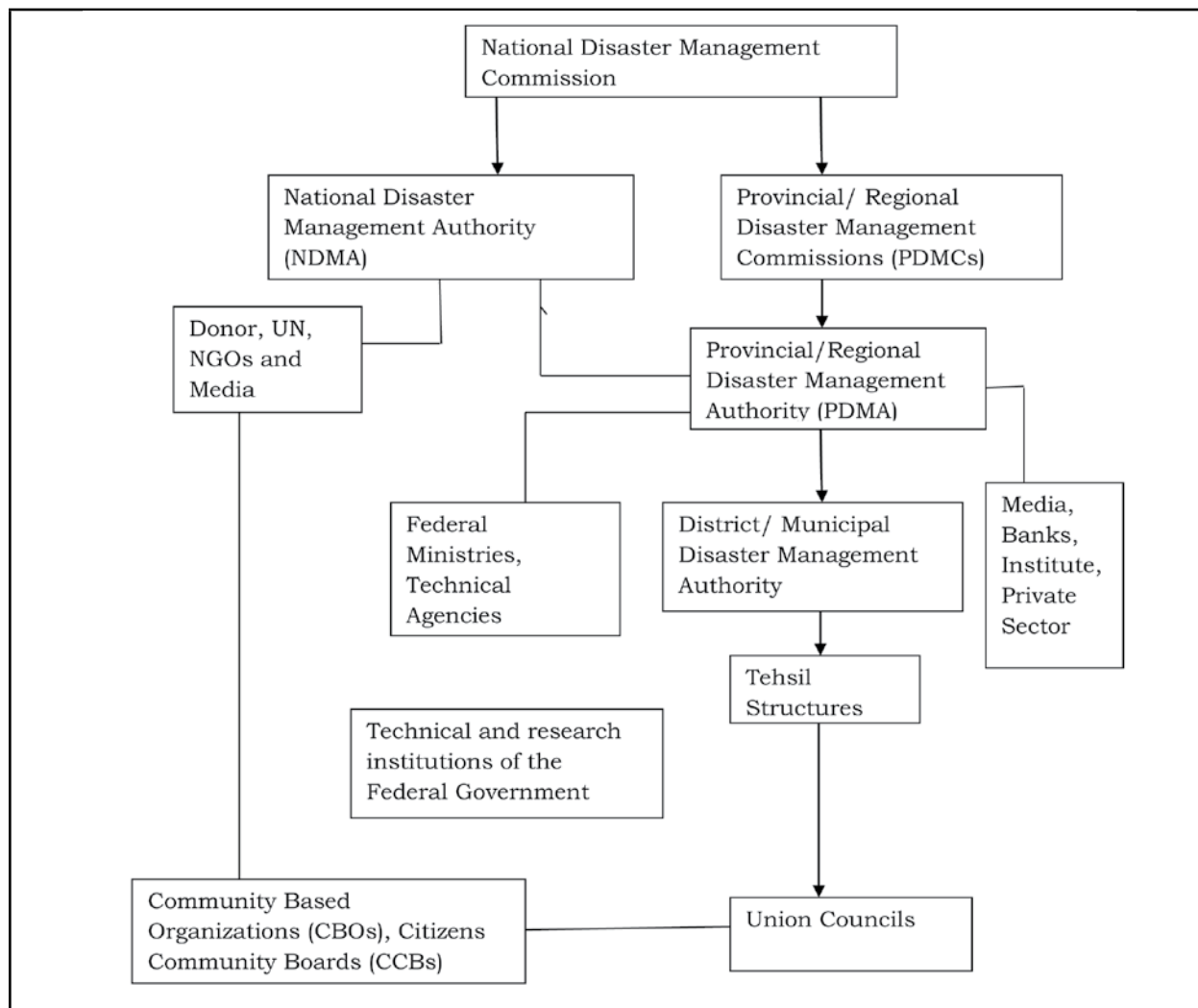
51 Ibid.

52 The Economist Intelligence Unit, The *South Asia Women's Resilience Index: Examining the role of women in preparing for and recovering from disasters* (London. 2015). http://www.economistinsights.com/infrastructure-cities/analysis/south-asia-womens-resilience-index

53 Members include UN agencies (WHO, UNICEF, UNAIDS, UNHCR, UN Women), international organizations (International Medical Corps (IMC), Muslim Aid, Save the Children), national organizations (Sarhad Rural Support Programme, NHSD, Aurat Foundation, Rozan, Rahnuma-Family Planning Association of Pakistan, and the Army.
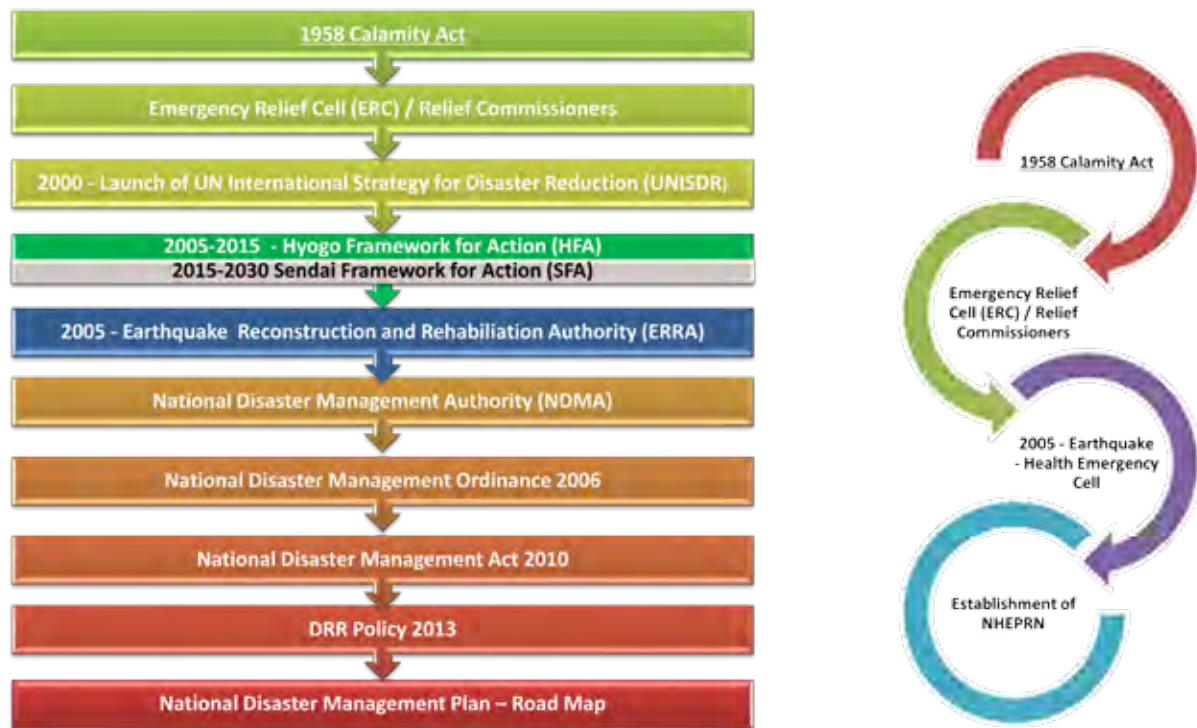
include UN agencies, international organizations, national organizations, and the Pakistani Army. The RHWG has developed an annual work plan that highlights SRH during preparedness, response and recovery.

Figure 1: Pakistan's Disaster Risk Management System

(Received from UNFPA Pakistan)

Evolution of the Disaster Management System in Pakistan

Members of the RHWG have developed a *Provincial Action Plan for Sindh,* which includes establishing an RHWG presence at the provincial level and implementing MISP trainings. Additionally, the Rahnuma Family Planning Association of Pakistan (R-FPAP) has led the integration of SRH into the SOPs of Provincial Disaster Management Authority (PDMA) policies in seven provinces and regions: Punjab, Sindh, Khyber Pakhutnkhwa, Balochistan, Federally Administered Tribal Areas, Gilgit Baltistan, and Azad Jammu and Kashmir. This gain was possible due to direct lobbying with the PDMA team, and the sensitization of civil society and other partners, including media.

At the district level, health departments have disaster management plans that are reviewed every year in advance of the monsoons. The MISP has not yet been integrated into district-level plans, although advocacy to that end is underway in certain districts. In the meantime, the RHWG is focusing on training district-level staff.

Implementing the preparedness action plan

The RHWG prioritized three strategies in its 2015 work-plan that are based on the MISP objectives:

1. **Advocacy**, to integrate the MISP into federal-, provincial- and district-level contingency plans.

2. **Capacity building**, through creating a pool of trainers and following up with echo trainings. Activities aim to integrate the MISP into trainings for government and humanitarian actors.

3. **Service delivery**, to ensure MISP implementation in emergencies, as well as to implement Pakistan's 2015 *Humanitarian Response Plan*, as part of the Health Cluster/Sector activities.

National level

1. Advocacy

At the national level, R-FPAP collaborates with the Pakistan Institute of Medical Sciences and the Health Services Academy to drive the inclusion of the MISP in nursing, medical, and public health curricula. The Health Sciences Academy has included a three-credit class on the MISP in its master's program to help develop the workforce that will eventually become RH coordinators.

2. Capacity building

The RHWG and its members have focused extensively on training key stakeholders on the MISP. In 2014, UNFPA, in coordination with R-FPAP and NHEPRN, conducted trainings on the MISP and clinical management of rape survivors for various health providers. Under the 2015 work plan, UNFPA has organized 11 trainings on the MISP at national and provincial levels in collaboration with Muslim Aid, NHEPRN and IMC. Almost 250 health/emergency practitioners from the government, the Army, and NGOs have been trained to date. Since 2013, R-FPAP has also trained more than 30 master trainers on the MISP. UNFPA, Muslim Aid, R-FPAP and others have additionally developed a database of MISP trainees for monitoring purposes and further roll-out activities at the provincial level.

The RHWG has developed several tools to support preparedness and response efforts, including MISP videos in three languages, a catalogue and database of IEC materials, and translations of MISP cheat sheets/advocacy sheets and other training resources.

3. Service delivery

The RHWG has addressed commodity security at the national and provincial levels through procuring RH kits, newborn and dignity kits, and assessing SRH capacities. These kits are held under the NHEPRN and Pakistan's NDMA contingency plans and

are stockpiled by UNFPA.

Provincial level

At the provincial level, under SPRINT Phase I, R-FPAP implemented ToT activities in Balochistan, Azad Jammu and Kashmir, and other disaster-prone areas. Participants covered the cost of their own participation to spread training costs across agencies. The echo-training was conducted in Islamabad, with participants from Balochistan, Kashmir and the Federally Administered Tribal Areas. The provincial RHWG bodies are also planning activities, including further trainings that reflect their input.

District level

At the district level, UNFPA has partnered with Muslim Aid to prepare for an SRH response in advance of cyclical flooding in Jhang District, Punjab Province. Jhang District was selected as it is exposed to monsoon rains and frequent flooding by two rivers. A water dispute between India and Pakistan has resulted in India releasing water into the rivers, flooding districts including Jhang, periodically. The pilot aims to reduce maternal and newborn mortality through strengthening the capacity of existing

Men and adolescent boys on a transit walk with master trainer and project staff.

©Rizwan Baig, Muslim Aid; and UNFPA

health facilities, providing RH kits and other medical and non-medical equipment, and increasing awareness in the community on SRH and GBV issues.

The leading partners implemented the intervention in Jhang in coordination with the District Disaster Management Authority (DDMA), Department of Health (DoH), Rescue 1122 and local communities, which are usually the first responders. The pilot leveraged strong community networks, establishing four DRR village committees for women, four for adult men, and four for adolescents to sensitize constituents on birth preparedness, safe and skilled delivery, STIs, HIV, GBV, and disaster preparedness and mitigation. The committees comprised lady health volunteers (LHVs), lady health workers, midwives, school teachers, pregnant and lactating women, adolescent boys and girls, community elders, and religious leaders. Project officers, health promoters, and social mobilizers supported the committees.

> *It is important to integrate community participation efforts and work with trained youth volunteers, medics, and women's groups, as they are the agents of change.*
>
> Stakeholder working in Pakistan

A ToT on integrating SRH and GBV into EDRM-H was conducted to create a pool of 26 master trainers from DDMA, Rescue 1122, DoH, and the Social Welfare and Education Departments. The trainers then organized six community-based SRH and DRR trainings that employed participatory research approaches such as hazard profiling, transect walks, and historical mapping.[54]Participants were entrusted to develop two village preparedness plans that addressed the SRH needs of pregnant and lactating women and adolescents. The plans identified accessible and secure storehouses that are resilient to floods and earthquakes. Boats, tarpaulins, clean-delivery, dignity- and newborn kits have been stored at these locations for distribution in emergencies.

In addition to village mappings, youth committees have conducted blood-group listings of the entire Union Council to identify potential blood donors for pregnant women. They also received training to liaise with government health officials and to facilitate access by adolescent girls and pregnant women, in particular, to medical assistance. The committees have been provided with boats to reach rural health centers, as well as adapted IEC materials. Women's committees have documented expected delivery dates and evacuation plans for pregnant women. The youth and women's committees have further identified both structural and nonstructural improvements for inclusion in the district health department's contingency plans for the monsoon season, and

---

54 These are activities to map resources in the community and identify risks.

annual development plans.

Support has also been provided to aid referrals for pregnant women, so that they can access comprehensive EmOC. Traditional Birth Attendants (TBAs) have also been engaged to identify and support pregnant women in seeking antenatal care (ANC) services, as¬ male heads of households often prevent women from using health services due to cultural factors and distance. SRH services that are supported through the pilot include basic EmOC and newborn care at two health facilities, ANC, postnatal care (PNC), prevention and treatment of STIs, GBV, and family planning support (condoms, injectables, and pills).

Responding to new emergencies

As a result of the EDRM-H interventions in Jhang District, ANC visits have increased by 810 percent, while PNC and facility-based deliveries have increased by 195 and 246 percent, respectively. There is now an *average* of 810 ANC visits, 65 PNC visits, and 83 facility-based deliveries per month. The quality of facility-based care has improved with the distribution of medical and nonmedical equipment, including RH Kits 1-10, as well as clean-delivery, newborn, and dignity kits. Increased compli-ance towards institutional deliveries has also been observed, which is addressing the current average of 246 births per month that take place in the home.

Indicators	Target	Achieved
# women accessing basic SRH services	36,500	36,793
# men accessing basic SRH services	12,251	25,875
# pregnant women accessing basic EmOC and newborn care	6,920	9,550
# pregnant women referred for comprehensive EmOC and newborn care	217	484
# women attending awareness-raising session on SRH/DRR in the community	10,250	13,296
# men attending awareness-raising session on SRH/DRR in the community	2,561	5,616
# women attending awareness-raising sessions on SRH issues	2,263	3,370
# men attending awareness-raising sessions on SRH issues	682	963

What challenges did Pakistan face, and how did stakeholders overcome them?

Lack of awareness around SRH needs and priorities in emergencies: Policy makers and government staff were initially reluctant to institutionalize SRH into EDRM-H, considering it a non-issue. They were not aware that rape cases existed, and while they recognized the possibility of pregnancy complications, it was not a priority. SRH was therefore not well understood or seen as a priority in preparedness efforts.

- Led by NHEPRN, the RHWG, UNFPA, and R-FPAP played a pivotal role in sensitizing the government. The Pakistan NDMA sent a large contingent to the World Conference on Disaster Risk Reduction, which further helped to educate policy makers.

Lack of coordination among different departments and line ministries: Initially, departments and line ministries were not coordinating, especially between and across levels. In Jhang District, this included the DDMA, District Health Department, Rescue 1122, and the local communities.

- The founding of a functional RHWG improved coordination tremendously. At the district level, Muslim Aid also took a team approach, coordinating with various actors at the federal and district levels to ensure effective integration.

Pre-existing low quality services: The health infrastructure at the district level was poor, which stymied preparedness efforts; in particular, rural health centers did not have adequate human resources or supplies.

- To support rural health centers, UNFPA provided human resources (women medical officers, LHVs, midwives and pharmacists), lifesaving drugs, medicines, and equipment. Providers were also trained on clinical MISP services. The RHWG was formed to include a range of sectors and agencies, such as UNICEF and WFP, and was thus able to provide a complementary and more coordinated multi-sectoral response, including in rural areas.

Sensitivities around GBV/rape and limited GBV coordination and response: There was lack of coordination around GBV, with different agencies addressing discrete components of a multisectoral response. District-level staff were not trained in survivor-centered approaches or on how to maintain confidentiality. So-called women-friendly spaces were reportedly of low quality.

- GBV coordination improved with a dedicated platform and a multisectoral approach. Thanks to concerted advocacy and awareness campaigns, rape survivors can now seek medical care without a police form. Health services are currently being linked with shelter and legal services for survivors. In Jhang District, Muslim

Aid is using messaging that focuses on creating a "happy family" to facilitate discussion on GBV issues with communities.

Implementing the MISP in its entirety: HIV was a challenging topic due to low prevalence in Pakistan and public sensitivity on the topic. Prevention and response to sexual violence was not consistently implemented, including in Jhang District. Rural health facilities did not provide EmOC 24 hours, seven days a week, and the transition to comprehensive RH services also needed to be better addressed. Security was an additional challenge.

- LHVs are being trained on MISP priorities, and necessary commodities are being included in RH kits. SPRINT and R-FPAP are examining how best to use RH Kit 8 (management of miscarriage and complications of abortion) and building the capacity of providers in manual vacuum aspiration. As in Pakistan, abortion is conducted under "menstrual regulation"; efforts are underway to have this package accepted at the highest level.

Limited financial resources for joint implementation of action plans: While dialogue has been effective within the RHWG from its earliest days, financial constraints have raised challenges to the implementation of action plans. Some agencies, especially non-SRH agencies, report being limited in their ability to implement the MISP without dedicated funding.

Why was Pakistan successful?

- The **strong leadership of NHEPRN** cannot be understated in the development of facilitative policies and in **identifying appropriate policy makers for trainings on the MISP**. NHEPRN was from the beginning heavily invested, for example convening the RHWG for a post-IAWG meeting to discuss the annual work plan. Funded by UNFPA, NHEPRN's Director General was part of the Pakistan delegation at the World Conference on Disaster Risk Reduction, and advocated for inclusion of SRH in the *Sendai Framework for Action*. The Director General also traveled to Nepal to learn from Nepal's RH crisis response programming; as a result, there is now cross-country information-sharing around MISP implementation.

- The **long-time existence and leadership of R-FPAP, NHEPRN, UNFPA, Muslim Aid, and IMC** was instrumental in building capacity to institutionalize the MISP. R-FPAP already had strong relationships with the government, which helped provide leverage. It had considered sustainability for the long term, and involved its leadership and used evidence-based advocacy strategies to raise awareness and achieve buy-in. R-FPAP also engaged in regional and global advocacy, such as

through the World Conference on Disaster Risk Reduction.

- **Seeking collaboration across agencies and within the RHWG was a key to success.** During crisis responses, agencies collaborated well. However, preparedness efforts proved more challenging, as not all organizations had a mandate to intersect DRR with SRH. UNICEF was involved in the RHWG, since the well-being of mothers was linked to its DRR focus on children. The WFP became involved through its work in nutrition, especially for pregnant and lactating women. Like those two agencies, organizations came to participate in the RHWG based on linkages that reflect their respective domains of interest. The RHWG thus succeeded in enabling non-RH-focused agencies to become integral to the group.

- **UNFPA's strong commitment to building capacity to better respond to RH needs at the onset of an emergency.** UNFPA was a key advocate on MISP integration into the national-, provincial- and district-level health and disaster-management plans.

What were the critical lessons learned?

- **Linking the MISP to preparedness mechanisms at all levels, including provinces and districts, is critical, since this is a missing link.**

    It is important to link the MISP to preparedness mechanisms, since this is the missing link.

    Stakeholder working in Pakistan

- **Working with the government is crucial for the government to own EDRM-H and to impact decision-maker attitudes.** UN agencies can slip into working for, rather than with, the government. In Pakistan, much time is spent in planning processes to ensure NHEPRN's views are reflected in MISP trainings, which includes training and sensitization of government representatives, including the Army. The request for an EDRM-H intervention came from the district level itself.

- **Inter-agency planning at the same time as integrating EDRM-H into individual agency mandates is essential.** While joint work can begin at the policy and advocacy level, without organizational, political, and management commitment, implementing real change is challenging.

- **Integrating community participation and working with trained youth volunteers, medics, and women's groups are both critical,** as communities and such groups are agents of change. The role of law enforcement agencies must also be recognized, as they are among the first responders.

- **Establishing a continuous monitoring and evaluation system with regular follow-up is critical for effective preparedness and sustainability.**

What are next steps for Pakistan?

The RHWG will continue to implement its work plan. Activities include establishing other RHWGs at the provincial level, developing IEC videos, continuing to train providers and LHVs, prepositioning RH kits using other supply chains, engaging at the district level, and building the capacity of public and private sector actors.

Other activities to consider may include:

- **Further integrating the MISP into preparedness policies, guidelines and institutions,** including at the provincial and district levels, as well as within the Army and training institutions.

- **Holding trickle-down workshops for line departments at the district level helps forge partnerships between the provincial and district level.** So far, only two Union Councils have been engaged in Jhang District. In 2016, UNFPA, in collaboration with Muslim Aid, NHEPRN, and IMC, is planning to organize MISP trainings in Balochistan, Gilgit Baltistan, Azad Jammu and Kashmir.

- **Contextualizing the MISP manual to the Pakistan policy context,** particularly for health service providers, such as women medical officers, LHVs, midwives, and pharmacists.

- **Prioritizing GBV prevention and response,** which continues to be a weaker intervention among the MISP priorities, including further training in clinical management of rape survivors, service quality improvements, and the development of SOPs at the district level to improve referrals and clarify responsibilities.

- **Clarifying mechanisms around pre-positioning supplies to better manage information.**

- **Developing culturally sensitive IEC materials on newborn care, beyond those that are project-specific.** This is important to address on its own and in the context of maternal health and can further contribute to achieving consistency in quality of care. Updates and common guidelines around breastfeeding and other interventions can help agencies implement consistent standards.

- **Engaging communities and tying them to federal-, provincial- and district-level EDRM-H mechanisms to facilitate a bottom-up planning and implementation approach.**

Bringing the Learning Together

Each of these case studies offers early learning that can inform work moving forward. Respectively, they highlighted:

- The process of assessing MISP readiness in the EECA region facilitated **coordi-nation among diverse stakeholders** and identified gaps and recommendations for collective action, with **built-in accountability and experience-sharing oppor-tunities** across countries in the region.

- Persistent advocacy and a multisectoral approach in Macedonia led to **policy setting at the national level and forging of partnerships** to prepare for a more coordinated MISP response.

- Reflections from recent emergency responses within a pre-existing RH working group in Pakistan allowed for national and provincial level preparedness planning, as well as a **district-level pilot to develop and implement SRH preparedness plans with community involvement.**

Common challenges across case studies include:

- **Lack of awareness, sensitivities, and SOPs at the policy level around SRH needs and priorities in emergencies.**

- **Lack of coordination among relevant departments, line ministries, UN agen-cies, and implementing organizations** prior to coming together to address SRH as part of EDRM-H.

- **Weaknesses of existing primary health care systems**—including for GBV prevention and response, comprehensive EmOC services, HIV care and treatment, and STI services—characterized limitations in existing health preparedness and response plans. Weaknesses also existed around pre-existing human-resource capacity to implement MISP activities in rural areas, as well as logistics systems to support related service delivery.

- **Limited engagement of community members,** particularly of at-risk groups.

- **Limited financing for SRH preparedness,** especially for actual implementation of action plans.

Lessons learned/reflections

Despite various endeavors across countries, learning remains nascent on the topic

of health, and specifically SRH, inclusion within disaster risk-management systems. Interestingly, the entry points for addressing SRH in EDRM-H have proven somewhat different across case study settings. When the MISP readiness tool was applied In the EECA region, in addition to spurring action plans for MISP preparedness, the assessment process revealed **weaknesses in pre-existing health policy and infrastructure,** particularly around the ability to provide medical care to survivors of sexual violence, as well as full services for pregnancy complications and HIV. The exercise thus served as an opportunity for reflecting on and advocating for improvements to the existing health-management system. In Macedonia, the experience of a response to a previous emergency enabled the SRH working group to identify weaknesses in that response, to pre-position supplies and forge additional partnerships to strengthen preparedness moving forward. In Pakistan, which had experienced conflict and recurring natural disasters, policy-advocacy and capacity-building efforts at the national and provincial levels were accompanied by inputs at the district level, including strengthening the health system to address the quality of services provided in rural areas.

As all the case studies illustrate, **efforts to integrate SRH into EDRM-H appear to take a non-linear path, based on opportunities, honest reflection, and iterative processes.** Further, where response capacity is overwhelmed in spite of preparedness efforts, **adaptability and flexibility** become important ingredients for continuous improvement. The following are additional lessons learned around integrating SRH into EDRM-H. They reflect the importance of:

Advocacy

- **Building awareness and sensitivities around the importance of including SRH into EDRM-H** among both SRH and disaster management stakeholders at the policy level.

Coordination and partnerships

- Implementing **processes such as the MISP readiness tool** can help identify gaps in SRH preparedness, provide opportunities for action planning, designate roles and responsibilities, foster government buy-in, and create a forum for communication and coordination.

- Taking an **intersectoral, multisectoral, or team approach** to engage all relevant sectors and actors, including SRH actors, disaster management agencies, and other line ministries, UN agencies, NGOs, the Red Cross movement, and other civil society actors. **RH working group members should work together as part-**

ners for coordinated advocacy and leveraging of the influence of each to impact policy and drive action. They should also work *with* the government rather than *for* the government, and address the specific concerns the government may have regarding privileging rights-based approaches to driving policy change and action planning. The RH working group should have a **formalized ToR with realistic actions plans and achievable outcomes,** and anticipate the need for creative approaches, to overcome staff turnover and enhance accountability among stakeholders.

Capacity-building

- **Building capacity of critical stakeholders to implement the MISP in emergencies.** This includes at all levels, including at the community level, where communities themselves are the first responders.

Leadership

- **Ensuring strong and committed government leadership** for a coordinated response.

- **Including preparedness/EDRM-H in UNFPA's country office work plan** to facilitate the process of SRH integration at regional, national, and subnational levels.

- **Establishing strong coordination among national, subnational, and district efforts** to ensure subnational efforts are embedded within official EDRM-H systems, feedback mechanisms work across levels, and funding becomes available to support localized efforts.

Ownership

- Encouraging agencies to plan together but to **integrate EDRM-H into their own mandates** for meaningful implementation of action plans, especially in contexts where funds are scarce.

Inclusion of communities and at-risk groups

- **Ensuring community participation in RH working group meetings and cluster discussions,** as well as working with community stakeholders, such as health providers, youth groups, and women's groups, to safeguard their needs and include their voices.

Building resilient primary health care systems

- Building resilient primary health care systems that include all activities under the MISP. This would also address the need to **develop skilled human resource capacity**, particularly in rural areas, as well as **logistics systems** to ensure sufficient SRH commodities and supplies.

- Ensuring a **continuous monitoring and evaluation system** with regular follow-up to achieve sustainability of SRH integration into EDRM-H processes, and to evaluate SRH action responses against preparedness efforts.

Financing

- Financing for resilient health systems, inclusive of SRH. **Donors are responsible for ensuring sustainable SRH integration into EDRM-H efforts** through efforts to provide funding for the entire disaster management cycle. **Private sector partnerships** may offer additional options for sustainable investments.

Case-study for sustainability – Philippines

In the Philippines, advocacy is being undertaken to include the MISP in the DoH's Administrative Order. The Administrative Order became effective in January 2016 and integrates the MISP into the health emergency package. This will enable the government to attach a budget for MISP preparedness and implementation. Advocacy is also being undertaken to integrate the MISP into the Joint Memorandum Circular, applicable to the DoH, Department of Social Welfare and Development (which handles GBV), Office of Civil Defense and the Department of Interior and Local Government. The Office of Civil Defense is in charge of the overall National Disaster Risk Management plan, which currently only includes water, sanitation and hygiene (WASH), nutrition, and health. The Office of Civil Defense also provides technical assistance to local governments to formulate their DRR plans. Once the Joint Memorandum Circular is adopted, it can be used for capacity building and preparedness. Both of these endeavors will officially embed the MISP into government resource-allocation channels, offering opportunities for locally owned, more sustainable preparedness.

Way forward

During outbreaks of conflict and or occurrences of a natural disaster, communities are often first responders. EDRM-H activities must incorporate local/community-level actors and address localized risks. Such efforts require significant support from lead-

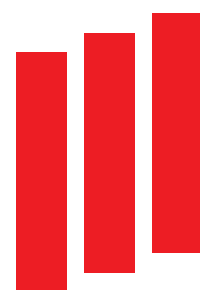ership at the local, subnational, and national levels.

Preparedness activities are more effective when community members and government bodies work together to identify and promulgate existing capacities to mitigate the risks and vulnerabilities inherent to an emergency. Community-driven action-plans can inform and complement government-focused activities, such as contingency planning, emergency preparedness, and resilience-building initiatives. The WRC/UNFPA pilot of a community-based gender, SRH, and DRR training curriculum, *Community Preparedness for Reproductive Health and Gender*, in the Philippines has yielded preliminary learning on the importance of a bottom-up approaches to complement policy-level and supply-side endeavors. For example, Zone One Tondo Organization, working in Barangays Daang Hari, Northbay Boulevard South, and Tangos of Navotas City, has reported dialogue around MISP priorities at the community level as mobilizing youth, facilitating inclusion of a gender perspective into response planning, and enhancing community unity. Such cohesion is critical to ensuring a successful community-based MISP response, when, again, women, men, and youth are the first responders.

More initiatives that **strengthen community capacity** are needed, as well as evidence and tools to support this focus. Evidence-based practices can prevent SRH from being sidelined in preparedness and empowerment activities at the community level, prompting optimal response when crises occur.

Informants and Stakeholders Consulted

Name	Title	Organization
EECA Region		
Dr. Behire Özek	Humanitarian Officer	UNFPA Turkey
Mr. Ezizgeldi Hellenov	Deputy Representative	UNFPA Yemen
Ms. Lena Luyckfasseel	Programme Director	IPPF European Network
Ms. Nesrine Talbi	Programme Advisor	IPPF European Network
Dr. Predrag Zivotic	Reproductive Health Programme Analyst	UNFPA Serbia
Dr. Sophie Pecourt	Independent consultant	IAWG EECA Region
Macedonia		
Ms. Afrodita Shalja-Plavjanska	SRH National Program Officer	UNFPA Macedonia
Dr. Bojan Jovanovski	Executive Director	Health Education and Research Association Macedonia
Dr. Mihail Kochubovski	Professor	Institute of Public Health of the Republic of Macedonia
Dr. Sophie Pecourt	Independent consultant	IAWG EECA Region
Pakistan		
Dr. Anjum Rizvi	Director, Program Management Division	Rahnuma Family Planning Association of Pakistan
Ms. Hira Hashmey	Humanitarian Analyst	UNFPA Pakistan
Dr. Ijaz Habib	Programme Officer	WFP Pakistan
Dr. Nashmia Mahmood	Health Officer	UNICEF Pakistan
Dr. Muhammad Afzal	Health and Nutrition Coordinator	Muslim Aid Pakistan
Dr. Muneer Ahmed Mangrio	Director General	National Health Emergency Preparedness and Response Network, Pakistan

Ms. Nabila Malick	Director Advocacy, Resource Mobilization and Donor Liaison	Rahnuma Family Planning Association of Pakistan
Mr. Rizwan Baig	Head of Humanitarian Affairs	Muslim Aid Pakistan
Mr. Stenley Hely Sajow	Humanitarian Response Coordinator	UNFPA Myanmar
Global/Other		
Ms. Florence Tayzon	Assistant Representative	UNFPA Philippines
Dr. Heather Papowitz	Senior Advisor, Health-Emergencies	UNICEF New York
Ms. Mollie Fair	Regional Humanitarian Response Coordinator	UNFPA Arab States Regional Office
Ms. Nimisha Goswami	Regional Manager, SPRINT Initiative, IPPF South Asia Region	
Mr. Ronnel Tupaz Villas	Humanitarian Coordinator	UNFPA Philippines
Dr. Sophie Pecourt	Independent consultant	IAWG EECA Region
Staff		Zone One Tondo Organization (ZOTO); Barangays Daang Hari, NBBS and Tangos of Navotas City, Philippines
Staff		UNFPA Philippines