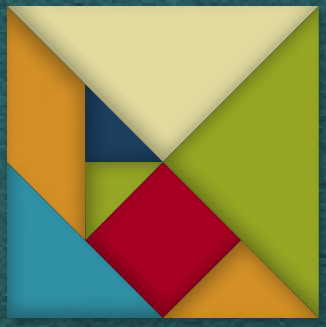
WOMEN'S REFUGEE COMMISSION

RESEARCH. RETHINK. RESOLVE.

Facilitator's Kit: Community Preparedness for SEXUAL and REPRODUCTIVE HEALTH and GENDER



3- to 4-Day
Training Curriculum

Acknowledgements
This curriculum has been made possible with UK aid from the UK government, as part of the ACCESS Consortium led by the International Planned Parenthood Federation (IPPF).

The pandemic preparedness module benefited from four co-creation workshops facilitated by The Open University and involving the Family Planning Association of Nepal (FPAN), IPPF, and the Women's Refugee Commission (WRC).

Women's Refugee Commission mission statement
The Women's Refugee Commission (WRC) is a U.S.-based research and advocacy organization. It improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. The WRC researches their needs, identifies solutions, and advocates for programs and policies to strengthen their resilience and drive change in humanitarian practice.

About the ACCESS Consortium
The Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights (ACCESS) Consortium aims to increase access to comprehensive sexual and reproductive health (SRH) for hard-to-reach populations, to ensure progress towards universal SRH and reproductive rights. The Consortium is examining scalable, evidence-based approaches to mobilize marginalized and under-served populations across the humanitarian-development contexts of Lebanon, Mozambique, Nepal, and Uganda.

Authors of the curriculum
This curriculum was developed by the Women's Refugee Commission, based on activities supported by and with original input from UNFPA/Philippines, Family Plannning Association of Pakistan/Rahnuma, and feedback from the ACCESS Consortium.

The views expressed do not necessarily reflect the UK government's official policies or those of all Consortium partners.

Dedication
This revised curriculum is dedicated to Jennifer Schlecht, the author of the original 2014 curriculum. We are grateful to you for using the curriculum to carry Jennifer's legacy forward.

Design & Production: Green Communication Design inc. www.greencom.ca

Women's Refugee Commission
15 West 37th Street, 9th Floor
New York, NY 10018
(212) 551 3115
info@wrcommission.org
womensrefugeecommission.org

ACCESS CONSORTIUM
Approaches in complex & challenging environments for sustainable SRHR

UKaid from the British people

IPPF · FRONTLINE AIDS · Internews · LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE · The Open University · WOMEN'S REFUGEE COMMISSION

Table of Contents

Introduction

Shifts in the Earth's climate are leading to increasingly frequent, severe, and large-scale natural disasters around the world, with significant impact on social, economic, and public health realities.[1] In March 2015, the *Sendai Framework for Disaster Risk Reduction 2015-2030*[2] was adopted by member states at the United Nations (UN) World Conference on Disaster Risk Reduction in Sendai, Japan. The framework calls for increased attention to resilience and identifies health as a critical aspect of strengthening individual and community resilience.

Purpose of the curriculum

The revised *Facilitator's Kit: Community-based Preparedness for Sexual and Reproductive Health and Gender* is a three-day training that aims to build capacity at the community level to prepare for and respond to risks and inequities faced by women, girls, and marginalized and underserved sub-populations in emergencies. There is an optional additional half-day module on pandemic/epidemic preparedness. It is intended for use by district health policymakers, disaster management agencies, and program managers that are responsible for preparedness and rebuilding more resilient communities after a crisis. The curriculum is also designed for health providers and representatives from civil society groups and networks (women's groups, organizations of persons with disabilities, and other organizations of persons from marginalized and underserved groups) with a health background.

Background on curriculum development

The original *Facilitator's Kit: Community-Based Preparedness for Sexual and Reproductive Health and Gender* was developed, adapted, and refined by the Women's Refugee Commission (WRC) in collaboration with the United Nations Population Fund (UNFPA) and local partners in the Philippines through eight trainings across five diverse settings in 2013. WRC has since piloted the tool in northern Iraq, Pakistan, and three additional sites in the Philippines. The 2020 update includes learning from these pilots, as well as feedback from the Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights (ACCESS) Consortium[3] members and staff from other Inter-Agency Working Group (IAWG) on Reproductive Health in Crises partners.

---

1 McMichael AJ, Woodruff RE, Hales S. Climate change and human health: present and future risks. *The Lancet*. 2006;367: 859-869.

2 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.

3 The Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights (ACCESS) Consortium aims to increase access to comprehensive sexual and reproductive health (SRH) for hard-to-reach populations, to ensure progress towards universal SRH and reproductive rights. Members of the ACCESS Consortium are International Planned Parenthood Foundation, Open University, London School of Hygiene and Tropical Medicine, Frontline AIDS, Internews, Women's Refugee Commission.

Background for the Facilitator

Scale of conflict and disasters

Emergencies and large-scale disasters have a significant impact on public health, health infrastructure, and the delivery of health care. The past decade has seen a substantial increase in the number of persons affected by man-made and natural disasters. The worldwide population of persons forcibly displaced by conflict, persecution, and violence stood at 70.8 million at the end of 2018.[4] Among them, 25.9 million were refugees, 41.3 million were internally displaced persons, and 3.5 million were asylum seekers. Natural disasters have also resulted in large-scale displacement: 17.2 million persons were newly displaced by natural disasters in 2018 alone.[5] Humanitarian crises continue to be protracted; at the beginning of 2019, 78 percent of all refugees were in situations lasting more than five years, a sharp rise from 66 percent in 2018.[6] Additionally, in 2020, the novel coronavirus 2019 (COVID-19) had global implications, resulting in massive worldwide deaths.[7]

There is growing recognition of the relationship between natural disasters or limited resources and cyclic conflict, and appreciation of the predictability of instability, conflict, or disaster.[8] In 2019, prior to the onset of the COVID-19 pandemic, The UN estimated that nearly 168 million people would need humanitarian assistance and protection in 2020.[9] This represents roughly 1 in 45 people globally, the highest number in decades. The impact of COVID-19 will be devastating, and further exacerbate the scale and severity of humanitarian need around the world. The situation will also likely continue to worsen unless climate change and the root causes of conflict are better addressed. Projections—also published prior to the COVID-19 pandemic—show that more than 200 million people could require assistance by 2022.[10]

Impact of disasters on women, children, adolescents, and other sub-groups

Emergencies have a disproportionate effect on the poorest and most vulnerable, particularly women, children, adolescents, persons with diverse sexual orientations and gender identities, and persons with disabilities, among others.[11] Women and girls face elevated rates of maternal death; sexual assault and other forms of sexual and gender-based violence; unintended pregnancy; unsafe abortions; and sexually transmitted infections (STIs), including HIV, in humanitarian settings. Moreover, these risks and violations are often compounded for persons who experience intersecting forms of marginalization.[12] [13]

---

4 UNHCR. Global Trends: Forced Displacement in 2018. June 2019. Available at: https://www.unhcr.org/globaltrends2018/.

5 IDMC. Global Report on Internal Displacement 2018. Available at: http://www.internal-displacement.org/global-report/grid2019/.

6 UN OCHA. *Global Humanitarian Overview 2020*. Dec 2019. https://www.unocha.org/sites/unocha/files/GHO-2020_v9.1.pdf.

7 Johns Hopkins University and Medicine, "Coronavirus Resource Center," March 24, 2020, https://coronavirus.jhu.edu/ map.html.

8 UN OCHA (2019). World Humanitarian Data and Trends (WHDT) 2018. http://interactive.unocha.org/publication/datatrends2018/.

9 UN OCHA. *Global Humanitarian Overview 2020*. Dec 2019. https://www.unocha.org/sites/unocha/files/GHO-2020_v9.1.pdf.

10 UN OCHA. *Global Humanitarian Overview 2020*. Dec 2019. https://www.unocha.org/sites/unocha/files/GHO-2020_v9.1.pdf.

11 EWEC (2018). *Deep Dive Report: Commitments in Support of Humanitarian and Fragile Settings 2015-2017*. https://www.everywomaneverychild.org/global-strategy/2018-commitments-to-ewec-global-strategy/

12 S. Barot (2017). *In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations*, Guttmacher Institute.

13 EWEC. Deep Dive Report: Commitments in Support of Humanitarian and Fragile Settings, 2015-2017.

Indeed, six of the ten countries with the highest estimated point maternal mortality ratios are considered at very high risk of crises.[14] Neonatal mortality rates are also highest in areas affected by humanitarian emergencies.[15] Emergencies linked to displacement, food insecurity, and poverty increase vulnerability to HIV and negatively affect the lives of those already living with HIV. Population pressures, combined with poorly planned urban and rural development and climate change, make communities more vulnerable to, and increase the risk of, emergencies and disasters.[16]

Gendered impacts of disasters

Gender differences in disasters have also been found to be closely linked to economic and social rights pre-crisis.[17] Gender may impact women's ability to access warning systems, or they may not be trained in survival skills.[18] Gender roles and household expectations may also prevent women from fleeing to safety if they feel the need to stay behind to look after the household, or feel uncomfortable leaving without a male escort.[19] Even outbreaks of disease such as COVID-19 have disproportionate effects on women and girls, including adverse effects on their education, food security and nutrition, health, livelihoods, and protection.[20] Against this backdrop, communities, especially marginalized groups, already have limited access to lifesaving sexual and reproductive health (SRH) services during and in the aftermath of a crisis.[21]

Health emergency and disaster risk management (HEDRM)

From 2005 to 2015, the United Nations Office for Disaster Risk Reduction (UNDRR) (formerly the UN International Strategy for Disaster Reduction or UNISDR) *Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters* guided global dialogue and encouraged international and national stakeholders to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies.[22] In March 2015, the

---

14 UNFPA, WHO, UNICEF, World Bank Group, and the UN Population Division (2019). *Trends in Maternal Mortality 2000-2017*. Available at https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf. (Countries with the highest point MMR include South Sudan (1150)**, Chad (1140)**, Sierra Leone (1120)*, Nigeria (917)**, CAR (829)**, Somalia (829)**, Mauritania (766)*, Guinea Bissau (667)*, Liberia (661)*, and Afghanistan (638)**.) **indicates very high risk and *indicates high risk according to the INFORM Risk Index 2017.

15 J.O. Lamet al., "Neonatal survival interventions in humanitarian emergencies: a survey of current practices and programs," *Conflict and Health* 2012, 6:2 doi:10.1186/1752-1505-6-2.

16 World Health Organization (2019), *Health and Emergency and Disaster Risk Framework*, Geneva.

17 E. Neumayer and t. 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. 2007. 97:3, 551-566, https://doi.org/10.1111/j.1467-8306.2007.00563.x.

18 Irene Dankelman et al., Gender, Climate Change and Human Security: Lessons from Bangladesh, Ghana and Senegal (Women's Environment and Development Organization, May 2008).

19 World Bank, "Gender, Disasters and Climate Change."

20 CARE, Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings (March 2019). https://www.care.org/sites/default/files/gendered_implications_of_covid-19_-_executive_summary.pdf?mc_cid=89788b752d&mc_eid=bd0dd79b25

21 S.E. Casey, "Evaluations of reproductive health programs in humanitarian settings: a systematic review," *Conflict and Health*. 2015, 9 (Suppl 1): S1.

22 United Nations International Strategy for Disaster Risk Reduction, Hyogo Framework for Action 20015-2015: Building the Resilience of Nations and Communities, March 2005, https://www.unisdr.org/2005/wcdr/intergover/official-doc/L-docs/Final-report-conference.pdf

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

> *"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 World Health Organization."*[23]

If a community is prepared to respond to health needs before an emergency occurs, through assessing disaster risks, vulnerability, capacity, exposure, hazard characteristics and their possible effects, and planning and acting accordingly, greater resilience is anticipated at the community level with fewer negative health consequences.[24] The *Sendai Framework* has defined four priorities to strengthening resilience, including understanding priority risks; strengthening emergency preparedness; investing in preparedness; and enhancing preparedness for effective response and to "Build Back Better."[25]

"Building back better" aims to ensure that recovery efforts in the aftermath of a crisis build resilience and reduce a community's vulnerability to future emergencies. Greater emphasis has also been placed on transitioning from acute emergency response to more comprehensive services, taking into account the World Health Organization's (WHO) health systems building blocks.[26] **Emergency preparedness and recovery are thus considered two entry points within the continuum of an emergency** that provide an opportunity to strengthen local capacity to prepare for future emergencies.[27]

Prepared health systems, based on strong primary health care at the sub-national, district, and community levels,:

- reduce the vulnerability of marginalized and underserved populations before an emergency occurs;
- build the capacity of communities to prevent, prepare, respond to, and recover from emergencies, thus protecting public health, health services, and infrastructure;
- provide the basis for scaling up measures to meet wide-ranging health needs in emergencies;
- prevent avoidable morbidity and mortality, particularly among women, children, and adolescents; and
- use the opportunities during recovery to strengthen services and reduce risk of future events.

---

23 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.

24 Ibid.

25 Ibid.

26 World Health Organization *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies* (Geneva. 2010). https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf.

27 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (New York. 2019).

Addressing SRH in emergencies: MISP for SRH

At any given time, roughly 25 percent of a population will be women of reproductive age and 4 percent will be pregnant.[28] In emergency situations where demands on health services are high and time and resources are limited, SRH services are prioritized on the basis of saving lives and optimizing scarce resources. Since 1997, the Minimum Initial Service Package (MISP) for SRH has been the standard of care for SRH interventions in humanitarian settings. The standard was updated in 2018 and encompasses the following objectives:[29]

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health systems building blocks.

The MISP for SRH also calls for safe abortion care to be available—to the full extent of the law—in health centers and hospitals.[30]

Integration of SRH into HEDRM at the policy level

The Sendai Framework was a landmark development for SRH, as it identified SRH as a critical aspect of health and individual and community resilience.[31] Priority 3 on investing in disaster risk reduction further calls for:

> *"Strengthen[ing] 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]

Many policy developments also reaffirm the need to address SRH in recovery and preparedness, and the humanitarian-development nexus. The outcome document from the Rio+20 UN Conference on Sustainable Development, *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health 2016-2030*, the Sustainable Development Goals, and the outcome document from the UN Conference on Population and Development, Cairo+25, all endorse universal access to SRH—including family planning and sexual health—as essential to development progress, resilience, and recovery, and state they should be integrated into national and local strategies and programs.[33] [34]

---

28 Ibid.
29 Ibid.
30 Ibid.
31 United Nations Office for Disaster Risk Reduction, Sendai Framework.
32 Ibid.
33 United Nations (2012), *The future we want: Outcome document adopted at Rio+20*, New York: Department of Public Information. Available at http://www.un.org/en/sustainablefuture/.
34 World Health Organization (2019), *Health and Emergency and Disaster Risk Framework*, Geneva.

Based on the *Sendai Framework* priorities, the WHO has further developed components and functions of HEDRM that also includes SRH.[35]

Efforts to integrate SRH into HEDRM at multiple levels

To date, numerous efforts have been undertaken at global, regional, district, and community levels to address SRH in preparedness efforts. An RH working group has been created within the UNISDR (now UN Office for DRR, UNDRR) Thematic Platform for Health, which has developed a policy brief,[36] fact sheet,[37] and tool[38] to guide SRH integration in HEDRM at the national level. The IAWG on RH in Crises' Eastern European and Central Asia region developed a "MISP Readiness Assessment tool" in 2013 to assess the extent to which countries within the region were ready to develop and implement an adequate SRH response in emergencies. The original *Facilitator's Kit: Community-Based Preparedness for Sexual and Reproductive Health and Gender* was developed to address SRH preparedness at the community level, given the role that the community plays in first response. IAWG member agencies and others are additionally examining SRH preparedness within their own organizations, especially around building organizational capacity. FP2020 also recently launched *Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health in Emergencies*.[39] For the latest information and to see how to link with ongoing initiatives at various levels, please consult the IAWG website.[40]

Good practices and lessons identified to integrate SRH into HEDRM at the community level

Global learning has shown that advocacy, coordination and partnerships, capacity-building, leadership, ownership, inclusion of community and marginalized and underserved groups, resilient primary health care systems, and financing appear to be critical for the successful integration of SRH into preparedness efforts.[41] Field experience has additionally shown that the transition from acute emergency response in the form of the MISP for SRH to more comprehensive SRH services requires vision, leadership, effective coordination, and a sound understanding of the local situation and opportunities for health systems strengthening.[42]

Learning has further shown that preparedness activities are more effective when community members and government bodies work together to identify and build on existing capacities to mitigate the risks and vulnerabilities inherent in an emergency. Community-driven action plans can inform and complement government-focused activities, such as contingency planning, emergency preparedness, and resilience-building.

---

35 World Health Organization (2019), *Health and Emergency and Disaster Risk Framework*, Geneva.

36 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.

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 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).

39 FP2020, *Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health in Emergencies* (2020) https://familyplanning2020.org/srh-toolkit

40 https://iawg.net/.

41 M. Tanabe, Building National Resilience for SRH: Learning from Current Experiences. New York: WRC, 2016.

42 S.E. Casey et al., Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies, *Confl Health*. 2015; 9: S3.

The leadership role of national and local authorities, communities, and individuals in ensuring access to MISP for SRH services should be recognized and supported from the development of policies to action planning. At the community level, it is important to:

- **Implement assessments of SRH risks, vulnerabilities, and capacities,** informed by poverty, gender, and disability analyses. SRH should be integrated into health risk and capacity assessments, and communities and marginalized and underserved groups should be included within those assessments.
- **Provide early warning** for communities through involving women and marginalized groups and ensuring that their needs are addressed and that systems are gender responsive.
- **Integrate SRH into health planning and coordination**. Mechanisms to elevate community concerns to sub-national and national levels should be identified, and an SRH working group should be activated with key actors in stable times.
- **Build knowledge and capacity of district and community actors on SRH preparedness, response, and recovery** through integrating SRH preparedness and response into professional training curricula for nurses, midwives, physicians, and other health providers. The local health work force and policymakers should also be trained in the components of the MISP, with SRH integrated into disaster response simulations and preparedness exercises.
- **Ensure that activities to support SRH preparedness activities are included within costed HEDRM plans** and that preparedness is part of all SRH systems strengthening efforts. Contingency funds should be available for SRH crisis response.
- **Create an environment of learning and awareness** through fostering a culture of improving community health, safety, and resilience.
- **Ensure the SRH health system and SRH commodity supply chains can withstand local hazards**. Steps should be taken to support resilience of facilities and outreach mechanisms created to provide MISP for SRH services. The flexibility and resilience of the SRH supply chain should be improved at health facilities and primary health care centers to address commodity risk management, supply pre-positioning or stockpiling, and plans for obtaining emergency SRH supplies.
- **Prepare existing SRH services to absorb impact, adapt, and respond to and recover from hazards**. Lifesaving SRH facility services (including post-exposure prophylaxis for HIV, safe blood supply, contraceptive commodities, and emergency obstetric and newborn care) and referral networks should be secured. Vehicles and protocols for referral of complications should be maintained, and clear policies and procedures developed for coordination across sectors, to ensure a comprehensive, well-coordinated SRH response.
- **Build knowledge and capacity of sub-national, district, and community actors on SRH preparedness** through identifying indicators for preparedness and documenting concrete examples and lessons learned.

Key Concepts and Definitions

The following key concepts are the foundation for this training. Trainers would benefit from familiarity with the following concepts and their application.

BUILD BACK BETTER:

The use of the recovery, rehabilitation, and reconstruction phases after a disaster to increase the resilience of communities through integrating disaster risk reduction measures into the restoration of physical infrastructure and societal systems, and into the revitalization of livelihoods, economies, and the environment. (UNDRR terminology, updated Feb 2017)

https://www.undrr.org/terminology

CONTINGENCY PLANNING:

A management process that analyses disaster risks and establishes arrangements in advance to enable timely, effective, and appropriate responses. Based on scenarios of possible emergency conditions or hazardous events, it allows key actors to envision, anticipate, and solve problems that can arise during disasters. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-c

DISASTER:

A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability, and capacity. These can lead to human, material, economic, and environmental losses and impacts. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-d

DISASTER RISK MANAGEMENT:

The application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-d

DISASTER RISK REDUCTION:

Aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and achievement of sustainable development.

Disaster risk reduction strategies and policies define goals and objectives across different timescales and with concrete targets, indicators, and timeframes. In line with the *Sendai Framework*, these should be aimed at preventing the creation of disaster risk, the reduction of existing risk, and the strengthening of economic, social, health, and environmental resilience. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-d

EARLY WARNING SYSTEM:

An integrated system of hazard monitoring, forecasting and prediction, disaster risk assessment, communication and preparedness activities systems, and processes that enables individuals, communities, governments, businesses, and others to take timely action to reduce disaster risks in advance of hazardous events. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-e

EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC):

The care required to manage obstetric emergencies. Signal functions for basic emergency obstetric and newborn care, provided in health centers, large or small, includes the capabilities for:

- Administration of parenteral antibiotics for treatment of sepsis.
- Administration of uterotonic drugs for treatment of postpartum hemorrhage.
- Administration of parenteral anticonvulsant drugs (i.e., magnesium sulfate) to manage severe preeclampsia and eclampsia.
- Manual removal of the placenta.
- Removal of retained products following miscarriage or abortion.
- Assisted vaginal delivery, preferably with vacuum extractor.
- Basic neonatal resuscitation with bag and mask.

Comprehensive emergency obstetric and newborn care, typically delivered in district hospitals, includes:

- All basic functions above.
- Caesarean section.
- Safe blood transfusion.

(*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#maternal-newborn

EPIDEMIC:

The occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy. (WHO, 2007)

https://www.who.int/hac/about/definitions/en/

ESSENTIAL NEWBORN CARE:

Newborn care is part of the continuum of care for mother and baby and includes thermal care; infection prevention/hygiene; feeding support; monitoring; and postnatal care checks. (*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#maternal-newborn

GENDER:

The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. (WHO)

http://www.who.int/gender/whatisgender/en/

GENDER-BASED VIOLENCE (GBV):

An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. The term "gender-based violence" is often used interchangeably with the term "violence against women." The nature and extent of specific types of GBV vary across cultures, countries and regions. GBV includes:

- Sexual violence, including sexual exploitation/abuse and forced prostitution.
- Domestic violence/intimate partner violence.
- Trafficking.
- Forced/early marriage.
- Harmful traditional practices such as female genital mutilation, honor killings, widow inheritance and others.

(IASC *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings*, 2018)

https://interagencystandingcommittee.org/system/files/legacy_files/guidelines_for_gender_based_violence_interventions_in_humanitarian_settings_english_.pdf

GENDER MAINSTREAMING:

Gender mainstreaming is a globally accepted strategy for promoting gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities, including policy development, research, advocacy/ dialogue, legislation, resource allocation, and planning, implementation and monitoring of programs and projects. (UN Women)

https://www.un.org/womenwatch/osagi/gendermainstreaming.htm

HAZARD:

A process, phenomenon, or human activity that may cause loss of life, injury, or other health impacts, property damage, social and economic disruption, or environmental degradation. Hazards may be single, sequential, or combined in their origin and effects. Each hazard is characterized by its location, intensity or magnitude, frequency, and probability. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-h

HEALTH SYSTEMS BUILDING BLOCKS:

The WHO has developed six "building blocks" for a health system that span service delivery, health workforce, information, medicines, financing, and governance. The building blocks are particularly pertinent to "build back better" in the transition from acute SRH response (MISP) to more comprehensive SRH services.

- **Service delivery:** Identify SRH needs in the community and identify suitable sites for SRH service delivery.
- **Health workforce:** Assess staff capacity, identify staffing needs and levels, and design and plan staff training.
- **Health information system:** SRH information in the health information system.
- **Medical commodities:** Identify SRH commodity needs and strengthen SRH commodity supply lines.
- **Financing:** Identify SRH financing possibilities.
- **Governance and leadership:** Review SRH-related laws, policies, protocols; coordinate with the Ministry of Health; and engage communities in accountability.

(*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

HYOGO FRAMEWORK FOR ACTION:

A comprehensive approach to reduce disaster risks, adopted in 2005, whose expected outcome was "The substantial reduction of disaster losses, in lives and the social, economic, and environmental assets of communities and countries." The *Sendai Framework for Disaster Risk Reduction 2015-2030* succeeded the Hyogo Framework in 2015. (UNDRR terminology)

https://www.unisdr.org/we/coordinate/hfa

INTER-AGENCY REPRODUCTIVE HEALTH KITS:

A set of 13 kits containing medicines and other commodities aimed at facilitating the implementation of priority SRH services of the MISP for SRH. The RH Kits complement the Inter-Agency Emergency Health Kit (IEHK), which is a standardized emergency health kit that also contains essential drugs, supplies, and equipment for the provision of primary health care services. (*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#supplies

INTER-AGENCY WORKING GROUP (IAWG) ON REPRODUCTIVE HEALTH IN CRISES:

A broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for persons affected by conflict and natural disaster. (IAWG on RH in Crises, 2018)

http://iawg.net/about-us/

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, INTERSEX, AND ASEXUAL (LGBTQIA) PEOPLE:

- **Lesbian:** A woman who is emotionally, romantically, or sexually attracted to other women.
- **Gay:** A person who is emotionally, romantically, or sexually attracted to members of the same gender.
- **Bisexual:** A person who is emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity, though not necessarily simultaneously, in the same way, or to the same degree.
- **Transgender:** An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
- **Queer:** A term often used to express fluid identities and orientations.
- **Questioning:** In addition to queer, many people include "questioning" in the LGBTQIA umbrella term. Questioning is a term often used to describe people who are in the process of exploring their sexual orientation or gender identity.
- **Intersex:** An umbrella term often used to describe a wide range of natural bodily variations. In some cases, these traits are visible at birth, and in others they are not apparent until puberty. Some chromosomal variations of this type may not be physically apparent at all.
- **Asexual:** The lack of a sexual attraction or desire for other people.

(Human Rights Campaign, cited in 2019 MISP Module)

https://www.hrc.org/resources/glossary-of-terms

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

A coordinated set of priority life-saving activities to be implemented at the onset of every crisis event. First developed in 1997 by UN agencies, governments and non-governmental organizations (NGOs), the standard is an essential element in an emergency response and its components are recognized in the Sphere Standards. The objectives of the MISP for SRH are:

- Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
- Prevent sexual violence and respond to the needs of survivors.
- Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
- Prevent excess maternal and newborn morbidity and mortality.
- Prevent unintended pregnancies.
- Plan for comprehensive SRH services, integrated into primary health care, as soon as possible.

The standard also recognizes that it is a priority to ensure safe abortion care to the full extent of the law, in health centers and hospital facilities. (*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#introduction

MITIGATION:

The lessening or minimizing of the adverse impacts of a hazardous event. Mitigation measures include engineering techniques and hazard-resistant construction, as well as improved environmental and social policies and public awareness. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-m

NATIONAL PLATFORM FOR DISASTER RISK REDUCTION:

National mechanisms for coordination and policy guidance on disaster risk reduction that are multisectoral and interdisciplinary, with public, private, and civil society participation involving all concerned entities within a country. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-n

PANDEMIC:

A pandemic is a global outbreak of disease. Pandemics happen when a new disease emerges to infect people and can spread between people sustainably. Because there is little to no pre-existing immunity against the new disease, it spreads worldwide. (CDC 2019)

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html#covid19-pandemic

PERSONS WITH DISABILITIES:

The Convention on the Rights of Persons with Disabilities defines "persons with disabilities" as those with "long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others." Persons with disabilities can include those in the community who have trouble: seeing, even if wearing glasses; hearing, even if using a hearing aid; walking or climbing steps; remembering or concentrating; caring for her or himself, such as washing all over or dressing; or understanding or being understood in their usual language. (Adapted from the *Washington Group on Disability's classification, 2009)*

http://www.cdc.gov/nchs/washington_group/wg_questions.htm.

POST-ABORTION CARE:

Treatment of hemorrhage or septic shock (immediate uterine evacuation via vacuum aspiration or misoprostol, sepsis treatment, referral for higher level care). (*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#other-priorities

PREPAREDNESS:

The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from the impacts of likely, imminent or current disasters.

Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as **contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises.** These must be supported by formal institutional, legal, and budgetary capacities. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-p

RECOVERY:

The restoring or improving of livelihoods and health, as well as economic, physical, social, cultural, and environmental assets, systems, and activities, of a disaster-affected community or society, aligning with the principles of sustainable development and "build back better," to avoid or reduce future disaster risk. (UNDRR terminology, updated Feb 2017)

https://www.unisdr.org/we/inform/terminology#letter-r

RESILIENCE:

The ability of a system, community, or society exposed to hazards to resist, absorb, accommodate, adapt to, transform, and recover from

the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management. (UNDRR terminology, updated Feb 2017)

Resilience means the ability to "spring back from" a shock. The resilience of a community in respect to potential hazard events is determined by the degree to which the community has the necessary resources and is capable of organizing itself both prior to and during times of need. (UNISDR terminology)

https://www.unisdr.org/we/inform/terminology#letter-r

SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW:

Provision of accurate information; explanation of any legal requirements, and where and how to obtain safe, legal abortion and their cost; provision of medication abortion (mifepristone/misoprostol or misoprostol-alone), vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by WHO; provision of post-abortion contraception; and provision of presumptive treatment for gonorrhea and chlamydia in settings with high STI prevalence. (*Inter-agency Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

https://iawgfieldmanual.com/manual/misp#other-priorities

SENDAI FRAMEWORK FOR DISASTER REDUCTION:

The *Sendai Framework for Disaster Risk Reduction 2015-2030* (Sendai Framework) is the first major agreement of the post-2015 development agenda, with seven targets and four priorities for action. It was endorsed by the UN General Assembly following the 2015 Third UN World Conference on Disaster Risk Reduction (WCDRR). It succeeds the Hyogo Framework for Action. (UNDRR)

https://www.unisdr.org/we/coordinate/sendai-framework

SEX:

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. (WHO)

http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

SEXUAL AND REPRODUCTIVE HEALTH:

A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. A positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. (Guttmacher–Lancet Commission, June 2018)

https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

SEXUAL HEALTH:

"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO)

http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

SEXUALITY:

"...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors." (WHO)

http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

SEXUALLY TRANSMITTED INFECTIONS (STIS):

Infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses, and parasites. The most common conditions they cause are gonorrhea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV) infection, and hepatitis B infection.

Several, in particular HIV and syphilis, can also be transmitted from mother to child during pregnancy and childbirth, and through blood products. (WHO)

http://www.who.int/topics/sexually_transmitted_infections/en/

SEXUAL VIOLENCE:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. (WHO *Report on Violence and Health)*

Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion. *(IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings)*

http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

UN OFFICE FOR DISASTER RISK REDUCTION (UNDRR):

UNDRR (formerly known as UNISDR) is the focal point of the UN system for disaster risk reduction and the custodian of the *Sendai Framework*, supporting countries and societies in its implementation, monitoring, and review of progress. (UNDRR)

https://www.unisdr.org/

VOLUNTARY CONTRACEPTION:

Contraception prevents pregnancy by interfering with ovulation, fertilization, and/or implantation. Family planning refers to the comprehensive range of practices that allow individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. The use of contraception should be on a strictly voluntary basis. (WHO)

https://www.who.int/en/news-room/fact-sheets/detail/family-planning-contraception

How to Use This Facilitator's Guide

This curriculum is designed to be participatory, adaptable, and flexible to address the needs and interests of training participants and the context. A suggested agenda and set of activities are provided in this kit. However, facilitators and trainers are encouraged to use supplemental tools, materials, and resources to craft a context-specific and individualized training to achieve a community's goals. In the curriculum's online version, supplemental materials are linked throughout. In the curriculum's print version, supplemental materials are noted through links within the text, and also in the appendix at the end.

THE FACILITATOR'S GUIDE IS DIVIDED INTO THE FOLLOWING KEY SECTIONS:

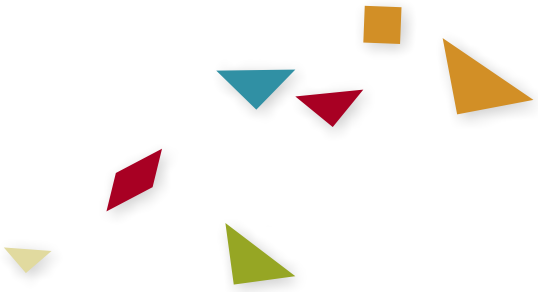
1. **Assessing the Community** includes tools to examine the community's capacities, needs, and gaps to inform the training.
2. **Training Preparation** includes a facilitator's agenda, preparation guides, and suggestions regarding mobilization and partnerships prior to the training.
3. **Curriculum** presents a three-day curriculum divided into key learning modules. Each module lays out individual learning objectives, materials, time, activities, presentations, and audio-visual elements that are recommended to achieve the specified objectives. Modules are laid out in a sequence that, through piloting, demonstrated success in achieving the overall goals of the training. However, facilitators may need to shift or adjust some elements in order to accommodate the needs of various training groups.

a. ▶ Day 1 **Introducing Localized Risks:** The first day of the training is composed of five modules. This day provides an introduction to local risks, discusses the importance of disaster risk reduction at the community level, reviews the local disaster management framework, introduces SRH and gender considerations in disasters, and examines resilience in the context of the health systems building blocks.

b. ▶ Day 2 **Understanding Sexual and Reproductive Health in Emergencies:** The second day of training is composed of six modules. It provides details of the Minimal Initial Service Package (MISP) for SRH, as well as critical gender issues that should be considered during an emergency.

c. ▶ Day 3 **From Knowledge to Action:** The third day of training is composed of three modules. It provides an opportunity to apply knowledge gained through examining household and community preparedness. Participants will then develop an action plan to improve their community's preparedness and response to SRH needs in emergencies.

d. ▶ Day 4 **Preparing for a pandemic/epidemic:** There is an optional additional half-day module on pandemic/epidemic preparedness.



4. **Handouts:** Materials located in this section of the facilitator's guide are meant to be photocopied or printed, and made available to each participant. Such materials can be provided to participants through a training folder at the beginning of the training (recommended), or a facilitator can hand them out as needed. Developers of this facilitator's guide have attempted to place handouts in an order that corresponds to the daily training curriculum.

5. **Appendix**: The appendix provides additional materials for the facilitator that might make the implementation of the curriculum easier. For example, the appendix includes materials for community mobilization, sign-in sheets for the training, and an answer key to the pre- and post-tests.

ICON GUIDE


HYPERLINK


GOAL/
OBJECTIVES


TIME/
DURATION


SUPPLIES


ACTIVITY


PRESENTATION/
POWER POINT


PRESENTATION/
VIDEO

Laying the Groundwork

Ensuring success of community-based trainings

Disaster risk reduction (DRR) activities are ideally focused at the local/community level and address localized risks. Yet, such efforts require significant support from leadership at the local, regional, and national levels. Preparedness activities are more effective when community members and government bodies work together to mitigate the risks and vulnerabilities to an emergency. At the end of this three-day training, community members produce action plans that should then be discussed with local government offices. Community-driven action plans can inform and complement government-focused activities, such as contingency planning, emergency preparedness, and resilience-building initiatives.

In order for a community model to be successful, local government offices—especially those responsible for disaster risk management for health—are critical partners from the start. Government staff should be included in trainings on SRH and DRR or, at a minimum, introduced to the MISP for SRH and *Guidelines for Gender-Based Violence in Humanitarian Settings*.

https://iawg.net/search?q=MISP

https://interagencystandingcommittee.org/gender-and-humanitarian-action-0/documents-public/iasc-guidelines-gender-based-violence-5

Before undertaking trainings at the community level, trainers should meet with the mayor, provincial and/or municipal disaster risk management officers, and local government officials in order to convey planned activities and let them know the support that is expected of them. A printable document is available in the Appendix, which can be given to local government officials in order to outline the training objectives and lay out responsibilities and expectations. The following criteria were found, within the pilot project, to assist in the success of trainings at the community level.

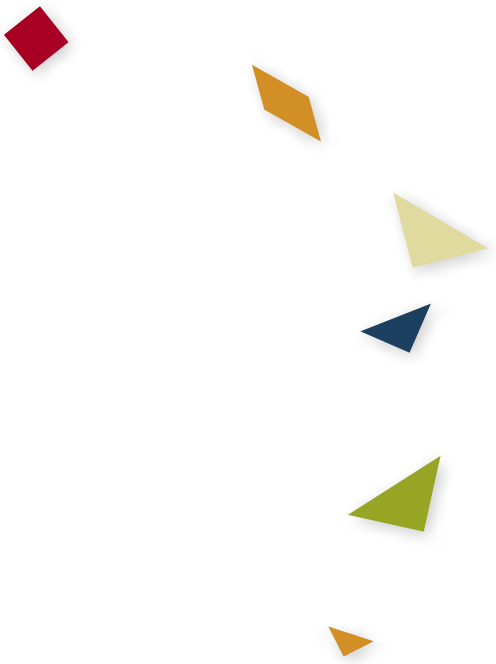
COMMUNITIES SHOULD BE SELECTED BASED ON THE FOLLOWING CRITERIA:

1. The community frequently faces high-risk emergencies leading to displacement.
2. Local government offices, and specifically the mayor or equivalent of the proposed community, are supportive of gender mainstreaming and women's health issues.
3. The following members are available for capacity building over the course of the project:
   a. Mayor or equivalent
   b. At least two (2) representatives from the local disaster risk management agency
   c. Leaders of that community
   d. Four (4) to five (5) representatives—preferably with a health background—from community-based organizations, including women's groups, organizations of persons with disabilities, and other groups representing marginalized and underserved populations
   e. At least two community health workers.

4. Community groups/civil society organizations/women's groups that work with marginalized and underserved members of the community.
5. The local government is familiar with the MISP for SRH and supports its implementation as part of an emergency response.
6. Other considerations:
   - An appropriate facility in which to hold the training can be identified near the selected community
   - DRR trainings have already been conducted in the area (preferred).

THE LOCAL GOVERNMENT (INCLUSIVE OF MEMBERS IDENTIFIED ABOVE) WILL IDEALLY COMMIT TO THE FOLLOWING:

1. Strengthen, as needed, knowledge with regard to:
   a. DRR
   b. Community-based disaster risk management
   c. Coordination during emergency response
2. Attend gender mainstreaming and MISP for SRH trainings as available.
3. Attend specific planning elements during Day 3 of training.
4. Ensure that preparedness activities within the developed actions plans are systematically funded through the appropriate budgetary allocations.



Assessing Community Capacity and Needs

Before the training, it will be helpful to map the community as much as possible, so that everyone has an accurate assessment of capacities and gaps in the community for action planning purposes. We have created a package of **community capacity and needs assessment** tools for four levels of stakeholders in the community: 1) policymakers; 2) health providers; 3) community health workers; and 4) community members. The assessment tools are designed to guide your efforts and make the process as inclusive as possible; if community capacity and gaps around SRH have recently been identified through other processes, then you can be selective as to which activities you undertake prior to the workshop. Please review the table below—especially the Domains assessed column—to see if any major gaps exist around the information you already have from the community, so that you can plan accordingly.

Application of the **community capacity and needs assessment** tools will enable you to:

- map the district's existing disaster management framework and links to national and sub-national systems;
- understand health facility capacity to implement the MISP for SRH in emergencies;
- explore the community's definitions and understanding of resilience, and the end points of recovery or "building back better";
- identify existing community capacities to respond to crises, what capacities need strengthening, and the community's recommendations to achieve them;
- identify vulnerabilities and risks in the community that may have less capacity to absorb shocks, including specific sub-populations or societal infrastructure; and
- identify priorities for preparedness or "building back better".

All of these findings should feed into the three-day workshop and development of action plans. Details around what will be assessed for each of the four stakeholder groups are noted in the table below. Please refer to the annexed tools for instructions on how to implement each tool.

TARGET GROUP	DOMAINS ASSESSED	TOOLS	TIME	SUGGESTED # BEFORE WORKSHOP
I. Policymaker • District disaster management staff • Mayor or other government representatives • Chief medical officer	• National, sub-national, and district disaster management framework • Level of SRH preparedness at the district level per the *Sendai Framework*'s four priorities • District capacity to respond to SRH needs in emergencies, as well as barriers and gaps • Protection of marginalized and underserved groups and community inclusion in preparedness planning, and response	Interview guide	1-1.5 hour/ interview	At least 1 interview
II. Health provider • Health facility manager • Physician, nurse, midwife, and other clinical staff	• Level of SRH preparedness at the facility level per the *Sendai Framework*'s four priorities • Health facility and provider capacity to implement the MISP for SRH in emergencies • Current availability of SRH services for the MISP for SRH	Interview guide	1-1.5 hour/ interview	
		Facility assessment tool (+ data entry spreadsheet)	1 day/ assessment	1 hospital and 5 health facilities per 500,000 population
III. Community health worker • Community health worker, community outreach workers, peer educators, and other community resource persons	• Community capacity to implement the MISP for SRH in emergencies • SRH risks, vulnerabilities, protective strategies, coping capacities, and resources in the community	Focus group discussion (FGD) guide	1.5-2 hours/ FGD	At least 1 per sub-group

TARGET GROUP	DOMAINS ASSESSED	TOOLS	TIME	SUGGESTED # BEFORE WORKSHOP
IV. Community member • **Community leader** • **Representatives from civil society groups and networks,** including women's groups, youth/ adolescent groups, organizations of persons with disabilities, LGBTQIA groups, organizations of persons who engage in sex work, organizations representing other minority groups, etc. • Teachers, law enforcement, first responders, social service workers, etc.	• SRH risks, vulnerabilities, protective strategies, coping capacities, and resources in the community • Gender and other norms that perpetuate violence, vulnerability, and inequality • Definitions of resilience and end points of recovery or "building back better"	Interview guide	1-1.5 hour/ interview	At least 3 interviews
• **Members of the community,** including women, adolescent girls, persons with disabilities, LGBTQIA persons, persons engaged in sex work, other minority members		FGD guide	2-2.5 hours/ FGD	At least 1 per sub-group

While each tool includes suggested instructions on how to identify respondents and participants, as well as how to conduct the activity, some tips are also noted below. For all activities, make sure you have addressed the following before proceeding:

- Obtain any necessary permissions from the community. This may be through meeting with community leaders and/or local government representatives to explain the purpose of the activities.
- Review procedures for consent and assent, and what is needed to obtain consent and assent in the local context and with communities (e.g. consent and assent procedures may differ when working with adolescents or persons with disabilities).
- Review tools for appropriateness, especially if they have been translated. If time allows, it may be beneficial to pre-test the translated tools among persons similar to potential respondents and translate responses back into English to determine the appropriateness of the translation, including questions and wording.
- Discuss ways to maximize participation, including with persons with disabilities, and implement any accommodations they may request.
- Determine roles for facilitators, notetakers, and interpreters, and ensure all team members are trained adequately.
- Consider whether potential workshop participants may be involved as facilitators, notetakers, or interpreters. While this may add bias if not all respondents feel comfortable sharing their opinions due to potential power dynamics, it may help gain buy-in and commitment from community stakeholders to realize the action plan, if they are more involved in processes from the beginning.
- Find a private location for interviews and focus group discussions—such as a central office—that is convenient, comfortable, and accessible for all participants, including those with disabilities.
- Identify a referral pathway for health/psychosocial/protection concerns that may be raised by participants.
- Identify appropriate local contacts for any complaints, concerns, or follow-up.
- Identify a means of sharing findings with participants and the community.
- Identify a secure means of storing information for any data that you collect.

NOTE ON WORKING WITH INTERPRETERS

If you need to work with an interpreter, try to find an objective interpreter with prior experience in qualitative methods of data collection. The nationality, ideology, ethnicity, and gender of the interpreter should be considered, as well as any other characteristics that may make participants uncomfortable or affect their participation in any way. It would be helpful to work with the interpreter in advance to review the questions in the relevant tools. It is also important to review protocols and ethical guidelines with the interpreter so that they are familiar with protocols and how to uphold a safe environment.

With interviews and focus group discussions, there is a choice between translator facilitation and translated facilitation. Translator facilitation is when trained interpreter(s) facilitate the activity in the participants' language with no interrupted interpretation. Translated facilitation is when the interpreter interprets what the facilitator and participants say, at each interval.

Translator facilitation would require more time for training the interpreter(s) to ensure they are appropriately trained to facilitate the interview or

focus group discussion on their own, although it would cut implementation time during the actual activity. A longer debriefing session may also be needed, which may not always be feasible. However, training local partners in facilitation skills may encourage their professional development and ownership of the process, and enable them to implement similar activities in the future and for monitoring and evaluation purposes.

Translated facilitation is more feasible in assessments with limited time, although each session would require more time for interpretation, with interruptions to discussion. It is important to note that the quality of data may be affected with either method. For more information on how to implement each method and the pros/cons, please see: Gisele Maynard-Tucker, "Conducting Focus Groups in Developing Countries: Skill Training for Local Bilingual Facilitators," *Qualitative Health Research,* Vol. 10 No. 3, May 2000, 396-410.[43]

1. Interviews

Interview guides have been developed for policymakers, health facility staff, and representatives of community-based organizations (see table above).

SELECTING PARTICIPANTS

The interview tool is intended for use among those who can speak to district or community capacity to prepare for and respond to SRH needs in emergencies. Policymakers should be versed in the health system, relevant health policy, budgets, and district preparedness, while health facility staff should be able to speak to facility-level preparedness efforts.

Representatives from community-based organizations may not be as familiar with government policies; however, they should have a good understanding of need and current SRH preparedness and response capacities as it pertains to their roles and expertise.

CONDUCTING THE INTERVIEWS

Each interview is intended to last 1-1.5 hours. Informed consent should be obtained from all participants prior to beginning the interview. Privacy should also be ensured, including the selected venue. Please see the interview tool for more information.

Since the interviews should inform the training workshop, the facilitator should focus on writing key phrases and points. There is no need to audio-record the interviews.

DATA ANALYSIS TIPS

A major focus of the interviews is to solicit stakeholder feedback around resources, capacities, and gaps to respond to SRH needs in emergencies that can be used to inform and shape the training. Analysis does not need to be formal or detailed, but conducted in a manner where key information, including common trends and positive or negative anomalies, that support this goal can be identified.

WHAT TO PULL FROM THE FINDINGS

The facilitator should pull out findings around existing resources, capacities, needs, gaps, and barriers that respondents raise around preparing for and responding to SRH needs in emergencies, as well as risks and vulnerabilities that they observe in their district/community. Gaps as they pertain to the MISP objectives/services and SRH preparedness are particularly important to identify, as action planning can focus on these areas. The facilitator can write findings on meta cards (index cards, or equivalent) for participants to prioritize gaps and actions during the action planning process.

[43] Note that this article is behind a paywall in an academic journal.

In Module 1.3 on the "Disaster Management Framework" (Day 1), participants will be introduced to the national, sub-national, and local disaster management framework. The facilitator can present the structure as obtained from the policymaker interview (Q4a-c) to participants directly. Please see Module 1.3 for the template to which responses can be entered/written.

Module 1.5 on "Understanding Resilience within the Health Systems Building Blocks" (Day 1) includes a presentation on the district's current level of emergency preparedness overall and for SRH specifically, based on the Sendai Framework priorities for DRR. This information can be obtained from the policymaker interview (Q10-11) and presented in the form of a table in Module 1.5.

2. Facility assessments

The aim of the facility assessments is to understand the availability and functioning of SRH services, to identify gaps that should be prioritized for preparedness efforts. Availability is defined as services available in the past three months.

SELECTING THE FACILITIES TO ASSESS

At least one tertiary care facility (hospital, if available) should be assessed, as well as health centers and health posts that serve the communities. Since the assessment is intended to generate a snapshot of service availability, it is not necessary to survey all health facilities in the district, unless the team feels this is necessary, useful, and feasible.

CONDUCTING THE ASSESSMENT

The facility assessment tool has been adapted from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises' 2012-2014 global evaluation of SRH services, with updates incorporated from the 2018 IAWG on RH in Crises' *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. The tool is a structured interview and observation guide to be used with the health facility manager or equivalent representative. Some questions overlap with the interview tool; if the same respondent is answering both, please refer to the instructions on both guides around which questions to ask or omit.

DATA ANALYSIS TIPS

Once the data are collected, the facilitator can enter them into the accompanying Excel data entry spreadsheet. The data only need to be inputted into the "Data entry" tab. Each health center will have its own column for data entry. The rest of the tabs will auto-populate once the raw data are entered. If more than five facilities are assessed, you can add additional columns to the spreadsheet, but make sure the formulas cover the added column(s). If you are unfamiliar with Microsoft Excel, several tutorials are available online.

WHAT TO PULL FROM THE FINDINGS

Since the focus of this exercise is to inform the workshop, the facilitators should review the auto-populated summary tables to see what can be pulled out and shared with participants for subsequent action planning. Critical areas to review are **availability and functioning of services** that are common to both the MISP standard and comprehensive SRH, since those services

should be available regardless of setting. The "MISP only" services should be available in an acute response, while more comprehensive SRH services should be available in chronic settings, or as acute emergency response is transitioned to more comprehensive services.

On the third day of the workshop, participants will translate their knowledge into action through addressing preparedness and action planning. As part of Activity 1B of Module 3.2 (Day 3), participants will identify the social assets and human resources that can help address SRH and gender protection in their community. The table includes demographics, some of which can be pulled from the facility assessment results. See Module 3.2 for the relevant table.

In Module 3.3 on "Action Planning" (Day 3), participants will be asked to develop an action plan based on the MISP objectives and activities. The template uses the *Inter-Agency Field Manual on Reproductive Health in Crises*' MISP checklist. The facility assessment results can feed directly into the "Baseline" column of the action plan. A service can be said to be available ("Yes") if all assessed sites offered it over the past three months (at the appropriate level). A service is not available ("No") if only some of the assessed sites have offered it over the past three months. See Module 3.3 for the action plan table; the facilitator can complete the relevant columns in advance of the workshop to focus the discussions around addressing gaps.

3. Focus Group Discussions

The focus group discussion (FGD) tool is designed to solicit feedback from the community health workforce and members of the community, particularly sub-groups who may be marginalized or underserved.

SELECTING PARTICIPANTS

It is important to ensure representation of marginalized and underserved groups, as vulnerability and risk factors, as well as access to services in prior emergencies, are critical areas explored by the tools. Each group should be convened based on similar characteristics of participants, so that they can feel comfortable sharing related experiences. Participants should be grouped by age (adolescents and adults), membership in a societal group (persons with disabilities, LGBTQIA persons, persons engaged in sex work, persons from minority groups, or other), or marital status (unmarried, married). Groups should be convened in a manner that minimizes discrimination. While it may not be necessary or feasible to convene individual groups for every characteristic, segmentation should be based on pre-existing societal vulnerabilities, as well as who typically is not reached in community consultations. It is unnecessary for potential participants to "prove" membership in a specific group (such as disability or sexual orientation) for them to participate in a group.

Before mobilizing participants, it may be helpful to meet with community leaders and/or local government representatives to explain the purpose of the activities. Where possible, link with a range of local women's leaders—formal and informal—and representatives from community networks of marginalized and underserved groups. Community-based organization leaders may be involved in one group, but should not be present in other groups to ensure that participants can speak openly. Scripts for participant recruitment are included in the tools.

If parental consent is necessary for adolescents, please follow local guidelines on age of majority. Scripts are provided for parental consent. Scripts are also included to assess the degree that potential participants understand the purpose of the FGD, where consenting capacity may be questionable.

CONDUCTING THE DISCUSSIONS

The FGD tool is intended for use in small group discussions of four to 10 participants, with an estimated time of one-and-a-half to two hours. There should be one facilitator and at least one notetaker, as well as an interpreter (including sign) as needed. Those running the FGDs should have prior experience facilitating FGDs, in order to reduce any stigma against diverse participants. For groups where persons with disabilities will be present, consult with them in advance so you can provide any helpful accommodations. Often, the most requested accommodation is transport to/from the venue (physical or funding), sign interpretation if working with those who sign, or accessible restrooms for persons with certain mobility impairments.

Informed consent should be sought from all participants prior to beginning each FGD. Questions should focus on soliciting collective experiences to prevent disclosure of private information. Please see the FGD tools for more information.

The facilitator should be particularly careful to give opportunities to all participants to voice their opinions as they feel comfortable, especially those who may have never been consulted due to their disability status or standing in society. Engaging a trained facilitator with a disability, for example, may also offer opportunities for their professional growth and empowerment, as well as create a conducive environment for other participants with disabilities to openly share their thoughts.

Since the FGDs should inform the workshop, the notetaker should focus on documenting key points and phrases if it is not possible to record the discussion verbatim. There is no need to audio-record the discussion for subsequent transcription, since the analysis is not intended to be as thorough as if the FGDs were conducted for research purposes.

A security mapping exercise is included as a participatory exercise. While instructions are listed in the FGD tool, the facilitator is encouraged to provide as much support to participants as needed. Further, if a systematic walk through the community with community members (transect walk) of the district is feasible, this may be another participatory means of identifying potential hazards or risks in the community. Any hazards or risks identified during a transect walk can be added to the maps.

TIPS ON ANALYSIS

The key focus of the FGDs is to solicit community feedback that can be introduced into the workshop. Analysis does not need to be formal or detailed, but conducted in a manner in which common trends and anomalies can be identified.

WHAT TO PULL FROM THE FINDINGS

The facilitator should focus on examining access to services for different populations in past emergencies per SRH theme, community coping capacities, as well as suggestions from the community around engaging them in preparedness efforts and recommendations for improvement. The facilitator can write findings and quotes on meta cards for participants to prioritize gaps and actions during the action planning process.

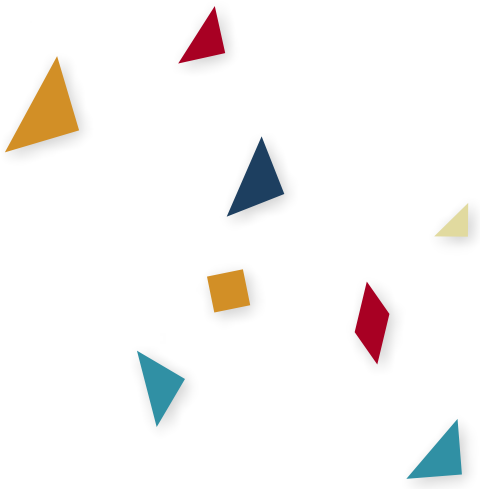
In Module 1.5 “Understanding Resilience within the Health Systems Building Blocks” (Day 1), concepts of resilience are addressed. The facilitator can pull out key quotes around how the community and community health workforce define resilience. Quotes can be written on meta cards, and the facilitator can read from them during this session of the workshop. Please see Module 1.5 for more details.

Day 2 is further spent discussing SRH topics and the priorities of the MISP standard. It may be helpful to pull out a few quotes or key

findings that pertain to risky behaviors (e.g., what women do if they are pregnant but do not want to be, and cannot access safe and legal abortion at a health facility) or barriers/challenges that prevent access to care. These can be mentioned as relevant, so that participants can keep issues in mind as they action plan on Day 3.

In Module 3.2 "Community Preparedness" (Day 3), participants explore social assets and human resources in the community that can address SRH and gender protection in emergencies. The FGDs for community health resource persons include activities that map the types of SRH services each cadre can provide, based on policy restrictions. This information can be pulled into the social assets and human resources table (Health Workforce section) in Module 3.2.

The facilitator should safely store the security maps to be introduced during Module 3.2 (Day 3) when participants will also map physical resources and capacities, and identify gaps.



Training Overview

TITLE:

Community Preparedness for Sexual and Reproductive Health and Gender

LENGTH:

This 3-4 day training is divided into 14 modules. Depending on the knowledge base of participants, facilitators can select specific modules and customize the training to each group and timeframe available. There is also an optional module on planning for a pandemic.

PARTICIPANTS:

Policymakers responsible for disaster risk management for health, including SRH; health providers; community leaders; and representatives with a health background from community-based organizations serving marginalized and underserved groups.

PURPOSE:

To build community capacity to prepare for and respond to risks and inequities faced by women, girls, and other marginalized and underserved populations in emergencies.

OBJECTIVES:

At the end of the training, each participant will be able to:

1. Identify risks faced by women, girls, and other marginalized and underserved groups during an emergency (with a specific focus on SRH and gender), as well as their coping capacities.
2. Provide a description of the MISP for SRH, inclusive of:
   a. its importance;
   b. the priority actions included within; and
   c. the key actions that could be taken to improve MISP preparedness.
3. Apply knowledge of SRH and gender risks to existing hazard and risk maps.
4. Identify community-level capacities and gaps for gender and SRH preparedness and response.
5. Discuss community-level actions that could be taken to improve preparedness and enhance participation of marginalized and underserved groups (adolescents, persons with disabilities, LBGTQIA persons, ethnic and religious minorities, and other sub-populations).
6. Develop community-level action plans that respond to identified gaps and needs related to SRH and gender, and that leverage existing resources and capacities, with accountability mechanisms that ensure a more robust gender and SRH response.

Facilitator's Agenda Day 1:

To engage participants as local experts, and introduce concepts of preparedness and risk.

ITEM	COMPONENT(S)	OBJECTIVES
Training set-up (1 hour)	• Training site set-up • Welcome and participant registration	
Introduction and Housekeeping (1 hour)	• Training pre-test • Activity: Icebreaker: Ball toss name game • Ground rules and expectations • Presentation: *Training Overview*	• To create a conducive and cohesive learning environment to learn about building community capacity to prepare for and respond to SRH needs and gender protection in emergencies.
MODULE 1.1: Local Risks and Experiences (30 minutes)	• Activity: Disaster Timeline	• To identify natural and manmade disasters that affect the community. • To brainstorm the impact of disasters on the community.
MODULE 1.2: Community-Based Disaster Risk Reduction (1 hour)	• Presentation: *Involving Communities in Disaster Risk Reduction and Preparedness* • Activity: *Island Expansion*	• To increase understanding and knowledge about DRR, and the importance of community involvement in these efforts. • To review the disproportionate impact of disasters on women/girls and marginalized and underserved populations.
MODULE 1.3: Disaster Management Framework (30 minutes)	• Presentation or alternative activity: Local disaster risk management framework	• To explore the disaster risk management infrastructure at the national, sub-national, and community levels, and examine where participants fit in the system.
MODULE 1.4: Sexual and Reproductive Health Priorities in Emergencies (1.5 hours)	• Activity: SRH case study • Presentation: *Priorities for SRH and Gender in Emergencies*	• To understand the importance of prioritizing SRH and protection during preparedness and response activities. • To provide an overview of the MISP for SRH as a priority intervention in emergencies.
MODULE 1.5: Understanding resilience within the health systems building blocks (1 hour)	• Presentation: *Understanding Resilience within the Health Systems Building Blocks* • Discussion: Preparedness and community resilience	• To understand resilience within the context of the Health Systems Building Blocks. • To examine the district's current level of health and SRH preparedness, as well as define the community's understanding of resilience.
Closing and Next Steps (30 minutes)	• Gratitude • Daily evaluation • Items for tomorrow	• To pull together learning from the day and ensure understanding of both content and logistics information.

Facilitator's Agenda Day 2:

To increase knowledge and understanding of the components of the MISP for SRH and gender protection.

ITEM	COMPONENT(S)	OBJECTIVES
Welcome, Review, and Housekeeping (20 minutes)	• Review and housekeeping	
MODULE 2.1: Maternal Newborn Health (MNH) (45 minutes)	• Video: *Atlas of Birth* • Presentation: *Maternal and Newborn Health*	• To increase understanding of maternal and newborn health; knowledge of the three delays and pregnancy danger signs; awareness of the priorities of the MISP; and familiarity with safe birth plans.
MODULE 2.2: Voluntary Contraception (40 minutes)	• Presentation: *Voluntary Contraception*	• To increase understanding of the importance of voluntary contraception; the types of contraceptive methods available; and the priorities in the MISP.
MODULE 2.3: Safe Abortion Care/Post-abortion Care (1.5 hours)	• Activity: *Cross the Line* • Presentation: *Safe abortion care/Post-abortion care*	• To increase understanding of the importance of ensuring safe abortion care within the full extent of the law.
MODULE 2.4: Sexually Transmitted Infections (STIs), including HIV (45 minutes)	• Presentation: *STIs, Including HIV*	• To increase understanding of the importance of prevention, management, and care of STIs, including HIV, in emergencies, and the priorities in the MISP.
MODULE 2.5: Gender-Based Violence (GBV) (1.5 hours)	• Presentation: *Gender-Based Violence* • Activity: Referral web	• To build knowledge, awareness, and sensitivity to GBV; the importance of referral pathways for survivors of sexual violence during an emergency; and the priorities in the MISP.
MODULE 2.6: Jeopardy! (45 minutes – 1 hour)	• Activity: Jeopardy!	• To provide a fun and easy way to review knowledge gained over the past two days.
Closing and Next Steps (15-20 minutes)	• Gratitude • Daily evaluation • Items for tomorrow	• To pull together learning from the day and ensure understanding of both content and logistics information.

Facilitator's Agenda Day 3:

To apply knowledge obtained over the past two days of training to household and community preparedness plans.

ITEM	COMPONENT(S)	OBJECTIVES
Welcome, Review, and Housekeeping (20 minutes)	• Review and housekeeping	
MODULE 3.1: Household Preparedness (40 minutes)	• Activity: Household preparedness brainstorm	• To place learning over the past two days within the context of preparedness. • To help participants distinguish between "household preparedness" and "community preparedness."
MODULE 3.2: Community Mapping (1 hour 30 minutes)	• Activity 1A: Mapping of existing physical resources and capacities for SRH • Activity 1B: Mapping social assets and human resources • Report Back and Discussion	• To identify existing physical, social, and human resource capacities and gaps to address SRH needs and gender protection in emergencies.
MODULE 3.3: Action Planning (2.5 hours)	• Activity: Developing an action plan for SRH preparedness and gender protection	• To apply knowledge of current capacities and gaps in MISP services to activities that could be implemented to overcome these gaps.
Wrap-up and Closing (1 hour)	• Post-test • Final evaluation • Closing Ceremony	• To pull together learning from the three days of training, ensure there is understanding of the content covered, and provide closure to the event (sharing any plans for follow-up).

Nuts and Bolts: Getting Ready for Your Training

Trainers and support staff needed

- The training can be successfully implemented by one or two facilitators who have experience training at the local and community levels and are familiar with the MISP for SRH. If participants speak a different language or local dialect from the facilitator(s), the trainers should engage an interpreter who can assist the facilitator in understanding the ongoing conversations and dialogue throughout the workshop.
- It may be helpful to include the hosting agency or partner staff as part of the facilitator team, so that you can consult their expert opinion and knowledge of the local context. They can also help complete some of the tables in the modules that require advance planning, primarily by extracting data from the pre-workshop **community capacity and needs assessments** and filling in the blanks.

Policy landscape

- If the pre-workshop **community capacity and needs assessment** is undertaken, then the facilitator will be informed of the political landscape and any restrictions around the provision of certain SRH services. It is essential for the facilitator to understand any laws around abortion and what "safe abortion care to the full extent of the law" means in the particular setting, so that discussions can avoid misconceptions, misinformation, and myths about the legal status of abortion and/or availability of safe abortion care that may result in challenges to access for women.
- In Module 1.3 on "Disaster Management Framework" on Day 1, there is an opportunity for an official from the local disaster risk management agency to present on the local disaster risk management framework. If this presentation will be given, the facilitator should identify a speaker.

Participant recruitment

- The training is designed to support 20 to 30 participants to ensure each participant can voice their concerns and actively participate, while also having enough participants for the group activities.
- Participants can include district health policymakers, disaster management agencies, and program managers that are responsible for preparedness and rebuilding more resilient communities after a crisis. Health providers—especially facility managers—who are responsible for responding to emergencies should also be invited to attend.
- Community participants should be recruited from women's groups, organizations of persons with disabilities, and other organizations of persons from specific marginalized and underserved groups who can play critical roles to protect women, girls, and other vulnerable groups in emergencies. The recruited participants should ideally have a health background, so that they can better appreciate the related clinical components.

- The training is designed to be accessible, action-oriented, and collaborative to ensure community investment in SRH and DRR in emergencies.

Requirements for participants

- The training assumes some level of participant familiarity with SRH concepts and services. Thus, all participants are heavily encouraged to take the MISP for SRH Distance Learning Module prior to attending the training. This will help facilitate understanding of the SRH priorities in emergencies and focus discussions and activities around action planning.

Language, interpretation, and translation

- The training is best implemented when the participants can express themselves in their language and dialect of choice. An interpreter, as mentioned above, can convey messages from participants to the facilitator if needed. This approach allows for further participant investment in DRR activities and comprehension of DRR's nuanced issues. Furthermore, the choice of language is critical in maintaining cultural competency and sensitivity to the local context. Also consider sign interpretation for participants who use sign language.
- Translation of materials in this curriculum may be needed to ensure participants are able to fully engage. Plan for sufficient time and funding for such translation.

Accessibility and accommodation

- For persons who may need specific accommodations to participate in the workshop, reach out to them in advance to determine their specific needs and how to best facilitate their active participation. Common requests may be transport to/from the training venue, sign interpretation, electronic resources, accessible restrooms, or personal assistants. Ask if there are adaptations that have worked for participants in the past. Participants can be encouraged to bring their own devices or work with persons who are familiar with their needs. The workshop can better address inclusion if a budget is available for accessibility and accommodations.

Cultural sensitivity

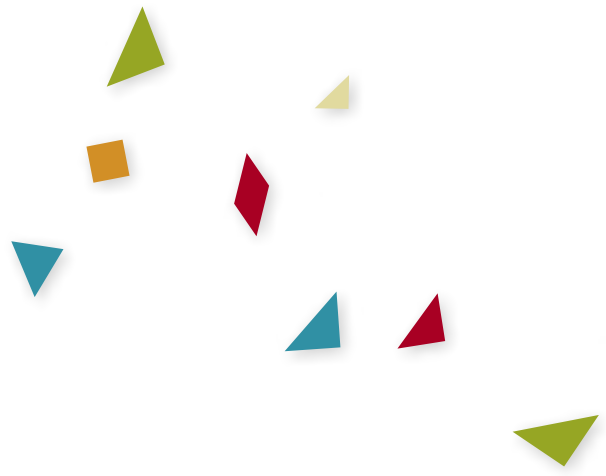
- Even within a single country, there is much diversity. Prior to organizing a training in a new or less familiar region, facilitators should engage in significant planning to ensure religious, cultural, or traditional daily activities (such as prayer) are respected during the training.

Identifying a training space

- Participants will spend a full three days in the training space of choice. There are a few issues to consider when identifying a training space:
  1. Convenient location to public transportation or other modes of accessible transportation.
  2. Neutral location for a diverse range of participants. Avoid hosting the training at a location (organization, government office, etc.) where there may be tension or discomfort between any participant and the staff of the training venue.
  3. Location with amenities or possibility to make accommodations, such as accessibility for persons with disabilities, appropriate restrooms, and space for prayer, as needed.
  4. Location with privacy for participants to be able to share their thoughts and engage in group activities without fear of being overheard.

Training evaluation

- The three-day training has multiple evaluation components to ensure participant satisfaction, participant learning, and training effectiveness. The components include:
  - Pre- and post-test: Each participant will take a pre-test and a post-test to assess current knowledge of SRH and DRR and change in knowledge after the training.
  - Daily evaluation: During the closing of each training day, the facilitator can engage in an informal, open, and safe discussion with participants to gauge their satisfaction with the material and to highlight any concerns.
  - End-of-training evaluation.
- This training can be supported by a follow-up system via local SMS technology as available. This option can be discussed with participants as part of action planning during the workshop.
- Each evaluation component is appropriately addressed in the training curriculum.



Training Preparation and Material Checklists

TRAINING PREPARATION CHECKLIST	✓
Identify possible communities/participants, and select based on suggested criteria	
Meet with local government to discuss interest and possible plans for training	
Recruit training staff (1 or 2 facilitators, translator, and notetaker)	
Identify a training venue	
Recruit 20 to 30 participants (as noted in preparation guidance)	
Test computer, projector, audio equipment, and screen before Day 1	
Organize tea breaks and meals for the duration of the training	
Review curriculum and facilitator notes prior to training	

MATERIALS	QUANTITY	✓
Flip chart	2-3 flip chart packs	
Card stock (roughly 3"x 11" [7.5cm x 28cm]) (meta cards)	100 (depending on use)	
Markers (good quality)	10-15	
Pens for participants	30-50	
Tape	3 rolls	
Participant and trainer name tags for each day	3 multiplied by # of participants	
Balls	3	
Coin and colored money	6 x $100-$500 colored money for Jeopardy	
Treats to use for prizes and games	2 bags of nice candies (Jeopardy prize) Candies for Island Expansion activity	
Large ball of yarn	1	
Supplies for Island Expansion activity	15 trees (consider paper cups) 1 school and 1 hospital (consider a Bowl or folded card stock)	
Colored stickers	2 packs	
Certificates for participants	# of participants	
Projector	1	
Computer	1	
Speakers	1 set	

ITEMS FOR FACILITATOR TO PRINT		
Registration/sign-in sheet	1	
Participant agenda	# of participants	
Pre-test	# of participants	
Post-test	# of participants	
End-of-training evaluation	# of participants	
All handouts (packet)	# of participants	
Certificates for participants	# of participants	

Facilitator's Training Curriculum

PREPARATION & DAY 1

Introducing Localized Risks

GOAL:

To engage participants as local experts, and introduce concepts of preparedness and risk

MODULE 1.1: Local Risks and Experiences

MODULE 1.2: Community-Based Disaster Risk Reduction

MODULE 1.3: Disaster Management Framework

MODULE 1.4: Sexual and Reproductive Health Priorities in Emergencies

MODULE 1.5: Understanding Resilience within the Health Systems Building Blocks

Facilitator's Agenda Day 1

TIME	ITEM	COMPONENT(S)	SUPPLIES
8:00-9:00	**Training set-up**	• Training site set-up • Welcome and participant registration	• Laptop (and power cord) • Projector and screen • Sign-in sheets • Participant folders • Pens
9:00-10:00	**Introduction and Housekeeping**	• Training pre-test • Activity: Icebreaker: Ball toss name game • Ground rules and expectations • Presentation: *Training Overview*	• Computer • Projector and screen • Pre-tests • Three balls • Flip chart paper • Markers • Presentation: *Training Overview*
10:00-10:30	**MODULE 1.1:** Local Risks and Experiences	• Activity: Disaster Timeline	• Long flip chart attached to the wall (timeline) • Facilitator marker pen • Meta cards • Participant markers
10:30-11:00	**Tea Break**		
11:00-12:00	**MODULE 1.2:** Community-Based Disaster Risk Reduction	• Presentation: *Involving Communities in Disaster Risk Reduction and Preparedness* • Activity: *Island Expansion*	• Laptop • Projector and screen • Supplies for "Island Expansion" Activity » Items to represent hospital and school » Items to represent trees » Items to represent fish (eg. hard candy) » Large paper to represent an island » Printed script for role play » Facilitator marker pens • Presentation: *Involving Communities in Disaster Risk Reduction and Preparedness*
12:00-13:00	**Lunch**		
13:00-13:30	**MODULE 1.3:** Disaster Management Framework	• Presentation or Alternative Activity: Local disaster risk management framework	• Laptop • Projector and screen • *Local disaster risk management framework presentation* (if representative present) • *Disaster risk management framework matrix* (alternative activity; includes findings from pre-workshop **policy assessment tool**) • Marker and tape
13:30-14:30	**MODULE 1.4:** Sexual and Reproductive Health Priorities in Emergencies	• Activity: SRH case study	• Laptop • Projector and screen • Supplies for case study activity • Print out a case study for each participant • Card stock/meta cards to label assigned groups • Facilitator marker pens
14:30-15:00	**Tea Break**		
15:00-15:30	**MODULE 1.4** Continued	• Presentation: *Priorities for SRH and Gender in Emergencies*	• Presentation: *Priorities for Reproductive Health and Gender in Emergencies*
15:30-16:30	**MODULE 1.5:** Understanding resilience within the health systems building blocks	• Presentation: *Understanding Resilience within the Health Systems Building Blocks* • Discussion: Preparedness and community resilience	• Laptop (with audio) • Projector and screen • Presentation: *Understanding Resilience within the Health Systems Building Blocks* • *District emergency health preparedness table* • Meta cards with community quotes around resilience from the pre-workshop **community capacity and needs assessment** • Tape
16:30-17:00	**Closing and Next Steps**	• Gratitude • Daily evaluation • Items for tomorrow	• Paper for daily evaluation • Information about dinner or any evening activities

TRAINING SET-UP

1 hour

Trainers should plan to arrive at your training site at least 30-45 minutes in advance of when participants will arrive. Participants may arrive early and there may be more set-up required than expected.

- Post signs for the training at the site, if needed, to allow participants to find the training room.
- Establish a "registration table" that includes a sign-in sheet for participants to register when they arrive (name, position, organization, phone, and email should be included if electronic follow-up is expected).
- Prepare or designate the area where tea, breakfast, lunch, or any other meals and snacks will be served.
- Prepare and test any audio and visual equipment, including electrical plugs, projector, screen, computer, audio connections, and internet.
- Set up tables in the shape of a U, a circle, or in small clusters.
- Ensure you have participant handouts prepared in folders for the participants.
- Meet with your notetaker (if you have one present) to ensure they understand the format of the day and the focus of the notes you wish to have documented.
- Meet with your interpreter(s) to provide them with any background information that may be helpful. If a sign interpreter is present, find a time to brief the interpreter and participant(s), to help facilitate interpretation.
- If participants with disabilities have requested specific accessibility/accommodations, confirm they are available and adequate for participants. Spend some time to get to know the participants and how best they will learn or participate.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Sign-in sheets
- Participant folders
- Pens

Introduction and Housekeeping

1 hour

Facilitator's tip

On the first day of training, one of your primary goals is to establish rapport with participants. Facilitators should encourage active participation from each individual. Initial activities should be focused around topics and points of discussion that emphasize participants as experts (and discussions focused around topics for which they have an abundance of information). This will help to ensure their full engagement as experts and set the tone for the rest of the workshop.

As participants enter, distribute (or display on flip chart) the daily agenda and pre-test.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Pre-tests
- Three balls
- Flip chart paper
- Markers
- Presentation: *Training Overview*

Goal:

To create a conducive and cohesive learning environment to learn about building community capacity to prepare for and respond to SRH needs and gender protection in emergencies.

PRE-TEST

10-15 minutes

The pre-test should be completed before the training begins. Time indicated suggests the amount of time that could be allowed for all to focus on the pre-test, before initiating introductions. However, keep in mind that participants will start the test at different times and the facilitator may wish to allow some to continue working on the pre-test when introductions begin. Remind individuals that:

- A pre-/post-test will be done in order to evaluate the trainer and the ability of the training itself to convey specific information.
- A pre-/post-test should be completed individually, as the goal of the training is to reach everyone in the room, rather than just a few. If a participant has a visual impairment and the pre-/post-test is not available in electronic form, braille, or another mode that the participant uses, the facilitator or assistant can verbally administer the test.
- A pre-/post-test is not an evaluation of participants. Therefore, names and any other identifying information should not be used on the forms. Participants should answer questions as best they can, but they are not expected to know all the answers before the training begins.

INTRODUCTION

10 minutes

At the designated start time of the training:

- Welcome participants to the *Community Preparedness for Sexual and Reproductive Health and Gender* training.
- Explain that we will discuss more about the training and objectives shortly.
- Introduce the trainer(s).
- Discuss the language of instruction. If the facilitator is not speaking the local language, explain that there is an interpreter to translate information back to the facilitator so that participants can feel comfortable expressing themselves in their local dialect.
- Express interest in meeting participants. Go around the room and have everyone share their name and their role in the community.
- Spend some time getting to know participants, to see how they can help each other learn and contribute. Encourage participants with disabilities to share how others can help them actively participate.
- Identify three "host-teams" to support the facilitator with ice breakers and energizers through each of the three days. The host team assigned for each day will be responsible for energizers, time keeping, and the morning feedback the next day.
- Open the session by playing an ice breaker game to build rapport before diving into formal introductions and an overview of the training.

ICE BREAKER: Ball Toss Name Game*

20 minutes

Activity goal: Emphasize the need for communication and coordination when planning and implementing programs in a fast-paced, stressful, and ever-changing environment.

- Introduce the exercise as a way to energize the group and as a method to understand the importance of communication in an emergency.
- Have participants create circles of about 8-12 people with plenty of space behind them in case they jump or move backward to catch a ball. If there are not enough participants for two groups, one large circle can be formed.
- Ask participants to say their names slowly and go around the circle, repeating names a couple of times. Ensure that participants hear the names.

* Youth Peer Education Electronic Resource, Peer Education Training of Trainers Manual, UN Interagency Group on Young People's Health Development and Protection in Europe and Central Asia, Sub-Committee on Peer Education, 2003.

- Then, explain that the person holding the ball will call out a person's name and toss the ball to them. If a participant forgets a name, they can ask him/her to repeat it.
- Begin to play the game with one ball per circle.
- After a couple of minutes, throw in a second ball.
- After a couple of minutes, throw in a third ball. Continue with all three for a short time.
- End activity.
- **Discussion:** Ask participants for reflections and thoughts about the exercise and how communication is important in an emergency. (What made this activity easier? What made it harder? Did knowing the names before the activity become stressful or assist with your ability to complete the activity successfully?)
- Emphasize the need for clarity, focus, and cooperation for an emergency response.

Adapt the activity as needed depending on participants' abilities. If some participants are unable to catch a moving ball, an alternate activity is below.

ALTERNATE ICE BREAKER: Telephone Game

- Players should sit in a circle or stand in a straight line. They need to be close enough that whispering is possible, but not so close that players can hear each other whisper.
- The first person in the line or circle whispers a word or phrase into the ear of the person sitting or standing to their right. The phrase can be something related to the humanitarian context, such as, "Women who are pregnant can get information about how to prepare for childbirth if they go to X location at 11:00 on Wednesdays."
- Players whisper the phrase to their neighbors until it reaches the last player in line.
- The last player says the word or phrase out loud so everyone can hear how much it has changed from the first whisper at the beginning of the circle or line.
- End activity.
- **Discussion:** Ask participants for reflections about the exercise and how communication is important in an emergency. (What made this activity easier? What made it harder?)
- Emphasize the need for clarity, communication, and cooperation to implement an emergency response.

NOTES:

GROUND RULES AND GROUP EXPECTATIONS

10 minutes

The facilitator should have participants brainstorm ground rules for the training. These are items that keep a training moving along smoothly (turning off cell phones, active participation, etc.). Ask participants to think of ground rules and expectations for both the facilitator and participants to help guide the training over the next three days. Ask individuals to write their ground rules on colored pieces of paper and post them to the wall.

After all participants post their ground rules on the wall, go through each ground rule and ask for volunteers to read aloud items that have been posted. Ensure participants have a complete understanding of the ground rules and that there is agreement on their premise. When all ground rules are reviewed, ask if there are any additional ground rules to include.

Some ground rules to consider adding at the end of participant input may include:

1. Respect opinions.
2. One person speaks at a time.
3. Respect participants' different capacities.
4. Turn off cell phones.
5. Respect time (facilitator will keep the day on schedule and provide ample breaks and time to make phone calls, stretch legs, etc.).

Review final ground rules and group expectations, post on flip chart, and place in a visible place inside the training room.

PRESENTATION: TRAINING OVERVIEW

10 minutes

After establishing rapport and introductions, transition into an overview of the training, and its goals and objectives. This introductory framework will provide a roadmap for participants to understand the content of the training, as well as its purpose. After presenting the information, allow participants to ask questions and discuss, if needed. Spend ample time ensuring there is broad-based understanding of the training's purpose and participant and trainer roles. Discuss and address any concerns that may arise.

- Facilitators can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.

- Before transitioning from the overview to the training, circulate the agenda if participants do not already have it. Ask for any questions, comments, and concerns.
- Finally, close the introduction with housekeeping items, including location of restrooms, tea and lunch, and any other relevant items.

PRESENTATION: TRAINING OVERVIEW: 7 SLIDES

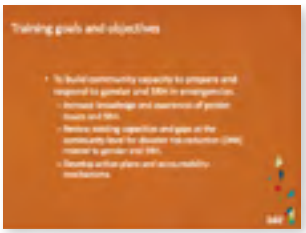
Hover your mouse over the image to get a description of the slide contents.

SLIDE 1

Most participants should know that the training is related to emergency preparedness and somehow connected with gender and reproductive health

The facilitator will now spend time explaining this linkage and the purpose of the training.

SLIDE 2



This training has been designed with the goal of building community capacity to prepare for, and respond to, gender issues and sexual and reproductive health (SRH) during emergencies (both natural and man-made). Participants should:

- Increase knowledge and awareness of gender issues and sexual and reproductive health (SRH).
- Review existing capacities and gaps at the community level for disaster risk reduction (DRR) related to gender and SRH.
- Develop action plans and accountability mechanisms.

Although trainings at the community level can be implemented on many different topics as they relate to risk reduction and emergency preparedness (livelihoods, coordination, water and sanitation, etc.), this training is focused on SRH and gender.

That does not mean that SRH and gender issues are more important than other preparedness activities; however, the training emphasizes that these topics are important for inclusion within broader preparedness activities. Many times, without a specific focus on these topics and issues, they are forgotten or overlooked.

SLIDE 3

The original *Facilitator's Kit: Community-based Preparedness for Reproductive Health and Gender* was developed, adapted, and refined by the Women's Refugee Commission (WRC) in collaboration with the United Nations Population Fund (UNFPA) and local partners in the Philippines through eight trainings across five diverse settings. Since then, the WRC has piloted the tool in Northern Iraq, Pakistan, and three additional sites in the Philippines.

The 2020 update includes learning from these endeavors, as well as feedback from ACCESS Consortium members and other Inter-Agency Working Group (IAWG) on RH in Crises partner staff.

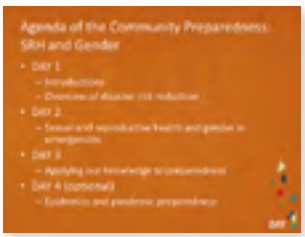
PRESENTATION: TRAINING OVERVIEW (cont'd)

SLIDE 4

The ACCESS Consortium is a partnership between the International Planned Parenthood Federation (IPPF), Women's Refugee Commission, Frontline AIDS, London School of Hygiene and Tropical Medicine, Open University, and Internews. The Consortium aims to bridge the gap between the humanitarian and development divide to increase access to comprehensive SRH for hard-to-reach populations and ensure progress towards universal SRH and reproductive rights.

The Consortium is developing scalable, evidence-based approaches to mobilize marginalized and under-served populations across humanitarian-development contexts in Lebanon, Mozambique, Nepal, and Uganda; all countries with complex histories of conflict, disasters, displacement, and interventions. It is working to achieve four major outcomes around resilience, service quality, equity, and impact. With evidence generated from the project, the Consortium intends to influence policy, practice, information ecosystems, and social norms across the humanitarian-development continuum.

SLIDE 5



Provide a brief overview of the plan for the training days so that topical expectations are clear as well as time commitments that are sought.

SLIDE 6

At the end of the training, each participant will be able to:

- Identify risks faced by women, girls, and other at-risk groups during an emergency (with a specific focus on SRH and gender), as well as their coping capacities.
- Provide a description of the MISP for SRH, inclusive of:
  - Its importance
  - The priority actions included within the MISP, and
  - The key actions that could be taken to improve MISP preparedness.
- Apply knowledge of SRH and gender risks to existing hazard and risk maps.

SLIDE 7

- Identify community-level capacities and gaps for gender and SRH preparedness and response.
- Discuss community-level actions that could be taken to improve preparedness and enhance participation of at-risk and vulnerable groups (adolescents, persons with disabilities, LBGTQIA individuals, ethnic and religious minorities, and other sub-populations).
- Develop community-level action plans that respond to identified gaps and needs related to SRH and gender, and that leverage existing resources and capacities, with accountability mechanisms that ensure a more robust gender and SRH response.

MODULE 1.1:
Local Risks and Experiences

30 minutes

Goal:

To engage participants as experts and set the context of discussion around natural disasters and emergencies.

- To identify natural and man-made disasters that affect the community.
- To brainstorm the impact of disasters on the community.

Summary: Transition the training into an interactive and engaging timeline activity in which participants are experts. Introduce this activity as an opportunity for participants to articulate the local experiences and response to past disasters. Participants engage in a brainstorming session to recall past emergencies, their impact, and frequency.

Supplies:

- Long flip chart paper attached horizontally to the wall (timeline)
- Facilitator marker pen
- Meta cards
- Participant markers

ACTIVITY: DISASTER TIMELINE

- Activity Prep: Post a series of flip chart sheets on a wall in the training room to create a blank timeline. If needed, reconfigure tables in a half circle or U shape to cluster around the timeline.
  - » Option: It can be helpful to have participants clustered in small groups that could ease participation (divide by location, etc.).
- The facilitator can start by asking the participants to recall major events in their community and discuss them at their tables. These may include the following:
  - » Major events significant to the community.
  - » Major disasters and their effects.
- The facilitator should then ask for volunteers to share the major events that were discussed—starting with the one furthest back in time. It is helpful to have many age groups represented to ensure a long history.

Facilitator's tip

Heavily emphasize that the participants are the experts in the disaster risk reduction process. Participants are members of the community who have lived through a variety of disasters. Furthermore, they understand what capacities and facilities/services are available, how well they work, and mechanisms to improve the response.

- Call up a participant to place the name of the major event on the timeline (using card stock/meta cards).
- Ask for group agreement—is there anything before this event that should have been placed on the time-line? Was the "name" remembered correctly?
- The facilitator should then elicit details from this disaster and write this information on the timeline. (Date should be on the timeline, followed by the name of the event, followed by the type of event—conflict, typhoon, flooding, etc., followed by impact.)
- The facilitator will then help the group to build out the timeline, gradually moving to the most recent events.
- When the timeline is complete, the facilitator will be able to show past events (pointing out the disasters experienced), and what the impact has been over time. The disaster time-line will make people aware of climate change and present perceptions, and can serve as a basis for discussions on future programs or projects within the community.
- Discussion: The facilitator will be able to extract climate change- and ecosystem-related information, as well as health risks, with the following questions:
  - Are there any trends or changes in the frequency of events over time?
  - Have weather- and climate-related events such as flood, drought, and cyclones changed in number or severity?
  - What systems have been most impacted in these disasters (health, education, social)?
  - What events do you expect will occur in the future? When? Why?
  - What steps have been taken in recent years to secure the provision of health services—even in a disaster? Have communities been involved in these efforts?

TEA BREAK

30 minutes

MODULE 1.2:
Community-Based Disaster Risk Reductions

1 hour

Goal:

To increase understanding and knowledge about Disaster Risk Reduction.

Summary: This session will open with a PowerPoint presentation and then move to an activity that should solidify the concepts around disaster risk, specifically as they relate to changing dynamics between the population and the environment.

PRESENTATION: INVOLVING COMMUNITIES IN DISASTER RISK REDUCTION AND PREPAREDNESS

- Before beginning the activity, remind participants of what was just discussed in the timeline activity and its purpose as a roadmap for the rest of the training. The timeline will serve as the context to build knowledge on local disaster risk.
- Check if there are any questions about the timeline.
- Facilitators can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Supplies for "Island Expansion" Activity
  - » Items to represent hospital and school
  - » Items to represent trees
  - » Items to represent fish (consider a hard candy)
  - » Large paper to represent an island
  - » Printed script for role play
  - » Facilitator marker pens
- Presentation: *Involving Communities in Disaster Risk Reduction and Preparedness*

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS: 22 SLIDES

SLIDE 1

Before the break, we had the opportunity to learn about risks that are faced in your community.

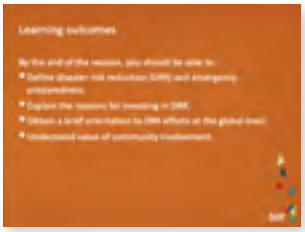
The risks that your community faces, might be different from those of communities that are in a slightly different location—even within the same region.

Disaster risk is highly localized. This is one of the reasons that communities are so important with risk reduction and preparedness activities. They should be involved in identifying risks.

Therefore, the role of communities themselves within disaster risk reduction and emergency preparedness activities is critical.

We are going to spend a little time now understanding local risks and how they might have changed in recent decades. We will also discuss what is known about protecting communities from identified risks.

SLIDE 2



Review learning objectives

SLIDE 3

Ask participants to consider the disaster timeline they created and to reflect on how health and health services were affected during the emergencies.

Then, ask participants to consider who was most impacted in their communities. Did everyone face similar problems or challenges, or were certain people more at risk? Why were these people most at risk, or most impacted?

Photos: Women's Refugee Commission; Aceh, Indonesia after the tsunami, and Kenya after the 2008 post-election violence.

SLIDE 4

Over the past decade, humanitarian crises have been increasing in number and duration.

- Between 2005 and 2017, the average length of crises with an active inter-agency appeal for humanitarian aid rose from four to seven years, while the number of active crises receiving an internationally led response almost doubled, from 16 to 30. The majority of people targeted receive assistance for five years or more (nearly 60 percent).[1]
- Since 2015, appeals for crises lasting five years or longer have spiked and now command most funding received and requested (80 percent).[1]
- These trends emphasize the need for closer collaboration between humanitarian and development actors to decrease vulnerability in the long term.[1]

1. UN OCHA (2019). World Humanitarian Data and Trends (WHDT) 2018. http://interactive.unocha.org/publication/datatrends2018/.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 4 (cont'd)

Displacement

- The total population of persons forcibly displaced by conflict, persecution, and violence stood at 70.8 million in 2018. Among them, 25.9 million were refugees, 41.3 million were internally displaced persons, and 3.5 million were asylum seekers.[2] Refugees are persons who have crossed a border and have been recognized by the United Nations High Commissioner as someone fulfilling refugee criteria based on a well-founded fear. Internally displaced persons are those that are displaced within their own borders (still in their own country). Asylum seekers are persons seeking safe haven in another country, but have not been granted legal status yet.
- The world is seeing a record number of displaced persons, in part due to deterioration of conflict in countries such as Yemen, Iraq, Democratic Republic of Congo, South Sudan, Ethiopia, Myanmar, and Central America.[2]
- Natural disasters have also resulted in large-scale displacement: 17.2 million persons were newly displaced in 2018 alone.[3] Natural disasters and climate change have a high human cost. Disasters affect 350 million people on average each year and cause billions of dollars in damage.[4]
- The average humanitarian crisis now lasts more than nine years; nearly three quarters of persons receiving assistance in 2018 were in countries affected by humanitarian crisis for more than seven years.[4]

The impacts of such disasters vary greatly.

- The general trend appears to be that mortality is declining, but economic impacts continue to show an annual increase.[5]
- There is also a difference in resulting impact between frequent small-scale disasters and large-scale catastrophic events. Small-scale disasters tend to have a far greater impact on poor and vulnerable communities.[5] They are less likely to receive political and international attention, and the burden of cyclic destruction is often borne by persons with fewest resources.

Vulnerabilities are increasing at the population level.

- Increased urbanization
- Unplanned/unsafe settlements
- Exposed coastal areas
- Poverty
- Illness/disease/HIV prevalence
- Inadequate attention to risk patterns
- Global interconnectedness and rapid spread of disease/dependence on imports that could be disrupted

Disasters are a major stumbling block in attaining development goals[5]

2. UNHCR (2019). *Global Trends: Forced Displacement in 2018*. https://www.unhcr.org/globaltrends2018/.
3. IDMC (2019). *Global Report on Internal Displacement 2018*. http://www.internal-displacement.org/global-report/grid2019/.
4. UN OCHA (2018). *Global Humanitarian Overview 2019.* https://www.unocha.org/sites/unocha/files/GHO2019.pdf.
5. UNISDR (2015). *Sendai Framework for Disaster Risk Reduction 2015- 2030*. Geneva. http://www.unisdr.org/we/coordinate/sendai-framework.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 5

Cyclic conflicts may have more links to disasters than we might initially think.

This timeline from UN OCHA illustrates the flow of displacement captured through its Internal Displacement Event Tagging and Clustering Tool (IDETECT). The data are presented against events that took place in Nigeria in 2017. The data reflect that in many cases, incidents of insecurity took place immediately following a natural disaster, showing the potential links between natural disasters and conflict/insecurity.[1]

Conflict displaces people from their land and disrupts food markets and transport systems, increasing food prices. Climate change further exacerbates cycles of drought and floods—roughly 80% of the world's chronically malnourished and stunted children live in countries in conflict.[2]

In 2017, water played a major role in conflict in at least 45 countries.[1] OCHA estimates that climate change may result in the internal displacement of 140 million people by 2050.[1] Hence, conflicts may have more links to disasters than we might initially think.

1. UN OCHA (2019). *World Humanitarian Data and Trends (WHDT) 2018*. http://interactive.unocha.org/publication/datatrends2018/.
2. UN OCHA (2018). *Trends in Humanitarian Needs and Assistance*. https://www.unocha.org/sites/unocha/files/Trends%20in%20Humanitarian%20Needs%20and%20Assistance%20Factsheet.pdf.

SLIDE 6

In addition to the increase of disaster EVENTS, there are also changing population dynamics that are considerations in understanding risk.

What are some behaviors of people or communities, that tend to place them at higher risk? (Brainstorm for a bit.)

….What happens when populations get bigger and people start moving closer to the water?

….Or: Poverty introduces more competition for resources (fisherfolk might need to be out at risky times, live close to the water, etc.)

Population growth has multiple influences upon population risks:

- It contributes to widespread poverty and competition for resources.
- People in low-income countries are 4 times more likely to die from extreme natural events than those in high-income countries.
- Overcrowding increases the risks of epidemics/pandemics to spread, where physical distancing is difficult to practice.
- Poverty and population growth will increase competition for resources, which leads to related behaviors that put populations at greater risks:
    - Families or workers will move into high-risk areas previously uninhabited (landfills, waterfront, unstable slopes).
    - Many times such moves into less inhabitable areas are driven by desire to be closer to income (fisherfolk moving to the water's edge, for example).
    - Communities may farm areas previously kept as forests, marshland, or other (removing natural protections from environmental hazards).
    - Economic strains may lead to less stable constructions (construction may be flimsy; apartment buildings going higher or with less firm foundation than they should).

Some populations are at risk because of where they live geographically. Asia, for example, is higher risk than Europe for natural hazards.

It is also important to remember that populations that are healthier before emergencies are more likely to survive the consequences/impact of disaster than populations that are less healthy. The spread of infectious diseases, malnutrition, or underlying health conditions will all impact a population's overall resilience during disasters.

1. World Health Organization (2002). Gender and Health in Disasters. http://www.who.int/gender/other_health/en/genderdisasters.pdf.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 7

Women and girls are disproportionately affected by emergencies, both natural and man-made.

Gender differences appear to be linked to economic and social rights pre-crisis.

Natural disasters, including epidemics and pandemics, push ordinary gender disparities to the extreme, revealing development failures and societal issues.

SLIDE 8

In the immediate aftermath of an emergency, women are more likely to die than their male counterparts.

- Bangladesh cyclone of 1991—3 women killed for every 1 man[6] (46 (21%) of 222 females aged >10 years died, versus 17 (7%) of 258 males in the same age range); some estimates are much higher, stating that women represented 90% of deaths.[1,2,3]
- Tsunami of 2004—death rates for women were estimated at 4-5x higher than for men, and some noted up to 80% who died were women.[1,2,3]

Gender may impact one's ability to access warning systems, gain skills of survival, or access rescue mechanisms.

Gender also influences roles and household expectations, which impacts decisions made during a crisis and results in different survival outcomes.

- In the 1991 Bangladesh Cyclone, many women perished at home, waiting with children for their husbands to return to make evacuation decisions.[1]
- The 2010 cholera epidemic in Haiti and the 2014–16 Ebola outbreak in West Africa showed a three-fold caregiver burden on women and girls: they were responsible for household-level disease prevention and response; at greater risk of infection; and subject to emotional, physical, and socioeconomic harm.[12]

Although less common, gender roles will sometimes place men and boys at higher risks; gender does not equal women.

- As the protector, men are often recruited to rescue teams, placing them at risk.
- When fishing or coastal living is predominantly male, related risks are routinely taken.

We also know that during ongoing displacement from natural disasters or conflict, women and girls remain disproportionately affected.

- Women and particularly adolescent girls face risks of gender-based violence (GBV), including rape, sexual assault, forced prostitution, trafficking, and early or forced marriage. Such risks increase the risks of sexually transmitted infections (STIs) including HIV, unwanted pregnancy, and unsafe abortions.[4]

1. Ikeda, Keiko (1995) "Gender Differences in Human Loss and Vulnerability in Natural Disasters: A Case Study From Bangladesh." *Indian Journal of Gender Studies.* 2(2):171-9.
2. APWLD (2005) "Why are women more vulnerable during disasters?" Asia Pacific Forum on Women, Law and Development, NGO in consultative status at UN ECOSOC. http://www2.lse.ac.uk/geographyAndEnvironment/whosWho/profiles/neumayer/pdf/Disastersarticle.pdf.
3. Plan International (2011). *Weathering the Storm: Adolescent Girls and Climate Change 2011*. www.plan-uk.org/resources/documents/35316/.
4. Barot, Sneha (2017). *In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations.* Guttmacher Institute. https://www.guttmacher.org/gpr/2017/02/state-crisis-meeting-sexual-and-reproductive-healthneeds-women-humanitarian-situations.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

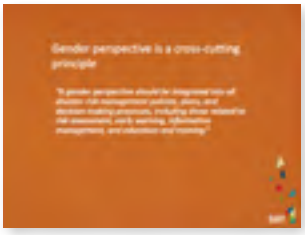
SLIDE 8 (cont'd)

- Girls are also more vulnerable as families are forced to prioritize resources.[5]
- Studies show that pregnant women in conflict settings experience increased risks of gestational hypertension and anemia, as well as negative pregnancy outcomes, including low birth weight or preterm birth.[6] They are also at risk of pregnancy-related morbidity and mortality due to pre-existing nutritional deficiencies, susceptibility to infectious diseases, lack of access to antenatal care, and lack of access to assisted deliveries and emergency obstetric care.[7] Seventy-six percent of preventable maternal deaths, and 53% of under-five deaths take place in settings of fragility, and/or conflict, displacement, and natural disasters.[8,9]

Crises can further exacerbate gender inequalities. Girls in conflict settings are 2.5 times more likely to be out of school than boys.[10] Persons with disabilities, LGBTQIA persons, ethnic and religious minorities, and other sub-populations can experience additional health risks as a result of underlying discrimination and prevailing social norms.[11]

5. World Health Organization (2002). Gender and Health. http://www.who.int/gender/other_health/en/genderdisasters.pdf.
6. WHO (2017). *Leading the realization of human rights to health and through health: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents*, Geneva.
7. Save the Children (2014). *State of the world's mothers 2014. Saving mothers and children in humanitarian crises*. www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SOWM_2014.PDF.
8. OECD (2015). *States of fragility 2015: Meeting post-2015 ambitions*. Paris: OECD Publishing. As cited in: WHO (2015). Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva. http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/.
9. UN (2015). *Every Woman Every Child, Abu Dhabi Declaration*. http://www.who.int/pmnch/media/news/2015/abudhabi_declaration.pdf.
10. UN OCHA (2018). *Global Humanitarian Overview 2019*. https://www.unocha.org/sites/unocha/files/GHO2019.pdf.
11. IAWG on RH in Crises (2018). *Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual*. Geneva: IAWG on RH in Crises.
12. IASC GBV Sub-Sector Nigeria (2017). "Briefing Note: Integrating Gender In Cholera Prevention And Control Interventions In North East Nigeria" https:.//interagencystandingcommittee.org /system/files/briefing_note-gender_in_cholera_response.pdf.

SLIDE 9

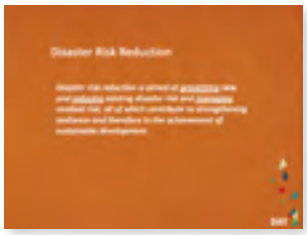


Gender is the socially ascribed notion of how a woman or man should be in society. A gender perspective looks at how roles and norms around gender may have a different effect on how people experience situations. We will cover the differences between gender and sex in more detail tomorrow.

* From ISDR, UNDP and IUCN. Making Disaster Risk Reduction Gender Sensitive: Policy and Practical Guidelines. http://www.preventionweb.net/files/9922_MakingDisasterRiskReductionGenderSe.pdf.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 10



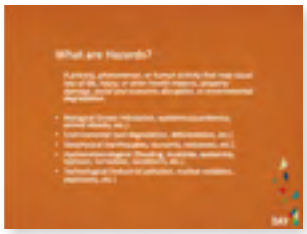
Disaster risk is the potential loss of life, injury, or destroyed or damaged assets which could occur to a system, society, or a community in a specific period of time.

Residual risk is the disaster risk that remains even when effective disaster risk reduction measures are in place, and for which emergency response and recovery capacities must be maintained. The presence of residual risk implies a continuing need to develop and support effective capacities for emergency services, preparedness, response, and recovery, together with socioeconomic policies such as safety nets and risk transfer mechanisms, as part of a holistic approach.

Disaster risk management is the application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk, and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses.

UNISDR terminology. https://www.unisdr.org/we/inform/terminology.

SLIDE 11



Facilitator should present the different types of natural hazards through a discussion of what types of hazards most affect this area. Help the group to understand their "disaster profile."

UNISDR terminology. https://www.unisdr.org/we/inform/terminology.

SLIDE 12

Natural hazards are not the same as natural disasters.

A hazard becomes a disaster when a) people and/or their assets and property are present, and b) coping mechanisms are overwhelmed.

***

Disaster risk is the potential loss of life, injury, or destroyed or damaged assets which could occur to a system, society, or a community in a specific period of time, *determined probabilistically as a function of hazard, exposure, vulnerability, and capacity*.

The definition of disaster risk reflects the concept of hazardous events and disasters as the outcome of continuously present conditions of risk. Disaster risk comprises different types of potential losses which are often difficult to quantify. Nevertheless, with knowledge of the prevailing hazards and the patterns of population and socioeconomic development, disaster risks can be assessed and mapped, in broad terms. It is important to consider the social and economic contexts in which disaster risks occur and that people do not necessarily share the same perceptions of risk and their underlying risk factors.

UNISDR terminology. https://www.unisdr.org/we/inform/terminology.

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 13

Emergency preparedness aims to effectively **anticipate, respond to**, and **recover** from the impacts of likely, possible, or current disasters.

Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes activities such as contingency planning; stockpiling of equipment and supplies; arrangements for coordination, evacuation, and public information; and training and field exercises. These must be supported by formal institutional, legal, and budgetary resources. The related term "readiness" describes the ability to quickly and appropriately respond when required.

A **preparedness plan** develops arrangements in advance of an emergency to enable timely, effective, and appropriate responses to specific possible hazardous events or emerging disaster situations that might threaten society or the environment.

It is important to prepare for emergencies to reduce death, disability, and illness, and because we know that disasters impact our communities differently based on pre-existing societal vulnerabilities. Preparing for an emergency can also help communities become more resilient to withstand the impact of a disaster or conflict.

Adapted from UNISDR terminology. https://www.unisdr.org/we/inform/terminology.

SLIDE 14

If a community is prepared to respond to health needs before an emergency occurs, through assessing disaster risks, vulnerability, capacity, exposure, hazard characteristics and their possible effects, and planning and acting accordingly, we anticipate greater resilience and fewer negative health consequences.

Prepared communities will be able to withstand and absorb disasters/shocks, minimizing disruption to services and maintaining health access.

Communities without preparedness will be overwhelmed by disasters/shocks, and will be unable to meet immediate health needs, possibly leading to excess death, disability, illness, and other health consequences.

Photos: Haiti after 2010 earthquake, Women's Refugee Commission

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 15

From 2005 to 2015, 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* guided global dialogue and encouraged international and national stakeholders to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies. In March 2015, *the Sendai Framework for Disaster Risk Reduction 2015-2030* was adopted by member states at the UN World Conference on Disaster Risk Reduction in Sendai, Japan. The framework calls for increased attention to resilience and identifies health as a critical aspect of strengthening individual and community resilience.

Between 2015 and 2030, the Sendai Framework aims to achieve the following outcome: "The substantial reduction of disaster risk and losses in lives, livelihoods, and health and in the economic, physical, social, cultural, and environmental assets of persons, businesses, communities, and countries."

* Note that UNISDR is now UNDRR – UN Office for Disaster Risk Reduction.

Resources:

- United Nations Office for Disaster Risk Reduction (2007). *Hyogo Framework for Action: Building the resilience of nations and communities to disaster*. Geneva. https://www.unisdr.org/we/inform/publications/1037.
- United Nations Office for Disaster Risk Reduction (2015). *Sendai Framework for Disaster Risk Reduction 2015- 2030*. Geneva. http://www.unisdr.org/we/coordinate/sendai-framework.

SLIDE 16

The next few slides will go through each of the priorities and how they apply to the local level.

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

SLIDE 17

Priority 1. Understanding disaster risk

Disaster risk management should be based on an understanding of disaster risk in all its dimensions of ***vulnerability, capacity, exposure of persons and assets, hazard characteristics, and the environment****. Such knowledge can be used for risk assessment, prevention, mitigation, preparedness, and response.*

In terms of Priority 1, at **national and local levels**, the Sendai Framework recommends:

- To encourage the use of and strengthening of baselines and periodically assess **disaster risks, vulnerability, capacity, exposure, hazard characteristics**, and their possible sequential effects.
- To **build the knowledge** of government officials, civil society, communities, and the private sector on disaster risk reduction.
- To **enhance collaboration** among persons at the local level to disseminate disaster risk information.

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

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 18

Priority 2. Strengthening disaster risk governance to manage disaster risk

Disaster risk governance at the national, regional, and global levels is very important for prevention, mitigation, preparedness, response, recovery, and rehabilitation. It fosters collaboration and partnership.

In terms of Priority 2, at **national and local levels**, the Sendai Framework recommends:

- To **mainstream and integrate disaster risk reduction** within and across all sectors.
- To encourage the **establishment of mechanisms and incentives to ensure compliance** with existing safety-enhancing provisions, including health and safety standards.
- To **empower local authorities to work and coordinate with civil society and communities** in disaster risk management at the local level.

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

Photos: WRC; October 2014 EECA regional forum, Kristina Puzarina IPPF.

SLIDE 19

Priority 3. Investing in disaster risk reduction for resilience

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.

In terms of Priority 3, at **national and local levels**, the Sendai Framework recommends:

To **allocate the necessary resources, including finances and logistics**, for disaster risk reduction.

To **revise building codes** and strengthen disaster-resilient schools and hospitals; **building better from the start** to withstand hazards.

To **integrate disaster risk management into primary, secondary, and tertiary health care**, especially at the local level, for a resilient health system.

To **strengthen inclusive policies and enhance access to basic health care**, including SRH.

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

PRESENTATION: INVOLVING-COMMUNITIES-IN-DRR-AND-PREPAREDNESS (cont'd)

SLIDE 20

Priority 4. Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation, and reconstruction

The growth of disaster risk means there is a need to strengthen disaster preparedness for response, take action in anticipation of events, and ensure capacities are in place for effective response and recovery at all levels. The recovery, rehabilitation, and reconstruction phase is a critical opportunity to build back better, including through integrating disaster risk reduction into development measures.

In terms of Priority 4, at **national and local levels**, the Sendai Framework recommends:

- To **periodically update disaster preparedness and contingency policies and plans**.
- To develop and maintain people-centered, multi-hazard, multisectoral **forecasting and early warning systems**.
- To **stockpile** necessary supplies.
- To **train** the existing workforce in disaster response.
- To facilitate the link between relief, rehabilitation, and development; **use opportunities during recovery to develop capacities that reduce disaster risk** in the short, medium and long term.

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

SLIDE 21

Health systems-strengthening, based on primary health care at the community level, can:

- Reduce the vulnerability of at-risk populations before an emergency.
- Build the capacity of communities to prevent, prepare, respond to, and recover from emergencies, thus protecting public health, health services, and infrastructure.
- Provide the basis for scaling up measures to meet wide-ranging health needs in emergencies.
- Prevent avoidable morbidity and mortality, particularly among women, children, and adolescents.
- Use opportunities during recovery to strengthen services and reduce the risks of future events.

SLIDE 22

ACTIVITY: ISLAND LIVING

(Adapted from http://www.pfpi.org/pdf/ipopcorm/couple-peer-educators-training-manual.pdf.)

1. Put a plain sheet of paper on the floor (one or two sheets of large flip chart paper should work fine for this activity). This paper is your island, and the area around it is the ocean. Put two to three key features on this map that represent vulnerable or safe areas (consider a mountain and a coastline).
2. Assign or seek volunteers for each of the characters needed in this activity (husband, wife, young girl, neighbor, and young boy).
3. Introduce your characters.
4. Place objects on the paper that will represent trees (paper cups or similar) and "fish" in the ocean (using real candy on a paper plate is usually a big hit, although not necessary).
5. Provide scripts to each participant.
6. Read through the script. The facilitator can play the role of the narrator and can remove objects and items as noted.
7. Debrief from the activity.

The facilitator can further adapt the activity to the local context, as needed. The disaster can be what is locally experienced, such as flooding, earthquake, tsunami, drought, or recurrent fighting. For example, if participants are from:

- A mountainous region, you can replace the sea with a forest at risk of deforestation, and the fish can be edible plants.
- Arid environments, the sea can be the desert, and the fish can be firewood or other sources of fuel or food.
- Urban environments, the sea can be a slum or settlement, and the fish can be locally available fruit or vegetables.

You can be creative with this activity!

Island Expansion activity in the Philippines.

SCRIPT FOR ACTIVITY

Adapt as needed. Italics are instructions for the facilitator.

Husband and Wife: We live peacefully on this beautiful piece of land. There are so many fish for us to eat, and the trees shade us from the sun in the heat of the day.

Narrator: This husband and wife have many children who have many children. (*Narrator adds three people to the "island." Space is tighter; remove some trees. Remove some fish from the sea.)*

Young girl: There are schools for the children to attend, and there is a hospital that was built to make sure that we stay healthy. I go to school all day and play all evening. We have plenty of food, so I do not need to work very hard at night to prepare rice. Fresh food is always here.

Narrator: (*Add a hospital and two schools.*) This population also has many children, and some new families have arrived by boat from a faraway place looking for a better life. (*Add three more people to the piece of paper. Remove some trees. Remove some fish from the sea.*)

Neighbor: We are new to this area and we hoped to find a better life—but it is a bit crowded here and not so different from the place we came from. We will have to struggle to make a living here, but my husband is a fisherman. If we move closer to the sea, I am sure that we will be able to survive—as we will be the first to reach the water each morning.

Narrator: Many families follow this idea and move closer to the coastline in order to be closer to their livelihood. This population continues to grow over many years. (*Add 3 more people to the community. Take away fish and remove trees.*)

Mother: The hospital is too crowded. I took my son there the other day because he was very sick—but he was not seen. He is still very sick and there is no other hospital for us to go to. We will have to pray that his health improves.

Narrator: *This population continues to grow over many years. Because of the strain on the hospital, they are now training community health workers to help bring medicines to people in the community.* (*Add 8 more people to the community. Take all the fish, remove all the trees.*)

Narrator: (*Ask participants*)*:* What is happening to where you must stand? Many may be standing on one foot by now... Think about what this means for housing structures*. Interview each participant to share their reflections about how this situation might be similar to what has happened in their own community.*

Young boy: Yesterday there was a typhoon which came to our place. We lost many things.

Narrator: (*Ask participants*)*:* Which people on our "land" would be most affected by the typhoon*? They should be asked to leave.* Be sure to pay attention to those on one foot, those who are sick. Consider how to reflect an increased impact on women. What are the similarities with the events that occurred where you live?

LUNCH

1 hour

Before launching into the second half of Day 1, check in with participants to see if there are any questions or items to discuss.

Preparation: Set up participant workstations for small group activities with five to seven individuals in each group (for Module 1.4).

MODULE 1.3:

Disaster Management Framework 30 minutes

Goal:

To explore the disaster risk management infrastructure at the national, sub-national, and community levels, and examine where the community fits in the system.

Summary: This session will orient participants to the disaster risk management framework at the national, sub-national, and community levels, and where the community fits in the system.

PRESENTATION: LOCAL DISASTER RISK MANAGEMENT FRAMEWORK (IF PRESENTER AVAILABLE)

- Ideally, a colleague from the local disaster risk management team can present on national, sub-national, and local DRR policies and procedures. The presentation should be focused on what is relevant to participants at the community level.
- After the presentation, the facilitator can encourage participants to ask questions about where the community links with the overall system at multiple levels, if this is not clear.
- If a local disaster risk management representative is not available to present, participants can be engaged in the alternative activity below.

ALTERNATVE ACTIVITY: (If a local disaster risk management presentation is not feasible)

- Project the matrix on the screen or copy it on flip chart paper prior to the training. The first three columns are from the **community capacity and needs assessment policymaker tool**. If this tool is implemented before the training, the facilitator can transfer the results to columns 2 (Yes/No) and 3 (Details). The facilitator should attempt to complete columns 2 and 3 as much as possible before the training, so that more time can be spent on discussion and filling in any gaps.

Supplies:

- Laptop (and power cord)
- Projector and screen
- *Local disaster risk management framework presentation* (if representative present)
- *Disaster risk management framework matrix* (if alternative activity will be implemented; includes findings from pre-workshop **policy assessment** tool)
- Marker and tape

- The facilitator can review the matrix briefly with participants so that they are aware of the national, sub-national, and district policy framework. For each row, the facilitator can engage participants to see how the community links to the broader system, as relevant. The national and sub-national level systems may be more for awareness (hence, this can be brief); most time should be spent around the district level, unless community representatives have direct links to the sub-national and national levels.
- Since participants will not yet have discussed the MISP for SRH in the training (although they should be familiar through the *MISP Module*), briefly mention that more details around the standard will be discussed later.
- Once the matrix is complete, and if it is on paper, it can be posted on the wall so that participants can refer to it throughout the training, especially during action planning.

Disaster management framework (for Alternative Activity)

LEVEL	Y/N	DETAILS	WHAT IS THE LINK TO THIS COMMUNITY'S LEVEL?
National level			
National government body that addresses disaster risk reduction		**Name of the government body and where is it housed**	
National Platform for Disaster Risk Reduction to coordinate efforts		**Agencies are involved** (*National Disaster Management Agency, Civil Protection, Ministry of Health, Ministry of Interior, etc.*)	
National emergency **preparedness** plan for health		**Name and date**	
National emergency **response** plan for health		**Name and date** (*Response plan may be part of the preparedness plan, depending on the context.*)	
Lead agency identified for health for emergencies at the **national** level		**Lead agency**	
Integration of minimum services of SRH as described in the MISP in the **response** plan(s) for health at the **national** level		**Integrated services** (*Coordination; services to prevent and treat survivors of sexual violence; services to prevent maternal and newborn death and disability, prevent HIV/STIs, prevent unintended pregnancy, prevent unsafe abortion, transition from MISP to comprehensive SRH.*)	

(cont'd)

LEVEL	Y/N	DETAILS	WHAT IS THE LINK TO THIS COMMUNITY'S LEVEL?
Integration of the minimum services of SRH as described in the MISP in **preparedness** plan(s) for health at the **national** level		**Integrated services**	
Health coordination group at the **national** level		**Member agencies**	
SRH coordination group at the **national** level		**Member agencies**	
Protection coordination group at the **national** level		**Member agencies**	
Separate GBV coordination group at the **national** level		**Member agencies**	
Separate HIV coordination group at the **national** level		**HIV coordination group lead**	
SRH focal point appointed at the **national** level			
Protection focal point appointed at the **national** level			
Separate GBV focal point appointed at the **national** level			
Separate HIV focal point appointed at the **national** level			
Integration of emergency and disaster risk management for health (EDRM-H) and/or preparedness in the UNFPA Country Program			
Sub-national level *(Provincial or regional level that houses the particular district of interest)*			
Sub-national Platform for Disaster Risk Reduction		**Agencies**	
Sub-national emergency **preparedness** plan		**Name and date**	
Sub-national emergency **response** plan		**Name and date**	
Integration of minimum services of SRH as described in the MISP in the **response** plan(s) for health at the **sub-national** level		**Integrated services**	
Integration of minimum services of SRH as described in the MISP in **preparedness** plan(s) for health at the **sub-national** level		**Integrated services**	
Health coordination group at the **sub-national** level		**Member agencies**	

(cont'd)

LEVEL	Y/N	DETAILS	WHAT IS THE LINK TO THIS COMMUNITY'S LEVEL?
SRH coordination group at the **sub-national** level		**Member agencies**	
Protection coordination group at the **sub-national** level		**Member agencies**	
Separate GBV coordination group at the **sub-national** level		**Member agencies**	
Separate HIV coordination group at the **sub-national** level		**Member agencies**	
SRH focal point appointed at the **sub-national** level			
Protection focal point appointed at the **sub-national** level			
Separate GBV focal point appointed at the **sub-national** level			
Separate HIV focal point appointed at the **sub-national** level			
District level			
District emergency **preparedness** plan		**Name and date**	
District emergency **response** plan		**Name and date**	
Integration of minimum services of SRH as described in the MISP in the **response** plan(s) for health at the **district** level		**Integrated services**	
Integration of SRH as described in the MISP in **preparedness** plan(s) for health at the **district** level		**Integrated services**	
Health coordination group at the **district** level		**Member agencies**	
SRH coordination group at the **district** level		**Member agencies**	
Protection coordination group at the **district** level		**Member agencies**	
Separate GBV coordination group at the **district** level		**Member agencies**	
Separate HIV coordination group at the **district** level		**Member agencies**	

MODULE 1.4:

Sexual and Reproductive Health Priorities in Emergencies

1.5 hours

Goal:

- To understand the importance of prioritizing SRH and gender protection during preparedness and response activities.
- To provide an overview of the MISP for SRH as a priority intervention in emergencies.

Summary: This session will open with a small group activity involving a case study, for participants to appreciate the risks that women and girls can face in an emergency. It will then move into a presentation to review the MISP for SRH.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Supplies for case study activity
- Print out a case study for each participant
- Card stock/meta cards to label assigned groups
- Facilitator marker pens
- Presentation: *Priorities for Reproductive Health and Gender in Emergencies*

ACTIVITY: SEXUAL AND REPRODUCTIVE HEALTH CASE STUDY

This exercise is best implemented with three or four small groups of five to eight participants. Each group will receive a printout of the selected case study, as well as a small group discussion guide (see Annex). Each group should designate a spokesperson to quickly summarize their discussion. Three case study options are available, depending on what may be most relevant for the group. Alternatively, the facilitator can develop a case study from the most recent emergency, if that will be more relevant.

- Divide participants into small groups of 5-8 depending on training size; assign each group with a population of interest (and write this on folded placards or meta cards):
  - » Adolescents – both boys and girls
  - » Pregnant and lactating women
  - » Persons living with a chronic health condition, such as HIV or AIDS
  - » Persons with disabilities and the elderly
  - » Any other group that may be particularly at risk in the community (refer to your **community capacity and needs assessment** findings)
- Read through the case study together as a group—encouraging different members to read a few sentences at a time. Pause to allow for translation or clarification.

CASE STUDY I: Earthquake in Nepal

On April 25, 2015, an earthquake of 7.8 magnitude hit Nepal, followed by more than 300 aftershocks, including one of 7.3 magnitude on May 12, 2015. Thirty-five of the 75 districts in the country were affected, close to 9,000 people died, and over 22,000 people were injured. The total number displaced persons is 2.8 million, with around 600,000 houses destroyed and 290,000 damaged. UNFPA estimates that 5.6 million people are affected, including 1.4 million women of reproductive age.

Approximately 93,000 women are estimated to be pregnant, including 1,000-1,500 women likely to experience complications. Twenty-eight thousand women are estimated to be at risk of sexual violence. In Kathmandu, 20.1% of the district's population (350,676 people) and in Sindhupalchowk, 99.9% of the district's population (287,574 people) are in need of assistance.

Currently, adolescents are not permitted to access sexual and reproductive health (SRH) services from health centers without parental consent. Communities, however, are eager to participate in the response through distributing materials, disseminating information about distributions, and identifying those most in need. Only one organization has reached out to address the SRH needs of persons with disabilities.

Krause, S., et al., *Evaluation of the MISP for Reproductive Health Services in Post-earthquake Nepal,* New York: Women's Refugee Commission, 2016.

Myers, A., Sami, S., Onyango, M.A. et al., Facilitators and barriers in implementing the Minimum Initial Services Package (MISP) for reproductive health in Nepal post-earthquake, *Confl Health* 12, 35 (2018). https://doi.org/10.1186/s13031-018-0170-0.

CASE STUDY II: Flooding in Mozambique

On March 14, 2019, Cyclone Idai made landfall in Mozambique, bringing devastation to the port city of Beira and surrounding areas. The following days, turbulent weather swept through Sofala, Zambezia, Manica, and Inhambane provinces, causing massive flooding and leaving entire communities submerged under 10 meters of water.

Sofala province has been hardest hit, with some 660,000 people affected, and roads cut. Due to high winds and floods, the central hospital in Beira is damaged. Some 19 sub-provincial level health facilities are also damaged and dysfunctional in Sofala.

More than 462,000 people are women of reproductive age, with 55,500 estimated to be pregnant. In the next three months, 19,000 live births are expected, and 3,000 women are expected to experience complications during pregnancy or childbirth. There are also 77,000 women living with HIV.

In Beira town (Sofala), the transit centers are used during the day for displaced persons, and the men often go back home for fear of robberies. The rooms are shared with other men who are strangers; the latrines are dirty from the storm and have no doors.

The needs of adolescents, persons with disabilities, and LGBTQIA persons are not known at this time.

UNFPA East and Southern Africa Regional Office, Cyclone Idai Regional Appeal, April 1, 2019. https://mozambique.unfpa.org/en/publications/cyclone-idai-regional-appeal.

UNFPA, UNFPA response to Mozambique – Cyclone Idai, March 20, 2019. https://reliefweb.int/report/mozambique/unfpa-response-mozambique-cyclone-idai.

CASE STUDY III: Ebola Virus Disease in the Democratic Republic of the Congo

As of April 2020, the eastern Democratic Republic of the Congo continues to experience an outbreak of Ebola Virus Disease (EVD). On August 1, 2018, the Ministry of Health declared the current outbreak as the second largest recorded, globally. The EVD outbreak is occurring in Ituri and North Kivu, which are conflict-affected provinces with high-density population areas, highly transient populations, significant insecurity-related access constraints, high volume of cross-border commerce, and porous borders with neighboring countries.

As of February 17, 2020, over 3,431 cases and 2,253 deaths have been reported from this outbreak. The overall case fatality rate is 66%, which is well above the final case fatality rate of 43% in the West African EVD crisis. Of the total confirmed and probable cases, 56% are female, 28% are children under 18 years, and 6% are health workers.

Decades of conflict between state and non-state armed groups and the postponement of the 2018 presidential elections in the region have resulted in widespread distrust of national authorities. Given the limited engagement of humanitarian actors even prior to the EVD outbreak, the local community is suspicious of the national government and the international humanitarian actors that are attempting to manage the disease. The politicization of EVD has contributed to the spread of misinformation about the disease, as well as hostility and violence towards government- and United Nations-led response efforts. Health workers are reporting high levels of stress, which is leading to absenteeism, errors at work, and high risks of health care-associated infections.

Against the backdrop of EVD, localized conflict targeting civilians has continued to fuel sexual violence and trigger internal displacement and refugee outflows into neighboring countries.

One organization that is providing SRH services in the region has noted that it is seeing increased delays for women in accessing emergency obstetric care and other SRH services, due to added barriers inadvertently introduced as part of the EVD response.

IAWG on RH in Crises, Ebola Outbreak in Democratic Republic of the Congo, May 20, 2020. https://iawg.net/emergencies/ebola-outbreak-in-democratic-republic-of-the-congo.

McKay G, Black B, Mbambu Kahamba S, Wheeler E, Mearns S, Janvrin A, *Not All That Bleeds Is Ebola: How has the DRC Ebola outbreak impacted Sexual and Reproductive Health in North-Kivu?* New York, USA: The International Rescue Committee 2019.

- Provide the following instructions to the large group:
  You have been assigned to consider the risks faced by a particular group during an emergency. Before you start, make sure that everyone in your group understands which group you have been assigned to.
  - » *Read through the case study again as a group.*
  - » *Considering the group you have been assigned to—go back and underline or highlight information that you feel may be important to understand the risks faced by this particular group. (e.g., loss of health facilities, no lights/electricity, etc.)*
  - » *In your group, discuss the reasons why particular items were underlined, and determine the influence that this particular aspect of an emergency might have on your assigned group. Remember,*

there could be multiple concerns arising from one identified issue. (e.g., there is no emergency medical care for pregnant women if she is in labor; passage to latrines might be unsafe at night.)

- » *In your group, determine what risks might result for this population. What are the potential consequences of these risks? (Maternal death, sexual violence, etc.)*
- » *Record this information for feedback to the larger group (this can be done on flip chart paper or using meta cards). Note the groups have been provided with further instructions for their small group discussion.*

- After 20-25 minutes, encourage the entire group to come together for a larger discussion.
- Have each group share what they noted on their flip chart paper:

issues ▸ concerns ▸ risk

- » At the end of each group presentation, the facilitator should ask if other groups have questions or additional comments.
- » As many participants may have experienced an emergency in recent memory, it is also possible to ask if there are additional comments they would like to share about a particular population and risks they faced.
- » The large group should applaud each small group's efforts.

- The facilitator should expand on the presentations or share additional comments about the topics raised as needed.
  - » The facilitator should then review some of the following questions:
  - » What are the risks of living in a temporary shelter/ settlement that have not been mentioned yet?
  - » How does age affect your risks? How does gender affect risk? What other factors play significant roles in your safety?
  - » What other populations in the community may be at risk (probe for persons with disabilities, LGBTQIA persons, persons who engage in sex work, etc.)? What additional risks might they face?
  - » Who is most affected by the lack of health centers/hospitals?
  - » What about gaps in communication?
  - » What services are needed to protect our community from some of these risks?
  - » Are these services typically in place?

TEA BREAK

30 minutes

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES

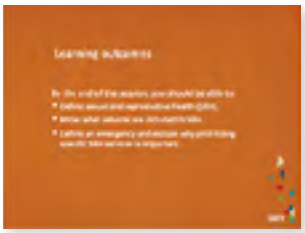
- Before beginning the presentation, ask participants if they have additional questions from the previous activity.
- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES: 17 SLIDES

SLIDE 1

We have just completed an activity that has us all thinking about a recent emergency, and how different members of our community were affected. We're now going to move to a presentation that should reinforce some of the ideas that we were starting to touch on.

SLIDE 2



SLIDE 3

Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES (cont'd)

SLIDE 3 (cont'd)

- decide whether, when, and by what means to have a child or children, and how many children to have; and
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Reference:
Starrs, A. et al. Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet*. 391(10140):P2642-2692, June 30, 2018. Available at https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights.

SLIDE 4

As defined by the Guttmacher-Lancet Commission, the full essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health.

Availability: Need to have sufficient quantity of functioning public health and health care facilities, goods and services, and programs.

Accessibility: Health facilities, goods, and services have to be accessible (physically accessible, affordable, and accessible information) to everyone without discrimination.

Acceptability: The social and cultural distance between health systems and their users determine acceptability. All health facilities, goods, and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and age. They also need to be designed to respect confidentiality and improve the health status of those concerned.

Quality: Health facilities, goods, and services must be scientifically and medically approved and of good quality.[1]

The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.[2]

1. WHO (2016). *Availability, accessibility, acceptability, quality Infographic*. https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf.
2. Starrs, A. et al. Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet*. 391(10140):P2642-2692, June 30, 2018. Available from https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights.

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES (cont'd)

SLIDE 5

As defined by the Guttmacher-Lancet Commission, the full essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

Resource:
Starrs, A. et al. Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet*. 391(10140):P2642-2692, June 30, 2018. Available from https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights.

SLIDE 6

However, in times of conflict and natural disasters, it becomes necessary to narrow the scope of services provided. Fewer resources are available, and some life-saving services must be prioritized.

SLIDE 7

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES (cont'd)

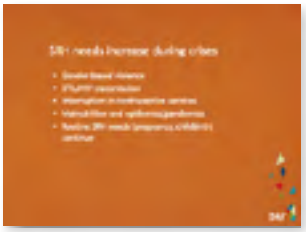
SLIDE 8

Ask participants to consider why women and girls may be at an increased risk if SRH needs are not prioritized in a response.

Women face ongoing health risks, specifically reproductive health risks, due to gaps in health services during and in the aftermath of an emergency.

- Anywhere from 4-16% of women of reproductive age (WRA) will be pregnant at any given time; 15% of these women will experience life-threatening pregnancy complications.
- There is an increased risk of sexual violence as civil society is destabilized; displacement often means lack of security.
- Health infrastructure is damaged = lack of access to services.
- Increased risks for HIV transmission (loss of protocols/compromised universal precautions, no access to condoms, no safe blood supply).
- Lack of access to routine contraceptive methods and condoms increase risk of unplanned pregnancy and risk for STIs.
- Taboos around menstruation can cause further health risks for girls and women.

SLIDE 9



Sexual and reproductive health needs increase during times of crisis.

- As societal structures are compromised, there is an increase in gender-based violence.
- Because health services are lacking, and taking preventative steps is more challenging—there is an increase in STI/HIV transmission.
- There are interruptions in existing contraceptive services, which will lead to an increase in unplanned pregnancies and thereby increase the risks to unsafe abortion and maternal death.
- The general health of the population declines—so all health needs increase.
- Routine SRH needs to not disappear—sexual activity, pregnancy, and child-birth will continue during these times of instability.

SLIDE 10

Disruptions in the supply chain can result in lack of supplies; damage to equipment and inability to fix them; displacement of health providers causing health worker shortages; etc.

SLIDE 11

During an emergency, it is critical to prioritize services that are lifesaving.

The Inter-Agency Working Group on Reproductive Health in Crises revised the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* in 2018, along with the Minimum Initial Service Package for Sexual and Reproductive Health standard.

Within this training, we will be referring the Inter-Agency Field Manual and the MISP for SRH to shape our discussion of emergency preparedness and response.

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES (cont'd)

SLIDE 12

Let's talk a bit more about what the MISP actually includes and does not include.

SLIDE 13

SLIDE 14

In emergency situations where demands on health services are high, and time and resources are limited, SRH services are prioritized on the basis of saving lives, optimizing scarce resources, and responding to needs. Since 1997, the Minimum Initial Service Package (MISP) for SRH has been the standard of care for SRH interventions in humanitarian settings. The standard was updated in 2018 and encompasses the following objectives:

- Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
- Prevent sexual violence and respond to the needs of survivors.
- Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
- Prevent excess maternal and newborn morbidity and mortality.
- Prevent unintended pregnancies.
- Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks.

It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Inter-Agency Working Group on Reproductive Health in Crises (2019). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York.

SLIDE 15

In acute emergencies, SRH supply chains often rely on Inter-Agency Emergency RH Kits.

RH Kits: complementary to other inter-agency emergency health kit.

PRESENTATION: PRIORITIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER IN EMERGENCIES (cont'd)

SLIDE 16

Special considerations for specific populations[1]

Adolescents: Adolescent girls especially are highly vulnerable to sexual coercion, exploitation, and violence, and many may engage in high-risk or transactional sex (sex for money or other goods/services) for survival. Adolescents are also a heterogenous group; their risks and needs may vary depending on the environment, marital status, education level, disability status, gender and gender identity, bodily identify, sexual orientation, and socioeconomic status.

Male survivors: Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and non-discriminatory services that provide comprehensive care.

Persons with disabilities: Persons with disabilities are at a higher risk of sexual violence and often face extreme discrimination by service providers. Host organizations of persons with disabilities may have resources to ensure clinical care for survivors is provided to this often-hidden population.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA) individuals: Each population has separate needs and faces different risks. Engaging with LGBTQIA self-help or rights groups and making health facilities more respectful of diversity would allow critical health services to become more accessible.

Persons who engage in sex work: This population often faces stigmatization and discrimination by health providers. Organizations led by refugees and persons who engage in sex work often have the expertise and connections to effectively provide clinical services to these groups.

Persons living with HIV/AIDS: Access to antiretroviral treatment remains a challenge in humanitarian settings. The largest group without access in humanitarian settings are children and adolescents. Stigma continues to exist against persons living with HIV/AIDS.[2]

Persons who inject drugs: Women who inject drugs are particularly stigmatized and are vulnerable to violence and HIV. Insufficient coverage of programs is of concern because of high risks for HIV and other infections such as viral hepatitis.

Ethnic and religious minorities: Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence. Specific barriers should be considered when designing programs to reach survivors.

1. Inter-Agency Working Group on Reproductive Health in Crises (2019). "Chapter 3: Minimum Initial Service Package." *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. New York.*
2. Inter-Agency Working Group on Reproductive Health in Crises (2019). "Chapter 11: HIV." *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York. https://iawgfieldmanual.com/manual/hiv

Photo: Adolescents in Mae Sot, Thailand; Women's Refugee Commission.

SLIDE 17

Tomorrow—we will spend the day going through each of these areas. We will also discuss safe abortion care to the full extent of the law, in health centers and hospital facilities.

MODULE 1.5:

Understanding Resilience within the Health Systems Building Blocks

1 hour

Goal:

- To understand resilience within the context of the health systems building blocks.
- To examine the district's current level of health and SRH preparedness, as well as define the community's understanding of resilience.

Summary: This session will discuss human resources, supply chain, and other factors that are important to preparedness and "building back better." Participants will then examine the district's current level of health and SRH preparedness, and discuss their understanding of resilience in their own communities.

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS

- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides
- Following the presentation, the facilitator can reinforce that emergency preparedness and recovery are two entry points within the continuum of an emergency that provide an opportunity to build resilience to reduce the impact of emergencies, improve response, and facilitate recovery.

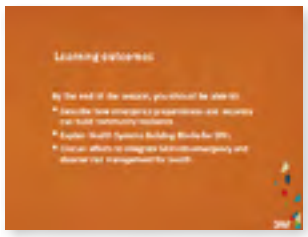
Supplies:

- Laptop with audio hook-up (and power cord)
- Projector and screen
- Presentation: *Understanding Resilience within the Health Systems Building Blocks*
- *District emergency health preparedness table*
- Meta cards with community quotes around resilience from the pre-workshop **community capacity and needs assessment**
- Tape

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS: 16 SLIDES

SLIDE 1

SLIDE 2



SLIDE 3

Acute Response – This is the immediate response right after a disaster occurs. Humanitarian agencies mobilize to get services and supplies to people affected by crises as quickly as possible. This is when the Minimum Initial Service Package (MISP) for SRH should be implemented.

Protracted Response – This is after the immediate chaos of a new emergency, when humanitarian agencies aim to provide more comprehensive services to meet longer-term needs. It can look very different in different settings.

In some cases, a full country may be affected – for example, Syria, Yemen.

In other cases, it may be a protracted crisis in one region of a more stable country – for example, Northeast Nigeria, Democratic Republic of the Congo.

Sometimes protracted crises can go on for a long time, depending on the type of emergency. But at this point, we expect people living in these settings to have access to comprehensive SRH services.

Recovery – This is the period during which things start to return to "normal." At this stage, the aim is to restore health systems and even strengthen them from the pre-crisis stage.

Preparedness – This is what can be done before an emergency strikes to better prepare for an emergency. Underpinning preparedness: Crises are often predictable – natural disasters recur, conflict is cyclical, or spread of disease can be anticipated. There are activities that can be done prior to a crisis to mitigate the consequences. This ranges from policies to capacity building to building flood walls to establishing a resilient supply chain.

Crisis-affected settings are very diverse – they fall all along this cycle.

Different interventions are needed depending on where in the cycle a particular setting is.

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS (cont'd)

SLIDE 4

The MISP was designed to form the starting point for SRH programming at the onset of an emergency. As highlighted in Objective 6, the clinical services of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction.

Priorities for achieving comprehensive SRH should include the broadening and strengthening of MISP services, as well as the inclusion of SRH services that fall outside of the MISP.

Ask participants to define and name the components of comprehensive SRH that were discussed in the prior module. Allow participants to continue until they have named all of elements, or all the elements they can recall.

As discussed earlier, according to the Guttmacher-Lancet Commission, comprehensive SRH services are "essential SRH services that must meet public health and human rights standards, including the 'Availability, Accessibility, Acceptability, and Quality' framework of the right to health." The services should include:[1]

- accurate information and counselling on SRH, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care, to the full extent of the law;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers."

Areas to consider in the transition include: communication among decision-makers (including national governments) and implementing partners; adequate financing; effective coordination; supply chain management; human resources management; monitoring and evaluation; system of information sharing, feedback, and accountability to the affected community; and development of an exit strategy for humanitarian partners.[2] These align with the WHO's Health System Building Blocks.

1. Guttmacher–Lancet Commission (2018). *Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission*. https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights.
2. Inter-Agency Working Group on Reproductive Health in Crises (2019). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York.

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS (cont'd)

SLIDE 5

Efforts to re-establish comprehensive SRH services should keep in mind WHO's Health Systems Building Blocks to "Build Back Better." "Building back better" aims to ensure that recovery efforts in the aftermath of a crisis build resilience and reduce a community's vulnerability to future emergencies.

The six components contribute to building a community's resilience since they form the basic foundations of a health system.

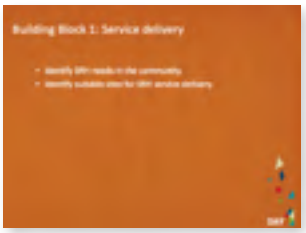
Reference:

- Inter-Agency Working Group on Reproductive Health in Crises (2019). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York.
- WHO (2010). M*onitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf.

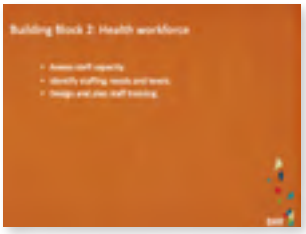
SLIDE 6

Emergency preparedness and **recovery** are, thus, two entry points within the continuum of an emergency that provide an opportunity to build local and national resilience to mitigate the impact of emergencies, improve response, and facilitate efficient and effective recovery.

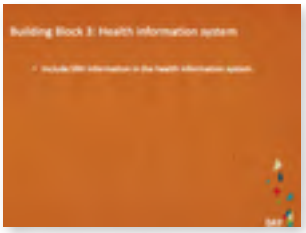
SLIDE 7



SLIDE 8

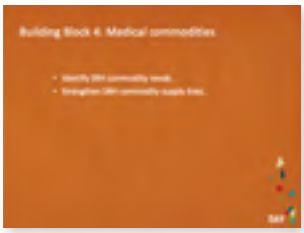


SLIDE 9



PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS (cont'd)

SLIDE 10

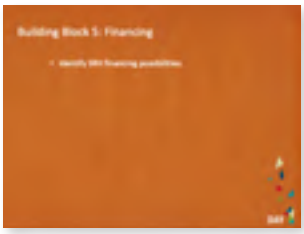


In acute emergencies, SRH supply chains often rely on Inter-Agency Emergency RH Kits.

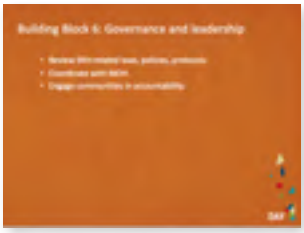
Transition from emergency supply chain to stable supply chain:

- Making the supply chain more responsive to demand.
- Making the supply chain more cost-effective (reducing both wastage and stock-outs).
- Enabling expansion of services beyond MISP.

SLIDE 11



SLIDE 12



SLIDE 13

In 2016, the Women's Refugee Commission undertook a review of existing efforts to integrate SRH into health emergency and disaster risk management (HEDRM) at regional, national, and district levels. Learning has shown that efforts to integrate SRH into HEDRM appear to take a non-linear path, based on opportunities, honest reflection, and iterative processes. Where response capacity is overwhelmed despite preparedness efforts, adaptability and flexibility have been important for continuous improvement. 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 HEDRM.

Learning has further shown that 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.

Before moving to the next slide, ask participants to think through challenges they can foresee when working to integrate SRH into HEDRM efforts in their context.

Reference:
Women's Refuge Commission (2016). *Building National Resilience for SRH: Learning from Current Experiences*. New York.

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS (cont'd)

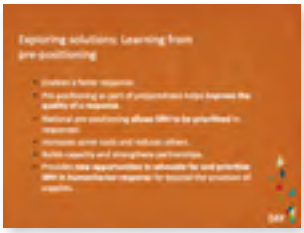
SLIDE 14

Common challenges have been faced by stakeholders in their efforts to integrate SRH into HEDRM. These have included:

- Lack of awareness, sensitivities, and standard operating procedures at the policy level around SRH needs and priorities in emergencies.
- Lack of coordination among relevant departments, line ministries, UN agencies, and implementing organizations to address SRH as part of HEDRM.
- Weaknesses of existing primary health care systems—including for GBV prevention and response, comprehensive emergency obstetric care services, HIV care and treatment, and STI services—as well as human resource capacity and logistics systems that limit health preparedness and response plans.
- Limited engagement of community members, particularly of at-risk groups.
- Limited financing for SRH preparedness, especially for actual implementation of action plans.

Reference:
Women's Refuge Commission (2016). *Building National Resilience for SRH: Learning from Current Experiences*. New York.
Photo: Kenya in 2008, Women's Refugee Commission.

SLIDE 15



Enabling policy environment: Ensuring drugs in the kits are registered and on the Essential List of Medicines.

Pre-positioning: Keeping stocks of selected products or kits for use in an emergency. Example: In the Nepal earthquake, SRH supplies were available at the onset of the crisis only because they were pre-positioned.

Building flexible and resilient supply chains in advance of an acute humanitarian response

- Training people along the supply chain to be ready for an emergency.

PRESENTATION: UNDERSTANDING RESILIENCE WITHIN THE HEALTH SYSTEMS BUILDING BLOCKS (cont'd)

SLIDE 16

Integrate SRH into health risk assessments and provide early warning for communities. Incorporate assessments of SRH risks, vulnerabilities, and capacities, informed by gender and disability analyses. Estimate the impact of identified SRH risks (such as vulnerable populations, percentage of home deliveries, or access to vehicles for obstetric and newborn complications) to strengthen the overall primary health care system and plan for response.

Identify and reduce risks for vulnerable communities and SRH services. Address underlying health vulnerabilities by ensuring strong primary health care and preventive health measures with key provisions for SRH. Establish community networks to identify and monitor local vulnerabilities and capacities, build health facilities to withstand local hazards, and ensure that these facilities remain functional to provide SRH services, including care for childbirth and obstetric and newborn complications during emergencies.

Develop community action plans that prepare existing SRH services to absorb impact, adapt, respond to, and recover from emergencies. Action plans should address inclusion of at-risk populations (women, adolescents, newborns, persons with disabilities, LGBTQIA persons, and other minorities) that reflect risk assessment, gender, and other analyses. Build capacity of critical stakeholders to implement the MISP, pre-position RH Kits, maintain vehicles for referrals, and clarify roles and responsibilities to ensure a comprehensive, well-coordinated response.

Actively involve at-risk groups—including women, adolescents, persons with disabilities, LGBTQIA persons, and other minorities—and work with community stakeholders, such as health providers, youth groups, and women's groups, in all preparedness planning and to ensure discrimination is minimized. Encourage community participation in RH working groups and cluster discussions and support their role as critical first responders in emergencies.

The development and implementation of health emergency response plans at all levels should include provisions for the MISP. During disaster recovery, a plan should be made for sustainable consolidation and expansion of SRH services based on local needs as soon as the situation permits. After the initial response, SRH services should be expanded to address recovery, restoration, and quality improvement.

Ask participants to take a moment to think about their professional role and the organization they work with. Thinking specifically about these activities, how could their organization, or someone in their role, be engaged to build resilience for SRH at the community level?

Participants should keep these ideas in mind as they develop concrete action plans for their communities on Day 3.

DISCUSSION: PREPAREDNESS AND COMMUNITY RESILIENCE

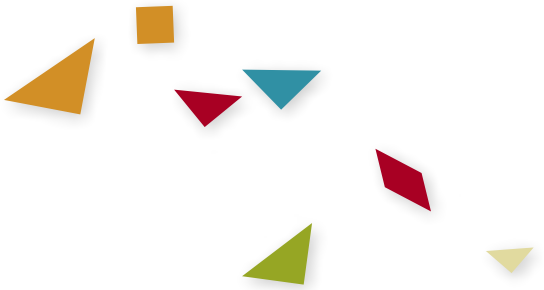
- Next, the facilitator can discuss the district's current level of emergency preparedness overall and for SRH specifically, based on the *Sendai Framework* priorities for DRR to bring the learning from this session and prior sessions together. The information can be presented from the pre-workshop **community capacity and needs assessment** findings (see table below). The facilitator should attempt to engage participants through sharing details as reported by key informants, rather than merely reading through the list.

DISTRICT EMERGENCY HEALTH PREPAREDNESS	Y/N
Process to review building codes and standards, and rehabilitation and reconstruction practices.	
Periodic assessment of disaster risks, vulnerability, capacity, exposure, hazard characteristics, and their possible sequential effects for risk assessment, prevention, mitigation, preparedness, and response purposes.	
Multi-hazard, multisectoral forecasting and early warning system.	
Emergency communications mechanisms to alert the community to potential hazards and risks in the event of an emergency.	
Budget for preparedness and contingency planning.	
Systematic allocation of a proportion of the budget to disability inclusion, and inclusion of and outreach to other marginalized and underserved groups.	
Routine review of the supply chain for commodity risk management and pre-positioning.	
Routine implementation of disaster response simulations/drills.	
Routine training or retraining of key personnel in emergency response.	
Support training of community groups in disaster risk reduction approaches in health.	

(cont'd)

DISTRICT PREPAREDNESS FOR SRH	Y/N
National or sub-national policies, laws, protocols, and strategies that **hinder the provision** of comprehensive SRH services to marginalized and underserved groups at the district level at any given time.	
National or sub-national policies, laws, protocols, and strategies that are **conducive to the provision** of comprehensive SRH services to marginalized and underserved groups at the district level at any given time.	
Laws, policies, or protocols that are conducive to the provision of comprehensive SRH services.	
Routine gender/SRH/disability risk assessment.	
SRH focal point for emergencies.	
Budget for SRH preparedness and contingency planning specifically.	
Action plan to address preparedness for SRH that includes all components of the MISP for SRH.	
Mechanisms to monitor the implementation of action plans to address preparedness for SRH.	
Routine implementation of disaster response simulations/drills for SRH specifically.	
Staff trained in the MISP specifically.	
Routine training or retraining of key personnel in emergency response for SRH (MISP) specifically.	
Work with groups serving marginalized and underserved populations to ensure their voices are heard in processes to build community resilience.	
Pre-positioning of supplies and equipment to provide MISP for SRH services should an emergency occur.	

- Ask participants if they would like to add additional information from their various roles and what they know of district level preparedness for health and SRH.
- To conclude, the facilitator can share brief quotes from the pre-workshop **community capacity and needs assessment** with regard to the community's perspectives around resilience, if they are available. The facilitator can read the prepared meta cards and post them to the wall for participants to review throughout the training.
- See if participants have other thoughts to add in terms of the resilience they would like to see in their communities.



Closing and Next Steps

30 minutes

Goal:

To pull together learning from the day and ensure understanding of both content and logistics information.

Summary: The end of Day 1 is a crucial time to connect with participants about their experience thus far and look ahead to Day 2. The nature of this training can be sensitive. Therefore, allow ample time to digest or address any topics that participants raise.

Supplies:

- Paper for daily evaluation (a quarter sheet of printing paper is sufficient for each participant)
- Information about dinner or any evening activities

Spend some time reviewing the material from the day to ensure understanding and comprehension. Mention concepts of DRR, and why it is important to take a gendered approach to disaster preparedness to prevent negative health consequences for communities. Leave space for open-ended questions. Questions can include:

- What is something new that you learned today?
- Would anyone like to review some of the key pieces of information that we learned today?
- Would anyone like to share any thoughts or reflections from today's activities?

Facilitator's Tip:

The closing is a perfect time to check in with participants and allow participants an informal and free-form space to discuss what they are thinking. Allow participants to guide this process.

END-OF-DAY EVALUATION:

Facilitate an informal discussion guided by the questions below. Take notes and ensure appropriate follow-up of items. The goal of the daily evaluations is to improve learning and participant experience for the remainder of the training.

1. What went well with the training today?
2. What can be improved?
3. Is there anything you would like to see change for tomorrow?
4. Is there anything you would like to see stay the same for tomorrow?

- *(In private if more appropriate)* Confirm whether accessibility/accommodations are adequate for participants with disabilities. Solicit additional suggestions for accommodations that may be feasible.

CLOSING AND NEXT STEPS:

Take a couple of minutes to discuss next steps, including when the next day's training will begin.

DAY 2

Understanding Sexual and Reproductive Health in Emergencies

GOAL:

Increase knowledge and understanding of the components of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health and gender protection in emergencies.

MODULE 2.1: Maternal and Newborn Health

MODULE 2.2: Voluntary Contraception

MODULE 2.3: Safe Abortion Care/Post-Abortion Care

MODULE 2.4: Sexually Transmitted Infections (STIs), HIV

MODULE 2.5: Gender-Based Violence

MODULE 2.6: Jeopardy!

Facilitator's Agenda Day 2

TIME	ITEM	COMPONENT(S)	SUPPLIES
8:30-8:50	**Welcome, Review, and Housekeeping**	• Review and housekeeping	
8:50-9:35	**MODULE 2.1:** Maternal Newborn Health (MNH)	• Video: *Atlas of Birth* • Presentation: *Maternal and Newborn Health*	• Laptop (with audio hook-up) • Projector and screen • *Atlas of Birth* Video (2012) http://www.youtube.com/watch?v=1rzlLy2UWQw&feature=c4-overview&list=UUuotZ_gy7TTUD7oy0Br3JKA • Presentation: *Maternal and Newborn Health* • IEC materials (including *Danger Signs During Childbirth, Signs of a Complicated Pregnancy,* and *Preparing for Childbirth*) • Relevant findings from pre-workshop **FGDs** • Flip chart paper and markers
9:35-10:15	**MODULE 2.2:** Voluntary Contraception	• Presentation: *Voluntary Contraception*	• Laptop • Projector and screen • Handouts on contraceptive options • Presentation: *Voluntary Contraception* • Relevant findings from pre-workshop **FGDs** • Flip chart paper and markers
10:15-10:45	**Tea Break**		
10:45-12:15	**MODULE 2.3:** Safe Abortion Care/ Post-Abortion Care	• Activity: *Cross the Line* • Presentation: *Safe Abortion care/ Post-Abortion care*	• Laptop • Projector and screen • Marker pens • Yarn (2-3 meters) • Presentation: *Safe Abortion Care/Post-Abortion Care* • Relevant findings from pre-workshop **FGDs** • Flip chart paper
12:15-13:00	**Lunch**		
13:00-13:45	**MODULE 2.4:** Sexually Transmitted Infections (STIs), Including HIV	• Presentation: *STIs, Including HIV*	• Laptop • Projector and screen • Presentation: *STIs, Including HIV* • Relevant findings from pre-workshop **FGDs** • Flip chart paper and markers
13:45-15:15	**MODULE 2.5:** Gender-Based Violence (GBV)	• Presentation: *Gender-Based Violence* • Activity: Referral web	• Laptop • Projector and screen • Presentation: *Gender-Based Violence* • Very large ball of yarn • Name tags for actors in activity • Sexual violence referral script • Relevant findings from pre-workshop **FGDs** • Flip chart paper and markers
15:15-15:45	**Tea Break**		
15:45-16:45	**MODULE 2.6:** Jeopardy!	• Activity: Jeopardy!	• Laptop • Projector and screen • Small papers for each group, one with #1 for game order • Paper money (in colored paper) • Prizes
16:45-17:00	**Closing and Next Steps**	• Gratitude • Daily evaluation • Items for tomorrow	• Paper for daily evaluation • Information about dinner or any evening activities

Introduction

20 minutes

WELCOME AND HOUSEKEEPING

- Welcome participants to Day 2 of the training.
- Start the day with a morning blessing/prayer as appropriate.
- Invite the host team from the prior day to share with participants the key activities and points of learning from Day 1 (see key concepts below).
- Identify the Day 2 host team and remind them of their tasks (ice breakers, recorder for the day).
- Review any logistical issues or concerns from Day 1.

KEY CONCEPTS FROM DAY 1

- Spend 10 to 15 minutes reviewing the key concepts of Day 1.
- Basic definition and comprehension of disaster risk reduction as it relates to SRH and gender.
- Specific risks and vulnerabilities unique to women, girls, and other marginalized and underserved groups in disasters.
- Concept of the MISP as a framework for minimum response in emergencies.

GOALS AND AGENDA FOR DAY 2

The purpose of Day 2 is to increase knowledge and understanding of the components of the Minimum Initial Service Package (MISP) for SRH. Today's learning will contrast with yesterday's focus on local risks and needs—and move to new learning on the topic of SRH and gender, and critical priorities during crises.

Learning objectives include:

- Familiarity with the SRH elements included in the MISP for SRH. Specifically including:
  - » Maternal newborn health, with a focus on safe birth planning and what to do in case of emergencies.
  - » Voluntary contraception, with a focus on building knowledge around methods and availability before an emergency.
  - » Safe abortion care and post-abortion care.
  - » HIV/STI prevention, with a focus on condom availability and standard precautions.
  - » Gender-based violence, with a focus on prevention and medical care for survivors of sexual violence.

Facilitator's Tip:

On the second day of training, the facilitator(s) should focus on ensuring that knowledge on SRH topics is concretized. The facilitator(s) will be more active today, focusing on activities and presentations that highlight the importance of SRH services, and emphasizing components or entry points for community involvement.

MODULE 2.1:
Maternal and Newborn Health

45 minutes

Goal:

Increase understanding of maternal and newborn health; knowledge of the three delays and pregnancy danger signs; awareness of the priorities of the MISP for SRH; and familiarity with safe birth plans.

Summary: This module covers a number of activities that help bring to life the concepts and messages around maternal and newborn health and priority interventions during an emergency.

VIDEO: ATLAS OF BIRTH

- After the video has finished, note that this is a global advocacy film. As such, it has an established agenda of building awareness around the issue of maternal death.
- Engage the group in a discussion by allowing participants to share their thoughts and ask questions.
- Facilitate discussion of the film by asking questions such as:
  - » Why are so many women dying during childbirth (e.g., lack of trained health workers, poverty, delays in seeking care due to permission/money/transportation, poor health facilities)?
  - » What are some of the delays that women might face in getting to a health facility when there is a problem during childbirth?
  - » What are some of the impacts of maternal death on the community?
  - » How would trained health workers help?
  - » In your community, do women and newborns die during pregnancy/childbirth? Do you know how many? Have you seen things that have helped to reduce these deaths?
  - » What systems and structures need to be maintained in an emergency in order to ensure that women and newborns do not die during childbirth?

Supplies:

- Laptop with audio hook-up (and power cord)
- Projector and screen
- *Birth and Death* Video (2012) http://www.youtube.com/watch?v=1rzlLy2UWQw&feature=c4-overview&list=UUuotZ_gy7TTUD7oy0Br3JKA
- Presentation: *Maternal and newborn health*
- IEC materials (including *Danger Signs During Childbirth, Signs of a Complicated Pregnancy,* and *Preparing for Childbirth*)
- Relevant findings from pre-workshop **focus group discussions**
- Flip chart paper and markers

PRESENTATION: MATERNAL AND NEWBORN HEALTH

- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- If relevant, share a few quotes or findings from the pre-workshop **focus group discussions**, especially around any risky behaviors or challenges/barriers that the community reports around access to maternal and newborn health services.
- Reiterate the importance of safe birth planning, as this is an area where community-based organizations and the community health workforce can play a critical role to help women prepare for childbirth and any pregnancy complications.
- To close the discussion, ask participants to consider ways to identify or reach pregnant women in their community who may suddenly find themselves isolated, such as in an epidemic/pandemic. Write any relevant suggestions on flip chart paper and post them to a wall.

PRESENTATION: MATERNAL AND NEWBORN HEALTH: 11 SLIDES

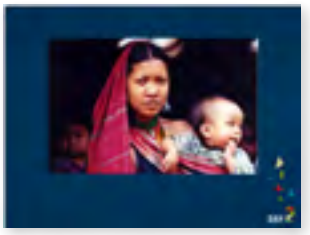
Hover your mouse over the image to get a description of the slide contents.

SLIDE 1

We are now going to spend much of our morning discussing safe motherhood/maternal and newborn health.

Photo credit: Peter Biro, IRC; Indonesia.

SLIDE 2



WHO Key Facts:[1]

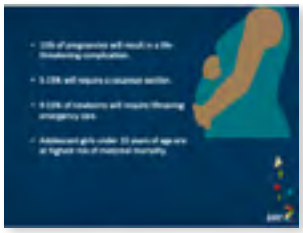
- Every day, approximately 810 women die from preventable causes related to pregnancy and childbirth (2017 data).
- 94% of all maternal deaths occur in low- and lower-middle-income countries. The maternal mortality ratio in low-income countries in 2017 was 462 per 100,000 live births versus 11 per 100,000 live births in high-income countries. A woman's lifetime risk of maternal death is the probability that a 15-year-old woman will eventually die from a maternal cause. In-high income countries, this is 1 in 5,400, versus 1 in 45 in low-income countries.
- Skilled care before, during, and after childbirth can save the lives of women and newborns.

References:
1. WHO. Key facts—Maternal Mortality. Last edited 19 September 2019. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

Photo Credit: Women's Refugee Commission.

PRESENTATION: MATERNAL AND NEWBORN HEALTH (cont'd)

SLIDE 3



- 15% of pregnancies will result in a life-threatening complication.[1]
- 5-15% will require a cesarean section.[1]
- WHO estimates that 9-15% of newborns will require lifesaving emergency care.[1]
- Adolescent girls are at highest risk of maternal mortality: The risk of maternal mortality is highest for adolescent girls under 15 years old, and complications in pregnancy and childbirth are higher among adolescent girls age 10-19 (compared to women aged 20-24).[2]
- Evidence indicates risks/mortality is higher in emergency settings.

References:
1. Cited in Inter-Agency Working Group on Reproductive Health in Crises (2018). Maternal Newborn Health Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/mnh.
2. WHO. Key facts-Maternal Mortality. Last edited 19 September 2019. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

SLIDE 4

Why do women die?

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for nearly 75% of all maternal deaths are:[1]

- Severe bleeding (mostly bleeding after childbirth)
- Infections (usually after childbirth)
- High blood pressure during pregnancy (pre-eclampsia and eclampsia)
- Complications from delivery
- Unsafe abortion

- Maternal and newborn health care, by which we mean services that cover pregnancy and its outcomes (live birth, miscarriage, stillbirth, or abortion), currently prevents 198,000 maternal deaths and 1.8 million newborn deaths per year in developing countries.[2]
- Providing all pregnant women and their infants with the level of maternal and newborn health care recommended by the World Health Organization would reduce maternal deaths by 64%, to 112,000 per year, assuming no change in contraceptive use or in the number of unintended pregnancies. Newborn deaths would drop by 76%, to 655,000.[2]
- If full care for all pregnant women and newborns were combined with full provision of modern contraception to women who want to avoid pregnancy, maternal deaths would drop from 308,000 to 84,000 per year, and newborn deaths would drop from 2.7 million to 538,000 per year.[3]

References:
1. WHO Key facts—Maternal Mortality. Last edited 19 September 2019. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.
2. Guttmacher Institute (2017). Adding It Up: Investing in Contraception and Maternal and Newborn Health. New York. https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017.

PRESENTATION: MATERNAL AND NEWBORN HEALTH (cont'd)

SLIDE 5

Facilitator should reference handouts of IEC materials.

See link for IEC materials: http://iawg.net/resource/universal-adaptable-information-education-communication-iec-templates-misp/.

SLIDE 6

Although having emergency obstetric care available at a health facility is critical, there are a number of societal factors that influence the ability of a mother to get needed treatment and prevent maternal death. "The Three Delays Model" focuses on these factors. These delays are particularly important for community groups and community members to understand. In addition to checking health facilities for a basic level of care, communities can proactively address some of these delays through education and outreach.

The following is an excerpt from UNFPA's 2002 publication: *Maternal Mortality Update 2002: A Focus on Emergency Obstetric Care*.

In most instances, women who die in childbirth experienced at least one of the following three delays:

- **The First Delay is the delay in deciding to seek care for an obstetric complication**. This may occur for several reasons, including late recognition that there is a problem, fear of the hospital, or of the costs that will be incurred there, or the lack of an available decision-maker.
- **The Second Delay is a delay in actually reaching the care facility** and is usually caused by difficulty in transport. Many villages have very limited transportation options and poor roads. Some communities have developed innovative ways to address this problem, including prepayment schemes, community transportation funds, and a strengthening of links between community practitioners and the formal health system.
- **The Third Delay is the delay in obtaining care at the facility**. This is one of the most tragic issues in maternal mortality. Often, women will wait for many hours at the referral center because of poor staffing, prepayment policies, or difficulties in obtaining blood supplies, equipment, or an operating theater. The third delay is the area that many planners feel is easiest to correct. Once a woman has actually reached an emergency obstetric care facility, many economic and sociocultural barriers have already been overcome.

Focusing on improving services in the existing centers is a major component in promoting access to emergency obstetric care. Programs designed to address the first two delays are of no use if the facilities themselves are inadequate.

Reference:
1. United Nations Population Fund (UNFPA), *Maternal Mortality Update 2002: A Focus on Emergency Obstetric Care*. New York: UNFPA; 2003. http://unfpa.org/public/home/ publications/pid/2478.

PRESENTATION: MATERNAL AND NEWBORN HEALTH (cont'd)

SLIDE 7

In any given population, 25% of the population are women of reproductive age (WRA). Anywhere from 4-16% of WRA will be pregnant at any given time; 15% of these will experience life-threatening pregnancy complications.

In emergency settings, the three delays can be compounded at each level by insecurity, lack of functioning supply chains, and limited availability of health providers.

In epidemic/pandemic situations, additional challenges may emerge, including risks of pregnant women contracting disease either in the community or in a health care setting that could increase risks of adverse outcomes, as well as concerns for physical and emotional isolation if mobility is constrained or quarantines are issued.

Ask participants to reflect on the most recent emergency, and brainstorm each of the three delays and how they played out for women during the emergency. Participants should think also of existing social and economic factors that could contribute to delays in stable times, and how these factors may have played a role or been exacerbated during the emergency.

References:

- Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. I*nter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
- UNFPA (March 2020). COVID-19: *A Gender Lens. Technical Brief Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf

SLIDE 8

MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services 24 hours per day, 7 days per week, including:
  - **At referral hospital level**: Skilled medical staff and supplies for provision of **comprehensive emergency obstetric and newborn care (CEmONC)**.
  - **At health facility level**: Skilled birth attendants and supplies for **uncomplicated vaginal births and provision of basic obstetric and newborn care (BEmONC)**.
  - **At community level**: **Provision of information** to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. **Clean delivery kits** should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
- Establish a 24 hours per day, 7 days per week **referral system** to facilitate transport and communication from the community to the health center and hospital.
- Ensure the **availability of lifesaving post-abortion care** in health centers and hospitals.
- Ensure availability of supplies and commodities for **clean delivery and immediate newborn care** where access to a health facility is not possible or unreliable.

PRESENTATION: MATERNAL AND NEWBORN HEALTH (cont'd)

SLIDE 8 (cont'd)

Definitions for the facilitator

Basic EmONC: Parenteral antibiotics for treatment of sepsis; uterotonic drugs (i.e., parental oxytocin or misoprostol tablets) and intravenous tranexamic acid for postpartum haemorrhage; parenteral anticonvulsant drugs (i.e., magnesium sulfate) for severe preeclampsia and eclampsia; assisted vaginal delivery (e.g., vacuum extraction); manual removal of the placenta; removal of retained products of conception after delivery or incomplete abortion; and basic neonatal resuscitation (e.g., with bag and mask).

Comprehensive EmONC: Surgery (e.g., caesarean section); safe blood transfusions.

Newborn care: Newborn resuscitation, including a bag and mask; thermal protection (delayed bathing, drying, and wrapping and immediate and continued skin-to-skin contact); prevention of infection (hand washing, dry cord care or use of chlorohexidine, and eye care); immediate and exclusive breastfeeding; antibiotics (gentamycin and ampicillin) for newborn infections and early referral; care for preterm/low birth weight babies (Kangaroo mother care, etc.).

Reference:
Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 9

While the 2018 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* includes detailed updates, a few new elements under this objective of the MISP include:

Chlorhexidine for clean cord care at home.[1]

Application of 7.1% chlorhexidine digluconate, delivering 4% chlorhexidine (CHX) to the umbilical cord, especially on the day of birth, is a low-cost intervention that has been shown to reduce newborn mortality. It can be used in settings with high newborn death where women have been trained on how to use it.

CHX was added to the 2013 WHO *List of Essential Medicines for Children* (https://wrc.ms/WHO-essential-meds), specifically for umbilical cord care. In January 2014, WHO issued a new recommendation for umbilical cord care that prioritized daily CHX application to the umbilical cord stump during the first week of life for newborns born in home settings with high neonatal mortality (30 or more neonatal deaths per 1,000 live births).

Kangaroo mother care for preterm and low birth weight babies.[1]

- Kangaroo mother care (KMC) is one of the most promising ways to save preterm and low birth weight babies in all settings. This form of care, initiated in health facilities, involves teaching health workers and caregivers on how to keep newborns warm through continuous, 24 hours per day, skin-to-skin contact on the mother or caregiver's chest. KMC may significantly enhance other well-known treatments for treating prematurity, such as thermal care, breastfeeding support, infection prevention and management, and neonatal resuscitation.

Reference:
Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

PRESENTATION: MATERNAL AND NEWBORN HEALTH (cont'd)

SLIDE 10

Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 11

Safe birth plan: Talking with family to plan about picking up a birthing kit; planning to use a skilled birth attendant and, if possible, giving birth in a facility; and planning for emergency transportation.

Clean delivery kit: Includes one sheet of plastic (for women); bar of soap; pair of gloves; one clean razor blade or other cutting instrument, new and wrapped in its original paper, to cut umbilical cord; three pieces of umbilical tape to tie umbilical cord; and two pieces of cotton cloth to dry and use as diaper. It may also include misoprostol tablets (600 mcg) and chlorhexidine for cord care, depending on the context.

If **newborn kits** are also distributed, they can include: baby blanket 50x75 cm, polyester fleece, newborn cap, newborn romper suit, baby socks, and a small cotton towel.

Ask participants to take a moment to think about their professional role, and the organization they work with. How could their organization, or someone in their role, be engaged to support community preparedness for maternal and newborn health in emergencies? Then, call on several participants to share concrete examples.

Reference:
Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

MODULE 2.2:
Voluntary Contraception

40 minutes

Goal:

Increase understanding of the importance of voluntary contraception; the types of contraceptive methods available; and the priorities in the MISP for SRH.

Summary: This session includes one presentation. It is designed to be short and focused on building general knowledge on the topic.

PRESENTATION: VOLUNTARY CONTRACEPTION

- Remind participants that today you are gradually moving through the health areas that are prioritized during an emergency response.
- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- If relevant, share a few quotes or findings from the pre-workshop **focus group discussions**, especially around any risky behaviors or challenges/barriers that the community reports around access to contraceptive services.
- To close the discussion, ask participants to consider how to provide contraception if mobility is restricted, such as during an outbreak of violence or an epidemic/pandemic. Write any relevant suggestions on flip chart paper and post them to a wall.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Handouts on contraceptive options
- Presentation: *Voluntary Contraception*
- Relevant findings from pre-workshop **focus group discussions**
- Flip chart paper and makers

PRESENTATION: VOLUNTARY CONTRACEPTION: 13 SLIDES

SLIDE 1

SLIDE 2

Improving access to contraception for women in crises has a significant impact on multiple fronts. It safely and cost-effectively prevents unintended pregnancies and reduces maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. The provision of comprehensive family planning information and services also leads to substantial improvements in women's earnings and children's schooling.

Access to contraception will also increase the engagement of women and girls in education, protection, life skills, and livelihoods programming by allowing them control over their fertility. The inability to control fertility and access these critical programs during crises will impact their life trajectories long after the emergency has passed.

References:
Cited in Inter-Agency Working Group on Reproductive Health in Crises (2018). Voluntary Contraception. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/contraception.

SLIDE 3

In 2008, contraceptive use reduced maternal deaths around the world by 272,042 (44% reduction). Satisfying unmet need for contraception could prevent another 104,000 maternal deaths per year (29% reduction).[1]

Roughly 90% of unsafe abortion-related morbidity can be prevented by the use of contraception.[2]

Before moving to the next slide, ask participants to call out different contraceptive methods. Move to the next slide once the group cannot name any additional methods.

References:
1. Saifuddin Ahmed, Qingfeng Li, Li Liu, Amy O Tsui . Maternal deaths averted by contraceptive use: an analysis of 172 countries. Lancet 2012; 380: 111–25. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60478-4/fulltext.
2. Cited in Inter-Agency Working Group on Reproductive Health in Crises (2018). Voluntary Contraception. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/contraception.

SLIDE 4

Facilitator should describe each method of contraception:

LAM: A structured method of breastfeeding that suppresses ovulation. To be used as a family planning method, breastfeeding must be exclusive for up to 6 months; breast milk is the exclusive form of sustenance for the infant. Feedings should be regular, and no more than 4 hours apart during the day; no more than 6 hours between feedings at night. Once menstruation resumes, LAM is no longer effective.

PRESENTATION: VOLUNTARY CONTRACEPTION (cont'd)

SLIDE 4 (cont'd)

Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and Two-Day Method) may be the easiest to use and consequently more effective.

Pills: Oral contraceptive pills are taken daily and are available in both progestin-only (mini-pills) and combination hormonal pills. Progestin-only pills must be taken at the exact same time every day in order to be most effective.

Injectable: A progestin-only hormonal method of contraception (frequently Depo-Provera) that is administered through an injection every three months.

Patch: Hormonal method of contraception that is delivered through an adhesive "patch" to the skin; must stay in place and be changed monthly.

Vaginal ring: Hormonal method of contraception that is inserted as a small, flexible ring directly into the vagina; changed monthly.

IUD: A small, T-shaped device that is inserted by a trained clinician into the uterus. There are hormonal and non-hormonal IUDs. The hormonal IUD (Morena or Skyla) releases levonorgestrel (progestin) which damages sperm and changes the cervical mucus and uterine lining. The copper-T is non-hormonal and damages/kills sperm.

Implant: Progestin-only hormonal contraception that is surgically inserted into a woman's upper arm. Depending on the brand used, implants may last for up to 5 years before needing replacement.

Vasectomy and **tubal ligation** are permanent methods of contraception.

Emergency contraception: A "post-coital" method of family planning that is used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure, misuse (such as forgotten pills or torn condoms), rape, or coerced sex. Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation. Emergency contraceptive pills cannot interrupt an established pregnancy or harm a developing embryo. Emergency contraception can be used up to 120 hours (five days) after unprotected sex to prevent pregnancy.

There are two main types of emergency contraception:

- Emergency contraceptive pills, which are more effective the sooner they are taken.
- The copper-T IUD, which can be used to prevent pregnancy up to five days after unprotected sex. It prevents fertilization by causing a chemical change in sperm and egg before they meet.

Reference:
WHO. Emergency Contraception. Updated 2 February 2018. http://www.who.int/mediacentre/factsheets/fs244/en/.

Photo credit: IAWG on RH in Crises.

SLIDE 5

Facilitator should draw attention to the CDC handout in their folders and/or review the methods in the subsequent slides.

Point to the decisions that many make between hormonal and non-hormonal methods, as well as temporary, long-acting, and permanent.

Figure: https://www.researchgate.net/figure/Effectiveness-of-family-planning-methods_fig1_315629787.

If the facilitator needs more information around the pros and cons of each method, please see this fact sheet: https://www.reproductiveaccess.org/wp-content/uploads/2014/06/contra_choices.pdf.

PRESENTATION: VOLUNTARY CONTRACEPTION (cont'd)

SLIDE 6

Template C from IAWG on RH in Crises. Universal & Adaptable Information, Education & Communication (IEC) Templates on Family Planning. http://iawg.net/resource/template-c-explanation-family-planning-methods/.

SLIDE 7

Template C from IAWG on RH in Crises. Universal & Adaptable Information, Education & Communication (IEC) Templates on Family Planning. http://iawg.net/resource/template-c-explanation-family-planning-methods/.

SLIDE 8

Template C from IAWG on RH in Crises. Universal & Adaptable Information, Education & Communication (IEC) Templates on Family Planning. http://iawg.net/resource/template-c-explanation-family-planning-methods/.

SLIDE 9

Template C from IAWG on RH in Crises. Universal & Adaptable Information, Education & Communication (IEC) Templates on Family Planning. http://iawg.net/resource/template-c-explanation-family-planning-methods/.

SLIDE 10

Template C from IAWG on RH in Crises. Universal & Adaptable Information, Education & Communication (IEC) Templates on Family Planning. http://iawg.net/resource/template-c-explanation-family-planning-methods/.

SLIDE 11

Ask participants to think back to what they have learned about the importance of SRH during emergencies on Day 1. Why is providing voluntary contraception to prevent unintended pregnancies lifesaving during emergencies? Allow all participants who wish to speak to do so before moving to the next slide.

PRESENTATION: VOLUNTARY CONTRACEPTION (cont'd)

SLIDE 12

MISP Objective 5: Prevent unintended pregnancy

Ensure availability of a range of **long-acting reversible and short-acting contraceptive methods** (including male and female condoms and emergency contraception) at primary health care facilities to meet demand.

Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination.

Ensure the **community is aware** of the availability of contraceptives for women, adolescents, and men.

Due to personal preference and changing needs over the life course, it is important to ensure a broad range of contraceptive methods. Method mix, including long-acting reversible contraception and emergency contraception, is important to address informed and voluntary choice and changing client needs. This is true from the earliest phases of the emergency.

In an epidemic/pandemic, or even situations of increased insecurity, providing continuity of contraceptive coverage may become a challenge with disruptions to the supply chain and access. In such situations, it will be important to consider self-management options or provide a longer-term supply. Long-acting methods will also be useful for this purpose.

As the situation stabilizes and program capacity improves, it becomes increasingly important to ensure that an appropriate method mix is available for the entire population and that family planning intentions are understood and met. Programs need to address the context of their operations, as the expectations of the affected population will be shaped by their previous exposure and use of a broader contraceptive method mix.

References:

- Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
- Inter-Agency Working Group on Reproductive Health in Crises (2018). Contraception Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/contraception#service-availability.
- Inter-Agency Working Group on Reproductive Health in Crises, et al (2020). *Programmatic Guidance Regarding Sexual and Reproductive Health Care in Face of COVID.*

SLIDE 13

Inter-Agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

TEA BREAK

30 minutes

During this time, clear a large area of the room to allow participants to move around, and place the yarn from Day 1 in a straight line in the middle of this area.

MODULE 2.3:
Safe Abortion Care/ Post-Abortion Care

1.5 hours

Goal:

Increase understanding of the importance of safe abortion care/post-abortion care in humanitarian settings, and the priorities in the MISP for SRH.

Summary: This session includes an exercise on values clarification around induced abortion, as well as a presentation on safe abortion care/post-abortion care in humanitarian settings. The activities are intended to help participants understand the importance of attending to unwanted pregnancy in humanitarian settings and, at a minimum, making post-abortion care available in all circumstances.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Marker pens
- Yarn (2-3 meters)
- Presentation: *Safe Abortion Care/ Post-Abortion Care*
- Relevant findings from pre-workshop **focus group discussions**
- Flip chart paper

ACTIVITY: CROSS THE LINE

45 minutes

Adapted from Ipas's "Cross the Line," *Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences*, 2018. Available from: https://www.ipas.org/resources/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences

- The values clarification exercise is intended to bring to light where participants stand around the concept of induced abortion and the provision of safe abortion care.
- Before this exercise, reiterate the ground rules of this training in terms of maintaining respect for all participants. It is important to create a safe environment for all participants, regardless of their views.
- Explain that you will read a series of statements and that participants should step entirely across the line (that was placed in the middle of the room during the tea break) when a statement applies to their beliefs or experiences.

- Remind participants that there is no "in between," which means they must stand on one side of the line or the other, and that there are no right or wrong answers. Encourage participants to stand on the side of the line that best reflects their own beliefs and not feel pressured to move with the rest of the group.
- The facilitator should stand at one end of the line and start with a practice statement, such as: "Cross the line if you had coffee this morning." Then, the facilitator should go through the first several "Cross the line if" statements below.
- Once some people have crossed the line, give participants an opportunity to observe who crossed the line and who did not. Invite participants to notice how it feels to be where they are.
- Ask someone who crossed the line and then someone who did not to briefly explain their reasons for crossing or not crossing the line. If someone is the only person who did or did not cross the line, ask them what that feels like.
- Invite all participants to move back to one side of the line.
- Repeat this for several of the "Cross the line" statements (see list below). Select the statements that most apply to participants. When you are finished, ask participants to take their seats.
- Discuss the activity, including with questions such as:
  - What did you learn from this activity? (or: What did you learn about your own and others' views on safe abortion care?)
  - Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
  - What does this activity teach us, in general, about the stigma and cultural norms related to safe abortion care?
  - How might stigma and cultural norms influence a woman's decision about terminating a pregnancy?
  - How might stigma and cultural norms influence the comfort of staff in your agency with providing or supporting the provision of safe abortion care in your projects?
- Summarize the key points from this activity:
  - Not all of us may be comfortable with abortion care services, but regardless, we have a responsibility to ensure women can access safe services.
  - If you are uncomfortable or unable to provide a safe abortion service, be sure to refer women to a provider that can provide a safe service.
  - We may feel afraid to talk about abortion work, but the bottom line is that safe abortion services save women's lives.

NOTES:

"CROSS THE LINE IF" STATEMENTS

Cross the line if:

- You were raised to believe that abortion should not be openly discussed.
- At some point in your life, you believed abortion is wrong.
- You have been asked to keep someone's abortion a secret.
- You have ever felt uncomfortable talking about abortion.
- You have ever heard a friend or family member talking in a negative manner about women who have had abortions.
- You or someone you are close to has had an abortion.
- You have ever avoided the topic of abortion in order to avoid conflict.
- You have heard the term "baby killers" applied to women who have abortions, or medical staff or other health-care workers who provide safe abortion care.
- At some point in your life, you believed that relief is a common reaction after a safe abortion.
- You believe there is a medical need for safe abortion care to be available to women, in general.
- You are committed to addressing all the main causes of maternal death, including unsafe abortion.
- You have had to tell a woman that she cannot have an abortion.
- You have had to tell a woman with an unwanted pregnancy as a result of rape that she cannot have an abortion.

PRESENTATION: SAFE ABORTION CARE/ POST-ABORTION CARE

45 minutes

- Transition to a presentation on safe abortion care/post-abortion care.
- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- Reiterate that per the MISP for SRH standard, safe abortion care should be provided to the full extent of the law. At a minimum, post-abortion care should be made accessible and available under all circumstances.

- If relevant, share a few quotes or findings from the pre-workshop **focus group discussions**, especially around any risky behaviors or challenges/barriers that the community reports around access to safe abortion services.
- Ask participants to consider how to provide safe abortion care if mobility is restricted, such as during an outbreak of violence or an epidemic/pandemic. Write any relevant suggestions on flip chart paper and post them to a wall.
- Close the discussion by sharing that even though not everyone may be supportive of abortion, the bottom line is that safe abortion saves women's lives. It is important to remember that what participants can do helps some of the most vulnerable women when they feel they do not have any other option, and that their work contributes to saving women's lives. Thank participants for being advocates for women and girls and for decreasing maternal mortality.

PRESENTATION: SAFE ABORTION CARE/POST-ABORTION CARE: 11 SLIDES

SLIDE 1

We are now going to spend much of our morning discussing safe abortion care and post-abortion care.

Photo credit: Cited in Inter-agency Working Group on Reproductive Health in Crises website. http://iawg.net/areas-of-focus/safe-abortion-care/.

SLIDE 2

WHO (2019) Key Facts:[1]

- There were 35 induced abortions per 1,000 women aged between 15 and 44 years.
- 25% of all pregnancies ended in an induced abortion.
- Around 25 million unsafe abortions were estimated to have taken place worldwide each year, almost all in developing countries. Among these, 8 million were carried out in the least-safe or dangerous conditions.
- Each year, between 4.7% and 13.2% of maternal deaths can be attributed to unsafe abortion.
- Around 7 million women are admitted to hospitals every year in developing countries as a result of unsafe abortion.
- The annual cost of treating major complications from unsafe abortion is estimated at US$553 million.

Unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. The people, skills, and medical standards considered safe in the provision of induced abortions are different for medical abortion (which is performed with drugs alone), and surgical abortion (which is performed with a manual or electric aspirator). Skills and medical standards required for safe abortion also vary depending upon the duration of the pregnancy.

PRESENTATION: SAFE ABORTION CARE/POST-ABORTION CARE (cont'd)

SLIDE 2 (cont'd)

- They are less safe when done using outdated methods like sharp curettage even if the provider is trained or if women using tablets do not have access to proper information or to a trained person if they need help.
- Abortions are dangerous or least safe when they involve ingestion of caustic substances or when untrained persons use dangerous methods such as insertion of foreign bodies or use of traditional remedies.

Women and girls in humanitarian settings may be at increased risk of unsafe abortion, due to limited access to contraceptive services and prevalence of rape and other forms of sexual violence.[2]

References:
1. WHO. Preventing unsafe abortion. Last edited 26 June 2019. https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion.
2. Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.* https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

Photo Credit: Women's Refugee Commission.

SLIDE 3

While restrictive laws can be barriers, there is often widespread misinformation (even among health care providers) about the legal status of abortion. Women can be turned away as a result, even when they should be able to receive services.

Reference:
WHO. Preventing unsafe abortion. Last edited 26 June 2019. https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion.

SLIDE 4

Following unsafe abortion, women may experience a range of harms that affect their quality of life and well-being, with some women experiencing life-threatening complications. The major life-threatening complications resulting from the least safe abortions are hemorrhage, infection, and injury to the genital tract and internal organs. Unsafe abortions when performed under least safe conditions can lead to complications such as:

- Incomplete abortion (failure to remove or expel all of the pregnancy tissue from the uterus)
- Hemorrhage (heavy bleeding)
- Infection
- Uterine perforation (caused when the uterus is pierced by a sharp object)
- Damage to the genital tract and internal organs by inserting dangerous objects such as sticks, knitting needles, or broken glass into the vagina or anus.

Reference:
WHO. Preventing unsafe abortion. Last edited 26 June 2019. https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion.

SLIDE 5

The critical signs and symptoms of complications that require immediate attention include:

- Abnormal vaginal bleeding
- Abdominal pain
- Infection
- Shock (collapse of the circulatory system)

Reference
WHO. Preventing unsafe abortion. Last edited 26 June 2019. https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion.

PRESENTATION: SAFE ABORTION CARE/POST-ABORTION CARE (cont'd)

SLIDE 6

Complications arising from unsafe abortions and their treatments include:

- Hemorrhage: Timely treatment of heavy blood loss is critical, as delays can be fatal.
- Infection: Treatment with antibiotics along with evacuation of any remaining pregnancy tissue from the uterus as soon as possible.
- Injury to the genital tract and/or internal organs: Early referral to an appropriate level of health care is essential.

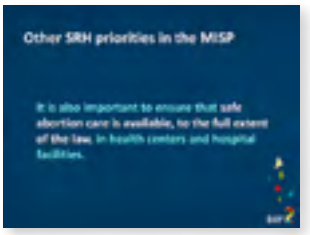
References:

- WHO. Preventing unsafe abortion. Last edited 26 June 2019. https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion..
- Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 7

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 8



Most countries now allow abortion to be performed on multiple grounds, including when the pregnancy endangers the woman's life, threatens the woman's physical and/or mental health, is the result of rape or incest, or involves a fetus with a severe impairment.

Evidence demonstrates that access to safe abortion for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality.

As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of safe abortion care (SAC) for women who are raped in crises; international human rights law supports access to SAC across all settings.

Reference:

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

PRESENTATION: SAFE ABORTION CARE/POST-ABORTION CARE (cont'd)

SLIDE 9

In most settings safe abortion care is legally permissible for some or all reasons and capacity exists to provide and/or refer women to SAC services. If the woman chooses an abortion, health care workers should:

- **Provide medically accurate information** about abortion services in a form women can understand and recall.
- **Explain any legal requirements** for obtaining safe abortion care.
- **Explain where and how to obtain safe, legal abortion services** and their cost.
- **Provide medication abortion, with mifepristone/misoprostol if available or misoprostol-alone** if mifepristone is unavailable, **vacuum aspiration, dilatation and evacuation, or induction procedures** as recommended by WHO.
- **Provide information and offer counseling to women on post-abortion contraceptive use** and provide contraception to women who accept a method.
- **Consider providing presumptive treatment** for gonorrhea and chlamydia in settings with a high prevalence of STIs.

Reference:
Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 10

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. Inter-agency *Field Manual on Reproductive Health in Humanitarian Settings.* https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

SLIDE 11

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. Inter-agency *Field Manual on Reproductive Health in Humanitarian Settings.* https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

LUNCH

45 minutes

MODULE 2.4:
Sexually Transmitted Infections (STIs) and HIV

45 minutes

Goal:

Increase understanding of the importance of prevention, management, and care of STIs, including HIV, in emergencies, and the priorities in the MISP for SRH.

Summary: The format for this module is a short presentation.

PRESENTATION: SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV

- Before the presentation, ask participants if they have outstanding questions or concerns from the previous topic.
- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- If relevant, share a few quotes or findings from the pre-workshop **focus group discussions**, especially around any risky behaviors or challenges/barriers that the community reports around access to HIV/STI services.
- Ask participants to consider how to provide antiretroviral therapy if mobility is restricted, such as during an outbreak of violence or an epidemic/pandemic. Write any relevant suggestions on flip chart paper and post them to a wall.
- Stress the importance of standard precautions and good hygiene practices in the community, even if there is no current outbreak of disease.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Presentation: *Sexually Transmitted Infections, Including HIV*
- Relevant findings from pre-workshop **focus group discussions**
- Flip chart paper and markers

PRESENTATION: STIs INCLUDING HIV: 11 SLIDES

SLIDE 1

Photo Credit: Women's Refugee Commission; Kenya.

SLIDE 2

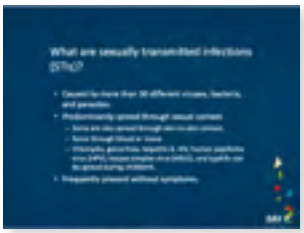
This presentation is based on facts available through WHO's current fact sheets:[1]

- More than 1 million sexually transmitted infections (STIs) are acquired every day worldwide.
- Each year, there are an estimated 376 million new infections with 1 of 4 STIs: chlamydia, gonorrhea, syphilis, and trichomoniasis.
- The majority of STIs have no symptoms or only mild symptoms that may not be recognized as an STI.
- 988,000 pregnant women were infected with syphilis in 2016, resulting in over 350,000 adverse birth outcomes, including 200,000 stillbirths and newborn deaths.

Reference:
1. WHO. Sexually transmitted infections. Updated 14 June 2019. https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

Photo Credit: Women's Refugee Commission

SLIDE 3

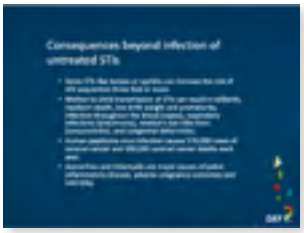


What are sexually transmitted infections and how are they transmitted?[1]

- STIs are caused by more than 30 different bacteria, viruses, and parasites, and are spread predominantly by sexual contact, including vaginal, anal, and oral sex.
- Some STIs may be spread via skin-to-skin sexual contact. The organisms causing STIs can also be spread through non-sexual means, such as blood products and tissue transfer. Many STIs—including syphilis, hepatitis B, HIV, chlamydia, gonorrhea, herpes, and human papilloma virus (HPV)—can also be transmitted from mother to child during pregnancy and childbirth.
- A person can have an STI without having obvious symptoms of disease. Therefore, the term "sexually transmitted infection" is a broader term than "sexually transmitted disease" (STD).

Reference:
1. WHO. Sexually transmitted infections. Updated 14 June 2019. https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

SLIDE 4

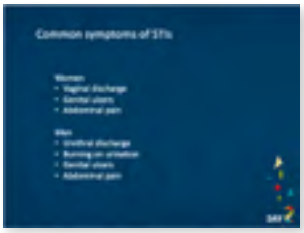


Untreated STIs can also have painful social consequences, suffered primarily by women in the developing world. For too many, social stigma and personal damage due to infertility and loss of pregnancy may result in divorce or commercial sex work. In addition to the impact of infertility, STIs can give rise to conflicts between couples, their families who become aware, and friends who are part of their support system. The number of incidents of violence and abusive behavior or retribution as a result of discovering an STI remains undocumented, but experience shows that an STI can bring emotional consequences, including depression and its medical and social effects.

Reference:
1. WHO. Sexually transmitted infections. Updated 14 June 2019. https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

PRESENTATION: STIs INCLUDING HIV (cont'd)

SLIDE 5



Common symptoms of STIs include vaginal discharge, urethral discharge or burning in men, genital ulcers, and abdominal pain. However, people who have STIs may also not notice any symptoms (asymptomatic). The majority of STIs have no symptoms or only mild symptoms that may not be recognized as an STI.

All sexually active men and women as well as those who have been sexually abused (including children) are at risk of developing an STI.

Reference:
1. WHO. Sexually transmitted infections. Updated 14 June 2019. https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

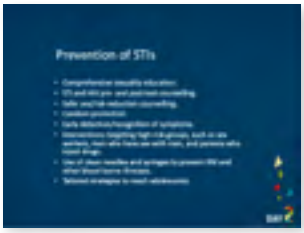
SLIDE 6

Eight of the most common pathogens are linked to the greatest incidence of STIs. Of these 8 infections, 4 are currently curable: syphilis, gonorrhea, chlamydia, and trichomoniasis. The other 4 are viral infections which are incurable: Hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV). Both HPV and hepatitis B infections are preventable with vaccination.

More than 1 million STIs are acquired every day. In 2016, WHO estimated 376 million new infections with 1 of 4 STIs: chlamydia (127 million), gonorrhea (87 million), syphilis (6.3 million) and trichomoniasis (156 million). More than 500 million people are living with genital HSV (herpes) infection and an estimated 300 million women have an HPV infection, the primary cause of cervical cancer. An estimated 240 million people are living with chronic hepatitis B globally.

WHO. Sexually transmitted infections. Updated 14 June 2019. https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis).

SLIDE 7



Comprehensive sexuality education should enable people to:[1]

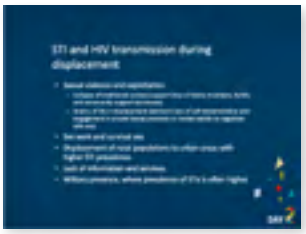
- acquire accurate information on sexual and reproductive rights, information to dispel myths, and references to resources and services;
- develop life skills, including critical thinking, communication and negotiation, self-development and decision-making; sense of self; confidence; assertiveness; ability to take responsibility; ability to ask questions and seek help; and empathy;
- nurture positive attitudes and values, including open-mindedness, respect for self and others, positive self-worth/esteem, comfort, nonjudgmental attitude, sense of responsibility, and positive attitude toward their sexual and reproductive health.

Before moving to the next slide, ask participants how they think emergencies could affect the transmission and treatment of STIs and HIV. Allow all participants who wish to speak to share their ideas before presenting the content.

Reference:
1. Guttmacher Institute. A Definition of Comprehensive Sexuality Education. https://www.guttmacher.org/sites/default/files/report_downloads/demystifying-data-handouts_0.pdf.

PRESENTATION: STIs INCLUDING HIV (cont'd)

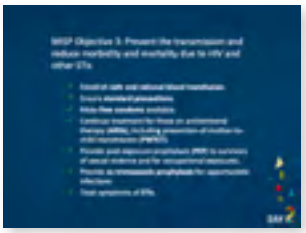
SLIDE 8



HIV spreads fastest in conditions of poverty, powerlessness, and social instability. These conditions are often compounded in situations of forced migration. During civil strife and flight, displaced persons, especially women and girls, are at increased risk of sexual violence, including rape. The disturbance of community and family life among displaced persons may disrupt social norms governing sexual behavior. Adolescents may take sexual risk and face exploitation in the absence of traditional sociocultural constraints. Women and children may be coerced into having sex to obtain their survival needs. Vulnerability to HIV increases when human rights are violated.

In situations of forced migration, populations from low-prevalence areas may be living close to a population with high prevalence. Peacekeeping forces, military, and police tend to have higher prevalence of STIs, including HIV, and may also be susceptible to infection and a source of HIV exposure in situations of forced migration.

SLIDE 9



Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs:[1]

- Establish safe and rational use of blood transfusion.
- Ensure application of standard precautions.
    - Hand washing, wear gloves, wear protective clothing, safe handling of sharps, safe waste disposal, decontaminate instruments.
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs.
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure.
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

The practice of standard precautions (see definition below)—including washing hands frequently with soap and water—is particularly important to prevent the spread of not just HIV and hepatitis, but other illnesses including respiratory viruses.[2]

Definitions for the facilitator

Standard precautions:[1] Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health workers. Under the "standard precautions" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person. Standard precautions prevent the spread of infections such as HIV, hepatitis B, hepatitis C, and other pathogens within health care settings. **Standard precautions include frequent hand washing; wearing gloves; wearing protective clothing; safe handling of sharp objects; safe disposal of waste material; instrument processing; and housekeeping.**

In some instances, the use of personal protective equipment (PPE) may be warranted. These might include: gloves, medical masks, goggles or a face shield, and gowns, respirators (i.e. N95 or FFP2 standard or equivalent), and aprons.[2]

Occupational exposure:[1] Exposure to blood or bodily fluids in the workplace setting. PEP should be made available within the health sector as part of a comprehensive standard precautions package to reduce staff exposure to infectious hazards at work.

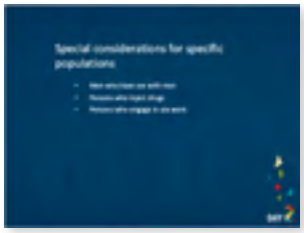
PRESENTATION: STIs INCLUDING HIV (cont'd)

SLIDE 9 (cont'd)

Opportunistic infections:[3] Opportunistic infections are infections that occur more often in people with weakened immune systems than in people with healthy immune systems. Those with weakened immune systems include persons living with HIV. HIV-related opportunistic infections are pneumonia, Salmonella infection, candidiasis (thrush), toxoplasmosis, and tuberculosis.

References:
1. Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
2. WHO (2019). Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19). https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf.
3. U.S. Department of Health and Human Services. *HIV and Opportunistic Infections, Coinfections, and Conditions*. Last updated May 28, 2019. https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/26/86/what-is-an-opportunistic-infection-.

SLIDE 10



Special considerations for specific populations who may be at increased risk of STIs, including HIV.

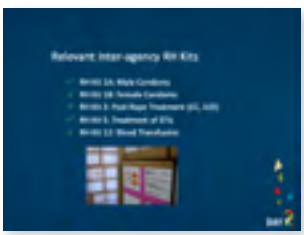
Men who have sex with men: Men who have sex with men (MSM) include all men who have same-sex relations, regardless of their self-identified sexual orientation (gay, bisexual, or heterosexual). Worldwide, MSM are estimated to be 24 times more likely to be infected with HIV than the general population, with HIV prevalence ranging from 14% to 18% across the Americas, Asia, and sub-Saharan Africa. Effective HIV programming for MSM includes community empowerment, protection from violence, provision of condoms and lubricant, provision of comprehensive and integrated health care.

Persons who inject drugs: Rates of new HIV infection have been found to be 24 times higher among people who inject drugs than the general population. HIV services for people who inject drugs should therefore focus on a harm reduction approach. The comprehensive package for the prevention, treatment, and care of HIV among people who inject drugs includes nine interventions: needle and syringe programs; opioid substitution therapy; HIV testing and counseling; antiretroviral therapy; prevention and treatment of STIs; condom promotion; targeted information, education, and communications; prevention, vaccination and treatment for viral hepatitis; and prevention, diagnosis, and treatment of tuberculosis.

Persons who engage in sex work: Globally, people who engage in sex work experience 10 times higher prevalence of HIV than the general population, with an average 12% rate of HIV infection. Strategies to reduce HIV within the context of sex work include empowering communities; addressing violence; providing condoms and lubricant; ensuring voluntary clinical services; and protecting against discrimination.

References:
1. Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
2. Inter-agency Working Group on Reproductive Health in Crises (2018). HIV Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/hiv#key-populations.

SLIDE 11



Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

MODULE 2.5:
Gender-Based Violence

1.5 hours

Goal:

To build knowledge, awareness, and sensitivity to GBV; the importance of referral pathways for survivors of sexual violence during an emergency; and the priorities in the MISP for SRH.

Summary: This module will start with a presentation that focuses on knowledge building related to terminology and the issue of GBV. It will also review the priority activities of the MISP for SRH. The presentation will be followed by an interactive activity in which referral pathways (and the problems that occur when they are not in place) are discussed.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Presentation: *Gender-Based Violence*
- Very large ball of yarn
- Name tags for actors in activity
- Sexual violence referral script
- Relevant findings from pre-workshop **focus group discussions**
- Flip chart paper and markers

PRESENTATION: GENDER-BASED VIOLENCE OVERVIEW

- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- Ask participants if they have any questions. Note that violence based on gender, discrimination based on gender, and different treatment based on gender fall along a continuum, and it is important to consider the consequences for people.

PRESENTATION: GENDER-BASED VIOLENCE: 20 SLIDES

SLIDE 1

Photo credit: IRC/Gerald Martone.

SLIDE 2

The terms 'gender-based violence' and 'violence against women' are frequently used interchangeably in literature and by advocates; however, the term gender-based violence (GBV) refers to violence directed against a person because of his of her gender and expectations of his or her role in a society or culture. GBV highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of GBV, especially sexual violence. The term is also used to describe targeted violence against LGBTQIA persons when referencing violence related to gender-inequitable norms of gender identity.

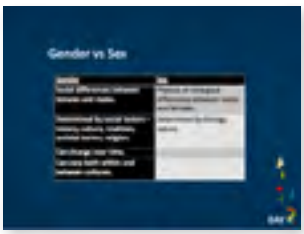
UNHCR has also developed a definition:

GBV Is violence that is **directed against** a person on the **basis of gender**. It includes acts that inflict physical, mental or sexual **harm** or suffering, threats of such acts, coercion and other deprivations of liberty…- UNHCR

Before moving to the next slide, ask participants if anyone can explain the difference between sex and gender.

Resource:
Inter-agency Standing Committee (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Reducing risk, promoting resilience and aiding recovery*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

SLIDE 3



SLIDE 4

Adapted from Williams, S. The Oxfam Gender Training Manual, Oxfam UK, 1994.

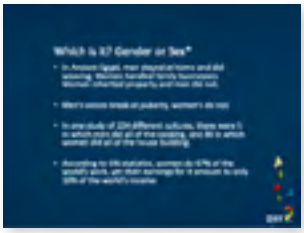
Third bullet: UNFPA (2020). COVID-19: A Gender Lens. Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality.

https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

Last bullet: UN OCHA. Global Humanitarian Overview 2019. Available at: https://www.unocha.org/sites/unocha/files/GHO2019.pdf.

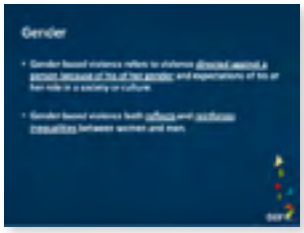
PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 5

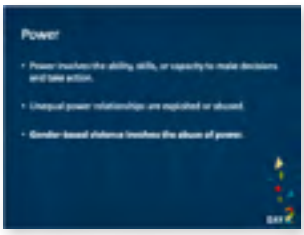


Adapted from S. Williams, The Oxfam Gender Training Manual, Oxfam UK, 1994.

SLIDE 6



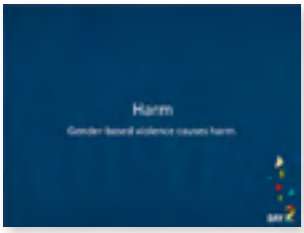
SLIDE 7



SLIDE 8

Abuse can also involve threats, verbal abuse, financial control, and neglect.

SLIDE 9



SLIDE 10

PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 11

GBV takes many forms, including the ones listed above. Perpetrators of GBV are often motivated by a desire for power and domination. GBV is often meant to hurt, control, and humiliate, while violating a person's physical and mental integrity.

Sexual Violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

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

Sexual abuse: Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

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

Domestic and intimate partner violence: Domestic violence takes place between current or former intimate partners (spouses, boyfriend/girlfriend) as well as between family members (e.g., mothers-in-law and daughters-in-law). Domestic violence may include sexual, physical, and psychological abuse. Other terms used to refer to domestic violence perpetrated by an intimate partner include "spousal abuse" and "wife battering."

Harmful traditional practices: Includes child, early, and forced marriage, female genital cutting, honor killings, widow inheritance, and menstrual isolation. In Nepal, for example, menstrual isolation practices in the form of "Chhaupadi" have been documented to have negative consequences for women and girls.[2]

It can sometimes be difficult to distinguish between discrimination based on gender (e.g. different pay between men and women) and violence based on gender (e.g. intimate partner violence). Often, harmful practices occur along a continuum, and some are more tolerated than others.

Forced, early marriage: This occurs when parents or others arrange for and force a minor to marry someone. Force may occur by exerting pressure or by ordering a minor to get married and may be for dowry-related or other reasons. Forced marriage is a form of GBV because the minor is not allowed to, or is not old enough to, make an informed choice.

Female genital cutting: Constitutes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

Trafficking: Includes sex trafficking, child trafficking, and labor trafficking.

Denial of resources: Denial of resources and lack of opportunities based on gender, sexual orientation, and/or gender identity.

References:
1. Inter-agency Working Group on Reproductive Health in Crises (2018). GBV Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/gbv.
2. UNFPA (2020). Literature Review on Harmful Practices in Nepal. https://reliefweb.int/sites/reliefweb.int/files/resources/desk_review_final.pdf

PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 12

Around the world, GBV has a greater impact on women and girls than on men and boys. It is important to note, however, that men and boys may also be survivors of GBV, especially sexual violence.

Although men and boys can often be seen as either perpetrators or survivors of GBV, men and boys are often also critical change agents in GBV prevention efforts.

SLIDE 13

GBV, and in particular sexual violence, is a serious, life-threatening protection issue primarily affecting women and children. It is well documented that GBV is a widespread international public health and human rights issue, and that adequate, appropriate, and comprehensive prevention and response are inadequate in most countries worldwide.

- 35% of women have experienced physical and/or sexual violence from an intimate partner, or sexual violence by a non-partner at some point in their lives.[1]
- 137 women across the world are killed by a member of their own family every day. More than a third of the women intentionally killed in 2017 were killed by their current or former intimate partner.[2]
- 21% of adolescent girls are married before their 18th birthday.[3]

References:

1. World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence, p.2. Cited in: https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures#notes.

2. United Nations Office on Drugs and Crime (2019). *Global Study on Homicide 2019*, p. 10. Cited in: https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures#notes.

3. UNICEF (2019). Child Marriage around the World. https://www.unicef.org/stories/child-marriage-around-world.

SLIDE 14

Risks for GBV are especially prominent in complex emergencies and natural disasters, where civilian women and children are often targeted for abuse and are the most vulnerable to exploitation, violence, and abuse, simply because of their gender, age, and status in society.[1]

Even in pandemics, risks of abuse such as domestic violence can increase, due to stay-at-home restrictions and heightened tensions in the household. Women and girls also face risks sexual exploitation and abuse: The economic impacts of the 2013-2016 Ebola outbreak in West Africa placed women and children at greater risk of exploitation and sexual violence.[2]

Reference:

1. Inter-agency Standing Committee (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Reducing risk, promoting resilience and aiding recovery*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

2. UNFPA (2020). COVID-19: *A Gender Lens. Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 15

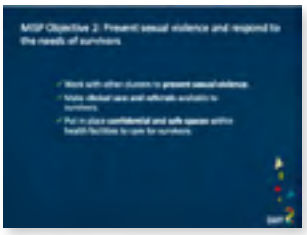
Risk factors for GBV increase during displacement due to collapse of protective mechanisms in society, lawlessness, lack of protection and insecurity, lack of resources, and enhanced inequalities and power dynamics.

The magnitude of GBV is difficult to determine. Incidents of GBV are widely under-reported. The factors contributing to under-reporting – fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services and the dispersion of families and communities – are all exacerbated in displacement contexts.

We should assume GBV exists in humanitarian settings, regardless of the presence or absence of concrete 'evidence.'

Photo: Showers without lockable doors in Leogane, Haiti, May 2010. Women's Refugee Commission.

SLIDE 16



Prevent sexual violence and respond to the needs of survivors:

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

*Clusters in the humanitarian sectors include Health; Protection; Water, Sanitation and Hygiene; Camp Coordination and Camp Management; Shelter; Nutrition; Logistics; among others. All clusters are responsible for preventing GBV from their own area of expertise. For more information about the cluster system, see https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach. For more information on the respective roles that each cluster should play in preventing GBV, see the IASC GBV Guidelines (reference below).

Reference:

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

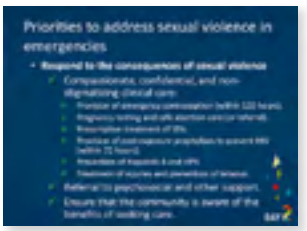
Inter-agency Standing Committee (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Reducing risk, promoting resilience and aiding recovery*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

SLIDE 17

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 18



Emergency contraception and PEP should be taken as soon as possible, the earlier the better.[1]

Where health systems are overburdened and preoccupied with handling epidemics or pandemics, clinical care for survivors may be sidelined. This care must still be made available with a survivor-centered approach, since post-rape care is time-sensitive. It is also critical to update GBV referral pathways to reflect changes in available care facilities and inform key communities and service providers about those updated pathways.[2]

References:
1. Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
2. UNFPA (2020). COVID-19: A Gender Lens. *Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

SLIDE 19

Special considerations for specific populations:

Children: Country-specific laws may prevail around age of consent for treatment, mandatory reporting requirements, or procedures for suspected child abuse.

Adolescents: Adolescent girls especially are highly vulnerable to sexual coercion, exploitation, and violence, and many may engage in high-risk or transactional sex for survival. Adolescents are also a heterogenous group; their risks and needs may vary depending on the environment, marital status, education level, disability status, gender and gender identity, bodily identify, sexual orientation, and socioeconomic status.

Male survivors: Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and non-discriminatory services that provide comprehensive care.

Persons with disabilities: Persons with disabilities are at a higher risk of sexual violence and often face extreme discrimination by service providers. Host organizations of persons with disabilities may have resources to ensure clinical care for survivors is provided to this often-hidden population.

LGBTQIA persons: Each population has separate needs and face different risks. Engaging with LGBTQIA self-help or rights groups and making health facilities more respectful of diversity would allow critical health services to become more accessible.

Persons who engage in sex work: This population often faces stigmatization and discrimination by health providers. Organizations led by refugees and persons who engage in sex work often have the expertise and connections to effectively provide clinical services to these groups.

Ethnic and religious minorities: Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence. Specific barriers should be considered when designing programs to reach survivors.

References:
1. Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.
2. Inter-agency Working Group on Reproductive Health in Crises (2018). Adolescent SRH Chapter. I*nter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawgfieldmanual.com/manual/asrh.

Photo credits: Save the Children; UNHCR.

PRESENTATION: GENDER-BASED VIOLENCE (cont'd)

SLIDE 20

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

Inter-agency Working Group on Reproductive Health in Crises (2018). MISP Chapter. Inter-agency Field Manual on Reproductive Health in Humanitarian Settings. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf.

ACTIVITY: ACCESSING CARE AS A SURVIVOR OF SEXUAL VIOLENCE

Source: Adapted from the SPRINT curriculum. This activity can be adapted based on the possible persons that may be involved if a person reports that they were sexually assaulted. The names of the actors included in this activity (e.g., protection officer, police, community health worker, etc.) should be adapted to reflect the relevant actors and their titles in the local community.

Note to facilitator: Be mindful of the sensitive topic and the possibility that participants may themselves be survivors.

The purpose of this activity is to build awareness and sensitivity to the challenges faced by survivors of sexual violence in seeking care.

- Ask for volunteers to be actors and play the role of different actors. Distribute the pre-made "service provider" name tags to the appropriate number of people. Ask these individuals to play the role of the person noted on their name tag.
- Seat the service providers in a circle with the 11 chairs. Ask the remainder of participants to stand on the outside of the circle so they can easily see the activity.
- Explain that the ball of yarn represents a 20-year-old young woman who was sexually assaulted. Confirm with participants that everyone understands the definition of sexual assault.
- As the facilitator, stand outside the circle and give the ball to the Mother. Explain that the young woman has told her mother about the incident.
- Instruct the Mother to hold the end of the string firmly.

- Tell the story below (script provided) of what happens to this young woman. Each time an actor is involved, the ball of string is tossed across the circle to that actor. Each actor who receives the ball will wrap it around a finger and then toss the ball to the next actor as instructed.
- Stop the game when the script is completed.
- There will be a large web in the center, with each actor holding parts of the string.
- Actors should let go of the string and let it drop to the floor. Leave the stringy chaotic mass sitting on the floor for all to see.
- Discussion: Pause to look at the web and ask some questions to generate discussion.
  - What do you see in the middle of this circle?
  - Was all of this helpful for the survivor? Traumatic?
  - Observers: How many times did the young woman have to repeat her story?
  - Might a situation like this happen here? The facilitator can share findings from the pre-workshop **focus group discussions**, if community members or the community-based workforce mentioned whom survivors would most likely report to.
  - What could have been done to avoid making this web of string?
- After closing this activity, ask participants for what in their community may additionally fuel violence and discrimination based on gender. Possibilities may include recent outbreaks of disease clustered among already marginalized populations. Women, children, and persons with disabilities may also be at risk of domestic violence if mobility restrictions exist, or due to heavy caregiver burdens.
- Ask participants to consider how they can help survivors access time-sensitive post-rape care if mobility is restricted, such as during an outbreak of violence or an epidemic/pandemic. Write relevant suggestions on flip chart paper and post to a wall.
- Reinforce the role that community-based organizations and community health workers can play to share information around the benefits of seeking care and where to access services, as well as serving as the first point of contact for survivors and helping them access time-sensitive care.

NOTES:

TEA BREAK

30 minutes

SCRIPT: Accessing care as a survivor of sexual violence

The actors can be modified based on the content and who may often be involved if a person reports being sexually assaulted.

A 20-year-old young woman was sexually assaulted by a man just outside an evacuation center, and she tells her mother:

- The **Mother** takes the young woman to the **Community Leader** to report what happened.
- The Community Leader refers the young woman to the **Community Health Worker** (CHW) because the leader is concerned about the medical condition of the daughter.
- The CHW helps, but the young woman needs more medical care for injuries than what the CHW can offer. The CHW asks the young woman to see her close colleague—the **Midwife**.
- The Midwife realizes that the young woman should be seen by a doctor, so she immediately contacts the **Doctor**.
- The Doctor provides treatment for injuries and a general check-up, and sends the young woman back to the **Midwife** hoping that the midwife might provide some extra support.
- The Midwife knows the young woman needs psychosocial care and wonders if there were other medical treatments that perhaps the young woman should receive (she has heard about preventing HIV following sexual violence). She refers the young woman to the **Community Outreach Worker**.
- The Community Outreach Worker promises the Midwife and the Mother to help, and to make sure that the young woman receives all services that she should. The Community Outreach Worker provides emotional support and discovers the young woman wants to involve the police. Knowing this is time sensitive, the young woman is immediately referred to the **Protection Officer**.
- The Protection Officer meets the young woman and takes her report. However, a medical report is needed for the report, and so the young woman is referred back to the **Doctor**.
- The Doctor completes the medical documentation and sends the young woman back to the **Protection Officer**.
- The Protection Officer sends the young woman to the **Police** with the medical file.
- The Police take a full report of the incident. However, in order to protect the young woman once the report is filed, they refer her to a **Lawyer** to ensure that she is represented.
- The Lawyer would like to discuss the case with the Prosecutor, so they contact the **Prosecutor** to speak with the survivor.
- The Prosecutor calls the Doctor to get information about the medical exam. The **Doctor** asks to see the survivor again because she forgot to collect a needed sample during the exam.
- The doctor refers the survivor to a **Social Worker** for psychosocial support.
- The Social Worker meets routinely with the young woman and sends her back to the Doctor for a check-up, and then to the **Protection Officer** to make sure that the case is progressing.
- The young woman then goes to talk with the **Community Leader**, whom she first saw, because she is confused about the process.
- The Community Leader contacts the **Prosecutor** to find out the status of the case.
- The Prosecutor suggests that they contact the **Police** for a clear update.
- The Police refer the Community Leader to the **Protection Officer**.

MODULE 2.6:
Jeopardy!

45 minutes – 1 hour

MISP 1 and 6	MISP 2	MISP 3	MISP 4	MISP 5+	DRR
100	100	100	100	100	100
200	200	200	200	200	200
300	300	300	300	300	300
400	400	400	400	400	400
500	500	500	500	500	500

Supplies:

- Laptop (and power cord)
- Projector and screen
- Small papers for each group, one with #1 for game order
- Paper money (in colored paper)
- Prizes

Goal:

To provide a fun and easy way to review knowledge gained over the past two days.

Summary: This review game should be implemented after the end of all knowledge-based modules. It is flexible enough to fit into the time available; the facilitator will just need to end after each group has had an equal opportunity to gain money, but a "last round" can be declared 15 minutes before the close of the day. Prizes are awarded to the winning team.

ACTIVITY: JEOPARDY!

- Divide participants into three or four teams. Ask participants to come up with a team name and identify a "spokesperson." Final answers from the team can only be expressed by the spokesperson.
- The facilitator provides an overview of the game.
- Each team will be asked to choose a topic and a money value for that particular topic. Each topic and point value corresponds to a question—larger money values are associated with more difficult questions.
- Have each team select a paper, one with a pre-written #1, indicating which team goes first.
- Teams will be given two minutes to answer the question they have selected. If they are unable to answer, or answer incorrectly, the question moves counterclockwise to the next team, and the next and the next depending on whether a correct answer is given and the "money is won." Whichever team answers correctly is awarded the dollar amount. The facilitator can hand out the colored paper money. The next question then moves to the team directly next to the team (counterclockwise) that the game started with, and so on.
- On the PowerPoint:
  - » Click on the chosen box for the question.
  - » To see if a group is correct, click again for the answer.
  - » Click the "Back to Board" button on the slide to return to the main board.
  - » The dollar values disappear after each question.
- Play the game until all boxes are completed, or until time runs out. It is alright if not all questions are answered.
- Each team should total their colored money. The team with the most money wins!
- The facilitator should award prizes to the winning team.

Note to facilitator: No matter who is awarded the colored money, question selection should move in order around the room so that each team gets a fair chance to "win" a question they have chosen.

NOTES:

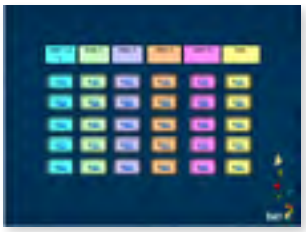
PRESENTATION: JEOPARDY: 34 SLIDES

SLIDE 1

- Divide participants into three or four teams. Ask participants to come up with a team name and identify a "spokesperson." Final answers from the team can only be expressed by the spokesperson.
- The facilitator provides an overview of the game.
- Each team will be asked to choose a topic and a money value for that particular topic. Each topic and point value corresponds to a question—larger money values are associated with more difficult questions.
- Flip a coin to decide which team goes first.
- Teams will be given two minutes to answer the question they have selected. If they are unable to answer or answer incorrectly, the question moves counterclockwise to the next team, and the next and the next depending on whether a correct answer is given and the "money is won." Whichever team answers correctly is awarded the dollar amount. The facilitator can hand out the colored paper money. The next question then moves to the team directly next to the team (counterclockwise) that the game started with, and so on.
- On the PowerPoint:
  - Click on the chosen box for the question.
  - To see if a group is correct, click again for the answer.
  - Click the "Back to Board" button on the slide to return to the main board.
  - The dollar values disappear after each question.
- Play the game until all boxes are completed, or until time runs out. It is alright if not all questions are answered.
- Each team should total their colored money. The team with the most money wins!
- The facilitator should award prizes to the winning team.

Adapted from: https://www.iup.edu/teachingexcellence/reflective-practice/past-events/2008-09/sample-games-to-be-used-in-the-classroom/instructions-for-playing-jeopardy/.

SLIDE 2



SLIDE 3

PRESENTATION: JEOPARDY (cont'd)

SLIDE 4

Objective 1: Ensure the health sector/cluster identifies an organization to lead implementation of the MISP. The Lead SRH Organization:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services.
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP.
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation.
- In tandem with health/GBV/HIV coordination mechanisms, ensures mapping and analysis of existing SRH services.
- Shares information about the availability of SRH services and commodities.
- Ensures the community is aware of the availability and location of reproductive health services.

SLIDE 5

- The Inter-Agency Working Group on Reproductive Health in Crises has developed **12 pre-packaged health kits** for community, primary health care, and referral hospital levels to complement the MISP standard.

SLIDE6

- **Adolescents**: Adolescent girls especially are highly vulnerable to sexual coercion, exploitation, and violence, and many may engage in high-risk or transactional sex for survival. Adolescents are also a heterogenous group; their risks and needs may vary depending on the environment, marital status, education level, disability status, gender and gender identity, bodily identify, sexual orientation, and socioeconomic status.
- **Male survivors**: Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and non-discriminatory services that provide comprehensive care.
- **Persons with disabilities**: Persons with disabilities are at a higher risk of sexual violence and often face extreme discrimination by service providers. Host organizations of persons with disabilities may have resources to ensure clinical care for survivors is provided to this often-hidden population.
- **LGBTQIA persons**: Each population has separate needs and face different risks. Engaging with LGBTQIA self-help or rights groups and making health facilities more respectful of diversity would allow critical health services to become more accessible.
- **Persons who engage in sex work**: This population often faces stigmatization and discrimination by health providers. Organizations led by refugees and persons who engage in sex work often have the expertise and connections to effectively provide clinical services to these groups.
- **Persons living with HIV/AIDS**: Access to antiretroviral treatment remains a challenge in humanitarian settings. Stigma continues to also exist against persons living with HIV/AIDS.
- **Persons who inject drugs**: Women who inject drugs are particularly stigmatized and are vulnerable to violence and HIV.
- **Ethnic and religious minorities**: Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence. Specific barriers should be considered when designing programs to reach survivors.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 7

- Objective 6 of the MISP is to plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health systems building blocks.

SLIDE 8

- The terms "gender-based violence" and "violence against women" are frequently used interchangeably in literature and by advocates; however, the term gender-based violence (GBV) refers to violence directed against a person because of his of her gender and expectations of his or her role in a society or culture. GBV highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of GBV, especially sexual violence. The term is also used to describe targeted violence against LGBTI populations when referencing violence related to gender-inequitable norms of gender identity.

SLIDE 9

Gender

- Social differences between females and males.
- Determined by social factors – history, culture, tradition, societal norms, religion.
- Can change over time.
- Can vary both within and between cultures.

Sex

- Physical or biological differences between males and females.
- Determined by biology, nature.

SLIDE 10

Prevent sexual violence and respond to the needs of survivors:

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

PRESENTATION: JEOPARDY (cont'd)

SLIDE 11

Protecting at-risk populations from sexual violence:

- Involve women, adolescents, persons with disabilities, and LGBTQIA persons in program design.
- Establish separate, lockable latrine and wash facilities for men and women.
- Ensure safe health facilities.
- Hire female service providers, community health. workers, program staff and interpreters.
- Distribute menstrual hygiene supplies.
- Provide safe water, food, and firewood collection strategies.
- Ensure code of conduct and reporting mechanisms for sexual exploitation and abuse.

SLIDE 12

Respond to the consequences of sexual violence

- Compassionate, confidential, and non-stigmatizing clinical care:
  - Provision of emergency contraception (within 120 hours).
  - Pregnancy testing and safe abortion care (or referral).
  - Presumptive treatment of STIs.
  - Provision of post-exposure prophylaxis to prevent HIV (within 72 hours).
  - Prevention of hepatitis B and HPV.
  - Treatment of injuries and prevention of tetanus.
- Referral to psychosocial and other support.
- Ensure that the community is aware of the benefits of seeking care.

SLIDE 13

Standard precautions: Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health workers. Under the "standard precautions" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person. Standard precautions prevent the spread of infections such as HIV, hepatitis B, hepatitis C, and other pathogens within health care settings. **Standard precautions include frequent hand washing; wearing gloves; wearing protective clothing; safe handling of sharp objects; safe disposal of waste material; instrument processing; and housekeeping**.

In some instances, the use of personal protective equipment (PPE) may be warranted. These might include gloves, medical masks, goggles or a face shield, and gowns, respirators (i.e., N95 or FFP2 standard or equivalent), and aprons.

SLIDE 14

Men who have sex with men: Men who have sex with men (MSM) include all men who have same-sex relations, regardless of their self-identified sexual orientation (gay, bisexual, or heterosexual). Worldwide, MSM are estimated to be 24 times more likely to be infected with HIV than the general population, with HIV prevalence ranging from 14% to 18% across the Americas, Asia, and sub-Saharan Africa. Effective HIV programming for MSM includes community empowerment, protection from violence, provision of condoms and lubricant, provision of comprehensive and integrated health care.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 14 (cont'd)

Persons who inject drugs: Rates of new HIV infection have been found to be 24 times higher amongst people who inject drugs than the general population. HIV services for people who inject drugs should therefore focus on a harm reduction approach. The comprehensive package for the prevention, treatment, and care of HIV among people who inject drugs includes nine interventions: needle and syringe programs; opioid substitution therapy; HIV testing and counseling; antiretroviral therapy; prevention and treatment of STIs; condom promotion; targeted information, education, and communications; prevention, vaccination and treatment for viral hepatitis; and prevention, diagnosis and treatment of tuberculosis.

Persons who engage in sex work: Globally, people who engage in sex work experience 10 times higher prevalence of HIV than the general population, with an average 12% rate of HIV infection. Strategies to reduce HIV within the context of sex work include empowering communities; addressing violence; providing condoms and lubricant; ensuring voluntary clinical services; and protecting against discrimination.

SLIDE 15

SLIDE 16

Eight of the most common pathogens are linked to the greatest incidence of STIs. Of these 8 infections, 4 are currently curable: syphilis, gonorrhea, chlamydia, and trichomoniasis. The other 4 are viral infections, which are incurable: hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV). Both HPV and hepatitis B infections are preventable with vaccination.

SLIDE 17

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

- Establish safe and rational use of blood transfusion.
- Ensure application of standard precautions.
    - Hand washing, wear gloves, wear protective clothing, safe handling of sharps, safe waste disposal, decontaminate instruments.
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs.
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure.
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 18

Why do women die?

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for nearly 75% of all maternal deaths are:

- Severe bleeding (mostly bleeding after childbirth)
- Infections (usually after childbirth)
- High blood pressure during pregnancy (pre-eclampsia and eclampsia)
- Complications from delivery
- Unsafe abortion.

SLIDE 19

In most instances, women who die in childbirth experience at least one of the following three delays:

- **The First Delay is the delay in deciding to seek care for an obstetric complication**. This may occur for several reasons, including late recognition that there is a problem, fear of the hospital, or of the costs that will be incurred there, or the lack of an available decision-maker.
- **The Second Delay is a delay in actually reaching the care facility** and is usually caused by difficulty in transport. Many villages have very limited transportation options and poor roads. Some communities have developed innovative ways to address this problem, including prepayment schemes, community transportation funds, and a strengthening of links between community practitioners and the formal health system.
- **The Third Delay is the delay in obtaining care at the facility**. This is one of the most tragic issues in maternal mortality. Often, women will wait for many hours at the referral center because of poor staffing, prepayment policies, or difficulties in obtaining blood supplies, equipment, or an operating theater. The third delay is the area that many planners feel is easiest to correct. Once a woman has actually reached an emergency obstetric care facility, many economic and sociocultural barriers have already been overcome.

SLIDE 20

Safe birth plan: Talking with family to plan about picking up a birthing kit; plans to use a skilled birth attendant and, if possible, giving birth in a facility; and planning for emergency transportation.

SLIDE 21

Chlorhexidine for clean cord care at home.

- Application of 7.1% chlorhexidine digluconate, delivering 4% chlorhexidine (CHX) to the umbilical cord, especially on the day of birth, is a low-cost intervention that has been shown to reduce newborn mortality. It can be used in settings with high newborn death where women have been trained on how to use it.
- CHX was added to the 2013 WHO List of Essential Medicines for Children, specifically for umbilical cord care. In January 2014, WHO issued a new recommendation for umbilical cord care that prioritized daily CHX application to the umbilical cord stump during the first week of life for newborns born in home settings with high neonatal mortality (30 or more neonatal deaths per 1,000 live births).

PRESENTATION: JEOPARDY (cont'd)

SLIDE 21 (cont'd)

Kangaroo mother care for preterm and low birth weight babies.

- Kangaroo mother care (KMC) is one of the most promising ways to save preterm and low birth weight babies in all settings. This form of care, initiated in health facilities, involves teaching health workers and caregivers on how to keep newborns warm through continuous, 24 hours per day, skin-to-skin contact on the mother or caregiver's chest. KMC may significantly enhance other well-known treatments for treating prematurity such as thermal care, breastfeeding support, infection prevention and management, and neonatal resuscitation.

SLIDE 22

In any given population, 25% of the population are women of reproductive age (WRA). Anywhere from 4-16% of WRA will be pregnant at any given time; 15% of these will experience life-threatening pregnancy complications.

SLIDE 23

IUD: A small, T-shaped device that is inserted by a trained clinician into the uterus. There are hormonal and non-hormonal IUDs. The hormonal IUD (Morena or Skyla) releases levonorgestrel (progestin), which damages sperm and changes the cervical mucus and uterine lining. The copper-T is non-hormonal and damages/kills sperm.

Implant: Progestin-only hormonal contraception that is surgically inserted into a woman's upper arm. Depending on the brand used, implants may last for up to 5 years before needing replacement.

SLIDE 24

Emergency contraception: Used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure, misuse (such as forgotten pills or torn condoms), rape, or coerced sex. Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation. Emergency contraceptive pills cannot interrupt an established pregnancy or harm a developing embryo. Emergency contraception can be used up to 120 hours (five days) after unprotected sex to prevent pregnancy.

There are two main types of emergency contraception:

- The copper-T IUD, which can be used to prevent pregnancy up to five days after unprotected sex. It prevents fertilization by causing a chemical change in sperm and egg before they meet.
- Emergency contraceptive pills, which are more effective the sooner they are taken.

Emergency contraception pill regimens: The two primary ECP regimens, packaged and labeled specifically for emergency contraception (EC), are:

- 1 tablet of levonorgestrel (LNG) 1.5 mg (also presented as 2 tablets of LNG 0.75 mg each, which can safely be taken together)
- 1 tablet of ulipristal acetate (UPA) 30 mg

Regardless of the regimen used, ECPs should be taken as soon as possible.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 25

The Yuzpe combined hormonal regimen uses certain types of regular birth control pills as emergency contraception (EC). This method can be used if dedicated EC pills are not available.

The levonorgestrel regimen reduces pregnancy risk by at least half and possibly by as much as 80-90% for one act of unprotected intercourse. The ulipristal and mifepristone regimens are more effective than the levonorgestrel regimen. Regular oral contraceptives used as EC (the "Yuzpe regimen") are less effective.

SLIDE 26

The critical signs and symptoms of complications that require immediate attention include:

- Abnormal vaginal bleeding
- Abdominal pain
- Infection
- Shock (collapse of the circulatory system).

SLIDE 27

In most settings, safe abortion care is legally permissible for some or all reasons and capacity exists to provide and/or refer women to safe abortion care (SAC) services. If the woman chooses an abortion, health care workers should:

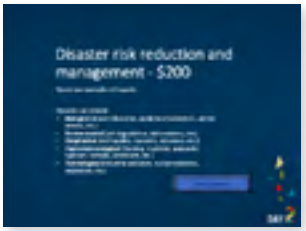
- **Provide medically accurate information** about abortion services in a form women can understand and recall.
- **Explain any legal requirements** for obtaining SAC.
- **Explain where and how to obtain safe, legal abortion services** and their cost.
- **Provide medication abortion, with mifepristone/misoprostol if available or misoprostol-alone if mifepristone is unavailable, vacuum aspiration, dilatation and evacuation, or induction procedures** as recommended by WHO.
- **Provide information and offer counseling to women on post-abortion contraceptive use** and provide contraception to women who accept a method.
- **Consider providing presumptive treatmen**t for gonorrhea and chlamydia in settings with a high prevalence of STIs.

SLIDE 28

- **Disaster risk** is the potential loss of life, injury, or destroyed or damaged assets that could occur to a system, society, or a community in a specific period of time.
- **Residual risk** is the disaster risk that remains even when effective disaster risk reduction measures are in place, and for which emergency response and recovery capacities must be maintained. The presence of residual risk implies a continuing need to develop and support effective capacities for emergency services, preparedness, response, and recovery, together with socioeconomic policies such as safety nets and risk transfer mechanisms, as part of a holistic approach.
- **Disaster risk management** is the application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk, and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 29



- Hazard: *A process, phenomenon, or human activity that may cause loss of life, injury, or other health impacts, property damage, social and economic disruption, or environmental degradation*.

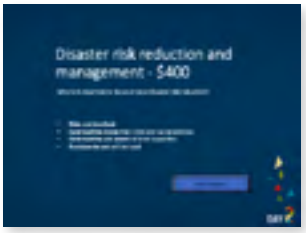
Hazards can include:

- Biological (insect infestation, epidemics/pandemics, animal attacks, etc.)
- Environmental (soil degradation, deforestation, etc.)
- Geophysical (earthquakes, tsunamis, volcanoes, etc.)
- Hydrometeorological (flooding, mudslide, avalanche, typhoon, tornado, sandstorm, etc.)
- Technological (industrial pollution, nuclear radiation, explosions, etc.)

SLIDE 30

Emergency preparedness and **recovery** are two entry points within the continuum of an emergency that provide an opportunity to build local and national resilience to mitigate the impact of emergencies, improve response, and facilitate efficient and effective recovery.

SLIDE 31



Health systems-strengthening, based on primary health care at the community level, can:

- Reduce the vulnerability of at-risk populations before an emergency.
- Build the capacity of communities to prevent, prepare, respond to, and recover from emergencies, thus protecting public health, health services, and infrastructure.
- Provide the basis for scaling up measures to meet wide-ranging health needs in emergencies.
- Prevent avoidable morbidity and mortality, particularly among women, children, and adolescents.
- Use opportunities during recovery to strengthen services and reduce the risks of future events.

PRESENTATION: JEOPARDY (cont'd)

SLIDE 32

The Four Priorities for Action in the Sendai Framework for Disaster Risk Reduction

- **Priority 1. Understanding disaster risk**

Disaster risk management should be based on an understanding of disaster risk in all its dimensions of vulnerability, capacity, exposure of persons and assets, hazard characteristics, and the environment. Such knowledge can be used for risk assessment, prevention, mitigation, preparedness, and response.

Priority 2. Strengthening disaster risk governance to manage disaster risk

Disaster risk governance at the national, regional, and global levels is very important for prevention, mitigation, preparedness, response, recovery, and rehabilitation. It fosters collaboration and partnership.

Priority 3. Investing in disaster risk reduction for resilience

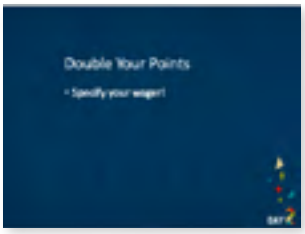
Public and private investment in disaster risk prevention and reduction through structural and non-structural measures are essential to enhance the economic, social, health, and cultural resilience of persons, communities, countries, and their assets, as well as the environment.

Priority 4. Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation, and reconstruction

The growth of disaster risk means there is a need to strengthen disaster preparedness for response, take action in anticipation of events, and ensure capacities are in place for effective response and recovery at all levels. The recovery, rehabilitation, and reconstruction phase is a critical opportunity to build back better, including through integrating disaster risk reduction into development measures.

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

SLIDE 33



SLIDE 34

Closing and Next Steps

15 – 20 minutes

Goal:

To pull together learning from the day and ensure understanding of both content and logistics information.

Spend some time reviewing the material from the day to ensure understanding and comprehension, especially around the priorities of the MISP for SRH. Ask if any participants have outstanding questions, and any thoughts or reflections they would like to share.

Supplies:

- Paper for daily evaluation (a quarter sheet of printing paper is sufficient for each participant).
- Information about dinner or any evening activities.

END-OF-DAY EVALUATION:

The goal of the daily evaluations is to improve learning and participant experience for the remainder of the training. Facilitator should post the following questions on flip chart paper, or on the A/V screen. Participants should provide quick responses on small pieces of paper, for the facilitator to review THAT day (to inform the next day of training).

1. What is one thing that you feel you learned from today that you did not know before?
2. What went well with the training today?
3. What can be improved?
4. Is there anything you would like to see change for tomorrow?

- (*In private if more appropriate) Confirm whether accessibility/ accommodations are adequate for participants with disabilities. Solicit additional suggestions for accommodations that may be feasible.*

CLOSING AND NEXT STEPS:

Take a couple of minutes to discuss next steps, including when the next day's training will begin.

DAY 3

From Knowledge to Action

GOAL:

Goal to apply knowledge obtained over the past two days of training to household and community preparedness plans.

MODULE 3.1: Household Preparedness

MODULE 3.2: Community Mapping

MODULE 3.3: Action Planning

Facilitator's Agenda Day 3

TIME	ITEM	COMPONENT(S)	SUPPLIES
9:00-9:20	**Welcome, Review, and Housekeeping**	• Review and housekeeping	
9:20-10:00	**MODULE 3.1:** Household Preparedness	• Activity: Household preparedness brainstorm	• Flip chart paper • Card stock/meta cards • Marker pens
10:00-10:30	**Tea Break**		
10:30-12:00	**MODULE 3.2:** Community Mapping	• Activity 1A: Mapping of existing physical resources and capacities for SRH • Activity 1B: Mapping social assets and human resources • Report back and discussion	• Flip chart paper • Colored stickers • Marker pens • Meta cards (2 colors) • *Safety mapping diagrams* from pre-workshop **community capacity and needs assessment** • *Social assets and human resources table* (soft copy or copied to flip chart)
12:00-13:00	**Lunch**		
13:00-14:30	**MODULE 3.3:** Action Planning	• Activity: Developing an action plan for SRH preparedness and gender protection	• Laptops (4-5 if available) • Projector and screen • Central list of capacities and gaps at the front of the room on meta cards • Maps and tables from prior modules posted on the walls behind groups • *MISP for SRH checklist matrix* (soft copy, pre-filled with **facility assessment** results from pre-workshop capacity assessment)
14:30-15:00	**Tea Break**		
15:00-16:30	**MODULE 3.3:** Continued	• Activity: Developing an action plan for SRH preparedness and gender protection	• As above • *Community engagement action tool* (paper copies)
16:30-17:30	**Wrap-Up and Closing**	• Post-test • Final evaluation • Closing ceremony	• Training evaluation • Post-test • Certificates for participants

Introduction

20 minutes

WELCOME AND HOUSEKEEPING

Welcome participants to Day 3. Review any logistical issues or concerns from Day 2 and discuss the agenda for Day 3. Invite the host team for Day 3 to lead the group in prayer/blessing as appropriate. Allow the "host team" from Day 2 to review key points from the prior day (see table below).

KEY CONCEPTS FROM DAY 2

Below are some points that the facilitator may need to stress if not covered by the host team.

- Importance of the MISP for SRH.
- Consequences of each MISP for SRH item if not addressed.
- Each MISP for SRH objective and its corresponding action items.
  - Maternal and newborn health
  - Voluntary contraception
  - Safe abortion care/Post-abortion care
  - STIs/HIV
  - Gender-based violence

GOALS AND AGENDA FOR DAY 3

On this third day of training, the facilitator should focus on tying the information together. Participants will be expected to apply the knowledge that they have gained to their own household and community preparedness plans.

Learning objectives include:

- Apply knowledge gained on SRH and gender to both household and community level preparedness.
- Identify capacities and current gaps within the community to respond to SRH and gender concerns during an emergency.
- Develop an action plan that prioritizes what gaps will be addressed, by whom, and in what timeline.

MODULE 3.1:
Household Preparedness

40 minutes

Goal:

To place learning over the past two days within the context of preparedness. This activity will help participants to distinguish between "household preparedness" and "community preparedness."

Summary: This activity is an important opener to the day, as community members have many roles within their community, as mothers, fathers, siblings, etc., but also as community leaders or health workers. The Household Preparedness activity is a warm-up exercise for participants to examine these different roles with regard to recent experiences of emergencies and preparedness steps.

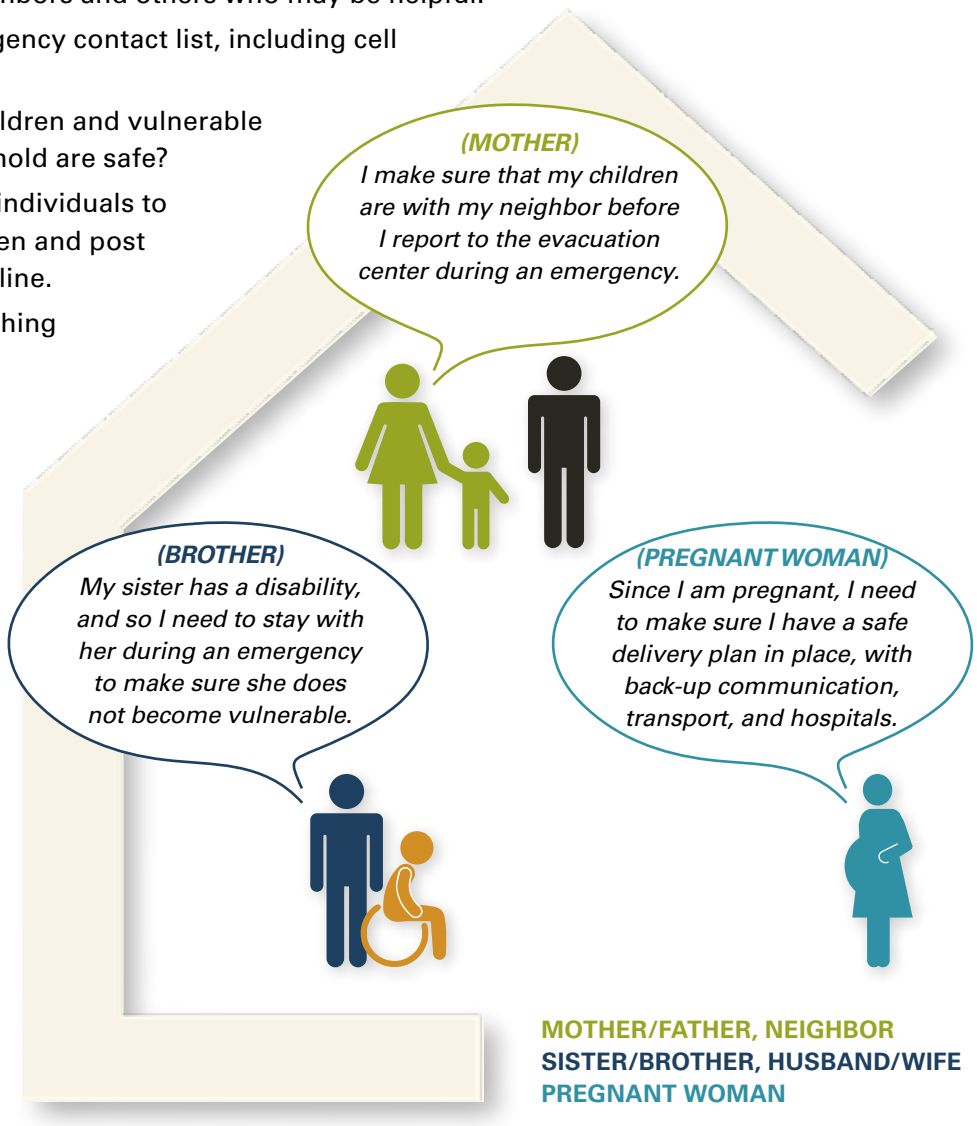
Supplies:

- Flip chart paper
- Card stock/meta cards
- Marker pens

ACTIVITY: HOUSEHOLD PREPAREDNESS BRAINSTORM

- Place a flip chart (or a couple of flip charts) on the wall. Draw an outline of a house to stress the concept of "household preparedness."
- Engage in an informal and open dialogue with participants about how they, as individuals, take care of themselves and those in their home both before and during an emergency.
  - » "Each of you in this room plays multiple roles in your household, and these roles might be different than those that you play within your community. For example, in your household, you may play the role of mother, father, brother/sister, neighbor, etc." (The facilitator should write each of these on meta cards and post them around the outline of the house).
  - » "I would like you to take a minute to think about what you DO, in this role, to protect those in your household from some of the gender or SRH risks that we have discussed."

- The facilitator should have everyone think of something they do or should do, either to prepare for or respond to an emergency, which improves the SRH or protection of those in their own household.
- Participants should write these ideas on meta cards. Prompting questions might include:
  - How do you secure your home and possessions when a disaster is expected?
  - What preparedness steps do you currently follow?
    - » Stocking supplies, including food, water, flashlight, batteries, cell phone charger, umbrella, clothing, shoes, outerwear, etc.
    - » Obtaining medicines, a medical kit, or hygiene supplies (toilet paper, tissues, alcohol sanitizer, menstrual hygiene supplies, gloves, face masks, etc.).
    - » Packing documents, such as vaccine records, birth certificates, etc.
    - » Storing cash.
    - » Getting to know neighbors and others who may be helpful.
    - » Developing an emergency contact list, including cell phone numbers.
  - How do you ensure children and vulnerable persons in your household are safe?
- The facilitator then invites individuals to share what they have written and post it within the household outline.
- The house may look something like the picture below, as ideas are generated.



Facilitator then leads a discussion with participants:

- Congratulate participants on thinking through their individual tasks as they relate to the topics discussed.
- Note that although we each have a role within a household, most of us also have a role within the community. What kind of roles might these be? (The facilitator should develop a list on meta cards outside of the house diagram above). Roles might include:
  - Community health or outreach worker
  - Women's group or other community-based organization member/leader
  - Midwife
  - Doctor
  - First responder
  - Disaster risk management team member
- These are critical roles and they speak to different roles and responsibilities that you have in your community. We will now shift our discussion for the rest of the day to what you, as COMMUNITY MEMBERS and LEADERS, can do to prepare and respond to SRH needs and gender risks during emergencies.

TEA BREAK

30 minutes

MODULE 3.2:
Community Mapping

1 hour 30 minutes

Goal:

To identify existing physical, social, and human resource capacities and gaps to address SRH needs and gender protection in emergencies.

Summary: This small-group activity launches the discussion into community preparedness and the application of learning from the past two days. This activity uses community mapping as a way to facilitate a discussion around existing capacities and gaps at the community level, as they relate to SRH services and gender protection.

The facilitator should build off the discussion before the tea break, which focused on the difference between household and community preparedness, to now focus the remainder of the day on community preparedness.

For the next activity, participants should be divided into two groups. One will examine physical resources and capacities in the community (1A), and the other will examine social assets and human resources (1B). At least one policymaker should join group 1B, so that they can provide data on the district/community. If more than one community is represented in the workshop, participants should make sure they are represented in each group. If only one facilitator is present, they should move back and forth between each group and let the groups self-facilitate as needed (especially 1B, where participants will follow a table).

Supplies:

- Flip chart paper
- Colored stickers
- Marker pens
- Meta cards (2 colors)
- *Safety mapping diagrams* from pre-workshop **community capacity and needs assessment**
- *Social assets and human resources table* (soft copy or copied to flip chart)

ACTIVITY PART 1A: COMMUNITY MAPPING OF PHYSICAL RESOURCES AND CAPACITIES

45 minutes

- Form groups based on their community (no more than three). If everyone is from the same community, they can be one group.
- Pass out a flip chart and markers/pens/pencils to each group.
- Instruct participants that they will spend the next 20 minutes drawing a map.
- As a group, they should agree on a landmark that is the "middle" of their community and the barriers to the north, east, south, and west.
- They should spend time drawing in their community, including **existing resources**, to the map that can help in the provision of SRH services and gender protection, such as:
  - Health facilities and hospitals
  - Social services
  - Protective services
  - Primary and secondary schools
  - Community-based organization offices
  - Relevant government offices
- Participants should mark/label these elements.
- Next, ask participants to identify facilities that currently serve as:
  - Evacuation centers
  - Storage centers/warehouses for emergency supplies
  - Communication channels (activation of emergency response)
  - Ambulances for referrals
- Participants should mark/label these elements too, as they exist.
- At this time, the facilitator should bring out the mapping activities conducted by community focus groups during the pre-workshop **community capacity and needs assessment**. If elements are missing on their map, they should add them. Additionally, participants should make note of what the community has identified as safe and unsafe spaces.

- The facilitator should now pass out stickers to each group (one color). Participants should place a colored sticker on services/capacities for SRH and gender protection that are **most likely to be available during a new emergency**. Be sure that they remember to mark the following, if they will be used in an emergency:
  - » Evacuation centers
  - » Emergency transportation
  - » Communication channels
  - » Coordination mechanisms
  - » Supply warehousing
  - » Safe areas for boys and girls
  - » Spaces for patient overflow (especially if epidemic/pandemic)

- Based on the infrastructure and services likely to be available, the facilitator should ask participants to determine capacities and gaps to addressing SRH needs and gender protection in an emergency.
  - » The facilitator should pass out meta cards of two different colors.
  - » Participants should write on one color their capacities and existing resources. They should then write on the other color gaps and what they are not able to fully address (or things that require improvement). They should post these meta cards next to their maps.

ACTIVITY PART 1B: COMMUNITY MAPPING OF SOCIAL ASSETS AND HUMAN RESOURCES

45 minutes

- With the remaining participants, the facilitator should project the table below and identify one participant who will enter the information into the table. Some of the cells can be pre-filled based on what the facilitator knows about the community and findings from the pre-workshop **community capacity and needs assessment**. Alternatively, the facilitator (and local host or partners) can make this table available on flip chart paper, and participants can write the information directly.
- Ask participants to discuss the **population** in the community, including the proportion of women, girls, boys, and men; ethnic groups; languages spoken; major religions; and other identifying characteristics. They should complete the relevant section of the table as they discuss.

- Next, participants can review the **leadership structure** in the community, including for health and protection (village leaders, etc.).
- Participants can then discuss **resources for health**, including the types of health facilities and health workers (community health workers, female health workers, midwives, first responders, emergency response personnel, etc.) in their community. They should discuss representation of minority groups, and if resources are accessible for persons from marginalized populations, including adolescents, persons with disabilities, and LGBTQIA persons. They should also discuss what care each cadre can provide, and any limitations to their role. Some of this information will be available from the pre-workshop **community capacity and needs assessment**.
- Participants can additionally examine **resources for protection**, including networks and community groups, social structures (order and norms in some cultures), and other protective resources. They should consider whether numbers are adequate, if minority groups are represented, as well as the student/teacher ratio, and if resources are accessible for persons from marginalized populations, including adolescents, persons with disabilities, LGBTQIA persons, etc.
- Based on the social assets and human resources available, the facilitator should ask participants to determine capacities and gaps for addressing SRH needs and gender protection in an emergency. If more information is needed, they should make a note if this, too.
  - » The facilitator should pass out meta cards of two different colors.
  - » Participants should write on one color their capacities and existing resources. They should then write on the other color gaps and what they are not able to fully address (or things that require improvement). Participants should make sure to consider representation of women and minorities in their leadership structures, as well as who is currently consulted in the community to ensure the needs of marginalized and underserved groups are addressed. Participants should post their cards where they can be seen.
- If this group finishes early, participants can join Activity 1A.

NOTES:

SOCIAL ASSETS AND HUMAN RESOURCES	NO.	DETAILS	DETAILS	COMMENTS
Population				
Adults (>20 years)		Female:	Male:	
Adolescents (10-19 years)		Female:	Male:	
Children (<9 years)		Female:	Male:	
Transgender persons		Female:	Male:	
Persons with disabilities		Female:	Male:	
Ethnic groups		List:		
Language(s) spoken		List:		
Major religion(s)		List:		
Other (specify)				
Emergency response mechanism				
Non-SRH protocols		List:		
Early warning mechanisms		List:		Related phone numbers:
Other (specify)		List:		
Leadership Structure				
Village leader(s)		Female:	Minorities:	
Religious leader(s)		Female:	Minorities:	
Other leader(s) (specify)		Female:	Minorities:	
Government				
Government offices (type)		List:		

SOCIAL ASSETS AND HUMAN RESOURCES	NO.	DETAILS	DETAILS	COMMENTS
Government officials		Female:	Minorities:	
Resources for health				
Health facilities				
Public health facilities		List:		
Private health facilities		List:		
Tertiary hospitals		List:		
Primary health care facilities		List:		
Community/Health posts		List:		
Mobile health units		List:		
Village health teams		List:		
Other (specify)		List:		
Health workforce				
Physicians		Female:	Minorities:	
Physician assistants		Female:	Minorities:	Role: Limits to scope:
Nurse practitioners		Female:	Minorities:	Role: Limits to scope:
Midwives		Female:	Minorities:	Role: Limits to scope:
Nurses		Female:	Minorities:	Role: Limits to scope:
Traditional birth attendants		Female:	Minorities:	Role: Limits to scope:

SOCIAL ASSETS AND HUMAN RESOURCES	NO.	DETAILS	DETAILS	COMMENTS
Community health workers		Female:	Minorities:	Role: Limits to scope:
Other (specify)		Female:	Minorities:	Role: Limits to scope:
Emergency response				
Emergency responders		Female:	Minorities:	
Ambulance drivers		Female:	Minorities:	
Other (please specify)		Female:	Minorities:	
Resources for protection				
Education				
Vocational schools		List:		
Secondary schools		List:		
Primary schools		List:		
Secondary school teachers		Female:	Minorities:	
Primary school teachers		Female:	Minorities:	
Teacher/student ratio (secondary)		Teacher:	Students:	
Teacher/student ratio (primary)		Teacher:	Students:	
Protection				
Social workers		Female:	Minorities:	
Case workers		Female:	Minorities:	
Law enforcement		Female:	Minorities:	

SOCIAL ASSETS AND HUMAN RESOURCES	NO.	DETAILS	DETAILS	COMMENTS
Lawyers		Female:	Minorities:	
Other		Female:	Minorities:	
Organizations working in the community				
International organizations		List:		
Regional organizations		List:		
National organizations (non-government)		List:		
Community-based organizations				
Women's groups		List:		Representation of minority groups: Available resources:
Youth groups		List:		Representation of minority groups: Available resources:
Organizations of persons with disabilities		List:		Representation of minority groups: Available resources:
Community groups for persons living with HIV/AIDS		List:		Representation of minority groups: Available resources:
LBGTQIA groups		List:		Representation of minority groups: Available resources:
Organizations for persons engaged in sex work		List:		Representation of minority groups: Available resources:
Other (please specify)		List:		Representation of minority groups: Available resources:
Community norms and resources				
Protective norms (norms or customs that provide protection in the community)	N/A	Describe:		
Other (please specify)		List:		Available resources:

REPORT BACK AND DISCUSSION

45 minutes

- After 45 minutes, participants in groups 1A and 1B will present their work:
  - Their map or table.
  - Existing infrastructure/available services and resources for SRH and gender protection.
  - Their list of capacities and gaps.

- As each group presents, the facilitator will look to the big group for agreement on these items. The facilitator should ask participants if an identified capacity or gap is a priority for the community, and if they agree, move the meta card to a central list in the front of the room.
- Once both groups present, the facilitator can bring out meta cards of findings from the pre-workshop **community capacity and needs assessment** and share any that have not yet been mentioned. If participants agree the capacity or gap is a priority, the meta card can be added to the central list.
- Items should not be moved to the front of the room if:
  - They do not directly address SRH or gender.
  - Are duplicates or are already on the central list.

Note to facilitator: During the presentations back to the group, the facilitator will need to help distinguish between items that are appropriate for SRH and gender issues, as opposed to those that are important and lifesaving but not related to the implementation of the activities discussed during this workshop. Again—it should be stressed that SRH and gender are components of preparedness and the focus of this workshop, but they should not be prioritized over other activities (such as first aid, search and rescue, etc.). Knowledge should be integrated and part of these other activities where appropriate.

LUNCH

1 hour

MODULE 3.3:

Action Planning

2.5 hours

Goal:

To apply knowledge of current capacities and gaps in MISP for SRH services to activities that could be implemented to overcome these gaps.

Summary: This module will transition the training to a discussion of how to take action given existing capacities and gaps identified in the morning activities, as well as over the past two days. Participants will review the MISP for SRH objectives and each of the activities to determine the current situation, how gaps will be addressed, the timeline, responsible leads, and mechanisms of monitoring that the action is undertaken.

Note to facilitator: This activity is best implemented before a final tea break, so that the facilitator can print the matrix for all participants (if printing facilities are available). If 4-5 laptops are not available, the facilitator should print hardcopies and be prepared to enter this information into a master matrix on the computer and share with participants as soon as feasible.

ACTIVITY: DEVELOPING AN ACTION PLAN FOR SRH PREPAREDNESS AND GENDER PROTECTION

- Ask groups to now work on developing activities that are related to improving existing systems or gaps identified.
- Divide participants into groups to examine each objective of the MISP for SRH, following the *MISP for SRH checklist*. Groups can be combined depending on the number of participants and available laptops.
  - » Coordination and demographics
  - » Preventing sexual violence and responding to the needs of survivors
  - » Preventing and responding to HIV/STIs

Supplies:

- Laptops (4-5 if available) (and power cords)
- Projector and screen
- Central list of capacities and gaps at the front of the room on meta cards
- Maps and tables from prior modules posted on the walls behind groups
- *MISP for SRH checklist matrix (soft copy, pre-filled with* **facility assessment** results from pre-workshop **community capacity and needs assessment**)
- *Community engagement action tool (paper copies)*

  - » Preventing excess maternal and newborn morbidity and mortality
  - » Preventing unintended pregnancies
  - » Planning for transition to comprehensive SRH services
  - » Safe abortion care and other

- The facilitator can provide the *MISP for SRH checklist*—which will serve as the action plan—to each group (in soft copy). One person should be identified to input the information into the relevant sections of the template. The matrix should already include **facility assessment** findings in the "Baseline" columns as available, for the groups to review and fill any gaps. This column is intended to serve as a baseline for if/when a new emergency occurs, and policymakers and providers can look to this table for necessary information to implement a response.
- Each group should then review the "What does this look like for this district/community?" column and complete it through examining the centralized list of items and tables/maps from the previous exercises, other tables posted to the walls, and any other findings from the pre-workshop **community capacity and needs assessment**.
- Each group can further complete the column "How will gaps be addressed?" through brainstorming around existing capacities, as well as identifying necessary resources.
- Groups should also consider items that require maintenance (for example, if health workers are monitoring pregnant women during emergencies and this is an existing capacity, it should be listed under maternal and newborn health that health workers will monitor pregnant women, and that awareness-raising may be needed about this role), as well as any broader issues that may be relevant to the specific MISP for SRH objective.
- Once the first three columns are completed, and during the tea break, groups should give their data to the facilitator to enter into one master matrix on the computer.

TEA BREAK (WORKING BREAK AS NEEDED)

 30 minutes

- Once all groups are finished, each group will present their portion of the table to the rest of the group. The facilitator can lead a discussion to see if others have anything to add, as well as seek any approvals from local government representatives, if present.
- The facilitator should then encourage participants to develop a timeline for achieving the action, designate who is responsible for ensuring the action is undertaken/activity is achieved, as well as agree on how the action will be monitored/measured to ensure it is undertaken.
    - Monitoring and follow-up activities that can be discussed include whether SMS technology or other platforms can be used to connect community members, as well as whether similar activities from the pre-workshop **community capacity and needs assessment** can be implemented at specific intervals to examine progress and engage community members.
- If many gaps exist, the facilitator can refer to the priorities in the central list from the morning activities, to help participants further prioritize (possibly up to three gaps per objective) and develop a timeline for short-term and long-term planning.
- Once the table is complete, the facilitator should review the central list again to see if any overarching gaps are missing. Things to consider are policy restrictions around task-sharing, issues around drug/regimen registration for use in emergency settings, and other regulatory or supply chain issues. It is also a good time to see if participants have additional suggestions or ideas.
- At this time, the facilitator should distribute the "*Community Engagement Action Tool*" and ask participants to consider their role in the community and the constituents they represent. For example, if they are a health facility manager, they can think of their catchment population. If they are a representative of a community-based organization, they should consider their members and who they serve. Each organization should then review the table and consider the following four questions:
    - How will you convey the information back to your constituents?
    - How will you continue to engage your constituents as the larger action plan is being implemented?
    - How can your constituents be part of the monitoring process for accountability purposes?
    - What is your timeline for activities?

NOTES:

- Organizations and representatives should take a few minutes to complete the *"Community Engagement Action Tool"* to identify major action items and next steps for their respective constituents. While the table is divided by MISP for SRH Objective, participants can develop broad actions if their plans are similar across objectives.
    - For example, a woman's group may decide that they will hold a community gathering to report back from this workshop. If they have been tasked with assembling newborn kits, for example, they can see if any members would be interested in helping knit infant hats and other activities that can capitalize on members' skills. As part of continued engagement, the organization can hold periodic meetings or focus group discussions before any larger group meetings to offer opportunities for members to contribute their thoughts and suggestions.
- Once participants are finished, they can share their plans with the larger group. The facilitator can add any new ideas into the master action plan as relevant, and then discuss how the group can determine check-in times so that they can come together (virtually or in person) to examine progress (one month, three months, six months, etc.).
- If members of the local government are not present, a plan should be made to bring the master action plan to relevant district policymakers to discuss items identified, including any resources or support that is needed to realize the action plan. Individual(s) or organization(s) who will be responsible for this activity should be directly identified to ensure this is undertaken.
- The facilitator should aim to give the final action plan to each participant as a key outcome document before the close of the training.

Note to facilitator: Action plans are the final output from this training. Participants should receive a copy, and copies should be shared and discussed with the Ministry of Health and relevant district offices in order to prioritize, make funds available, implement, and monitor.

NOTES:

ACTION PLANNING FOR SEXUAL AND REPRODUCTIVE HEALTH AND GENDER

Name of District/Community: **Number of Hospitals:** **Number of Health Centers:**

MISP for SRH Checklist		Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
1. SRH lead agency and SRH Coordinator								
1.1	Lead SRH agency identified at national level and SRH Coordinator functioning within the health sector/cluster	Y	N	Same as prior activities				
	Lead agency			Who?				
	SRH Coordinator			Who?				
1.2	SRH stakeholder meetings established and meeting regularly:	Y	N	Describe current system				
	National (MONTHLY)			Who participates?				
	Sub-national/district (BIWEEKLY)			Who participates?				
	Local (WEEKLY)			Who participates?				
1.3	Relevant stakeholders lead/participate in SRH Working Group meetings at the district level	Y	N	Refer to prior activities				
	Ministry of Health			Who participates?				
	UNFPA and other relevant UN agencies			Who participates?				
	International NGOs			Who participates?				
	Local NGOs			Who participates?				
	Protection/GBV			Refer to prior activities				
	HIV			Refer to prior activities				
	Civil society, including marginalized (adolescents, persons with disabilities, LGBTQIA persons)			Who participates?				
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensures mapping and vetting of existing SRH services	Y	N	Refer to prior activities				
2. Demographics								
2.1	Total population			Refer to Activity 1B	N/A	N/A	N/A	N/A
2.2	Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)			Comments:	N/A	N/A	N/A	N/A
2.3	Number of sexually active men (estimated at 20% of population)			Comments:	N/A	N/A	N/A	N/A
2.4	Crude birth rate (national host and/or affected population or estimated at 4% of the population)			Comments:	N/A	N/A	N/A	N/A

(cont'd)

MISP for SRH Checklist		Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
3. Prevent sexual violence and respond to the needs of survivors								
3.1	Multi-sectoral coordinated mechanisms to prevent sexual violence are in place	Y	N		Current system			
3.2	Safe access to health facilities	Y	N	Which are unsafe?				
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside, lighting around health facility, system to control who is entering or leaving facility, i.e., guards or reception)		%	Which are safe?				
3.3	Confidential health services to manage survivors of sexual violence	Y	N	Where?				
	Percentage of health facilities providing clinical management of survivors of sexual violence (Number of health facilities offering care/all health facilities) x 100%		%	Which facilities provide?				
	Emergency contraception	Y	N	What are the gaps?				
	Pregnancy test			What are the gaps?				
	Pregnancy			What are the gaps?				
	Post-exposure prophylaxis (PEP) for HIV			What are the gaps?				
	Antibiotics to prevent and treat sexually transmitted infections			What are the gaps?				
	Tetanus toxoid/Tetanus immunoglobulin			What are the gaps?				
	Hepatitis B vaccine			What are the gaps?				
	Safe abortion care			What are the gaps?				
	Referral to health services			Where?				
	Referral to safe abortion services			Where?				
	Referral to psychological, social support services			Where?				
3.4	Number of incidents of sexual violence reported to health services			Comments (timeframe, etc.)				
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident (Number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100%		%	Comments (timeframe, etc.)				
3.5	Communities informed on the benefits and location of care for survivors of sexual violence	Y	N	How are people informed (radio, leaflets, community meetings)?				

(cont'd)

	MISP for SRH Checklist	Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
4. Prevent and respond to HIV								
4.1	Safe and rational blood transfusion protocols in place	Y	N	What are the gaps?				
4.2	Units of blood screened/all units of blood donated x 100			Screened for what?				
4.3	Health facilities have sufficient materials to ensure standard precautions in place			What is missing?				
4.4	Lubricated condoms available free of charge:	Y	N	What are the gaps?				
	Where are they available?			Where unavailable?				
	For whom? (Adolescents, LGBTQI, persons with disabilities, sex workers, etc.)			Who lacks access?				
4.5	Approximate number of condoms taken this period (1 or 3 months)			Comments (timeframe)				
4.6	Number of condoms replenished in distribution sites this period (specify locations)	N/A		Any supply chain issues?				
4.7	Antiretrovirals available to provide treatment for people with HIV, including prevention of mother-to-child transmission			Who provides ART? How are people informed?				
4.8	PEP available for survivors of sexual violence? PEP available for occupational exposure?			What are the gaps?				
4.9	Co-trimoxazole prophylaxis for opportunistic infections			What are the gaps?				
4.10	Syndromic diagnosis and treatment for STIs available at health facilities			What are the gaps?				
5. Prevent excess maternal and newborn morbidity and mortality								
5.1	Availability of emergency obstetric and newborn care (EmONC) basic and comprehensive per 500,000 population	Y	N	Where?				
	Health center with basic EmONC, five per 500,000 population			Where?				
	Hospital with comprehensive EmONC, one per 500,000 population			Where?				

(cont'd)

MISP for SRH Checklist		Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
5.2	Health center (to ensure basic EmONC 24/7)			Where? What are the gaps?				
	One qualified health worker on duty per 50 outpatient consultations per day			What are the gaps?				
	Adequate supplies, including newborn supplies, to support basic EmONC available			What are the gaps?				
	Hospital (to ensure comprehensive EmONC 24/7)			Where? What are the gaps?				
	One qualified service provider on duty per 20-30 inpatient beds for the obstetric wards			What are the gaps?				
	One team of doctor/nurse/midwife/anesthetist on duty			What are the gaps?				
	Adequate drugs and supplies to support comprehensive EmONC 24/7			What are the gaps?				
	Post-abortion care (PAC)			Where?				
	Coverage of PAC (number of health facilities where PAC is available/number of health facilities) x 100%		%	What are gaps to PAC access?				
	Number of women and girls receiving PAC			What are the gaps?				
5.3	Referral system for obstetric and newborn emergencies functioning 24/7, means of communication (radios, mobile phones)	Y	N	What is the system?				
	Transport from community to health center available 24/7			How far nearest facility?				
	Transport from health center to hospital available 24/7			How far nearest facility?				
5.4	Functioning cold chain (for oxytocin, blood screening tests) in place			What are the gaps?				
5.5	Proportion of all births in health facilities (number of women giving birth in health facilities in specified period/expected number of births in the same period)		%	Where do most births take place (home, hospital, etc.)?				
5.6	Need for EmONC met (number of women with major direct obstetric complications treated in EmONC facilities in specified period/expected number of women with severe direct obstetric complications in the same area in the same period)		%	What are gaps to EmONC access?				
5.7	Number of cesarean deliveries/number of lives births at health facilities x 100% (total)		%	What are the gaps?				

(cont'd)

MISP for SRH Checklist		Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
5.8	Supplies and commodities for clean delivery and newborn care	Y	N	What are the gaps?				
5.9	Clean delivery kit coverage (number of clean delivery kits distributed where access to health facilities is not possible/estimated number of pregnant women) x 100%		%	What are the gaps?				
5.10	Number of newborn kits distributed, including clinics and hospitals			What are the gaps?				
5.11	Community informed about the danger signs of pregnancy and childbirth complications and where to seek care	Y	N	How are people informed?				
6. Prevent unintended pregnancies								
6.1	Where do community members access contraception (e.g., health facilities, mobile clinics, pharmacies)?	N/A		List				
6.2	Short-acting methods (condoms, emergency contraception, oral contraceptive pills, injectables) available in at least one facility	Y	N	Where?				
6.3	Number of health facilities that maintain a minimum of 3-month supply of each			Where?				
	Condoms	Y	N	What are the gaps?				
	Emergency contraception (progestin-only pills)			What are the gaps?				
	Combined oral contraceptive pills			What are the gaps?				
	Progestin-only contraceptive pills			What are the gaps?				
	Injectables			What are the gaps?				
	Implants			What are the gaps?				
	Intrauterine device			What are the gaps?				
7. Planning for transition to comprehensive SRH services								
7.1	Service delivery	Y	N	What services are not available?				
	SRH needs in the community identified			What are the needs?				
	Suitable sites for SRH service delivery identified			Where?				
7.2	Health workforce			What are the gaps?				
	Staff capacity assessed			What are the gaps?				
	Staffing needs and levels identified			What are the gaps?				
	Training(s) designed and planned			When, for whom, and on what?				

(cont'd)

MISP for SRH Checklist		Baseline		What does this look like for this district/ community?	How will gap be addressed?	Timeline to address gap	Responsible lead	How measured?
7.3	Health information system			What system is used?				
	SRH information included in health information system			What indicators?				
7.4	Medical commodities			What supply chain (including cold chain) gaps exist?				
	SRH commodity needs identified			What are the needs?				
	SRH commodity supply lines identified, consolidated, and strengthened			Describe				
7.5	Financing			How much do people pay at public and private facilities?				
	SRH funding possibilities identified			What sources?				
7.6	Governance, leadership			Describe				
7.7	SRH-related laws, policies, and protocols reviewed			Which policies?				
8. Other priority activity: Safe abortion care (SAC)								
8.1	Women and girls have access to SAC to the full extent of the law?	Y	N	Describe policy environment and barriers to access				
8.2	Coverage of SAC (number of health facilities where SAC is available/number of health facilities) x 100%		%	What are gaps to SAC access?				
8.3	Number of women and girls receiving SAC			What are the gaps?				
8.4	Number of women and girls treated for complications of abortion (spontaneous or induced)			What are the gaps?				
9. Special notes								
9.1	Other (as relevant)							

* Adapted from IAWG on RH in Crises, MISP Checklist, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

COMMUNITY ENGAGEMENT ACTION TOOL

Major **action items**	How will you **convey the information** back to your constituents?	How will you **continue to engage** your constituents as the larger action plan is being implemented?	How can your constituents be **part of the monitoring process**?	What is your **timeline** for activities?
Overarching/Objective 1: Coordination				
Objective 2: Preventing Sexual Violence and Responding to the Needs of Survivors				
Objective 3: Preventing Transmission of HIV/STIs				
Objective 4: Preventing Excess Maternal and Newborn Morbidity and Mortality				
Objective 5: Preventing Unintended Pregnancies				
Objective 6: Planning for Comprehensive SRH/ Building Resilience				

Wrap-Up and Closing

1 hour

Goal:

To pull together learning from the three days of training, ensure there is understanding of the content covered, and provide closure to the event (sharing any plans for follow-up).

Supplies:

- Training evaluation
- Post-test
- Certificates for participants

POST-TEST AND FINAL EVALUATION

- Before the close of the training, distribute post-tests and final evaluations for participants to fill out. Emphasize that the evaluations are confidential and anonymous, and should not have any identifying information on them.
- Similar to the pre-test, if a participant has a visual impairment and the post-test is not available in electronic form, braille, or another mode that the participant uses, the facilitator or assistant can verbally administer the test.

CLOSING CEREMONY AND CERTIFICATES

- Organize and implement a culturally appropriate closing ceremony with certificate distribution. End the training with appreciation and praise of all participants. Encourage participants to support each other and stay connected.

Facilitator's Tip:

The final closing at the end of the training is crucial. It will encourage and emphasize the use of action plans to better address the needs of women, girls, and others at risk in emergency preparedness, disaster risk reduction, and response. Spend ample time discussing how to best implement action plans and sustain monitoring activities, including obtaining buy-in from leadership and funding, as this is the desired goal of the training.

DAY 4 (Optional)

Examining Epidemic and Pandemic Preparedness

GOAL:

To explore epidemic and pandemic preparedness as it relates to sexual and reproductive health (SRH) and gender, and to refine and tailor preparedness activities at the community level to ensure SRH access and gender protection, including for marginalized and underserved groups, in the event of an epidemic or pandemic.

MODULE 4.1: Introduction to Epidemics and Pandemics

MODULE 4.2: SRH and Gender Protection in Epidemics/Pandemics

MODULE 4.3: Action Planning

BACKGROUND

Low resource and humanitarian settings pose particular challenges for infectious disease prevention and control.[1] Insecurity, pre-existing limitations to health access, overcrowding, lack of access to sanitation and hygiene, and already weak health systems have made public health responses significantly more complex, including in recent large-scale disease outbreaks, such as the 2014-16 Ebola virus disease (EVD) epidemic in West Africa, 2016 Zika virus epidemic in Latin America, and the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19) pandemic in 2020.[2] [3] [4]

Recent epidemics and pandemics have resulted in disproportionate effects on women and girls, including adverse consequences to their education, food security, health, livelihoods, and protection.[5] [6] During the 2014-16 West Africa EVD outbreak, fear of contracting the disease resulted in fewer women attending health clinics.[7] Coupled with resource diversion from primary health care services and prevailing social norms, vaccination coverage decreased and maternal mortality increased by 75 percent in three of the affected countries.[8]

Epidemic and pandemic responses can be further complicated by the politicization of response, leading to the spread of misinformation, hostility, and violence toward response efforts and personnel, and limited access to sexual and reproductive health (SRH) services.[9] All of these consequences have been seen in the EVD outbreak in 2020 in eastern Democratic Republic of the Congo.[10] The global response to the COVID-19 pandemic is additionally seeing disproportionate impacts on the health and well-being of women, girls, and vulnerable populations.[11] Countries have reported an increase in gender-based violence (GBV) due to movement restrictions and quarantine measures. Experiences show that this type of violence is linked to increases in unsafe abortion, maternal mortality and low birth weight, miscarriage, premature labor, and sexually transmitted infections (STIs) for girls, women, and gender non-conforming people, including in humanitarian settings.[12]

---

1 Inter-agency Standing Committee (March 2020*). Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings*. Available at: https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp.

2 IAWG on RH in Crises (March 2020). *Ebola Outbreak in Democratic Republic of the Congo*. Available at: https://iawg.net/emergencies/ebola-outbreak-in-democratic-republic-of-the-congo.

3 J. Smith, "Overcoming the 'tyranny of the urgent': integrating gender into disease outbreak preparedness and response," *Gender & Development* 27, no. 2, accessed March 14, 2020, https://doi.org/10.1080/13552074.2019.1615288.

4 CARE International (March 2020). *Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings*. Available at: https://www.care.org/sites/default/files/gendered_implications_of_covid-19_executive_summary.pdf?mc_cid=89788b752d&mc_eid=bd0dd79b25.

5 UNFPA (March 2020). COVID-19: *A Gender Lens: Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality*. Available at: https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

6 UN (April 2020). Policy Brief: The Impact of COVID-19 on Women. Available at: https://www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_women_9_apr_2020_updated.pdf.

7 S.E. Davies and B. Bennett, A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies. *Int Aff* 2016;92:1041–60.

8 ACAPS (February 2016), "Beyond A Public Health Emergency," ACAPS. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/a-potential-secondary-humanitarian-impacts-of-a-large-scale-ebola-outbreak.pdf.

9 IAWG on RH in Crises (March 2020). *Ebola Outbreak in Democratic Republic of the Congo*. Available at: https://iawg.net/emergencies/ebola-outbreak-in-democratic-republic-of-the-congo.

10 G. McKay et al. (2019). *Not All That Bleeds Is Ebola: How has the DRC Ebola outbreak impacted Sexual and Reproductive Health in North-Kivu*? New York, USA: The International Rescue Committee. Available at: https://www.rescue.org/report/not-all-bleeds-ebola-how-drc-outbreak-impacts-reproductive-health.

11 K.S. Hallet al. "Centering sexual and reproductive health and justice in the global COVID-19 response," *Lancet*. 2020;395(10231):1175–1177. doi:10.1016/S0140-6736(20)30801-1. Available at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30801-1.pdf.

12 IAWG on RH in Crises (May 2020). *IAWG expresses its support, the continued commitment of the United Nations to protect, respect and fulfill the sexual and reproductive health and human rights of all girls, women, and gender non-conforming people in humanitarian settings*. Available at: https://iawg.net/resources/iawg-un-srhr-covid?mc_cid=42124c6d32&mc_eid=bd0dd79b25.

Access to other SRH services, including voluntary contraception and safe abortion care, can also be significantly curtailed, due to global supply chain disruptions, diversion of resources away from essential SRH care, and politicization of SRH services.[13] Mobility restrictions, fear of disease transmission, and social stigma can limit pregnant women's access to safe delivery and emergency obstetric care, increasing risks of maternal and child morbidity and mortality.[14]

Marginalized and underserved communities are at significantly added risks, as their vulnerabilities are compounded during crises.[15] These communities can include adolescents, migrants, persons with disabilities, and persons with diverse sexual orientations, gender identities, gender expressions, and sex characteristics" (SOGIE).[16] In such situations, innovative, community-based strategies become all the more necessary to ensure continued access to SRH services—especially time-sensitive care such as care for survivors of sexual violence and childbirth services—to minimize excess morbidity, mortality, and disability.

In addition to health and protection, during epidemics and pandemics, women, girls, and at-risk and marginalized communities are likely to have increased needs for sanitation, shelter, education, food, and livelihoods. Recommendations have focused on supporting their participation and leadership to ensure prevention and control measures do not exacerbate harmful norms; strengthening water, sanitation, and hygiene services; preparing and responding to possible surges in GBV and sexual exploitation and abuse; and ensuring marginalized communities are included in national surveillance, preparedness, and response plans and activities.[17] Epidemic and pandemic preparedness is thus critical to ensuring gender protection, SRH rights, and uninterrupted access to life-saving SRH services for all persons.

PURPOSE

The complementary workshop is half a day and builds on the work that was done on Day 3 of the *SRH and DRR* workshop. There are three modules in this section. Participants will explore pandemic preparedness as it relates to SRH and gender, and learn about the additional challenges to preparing for this type of emergency. They will examine the differences and considerations around preparedness activities for SRH and gender; specifically, as it pertains to implementing the Minimum Initial Service Package (MISP) for SRH. They will then refine and tailor preparedness activities at the community level to ensure SRH access and gender protection, including for marginalized and underserved groups.

OBJECTIVES

1. To explore how SRH and gender inequalities are likely to be affected by epidemics and pandemics.
2. To examine the considerations around preparedness activities for SRH and gender; specifically, as they pertain to ensuring the availability of essential MISP for SRH services in epidemics/pandemics.

---

13 C. Purdy, Opinion: how will COVID-19 affect global access to contraceptives—and what can we do about it? Devex. Available at: https://www.devex.com/news/opinion-how-will-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745.

14 S. A. Rasmussen et al., Coronavirus Disease 2019 (COVID-19) and pregnancy: what obstetricians need to know. *Am J Obstet Gynecol*. 2020; (published online Feb 24.) DOI:10.1016/j.ajog.2020.02.017.

15 Inter-agency Working Group on Reproductive Health in Crises (April 2020). *Programmatic Guidance Regarding Sexual and Reproductive Health Care in the Face of COVID*. Available at: https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic.

16 IAWG on RH in Crises (May 2020). *COVID-19 Pandemic Further Threatens Women and Girls Already at Risk in Humanitarian and Fragile Settings*. Available at: https://cdn.iawg.rygn.io/documents/IAWG-COVID-ADVOCACY-STATEMENT.pdf?mtime=20200512014036&focal=none.

17 S. Fuhrman et al., "Gendered implications of the COVID-19 pandemic for policies and programmes in humanitarian settings," *BMJ Global Health* 2020;5:e002624.

3. To explore how to improve access to SRH services by challenging stigma and discrimination that arise due to epidemics/pandemics.
4. To refine and tailor preparedness activities at the community level to improve SRH access and gender protection for marginalized and underserved groups during epidemics/pandemics.

PARTICIPANTS

Participants will be similar to those for whom the broader curriculum is designed; hence, persons with some relevant health background, including district health policymakers, disaster management agencies, program managers responsible for preparedness, and civil society groups and networks. Participants will still be required to undertake the MISP for SRH Distance Learning Module before attending the workshop.

TIMING

The ideal timing to implement this module is as part of an additional, optional fourth day of the training (if a disease outbreak is foreseeable or imminent), after action planning has been undertaken more broadly on Day 3. Alternatively, if there is already a coordinated and well-functioning group that has emerged from the training that is responsible for implementing the original action plan, any pandemic preparedness can build on existing structures, systems, and strengths at a later time.

If the latter, the half-day training could possibly be converted into a full-day training with the morning spent discussing progress and challenges since the last check-in by participants, and the afternoon dedicated to epidemic/pandemic preparedness activities.

PREREQUISITES

The **community capacity and needs assessment** will have been undertaken prior to the main workshop to maximize community contributions to the training. If the epidemic/pandemic module will be implemented months after the original workshop, and community needs, resources, and capacities have changed since the initial community capacity and needs assessments, it may be helpful to implement select community-based information-gathering activities (focus group discussions, for example) to identify emerging challenges, as well as community members' suggestions and recommendations for SRH and gender protection.

Since this module is intended to complement the *SRH and DRR Curriculum*, it will not separately review the technical content that examines disaster risk reduction and SRH in emergencies. If participants need a refresher, they can be encouraged to complete the MISP for SRH Distance Learning Module again.

KEY OUTPUT

The key output from this module is a refined action plan from Day 3 activities that addresses epidemic/pandemic preparedness.

PREPARING FOR THE TRAINING

Please see preparations for the broader training to plan for this half-day segment. Similar to the rest of the training, the guidance in the Epidemic and Pandemic Preparedness Module is a recommendation of activities and facilitation techniques. The facilitator(s) can adapt the workshop to suit the profile of participants and the local context.

Facilitator's Agenda Day 4 (Optional)

ITEM	COMPONENT(S)	SUB-OBJECTIVES
Welcome and Housekeeping (20 minutes)	• Housekeeping.	
MODULE 4.1: Introduction to Epidemics and Pandemics **(30 minutes)**	• Presentation: What are epidemics and pandemics, and what are the implications for SRH and gender? • Discussion: Values clarification on potential stigma/ discrimination	1. **To provide an overview of different types of epidemics and pandemics** (*when a health problem becomes a crisis; definitions of epidemics/pandemics; characteristics of diseases, including varying modes of transmission, infection prevention, and health consequences; link to global and country-specific data and other resources as available*). 2. **To examine the gendered implications of epidemics and pandemics** (*including gender roles/burden of care and risks of disease exposure; consequences of factors such as mobility restrictions on domestic violence/sexual violence/childbirth; increased gender-based discrimination against certain groups; gendered impact on stress levels and coping capacities; etc.*). 3. **To identify anticipated challenges that may threaten the health and well-being of the community** (*including lack of recognition of SRH as "essential" services, especially safe abortion care; inability to social distance or practice other infection prevention measures; added vulnerabilities for marginalized groups, including people with disabilities (PWDs); different levels of stigma/discrimination, including towards health providers, marginalized communities; etc.*).
MODULE 4.2: SRH and Gender Protection in Epidemics/ Pandemics **(30 minutes)**	• Discussion: Specific considerations around ensuring availability of essential MISP services • Discussion: Community-specific challenges, including around stigma and discrimination	1. **To examine considerations around ensuring essential MISP services in epidemics/pandemics** (*including likely need for PPE and other infection prevention supplies; addressing access to time-sensitive and life-saving care—especially post-rape care, safe abortion care, delivery care, and HIV care—amidst any mobility restrictions; considerations for provider and community mental and psychosocial well-being; etc.*). 2. **To identify challenges to ensuring essential MISP services at the community level** (*to be identified by participants, but examples include: increased stigma/ discrimination against specific groups, including service providers; prevailing lack of supplies or impact of disrupted global and local supply chains on contraceptive availability, ARV medications, etc.; limited access to SRH services increasing risks for maternal and other SRH-related mortality; overcrowding and lack of water/sanitation resources; distrust toward aid providers hindering disease prevention efforts; already low levels of skilled attendance at birth and implications after pandemic; barriers imposed by cost; other local impacts of global concerns; etc.*).

(cont'd)

ITEM	COMPONENT(S)	SUB-OBJECTIVES
MODULE 4.3: Action Planning **(1 hour)**	• Activity: Refining an action plan for SRH and gender protection for epidemic/pandemic preparedness	1. **To examine how to ensure SRH access and gender protection for marginalized and underserved groups during epidemics/pandemics** (*developing solutions to the above challenges; involving all actors that may be involved in the response, including the private sector; addressing coordination across all coordination bodies that may play a role in response; considering the formation of rapid response teams; operationalizing innovative community-based approaches and mobile outreach to providing SRH care, especially for post-rape care and safe abortion care; supporting self-care; maintaining supplies and addressing coordination between facilities and organizations; addressing potential cost-related barriers; developing strategies for quarantined persons; developing messaging and communication strategies to address stigma/discrimination; addressing monitoring and reporting of service use, including routine data to inform response; etc.*). 2. **To identify responsible persons, timeline, accountability mechanisms, and resources to implement action plan for epidemic/pandemic preparedness** (*build on action plan from Day 3*).
Wrap-up (30 minutes)		3. To confirm next steps around implementing preparedness activities, including monitoring and participation of marginalized and underserved groups, to foster community and political ownership.

Introduction

20 minutes

Goal:

To introduce the objectives of the half-day workshop.

- To explore how SRH and gender inequalities are likely to be affected by epidemics and pandemics.
- To examine the considerations around preparedness activities for SRH and gender; specifically, as they pertain to ensuring the availability of essential MISP for SRH services in epidemics/pandemics.
- To explore how to improve access to SRH services by challenging stigma and discrimination that arise due to epidemics/pandemics.
- To refine and tailor preparedness activities at the community level to improve SRH access and gender protection for marginalized and underserved groups during epidemics/pandemics.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Presentation: *Overview of the epidemic/pandemic preparedness and SRH workshop*
- Markers
- Flip chart paper

Summary: This brief introductory segment is intended to introduce participants to the objectives of the workshop.

WELCOME & HOUSEKEEPING

- Welcome participants to the training.
- Start the day with a morning blessing/prayer as appropriate.

PRESENTATION: OVERVIEW OF THE EPIDEMIC/PANDEMIC PREPAREDNESS AND SRH WORKSHOP

- Facilitators can use a pre-made PowerPoint presentation or adapt the information to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitators in highlighting key points from the slides.
- Ask participants if they have questions or anything they would like to add.

Facilitator's Tip:

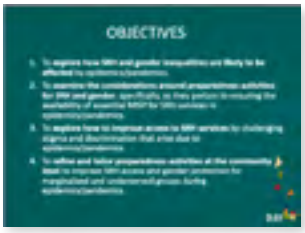
The dynamics of the workshop will depend on the cohesiveness of the group and when this component is implemented. If the workshop is part of Day 4, then the introduction can be brief, whereas, if several weeks or months have passed since the original workshop, some time may need to be spent reorienting participants.

PRESENTATION: OVERVIEW OF THE EPIDEMIC/PANDEMIC PREPAREDNESS : 3 slides

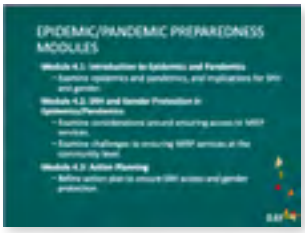
Hover your mouse over the image to get a description of the slide contents.

SLIDE 1

SLIDE 2



SLIDE 3



MODULE 4.1:
Introduction to Epidemics and Pandemics

30 minutes

Goal:

To explore epidemic and pandemic preparedness as it relates to SRH and gender.

- To provide an overview of different types of epidemics and pandemics.
- To examine the gendered implications of epidemics and pandemics.
- To identify anticipated challenges that may threaten the health and well-being of the community.

Supplies:

- Laptop (and power cord)
- Projector and screen
- Presentation: *What are epidemics and pandemics, and what are the implications for SRH and gender?*
- Markers
- Flip chart paper

Summary: The session will open with an introductory presentation on epidemics and pandemics, what makes a health issue become an epidemic/pandemic, and potential health and societal consequences. It will further examine the gendered implications and consequences for SRH based on past disease outbreaks. Following the presentation, participants will explore any biases they may foresee in the community that can contribute to new or added stigma and discrimination against certain groups.

Facilitator's Tip:

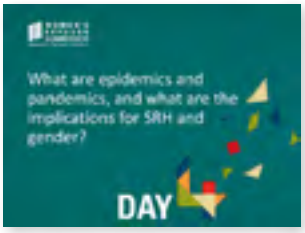
This session is intended to present a broad overview of epidemics and pandemics, and their gendered implications. It would be helpful for the facilitators to keep the session broad, since Module 4.2 focuses on community-specific challenges and scenarios. While data from past outbreaks are noted in the slides, the facilitators can share them at their discretion based on relevance and time available.

PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER

- The facilitators can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own. The prepared presentation includes pointers in the "Notes" sections to aid the facilitator in highlighting key points from the slides.
- The facilitators can end the presentation with a discussion on the most imminent disease outbreak on which the remainder of the workshop will focus.

PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER: 8 SLIDES

SLIDE 1



SLIDE 2

Ask participants when they think a health problem becomes a crisis. What makes a crisis an epidemic or pandemic?

Definitions:

- An **epidemic** is the occurrence of illness, health-related behavior, or other health-related event at a higher rate than expected within a population. An epidemic does not have to be from a virus or disease.
- An **outbreak** is often used synonymously with epidemic, but outbreaks are localized to a small geographic area, such as a neighborhood, city, or region. A key characteristic of an epidemic or an outbreak is that the number of new cases must be more than expected, compared to the relative frequency of the disease.
- Diseases can be **endemic** within a population; where they are constantly present. For example, influenza, malaria, dengue, and other diseases are endemic in many communities. When the number of cases exceeds the normal frequency of the disease, an epidemic may be occurring.
- A **pandemic** is an epidemic affecting populations of an extensive region, country, or continent.

Reference:
Nash, David B., Fabius, Raymond J., Skoufalos, Alexis, Oglesby, Willie H. (2019). "Chapter 2: Epidemiology." *Population Health: Creating a Culture of Wellness*. Third Edition. Jones & Bartlett Learning.

SLIDE 3

There have been numerous epidemics and pandemics in the past, especially if we think of dengue and cholera, but here are some other examples.

Past disease outbreaks have had varying modes of transmission, requiring different prevention measures, as well as differing symptoms and health consequences.

2002-2003 SARS outbreak: The SARS coronavirus (SARS-CoV) epidemic affected 26 countries and resulted in more than 8,000 cases in 2003. Transmission of SARS-CoV was primarily from person to person.[1]

2014-2015 Ebola virus disease (EVD) outbreak: The 2014-2015 EVD outbreak spread from Guinea to Liberia, Sierra Leone, Nigeria, Senegal, and Mali. Nearly 29,000 probable, suspected, and lab-confirmed cases were identified, with more than 11,000 deaths. These included 881 infected health care workers, of whom 60% died. Data suggest that bats are at least one of the reservoir hosts. Primary transmission was from contact with infected blood, feces, and vomitus, although transmission from direct contact with the skin of an infected person was also documented.[2] Though it crossed international borders, the 2014–2016 epidemic of Ebola in West Africa was not considered a pandemic because it was localized to West Africa.

PRESENTATION: PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER (cont'd)

SLIDE 3 (cont'd)

2015–2016 Zika virus outbreak: In 2015-2016, an outbreak of Zika virus began in Brazil and spread to other parts of South and North America, as well as several islands in the Pacific, and Southeast Asia. WHO declared the outbreak a Public Health Emergency of International Concern in February 2016. The virus was spread primarily by mosquitos; maternal-child transmission was linked to microcephaly (small head size) and brain anomalies in infants. In adults, symptoms included neurologic complications. Sexual transmission and transmission through blood were also documented.[3]

1918 influenza: Lasting roughly 15 months from spring 1918 to early summer 1919, the H1N1 influenza A virus infected 500 million people globally, with an estimated 17 million to 50 million deaths.[4]

2009 H1N1 influenza: The 2009 H1N1 influenza pandemic lasted for about 19 months, from January 2009 to August 2010. First described in April 2009, the virus resulted from a triple reassortment of bird, swine, and human flu viruses. Like other types of flu, transmission primarily occurred through coughing or sneezing. The pandemic is estimated to have caused about 284,000 (range from 150,000 to 575,000) deaths.[5]

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19): First detected in China's Hubei Province in late 2019, COVID-19 has spread rapidly, leading the WHO to declare a global pandemic on 11 March 2020. Transmission is primarily through respiratory droplets. The disease, which can cause severe respiratory symptoms, has been reported in at least 180 countries, and has caused global morbidity and mortality.[6] WHO recommends the use of PPE, masks, hand hygiene practices, and social distancing to prevent disease transmission.[7]

References

1. WHO. SARS (Severe Acute Respiratory Syndrome). Available at https://www.who.int/ith/diseases/sars/en/.

2. WHO. Ebola Situation Report – 11 Nov 2015. Available at https://apps.who.int/iris/bitstream/handle/10665/194050/ebolasitrep_11Nov2015_eng.pdf?sequence=1.

3. CDC. About Zika. Available at https://www.cdc.gov/zika/about/index.html.

4. CDC. 1918 Pandemic (H1N1 virus). Available at https://www.cdc.gov/flu/pandem ic-resources/1918-pandemic-h1n1.html.

5. CDC. "First Global Estimates of 2009 H1N1 Pandemic Mortality Released by CDC-Led Collaboration". 25 June 2012. Available at https://www.cdc.gov/flu/spotlights/pandemic-global-estimates.htm.

6. Johns Hopkins University. COVID Resource Center. Available at https://coronavirus.jhu.edu/us-map. Last accessed 7 June 2020.

7. WHO. Scientific Brief: Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations. 29 March 2020. Available at https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations.

PRESENTATION: PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER (cont'd)

SLIDE 4

Epidemics and pandemics can have disproportionate effects on women and girls.

Gender roles and risks of disease exposure: Social norms—such as expectations that women and girls are responsible for doing domestic chores and nursing sick family members—can expose women and girls to greater health risks.[1] The 2010 cholera epidemic in Haiti and 2014–16 EVD outbreak in West Africa showed a three-fold caregiver burden on women and girls: They were responsible for household-level disease prevention and response efforts; at greater risk of infection; and subject to emotional, physical, and socioeconomic harm.[2] Women comprise more than 75 percent of the health care workforce in many countries, which increases the likelihood that they will be exposed to infectious diseases.[3]

Consequences of disease prevention efforts: During the 2014-16 West Africa EVD outbreak, fear of contracting the disease resulted in fewer women attending health clinics.[4] Coupled with resource diversion from primary health care services and prevailing social norms, vaccination coverage decreased and maternal mortality increased by 75 percent in three of the affected countries.[5]

Pandemics further compound existing gender inequalities and vulnerabilities, increasing risks of abuse. During disease outbreaks, women and girls may be at higher risk of intimate partner violence and other forms of domestic violence due to heightened tensions in the household.[3]

Politicization of SRH and limited access to specific services: Epidemic and pandemic responses can be further complicated by the politicization of response, leading to the spread of misinformation, hostility and violence toward response efforts, and limited access to SRH services.[6] All of these consequences have been seen in the renewed EVD outbreak in 2020 in eastern Democratic Republic of the Congo.[7]

Increased gender-based discrimination against certain groups: Women and girls face increased risks of gender-based violence (GBV), including sexual exploitation and abuse. For example, the economic impacts of EVD in West Africa placed women and children at greater risk of exploitation and sexual violence.[3] With prevailing social norms and stigma against persons with diverse gender expressions, gender identities, sexual orientation and sex characteristics, such persons may be further marginalized and stigmatized.[8]

In addition, lifesaving care and support to GBV survivors (e.g., clinical management of sexual violence and mental health and psychosocial support) may be cut off in the health care response when health service providers are overburdened and preoccupied with handling epidemic/pandemic itself.[3]

Gendered impact on stress levels and coping capacities: Epidemics and pandemics can increase the need for mental health and psychosocial support services, just as resource diversions can jeopardize them. Women and girls playing a caregiving role as frontline health workers or in their families may be exposed to stigma and discrimination from community members who may be fearful of becoming infected. This can add additional stresses on women and girls and overwhelm coping capacities.[8]

References

1. CARE (March 2019). Gender Implications of COVID-19 *Outbreaks in Development and Humanitarian Settings*. Available at: https://www.care.org/sites/default/files/gendered_implications_of_covid-19_-_executive_summary.pdf?mc_cid=89788b752d&mc_eid=bd0dd79b25.

2. Interagency Standing Committee (IASC) GBV Sub-Sector Nigeria (September 2017). "Briefing Note: Integrating Gender In Cholera Prevention And Control Interventions In North East Nigeria," IASC. Available at: https://interagencystandingcommittee.org /system/files/briefing_note-gender_in_cholera_response.pdf.

PRESENTATION: PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER (cont'd)

SLIDE 4 (cont'd)

3. UNFPA (March 2020). COVID-19: A Gender Lens: Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality. Available at: https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

4. Davies SE, Bennett B. A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies. Int Aff 2016;92:1041–60.

5. ACAPS (February 2016). "Beyond A Public Health Emergency," ACAPS. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/a-potential-secondary-humanitarian-impacts-of-a-large-scale-ebola-outbreak.pdf.

6. AWG on RH in Crises (March 2020). *Ebola Outbreak in Democratic Republic of the Congo*. Available at: https://iawg.net/emergencies/ebola-outbreak-in-democratic-republic-of-the-congo.

7. McKay G, Black B, Mbambu Kahamba S, Wheeler E, Mearns S, Janvrin A. (2019). *Not All That Bleeds Is Ebola: How has the DRC Ebola outbreak impacted Sexual and Reproductive Health in North-Kivu?* New York, USA: The International Rescue Committee.

8. Fuhrman S, Kalyanpur A, Friedman S, et al. Gendered implications of the COVID-19 pandemic for policies and programmes in humanitarian settings. *BMJ Global Health 2020*;5:e002624.

SLIDE 5

The global response to the COVID-19 pandemic has seen disproportionate impacts on the health and well-being of women, girls, and vulnerable populations.

Increased burden of care on women and girls: Due to prevailing social norms and primary caregiving responsibilities, the pandemic has seen an increased burden of care on women and girls. This has increased their exposure and vulnerability to COVID-19.[1]

Lack of access to health services, including SRH services: Mobility restrictions, lack of PPE, and global and local supply chain disruptions have resulted in limited access to health and SRH services. Marginalized and underserved communities are at significantly added risks, as their vulnerabilities are compounded during crises. These communities can include adolescents, migrants, persons with disabilities, and persons with diverse gender expressions, gender identities, sexual orientation and sex characteristics.[2 3]

Reports of maternal mortality: Mobility restrictions, fear of disease transmission, and social stigma have limited pregnant women's access to safe delivery and emergency obstetric care.[2] Reports of maternal death have emerged as a result.[4]

Increased reports of GBV, including domestic violence: Countries have reported an increase in GBV due to movement restrictions and quarantine measures.[5 6] Concerns also exist around increases in female genital cutting/mutilation as well as child marriage, due to the halting of programs to address these issues.[7]

Increased risks of unplanned pregnancy: Access to voluntary contraception and safe abortion care has been curtailed, due to global supply chain disruptions, diversion of resources away from essential SRH care, and politicization of SRH services.[2] According to a study by Johns Hopkins University, Victoria University, and Avenir Health, seven million unplanned pregnancies may result if restrictions continue for six months.[7]

Concerns of home deliveries: Due to mobility restrictions and fears of contracting the virus, concerns have emerged of women possibly choosing home deliveries over facility-based deliveries, raising concerns for lack of skilled attendance at birth.[2]

1. UNFPA (March 2020). COVID-19: A Gender Lens: Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality. Available at: https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf.

PRESENTATION: PRESENTATION: WHAT ARE EPIDEMICS/PANDEMICS, AND WHAT ARE THE IMPLICATIONS FOR SRH AND GENDER (cont'd)

SLIDE 5 (cont'd)

2. IAWG on RH in Crises (May 2020). COVID-19 *Pandemic Further Threatens Women and Girls Already at Risk in Humanitarian and Fragile Settings*. Available at: https://cdn.iawg.rygn.io/documents/IAWG-COVID-ADVOCACY-STATEMENT.pdf?mtime=20200512014036&focal=none.

3. IAWG on RH in Crises (May 2020). *IAWG expresses its support, the continued commitment of the United Nations to protect, respect and fulfill the sexual and reproductive health and human rights of all girls, women, and gender non-conforming people in humanitarian settings*. Available at: https://iawg.net/resources/iawg-un-srhr-covid?mc_cid=42124c6d32&mc_eid=bd0dd79b25.

4. Reuters (9 April 2020). In Uganda, mothers in labour die amidst coronavirus lockdown. Available at: https://news.trust.org/item/20200409135823-9awyd.

5. DCA Alliance (27 April 2020). Covid19: Nepal Response Situation Report No. IV, As of April 27, 2020, Banke, Bardia, Kailali, Kanchanpur, Doti and Dailekh. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/DCA_SitRep%20IV_Covid19_April%2027%202020_DCA.pdf.

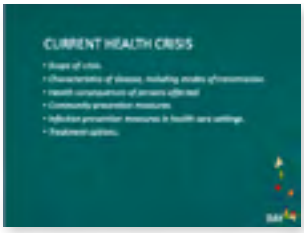
6. Azhari, Timour (17 April 2020). "Domestic abuse cases soar in Lebanon amid coronavirus lockdown". Aljazeera. https://www.aljazeera.com/news/2020/04/domestic-abuse-cases-soar-lebanon-coronavirus-lockdown-200416233054044.html.

7. UN News (28 April 2020). "COVID-19 could lead to millions of unintended pregnancies, new UN-backed data reveals". Available at: https://news.un.org/en/story/2020/04/1062742.

SLIDE 6

The gendered impact of pandemics such as COVID-19 can be seen within the socio-ecological model that examines the varied impacts by different levels.

SLIDE 7



The facilitator should complete this slide with known information about the most imminent disease outbreak.

SLIDE 8

The facilitator should complete this slide with known information about the most imminent disease outbreak.

While the facilitator can include information on vulnerabilities and pre-existing stigma/discrimination in the community, the activity following the presentation will further examine potential stigma/discrimination and who will be most impacted. As such, this section can focus on teasing out the potential stigma at various levels, including individual, community, media, national, regional, global, etc., and overlapping vulnerabilities.

DISCUSSION: VALUES CLARIFICATION ON POTENTIAL STIGMA AND DISCRIMINATION

- Having discussed the potential possibilities for stigma and discrimination, transition to a conversation on clarifying values around potential and/or added stigma and discrimination as result of a potential epidemic/pandemic.
- Begin by asking participants what they themselves fear about the potential disease. Further suggested prompts include:
  - Where do you think the biases are from?
  - What do you think would help reduce the bias for yourselves?
  - What do you think would be the community's reaction to the potential disease and persons who are infected?
  - Who would be most targeted by stigma and discrimination (including health workers)?
  - Based on past disease outbreaks, what do you think could happen to those who experience stigma and discrimination?
- Ask participants to keep these thoughts in mind for the next activities.

NOTES:

MODULE 4.2:
SRH and Gender Protection in Epidemics/Pandemics

30 minutes

Goal:

To examine considerations and community-specific challenges to ensuring essential MISP services, including possible stigma and discrimination against specific groups.

- To examine considerations around ensuring essential MISP services in epidemics/pandemics.
- To identify challenges to ensuring essential MISP for SRH services at the community level.

Summary: In this session, participants will discuss considerations and community-specific challenges to ensuring the MISP for SRH in epidemic/pandemic preparedness. This session will serve as a brainstorm for action planning in the next module.

Supplies:

- Markers
- Flip chart paper
- Related findings from pre-workshop **community capacity and needs assessment**

Facilitator's Tip:

While prompts are provided, the facilitators may wish to facilitate the discussions somewhat systematically, to keep to time and to ensure MISP for SRH activities are not missed. The more knowledgeable participants are about the activities that make up the MISP for SRH, the more efficient discussions may be. If the facilitators are aware that participants may have a limited understanding, they should encourage participants to review the MISP for SRH standard in advance of the workshop (evening of Day 3 or prior to this segment).

DISCUSSION: SPECIFIC CONSIDERATIONS AROUND ENSURING AVAILABILITY OF ESSENTIAL MISP FOR SRH SERVICES

- Lead participants in a discussion on considerations that may need to be addressed to ensure the availability of essential MISP for SRH services in an epidemic/pandemic. The below prompts are merely guides. If it is easier, the facilitators can go through each objective of the MISP for SRH to discuss any needs for innovation or adaptation, rather than follow the broader questions below.
  - An epidemic/pandemic will likely increase the need for personal protective equipment (PPE) and other infection prevention supplies. What MISP for SRH services may be most impacted if such supplies are scarce or unavailable?
  - Many services in the MISP for SRH are time sensitive, including clinical care for survivors of sexual violence, safe abortion care, delivery care, and treatment for persons on antiretroviral therapy. What challenges do participants foresee if "shelter-in-place" or other mobility restrictions

are instituted, and what can be addressed in advance (e.g., enabling community-based provision of specific services, permitting extended supplies of contraceptives, etc.)?
    - An epidemic/pandemic will likely create much stress on health care workers, as well as the community's mental and psychosocial well-being. What specific concerns should be anticipated for health care workers and for the community?
    - What other MISP for SRH services may be impacted by epidemics/pandemics, for which we would like to develop strategies in advance?
- As participants mention considerations that will require action or innovation, the facilitator should write these on flip chart paper.
- The facilitator can mention any pre-workshop **community capacity and needs assessment** findings that may also be relevant to epidemics/pandemics.

DISCUSSION: COMMUNITY-SPECIFIC CHALLENGES, INCLUDING AROUND STIGMA AND DISCRIMINATION

- Lead participants in conversations around specific challenges that they foresee in their community that could impede the provision of MISP for SRH services and access to services for community members. The below prompts are merely guides. If it is easier, the facilitator can go through each objective of the MISP for SRH to discuss any community-specific concerns, rather than follow the broader questions below.
    - Who is most vulnerable in the community, and what additional discrimination or social stigma may emerge from the epidemic/pandemic (omit if previously discussed)?
    - What are the greatest concerns that impact SRH at the community level (e.g., mobility restrictions preventing access to emergency obstetric care, leading to maternal mortality)?
    - The supply chain for contraception and other SRH supplies can be disrupted due to halting of manufacturing, import/export closures, and general shortages. What concerns are probable with such disruptions?
    - What other local impacts can be seen from global concerns (including politicization of SRH)?
    - Where overcrowding and lack of water/sanitation resources can hinder disease prevention, what new concerns may emerge in the community?
    - What are the community's attitudes toward aid/health providers, and what concerns exist that could hinder disease prevention efforts?

NOTES:

  - What considerations will need to be made for routine pregnancy care such as antenatal and post-natal care? Where skilled attendance at birth is already low, what considerations will need to be made so that pregnant women still seek skilled attendance at birth during and after the epidemic/pandemic?
  - What potential barriers may emerge as a result of cost?
  - Are there other concerns that are specific to this community that could hinder the efforts to ensure essential MISP for RH services?

- As participants mention challenges, the facilitator should write these on flip chart paper.
- The facilitator can mention any pre-workshop **community capacity and needs assessment** findings that may be relevant to epidemics/pandemics

TEA BREAK

 30 minutes

MODULE 4.3:
Action Planning

1 hour

Goal:

To refine and tailor preparedness activities at the community level to ensure SRH access and gender protection for marginalized and underserved groups in the event of an epidemic or pandemic.

- To examine how to ensure SRH access and gender protection for marginalized and underserved groups during epidemics/pandemics.
- To identify responsible persons, timeline, accountability mechanisms, and resources to implement action plan for pandemic preparedness.

Summary: Participants will review their pre-existing action plan for SRH preparedness and gender protection to adapt it for epidemic/pandemic preparedness purposes, based on the considerations and challenges identified in Module 4.2.

Supplies:

- Laptops (4-5 if available, with power cords)
- Projector and screen
- *Action plan for SRH preparedness and gender protection* (soft copy, from main training)
- *Community engagement action tool* (paper copies)

Facilitator's Tip:

While this session divides participants into groups, if considerations/challenges/gaps identified are cross-cutting or are focused on a few key areas, the activity can be converted into a plenary, with all participants contributing to one master action plan.

ACTIVITY: REFINING AN ACTION PLAN FOR SRH AND GENDER PROTECTION FOR EPIDEMICS/PANDEMIC PREPAREDNESS

The facilitator should bring out the latest *action plan for SRH preparedness and gender protection* that participants collectively developed on Day 3 or have been updating (if this workshop is taking place weeks or months later).

- Divide participants into groups to examine each objective and specific activities of the MISP for SRH, following their *action plan for SRH preparedness and gender protection*. Groups can be combined depending on the number of participants, available laptops, and identified gaps.
  - Coordination and demographics
  - Preventing sexual violence and responding to the needs of survivors

- Preventing and responding to HIV/STIs
- Preventing excess maternal and newborn morbidity and mortality
- Preventing unintended pregnancies
- Planning for transition to comprehensive SRH services
- Safe abortion care and other

- The facilitator can provide the *action plan for SRH preparedness and gender protection* to each group (in soft copy). One person should be identified to input the information into the relevant sections of the template.
- The groups should go through their assigned sections of the *action plan for SRH preparedness and gender protection* against the raised considerations and challenges listed on flip chart paper, to develop potential solutions for epidemic/pandemic preparedness. Areas to discuss can include (but not limited to), as relevant:
  - Considering inclusion of all actors who may be involved in the response, including communities and the private sector.
  - Addressing coordination across all coordination bodies that may play a role in the response, not merely the health cluster.
  - Considering the formation of a rapid response team as appropriate.
  - Operationalizing innovative community-based approaches or mobile outreach to providing SRH care, especially clinical care for survivors of sexual assault, contraception and safe abortion care.
  - Supporting mental health and psychosocial support and care for health care providers.
  - Maintaining contraceptive (including emergency contraception) and other essential SRH supplies, and addressing coordination between organizations and facilities to ensure availability of supplies between facilities and partners.
  - Addressing potential cost-related barriers.
  - Developing strategies and services for persons quarantined after travel, including psychosocial support.
  - Developing messaging and communication strategies to address stigma/discrimination, etc.
  - Addressing monitoring and reporting of service use, including by marginalized or underserved populations, and the use of routine data to inform the response in real time.

NOTES:

- Once all groups are finished, each group will present their portion of the table to the rest of the group. The facilitator can lead a discussion to see if others have anything to add, as well as identify any considerations/challenges that do not have a proposed solution.
- The facilitator should then encourage participants to develop a timeline for achieving the actions/activities, designate who is responsible for ensuring the action is undertaken/activity is achieved, as well as agree on how the action will be monitored/measured to ensure it is undertaken.
    - Monitoring and follow-up activities that can be discussed include whether SMS technology or other platforms can be used to connect community members, as well as whether similar activities from the pre-workshop **community capacity and needs assessments** can be implemented at specific intervals to examine progress and engage community members.
- Organizations and representatives should take a few minutes to update their "*Community Engagement Action Tool*" to identify major action items and next steps for their respective constituents. While the table is divided by MISP Objective, participants can develop broad actions if their plans are similar across objectives.
- When participants have finished, they can share their plans with the larger group. The facilitator can add any new ideas into the master *epidemic/pandemic preparedness action plan* as relevant, and then discuss how the group can determine check-in times so that they can come together (virtually or in person) to examine progress (1 month, 3 months, 6 months, etc.). Depending on when this workshop is held, participants can discuss how monitoring activities for epidemic/pandemic preparedness fits with monitoring for broader SRH preparedness activities.

NOTES:

Wrap-Up

30 minutes

Goal:

To confirm next steps around implementing preparedness activities, including monitoring and participation of marginalized and underserved groups, to foster community and political ownership.

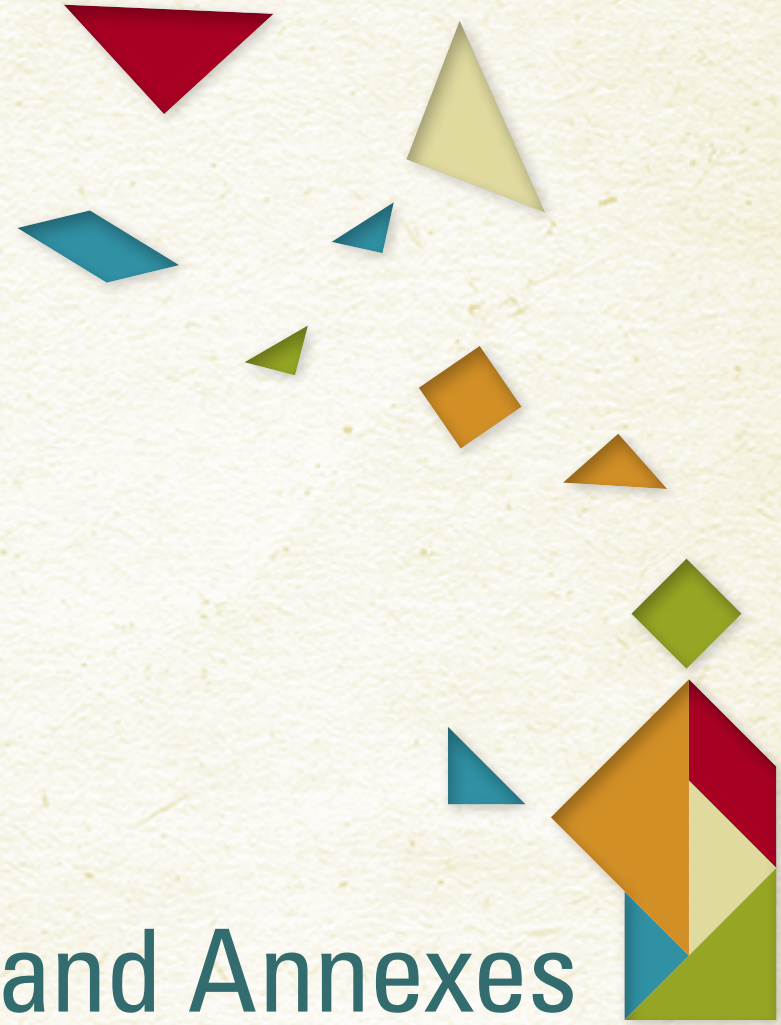
Summary: This section closes the half-day workshop, with the group confirming next steps around implementing epidemic/pandemic preparedness activities.

CLOSING DISCUSSION

- If members of the local government are not present, a plan should be made to bring the master *epidemic/pandemic preparedness action plan* to relevant district policy makers to discuss items identified, including any resources or support that is needed to realize the action plan. Individual(s) or organization(s) who will be responsible for this activity should be directly identified to ensure this is undertaken.
- The facilitator should aim to give the final *epidemic/pandemic preparedness action plan* to each participant as a key outcome document before the close of the training.
- The facilitators should review next steps as determined by the group and thank members for their active engagement.

Facilitator's Tip:

The final closing at the end of the training is crucial. Spend plenty of time discussing how to best implement action plans and sustain monitoring activities, including obtaining buy-in from leadership and funding, as this is the desired goal of the training. If this wrap-up is the final closing of the entire training, please see the wrap-up section of Day 3 and follow the guidance in that section.



Handouts and Annexes

Community-Based Disaster Preparedness and Response

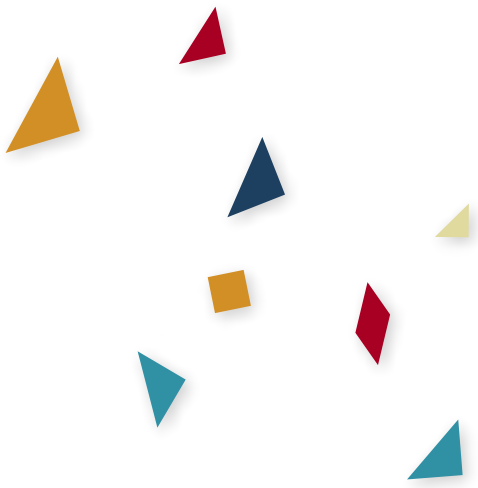
PURPOSE:

To build capacity at the community level to prepare and respond to risks faced by women and girls during emergencies.

OBJECTIVES:

At the end of the training, each participant will be able to:

1. Identify risks faced by women, girls, and other marginalized and underserved groups during an emergency (with a specific focus on SRH and gender).
2. Provide a description of the MISP for SRH, inclusive of:
   a. its importance;
   b. the priority actions included within; and
   c. the key actions that could be taken to improve MISP preparedness.
3. Apply knowledge of SRH and gender risks to existing hazard and risk maps.
4. Identify community-level capacities and gaps for gender and SRH preparedness and response.
5. Discuss community-level actions that could be taken to improve preparedness and enhance participation of marginalized and underserved groups (adolescents, persons with disabilities, LBGTQIA persons, ethnic and religious minorities, and other sub-populations).
6. Develop community-level action plans that respond to identified gaps and needs related to SRH and gender, and that leverage existing resources and capacities, with accountability mechanisms that ensure a more robust gender and SRH response.



Agenda

Day 1: Introducing Localized Risks

Time	Item
9:00-10:00	Introduction and Housekeeping
10:00-10:30	**MODULE 1.1:** Local Risks and Experiences
10:30-11:00	Tea Break
11:00-12:00	**MODULE 1.2:** Community-Based Disaster Risk Reduction
12:00-13:00	Lunch
13:00-13:30	**MODULE 1.3:** Disaster Management Framework
13:30-14:30	**MODULE 1.4:** Sexual and Reproductive Health Priorities in Emergencies
14:30-15:00	Tea Break
15:00-15:30	**MODULE 1.4:** Continued
15:30-16:30	**MODULE 1.5:** Understanding Resilience within the Health Systems Building Blocks
16:30-17:00	Closing and Next Steps

Day 2: Understanding Sexual and Reproductive Health in Emergencies

Time	Item
8:30-8:50	Welcome, Review, and Housekeeping
8:50-9:35	**MODULE 2.1:** Maternal Newborn Health (MNH)
9:35-10:15	**MODULE 2.2:** Voluntary Contraception
10:15-10:45	Tea Break
10:45-12:15	**MODULE 2.3:** Safe Abortion Care/Post-Abortion Care
12:15-13:00	Lunch
13:00-13:45	**MODULE 2.4:** Sexually Transmitted Infections (STIs), Including HIV
13:45-15:15	**MODULE 2.5:** Gender-Based Violence (GBV)
15:15-15:45	Tea Break
15:45-16:45	**MODULE 2.6:** Jeopardy!
16:45-17:00	Closing and Next Steps

Day 3: From Knowledge to Action

Time	Item
9:00-9:20	Welcome, Review, and Housekeeping
9:20-10:00	**MODULE 3.1:** Household Preparedness
10:00-10:30	Tea Break
10:30-12:00	**MODULE 3.2:** Community Mapping
12:00-13:00	Lunch
13:00-14:30	**MODULE 3.3:** Action Planning
14:30-15:00	Tea Break
15:00-16:30	**MODULE 3.3:** Continued
16:30-17:00	Wrap-Up and Closing

Date: _____ Location: _____

Pre-/Post-Test for Participants

DIRECTIONS: PLEASE ANSWER EACH QUESTION BY PUTTING AN "X" BELOW TRUE OR FALSE	TRUE	FALSE
1. In an emergency, access to sexual and reproductive health services saves lives.		
2. In an emergency, there are NO minimum requirements for services that should be provided.		
3. During displacement, women and girls face higher risks to their health and safety than their male counterparts.		
4. Persons who are socially marginalized or discriminated against can experience increased risks to their safety and well-being in an emergency.		
5. It is recommended that men and women share wash and latrine facilities.		
6. Simple locks should always be available on the inside of latrine doors.		
7. After sexual violence, there are no services or treatment that can be provided to help the survivor.		
8. Communities themselves are frequently the first responders during the first 72 hours (3 days) of an emergency.		
9. Emergency preparedness and response are two entry points to build resilience at the community level.		
10. Communities are best positioned to develop solutions to address the risks they identify in their own community.		

11. Name at least four areas of sexual and reproductive health that should be addressed in an emergency.

_____

12. Who should develop a safe birth plan (circle only the most appropriate answer)?

a. Every pregnant woman.
b. Pregnant women who have had complications in the past.
c. Women who do not have others in the house to help care for her.

13. Name three methods of contraception for couples to prevent pregnancy or space births.

_____

14. Name two medical services that should be provided if a girl experiences sexual violence.

_____

15. What is one way that HIV transmission can be reduced in an emergency?

_____

MODULE 1.4:
Sexual and Reproductive Health and Gender Protection in Emergencies

CASE STUDY: Question Guide for Small Group Discussion:

You have been assigned to consider the risks faced by a particular group during an emergency. Before you start, make sure that everyone in your group understands which group you have been assigned to.

1. Read through the case study again as a group.
2. Considering the group you have been assigned, go back and underline or highlight information that you feel may be important to understanding the risks faced by this particular group in this scenario (e.g., loss of health facilities, no lights/electricity).
3. In your group, discuss the reasons why particular items were underlined, and determine the influence that this particular aspect of an emergency might have on your assigned group. Remember, there could be multiple concerns arising from one identified issue (e.g., there is no emergency medical care for pregnant women if she is in labor, passage to latrines might be unsafe at night).
4. Now in your group, determine what risks might result for this population. What are the risks that result (maternal death, sexual violence, etc.)?
5. Record this information for feedback to the larger group (this can be done on flip chart paper or using meta cards).

Identified Issue	Concern	Risk to group
Loss of health facilities	*No emergency medical care for pregnant women*	*Maternal death*
No electricity/ lights	*Passage to latrines at night might be unsafe*	*Sexual violence*

Be sure to consider many of the infrastructure elements that might appear within the case study, as well as any additional factors that you have seen in emergencies your community may have experienced:

- Not having good lighting and phone communications.
- Not having private bathing areas and latrines.
- Not having medicines and skilled medical providers.
- Not having reliable food and shelter.
- Being separated from parents or caretakers.

OVERVIEW

COMMUNITY-BASED DISASTER PREPAREDNESS AND RESPONSE: A training for community representatives on sexual and reproductive health and gender

Length:

A three-day training that focuses on introducing sexual and reproductive health (SRH) and gender components in a disaster and turning knowledge into action at the community level. Depending on the knowledge base of participants, facilitators can select specific modules and cater the training to each group and time frame available.

Participants:

Policymakers responsible for disaster risk management for health, including SRH; health providers; community leaders; and representatives with a health background from community-based organizations serving marginalized and underserved groups.

Purpose:

To build community capacity to prepare for and respond to risks and inequities faced by women, girls, and other marginalized and underserved populations in emergencies.

Objectives:

At the end of the training, each participant will be able to:

1. Identify risks faced by women, girls, and other marginalized and underserved groups during an emergency (with a specific focus on SRH and gender).
2. Provide a description of the Minimum Initial Services Package (MISP) for SRH, inclusive of:
   a. its importance;
   b. the priority actions included within; and
   c. the key actions that could be taken to improve MISP for SRH preparedness.
3. Apply knowledge of SRH and gender risks to existing hazard and risk maps.
4. Identify community-level capacities and gaps for gender and SRH preparedness and response.
5. Discuss community-level actions that could be taken to improve preparedness and enhance participation of marginalized and underserved groups (adolescents, persons with disabilities, LBGTQIA persons, ethnic and religious minorities, and other sub-populations).
6. Develop community-level action plans that respond to identified gaps and needs related to SRH and gender, and that leverage existing resources and capacities, with accountability mechanisms that ensure a more robust gender and SRH response.

Model

Disaster risk reduction and management activities are ideally focused at the local/community level and address localized risks. Yet, such efforts require significant support from leadership at the local, regional, and national level. A supportive environment is important when attempting to empower and support community members to undertake actions related to mitigating their risks and build resiliency.

In order for a community model to be successful, local government units are critical partners. They should receive support, so that they fully understand the skills and knowledge to be gained by communities. In turn, they will be expected to provide strategic support to community groups who have been trained, so that actions might be possible after the training.

This document helps to lay out likely expectations and assumptions, so that groups (both communities themselves and local governments) can decide whether they are prepared and interested to embark on a partnership.

Locations should be selected based on the following criteria:

1. The community frequently faces high-risk emergencies leading to displacement.
2. Local government offices, and specifically the mayor or equivalent of the proposed community, are supportive of gender mainstreaming and women's health issues.
3. The following members are available for capacity building over the course of the project:
   a. Mayor or equivalent.
   b. At least two (2) representatives from the local disaster risk management agency.
   c. Leaders of that community.
   d. Four (4) to five (5) representatives—preferably with a health background—from community-based organizations, including women's groups, organizations of persons with disabilities, and other groups representing marginalized and underserved populations.
4. Community groups/civil society organizations/women's groups exist and can support marginalized and underserved members of the community.
5. The local government is familiar with the MISP for SRH and supports its implementation as an emergency response.
6. A training facility can be identified near the selected community.
7. Disaster risk reduction trainings have already been conducted in the area (preferred).

The local government (inclusive of members identified above) will ideally commit to the following:

1. Strengthen, as needed, knowledge with regard to:
   a. Disaster risk reduction
   b. Community-based disaster risk management
   c. Coordination during emergency response
2. Attend gender mainstreaming and MISP for SRH trainings as available.
3. Attend specific planning elements during Day 3 of training.
4. Depending on capacity, conduct a follow-up visit to the site 1-3 months post training.
5. Provide a portion of their annual budget (possibly money that is earmarked for preparedness) to ensure that some actions within the action plans developed that address SRH and gender for preparedness can be implemented.

Registration

Provide initials for each day attended.

NAME	COMMUNITY POSITION/ROLE	MOBILE NUMBER	DAY 1	DAY 2	DAY 3

ANSWER KEY - Pre-Post-Test

DIRECTIONS: PLEASE ANSWER EACH QUESTION BY PUTTING AN "X" BELOW TRUE OR FALSE	TRUE	FALSE
1. In an emergency, access to sexual and reproductive health services saves lives.	X	
2. In an emergency, there are NO minimum requirements for services that should be provided.		X
3. During displacement, women and girls face higher risks to their health and safety than their male counterparts.	X	
4. Persons who are socially marginalized or discriminated against can experience increased risks to their safety and well-being in an emergency.	X	
5. It is recommended that men and women share wash and latrine facilities.		X
6. Simple locks should always be available on the inside of latrine doors.	X	
7. After sexual violence, there are no services or treatment that can be provided to help the survivor.		X
8. Communities themselves are frequently the first responders during the first 72 hours (3 days) of an emergency.	X	
9. Emergency preparedness and response are two entry points to build resilience at the community level.	X	
10. Communities are best positioned to develop solutions to address the risks they identify in their own community.	X	

11. Name at least four areas of SRH that should be addressed in an emergency.
(Accept: Maternal and newborn health, contraception, safe abortion care/post-abortion care, HIV/ sexually transmitted infections, gender-based violence)

12. Who should develop a safe birth plan (circle only the most appropriate answer)?

a. Every pregnant woman.

b. Pregnant women who have had complications in the past.

c. Women who do not have others in the house to help care for her.

13. Name three methods of modern contraception for couples to prevent pregnancy or space births.
(Accept: Male and female condoms, injectable contraceptives, oral contraceptive pills, implants, intrauterine devices, tubal ligation, vasectomy, emergency contraception.)

14. Name two medical services that should be provided if a girl experiences sexual violence.
(Accept: Emergency contraception/prevent pregnancies, treatment of injuries, post-exposure prophylaxis/prevent HIV, presumptive treatment of STIs/prevent illness or disease)

15. What is one way that HIV transmission can be reduced in an emergency?
(Accept: Free and available condoms, provide post-exposure prophylaxis to survivors **of sexual violence, ensure that ARVs are provided for those already on treatment, practice standard precautions—wash hands, wear gloves, wear protective clothing, safe handling of sharps, safe waste disposal, decontaminate instruments.)**

Capacity and Needs Assessment Tools to Build Community Resilience **Background**

The past decade has seen a substantial increase in the number of persons who have been affected by man-made and natural disasters.[1]

Emergencies have a disproportionate effect on the poorest and most vulnerable, particularly women, children, and adolescents.[2] Women and girls consistently face higher mortality rates both during and after natural disasters.[3] Seventy-six percent of preventable maternal deaths, and 53 percent of under-five deaths take place in settings of fragility, and/or conflict, displacement, and natural disasters.[4] [5] Women and girls are further exposed to violence, exploitation and abuse, unwanted pregnancy, unsafe abortion, and sexually transmitted infections, including HIV, due to the collapse of social and structural support systems.[6] [7] Persons with disabilities, LGBTQIA, ethnic and religious minorities, and other sub-populations experience additional risks, as a result of underlying discrimination and prevailing social norms.[8]

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* guided global dialogue and encouraged international and national stakeholders to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies.[9] In March 2015, *the Sendai Framework for Disaster Risk Reduction 2015-2030* was adopted by member states at the UN World Conference on Disaster Risk Reduction in Sendai, Japan.

1 UNHCR. Global Trends: Forced Displacement in 2017. https://www.unhcr.org/globaltrends2017/.

2 EWEC. Deep Dive Report: Commitments in Support of Humanitarian and Fragile Settings, 2015-2017.

3 Neumayer E and Plümper T. 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. 2007. 97:3, 551-566, https://doi.org/10.1111/j.1467-8306.2007.00563.x.

4 OECD. States of fragility 2015: Meeting post-2015 ambitions. Paris: OECD Publishing; 2015. As cited in: WHO. Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva; 2015. http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/.

5 United Nations, Every Woman Every Child, Abu Dhabi Declaration (New York. 2015).

6 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/.

7 Barot S. In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations. Guttmacher Institute, 2017. https://www.guttmacher.org/gpr/2017/02/state-crisis-meeting-sexual-and-reproductive-healthneeds-women-humanitarian-situations,

8 IAWG on RH in Crises. Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.

9 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.

The framework calls for increased attention to resilience and identifies health as a critical aspect of strengthening individual and community resilience.[10] It also defined four priorities to strengthening resilience, including understanding priority risks; strengthening emergency preparedness; investing in preparedness; and enhancing preparedness for effective response and to "Build Back Better".[11]

Emergency preparedness and recovery are two entry points within the continuum of an emergency that provide an opportunity for humanitarian and development actors to explicitly collaborate with communities, civil society organizations, and governments, to build local and national resilience to mitigate the impact of emergencies, improve response, and facilitate efficient and effective recovery. Numerous tools have thus been developed by various sectors and agencies to assess pre-existing vulnerabilities, and prepare communities for, and build from, emergencies.

Objectives

- To map the district's existing disaster management framework and links to national and sub-national systems.
- To understand health facility capacity to implement the Minimum Initial Service Package (MISP) for SRH in emergencies.
- To explore the community's definitions and understanding of resilience, and the end points of recovery or "building back better".
- To identify existing community capacities to respond to crises, what capacities need strengthening, and the community's recommendations to achieve them.
- To identify vulnerabilities and risks in the community that may have less capacity to absorb shocks, including specific sub-populations or societal infrastructure.
- To identify priorities for preparedness or "building back better".

Timeframe of implementation

- The tool is to be implemented prior to a crisis or during recovery, to assess existing community capacity to respond or build back better.

Target users

- The intended users are district health policymakers, disaster management agencies, and program managers that are responsible for preparedness and "building back better". They also include civil society organizations and others committed to building resilience.

Target audience

1. **Policy maker**
   - District disaster management staff.
   - Mayor or other government representatives.
   - Chief medical officer.
2. **Health provider**
   - Health facility manager.
   - Physician, nurse, midwife, and other clinical staff.
3. **Community health worker**
   - Community health worker, community outreach workers, peer educators, and other community resource persons.

[10] 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.

[11] 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.

4. **Community member**
   - Community leader.
   - Representatives from civil society groups and networks, including women's groups, youth/adolescent groups, organizations of persons with disabilities, LGBTQIA groups, organizations of persons who engage in sex work, organizations representing other minority groups, etc.
   - Members of the community including women, adolescent girls, persons with disabilities, LGBTQIA, persons engaged in sex work, other minority members.
   - Teachers, law enforcement, first responders, social service workers, etc.

Domains assessed

1. **Policy maker**
   - National, sub-national, and district disaster management framework.
   - Level of SRH preparedness at the district level per the *Sendai Framework's* four priorities.
   - District capacity to respond to SRH needs in emergencies, as well as barriers and gaps.
   - Protection of at-risk groups and community inclusion in preparedness planning and response.
2. **Health provider**
   - Level of SRH preparedness at the facility level per the *Sendai Framework's* four priorities
   - Health facility and provider capacity to implement the MISP for SRH in emergencies.
   - Current availability of SRH services for the MISP for SRH.
3. **Community health worker**
   - Community capacity to implement the MISP for SRH in emergencies.
   - SRH risks, vulnerabilities, protective strategies, coping capacities, and resources in the community.
4. **Community member**
   - SRH risks, vulnerabilities, protective strategies, coping capacities, and resources in the community.
   - Gender and other norms that perpetuate violence, vulnerability, and inequality.
   - Definitions of resilience and end points of recovery or "building back better".

Specific tools

1. **Policy maker**
   - Interview guide.
2. **Health provider**
   - Interview guide.
   - Facility assessment tool pertaining to the MISP for SRH services.
3. **Community health worker**
   - Focus group discussion (FGD) guide.
4. **Community member**
   - FGD guide with participatory activities for community members.
   - Interview guide for community leader, representatives from civil society groups and networks, teachers, law enforcement, first responders, social service workers, etc.

Data analysis

- Pointers for data analysis from interviews and FGDs.
- Facility assessment data entry template and tables for auto-population.

Use of data

Findings will be used to inform a workshop for first responders and civil society networks/organizations. During this workshop, participants will develop community action plans with accountability mechanisms to strengthen SRH preparedness at the community level.

GROUP 1: General/Comprehensive/Policy Maker

Capacity and Needs Assessment Tool to Build Community Resilience
Interview Guide for Policy Makers

This tool can be used with the national, sub-national, district disaster management or Ministry of Health staff; mayor or other government representatives; or the chief medical officer who is familiar with the disaster risk management framework, especially at the district level.

The focus is to solicit feedback around resources, capacities, and gaps to respond to sexual and reproductive health (SRH) needs in emergencies that can be used to inform and shape the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training.

In Module 1.3 on the "Disaster Management Framework" (Day 1), participants will be introduced to the national, sub-national, and local disaster management framework. Questions 4a-c are relevant for this activity.

Module 1.5 on "Understanding Resilience within the Health Systems Building Blocks" (Day 1) includes a presentation on the district's current level of emergency preparedness overall and for SRH specifically, based on the *Sendai Framework* priorities for disaster risk reduction. Questions 10-11 are relevant for this purpose.

Please refer to the *Facilitator's Guide* for more information on selecting participants, conducting the interview, data analysis tips, and what to pull from the findings.

GROUP 1: General/Comprehensive/Policy Maker

Date:	**Location:** District/County _____
Facilitator(s):	State/Province/Region _____
Interviewee characteristics ☐ Female ☐ Male ☐ Other _____	Country _____
Interviewee level ☐ National level ☐ Sub-national level ☐ District level	**Interviewee occupation** ☐ Disaster management staff (specify) _____ ☐ Mayor ☐ Other government representative (specify) _____ ☐ Chief medical officer ☐ Other policy maker (specify) _____
Translation used: Yes No	If yes, translation from _____ (language) to _____ (language)
Begin time:	**End time:**

I verify that informed consent was obtained.

_____

(Signature of facilitator)

Hello and thank you for making yourself available for this interview. My name is _____ and I am from the ACCESS Project. I am interested in examining this community's capacity and resilience, and to identify priorities for preparedness and "building back better," especially for health and protection. "Building back better" aims to ensure that recovery efforts in the aftermath of a crisis build resilience and reduce a community's vulnerability to future emergencies. You were identified for this interview since you are a policy maker familiar with emergency preparedness and the disaster management framework for this district.

The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way, with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.

This discussion will last roughly 1-1.5 hours. I would like to take notes of what you say, if that is alright with you.

Thank you again for your time. If you have any questions after the end of our discussion, please contact _____.

INTRODUCTION

1. What is your role around emergency preparedness and disaster risk reduction?

2. What were some of the health and sexual and reproductive health challenges in the most recent emergency (*outbreak of violence, natural disaster*)?

3. To what degree are you aware of the Minimum Initial Service Package for Sexual and Reproductive Health?

   3.1 What training(s) have you or your staff had, if any, to build your current capacity in responding to sexual and reproductive health (SRH) needs in emergencies (MISP for SRH training, inter-agency guidelines, etc.)?

If respondent is not familiar with the MISP standard, please review the objectives of the MISP ***in preparation for subsequent sections pertaining to SRH services as described in the MISP.***

Question 4 pertains to the disaster management framework at the national, sub-national, and district levels. Please ask the questions appropriate to your respondent's level of work.

If respondents have already provided a detailed overview of the disaster management framework at all levels, you can skip this question and go to question 5.

Disaster management framework

4a. Questions	4b. Y/N	4c.
National level		
Is there a national government body that addresses disaster risk reduction?		**If yes, what is the name of the government body and where is it housed?**
Is there a **National** Platform for Disaster Risk Reduction to coordinate efforts?		**If yes, what agencies are involved?** (*National Disaster Management Agency, Civil Protection, Ministry of Health, Ministry of Interior, etc.*)
Is there a national emergency **preparedness** plan for health?		**If yes, what is this plan called, and when is this from?**
Is there a national emergency **response** plan for health?		**If yes, what is this plan called, and when is this from?** (*Response plan may be part of the preparedness plan, depending on the context.*)
Is there a lead agency identified for health for emergencies at the **national** level?		**If yes, who is this lead agency?**
Are minimum services of SRH as described in the MISP integrated into the **response** plan(s) for health at the **national** level?		**If yes, what services are integrated?** (*Coordination; services to prevent and treat survivors of sexual violence; services to prevent maternal and newborn death and disability, services to prevent HIV/STIs, prevent unintended pregnancy, prevent unsafe abortion, transition from MISP to comprehensive SRH*) **If no, what services are yet to be integrated?**
Are the minimum services of SRH as described in the MISP integrated into **preparedness** plan(s) for health at the **national** level?		**If yes, what services are integrated?** **If no, what services are yet to be integrated?**
Is there a health coordination group at the **national** level?		**If yes, who are some of the member agencies?**
Is there an SRH coordination group at the **national** level?		**If yes, who are some of the member agencies?**
Is there a Protection coordination group at the **national** level?		**If yes, who are some of the member agencies?**
Is there a separate GBV coordination group at the **national** level?		**If yes, who are some of the member agencies?**
Is there a separate HIV coordination group at the **national** level?		**Who leads the HIV coordination group?**
Is there an SRH focal point appointed at the **national** level?		

4a. Questions	4b. Y/N	4c.
Is there a Protection focal point appointed at the **national** level?		
Is there a separate GBV focal point appointed at the **national** level?		
Is there a separate HIV focal point appointed at the **national** level?		
Is emergency and disaster risk management for health (EDRM-H) and/or preparedness integrated into the UNFPA Country Program?		
Subnational level *(Provincial or regional level that houses the particular district of interest)*		
Is there a **Subnational** Platform for Disaster Risk Reduction?		**If yes, what agencies?**
Is there a **Subnational** emergency **preparedness** plan?		**If yes, what is this plan called, and when is this from?**
Is there a **Subnational** emergency **response** plan?		**If yes, what is this plan called, and when is this from?**
Are minimum services of SRH as described in the MISP integrated into the **response** plan(s) for health at the **sub-national** level?		**If yes, what services are integrated?** **If no, what services are yet to be integrated?**
Are minimum services of SRH as described in the MISP integrated in **preparedness** plan(s) for health at the **sub-national** level?		**If yes, what services are integrated?** **If no, what services are yet to be integrated?**
Is there a health coordination group at the **sub-national** level?		**If yes, who are members?**
Is there an SRH coordination group at the **sub-national** level?		**If yes, who are members?**
Is there a Protection coordination group at the **sub-national** level?		**If yes, who are members?**
Is there a separate GBV coordination group at the **sub-national** level?		**If yes, who are members?**
Is there a separate HIV coordination group at the **sub-national** level?		**If yes, who are members?**
Is there an SRH focal point appointed at the **sub-national** level?		
Is there a Protection focal point appointed at the **sub-national** level?		
Is there a separate GBV focal point appointed at the **sub-national** level?		

4a. Questions	4b. Y/N	4c.
Is there a separate HIV focal point appointed at the **sub-national** level?		
District level		
Is there a **district** emergency **preparedness** plan?		**If yes, what is this plan called, and when is this from (date)?**
Is there a **district** emergency **response** plan?		**If yes, what is this plan called, and when is this from (date)?**
Are minimum services of SRH as described in the MISP integrated into the **response** plan(s) for health at the **district** level?		**If yes, what services are integrated?** **If no, what services are yet to be integrated?**
Are minimum services of SRH as described in the MISP integrated in **preparedness** plan(s) for health at the **district** level?		**If yes, what services are integrated?** **If no, what services are yet to be integrated?**
Is there a health coordination group at the **district** level?		**If yes, who are members?**
Is there an SRH coordination group at the **district** level?		**If yes, who are members?**
Is there a Protection coordination group at the **district** level?		**If yes, who are members?**
Is there a separate GBV coordination group at the **district** level?		**If yes, who are members?**
Is there a separate HIV coordination group at the **district** level?		**If yes, who are members?**

The remaining questions are specific to the district level.

RISKS AND VULNERABILITIES

5. **Who**, within your community, may be most at-risk or vulnerable when a crisis occurs?

   5.1 Probe for persons with disabilities, the elderly, LGBTQIA persons, persons who engage in sex work, persons from minority groups, adolescents, etc.

   5.2 Probe: **How and why** are such persons more vulnerable?

6. **Are such persons currently engaged** to ensure health services, especially sexual and reproductive health services, best meet their needs? How so, and to what extent?

RESOURCES, CAPACITIES, AND PREPAREDNESS FOR SRH

7. **What health-related resources and capacities** would you say the district has to respond to an emergency?

8. What is the **coordination mechanism** in this district to coordinate the work of the health and humanitarian sector in the event of an emergency?

   8.1 Does the health and humanitarian sector have regular meetings during an emergency response?

9. What are the **main challenges the district has experienced when responding to the community's sexual and reproductive health needs in past emergencies**?

   9.1 What services were disrupted, and how did that affect the community?

   9.2 What attempts were made to continue providing disrupted services?

   9.3 Which of these challenges could have been addressed before the emergency, and in what way?

10a. **Now, I would like to ask about the district's emergency preparedness efforts.**	10b. **Y/N**	10c.
Does the district have a process to review building codes and standards, and rehabilitation and reconstruction practices?		**If yes, please describe the process.** **Does the district have the ability to enforce these codes to ensure structures are disaster-resistant**?
Does the district periodically assess disaster risks, vulnerability, capacity, exposure, hazard characteristics, and their possible sequential effects for risk assessment, prevention, mitigation, preparedness, and response purposes?		**If yes, what does the district assess, and how often?** **If not, why not?**
Does the district have a multi-hazard, multisectoral forecasting and early warning system?		**If yes, what does this look like?** **If not, why not?**
Does the district have emergency communications mechanisms to alert the community to potential hazards and risks in the event of an emergency?		**If yes, what does this look like?** **If not, why not?**
Does the district allocate a budget for preparedness and contingency planning?		**If yes, how much, or what proportion of the health budget?** **If not, why not?**
Does the district systematically allocate a proportion of the budget to disability inclusion, and inclusion of and outreach to other at-risk groups?		**If yes, how much?** **If not, why not?**

10a. Now, I would like to ask about the district's emergency preparedness efforts.	10b. Y/N	10c.
Does the district routinely review the supply chain for commodity risk management and pre-positioning?		**If yes, how often, and what is reviewed?** **If not, why not?**
Does the district routinely implement disaster response simulations/drills?		**If yes, how often, and who takes part?** **If not, why not?**
Does the district routinely train or retrain key personnel in emergency response?		**If yes, who is trained/retrained, how often, and what topics are covered?** **If not, why not?**
Does the district support and train community groups in disaster risk reduction approaches in health programs?		**If yes, what does this look like?** **If not, why not?**
Is there anything else you would like to share?		**If yes, please describe.**

11. How is this district **addressing emergency preparedness for sexual and reproductive health in particular**?

11a. Now I would like to ask more specifically about emergency preparedness for SRH.	11b. Y/N	11c.
Are there **national or sub-national** policies, laws, protocols, and strategies that **hinder the provision** of comprehensive SRH services to at-risk groups at the district level at any given time?		**If yes, what are they?**
Are there **national or sub-national** policies, laws, protocols, and strategies that are **conducive to the provision** of comprehensive SRH services to at-risk groups at the district level at any given time?		**If yes, what are they?**
Does the **district itself** have laws, policies, or protocols that are conducive to the provision of comprehensive SRH services?		**If yes, what are they?**
Does the district routinely undertake a gender/SRH/disability risk assessment?		**If yes, how often are the assessments?** **When was the last one, and what was assessed**?

11a. Now I would like to ask more specifically about emergency preparedness for SRH.	11b. Y/N	11c.
Has the district identified an SRH focal point for emergencies?		**If yes, who plays this role?** **If not, why not?**
Does the district allocate a budget for SRH preparedness and contingency planning specifically?		**If yes, how much, or what proportion of the health budget?** **If not, why not?**
Has the district developed an action plan to address preparedness for SRH that includes all components of the MISP for SRH?		**If yes, what does this look like?** **If not, why not?**
Does the district have mechanisms to monitor the implementation of action plans to address preparedness for SRH?		**If yes, what does this look like?** **If not, why not?**
Does the district routinely implement disaster response simulations/drills for SRH specifically?		**If yes, how often, and who takes part?** **If not, why not?**
Does the district have staff trained in the MISP specifically?		**If yes, how many?** **If not, why not?**
Does the district routinely train or retrain key personnel in emergency response for SRH (MISP) specifically?		**If yes, who is trained/retrained, how often, and what topics are covered?** **If not, why not?**
Does the district work with groups serving at-risk populations to ensure their voices are heard in processes to build community resilience?		**If yes, what does this look like?** **If not, why not?**
Has the district pre-positioned supplies and equipment to provide MISP for SRH services should an emergency occur?		**If yes, what supplies have been pre-positioned, and how many weeks/months supply?** **If not, why not?**
Is there anything else you would like to share?		**If yes, please describe.**

12. What do you think **needs to be strengthened or improved** for this district to better address preparedness for sexual and reproductive health in emergencies?

13. Do you foresee any barriers that could impede efforts to strengthen or improve the district's capacity to address preparedness for sexual and reproductive health in emergencies? If so, what are they?

13.1 *Probe for institutional support, time, and financial, logistic (equipment and supplies/commodities) or policy barriers, especially to providing maternal and newborn care, family planning, care for sexually transmitted infections/HIV/AIDs, comprehensive abortion care, and gender-based violence, etc.*

14. What are ways you think the barriers can be addressed?

14.1 *Probe for financial support, district/sub-national/national political support, coordination, technical support, logistics (equipment and supplies/commodities) technology, etc.*

15. What are your **priorities for preparedness** for this district?

Thank you for your excellent work. We applaud all that you do.

GROUP 2: Health Provider

Capacity and Needs Assessment Tool to Build Community Resilience **Interview Guide for Health Providers**

This tool should be used in interviews with the health facility manager and other clinical providers that specifically provide sexual and reproductive health (SRH) services.

The focus is to solicit feedback from the health facility around resources, capacities, and gaps to respond to SRH needs in emergencies that can be used to inform and shape the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training. Gaps as they pertain to the Minimum Initial Service Package (MISP) objectives/services and SRH preparedness are particularly important to identify, as action planning during the training can focus on these areas.

Please refer to the *Facilitator's Guide* for more information on selecting participants, conducting the interview, data analysis tips, and what to pull from the findings.

GROUP 2: Health Provider

Date:	**Location:** Health facility (name) _____
Facilitator(s):	District _____
Facility type ☐ Health post ☐ Health center ☐ Hospital ☐ Other _____	State/Province _____ Country _____
Interviewee characteristics ☐ Female ☐ Male ☐ Other _____	**Interviewee occupation** ☐ Health facility manager _____ ☐ Physician ☐ Nurse ☐ Midwife ☐ Other clinical staff (specify) _____
Translation used: Yes No	If yes, translation from _____ (language) to _____ (language)
Begin time:	**End time:**

I verify that informed consent was obtained.

_____
(Signature of facilitator)

Hello and thank you for making yourself available for this interview. My name is _____ and I am from the ACCESS Project. I am interested in examining this community's capacity and resilience, to identify priorities for preparedness and "building back better," especially for health and protection. You were identified for this interview since you are a clinical provider who provides sexual and reproductive health services at this health facility.

The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way, with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.

This discussion will last roughly one hour. I would like to take notes of what you say, if that is alright with you.

Thank you again for your time. If you have any questions after the end of our discussion, please contact _____.

INTRODUCTION

1. What is your role in this health facility?

RISKS AND VULNERABILITIES

2. What were the health and sexual and reproductive health-related challenges that people in this community faced during the most recent emergency?

3. **Who**, within your community, may be most at-risk or vulnerable when a crisis occurs?

   3.1 *Probe for persons with disabilities, elderly people, LGBTQIA persons, persons who engage in sex work, persons from minority groups, adolescents, etc.*

   3.2 **How** are such persons more vulnerable?

4. Are persons from these at-risk groups (persons with disabilities, elderly people, LGBTQIA persons, persons who engage in sex work, persons from minority groups, adolescents, etc.) able to access health services, especially sexual and reproductive health services?

   4.1 Do such persons face any particular challenges to access health and reproductive health information and services? What are these challenges?

   4.2 Does your health facility have any special measures in place to ensure that these persons can access services, despite these challenges? (*For example, mobile outreach teams to reach persons with disabilities and/or elderly people.*)

5. **How are such persons currently engaged** to ensure health services, especially sexual and reproductive health services, best meet their needs? (*For example, working with persons who engage in sex work as outreach workers to reach other persons engaged in sex work.*)

RESOURCES, CAPACITIES, AND PREPAREDNESS FOR SEXUAL AND REPRODUCTIVE HEALTH

6. What are the sexual and reproductive health services that your facility provides?

7. What are the **main challenges that you have experienced when responding to the community's sexual and reproductive health needs in the last emergency**?

   7.1 What services were disrupted, and how did that affect the community? What caused these disruptions?

   7.2 What attempts were made to continue providing disrupted services? Were these attempts successful? Why or why not?

   7.3 Are there any preparations that you think could have been made in advance to prevent or help with these challenges?

Only ask 8 and 9 if you are not concurrently implementing the facility assessment tool.

8. How is this facility **addressing emergency preparedness overall**?

8a. Probe	8b. Y/N	8c.
Does the facility have a process to review building codes and standards, and rehabilitation and reconstruction practices?		**If yes, please describe the process.** **Does the facility have the ability to enforce these codes to ensure structures are disaster-resistant?**
Does the facility periodically assess disaster risks, vulnerability, capacity, exposure, hazard characteristics, and their possible sequential effects for risk assessment, prevention, mitigation, preparedness, and response purposes?		**If yes, what does the facility assess, and how often?** **If not, why not?**
Does the facility have a multi-hazard, multisectoral forecasting and early warning system?		**If yes, what does this look like, and how effective is it?** **If not, why not?**
Does the facility have emergency communications mechanisms to alert the community to potential hazards and risks in the event of an emergency?		**If yes, what does this look like, and how effective is it?** **If not, why not?**
Does the facility allocate a budget for preparedness and contingency planning?		**If yes, how much, or what proportion of the health budget?** **If not, why not?**
Does the facility systematically allocate a proportion of the overall budget to disability inclusion, and inclusion of and outreach to other at-risk groups?		**If yes, how much?** **If not, why not?**
Does the facility routinely review the supply chain for commodity risk management and pre-positioning?		**If yes, how often, and what is reviewed?** **If not, why not?**
Does the facility routinely implement disaster response simulations/drills?		**If yes, how often, and who takes part?** **If not, why not?**
Does the facility routinely train or retrain key personnel in emergency response?		**If yes, who is trained/retrained, how often, and what topics are covered?** **If not, why not?**

8a. Probe	8b. Y/N	8c.
Does the facility support and train community groups in disaster risk reduction approaches in health programs?		**If yes, what does this look like?** **If not, why not?**
Is there anything else you would like to share?		**If yes, please describe.**

9. How is this facility **addressing emergency preparedness for sexual and reproductive health in particular**?

9.1 What training(s) have you had, if any, to build your current capacity in responding to sexual and reproductive health needs in emergencies (MISP for SRH training, inter-agency guidelines, etc.)?

9a. Additional probes	9b. Y/N	9c.
Does the facility routinely undertake a gender/SRH/disability risk assessment specifically?		**If yes, how often are the assessments?** **When was the last one, and what was assessed**?
Has the facility identified an SRH focal point for emergencies?		**If yes, who plays this role?** **If not, why not?**
Does a representative of the facility attend any standing SRH coordination meetings?		**If yes, how often?** **If not, why not?**
Does the facility allocate a budget for SRH preparedness and contingency planning specifically?		**If yes, how much, or what proportion of the health budget?** **If not, why not?**
Does the facility routinely implement disaster response simulations/drills for SRH specifically?		**If yes, how often, and who takes part?** **If not, why not?**
Does the facility have staff trained in the MISP specifically?		**If yes, how many?** **If not, why not?**

9a. Additional probes	9b. Y/N	9c.
Does the facility routinely train or retrain key personnel in emergency response for SRH (MISP) specifically?		**If yes, who is trained/retrained, how often, and what topics are covered?** **If not, why not?**
Does the facility work with groups serving at-risk populations to ensure their voices are heard in processes to build community resilience?		**If yes, what does this look like?** **If not, why not?**
Has the facility pre-positioned supplies and equipment to provide MISP for SRH services should an emergency occur?		**If yes, what supplies have been pre-positioned, and how many weeks/months supply?** **If not, why not?**
Is there anything else you would like to share?		**If yes, please describe.**

10. What do you think **needs to be strengthened or improved** for this facility to better address preparedness for sexual and reproductive health in emergencies?

11. What **barriers** could prevent the facility from strengthening or improving its capacity to address preparedness for sexual and reproductive health in emergencies?

11.1 *Probe for institutional support, time, and financial, logistic (equipment and supplies/commodities), or policy barriers, especially to providing maternal and newborn care, family planning, care for sexually transmitted infections/HIV/AIDs, comprehensive abortion care, and gender-based violence, etc.*

12. What are ways you think the barriers can be addressed?

12.1 *Probe for financial support, district/sub-national/national political support, coordination, technical support, logistics (equipment and supplies/commodities) technology, etc.*

13. What are your **priorities for preparedness** or "building back better" for this health facility?

Thank you for your excellent work. We applaud all that you do.

Facility ID

Capacity and Needs Assessment Tool to Build Community Resilience
Assessment of MISP-related service availability

The aim of the facility assessments is to understand the availability and functioning of sexual and reproductive health (SRH) services, to identify gaps that should be prioritized for preparedness efforts. Availability is defined as services available in the past three months. The tool is a structured interview and observation guide to be used with the health facility manager or equivalent representative.

This tool includes an accompanying excel data entry spreadsheet, which auto-populates once the data are inputted. The summary data can be fed into the "Baseline" column of the action plan that will be developed on Day 3 of the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training. The action plan uses the *Inter-agency Field Manual on Reproductive Health in Crises*' Minimum Initial Service Package (MISP) checklist as a template.

Please refer to the *Facilitator's Guide* for more information on selecting facilities, conducting the assessment, data analysis tips, and what to pull from the findings.

Facility ID

IDENTIFICATION INFORMATION

ID1: Facility Name	**ID2:** District Name	**ID3:** Country Name

ID4: Date of data collection			**ID5:** Data collector	
Day	Month	Year	Name	Organization

ID6	Type of facility *(circle one)*	Hospital 1 Health center 2 Health post 3 Other (specify)_____4
ID7	Type of operating agency *(circle one)*	Government/Public 1 Private 2 NGO 3 Faith-based Organization 4 Government facility managed by other partner 5 Other (specify)_____6
ID8	Population in the catchment area of this facility	_____
ID9	Number of women of reproductive age (15-49) (~25% of population)	_____
ID10	Number of sexually active men (~20% of population)	_____
ID11	Crude birth rate	_____

Facility ID

A. GENERAL

Find an appropriate staff member (facility director) and introduce yourself and proceed with the assessment tool as indicated. This staff member should be capable of linking you to additional respondents as needed.

No.	Item	Response	Skip to
Hello, my name is ..... I am representing the ACCESS project, who is looking at preparedness for sexual and reproductive health in emergencies. We are assessing SRH services availability in many health facilities in this area. We thank you for allowing us to visit this facility and speak with your staff. Your participation in this assessment is completely voluntary, and responses will not be connected with individuals at this facility in any way. We are grateful for your time. Do you have any questions? May I continue with the interview? _____(Data collector Initials)			
First, I'd like to ask you some basic questions about the facility itself.			
A1	Is there a functioning system for power?	No 0 Yes 1	
A2	What is the source of power for this facility? ***[Probe for all sources. Ask about a back-up generator.]***	***1=mentioned, 0=not mentioned*** a. Power lines 1 0 b. Solar 1 0 c. Generator 1 0 d. Other(specify)_____ 1 0	
A3	Is there a functioning system for clean water?	No 0 Yes 1	
A4	How is the facility's clean water supplied? ***[Probe for all sources of water]***	***1=mentioned, 0=not mentioned*** a. Inside plumbing (external source) 1 0 b. Inside plumbing (from within the facility) 1 0 c. Outdoor pump 1 0 d. Outdoor protected well 1 0 e. Rainwater catchment 1 0 f. Water delivery 1 0 g. Other (specify) _____ 1 0	
A5	Is there a functioning cold chain?	No 0 Yes 1	

Facility ID

WASTE MANAGEMENT

Data collectors should ask and observe these components

Now I'd like to explore the ways this facility handles medical waste			
No.	**Item**	**Response**	**Skip to**
A6	How is solid medical waste disposed of?	***1=mentioned, 0=not mentioned*** a. Burned in the incinerator 1 0 b. Dumped in a covered waste pit 1 0 c. Dumped in an uncovered pit/hole 1 0 d. Transported off-site for disposal 1 0	
A7	Are sharps bins/boxes used for sharps disposal?	No 0 Yes 1	
A8	Where / How are sharps disposed? ***[If sharps boxes are used, how are they disposed of when they are full?]***	In a pit latrine 1 Waste pit 2 Burned / incinerator 3 Other (specify) _____4	

TRANSPORT AND COMMUNICATION

Now I would like to ask you about the extent to which communication and transportation are available.			
No.	**Item**	**Response**	**Skip to**
A9	Does the facility have a communications network available 24/7?	No 0 Yes 1	→ A13
A10	What type(s) of communication networks are available and functioning 24/7 in this facility? ***[Probe for all sources.]***	***1=mentioned, 0=not mentioned*** a. Land telephone(s) (external lines) 1 0 b. Mobile phone(s) 1 0 c. Satellite phone(s) 1 0 d. Radio communication 1 0 e. Other (specify)_____ 1 0	
A11	Does the facility have a back-up communications network?	No 0 Yes 1	→ A13
A12	What type(s) of communication networks are available as back-up?	***1=mentioned, 0=not mentioned*** a. Land telephone(s) (external lines) 1 0 b. Mobile phone(s) 1 0 c. Satellite phone(s) 1 0 d. Radio communication 1 0 e. Other (specify)_____ 1 0	
A13	Does this facility have a means of transporting patients from the community to the facility 24/7?	No 0 Yes 1	→ A17

Facility ID

No.	Item	Response	Skip to
A14	What are the means of transport that is available and functioning 24/7? ***[Probe for all sources.]***	***1=mentioned, 0=not mentioned*** Designated Emergency Vehicle (Ambulance) 1 0 Other motor vehicle (4 wheel) 1 0 Motorcycle 1 0 Boat 1 0 Bicycle 1 0 Animal-drawn cart 1 0 Other:_____ 1 0	
A15	Does the facility have a back-up means of transporting patients from the community to the facility?	No 0 Yes 1	→ A17
A16	What type(s) of transportation are available as back-up?	***1=mentioned, 0=not mentioned*** Designated Emergency Vehicle (Ambulance) 1 0 Other motor vehicle (4 wheel) 1 0 Motorcycle 1 0 Boat 1 0 Bicycle 1 0 Animal-drawn cart 1 0 Other:_____ 1 0	
A17	Does this facility have a means of transporting patients from the facility to a higher-level facility 24/7?	No 0 Yes 1	→ A21
A18	What are the means of transport that is available and functioning 24/7? ***[Probe for all sources.]***	***1=mentioned, 0=not mentioned*** Designated Emergency Vehicle (Ambulance) 1 0 Other motor vehicle (4 wheel) 1 0 Motorcycle 1 0 Boat 1 0 Bicycle 1 0 Animal-drawn cart 1 0 Other:_____ 1 0	
A19	Does the facility have a back-up means of transporting patients from the facility to a higher level facility?	No 0 Yes 1	→ A21
A20	What type(s) of transportation are available as back-up?	***1=mentioned, 0=not mentioned*** Designated Emergency Vehicle (Ambulance) 1 0 Other motor vehicle (4 wheel) 1 0 Motorcycle 1 0 Boat 1 0 Bicycle 1 0 Animal-drawn cart 1 0 Other:_____ 1 0	

Facility ID

If the facility has an ambulance or designated emergency vehicle, go to A21.
If they have no ambulance or vehicle for emergencies, please go to A29.

No.	Item	Response	Skip to
A21	Is there an available source of maintenance/ repair for vehicles (or other transportation means) when necessary?	No 0 Yes 1	
A22	Who is responsible for ensuring that vehicles (or other transportation means) are in working order?	Facility director 1 Community 2 District health office 3 NGO 4 Other (specify) _____ 5 No one takes this responsibility 6	
A23	Are there funds available today for maintenance/repair if they were needed?	No 0 Yes 1	
A24	Is sufficient fuel available today for any motor vehicles, in case a patient requires emergency transport?	No 0 Yes 1	
A25	Is there a prepositioned supply of fuel for a largescale emergency?	No 0 Yes 1	→ A27
A26	How many days of fuel is available?	_____days	
A27	How do you contact the ambulance when a patient requires emergency transport?	***1=mentioned, 0=not mentioned*** With facility communication device 1 0 With personal mobile phone (facility provides credit) 1 0 With personal mobile phone (using my own credit) 1 0 Other (specify)_____ 1 0	
A28	How far is the nearest referral hospital?	_____km	
A29	How long does it take to get to the nearest referral hospital in a working vehicle? ***[Record hours OR minutes under normal circumstances]***	_____hours _____minutes	

Facility ID

No.	Item	Response	Skip to
A30	Consider the last time an emergency patient was transferred to the hospital. How long did it take from the time the decision to transfer was made until she reached the hospital? ***[Record hours OR minutes]***	_____hours _____minutes	
A31	If the time mentioned above is greater than the transfer time under normal circumstances, ask for the causes of delay.	**Causes of delay:**	

Skip SRH preparedness section if questions have already been answered through the qualitative tool.

SRH PREPAREDNESS

Now I would like to ask you about preparedness.

No.	Item	Response	Skip to
A32	When was the last gender, SRH, disability and disaster risk assessment conducted for this facility's catchment area?	a. Within the last 12 months 1 b. Within the last 1-5 years 2 c. More than 5 years ago 3 d. Never 4 d. Don't know 5	
A33	Has the facility identified an SRH focal point?	No 0 Yes 1	
A34	Does a representative of the facility routinely attend SRH coordination meetings?	No 0 Yes 1	
A35	How often are building codes and standards reviewed for this facility to foster disaster resistant structures?	a. Once a year 1 b. Once every 2-5 years 2 c. Other _____ 3 c. Never 4 d. Don't know 5	
A36	Does this facility have an early warning system or emergency communications mechanism to alert communities about potential hazards and risks in an emergency?	No 0 Yes 1	
A37	Does this facility have a contingency budget to adapt services or procure additional supplies in the event of an emergency?	No 0 Yes 1	

Facility ID

No.	Item	Response	Skip to
A38	Does this facility have a mechanism to routinely engage at-risk populations in the community to ensure their needs are met?	No 0 Yes 1	
A39	How often are disaster response simulations or drills conducted at this facility?	a. More than once a year 1 b. Once a year 2 c. Once every 2-5 years 3 d. Other _____ 4 e. Never 5 f. Don't know 6	
A40	How often are clinical staff at this facility re-trained in the priority SRH services in the event of an emergency?	a. Once a year 1 b. Once every 2-5 years 2 c. Other _____ 3 d. Never 4 e. Don't know 5	
A41	How often is the supply chain reviewed for commodity risk management and pre-positioning?	a. More than once a year 1 b. Once a year 2 c. Once every 2-5 years 3 d. Other _____ 4 e. Never 5f. Don't know 6	

Facility ID

B. HUMAN RESOURCES (Adapt list to local context)

Instructions: *The following questions should be directed towards the facility director and the person responsible for obstetrics / maternity.*

Now, I would like to ask about the clinical staff (e.g. doctors, nurses, midwives, clinical officers, etc.) currently working at this facility, particularly those providing SRH services.			
No.	**Clinical staff**	**Yes**	**No**
B1	Is there at least one trained medical doctor present at the facility 24/7?	1	0
B2	Is there at least one trained mid-level provider (nurse, midwife, clinical officer) present at the facility 24/7?	1	0
B3	Is there at least one staff member who routinely attends health coordination meetings?	1	0
B4	Is there at least one trained clinical staff to provide short-acting contraceptive methods?	1	0
B5	Is there at least one trained clinical staff to provide long-acting contraceptive methods (IUDs and/or implants)?	1	0
B6	Is there at least one trained clinical staff to remove long-acting contraceptive methods (IUDs and/or implants)?	1	0
B7	Is there at least one trained clinical staff trained to provide permanent contraceptive methods (tubal ligation and/or vasectomy)?	1	0
B8	Is there at least one trained clinical staff to provide basic EmONC services?	1	0
B9	Is there at least one trained clinical staff on duty per 50 outpatient consultations per day?	1	0
B10	Is there at least one trained clinical staff to provide caesarean sections?	1	0
B11	Is there at least one trained clinical staff on duty 24/7 per 20-30 inpatient beds for the obstetrics ward?	1	0
B12	Is there at least one team of doctor/nurse/midwife/anesthetist on duty 24/7 to address obstetric complications?	1	0
B13	Is there at least one trained clinical staff to provide blood transfusions?	1	0
B14	Is there at least one trained clinical staff to provide essential newborn care?	1	0
B15	Is there at least one trained clinical staff to provide post-abortion care with manual vacuum aspiration and/or misoprostol?	1	0
B16	Is there at least one trained clinical staff to provide induced abortions by manual vacuum aspiration and/or misoprostol and mifepristone and/or misoprostol alone?	1	0
B17	Is there at least one female clinical staff trained to provide care for survivors of sexual assault?	1	0
B18	Is there at least one male clinical staff trained to provide care for survivors of sexual assault?	1	0
B19	Is there at least one trained clinical staff to provide HIV care and treatment?	1	0
B20	Is there at least one trained clinical staff to provide STI diagnosis and treatment?	1	0
B21	Is there at least one clinical staff trained to provide adolescent-friendly services?	1	0
B22	Is there at least one clinical staff trained to address disability inclusion?	1	0
B23	Is there at least one clinical staff trained to work with the LGBTI population?	1	0

Facility ID

C. SRH SERVICE AVAILABILITY

The questions in this section should be directed to the director of obstetrics/ maternity, midwives or those responsible for the specific services.

White fields indicate that an activity, service, or commodity is part of both the MISP for SRH and comprehensive SRH. Pink fields indicate that an activity, service, or commodity is only part of the MISP for SRH, and is not included as part of comprehensive SRH. Purple fields indicate that an activity, service, or commodity is only part of comprehensive SRH, and is not included in the MISP for SRH.

Color scheme:	**MISP only**	Both MISP and comprehensive SRH	**Comprehensive SRH only**

Preventing unintended pregnancies

No	Item	Response	Skip to
C1	Is contraceptive counseling available at this facility?	No 0 Yes 1	 → C3
C2	What is the main reason that this service is not provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C3	Have OCPs been provided in the past three (3) months?	No 0 Yes 1	 → C5
C4	What is the main reason that this method has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → C6
C5	What OCPs have been provided in the past three (3) months?	a. Combined OCPs 1 b. Progestin-only OCPs 2 c. Both 3	
C6	Have injectable contraceptives been provided in the past three (3) months?	No 0 Yes 1	 → C8
C7	What is the main reason that this method has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → C9
C8	What injectable contraceptives have been provided in the past three (3) months?	a. Depo Provera 1 b. Sayana Press 2 c. Both 3	
C9	Have IUDs been inserted in the past three (3) months?	No 0 Yes 1	 → C11
C10	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → C12

Facility ID

No	Item	Response	Skip to
C11	What IUD has been inserted in the past three (3) months?	a. Copper IUD 1 b. Progestin IUD 2 c. Both 3	
C12	Have IUDs been removed in the past three (3) months?	No 0 Yes 1	→ C14
C13	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C14	Have contraceptive implants been inserted in the past three (3) months?	No 0 Yes 1	→ C16
C15	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C16	Have contraceptive implants been removed in the past three (3) months?	No 0 Yes 1	→ C18
C17	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C18	Has tubal ligation (TL) been performed in the past three (3) months?	No 0 Yes 1	→ C20
C19	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C20	Has vasectomy been performed in the past three (3) months?	No 0 Yes 1	→ C22

1. *Lack of skilled staff/training*
   - *a. Authorized cadre is available, but not trained*
   - *b. Lack of confidence in providers' skills*
2. *Lack of supplies/equipment*
   - *a. Supplies/equipment are not available, not functional, or are broken*
   - *b. Needed drugs are unavailable*
3. *Not authorized to provide*
   - *a. Required level of staff are not posted to this facility in adequate numbers (or at all)*
   - *b. National policies do not allow function to be performed*
   - *c. Not mandated at this facility*

Facility ID

No	Item	Response	Skip to
C21	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
C22	Has emergency contraception (EC) been provided outside of care for survivors of sexual violence in the past three (3) months?	No 0 Yes 1	→ C24
C23	What is the main reason that this method has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → C25
C24	What types of emergency contraception have been provided in the past three (3) months?	***1=mentioned, 0=not mentioned*** a. Progestin-only (levonorgestrel) 1 0 b. Ulipristal acetate 1 0 c. Combined hormonal oral contraceptive pills 1 0 d. Copper IUD 1 0 e. Other _____ 1 0	
C25	Have condoms been provided for contraception in the past three (3) months?	No 0 Yes 1	→ C27
C26	What is the main reason that this method has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → C28
C27	What type of condoms was provided?	Male condom 1 Female condom 2 Both 3	
C28	Does this facility offer community-based distribution (by community health workers) of contraceptive methods?	No 0 Yes 1	
C29	Does this facility provide SRH services through mobile teams or outreach services?	No 0 Yes 1	→ C31
C30	Which SRH services are conducted through mobile clinics or outreach services?	***1=mentioned, 0=not mentioned*** a. Short acting contraceptive methods 1 0 b. Long acting contraceptive methods 1 0 c. Emergency contraception 1 0 d. Post-abortion care 1 0 e. Ante-natal care (ANC) 1 0 f. Post-natal care (PNC) 1 0 f. Other_____	

Facility ID

No	Item	Response	Skip to
C31	Does this facility create demand for contraceptive services?	No 0 Yes 1	→ D1
C32	How does this facility create demand for contraceptive services?	***1=mentioned, 0=not mentioned*** a. Through volunteers (including peers) 1 0 b. Through women's/youth/other groups 1 0 c. Other_____ 1 0	

Post-Abortion Care (PAC)/Comprehensive Abortion Care (CAC) Services

No	Item	Response	Skip to
D1	Is post-abortion counseling available at this facility?	No 0 Yes 1	 → D3
D2	What is the main reason that this service is not provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
D3	Has PAC (removal of retained products of conception) with MVA been provided in the past three (3) months?	No 0 Yes 1	 → D5
D4	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
D5	Has PAC using medication (misoprostol) been provided in the last 3 months at this facility?	No 0 Yes 1	 → D7
D6	What is the main reason that this service is not provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
D7	Has PAC with any other method been provided in the past three (3) months?	No 0 Yes 1	→ D9
D8	What other method of PAC has been provided?	***1=mentioned 0=not mentioned*** a. Dilatation and curettage (D&C) 1 0 b. Dilatation and evacuation (D&E) 1 0 c. Other_____ 1 0	
D9	Has induced abortion been provided in the past three (3) months?	No 0 Yes 1	 → D11
D10	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → D14

Facility ID

No	Item	Response	Skip to
D11	What trimester abortion is the facility able to administer?	***1=yes, 0=no*** a. First trimester 1 0 b. Second trimester 1 0 c. Third trimester 1 0	
D12	What methods for induced abortion have been provided to women and girls up to 12 weeks of pregnancy in the past three (3) months?	***1=yes, 0=no*** a. Mifepristone and Misoprostol 1 0 b. Misoprostol only 1 0 c. Manual Vacuum Aspiration 1 0 d. Other_____ 1 0	
D13	What methods for induced abortion have been provided to women and girls in their second trimester and beyond in the past three (3) months?	***1=yes, 0=no*** a. Mifepristone and Misoprostol 1 0 b. Misoprostol only 1 0 c. Dilation and evacuation (D&E) 1 0 d. Other_____ 1 0	
D14	Is contraception offered to all clients who receive abortion services (PAC or induced) before they leave the facility?	No 0 Yes 1	→ D16
D15	What is the main reason contraception is not offered to all clients who receive abortion services (PAC or induced) before they leave the facility?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E1
D16	What methods of contraception have been provided to clients who receive abortion services (PAC or induced) before they leave the facility in the past three (3) months?	***1=mentioned, 0=not mentioned*** a. Male condoms 1 0 b. Female condoms 1 0 c. OCPs 1 0 d. Emergency contraception 1 0 e. Injectable contraceptives 1 0 f. Implants 1 0 g. IUDs 1 0	

Preventing excess maternal and newborn morbidity and mortality

No	Item	Response	Skip to
E1	Has a normal delivery been performed in the past three (3) months?	No 0 Yes 1	→ E3
E2	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E3	Have parenteral antibiotics been administered for obstetric cases in the past three (3) months?	No 0 Yes 1	→ E5

Facility ID

No	Item	Response	Skip to
E4	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E5	Have parenteral uterotonics (or misoprostol) been administered (for complications such as prolonged labor) in the past three (3) months? ***[Do not include routine use such as AMTSL]***	No 0 Yes 1	→ E7
E6	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E8
E7	What type(s) of uterotonics were used?	***1=mentioned, 0=not mentioned*** a. Oxytocin 1 0 b. Ergometrin 1 0 c. Misoprostol 1 0 d. Tranexamic acid 1 0 d. Other (specify) _____ 1 0	
E8	Have parenteral anticonvulsants been administered for obstetric cases in the past three (3) months?	No 0 Yes 1	→ E10
E9	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E11
E10	Which types of medication were used?	***1=mentioned, 0=not mentioned*** a. Magnesium Sulfate 1 0 b. Diazepam 1 0 c. Other (specify) _____ 1 0	
E11	Has manual removal of the placenta been performed in the past three (3) months?	No 0 Yes 1	→ E13
E12	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E13	Has assisted vaginal delivery been performed in the past three (3) months?	No 0 Yes 1	→ E15

Facility ID

No	Item	Response	Skip to
E14	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E16
E15	What instrument was used?	Vacuum extractor 1 Forceps 2 Both 3	
E16	Has newborn resuscitation with bag and mask been performed in the past three (3) months?	No 0 Yes 1	→ E18
E17	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E18	Has blood transfusion been performed in the past three (3) months?	No 0 Yes 1	→ E20
E19	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E24
E20	What is the source of the blood supply?	Blood comes from an external blood bank 1 Blood comes from facility blood bank 2 Blood is collected from family or friends as needed (live transfusion) 3 Other _____4	
E21	How many units of blood have been donated in the past three (3) months?	Units: _____	
E22	How many units of donated blood have been screened in the past three (3) months?	Units: _____	
E23	Which of the following is blood screened for: **[READ LIST]**	***1=yes, 0=no*** a. HIV 1 0 b. Syphilis 1 0 c. Hepatitis B 1 0 d. Hepatitis C 1 0 e. Malaria 1 0	
E24	Has a cesarean delivery been performed in the past three (3) months?	No 0 Yes 1	→ E26

Facility ID

No	Item	Response	Skip to
E25	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E27
E26	What type of anesthesia is provided at facility?	***1= mentioned, 0= not mentioned*** a. General 1 0 b. Spinal (rachianesthesia) 1 0 c. Ketamine 1 0 d. Other (specify) _____ 1 0	
E27	Have corticosteroids been administered for pre-term labor in the past three (3) months?	No 0 Yes 1	→ E29
E28	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E29	Has the partograph been used to manage labor in the past three (3) months?	No 0 Yes 1	→ E31
E30	What is the main reason the partograph was not used?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E31	Is active management of 3rd stage of labor (AMTSL) performed at this facility?	No 0 Yes 1	→ E33
E32	What is the main reason AMTSL has not been performed?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E34
E33	Which components of AMTSL are routinely done?	***1=mentioned, 0=not mentioned*** Immediate Oxytocin 1 0 Immediate Misoprostol 1 0 Immediate Ergometrine 1 0 Controlled cord traction 1 0 Uterine massage 1 0 Other_____ 1 0	
E34	Is essential newborn care provided routinely at this facility?	No 0 Yes 1	→ E36

Facility ID

No	Item	Response	Skip to
E35	What is the main reason essential newborn care is not routinely provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → E37
E36	What components of essential newborn care are routinely done?	***1=Yes , 0=No*** Thermal care (drying, warming, skin-to-skin contact, delayed bathing) 1 0 Infection prevention/hygiene (Clean birth practices, hand washing, clean cord/skin/ eye care) 1 0 Feeding support (Skin-to-skin, immediate and exclusive breastfeeding, not discarding colostrum) 1 0 Monitoring (frequent assessment of serios infections and other conditions) 1 0 e. Post-natal care checks 1 0	
E37	Is care for prematurity and low birthweight provided at this facility?	No 0 Yes 1	→ E39
E38	Why is care for prematurity and low birthweight care not provided at this facility?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E39	Can the facility manage signs of possible bacterial infections in newborns?	No 0 Yes 1	→ E41
E40	Why can the facility not manage newborn infections?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E41	Does the facility promote Kangaroo Mother Care for clinically stable mothers and babies?	No 0 Yes 1	→ E43
E42	Why does the facility not promote Kangaroo Mother Care for clinically stable mothers and babies?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E43	Has the community been informed of the danger signs of pregnancy and childbirth, and where to seek care, in the past three (3) months?	No 0 Yes 1	→ E45

Facility ID

No	Item	Response	Skip to
E44	How has the community been informed of the danger signs of pregnancy and childbirth, and where to seek care, in the past three (3) months?	***1=yes, 0=no*** a. Community outreach session 1 0 b. Fliers 1 0 c. Text messaging 1 0 f. Other (specify) _____ 1 0	→ All to E49 if emergency response
E45	Has antenatal care been provided to pregnant women?	No 0 Yes 1	→ E47
E46	Why has antenatal care not been provided to pregnant women?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E47	Has postnatal care been provided to mothers within 6 weeks of delivery?	No 0 Yes 1	→ E49 if emergency; otherwise, F1
E48	Why has postnatal care not been provided to mothers within 6 weeks of delivery?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
E49	Have clean delivery kits been distributed to visibly pregnant women in the past three (3) months?	No 0 Yes 1	→ E51
E50	What is in the clean delivery kit?	***1= mentioned, 0= not mentioned*** One sheet of plastic 1 0 Bar of soap 1 0 Pair of gloves 1 0 One clean razor blade 1 0 Three pieces of umbilical tape 1 0 Two pieces of cotton cloth 1 0 Misoprostol tablets (600 mcg) 1 0 Chlorhexidine gel/solution 7.1% (delivering 4%) 1 0 Other_____	
E51	Have newborn kits been distributed to new mothers in the past three (3) months?	No 0 Yes 1	→ F1

Facility ID

No	Item	Response	Skip to
E52	What is in the newborn kits?	***1= mentioned, 0= not mentioned*** a. Baby blanket (50x75 cm or eq.) 1 0 b. Polyester fleece 1 0 c. Newborn cap, cotton 1 0 d. Newborn romper suit, cotton 1 0 e. Baby socks, size extra small 1 0 f. Small, cotton towel 1 0 g. Tetracycline hydrochloride 1% 1 0 h. Other (specify) _____1 0	

Prevent sexual violence and respond to the needs of survivors

No	Item	Response	Skip to
F1	Are there Standard Operating Procedures in place for referral of survivors of sexual violence?	No 0 Yes 1	→ F3
F2	What is included in the Standard Operating Procedures?	***1=mentioned, 0=not mentioned*** Safety and security 1 0 Confidentiality 1 0 Respect 1 0 Non-discrimination 1 0 Roles and responsibilities of different sectors 1 0 Links with community groups 1 0 Other: _____ 1 0	*All to* → F4
F3	Why are there no Standard Operating Procedures in place?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of political support 1 0 c. Other: _____ 1 0	
F4	Does the facility have sex-segregated latrines?	No 0 Yes 1	
F5	Do all latrines lock from the inside?	No 0 Yes 1	
F6	Is there adequate lighting around the health facility?	No 0 Yes 1	
F7	Does the facility have a system to control who is entering or leaving the facility?	No 0 Yes 1	
F8	Can privacy be ensured for confidential care for survivors of sexual violence?	No 0 Yes 1	

Facility ID

No	Item	Response	Skip to
F9	Number of incidents of sexual violence reported to this health facility in the past three (3) months	***Number*** _____	→ F32
F10	Has emergency contraception been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F12
F11	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → F13
F12	What types of emergency contraception have been provided following sexual violence in the past three (3) months?	***1=mentioned, 0=not mentioned*** a. Progestin-only (levonorgestrel) 1 0 b. Ulipristal acetate 1 0 c. Combined hormonal oral contraceptive pills 1 0 d. Copper IUD 1 0 e. Other _____ 1 0	
F13	Has pregnancy testing been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F15
F14	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F15	Has post-exposure prophylaxis (PEP) been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F17
F16	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → F18
F17	What drugs are used for HIV-PEP?	***1=yes, 0=no*** a. Two drug regimen 1 0 b. Three drug regimen 1 0 c. Other 1 0	
F18	Has antibiotics to prevent sexually transmitted infections (STI) been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F20
F19	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	

Facility ID

No	Item	Response	Skip to
F20	Has tetanus toxoid/tetanus immunoglobulin been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F22
F21	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F22	Has Hepatitis B vaccine been provided following sexual violence in the past three (3) months?	No 0 Yes 1	→ F24
F23	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F24	Has the HPV vaccine been provided following sexual violence to anyone age 26 or younger?	No 0 Yes 1	→ F26
F25	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F26	Has safe abortion care been provided to survivors of sexual violence in the past three (3) months?	No 0 Yes 1	→ F28
F27	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F28	Has referral to psychological or social support services been provided to survivors of sexual violence in the past three (3) months?	No 0 Yes 1	→ F30
F29	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
F30	Has a follow-up visit been provided at the health facility to survivors of sexual violence in the past three (3) months?	No 0 Yes 1	→ F32

Facility ID

No	Item	Response	Skip to
F31	What is the main reason that a follow-up visit has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0 d. Survivor did not follow-up 1 0	
F32	Has information to communities on the benefits and location of care for survivors of sexual violence been provided in the past three (3) months?	No 0 Yes 1	→ F34
F33	What is the main reason that information has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	*All to* → G1
F34	How has the community been informed of the benefits and location of care for survivors of sexual violence been provided in the past three (3) months?	***1=yes, 0=no*** a. Community outreach session 1 0 b. Fliers 1 0 c. Text messaging 1 0 f. Other (specify) _____1 0	

Prevent and respond to HIV/Sexually Transmitted Infections

No	Item	Response	Skip to
G1	Is equipment sterilized in this facility?	No 0 Yes 1	→ G3
G2	What is the main reason that equipment is not sterilized in this facility?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G3	How does this facility sterilize equipment?	***1=yes, 0=no*** a. Autoclave 1 0 b. Hot air sterilizer 1 0 c. Steam sterilizer (electric) 1 0 d. Steam sterilizer/pressure cooker (non-electric) 1 0 e. High level disinfection1 0 f. Other (specify) _____1 0	
G4	Are lubricated condoms available free of charge at the health facility?	No 0 Yes 1	→ G6
G5	What is the main reason that condoms are not available at the health facility?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	→ All to G9

Facility ID

No	Item	Response	Skip to
G6	Are lubricated condoms available free of charge to? **[READ LIST]**	***1=yes 0=no*** a. Adolescents 1 0 b. LGBTQIA persons 1 0 c. Persons with disabilities 1 0 d. Sex workers 1 0	
G7	Roughly how many condoms were taken this period from health facility in the past three (3) months?	***Number*** _____	
G8	How many condoms were replenished in the health facility in the past three (3) months?	***Number*** _____	
G9	For mothers with unknown HIV status, has rapid testing been performed in the maternity /labor ward in the past three (3) months?	No 0 Yes 1	→ G11
G10	What is the main reason that this service has not been performed?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G11	Have antiretrovirals been given to mothers in maternity / labor ward (PMTCT) in the past three (3) months?	No 0 Yes 1	→ G13
G12	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G13	Have antiretrovirals been given to newborns in maternity / labor ward (PMTCT) in the past three (3) months?	No 0 Yes 1	→ G15
G14	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G15	Have syndromic diagnosis and treatment of STIs/ reproductive tract infections been performed in the past three (3) months?	No 0 Yes 1	→ G17

Facility ID

No	Item	Response	Skip to
G16	What is the main reason that this service has not been performed?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G17	Has cotrimoxazole prophylaxis for opportunistic infections been provided in the past three (3) months?	No 0 Yes 1	→ G19
G18	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G19	Has post-exposure prophylaxis (PEP) been provided following occupational exposure in the past three (3) months?	No 0 Yes 1	→ G21
G20	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G21	Has antiretroviral treatment (ART) for people living with HIV (PLWH) been provided in the past three (3) months?	No 0 Yes 1	→ I1 if emergency response. Otherwise, G23
G22	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	→ All to I1 if emergency response
G23	Have laboratory diagnosis and treatment of STIs/ reproductive tract infections been performed in the past three (3) months?	No 0 Yes 1	→ G25
G24	What is the main reason that this service has not been performed?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G25	Has voluntary HIV counseling and testing (non-PMTCT) been provided in the past three (3) months?	No 0 Yes 1	→ G27

Facility ID

No	Item	Response	Skip to
G26	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	
G27	Has non-ART care for PLWH been provided in the past three (3) months (*Tuberculosis treatment, food and nutrition support, psychosocial care, etc.*)?	No 0 Yes 1	→ H1
G28	What is the main reason that this service has not been provided?	***1=mentioned, 0=not mentioned*** a. Lack of skilled staff/training 1 0 b. Lack of supplies / equipment 1 0 c. Not authorized to provide 1 0	

Other SRH Services

Instructions: *Please answer the following questions about these other SRH services. Record whether the function has been performed in the past three (3) months, and why not.*

No.	Item	Response	Skip to
H1	Have patients with cervical or breast cancer been referred to a tertiary care hospital for specialist diagnosis and treatment in the past three (3) months?	No 0 Yes 1	→ H3
H2	What is the main reason that this service has not been provided?	Lack of skilled staff/training 1 0 Lack of supplies / equipment 1 0 Not authorized to provide 1 0 No Indication/No Clients 1 0	
H3	Has the human papillomavirus (HPV) vaccine been provided outside of the context of sexual violence in the past three (3) months?	No 0 Yes 1	→ H5
H4	What is the main reason that this service has not been provided?	Lack of skilled staff/training 1 0 Lack of supplies / equipment 1 0 Not authorized to provide 1 0 No Indication/No Clients 1 0	
H5	Has counseling for patients presenting with infertility been provided in the past three (3) months?	No 0 Yes 1	→ H7
H6	What is the main reason that this service has not been provided?	Lack of skilled staff/training 1 0 Lack of supplies / equipment 1 0 Not authorized to provide 1 0 No Indication/No Clients 1 0	

Facility ID

No.	Item	Response	Skip to
H7	Has health care specific to care for transgender clients (e.g. hormone therapy) been provided in the past three (3) months?	No 0 Yes 1	→ I1
H8	What is the main reason that this service has not been provided?	Lack of skilled staff/training 1 0 Lack of supplies / equipment 1 0 Not authorized to provide 1 0 No Indication/No Clients 1 0	

Access to SRH Services

No	Item	Response	Skip to
I1	Is the facility set up to ensure privacy and confidentiality for clients seeking SRH services (e.g. *auditory and visual privacy for consultations and service delivery, SRH clients are not forced to identify themselves through separate waiting areas, etc.*)?	No 0 Yes 1	
I2	Is the facility open during hours that are convenient for adolescents (particularly in the evenings or at the weekend)?	No 0 Yes 1	
I3	Are there specific clinic times or spaces set aside for adolescents?	No 0 Yes 1	
I4	Can adolescents be seen in the facility without the consent of their parents or spouses?	No 0 Yes 1	
I5	Does the facility have accommodations for persons with disabilities?	No 0 Yes 1	→ I6
I6	What accommodations are available for persons with disabilities?	***1=mentioned, 0=not mentioned*** Wheelchair accessible ramps 1 0 Accessible toilets 1 0 Sign interpreter 1 0 Accessible IEC materials 1 0 Other: _____ 1 0	
I7	Is the facility able to provide interpretation for clients speaking different languages?	No 0 Yes 1	

Facility ID

D. PAYMENT FOR SERVICES

Now I would like to ask you about payment for services, specifically during obstetric/gynecological emergencies.

No.	Item	Response	Skip to
J1	Is there a user fee (i.e. formal payment) required for consultation and/or treatment?	No 0 Yes 1	→ K1
J2	In an obstetric/gynecological emergency, is any payment required before a woman can receive treatment (e.g. procedure)?	No 0 Yes 1	
J3	In an obstetric/gynecological emergency, is payment required for medications before a woman can receive them?	No 0 Yes 1	
J4	Is there a fee schedule posted in a visible and public place?	No 0 Yes 1	
J5	What is the standard, unadjusted cost (in local currency) of the following services or methods: **[Write N/A if service not available]** ***Exchange Rate*** *US$1= _____ currency*	1. Outpatient consultation _____1 2. Manual vacuum aspiration (MVA) _____2 3. Dilation and curettage (D&C) _____3 4. Removal of retained products with medication (misoprostol) _____4 5. Oral contraceptives _____5 6. Injectable contraceptives _____6 7. IUD _____7 8. Implant _____8 9. Tubal Ligation _____9 10. Vasectomy _____10 11. Emergency Contraception _____11 12. Male condoms _____12 13. Female condoms _____13 14. Normal delivery _____14 15. Vacuum delivery _____15 16. Cesarean section _____16	
J6	Are costs adjusted for clients who have limited resources?	No 0 Yes 1	
J7	Do the costs of care differ between refugees/displaced and the local population?	No 0 Yes 1	

Facility ID

E. Data

Please review clinic records from the past three months.

Contraception

	Year:	Month 1	Month 2	Month 3	Total
Number of clients who start a modern contraceptive method (Please include any client who starts a modern method, including those switching from another method.)					
K1	Number of clients who start an IUD				
K2	Number of clients who had an IUD removed				
K3	Number of clients who start an implant				
K4	Number of clients who had an implant removed				
K5	Number of clients who receive tubal ligation				
K6	Number of clients who receive vasectomy				
K7	Number of clients who start OCPs				
K8	Number of clients who start injectables				
K9	Number of clients who start using male condoms for contraception				
K10	Number of clients who start using female condoms for contraception				
K11	Number of clients receiving EC outside of care for survivors of sexual violence[12]				

[12] Do NOT include GBV clients. This should include new and repeat EC clients.

Facility ID

Comprehensive Abortion Care (CAC) and Emergency Obstetric Care Data

	Year:	Month 1	Month 2	Month 3	Total
K12	Number of clients treated for complications of abortion				
K13	Number of clients who received induced abortions at the facility				
K14	Number of clients who received abortion services* obtaining IUD				
K15	Number of clients who received abortion services* obtaining implant				
K16	Number of clients who received abortion services* obtaining tubal ligation				
K17	Number of clients who received abortion services* obtaining OCPs				
K18	Number of clients who received abortion services* obtaining injectables				
K19	Number of deliveries in the facility				
K20	Number of stillbirths				
K21	Number of women with direct obstetric complications treated in the facility				
K22	Number of cesarean deliveries in the facility				
K23	Number of maternal deaths among women treated for direct obstetric complications in the facility				
K24	Number of newborn deaths (within 28 days of birth)				
K25	Number of antenatal care visits in the facility				
K26	Number of clean delivery kits distributed to visibly pregnant women				
K27	Number of newborn kits distributed				

**Abortion services are defined as those treated for complications of abortion and those who received induced procedures.*

Facility ID

Other SRH Indicators

	Year:	Month 1	Month 2	Month 3	Total
K28	Number of sexual violence clients eligible for EC				
K29	Number of sexual violence clients who received EC				
K30	Number of sexual violence clients eligible for PEP				
K31	Number of sexual violence clients who received PEP				
K32	Number of HIV+ women who delivered at facility				
K33	Number of HIV+ women/ infant pairs who delivered and who completed PMTCT protocol after delivering at the facility				
K34	Number of HIV+ clients who received ARVs				
K35	Number who received syndromic STI treatment				

Facility ID

F. Essential Drugs, Equipment, and Supplies

No.	Item	Is at least 1 available and functional?	
		Yes	No
L1	Blood pressure cuff	1	0
L2	Stethoscope	1	0
L3	Needles and syringes	1	0
L4	Speculum	1	0
L5	Uterine sound	1	0
L6	Sponge forceps	1	0
L7	Artery forceps	1	0
L8	Tenaculum	1	0
L9	Scalpel handle (No. 3) and scalpel blade	1	0
L10	Suture needles and sutures	1	0
L11	MVA syringe, adapters and cannulae	1	0
L12	Vacuum extractor	1	0
L13	Partograph	1	0
L14	Ambu bag and infant face mask	1	0
L15	Infant scale	1	0
L16	Foetoscope	1	0
L17	Plastic sheeting	1	0
L18	Non-sterile gloves	1	0
L19	Sterile gloves	1	0
L20	Washing station with soap	1	0
L21	Antiseptics	1	0
L22	Apron	1	0
L23	Autoclave (or other appropriate equipment for sterilization)	1	0

Facility ID

Please check the availability of the following supplies and note whether the item is available and un-expired in the pharmacy (main pharmacy store plus distribution area). If only expired drugs are available, mark No.

SRH Commodities		Yes	No
L24	Magnesium sulfate	1	0
L25	Oxytocin	1	0
L26	Misoprostol	1	0
L27	Dexamethasone	1	0
L28	Penicillin	1	0
L29	Erythromycin	1	0
L30	Chlorhexidine gel/solution	1	0
L31	Tetracyline hydrochloride 1%	1	0
L32	Ampicillin	1	0
L33	Gentamycin	1	0
L34	Ceftriaxone	1	0
L35	Injectable Metronidazole	1	0
L36	ARVs for PMTCT for the mother	1	0
L37	ARVs for PMTCT for the infant	1	0
L38	Post-Exposure Prophylaxis for HIV (PEP)	1	0
L39	Emergency Contraception (progestin-only pills)	1	0
L40	Combined oral contraceptive pills	1	0
L41	Progestin-only contraceptive pills	1	0
L42	Injectable contraceptives (Depo Provera)	1	0
L43	Injectable contraceptives (Sayana Press)	1	0
L44	Copper IUD	1	0
L45	Progestin IUD	1	0
L46	Implants	1	0

Facility ID

Have any of the following Inter-agency Emergency Reproductive Health Kits been ordered in the past three (3) months?

Inter-agency Emergency Reproductive Health Kits		Yes	No
L47	Kit 0: Administration and Training	1	0
L48	Kit 1A: Male Condoms	1	0
L49	Kit 2A: Clean Delivery (Individual packages)	1	0
L50	Kit 2B: Clean Delivery (Supplies for birth attendants)	1	0
L51	Kit 3: Post-Rape Treatment	1	0
L52	Kit 4: Oral and Injectable Contraception	1	0
L53	Kit 5: Sexually Transmitted Infections	1	0
L54	Kit 6A: Clinical Delivery Assistance (Reusable equipment)	1	0
L55	Kit 6B: Clinical Delivery Assistance (Drugs and disposable equipment)	1	0
L56	Kit 7A: Intrauterine Device (IUD)	1	0
L57	Kit 7B: Contraceptive Implant	1	0
L58	Kit 8: Management of Complications of Miscarriage or Abortion	1	0
L59	Kit 9: Repair of Cervical and Vaginal Tears	1	0
L60	Kit 10: Assisted Delivery with Vacuum Extraction	1	0
L61	Kit 11A: Obstetric Surgery and Severe Obstetric Complications (Reusable)	1	0
L62	Kit 11B: Obstetric Surgery and Severe Obstetric Complications (Consumable)	1	0
L63	Kit 12: Blood Transfusion	1	0

Have any of the complementary commodities been ordered in the past three (3) months?

Complementary Commodities		Yes	No
L64	Kit 1A: Female Condoms (Kit 1B)	1	0
L65	Kit 2A: Chlorhexidine Gel	1	0
L66	Kit 2B: Misoprostol	1	0
L67	Kit 2A/B: UNICEF/Save the Children Newborn care supply kit - community	1	0
L68	Kit 4: Depot-medroxyprogesterone acetate-sub-cutaneous (DMPA-SC)	1	0
L69	Kit 4: Intrauterine Device (IUD) (Kit 7A)	1	0
L70	Kit 4: Contraceptive Implant (Kit 7B)	1	0
L71	Kit 6A: Non-Pneumatic Anti-Shock Garment	1	0
L72	Kit 6B: Oxytocin	1	0
L73	Kit 6A/B: UNICEF/Save the Children Newborn care supply kit - primary health facility	1	0
L74	Kit 8: Mifepristone	1	0
L75	Kit 10: Hand-held Vacuum Assisted Delivery System	1	0
L76	Kit 11A: Interagency emergency health kit supplementary malaria module	1	0
L77	Kit 11A/B: UNICEF/Save the Children Newborn care supply kit -hospital	1	0

Proceed to the next section only if site is actively implementing the MISP.

Facility ID

G. Planning for comprehensive SRH services

Now, I would like to ask you about planning for comprehensive SRH services

No	Item	Response	Skip to
M1	Have the SRH needs in the community been identified?	No 0 Yes 1	→ M3
M2	What are the SRH needs that have been identified?	***1=mentioned, 0=not mentioned*** a. Need to improve accessibility for certain populations 1 0 b. Need to improve availability of specific services 1 0 c. Need to improve service quality 1 0 d. Other: _____ 1 0	
M3	Have suitable sites for SRH service delivery been identified?	No 0 Yes 1	→ M5
M4	Where are the suitable site(s)?	***Location(s)*** _____	
M5	Have staffing needs been identified?	No 0 Yes 1	→ M7
M6	What are the needs?	***1=mentioned, 0=not mentioned*** a. Need more staff 1 0 b. Need more training 1 0 c. Other: _____ 1 0	
M7	Have trainings for SRH have been designed and planned?	No 0 Yes 1	→ M9
M8	What SRH trainings are planned?	***Training(s)*** _____	
M9	Is SRH information included in health information systems?	No 0 Yes 1	
M10	Have SRH commodity needs been identified?	No 0 Yes 1	→ M13
M11	What are the SRH commodity needs that have been identified?	**SRH commodity needs** _____	
M12	What is the timeframe of the SRH commodity needs the facility is planning for?	***1=mentioned, 0=not mentioned*** a. Current service provision 1 0 b. Next 1 month 1 0 c. Next 3 months 1 0 d. Prepositioning for future emergency 1 0 e. Other: _____1 0	

Facility ID

No	Item	Response	Skip to
M13	Have SRH commodity supply lines been identified, consolidated, or strengthened?	No 0 Yes 1	
M14	Have SRH funding possibilities been identified?	No 0 Yes 1	
M15	Have SRH-related laws, policies, and protocols been reviewed?	No 0 Yes 1	

Capacity and Needs Assessment Tool to Build Community Resilience
Focus Group Discussion Guide for Community Health Resource Persons

Focus Group Discussions[13]

This tool should be used during small group discussions with 4 to 10 participants that work in the community. Participants can be community health workers (CHWs), traditional birth attendants (TBAs), community outreach workers, or peer educators, among other community health resource persons. The discussion should not last more than 1.5-2 hours.

The focus is to solicit feedback around sexual and reproductive health (SRH) risks, vulnerabilities, protective strategies, coping capacities, and resources that can be used to inform and shape the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training. It also examines community capacity to implement the Minimum Initial Service Package (MISP) for SRH in emergencies.

Some of these questions are sensitive. You should take all potential ethical concerns into consideration before the discussion, considering the safety of the location and of the respondent.

While this tool is appropriate for use with members of diverse health cadres, if there are significant differences in the roles and responsibilities of particular cadre members that could affect the discussion, and if time and capacity allows, you may wish to conduct separate focus group discussions with these different cadres.

Please review the Women's Refugee Commission's Ethical Guidelines for Working with Displaced Populations to implementing focus group discussions for details on how to organize and implement activities.[14] Also refer to the *Facilitator's Guide* for more information on selecting participants, conducting the interview, data analysis tips, and what to pull from the findings.

Participant Recruitment

- Before mobilizing community health resource persons, meet with community leaders and/or local government representatives to explain the purpose of the exercise and the presence of the team in the community.
- Ensure broad representation in the focus group discussions if such persons also work as a community health resource person, including persons with disabilities, LGBTI persons, persons engaged in sex work, and persons from other minority or at-risk groups.
- Obtain parental consent for adolescents if needed (script provided).

[13] Adapted from FGD guides used in the MISP assessments and in-depth studies from the IAWG on RH in Crises 2012-2014 Global Evaluation of Reproductive Health in Humanitarian Settings.

[14] Women's Refugee Commission. Ethical Guidelines for Working with Displaced Populations, Mary 2016. Other resources include: Reproductive Health Response in Crises Consortium, "Focus Group Discussion Protocol," RHRC Consortium Monitoring and Evaluation Toolkit, 2004. Another good resource is: Morgan, David L. Focus Groups as Qualitative Research. Sage Publications, Thousand Oaks, CA. 1997.

SCRIPT FOR PARTICIPANT RECRUITMENT

Hello, we are from the ACCESS Project. We would like to talk to you about a study we are doing. We are asking you to join a group discussion because program staff from [collaborating agency] or a community member gave us your name as a community health resource person.

If you agree to join this activity, you will be asked to join a group with around 4 to 10 other participants. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community; and to discuss your roles as community health resource persons in the community.

The activity will take about 1.5-2 hours total. You will only need to participate this one time. We will be taking notes during the activity, but we will not record your name anywhere. The information we collect will be kept private.

You may feel there are some questions you do not wish to answer. That is okay. You do not have to answer all of the questions and you may leave at any time.

You will not receive any direct benefits from joining this group activity. However, we may learn something that may help improve your ability to serve your community.

You do not have to join this activity. It is up to you. You can say okay now, and you can change your mind later. All you have to do is tell us. No one will be upset with you if you change your mind.

Before you say yes to joining this activity, we will answer whatever questions you have.

Only if under age of majority and not emancipated from parents:
If you have said yes, because you are under x age, we would like to ask permission from your parent or guardian for you to participate.

PARENT/GUARDIAN PERMISSION IF PARTICIPANT IS UNDER AGE OF MAJORITY AND NOT EMANCIPATED

Hello, we are from the ACCESS Project and we would like to talk to your child about her/his/their work as a community health resource person. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community; and to discuss the role of adolescents who are serving their community. We are asking your child to help us in our work because she/he/they were identified by [collaborating agency]. Your child has expressed interest in participating, but you do not have to give permission, it is your choice.

If you say yes, we will ask your child to join a group activity with around 4 to 10 other participants. The activity will take about 1.5-2 hours total.

We will be taking notes during the discussion, but we will not record your name or your child's name anywhere. The information we collect will be kept private.

You or your child will not receive any direct benefits from participating in this activity. We will use the answers to reach out to policy makers, program managers, and health staff to improve the community's access to and quality of health services and help prepare for an emergency.

We will not pay you or your child to help us. We can help pay you back for any travel costs that your child might have for participating in this group activity.

Do you have any questions? You may contact [local name and study contact info] about your questions or problems with this work.

Can your child participate in the group activity?

___ Yes, parent/guardian gives permission for child to participate.

___ No, parent/guardian does not give permission for child to participate.

Before the Focus Group Discussion

- Review the tool for appropriateness, especially if they have been translated. If time allows, it may be beneficial to pre-test the translated tool among persons similar to potential participants and translate responses back into English to determine the appropriateness of the translation, including questions and wording.
- Consider whether potential *Community-based Preparedness for Sexual and Reproductive Health and Gender* workshop participants may be involved as facilitators, notetakers, or interpreters. While this may add bias, it may help gain buy-in and commitment from community stakeholders to realize the action plan that will be developed, if they are move involved in processes from the beginning.
- If the discussion will be conducted in another language, decide whether to use translator facilitation or translated facilitation. Translator facilitation is when trained interpreter(s) facilitate the activity in the participants' language with no interrupted interpretation. Translated facilitation is when the interpreter interprets what the facilitator and participants say, at each interval. See the *Facilitator's Guide* for more information.
- Find a private location—such as a central office—that is convenient, comfortable, and accessible for all participants, including participants with disabilities.
- Make sure you have identified a referral pathway for health/psychosocial/protection concerns that may be raised by participants.
- Identify appropriate local contacts for any complaints, concerns, or follow up regarding the focus group and the prevention of sexual exploitation and abuse.
- Identify a means of sharing findings with participants and the community.
- For groups where persons with disabilities will be present, consult with them in advance to be able to provide any helpful accommodations. Often, the most requested accommodation is transport to/from the venue (physical or funding), sign interpretation if working with those that sign, or accessible restrooms for persons with certain mobility impairments.
- Plan on reimbursing participants for transport if they incurred costs, especially persons with disabilities and any personal assistants.
- If you do not feel it is safe to have this discussion, or that it may cause risk for staff or participants, do not proceed. For example, if it is not possible to control any crowds that huddle, or if the security situation in the area is not safe, it may be better to find a safer space.

INTRODUCTORY SCRIPT

Thank you for coming today. My name is [facilitator's name] and with me are [notetaker's name] and [observer or other's name]. We are here in [location] with [collaborating agencies] as part of the ACCESS Project. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community; and to discuss your roles as community health resource persons in the community.

If you still agree to participate today, we will ask you some questions about your role helping women and girls during the last emergency. We are going to ask you these questions as a group, which will give you a chance to comment on each other's thoughts. Each of you has important ideas, and I hope to hear from each of you. Please try to help us along by making sure that your perspective is heard.

The activity will take about 1.5-2 hours in total. You will only need to participate this one time. We will be taking notes during the discussion, but we will not note your name anywhere. The information we collect will be kept private and will not be traced back to you. We will destroy our notes once we have analyzed the information.

Your participation is completely up to you. You may decide to participate or not. Although we would value your participation, you will not experience bad things for not participating. You may feel there are some questions you do not wish to answer. That is okay. You do not have to answer all of the questions and you may leave at any time.

There is also no right or wrong answer to the questions, so please do not worry if you are not sure about the answers. Since we are interested in learning about the experiences of community health resource persons in general, please try to think about and share experiences that are common to others, rather than your own personal experience. So that we can all feel comfortable sharing our thoughts, we ask that you keep each other's comments private, and that you do not to talk to people outside of this group about what was said here. This is very important.

We do not think any of the questions will be upsetting to you, but if you do become upset, we can help find someone for you to talk to or link you to services. If you share information that shows that you or someone else may be in danger, we will need to talk to someone who can help the situation. We will not be paying you or giving you anything to take part in this activity. There will be no direct benefit to you for participating in today's activity.

Once we have gathered all of the information, we will share key points with policy makers, program managers, and health staff to improve the community's access to and quality of health services and help prepare for an emergency, but again, no names will be shared.

Do you have any questions?

You can contact [local name and study contact information] with questions or any problems.

Would you like to take part in the group activity? Please raise your hand if you agree to participate. Please raise your hand if you do not wish to participate.

___ Yes, respondents consent to participate.

Let those that do not wish to participate leave the venue before beginning the group activity.

Tips of Facilitation

- Make sure you and your co-facilitators, note-takers, and any interpreters are well trained in facilitating focus group discussions. All of you should be familiar with the ethics of facilitation and your respective roles.
- Wherever possible, limit the number of observers present during the discussion, particularly if the group is comprised of a smaller number of participants.
- Engaging a trained facilitator with a disability or someone with similar characteristics as the groups convened may offer opportunities for their professional growth and empowerment, as well as create a conducive environment for other participants with similar traits to openly share their thoughts.
- Ask open-ended, non-leading questions.
- Do not probe about sexual violence or abuse, or try to identify victims of or perpetrators of violence (i.e., one specific armed *group).*
- Maintain a neutral and encouraging environment.
- Give opportunities to encourage shy participants to speak, so that no one person dominates the discussion.
- Encourage the notetaker to focus on documenting key points and phrases if it is not possible to record the discussion verbatim. There is no need to audio-record the discussion.

After the Focus Group

- Make sure to debrief immediately following the focus group discussion with the notetaker(s) and interpreter—question-by-question—to see what information was recorded, adding data from memory to fill gaps, reaching consensus on local terms or phrases, and reconciling the information if recorders wrote very different things in response to a specific question. This can serve as the basis for preliminary data analysis.
- Make sure to identify a secure means of storing data.
- Follow through on plans to share findings with participants and the community.
- See the *Facilitator's Guide* for information on data analysis tips and what to pull from the findings. Analysis does not need to be formal or detailed.
    - In Module 1.5 "Understanding Resilience within the Health Systems Building Blocks" (Day 1), concepts of resilience are addressed. Questions 15 may be useful for this purpose.
    - Day 2 is further spent discussing SRH topics and the priorities of the MISP standard. Risks and barriers/challenges that prevent access to care will be helpful to identify in this regard. Questions 3-9 may be helpful for this purpose.
    - In Module 3.2 "Community Preparedness" (Day 3), participants explore social assets and human resources in the community that can address SRH and gender protection in emergencies. The *Table of SRH Service Provision by Type of Community Health Resource Person* can be pulled into the social assets and human resources table (Health Workforce section) in this Module.
    - Day 3 is dedicated to developing an action plan for SRH preparedness and gender protection. Findings around additional gaps and barriers, community resources and capacities, and inclusion of marginalized and underserved communities can serve useful for this process.

Capacity and Needs Assessment Tools to Build Community Resilience
Focus Group Discussion Guide for Community Health Resource Persons

Date:	**Location:** Community _____ State/province _____ County/district _____ Country _____
Focus group discussion facilitator:	
Notetaker (if applicable):	
Translation used for focus group: Yes /No	If yes, translation from _____ (language) to _____(language)
Number of Participants in this group (total): _____ ☐ Female _____ ☐ Male _____ ☐ Other _____	**Important note regarding specific status:*** *If the focus group will be implemented among a certain group of participants with similar characteristics (e.g., outreach workers who are all sex workers, etc.), participants can self-identify with the group. The facilitator should never probe disability status, sexual orientation, profession, and other factors that could lead to discrimination.* *Be sure to revisit the* WHO guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies.
FGD participant characteristics: ☐Type of community health resource ☐ Community health worker (specify number) _____ ☐Traditional birth attendant (specify number) _____ ☐ Community outreach worker (specify number) _____ ☐ Adolescent peer educator (specify number) _____ ☐ Other outreach worker (specify type* and number) _____ ☐ Other (specify number) _____	

I verify that the introduction to this focus group was read to all participants, and that informed consent was obtained from all participants in a language which was understood by all.

_____

(Signature of facilitator)

QUESTIONS

First, I would like to ask about your role in the community.

1. What kind of work do you do in this community to help members with their health concerns?

2. What was the **last big emergency**, such as an outbreak of conflict or a natural disaster, where there was a major disruption to your daily activities?

   2.1 Was there any warning from any source that gave you information on what risks or hazards may be present during this emergency, and how to prepare for them? If yes, what did this look like? Who gave you information and how?

   2.2 What role did you play as community health resource persons in warning communities about possible risks and hazards during the emergency, and what communities can do to protect themselves?

   2.3 How did you provide and share information in such times? Were you prepared and supported to do this?

   2.4 Thinking back, what information do you wish you had that was not provided?

Please continue to refer to this emergency when we talk about the last emergency. We will be focusing on sexual and reproductive health issues in today's discussion. If you are unsure what is included in sexual and reproductive health; please do not worry. I will guide you through the discussion.

Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH)-related challenges and capacities

3. In the last emergency, **what role did you play for pregnant women and girls**?

   3.1 What challenges did pregnant women/adolescent girls face as they prepared for or delivered their babies?

   3.2 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

   3.3 What role did you play as community health resource persons in addressing these challenges?

   3.4 If a pregnant woman/adolescent girl faced a complication during pregnancy, what challenges did she face in accessing care? What if she was from an at-risk group?

   3.5 What role did you play as community health resource persons in addressing these challenges?

   3.6 In your specific role, can you directly provide:*
   a. Misoprostol to prevent bleeding after delivery
   b. Chlorohexidine to clean the umbilical cord

**If multiple health cadres are represented in your group, review the table in Annex I with participants per SRH category. If the group is only comprised of one cadre, proceed with the discussion as written.*

4. In the last emergency, what role did you play if **community members wished to prevent or postpone becoming pregnant** (*probe for awareness-raising sessions, community-based distribution, etc.*)?

   4.1 Where did community members go to access family planning/contraceptive services?

4.2 What challenges did community members face in accessing family planning/ contraceptive services?

4.3 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

4.4 What role did you play as community health resource persons in addressing these challenges?

4.5 In your specific role, can you directly provide:*
a. Male and female condoms
b. Oral contraceptive pills
c. Injectable contraceptives (Depo Provera)
d. Injectable contraceptives (Sayana Press)
e. Emergency contraceptives
f. What other methods, if any?

**If multiple health cadres are in your group, review the table in Annex I.*

5. In the last emergency, what role did you play if women/adolescent girls in this community were **pregnant but did not wish to be**?

5.1 What challenges did women/adolescent girls face if they wanted to seek services so that they did not remain pregnant?

5.2 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

5.3 What role did you play as community health resource persons in addressing these challenges?

5.4 What role did you play to inform community members of the benefits of seeking care and where to access services after a spontaneous or induced miscarriage?

5.5 If a pregnant woman needed a referral, what role did you play, and how did you follow-up on the care they received?

5.6 In your specific role, can you directly provide:*
a. Mifepristone
b. Misoprostol

**If multiple health cadres are in your group, continue adding to the table.*

6. In the last emergency, what role did you play to **prevent the spread of HIV or other sexually transmitted infections**?

6.1 What challenges did the community face in accessing free condoms?

6.2 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

6.3 What role did you play as community health resource persons in addressing these challenges?

6.4 What challenges did pregnant mothers face to access services to prevent mother-to-child transmission of HIV? How about those from at-risk groups?

6.5 What role did you play as community health resource persons in addressing these challenges?

6.6 In your specific role, can you directly provide:*
a. Co-trimoxazole to prevent infections for persons already diagnosed with HIV.
b. Post-exposure prophylaxis (PEP) to prevent HIV.

**If multiple health cadres are in your group, continue adding to the table.*

7. In the last emergency, what role did you play to **help persons living with HIV access or continue accessing treatment** (*probe for outreach via cell phone, etc.*)?

7.1 What challenges did the community face in accessing anti-retroviral treatment?

7.2 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

7.3 What role did you play as community health resource persons in addressing these challenges?

8. In the last emergency, what role did you play to **protect community members from violence, including sexual violence**?

8.1 What role did you play to **inform community members of the benefits of seeking care and where to access services after sexual violence** (*probe for awareness-raising sessions, outreach via text-messaging, etc.*)?

8.2 What issues or challenges did survivors face in accessing care after sexual violence?

8.3 *Probe if any populations, such as unmarried women and girls, adolescents, LGBTI persons, persons with disabilities, or other marginalized groups faced additional challenges, and what those challenges were.*

8.4 What role did you play as community health resource persons in addressing these challenges?

8.5 In your specific role, can you directly provide:*

a. Emergency contraception to prevent pregnancy.
b. Pregnancy test to confirm pregnancy.
c. Post-exposure prophylaxis to prevent HIV (including PEP initiation).
d. Antibiotics to prevent and treat sexually transmitted infections.
e. Tetanus toxoid/Tetanus immunoglobulin to prevent tetanus/lock jaw.
f. Hepatitis B vaccine to prevent liver disease.
g. Basic wound care for injuries.

**If multiple health cadres are in your group, continue adding to the table.*

9. In the last emergency, did you take part in distributing any **sexual and reproductive health supplies** to women or girls in the community? These would include supplies for women to manage their menstruation, delivery kits for pregnant women, newborn kits for newly born babies, and hygiene kits.

9.1 What supplies did you distribute?

9.2 What did the community think about these distributions?

9.3 Were there any challenges to note with regards to distribution?

9.4 If an emergency were to occur again, what would you like to see improved or done differently in terms of these distributions?

Accessibility and Quality

10. Overall, how was **access to sexual and reproductive health services affected** during the last emergency? By sexual and reproductive health, we mean all of the issues we have discussed, including pregnancy, family planning, STIs and HIV/AIDS, and violence.

10.1 Did adolescents have **the same level of access** as adults? Why or why not?

10.2 Did unmarried adolescents have the same level of access as married adolescents? Why or why not?

10.3 How about unmarried adult women or widows? Why or why not?

10.4 How about persons with disabilities? Why or why not?

10.5 How about persons who have a different gender identity or expression, or sexual orientation (LGBTQIA persons)? Why or why not?

10.6 Were there other groups of people in the community who had a hard time accessing services, and if so, in what way (*Probe for persons who engage in sex work, persons from minority groups, adolescents, etc.*)?

10.7 **What norms or perceptions** in the community may have been perpetuating violence, vulnerability, or inequality in your community?

10.8 What role did you play, if any, to help these groups access the information and services they needed?

11. How was **quality of sexual and reproductive health services affected** during the last emergency?

11.1 *Probe for availability of supplies, provider turnover, provider skills, and damages to health facilities/infrastructure that may have affected service provision.*

11.2 From your perspective, what services suffered the most loss in quality? Why?

Capacity

12. From your experience, how would you evaluate your **capacity to provide SRH services** in emergencies?

12.1 Are there areas you feel you need additional training?

12.2 How do you feel about the level of supervision (*probe for who supervises*)?

12.3 What would you need for you to do your work better?

13. From your knowledge, have women/adolescents or women's groups/youth groups been **involved in designing or delivering services** in this community? If yes, how and to what extent?

13.1 What other groups have been involved in designing or delivering services in the community? (*Probe around groups of marginalized people, including persons with disabilities, LGBTI persons, persons engaged in sex work, and persons living with HIV/AIDs.*) How, and to what extent?

13.2 How often do the district staff reach out to you to hear your concerns or suggestions?

13.3 Overall, how receptive is the district to your feedback?

14. Overall, **how do you think services for women, adolescent girls, and other persons at-risk in the community can be improved** in the next emergency?

14.1 In what additional ways would you like to help women and girls or other persons at-risk in this community in an emergency?

14.2 What would you need for you to be able to do this?

Resilience

15. Lastly, **what do you envision your community would look like** when it can recover better from a sudden disaster or another outbreak of violence? For example, what services would need to be in place?

15.1 Do you have any other suggestions or recommendations?

I thank you for your time. You have all helped to provide a good understanding of your experiences in the past, and how we can better prepare for future emergencies. Your contributions are greatly appreciated, and we will share your perspectives with those with the means to design policies and programs. If you have any concerns, or think of additional information that you would like to share, you can contact us in this manner through the following contacts.

We plan to give you an update of what has become of your suggestions and recommendations, in xx time.

(Provide each participant with information about local contacts for complaints, concerns, or follow up.)

Annex I

TABLE OF SRH SERVICE PROVISION BY TYPE OF COMMUNITY HEALTH RESOURCE PERSON

Please add columns for the different levels of community health resource persons in the community, who are represented in the focus group. Note "Yes" if the cadre can provide the service/commodity, and "No" if policy or other restrictions exist around their provision by the particular cadre.

SRH services provided by cadres		**Cadre**		
SRH	**Service**	**CHW**	**TBA**	
Pregnancy Care	*Misoprostol to prevent bleeding after delivery*	*e.g. Yes*	*e.g. Yes*	*e.g. No*
	Chlorohexidine to clean the umbilical cord			
Contraception	*Male and female condoms*			
	Oral contraceptive pills			
	Injectable contraceptives (Depo Provera)			
	Injectable contraceptives (Sayana Press)			
	Emergency contraception			
Abortion care	*Mifepristone*			
	Misoprostol			
HIV/STI care	*Co-trimoxazole to prevent infections for persons already diagnosed with HIV*			
	Post-exposure prophylaxis (PEP) to prevent HIV			
Care for survivors of sexual violence	*Emergency contraception to prevent pregnancy*			
	Pregnancy test to confirm pregnancy			
	Post-exposure prophylaxis to prevent HIV (including PEP initiation)			
	Antibiotics to prevent and treat sexually transmitted infections			
	Tetanus toxoid/Tetanus immunoglobulin to prevent tetanus/lock jaw			
	Hepatitis B vaccine to prevent liver disease			
	Basic wound care for injuries			

Group 4: Community Member

Capacity and Needs Assessment Tool to Build Community Resilience **Focus Group Discussion Guide for Community Members**

Focus Group Discussions[15]

This tool should be used during small group discussions with 4 to 10 members of the community to discuss concerns and health needs for women, adolescent girls, and others at-risk in the community to improve access to services and better prepare for emergencies. The discussion should not last more than 2-2.5 hours.

The focus is to solicit feedback around sexual and reproductive health (SRH) risks, vulnerabilities, protective strategies, coping capacities, and resources in the community that can be used to inform and shape the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training. Other critical areas to explore are gender and norms that perpetuate violence, vulnerability, and inequality, as well as definitions of resilience and "building back better". "Building back better" aims to ensure that recovery efforts after a crisis build resilience and reduce a community's vulnerability to future emergencies.

Some of these questions are sensitive. You should take all potential ethical concerns into consideration before the discussion, considering the safety of the location and of respondents.

Please review the Women's Refugee Commission's Ethical Guidelines for Working with Displaced Populations to implementing focus group discussions for details on how to organize and implement activities.[16] Also refer to the *Facilitator's Guide* for more information on selecting participants, conducting the interview, data analysis tips, and what to pull from the findings.

[15] Adapted from FGD guides used in the MISP assessments and in-depth studies from the IAWG on RH in Crises 2012-2014 Global Evaluation of Reproductive Health in Humanitarian Settings.

[16] Women's Refugee Commission. Ethical Guidelines for Working with Displaced Populations, Mary 2016. Other resources include: Reproductive Health Response in Crises Consortium, "Focus Group Discussion Protocol," RHRC Consortium Monitoring and Evaluation Toolkit, 2004. Another good resource is: Morgan, David L. Focus Groups as Qualitative Research. Sage Publications, Thousand Oaks, CA. 1997.

Participant Recruitment

- Each group should be convened based on similar characteristics of participants, so that participants can feel comfortable sharing similar experiences. Participants should be grouped by age (15-19 years; 20-40 years; or >41 years), membership in a societal group (persons with disabilities, LGBTQIA persons, persons engaged in sex work, persons from minority groups, or other), or marital status (unmarried, married). Groups should be convened in a manner that minimizes discrimination against certain participants.
- For persons with disabilities, their disability can be self-identified; it is unnecessary to "prove" a reported disability. Persons with disabilities can include those in the community who have trouble:
  - seeing, even if wearing glasses; or
  - hearing, even if using a hearing aid; or
  - walking or climbing steps; or
  - remembering or concentrating; or
  - caring for her or himself, such as washing all over or dressing; or
  - understanding or being understood in their usual language.
- Before mobilizing participants, meet with community leaders and/or local government representatives to explain the purpose of the exercise and the presence of the team in the community.
- Where possible, link with a range of local women's leaders – formal and informal – and representatives from community networks of at-risk groups during participant recruitment. Community-based organization leaders may be involved in one group, but should not be present in other groups to ensure that participants feel free to speak openly.
- Obtain parental consent for adolescents if needed (script provided).
- For anyone whose capacity to provide informed consent is questionable, review the interactive questions (script provided) to gauge their level of understanding.

SCRIPT FOR PARTICIPANT RECRUITMENT

Hello, we are from the ACCESS Project. We would like to talk to you about a group discussion we are holding. We are asking you to join the discussion because a program staff from [collaborating agency] or a community member gave us your name.

If you agree to join this activity, you will be asked to join a group with around 4 to 10 other people. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community, to improve access to services and better prepare for emergencies.

The activity will take about 2-2.5 hours in total. You will only need to participate this one time. We will be taking notes during the activity, but we will not record your name anywhere. The information we collect will be kept private.

You may feel there are some questions you do not wish to answer. That is okay. You do not have to answer all of the questions and you may leave at any time.

You will not receive any direct benefits from joining this group activity. However, we may learn something that may help improve your ability to serve your community.

You do not have to join this activity. It is up to you. You can say okay now, and you can change your mind later. All you have to do is tell us. No one will be mad at you if you change your mind.

Before you say yes to joining this activity, we will answer whatever questions you have.

If the person has a mild intellectual impairment or you are concerned about their level of understanding, go through the steps below.[17] Otherwise, skip to the next section.

I would also like to make sure I have explained everything properly by asking you a few questions:

1. ***What will we be talking about in the group activity?**
2. **How long will the group activity be?**
3. **Can you think of a reason why you might not want to join the group activity?**
4. ***If you do not want to answer any of the questions, what can you do?**

Questions 1 and 4 must be answered correctly.

For persons with mild intellectual impairments: *If the person does not answer questions 1 and 4 correctly, but still says "yes" to participate, obtain caregiver/family member permission.*

Since you have said yes, we would like to ask permission from your caregiver or family member for you to participate.

If under age of majority and not emancipated from parents:
If you have said yes, because you are under x age (*age of majority in local context*), we would like to ask permission from your parent or guardian for you to participate.

PARENT/GUARDIAN PERMISSION

Hello, we are from the ACCESS Project and we would like to talk to your child about her/his/their experiences in this community. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community, to improve access to services and better prepare for emergencies. We are asking your child to help us in our work because she/he/they were identified by [collaborating agency]. Your child has already said yes, but you do not have to give permission. It is your choice.

If you say yes, we will ask your child to join a group activity with around 4 to 10 other people. The activity will take about 2-2.5 hours in total.

We will be taking notes during the discussion, but we will not record your name or your child's name anywhere. The information we collect will be kept private.

You or your child will not receive any direct benefits from participating in this activity. We will use the answers to reach out to policy makers, program managers, and health staff to improve the community's access to and quality of health services and help prepare for an emergency.

We will not pay you or your child to help us. We can help pay you back for any travel costs that your child might have for participating in this group activity.

Do you have any questions? You may contact [local name and contact info] about your questions or problems with this work.

Can your child participate in the group activity?

___ Yes, parent/guardian gives permission for child to participate.

___ No, parent/guardian does not give permission for child to participate.

[17] From Tanabe M, Nagujjah Y, Rimal N, Bukania F, Krause S. Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda. Sex Disabil. 2015;33(4):411–427. doi:10.1007/s11195-015-9419-3.

Before the Focus Group Discussion

- Review the tool for appropriateness, especially if they have been translated. If time allows, it may be beneficial to pre-test the translated tool among persons similar to potential participants and translate responses back into English to determine the appropriateness of the translation, including questions and wording.
- Consider whether potential *Community-based Preparedness for Sexual and Reproductive Health and Gender* workshop participants may be involved as facilitators, notetakers, or interpreters. While this may add bias, it may help gain buy-in and commitment from community stakeholders to realize the action plan that will be developed, if they are move involved in processes from the beginning.
- If the discussion will be conducted in another language, decide whether to use translator facilitation or translated facilitation. Translator facilitation is when trained interpreter(s) facilitate the activity in the participants' language with no interrupted interpretation. Translated facilitation is when the interpreter interprets what the facilitator and participants say, at each interval. See the *Facilitator's Guide* for more information.
- Find a private location—such as a central office—that is convenient, comfortable, and accessible for all participants, including those with disabilities.
- Make sure you have identified a referral pathway for health/psychosocial/protection concerns that may be raised by participants.
- Identify appropriate local contacts for any complaints, concerns, or follow-up regarding the focus group and the prevention of sexual exploitation and abuse.
- Identify a means of sharing findings with participants and the community.
- For groups where persons with disabilities will be present, consult with them in advance to be able to provide any helpful accommodations. Often, the most requested accommodation is transport to/from the venue (physical or funding), sign interpretation if working with those that sign, or accessible restrooms for persons with certain mobility impairments.
- Plan on reimbursing participants for transport if they incurred costs, especially persons with disabilities and any personal assistants.
- If you do not feel that it is safe to have this discussion, or that it may cause risk for staff or participants, do not proceed. For example, if it is not possible to control any crowds that huddle, or if the security situation in the area is not safe, it may be better to find a safer space.

Supplies: Large sheet of paper and five different colored markers (black, blue, red, green, and yellow).

INTRODUCTORY SCRIPT

Thank you for coming today. My name is [facilitator's name] and with me are [notetaker's name] and [observer or other's name]. We are here in [location] with [collaborating agencies] as part of the ACCESS Project. We would like to understand concerns and health needs for women, adolescent girls, and others at-risk in the community to improve access to services and better prepare for emergencies.

If you still agree to participate today, we will ask you some questions about your experiences in the last emergency. We are going to ask you these questions as a group, which will give you a chance to comment on each other's thoughts. Each of you has important ideas that I would hope to hear for each question. Please try to help us along by making sure that your perspective is heard for each question.

The activity will take about 2-2.5 hours in total. You will only need to participate this one time. We will be taking notes during the discussion, but

we will not note your name anywhere. The information we collect will be kept private and will not be traced back to you. We will throw away our notes once we have analyzed the information.

Your participation is completely up to you. You may decide to participate or not. Although we will value your participation, you will not experience bad things for not participating. You may feel there are some questions you do not wish to answer. That is okay. You do not have to answer all of the questions and you may leave at any time.

There is also no right or wrong answer to the questions, so please do not worry if you are not sure about the answers. Since we are interested in learning about the experiences of women, girls, and other persons at-risk in the community in general, please try to think about and share experiences that are common to others, rather than your own personal experience. So that we can all feel comfortable sharing our thoughts, we ask that you keep each other's comments private, and that you do not to talk to people outside of this group about what was said here. This is very important.

We do not think any of the questions will be upsetting to you, but if you do become upset, we can help find someone for you to talk to or link you to services. If you share information that shows that you or someone else may be in danger, we will need to talk to someone who can help the situation. We will not be paying you or giving you anything to take part in this activity. There will be no direct benefit to you for taking part in today's activity.

Once we have gathered all of the information, we will share some key points with policy makers, program managers, and health staff to improve the community's access to and quality of health services and help prepare for an emergency, but again, no names will be shared.

Do you have any questions?

You can contact [local name and study contact information] about your questions or any problems.

If the group includes persons with mild intellectual impairments, or you are concerned about the comprehension level of some participants, go through the steps below.[18] Otherwise, skip to the next section.

I would like to make sure I have explained everything clearly by asking you a few questions:

1. *What will we be talking about in the group activity?

2. How long will the group activity be?

3. Can you think of a reason why you might not want to join the group activity?

4. *If you do not want to answer any of the questions, what can you do?

5. *When would I have to tell someone else what you have told me?

6. *Would you still like to take part in this activity?

Questions 1, 4 and 5 must be answered correctly. Question 6 must be answered "yes" by each person.

Would you like to take part in the group activity? Please raise your hand if you agree to participate. Please raise your hand if you do not wish to participate.

___ Yes, respondents consent to participate.

Let those that do not wish to participate leave the venue before beginning the group activity.

[18] From Tanabe M, Nagujjah Y, Rimal N, Bukania F, Krause S. Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda. Sex Disabil. 2015;33(4):411–427. doi:10.1007/s11195-015-9419-3.

Tips for Facilitation

- Make sure you and your co-facilitators, note-takers, and any interpreters are well trained in facilitating focus group discussions. All of you should be familiar with the ethics of facilitation and your respective roles.
- Wherever possible, limit the number of observers present during the discussion, particularly if the group is comprised of a smaller number of participants.
- Engaging a trained facilitator with a disability or someone with similar characteristics as the groups convened may offer opportunities for their professional growth and empowerment, as well as create a conducive environment for other participants with similar traits to openly share their thoughts.
- Ask open-ended, non-leading questions.
- Do not probe about sexual violence or abuse or try to identify victims or perpetrators of violence (i.e., one specific armed group).
- Maintain a neutral and encouraging environment.
- Give opportunities to encourage shy participants to speak, so that no one person dominates the discussion.
- Encourage the notetaker to focus on documenting key points and phrases if it is not possible to record the discussion verbatim. There is no need to audio-record the discussion.

After the Focus Group

- Make sure to debrief immediately following each focus group discussion with the notetaker(s) and interpreter—question-by-question—to see what information was recorded, adding data from memory to fill gaps, reaching consensus on local terms or phrases, and reconciling the information if recorders wrote different things to a specific question. This can serve as the basis for preliminary data analysis.
- Make sure to identify a secure means of storing data. The security mapping diagrams will be used during Module 3.2 of the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training.
- Follow through on plans to share findings with participants and the community.
- See the *Facilitator's Guide* for information on data analysis tips and what to pull from the findings. Analysis does not need to be formal or detailed.
    - » In Module 1.5 "Understanding Resilience within the Health Systems Building Blocks" (Day 1), concepts of resilience are addressed. Questions 16 may be useful for this purpose.
    - » Day 2 is further spent discussing SRH topics and the priorities of MISP standard. Risks and barriers/challenges that prevent access to care will be helpful to identify in this regard. Questions 3-10 may be helpful for this purpose.
    - » Day 3 is dedicated to developing an action plan for SRH preparedness and gender protection. Findings around additional gaps and barriers, community resources and capacities, and inclusion of marginalized and underserved communities can serve useful for this process.

Capacity and Needs Assessment Tools to Build Community Resilience
Focus Group Discussion Guide for Community Members

Date:	**Location:** Community _____ County/district _____ State/province _____ Country _____
Focus group discussion facilitator:	
Notetaker (if applicable):	
Translation used for focus group: Yes /No	If yes, translation from _____ (language) to _____(language)
Number of Participants in this group (total):	**Important note regarding age:** *Given the nature of these focus groups, it is recommended that adults (≥20 years) and adolescents (15-19 years) be separated during focus group discussions.*
FGD participant characteristics: ☐ Female (specify number) _____ ☐ 15-19 years (specify number) _____ ☐ 20-40 years (specify number) _____ ☐ Over 41 years (specify number) _____ ☐ Male (specify number) _____ ☐ 15-19 years (specify number) _____ ☐ 20-40 years (specify number) _____ ☐ Over 41 years (specify number) _____ ☐ Persons from at-risk groups (specify number) _____ ☐ PWD (specify number) _____ ☐ LGBTQIA (specify number) _____ ☐ Person engaged in sex work (specify number) _____ ☐ Person from minority group (specify number) _____ ☐ Other (specify number) _____ ☐ Marital status (specify number) _____ ☐ Unmarried (specify number) _____ ☐ Married (specify number) _____	**Important note regarding specific status:** *Participants can self-identify their disability status, sexual orientation, and membership in a particular group. Proof of membership is not required.* *Be sure to revisit the* WHO guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies.

I verify that the introduction to this focus group was read to all participants, and that informed consent was obtained from all participants in a language which was understood by all.

_____
(Signature of facilitator)

QUESTIONS

First, I would like to begin by asking what made you smile today (ice breaker).

Now, I would like to ask you some general questions about the situation for women and girls (replace with persons with disabilities, LGBTQIA persons, persons who engage in sex work, persons from your group, etc., as relevant**) in this community.**

General

1. What are the issues of **greatest concern** among (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) in this community?

Next, I would like to ask you some questions about health services for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) **now, and in the last emergency** (*outbreak of violence, natural disaster, or an event that participants can pinpoint*).

2. What was the **last big emergency**, such as an outbreak of conflict or a natural disaster, where there was a major disruption to your daily activities?
   - **2.1** Was there any warning from the government or another source that gave you information on what risks or hazards may be present, and how to prepare for them? If yes, what did this look like? How did you receive this information?
   - **2.2** Did these warning messages give you the information you needed to effectively act?
   - **2.3** Thinking back, what information do you wish you had that was not provided?

Please refer to this emergency when we talk about the last emergency.

SRH Concerns and Gaps per the MISP for SRH

3. Where do women/adolescent girls seek **health care when they are pregnant**? How about when they are giving birth? How about after they give birth?
   - **3.1** In the last emergency, what challenges did pregnant women/adolescent girls face as they prepared for or delivered their babies?
   - **3.2** Were these challenges different for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? If so, how?
   - **3.3** How were the challenges overcome?
4. If a woman is having **problems with her pregnancy or the delivery** of her child, what will she do? Where will she go?
   - **4.1** In the last emergency, if a pregnant woman/adolescent girl faced a complication during pregnancy or delivery, what challenges did she face in accessing care?
   - **4.2** Were these challenges different for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? If so, how?
   - **4.3** How were the challenges overcome?
5. What do women and men do to **prevent or postpone having babies**?
   - **5.1** Where would they find trusted sources of information about contraception and family planning?
   - **5.2** In the last emergency, what challenges did women/adolescent girls face in accessing contraceptives and family planning services?

5.3 Were these challenges different for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? If so, how?

5.4 What would you like to see improved around access to contraceptives and family planning services when an emergency occurs?

5.5 Are there any improvements that would be especially important for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)?

6. What do women/adolescent girls in this community do when they think or know they are **pregnant but do not want to be**?

6.1 Were there additional difficulties that (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) faced when they know they are pregnant and do not want to be in the last emergency?

6.2 How were the challenges overcome?

7. What do women/adolescent girls in this community do after they have a **miscarriage**?

7.1 Were there additional difficulties that (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) faced around accessing care after a miscarriage in the last emergency?

7.2 How were the challenges overcome?

8. Are there places in this community where **free male and female condoms** can be easily found?

8.1 How have community members learned about where these condoms can be found?

8.2 What barriers do (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) face in accessing them?

8.3 What additional barriers did (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) face in accessing condoms in the last emergency?

8.4 How were the barriers overcome?

Now, we are going to work on a group activity. Can we draw what this community looks like on this paper?

Pass out a large piece of paper and markers. The facilitator should allow participants to work by themselves to draw their own communities for approximately 10-15 minutes. If a group is having a hard time getting started, the facilitator can step in, and help the group identify what they consider to be the "center" of their community. They can then identify the "edges of their community". The facilitator can guide the activity, by suggesting that they draw the parts of their community between the center and the boundary.

Guide participants to add homes and residential areas, schools and places of learning, places of worship, places where people socialize, and places people go to collect water, food, and other social services.

9. Where on this map are the places that are currently **safe** for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? Can you circle those in blue?

9.1 Were those places safe for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) during the last emergency? What about after the emergency?

9.2 Where on this map are the places that are currently **unsafe** for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? Can you circle those in red?

9.3 In the last emergency, were there other locations that were not safe for (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)? Can you circle those in yellow?

9.4 What measures are currently in place to **protect** (*women/girls with disabilities, LGBTQIA, women/girls who engage in sex work, women/girls from your group, etc.*) from violence in this community?

10. When a woman or girl is a **victim of violence**, what would she do?

10.1 What options or services are currently available to her in this community? Can you circle the services in green on the map?

10.2 How is **information about available services shared** with the community?

10.3 What reasons might (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) not use these services?

10.4 What issues or challenges did (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*) face in accessing these services in the last emergency?

10.5 How were the challenges overcome?

11. In the last emergency, were any **sexual and reproductive health supplies distributed** to women or girls in the community? These would include menstruation supplies, delivery kits, and hygiene kits. Who distributed these supplies?

11.1 What did the community think about these distributions?

11.2 If an emergency were to occur again, what would you like to see improved or done differently in terms of these distributions?

Accessibility and Quality

12. Was **access to sexual and reproductive health services affected** during the last emergency? How?

12.1 Did adolescents have **the same level of access** as adults?

12.2 Did unmarried adolescents have the same level of access as married adolescents?

12.3 How about unmarried adult women or widows?

12.4 How about (*women/girls with disabilities, LGBTQIA women/girls, women/girls who engage in sex work, women/girls from your group, etc.*)?

12.5 Were there other groups of people who had a hard time accessing services, and if so, in what way?

13. Was the **quality of sexual and reproductive health services affected** during the last emergency? How?
    - 13.1 What services suffered the most loss in quality?

Capacity

14. What **resources and capacities currently exist** within the community for the community to respond to a crisis?
15. From your knowledge, to what extent have women/adolescents or women's groups/youth groups been **involved in designing or delivering services** in this community?
    - 15.1 What other groups have been involved in designing or delivering services in the community?
    - 15.2 How often do the district staff reach out to the community for community members to voice their concerns or make suggestions?
    - 15.3 Overall, how receptive is the district to feedback from different members of the community?
16. Overall, **how do you think services for women and adolescent girls and other persons in the community can be improved** in the next emergency?
    - 16.1 If you could help women and girls or other persons in this community in an emergency, in what ways would you like to help?
    - 16.2 What would you need for you to be able to do this?

Resilience

17. Lastly **what do you envision your community would look like** when it can recover better from a sudden disaster or another outbreak of violence? For example, what services or resources would need to be in place?
    - 17.1 Do you have any other suggestions or recommendations?

I thank you for your time. You have all helped to provide a good understanding of your experiences in the past, and how we can better prepare for future emergencies. Your contributions are greatly appreciated, and we will share your perspectives with those with the means to design policies and programs. If you have any concerns, or think of additional information that you would like to share, you can contact us in this manner through the following contacts.

(Provide each participant with information about local contacts for complaints, concerns, or follow up.)

Group 4: Community Member

Capacity and Needs Assessment Tool to Build Community Resilience
Interview Guide for Community Representatives

This tool should be used in interviews with community leaders, civil society representatives, and first responders.

The focus is to solicit feedback around sexual and reproductive health (SRH) risks, vulnerabilities, protective strategies, coping capacities, and resources in the community that can be used to inform and shape the *Community-based Preparedness for Sexual and Reproductive Health and Gender* training. Other critical areas to explore are gender and norms that perpetuate violence, vulnerability, and inequality, as well as definitions of resilience and "building back better". "Building back better" aims to ensure that recovery efforts after a crisis build resilience and reduce a community's vulnerability to future emergencies.

In Module 1.5 "Understanding Resilience within the Health Systems Building Blocks" (Day 1), concepts of resilience are addressed. Questions 4-5 and 13 may be useful for this purpose.

Day 2 is further spent discussing SRH topics and the priorities of the Minimum Initial Service Package (MISP) standard. Risks and barriers/challenges that prevent access to care will be helpful to identify in this regard. Questions 2-3 and 10 may be helpful for this purpose.

Day 3 is dedicated to developing an action plan for SRH preparedness and gender protection. Findings around additional gaps and barriers, community resources and capacities, and inclusion of marginalized and underserved communities can serve useful for this process.

Please refer to the *Facilitator's Guide* for more information on selecting participants, conducting the interview, data analysis tips, and what to pull from the findings.

Group 4: Community Member

Date:	**Location:** Community _____
Facilitator(s):	County/district _____
Interviewee sex (if relevant) ☐ Female ☐ Male ☐ Other	State/province _____ Country _____
Interviewee characteristics ☐ Adolescent ☐ Person with a disability ☐ Other (please specify) _____	**Interviewee occupation** ☐ Community leader (specify) _____ ☐ Representative of community organization (specify) _____ ☐ Social service provider (specify) _____ ☐Teacher (specify) _____ ☐ First responder (specify) _____ ☐ Other (specify) _____
Translation used: Yes No	If yes, translation from _____ (language) to _____(language)
Begin time:	**End time:**

I verify that informed consent was obtained.

_____
(Signature of facilitator)

Hello and thank you for making yourself available for this interview. My name is _____ and I am from the ACCESS project. I am interested in examining this community's capacity and resilience, to identify priorities for preparedness and "building back better," especially for health and protection. "Building back better" aims to ensure that recovery efforts in the aftermath of a crisis build resilience and reduce a community's vulnerability to future emergencies. You were identified for this interview since you are you represent a community-based organization/network that is integral to serving the community in times of crisis.

The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way, with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. None of the questions should be upsetting to you, but you are welcome to stop this interview at any time.

This discussion will last roughly 1-1.5 hours. I would like to take notes of what you say, if that is alright with you.

Thank you again for your time. If you have any questions after the end of our discussion, please contact _____.

INTRODUCTION

1. What is your role in helping the community prepare for and respond to emergencies, such as a sudden natural disaster or an outbreak of violence?
   - 1.1 *If representative of a community-based organization:* What does your organization do in the community to prepare for and respond to emergencies?
   - 1.2 What role does your organization play in in warning communities about possible risks and hazards during the emergency, and what communities can do to protect themselves?

RISKS AND VULNERABILITIES

2. **Who**, within your community, may be most at-risk or vulnerable when a crisis occurs?
   - 2.1 *Probe for persons with disabilities, elderly, LGBTQIA, persons who engage in sex work, persons from minority groups, adolescents, etc.*
   - 2.2 **How** are such persons more vulnerable?
3. **What norms or perceptions** in the community may be perpetuating violence, vulnerability, or inequality in your community?

RESILIENCE

4. What does **"resilience"** mean to you?
5. What does a **"resilient community"** mean to you? When would you say resilience has been achieved in this community?
   - 5.1 Would resilience look different for different at-risk groups in this community, and if so, how?

INDIVIDUAL AND COMMUNITY RESOURCES AND CAPACITIES

6. **What resources and capacities** would you say you have to respond to a crisis based on your occupation and role in this community?
   - 6.1 How about in health specifically, especially sexual and reproductive health? (*If the respondent is unsure of what comprises SRH, briefly review the scope of SRH in the MISP.*)
   - 6.2 How about in protecting people in this community, including those at-risk?
   - 6.3 What training(s) have you had, if any, to build your current capacity in health and/or in protecting people (*emergency response, etc.*)?

7. **What resources and capacities currently exist within the community** for the community to respond to a crisis?
   - 7.1 *Probe for community networks for PWDs, women, and minorities, as well as community leaders, social networks, sports, religious groups, etc.*

8. What are the **main challenges that you have experienced when responding to the community's sexual and reproductive health needs in the last emergency**?
   - 8.1 What services were disrupted, and how did that affect the community?
   - 8.2 What attempts were made to continue providing services?
   - 8.3 How could the community have better prepared for these challenges before the emergency?

9. What do you think **needs to be strengthened or improved** for the community to be able to adequately respond to a crisis?
   - 9.1 How about to address sexual and reproductive health needs?

10. What **barriers** might prevent efforts to strengthen or improve capacity to adequately respond to the community's sexual and reproductive health needs in a crisis?
    - 10.1 *Probe for institutional support; time; and financial, logistic (equipment and supplies/commodities) or policy barriers, especially to providing maternal and newborn care, family planning, care for sexually transmitted infections/HIV/AIDs, and comprehensive abortion care; etc.*

11. What are ways you think the barriers can be addressed?
    - 11.1 *Probe for financial support, national/regional political support, coordination, technical support, logistics (equipment, supplies/commodities) technology, etc.*

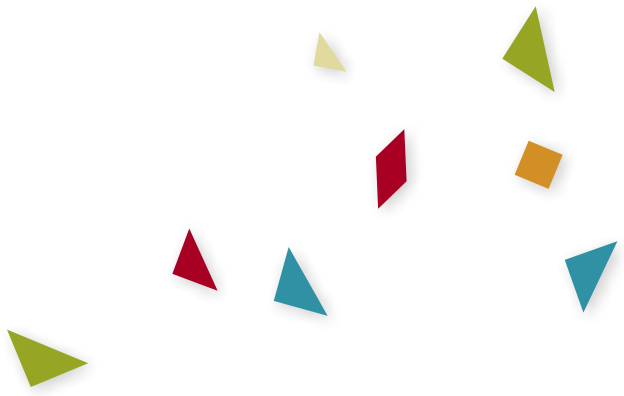
12. Given the risks and vulnerabilities that we discussed, and your role in this community, how would you go about **addressing the inclusion of at-risk and vulnerable groups** to build this community's capacity and resilience?

13. What are the **priorities for preparedness** and "building back better" for you in your role in the community?

Thank you for your excellent work. We applaud all that you do.

Abbreviations

ACCESS Consortium	Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights Consortium
ANC	Antenatal care
CBDRM	Community-based disaster risk management
DRR	Disaster risk reduction
EC	Emergency contraception
EmOC	Emergency obstetric care
GBV	Gender-based violence
HEDRM	Health Emergency and Disaster Risk Management
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSV2	Herpes simplex virus 2
IASC	Inter-agency Standing Committee
IAWG on RH in Crises	Inter-Agency Working Group on Reproductive Health in Crises
IEC	Information, Education, and Communication (materials)
IUD	Intrauterine device
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package for Sexual and Reproductive Health
NGO	Nongovernmental organization
PEP	Post-exposure prophylaxis
PID	Pelvic inflammatory disease
RH	Reproductive health
SAC	Safe abortion care
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWG	Sub-working group
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees (UN Refugee Agency)
UNISDR	United Nations International Strategy for Disaster Reduction
VAW	Violence against women
WHO	World Health Organization
WRA	Women of reproductive age
WRC	Women's Refugee Commission



WOMEN'S REFUGEE COMMISSION
RESEARCH. RETHINK. RESOLVE.

Women's Refugee Commission
15 West 37th Street, 9th Floor
New York, NY 10018

(212) 551 3115

info@wrcommission.org
womens**refugee**commission.org

ACCESS
CONSORTIUM