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<th>Description</th>
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<tr>
<td>AECI</td>
<td>Spanish Agency for International Cooperation</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>APCRSHR</td>
<td>Asia Pacific Conference on Reproductive and Sexual Health and Rights</td>
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<td>ARHA</td>
<td>Australian Reproductive Health Alliance</td>
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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere</td>
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<tr>
<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<tr>
<td>CDC</td>
<td>US Centers for Disease Control and Prevention</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DRR</td>
<td>Disaster risk reduction</td>
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<td>EmONC</td>
<td>Emergency obstetric and newborn care</td>
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<td>FPOP</td>
<td>Family Planning Organization of the Philippines</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<td>GHC</td>
<td>Global Health Cluster</td>
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<td>HAC</td>
<td>Health Action in Crises</td>
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<td>HEMS</td>
<td>Health Emergency Management Staff</td>
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<td>HeRAMS</td>
<td>Health Resources Availability Mapping System</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HRB</td>
<td>Humanitarian Response Branch</td>
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<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<td>IAWG</td>
<td>Interagency Working Group on Reproductive Health in Crises</td>
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<td>IBI</td>
<td>Indonesian Midwives Association</td>
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<td>IDP</td>
<td>Internally displaced person</td>
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<td>IPPA</td>
<td>Indonesian Planned Parenthood Association</td>
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<tr>
<td>IPPF-ESEAOR</td>
<td>International Planned Parenthood Federation – East and South East Asia &amp; Oceania Region</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>MISP</td>
<td>Minimum Initial Service Package (for Reproductive Health)</td>
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<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MVA</td>
<td>Manual vacuum aspiration</td>
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<tr>
<td>NDMO</td>
<td>National Disaster Management Office</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>PGPD</td>
<td>Parliamentary Group on Population and Development</td>
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<td>PHEMAP</td>
<td>Public Health and Emergency Management in Asia and the Pacific</td>
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<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
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<td>RAISE</td>
<td>Reproductive health Access, Information &amp; Services in Emergencies</td>
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<td>SGBV</td>
<td>Sexual and gender-based violence</td>
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<td>SPRINT</td>
<td>Sexual and Reproductive Health Programme in Crises and Post-Crises in East, South East Asia &amp; Pacific</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>SROP</td>
<td>Sub-Regional Office for the Pacific</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>ToT</td>
<td>Training of trainers</td>
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<td>TRANSFER</td>
<td>Training Partnership for Sexual and Reproductive Health in Crises</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNSW</td>
<td>University of New South Wales</td>
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<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WRC</td>
<td>Women’s Refugee Commission</td>
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Summary of Recommendations and Lessons Learned
from the First Annual SPRINT Review Meeting

Sexual and reproductive health (SRH) problems are the leading cause of women’s ill health and death world-wide, and SRH needs often increase during conflict or disaster. The Sexual and Reproductive Health Programme in Crises and Post-crisis in East, South East Asia & Pacific, also known as the SPRINT Initiative, was launched in 2007 with support from AusAID to address this through building the capacity of local humanitarian actors and health workers to implement the priority, life-saving services of the Minimum Initial Service Package (MISP) for SRH as well as support advocacy to integrate SRH into national emergency preparedness and response plans. SPRINT convened its first annual SPRINT Review Meeting in Beijing, China from 21 to 22 October, 2009. The objectives of the meeting were to:

1. Review the rollout of the SPRINT in-country echo trainings;
2. Identify good practices and cross-cutting challenges in implementation of the MISP;
3. Share experiences and lessons learned in advocating to integrate the MISP into national emergency response plans; and
4. Brainstorm next steps to scale up awareness and implementation of the MISP where needed in the region.

The meeting brought together 44 participants representing 19 organizations from 14 countries, including many from outside of the region: Bangladesh, Myanmar, Nepal, Sri Lanka, Switzerland and USA. Participants included practitioners providing services in crisis-affected countries, representatives from four governments, five international NGOs, three UN agencies, three local NGOs and two academic institutions. The participants identified the following key recommendations and good practices.

Echo Trainings
Lessons learned
- It is important to allow sufficient time for the planning and preparation of the echo trainings (at minimum of two months).
- Making funding available at the onset of planning assists efficient implementation.
- Adherence to the agenda is good practice for the training ensuring that all aspects of the content are covered.
- If possible, and appropriate, the Ministry of Health (MoH) should be engaged to facilitate training.
- Three days for the in-country training is often not sufficient to cover all of the content and to produce trainees skilled in facilitating implementation of the MISP; however, it can also be difficult for participants to commit to a longer period of time.
- For the training to be effective, it is essential that participants are appropriately qualified and positioned, as well as have completed the MISP Distance Learning Module prior to the training.
- The inter-agency country team approach should be maintained.
- An orientation to the MISP for advocates and policy makers and further training for implementers is effective in advancing the MISP.

Recommendations
Country level:
- Monitoring and evaluation (M&E) is needed to ensure the quality and effectiveness of the echo trainings and subsequent multiplier trainings.
The length and focus of the training should be flexible taking into account the specific context and the participants’ background, professional level and experience with the MISP.

- Key documents should be translated into local language(s).
- Specialists can be invited to assist in facilitating challenging subjects in the training (e.g., the module on sexual and gender-based violence).
- Care should be taken to select appropriate participants.
- The training should include an opportunity for participants to address potential inconsistencies between international standards and national policies.
- The echo training should be rolled out on multiples levels (national and sub-national).
- A mechanism to follow up with and keep track of trainees should be established.
- The country team should meet with the MoH and the national disaster management/planning agency before training to support understanding and buy-in.
- A funding source for provincial roll out of training or action plans should be secured.

**Secretariat level:**

- Document and share lessons learned on echo training with SPRINT country teams throughout the region.
- Gender issues should be addressed and men and boys should be included where appropriate in the training content.
- The ToT should remain five days in length and the in-country training should be adapted to the national context of each setting, in terms of content, structure, and length. The SPRINT Secretariat should provide suggestions and examples on how to do this.
- The training structure needs to be adapted for less technical participants. A section focused specifically on advocacy and coordination has been suggested. However, actors from different sectors should continue to be trained together to establish relationships and improve advocacy efforts post-training.
- The MISP should be a greater focus of the training as it can be lost amongst the comprehensive components included in the current structure.
- The training should continue to be updated with new technical and coordination related information to assure adherence to international standards.
- Refresher trainings should be considered for those already trained as well as training new participants.
- Develop a standard advocacy package to address awareness-raising on the MISP.
- Pull together the advocacy messages in the training and empower trainees to utilise them.
- IAWG should develop a training module on advocacy for the MISP.

**MISP Implementation**

**Lessons learned**

- Increased understanding and capacity of emergency responders is needed to improve implementation of the MISP.
- A strong coordination mechanism is essential to ensure SRH is addressed in a crisis.
- A strong SRH working group, integrated into the Health Cluster/Sector, improves the effectiveness of Health Cluster/Sector.
- Rapid assessments can be localized by engaging local partners and leaders.
- High doses of existing oral contraceptive pills can be used if a dedicated emergency contraceptive product is not available in country.
Developing a long term agreement with a local agency can ensure the availability of hygiene supplies and minimize the risk of running out of stock.
Integration of MISP into national disaster plans provides a strong platform for advocacy.
Identifying implementing partners with the technical capacity to provide services prior to a crisis benefits emergency preparedness.
One agency is not responsible for implementing the MISP – link with partners to ensure all services are available.
Newly developed Health Cluster tools, such as the IASC Health Cluster Guide and HeRAMS, can be utilised to advocate within the health and other clusters/sectors.
Maternal and neonatal health can be used as an entry point for SRH response.
Broader coalitions can be utilized to address specific issues concerning the MISP.
Communities should be informed about where and why to receive care. Engaging local organisations with existing connections in the community can be effective to promote SRH.

**Recommendations**

**Preparedness phase:**
- Disaster Risk Reduction (DRR) strategies should be linked with SRH programming to advance implementation of the MISP.
- National protocols and laws that hinder MISP implementation should be identified and addressed, during the preparedness phase where possible.
- Smaller RH kits for less populated settings should be considered in the Interagency RH Kits revision process.

**Coordination:**
- SRH issues and challenges should be brought to the attention of the Health Cluster/Sector to conduct inter-agency advocacy.
- If an SRH lead agency is not identified with the Health Cluster/Sector at country level from the onset of an emergency, advocacy to the Health Cluster/Sector should be undertaken.
- UNFPA suggested the need for a meeting between UN agencies to orient them to UNFPA’s role in humanitarian crisis.
- Partners should submit information on SRH and gender activities to the Health Cluster coordinator for inclusion in cluster situation reports.
- The Health Cluster coordinator should be aware of the life-saving importance of SRH in crises and support its inclusion in the health response.
- Programming should be adapted to non-traditional displaced settings, such as urban displacement, to address the dispersed nature of the affected population.
- Although distribution of hygiene kits is important and a key activity for prevention of gender-based violence, it is not part of the MISP. It is important to prioritize the activities of the MISP at the onset of an emergency. Hygiene kit distribution is often through the Non Food Item cluster/sector and health actors can advocate to ensure the distribution of these supplies. If health actors choose to distribute hygiene kits, they can be distributed at the same time as MISP implementation, as long as distribution does not detract from the priority activities of the MISP.
- If an agency is not able to provide an SRH service directly, a strong referral system should be established so the client can be referred to a facility and receive appropriate care.
- Health workers affected by a crisis should be referred to psychosocial support.
- The MoH should undertake advocacy if service providers are unaware or do not enforce a positive SRH related law or policy.
- Religious leaders should be engaged to gain support for the MISP and increase awareness.
- Advocacy to other humanitarian agencies providing health services should be undertaken to increase understanding of the importance and prioritisation of the MISP in emergency response.
- Higher level policy makers should be engaged to facilitate procurement and movement of commodities to ensure that psychosocial and other SRH needs in crises are addressed.
- Youth, volunteers and members of the affected population should be engaged to support MISP implementation.
- Community health care workers from unaffected areas can be deployed to relieve the personnel from the crisis-affected area.
- The logistics cluster should be engaged to overcome difficulties in accessing affected areas.

**Sexual violence prevention and management:**
- Health actors or SRH officers should improve collaboration with the protection cluster and the gender-based violence working group (or sub-cluster) and draw on their expertise on how to adequately address sexual violence.
- Male involvement and sensitization of service providers should be undertaken to prevent and respond to sexual violence.

**Planning for comprehensive SRH:**
- Local supply chains should be engaged as soon as possible to avoid delays in RH kit procurement and sustainable procurement mechanisms should be established.
- M&E should be prioritized and when possible carried out even during the acute phase of an emergency.
- The MISP can be utilised to increase national health service provision standards outside of the emergency phase.
- All elements of the MISP, including the prevention of sexual violence and care for survivors, must be fully implemented and sustained before introducing additional services or components of comprehensive SRH.

**Integrating SRH into National Emergency Preparedness and Response Plans**

**Lessons Learned**
- Outreach to parliamentarians can be very useful to advance SRH in crises. When meeting with policy-makers, provide a few moving, motivating and evidence-based facts; more detailed information can be provided separately.
- Inviting international experts to speak on the issues and ensuring they get media coverage can bring attention to SRH in crises.
- Engaging beneficiaries themselves to speak in front of policy-makers on their experiences can be a good way to influence them.
- MISP will take time to be fully integrated into the national disaster management plan.
- Champions should be identified, consistent messages developed and the use of acronyms minimised to ensure advocacy messages are accessible to a wider audience.
- Engaging a human rights approach or alternatively utilising the international standards that identify the MISP as part of emergency response (including the Sphere guidelines) can be very effective to support advocacy to integrate SRH into emergency plans.
- Outsourcing the integration of SRH into the national action plan to a school of public health in a national university can help move the process forward in a timely manner and provide the opportunity for input from academic experts.
**Recommendations**

- Engaging with (or establishing) the national Parliamentarian’s Group on Population and Development can help advance MISP advocacy.
- Policies and protocols related to the MISP should be identified and advocacy conducted to align them to facilitate operationalising the MISP.
- Parliamentarians that support SRH and/or humanitarian response should be engaged.
- Advocacy targets should be broadened, e.g. to the general public.
OPENING SESSION

Sun Paranjothy from the International Planned Parenthood Federation - East and South East Asia & Oceania Region (IPPF-ESEAOR) opened the meeting and welcomed the participants to the first annual SPRINT Review Meeting. She thanked AusAID for its generous support of the SPRINT Initiative, as well as the SPRINT partners, which include the Australian Reproductive Health Alliance (ARHA), the United Nations Population Fund (UNFPA) and the University of New South Wales (UNSW), for their contribution to SPRINT. She welcomed Senator Mark Furner from Australia as well as the representatives from the US Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).

Amanda Jennings from AusAID thanked everyone for their contribution to SPRINT and for participating in the meeting. She underscored AusAID’s strong support for the SPRINT Initiative.

Sarah Chynoweth from IPPF-ESEAOR welcomed the participants and outlined the meeting objectives.

Amy Watts from IPPF-ESEAOR greeted everyone and explained the contents of the participant packet.

SESSION 1: Overview of SPRINT Initiative

SPRINT Initiative – Progress & Impact
Sarah Chynoweth and Amy Watts from IPPF-ESEAOR provided an overview of the SPRINT Initiative, its objectives, activities and lessons learned. SPRINT was developed in 2007 to address gaps in sexual and reproductive health (SRH) response in crises. These gaps were identified by a number of different assessments, particularly the 2004 Interagency Working Group (IAWG) on Reproductive Health in Crises global survey which identified a dearth of qualified health workers, lack of awareness of international standards, limited funding and poor coordination among agencies. As such, SPRINT aims to increase access to SRH services and information to communities in humanitarian settings throughout the region through capacity building to coordinate and implement the Minimum Initial Service Package (MISP) for Reproductive Health, supporting SRH implementation in crises and protracted crisis settings, and advocacy to governments and organisations to integrate SRH into their national emergency preparedness and response plans. The AusAID funded Initiative is coordinated by IPPF-ESEAOR through a secretariat at its Regional Office in Kuala Lumpur in partnership with UNSW, ARHA and UNFPA Humanitarian Response Branch (HRB). The Initiative is based on developing strong partnerships and coordination among a variety of actors. SPRINT activities are carried out by IPPF member associations, Ministries of Health (MoH), international and local relief organizations as well as UN agencies. Key lessons learned over the 1.5 years of the project show that agencies should not wait for an emergency to address the MISP. Further, an effective response requires an interagency collaborative approach to promote ownership, commitment and accountability, build strong relationships, encourage understanding and linkages between humanitarian actors and SRH agencies, and build upon the existing knowledge and skills in each different setting.

SPRINT Going Global
N. Toan Tran presented on the global roll-out of SPRINT activities. To date a Training of Trainers (ToT) on the MISP has been held for the South Asia West Asia region, in-country MISP trainings have been held in Haiti and Chad, and seed funding from AusAID has been
secured to begin the roll-out of SPRINT Africa through UNFPA HRB and IPPF Africa Region. A SPRINT Secretariat is currently being established in Nairobi, Kenya (sprintafrica@ippfar.org) with at least two ToTs planned, one for East Africa in November 2009 and another for West Africa in February 2010, to be followed by a ToT for South Africa later in 2010. SPRINT will also be rolled out in the Middle East North Africa region. UNFPA and RAISE have provided funding for UNFPA Arab States Regional Office to lead the roll-out with a ToT on SRH Coordination planned for December 2009. Latin America is being explored as the next possible site for roll-out.

**Monitoring and evaluation of SPRINT Initiative**

Anna Whelan, Kristen Beek, Carina Hickling from UNSW and Amy Watts and Sarah Chynoweth from IPPF-ESEAOR discussed the monitoring and evaluation (M&E) mechanism of the SPRINT Initiative. In addition to regular M&E activities carried out by the Secretariat in collaboration with local partners, UNSW engaged four PhD students to undertake research of different components of the SPRINT Initiative to establish a regional body of evidence to inform policy and practice in relation to SRH in crisis and post-crisis situations.

Ms. Beek’s research explores the factors between work spaces and training spaces that moderate the effectiveness of SPRINT training in SRH for in crises. This study analyses whether moderating factors can be controlled to ensure training effectiveness when designing training programs for SRH in crises. This study will apply the framework of Participatory Action Research through a consultative cycle of research instrument design, data gathering, data analysis and results dissemination in collaboration with research participants, informants and fellow PhD students. Data will be gathered using the qualitative methods of interview, observation, and focus group discussions and through a series of quantitative surveys.

Ms. Hickling’s research explores what happens inside the key organizations participating in the SPRINT Initiative and how the SPRINT Initiative facilitates nongovernment organisational (NGO) change and development. This study analyses the impact of the capacity building aspect of SPRINT, investigating the targets and impetus of organisational development and organisational change. The aims of this study include to 1) analyse the impact of the SPRINT initiative in respect to institutionalising the MISP in selected participating organisations; 2) illuminate organisational development aspects taking place as a response to participating in the SPRINT; and 3) analyse the process of systemising SPRINT initiated change within the organisation. The research will be conducted as participatory research. Data will be collected through a combination of methods such as key informant interviews, individual and group interviews, document and policy analysis and opportunistic observations.

Ms. Watts’ research explores whether SRH interventions in a conflict setting can constitute an effective tool towards peace building. The study assesses the potential for SRH interventions to actively contribute to peace building in a conflict or post-conflict setting. It addresses the issue of integration into practical implementation as well as at the organizational level, and investigates if and how peace building can be effectively mainstreamed into program planning and implementation. This study primarily involves qualitative research, and evidence is sought through a comparative case study approach, involving two organisations implementing SRH projects under the SPRINT Initiative in Mindanao, Philippines and East Nusa Tenaggara, Indonesia. The Health and Peacebuilding Filter, developed by the UNSW, will be applied to both settings as a program planning and evaluation tool to facilitate the integration of peace building into the SRH interventions and will also be critically assessed as part of the study. The dynamics of any change processes at agency levels as well as the impact on the ground will be
documented. Specific methods will include semi-structured interviews; questionnaire; focus group discussions; and observational checklists. Research instruments will be refined per each assessment.

Ms. Chynoweth’s research explores the role of emergency preparedness in the implementation of priority SRH services in a humanitarian emergency. This study tries to identify the factors that support and hinder MISP implementation, specifically exploring the effectiveness of SPRINT’s emergency preparedness by evaluating the SRH response in a crisis by SPRINT trainees. The study uses a mixed-method approach focusing on action research. Data sources will include individual and focus group discussions with crisis-affected populations, semi-structured and unstructured interviews with SPRINT trainees and other health actors working in the crisis, data checklists of SRH services developed by the Inter-Agency Working Group on SRH in Crises, document analysis and review of existing policies. Assessments of SRH interventions by SPRINT trainees will be undertaken in Metro Manila (after the flooding in October 2009 from Typhoon Ketsana) and in Sumatra, Indonesia (after the earthquake in October 2009).

**Parliamentary Advocacy**

**Alice Ruxton** from ARHA presented on ARHA’s role within SPRINT and its related work. ARHA is a small yet influential advocacy organization that promotes public support for enhanced SRH in Australia and internationally, and promotes the advancement of the status of women and girls. ARHA is a key SPRINT partner that advocates to policy-makers at the highest government levels to increase attention, funding and policy support for SRH in humanitarian settings. It works to establish links between the SPRINT Initiative and parliamentarians, regional policy makers, donors and the general public. ARHA provides the secretariat to the Parliamentary Group on Population and Development, (PGPD), which works to engage Australian parliamentarians in supporting and promoting women’s human rights and empowerment in the Asia Pacific region, with particular emphasis on their SRH rights. ARHA and the PGPD hosted the official launch of the SPRINT Initiative at Parliament House in February 2008. The Parliamentary Secretary for International Development Assistance, the Honourable Bob McMullan, Member of Parliament (MP), who is also a member of the PGPD, officially launched the Initiative. In addition, two PGPD members attended part of the SPRINT ToT in Kuala Lumpur in 2008. Part of ARHA’s SPRINT parliamentary advocacy mandate is to conduct two study tours for parliamentarians to visit a crisis or post-crisis area where SPRINT is working. One will take place in the Philippines in early December 2009 and will look at the Family Planning Organization of the Philippines’ (FPOPs) work to implement the MISP after a series of typhoons affected millions of people across the country. The second study tour will take place in 2010 and the site has not yet been determined. As Australia is one of the largest aid donors in the Asia Pacific region, showing parliamentarians the reality of SRH in emergencies is essential for ensuring commitment to initiatives such as SPRINT.

**Questions and Discussion**

Mark Furner from the Australian Parliament asked whether SPRINT focused exclusively on women and girls or also included men. Sarah Chynoweth from IPPF-ESEAOR responded that SPRINT does include men in its trainings, advocacy and implementation. Imtiazul Islam from CARE Bangladesh asked whether SPRINT is addressing issues of sexuality, gender and masculinity within the context of social change. Ms. Chynoweth responded that SPRINT is exploring issues of social change, particularly through the research students. She gave the example that Amy Watts is exploring SRH service provision as a platform for peace-building, which includes challenging social norms, stigma, gender roles, and so on.

Florence Tayzon from UNFPA Philippines commented that even in an emergency it is important to conduct M&E. She asked whether the research studies will be useful for
programming or if they are primarily focused on theory. Sarah Chynoweth from IPPF-ESEAOR commented two of the PhD students’ research (Sarah and Amy’s) will focus on exploring the operational aspects of MISP implementation within a theoretical context. As such it will be useful to inform program implementation. Anna Whelan from UNSW commented that all the researchers are focusing on the Philippines and in-depth M&E will take place there. There are limited studies of this scope that have taken place in crises. Amy Watts noted that SPRINT is also collaborating with CDC on the development of M&E tools for MISP implementation that will also be useful to inform programming. Sandra Krause from the Women’s Refugee Commission (WRC) also noted the Health Resources Availability Mapping System (HeRAMS) that is a very useful M&E tool for programming. Sun Paranjothy from IPPF-ESEOA noted that M&E is essential in order to determine whether SPRINT is working effectively.

SESSION 2: Review of Echo Trainings

Brief Review of Recommendations
Ann Burton from the United Nations High Commissioner for Refugees (UNHCR) provided an overview of the recommendations for the SPRINT echo trainings developed from formal and informal feedback from trainers and participants who have taken part in SPRINT training. Recommendations focus on both the conduct of the training and the content. First, it was recognized that for an echo training to be effective, all participants must meet minimum qualifications that serve as grounding for the content of the training. They should be required to fill out a standard training application used to screen applicants to ensure they have the right qualifications to fully gain from participating and will integrate the knowledge acquired into their organization’s programming. Further, countries that have had the most success in building on the momentum of an echo training have utilized a preparatory meeting to engage with high-level policy makers including the MoH, government emergency response and planning departments, and other key health or emergency response actors on the importance of SRH in humanitarian settings and to gain their support for the SPRINT echo training. The sexual and gender based violence (SGBV) session of the training can often be challenging for facilitators in settings where discussing SGBV is particularly sensitive, or when country team facilitators do not have experience in the subject. As such it is not necessary to limit facilitators to those who have taken part in the ToTs; however, facilitators should be reminded to adhere to the international standards articulated in the training curriculum. Sometimes country level practices do not always meet international standards. Participants and facilitators can discuss how their experiences have differed from international standards and how they can work to improve this in their own context as a standard part of the conclusion of each daily session. Many participants have also flagged that they often feel ill equipped to undertake advocacy on the MISP. Consistent feedback from participants also highlights that the training includes too many technical components. While it is important for health and SRH coordinators and service providers to understand the technical components of the MISP, other emergency responders, advocates and policy makers need to grasp the bigger picture and the impact of the training can be weakened if they lose focus on the more clinical sections. One suggestion is to remove the training sessions on comprehensive SRH topics. This would help participants understand what activities should be prioritized during emergency response as well as reduce the number of topics covered within a typical SPRINT training. Thus, the SPRINT training could include a one-day advocacy module, followed by a three day clinical training on the MISP and an optional one day on comprehensive SRH. The need to allow more time of focus on the coordination mechanism for SRH in a crisis, logistics, M&E and planning for comprehensive SRH was also noted.

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1 In-country SPRINT trainings on the MISP are also called “echo trainings”. They are usually three to four days in duration and are not as in-depth as the five day SPRINT ToT.
Case Studies

Indonesia

Dr Rosilawati Anggraini from UNFPA Indonesia presented on the roll-out of the SPRINT in-country training in Indonesia. Indonesia is extremely vulnerable to disaster, thus emergency preparedness including building the capacity to respond to SRH needs in crises is crucial. Four representatives from Indonesia attended a SPRINT ToT in 2008. Upon return, MISP echo trainings were made a priority activity under the UNFPA humanitarian programme in collaboration with the MOH. The main target of the trainings has been the staff of the MoH regional crisis centers, but trainings have also been held for staff of NGOs and of the Indonesian Red Cross from central and provincial levels. After completing one national ToT and one echo training, the issue of accreditation with the MoH was raised since accreditation was required for the training to be extended to MoH participants nationwide. This posed a challenge in that nine trainings had been scheduled for 2009 and thus had to be postponed until accreditation was attained. Further, advocacy had to be undertaken to gain the support of MoH and to adapt the materials to comply with national standards and policies. The latter raised a number of specific issues. For example, the MISP promotes distribution of the clean delivery kits to all visibly pregnant women; however, the government is concerned that this will promote home delivery rather than seeking care at a health facility when it is available and accessible. Further, safe abortion practices contradict the national health and population laws. However, a major recent achievement is the revision of the health law in November 2009 that allowed abortion for rape survivors. A challenge in responding to crises has been clearing the RH Kits through customs. This has been addressed by the development of local RH Kits, and information on these kits and how to order them has been integrated into the Indonesian echo training. Key recommendations that have come out the trainings conducted in Indonesia include: describe clearly the criteria for participants and divide the training into two main topics: (1) MISP for SRH in humanitarian settings, and (2) Technical aspects of the MISP. Further experience has shown the need to develop a mechanism for post training M&E and tracking of trainees. UNFPA will also seek to document and disseminate the lessons learned and best practices in implementing MISP in Indonesia.

Myanmar

Thwe Thwe Win from UNFPA Myanmar and Khin Oo Zin from UNHCR Myanmar presented on the rollout of the SPRINT echo trainings in Myanmar. Dr Win and Dr Zin attended a SPRINT ToT in 2008. Shortly after the ToT, Cyclone Nargis devastated the Irrawaddy Delta. Dr Win and Dr Zin immediately initiated awareness-raising sessions and training on the MISP for humanitarian actors in an effort to integrate the MISP into the response and facilitate coordination. Over 3,000 humanitarian actors have been trained through these efforts. Some of the challenges in rolling out the echo trainings included the tension between the three day training being too short to adequately cover all the relevant material and the fact that many staff cannot attend longer trainings. As a result, the decision was made to split the training into two: one for service providers and one for non-medical staff. Additional challenges include the dearth of medical personnel qualified to perform emergency obstetric and newborn care (EmONC) and provide care for survivors of rape. The practice of standard precautions was also a challenge, as they were not respected even before the disaster. Finally, regular monitoring and supervision is needed to ensure the quality of the multiplier trainings. Recommendations for the echo trainings included continuing adaptation of the MISP according to the local context; to share and learn from other training experiences especially from the region; document the experiences, success and lessons learned; and assess and evaluate the outcome of the trainings.
Pacific

Dr Wame Baravilala from UNFPA Fiji, Sub-Regional Office for the Pacific (SROP) presented on the experience of SPRINT trainings in the Pacific region. The Pacific island countries that took part in the SPRINT ToT in 2008 include: Cook Islands, Fiji, Federated States of Micronesia, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. General feedback from the ToT was that the training was a positive experience, useful and timely. Further, SPRINT’s international multi-agency approach provides a rational basis for emergency response. For example, prior to the training, the national response to the Solomon Islands’ tsunami in 2007 had been primarily based on assumptions rather than on international standards developed from evidenced-based research. Echo trainings have been successfully rolled out in the Solomon Islands and Vanuatu. In the Solomon Islands, it was the first time that the National Disaster Management Office (NDMO), the pharmacy officers and RH coordinators under the MoH had been trained together. A MoH representative stated that they had never worked before but now knew each other and would be able to identify the right person in each province should a disaster strike. All participants drew up provincial plans for training and integration of SRH into emergency response. The NDMO also invited the country team and the SPRINT Secretariat to assist in integrating SRH into the national emergency response structure and planning as a result of the training. In Vanuatu participants noted that the group work stations were particularly useful in the learning process as they could relate this to their own settings. The participants also came to a consensus to carry out training at the provincial level, debrief their counterparts and draw up budget plans for 2010. A challenge that presented in both settings was how to secure funding for the provincial trainings. Both countries also experienced other common challenges, including: delay in receiving funding for their echo trainings due to a long planning process as well as delays from Regional Office. Training materials were held up in Solomon Islands customs causing further difficulties in carrying out the training. Both countries noted that the PowerPoints were too technical for the non-health participants and suggested they be simplified. Both indicated that three days was too short for the training; in Vanuatu the time constraints resulted in the group work being shortened or eliminated and insufficient time for discussion to develop a strong understanding of the material. The Solomon Islands team recommended five days for the echo training. The next countries to roll out their echo training will be the Cook Islands, Fiji and Tuvalu.

Sri Lanka

Dinesh Fernandao from the University of Peradeniya presented on the rollout of the SPRINT echo trainings in Sri Lanka. Seven master trainers from Sri Lanka were trained at the SPRINT ToT in February 2009. Two in-country trainings were subsequently rolled out: one in July 2009 which targeted SRH coordinators from all 25 districts of Sri Lanka and one in September 2009 which targeted medical officers and regional epidemiologists. A total of 55 medical officers and one nurse were trained. Some challenges in rolling out the training included the availability of only four of the seven master trainers to participate, the inability of the University of Peradeniya to invite participants directly, the lack of prompt responses from participants and delays in funding. Another challenge identified was the difficulty for some of the master trainers to obtain leave from their institutions to facilitate the training. Lessons learned included that echo training planning must begin two months in advance, funding should be available at the onset of the planning, an agenda with a time line is essential and strict adherence to the agenda should be maintained. In addition, co-facilitation of each session is encouraged as well as facilitator familiarity with each presentation.

Questions and Discussion
Dinesh Fernando from the University of Peradeniya, Sri Lanka, explained that Sri Lankan law requires a rape survivor to report the crime. However, doctors and other medical professionals have an ethical and moral duty to the patient first and the law second. N. Toan Tran from UNFPA asked the panel if and how they conducted M&E after the training. Thwe Thwe Win from UNFPA Myanmar stated that they conducted follow up with trainees after the initial training. Rosilawati Anggraini from UNFPA Indonesia remarked that they hold regular meetings of the national team on SRH in crises made up of stakeholders from government, armed forces, NGOs and UN agencies, and commented that an annual review meeting would be a good idea to share lessons learned on implementation. A question was raised whether the echo training should be separated into two separate trainings – one for clinical staff and one for public health/non-clinical staff. Imtiazul Islam from CARE Bangladesh remarked that it was important to train clinical and non-clinical staff together. N. Toan Tran from UNFPA commented that the trainings contain technical information that is useful for everyone, not just clinical practitioners. Dinesh Fernando from the University of Peradeniya, Sri Lanka, suggested that modifications to the trainings should be made depending on the audience (e.g., doctors versus nurses, clinical versus non-clinical, etc). Khin Oo Zhin from UNHCR Myanmar noted that they had already separated the training into two: for medical and non-medical participants. Anna Whelan from UNSW suggested that a list of trainees should be kept at the country level with UNFPA, MOH or another agency. She also questioned whether focus should be placed on refresher trainings of those already trained, or training new staff. Thwe Thwe Win from UNFPA Myanmar noted that in Myanmar the MOH holds the list of trainees. Sun Paranjothy from IPPF-ESEAOR commented that it is important that there is a coordination mechanism in place once a disaster strikes. Saramma Mathai from UNFPA remarked that many countries do not follow international standards and that this can be a tension in the training. Amy raised the question on how to address the need for smaller kits for the Pacific Island Countries, and whether they could be procured and prepared in the Pacific region. Warne Baravelilala from UNFPA SROP stated that where possible the kits could be broken up and distributed by the regional office in Fiji. Chen Reis from WHO noted that the revision of the RH Kits will be undertaken and the working group for the revision should take note of this. Ann Burton from UNHCR asked whether MISP has been utilised to identify existing gaps at the country level in terms of service provision. Amy responded with the example of Mongolia: participants in the echo training realised that the minimum standards outlined in the MISP do not exist in their current setting and committed to putting them in place.

SESSION 3: Implementing the MISP – Challenges and Lessons Learned

Case Studies

China

Guo Wei from UNFPA China presented on the implementation of the MISP after the Sichuan earthquake in China in May 2008. The earthquake was one of the most destructive in China’s recent history, affecting more than 46 million people and displacing more than 15 million. The government responded swiftly to the crisis, and UNFPA was one of the lead agencies for SRH. During the first three months after the earthquake, UNFPA provided RH kits including sexually transmitted infection (STI) treatment (kit 5), clinical delivery assistance (kit 6), referral level for RH (kit 11) and blood transfusion (kit 12) as well as hygiene kits and blankets. After the acute phase, UNFPA supported psychosocial seminars and resource development, translated a variety of key SRH in emergencies resources into Chinese, held two national trainings on the MISP and provided hygiene kits to displaced women and girls for the winter. Lessons learned on the MISP rollout in China (implementation and trainings) included that the MISP will take time to be fully integrated.
into the national disaster management plan, capacity building is needed for responders to fully understand and absorb the MISP, and a stronger coordination mechanism for SRH in emergencies is needed. In terms of next steps, UNFPA plans to support the MOH to develop a national protocol on SRH in crisis and post-crisis situations, advocate for the MISP to be to be institutionalized into local disaster management plans, explore establishing a local procurement system for SRH kits, and work with the MOH to integrate the MISP into the upcoming health reform process.

Myanmar
Thwe Thwe Win from UNFPA-Myanmar presented on the implementation of the MISP after Cyclone Nargis hit the Irrawaddy Delta in Myanmar in May 2008. The cyclone affected 2.4 million people and caused up to 140,000 deaths. Dr Win and Dr Khin Oo Zin from UNHCR-Myanmar had just completed the SPRINT ToT when the cyclone hit. Upon return to Myanmar, they advocated and coordinated to implement the MISP. UNFPA recruited seven new staff members, including two MISP trainers. UNFPA led and held regular meetings for the SRH/HIV/AIDS technical working group under the Health Cluster and the women’s protection technical working group under the protection cluster. In addition, a number of trainings, orientations and workshops on the MISP, SRH, protection, gender and gender-based violence (GBV) were held for more than 3,000 humanitarian actors. Information on the clinical management of rape and related legal issues were shared with medical staff of partner agencies and protection was discussed with great interest during trainings and awareness-raising sessions as it was a new issue. UNFPA noted a lack of understanding that HIV prevention was a priority at the onset of an emergency. It and partner organizations worked to increase community awareness on HIV and to ensure free access to condoms. RH kit 12 was distributed for safe blood transfusion, but not all townships were covered. Preventing excess maternal and neonatal death and disability was the entry point of the SRH response activities for UNFPA as well as other NGO partners. Referral services for EmONC were coordinated through the SRH technical working group. Maternity waiting homes were piloted and found to be very successful in supporting high risk mothers from villages with limited access to health facilities. Planning for comprehensive SRH services was led by the Department of Health (DoH) with the support of UNFPA and other partners, and emergency preparedness for SRH was included into the National SRH Strategic Plan for 2009 to 2013. A number of challenges to MISP implementation were identified. Authorities and humanitarian actors were not aware of the MISP and thus SRH and women’s protection were not prioritized. Coordination on SRH was inadequate, especially at the field level, resulting in overlap of programming by different organizations. Remote areas were difficult to access, and appropriate implementing partners with technical capacity and authorization from the government to implement SRH were limited. Sexual violence and protection are culturally and politically sensitive issues, and thus difficult to address. A mechanism for referring sexual violence cases was not developed and service provision for rape survivors was insufficient. RH kits were also difficult to distribute during the emergency phase leading to the expiry of some items. The key findings include that the SPRINT ToT was a catalyst in ensuring the MISP was addressed in the crisis. Awareness was widely spread among the humanitarian actors during the cyclone response and post disaster periods, and UNFPA and partner agencies are continuing with the response activities. Although the unmet needs for SRH have been significantly reduced, many gaps in SRH service provision still exist due to the low priority of SRH among humanitarian actors, cultural sensitivity, and the lack of effective coordination, especially to prevent and respond to sexual violence.

Philippines
Florence M. Tayzon and Rene Llorin from UNFPA Philippines and FPOP respectively, presented on the lessons learned from facilitating implementation of the MISP in the three separate humanitarian crises in the Philippines: armed conflict in Mindanao and Typhoons
Ondoy and Pepeng (Ketsana and Parma) in Metro Manila and Luzon. In 2008 the Philippines had highest number of newly displaced people in the world as result of the ongoing conflict in Mindanao. As of October 145,209 internally displaced persons (IDPs), including approximately 5,808 pregnant women, were in 114 evacuation camps in Mindanao from a high of 600,000 in May 2009. UNFPA conducted SRH assessments in March, May and August which showed increasing numbers of pregnant women in the camps and at least 10% of births delivered by untrained birth attendants, early marriages on the rise with 17% of pregnant women below 19 years old and more than 1,000 continuing users of contraceptives were identified among the IDPs; however, pills and injectables are in short supply. Further, a culture of silence surrounds the issue of GBV. The Health Cluster was activated in Mindanao, and a GBV Sub-cluster has also been formed. However, SRH remains inadequately integrated in other clusters. UNFPA and FPOP have deployed full-time SRH Coordinators, distributed 5,000 clean delivery and hygiene kits, provided RH kits to health service providers, set up a mobile clinic for IDPs in remote areas, deployed skilled birth attendants and mobilized six IDP teams in the camps, comprised of health workers and leaders from the IDP community. In the typhoon affected areas, 97,541 individuals were displaced and 244 evacuation centers set up. At the onset of the emergency, there was breakdown of the health infrastructure; no SRH services were available for pregnant women and newborns; no measures were put in place to prevent sexual violence and no clear system of referral to secondary and tertiary level health facilities existed. Clusters were established, including the Health Cluster, Protection Cluster and GBV Sub-cluster; however, as the GBV Sub-cluster was not formalized at the national level, it can only function informally. Rapid assessments were undertaken and almost daily meetings held for inter-cluster coordination and preparation of situation reports. UNOCHA prepared Flash Appeals and Central Emergency Relief Fund (CERF) proposals, which included SRH, and resources were mobilized. The country team conducted SRH medical missions and information sessions in the eight most affected sites, provided RH kits including clean delivery kits, oral contraceptives, injectables and clinical service delivery kits to provincial and city health offices. Major accomplishments include: training a core of over 220 humanitarian workers in the MISP, instigating creation of the GBV Sub-cluster, linking with partners to respond to SRH needs, inclusion of SRH in Inter-Agency Standing Committee (IASC) contingency planning, and development of tools and instruments including SRH Rapid Assessment Forms. This process was facilitated by supportive national and local government officials, dedicated staff and volunteers, ability to utilize local NGOs to ensure that supplies reach the targeted beneficiaries, technical assistance and support for UNFPA and SPRINT, including south-south cooperation with technical assistance from UNFPA Indonesia and funding support from the Spanish Agency for International Cooperation (AECI), AusAID and CERF. UNFPA faces a challenge in accessing the forum to directly advocate for the integration of MISP into the other clusters as they are not a Cluster Lead. SRH is also awaiting integration into the national policy level which hinders implementation and advocacy efforts. Poor coordination of assistance remains due to the vertical program mentality of some humanitarian organizations, and it is difficult to identify appropriate partners with the capacity and staff to provide sexual violence counseling. Further, the response time for humanitarian support needs to be clearly determined for accountability purposes. It is important to engage and keep national and regional authorities informed about what, where and when assistance is provided. Presence of an SRH agency in UN rapid assessment teams and inter-cluster coordination meetings is important for SRH visibility in situation reports and funding appeals. In future a mechanism needs to be developed for Local Government Units to follow through treatment for pregnant, delivering and post-partum women after the medical missions and coordination mechanisms at all levels need to be improved in terms of implementation, monitoring and reporting.

Indonesia

First Annual SPRINT Review Meeting
Asmuyeni Mucthar from Jhpiego Indonesia presented on the reestablishment of SRH services after the 2004 tsunami in Aceh, Indonesia. Jhpiego’s SRH response included conducting a joint assessment with UNFPA and the Indonesian Midwives Association (IBI). In assessing the SRH delivery capacity, rapid response interventions were defined with partners including the MoH. Emergency delivery of items was conducted, including equipment and supplies for delivery, baby blanket and clothes, linens and towels. Jhpiego assisted in connecting midwives and other service providers with the health office and concentrated on coordination. A grant was also provided to IBI to provide district level services. The government response consisted of clean water, food, tent and non-food item distribution. In Aceh, Jhpiego’s response focused on maternal and newborn health, and as a result 2,400 women living in camps received services free of charge for antenatal care, labor and birth, postpartum care, newborn care, family planning, and immunization. Selected midwives in Banda Aceh, Aceh Besar, and Meulaboh received supplies and equipment to enable them to resume their livelihoods. Three hundred midwives were trained in basic delivery care training, counseling, contraception technical updates and infection prevention. Communities in 100 villages mobilized for birth preparedness and complication readiness. The challenges faced include difficulties in identifying exact number and location of IDPs during emergency phase, a lack of coordination between health service donors especially during emergency phase, lack of special place for maternity health services in some camps and the traumatisation of health providers. The lessons learned were that health services during emergency response should specifically include the SRH services, and that it is important to supply health providers (particularly midwives) with equipment and supplies as they have may direct access to the affected area. Jhpiego recommends that the distribution of selected RH kits to implement the MISP should go through health providers as skill is needed to provide the services.

Questions and Discussion
Amy Watts from IPPF-ESEAOR asked the panellists from the Philippines what the challenges were and how they are responding to the shift of IDPs from the evacuation centres to a more urban setting in the response to Typhoon Ondoy in Metro Manila. Renee Llorin from FPOP remarked that they needed to quickly adapt to the changing situation and adjust their plans to concentrate on the areas with the most need. As evacuees return home and there is a continuing lack of services, a shift in the assistance strategy was required. It has been important to utilise local organisations that are already engaged with the communities to help identify needs and distribute supplies. A major challenge was how to track the movement of those affected once they leave the evacuations centres and return home. In terms of coordination, it continued to be important to prioritize the areas with the most need with all partners and to coordinate at the local level. Amanda Jennings from AusAID remarked that it would be interesting to learn more on how Indonesia ensures the safety of their medical personnel. Nirmal Rimal from the Association of Medical Doctors of Asia in Nepal commented that it was important to provide health workers time for themselves to recover after an emergency. Ramona Sari from the Indonesian Planned Parenthood Association (IPPA) questioned how to provide family planning supplies to adolescents when the Indonesian law only permits supply to married persons. A comment was made that that negotiation and coordination with the government was key to success. Mr. Llorin noted that various meetings and discussions had to be held to ensure government buy-in to the project prior to distribution of supplies. Florence Tayzon from UNFPA Philippines responded that inter-cluster coordination is important to ensure that SRH is fully addressed. Ms. Tayzon also noted that coordination at the national and regional levels are as important as at the local level since the local level can only function informally until the national level sub-cluster is formalised. Chen Reis from WHO commented that the Global Health Cluster (GHC) does not support the establishment of SRH sub-clusters as this results in too many meetings and uncoordinated efforts and as SRH is integrated within the tools and guidance of the Health Cluster. While at country
level it may be that SRH has not been a priority within the Health Cluster/Sector to date, effective solutions to address this are being developed and sub-clusters do not help advance SRH. Any stakeholder meetings that are held for SRH need to be fed back into the Health Cluster/Sector. The need to create a standard hygiene kit prior to a crisis to prevent tension among recipients resulting from disproportionate contents was also highlighted.

SEASON 4: Integrating SRH into National Emergency Plans: Advocacy to Action

Case Studies

Indonesia

Christina Manurung from the MoH Indonesia presented on the process of integrating MISP into the national emergency preparedness and response plan in Indonesia. Indonesia is an extremely disaster prone area. The tsunami that devastated Aceh and North Sumatera in 2004 was of historic proportions, and the earthquake that occurred on 30 September in Padang, West Sumatera is another recent example. Much effort has been put into both preparedness and response activities by the government and the NGO community; however, only limited attention has been given to SRH in crises. A key contributor to this is the lack of preparedness of local SRH stakeholders for emergency response. Thus, it is important to develop this capacity through development of a SRH Preparedness Plan at all levels. Currently, the MoH has a crisis center in each of the nine regions in Indonesia, covering the 33 provinces, which can be utilized to coordinate the SRH response. Further, under the disaster law, it is clearly stated that vulnerable groups should be given the priority for life saving, evacuation, protection, health services and psychosocial support. However, the existing guidance from the MoH on the “The guideline on health disaster management” does not yet include MISP as part of the services to be implemented in early emergency response and thus it is not systematically implemented. There is an urgent need to revise the guidance to include the MISP. To achieve this, the MoH member of the SPRINT country team is working with counterparts to draft a national SRH preparedness plan and is conducting advocacy on the importance of SRH in crises at the national and sub-national levels. She has also participated in the establishment of a national team on SRH in crises. The members of this team include the MoH (across programs and including the crisis centers), Ministry of Women Empowerment, National Family Planning Coordinating Board, Women’s National Commission, Family Welfare Association, the Indonesian Army and Navy, local and international NGOs (including the IPPF member association), professional organisations and UN agencies. A major challenge faced in integrating SRH is the long, bureaucratic process for modifying legal documents in the national system. There is also a need to improve coordination among units at the MoH and speed up the integration process. Further, effort is required to achieve strong commitment from all members of SRH national team and the SRH preparedness activities must be expanded to the sub national level.

Philippines

Dr Nestor Santiago from the DoH Center for Health Development Bicol presented on the integration of MISP in the Health Emergency Preparedness Plan in the Philippines. The Philippines government is somewhat decentralised allowing some autonomy at the regional or provincial levels to form policies and practices. This permitted the Dr Santiago, a SPRINT trainee, to integrate the MISP into legislation in Bicol region, including the development of a specific Health Emergency Team and SRH Coordinator to focus on the MISP in the event of a crisis. This is particularly relevant for the Bicol region that frequently experiences disasters, from volcanic eruptions, to typhoons and armed conflict. A SPRINT echo training has also been held in Bicol for the Health Emergency Management Staff.
(HEMS) as well as SRH Coordinators under the MoH and UN and NGO partners. Dr. Santiago is also leading the integration of the MISP into national level policy; a draft has been submitted to the DoH-HEMS Director. In addition to advocacy to pass this policy and for its implementation down to the local level, Dr. Santiago has also achieved integration of the MISP into the national Public Health and Emergency Management in Asia and the Pacific (PHEMAP) training which all RH coordinators and HEMS staff will undertake. DoH is also coordinating with UNFPA to stockpile RH kits where possible and is procuring hygiene kits locally in preparation for a volcanic eruption. The enabling factors to this success has been the presence of supportive agencies, including the DoH, UNFPA and FPOP, committed advocates for implementation of the MISP at the local level, strong inter-agency collaboration and committed local health workers. However, some challenges have included the difficulty in collaborating with agencies that do not understand the importance of SRH in crises in health and humanitarian sectors, the lack of earmarked funds for MISP implementation, non-functional disaster coordinating committees and a lack of preparedness plans at the local level.

**Vietnam**

**Nguyen Toan Tran** from UNFPA presented on the integration of SRH into the national emergency preparedness plan in Vietnam. Vietnam has a relatively solid health care system, network of clinics and hospitals and sets of national guidelines on SRH. UNFPA has advocated for SRH in crises to the MOH and key national stakeholders. They translated the MISP Distance Learning into Vietnamese and spearheaded a working group to mainstream SRH into the national action plan on health in emergencies. An outcome of the working group was to work with the Hanoi School of Public Health on the national action plan. Outsourcing the drafting of the national action plan and the integration of SRH into it—with oversight from the MOH and UNFPA—helped move the process forward in a timely manner and provided the opportunity for input from academic experts.

**Advocacy to Regional Parliamentarians**

**Jane Singleton** from ARHA presented on the importance of engaging policy-makers and the media to raise awareness on and gain support for SRH in crises. Ms. Singleton gave examples of the ways in which ARHA has engaged key parliamentarians to advance SRH. First, ARHA approached the Parliamentary Secretary on International Development Assistance to launch the SPRINT Initiative in Parliament House. This provided an opportunity for him to ensure his and the government’s unequivocal support. Second, Robert Oakeshott MP was invited to the last Asia Pacific Conference on Reproductive and Sexual Health and Rights (APCRSHR) and became very engaged by the issues. He remained a keen member of the Parliamentary Group and attended the SPRINT training in Kuala Lumpur. He has now become one of the leaders in the parliamentary movement for male parliamentarians to work on the issue of violence against women and is also a member of the Asia Pacific GBV Parliamentary Group which made a policy commitment to SPRINT on 19th October 2009. Ms. Singleton provided practical advice on how to engage with policy makers. She suggested seeking meetings with parliamentarians to explain the issues and start with the ones that support your cause. Seeking their advice is a good way to secure an appointment and start the discussion. During the meeting, it can be helpful to provide a few moving, motivating and evidence-based facts; more detailed information can be provided separately. It is important to remember that parliamentarians are influenced by the media and need votes. Inviting international experts to speak on the issues and ensuring they get media coverage can bring attention to the issues. Another strategy is to engage the beneficiaries themselves to speak in front of policy-makers on their experiences. An ideal way to influence parliamentarians is through Parliamentary Groups on Population and Development, which are established in 70 countries in the world. The groups have representatives from all parties, are informed on and active in relevant policy areas and meet more or less regularly. They can engage Ministers, raise questions in
Parliament and conduct other high level advocacy to move SRH in emergencies forward on the government agenda.

**Questions and Discussion**

**N. Toan Tran** from UNFPA asked whether the progress on the MISP that has been made in the Bicol region of the Philippines can be expanded to other regions. Nestor Santiago from the DoH, Philippines responded that they are working to advance the MISP at the national level, but influence of other regions is limited as they are autonomous. Saramma Matthai from UNFPA commented that it is essential to address other issues, such as laws, culture and religious issues, in order to advance the MISP. Jane Singleton from ARHA added that it is important to work with Parliamentarians and that SPRINT can be used as an advocacy tool. Rosilawati Anggraini from UNFPA Indonesia commented that due to continuous advocacy the health law has been amended in Indonesia, allowing abortion for rape survivors and in the case of medical emergencies. Dr. Sari responded that although the law had been passed, barriers within the community still exist. Sun Paranjothy from IPPF-ESEAOR commented that it is important to have new laws such as the abortion law in Indonesia endorsed by the MOH and to build awareness at the community level. Sandra Krause from the WRC asked how to address the policy barriers to operationalising the MISP once it has been integrated into national emergency preparedness plans, highlighting the importance of addressing the related policies and not stopping at integrating the MISP into national disaster planning. Mr. Santiago responded that it was important to conduct joint trainings and raise awareness with people from different sectors so they can advocate operationalising MISP. Dr. Tran noted that Vietnam was working on ways to operationalise the MISP and exploring the protocols and policies related to MISP implementation to ensure they are in accord. Roberto Ador from FPOF asked whether the MISP had been integrated into Australia’s emergency preparedness plan. Amanda Jennings from AusAID responded that SPRINT has conducted ToTs in Australia and advocacy has been undertaken to increase the level of awareness on SRH in crises. The importance of integrating MISP into Australia’s emergency response efforts within the region was also highlighted.

**SESSION 5: Global Progress on the MISP**

**Granada Consultation: SRH in Protracted Crises & Recovery**

**Dörte Wein** presented on the Granada Consensus which summarises the conclusions and recommendations that were agreed upon at the Consultation on Sexual and Reproductive Health in Protracted Crisis and Recovery hosted by the Andalusian School of Public Health in Granada, Spain, and convened jointly by WHO and UNFPA. This discussion forum was organized to address the SRH challenges faced on protracted crisis and recovery settings, namely the lack of access to basic and comprehensive EmOC, lack of treatment for survivors of sexual violence, insufficient services for prevention and treatment of STIs including HIV and the unmet needs for basic family planning. Participants included practitioners directly involved in the provision of services in affected countries, representatives from UN agencies and other humanitarian organisations, academic experts and donors. The following priorities for action were identified: 1) Mainstream SRH in all health policies and strategies that aim to revitalize the health system during the recovery period and/or a protracted crisis. 2) Achieve sustainable consolidation and expansion of SRH services in protracted crises and recovery. 3) Secure the commitment of humanitarian and development actors to bridge the current service delivery and funding gaps. 4) Recognize and support the leadership role of national and local authorities, communities and beneficiaries in ensuring SRH.

**Sandra Krause** from the WRC added that this is the first time that it has been agreed upon
that the MISP forms the starting point for SRH service provision and must be sustained before other comprehensive SRH components are introduced.

**Amy Watts** from IPPF-ESEAOR added that the consultation also identified the need for the transition to comprehensive SRH to be based on not only the needs but also the opportunities specific to each setting, including assessment of the existing capacity and critical building blocks of system development.

**Anna Whelan** from UNSW highlighted that sustainable human resources for SRH was identified as a major area of focus, including identification of national funding mechanisms to be strengthened and utilised.

**Using Disaster Risk Reduction to Expand MISP Implementation**

**Janet Meyers** from CARE presented on Disaster Risk Reduction (DRR) and how it can be used as an entry point to address the MISP. DRR refers to techniques and/or tools that prevent or minimise the effects of disasters. DRR is a cross-cutting issue: it is an approach where disaster risk is systematically assessed in a holistic way, and where relevant and possible, addressed through the development of activities that will increase the resilience of the community. Disaster risk depends on the result of exposure of a community to a hazardous event (e.g. earthquake, political upheaval) and the vulnerability of the community towards this event. Disasters can be avoided or the negative effects attenuated by building capacity. In January 2005, the World Conference on Disaster Reduction adopted the Hyogo Framework for Action. The UN and other institutions were called to integrate DRR considerations into development frameworks. This included the Common Country Assessments, the UN Development Assistance Framework and poverty reduction strategies. DRR is priority within CARE’s mandate for humanitarian assistance, reconstruction and development. CARE has engaged in a number of activities to link DRR and SRH. For example, internal advocacy was conducted with country offices in Nepal, Cambodia, Bangladesh, Haiti, Ethiopia, Kenya, DRC and Uganda to integrate SRH into emergency preparedness plans. CARE Bangladesh is integrating the MISP into women’s empowerment programming and male involvement and gender work. In addition, senior staff from country offices have been trained in the MISP through SPRINT and other training opportunities. Formal agreements have also been established with partners for services and supplies. These are some of the steps CARE has taken to integrate DRR into SRH related work.

**Health Cluster Rollout & Sexual and Reproductive Health**

**Chen Reis** from WHO HAC presented on the development of the cluster approach, the rollout of the new GHC guidance as well as the role of SRH within the Health Cluster. In 2005 the international humanitarian community launched the humanitarian reform process to improve the effectiveness of humanitarian response. The key elements of the reform include: (1) the cluster approach; (2) a strengthened Humanitarian Coordinator system; (3) more adequate, timely, flexible and effective humanitarian financing; and (4) the development of strong partnerships between UN and non-UN actors. The aim of the cluster approach is to maintain high standards of predictability, accountability and partnership in all sectors or areas of activity; ensure more strategic responses; and better prioritize available resources. The Health Cluster is led by WHO and is comprised of a large number of UN and NGO partners. Ms Reis suggested that the SPRINT Initiative could consider requesting to be an observer on the GHC. Identifying and filling gaps in the health response as well as ensuring continuous improvements are key functions of the Health Cluster. The new GHC guidance is currently being rolled out and includes global tools and guidelines of the Health Cluster. These tools and guidance reflect the position and commitment of the Health Cluster and WHO as Health Cluster lead. The Health Cluster endorses the MISP as a minimum package of SRH services and recognizes the MISP as a key priority component of health response in humanitarian settings. The Health Cluster is
working to mainstream SRH into all cluster functions. At the onset of an emergency, the country Health Cluster must designate an SRH lead agency to help ensure SRH issues are appropriately addressed.

**Application and Evolution of the Priority Activities in the MISP**

*Sandra Krause* from the WRC presented on the history of the MISP and on recent changes to the MISP in the Interagency Field Manual revision. The MISP was first articulated in the 1996 field draft version of *Reproductive Health in Refugee Situations: An Interagency Field Manual*. The Field Manual was developed by the IAWG on Reproductive Health in Refugee Settings (later the IAWG on Reproductive Health in Crises), which was comprised of over 30 UN agencies, INGOs, governments and academic institutions. IAWG conducted a global evaluation on SRH in humanitarian settings from 2002 to 2004, which showed that while progress had been made, significant gaps in SRH service provision, including MISP implementation, remained. IAWG engages in global advocacy to advance SRH on the humanitarian agenda, which assisted in the integration of the MISP into the 2004 revision of the Sphere guidelines and the integration of the MISP and comprehensive SRH into the GHC tools and guidelines. The WRC, a key member of IAWG, has conducted a number of MISP assessments since 2002; the earlier assessments showed that humanitarian actors were generally not aware of the MISP or familiar with its objectives. To address this, the WRC developed the MISP Distance Learning Module. The WRC also leads the MISP working group with the IAWG. Currently, the IAWG has more than 550 members and has established three regional networks. IAWG has been leading the revision of the Field Manual since 2007 for completion at the end of 2009. A few key changes to the MISP have been made in this revision process. Specifically, the first objective is now to ensure the health sector/cluster identifies an organization to lead implementation of the MISP. Regarding objective two—prevent and manage the consequences of sexual violence—an activity has been added to ensure the community is aware of the available clinical services. Objective four—prevent excess maternal and newborn death and disability—has an added activity: to ensure availability of basic EmONC services. The Field Manual also notes that it is important to ensure common contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals are available to continue treatment for people already on antiretrovirals, including for prevention of mother-to-child transmission.

**Creating a Standardized Tool and Methodology to Enhance MISP Evaluations**

*Inas Mahdi* from the CDC presented on the development process of a tool and method to enhance and standardize MISP evaluations. The WRC has conducted assessments of the MISP in Pakistan, Chad, Aceh, Kenya, Northern Uganda, Thailand and Jordan. These assessments have primarily used qualitative methods, such as observational checklists, facility assessments, key informant interviews and focus group discussions. Assessment findings have shown poor overall coordination, inadequate knowledge of MISP priorities and activities, poor quality and/or availability of referral services, inadequate monitoring of service delivery, limited human resources, variations in availability of trained staff and supplies and lack of donor support. These assessments demonstrated the need to develop a framework for the evaluations and to enable more data and information collection. The goal of the evaluation tool is to enhance the use of SRH indicators and the strengthened design, M&E of MISP implementation and coverage. Objectives include the development of a method and tool, defining indicators and an innovative framework. The framework approach includes clarifying the objectives of any project, program, or policy; identifying the expected causal links inputs, processes, outputs and coverage; and leading to the identification of performance indicators at each stage in the causal links. The goal of the specific tool is to provide a comprehensive body of information on global performance of sites implementing MISP; describe service availability and assess differences; and provide
baseline information on collection of key SRH indicators, level of standardization and recent trends. Ms. Mahdi provided hard copies of the draft tool and requested feedback from participants.

Questions and Discussion
Sarah Chynoweth from IPPF-ESEAOR asked WHO how SRH sits within the Health Cluster and if the Health Cluster is supportive of stakeholder meetings. Chen Reis from WHO responded that it depends on the country as each setting is different. If there is a need for SRH stakeholder meetings, the discussion outcomes must systematically be fed into the Health Cluster in order for effective coordination to take place. Thwe Thwe Win from UNFPA Myanmar commented that after Cyclone Nargis, multiple clusters on the different components for SRH were created because SRH was being subsumed in the Health Cluster. Rosilawati Angraini from UNFPA Indonesia commented that the SRH sub-cluster in her setting works well and the main issues are brought to the Health Cluster meetings. Ms. Reis responded that adaptation is made at country levels, but often the work of an SRH sub-cluster is not integrated in the Health Cluster and this has been very problematic. Saramma Mathai from UNFPA raised a question about the dearth of data on SRH in crises. Roberto Ador from FPOP remarked that there is no agreed upon definition of a “timely response” to a crisis or when the acute phase is actually over. He emphasized the need for emergency preparedness and to put in place systems to support the response. Janet Meyers from CARE USA commented that although it is difficult to plan for emergencies, it is essential to try to ensure humanitarian space to respond. Amanda Jennings from from AusAID noted that it was important to receive funding from a variety of sources. N. Toan Tran from UNFPA suggested locally procuring kits in order to avoid delays in service provision as per the examples in Vietnam and Indonesia.

DAY 2
SESSION 6: Clarifications

Abortion and MVA, local procurement
N. Toan Tran from UNFPA clarified some of the questions from the previous day pertaining to abortion. Manual vacuum aspiration (MVA) is a method of uterine evacuation and is appropriate for treatment of incomplete abortion (removal of retained products of conception from a miscarriage or induced abortion) and first-trimester abortion. MVA should only be performed by trained medical personnel. When performed by skilled medical staff, MVA is extremely effective and very safe. MVA is part of emergency obstetric care signal functions.

Other issues were raised in this discussion. Tensions between the activities set forth in the MISP and the national laws were raised. For example, although providing clinical care for rape survivors is part of the MISP, emergency contraception is not legal in some settings such as the Philippines. Advocacy is being undertaken to address this. It was suggested that issues like these are brought to the attention of the Health Cluster to conduct inter-agency advocacy on this issue. In the Philippines, the DoH is part of the Health Cluster and it is thus difficult to raise such issues in that forum. It was also suggested to use high doses of oral contraceptive pills if a generic emergency contraceptive product is not available in country.

In some settings there is too much reliance on the Interagency RH Kits. A lot of wastage occurs. It is better to engage local supply chains. One should not reorder RH Kits – they are designed for the acute phase of an emergency and reliable procurement channels need to be established. This requires a strong logistics system. To ensure supply and
logistic issues are adequately addressed, coordination between SRH partners is important and should be linked in with the health sector/cluster.

Ensure a strong referral system. If one agency is not able to provide an SRH service directly, ensure a referral system is established so the client can be referred to a facility and receive appropriate care.

In regards to rapid assessments, it was recommended that the process should be localized by engaging local partners and leaders. It was suggested to include an SRH focal point and women on emergency response team/needs assessments team. However, this depends on the specific emergency; SRH should be integrated into contingency plan to help ensure these issues are addressed from the beginning (e.g., integrating into rapid assessment plan) and working through Health Cluster/Sector. It was recommended that the Health Cluster coordinator must have strong SRH background and must be able to advocate for inclusion of SRH into the health response.

A question was raised on how to integrate SRH into situation reports. Situation reports routinely omit SRH. A template for situation reports exists, but it is generic and brief. When partners submit information to the Health Cluster/Sector, OCHA and the UN Country Team, ensure SRH is included and request that it is included in the situation report. Further, suggest that SRH information should be sought out for standard inclusion in the reports.

**Health cluster**

**Amy Watts** from IPPF-ESEAOR clarified where and how SRH sits within Cluster Approach. Ms. Watts explained that SRH should be fully integrated within Health Cluster. At the same time, it is important for SRH actors to collaborate and coordinate with one another. An SRH “sub-cluster” is not encouraged; instead, a stakeholders meeting or working group under the health sector/cluster may be established, depending on the setting. In such a case, key issues should be systematically fed back into the Health Cluster. WHO/GHC are trying to ensure country level offices understand their role in regards to SRH. Field actors also need to advocate and push for SRH at the country level. If a strong SRH working group is in place and is integrated into the Health Cluster, the effectiveness of Health Cluster and the SRH response improves. A question was posed whether WHO has a standard number of participants in Health Cluster at country level. This varies per country. All health actors are invited to attend the Health Cluster meeting. OCHA should have information on when meetings are held. The members of the Health Cluster, not WHO alone, should identify lead agency for SRH. Advocacy may need to be undertaken to ensure this happens at the onset of every crisis. A question was raised about what to do if the Health Cluster excludes local NGOs. If issues such as these arise, try to resolve them with all partners of the Health Cluster not just WHO, such as by referring to the relevant parts of the Health Cluster guide. Issues can also be brought to the humanitarian country team, if it is in place, which does not just include UN agencies.

**Hygiene kits**

**Sarah Chynoweth** from IPPF-ESEAOR explained how hygiene kits fit within the context of the MISP. She explained that although distribution of hygiene kits was important, it is not a life-saving intervention and is not part of the MISP. It is important to prioritize the MISP at the onset of an emergency. Hygiene kits can be distributed at the same time as MISP implementation, as long as distribution does not detract from the priority activities of the MISP. A comment was made that distribution of hygiene kits is an activity for the prevention of gender-based violence. However, this does not mean health actors necessarily should distribute hygiene kits; the issue can be brought to the Non Food Items cluster/sector meeting and ensure that it is addressed through those actors. Another comment was made that people tend to do what is easiest at the onset of an emergency,
and hygiene kits are easy to assemble and distribute. However, the priority and focus of the SRH intervention should be on reducing mortality and morbidity. One suggestion was to develop a long term agreement with a local agency to ensure hygiene supplies are available and to avert shortage of supplies.

**Contraceptives for single youth**

Anna Whelan from UNSW discussed the issue of making contraceptives available to young unmarried/single people. The newly revised Interagency Field Manual for RH in Crisis Situations outlines that health actors should make contraceptives available to meet demand at the same time as implementing the activities of the MISP. Comprehensive family planning programming is not possible at the onset of an emergency. However, providing contraceptives to young single people should be addressed in emergency preparedness and contingency planning and should be established once the MISP is in place.

**MISP and other minimum standards**

A question was raised regarding how the MISP fits with other minimum standards, such as the revised IASC guidelines. Sandra Krause from the WRC explained that the HIV standard in the MISP, while primarily consistent, is slightly different than the HIV standard in the revised IASC guidelines. Specifically, setting up prevention of mother to child transmission (PMTCT) services is a minimum standard in the IASC HIV guidelines, but is not part of the MISP. Antenatal care services are a requirement in order to establish PMTCT, although they are not part of the MISP. In the revised Interagency Field Manual on RH in Humanitarian Situations, a priority activity is to provide antiretrovirals for continuing users including PMTCT. Antenatal care does not need to be established in order to continue anti-retroviral use for PMTCT. This is currently being discussed in the revision of the health chapter for the Sphere guidelines as well.

**SESSION 7: Good Practices**

**Capacity Building**

A number of good practices were identified from the discussion on Day 1 including: identifying national protocols that support or hinder MISP implementation; translating key documents into local language(s); ensuring the appropriate participants are invited; adapting the training to the local context; rolling out training on multiples levels (national and sub-national); setting up a mechanism to follow up with and keep track of trainees; regional and local sharing of experiences to advance the MISP; meeting with MoH before training to support buy-in; and using DRR to advance MISP.

**Advocacy**

Good practices surrounding advocacy included engaging with a variety of actors including: the MOH to facilitate training and implementation; religious leaders to gain support of the MISP and increase awareness; humanitarian agencies to understand the importance of and prioritize the MISP in emergency response; higher level policy makers to facilitate procurement and movement of commodities and to address psychosocial and other SRH needs in crises; Parliamentarians who support SRH and/or humanitarian response (particularly if there is PGPD established); and finally broader advocacy targets such as the general public. It is also important to identify champions, develop consistent messages and minimize use of acronyms to ensure advocacy messages are accessible to a wider audience. The sharing of experiences by beneficiaries can be a very powerful tool to highlight SRH needs in crises. Engaging a human rights approach or alternatively utilising the international standards that identify the MISP as part of emergency response can be very effective. It is also important to note that broader coalitions can be utilized to address
specific issues and that spreading messages about women’s protection needs can be achieved through various means.

**Implementation**

Good practices identified on implementation of the MISP include: using the available tools and documents to advocate within the health and other clusters/sectors; using maternal and neonatal health as an entry point for SRH response; contracting out to a university’s School of Public Health to draft emergency preparedness plan (including SRH); sourcing and procuring supplies locally; engaging with youth, volunteers and members of the affected population to support MISP implementation; considering bringing in community health care workers (e.g., midwives) from unaffected areas to relieve the affected personnel; and working with the logistics cluster to overcome difficulties in accessing affected areas. When the affected population shifts from a camp or evacuation center to a non-traditional setting (e.g. urban), it is important to adapt programming to address the dispersed nature of the affected population. This can include engaging local organisations with existing connections in the community to implement the MISP and ensure communities are informed about where and why to receive care (e.g., clinical care after rape). It was noted that an IASC Task Force on Meeting Humanitarian Challenges in Urban Areas has been established and input on SRH in urban settings can be sent in to the task force. (For more information, see [www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=74](www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=74).) Another participant emphasized that before introducing additional services or components of comprehensive SRH, the MISP must be fully implemented and sustained. It was also noted that service provision at a community level in the case of pandemics will be addressed in the next IAWG meeting to be held in the Dominican Republic in May 2010. For more information, see [http://www.iawg.net/2010/](http://www.iawg.net/2010/).

**Questions and Discussion**

*Should we modify the SPRINT in-country training curriculum?*

The discussion highlighted that it will be important to continue to update the training with new technical and coordination related information so that it is in line with international standards.

**Length**

It was indicated that three days for the in-country training is not sufficient to cover all of the content and to produce trainees skilled in facilitating implementation of the MISP, though it can also be difficult for participants to commit to a longer period of time. In response it was noted that the training is flexible and thus the timing should depend upon each setting and the previous exposure of the participants to the MISP. It was agreed that the ToT should remain at five days in length and the in-country training should be adapted to the national context of each setting, in terms of content, structure, and length. The SPRINT Secretariat should provide suggestions and examples on how to do this. Strict screening of participants to ensure they are appropriately qualified and positioned, as well as ensuring they complete the MISP Distance Learning Module prior to the training, will help promote a more effective training.

*Advocacy and coordination*

Meeting participants discussed strengthening the advocacy and coordination components and focusing the technical components of the training while still maintaining an inter-agency country team approach. The question was raised as to how many different echo trainings should be conducted. A recommendation that emerged is to include a one-day advocacy/coordination module where both medical and non-medical participants could be
trained together, followed by a three day clinical training on the MISP for medical participants. This would provide an orientation to the MISP for advocates and policy makers, and further training for implementers. Another suggestion was that the training be divided into two – one component on management and coordination and the second on implementation of services. It was also noted that a standard package to address awareness raising and other key aspects would be useful. Though advocacy messages are currently highlighted in the training, it would be useful to pull these together and empower trainees to utilise them. Since IAWG aims to address gaps in responding to SRH in crises, the need for advocacy training on the MISP could be highlighted for their action. Trainees could also be encouraged to utilise advocacy units within other agencies. It was noted that coordination is a key component of the MISP and the focus of the echo training; however, echo training participants have repeatedly voiced that they do not feel confident in coordinating and advocating for MISP implementation. In addition, a need for concise material to use for MISP advocacy was mentioned, and a participant responded that a document addressing a document on the top ten advocacy messages on the MISP is currently being finalized by IAWG.

Focus on the MISP (including planning for comprehensive SRH)
It was suggested that the in-country training should focus on the essential activities and services of the MISP and move the comprehensive SRH components of the training into an additional optional day of training. It was agreed that the MISP should be a greater focus of the training as it can be lost in the current structure.

How can we operationalise the integration of MISP into emergency preparedness programming and response plans if there are barriers in national law?
Emphasis was put on the importance of identifying and working on aligning related policies and protocols with the MISP through advocacy.

Sexual violence was raised repeatedly in the presentations as a difficult issue to address. Why? What can be done to fully implement prevention and response to sexual violence?
One participant noted that sexual violence is often perceived as a “non-issue” in many settings. Cultural barriers are also significant factors that contribute to the neglect of sexual violence programming. Alternative ways need to be identified for communities to discuss this issue. Further, service providers need training on how to effectively prevent and respond to sexual violence; in particular, they need to be sensitized on how to interact with a survivor appropriately and compassionately. Male involvement was also noted as a critical factor in addressing sexual violence. Lack of confidentiality and the lack of support from service providers were mentioned as some of the reasons as to why survivors do not seek care. Lack of reported cases also leads to a lack of service provision. It was emphasized that the MISP requires provision of clinical care for survivors regardless of the number of reported cases. In addition, the community must be informed of why and where to receive services. However, addressing gender norms are part of comprehensive SRH and are not an immediate priority. Another participant noted that health actors should also improve collaboration with the protection cluster and the GBV working group (or sub-cluster) and to draw on their expertise on how to adequately address sexual violence. GBV is a cross-cutting issue and should be addressed in each cluster. Further, it is important to ensure that care for survivors is addressed in the Health Cluster/Sector meetings, and not only the protection and GBV meetings. Existing GBV programs in-country should also be explored on how to address these issues.

How can agencies link with WHO and the health cluster to secure support and buy-in to advance SRH?
Advocacy can be undertaken to the Health Cluster lead on critical issues that need to be raised in cluster lead meetings. Further, WHO Geneva can advocate or issue a memorandum to inform its country level office on their responsibilities to support SRH. As the Health Cluster is a partnership, agencies should work together to appoint a lead agency for SRH; the power to appoint the SRH lead agency is with the Health Cluster partners, not WHO specifically. A participant noted that learning how to function with the Health Cluster, such as problem solving, is different than advocating to the Health Cluster.

**Is there a need for independent protection cluster in a conflict setting?**

In many conflict affected settings, the government is a party to conflict. As such, it can be difficult to establish an effective protection cluster if the government participates in the cluster or if the cluster can only be established with consent of the government. UNHCR is the cluster lead for protection.

**SESSION 8: The Way Forward**

**SPRINT Initiative: Next Steps**

Sarah Chynoweth from IPPF-ESEAOR presented on the next phase of the SPRINT Initiative. The current SPRINT grant ends in December 2010. During the next fourteen months, the Initiative will continue to support and provide technical guidance for the rollout of in-country trainings on the MISP. Emphasis will be given to MISP implementation and assessments. Specifically, SPRINT will support its country teams to implement the MISP in acute crises and protracted settings. The Secretariat will provide active oversight of these projects to give technical assistance and support. It will conduct assessments to evaluate the capacity of SPRINT trainees to facilitate MISP implementation. National, regional and global advocacy to governments, UN agencies, international and national NGOs as well as donors will be continued to encourage the integration of SRH into humanitarian response programming and emergency preparedness plans. The SPRINT Secretariat will also collaborate with other regions to ensure cross fertilization and sharing of lessons learned as the SPRINT model is rolled out globally.

**Monitoring and Evaluation of SPRINT Initiative**

Carina Hickling of the UNSW presented on the SPRINT M&E team’s next steps. The research team will continue to monitor the SPRINT Secretariat’s activities and the general implementation of the SPRINT Initiative. Ms. Kristen Beek will continue to explore the capacity building process and will follow up with trainees in-country. She is looking specifically at how to maintain capacity and the formation of communities of practice. She is exploring how trainees retain the knowledge learned in the training and how to keep that knowledge fresh and evolving. Ms. Hickling will continue to follow up with organisational changes. A formal agreement between IPPF and UNSW is being developed to address this matter. She will also look at documenting the organisational changes that are occurring outside of IPPF due to the SPRINT Initiative activities. A technical working group is currently being formed with UNSW and UNFPA as key partners to support advancement of the SPRINT Initiative and assist the Secretariat. This will be an important component of the feedback loop of the M&E process.

**Beyond SPRINT: TRANSFER Initiative**

N. Toan Tran from UNFPA presented on the IAWG Training Partnership for Sexual and Reproductive Health in Crises (also known as the TRANSFER Initiative). The objective of the Training Partnership is to establish partnerships between IAWG and training institutions from developing countries in order to assure quality training for humanitarian staff on SRH in emergencies on a regular and sustainable basis. It is a new strategy to synergize the different levels of trainings and expertise on SRH in crises into a more systematic and
long-term planned programme. It proposes a collective approach built on successful models, such as the SPRINT Initiative, which involves: a coordinating body; inputs from various partnering agencies, such as UNFPA, UNSW, IPPF, WHO, RAISE; a training curriculum of high quality using a cascade training approach with key master trainers; and multiplying trainings to reach the grassroots level. To ensure sustainability, the Training Partnership will focus in particular on building the capacity of national and regional training institutions to uphold knowledge and skills pertaining to SRH in crises. The outcomes of the Partnership include increased capacity of key training institutions to respond to the training needs of the field with regard to SRH in humanitarian settings; coordination and management of information and trainings on SRH in humanitarian settings established at the national, regional and global levels, with emphasis given to South-South collaboration; access to quality SRH information and services for populations living in crisis situations in selected countries made available; and capacity of the global research network of research institutions from crisis-affected countries enhanced with regard to research methodologies; and quality action research published.

Closing Session
Amanda Jennings from AusAID announced that AusAID had generously committed to further funding for the SPRINT Initiative both regionally and globally.

Sun Paranjothy and Sarah Chynoweth from IPPF-ESEAOR thanked the participants for a productive and collaborative meeting. A gift was presented to Ms. Yolanda Lopez, consultant for the SPRINT Review Meeting, for her efforts.
## Appendix 1 - Participant List

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