



**EECA Team**

# Minimum Initial Service Package (MISP) roll out in EECA region

Summary report on first round in 2011

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## **INTRODUCTION**

A major objective of the Programme of Action adopted at the International Conference on Population and development (ICPD PoA), in Cairo in September 1994, was to make reproductive health care, including family planning, accessible to all by 2015. The PoA drew attention to the needs of especially vulnerable populations, including displaced persons and refugees. RH had previously rarely been considered in responses to humanitarian emergencies and, with this mind, the concept of MISP was developed at the Inter-Agency Symposium on RH in Emergency Situations held in June 1995.

The MISP is a coordinated set of life-saving priority activities that can and should be implemented without an in-depth needs assessment, as it is intended to meet acute RH needs during the initial phases of an emergency. The objectives of the MISP include identifying a RH coordination point person/organization, putting in place programs to prevent and respond to sexual violence; to prevent excess newborn and mother illness and death; to reduce HIV transmission. The MISP also lays the groundwork for comprehensive SRH programming, as its fifth objective is planning for comprehensive RH services integrated into primary health care. Lesson 2 of this module provides further information on the MISP.

MISP activities must be fully implemented in all areas affected by the emergency in a sustainable manner, as this will be a solid foundation for planning a wider integrated package of comprehensive SRH interventions.

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

The acronym “MISP” means:

**Minimum:** Basic, limited RH services

**Initial:** For use in an emergency, without a site-specific in-depth RH needs assessment

**Services:** Reproductive Health care for the population

**Package:** Coordination and planning, supplies and activities,



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### BACKGROUND INFORMATION ON SPRINT<sup>1</sup> INITIATIVE

To address the gap related to RH in emergencies, IPPF-ESEAOR, the [University of New South Wales](#) (UNSW), [Australian Reproductive Health Alliance](#) (ARHA) and the [United Nations Population Fund](#) (UNFPA) developed the SPRINT Initiative in December 2007. With funding from [AusAID](#), the programme works to increase access to sexual and reproductive health services and information for persons living in both emergency and protracted situations throughout the region.

The SPRINT Initiative is a rights-based initiative that aims to uphold the right to life and security of persons, as well as the right to the highest attainable standard of health – including sexual and reproductive health - for all people affected by conflict and natural disaster.

In the Asia and Pacific region SPRINT has trained over 3,900 people in 18 countries and 76 in-country trainings have been rolled out. The success of these trainings has led to SPRINT regional trainings being rolled out in the Africa and Middle East and North Africa regions in partnership with UNHCR and UNFPA.

Therefore, UNFPA has decided to introduce this experience in the emergency prone countries of EECA region.

### MISP ROLL OUT IN EECA REGION

One of the key recommendation of UNFPA 2010 Global planning meeting was “Improved humanitarian response and emergency preparedness systems are needed”. Consequently, during 2010 EECA regional meeting, EECA S/RO made also a commitment to work together in this important area, particularly in emergency/ crisis prone countries in the region.

The MISP roll out in EECA region has been divided into two rounds.

#### First round MISP roll out

For the first round the following seven countries have been selected. **Four (4) CA countries:** **Kyrgyzstan** (*post conflict, natural disasters*), **Uzbekistan** (*natural disasters and had an experience related to 2010 Kyrgyzstan crisis*), **Tajikistan** (*possibility of conflict and natural disaster*), and **Turkmenistan** (*possibility of earthquake and population influx from Afghanistan*).

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<sup>1</sup> SPRINT: Sexual and Reproductive Health PProgramme IN Crisis and PosT-Crisis Situations



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**Three (3) countries from EE: Georgia** (*post-conflict*), **Moldova** (*flood response*) and **Turkey** (natural disasters).

It was agreed between HRB and EECA Team that the MISP roll out will follow already institutionalized SPRINT initiative, where IPPF is taking the leadership.

### **Regional Training of Trainers (ToT) on MISP**

The regional ToT was held in Istanbul on 28 March – 1 April 2011. 27 participants from above mentioned seven (7) emergency prone countries were invited: Georgia (4), Moldova (4), Kyrgyzstan (4), Tajikistan (4), Turkey (4), Turkmenistan (4) and Uzbekistan (3).

A total of 28 participants attended: 27 from EECA region and one participant from Africa region.

Country teams were requested to (a) take MISP distance learning module and obtain certificates, (b) draft national action plans (NAPs) and prepare short presentations in advance to the ToT. Following these requests 24 participants out of 27 (89%) passed distance learning module and obtained certificates. All 7 country teams presented their draft action plans on inclusion of MISP into national preparedness and contingency plan and then updated them based on the achieved knowledge during the training.

A 10 questions test is proposed to participants on the second day and the last day of the training. These tests show a significant improvement of knowledge after the training: **the average of % corrected answers increased from 51% up to 79%**

The ToT Evaluation forms completed at the end of the session have shown a global interest and satisfaction of participants. All participants found training topics very useful.

### **Follow-up to ToT**

During the ToT the below two follow up actions have been agreed with all country teams:

1. The Country Teams have been working on their Action Plan: by the end of 2011, they will be solicited by the Facilitators' team to give a feedback about their achievements in term of coordination, in country roll-outs etc.
2. Country Teams already planned their in-country training courses and passed their budget needs to ECCARO Focal Point. Total need for six countries is about \$55,000

### **MISP: In-country roll outs**



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Based on initial agreement each Country Team organized in-country training in their respective countries (Annex 1). In general 197 service providers, health managers, staff from other UN agencies and non-governmental organizations have been trained. Total number of conducted in country trainings is seven. For the in-country roll out trainings was spent \$266 per participant.

The workshop pre- and post-tests showed that participants' knowledge has been significantly increased. In each country the draft national action plans from ToT has been updated during the in-country training and submitted to the relevant Ministry's approval.

### **Participants' feedback**

All participants expressed high satisfaction to in-country training content, materials and facilitation by national master-trainers/ SRH Coordinators.

Participants' provided recommendations on how to improve the roll out process. The key recommendations from each country summarized in Annex 1.

### **Key recommendations on:**

#### **a) MISRP roll out in-country training**

1. Prolong duration of the training to five days
2. Organize ToT trainings for the staff working in this field, and Health Care providers, local municipalities and for the staff working involved in the management of emergency situations
3. To present the content of some UNFPA RH kits;
4. Use simulation games of crisis situations to practice knowledge and skills;
5. Make shorter presentation and work with kits
6. Translation of training materials to local language is crucial
7. The separate training on infection control and STI management is needed;

#### **b) Way Forward**

1. Strengthen partnerships among Government, NGOs and International organizations for the implementation of National Action Plan (NAP)
2. Take active part in the implementation of the action plan on MISRP and advocate for action at national level;
3. Organize a post-training meeting with the participants and share the National Action Plan on RHS on crisis and post-crises situations.
4. updating the national list of essential medicine and supplies as a stockpile for emergency purposes (Egg: Initial Care Bag/First Aid Bag)
5. To work with working group on UNDAF outcome on peace and security for the working out one UN approach to the life saving strategies in humanitarian settings



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6. Advocate Ministry of Health on endorsement of National Action Planning Matrix

### Facilitators' Feedback

Above-mentioned 7 in-country training have been facilitated by 21 master-trainers. The evaluation forms were received from 20 facilitators. Almost all facilitators showed their satisfaction with the training content and design: average rating is 6.15 out of 7.

All facilitators put high rating for the usefulness of Facilitator's manual, Power point presentations provided by SPRINT initiative and to all sessions of in-country training (see below matrix<sup>2</sup>).

Question/ Training session	Rating
How useful was the Facilitator's Manual for this training?	3.85
How useful were the PowerPoints provided by the SPRINT Initiative?	3.75
A. MISP Pre-test & Post-test	3.45
B. MISP Overview & Coordination	3.45
C. Sexual and Gender Based Violence	3.55
D. Maternal and Newborn Health	3.25
E. HIV and STI	3.45
F. SRH Supplies and Logistics	3.3
G. Monitoring and Evaluation	3.15
H. Country Action Planning	3.3

Facilitators' summarized feedback is provided in annex 2. Even they provide high rating of training sessions, facilitators raised relevant recommendations, which will be shared with SPRINT initiative.

### The Way Forward after first round of MISP roll out

1. The implementation Country Team's NAP in addition to UNFPA MISP Focal Point should also be monitored by UNFPA Representative/ Country Director and Assistant Representative in respective country. It should be included into CO's list of priorities and OMP.

<sup>2</sup> Rating (from 1 to 4): 1 - Unsatisfactory and 4 - Excellent



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2. Advocacy efforts should be undertaken at UNCT (UNFPA Representative/ Country Director or Assistant Representative to table the issue) and UNDAF Thematic Group meetings (Assistant Representative and National Programme Officers to table the issue).
3. COs should secure the relevant staff time and budget for the implementation above-raised recommendations by including the special activity in the relevant AWP.
4. All news/ additional activities should be shared among colleagues, working in other COs. For this the Fusion asset should be utilized.

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**EECA 1st round of MISP roll out: in-country trainings**

**Annex 1**

<b>Country Date and Number of workshops</b>	<b># of trained specialists</b>	<b>Evaluation of knowledge in % (before/ after)</b>	<b>Training evaluation bay participants</b>	<b>The country action plan has been updated: (Yes/ No)</b>	<b>Expenditure (in USD)</b>	<b>Key recommendations/ way forward</b>
Georgia, 14-16 July 2011, One workshop	35 (including representatives 4 Participants - Ministry of Internal Affairs, 2 Ministry of Health, 14 Regional Coordination Centers/Social Service Agency (Ministry of Health), 9 – UN agency (UNFPA, UNDP, WHO, UNHCR, UNICEF), 5 Private Hospital Sector (Regional/Referral ) and 1- Red Cross	15/61	<b>High satisfaction of participants: between 87% - 100%.</b>	Yes	13,995	1. Prolong duration of the training to five days 2. Organize ToT trainings for the staff working in this field, and Health Care providers, local municipalities and for the staff working involved in the management of emergency situations 3. Strengthen partnerships among Government, NGOs and International organizations for the implementation of NAP
Moldova 8-10 June One	36 (the main specialists on mother and child healthcare representing all the Primary	52.7/ 72.8	<b>High satisfaction of participants (between 3.8-4.0)</b>	Yes	6,594	1) to present the content of some UNFPA RH kits; 2) Use simulation games of crisis



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workshop	Healthcare Centers from all rayons, thus ensuring the coverage of the whole country)					situations to practice knowledge and skills; 3) Take active part in the implementation of the action plan on MISP and advocate for action at national level; 4) Organize a post-training meeting with the participants and share the National Action Plan on RHS on crisis and post-crises situations.
Tajikistan 20-23 June One workshop	(National and Regional RH specialists, MoH)  22	47/ 73.7	<b>High satisfaction of participants</b> (between 3.5-4.0)	Yes	6,992	1) the simulation exercise; 2) updating the national list of essential medicine and supplies as a stockpile for emergency purposes (Egg: Initial Care Bag/First Aid Bag)
Turkmenistan 27-29 June One workshop	22 (RH specialists)	30/75	<b>High satisfaction of participants</b> (between 3.0-4.0)	Yes	5,720	To work with working group on UNDAF outcome on peace and security for the working out one UN approach to the life saving strategies in humanitarian settings - deadline November 2012
Kyrgyzstan 28 - 2 July	62 (health managers)	16.3/85.8 (Bishkek)	<b>High satisfaction of participants</b>	Yes	10,428	1) make shorter presentation and work with kits;



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and 3-7 July 2011 Two workshops		training) 15/66 (Osh training)	(between 3.7-3.8)			2) it is expected that - The National Action Planning Matrix will be endorsed at the end of September 2011 by MOH( Prikaz MOH)
Uzbekistan 22-24 August One workshop Note: in addition there was organized orientation session as preparatory activity	20 (service providers from three regions)	25,9/81.8	<b>High satisfaction of participants</b> (between 3.0-4.0)	Yes	8,682	1) translation of training materials to local language is crucial; 2) the separate training on infection control and STI management is needed; 3) inter-country training should be expanded; 4) The updated national Plan will be send to MoH's consideration
Total		197			52,411	
Cost-efficient	\$266 per participant					



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Annex 2

**Facilitators' feedback**

<b>Question</b>	<b>Comments/ recommendations</b>
<p>What suggestions do you have to improve the SPRINT In country Training?</p>	<ol style="list-style-type: none"> <li>1. Prolong duration of the training to 5 days</li> <li>2. Conduct additional trainings for specialists/ managers, who are involved in the management of emergency situations.</li> <li>3. Disseminate good reproductive health practices and lessons learned on reproductive health in humanitarian settings.</li> <li>4. Increasing time in HIV and STI sessions.</li> <li>5. Requires a deeper study and a higher awareness of health system workers.</li> <li>6. It would be better to adjust the presentation's photos and also the information to the situations more common to the European side.</li> <li>7. The group to be trained not to exceed 25 people.</li> <li>8. More visual and movie made practical approaches should also be considered since participants usually think emergencies to be of a conflict related matter leaving natural disasters to a second place.</li> <li>9. To have in country ToT (similar to Istanbul ToT) for conducting the cascade trainings all over the country.</li> <li>10. It could be helpful to make a division of roles between RH coordinator and service provider. The training itself is a bit mixed and in my sense is more inclined to the role of RH coordinator with some practical roles of service providers. I think it may be useful to divide the training for RH coordinators and Service providers.</li> <li>11. to include recommendations for country facilitators to organize preliminary meetings with key people who could contribute further to training design</li> </ol>



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<p>What changes would you suggest for the Facilitator’s Manual?</p>	<ol style="list-style-type: none"> <li>1. Manuals should be better adapted to the situations of the definite region and country.</li> <li>2. More practical examples, with some statistical data.</li> <li>3. The working group stations could be improved taking into account the region for which it will be designed to and as well, preparing for in country training many of the additional equipment (models) weren’t available and as consequent working station were changed or not applicable.</li> <li>4. More interactive exercises</li> </ol>
<p>What changes would you suggest for the Power Points provided by the SPRINT Secretariat?</p>	<ol style="list-style-type: none"> <li>1. The Power Points adopted according to each country situation.</li> <li>2. The cutting presentations on STI/HIV and infection control and do shorter. For example: in PP was information regarding treatment of STI in details. However we think that this information should be presented as handouts or separate training should be on Clinical aspects.</li> <li>3. Using the national data</li> </ol>
<p>A. MISP Pre-test &amp; Post-test: How could this session be improved?</p>	<ol style="list-style-type: none"> <li>1. Conducting trainings in the regions (especially in vulnerable areas).</li> <li>2. Taking MISP distance learning module before the training.</li> </ol>
<p>B. MISP Overview &amp; Coordination: How could this session be improved?</p>	<ol style="list-style-type: none"> <li>1. By presenting some concrete cases, by organizing one more training in this field and addressing the issues raised on the country side.</li> <li>2. The learning materials could be better adapted to the regions.</li> <li>3. Sometimes participants doesn’t fully understand the word “coordination”, it is useful to discover this word through easy practical exercises which may show the objective and meaning of coordination.</li> <li>4. In my opinion service providers are more attracted to practical provision of services. Coordination is a work of RH coordinators. In connection with this I may only suggest to think over division of theoretical issues that RH coordinators must know and practical ones that service providers will be interested in.</li> <li>5. The session should be also realigned based on local specificities of organizing support during emergency.</li> </ol>
<p>C. Sexual and Gender Based Violence: How could this session be improved?</p>	<p>No comments</p>
<p>D. Maternal and Newborn Health: How</p>	<p>No comments</p>



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could this session be improved?	
E. HIV and STI How could this session be improved?	<ol style="list-style-type: none"> <li>1. Would be good to organize visits to the AIDS centres to see how specialists working in center.</li> <li>2. STI case management approach should be updated with the latest information available up to date of training</li> <li>3. Samples of drugs and female/male condom and anatomic models would be useful for this session.</li> </ol>
F. SRH Supplies and Logistics How could this session be improved?	<ol style="list-style-type: none"> <li>1. In national training it should be more equipment for presentations to the training participants</li> <li>2. Theoretically we understood the way we should act. Practically, I consider it might be useful to play a scenario with UNFPA HRB, this might be a phone conversation or internet based approach. We should think over this approach as well</li> <li>3. Inter-Agency Manual on RH Kits for Crisis Situations also could be a part of training materials for Russian speaking countries.</li> </ol>
G. Monitoring and Evaluation How could this session be improved?	<ol style="list-style-type: none"> <li>1. After the works in groups, would be nice to show the movie on Monitoring and evaluation in real crisis situations.</li> <li>2. I know that each country has its own mechanism of M&amp;E. However, this might be useful to think over a standard, simple, easy to understand M&amp;E check list or mechanism that could be applied practically everywhere.</li> </ol> <p>Discussion and elaboration in a more restricted group of people that have necessary competencies</p>
H. Country Action Planning How could this session be improved?	<p>Discussion and elaboration in a more restricted group of people that have necessary competencies</p>
How many days would be appropriate for a typical SPRINT Training?	<ol style="list-style-type: none"> <li>1. Approximately 4-5 days would be ideal for a typical SPRINT Training.</li> <li>2. Three days</li> <li>3. Four days</li> <li>4. 3 days for implementers and 2 days training for managers.</li> </ol>
Any other comments?	<ol style="list-style-type: none"> <li>1. The follow up meeting for the facilitators is very important, in order to discuss in details; make deep analysis of feedbacks; exchange the experiences and lessons learn of in country trainings among all countries;</li> <li>2. Work out the future work plans for program with cooperation of facilitator's in country.</li> <li>3. Work out the mechanisms of continuity of SPRINT program in country.</li> <li>4. "Refreshment training" for facilitators to redesign their knowledge and upgrade skills.</li> </ol>



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- 5. MISIP should be available on local languages.
- 6. Some of humanitarian actors may not see RH as a priority, therefore there is a need, point out that including the MISIP is a Health Cluster standard and contingency plan and all components of the MISIP should be implemented and can be sustained.
- 7. Besides the theoretical training it might be useful to think over practical, field based one. It can be a simulation exercise where other UN agencies, international NGOs, federations and etc. can also make their input into the overall emergency simulation exercise thus showing coordination mechanism, who is doing what, where and when and how coordinators and service providers are dealing with MISIP and SRH services in a simulated setting or temporary tent camp or etc.