Family Planning

Length	45 minutes
Overview	This session reviews the principles of providing family planning services in crisis settings. Emergency contraception was discussed in the SGBV session.
Learning outcomes	See below
Preparation	Ensure that PowerPoint presentation handouts are copied
Materials	Markers and flip charts or whiteboards
Methodology	Interactive presentation

Process

1.

Learning outcomes:
by the end of the session, you should be able to:

Discuss the role of family planning (FP) in crisis and post-crisis situations:

- Benefits of family planning
- Importance of integrating STI management and FP
- Elements of service delivery, supplies & logistics
- Addressing SRH needs of young people

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

2.

Why Family Planning?

ADVOCACY

- It is a human right
- Saves women's lives, preserves their health
- Saves children's lives
- Offers women more choices
- Encourages adoption of safer sexual behavior

- Ask participants: 'Why is Family Planning important for women, families and communities?'
- Briefly facilitate feedback and click to show proposed answers.
- Explain that where birth rates are high, over 30% of maternal deaths and nearly 10% of childhood deaths can be avoided by the use of family planning. Family planning decreases poverty and hunger, and contributes to women's empowerment, education, and economic stability.[1]

[1] Cleland J et al. Sexual and Reproductive Health 3 – Family planning: the unfinished agenda. Lancet 2006; 368(9549):1810-27.

3.

- Explain that there is a large unmet need for effective FP services.
- Ask participants to guess the percentage of unintended pregnancies and induced abortions worldwide.
- Click to show proposed answers.

4.

- Ask participants to name some benefits of FP for women, their children and family.
- Briefly facilitate feedback and click to show proposed answers.

5.

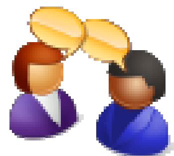
- As part of the advocacy messages for FP, explain the 4 too's coming from the lack of FP.

6.

Subject area	Minimum (MISP) RH services	Comprehensive RH services
FAMILY PLANNING	None* **Although family planning programming is no part of the MISP, make contraceptives available for any demand, if possible*	+ Source and procure contraceptive supplies + Offer sustainable access to a range of contraceptive methods + Provide staff training + Provide community IEC

- Although FP programming is not part of the MISP, experience shows that providing basic contraceptive methods such as pills and injectables for continuing users is essential from the beginning of an emergency. There is ongoing debate about the inclusion of FP programming into the MISP and your audience may have similar reactions. Explain that the choice was made on the basis that the MISP should prioritize immediately life-saving interventions. In addition, FP programming requires a stable situation. As such, FP programming is not part of the priority interventions during emergencies. However, there are several ways of including FP programming as soon as possible into SRH activities, such as engaging the national FP associations in the contingency planning and emergency response. SRH Coordinators should adapt to the situation at hand and make decisions based on opportunities to provide basic FP methods and start planning for comprehensive FP programming whenever possible.

7.



Group discussion

- What are some of the issues and concerns regarding FP in your crisis/post-crisis setting?
- Is there a problem of unintended pregnancy in your setting and why?
- What are the community attitudes toward FP?
- What are the patterns of contraceptive use in your setting?

- Divide the 4 questions among the participants' tables and give 3 minutes for group work.

8.

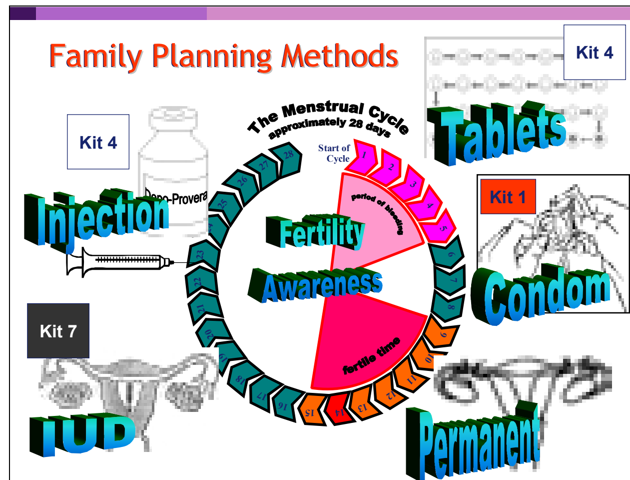
Key Points

Issues and concerns regarding family planning in situations of forced migration may include:

- Desire to continue family planning method used before onset of crisis
- Pressure on women to give birth to replenish population
- Some desire to replace children who have died or disappeared
- Some women's desire to not get pregnant in this unstable situation because they may have to flee again
- Separation of families
- Women's authority to control their fertility may be eroded by social changes
- Lack of access to family planning services, leading to an increase in unwanted pregnancies and possibly unsafe abortions.

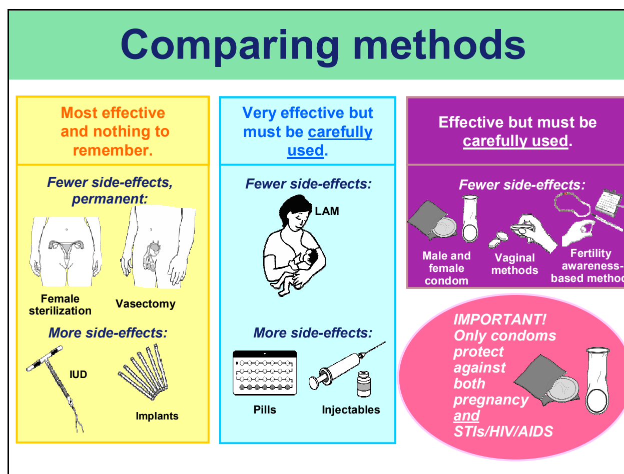
- Take 3 minutes to facilitate reporting from each table and click to present some proposed discussion points.

9.



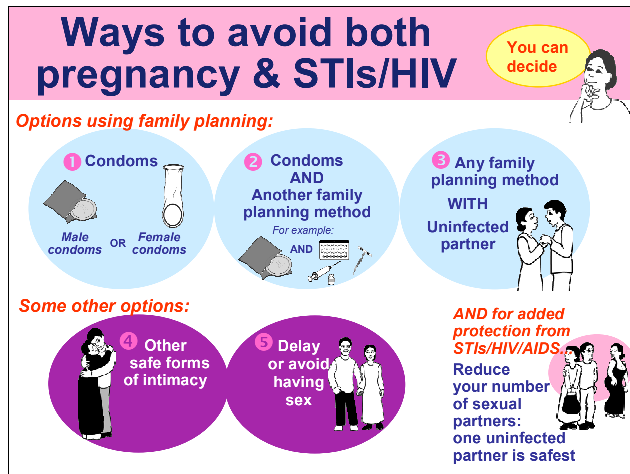
- Ask participants to name some family planning methods.
- Click to show the different methods. Explain that the RH Kits contain 3-month injectables, combined OCP (oral contraceptive pills), IUD (intra-uterine devices), condoms and ECP (emergency contraceptive pills).
- Stress again that FP methods should be made available for continuing users or people who spontaneously request FP.
- Explain that condoms and emergency contraception should be free and immediately available in the earliest phases of an emergency (through other components of the MISP, such as with Kit 3, rape treatment). Stress that there should be no restrictions on access to ECP (i.e. available to everyone) or requirements such as physical examination.

10.



- Briefly compare some of the methods.

11.



- Briefly review methods to avoid both pregnancy and STIs. It is important for young people to know and have access to both condoms and other forms of FP methods for dual protection.

12.

Integrate STI Management in Family Planning

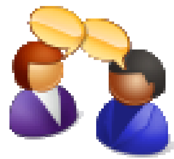
- Discuss STI with all clients at each visit
  - Risk assessment
- Enquire if symptoms (in client or partner)
  - Treatment using syndromic approach
  - Arrange for treatment of partner
- Screen for STIs
- Encourage dual protection!
  - Condoms
  - Method of choice PLUS condoms
- Beware IUD use in areas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

- Stress the importance for SRH coordinators to integrate STI management into FP.

13.

Elements of Family Planning Service Delivery in Your Setting (group work)

- **Needs and resources assessment**
- **Supplies and logistics**
- **Service delivery standards and protocols**
- **Service delivery sites**
- **Human resources: training and supervision**



Kit 1 Kit 4 Kit 7

Community involvement

- Ask participants to take 5 minutes to work by table to address the question: 'As SRH Coordinators, how would you implement FP services in your setting?' Groups should address some of the bullet points.

14. After 5 minutes, facilitate the reporting process and go through the next 3 slides to present some of the elements that SRH coordinators should have addressed in their group work:

Needs and Resources Assessment

- Background information from country of origin
- Review host country program and services
- Community beliefs and practices

3

- Explain that it is important to consider national protocols, service provider capacity and training, logistics and supplies.

15.

Supplies and Logistics

- Select contraceptives
- Estimate and procure
- Record keeping system
- Management of procurement, distribution and inventories

4

- Family planning services should be of high quality, and reliable contraceptive procurement and distribution mechanisms must be ensured. SRH coordinators should link program procurement mechanisms to national or agency supply systems. Stock-outs must be avoided at all costs.

16.

Quality of family planning programming

- ✓ As many methods as possible: needs and resources assessment
  - No excuse for running out of supplies
- ✓ As many outlets as possible
  - Outreach health posts
  - Health centers
  - Integration into primary health care
- ✓ As many population groups as possible
  - Men
  - Women
  - Adolescents
- ✓ Accessible facilities
  - Private room
  - Equipment/supplies for infection prevention
- ✓ Trained personnel
  - Technical competence and counselling skills
  - Provided with guidelines
- ✓ Monitoring, evaluation and information system
  - Supervision
- ✓ Links with other components of RH

- Explain that providing FP services is not enough. SRH coordinators should ensure quality of care for the services provided.

17.

Access to FP Services for Men & Young People

Men

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

Access for youth

- Appropriate opening times
- Access for unmarried people
- Services in combination with other youth activities
- Provide comprehensive information
- Respect and confidentiality

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

18.

Key Messages

- FP not part of MISP, but ensure basic supplies are available for continuing users
- Ensure variety of methods to choose from
- Ensure access for young people

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

Suggested further reading

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

* Women's Commission for Refugee Women and Children, *Resource List for Adolescent Reproductive Health Programming in Conflict Settings*, 2006.

MNH Group Work Stations

Length	1 hour and 30 minutes
Overview	The group work stations will address: 1. Clean delivery and immediate newborn care (25 minutes) 2. Post-abortion care (25 minutes) 3. Quality of care (QOC) in MNH (25 minutes)
Learning outcomes	By the end of the session, participants should be able to: - Apply the contents of the clean delivery Kit for immediate newborn care - Plan the distribution of delivery Kits to crisis - Discuss the impact of unsafe abortion in crisis situations - Describe elements of post-abortion care (PAC) services - List major causes of death and disability in mothers and newborns - Discuss the relevance of QOC in preventing the third delay.
Preparation	- Ensure participants' worksheets for these station are copied (if possible copy page 2 at the back of page 1) and staple all of them together - For other copies and preparation activities, see below. - A facilitator is assigned to each station to set it up and facilitate it. - The three stations need to be set up the evening before in different physical spaces or with enough distance between them so that groups do not disturb each other. - If possible, assign a time keeper to inform each group to start wrapping up their work 5 minutes before the end of each session.
Materials	See below
Methodology	Facilitated group work

Process

1. Ensure participants' have their worksheets for the three stations.
2. Divide participants into three groups (try using a game to do so).
3. Assign each group to a station.
4. Facilitate the group work and by gentle probing and constructive feedback, ensure that the group addresses key discussion points.
5. After 25 minutes of group work, take 5 minutes to allow each group to rotate to the next station.
6. At the end of the 3 sessions, bring participants together in large group and take 5 minutes to debrief.

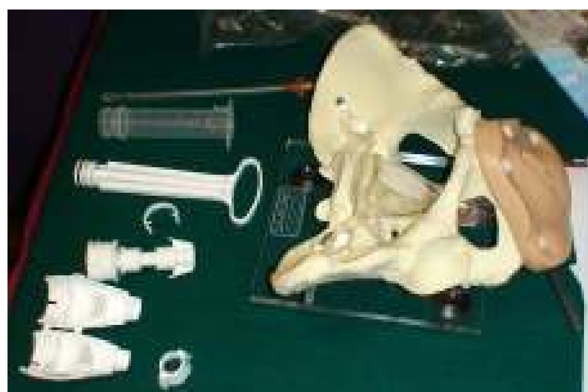
MNH - Group work station 1: Clean delivery Kits and immediate newborn care (25 minutes)

Checklist

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

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

Clean delivery Kit and baby doll



MVA and Pelvic Model

MNH - Group work station 2: Post-abortion care (25 minutes)

Checklist

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

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

MNH - Group work station 3: Quality of Care in MNH (25 minutes)

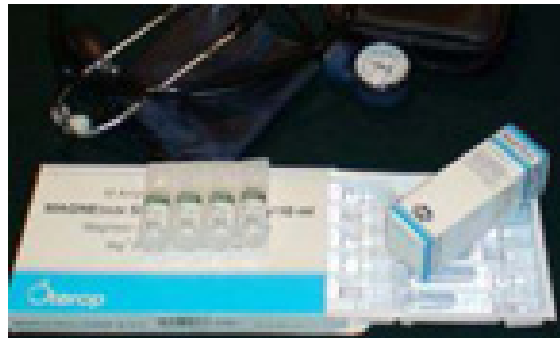
Checklist

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

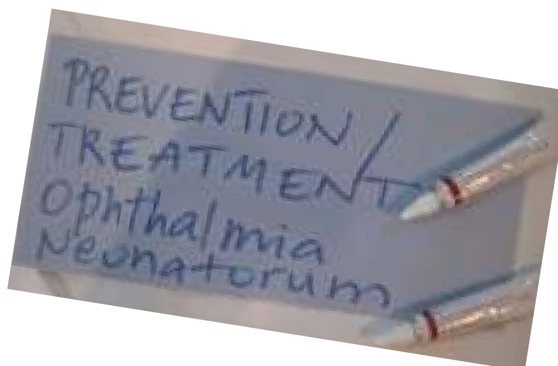
X	Number	Item	Comments
	1	Blood pressure cuff	
	1	Urinary protein test strips	
	1	Magnesium sulfate, injectable	
	1	Calcium gluconate, injectable	
	1	Oxytocin	
	1	IV fluids, saline 0.9%	
	1	Tetracyclin eye ointment	
	1	Vacuum extractor	
	1	Kiwi cup and/or vacuum extractor	
	1	Amoxicillin 250mg, tablets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

Note: this is a session that requires careful timing. You may want to have 2 co-facilitators for this station.

Bird Vacuum Extractor



Magnesium Sulphate, Calcium Gluconate, BP Cuff



Suggested further reading

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

MNH - Group work station 1 (Page 1 of 2)
Clean delivery Kits and immediate newborn care

Participants' Worksheet

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

5 min

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

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

2. Exercise: order clean delivery Kit
Use the CBR (4%) to calculate the supplies and services needed for a population of 10,000 for 3 months to ensure pregnant women have a safe delivery.

10 min

10 min

3. Facilitate a group discussion, using some of the following triggers
- To whom do you plan to distribute the clean delivery Kits in your setting?
- What are the challenges in distributing the clean delivery Kits in your setting?
- How can you to assemble the clean delivery Kits locally?

____
____
____
____
____
____
____

MNH - Group work station 1 (Page 2 of 2)
Clean delivery Kits and immediate newborn care

Participants' Worksheet

Key messages

- Approximately two-thirds of infant deaths occur within the first 28 days. The majority of these deaths are preventable by initiating essential actions that can be taken by health care workers, mothers or other community members.

- Clean delivery Kits need to be distributed to all visibly pregnant women (6-9 months), even in flight, for use by birth attendant or herself. It should be emphasized that at the very least, women should receive supportive care during childbirth and should never be left unattended. Clean delivery Kits can be procured or assembled locally.

Solution to exercise: order clean delivery Kit

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

MNH - Group work station 2 (Page 1 of 2)
Post-abortion care

Participants' Worksheet

1. MVA demonstration (Kit 8): application on pelvic model, dismantlement and reassembling of MVA. (If MVA not available, proceed to point 2)

5 min

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

20 min

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

Notes:

MNH - Group work station 2 (Page 2 of 2)
Post-abortion care

Participants' Worksheet

Key Messages

- Unsafe abortion is a major contributor to maternal morbidity and mortality. Up to 15 percent of pregnancy-related deaths worldwide are due to unsafe abortion, and in some countries, deaths due to unsafe abortion may be responsible for up to 45 percent of all maternal deaths.

- UNFPA estimates that 25-50% of maternal deaths in refugee settings may be related to unsafe abortion.[*]

- Contraceptive failure as a result of disrupted use during flight, interruption of health services, rape and sexual violence place refugee women and adolescent girls at particular risk of unintended pregnancy and unsafe abortion.

- Abortions will occur despite restrictive legislation. Settings with restrictive abortion laws have higher rates of maternal mortality due to unsafe abortion. This is even further magnified in crises.

- Deaths from abortion complications are avoidable. Governments, UN agencies, and humanitarian organizations have an obligation to ensure that health services are able to respond to complications from unsafe abortion.

- Post-abortion care (PAC) is the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. The elements of PAC include:
> Emergency management of incomplete abortion and potentially life-threatening complications
> Post-abortion family planning counseling and services
> Linkages between post-abortion emergency services and other RH care services

- Post-abortion care involves all levels of service, including education in the community about prevention of unsafe abortion.

- Post-abortion services should include treatment and/or referral for:
    - STIs;
    - Voluntary counseling and testing for HIV;
    - Services following sexual violence;
    - Family planning;
    - Antenatal care;
    - Nutrition.

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

MNH - Group work station 3 (Page 1 of 2)
Quality of Care (QOC) in MNH

Participants' Worksheet

10 min

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

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

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

15 min

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

Notes:

____

____

____

____

____

____

____

____

____

____

MNH - Group work station 3 (Page 2 of 2)
Quality of Care (QOC) in MNH

Participants' Worksheet

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

Key Messages

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

Elements in QOC include:
- **Availability** (the services exist and there are no legal, procedural, or logistical barriers restricting their availability);
- **Access** (the services are convenient, affordable, respectful);
- **Acceptability** of services (the services conform to socio-cultural norms of the community, respect clients' concerns);
- **Organization of care** — integration of SRH services into primary health care; referral systems; continuity of care;
- **Technical competence** — quantity and quality of staff; standards and protocols for care; supervision;
- **Facilities and supplies** — appropriate technologies; logistics; and
- **Client rights** — privacy; confidentiality; informed consent; respect; courtesy; safety.

Quality should be measured from the perspective of the manager, the provider and the client or community. Possible indicators include:
- % of facilities equipped with appropriate equipment, supplies, and physical structure (specification of 'appropriate' to be defined for each case) [Source of information: supervisory checklist, assessed quarterly]
- % of providers who follow clinical/technical protocols, offer information, use educational materials [Source of information: Supervisor's observation with checklist]
- % of clients who report that they feel respected, are treated with courtesy and get the information they want. [Source of information: Exit interviews]

HIV and STIs

Learning outcomes:

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

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

Agenda:

Day 2 Afternoon - HIV and STIs	
1330 - 1445	Preventing HIV/STIs in Crises
1445 - 1530	Planning for comprehensive STI and HIV programming
1530 - 1545	Break
1545 - 1645	Group work: 1: Standard precautions 2: Condoms 3: STI syndromic approach
1645 - 1730	National plan review and discussions

Notes:

Preventing HIV/STIs in Crises

Length	1 hour 15 minutes
Overview	This session discusses the challenges of introducing HIV and STI prevention measures in emergencies. It provides an overview of the links between HIV, STI, and SGBV, outlines coordination mechanisms related to HIV and introduces inter-agency coordination tools.
Learning outcomes	See below
Preparation	- Ensure that PowerPoint presentation handouts are copied - Post the HIV and SGBV Coordination Matrix on the wall if available
Materials	- IASC HIV Guideline - Markers and flip charts or whiteboards
Methodology	Interactive presentation

Process

1.

Objectives

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

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

2.

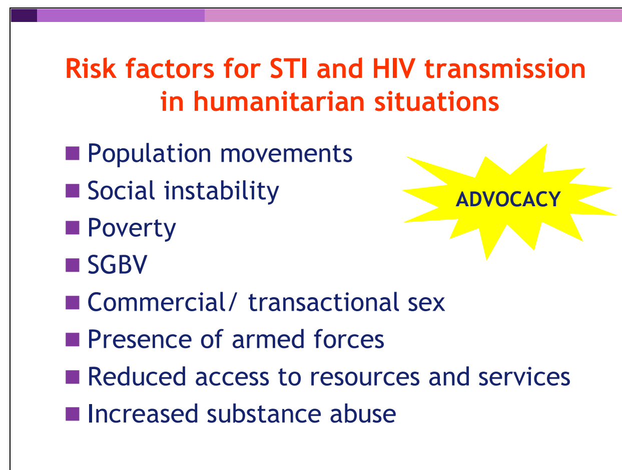
MISP

Objective 3: Reduce Transmission of HIV by

- Enforcing respect for universal precautions
- Ensuring blood for transfusion is safe
- Guaranteeing the availability of free condoms

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

3.



- Ask participants: 'Can you name some risk factors for STI and HIV transmission in crisis situations?'
- Briefly facilitate feedback and click to show proposed answers.

(Background information for facilitators:
> Population movements and migration are recognized as important risk factors for the transmission of STIs and HIV. Spread of STIs may result from sexual interaction between populations with different STI prevalence, for example, between displaced and host communities, returnees and home communities, urban and rural populations, or among displaced populations from different geographical areas or cultures.
> Social instability: disruption of family and social structures as well as the psychological trauma of conflict and displacement may result in changes in sexual behavior. Lack of work, educational and recreational opportunities, and the accompanying boredom and frustration, further contribute to risky sexual behavior. Young people are particularly at risk.
> Poverty: increased economic vulnerability of women and unaccompanied minors in conflict situations may result in survival sex, involving commercial sex or the bartering of sex for basic commodities and shelter.
> Commercial sex trade may flourish in conflict-affected situations, with an influx of commercial sex worker from other areas. Clients may include the displaced population, as well as military or peacekeeping forces and relief workers.
> Presence of military or peacekeeping forces: armed forces are vulnerable to STIs due to factors such as young age, mobility, separation from families, high stress work environments, lack of recreational outlets and alcohol misuse, all of which may predispose soldiers to risky sexual behavior. During peacetime, HIV prevalence among armed forces is generally two to five times higher than in civilian populations; in times of conflict the difference can be much greater. Soldiers interact with civilian populations where they are stationed and upon returning home also spread STIs into their home communities.
> Reduced access to health services: conflict may disrupt curative services and prevention programs. Access to condoms may be limited. Health facilities may be destroyed. High workloads, shortages of trained staff and lack of supplies may result in risky health care practices, such as neglect of standard precautions, unsafe injections and unscreened blood transfusions. Conflict-related injuries may result in an increased need for blood transfusions. Where health services remain functional, access may be limited because of insecurity, lack of transport or lack of money.
> Increased substance abuse: conflict has been associated with increased use of alcohol and drugs. Risks include both those associated with injecting drug use as well as risky sexual behavior while under the influence of drugs or alcohol.)

4.

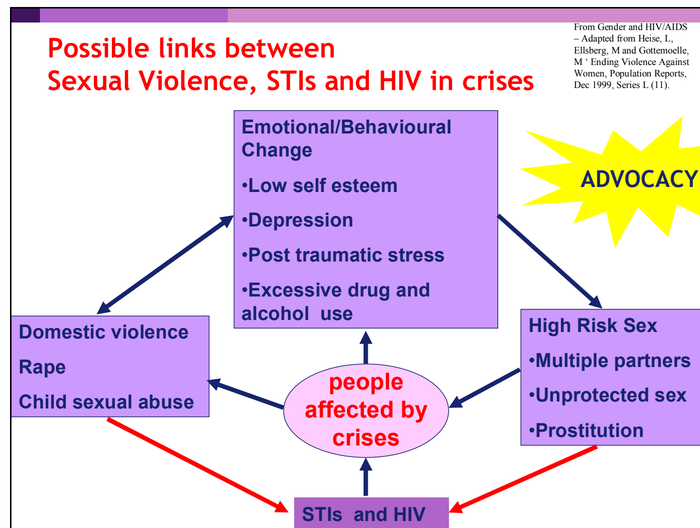
ADVOCACY

STI and HIV: the link

- Unprotected sex increases the risk of both STIs *and* HIV
- The presence of STIs facilitates transmission of HIV
  - ✓Open ulcers; broken skin (syphilis and herpes)
  - ✓Discharge; increased presence of white blood cells (chlamydia, gonorrhoea and trichomonas)
- HIV can make people more susceptible to STIs
- HIV increases the severity of some STIs

- Ask participants: 'What is the link between the transmission of STIs and HIV?'
- Facilitate feedback for 1 minute in the large group and click to give answer and explain each bullet one by one. There is a clear link between STIs and HIV in that:
  - Certain STIs facilitate the transmission of HIV: a person with ulcers in the genital area is much more likely to contract and transmit HIV. STIs associated with discharge, such as Chlamydia or Gonorrhea can also facilitate the transmission of HIV because the discharge contains a high number of white blood cells, which are a source of HIV.
  - The presence of HIV can make people more susceptible to become infected with an STI: HIV weakens the body's immune system.
  - The presence of HIV increases the severity of some STIs (for instance herpes).

5.



- Ask participants: 'Now thinking back to our SGBV session, what are the possible links between Sexual Violence and STIs/HIV transmission in crises?'
- Facilitate discussion for 1 minute in the large group, and click to show a possible model. Do not spend a long time on this slide

6.

IASC Guidelines for HIV/AIDS interventions in emergency settings

In the past HIV and AIDS were viewed primarily as a health-sector concern

But, like SGBV, HIV/AIDS is a multisectoral responsibility

HIV/AIDS priorities must be integrated into all emergency planning/response

- In view of what was just discussed, the IASC developed guidelines for HIV/AIDS interventions in emergency settings. Like GBV, HIV prevention and response must also be mainstreamed throughout the sectors and requires a multisectoral approach in emergency settings. The IASC HIV guidelines are similar to the GBV guidelines. The matrices are parallel and many of the sector activities in the minimum response column are the same in both guidelines (show both matrices).
- **Group work** (5 minutes)**:** ask participants to form a group at each table. Divide up the "sectors" among the tables. Give one group the water/sanitation, food and nutrition and shelter and site planning. Divide the other sectors among the other groups. Each group should compare the minimum response activities (middle column) of the assigned sectors in both HIV and GBV matrices. Participants should determine whether the activities are similar and if not, where they differ.
- Take 2 minutes to facilitate feedback from the different groups.
(For the facilitator: The minimum response activities in both matrices are very similar. Notable differences are that the GBV matrix has a "sector" called "Human Resources" that outlines measures to prevent Sexual Exploitation and Abuse (SEA). The corresponding "sector" in the HIV guidelines is "HIV in the Workplace", which deals with protecting staff from HIV-related discrimination and provision of PEP. In the HIV matrix, SEA is an activity under the Protection sector. The Health sector in both matrices is different in that HIV prevention activities (MISP) are mentioned in the HIV matrix, but not in the GBV matrix (apart from medical services for rape survivors). The IEC "sector" in the GBV matrix (= BCC in the HIV matrix) has an additional human rights-related activity. Despite these differences, in smaller response operations, both matrices can be merged for more effective coordination.)
- Often, especially in larger emergencies, a HIV Coordinator as well as a GBV and a SRH Coordinator will be appointed. It is very important to agree on a division of responsibilities and accountability between these 3 people, as well as the Health Coordinator. All should participate in the regular health coordination meetings, in order to identify and address gaps and overlaps between the general health, SRH, GBV and HIV/AIDS interventions. In reviewing and adapting the matrices from both guidelines a site-specific coordination matrix can be developed to ensure effective working relations and find practical solutions to overcome challenges.

7.

Ensure Adherence to Standard (Universal) Precautions

- Explain that you will now review universal precautions that are now called 'standard' precautions.

8.

What are standard (universal) precautions?

- **Simple infection control measures** that reduce the risk of transmission of blood borne pathogens through **exposure to blood or body fluids** among patients and health care workers

- Blood and body fluids from **all persons** should be considered as **infected with HIV**, regardless of the known or suspected status of the person

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

9.

HIV transmission in health care settings

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

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

causing

ADVOCACY

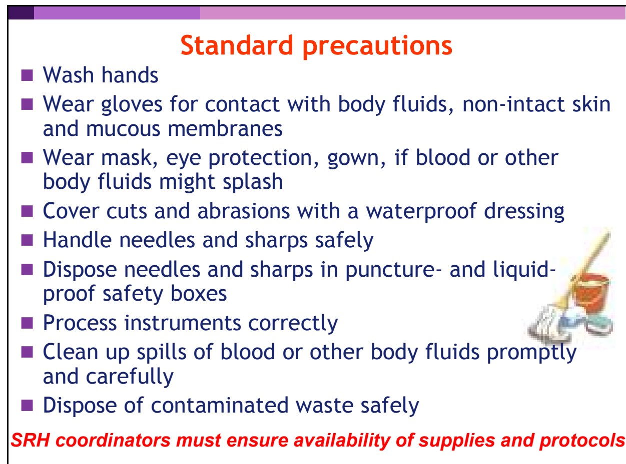
49 000 Hep B; 24 000 Hep C; 210 000 HIV **deaths**

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

Technical Guidance for Round 8 Global Fund HIV Proposals, Broad Area: Prevention, Service Delivery Area: Blood safety and universal precautions. UNAIDS/WHO, 2 April 2008

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

10.



- Ask participants: 'Can you name the activities that are part of standard precautions?'
- Take 1 minute to facilitate feedback and click to show answers and emphasize the message at the bottom: the importance for SRH Coordinators to have supplies available and protocols in place.

11.

Handwashing

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

Happy Birthday to You

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

12.

Antiseptics

What are antiseptics?

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

Use

- Before clinical procedure
- For surgical scrub
- For handwashing in high-risk situations

Antiseptics in the kits

- Povidone iodine
- Chlorhexidine gluconate

- Explain the slide, stressing under the 1st bullet point that antiseptics are to be used for skin and mucous membranes. The word ‘antiseptics’ is often confused with ‘disinfectants’, which will be explained later on.
- 3rd bullet point under ‘Use’: high risk situations include protection in susceptible persons (newborn, immunosuppressed persons) or before invasive procedures.
- Antiseptics included in the Reproductive Health kits are povidone iodine and chlorhexidine gluconate

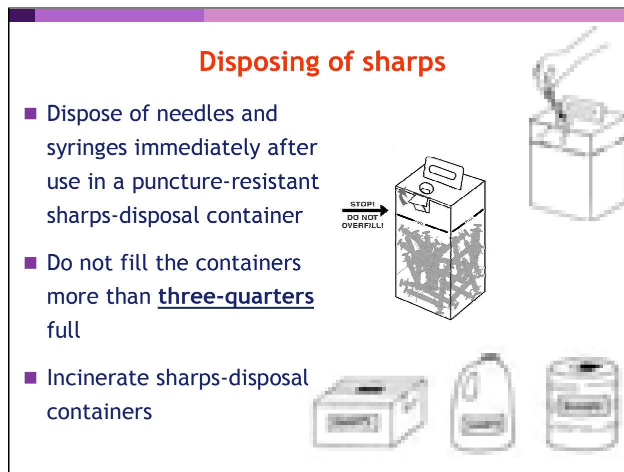
13.

Safe injections

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

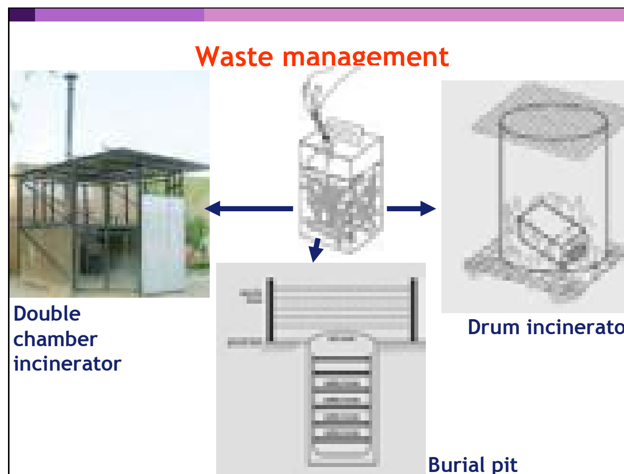
- Ask participants: ‘What do health care workers need to do to make injections safe?’
- Briefly facilitate feedback and click to show the answers and highlight points that were not mentioned.

14.



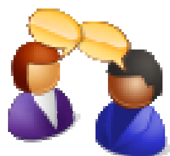
- Explain the slide and highlight that the incineration of the containers may be an issue in crisis settings.

15.



- Explain the different methods of waste management in emergencies.

16.



Example of burial pit

- Ask participants to take 1 minute to work in pairs: 'As SRH Coordinators, how would you assess the appropriateness of this burial pit for sharps?' (Fence and cover are missing)

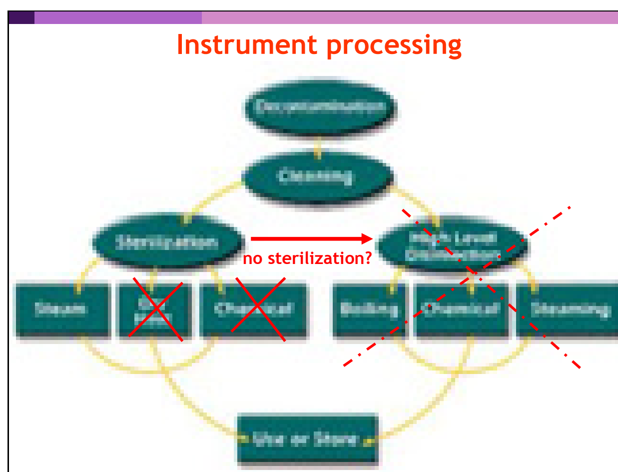
17.

Occupational exposure: first aid

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

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

18.



- Explain that the 4 steps of instrument processing consist of 1. Decontamination, 2. Cleaning, 3. Sterilization (when not feasible High Level Disinfection (HLD)) and 4. Immediate use or storage of sterilized equipment.
- Stress that sterilization using steam (autoclave) is the gold standard. Sterilization with dry heat or chemical sterilization (with glutaraldehyde for instance) is no longer recommended. SRH Coordinators may consider HLD with chlorine in emergency settings until sterilization equipment is available.

19.

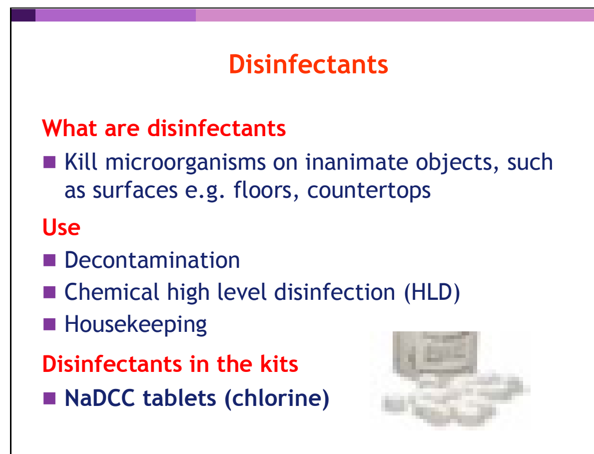
Instrument processing

It is important to perform the steps in the appropriate order for several reasons:

1. Decontamination kills viruses (HIV and Hep B) and should always be done first to make items safer to handle
2. Cleaning should be done before sterilization or HLD to remove debris
3. Sterilization (eliminates all pathogens) should be done before use or storage to minimize the risk of infections during procedures. (HLD may not eliminate spores)
4. Items should be used or properly stored immediately after sterilization

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

20.



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

21.

Autoclaving

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

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

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

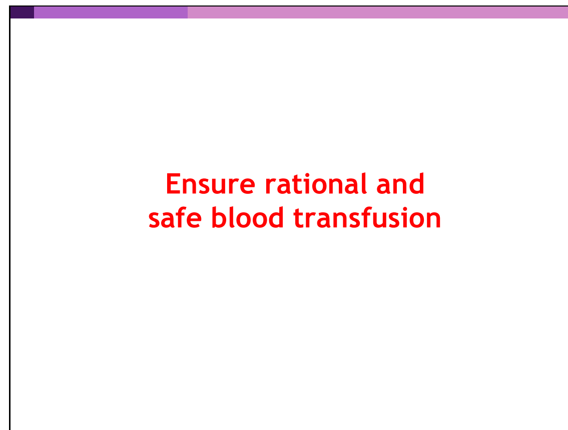
22.

Not recommended

- Dry heat sterilization:
  electricity dependent and time consuming
- Chemical sterilization:
  time consuming, glutaraldehyde is toxic
- Boiling instruments:
  a form of HLD
- Storing instruments in liquid antiseptic
  ineffective
- "Flaming" instruments:
  ineffective

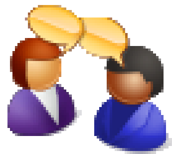
- Explain the slide and stress that: glutaraldehyde is toxic.

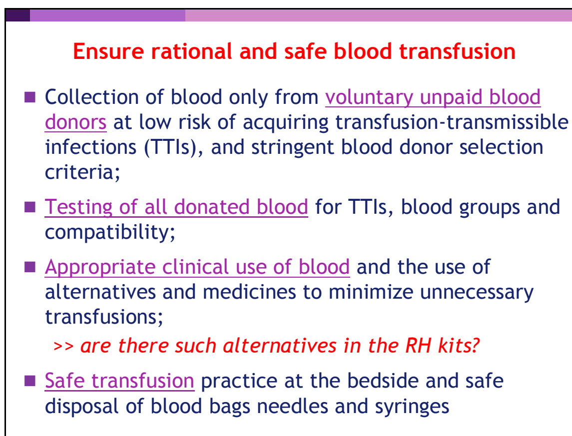
23.



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

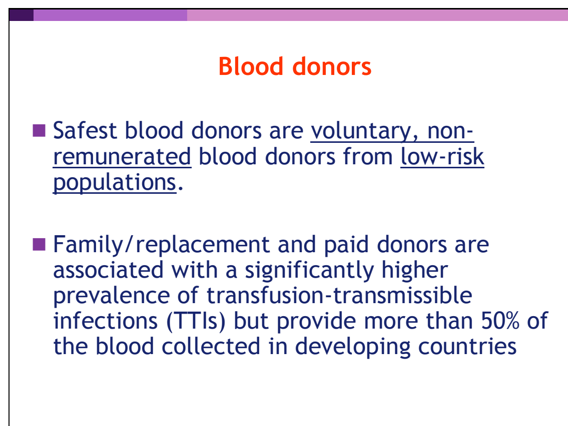
24.





- Ask participants: 'What do you think that rational and safe blood transfusion mean?' Prompt them by asking about 'rational' and 'safe' separately.
- Take 1 minute to facilitate feedback and click to show bullet points and explain.
- 2nd bullet point: transfusion-transmitted infections (TTIs) include HIV, Syphilis, Hep B and Hep C. Malaria should be tested in endemic areas. Staff should be made aware that the purpose of the tests is to screen the blood and not the donor status. One positive HIV test result is not enough to make a patient diagnosis. Therefore, test results should not be divulged to the donor. For this, VCT services with different testing strategies are needed.
- 3rd bullet point: ask participants to take 1 minute to discuss in pairs possible alternatives to blood and medicines to manage bleeding. The RH Kits contain sodium chloride (NaCl) and plasma expanders as fluid replacement alternatives and oxytocin to prevent and manage post-partum hemorrhage.

25.



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

26.

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

27.

28.

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

29.

Guarantee availability of free condoms

- Condoms are an effective method for prevention of HIV and STI transmission
- Make good quality condoms available
- Ensure sufficient supplies
- Distribution strategy
- Humanitarian staff also use condoms
- Where possible include existing IEC materials
- Monitor uptake (≠ “use”)
- Re-order based on uptake

- Explain that condoms are a key method of protection for the prevention of HIV and other STIs. Although not all of the population will be knowledgeable about them, experience shows that in all populations some people use condoms, even in the most traditional societies. Therefore condoms should be available in accessible, private areas from the earliest days of an emergency so that anyone who is familiar with them, both the affected populations and humanitarian staff, has access to them. Condoms should also be made available where young people congregate. Sufficient supplies should be ordered immediately.

2nd bullet point: as well as providing condoms on request, field staff should make sure that the community is aware that condoms are available and where they can be obtained.

- 4th bullet point: Do not conduct condom awareness campaigns during the chaotic acute phase of an emergency. This is not a priority and could be offensive to the population if it is not well prepared. Consult with local staff about how condoms can be made available in a culturally sensitive way: they can be widely distributed with the non-food items, or put out in bars, latrines and other public places. Condoms should be made available in health facilities, and should be provided when treating STIs.
- 7th bullet point: stock cards should be used to monitor distribution. On the cards it should be noted how many (boxes) of condoms have been placed where. The distribution places should be visited every week or every 2 weeks and the uptake monitored and condoms replaced as needed. Note that monitoring distribution numbers is not the same as knowing the usage rate. For the latter a behavioral surveillance study would need to be conducted in the post-acute phase

30.

Although not in the MISP, it is important to:

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

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

31.

Indicators

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

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

32.

For more information

- www.engenderhealth.org/ip/index.html
- www.who.int/bloodsafety/en/
- www.healthcarewaste.org

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

33.

Key messages

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

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

Planning for Comprehensive STI and HIV Programmes

Length	45 minutes
Overview	This session discusses the syndromic approach to STI case management and outlines the key components of comprehensive care programs and priority interventions for PLHIV.
Learning outcomes	See below
Preparation	Ensure that PowerPoint presentation handouts are copied
Materials	Markers and flip charts or whiteboards
Methodology	Interactive presentation

1.

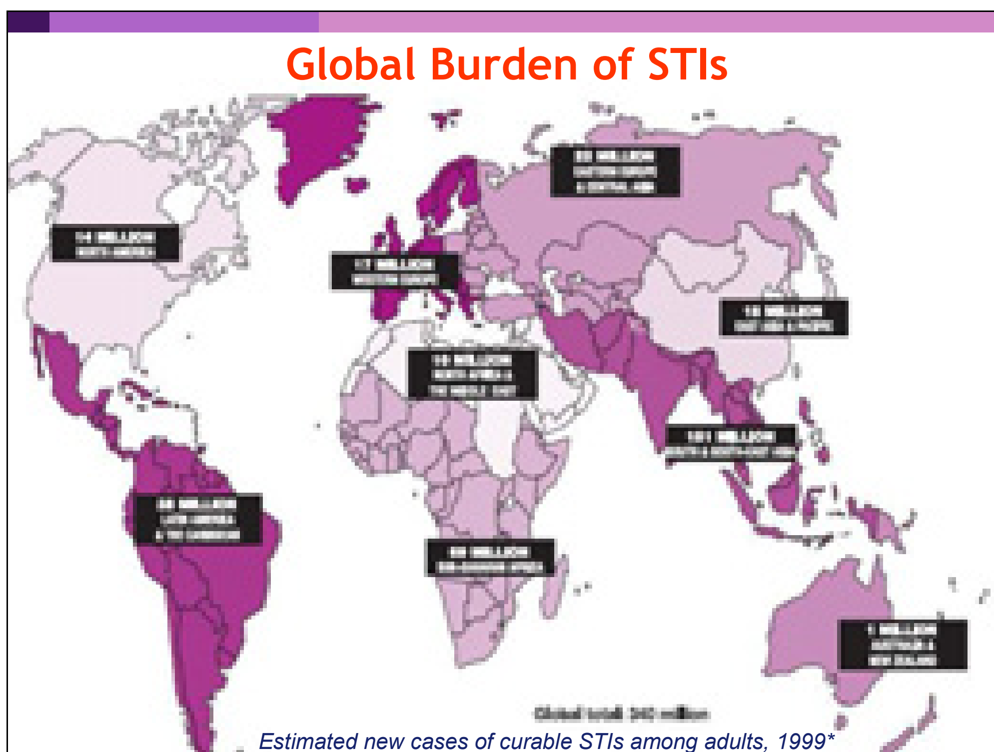
Objectives

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

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

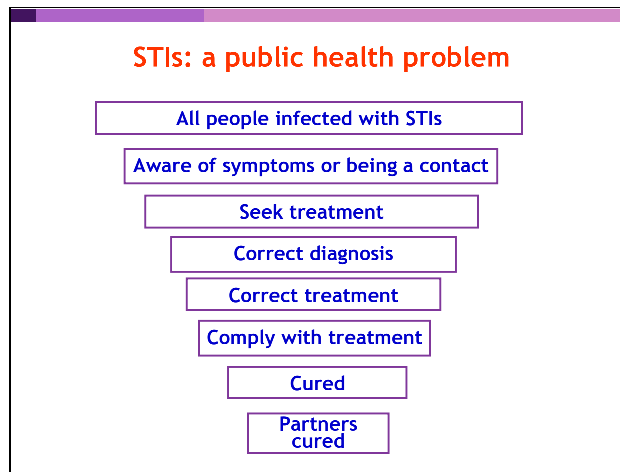
- Read the learning outcomes of the session, stressing that you will not address detailed clinical issues but will highlight practical information relevant for SRH Coordination.

2.



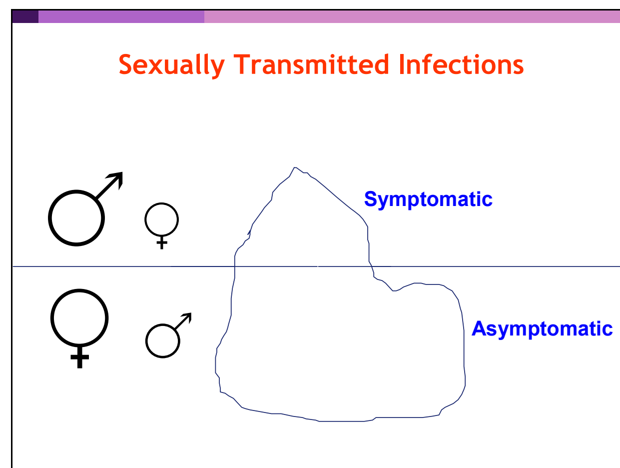
- STIs are a common and serious problem worldwide. WHO estimates that globally, more than 340 million new cases of syphilis, gonorrhea, chlamydia and trichomoniasis occur every year in men and women between 15-49 years old. In East and Southeast Asia, an estimated 48 million people have a curable STI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

3.



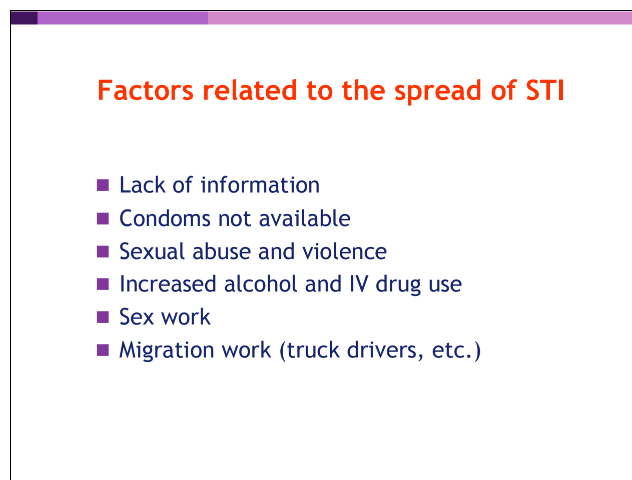
- Explain the inverse pyramid and how the number of individuals eventually cured is much smaller than all the people who are infected with STIs. The next slides will explain some of the reasons behind this public health issue.

4.



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

5.



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

6.

Consequences of STIs

Ascending infections
- endometritis
- salpingitis
- pelvic inflammatory diseases
- peri-hepatitis
- epididymitis
- infertility

Other
- blindness in infants
- extensive organ and tissue destruction in children
- permanent brain and heart disease
- vaginal, cervical, anal, and liver cancer

Pregnancy
- ectopic pregnancy
- abortions, stillbirths
- preterm delivery
- premature rupture of membranes
- post-partum infections

Social and Economic
- stigma, conflict
- cost of treatment
- loss of life and productivity

- Ask participants: 'Can you name some consequences of STIs?' Facilitate feedback for 1 minute.
- Click to show proposed answers and highlight the social and economic consequences.

7.

Comprehensive STI case management

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

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

8.

How can we best diagnose a STI?

Diagnosis	Disadvantages
Clinician diagnosis (etiological)	• not sensitive / specific • cannot detect mixed infections
Laboratory diagnosis (tests)	• there are no reliable, inexpensive, simple to use tests • results not available within a short time
Syndromic approach	• •

- There are 3 different ways to diagnose a STI: clinical diagnosis (the provider diagnoses the pathogen by examining the patient's signs and symptoms), laboratory tests (swabs are taken and sent to the laboratory for identification of the causative pathogen), or syndromic approach. Click to show the disadvantages of the first two methods.
- Ask participants: 'What is syndromic approach?' Click to show the next slide

9.

Syndromic approach

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

- Explain what a syndromic approach means.

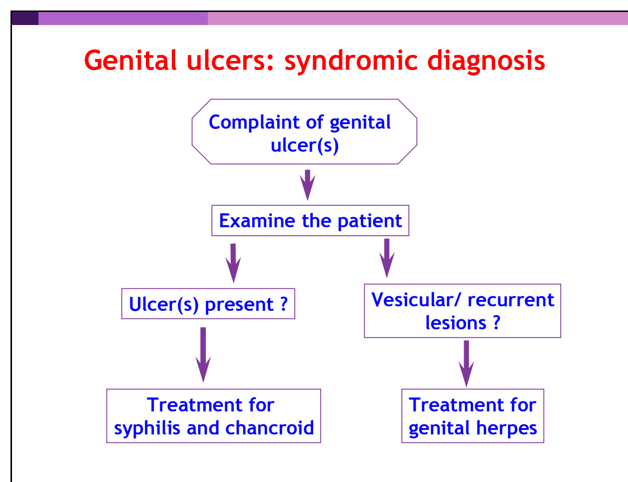
10.

Examples of STI syndromes

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

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

11.



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

12.

STI syndromic case management

Advantages
- Faster treatment
- ↓ in transmission
- ↓ in complications
- Cost-saving (no expensive lab tests)
- Client satisfaction
- Standardisation
  - > diagnosis and treatment
  - > supplies management
  - > training
  - > monitoring and surveillance

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

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

13.

Algorithms need to be adapted

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

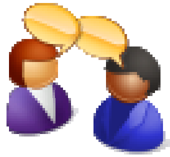
- 3rd bullet point: explain that the antibiotics selected to treat STI syndromes must be tested to ensure that certain pathogens in the region (mainly Neisseria Gonorrhea or Hemophilus Ducreyi, the cause of chancroid) have not become resistant to certain antibiotics over time. The adaptation of syndromic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

14.

Comprehensive STI case management (2)
- *Identify the syndrome*
- Antibiotic treatment for the syndrome
  - ✓ High efficacy (at least 95%)
  - ✓ Low cost
  - ✓ Few side effects
  - ✓ No anti-microbial resistance
  - ✓ Single oral dose
  - ✓ No contraindication
  - ✓ Available at first point of contact (incl. private sector)
- Education and counselling of the patient
- Condom supply
- Partner notification and management

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

15.



Educate and counsel the patient (group work)

- Nature of the infection and medication
- Promote safer sexual behaviour
- Demonstrate and provide condoms
- Compassionate and sensitive counselling
  - ✓ Informing partner
  - ✓ HIV testing
  - ✓ Complications, i.e. infertility or incurable disease
  - ✓ Preventing future infections
  - ✓ Communicating with partner
  - ✓ Confidentiality, disclosure
  - ✓ Risk of violence or stigma

- 2-minute group work: ask participants to group in pairs at their table. One person plays the service provider giving STI counseling to the other person who will play the patient.
- Recall participants, take 1 minute to ask them to give you feedback on what they discussed in their counseling session, and click to show the information to be discussed with the patient.

16.

Ways to avoid both pregnancy & STIs/HIV

You can decide

Options using family planning:

1. Condoms
   Male condoms OR Female condoms
2. Condoms AND Another family planning method
   For example: AND
3. Any family planning method WITH Uninfected partner

Some other options:

4. Other safe forms of intimacy
5. Delay or avoid having sex

AND for added protection from STIs/HIV/AIDS:
Reduce your number of sexual partners: one uninfected partner is safest

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

17.

Partner management

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

- 1st and 2nd bullet points: explain
- 3rd bullet point: ask participants 'In your experience how can we best contact partners of STI patients?'
- Briefly facilitate feedback and click to show answers.

The purpose of partner management is to treat as many of the patient's sexual partners as possible. There are two approaches to contacting sexual partners:
1) by the patient: this is known as *patient referral*;
2) by a service provider: this is known as *provider referral*.

Because of the expenses of provider referral and the perceived threat to patient confidentiality, the more practical and workable option is patient referral. This is also the approach recommended by WHO.

-Ask participants: 'From how far back should we contact an STI patient's sexual partners?' Click to show the next slide

18.

Partner management

Contacts over past 2 months

Kindly present yourself to:
Townville Clinic, New Town
Tel: 456 834
Opening hours
Monday 9.00 am – 3.00 pm
Tuesday 9.00 am – 3.00 pm
Wednesday 9.00 am – 3.00 pm
Friday 9.00 am – 1.30 pm
29/04/08 ***Referral ABC***

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

- All partners from the last 2 months should be contacted.
- Lower box: explain that this is an example of a patient referral method with a coded card that the patient will give to sexual partner(s) from the past 2 months.
- The code at the bottom of the card (ABC) refers to the syndrome that the initial patient (or 'index patient') presented with.

19.

Quality of Care in STI Programme

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

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

20.

The Public Health Package

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

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

21.

Integrated STI management

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

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

22. Now moving on to comprehensive HIV programming:

Comprehensive HIV Programming

23.

Comprehensive HIV programming

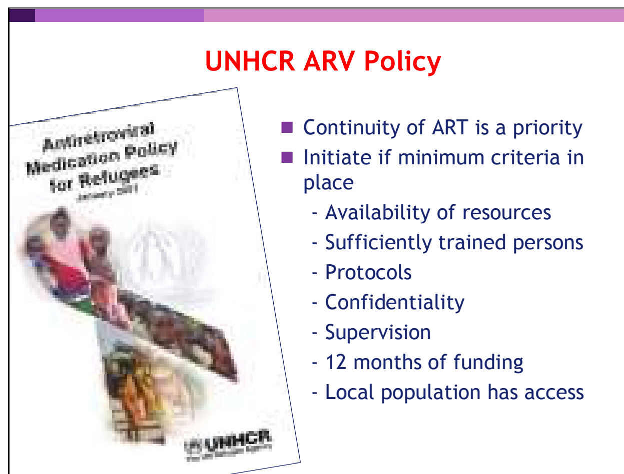
Principles: in post-crisis, aim to integrate programming for displaced populations and host community. Aim for services to be similar to those the host community has.

Interventions:

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

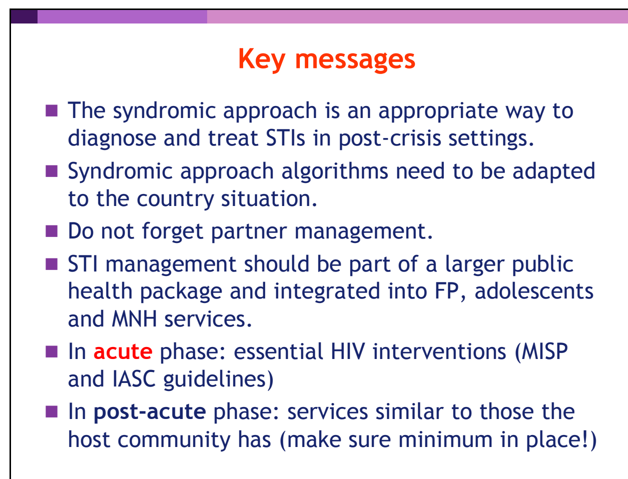
- Principles: explain that if the host population has access to a particular HIV service then displaced communities should also have access to it.

24.



- According to UNHCR ARV policy:
- 1st bullet point: continuation of ARVs for people already on HAART is a priority and should be ensured as soon as possible in an emergency response.
- 2nd bullet point: initiation of ART programmes should be planned for and included in the post-acute phase response if the minimum criteria are in place.

25.



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

Suggested further reading

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

HIV/STIs Group Work Stations

Length	1 hour and 30 minutes
Overview	The group work stations will address: 1. Standard (standard) precautions (25 minutes) 2. Condoms (25 minutes) 3. STI syndromic approach (25 minutes)
Learning outcomes	By the end of the session, participants should be able to: - Assess the implementation of standard precautions at a service delivery point - Explain how access to free condoms can be ensured in emergency settings - Calculate condom supplies - Describe the importance of adapting the STI syndromic approach to national guidelines
Preparation	- Ensure participants' worksheets for these station are copied (if possible copy page 2 at the back of page 1) and staple all of them together - For other copies and preparation activities, see below - A facilitator is assigned to each station to set it up and facilitate it - The three stations need to be set up the evening before in different physical spaces or with enough distance between them so that groups do not disturb each other - If possible, assign a time keeper to inform each group to start wrapping up their work 5 minutes before the end of each session
Materials	See below
Methodology	Facilitated group work

Process

1. Ensure participants have their worksheets for the three stations.
2. Divide participants into three groups (try using a game to do so).
3. Assign each group to a station.
4. Facilitate the group work and by gentle probing and constructive feedback, ensure that the group addresses key discussion points.
5. After 25 minutes of group work, take 5 minutes to allow each group to rotate to the next station.
6. At the end of the 3 sessions, bring participants together in large group and take 5 minutes to debrief.

HIV/STIs - Group work station 1: Standard precautions (25 minutes)

The key messages of this station are very simple and clear, but often overlooked by SRH Coordinators. Having a practical station will help participants better remember and reinforce standard precautions in their project areas.
In a corner of the training, set up a nurses' station where the following items are displayed (some of them inappropriately, as not to respect standard precautions). The hotel or training center will have panels and curtains that you can use to build your station. Be creative and the participants will have fun learning!
(If stetting up the station is not possible, project the PowerPoint presentation containing pictures of the station for participants to comment.)

Checklist

X	Number	Item	Comments
	1	Sign 'Nurses' Station'	
	1	Wall protocol on safe injections	
	1	Mask	
	1	Apron	
	1	Pair of rubber gloves	
	1	Bucket	
	1	Mop	
	1	Injection table	
	1	Box of gloves	
	1	Needle in vial	
	1	Uncapped used syringe	
	1	Kidney basin	
	1	Water dispenser & soap	
	1	Nurse's table	
	1	Burn box full of syringes	
	1	Stethoscope	
	1	Blood pressure cuff	
	1	Trash can with recapped syringe inside	
	5	Patient's files	

Injection table

Hand washing station

HIV/STI - Group work station 1 (Page 1 of 1)
Standard precautions

Participants' Worksheet

1. **You are conducting a supervisory visit to a health post**

- Look around and observe how well standard precautions are implemented.
- Give feedback to the nurse on the following standard precautions measures

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

Notes:
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

HIV/STIs - Group work station 2: Condoms (25 minutes)

Checklist

X	Number	Item	Comments
	1	Penis model	
	1	Pelvis model	Optional
	1/pers	Male condom	
	1/pers	Female condom	
	1/pers	Male and female condom instructions	Available at: http://www.femalehealth.com/Resources/resources_PDFs/MultilingualSheetp.pdf

Female condoms in action

HIV/STIs - Group work station 3: STI syndromic approach (25 minutes)

Checklist

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

X	Number	Item	Comments
	1/5 pers	STI syndromic wallchart	
	60	Post-its	
	1/pers	Contact cards	

Adapting the STI syndromic poster

HIV/STI - Group work station 2 (Page 1 of 2)
Condoms

Participants' Worksheet

1. Condom demonstration

10 min

Take turns in demonstrating how to use male and female condoms

2. Discuss the following:

15 min

- How would you ensure that condoms are available in an acute crisis in your country?
- How would you monitor the uptake of condoms?
- Using the formula below, calculate how many condoms you would need to order for a population of 30 000 people for 3 months

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

Notes:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

HIV/STI - Group work station 2 (Page 2 of 2)
Condoms

Participants' Worksheet

Key Messages

- Do not order female condoms for emergencies if the population has not been exposed to them.

- Condoms can be made available in many ways, but SRH Coordinators must be creative and take cultural sensitivities into consideration. They should discuss with young men and women (separately) and ask them where the best place to pick up condoms would be if people need them.

- Some examples are: making condoms available at registration sites; providing them in the non-food distribution; putting them out during the food distribution, put supplies in the latrines, in schools, in clinics, through community leaders, community health workers or TBAs.

- SRH Coordinators must ensure that distribution sites are selected so that condoms can be displayed in such a way that they do not spoil, preferably in a cool shady spot and away from dirt and pests. Instruct "distributors" who are responsible for re-supply to check the quality from time to time by taking a condom out of its package and visually inspecting it.

- Important to keep track of how many condoms are distributed. Check weekly how many condoms are taken from the distribution places.

- Monitoring distribution is different from monitoring usage rates: for this you need to do a behavior survey.

Answer

30,000 x 20 %= 6,000 sexually active men
6,000 x 20 % = 1,200 men use condoms
1,200 x 12 condoms = 14,400 condoms needed per month
14,400 x 3 months = 43,200 condoms
43,200 x 20% wastage = 8,640 extra condoms.
43,200 + 8,640 **= 51,840 condoms** need to be ordered in total

HIV/STI - Group work station 3 (Page 1 of 2)
STI syndromic approach

Participants' Worksheet

1. Explanation of exercise

15 min

Review the STI wall poster from Kit 5
The acute phase of the emergency is over and you have to **adapt** the STI syndromic poster to the national protocol (below).
Write the appropriate national syndromic treatment on stickers and stick them in the correct place on the wall poster.

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

2. Discuss
- What key messages would you give patients?

3. Examine the sample contact cards and discuss:
- How would you improve/adapt these contact cards?
- How are the contact cards used?

Kindly present yourself to:

Townville Clinic, New Town
Tel: 456 834

Opening hours
Monday 9.00 am - 3.00 pm
Tuesday 9.00 am - 3.00 pm
Wednesday 9.00 am - 3.00 pm
Friday 9.00 am - 1.30 pm
29/04/08 *Referral ABC*

Notes:

____

____

____

____

HIV/STI - Group work station 3 (Page 2 of 2)
STI syndromic approach

Participants' Worksheet

-The aim of STI prevention and care programes is to:
> interrupt the transmission of sexually transmitted infections
> prevent development of diseases, complications and sequelae in individual patients and their partners
> reduce the risk of HIV infection

- The STI antibiotics in the RH Kit 5 are not specific to a region. It is important to adapt the syndromic treatment choices to national protocols and available anitbiotics

- Patient counseling to include:
> Nature of the infection
> Medication compliance
> Promote safer sexual behaviour to prevent future infections
> Demonstrate and provide condom (for 3 months, until confirmatory HIV testing)
> Informing partner
> HIV testing
> Complications, i.e. infertility or incurable disease
> Communicating with partner
> Confidentiality, disclosure
> Risk of violence or stigma

National Plan Review and Discussions

Length	45 minutes
Overview	This session will allow the master trainers to continue their presentation of the action plan they worked on during the Training of Trainers, and to engage all participants to reflect on its relevance.
Learning outcomes	By the end of this session, participants should be able to: - Outline elements of the national plan related to MNH and HIV/STIs - Assess the relevance of the proposed activities and discuss alternatives as needed
Preparation	Participants should already have the national plan worked by master trainers and 'Suggested Preparedness Activities'
Materials	Markers and flip charts or whiteboards
Methodology	Self-reflection and group discussion

Process

1. Ask participants to take their handouts ('Suggested Preparedness Activities' and the national plan as proposed by the master trainers).

2. Review the proposed activities under MNH and HIV/STIs with the whole group. Ask participants in groups of 3 or 4 to take 30 minutes to reflect on their relevance and brainstorm on new ideas.

3. Bring the national planning session to an end and take 10 minutes to debrief the day in large group.

4. Close the day by thanking participants. Ensure that you have identified volunteers to do the review of day 2 for tomorrow's first session.

5. Inform participants that you will be available for further questions and comments after the end of the session.

Remaining happy trainers

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

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

Action Planning

Learning outcomes:

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

1. Order SRH Kits and plan in-country distribution
2. Conduct basic monitoring and evaluation for the MISP implementation and outline existing needs assessment tools to plan for comprehensive SRH
3. Clarify roles and responsibilities for implementing the MISP at the national level
4. Complete and present action plan to integrate the MISP into national emergency preparedness plans

Agenda:

Day 3 – Action Planning	
Time	**Session**
0830 – 0845	Review of Day 2
0845 – 1100 **(with break)**	SRH supplies and logistics
1100 – 1200	Monitoring and evaluation
1200 - 1300	**Lunch**
1300 – 1500	Country action planning
1500 - 1515	**Break**
1515 – 1600	Post-test and feedback Q&A
1600 – 1615	Review of participants' expectations
1615 – 1630	Evaluation of training
1630 – 1700	Closing

Notes:

Review of Day 2

Length	15 minutes
Overview	This session will allow participants to review key messages of day 2
Learning outcomes	By the end of this session, participants should be able to: - Recall key points from Day 2
Preparation	Invite 2 or 3 volunteers at the end of day 2 to prepare this session
Materials	As needed by the volunteers
Methodology	As planned by the volunteers. Encourage volunteers to make it fun and interactive.

Notes:

SRH Supplies and Logistics

Length	2 hours
Overview	After reviewing the basics of the RH Kits (30 minutes), participants will embark onto a comprehensive logistics exercise (90 minutes) that will allow them to put into practice the information received from the first day of the training.
Learning outcomes	See below.
Preparation	- Ensure that PowerPoint presentation handouts are copied - Ensure that the Case Study Alphaland-Betaland is copied (3 pages)
Materials	- MISP cheat sheet - RH Kits booklet - Calculator - Markers and flip chart or marker for each group (5-8 individuals)
Methodology	Interactive presentation and group exercise

Process

1.

Objectives

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

- Order Reproductive Health Kits and be familiar with the RH kit booklet
- Plan in-country distribution

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

2.

Inter-Agency Working Group
on RH in Crises (IAWG)

✓ Minimum Initial Service Package (MISP)

✓ Inter-Agency Field Manual and other guidelines

➢ ***Inter-Agency RH Kits for Emergency Situations***

- Explain that apart from the MISP and the Inter-Agency Field Manual, the IAWG also designed the RH Kits for emergency situations. The Kits contains the medical supplies and drugs to put in place the MISP, without having to do an in-depth need assessment first. The contents of the Kits are regularly revised by the IAWG, under the technical guidance of WHO. The Kits are assembled and stockpiled by UNFPA

3.

- Ask participants to look at back side of their MISP cheat sheet where there is a summary of the RH Kits.
- Explain Blocks 1, 2 and 3, their respective facility level and population coverage. The 12 Kits are divided into 3 Blocks. Each block has a number of kits designed for a different level of health service delivery, and contains RH supplies for the relevant number of people for each level, for 3 months, after which further needs should be calculated based on monthly consumption. Further supplies should be ordered through the usual supply systems of the ministry or organization implementing the services. You can re-order the Kits, if needed, but this is not recommended. They are meant to implement services where none exist at all.

4.

- Explain that the supplies in the Kits are calculated for a 'standard' population, with these assumptions (i.e. 20% adult males, 25% WRA, etc.). Therefore there is no need to redo these calculations when ordering the supplies. SRH coordinators only need to know the number of affected people and the distribution of health services and staff that this population has access to.

5.

- Explain that Block 1 contains 6 Kits and is designed for the above interventions.

6.

- This is a picture to illustrate one of the Kits (Kit 3: treatment of rape survivors).
- Ask participants to take 1 minute to open their RH Kit booklet and examine the contents of Kit 3 A and B.

7.

RH Kits for emergency situations

Block 2

Health centre level or referral level
30 000 people for 3 months

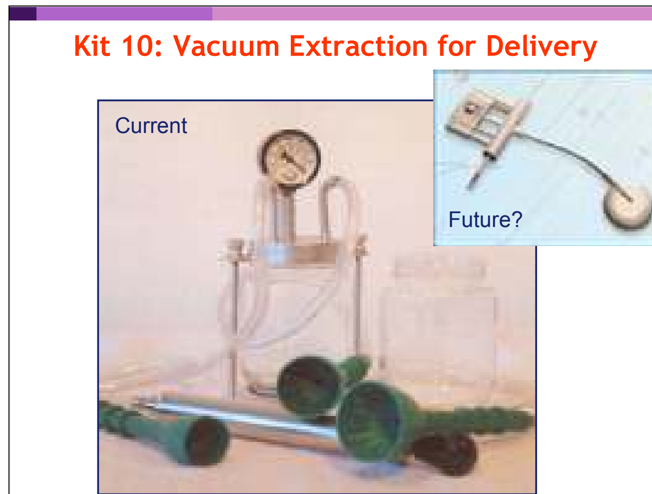
Kit	
6	Delivery (Health Facility)
7	IUD insertion
8	Management of complications of abortion
9	Suture of cervical and vaginal tears
10	Vacuum extraction

- Explain that Block 2 contains 5 Kits and is designed for the above interventions.

8.

- This is a picture to illustrate Kit 6. Many of the Kits consist of more than 1 box. For instance Kit 6 consists of 5 boxes, of which 1 is a cold-chain box with oxytocin.

9.



- This is a picture to illustrate Kit 10. The IAWG is currently examining the Kiwi Omni Cup.

10.

RH Kits for emergency situations

Block 3

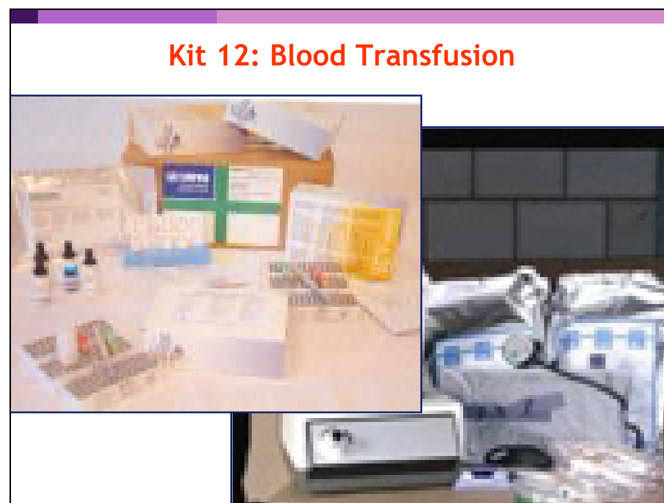
Referral level

150 000 people for 3 months

Kit		
11	A	Surgical (reusable equipment)
	B	Surgical (consumable items and drugs)
12		Blood transfusion

- Explain that Block 3 contains 2 Kits for the referral level and is designed for the above interventions.

11.



- This is a picture to illustrate Kit 12.

12.

Hygiene Supplies

- No "global" kit, community specific
- For women:
  - ✓ sanitary supplies for 3 months
  - ✓ underwear (3 large)
  - ✓ soap, soap powder, toothpaste, toothbrush, aspirin
  - ✓ bucket for washing
  - ✓ what else? ASK!
- For men
  - ✓ shaving supplies, soap, toothbrush, toothpaste
  - ✓ condoms
  - ✓ what else? ASK!

- 1st bullet point: explain that hygiene supplies need to be specific to the needs of the community. Therefore, there are no hygiene supplies in the RH Kits. Agencies need to consult with the community about their needs (for instance using focus group discussions) and assemble such hygiene supplies locally.
- 2nd bullet point: ask participants 'What would you include in hygiene kits for women?' (3 minutes group work by table)
- Take 2 minutes to facilitate feedback. Click to show proposed items and highlight those not yet mentioned. Large underwear are more practical as women can amend them to smaller sizes. 'What else'? Stress that the affected women should be asked what they need. In Indonesia for instance women asked for a piece of fabric to be used as a veil (so that they could go out and participate in daily life activities).
- 3rd bullet point: ask participants 'What would you include in hygiene kits for men?'
- Facilitate immediate feedback. Click to show proposed items and highlight those not yet mentioned.

13.

RH kits for emergency situations
Local logistics issues

- Customs clearance
- Observing the cold chain (when necessary)
- In-country distribution plan
- In-country transport
- In-country warehousing
- Coordinating with local partners (MOH, NGOs, other UN agencies)

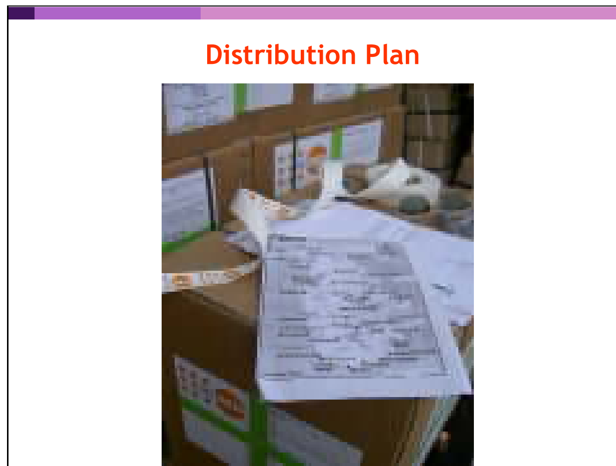
- 2nd bullet point: the cold chain is needed for instance for oxytocin (Kit 6, 8, 11) and blood screening tests (Kit 12).

14.

RH Kits at Sri Lanka airport

- This picture illustrates the large size of an RH Kits order (in Sri Lanka after the tsunami). It also demonstrates the color coding on the different RH Kits. The light green marked boxes are in kit 11B, which has 35 boxes.

15.



- This picture illustrates an example of a distribution plan mapped out in detail.

16.

- The pictures illustrate different ways to transport the Kits to the health facilities. The picture on the left shows a large-scale distribution operation in Sri Lanka with the Army doing the logistics. The picture on the right shows a doctor from UNFPA delivering RH Kits while on a technical support mission in the camps in Eastern Chad.

17.

UNFPA-ElFasher Field Office

To : Dr.Jonathan Ndzi- UNFPA Team Leader
From : Osman Daud - Admin/Finance Assistant.
Cc : Dr.Ashruf ishag - RH Officer
Ref: Hand over balance of Kits in the ware houses ,11/5/06

Date	31/12/05	21/2/06	Total				
	quantity received in (boxes)		Received	Total released	Balance	Location	Comments
kit 0	0	4	4	2	2	warehouse 2	
kit 1 A	30	48	78	29	49	warehouse 1	1broken has 8 packets
kit 1B	1	2	3	0	3	warehouse 1	quantities release in Pieces (400 PCS),2 cartons partly damage
kit 2 A	0	660	660	632	28	warehouse 2	1 carton is broken
kit 2 B	2	13	15	11	4	warehouse 1	
kit 3	0	15	15	9	6	warehouse 2	
kit 4	0	24	24	15	9	warehouse 1&2	In warehouse 14 boxes.8 in warehouse1& 6 in 2
kit 5	0	35	35	34	1	warehouse 1	
kit 6	0	94	94	80	14	warehouse 2	
kit 7	2	2	4	2	2	warehouse 1&2	1boxes in ware house1, 2boxes in ware house 2
kit 8	3	19	22	11	11	warehouse 2	
kit 9	3	10	13	13	0		
kit 10	5	1	6	0	6	warehouse 1	
Kit 11A		6	6	5	1	warehouse 2	
kit 11B	97	163	260	259	1	warehouse 1& 2	64in warehouse 2
kit 12		11	11	10	1	warehouse 1&2	1box in ware house 1 & 3 boxes in ware house 2
Total	143	1107	1250	1112	138		
kit 1B	740	1040	1780	400	1380	warehouse 1	Amounts in Pieces

Osman Daud Mohamed
Admin /Finance Assistant
Signature : ……………..
Date : …………………..

Dr. Ashruf Ishag
RH Officer
Signature:……………….
Date :………………………

- This is an example of warehouse balance sheet to track the status of the RH Kits.

18.

RH Kits for emergency situations
Who does what?

- First: determine needs and make a distribution plan
- Contact UNFPA Country Office or HQ
  - HRB (Humanitarian Response Branch), or
  - PSB (Procurement and Supply Branch)
- Funding: NGO's own funds, Flash, CERF, CAP
- UNFPA - HRB can assist in determining needs
- UNFPA Procurement Services: pro-forma invoice, contacts shipping agents, makes shipping arrangements
- Supplies shipped within 48 hours

- Explain the different steps and functions of the different stakeholders.

19.

After the Crisis

- Do not re-order kits
- Develop/strengthen a logistics supply chain for medical supplies
- Join or build onto existing systems

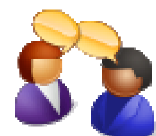
- First bullet point: emphasize that reordering RH Kits after the crisis in not recommended. As soon as possible, supplies should be procured through local channels.

20.

Resources

- Essential List of RH Medicines (WHO)
- UNICEF supplies catalogue; http://www.unicef.org/supply/index.html
- John Snow Inc; http://deliver.jsi.com/dhome/topics/supplychain/logistics

21. Proceed with the group work: logistics exercise (90 minutes)



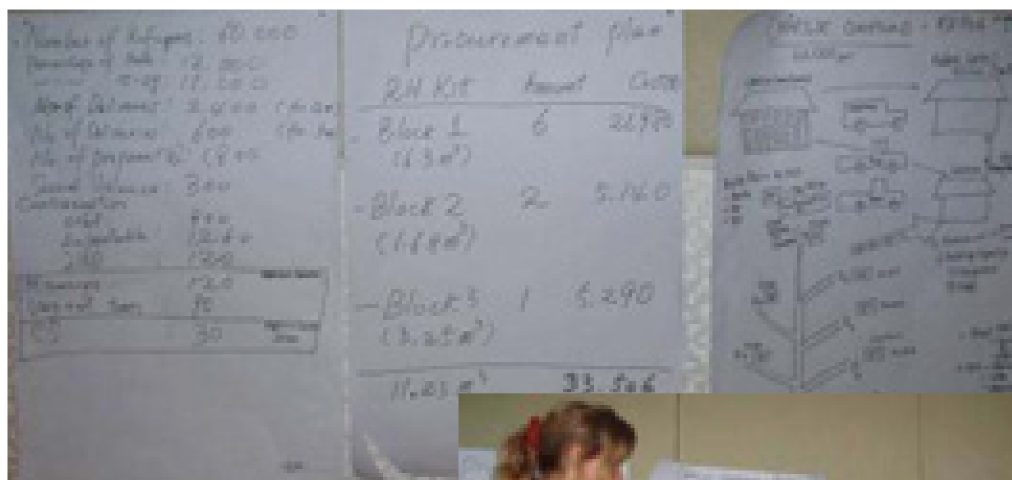
Logistics Exercise

Process

1. Divide participants into groups of 5 to 8 people.
2. Distribute the participants' handouts.
3. Explain the exercise (instructions are on the handout 'Case Study Alphaland-Betaland), stressing that each group needs to present their work on flip charts at the end of the exercise.
4. Let the groups start the exercise on their own.
5. Facilitate the group work and by gentle probing and constructive feedback, ensure that the groups keep to the allocated time as to address all the questions required.
6. After 60 minutes of group work, take 30 minutes for presentation. Each group will take turn to present their work and receive your feedback (in total, 5-10 minutes per group depending on the number of groups).

Answers to some discussion points (refer to next page: Case Study Alphaland-Betaland)

1. Which assessments need to be made?
    - None, except an estimate of the number of affected population and an assessment of the location of health care facilities and staff
2. Which priority RH interventions will you put in place immediately?
    - The components of the MISP
3. Which Kits will you order and how many?
    - The handout 'RH Indicators for Alphaland' is aimed to confuse participants.
    - Clue: there is no need for calculating Kits based on these DHS indicators, but they can be used to compare the affected population with the "standard" population assumptions used to calculate the supplies in the Kits. They also give an indication of what not to order (low use of IUDs, and no exposure to female condoms)
    - The RH Kits are already pre-calculated based on population assumptions. These assumptions can be found on the last page of the Inter-Agency RH Kits Manual.
4. How much will this cost?
    - Use the UNFPA revised price list to make the calculations
5. Calculate your storage requirement (in cubic meter)
    - Note: 1 extra cubic meter is needed for staff to move around the Kits. Kits should not be stacked more than 2 meters high



Example of logistics plans

Logistics Exercise

Participants' handout (page 1 of 3)

Case Study Alphaland- Betaland

(adapted from the ICRC HELP course)

/

Report

Following recent violent fighting between the Kuloro rebels and the government army in Alphaland, an unknown number of Alphaland civilians have fled across the border into Betaland.. At least 20 000 refugees have created an ad hoc settlement near the village of Awalei, about 34 km from the border with Alphaland, in a remote mountainous region of Gamma district. At the present time, according to the Provincial Office of Refugee Affairs who are coordinating the humanitarian response, there still up to 1000 refugees a day coming into the area. The refugees are overwhelming resources as they settle down in Gamma district. Unable to deal with their needs, the Betaland government has requested international assistance. At the same time the Betaland government is attempting mediation efforts between the two parties to the Alphaland conflict.

Refugees are living in temporary shelter they have made from grass, branches, and some banana leaves. Water is obtained from the Bowi River not far from the camp, but there are problems with this water source. Reports indicate that there are poor sanitation provisions for the refugees. Oxfam has been asked to dig latrines and set up water distribution points.

Cooking fuel is a problem, but there are some woods 1 km away, where women go to get firewood. The refugees brought with them some food supplies, but these have been exhausted. The local community and various Betaland organisations have been trying to help out, but this is clearly not enough and WFP has initiated a food pipeline.

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

There are health centres and health posts scattered around the three districts of Gamma province. The provincial hospital is in the city of Gamma (50 km from the refugee camp) and there are smaller hospitals in the towns of Brew, Khron, and Takri. The hospital at Khron is the closest (20 km) and seems so far the most affected by the refugee influx and demands for services. A training of Primary Health Care Workers (PHCW) was undertaken in Betaland several years ago, but not as many as needed have been trained. Some TBAs received training about 10 years ago. Several organizations are starting limited health services for refugees (IRC, MSF, Betaland Red Cross, Islamic Relief). Already a major shortage of drugs and supplies is looming

Transport into the area is possible by road, rail and air. All of these are problematic at times. Roads around Khron are subject to flooding, and access to some areas may be cut off for several days.

Your job

This morning in the inter-agency emergency coordination meeting you were given the above briefing and you were asked to take on RH coordination. You are now holding a meeting with health NGOs to discuss putting in place the most essential sexual and reproductive health interventions for the refugees in Gamma province. Before your meeting you found some RH indicators for the Alphaland population on the internet (see attached sheet).

Discuss next steps

1. Which assessments need to be made?
2. Which priority RH interventions will you put in place immediately?
3. Which Kits will you order and how many?
4. How much will this cost?
5. Calculate your storage requirement (in cubic meter)
6. Make a distribution plan: **What** (Kit) goes **Where** (which place), for **Whom** (implementing partner) and **How** (what form of transport)? (Make a table)

Drawing a map may be helpful. Brainstorm for 45 minutes and write down your conclusions on a flipchart (15 minutes)

REPRODUCTIVE HEALTH INDICATORS FOR ALPHALAND

(Most figures date from the last DHS 1998)

Basic demographic indicators

Total population	23 300 000
Sex Ratio (M:100 F)	99.6
% of women who are aged 15 – 49	24.6 %
Percentage <5 years of age	20.1 %
Total fertility rate (per woman)	7.1

Safe Motherhood indicators

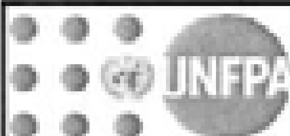
Crude birth rate (per 1000 population)	51
Neonatal mortality rate (0 – 4 weeks) (per 1000 live births)	25
Maternal mortality ratio (per 100.000 live births)	1100 (estimated range: 900 1200)
Lifetime risk of maternal death	1 in 11
Unsafe abortion	n.a.
Anaemia in pregnant women	n.a.

STDs, including HIV/AIDS

Adults living with HIV/AIDS (%)	9 % (rural) – 22% (urban)
Men reporting (15- 49) reporting urethritis in last year (%)	11.7 % (rural) – 18.7 % (urban)

Family planning indicators

Contraceptive prevalence (all methods) (% of women 15 – 49)	15 % (1995)
Contraceptive method mix	
Condom	10 %
Pill	7 %
Injection	28 %
IUD	0.4 %
Female sterilization	1 %
Traditional methods	53 %



REVISED PRICE LIST RH KITS

Revised: 18 January, 2008

NAME	KIT NOs.	Unit Price US$	Remarks
Administration and Training Kit	Kit No.0	160	
Male Condom Kit	Kit No.1A	405	
Female Condom Kit	Kit No.1B	545	
Clean Delivery Kit - Individual	Kit No.2A	450	
Clean Delivery Kit - for Birth Attendants	Kit No.2B	110	
Rape Treatment Kit	Kit No.3A	90	
Post Exposure Prophylaxis for HIV, incl Treatment for Children Kit	Kit No. 3B	880	PEP for HIV for treatment of 30 adults and 8 children
Oral and Injectable Contraception Kit	Kit No.4	540	
STD Drug Kit	Kit No.5	400	
Clinical Delivery Assistance Kit	Kit No.6	900	
Intra Uterine Device Kit	Kit No.7	230	
Mgt.of Complication of Miscarriage Kit	Kit No.8	895	
Suture of Cervical and Vaginal Tears Kit	Kit No.9	380	
Vacuum Extraction Kit	Kit No.10	145	
Referral Level Kit A - Reusable Equipment	Kit No.11A	250	
Referral Level Kit B - Drugs & Disposable equipment	Kit No.11B	3,890	
Blood Transfusion Kit	Kit No. 12	1,350	
Freight Charges			
Subtotal in US $			
5% HANDLING COST			
Grand total			

David Smith
Chief Procurement Services Branch

Orders placed after January 18, 2008 will be quoted on the prices listed here.

Monitoring and Evaluation (M&E)

Length	60 minutes
Overview	This session will outline selected tools for monitoring and evaluation of SRH programming in crisis and post-crisis situations. Participants will have the opportunity to apply these tools in a group exercise.
Learning outcomes	See below
Preparation	- Ensure that PowerPoint presentation handouts are copied - Ensure that participants have the Case Study Alphaland-Betaland (already used during the logistics exercise)
Materials	- Markers and flip charts or whiteboards - MISP Distance Learning Module (if not available, copy pages indicated below) - The Inter-Agency Field Manual (if not available, copy pages indicated below)
Methodology	Interactive presentation and group work

Process

1.

Learning outcomes:
by the end of the session, you should be able to:

1. Conduct basic monitoring and evaluation for the MISP implementation
2. Outline existing needs assessment tools to plan for comprehensive SRH

- Review the learning outcomes.
- Explain that you assume that all participants have experience in M&E and that this session will only briefly present M&E tools related to SRH in crises.

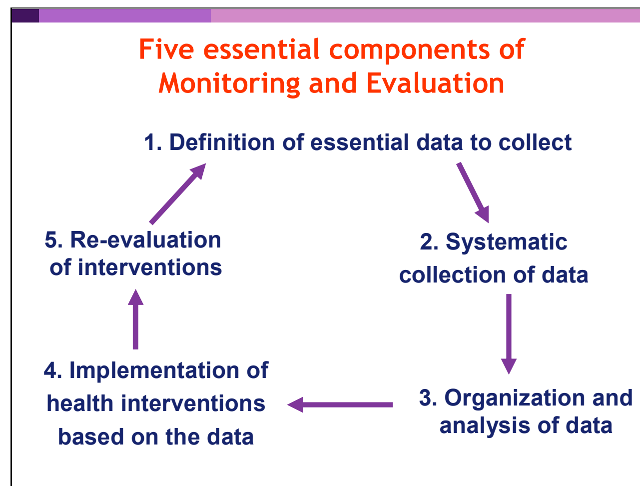
2.

Plan for COMPREHENSIVE SRH services, integrated into Primary Health Care

- Baseline SRH information and Monitoring and Evaluation
- Identify sites for future delivery of comprehensive SRH
- Assess staff and identify training protocols
- Procurement channels

- Ask participants to look at their MISP Cheat Sheet and remind them that M&E should take place as soon as possible and is part of the activities under objective 5 (Plan for comprehensive SRH services, integrated into Primary Health Care)

3.



- Explain the importance of the M&E cycle: M&E should feedback into interventions.
- Point 2: stress that collecting data needs to be sensitive and confidential, especially when dealing with investigating maternal deaths or sexual violence cases.

4.

MISP Basic Demographic and Health Information

Basic demographic and health information	JAN	F
Total population		
Number of women of reproductive age (ages 15 to 49, estimated at 25 percent of population)		
Number of sexually active men (estimated at 20 percent of population)		
Crude birth rate (estimated at 4 percent of the population)		
Age-specific mortality rate (including neonatal deaths 0 to 28 days)		
Sex-specific mortality rate		

Reference: MISP for RH in Crisis Situations - A Distance Learning Module, Women's Commission, 2006, p 74-75

- Explain that the MISP has a basic template for reporting MISP related activities including basic demographic and health information.
- Invite participants to open the MISP Distance Learning Module at Appendix A.

5.

MISP Indicators for M and E

COORDINATION	JAN	FEB
Overall RH Coordinator in place and functioning under the health coordination team		
RH focal points in camps and implementing agencies in place		
Material for implementation of the MISP available and used		
Basic demographic and health data collected		
SEXUAL VIOLENCE		
Coordinated multi-sectoral systems to prevent sexual violence in place		
Confidential health services to manage cases of sexual violence in place		
Staff trained (retrained) in sexual violence prevention and response		

- Explain that these indicators are straightforward and mirror the activities under each of the MISP objectives.
- As a summary of the MISP, quickly review the indicators shown in the next 3 slides.

6.

MISP Indicators for M and E

HIV TRANSMISSION		
Sufficient materials in place for practice of universal precautions by trained, knowledgeable health workers		
Condoms procured and made available		
Blood for transfusion consistently screened		
MATERNAL AND NEONATAL MORTALITY AND MORBIDITY		
Clean delivery kits available and distributed		
Calculate the number of clean delivery packages needed to cover for births for 3 mo. (estimated population x .04 x .25)		
Midwife kits available at the health center		
Referral hospital assessed and supported for adequate number of qualified staff, equipment and supplies		
Referral system for obstetric emergencies functioning 24/7		

7.

MISP Indicators for M and E

PLANNING FOR COMPREHENSIVE RH	
Basic background information collected	
Sites identified for future delivery of comprehensive RH services	
Staff assessed, training protocols identified	
Procurement channels identified and monthly drug consumption assessed	

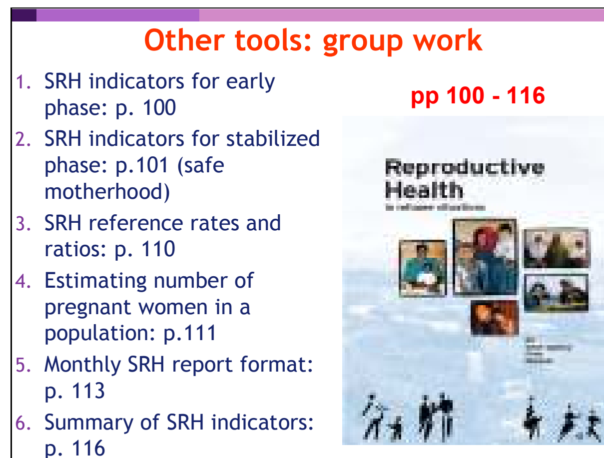
8.

MISP Monthly Data Collection

Monthly data collection

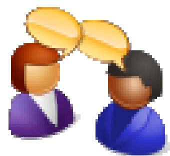
	JAN
Number of condoms distributed	
Number of clean delivery packages distributed	
Number of sexual violence cases reported in all sectors	
Number of health facilities with supplies for universal precautions	
Basic demographic and health data collected	

9.



- If available, invite participants to open the Inter-Agency Field Manual at the indicated pages and briefly introduce each tool.
- Explain that participants will have the opportunity to familiarize themselves with the tools in the group exercise.

10.



Group Work

Establish a M&E plan for

Case Study Alphaland-Betaland

- Invite participants to gather again in the same groups as for the logistics exercise.
- Give 30 minutes for each group to establish a M&E plan for their Alphaland-Betaland response, using the tools presented in the MISP and Inter-Agency Field Manual. Plans should be outlined on a flip chart for reporting.
- Facilitate the group work process as needed.
- After 30 minutes, invite each group to take few minutes to report to the large group. Provide feedback.

11.

- Before wrapping up the session, introduce other tools that can be found online: the RHRC and CDC toolkit.

12.

Key messages

- The purpose of monitoring is to improve your programme
- When monitoring, avoid blaming and being judgmental
- Use your findings to feedback into your programming

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

Notes:

Country Action Planning

Length	2 hours
Overview	This session will allow participants and master trainers to finalize the country action planning.
Learning outcomes	By the end of the session, participants should be able to: - Outline elements of the national plan related to the planning of comprehensive SRH services - Have a shared coordination vision among agencies - Document what changes are needed in order to integrate SRH into crises, and who will be the focal person for each of the activities
Preparation	Participants should refer back to the national plan that they worked on for the first 2 days along with the 'Suggested Preparedness Activities'
Materials	Flip charts and markers
Methodology	Self-reflection and group discussion

Process

1. Ask participants to take their handouts ('Suggested Preparedness Activities' and the national plan as proposed by the master trainers).

2. Review the proposed activities under Comprehensive SRH with the whole group. Ask participants to take few minutes to reflect on its relevance.

3. Facilitate the discussion.

4. Now that all participants have addressed each of the sections, ask them to take one hour to reexamine the whole country action plan as to agree on a focal person, resources needed and implementation timeframe for each of the activity. Remember that a key to successful implementation of your country action plan is to have a dedicated person to drive each of the activities.

5. Facilitate the plenary discussion. Try to get the team come to an agreement for the country action plan.

MISP Post-Test

Length	45 minutes
Overview	Participants' answers to the post-test will allow you to gauge the progress of the participants in their knowledge of the MISP. The session will also provide the last opportunity for participants to ask questions or discuss any issues.
Learning outcomes	By the end of the session, participants should be able to: - Assess their progress in their knowledge of the MISP.
Preparation	Ensure that the post-test (do not include in the participants' folder) and blank answer sheets are copied on separate pages (no recto verso, as participants will keep the questions)
Materials	Markers and flip charts or whiteboards
Methodology	Test (multiple choice questions), feedback and group discussion

Process

1. Explain that the purpose of the post-test is to help the facilitators better assess the impact of the training.
2. Distribute the post-test with the blank answer sheets (see below).
3. Inform participants that they have 20 minutes to complete the 20 questions of the post-test. Instruct participants to report their answers on the answer sheet without putting their name on it.
4. After 20 minutes, collect the answer sheets.
5. Quickly review each question and answer with the whole group.
6. Facilitate questions and answers on the post-test and any other issues as time allows.
7. While you address questions and answers, ask your co-facilitator to mark the test and calculate the mean score. Solutions can be found hereafter.
8. Write down the mean score of the pre and post-test on a flip chart. Comment on the progress made by participants and congratulate them.

Post-Test

Participants' handout (page 1 of 2)

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

1. A civil war has recently displaced tens of thousands of people and approximately 500 refugees are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority SRH activities you immediately undertake?
a. Ensuring survivors of domestic violence have access to psychosocial services
b. Providing clean delivery Kits to all visibly pregnant women and birth attendants to support clean deliveries
c. Ensuring blood for transfusion is safe
d. Ensuring safe access to cooking fuel

2. When should the MISP be implemented?
a. In the first days of a crisis situation
b. Once approval from UNFPA has been given
c. Once early mortality rates have stabilized
d. After the displaced population has been settled into camps

3. The activities of an SRH Coordinator facilitating the implementation of the MISP include:
a. Training/retraining staff to provide comprehensive RH services
b. Ensuring the presence of a same-sex, same-language health worker or chaperone during any medical examination of a survivor of sexual violence
c. Adapting and introducing simple forms for monitoring MISP activities
d. Ensuring the provision of family planning services

4. What health and demographic data should the SRH Coordinator determine/estimate after the MISP is in place?
a. Malnutrition rate
b. Number of sexually active men
c. Crude birth rate
d. Age-specific mortality rate

5. What type of services should be offered to a rape survivor?
a. Clinical services
b. Additional food rations for her extended family
c. Protection for her physical safety
d. Psychosocial care

6. Which of the following is a way that does not help to prevent sexual violence in a crisis situation?
a. Involve women in the distribution of materials and supplies
b. Ensure that women have their own individual registration cards
c. Communal bathing facilities for both men and women
d. Involve women in the decision-making process regarding the layout of the site/camp

7. What are the requirements of a referral-level facility for comprehensive obstetric care?
a. Child health care
b. Safe blood transfusion
c. Antenatal care
d. Medical staff that can perform c-sections available 24 hours per day, seven days per week

8. You are a newly assigned SRH Coordinator and have recently arrived in an emergency situation. What are some of the first SRH activities that you carry out?
a. Ensure SRH coordination meetings are established
b. Co-host trainings on HIV/AIDS
c. Discuss supply needs with UNFPA and other agencies
d. Coordinate community outreach on STI prevention

9. You are coordinating the implementation of the MISP and are trying to ensure that emergency obstetric care is available in the camp clinic. What activities do you undertake?
a. Ensure qualified staff at the camp clinic are available only during the day to stabilize the patient with basic emergency obstetric care
b. Ensure qualified physicians are available at the referral hospital
c. Establish a communication system to consult qualified providers for guidance on referrals
d. Establish trainings for medical staff on safe motherhood

10. You have tried to procure clean delivery Kits through UNFPA, but logistical challenges have significantly delayed the arrival of these supplies. Given this reality, what can you do to address this situation?
a. Contract with a local agency to produce Kits
b. Procure Kit contents locally and assemble on site
c. Order supplies from another source abroad and wait until they arrive
d. Discuss during the RH coordination meeting where to procure supplies

Post-Test: Participants' handout (page 1 of 2)

11. The code of conduct against sexual exploitation and abuse applies to:
a. International NGO staff
b. Local humanitarian staff
c. UN personnel
d. Individuals contracted from the host population

12. Which situation puts women at risk of sexual violence?
a. Men distribute food and other goods
b. Well-lighted paths to nearby latrines
c. Lack of fuel available in or near settlement/camp
d. Most, but not all, protection officers are female

13. What is NOT a MISP-related service for women and girls who survive sexual violence?
a. Psychosocial care
b. Antenatal care
c. Ensured physical safety
d. Access to emergency contraception and post-exposure prophylaxis

14. Condoms can be made available at:
a. Health facilities
b. Food distribution points
c. Community service offices
d. Latrines

15. Which of the following activities should be undertaken in order to ensure safe blood transfusion?
a. Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases
b. Avoid blood transfusions for non-serious medical conditions
c. Select donors from the displaced community
d. Ensure sufficient HIV and other tests and supplies for screening blood where needed

16. Which is a requirement for infection control?
a. Facilities for frequent hand washing
b. Safe handling of sharp objects
c. Cleaning, disinfecting and sterilizing medical equipment
d. Disposal of medical waste by burning materials and burying sharp objects outside the grounds of the health facility

17. Clean delivery Kits should be provided to all women over 20 years of age.
True
False

18. Approximately what proportion of the displaced population will be pregnant at a given time?
a. 25 percent
b. 20 percent
c. 15 percent
d. 4 percent

19. Female condoms are available in the Interagency SRH Kits.
True
False

20. For what time period are the SRH Kits designed for use?
a. 1 month
b. 3 months
c. 6 months
d. 1 year

Post-Test Answer Sheet

Participants' handout (to be collected)

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

Do not put your name

1.
a
b
c
d

2.
a
b
c
d

3.
a
b
c
d

4.
a
b
c
d

5.
a
b
c
d

6.
a
b
c
d

7.
a
b
c
d

8.
a
b
c
d

9.
a
b
c
d

10.
a
b
c
d

11.
a
b
c
d

12.
a
b
c
d

13.
a
b
c
d

14.
a
b
c
d

15.
a
b
c
d

16.
a
b
c
d

17.
True
False

18.
a
b
c
d

19.
True
False

20.
a
b
c
d

Pre and Post-Test Solutions

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

1. A civil war has recently displaced tens of thousands of people and approximately 500 refugees are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority SRH activities you immediately undertake?
a. Ensuring survivors of *domestic* violence have access to psychosocial services
b. Providing clean delivery Kits to all visibly pregnant women and birth attendants to support clean deliveries
c. Ensuring blood for transfusion is safe
d. Ensuring safe access to cooking fuel

2. When should the MISP be implemented?
a. In the first days of a crisis situation
b. Once approval from UNFPA has been given
c. Once early mortality rates have stabilized
d. After the displaced population has been settled into camps

3. The activities of an SRH Coordinator facilitating the implementation of the MISP include:
a. Training/retraining staff to provide comprehensive RH services (*planning for*)
b. Ensuring the presence of a same-sex, same-language health worker or chaperone during any medical examination of a survivor of sexual violence
c. Adapting and introducing simple forms for monitoring MISP activities
d. Ensuring the provision of family planning services

4. What health and demographic data should the SRH Coordinator determine/estimate after the MISP is in place?
a. Malnutrition rate
b. Number of sexually active men
c. Crude birth rate
d. Age-specific mortality rate

5. What type of services should be offered to a rape survivor?
a. Clinical services
b. Additional food rations for her extended family
c. Protection for her physical safety
d. Psychosocial care

6. Which of the following is a way that does not help to prevent sexual violence in a crisis situation?
a. Involve women in the distribution of materials and supplies
b. Ensure that women have their own individual registration cards
c. Communal bathing facilities for both men and women
d. Involve women in the decision-making process regarding the layout of the site/camp

7. What are the requirements of a referral-level facility for comprehensive obstetric care?
a. Child health care
b. Safe blood transfusion
c. Antenatal care
d. Medical staff that can perform c-sections available 24 hours per day, seven days per week

8. You are a newly assigned SRH Coordinator and have recently arrived in an emergency situation. What are some of the first SRH activities that you carry out?
a. Ensure SRH coordination meetings are established
b. Co-host trainings on HIV/AIDS
c. Discuss supply needs with UNFPA and other agencies
d. Coordinate community outreach on STI prevention

9. You are coordinating the implementation of the MISP and are trying to ensure that emergency obstetric care is available in the camp clinic. What activities do you undertake?
a. Ensure qualified staff at the camp clinic are available only during the day to stabilize the patient with basic emergency obstetric care
b. Ensure qualified physicians are available at the referral hospital
c. Establish a communication system to consult qualified providers for guidance on referrals
d. Establish trainings for medical staff on safe motherhood

10. You have tried to procure clean delivery Kits through UNFPA, but logistical challenges have significantly delayed the arrival of these supplies. Given this reality, what can you do to address this situation?
a. Contract with a local agency to produce Kits
b. Procure Kit contents locally and assemble on site
c. Order supplies from another source abroad and wait until they arrive
d. Discuss during the RH coordination meeting where to procure supplies

11. The code of conduct against sexual exploitation and abuse applies to:
a. International NGO staff
b. Local humanitarian staff
c. UN personnel
d. Individuals contracted from the host population

12. Which situation puts women at risk of sexual violence?
a. Men distribute food and other goods
b. Well-lighted paths to nearby latrines
c. Lack of fuel available in or near settlement/camp
d. Most, but not all, protection officers are female

13. What is NOT a MISP-related service for women and girls who survive sexual violence?
a. Psychosocial care
b. Antenatal care
c. Ensured physical safety
d. Access to emergency contraception and post-exposure prophylaxis

14. Condoms can be made available at:
a. Health facilities
b. Food distribution points
c. Community service offices
d. Latrines

15. Which of the following activities should be undertaken in order to ensure safe blood transfusion?
a. Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases
b. Avoid blood transfusions for non-serious medical conditions
c. Select donors from the displaced community
d. Ensure sufficient HIV and other tests and supplies for screening blood where needed

16. Which is a requirement for infection control?
a. Facilities for frequent hand washing
b. Safe handling of sharp objects
c. Cleaning, disinfecting and sterilizing medical equipment
d. Disposal of medical waste by burning materials and burying sharp objects ***outside*** the grounds of the health facility

17. Clean delivery Kits should be provided to all women over 20 years of age.
True
False

18. Approximately what proportion of the displaced population will be pregnant at a given time?
a. 25 percent
b. 20 percent
c. 15 percent
d. 4 percent

19. Female condoms are available in the Interagency SRH Kits.
True
False

20. For what time period are the SRH Kits designed for use?
a. 1 month
b. 3 months
c. 6 months
d. 1 year

Review of Participants' Expectations

<table>
<tr><td>Length</td><td>15 minutes</td></tr>
<tr><td>Overview</td><td>This short session will help you validate your training and see whether participants have met the course's learning objectives and their own expectations.</td></tr>
<tr><td>Learning outcomes</td><td>By the end of the session, participants should be able to:
- Describe whether they have achieved the learning objectives of the training</td></tr>
<tr><td>Preparation</td><td>- Prepare a PowerPoint presentation with:
– the general learning outcomes for the whole training (day 1 presentation):
Upon completion of the training, participants should be able to:
1. Advocate for SRH in crises
2. Apply core concepts and techniques provided in the MISP
3. Apply coordination skills for the implementation of the MISP
4. Produce an action plan to integrate SRH into national emergency preparedness plans
– the summary of participants' expectations.
[Alternative: review the flip charts where the above were posted]
- Write in big letters on separate A4 pages: 0%, 50%, 60%, 70%, 80%, 90%, 100%
- Place the different % proportionally along a imaginary line in the room</td></tr>
<tr><td>Materials</td><td>Markers and flip charts or whiteboards</td></tr>
<tr><td>Methodology</td><td>Interactive format</td></tr>
</table>

Process

1. Review the learning outcomes and participants' expectations.

2. Ask participants to stand up. Explain the imaginary line and the different percentages.

3. Ask participants: 'How would you grade your ability to advocate for SRH in crises? Place yourself along the line.'

4. Allow participants to move along the line. Observe, take note and invite comments from participants.

5. Ask participants: 'How would you grade your ability to apply core concepts and techniques provided in the MIS? Place yourself along the line.'

6. Allow participants to move along the line. Observe, take note and invite comments from participants.

7. Repeat the process with:

'How would you grade your ability to apply SRH coordination skills to implement the MISP? Place yourself along the line.'

'How would you grade your ability to advance the integration of SRH into national emergency preparedness plans? Place yourself along the line.'

8. Facilitate comments and impressions from participants as time allows.

Evaluation of the Training

Length	15 minutes
Overview	Participants will complete an anonymous evaluation form addressing the different aspects of the training course. This will allow the training team to reflect on strengths and weaknesses of the course and improve for the following trainings.
Learning outcomes	By the end of the session, participants should be able to: - Provide objective and anonymous feedback on the whole course
Preparation	Ensure that evaluation forms are copied
Materials	None
Methodology	Written evaluation

Process

1. Distribute the evaluation forms.

2. Inform participants to take 10 minutes to fill the evaluation form. This is anonymous and will allow the training team to assess the quality of the whole course and find ways to improve subsequent trainings.

3. Collect the evaluation forms after 10 minutes.

4. Ensure that the whole training team takes time at the end of the training to review the evaluation forms and debrief together.

Training Evaluation Form (Participants' handout, page 1)

Thank you for taking the time to complete this evaluation form. Your feedback will assist us in assessing the effectiveness of this training and help us improve the planning and organisation of future trainings.

Please indicate your choice according to the following rating for the entire training:

1	–	Unsatisfactory	3	–	Good			
2	–	Fair	4	–	Excellent	NA	–	Not Applicable

No	Item	Rating					Any comments?
1.	Achievement of training objectives	1	2	3	4	NA	
2.	Materials distributed	1	2	3	4	NA	
3.	Facilitation of training	1	2	3	4	NA	
4.	Timeframe allocated for the training programme	1	2	3	4	NA	
5.	Opportunities for sharing and participation	1	2	3	4	NA	
6.	What did you learn from this training?						
7.	Was this training relevant to your work?	☐ Yes	If yes, how will you use it?				
		☐ No	If no, please explain.				
8.	Which 3 sessions were the most beneficial? List in order of priority. Please comment on how to improve them.						
9.	Which 3 sessions were the least beneficial? List in order of priority. Please comment on how to improve them.						

No	Item	Rating					Any comments?
LOGISTICS							
10.	Accommodation	1	2	3	4	NA	
11.	Food	1	2	3	4	NA	
12.	Travel arrangements	1	2	3	4	NA	
13.	Meeting arrangements	1	2	3	4	NA	
14.	Administrative support	1	2	3	4	NA	
15.	Any other comments/suggestions for future trainings:						

Thank you for your feedback!

Closing

Length	30 minutes
Overview	This session will allow you to celebrate participants' efforts and work.
Learning outcomes	Not applicable
Preparation	Prepare this session according to your customs and culture and to suit your training budget. Participants may appreciate the following: - Training Certificate - CD-ROM with training presentations and key resources - Group picture
Materials	As needed
Methodology	Try to have a mix of official and fun time. This is your celebration!

Notes:

Feedback Form

The Facilitator's Manual is a living document. Have you used it? If so, help us improve the document by sharing with us your comments and feedback. Thank you!

MISP Overview and Coordination

____

____

____

____

SGBV

____

____

____

____

Maternal and Newborn Health

____

____

____

____

HIV and STIs

____

____

____

____

Action Planning

____

____

____

____

Other

____

____

____

____

____

____

Return the form by fax (+603 4256 6386) or email (ippfklro@ippfeseaor.org and doedens@unfpa.org)

Notes

Notes

Photo Credits

Cover:
Tran Nguyen Toan

Interior:
IPPF ESEAOR

How to order copies

The Facilitator's Manual is available online at www.ippfeseaor.org and www.rhrc.org as well as on CD-ROM and in print. To order CDs or print copies, please email ippfklro@ippfeseaor.org.

Contact us

IPPF ESEAOR
246 Jalan Ampang
50450 Kuala Lumpur
Malaysia
T +603 4256 6122
F +603 4256 6386

UNFPA, Humanitarian Response Branch
11, Chemin des Anémones
1219 Châtelaine
CH – Geneva (Switzerland)
T +41 22 917 8315
F +41 22 917 8047