

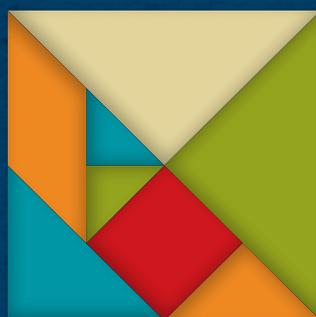


WOMEN'S
REFUGEE
COMMISSION

Research. Rethink. Resolve.



Community Preparedness: REPRODUCTIVE HEALTH and GENDER



A Facilitator's Kit for a
3-day Training Curriculum

Acknowledgments

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Mission Statements of WRC and UNFPA

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

The United Nations Population Fund (UNFPA) is the lead UN agency for delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled. UNFPA works by anticipating and responding to tomorrow's challenges today. It helps countries use population data to assess and anticipate needs, and to monitor progress and gaps. It provides technical guidance, training and support to empower partners and colleagues in the field. UNFPA helps to ensure that the reproductive rights of women and young people remain at the very center of development.

Authors of the Curriculum

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Additional Information and Resources

For more information about this training and other resources associated with it, please visit www.wrc.ms/drr-srh-curriculum

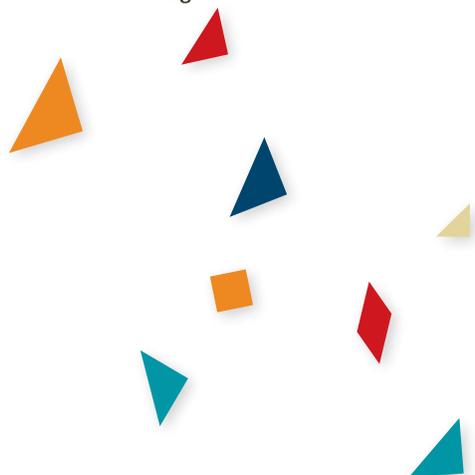
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Acronyms

| | | | |
|------------------|---|---------------|--|
| AMDD | Averting Maternal Death and Disability Program (Columbia University) | LCPC | Local Council for the Protection of Children |
| ANC | Antenatal Care | LGU | Local Government Unit |
| ARV | Anti-Retroviral | MDG | Millennium Development Goal |
| BHW | Barangay Health Worker | MISP | Minimum Initial Service Package (for Reproductive Health) |
| CCCM | Camp Coordination and Camp Management | NDHS | National Demographic & Health Survey |
| C/MSWDO | City/Municipal Social Welfare and Development Office | NGO | Non-governmental Organization |
| CBDRM | Community-based disaster risk management | PEP | Post-exposure Prophylaxis |
| DRR | Disaster Risk Reduction | PID | Pelvic Inflammatory Disease |
| DRRM | Disaster Risk Reduction and Management | RH | Reproductive Health |
| DRRMC | Disaster Risk Reduction and Management Council | SRH | Sexual and Reproductive Health |
| DRRMO | Disaster Risk Reduction and Management Office | STD | Sexually Transmitted Disease |
| DSWD | Department of Social Welfare and Development | STI | Sexually Transmitted Infection |
| EC | Emergency Contraception | TBA | Traditional Birth Attendant |
| EmOC | Emergency Obstetric Care | UNFPA | United Nations Population Fund |
| GBV | Gender-based Violence | UNHCR | United Nations Refugee Agency |
| HIV | Human Immune-Deficiency Virus | UNISDR | United Nations International Strategy for Disaster Reduction |
| HPV | Human Papillomavirus | VAW | Violence Against Women |
| HSV2 | Herpes Simplex Virus 2 | WHO | World Health Organization |
| IEC | Information, Education and Communication (materials) | WRA | Women of Reproductive Age |
| IUD | Intrauterine Device | WRC | Women's Refugee Commission |
| LAM | Lactation Amenorrhea Method | | |
| LCAT-VAWC | Local Committee on Anti-Trafficking and Violence against Women and Their Children | | |



Introduction

Shifts in the Earth's climate are leading to increasingly frequent, severe and large-scale natural disasters around the world, with significant impact on social, economic and public health realities.¹

In this context, civil society, governments and decision-makers are advocating for a better response to mitigate and adapt to a changing climate. The Hyogo Framework for Action 2005 – 2015: Building the Resilience of Nations and Communities to Disasters, drafted at the World Conference on Disaster Reduction with convening support from the UN International Strategy for Disaster Reduction (UNISDR), highlights global awareness and commitment to address the changing landscape of natural disasters.² Similarly, at the grassroots level, community-based organizations and networks of individuals are strategizing on how to better prepare for disasters.

Background

The Facilitator's Kit: *Community-based Preparedness: Reproductive Health and Gender* has been developed, adapted and refined by the Women's Refugee Commission in collaboration with UNFPA and local partners in the Philippines.

Eight training events conducted across five diverse settings in the Philippines contributed to its development. Trainings were implemented in Iligan City (April 2011), Navotas (June 2012), Sorsogon (December 2013), Compostela Valley (April 2014) and Maguindanao (June 2014). Each of the trainings incorporated a three- to five-day participatory training of various community members and members of the Local Government Unit (LGU)—including representatives of the provincial or municipal Disaster Risk Reduction and Management Office (DRRMO). This included action planning, pre- and post-tests, training evaluations and interviews with participants. Some training groups received text-based follow-up and monitoring, while others received in-person follow-up visits by a local organization. The various approaches and settings were used to cull learning from implementation.

As a result of piloted activities, participatory activities that were found to be most successful at conveying key concepts were selected for inclusion within this curriculum. Those that were received inconsistently were removed.



Emergencies have a disproportionate effect on the poorest and most vulnerable, particularly women and children. Sexual and reproductive health (SRH) is a significant public health need in all communities, including those facing emergencies... These services need to be strengthened in preparation for future events to reduce SRH-related morbidity and mortality. 

 http://www.who.int/entity/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf?ua=1

Key Concepts and Definitions

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

Contingency Planning:

A management process that analyzes specific potential events or emerging situations that might threaten society or the environment and establishes arrangements in advance to enable timely, effective and appropriate responses to such events and situations (UNISDR terminology).

<http://www.unisdr.org/we/inform/terminology>

Disaster:

A serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources (UNISDR terminology).

<http://www.unisdr.org/we/inform/terminology>

Disaster Risk Management:

The systematic process of using administrative directives, organizations, and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the possibility of disaster. Disaster risk management aims to avoid, lessen or transfer the adverse effects of hazards through activities and measures for *prevention, mitigation* and *preparedness*.

This term is an extension of the more general term "risk management" to address the specific issue of disaster risks (UNISDR terminology).

<http://www.unisdr.org/we/inform/terminology>

Disaster Risk Reduction:

The concept and practice of reducing disaster risks through systematic efforts to analyze and manage the causal factors of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events.

While the term "disaster reduction" is sometimes used, the term "disaster risk reduction" provides a better recognition of the ongoing nature of disaster risks and the ongoing potential to reduce these risks (UNISDR terminology).

<http://www.unisdr.org/we/inform/terminology>

According to the International Federation of the Red Cross and Red Crescent Societies (IFRC), there are several aspects to disaster risk reduction:

<http://www.ifrc.org/en/what-we-do/disaster-management/preparing-for-disaster/risk-reduction/reducing-disaster-risk/>

- **Disaster mitigation** – Structural and non-structural measures undertaken to limit the adverse impact of natural hazards
<http://www.ifrc.org/en/what-we-do/disaster-management/preparing-for-disaster/risk-reduction/reducing-disaster-risk/>
- **Early warning** – The provision of timely information enabling people to take steps to reduce the impact of hazards. Early warning is typically multi-hazard and requires genuine ownership of, and participation by, communities and other stakeholders
<http://www.ifrc.org/en/what-we-do/disaster-management/preparing-for-disaster/disaster-preparedness-tools/early-warning/>
- **Disaster preparedness** – Measures that help ensure a timely and effective "first line" of response
<http://www.ifrc.org/en/what-we-do/disaster-management/preparing-for-disaster/disaster-preparedness-tools/disaster-preparedness-tools/>

- **Recovery** – Decisions and actions taken after a disaster with a view to restoring or improving the pre-disaster living conditions of the affected community, while facilitating necessary adjustments to reduce disaster risk

 <http://www.ifrc.org/en/what-we-do/disaster-management/from-crisis-to-recovery/>

- **Support to livelihoods** – Projects that strengthen or diversify livelihoods that enable individuals or households to develop strategies to reduce risk

 <http://www.ifrc.org/en/what-we-do/disaster-management/from-crisis-to-recovery/what-is-a-livelihood/>

Emergency Obstetric Care (EmOC):

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

- Administration of antibiotics, oxytocic, and anticonvulsants
- Manual removal of the placenta
- Removal of retained products following miscarriage or abortion
- Assisted vaginal delivery, preferably with vacuum extractor
- Basic neonatal resuscitation (with bag and mask)

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

- All basic functions above
- Cesarean section
- Safe blood transfusion

A 2009 handbook developed by the World Health Organization (WHO), UNFPA and Averting Maternal Death and Disability (AMDD) stressed new EmOC standards that for every 500,000 people there should be five facilities offering basic and one facility offering comprehensive essential obstetric care (WHO, UNFPA and AMDD).

 http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/obstetric_monitoring.pdf

Gender:

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

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

Gender-based Violence (GBV):

An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many – but not all – forms of GBV are illegal and are criminal acts in national laws and policies. Around the world, GBV has a greater impact on women and girls than on men and boys. The term “gender-based violence” is often used interchangeably with the term “violence against women.” The term “gender-based violence” highlights the gender dimension of these types of acts; in other words, the relationship between females’ subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. The nature and extent of specific types of GBV vary across cultures, countries and regions.

Gender-based violence includes:

- Sexual violence, including sexual exploitation/abuse and forced prostitution
- Domestic violence
- Trafficking
- Forced/early marriage
- Harmful traditional practices such as female genital mutilation, honor killings, widow inheritance and others
(IASC Guidelines on Gender Based Violence Interventions in Humanitarian Settings)

 [https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20\(English\).pdf](https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20(English).pdf)

Hyogo Framework for Action:

A comprehensive approach to reduce disaster risks, adopted in 2005, whose expected outcome is “the substantial reduction of disaster losses, in lives and the social, economic and environmental assets of communities and countries.” (UNISDR terminology).

 <http://www.unisdr.org/we/coordinate/hfa>

International Strategy for Disaster Reduction (ISDR):

A vehicle for cooperation among Governments, organizations and civil society actors to assist in the implementation of the Hyogo Framework for Action (UNISDR terminology).

 http://www.adrc.asia/publications/LWR/LWR_abridged/preface2.pdf

Preparedness:

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

Preparedness is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response through to sustained recovery.

Preparedness is based on a sound analysis of disaster risks and includes such activities as:

- Contingency planning
- Stockpiling of equipment and supplies
- The development of arrangements for coordination
- Evacuation
- Public information
- Associated training and field exercises

These must be supported by formal institutional, legal and budgetary capacities (UNISDR terminology).

 <http://www.unisdr.org/we/inform/terminology>

Reproductive Health (RH):

A state of complete physical, mental and social well-being (not merely the absence of disease or infirmity) in all matters related to the reproductive system and to its functions and processes. Reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO).

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

Resilience:

The ability of a system, community or society exposed to hazards to resist, absorb, accommodate and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.

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

 <http://www.unisdr.org/we/inform/terminology>

Sex:

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

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

Sexual Health:

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

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

Sexuality:

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

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

Sexually Transmitted Infections (STIs):

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

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

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

Sexual Violence:

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

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

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

 [https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20\(English\).pdf](https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20(English).pdf)

How to Use This Facilitator's Guide

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

The facilitator's guide is divided into the following key sections:

1. Training Preparation:

Includes a facilitator's agenda, preparation guides and suggestions regarding mobilization and partnerships prior to training.

2. Curriculum:

Presents a three-day curriculum divided into key learning modules. Each learning module lays out individual learning objectives, materials, time, activities, presentations, and audio-visual elements that are recommended to achieve the specified objectives. Modules are laid out in a sequence that, through piloting, demonstrated success in achieving the overall goals of the training. However, facilitator's may need to shift or adjust some elements in order to accommodate the needs of various training groups.

▶ DAY 1- Introducing Localized Risks:

The first day of training is composed of three modules. As a whole, this day should provide a comprehensive overview of the agenda, an introduction to local risks, an overview of disaster risk reduction, review concepts related to risk (vulnerabilities and capacities) and introduce reproductive health and gender considerations in disasters.

▶ DAY 2- Understanding Reproductive Health, Including Gender-based Violence in Emergencies:

The second day of training is composed of four modules. The second day provides details of the Minimal Initial Service Package (MISP) for Reproductive Health in emergencies, as well as critical gender issues that should be considered during an emergency.

▶ DAY 3- From Knowledge to Action:

The third day of training is composed of three modules. It provides an opportunity to review concepts learned from Day 1 and Day 2, and apply knowledge through an assessment of local community capacity and vulnerabilities. As a result of the third day of activities, trainees should develop action plans that improve their community's preparedness and response to RH and gender-based violence in emergencies.

3. Handouts:

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

4. Appendix:

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

Resources,

Such as presentations and videos, can be downloaded at  www.wrc.ms/drr-srh-curriculum

Icon guide



GOAL/
OBJECTIVES



TIME/
DURATION



SUPPLIES



ACTIVITY



PRESENTATION/
POWER POINT



PRESENTATION/
VIDEO



LINK
(clickable
in the
interactive
version)

Laying the Groundwork

Ensuring success of community-based trainings

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

In order for a community model to be successful, LGUs are critical partners from the start. Ideally, members would be included in trainings on reproductive health and DRR or, at minimum, introduced to the Minimum Initial Service Package (MISP) for Reproductive Health and the IASC Guidelines on Gender-Based Violence in Humanitarian Settings.

 <http://www.misp.rhrc.org/>

 [https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20\(English\).pdf](https://docs.unocha.org/sites/dms/Documents/GBV%20Guidelines%20(English).pdf)

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

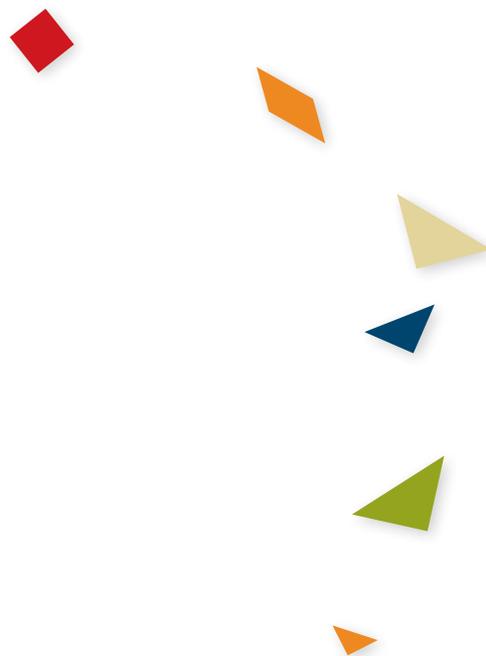
Municipalities selected based on the following criteria:

- 1) The community frequently faces high-risk emergencies leading to displacement.
- 2) LGUs, and specifically the mayor of the proposed municipality, are supportive of gender mainstreaming and women's health issues.
- 3) The following members of the LGU are available for capacity building over the course of the project:
 - a. The mayor
 - b. At least two (2) representatives from the Disaster Risk Reduction and Management Council (including the DRRMO)
 - c. The Barangay Captains of that LGU, and
 - d. Four (4) to five (5) health workers under each barangay.

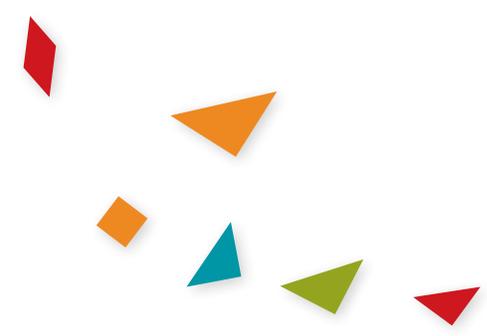
- 4) A community group/civil society organization/ women's group exists within this municipality and is capable of supporting ongoing training to others within the municipality's barangays.
- 5) The LGU is familiar with the Minimum Initial Service Package (MISP) for Reproductive Health, and supports its implementation as an emergency response.
- 6) A training facility can be identified near the selected community.
- 7) DRR trainings have already been conducted in the area (preferred).

The LGU (inclusive of members identified above) will ideally commit to the following:

- 1) Strengthen, as needed, knowledge with regard to:
 - a. Disaster risk reduction.
 - b. Community-Based Disaster Risk Management. (CBDRM)
 - c. Coordination during emergency response.
- 2) Attend gender mainstreaming and MISP trainings as available (www.misp.rhrc.org).
- 3) Attend specific planning elements during Day 3 of the training.
- 4) The LGU will ensure that preparedness activities within the developed action plans are systematically funded through the appropriate Internal Revenue Allocations.



Training Overview



Title:

Community Preparedness: Reproductive Health and Gender

Length:

This three-day training is divided into 10 modules. Depending on the knowledge base of participants, facilitators can select specific modules and customize the training to each group and time frame available.

Participants:

Women's groups and community members (including local service providers, local community-based organizations and community leaders).

Purpose:

To build community capacity to prepare and respond to risks and inequities faced by women and girls during emergencies.

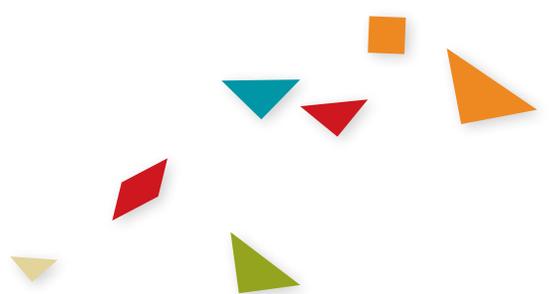
Materials

To download the presentations, videos, and other components that you will use in today's training, please visit:

 www.wrc.ms/drr-srh-curriculum

Objectives:

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

- 1) Identify risks faced by women and girls during an emergency (with a specific focus on reproductive health and gender).
 - 2) Provide a description of the Minimum Initial Service Package (MISP) for Reproductive Health, inclusive of:
 - a. Its importance,
 - b. The five priority actions included within it, as well as additional activities, and
 - c. The key actions that could be taken to improve MISP preparedness.
 - 3) Apply knowledge of RH and gender risks to existing hazard and risk maps.
 - 4) Identify community-level capacities and gaps for gender and reproductive health preparedness and response.
 - 5) Discuss community-level actions that could be taken to improve preparedness and that would improve RH response and reduce gender-related risks in emergencies.
 - 6) Develop action plans and accountability mechanisms that ensure a more robust gender and RH response.
 - 7) Develop community-level actions plans that respond to identified gaps and needs related to RH and gender, and leverage existing resources and capacities.
- 

Facilitator's Agenda Day 1:

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|---|---|---|
| 8:30-9:00 | Training set-up | <ul style="list-style-type: none"> Set up training site Welcome and register participants | <ul style="list-style-type: none"> Registration form Participant name tags Participant agenda |
| 9:00-9:50 | Introduction & Housekeeping | <ul style="list-style-type: none"> Training pre-test Activity: Icebreaker: Ball toss name game Ground rules and expectations Presentation: <i>Training Overview</i> | <ul style="list-style-type: none"> Pre-test handouts 3 balls Flip chart Colored card stock (roughly 3x11) or <i>Meta cards</i> Marker pens Projector and screen Computer Presentation: <i>Training Overview</i> |
| 9:50-10:30 | MODULE 1.1 Local Risks & Experiences | <ul style="list-style-type: none"> Activity: Disaster timeline | <ul style="list-style-type: none"> Flip chart Markers |
| 10:30-11:00 | Tea break | | |
| 11:00-12:00 | MODULE 1.2 Community-based Disaster Risk Reduction | <ul style="list-style-type: none"> Presentation: <i>Involving Communities in Disaster Risk Reduction and Preparedness</i> Activity: Island expansion <p><i>**Note: consider inviting a local DRRM expert or colleague to share a brief presentation of the local DRR policies and systems</i></p> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Involving Communities in Disaster Risk Reduction and Preparedness</i> Presentation from the local DRRMO (example, <i>Philippines DRRM Act</i>, is included) www.wrc.ms/drr-srh-curriculum Markers Flipchart Small creative items for Island expansion activity |
| 12:00-1:00 | Lunch | | |
| 1:00-1:10 | MODULE 1.3 Reproductive Health Priorities in Emergencies | <ul style="list-style-type: none"> Video: <i>India—Prioritizing Sexual and Reproductive Health in Disaster Response</i> | <ul style="list-style-type: none"> Video (download to computer or stream) https://www.youtube.com/watch?v=QaEATzpF2Kg www.wrc.ms/drr-srh-curriculum Computer (with audio hook up) Projector and screen |
| 1:10-2:30 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Activity: Reproductive health case study | <ul style="list-style-type: none"> Flip chart Markers Card stock/meta cards |
| 2:30-3:00 | Tea Break | | |
| 3:00-4:00 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Presentation: <i>Priorities for Reproductive Health and Gender in Emergencies</i> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Priorities for Reproductive Health and Gender in Emergencies</i> www.wrc.ms/drr-srh-curriculum |
| 4:00-4:10 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Video: <i>Planning Sexual & Reproductive Health before Emergencies: the MISP for Emergency Preparedness</i> | <ul style="list-style-type: none"> Video (download to computer or stream) https://www.youtube.com/watch?v=TzpqxsnFReg www.wrc.ms/drr-srh-curriculum Computer (with audio hook up) Projector and screen |
| 4:10-4:40 | Closing and Next Steps | <ul style="list-style-type: none"> Gratitude Daily evaluation Items for tomorrow | |

Facilitator's Agenda Day 2:

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|---|--|---|
| 9:00-9:20 | Welcome, Review and Housekeeping | <ul style="list-style-type: none"> Review & housekeeping | <ul style="list-style-type: none"> Flip chart Markers |
| 9:20-10:30 | MODULE 2.1 Safe Motherhood | <ul style="list-style-type: none"> Video: <i>Atlas of Birth</i> Presentation: <i>Maternal and Newborn Health</i> Activity: Safe birth plan | <ul style="list-style-type: none"> Computer (with audio hook-up) Projector and screen Presentation: <i>Maternal and Newborn Health</i> www.wrc.ms/drr-srh-curriculum Video (download to computer or stream) www.youtube.com/watch?v=1rzLY2UWQw& Flip chart Markers IEC handouts Safe birth planning worksheet |
| 10:30-11:00 | Tea break | | |
| 11:00-12:00 | MODULE 2.1 – cont'd | <ul style="list-style-type: none"> Role play of safe birth plan | <ul style="list-style-type: none"> Materials to encourage participants to role play |
| 12:00-1:00 | Lunch | | |
| 1:00-1:30 | MODULE 2.2 Sexually Transmitted Infections (STIs), HIV and Family Planning | <ul style="list-style-type: none"> Presentation: <i>STIs, Including HIV</i> Presentation: <i>Family Planning</i> Activity: True/False challenge | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>STIs, Including HIV</i> Presentation: <i>Family Planning</i> www.wrc.ms/drr-srh-curriculum True/False questions Team prizes |
| 1:30-2:30 | MODULE 2.3 Gender-based Violence | <ul style="list-style-type: none"> Presentation: <i>Gender-based Violence Overview</i> Activity: Referral web | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Gender-based Violence Overview</i> www.wrc.ms/drr-srh-curriculum Ball of yarn Service provider name tags Story for referral web exercise |
| 2:30-3:00 | Tea break | | |
| 3:00-4:00 | MODULE 2.3 cont'd | <ul style="list-style-type: none"> Presentation: <i>Responding to the Needs of Women and Girls</i> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Responding to the Needs of Women and Girls</i> www.wrc.ms/drr-srh-curriculum |
| 4:00-5:00 | MODULE 2.4 Quiz Show! | <ul style="list-style-type: none"> Activity: Quiz Show! | <ul style="list-style-type: none"> Quiz Show board Quiz Show questions Team prizes |
| 5:00-5:15 | Closing and Next Steps | | |

Facilitator's Agenda Day 3:

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|--|--|---|
| 9:00-9:30 | Welcome, Review and Housekeeping | <ul style="list-style-type: none"> Welcome, Review & Housekeeping | <ul style="list-style-type: none"> Flip chart Markers |
| 9:30-10:00 | MODULE 3.1 Household Preparedness | <ul style="list-style-type: none"> Activity: Household preparedness brainstorm | <ul style="list-style-type: none"> Meta cards Flip chart |
| 10:00-10:30 | Tea break | | |
| 10:30-12:00 | MODULE 3.2 Community Mapping | <ul style="list-style-type: none"> Activity: Mapping Activity: Identifying preparedness | <ul style="list-style-type: none"> Markers Flip chart Stickers Meta cards (2 colors) |
| 12:00-1:00 | Lunch | | |
| 1:00-2:30 | MODULE 3.3 Action Planning | <ul style="list-style-type: none"> Activity: Develop action plans | <ul style="list-style-type: none"> Markers Action planning matrix |
| 2:30-3:00 | Tea break | | |
| 3:00 | Wrap-up and Closing | <ul style="list-style-type: none"> Post-test Evaluations Photo consent Closing ceremony and certificates | <ul style="list-style-type: none"> Post-test Evaluations Photo consent forms Certificates |

Nuts and Bolts: Getting Ready for Your Training

Trainers and support staff needed:

- The training can be successfully implemented by one or two facilitators who have experience training at the local and community levels. If participants speak a different language or local dialect from the facilitator(s), the trainers should engage a translator who can assist the facilitator in understanding the ongoing conversations and dialogue throughout the three days.
- Participant recruitment: The training is designed to support 20 to 30 participants--to ensure each participant can voice his or her concerns and actively participate, while also having a sufficient number of participants for the group activities.
- Effort should be taken to work with women's groups or grassroots organizations that understand the experiences and constraints faced by women and girls in their communities. Trainings are enhanced by diversity with regard to age and sex.
- The training is designed to be accessible, action-oriented and collaborative to ensure community investment in reproductive health and disaster risk reduction issues in emergencies.

Language & translation:

- The training is best implemented when the participants can express themselves in their language and dialect of choice. A translator, as mentioned above, can convey messages from participants to the facilitator if needed. This approach allows for further participant

investment in DRR activities and comprehension of DRR's nuanced issues. Furthermore, the choice of language is critical in maintaining cultural competency and sensitivity to the local context.

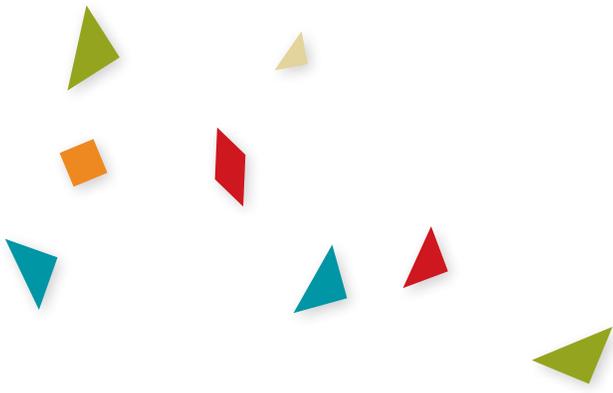
- Translation of materials in this curriculum may be needed to ensure participants are able to fully engage with the material. Plan for sufficient time for such translation.

Cultural sensitivity:

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

Identifying a training space:

- Participants will spend a full three days in the training space of choice. Thus, there are a few items to consider when identifying a training space:
 1. Convenient location to public transportation or other modes of transportation.
 2. Neutral location for a diverse range of participants: Avoid hosting the training at a location (organization, government office, etc.) where there may be tension or discomfort between any participant and the staff of the training venue.
 3. Location with amenities for participants such as accessibility for people with



disabilities and appropriate washrooms.

4. Location with privacy for participants to be able to share their thoughts and engage in group activities without fear of being overheard.

Downloading materials

- All guides, presentations, videos and other resources can be downloaded free of charge at www.wrc.ms/drr-srh-curriculum

Training evaluation:

- The three-day training has multiple evaluation components to ensure participant satisfaction, participant learning and training effectiveness. The components include:
 - » Pre- and post-test: Each participant will take a pre-test and a post-test to assess current knowledge of reproductive health and disaster risk reduction topics and change in knowledge after the training.
 - » Daily evaluation: During the closing of each training day, the facilitator engages in an informal, open and safe discussion with participants to gauge their satisfaction with the material and to highlight any concerns.
 - » End-of-training evaluation.
- If this training is supported by a broader initiative, there is also a training follow-up system that has been developed and designed for local SMS technology platforms.

Notes

- ¹ McMichael AJ, Woodruff RE, Hales S. Climate change and human health: present and future risks. *The Lancet*. 2006;367: 859-869.
- ² UNISDR. Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters. 18-22 January 2005. Kobe, Hyogo, Japan.
- ³ UNFPA. Women's Empowerment and Reproductive Health training.
<http://web.unfpa.org/intercenter/cycle/introduction.htm>.

Training Preparation and Material Checklists

| TRAINING PREPARATION CHECKLIST | | CHECK BOX |
|---|---|-----------|
| Identify possible communities for the training, and select based on suggested criteria | | |
| Meet with Mayor, LGU and DRRMO to discuss interest and possible plans for training | | |
| Recruit training staff (1 or 2 facilitators, translator and note-taker) | | |
| Identify a training venue | | |
| Recruit 20 to 30 participants (as noted in preparation guidance) | | |
| Download presentations, videos, and other resources from  www.wrc.ms/drr-srh-curriculum | | |
| Test computer, projector, audio equipment and screen before Day 1 | | |
| Organize tea breaks and meals for all 3 days | | |
| Review curriculum and facilitator notes prior to training | | |
| MATERIALS | QUANTITY | CHECK BOX |
| Flip chart | 2-3 flip chart packs | |
| Card stock (roughly 3"x 11") Also called meta cards | 100 (depending on use) | |
| Markers (good quality) | 10-15 | |
| Pens for participants | 30-50 | |
| Tape | 3 rolls | |
| Participant and trainer name tags for each day | 3 multiplied by # of participants | |
| Balls | 3 | |
| Treats to use for prizes and games | 2 bags of nice candies (team prizes for Quiz Show! and True/False challenge) Candies for Island Expansion activity (consider Swedish Fish) | |
| Large ball of yarn | 1 | |
| Supplies for Island Expansion Activity | 15 trees (consider paper cups) 1 school and 1 hospital (consider a Styrofoam bowl or folded card stock) | |
| Colored stickers | 2 packs | |
| Certificates for participants | # of participants | |
| Projector | 1 | |
| Computer | 1 | |
| Speakers | 1 set | |
| TRAINING PREPARATION CHECKLIST | | CHECK BOX |
| Registration/sign-in sheet | 1 | |
| Participant agenda | # of participants | |
| Pre-test | # of participants | |
| Post-test | # of participants | |
| End-of-training evaluation | # of participants | |
| All handouts (packet) | # of participants | |
| Certificates for participants | # of participants | |

Facilitator's Training Curriculum

| | | |
|--------------|---|----|
| DAY 1 | Introducing Localized Risks | 21 |
| DAY 2 | Understanding Reproductive Health, Including Gender-Based Violence in Emergencies | 49 |
| DAY 3 | From Knowledge to Action | 83 |

PREPARATION & DAY



Introducing Localized Risks

THE GOAL:

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

| | | |
|-------------------|---|----|
| MODULE 1.1 | Local Risks and Experiences | 29 |
| MODULE 1.2 | Community-based Disaster Risk Reduction | 31 |
| MODULE 1.3 | Reproductive Health Priorities in Emergencies | 40 |

Day 1: Facilitator's Agenda

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|---|---|---|
| 8:30-9:00 | Training set-up | <ul style="list-style-type: none"> Set up training site Welcome and register participants | <ul style="list-style-type: none"> Registration form Participant name tags Participant agenda |
| 9:00-9:50 | Introduction & Housekeeping | <ul style="list-style-type: none"> Training pre-test Activity: Icebreaker: Ball toss name game Ground rules and expectations Presentation: <i>Training Overview</i> | <ul style="list-style-type: none"> Pre-test handouts 3 balls Flip chart Colored card stock (roughly 3x11) or <i>Meta cards</i> Marker pens Projector and screen Computer Presentation: <i>Training Overview</i> |
| 9:50-10:30 | MODULE 1.1 Local Risks & Experiences | <ul style="list-style-type: none"> Activity: Disaster timeline | <ul style="list-style-type: none"> Flip chart Markers |
| 10:30-11:00 | Tea break | | |
| 11:00-12:00 | MODULE 1.2 Community-based Disaster Risk Reduction | <ul style="list-style-type: none"> Presentation: <i>Involving Communities in Disaster Risk Reduction and Preparedness</i> Activity: Island expansion <p>**Note: consider inviting a local DRRM expert or colleague to share a brief presentation of the local DRR policies and systems</p> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Involving Communities in Disaster Risk Reduction and Preparedness</i> Presentation from the local DRRMO (example, <i>Philippines DRRM Act</i>, is included) www.wrc.ms/drr-srh-curriculum Markers Flipchart Small creative items for Island expansion activity |
| 12:00-1:00 | Lunch | | |
| 1:00-1:10 | MODULE 1.3 Reproductive Health Priorities in Emergencies | <ul style="list-style-type: none"> Video: <i>India—Prioritizing Sexual and Reproductive Health in Disaster Response</i> | <ul style="list-style-type: none"> Video (download to computer or stream) https://www.youtube.com/watch?v=QaEATzpF2Kg www.wrc.ms/drr-srh-curriculum Computer (with audio hook up) Projector and screen |
| 1:10-2:30 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Activity: Reproductive health case study | <ul style="list-style-type: none"> Flip chart Markers Card stock/meta cards |
| 2:30-3:00 | Tea Break | | |
| 3:00-4:00 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Presentation: <i>Priorities for Reproductive Health and Gender in Emergencies</i> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Priorities for Reproductive Health and Gender in Emergencies</i> www.wrc.ms/drr-srh-curriculum |
| 4:00-4:10 | MODULE 1.3 – cont'd | <ul style="list-style-type: none"> Video: <i>Planning Sexual & Reproductive Health before Emergencies: the MISP for Emergency Preparedness</i> | <ul style="list-style-type: none"> Video (download to computer or stream) https://www.youtube.com/watch?v=TzpqxsNFReg www.wrc.ms/drr-srh-curriculum Computer (with audio hook up) Projector and screen |
| 4:10-4:40 | Closing and Next Steps | <ul style="list-style-type: none"> Gratitude Daily evaluation Items for tomorrow | |

TRAINING SET-UP

 45 minutes

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

- Post signs for the training at the site if needed to allow participants to find the training room.
- Meet with your note taker (if you have one present) to ensure they understand the format of the day and the focus of the notes you wish to have documented.
- Establish a “registration table” that includes a sign-in sheet for participants to register when they arrive (name, community, position, phone and email should be included if electronic follow-up is expected).
- Prepare or designate the area where tea, breakfast, lunch or any other meals and snacks will be served.
- Prepare and test any audio and visual equipment, including electrical plugs, projector, screen, computer, audio connections and Internet.
- Set up tables in the shape of a U, a circle or in small clusters.
- Ensure you have participant handouts prepared to put in folders for the participants.

INTRODUCTION & HOUSEKEEPING

 50 minutes

As participants enter, distribute (or display on flip chart) the daily agenda and pre-test to complete before the formal training begins.

Pre-Test (15-20 min):

The facilitator should distribute the pre-test to participants as they enter the room. Time indicated suggests the amount of time that could be allowed for all to focus on the pre-test, before initiating introductions. However, keep in mind that participants will start the test at different times—and the facilitator may wish to allow some to continue working on the pre-test when introductions begin.

Remind individuals that:

- A pre-/post-test will be done for this training in order to evaluate the trainer and the ability of the training itself to convey specific information.
- A pre-/post-test should be completed individually, as the goal of the training is to reach everyone in the room, rather than just a few.
- A pre-/post-test is not an evaluation of participants. Therefore, names and any other identifying information should not be used on the forms. Participants should answer questions as best they can, but certainly it would not be expected that they know all answers before the training begins.

Introduction (10 min):

At the designated start time of the training:

- Welcome participants to the *Community Preparedness: Reproductive Health and Gender Training*.
- Explain that we will discuss more about the training and objectives shortly.
- Introduce the trainer(s).
- Discuss the language of instruction (if the facilitator is not speaking in the local language, explain that there is a translator available to translate information back to the facilitator so that participants can feel comfortable expressing themselves in their local dialect).
- Express interest in meeting participants. Go around the room and have everyone share their name, the community they are from and their role in the community.
- Identify three “host-teams” to support the facilitator with ice-breakers and energizers through each of the three days. The host team assigned for each day will be responsible for energizers, time keeping and the morning feedback the next day.
- Open the session by playing an ice-breaker game to build rapport before diving into formal introductions and an overview of the training.



Facilitator's tip

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



ACTIVITY: Ice-Breaker (20 min) - Ball Toss Name Game¹

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

- Introduce exercise as a way to energize the group and as a method to understand the importance of communication in an emergency.
- Have participants create circles of about 8-12 people with plenty of space behind them in case they jump or move backward to catch a ball. If there are not enough participants for two groups, one large circle can be formed.
- Ask participants to say their names slowly and go around the circle, repeating names a couple of times. Ensure that participants hear the names.
- Then, explain that the person holding the ball will call out a person's name and toss the ball to that person. If a participant forgets a name, they can ask him/her to repeat it.
- Begin to play the game with one ball per circle.
- After a couple of minutes throw in a second ball.
- After a couple of minutes throw in a third ball. Continue with all three for a short period of time.
- End activity.

Discussion:

Ask participants for reflections and thoughts about the exercise and how communication is important in an emergency. (What made this activity easier? What made it harder? Did knowing the names before the activity become stressful or assist with your ability to complete the activity successfully?)

Emphasize the need for clarity, focus and cooperation to implement an emergency response.

GROUND RULES & GROUP EXPECTATIONS

 **10 minutes**

Facilitator should have participants brainstorm ground rules for the training. These are items that keep a training moving along

¹Youth Peer Education Electronic Resource, Peer Education Training of Trainers Manual, UN Interagency Group on Young People's Health Development and Protection in Europe and Central Asia, Sub-Committee on Peer Education, 2003.

smoothly (turning off cell phones, active participation, etc.). Ask participants to think of ground rules and expectations for both the facilitator and participants, to help guide the training over the next three days. Ask individuals to write their ground rules on colored pieces of paper and post them to the wall.

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

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

- 1) Respect opinions.
- 2) One person speaks at a time.
- 3) Turn off cell phones.
- 4) Respect time (facilitator will keep the day on schedule and provide ample breaks and time to make phone calls, stretch legs, etc., if participants can be fully present and active during the sessions).

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



PRESENTATION: Training Overview



10 minutes

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



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- Facilitators can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own.
- Before transitioning from the overview to the training itself, circulate the agenda to participants if they do not already have it. Review the agenda and ask for any questions, comments and concerns.
- Finally, close the introduction with housekeeping items, including location of washrooms, tea and lunch, and any other relevant items.

PRESENTATION: Training Overview: 8 slides

SLIDE 1



- ▶ Most participants should know that the training is related to emergency preparedness and somehow connected with gender and reproductive health. The Facilitator will now spend time explaining this linkage and how this training came to be.

SLIDE 2



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

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

Although trainings at the community level can be implemented on many different topics as they relate to risk reduction and emergency preparedness (livelihoods, coordination, water and sanitation, etc.), this training is focused on reproductive health and gender. That does not mean that reproductive health and gender issues are more important than other preparedness activities; however, the training emphasizes that these topics are important for inclusion within the broader preparedness activities. Many times, without a specific focus on these topics and issues, they are forgotten or overlooked.

There have been multiple partners involved in the development of this training:

- Women's Refugee Commission--Research and advocacy organization that developed, piloted and finalized the curriculum
- UNFPA--Financial and field support provided to a one-year pilot effort
- Bicol University--Supported follow-up to past training participants
- Local Government Academy--Expressed support and interest in rolling out training to Barangay officials
- Dimagi--technology company focused on SMS technology

Also the community partners where the pilot projects were implemented.

SLIDE 3



- ▶ The training that has been developed and which you are all part of for the next three days was developed as a result of multiple "pilot" or test trainings. Some pilot trainings were first implemented in Haiti, after the earthquake of 2010, while others were implemented in Uganda and South Sudan.

However, most pilot activities have focused on the Philippines between April 2011 and June 2014. Trainings have been implemented in the Philippines in collaboration with UNFPA/Philippines, as well as multiple government and local organizations in each area where training activities were implemented.



PRESENTATION: Training Overview (cont'd)

SLIDE 3 (cont'd)



•••► Five training activities have been implemented in diverse settings across the Philippines:

- Illigan (April 2011)
- Metro Manila (June 2012)
- Sorsogon (December 2013)
- Compostella Valley (April 2014)
- Maguindanao (June 2014)

Each of the trainings incorporated a 3-5 day participatory training of various community members and members of the LGU (including representatives of the provincial or municipal DRRMO), action planning, pre- and post-tests, training evaluations and interviews with participants. Some training groups received text-based follow-up and monitoring, others received in-person follow-up visits by a local organization. The various approaches and settings were used to cull learning from implementation.

SLIDE 4



•••► Before implementing this training with all of you here today, we ensured that we had the support of the DRRMO, the municipality and your barangay officials. Although communities are critical for disaster planning and preparedness, it is also very important that we ensure the support of your local leaders and involve them in our efforts.

(Facilitator should outline any meetings held or recognize participants in the room who represent various members of the DRRMO, LGU or barangay and thank them for their support and attendance so that the training can be as fruitful as possible.)

SLIDE 5



•••► The Women's Refugee Commission (WRC) has been interested in developing this training because we have seen for decades that community members are frequently first responders in the immediate aftermath of conflict and natural disasters. We also know from our work in many crisis settings that actions can be taken before an emergency to reduce some of the risks faced by women and girls, thereby reducing the death, disease and disability that they tend to experience at a higher rate than men and boys.

The Women's Refugee Commission has helped to draft this current training:

- To fill an identified gap in materials available to build the capacity of community members on gender mainstreaming, as well preparedness as it relates to gender and RH
- To ensure that community resilience and early involvement are viewed as critical elements of a successful response
- To ensure that community members are best positioned to develop local solutions to locally identified risks
- To demonstrate the feasibility of this approach

The WRC is a New York-based research and advocacy organization that is extremely invested in improving humanitarian response and the impact of emergencies experienced by especially vulnerable groups--specifically women and girls.



PRESENTATION: Training Overview (cont'd)

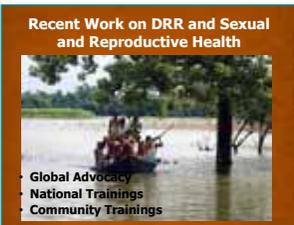
SLIDE 6



- ▶ The WRC produces guidance and materials that are widely accessed by humanitarian agencies:
 - MISP distance learning module
 - Contributed to the Inter Agency Field Manual for Reproductive Health in Humanitarian Settings
 - Established guidance on disability inclusion

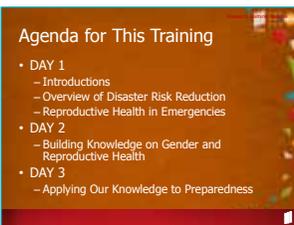
It is the vision of the WRC and UNFPA vision that the work conducted through this training can be duplicated in other settings. The training developed as a result of these efforts will become available to other organizations within the Philippines, through the development of a widely available curriculum--so that more community groups and members (like yourselves) can learn some of the basic risks to reproductive health and gender that are faced during an emergency as well as what can be done at the community level to reduce some of these risks.

SLIDE 7



- ▶ WRC and partner activities
 - Multi-level approach, ensuring that practice informs global guidance
 - Global Advocacy
 - International Strategy for Disaster Reduction (ISDR) RH sub-working group
 - Drafting of a policy brief & a preparedness and planning checklist
 - National Trainings (Sudan, Uganda, Haiti)
 - Partner with Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East, Southeast Asia and the Pacific (SPRINT) and other partners (UNFPA, CARE) to train country teams in the MISP and contingency planning
 - Piloting DRR curriculum to be added to the MISP
 - Community Empowerment (Haiti and the Philippines)
 - Training of community groups working with vulnerable populations on MISP and DRR

SLIDE 8



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

MODULE 1.1: Local Risks and Experiences

 40 minutes

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

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



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

ACTIVITY: Disaster Timeline

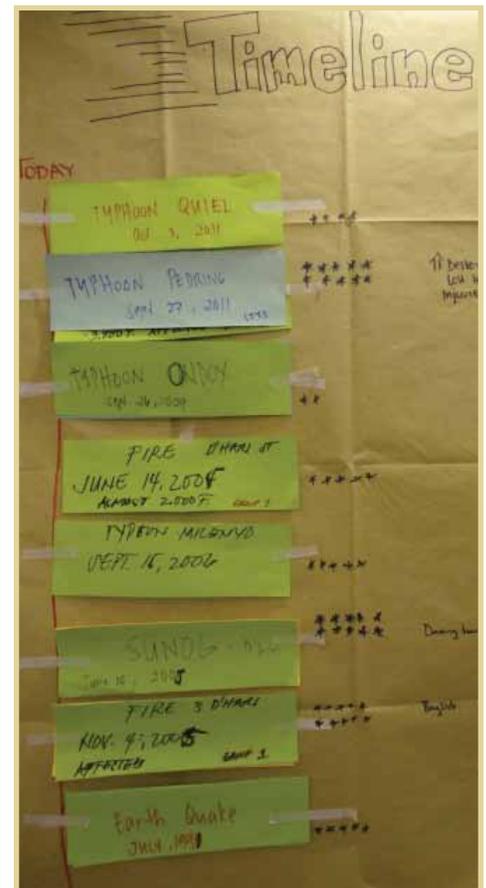
Activity Prep:

Post flip chart paper on a wall in the training room to create a blank timeline. If needed, reconfigure participant desks in a half circle or U to cluster around the timeline.

Option:

It can be helpful to have participants clustered in small groups around the timeline (could divide them male/female, or by location, etc.) as this can help with participation.

- The facilitator can start by asking the participants to recall major events in their community and discuss them at their tables. These may include the following;
 - Major events significant to the community
 - Major hazards and their effects
- Facilitator should then ask for volunteers to share the major events that were discussed—starting with the one furthest back in their memory. It is helpful to have many age groups represented to ensure a long history.
- Call up a participant to place the name of the major event on the timeline (using card stock/meta cards).



- Ask for group agreement—is there anything before this event that should have been placed on the timeline? Was the “name” remembered correctly?
- The facilitator should then elicit details from this disaster and write this information on the timeline. (Date should be on the timeline, followed by the name of the event, followed by the type of event—conflict, typhoon, flooding, etc., followed by impact.)
- The facilitator will then help the group to build out the timeline, gradually moving to the most recent events (see example on prior page).
- When the timeline is complete, the facilitator will be able to show past events (pointing out the hazards experienced), and what the impact has been over time. The hazard timeline will make people aware of climate changes and present perceptions, and can serve as a basis for discussions on future programs or projects within the community.

Discussion:

The facilitator will be able to extract climate change- and ecosystem-related information, as well as health risks, with the following questions:

- Are there any trends or changes in the frequency of events over time?
- Have weather- and climate-related events such as flood, drought and cyclones changed in number or severity?
- What systems have been most impacted in these disasters (health, education, social)?
- What events do you expect will occur in the future? When? Why?
- What steps have been taken in recent years to secure the provision of health services—even in a disaster? Have communities been involved in these efforts?



Facilitator's tip

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

TEA BREAK

 30 minutes

MODULE 1.2: Involving Communities in Disaster Risk Reduction and Preparedness

 1 hour



GOAL: To increase understanding and knowledge of disaster risk reduction and the importance of community involvement in these efforts. ²

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



PRESENTATION: Involving Communities in Disaster Risk Reduction and Preparedness

- Before starting the presentation, remind participants of what was just discussed within the timeline activity and its purpose as a roadmap for the rest of the training. The timeline will serve as the context to build knowledge on local disaster risk.
- Check if there are any questions about the timeline.
- Introduce community-based disaster risk reduction as the next topic, through a short presentation.
- The facilitator can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create his or her own.



- Computer
- Projector and screen
- Prepared presentation: *Community-based disaster risk reduction and preparedness*



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- Supplies for “Island Expansion” activity
 - » Items to represent hospital and school
 - » Items to represent trees
 - » Items to represent fish (consider a hard candy or Swedish Fish if available)
 - » Large paper to represent an island
 - » Printed script for role play
 - » Facilitator marker pens

²CordAid. Facilitating CMDRR Method and Process, Booklet 3, Module 2 (http://www.cordaid.org/media/publications/Booklet_3_Module_2_Facilitating_CMDRR_Method_and_Process_1.pdf)



PRESENTATION:

Involving Communities in Disaster Risk Reduction and Preparedness: 13 slides

SLIDE 1



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

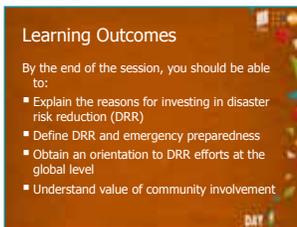
The risks that your community faces might be different from those of communities that are in a slightly different location--even within the same region.

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

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

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

SLIDE 2



....► Review learning objectives.

Learning Outcomes

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

- Explain the reasons for investing in disaster risk reduction (DRR)
- Define DRR and emergency preparedness
- Obtain an orientation to DRR efforts at the global level
- Understand value of community involvement

SLIDE 3



....► Globally, there is more and more attention to natural disasters.

But what has driven this focus?

• **Over the past two decades, the number of natural disaster occurring has doubled (from roughly 200 to 400 annually).¹**

• 9/10 of these disasters are climate-related.¹

• Conflict and displacement can then lead to further environmental degradation--creating a vicious cycle of more disasters.¹

• In 2012, an estimated 32.4 million people in 82 countries were newly displaced by disasters associated with natural hazard events. ¾ of these countries were affected by multiple disaster-induced displacement.²

• Changes in natural disasters are not just in places like the Philippines...but this is a global trend.

• Many locations that were previously safe from disasters are now experiencing new risks to natural hazards (similar to what we see in Mindanao – Specifically, Iligan and Compostella Valley--over the past few years; but this is also happening in the Sahel in Africa, other coastal areas such as the pacific islands and even the Atlantic Coast in the USA, etc.).

• **The impacts of such disasters vary greatly.³**

• In 2012, 357 natural disasters were registered; this was both less than the average annual disaster frequency observed from 2002 to 2011 (394), and represented a decrease in loss of lives.

• However, 2011 had demonstrated an increase in lives affected from previous years.

• The general trend appears to be that mortality (and human impact) is declining, but economic impacts continue to show an annual increase.

• There is also a difference in resulting impact between frequent small-scale disasters and large-scale catastrophic events. Small-scale disasters tend to have a far greater impact on the poor and vulnerable communities.



PRESENTATION: Involving Communities in Disaster Risk Reduction and Preparedness (cont'd)

SLIDE 3 (cont'd)



- **More than 1.5 billion people live in countries at risk.**⁴
 - Over the last decade, China, the United States, the Philippines, India and Indonesia constituted the top 5 countries that are most frequently hit by natural disasters.³
 - The single deadliest disaster in 2012, was Typhoon Bopha, which killed 1,901 people in the Philippines.³
 - Asia is the continent most at risk of natural disaster.¹
- **Vulnerabilities are increasing at the population level**
 - increased urbanization
 - unplanned/unsafe settlements
 - exposed coastal areas
 - poverty
 - illness/disease/HIV prevalence
 - inadequate attention to risk patterns
- **Disasters are a major stumbling block in attaining development goals**
 - Think about the recent Typhoon Yolanda (Haiyan) and the impact such a storm had on the health infrastructure. Such systems took years to establish.

References:

1. Norwegian Refugee Council (2008). Climate Change, the Environment and Displacement. Available at: http://www.nrc.no/arch/_img/9411999.pdf.
2. Internal Displacement Monitoring Center (IDMC) and Norwegian Refugee Council (NRC) (2012). Global Estimates 2012: People Displaced by Natural Hazard-Induced Disasters. Available at: <http://reliefweb.int/sites/reliefweb.int/files/resources/global-estimates-2012-may2013.pdf>.
3. Guha-Sapir D, Hoyois Ph., Below R. Annual Disaster Statistical Review 2012: The Numbers and Trends. Brussels: CRED; 2013. Available at: http://www.cred.be/sites/default/files/ADSR_2012.pdf.
4. World development report 2011: conflict, security, and development. Washington, World Bank (2011).

SLIDE 4



- In addition to the increase of disaster EVENTS, there are also changing population dynamics that are also considerations in understanding risk.
 - **What are some behaviors of people or communities, that tend to place them at higher risk? (Brainstorm for a bit).**
 -What happens when populations get bigger and people start moving closer to the water?
 -Or: Poverty introduces more competition for resources (fisherfolk might need to be out at risky times, live close to the water or farm land that they know is needed to avoid erosion, etc.)
- Population growth has multiple influences upon population risks:
 - Contributes to widespread poverty and competition for resources.
 - People in low-income countries are four times more likely to die from extreme natural events than those in high-income countries.⁵
 - Poverty and population growth will increase competition for resources, which leads to related behaviors that put populations at greater risks:
 - Families or workers will move into high-risk areas previously uninhabited (landfills, waterfront, unstable slopes)
 - Many times such moves into less inhabitable areas are driven by desire to be closer to income (fisherfolk moving to the water's edge, for example)
 - Communities may farm areas previously kept as forests, marshland or other (removing natural protections from environmental hazards)
 - Economic strains may lead to less stable constructions (construction may be flimsy; apartment buildings going higher or with less firm foundation than they should)



PRESENTATION: Involving Communities in Disaster Risk Reduction and Preparedness (cont'd)

SLIDE 4 (cont'd)



Some populations are at risk because of where they live geographically. Asia, for example, is higher risk than Europe for natural hazards. During the 1990s, more than two-thirds of the deaths from disasters occurred in Asia, which was also the continent most frequently hit by disasters.⁵

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

References:

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

SLIDE 5



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

Gender differences appear to be linked to economic and social rights pre-crisis, as well as overlaps with some biological factors.

Natural disasters push ordinary gender disparities to the extreme--revealing development failures and societal issues.

SLIDE 6



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

- Bangladesh cyclone of 1991 — 3 women killed for every 1 man⁶ (46 (21%) of 222 females aged >10 years died, versus 17 (7%) of 258 males in the same age range); some estimates go much higher, stating that women represented 90% of deaths.^{7, 8,9}
- Tsunami of 2004 — death rates for women were estimated at 4-5 times as great, and some noted up to 80% who died were women.^{7,8,9}

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

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

In the 1991 Bangladesh Cyclone, we know that many women perished at home, waiting with children for their husbands to return to make evacuation decisions.¹⁰

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

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

We also know that during ongoing displacement women remain disproportionately affected.

- Impacts on the health of the girl child, enrollment in school, risks of child, early and forced marriage, exposure to trafficking and survival sex, and of course the longer-term health consequences.

References:

⁶ Bern, C et al (1993). Risk factors for Mortality in the Bangladesh Cyclone of 1991. Bulletin of the World Health Organization 71 (1) 73-78. Available at: [http://whqlibdoc.who.int/bulletin/1993/Vol71-No1/bulletin_1993_71\(1\)_73-78.pdf](http://whqlibdoc.who.int/bulletin/1993/Vol71-No1/bulletin_1993_71(1)_73-78.pdf).

⁷ Ikeda, Keiko (1995) "Gender Differences in Human Loss and Vulnerability in Natural Disasters: A Case Study From Bangladesh." Indian Journal of Gender Studies. 2(2):171-9.

⁸ APWLD (2005) "Why are women more vulnerable during disasters?" Asia Pacific Forum on Women, Law and Development, NGO in consultative status at UN ECOSOC. <http://www2.lse.ac.uk/geographyAndEnvironment/whosWho/profiles/neumayer/pdf/Disastersarticle.pdf>.

⁹ Plan International (2011). Weathering the Storm: Adolescent Girls and Climate Change 2011. www.plan-uk.org/resources/documents/35316/.



PRESENTATION: Involving Communities in Disaster Risk Reduction and Preparedness (cont'd)

SLIDE 6 (cont'd)



- Girls are also more vulnerable as families are forced to prioritize resources.¹¹
- Studies have reported adverse reproductive outcomes following disasters, including early pregnancy loss, premature delivery, stillbirths, delivery-related complications and infertility.³ A study from Israel reported an increase in delivery rates during the 48 hours following an earthquake and a significant increase in the premature delivery rate.¹⁰

¹⁰ World Health Organization (2002). Gender and Health. http://www.who.int/gender/other_health/en/genderdisasters.pdf.

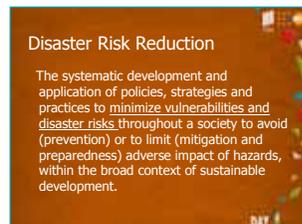
¹¹ UC Berkley News Center (2014). Report details high costs of Philippines typhoons for families, baby girls. Announcement explaining research available here: <http://newscenter.berkeley.edu/2013/11/19/report-details-high-costs-of-philippine-typhoons-for-families-baby-girls/>.

SLIDE 7



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

SLIDE 8



- UNISDR terminology.

SLIDE 9



- ** Note: Facilitator should present the different types of natural hazards through a discussion of what types of hazards most affect this area. This will help the group to understand their "disaster profile."

PRESENTATION: Involving Communities in Disaster Risk Reduction and Preparedness (cont'd)

SLIDE 10



....► Natural hazards are not the same as natural disasters.
A hazard becomes a disaster when a) people and/or their assets and property are present, and b) coping mechanisms are overwhelmed.

SLIDE 11

Hyogo Framework for Action 2005-2015
Building the Resilience of Nations and Communities to Disasters

- Priority Action 1: DRR is a national and a local priority
- Priority Action 2: Monitor risks and early warning
- Priority Action 3: Culture of safety and resilience
- Priority Action 4: Reduce the underlying risks
- Priority Action 5: Strengthen preparedness for response

SLIDE 12

Benefits of Local DRR

- Risks are localized
- Communities know their risks and vulnerabilities
- Communities are aware of their capacities
- Decisions to act will be local

SLIDE 13

"Preventive measures are most effective when they involve participation at all levels, from the local community through the national government to the regional and international level."

(IDNDR Conference Papers, Japan, 1994)

ACTIVITY: Island Expansion



LINK TO FULL PUBLICATION: adapted from <http://www.pfpi.org/pdf/ipopcorm/couple-peer-educators-training-manual.pdf>

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



MODULE 1.2 Community-based Disaster Risk Reduction (cont'd)

Script for activity:



Husband and Wife:

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

Narrator:

This husband and wife have many children who have many children. *(Narrator ADDS 3 people to the “island”; space is tighter; remove some trees. Remove some fish from the sea.)*

Young girl:

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

Narrator:

(Add a hospital and two schools). This population also has many children, and some new families have arrived by boat from a faraway place looking for a better life. *(ADD 3 more people to the piece of paper. Remove some trees. Remove some fish from the sea).*

Neighbor:

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

Narrator:

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

Mother:

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

Narrator:

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

Narrator:

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

Young boy:

Yesterday there was typhoon which came to our place. We lost many things....

Narrator:

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

MODULE 1.2 Community-based Disaster Risk Reduction (cont'd)

PRESENTATION: TBD (local disaster risk reduction and management)

- Ideally, a colleague from the local disaster risk management team can close the morning session with a presentation on local DRR policies and procedures.
- If this is not possible, some mention should be made of progress made nationally and locally. An example of such a presentation from the Philippines is included in the presentations for this curriculum. (Titled: *Philippines DRRM Act*)



PRESENTATION: Sample Philippine DRRM Act: 10 slides

SLIDE 1



SLIDE 2



SLIDE 3



SLIDE 4



SLIDE 5



SLIDE 6



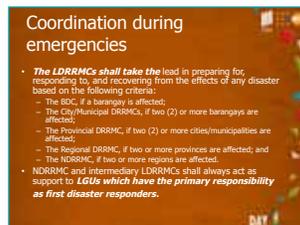
SLIDE 7



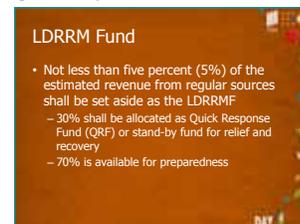
SLIDE 8



SLIDE 9



SLIDE 10



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LUNCH



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

Preparation:

Set up participant work stations for small group activities with five to seven individuals in each group.

MODULE 1.3: Reproductive Health Priorities in Emergencies

 2 hours



GOAL: To understand the importance of prioritizing reproductive health and gender protection during preparedness and response activities.

This session will open with showing a video that was developed by UNFPA/India which helps to orient participants to what happens to pregnant women and girls during an emergency. It will then move to a small group activity involving a case study from a recent emergency, followed by a summary presentation and closing video.



VIDEO: India—Prioritizing Sexual and Reproductive Health in Disaster Response

Open this module by showing a short video.

Post-video discussion:

After the video, ask the following questions to the group:

- Open discussion of initial responses to the video and whether similar concerns had arisen during recent emergencies in the Philippines.
- Do participants in the room have experience with camp settlements or evacuation centers? What risks do women and girls face in such settings?
- What additional risks do young girls face in emergencies?
- In this video, what is the message behind the “MISP”?
- Are these ideas specific to India? Or can they be applied to other settings?



- Computer (with audio hook-up)
- Projector and screen
- 2 videos downloaded to computer:
 - » India- *Prioritizing Sexual and Reproductive Health in Disaster Response*
- 🔗 LINK TO STREAM VIDEO: <http://www.youtube.com/watch?v=QaEATzpF2Kg>
- 🔗 LINK TO DOWNLOAD VIDEO: www.wrc.ms/drr-srh-curriculum
- » *Planning Sexual & Reproductive Health before Emergencies: the MISP for Emergency Preparedness*
- 🔗 LINK TO STREAM VIDEO: <http://www.youtube.com/watch?v=TzpqxsnFReg>
- 🔗 LINK TO DOWNLOAD VIDEO: www.wrc.ms/drr-srh-curriculum
- Supplies for case study activity
- Print out a case study for each participant
- Card stock/meta cards to label assigned groups
- Facilitator marker pens
- Presentation: *Priorities for Reproductive Health and Gender in Emergencies*

ACTIVITY: Reproductive Health Case Study

This exercise is best implemented with three to four small groups of five to eight participants. Each group will receive a print out of the case study, as well as a small group discussion guide. Each group should designate a spokesperson to quickly summarize their discussion.

- Divide participants into small groups of five to eight people depending on training size. Assign each group with a population of interest (and write this on folded placards or meta cards):
 - » Adolescents – both boys and girls
 - » Pregnant and lactating women
 - » Persons living with a chronic health condition, such as HIV or AIDS
 - » Persons with disabilities and the elderly
- Read through the case study together as a group—encouraging different members to read a few sentences at a time. Pause to allow for translation or clarification in local languages.

CASE STUDY I: Typhoon Haiyan/Yolanda

On 8 November 2013, Typhoon Yolanda made landfall in the Philippines. More than 12 million people were affected by the super storm: Roughly 3 million are women of reproductive age (15-45 years). UNFPA estimates that roughly 90,000 pregnant women are affected by the disaster, and 8,000 births are expected in the first month; 1,600 miscarriages will occur within this same time period. Additionally, it is estimated that there are 147,000 lactating women (breastfeeding) affected by the storm.

The health systems have been damaged or destroyed in many areas. Few to no health clinics and health centers are currently functioning. The regional hospital in Tacloban was hit by a storm surge and much of its medical equipment has been washed away. In other areas, medical supplies are exhausted. The ability to get new supplies has been disrupted. Where health facilities do exist, there are no sterile supplies. About 660,000 displaced people need essential health services. Immediately after Yolanda, the roads were blocked by debris making it difficult for relief efforts and supplies to reach people. Security is compromised in many areas.

As much as 90% of housing has been destroyed in some areas, Region 5 and 6 have the highest populations of displaced. Many people are living in evacuation centers: 4,600 pregnant and 8,900 lactating women are living in evacuation centers. There is very little space and no privacy, with very few bathing areas and bad sanitation. Many people left their homes with very little or just the clothes they are wearing. There is also a problem with electricity and lighting because the power has been cut. Telephone communications are not working. It is difficult for people to call or text family members or friends. Children may have been separated from their families and be unaccompanied. Young children and newborns can get very sick because of the small space to live and no sanitation.

MODULE 1.3: Reproductive Health Priorities in Emergencies (cont'd)

CASE STUDY II: Typhoon Bopha/Pablo

On 4 December 2012, Typhoon Bopha (locally known as Pablo) made landfall in the Philippines. Compostella Valley and Davao Oriental were among the most affected. More than 6.2 million people were impacted by the storm, including well over 900,000 displaced. Over 1,000 people died as a result of the storm and a near equal number were still missing nearly 2 months later.

As of February 2013, the impacts of the storm continue to affect the most vulnerable populations. Poor shelter and water result in severe acute malnutrition, especially among infants and children under 5 years, as families are forced to prioritize available resources. Additionally, electricity is yet to be returned to Davao Oriental, presenting safety concerns. Waste disposal in both municipalities is an increasing concern.

Food security and shelter remain ongoing challenges. In an assessment of shelter, more than 98% of homes surveyed have been destroyed or damaged, and 93% are considered uninhabitable. As of February, nearly 9,000 individuals are housed in evacuation centers. However, the majority, of those displaced from the emergency reside in makeshift shelters. There is a recognized gap in adequate latrines and bathing facilities, especially in these makeshift settlements. Female-headed households, persons with disabilities and the elderly are being prioritized for shelter programs.

The health system, especially in 12 difficult-to-reach barangays in Compostella Valley, is compromised. Rain and distances have also challenged service delivery and access to health care in a number of other municipalities. Additionally, there is a severe lack of available health providers and those trained in psychosocial support. Training requests have been made to build knowledge on emergency response for reproductive health and gender-based violence. Adolescents are considered to be a particularly neglected population with regard to health. UNFPA has implemented medical missions in an attempt to reach vulnerable groups.

- Provide the following instructions to the large group:
 - You have been assigned to consider the risks faced by a particular group during an emergency. Before you start, make sure that everyone in your group understands which group you have been assigned to.*
 - » *Read through the case study again as a group.*
 - » *Considering the group you have been assigned to—go back and underline or highlight information that you feel may be important to understanding the risks faced by this particular group in this scenario (e.g., loss of health facilities, no lights/electricity, etc.).*
 - » *In your group, discuss the reasons why particular items were underlined, and determine the influence that this particular aspect of an emergency might have on your assigned group. Remember—there could be multiple concerns arising from one identified issue (e.g., there is no emergency medical care for pregnant women if she is in labor; passage to latrines might be unsafe at night).*
 - » *Now in your group, determine what risks might result for this population. What are the risks that result? (Maternal death, sexual violence, etc.)*

MODULE 1.3: Reproductive Health Priorities in Emergencies (cont'd)

- » Record this information for feedback to the larger group (this can be done on flip chart paper or using meta cards)—note the groups have been provided with further instructions for their small group discussion.
- After 20-30 minutes, encourage the entire group to come back together for a larger discussion.
- Have each group share back what they have put down on their flipchart paper:

issues ► concerns ► risk

- » At the end of each group presentation, the facilitator should ask if other groups have questions or additional comments.
- » As many have experienced an emergency in recent memory, it is also possible to ask if there are additional comments they would like to share about a particular population and risks faced.
- » The large group should applaud each small group's efforts.
- » Facilitator should expand on the presentation or share additional comments about topics raised as needed.
- Facilitator should then review some of the following questions:
 - » What are the risks of living in an evacuation center or temporary settlement that have not been mentioned yet?
 - » How does age affect your risks? How does gender affect risk? What other factors play significant roles in your safety?
 - » Who is most affected by the lack of health centers/hospitals?
 - » What about gaps in communication?
 - » What services are needed to protect our community from some of these risks?
 - » Are these services typically in place?

TEA BREAK

 30 minutes

Transition the conversation to a presentation on *Priorities for Reproductive Health and Gender during Emergencies*.

PRESENTATION: Priorities for Reproductive Health and Gender in Emergencies

- Before starting the presentation, remind participants of what was just discussed in the case studies.
- Check whether there are any questions from the prior activity.
- Facilitators can use a pre-made PowerPoint presentation on this topic, or adapt the information contained within existing presentations to create their own.

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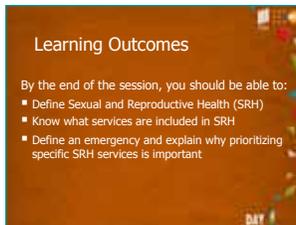
PRESENTATION: Priorities for Reproductive Health and Gender in Emergencies: 17 slides

SLIDE 1

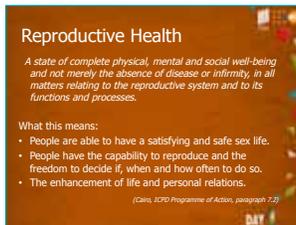


-▶ We've just completed an activity that has us all thinking about a recent emergency, and how different members of our community were affected. We're now going to move to a presentation that should reinforce some of the ideas that we were starting to touch on.

SLIDE 2



SLIDE 3



-▶ In 1994, the International Conference on Population and Development established what is now a near universally accepted definition of reproductive health. As you can see, the definition is broad. It speaks to health as not just being the absence of disease.
- The definition that speaks to reproductive health implies that:
- People are able to have a satisfying and safe sex life.
 - They have the capability to reproduce and the freedom to decide if, when and how often to do so.
 - The enhancement of life and personal relations.



PRESENTATION: Priorities for Reproductive Health and Gender in Emergencies (cont'd)

SLIDE 4



- ▶ Reproductive health services are not only important during times of pregnancy. They cover the entire life span, and include services for both men and women.

From WHO Continuum of Care:

http://www.who.int/pmnch/about/continuum_of_care/en/.

What is the Continuum of Care?

The "Continuum of Care" for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities.

The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

What are the dimensions and importance of the Continuum of Care?

The first dimension of the Continuum of Care is time—from pre-pregnancy, through pregnancy, childbirth, and the early days and years of life. (Figure 1 Connecting care giving across the Continuum for maternal, newborn and child health).

The second dimension of the Continuum of Care is place—linking the various levels of home, community and health facilities (Figure 2. Connecting care giving between households and health facilities to reduce maternal, newborn and child deaths).

Linking interventions in this way is important because it can reduce costs by allowing greater efficiency, increase uptake and provide opportunities for promoting related healthcare elements (e.g., postpartum/postnatal and newborn care).

SLIDE 5



- ▶ During stable times, the full package of reproductive health services might include:

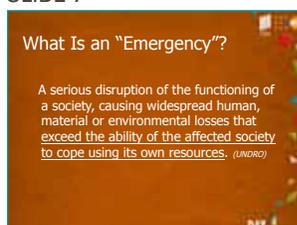
- Family Planning (all methods—including long-term and permanent, as well as emergency contraception)
- Prevention and management of sexually transmitted infections, including mother-to-child transmission of HIV and syphilis
- Pregnancy care (Antenatal care—vitamins, malaria)
- Childbirth care (including emergency obstetric care)
- Postnatal care (mother and newborn)
- Prevention and management of gender-based violence

SLIDE 6



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

SLIDE 7



PRESENTATION: Priorities for Reproductive Health and Gender in Emergencies (cont'd)

SLIDE 8

Women and girls are at increased risk if reproductive health needs are not prioritized in disaster response

- **Women face ongoing health risks, specifically reproductive health risks, due to gaps in health services during and in the aftermath of an emergency.**
 - Anywhere from 4-16% of women of reproductive age (WRA) will be pregnant at any given time; 15% of these will experience life-threatening pregnancy complications.
 - Increased risk of sexual violence as civil society is destabilized; displacement often means lack of security.
 - Health infrastructure is damaged = lack of access to services.
 - Increased risks for HIV transmission (loss of protocols/compromised universal precautions, no access to condoms, no safe blood supply).
 - Lack of access to routine family planning methods and condoms increase risk of unplanned pregnancy and risk for STIs.
 - Taboos around menstruation can cause further health risks for girls and women.
 - In the 1998 cyclone in Bangladesh, girls reported an increase in urinary tract infections and perineal rashes as they could not wash and properly dry menstrual rags.¹⁰

References:

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

SLIDE 9

SRH Needs Increase During Crises

- Gender-based violence
- STIs/HIV transmission
- Interruption in family planning services
- Malnutrition and epidemics
- Routine SRH needs (pregnancy, childbirth) continue

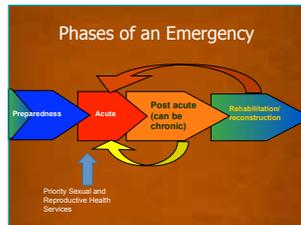
- **Sexual and reproductive health needs increase during times of crisis.**
 - As societal structures are compromised, there is an increase in gender-based violence.
 - Because health services are lacking, and taking preventative steps is more challenging--there is an increased risk of in STI/HIV transmission.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

SLIDE 10

Challenges Also Increase...

- Access to health services
- Availability of health care providers
- Communication and transportation
- Absence of routine health services
- Women, girls and other vulnerable groups tend to have lowest access to response systems

SLIDE 11



SLIDE 12

It is critical to prioritize services in order to save lives...

- **During an emergency, it is critical to prioritize services that are life saving.** Within this training, we will be referring to both the *Minimum Initial Service Package for Reproductive Health*, and the *Guidelines for Gender-based Violence Interventions in Humanitarian Settings* to shape our discussion of emergency preparedness and response. So let's take some time to learn more about each of these.



PRESENTATION: Priorities for Reproductive Health and Gender in Emergencies (cont'd)

SLIDE 13

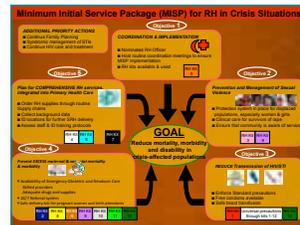


•••▶ We saw an introductory video to this package—but let’s talk a bit more about what the MISP actually includes and does not include.

SLIDE 14



SLIDE 15



•••▶ Facilitator should talk through each of the five objectives.

SLIDE 16



•••▶ Tomorrow—we will spend the day going through each of these areas.

SLIDE 17



•••▶ We will also talk further about protection from gender-based violence.

VIDEO: Planning RH Before Emergencies—The MISP for Emergency Preparedness

Post-video discussion:

Now that we’ve spent much of the afternoon—thinking about emergencies and what happens to populations during these emergencies, we hope that you are starting to feel more aware of the risks that result for reproductive health and with regard to gender protection.

- What information has been new to you?
- What has been most interesting from the afternoon discussion?
- Are there things you want to learn more about?

CLOSING AND NEXT STEPS

 30-40 minutes



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

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

Spend some time reviewing material from the day to ensure understanding and comprehension. Leave space for open-ended questions that are not guided. Questions can include:

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

END-OF-DAY EVALUATION

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

- What went well with the training today?
- What can be improved?
- Is there anything you would like to see changed for tomorrow?

CLOSING AND NEXT STEPS

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



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



Facilitator's tip

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

DAY



Understanding Reproductive Health, Including Gender-Based Violence in Emergencies

THE GOAL:

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

| | | |
|-------------------|---|----|
| MODULE 2.1 | Safe Motherhood | 51 |
| MODULE 2.2 | Sexually Transmitted Infections (STIs), HIV and Family Planning | 57 |
| MODULE 2.3 | Gender-based Violence | 69 |
| MODULE 2.4 | Quiz Show | 77 |

Day 2: Facilitator's Agenda

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|--|--|---|
| 9:00-9:20 | Welcome, Review and Housekeeping | <ul style="list-style-type: none"> Review & housekeeping | <ul style="list-style-type: none"> Flip chart Markers |
| 9:20-10:30 | MODULE 2.1 Safe Motherhood | <ul style="list-style-type: none"> Video: <i>Atlas of Birth</i> Presentation: <i>Maternal and Newborn Health</i> Activity: Safe Birth Plan | <ul style="list-style-type: none"> Computer (with audio hook-up) Projector and screen Presentation: <i>Maternal and Newborn Health</i> www.wrc.ms/drr-srh-curriculum Video (download to computer or stream) www.youtube.com/watch?v=1rzILy2UWQw Flip chart Markers IEC handouts Safe birth planning worksheet |
| 10:30-11:00 | Tea break | | |
| 11:00-12:00 | MODULE 2.1 – cont'd | <ul style="list-style-type: none"> Role play of safe birth plan | <ul style="list-style-type: none"> Materials to encourage participants to role play |
| 12:00-1:00 | Lunch | | |
| 1:00-1:30 | MODULE 2.2 Sexually Transmitted Infections (STIs), HIV and Family Planning | <ul style="list-style-type: none"> Presentation: <i>STIs, Including HIV</i> Presentation: <i>Family Planning</i> Activity: True/False challenge | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>STIs, Including HIV</i> Presentation: <i>Family Planning</i> www.wrc.ms/drr-srh-curriculum True/False questions Team prizes |
| 1:30-2:30 | MODULE 2.3 Gender-based Violence | <ul style="list-style-type: none"> Presentation: <i>Gender-based Violence Overview</i> Activity: Referral web | <ul style="list-style-type: none"> Computer Projector and screen <i>GBV Overview</i> presentation www.wrc.ms/drr-srh-curriculum Ball of yarn Service provider name tags Story for referral web exercise |
| 2:30-3:00 | Tea break | | |
| 3:00-4:00 | MODULE 2.3 cont'd | <ul style="list-style-type: none"> Presentation: <i>Responding to the Needs of Women and Girls</i> | <ul style="list-style-type: none"> Computer Projector and screen Presentation: <i>Responding to the Needs of Women and Girls</i> www.wrc.ms/drr-srh-curriculum |
| 4:00-5:00 | MODULE 2.4 Quiz Show! | <ul style="list-style-type: none"> Activity: Quiz Show! | <ul style="list-style-type: none"> Quiz Show! board Quiz Show! questions Team prizes |
| 5:00-5:15 | Closing and Next Steps | | |

WELCOME & HOUSEKEEPING

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



KEY CONCEPTS FROM DAY 1

Spend 10 to 15 minutes reviewing the key concepts of Day 1

- Basic definition of disaster risk reduction as it relates to reproductive health and gender
- Specific risks and vulnerabilities unique to women and girls in disasters
- Concept of the MISRP as a framework for minimum response in emergencies
- Concept of gender-based violence and its importance with respect to the health and well-being of women and girls

GOALS AND AGENDA FOR DAY 2

The purpose of Day 2 is to increase knowledge and understanding of the components of the MISRP for Reproductive Health. Today's learning will contrast with yesterday's focus on local risks and needs—and move to new learning on the topic of reproductive health and gender, and critical priorities during crises.

Learning objectives include:

- Familiarity with the reproductive health elements included in the MISRP for Reproductive Health. Specifically including:
 - Safe motherhood, with a focus on safe birth planning
 - HIV/STI prevention, with a focus on condom availability and standard precautions
 - Family planning, with a focus on building knowledge around methods and availability before an emergency
 - Gender-based violence, with a focus on referral protocols, the importance of confidentiality, women's safe spaces and building awareness around medical care for survivors of sexual violence



Facilitator's tip

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

MODULE 2.1: Safe Motherhood

 2 hours

 **GOALS:** Increase 1) understanding of safe motherhood, 2) knowledge of the three delays and pregnancy danger signs and 3) familiarity with safe birth plans.

This module covers a number of activities that help bring to life the concepts and messages around safe motherhood and priority interventions during an emergency. Depending on the time needed for discussion and role plays, it is very likely that this module will cover the time available before lunch. If necessary, the facilitator can shorten this module by putting very short time limits on the role play preparation or by excluding it entirely and asking each group to describe the birth plan that they developed.

VIDEO: Atlas of Birth

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



- Computer (with audio hook-up)
- Projector and screen
- Atlas of Birth Video
-  LINK TO STREAM VIDEO:
<http://www.youtube.com/watch?v=1rzLy2UWQw>
-  LINK TO DOWNLOAD VIDEO:
www.wrc.ms/drr-srh-curriculum
- Maternal and newborn health presentation
- IEC materials (including *Danger Signs During Childbirth, Signs of a Complicated Pregnancy and Preparing for Childbirth*)
- Preparing for safe birth activity handout
- Paper/supplies for role play (consider name tags)
- Masking tape

PRESENTATION: Maternal and Newborn Health

- Facilitators can use a pre-made PowerPoint presentation on this topic.
- Allow participants to ask any questions that came up in the safe motherhood presentation.
- Allow time to discuss any remaining issues or comments from participants.

 www.wrc.ms/drr-srh-curriculum

PRESENTATION: Maternal and Newborn Health: 9 slides

SLIDE 1



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

SLIDE 2



....▶ **WHO Key Facts:**¹
 Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth.
 99% of all maternal deaths occur in developing countries.
 Maternal mortality is higher in women living in rural areas and among poorer communities.
 Young adolescents face a higher risk of complications and death as a result of pregnancy than older women.
 Skilled care before, during and after childbirth can save the lives of women and newborn babies.
 Between 1990 and 2013, maternal mortality worldwide dropped by almost 50%.

References:

¹WHO Key facts--Maternal Mortality. Available at: <http://www.who.int/mediacentre/factsheets/fs348/en/>

SLIDE 3



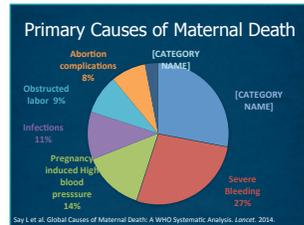
....▶

- **Pregnancy-related complications are the primary cause of death for adolescents aged 15-19 years**
 Adolescent girls are at the highest risk of maternal mortality: the risk of pregnancy-related death is twice as high for girls aged 15-19 and five times higher for girls aged 10-14 compared to women in their twenties. Further, pregnant adolescents are more likely than adults to pursue unsafe abortions; an estimated three million unsafe abortions occur every year among girls aged 15-19.¹
- **In the Philippines, 120 women die in pregnancy for every 1,000 live births (2009-2013 World Bank data); no change since 2004-2008 data²**
 The Philippines, a middle-income country with a growing economy, has made good progress on maternal and child survival in recent decades. The country is considered to be “on track” to reach Millennium Development Goal (MDG) #4 (with a child mortality ratio of 30 deaths per 1,000 live births) and “making progress” on MDG #5 (with a maternal mortality rate of 99 deaths per 100,000 live births) in 2014.³
- **15% of pregnancies will result in a life-threatening complication**
- **5% will require a cesarean section**



PRESENTATION: Maternal and Newborn Health (cont'd)

SLIDE 4



Why do women die?

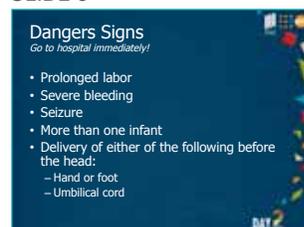
Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for nearly 75% of all maternal deaths are:¹

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- unsafe abortion

References:

¹WHO Key facts--Maternal Mortality. Available at: <http://www.who.int/mediacentre/factsheets/fs348/en>.

SLIDE 5

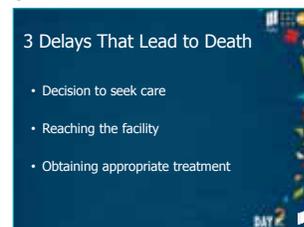


Facilitator should reference handouts of IEC materials

SLIDE 6



SLIDE 7



Although having emergency obstetric care available at a health facility is critical, there are a number of societal factors that influence the ability of a mother to get needed treatment and prevent maternal death. “The Three Delays Model” focuses on these factors.

These delays are particularly important for community groups and community members to understand. In addition to checking health facilities for a basic level of care, they can proactively address some of these delays through education and outreach.

Reference:

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

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

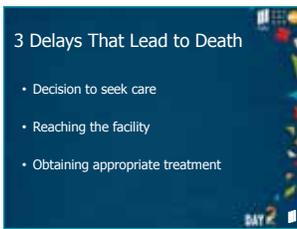
In most instances, women who die in childbirth experienced at least one of the following three delays:

- **The First Delay is the delay in deciding to seek care for an obstetric complication.** This may occur for several reasons, including late recognition that there is a problem, fear of the hospital or of the costs that will be incurred there, or the lack of an available decision-maker.



PRESENTATION: Maternal and Newborn Health (cont'd)

SLIDE 7 (cont'd)



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

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

SLIDE 8



SLIDE 9



ACTIVITY: Safe Birth Planning

Source: Developed by the Women's Refugee Commission, 2012

Divide participants into small groups of 3 to 5 individuals. Distribute the *Preparing for Safe Birth Activity* Handout and IEC templates. Introduce and describe how each of these will be used.

- Introduce small group activity “Safe Birth Planning”
- Have each group draw one from each of the following colored paper strips (all can be adjusted based on the local names and scenarios the trainer would like to stress):

| NAME | AGE | SETTING |
|----------|-----|--|
| Anna | 17 | Evacuation Center |
| Yolanda | 23 | Evacuation Center |
| Grace | 35 | Urban setting during active crisis |
| Christie | 26 | Rural or in transit during active crisis |

- Explain that the group has just learned the name, age and location of the woman that they will now be discussing in their small groups.
 - » The activity will last one hour.
 - » For the first 20 minutes, participants will create a birth plan for their character using the “Safe Birth Planning” handout in their small groups.
 - » Participants can use the other handouts as tools and helpful guides.



Meet _____ (name).

_____ (name) is 9 months pregnant. She lives in the Philippines and her community is frequently affected by natural disasters. There is NO way to know who will experience pregnancy complications. Therefore, it is important that those surrounding a pregnant woman know the dangers signs for which immediate care should be sought.



What are the key danger signs that indicate a life-threatening complication?

Your task is to make sure that _____ and her baby have a safe birth plan in place. This will help to ensure that she and her baby are safe through childbirth. Because she lives in an area frequently affected by disasters, her birth plan should include plans for an emergency, and should be routinely updated if such an emergency occurs.

1. What type(s) of disaster (man-made or natural) should this woman include in her planning?
2. When was this birth plan developed (during which month of pregnancy)?
3. Who will be included in developing this particular woman's birth plan, and what role will each take?
4. In an emergency, what are some available transportation options (include several)?
5. Which hospital will she go to (include a back-up option)?
6. Who will this woman call if she experiences danger signs and must get to the hospital (what phone numbers?) Will these work in a natural disaster? What is her back-up plan?

WORKING TEA BREAK

ACTIVITY: Safe Birth Plan Role Play

- After the *Preparing for Safe Birth Activity Handout* is completed, each small group will design a role play to present back the story of their character and the implementation of the birth plan.
- Role plays should be brief, and involve creative storytelling. The goal of the role play is to demonstrate key aspects of their birth plan being implemented during an emergency or protracted evacuation.
- The small groups will perform their role play in front of the big group.
- The facilitator should use the opportunity after each role play to reinforce messaging around safe birth planning, as well as maternal and newborn health more broadly, while observing positive elements demonstrated in each role play.

LUNCH



MODULE 2.2: Sexually Transmitted Infections (STIs), Including HIV & Family Planning

 1 hour, 20 minutes

 **GOAL:** Increase understanding of the importance of 1) prevention, management and care of STIs, including HIV, in emergencies and 2) family planning.

The next series of presentations and activities will shift to two more areas of the MISP: reducing transmission of STIs, including HIV and providing family planning to meet demand. The format for this learning will be two back-to-back presentations, followed by a review game. The presentations are designed to be short and focused on first building general knowledge on the topic, and then focusing on community-level activities as they relate to RH preparedness and response.



- Computer
- Projector and screen
- Statements for the true/false game
- Marker pens
- Prizes (small chocolates, or similar, for the winning team)

PRESENTATION: Sexually Transmitted Infections, Including HIV

- Come back after break (either first tea or lunch) and transition to a presentation on STIs/HIV and family planning. Remind participants that today, you are gradually moving through the health areas that are prioritized during an emergency response. The focus of the morning was on maternal and newborn health. You will now shift to talk about STIs and HIV, as well as family planning.
- Notify participants that after the two presentations, there will be an interactive game.

 www.wrc.ms/drr-srh-curriculum

PRESENTATION: STIs, Including HIV: 12 slides

SLIDE 1



SLIDE 2

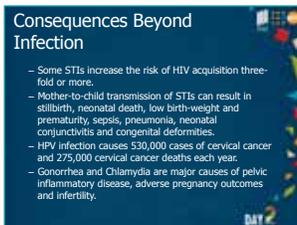


...▶ Presentation is based on facts available through WHO's current fact sheets. Found at: http://www.who.int/features/factfiles/sexually_transmitted_diseases/facts/en/index9.html.

SLIDE 3



SLIDE 4



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

SLIDE 5



...▶ **What are sexually transmitted infections and how are they transmitted?**
STIs are caused by more than 30 different bacteria, viruses and parasites and are spread predominantly by sexual contact, including vaginal, anal and oral sex. Some STIs may be spread via skin-to-skin sexual contact. The organisms causing STIs can also be spread through non-sexual means such as blood products and tissue transfer. Many STIs — including chlamydia, gonorrhoea, hepatitis B, HIV, HPV, HSV2 and syphilis — can also be transmitted from mother to child during pregnancy and childbirth. A person can have an STI without having obvious symptoms of disease. Therefore, the term "sexually transmitted infection" is a broader term than "sexually transmitted disease" (STD).



PRESENTATION: STIs, Including HIV (cont'd)

SLIDE 6



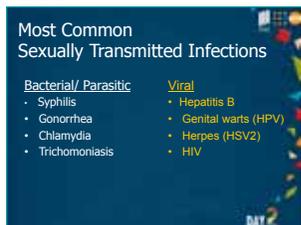
Common Symptoms

- Vaginal discharge
- Urethral discharge
- Genital ulcers
- Abdominal pain

Common symptoms of STIs include vaginal discharge, urethral discharge in men, genital ulcers, and abdominal pain.

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

SLIDE 7



Most Common Sexually Transmitted Infections

| Bacterial/ Parasitic | Viral |
|--|---|
| <ul style="list-style-type: none">• Syphilis• Gonorrhoea• Chlamydia• Trichomoniasis | <ul style="list-style-type: none">• Hepatitis B• Genital warts (HPV)• Herpes (HSV2)• HIV |

Eight of the more than 30 pathogens known to be transmitted through sexual contact have been linked to the greatest incidence of illness. Of these eight infections, four are currently curable: syphilis, gonorrhoea, chlamydia and trichomoniasis. The other four are viral infections and are incurable, but can be mitigated or modulated through treatment: hepatitis B, herpes, HIV and HPV.

SLIDE 8



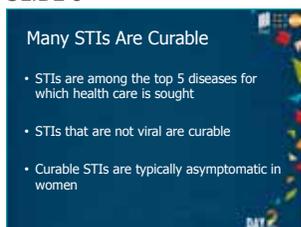
Estimated new cases of curable STIs



STIs have a profound impact on sexual and reproductive health worldwide, and rank among the top five disease categories for which adults seek health care.

More than 1 million people acquire a sexually transmitted infection every day. Each year, an estimated 500 million people acquire one of four sexually transmitted infections (STIs): chlamydia, gonorrhoea, syphilis and trichomoniasis. More than 530 million people are living with HSV2. More than 290 million women have an HPV infection, one of the most common STIs.

SLIDE 9



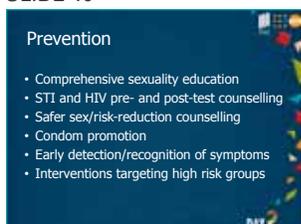
Many STIs Are Curable

- STIs are among the top 5 diseases for which health care is sought
- STIs that are not viral are curable
- Curable STIs are typically asymptomatic in women

STIs are among the top five diseases for which health care services are sought. With the exception of viral STIs (HIV, herpes and HPV), STIs can be cured, if they are detected early and treated. Globally, it is estimated that as many as 333 million new cases of curable STIs occur each year. 65 million of these new infections occur in sub-Saharan Africa. Rates of STIs vary considerably from region to region and among specific groups within a country.

The majority of curable STIs in women cause subclinical or asymptomatic infection. For example, gonorrhoea usually causes symptoms in men, allowing them to seek treatment, whereas women often have minor symptoms, if any. In women between 15 and 44 years of age, the morbidity and mortality due to STIs, not including HIV, are second only to maternal causes. The prevalence of curable STIs in women is highly variable by region and risk behavior.

SLIDE 10



Prevention

- Comprehensive sexuality education
- STI and HIV pre- and post-test counselling
- Safer sex/risk-reduction counselling
- Condom promotion
- Early detection/recognition of symptoms
- Interventions targeting high risk groups



PRESENTATION: STIs, Including HIV (cont'd)

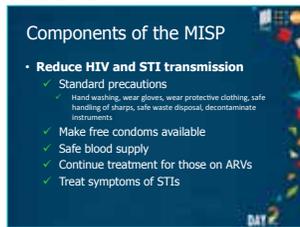
SLIDE 11



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

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

SLIDE 12



...▶ These should be included as basic elements of response to every situation of displacement.

PRESENTATION: Family Planning

- Transition to a presentation on family planning. Before launching into another presentation, ask if there are any questions, comments or concerns related to STIs/HIV.

www.wrc.ms/drr-srh-curriculum

PRESENTATION: Family Planning: 7 slides

SLIDE 1



SLIDE 2



SLIDE 3

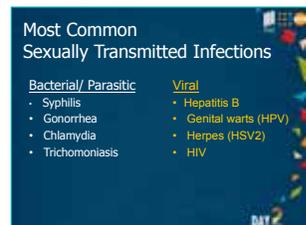


SLIDE 4



PRESENTATION: Family Planning (cont'd)

SLIDE 5



Facilitator should describe each method of family planning.

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

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

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

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

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

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

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

Implant: Progestin-only hormonal contraception that is surgically inserted into a woman's upper arm. Depending on the brand used, implants may last for up to 3 years before needing replacement.

Vasectomy and Tubal Ligation are permanent methods of contraception.

Emergency Contraception: A "post-coital" method of family planning used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills or torn condoms), rape or coerced sex. Emergency contraception is effective only in the first few days following intercourse before the ovum is released from the ovary and before the sperm fertilizes the ovum. Emergency contraceptive pills cannot interrupt an established pregnancy or harm a developing embryo. Emergency contraception can be used up to 120 hours (five days) after unprotected sex to prevent pregnancy.

There are two main types of emergency contraception:

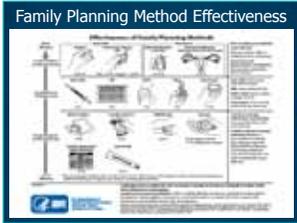
- Emergency contraceptive pills are more effective the sooner you take them.
- The copper T IUD which can be used to prevent pregnancy up to five days after unprotected sex.

WHO (<http://www.who.int/mediacentre/factsheets/fs244/en/>)



PRESENTATION: Family Planning (cont'd)

SLIDE 6



Facilitator should draw attention to the CDC handout in their folders. Point out that lactational amenorrhea is a highly effective temporary method of contraception. Also point to the decisions that many make between hormonal and non-hormonal methods as well as temporary, long acting and permanent methods.

SLIDE 7



These should be included as basic elements of response to every situation of displacement.



ACTIVITY: True/False STIs, HIV and Family Planning¹

Adapted from: Peer Education Training of Trainers, U.N. Interagency Working Group (IAWG) on Young People's Health, Development and Protection in Europe and Central Asia

- Divide participants into three or four small groups.
- The purpose of this activity is to review knowledge and identify perceptions and attitudes towards STIs, including HIV, and family planning.
- Before the training, create a list of 20 statements that participants can identify as either “True” or “False” (a sample list is on the next page).
- Ask each group to identify a speaker for their team and a team name.
- The facilitator will propose a statement to each team. The team can respond “true” or “false” and explain why. If the first team does not know or does not give the right answer, the next team will get a chance to answer it. If the team responds correctly, they will receive another statement.
- On flip chart, the facilitator will keep track of the points accumulated by each team. Each correct response receives one point.
- Each team will have a time limit of two minutes to come up with an answer.
- For the final round, the participants will have a chance to “bet” as many of their accumulated points to either double their points if they get the question right or lose all of them if they do not.
- The winning team receives a prize.

Notes:

¹Youth Peer Education Electronic Resource, Peer Education Training of Trainers Manual, UN Interagency Group on Young People's Health Development and Protection in Europe and Central Asia, Sub-Committee on Peer Education, 2003.

QUESTIONS AND ANSWERS: STIs, HIV and Family Planning

State each statement to participants. When participants have answered, encourage dialogue and discussion as to why the statement is true or false. Use the answer key to reinforce or correct participants and highlight key points.

| QUESTION | ANSWER AND EXPLANATION (Encourage Discussion) |
|--|---|
| <p>1 Outside of abstinence, condoms are the most effective protection against the spread of sexually transmitted infections (STIs).</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Abstinence from sexual intercourse is the best way to prevent the spread of STIs. Only complete sexual abstinence is 100% effective. • Condoms are the next best preventive method. Other family planning methods DO NOT protect against STIs, including HIV. |
| <p>2 Biologically, both men and women have an equal risk of acquiring an STI from a sexual partner.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • Women are more vulnerable to STIs than men because the area of the mucous membranes is both larger and more sensitive in women. Small tears are common in the vagina. |
| <p>3 Spacing of births and total fertility have a direct impact on the health of the mother and the outcome of each pregnancy.</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Preventing pregnancy-related health risks in women: Family planning can delay pregnancies in young women, who are at increased risk of health problems and death from early child-bearing, and can prevent pregnancies among older women who also face increased risks. Family planning enables women who wish to limit the size of their families to do so. • Evidence suggests that women who have more than four children are at increased risk of maternal mortality. • By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion. • Reducing infant mortality: Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health. |

| | | |
|---|---|--|
| 4 | <p>Condoms are not always effective in preventing HPV (human papilloma virus), which causes genital warts.</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Intercourse is not necessary: HPV can also be transmitted by touching (hand/genital or genital/genital) an infected person's lesions. • Genital warts can be found on other parts of the genitals (testicles, vulva), which are not covered/protected by a condom. • Genital warts are transmitted during an outbreak. However, you may not be aware that you or your partner are having an outbreak, since warts are not always visible to the naked eye. |
| 5 | <p>Women who take the birth control pill are protected from pregnancy and STIs.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • Fluid exchange puts you at risk of contracting STIs. The pill is not a barrier that protects fluids from being exchanged. • When taken consistently, the pill is an effective hormonal method for preventing pregnancy. • Some STIs (genital warts/HPV) are transmitted by touching (hand/genital or genital/genital) an infected person's lesions. |
| 6 | <p>Using two condoms at once (meaning two male or two female condoms) provides more protection against STIs.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • Condoms are made to be used alone – friction between two condoms can cause breakage. • Do not combine a male condom with a female condom. |
| 7 | <p>Most women who want to use contraception currently have access to it.</p> | <p>FALSE</p> <p>An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include:</p> <ul style="list-style-type: none"> • limited choice of methods • limited access to contraception, particularly among young people, poorer segments of populations or unmarried people • fear or experience of side-effects • cultural or religious opposition • poor quality of available services • gender-related barriers |



| QUESTION | ANSWER AND EXPLANATION (Encourage Discussion) |
|--|--|
| <p>8 Some STIs can be spread without there being any noticeable symptoms.</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Most people infected with chlamydia show no symptoms (the same is true for gonorrhea). If left untreated (with antibiotics), chlamydia (and also gonorrhea) can cause long-term complications (infertility and pelvic inflammatory disease (PID) in women and prostatitis in men). • Symptoms: In women—pain/dull ache in cervix, heavy feeling in pelvic area, pain when urinating or during intercourse, heavier menstrual flow, and heavy cervical discharge; in men — urethral discharge, pain when urinating, epididymitis. |
| <p>9 Lactational amenorrhea (LAM) is not an effective contraceptive method, because it is not a “modern method” of family planning.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • LAM—when used as a structured method—prevents the release of eggs from the ovaries (ovulation). • It is 99% effective with correct and consistent use; it is 98% effective as commonly used. |
| <p>10 STIs have serious consequences beyond the immediate impact of the infection itself.</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Some STIs increase the risk of HIV acquisition three-fold or more. • Mother-to-child transmission of STIs can result in stillbirth, neonatal death, low birth-weight and prematurity, sepsis, pneumonia, neonatal conjunctivitis and congenital deformities. • HPV infection causes 530,000 cases of cervical cancer and 275,000 cervical cancer deaths each year. • Gonorrhea and chlamydia are major causes of pelvic inflammatory disease (PID), adverse pregnancy outcomes and infertility. |
| <p>11 Viral STIs can be cured with antibiotics.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • There are two types of STIs: bacterial and viral. HPV, HIV and Hepatitis B are viral STIs. Bacterial STIs, such as gonorrhea and chlamydia, can be cured with antibiotics. Viral STIs stay with you, sometimes without symptomatic outbreaks (remission); antiretroviral drugs (ARVs) may help some people maintain a state of remission. |

| | | |
|----|--|--|
| 12 | <p>Those who are on treatment for HIV have the same risk of transmitting the virus as those who are not on treatment.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • Care and treatment for HIV is one of the best ways to prevent the spread of new infection. • Risk of transmission is largely determined by viral load in a person’s body. Treatment is not the same as a cure and HIV can still be spread by those on ARVs. However, if they are consistently able to keep their viral load undetectable, the risk of transmission is substantially reduced. • Condoms should always be used during sex, in order to provide the best protection from HIV and other STIs. |
| 13 | <p>Emergency contraception is only effective in the first days following intercourse.</p> | <p>TRUE</p> <ul style="list-style-type: none"> • Emergency contraception is effective only in the first few days following intercourse before the ovum is released from the ovary and before the sperm fertilizes the ovum. Emergency contraceptive pills cannot interrupt an established pregnancy or harm a developing embryo. • Levonorgestrel emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation. They may also work to prevent fertilization of an egg by affecting the cervical mucus or the ability of sperm to bind to the egg. • Levonorgestrel emergency contraceptive pills are not effective once the process of implantation has begun, and they will not cause an abortion. • Where a designated Emergency Contraception product is not available, the insertion of a copper-bearing IUD is an effective method of emergency contraception (if an individual presents within five days after unprotected sex and there was no earlier unprotected sexual act in this menstrual cycle). Additionally, combined oral contraceptive pills can also be taken as follows: A dose of 0.1 mg ethinyl estradiol plus 0.5 mg of levonorgestrel taken as soon as possible, followed by the same dose 12 hrs later. This later method is known as the Yuzpe method and should be taken within five days – the earlier it is taken the more effective it is. |
| 14 | <p>Only women can be tested for STIs.</p> | <p>FALSE</p> <ul style="list-style-type: none"> • Both men and women can be tested for most bacterial and viral STIs. • The tests differ for men and women, depending on a person’s sexual history and sexual practices (oral, cervical, urethral and anal cell cultures). • There are three types of STI tests: blood tests (syphilis, HIV); cell cultures (chlamydia, gonorrhea); and visual inspections (HPV, herpes). |

| | QUESTION | ANSWER AND EXPLANATION (Encourage Discussion) |
|----|--|---|
| 15 | STIs are frequently asymptomatic in women. | <p>TRUE</p> <ul style="list-style-type: none"> Gonorrhea usually causes symptoms in men, allowing them to seek treatment, whereas women often have minor symptoms, if any. |
| 16 | There are some STIs that can be passed from mother to child. | <p>TRUE</p> <ul style="list-style-type: none"> Some STIs, such as syphilis, gonorrhea and HIV, the virus that causes AIDS, can be passed from mother to child. |
| 17 | Ensuring that condoms are available during an emergency is the only action prioritized during an emergency to reduce HIV transmission. | <p>FALSE</p> <ul style="list-style-type: none"> Universal standard precautions, ARV provision to those already on treatment, and all the interventions related to GBV are also priority activities. The aspects of universal, standard precautions include: hand washing, wearing gloves, wearing protective clothing, safe handling of sharps, safe waste disposal and decontaminating instruments. |
| 18 | STIs can lead to infertility. | <p>TRUE</p> <ul style="list-style-type: none"> Health effects of undetected and untreated STIs include pelvic inflammatory disease (PID), which can cause infertility. Infertility as a result of PID accounts for 50 to 80 percent of the infertility in Africa; in Latin America, about 35 percent. |
| 19 | During an emergency, preventing the spread of STIs is not a priority (as outlined in the MISP). | <p>FALSE</p> <ul style="list-style-type: none"> There are many activities that reduce the spread of STIs which are included in the MISP. For example: <ul style="list-style-type: none"> » Preventing the spread of HIV is a priority objective. HIV is an STI. » The distribution of condoms, which is outlined in the MISP, prevents the spread of HIV and other STIs. » Safe blood transfusion not only protects a person from HIV transmission, but also from Hepatitis C, which can also be spread through sexual intercourse. » Providing treatment to people who present with symptoms of STIs. |
| 20 | The provision of all family planning methods is an important component of the MISP—and the full range of options should be made available within each emergency response. | <p>FALSE</p> <ul style="list-style-type: none"> The provision of family planning is a component of the MISP. However, “family planning should be provided to meet demand”: <ul style="list-style-type: none"> » This language speaks to the fact that a new family planning program should not be developed during an emergency response. » Family planning methods should be made available that were previously available in each context. |

MODULE 2.3: Gender-based Violence

 2 hours

 **GOALS:** To build knowledge, awareness and sensitivity to gender-based violence, and the importance of referral pathways for survivors of sexual violence during an emergency. To share the experiences of the Department of Social Welfare and Development (DSWD) and the UN Population Fund (UNFPA) during recent emergency responses in the Philippines.

Similar to safe motherhood, there is a great deal of information to be presented on gender-based violence (GBV). This module will start with a presentation that focuses on knowledge building related to terminology and the issue of GBV. It will be followed by an interactive activity in which referral pathways (and the errors occurring when they are not in place) are discussed. This activity will be followed by a discussion that is facilitated through a final presentation.



■ Presentation:
Gender-based Violence Overview

 **LINK TO DOWNLOAD PRESENTATION:**
www.wrc.ms/drr-srh-curriculum

■ Very large ball of yarn

■ Sexual violence referral script

■ Presentation:
Philippines- successful GBV models

PRESENTATION: Gender-Based Violence Overview

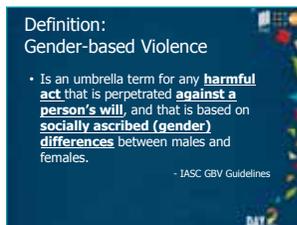
- Facilitators can use a pre-made PowerPoint presentation on this topic.

PRESENTATION: Gender-based Violence Overview: 21 slides

SLIDE 1



SLIDE 2



.....► The terms "gender-based violence" and "violence against women" are frequently used interchangeably in the literature and by advocates; however, the term gender-based violence refers to violence directed against a person because of his or her gender and expectations of his or her role in a society or culture. Gender-based violence (GBV) highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. IASC GBV Guidelines, p. 7.

The U.N. Refugee Agency (UNHCR) has also developed a definition:

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

PRESENTATION: Gender-based Violence Overview (cont'd)

SLIDE 3



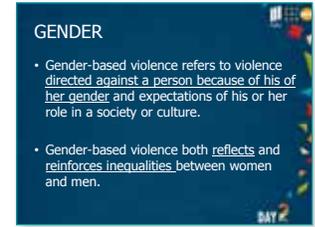
SLIDE 4

| GENDER VS. SEX | |
|--|--|
| Gender | Sex |
| Social differences between females and males | Physical or biological differences between males and females |
| Determined by social factors – history, culture, tradition, societal norms, religion | Determined by biology, nature |
| Can change over time | |
| Can vary both within and between cultures | |

SLIDE 5



SLIDE 6



SLIDE 7



SLIDE 8



SLIDE 9



SLIDE 10

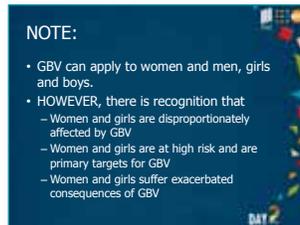


SLIDE 11



GBV takes many forms, including the ones listed above. Perpetrators of GBV are often motivated by a desire for power and domination. GBV is often meant to hurt, control and humiliate, while violating a person's physical and mental integrity. Sexual Violence—Any non-consented action of a sexual nature, including rape, attempted rape, sexual exploitation and sexual abuse. Harmful traditional practices include: child, early and forced marriage, and female genital cutting.

SLIDE 12



Around the world, GBV has a greater impact on women and girls than on men and boys. It is important to note, however, that men and boys may also be victims of GBV, especially sexual violence. While there is some evidence that sexual violence against boys occurs more often than previously known, we do not yet know enough about sexual violence against men and boys in any setting, including in emergencies. Although men and boys can often be seen as either perpetrators or victims of GBV, men and boys are often also critical change agents in GBV prevention efforts.

SLIDE 13



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

SLIDE 14



Assume GBV exists, unless there is conclusive proof that it does not. The magnitude of GBV is difficult to determine. Incidents of GBV are widely under-reported. The World Bank estimates that less than 10 percent of sexual violence cases in non-refugee situations are reported. The factors contributing to under-reporting – fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services and the dispersion of families and communities – are all exacerbated in refugee situations.

PRESENTATION: Gender-based Violence Overview (cont'd)

SLIDE 15

Gender-based violence is especially problematic in the context of emergencies



- GBV is especially problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse and are the most vulnerable to exploitation, violence and abuse simply because of their gender, age and status in society.
- [See page 1, IASC GBV Guidelines]

SLIDE 16

NATURE & EXTENT OF GBV IN HUMANITARIAN EMERGENCIES



- Survivors and rescuers struggle through the debris after a devastating landslide caused by a storm in eastern Bicol region in the Philippines in this March 2007 file picture. Heavy rains triggered floods and landslides from January 7 to 13, 2009 across the eastern seaboard of the Philippines, leaving nearly 200,000 displaced and nine dead.
- Image ID: 200901142 Daraga

SLIDE 17

- In Basilan, violence against women escalated during the period of conflict from 2000 to 2003.
- Their communities considered raped women unclean, and they were forced to marry the men who had raped them.

Magkalen-Fernandez, E. 2005. Conflict, State Fragility and Women's Reproductive Health: The Case of Basilan, Philippines. Washington DC: USAID.

- Risk of sexual violence**
- While no incidents of sexual violence have been reported, this did not mean it was not happening, activists warned.
- "We only get anecdotal accounts, most of the time not even from the complainants themselves, making it hearsay and gossip," said Raissa Jajurie, head of office for Saligan, a non-profit organization (NGO) engaged in developmental law in Mindanao. She noted that fear and shame were the primary factors for the silence.

"In conservative Muslim culture, this is a taboo subject. Women would be accused of bringing it upon themselves. Also, there is a fear that filing a complaint would cause retaliation and start a vicious clan war," Jajurie explained.

<http://www.irinnews.org/Report.aspx?ReportId=81708>

SLIDE 18

GBV Cases in Humanitarian Settings: Typhoon Pablo

- Compostela Valley

| | |
|---|--|
| January to December 2012 (before Typhoon Pablo) | December 2012 to April 2013 |
| 40 reported GBV cases | 110 reported GBV cases (7 of which are rape cases) |
- Davao Oriental

| | |
|-----------------------|---|
| 2007 to November 2012 | December 2012 to January 2013 |
| 50 reported GBV cases | 19 reported GBV cases (including 1 case of trafficking in person, 1 case of rape) |

- Data from Reception and Diagnostic Centre shows that 50 cases of GBV were reported in Davao Oriental from 2007 to November 2012. However, from December 2012 to January 2013 alone, there are 19 reported GBV cases, including one case of human trafficking, one case of rape and an undetermined number of minors (mostly high school students) involved in commercial sex work.

SLIDE 19

GBV Cases in Humanitarian Settings: Zamboanga Crisis

- From 9 September to 21 October, there were 3 reported rape cases
- From 9 September to 21 October, there were 14 reported cases of intimate partner violence (RA 9262)

- Source PNP-WCPD

SLIDE 20

Priorities to Address GBV during Emergencies

- Protection of vulnerable populations**
 - Involve women in evacuation center design
 - Divide communal shelters by family and sex
 - Establish separate latrine and wash facilities for men and women
 - Ensure working locks on latrine doors
 - Hire female service providers, community health workers, program staff and interpreters
 - Distribute sanitary materials to girls
 - Provide safe water, food and firewood collection strategies

SLIDE 21

Priorities to Address GBV during Emergencies

- Respond to the consequences of sexual violence**
 - Medical Response
 - Emergency contraception (within 120 hours)
 - Treatment of STIs
 - HIV counseling and testing
 - Post-exposure prophylaxis to prevent HIV (within 72 hours)
 - Treatment of injuries
 - Referral to psychosocial support
 - Ensure that the community is aware of the benefits of seeking care



MODULE 2.3: Gender-based Violence (cont'd)

ACTIVITY: Accessing Care as a Survivor of Sexual Violence

Source: Adapted from the SPRINT curriculum

The purpose of this activity is to build awareness and sensitivity to the challenges faced by survivors of sexual violence in seeking care.

- Ask for volunteers to be actors and play the roles of different individuals. Distribute the pre-made “service provider” name tags to the appropriate number of people. Ask these individuals to play the role of the person noted on their name tag.
- Seat the service providers in a circle with the 12 chairs. Ask the remainder of participants to stand on the outside of the circle so they can easily see the activity.
- Explain that the ball of yarn represents a 20-year-old woman who was sexually assaulted. Confirm with participants that everyone understands the definition of sexual assault.
- As the facilitator, stand outside the circle and give the ball to the Mother. Explain that the woman has told her mother about the incident.
- Instruct Mother to hold the end of the string firmly.
- Tell the story below, of what happens to this woman. Each time an actor is involved, the ball of string is tossed across the circle to that actor. Each actor who receives the ball will wrap it around a finger and then toss the ball to the next actor as instructed.
- Stop the game when the script is completed.
- There will be a large web in the center of the circle, with each actor holding parts of the string.

Notes:

Create name tags for the following Actors:

- Mother
- Community leader
- Traditional birth attendant (TBA)
- Midwife
- Doctor
- Community services worker
- DSWD community services officer
- DSWD protection officer
- Police
- Lawyer
- Social worker
- Prosecutor

MODULE 2.3: Gender-based Violence (cont'd)

Script: Accessing care as a survivor of sexual violence

A 20-year-old woman was sexually assaulted by a man just outside an evacuation center, and she tells her mother:

- **Mother** takes the woman to **Community Leader** in order to report what has happened.
- Community Leader refers the woman to the **TBA** because the leader is concerned about the medical condition of the daughter.
- The TBA helps, but the woman needs immediate medical care for injuries. The TBA asks the woman to go see her close colleague—the **Midwife**.
- The Midwife realizes that the woman should be seen by a doctor, so she immediately contacts the **Doctor**.
- The Doctor provides treatment for injuries and a general check-up, and sends the woman back to Midwife hoping that the **Midwife** might provide some extra support.
- The Midwife knows the woman needs psychosocial care and wonders if there were other medical treatments that perhaps the woman should receive (she has heard about preventing HIV following sexual violence). She refers the woman to the **Community Services Worker**.
- The Community Services Worker promises the Midwife and the Mother to help, and to make sure that the woman receives all the services that she should. The service worker provides emotional support and refers the woman to the **DSWD Community Services Officer** for an assessment, and asks about other programs or services that the woman should access.
- The DSWD Community Services Officer talks with the woman and discovers the woman wants to involve the police. Knowing this is time sensitive, the woman is immediately referred to the **DSWD Protection Officer**.
- The DSWD Protection Officer meets the woman and takes her report. However, a medical report is needed for the report, and so the woman is referred back to the **Doctor**.
- The Doctor completes the medical documentation and sends the woman back to the **DSWD Protection Officer**.
- The DSWD Protection Officer sends the woman to the **Police** with the medical file.
- The Police take a full report of the incident. However, in order to protect the woman once the report is filed, they refer her to a **Lawyer** to ensure that she is represented.
- The Lawyer would like to discuss the case with the Prosecutor, so he/she contacts the **Prosecutor** to speak with the survivor.
- The Prosecutor calls the Doctor about the survivor to get information about the medical exam. The **Doctor** asks to see the survivor again because she forgot to collect a needed sample during the exam.
- The Doctor refers the survivor to a **Social Worker** for psychosocial support.
- The Social Worker meets routinely with the woman, and sends her back to the Doctor for a check-up, and then to the **DSWD Protection Officer** to make sure that the case is progressing.
- The woman then goes to talk with the **Community Leader**, whom she first saw, because she is confused about the process.
- The Community Leader contacts the **Prosecutor** to find out the status of the case.
- The Prosecutor suggests that they contact the **Police** for a clear update.
- The Police refer the Community Leader to the **DSWD Protection Officer**.

MODULE 2.3: Gender-based Violence (cont'd)

Discussion:

Pause to look at the web and ask some questions to generate discussion:

- What do you see in the middle of this circle?
- Was all of this helpful for the survivor? Traumatic?
- Might a situation like this happen in your setting?
- What could have been done to avoid making this web of string?
- Observers: How many times did the girl have to repeat her story?

Actors should let go of the string and let it drop to the floor. Leave the stringy chaotic mass sitting on the floor for all to see.

TEA BREAK

 20 minutes

PRESENTATION: Responding to the Needs of Women and Girls in the Philippines

- Depending on time, the facilitator now has the opportunity to share experiences from the Philippines, of preparing for and responding to gender based violence during emergencies.

 www.wrc.ms/drr-srh-curriculum

PRESENTATION: Responding to the Needs of Women and Girls in the Philippines: 19 slides

SLIDE 1



SLIDE 2



SLIDE 3



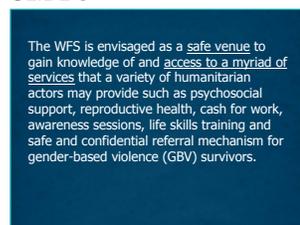
SLIDE 4



SLIDE 5



SLIDE 6



SLIDE 7



PRESENTATION: Responding to the Needs of Women and Girls in the Philippines (cont'd)

SLIDE 8



...► The establishment of Women-Friendly Spaces (WFS) in evacuation centers and relocation sites will be carried out in close coordination with Local Chief Executives and provincial/city/municipal Disaster Risk Reduction and Management Council, camp management team, local women's organizations and members of existing inter-agency protection mechanisms (e.g., Local Committee on Anti-Trafficking and Violence against Women and Their Children [LCAT-VAWC], Local Council for the Protection of Children [LCPC]).

The city/municipal social welfare and development office (C/MSWDO), together with other members of inter-agency protection mechanisms and Camp Coordination and Camp Management (CCCM) cluster, shall:

- Identify and tap local women's organizations in the area to co-manage the establishment and operationalization of WFS
- Identify women leaders among the internally displaced to be potential WFS Facilitators
- Advocate with government agencies, local and international NGOs, group and individual donors, U.N. agencies, and other humanitarian actors to support and utilize the WFS in terms of service delivery

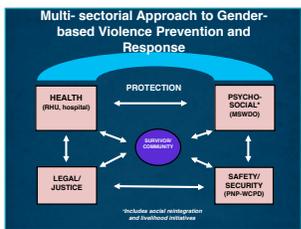
The WFS facilitators shall be responsible for creating awareness about the WFS and its various services to internally displaced women.

SLIDE 9



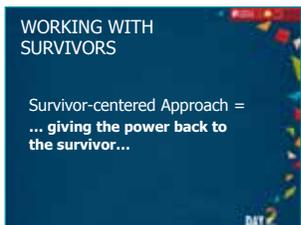
...► The **Guidelines in the Establishment and Management of a Referral System on VAW at the LGU level** is for "normal" times but service providers should refer to the column on IMMEDIATE INTERVENTIONS and verify if those services may at least be provided immediately after a disaster.

SLIDE 10



...► The **Guidelines in the Establishment and Management of a Referral System on VAW at the LGU level** is for "normal" times but service providers should refer to the column on IMMEDIATE INTERVENTIONS and verify if those services may at least be provided immediately after a disaster.

SLIDE 11



...► GBV is a manifestation of power inequalities and limited choice. If service providers – who are always placed in a powerful position relative to the survivor – impose their perspectives, opinions or preferences on the survivors, they may unintentionally create another experience where the survivor feels even further disempowered or abused.

SLIDE 12



SLIDE 13



PRESENTATION: Responding to the Needs of Women and Girls in the Philippines (cont'd)

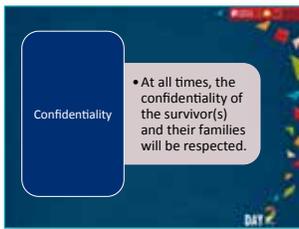
SLIDE 14



Security and safety

All actors will ensure the safety of the survivor, at all times. Remember that the survivor may be frightened and need assurance that she or he is safe. In all cases, ensure that the survivor is not placed at risk of further harm by the assailant. If necessary, ask for assistance from camp security, police, field officers, protection officers or others. Maintain awareness of the safety and security of people who are helping the survivor, such as family, friends, community service or GBV workers, and health care workers.

SLIDE 15



Confidentiality

At all times, the confidentiality of the survivor(s) and their families will be respected. This means that information will be shared only with others who need to know in order to provide assistance and intervention, as requested and agreed to by the survivor. All written information with identifying details will be maintained in secure, locked files. If any reports or statistics are to be made public, only one responsible officer in the organization will have the authority to release such information and any identifying information (e.g., name, address) will be removed.

The need for confidentiality stems from:

- The consequences of sexual violence for the survivors
- Fear of stigmatization and rejection
- Loss of virginity and the surrounding cultural/religious ramifications
- Fear of STIs and HIV/AIDS and the isolation often experienced by those suffering from such diseases
- The need for a humanitarian organization / response team to retain the trust of the community in which it operates

SLIDE 16



Respect

The actions and responses of all actors will be guided by respect for the wishes, the rights and the dignity of the survivor. For example, actors will:

- Conduct interviews in private settings.
- Conduct interviews and examinations by staff of the same sex as the survivor (e.g., woman survivor to woman interviewer) unless no other staff is available.
- Be a good listener.
- Maintain a nonjudgmental manner concerning the survivor and her or his behavior.
- Be patient; when possible, do not press for more information if the survivor is not ready to speak about the incident.
- Ask only relevant questions.
- Do not discuss the survivor's prior sexual history.
- Avoid asking the survivor to repeat the story in multiple interviews.
- Do not laugh or show any disrespect for the survivor and her or his culture, family or situation.

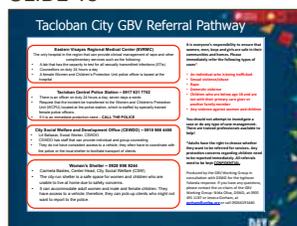
Non-discrimination

- All women (married or unmarried), girls, men and boys have access to services.
- Ensure same-sex interviewers, including: interpreter, doctor, police officer, protection officer, community service worker, others.

SLIDE 17



SLIDE 18



SLIDE 19



MODULE 2.4: Quiz Show!

 (flexible) 45 minutes - 1.5 hours



GOALS: To provide a fun and easy way to review knowledge gained over the past two days. The game provides an opportunity to reinforce 5 key messages for each topic area. Facilitator may adjust these based on the training group.

This review game should be implemented after the end of all knowledge-based modules. It is flexible enough to fit into the time available; the facilitator will just need to end after each group has had an equal opportunity to gain points, but a “last round” can be declared 15 minutes before the close of the day. Prizes are awarded to the winning team.



ACTIVITY: Quiz Show!

- Divide participants into three to four teams. Ask participants to come up with a team name, and identify a “spokesperson.” Final answers from the team can only be expressed by the spokesperson.
- Facilitator provides an overview of the game.
- Each team will be asked to choose a topic and a point/money value for that particular topic. Each topic and point value corresponds to a question—larger money values are associated with more difficult questions.



■ **To create a Quiz Show! game board—** on a large piece of flip chart paper, draw the following game board, with the peso/dollar amounts attached to the board with masking tape as indicated.

| | PRIORITIES FOR SRH AND GENDER IN EMERGENCIES | PREPAREDNESS | MATERNAL AND CHILD HEALTH | GENDER AND GBV | STIS AND HIV | FAMILY PLANNING |
|-----|---|---------------------|----------------------------------|-----------------------|---------------------|------------------------|
| 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| 200 | 200 | 200 | 200 | 200 | 200 | 200 |
| 300 | 300 | 300 | 300 | 300 | 300 | 300 |
| 400 | 400 | 400 | 400 | 400 | 400 | 400 |

MODULE 2.4: Quiz Show! (cont'd)

- Teams will be given two minutes to answer the question they have selected. If they are unable to answer or answer incorrectly, the question moves counter clock-wise to the next team, and the next and the next depending on whether a correct answer is given and the “money is won.” Whichever team answers correctly is awarded the dollar amount from the board (facilitator will remove it from the board and hand it to the winning team; that question value cannot be requested again). The next question then moves to the team directly next to the team (counter clockwise) that the game started with, and so on.

****Note to facilitator: No matter who is awarded the points, question selection should move in order around the room so that each team gets a fair chance to “win” a question they have chosen.**

- Flip a coin to decide which team goes first.
- The first team picks a category and point/money value to reveal the chosen box. The team has 2 minutes to give the answer.
- Play the game until all the boxes are completed, or until time for the day has expired.
- Total the points. The team with the most points wins!
- Facilitator should award prizes to the winning team.

Notes:

| MISP | DRR | GBV | Maternal & Newborn Health | Stb/ity/Family Violence |
|------|-----|-----|---------------------------|-------------------------|
| 100 | 100 | 100 | 100 | 100 |
| 200 | 200 | 200 | 200 | 200 |
| 300 | 300 | 300 | 300 | 300 |
| 400 | 400 | 400 | 400 | 400 |

MODULE 2.4: QUIZ SHOW! ANSWER KEY

| PTS | PRIORITIES FOR SRH AND GENDER IN EMERGENCIES | PREPAREDNESS | MATERNAL AND CHILD HEALTH | GENDER AND GBV | STIS AND HIV | FAMILY PLANNING |
|-----|--|--|---|--|---|---|
| 100 | <p>TRUE/FALSE</p> <p>Interventions to address reproductive health and gender-based violence are LIFE SAVING</p> <p>TRUE</p> | <p>What is a type of hazard faced in your community?</p> <p><i>List any: flooding, typhoon, tidal wave (tsunami), volcano, earthquake....</i></p> | <p>What information is included in a safe birth plan?</p> <p><i>Key people to be involved in planning, plan to get to hospital, who will monitor/support the mom, who will monitor her if there is an emergency, plans for transportation (including in the case of an emergency)</i></p> | <p>What is the definition of gender?</p> <p><i>The full range of physical, biological, mental and behavioral characteristics pertaining to, and differentiating between, masculinity and femininity. Gender is largely a social construct.</i></p> | <p>Are men or women more vulnerable to the transmission of HIV? Why?</p> <p><i>Women—due to the larger surface area of the mucous membrane.</i></p> | <p>What is one benefit to offering family planning to a population?</p> <ul style="list-style-type: none"> • Improved child nutrition/birth spacing • Reduces poverty • Improves maternal health • Reduces rates of unplanned pregnancy and therefore unsafe abortion |
| 200 | <p>Why are there priorities for reproductive health and gender protection during emergencies?</p> <p><i>To focus resources on services that reduce death, disability and disease, particularly for women and girls during emergencies.</i></p> | <p>What formula is used for calculating disaster risk?</p> <p><i>Disaster risk = Hazard x vulnerability</i></p> <p>Risk</p> <p>During what phase of the disaster cycle do services need to be narrowed and prioritized?</p> <p><i>Acute phase</i></p> | <p>What are two danger signs during pregnancy/childbirth?</p> <p>ANY:</p> <p><i>Severe bleeding, seizures, fever/chills, delivery of hand/foot before head, delivery of umbilical cord before head, more than one infant</i></p> | <p>What are two forms of gender-based violence?</p> <p>SEXUAL VIOLENCE</p> <ul style="list-style-type: none"> • Rape • Sexual exploitation and abuse, forced prostitution <p>DOMESTIC VIOLENCE</p> <p>HARMFUL TRADITIONAL PRACTICES</p> <ul style="list-style-type: none"> • Child, early and forced marriage • Female genital cutting • Honor killings • Widow inheritance <p>TRAFFICKING</p> | <p>What is the difference between bacterial and viral STIs?</p> <p><i>One is treatable with antibiotics (bacterial) and one is not (viral).</i></p> | <p>Please list two methods of contraception that are temporary (by this, I mean methods that do not last longer than a few months at a time)?</p> <ul style="list-style-type: none"> • Condoms and other barrier methods • Injunctables • Pills |

MODULE 2.4: QUIZ SHOW! ANSWER KEY (continued)

| | | | | | | |
|-----|--|--|---|---|--|--|
| 300 | <p>What are two examples of things that should be made available after an emergency to reduce maternal and newborn deaths?</p> <p>ANY OF THE FOLLOWING: Referral for EmOC, functioning EmOC (or high-level medical facility/referral hospital), provision of safe delivery kits to midwives (possibly to pregnant women), skilled attendance at birth</p> | <p>Why are communities at greater risk of the impacts of hazards than 30 years ago?</p> <p><i>Crowding, coastal construction, weak health system, unhealthy population, population growth, poverty, unstable constructions/buildings</i></p> | <p>What are three of the top four causes of maternal death?</p> <ul style="list-style-type: none"> • Hemorrhage (25%) • Indirect causes (20%) • Infection (15%) • Eclampsia (12%) | <p>What are steps that can be taken to protect populations from GBV during emergencies?</p> <p><i>Lights, locks on latrines, separate latrines and bathing facilities for men and women</i></p> | <p>What can be done to prevent transmission of STIs?</p> <ul style="list-style-type: none"> • Abstinence • Using condoms • Testing and treatment | <p>What are two long-acting or permanent methods of family planning?</p> <ul style="list-style-type: none"> • IUD • Implants • Vasectomy • Tubal ligation |
| 400 | <p>What activities should be prioritized during/after an emergency to protect and/or respond to sexual violence (please give three examples—one each from protection and response)?</p> <p>PROTECTION: <i>Lights, locks on latrines, separate latrines and bathing facilities for men and women</i></p> <p>RESPONSE: <i>Ensure men and women are represented within key positions, have a protocol for receiving survivors, medical treatment for survivors of sexual violence (EC, PEP, treatment of injuries, ongoing medical and psychosocial care)</i></p> | <p>Why are women and girls more affected by emergencies than their male counterparts?</p> <p><i>Not involved in design of early warning systems; less access to opportunities for learning skills of survival; more vulnerable to the long-term impacts of disasters</i></p> | <p>What are the three delays that lead to infant and/or maternal death?</p> <p>DELAY IN: 1- Decision to seek care 2- Reaching the facility 3- Obtaining appropriate medical care</p> | <p>What is included in the medical response for survivors of sexual violence (please give three examples)?</p> <p><i>Emergency Contraception (120hrs), Post-Exposure Prophylaxis (PEP) (72hrs), treatment of injuries, referral, treatment of other STIs (Hepatitis B, provision of antibiotics), follow-up medical and psychosocial care</i></p> | <p>In times of crisis or displacement, what is the standard of care for persons who are living with HIV or AIDS?</p> <p><i>Those who had initiated anti-retroviral (ARV) treatment prior to an emergency should be able to continue their ARV medication .</i></p> | <p>What is the most effective natural family planning method? Please describe it.</p> <ul style="list-style-type: none"> • Lactational amenorrhea • Exclusive breastfeeding for 6 months |



CLOSING AND NEXT STEPS

 30-40 minutes



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

END-OF-DAY EVALUATION

The goal of the daily evaluations is to improve learning and participant experience for the remainder of the training. Facilitator should post the following questions on flip chart paper, or on the audio-visual (A/V) screen. Participants should provide quick responses on small pieces of paper, for the facilitator to review THAT day (to inform the next day of training).

1. What is one thing that you feel you learned from today that you did not know before?
2. What went well with the training today?
3. What can be improved?
4. Is there anything you would like to see change for tomorrow?



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

CLOSING AND NEXT STEPS

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

DAY



From Knowledge to Action



THE GOAL:

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

| | | |
|-------------------|------------------------|----|
| MODULE 3.1 | Household Preparedness | 85 |
| MODULE 3.2 | Community Mapping | 88 |
| MODULE 3.3 | Action Planning | 91 |

Day 3: Facilitator's Agenda

| TIME | ITEM | COMPONENT(S) | MATERIALS |
|-------------|--|--|--|
| 9:00-9:30 | Welcome, Review and Housekeeping | <ul style="list-style-type: none"> Review & housekeeping | <ul style="list-style-type: none"> Flip chart Markers |
| 9:30-10:00 | MODULE 3.1 Household Preparedness | <ul style="list-style-type: none"> Activity: Household preparedness brainstorm | <ul style="list-style-type: none"> Meta cards Flip chart |
| 10:00-10:30 | Tea break | | |
| 10:30-12:00 | MODULE 3.2 Community Mapping | <ul style="list-style-type: none"> Activity: Community Mapping Activity: Preparedness Identification | <ul style="list-style-type: none"> Markers Flip chart Stickers Meta cards (2 colors) |
| 12:00-1:00 | Lunch | | |
| 1:00-2:30 | MODULE 3.3 Action Planning | <ul style="list-style-type: none"> Activity: Action Planning | <ul style="list-style-type: none"> Markers Action planning matrix |
| 2:30-3:00 | Tea break | | |
| 3:00 | Wrap-up and Closing | <ul style="list-style-type: none"> Post-test Evaluations Photo consent Closing ceremony and certificates | <ul style="list-style-type: none"> Post-test Evaluations Photo consent Certificates |

WELCOME & HOUSEKEEPING

Welcome participants to Day 3 of the training. Review any logistical issues or concerns from Day 2, and discuss the agenda for Day 3. Invite the host team for Day 3 to lead the group in prayer/blessing as appropriate. Allow the “host team” from Day 2 to review key points from the prior day.



KEY CONCEPTS FROM DAY 2

Below are some points that the facilitator may need to stress if not covered by the host team.

- Each MISP objective and its corresponding action items.
 - » Safe motherhood
 - » STIs/HIV
 - » Family planning
 - » Gender-based violence
- Consequences of each MISP item if not addressed.
- Importance of the MISP.

GOALS AND AGENDA FOR DAY 3

On this third day of training, the facilitator should focus on tying information together. Participants will be expected to apply the knowledge that they have gained to their own household and community preparedness plans. Participants will work in small groups for most of today's activities.

Learning objectives include:

- Apply knowledge gained on reproductive health and gender to both household and community preparedness.
- Identify capacities and current gaps within the community to respond to RH and gender concerns during an emergency.

MODULE 3.1: Household Preparedness

 30 minutes



GOALS: To place learning over the past two days within the context of preparedness. This activity will help participants to distinguish between “household preparedness” and “community preparedness.”

This activity is an important opener to the day, as community members have many roles within their community, as mothers, fathers, siblings, etc., but also as community leaders or health workers. The Household Preparedness Activity is a warm-up exercise for participants to examine these different roles with regard to recent experiences of emergencies and preparedness steps.



- Card stock/ meta cards
- Marker pens
- Handout—RH, including GBV Preparedness Checklists



ACTIVITY: Household Preparedness Brainstorm

Place flip chart paper on the wall. Draw an outline of a house to stress the concept of “household preparedness.”

Engage in an informal and open dialogue with participants about how they, as individuals, take care of themselves and those in their home both before and during an emergency.

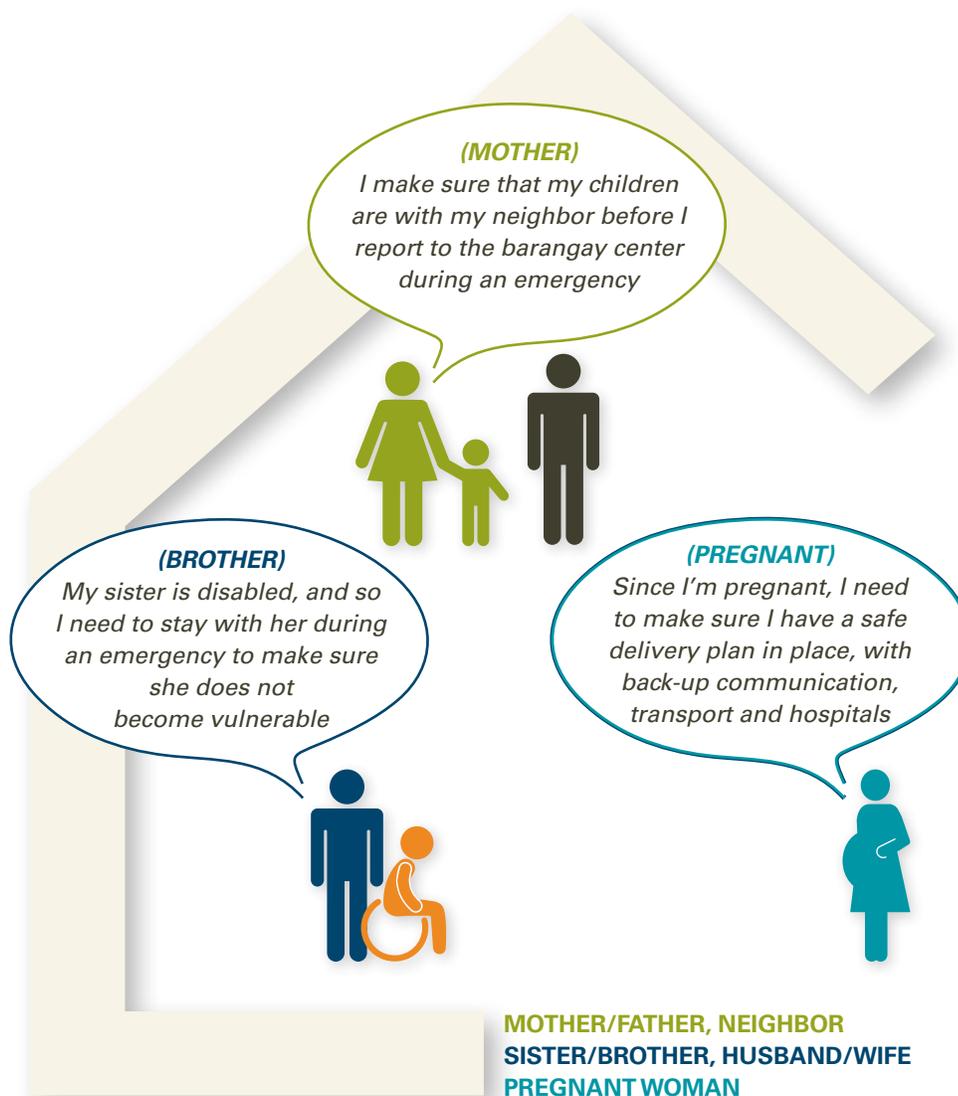
“Each of you in this room plays multiple roles in your household, and these roles might be different than those that you play within your community. For example, in your household, you may play the role of mother, father, brother/sister, neighbor, etc. (facilitator should write each of these roles on meta cards, and post them around the outline of the HOUSE).

I want you to take a minute to think about what you DO, in this role, to protect those in your household from some of the gender risks or reproductive health risks that we have discussed.”

- Facilitator should have everyone think of something they do or should do, either to prepare or respond to an emergency, which improves the reproductive health or protection of those in their own household.

MODULE 3.1: Household Preparedness (cont'd)

- Participants should write these ideas on meta cards. Prompting questions might include:
 - » How do you secure your home and possessions when a disaster is expected?
 - » What preparedness steps do you currently follow? For example:
 - » Back-up supplies
 - » Packing of documents or medicines
 - » Medical kit close at hand
 - » Agreeing on a household meeting point
 - » Developing a plan on how to get home or to a designated evacuation route from work
 - » How do you ensure children and vulnerable populations from your household are safe?
- Facilitator then invites individuals to share what they have written, and post it within the household outline.
- The house may look something like the picture to the right, as ideas are generated.



MODULE 3.1: Household Preparedness (cont'd)

Facilitator then leads a discussion with participants.

- Congratulate them on thinking through their individual tasks as they relate to the topics discussed.
- Note that although we each have a role within a household, most of us also have a role within the community. What kind of roles might these be? (Facilitator should develop a list on meta cards outside of the house diagram on the prior page). Roles might include some of the following:
 - » Barangay health worker
 - » Barangay captain or council member
 - » Ambulance driver
 - » Fire brigade
 - » Women's group member/leadership
 - » Midwife
 - » Doctor
 - » Disaster risk management team member
- These are critical roles and they speak to different roles and responsibilities that you each have in your community. We will now shift our discussion for the rest of the day to what you each, as COMMUNITY MEMBERS, can do in order to prepare and respond to reproductive health needs and gender risks during emergencies that we have discussed.

TEA BREAK

 30 minutes

MODULE 3.2: Community Mapping

 1 hour, 30 minutes

 **GOALS:** 1) To identify existing capacities available to deliver RH services 2) identify infrastructure that is likely to be resilient in an emergency and 3) identify the community's current ability to provide RH services in an emergency, and gaps or areas of improvement that are still needed.

This small-group activity launches the discussion into community preparedness and the application of learning from the past two days. This activity uses community mapping as a way to facilitate a discussion around existing capacities and gaps at the community level, as they relate to reproductive health services and gender protection.

Facilitator should build off the discussion before the tea break, which focused on the difference between household and community preparedness, to now focus the remainder of the day on community preparedness.

-  ■ Flip chart paper
- Colored stickers
- Marker pens
- Participants divided into groups

ACTIVITY PART 1: Community Mapping

- Form groups of five to seven participants from the same community.
- Pass out flip chart and markers/pens/pencils to each group.
- Instruct participants that they will spend the next 30 minutes drawing a map of their *barangay*.
- As a group, agree on a landmark that is the “middle” of their *barangay* and the barriers to the north, east, south and west.
- Include in the map things that will help in the provision of reproductive health services and gender protection needs:
 - » health facilities
 - » transportation
 - » health workers
 - » protection desk/police
 - » protection workers
- Mark/label these elements.



ACTIVITY PART 2: Preparedness Identification

- Although some participants will still be working on their maps, suggest that they should be wrapping up (after 30 minutes) and moving to the next set of instructions.
- Facilitator should now pass out stickers to each group (one color).
- Group will now focus on identifying those services (capacities) for RH and gender protection that are most likely to be available during an emergency. They will place a colored dot on it. Be sure that they remember to mark the following, if they will be used in an emergency:
 - » Evacuation centers
 - » Emergency transportation
 - » Systems of communication
 - » Coordination mechanisms
 - » Safe areas for boys and girls
- Facilitator should reference the RH, including GBV checklist that is available as a handout.
- Based on the infrastructure and services likely to be available after an emergency, facilitator should ask groups to determine which priority reproductive health services and gender protection mechanisms are likely to be available, and which are gaps, or will require improvement.
 - » Facilitator should pass out meta cards of two different colors to each table.
 - » On one color of cards, groups should write those services that they are currently able to provide using existing resources or infrastructure. They should then write on the other color those things that they are **not able** to address fully (gaps or things that require improvement). They should post these cards next to their maps.

MODULE 3.2: Community Mapping (cont'd)

- Facilitator should allow 30-45 minutes for this activity.
- Each group will then present its work to the rest of the participants:
 - » Their map
 - » Existing infrastructure/available services for RH and gender
 - » Their list of gaps and capacities
- As each small group presents, the facilitator will look to the big group for agreement on these items. Those items that identify gaps and existing capacities that are agreed to be priorities for this community (and relevant to this topic) will be moved to a central list in the front of the room.
- Items should not be moved to the front of the room if:
 - » They do not directly address RH or gender
 - » Are duplicates or are already on the central list

****Note to facilitator:** During the presentations back to the group, the facilitator will need to help guide those items that are appropriate for RH and gender issues, as opposed to those that are important and life saving but not related to the implementation of the activities discussed during this workshop. Again--it should be stressed that RH and gender are components of preparedness and the focus of this workshop, but they should not be prioritized over other activities (such as first aid, search and rescue, early warning, etc.). Knowledge should be integrated and part of these other activities where appropriate.



LUNCH BREAK

 1 hour

MODULE 3.3: Action Planning

 1 hour, 30 minutes



GOALS: To apply knowledge of current gaps in MISP services to activities that could be implemented to overcome these gaps.

This module will transition the training to a discussion of how to take action given existing capacities and gaps identified in the morning activities. Discussion will focus around activities that can be implemented to 1) leverage existing capacities or 2) fill identified gaps that are prioritized.

****Note to facilitator:** This activity is best implemented before a final tea break, so that the facilitator can collect drafted activities, transcribe them into an electronic work plan and print for all participants (if printing facilities are available).



- Participants divided into groups
- Flip chart paper
- Action planning table/worksheet for each group
- Computer and projector (to record action plans electronically)



ACTIVITY PART 1: Develop Action Plans

- Still in the same groups from the mapping activity, ask groups to now work on developing activities that are related to improving existing systems or gaps identified.
- Each group will be assigned to work on a list of activities related to either 1) maternal and newborn health, 2) gender protection and sexual violence, 3) reducing STIs, including HIV transmission or 4) other priorities (family planning or menstrual hygiene).
- Each group should select from the centralized list of items, developed by the group, which fall under their assigned category.
- They should then fill in the table (below) with activities that need to be implemented in order to overcome the identified gap, as well as who is responsible for taking this activity forward and what resources would be needed.
- Groups should also include in the table items that require maintenance in order to continue to be made available (for example, if barangay health workers (BHWs) are monitoring pregnant women during emergencies and this is an existing capacity, it should be listed under maternal and newborn health that BHWs will monitor pregnant women and perhaps there is awareness raising about this role).

MODULE 3.3: Action Planning (cont'd)

- Groups will hand their forms to the facilitator to be typed up.
- Each group will present back its list.
- Items are discussed and agreed within the broader group (including with approval from local governments, if available); facilitator comments or edits as needed.
- If members of the local government unit are not present, a plan should be made to bring these lists to the *barangay* captain and council or to the mayor to discuss items identified.
- Facilitator should aim to type up these lists and give them to each participant as a key outcome document before the close of the training.

****Note to facilitator:** Activity plans are the final output from this training. Participants should receive a copy and copies will be shared and discussed with the LGUs and barangay captain and council in order to prioritize, make funds available and implement.



ACTION PLAN: REDUCE MATERNAL AND NEWBORN DEATHS

| Action Item | Responsible person or group | What is needed to complete this activity? |
|-------------|-----------------------------|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

ACTION PLAN: PREVENT AND RESPOND TO GENDER-BASED VIOLENCE

Action Item

Responsible person or group

What is needed to complete this activity?

ACTION PLAN: REDUCE TRANSMISSION OF STIs, INCLUDING HIV

| Action Item | Responsible person or group | What is needed to complete this activity? |
|-------------|-----------------------------|---|
| | | |
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| | | |

ACTION PLAN: OTHER PRIORITIES - FAMILY PLANNING & MENSTRUAL HYGIENE

Action Item

Responsible person or group

What is needed to complete this activity?

| Action Item | Responsible person or group | What is needed to complete this activity? |
|-------------|-----------------------------|---|
| | | |
| | | |
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| | | |

CLOSING AND NEXT STEPS

 1 hour



GOALS: To pull together learning from the three days of training, and ensure there is understanding of the content covered, and provide closure to the event (sharing any plans for follow-up).

POST-TEST AND FINAL EVALUATION

Before the close of the training, distribute post-tests and final evaluations for participants to fill out. Emphasize that the evaluations should not have any identifying information on them, that the evaluations are confidential and anonymous.



- Training evaluation
- Post-test
- Certificates for participants

CLOSING CEREMONY AND CERTIFICATES

Organize and implement a culturally appropriate closing ceremony with certificate distribution. End the training with appreciation and praise of all participants. Encourage participants to support each other and stay connected.



Facilitator's tip

The final closing at the end of the training is crucial. It will encourage and emphasize the use of action plans to better address the needs of women and girls in emergency preparedness, disaster risk reduction and response. Spend ample time discussing how to best take action plans forward, including obtaining buy-in from leadership and funding, as this is the desired goal of the training.



Handouts

Community Preparedness: Reproductive Health and Gender

Training purpose and goals

Purpose:

To build capacity at the community level to prepare and respond to risks faced by women and girls during emergencies.

Objectives:

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

- 1) Identify risks faced by women and girls during an emergency (with a specific focus on reproductive health [RH] and gender);
- 2) Provide a description of the Minimum Initial Service Package (MISP) for Reproductive Health inclusive of:
 - a. Its importance
 - b. The 5 priority actions included within it, as well as additional activities
 - c. The key actions that should be taken to improve MISP preparedness
- 3) Apply knowledge of RH and gender risks to existing hazard and risk maps;
- 4) Identify existing community-level capacities and gaps at the community level for gender and RH preparedness and response;
- 5) Discuss community-level actions that could be taken to improve preparedness and which would improve RH response and reduce gender-related risks; and
- 6) Develop action plans and accountability mechanisms that ensure a more robust gender and RH response.

Agenda

Day 1: An Introduction to Reducing Risk for Women and Girls in Emergencies

| | |
|-------------|--|
| 9:00-9:50 | Introduction & housekeeping |
| 9:50-10:30 | MODULE 1.1 Local Risks & Experiences |
| 10:30-11:00 | Tea break |
| 11:00-12:00 | MODULE 1.2 Community-based Disaster Risk Reduction |
| 12:00-1:00 | Lunch |
| 1:00-2:30 | MODULE 1.3 Reproductive Health Priorities in Emergencies |
| 2:30-3:00 | Tea Break |
| 3:00-4:10 | MODULE 1.3 Reproductive Health Priorities in Emergencies (cont'd) |
| 4:10-4:40 | Closing and Next Steps |

Day 2: Understanding Sexual and Reproductive Health and Gender-based Violence in Emergencies

| | |
|-------------|---|
| 9:00-9:20 | Welcome, Review and Housekeeping |
| 9:20-10:30 | MODULE 2.1 Safe Motherhood |
| 10:30-11:00 | Tea break |
| 11:00-12:00 | MODULE 2.1 Safe Motherhood (cont'd) |
| 12:00-1:00 | Lunch |
| 1:00-1:30 | MODULE 2.2 Sexually Transmitted Infections (STIs), HIV and Family Planning |
| 1:30-2:30 | MODULE 2.3 Gender-based Violence |
| 2:30-3:00 | Tea break |
| 3:00-4:00 | MODULE 2.3 Gender-based Violence |
| 4:00-5:00 | MODULE 2.4 Quiz Show! |
| 5:00-5:15 | Closing and Next Steps |

Day 3: From Knowledge to Action

| | |
|-------------|--|
| 9:00-9:30 | Welcome, Review and Housekeeping |
| 9:30-10:00 | MODULE 3.1 Household Preparedness |
| 10:00-10:30 | Tea break |
| 10:30-12:00 | MODULE 3.2 Community Mapping |
| 12:00-1:00 | Lunch |
| 1:00-2:30 | MODULE 3.3 Action Planning |
| 2:30-3:00 | Tea break |
| 3:00 | Wrap-up and Closing |

Date: _____ Location: _____

PRE / POST

Pre-/Post-Test for Participants

Directions: Please answer each question by putting a "X" below true or false

| | TRUE | FALSE |
|---|------|-------|
| 1. In an emergency, access to reproductive health services saves lives | | |
| 2. In an emergency there are NO minimum requirements for services that should be provided | | |
| 3. Women and girls have higher rates of mortality during a disaster | | |
| 4. During displacement, women and girls face higher risks to their health and safety than their male counterparts | | |
| 5. It is recommended that men and women share wash and latrine facilities | | |
| 6. Simple locks should always be available on the inside of latrine doors | | |
| 7. After sexual violence, there are no services or treatment that can be provided to help the survivor | | |
| 8. The Philippines has a disaster risk management law | | |
| 9. Communities themselves are frequently the first responders during the first 72 hours (3 days) of an emergency | | |
| 10. Communities are best positioned to identify solutions to address the risks they identify in their own community | | |

11. If your sister or another woman in your household were pregnant, what could you do before an emergency to make sure she has a safe delivery even if a disaster strikes?

12. What are two (of the five) dangers signs during pregnancy that community members should be aware of, which signal the need to get a pregnant women to a higher-level health facility?

13. Name two medical services that should be provided (according to the MISP) if someone experiences sexual violence.

14. Who should develop a safe birth plan (circle only the most appropriate answer)?

- a) Every pregnant woman
- b) Pregnant women who have had complications in the past
- c) Women who do not have others in the house to help care for her

15. What is one way that HIV transmission is limited during an emergency?

MODULE 1.3: Case Studies

CASE STUDY I: Typhoon Haiyan/Yolanda

On 8 November 2013, Typhoon Yolanda made landfall in the Philippines. More than 12 million people were affected by the super storm: Roughly 3 million are women of reproductive age (15-45 years). UNFPA estimates that roughly 90,000 pregnant women are affected by the disaster, and 8,000 births are expected in the first month; 1,600 miscarriages will occur within this same time period. Additionally, it is estimated that there are 147,000 lactating women (breastfeeding) affected by the storm.

The health systems have been damaged or destroyed in many areas. Few to no health clinics and health centers are currently functioning. The regional hospital in Tacloban was hit by a storm surge and much of its medical equipment has been washed away. In other areas, medical supplies are exhausted. The ability to get new supplies has been disrupted. Where health facilities do exist, there are no sterile supplies. About 660,000 displaced people need essential health services. Immediately after Yolanda, the roads were blocked by debris, making it difficult for relief efforts and supplies to reach people. Security is compromised in many areas.

As much as 90% of housing has been destroyed in some areas, Regions 5 and 6 have the highest populations of displaced persons. Many people are living in evacuation centers: 4,600 pregnant and 8,900 lactating women are living in evacuation centers. There is very little space and no privacy, with very few bathing areas and bad sanitation. Many people left their homes with very little or just the clothes they are wearing. There is also a problem with electricity and lighting because the power has been cut. Telephone communications are not working. It is difficult for people to call or text family members or friends. Children may have been separated from their families and be unaccompanied. Young children and newborns can get very sick because of the small space to live and no sanitation.

MODULE 1.3: Case Studies (cont'd)

CASE STUDY II: Typhoon Bopha/Pablo

On 4 December 2012, Typhoon Bopha (locally known as Pablo) made landfall in the Philippines. Compostella Valley and Davao Oriental were among the areas most affected. More than 6.2 million people were impacted by the storm, including well over 900,000 displaced. Over 1,000 people died as a result of the storm and a near equal number were still missing nearly 2 months later.

As of February 2013, the impacts of the storm continue to affect the most vulnerable populations. Poor shelter and water result in severe acute malnutrition, especially among infants and children under 5 years, as families are forced to prioritize available resources. Additionally, electricity is yet to be returned to Davao Oriental, presenting safety concerns. Waste disposal in both municipalities is an increasing concern.

Food security and shelter remain ongoing challenges. In an assessment of shelter, more than 98% of homes surveyed have been destroyed or damaged, and 93% are considered uninhabitable. As of February, nearly 9,000 individuals are housed in evacuation centers. However, the majority, of those displaced from the emergency reside in makeshift shelters. There is a recognized gap in adequate latrines and bathing facilities, especially in these makeshift settlements. Female-headed households, persons with disabilities and the elderly are being prioritized for shelter programs.

The health system, especially in 12 difficult-to-reach barangays in Compostella Valley, is compromised. Rain and distances have also challenged service delivery and access to health care in a number of other municipalities. Additionally, there is a severe lack of available health providers and those trained in psychosocial support. Training requests have been made to build knowledge on emergency response for reproductive health and gender-based violence. Adolescents are considered to be a particularly neglected population with regard to health. UNFPA has implemented medical missions in an attempt to reach vulnerable groups.

MODULE 1.3: Case Studies (cont'd)

Question Guide for Small Group Discussion:

You have been assigned to consider the risks faced by a particular group during an emergency. Before you start, make sure that everyone in your group understands which group you have been assigned to.

1. Read through the Case Study again as a group.
2. Considering the group you have been assigned, go back and underline or highlight information that you feel may be important to understanding the risks faced by this particular group in this scenario (e.g., loss of health facilities, no lights/electricity).
3. In your group discuss the reasons why particular items were underlined, and determine the influence that this particular aspect of an emergency might have on your assigned group. Remember, there could be multiple concerns arising from one identified issue (e.g., there is no emergency medical care for pregnant women if she is in labor, passage to latrines might be unsafe at night).
4. Now in your group, determine what risks might result for this population. What are the risks that result (maternal death, sexual violence, etc.)?

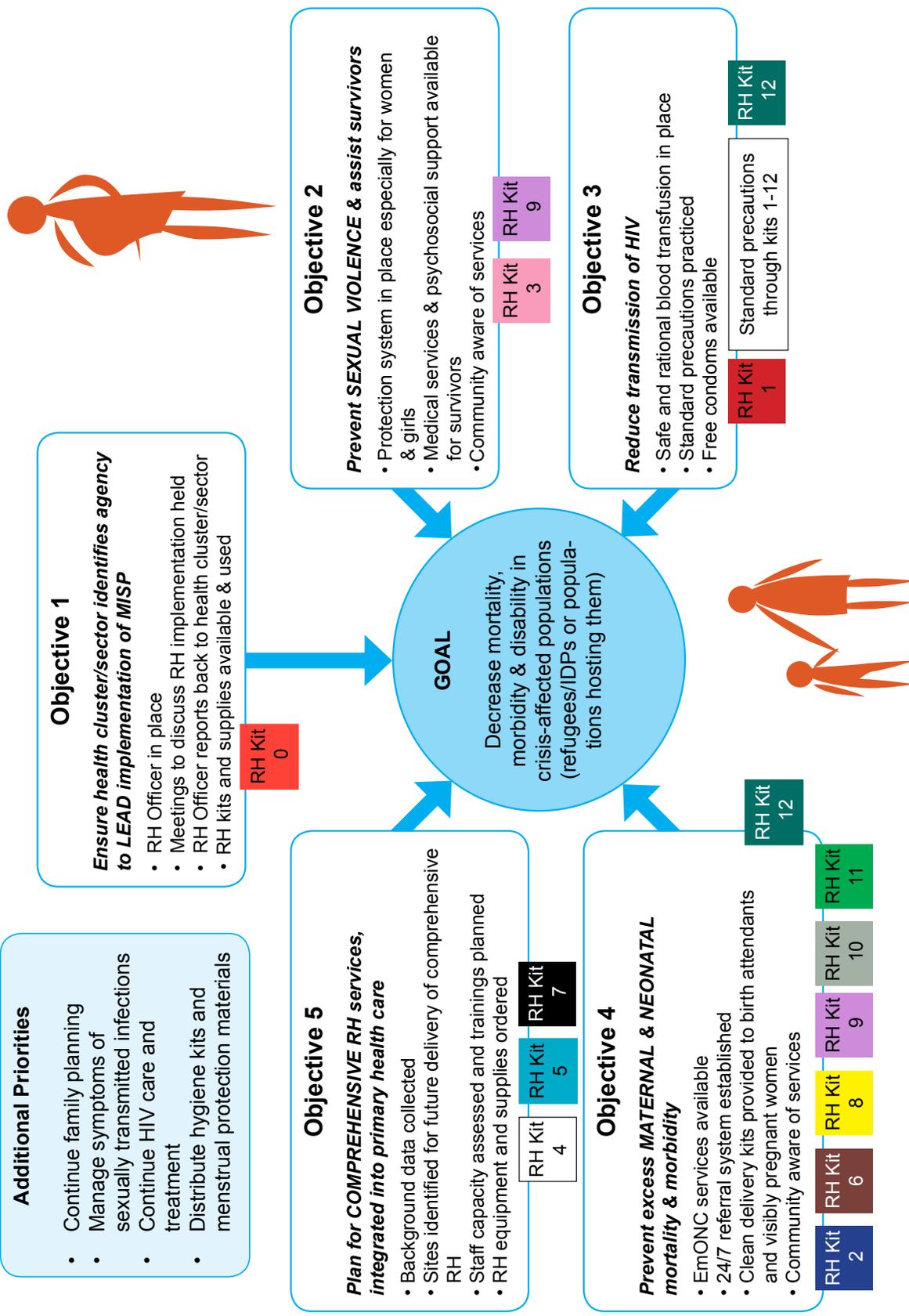
5. Record this information for feedback to the larger group (this can be done on flip chart paper or using meta cards).

Be sure to consider many of the infrastructure elements that might appear within the case study as well as any additional factors that you have seen in emergencies your community may have experienced, for example:

- Not having good lighting and phone communications
- Not having private bathing areas and latrines
- Not having medicines and skilled medical providers
- Not having reliable food and shelter
- Being separated from parents or caretakers

| IDENTIFIED ISSUE | CONCERN | RISK TO GROUP |
|---------------------------|--|-----------------|
| Loss of health facilities | No emergency medical care for pregnant women | Maternal death |
| No electricity/lights | Passage to latrines at night might be unsafe | Sexual violence |

Minimum Initial Service Package (MISP) for Reproductive Health



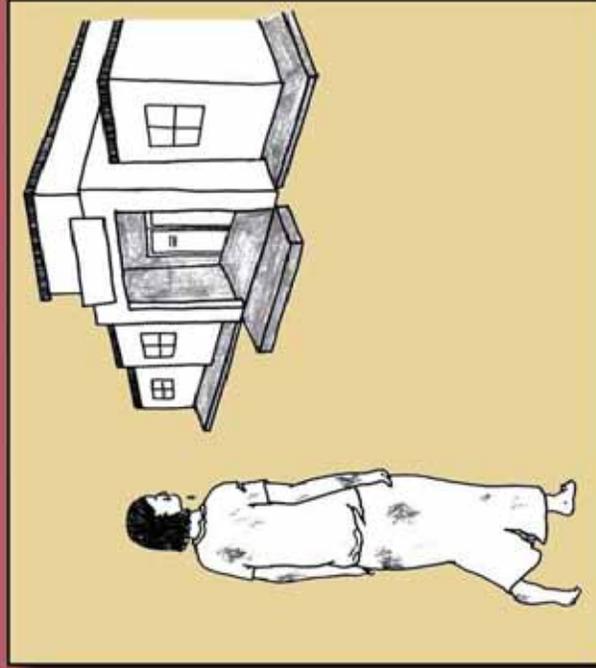
Template G

What to do after forced sex

Insert agency logo and map here.



If you were forced to have sex...



Going to a health facility as soon as possible can help you get health care, prevent pregnancy and serious illness, and receive counseling. Services are private and safe.

Template H

At the health center

Treat Injuries



Medications to prevent pregnancy and illness



Supportive Counseling



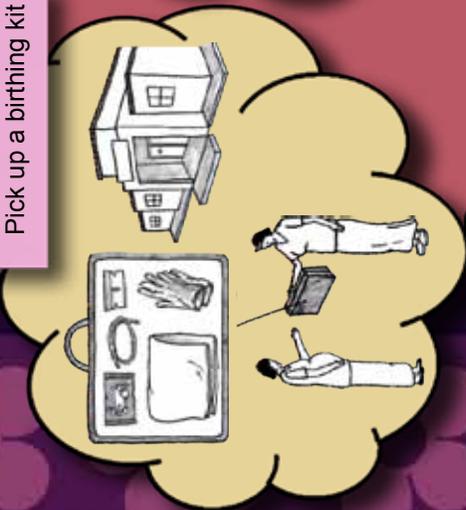
- To prevent pregnancy, seek emergency contraception (EC) at the clinic within 5 days.
- To prevent sexually transmitted infections, ask for antibiotics.
- To prevent HIV, ask for post-exposure prophylaxis (PEP) within 3 days.
- To prevent tetanus, ask for tetanus toxoid within 1 week.
- To prevent hepatitis, ask for a vaccination within 2 weeks.

Insert agency logo and map here.

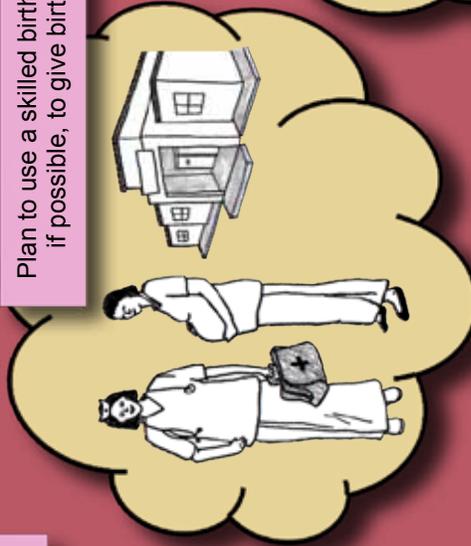
Preparing for Childbirth

Template I

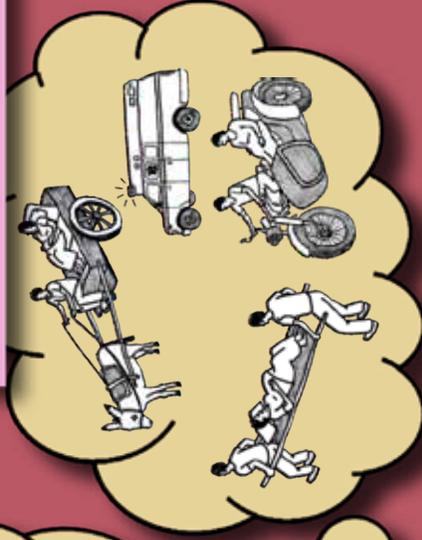
Pick up a birthing kit



Plan to use a skilled birth attendant and if possible, to give birth in a facility



Plan for emergency transportation



Talk with family to plan for an emergency

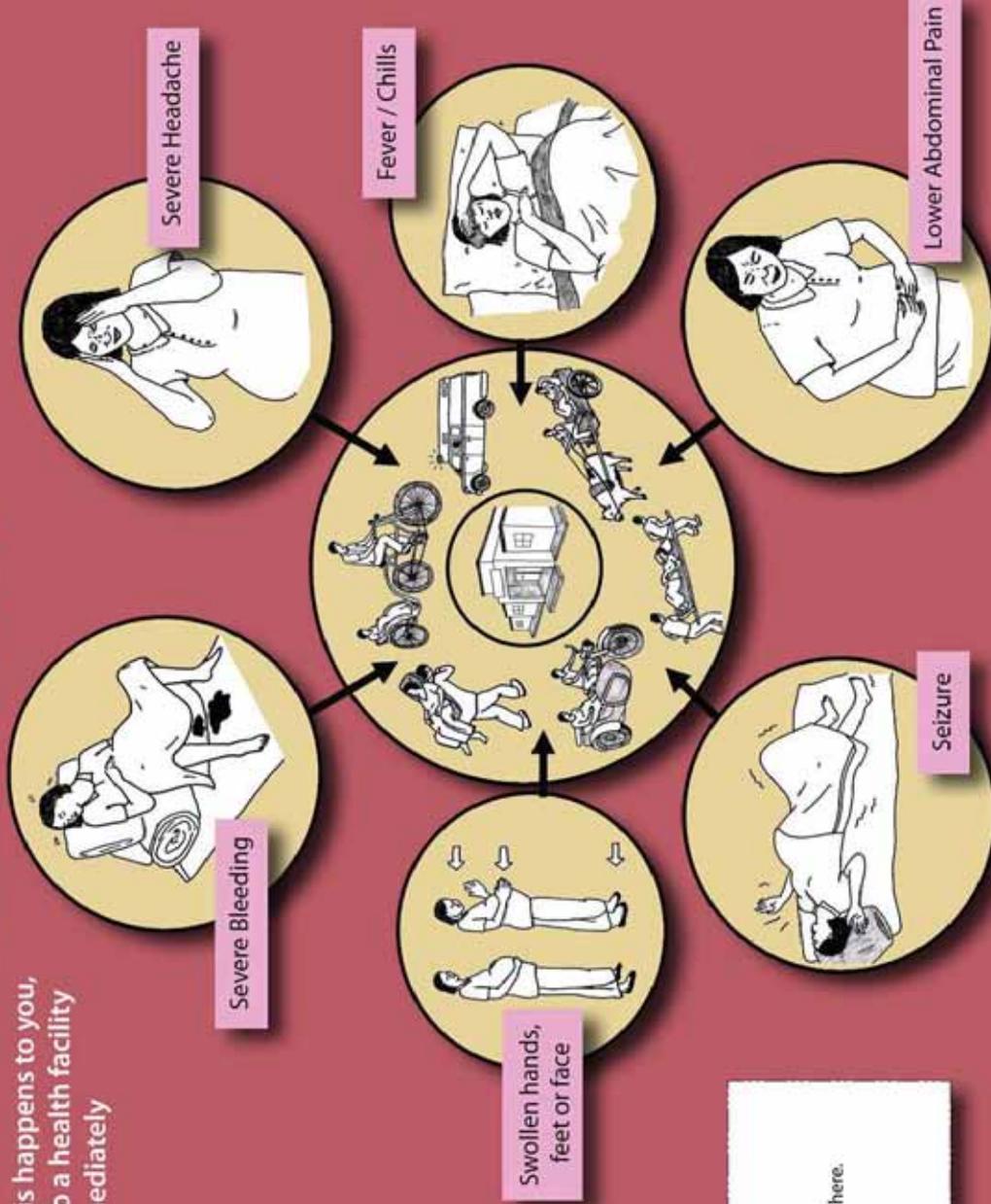


Insert agency logo and map here.

Signs of a Complicated Pregnancy

If this happens to you,
go to a health facility
immediately

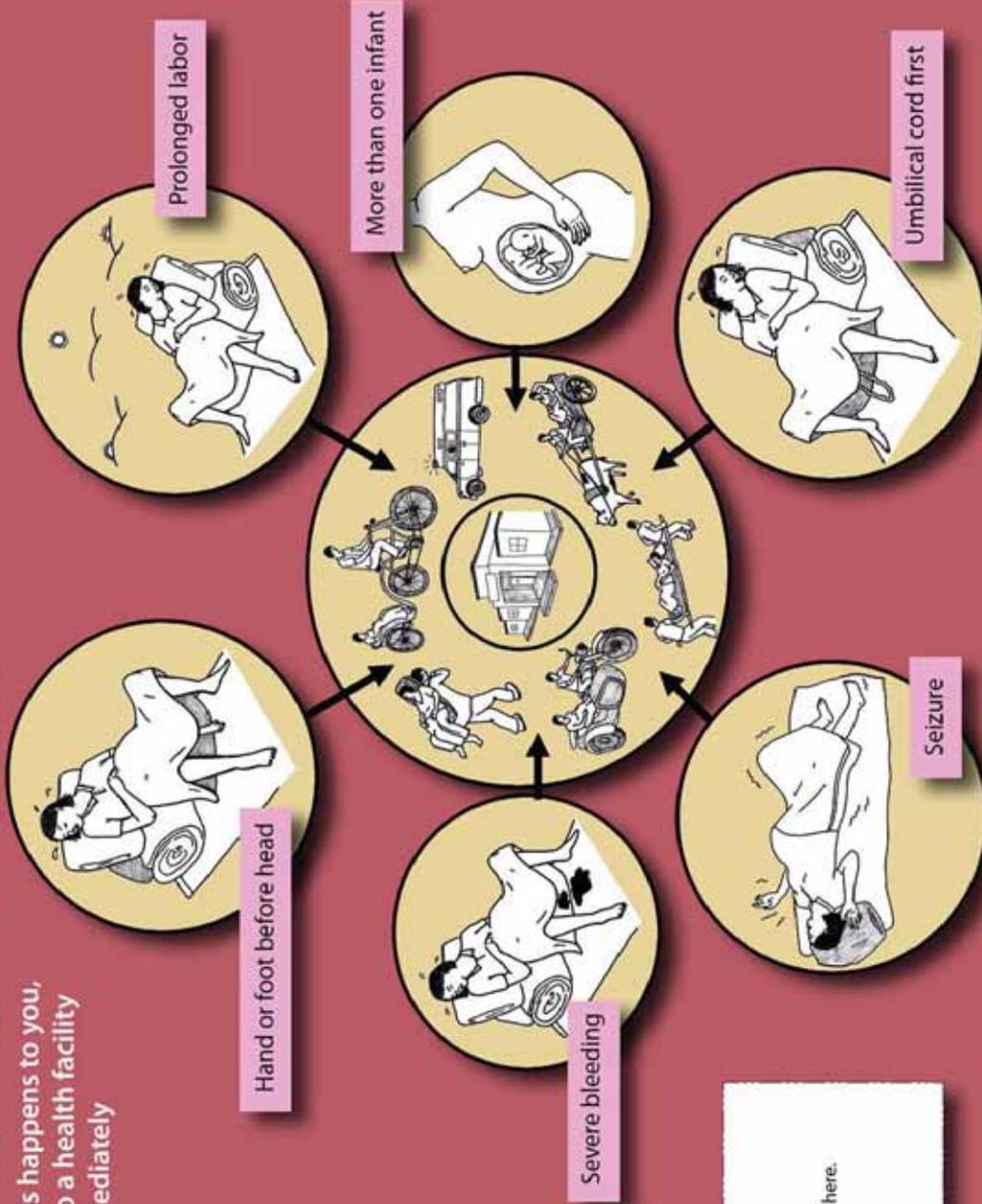
Template J



Insert agency logo and map here.

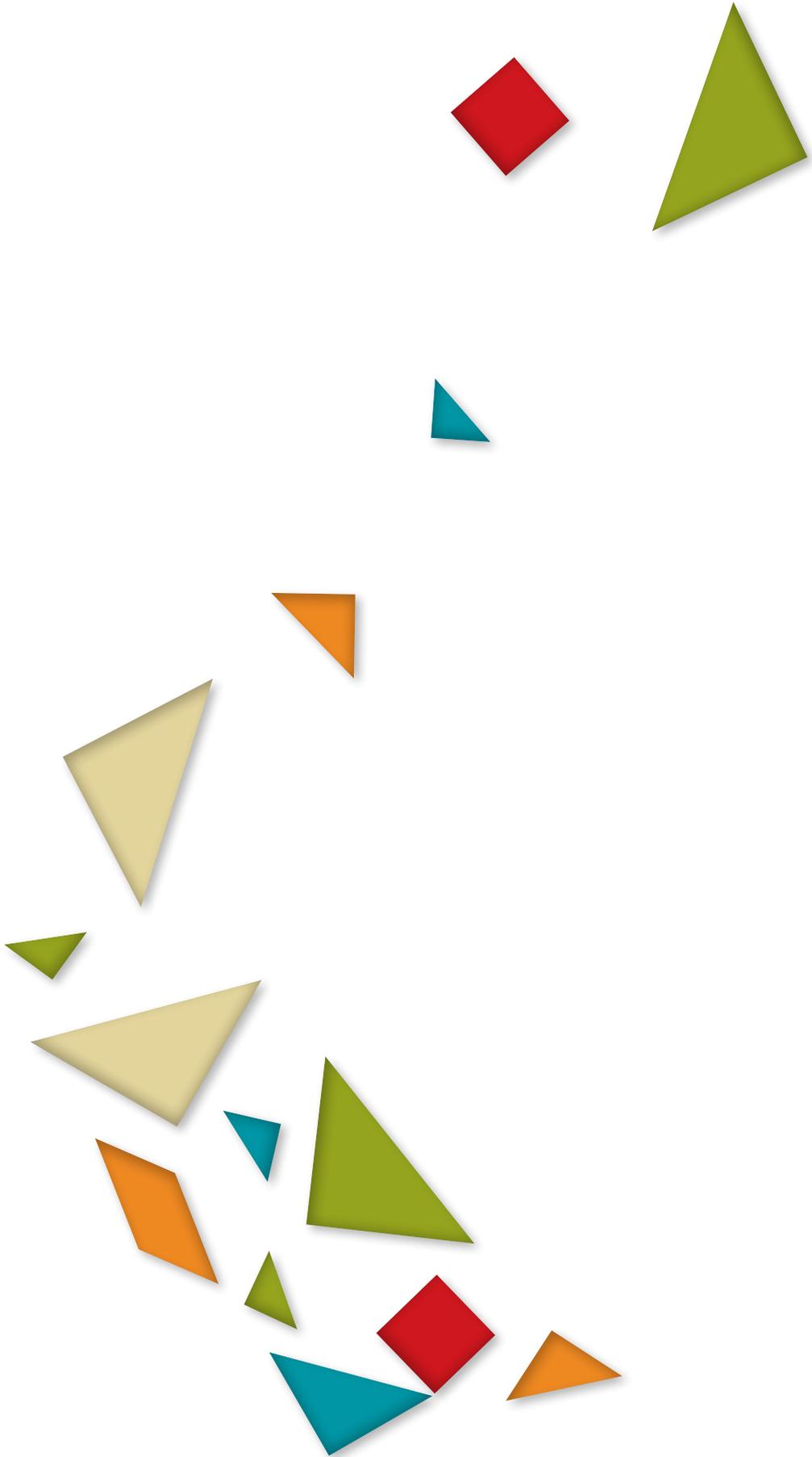
Danger Signs During Childbirth

If this happens to you,
go to a health facility
immediately



Template K

Insert agency logo and map here.



MODULE 2.1 Safe Birth Planning Activity

Meet _____ (name).



_____ (name) is 9 months pregnant. She lives in the Philippines and her community is frequently affected by natural disasters. There is NO way to know who will experience pregnancy complications. Therefore it is important that those surrounding a pregnant woman know the dangers signs for which immediate care should be sought.

What are the key danger signs that indicate a life-threatening complication?

Your task is to make sure that _____ and her baby have a safe birth plan in place. This will help to ensure that she and her baby are safe through childbirth. Because she lives in an area frequently affected by disasters, her birth plan should include plans for an emergency, and should be routinely updated if such an emergency occurs.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

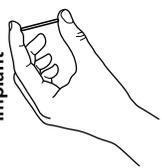
Your task is to make sure that _____ and her baby have a safe birth plan in place. This will help to ensure that she and her baby are safe through childbirth. Because she lives in an area frequently affected by disasters, her birth plan should include plans for an emergency, and should be routinely updated if such an emergency occurs.

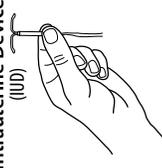
1. What type(s) of disaster (man-made or natural) should this woman include in her planning?
2. When was this birth plan developed (during which month of pregnancy)?
3. Who will be included in developing this particular woman's birth plan, and what role will each take?
4. In an emergency, what are some available transportation options (include several)?
5. Which hospital will she go to (include a back-up option)?
6. Who will this woman call if she experiences danger signs and must get to hospital (what phone numbers?) Will these work in a natural disaster? What is her back-up plan?

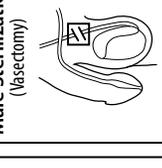
MODULE 2.2 Visual for Family Planning Presentation

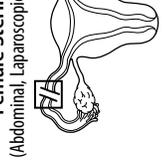
Effectiveness of Family Planning Methods

Reversible

Implant 0.05 %*  0.05 %*

Intrauterine Device (IUD) LNG - 0.2 % Copper T - 0.8 % 

Male Sterilization (Vasectomy) 0.15 % 

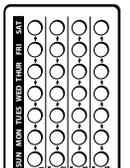
Permanent Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic) 0.5 % 

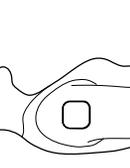
How to make your method most effective

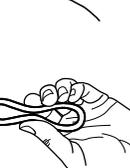
After procedure, little or nothing to do or remember.

Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable 6 % 

Pill 9 % 

Patch 9 % 

Ring 9 % 

Diaphragm 12 % 

Injectable: Get repeat injections on time.

Pills: Take a pill each day.

Patch, Ring: Keep in place, change on time.

Diaphragm: Use correctly every time you have sex.

Male Condom 18 % 

Female Condom 21 % 

Withdrawal 22 % 

Sponge 24 % parous women
12 % nulliparous women 

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.

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

Fertility-Awareness Based Methods 24 %

| | | | | | | |
|---------|----|----|----|----|----|----|
| JANUARY | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | X | X | X | X |
| X | X | X | X | X | X | X |
| X | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | 2 | 3 | 4 | |

Spermicide 28 %



Most Effective

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

Least Effective

* The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project, a global handbook for providers (2011 update). Baltimore, MD: Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397-404.

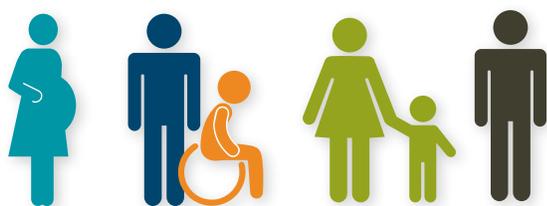
CS 242797



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Household Preparedness

- Mother/Father
- Sister/Brother
- Pregnant woman
- Neighbor
- Husband/Wife



Prepare Your Community

Gender And Sexual And Reproductive Health Preparedness*

GATHER INFORMATION



- What organizations are working to address GBV in your community?
 - » Is there an established procedure for receiving and responding to survivors of GBV?
 - » Where should a survivor go to first?
 - » Are providers trained in how to ensure confidentiality?
 - » Where can a survivor receive medical care following sexual violence?
 - » Where can a survivor receive mental health care following sexual violence?
- Obtain data that is currently available regarding the nature, scope and magnitude of GBV.
- Obtain data currently available regarding total fertility rate, HIV prevalence, and contraceptive prevalence.
- Know your national laws, policies, and enforcement on protection from GBV.

LOCATE SERVICES (and gaps)



- Map current reproductive health services:
 - » Know where the closest referral hospital, and backup hospital, is located
 - » Identify what transportation is available to reach it (24/7), including alternatives
 - » Map trained reproductive health providers at the community and facility level
- Check that the following services are available during stable times:
 - » Medical care to survivors of sexual violence
 - » Emergency contraception (EC pills, alternatively intrauterine device (IUD) or oral contraceptive pills can be used for this purpose)
 - » Antibiotics for treatment of sexually transmitted infections
 - » HIV counseling and testing
 - » Post-exposure prophylaxis (PEP) for prevention of HIV
 - » Care for minor injuries
- Pregnancy and delivery care
 - » Clean delivery kits
 - » Family planning
 - » Condoms
 - » Treatment for eclampsia (magnesium sulfide)
 - » Treatment for post-partum hemorrhage (misoprostol or other)
 - » Treatment for infections
 - » Cesarean delivery
- Determine the system for people on anti-retrovirals (ARVs) to continue ARVs in the event of an emergency.

ACT



- » Identify and pre-program cell phones with emergency contact numbers and alternative communication mechanisms.
- » Inform community members of the benefits of seeking medical care following sexual violence.
- » Develop safe birth plans for pregnant women, inclusive of what they will do in the case of an emergency should primary transportation and communication mechanisms be unavailable.
- » Establish confidential “entry points” where survivors and the community can seek assistance after an incident of sexual violence and/or make an incident report.
- » Establish confidential GBV referral mechanisms among and between actors providing care and treatment to survivors.
- » Identify security risks within your community, and develop actions to reduce risks
- » Raise community awareness about gender based violence (GBV).
- » Identify groups most at risk for GBV and agree on community support and monitoring mechanisms, including community watch teams.

Community Response during Emergencies

Gender and Sexual and Reproductive Health Response*

CONNECT



- Connect with the GBV working group if you are involved in responding to GBV.
- Connect with reproductive health (RH) working group.
- Be involved in the coordinated rapid situation analysis.

INFORM



- Help to distribute sanitary materials to women and girls.
- Help distribute clean delivery kits to barangay health workers (BHWs) and women in the last trimester of pregnancy.
- Distribute Information, Education, and Communication (IEC) materials and information on the following topics: Danger signs during pregnancy, the benefits of seeking care following sexual violence, location of medical services.

PROTECT



- Identify and monitor pregnant and lactating women.
- Ensure services and protection for those determined to be most vulnerable in your community.
- Advocate and monitor that where possible, communal shelters are divided by family and sex.
- Advocate and monitor that simple locks are placed on the insides of latrine doors.
- Advocate and monitor that latrines and wash facilities are separated by sex.
- Advocate and monitor availability of lighting in communal areas (especially latrines and showers) and for individual use (torches).
- Advocate and monitor availability of safe spaces for women.
- Advocate and monitor access to safe fuel and water collection strategies.
- Advocate and monitor that women are consulted during camp or evacuation center design, ensuring adequate protection.

*Based on recommendations for priorities laid out in the IASC *Guidelines on Gender-based Violence Interventions in Humanitarian Settings* and Minimum Initial Service Package for Reproductive Health.

ACTION PLAN: REDUCE MATERNAL AND NEWBORN DEATHS

| Action Item | Responsible person or group | What is needed to complete this activity? |
|-------------|-----------------------------|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

ACTION PLAN: PREVENT AND RESPOND TO GENDER-BASED VIOLENCE

Action Item

Responsible person or group

What is needed to complete this activity?

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

ACTION PLAN: REDUCE TRANSMISSION OF STIs, INCLUDING HIV

| Action Item | Responsible person or group | What is needed to complete this activity? |
|--------------------|------------------------------------|--|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

ACTION PLAN: OTHER PRIORITIES - FAMILY PLANNING & MENSTRUAL HYGIENE

Action Item

Responsible person or group

What is needed to complete this activity?

| Action Item | Responsible person or group | What is needed to complete this activity? |
|-------------|-----------------------------|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |

Appendices/ Resources for Facilitator



Overview

Community Preparedness: Reproductive Health and Gender:

A training for community-members on sexual and reproductive health and gender

Length:

A three-day training that focuses on introducing reproductive health (RH) and gender components in a disaster and turning knowledge into action at the community level. Depending on the knowledge base of participants, facilitators can select specific modules and cater the training to each group and time frame available.

Participants:

Women's groups and community members

Purpose:

To build the capacity at the community level to prepare and respond to risks and inequities for women and girls during emergencies.

Materials

To download copies of this guide, as well as classroom presentations, videos, and more, please visit:

 www.wrc.ms/drr-srh-curriculum

Objectives:

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

- 1) Identify risks faced by women and girls during an emergency (with a specific focus on reproductive health and gender),
- 2) Provide a description of the Minimum Initial Service Package (MISP) for Reproductive Health inclusive of:
 - a. Its importance,
 - b. The five priority actions included within it as well as additional activities, and
 - c. The key actions which could be taken to improve MISP preparedness.
- 3) Apply knowledge of reproductive health and gender risks to existing hazard and risk maps,
- 4) Identify existing community-level capacities and gaps at the community level for gender and reproductive health preparedness and response,
- 5) Discuss community level actions which could be taken to improve preparedness and which would improve RH response and reduce gender-related risks, and
- 6) Develop action plans and accountability mechanisms that ensure a more robust gender and reproductive health response.

Model:

Disaster risk reduction and management activities are ideally focused at the local/ community level and address localized risks. Yet such efforts require significant support from leadership at the local, regional and national level. This training was first piloted by Women's Refugee Commission and UNFPA/Philippines to build the capacity of communities to prepare for and respond to reproductive health needs in an emergency. Activities conducted in the Philippines, to date, have demonstrated the importance of a supportive environment when attempting to empower and support community members to undertake actions related to mitigating their risks and build resiliency.

In order for a community model to be successful, local government units are critical partners. They should receive support, so that they fully understand the skills and knowledge to be gained by communities. In turn, they will be expected to provide strategic support to community groups that have been trained, so that actions might be possible after the training.

This document helps to lay out likely expectations and assumptions, so that groups (both communities themselves and local governments) can decide whether they are prepared and interested to embark on a partnership.

Municipalities should be selected based on the following criteria:

- 1) The community frequently faces high risk emergencies leading to displacement.
- 2) Local governments (i.e.: LGU and specifically the Mayor) of proposed municipality is supportive of gender mainstreaming and women's health issues.

- 3) The following members of the LGU are available for capacity building over the course of the project
 - a. The Mayor
 - b. At least two (2) representatives from local disaster risk reduction and management teams
 - c. Community leader (i.e., a barangay captain and/or council)
 - d. 4-5 community health workers within each community (barangay health workers)
- 4) Local governments (i.e., the LGU) is familiar with the MISIP, and supports its implementation as an emergency response.
- 5) A training facility near the community can be selected.
- 6) Activities related to disaster risk reduction have previously been conducted in the area.

The community group — civil society organization — women's group conducting the training will:

- 1) Meet with LGUs and the Mayor of interested municipality to discuss training and localized interest in partnership on this topic.
- 2) Provide as needed, one day of training for local governments on topics related to reproductive health or gender.
- 3) Provide a three day training on gender mainstreaming and reproductive health within emergency preparedness. Size of training should not exceed 30 participants.

- 4) Facilitate the development of “action plans” for each community which address gender and sexual and reproductive health within preparedness and response. Action plans can then be shared with local governments for support and approval.
- 5) Depending on capacity, conduct a follow-up visit to the site one to three months post training.
- 2) Attend gender mainstreaming and MISP trainings as available.
<http://www.misp.rhrc.org>¹
- 3) Attend specific planning elements during Day 3 of the training.
- 3) The LGU will ensure that preparedness activities within the developed actions plans are systematically funded through the appropriate Internal Revenue Allocations.

LGU (inclusive of members identified above) will ideally commit to the following:

- 1) Strengthen, as needed, knowledge with regard to:
 - a. Disaster risk reduction and local community risk mapping
 - a. Disaster risk reduction
 - b. Community-based Disaster Risk Management (CBDRM)
 - c. Coordination during emergency response

¹The Mayor will agree to receive briefings on the training topics, but will not be expected to attend the full training in person

KEY ANSWER: Pre-/Post-Test for Participants

Community based Training on SRH and Gender within preparedness and response

| | TRUE | FALSE |
|---|------|-------|
| 1. In an emergency, access to reproductive health services saves lives | x | |
| 2. In an emergency there are NO minimum requirements for services that should be provided | | x |
| 3. Women and girls have higher rates of mortality during a disaster | x | |
| 4. During displacement, women and girls face higher risks to their health and safety than their male counterparts | x | |
| 5. It is recommended that men and women share wash and latrine facilities | | x |
| 6. Simple locks should always be available on the inside of latrine doors | x | |
| 7. After sexual violence, there are no services or treatment that can be provided to help the survivor | | x |
| 8. The Philippines has a disaster risk management law | x | |
| 9. Communities themselves are frequently the first responders during the first 72 hours (3 days) of an emergency | x | |
| 10. Communities are best positioned to identify solutions to address the risks they identify in their own community | x | |

11. If your sister or another woman in your household were pregnant, what could you do before an emergency to make sure she has a safe delivery even if a disaster strikes?
(Accept: develop a safe birth plan, have phone numbers for hospitals or emergency transportation saved in your phone, know where a referral hospital is located, have transportation and back-up transportation available)
12. What are two (of the five) dangers signs during pregnancy that community members should be aware of, which signal the need to get a pregnant women to a higher-level health facility?
(Accept: severe bleeding, seizure, prolonged labor, foot or hand delivered first, umbilical cord first, more than one infant)
13. Name two medical services that should be provided, according to the MISP, if someone experiences sexual violence.
(Accept: Emergency contraception/prevent pregnancies, treatment of injuries, post-exposure prophylaxis/prevent HIV, pre-emptive treatment of STIs/prevent illness or disease)
14. Who should develop a safe birth plan (circle only the most appropriate answer)?
- a) Every pregnant woman
 - b) Pregnant women who have had complications in the past
 - c) Women who do not have others in the house to help care for her
15. What is one way that HIV transmission is limited during an emergency?
(Accept: free and available condoms, provide post-exposure prophylaxis to survivors of sexual violence, ensure that ARVs are provided for those already on treatment, practice standard precautions- washing hands, wearing gloves, wearing protective clothing, safe handling of sharps, safe waste disposal, decontaminating instruments)

Additional Resources

Reproductive Health

The Minimum Initial Service Package for Reproductive Health (MISP) Distance Learning Module:

<http://www.misp.rhrc.org/>

Cheat sheet:

<http://misp.rhrc.org/archive/pdf/cheat%20sheet/MISP%20cheat%20sheet%20rev.04%202010.pdf>

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. 2010:

http://www.iawg.net/resources/field_manual.html

Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings. 2009:

http://www.iawg.net/resources/field_manual.html

Caring for Survivors of Sexual Violence in Emergencies: Training Guide. 2010:

<http://www.unicefemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>

IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings: focusing on prevention and response to sexual violence in emergencies. 2005:

<http://www.who.int/hac/techguidance/pht/GBVGuidelines08.28.05.pdf>

Averting Maternal Death and Disability. Emergency Obstetric and Newborn Care training program list:

<http://www.amddprogram.org/sites/default/files/EmONC%20Training%20Curricula%20Comparison%20May2010.pdf>

Jhpiego. Guidelines for in-service training in basic and comprehensive emergency obstetric and newborn care. 2012:

<http://reprolineplus.org/resources/guidelines-service-training-basic-and-comprehensive-emergency-obstetric-and-newborn-care>

IASC AND UNAIDS Guidelines for Addressing HIV in Humanitarian Settings. 2010:

http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767_iasc_doc_en.pdf

Disaster Risk Reduction

Policy Brief: Integrating sexual and reproductive health into health emergency and disaster risk management. 2012:

http://www.who.int/hac/techguidance/preparedness/SRH_policybrief/en/

Fact Sheet: Disaster Risk Management for Health: sexual and reproductive health:

<http://www.unisdr.org/we/inform/publications/19987>

IFRC Vulnerability and Capacity Assessment Toolkit:

<http://www.ifrc.org/Global/Publications/disasters/vca/vca-toolbox-en.pdf>

Integrating Gender Issues in Community Based Disaster Risk Management:

http://www.gfdrr.org/sites/gfdrr.org/files/Guidance_Note_4_Integrating_Gender_Issues_in_Community-based_Disaster_Risk_Management.pdf

APDC Community Based Disaster Risk Management: Field Practitioners Handbook:

<http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=14&ved=0CGUQFJAN&url=http%3A%2F%2Fwww.adpc.net%2Fpdr-sea%2Fpublications%2F12handbk.pdf&ei=ZW3ZU9yrIZSzyATpwIHYDA&usq=AFQjCNEhWfg2CTAZ-0s4F8oCckduFOu9w>

Making Disaster Risk Reduction Gender Sensitive:

http://www.preventionweb.net/files/9922_MakingDisasterRiskReductionGenderSe.pdf



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