Day 4: Supporting MISP Implementation

Training for Program Managers

Day 3 Review

MISP Objectives 4, 5 & 6; & Other SRH Priority Activity: Safe Abortion Care

Session 4.1: Adolescent SRHR in Emergencies

Training for Program Managers

Learning objectives

After this session, participants should be able to:

1. Explain why it is important to recognize and address the SRH needs of adolescents in emergencies
2. Define the characteristics of adolescent-friendly health services
3. Describe principles of meaningful participation of adolescents along the program cycle
4. Be familiar with tools for ensuring adolescent participation in SRH programming in emergencies

Adolescent SRHR

- There are approximately 1.2 billion adolescents globally—making up 16% of the world's population
- AIDS is now the leading cause of death among young people aged 10-24 years in Africa
- Every day in developing countries, 20,000 girls under age 18 give birth
- From 2009-2012 proposals for ASRH through humanitarian funding streams constituted less than 3.5% or all health proposals. Most were unfunded.

Adolescents

- Individuals aged 10 to 19 years
  - Very young adolescents: 10-14 years
  - Middle adolescents: 15-16 years
  - Older adolescents: 17-19 years
- Time of physical, behavioural & psychosocial change
- Heterogeneous group

Adolescent SRH in Emergencies

- Family, community & social structures disrupted
- Formal & informal education discontinued
- Fear, stress, boredom, hopelessness
- Loss of role models
- Increased risk behaviours
- Increased exposure to risks

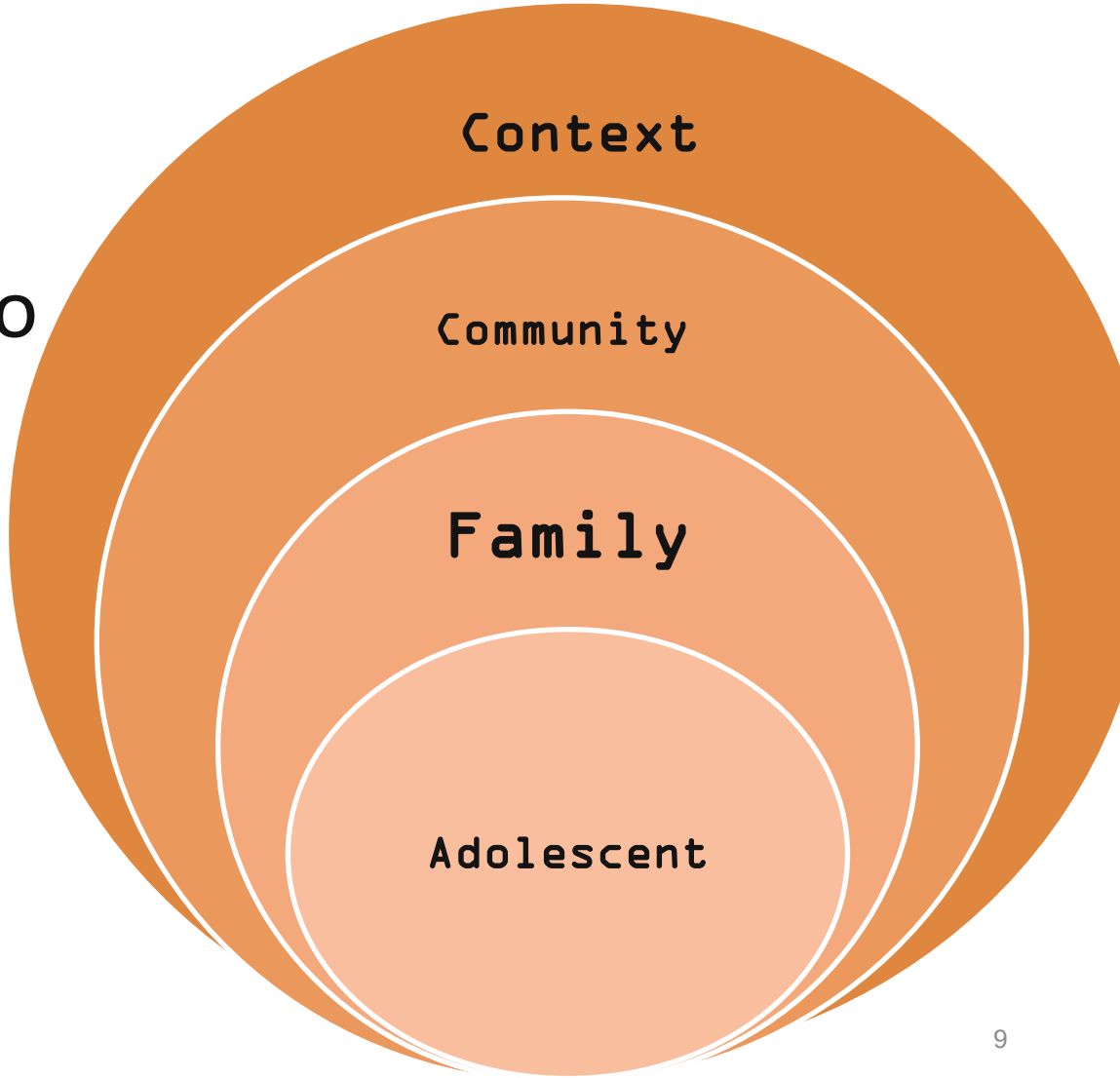
Adolescents at increased risk

- Pregnant adolescents
- Unaccompanied adolescents
- Adolescents engaged in exploitative labor
- Marginalized adolescents:
  - Adolescents living with HIV
  - Adolescents with disabilities
  - Adolescents who identify as LGBTIQ
  - Adolescents belonging to indigenous or migrant groups

Social ecological model

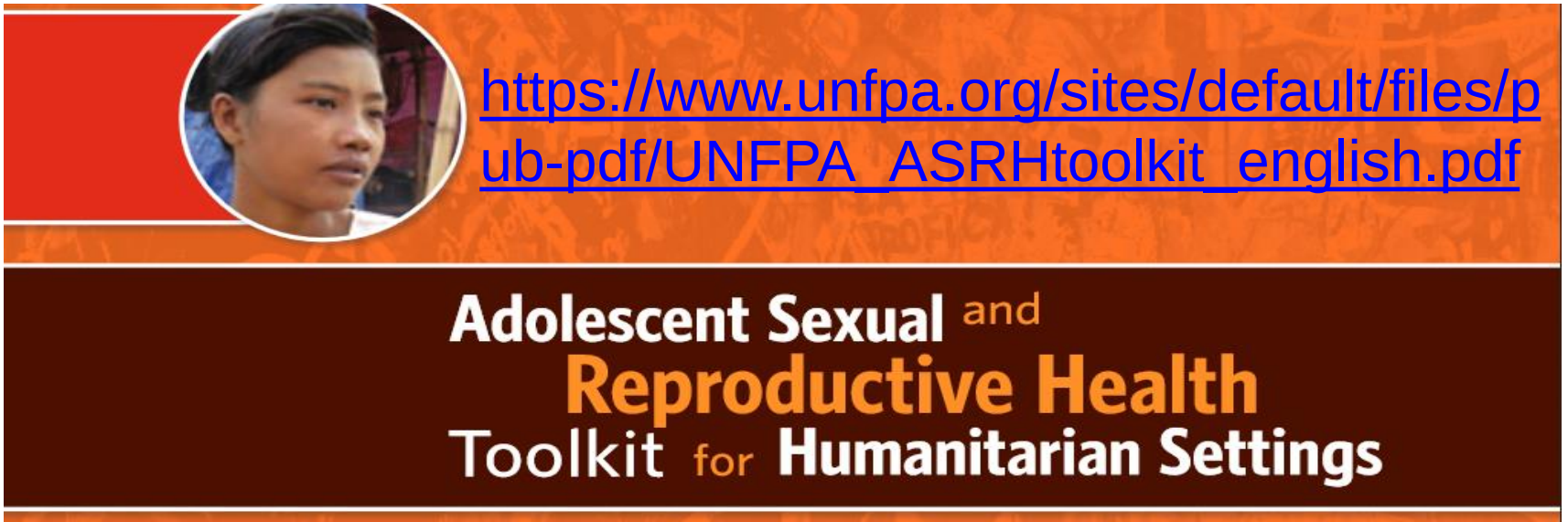
Different factors influence the individual's ability to make decisions and access services.

→SRHR outcomes



Adolescents SRH in humanitarian settings

- The ASRH in humanitarian toolkit is a complement to IAFM and MISP implementation
- Highlights principles of Adolescent Responsive Health Systems and meaningful engagement



Adolescent Responsive Health Systems

Progress toward universal health coverage requires a transition from adolescent-friendly health services to adolescent-responsive health systems including humanitarian crisis.

The ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth. (WHO, 2000)

Adolescent-friendly Services

- Adolescents face barriers to accessing SRH information & services:
  - Individual Barriers
  - Socio-cultural Barriers
  - Structural Barriers
- ASRH services must be:
  - Acceptable
  - Accessible
  - Affordable
  - Appropriate
  - Equitable
  - Effective
  - Efficient

Adolescent-Friendly Checklist

Adolescent-Friendly Health Services Checklist for Humanitarian Settings

(Adapted from African Youth Alliance/Pathfinder International)

Characteristics	Yes	No	Feasible suggestions for improvement and/or comments
Health Facility Characteristics			
1. Is the facility accessible and located within walking distance proximity of a place where adolescents–both female and male–congregate? (youth center, adolescent-friendly space, school, market, etc.) *Note: Define accessibility and proximity with your local team before using the checklist and agree on what is appropriate for the context. For example consider insecurity or infrastructure issues that might affect access.*			
2. Is the facility open during hours that are convenient for adolescents–both female and male (particularly in the evenings or on the weekend)? *Note: If only males or only females are congregating, mark "no."*			
3. Are there specific clinic times or spaces set aside for adolescents and are drop in clients welcomed (without appointments)? *Note: If only males or only females are able to access, mark "no."*			
4. Are SRH services offered for free to adolescents?			
5. Are waiting times short (less than one hour)?			
6. If both adults and adolescents are treated in the facility, is there a separate, discreet space for adolescents to ensure privacy?			
7. Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
8. Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback, or other accountability mechanisms about SRH services at the facility?			
9. Is there a Health Management Information System that includes age-disaggregated data, as outlined in international adolescent group			

Adolescent SRH in Humanitarian Emergencies

Identifying Good Practice

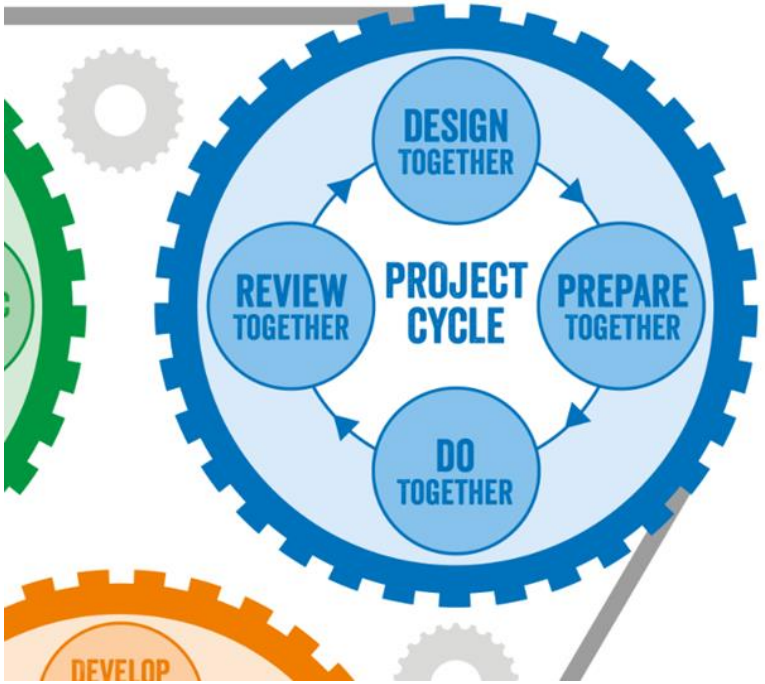
Contribution of Adolescents in Emergencies

- Resilient, resourceful & energetic
- Meaningful participation in programming
  - Planning & decision making
  - Peer educators
  - Youth centres
  - Adolescent outreach
  - Community outreach
  - Linking ASRH services to educational settings
- Stakeholder involvement to build community trust & adult support

Meaningful Engagement along the Program Cycle

How can we engage adolescents from the start to the end of a project?

- Design & Prepare Phases
  Consulting adolescents while developing program and conducting assessments
- Implementation Phase
  Feedback mechanisms
  Data collection
  Adolescents as first responders/implementers of activities
- Review Phase
  Exit interviews
  Evaluation surveys/assessments



Plan's PQIP (The Programme and Influence Quality Procedures) framework

Things to keep in mind when Engaging Adolescents

1. Policy for engaging volunteers under the age of 18
2. Orientation to your agency's ways of working
3. Clear selection criteria for adolescent and youth volunteers
4. Communication terms of engagement of adolescent and youth volunteers
5. **What else?**

Concluding thoughts

- Adolescents face particular risks in humanitarian settings
- It is vital to provide adolescent-responsive SRH services in these settings
- Adolescents bring particular strengths and capacities to SRH programming in emergencies
- It is critical that adolescents are engaged by SRH program managers through sincere and meaningful actions along the program cycle

Supporting MISP Implementation:

Funding; Logistics; Assessment, Monitoring & Evaluation; & Next Steps

Training for Program Managers

Learning objectives

After the following sessions, participants should be able to:

1. Describe funding mechanisms for SRH in emergencies.
2. Demonstrate an understanding of logistics for supporting SRH preparedness and response in emergencies.
3. Apply key concepts for assessment, monitoring & evaluation of SRH programming in emergencies.
4. Describe and commit to next steps in preparing for and responding to SRH needs in emergencies.

Session 4.2: Funding

Training for Program Managers

Humanitarian Funding Mechanisms

- Global funding mechanisms
- National funding mechanisms
- Funding for preparedness

Global Humanitarian Funding Mechanisms

1. The Flash Appeal
2. Central Emergency Response Fund
3. Consolidated Appeals Process
4. Country Based Pooled Funds

The MISP meets the life-saving criteria for Humanitarian Funding

Global Humanitarian Funding Mechanisms

1. The Flash Appeal

- Early strategic response plan: 5-7 days of emergency
- Used in any major sudden onset disaster
- Triggered by Humanitarian Coordinator in consultation with stakeholders: cluster/ sector leads compile response plans
- Clearly articulates most urgent humanitarian needs

Ensure SRH Coordinator Includes

MISP Project Proposals

Flash Appeal Proposals

Group Work

Global Humanitarian Funding Mechanisms

2. Central Emergency Response Fund (CERF)

- Developed simultaneously with Flash Appeal as part of the same process
- Flash is a planning instrument CERF is a funding instrument
- For rapid response & underfunded emergencies
- CERF is for interventions which meet life-saving criteria

= MISP

Ensure SRH Coordinator Includes

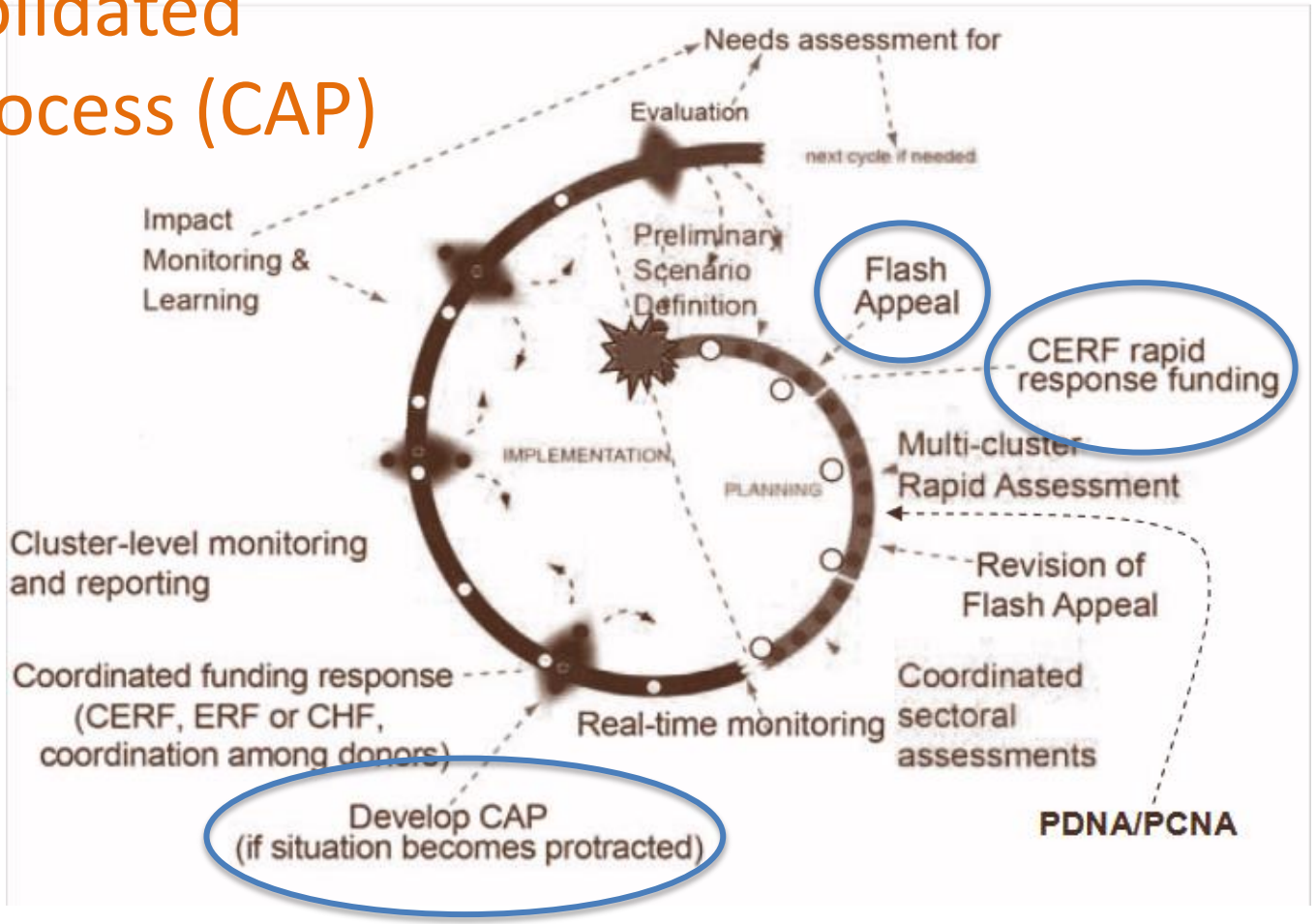
MISP Project Proposals

Global Humanitarian Funding Mechanisms

3. IASC Consolidated Appeals Process (CAP)

CAP

If an emergency continues for more than 6 months



https://www.unocha.org/sites/unocha/files/CAP_2011.pdf

Ensure SRH Coordinator Includes

MISP Project Proposals

Global Humanitarian Funding Mechanisms

4. Country Based Pooled Funds

- Established at country level
- Managed locally under Humanitarian Coordinator
- Support highest-priority projects of best-placed responders

Global Humanitarian Funding Mechanisms

Tips on accessing global humanitarian funding mechanisms:

- Find out which pooled fund mechanisms are available in context
- Check eligibility process
- Actively contribute to Flash Appeals
- Ensure consistent representation in coordination & cluster meetings

National Humanitarian Funding Mechanisms

Concluding thoughts

- The MISP for SRH meets the life-saving criteria for humanitarian funding.
- Global Humanitarian Funding Mechanisms include the Flash Appeal, Central Emergency Response Fund, Consolidated Appeals Process & Country Based Pooled Funds.
- Its important to ensure consistent representation of the MISP for SRH in global and national funding opportunities.

Session 4.3: Logistics

Training for Program Managers

Logistics

1. Products
2. Essential Program Information
3. Supply Chain Management

The 6 ‘RIGHTS’ of logistics

The **RIGHT** goods

In the **RIGHT** quantities

In the **RIGHT** condition

Delivered

To the **RIGHT** place

At the **RIGHT** time

For the **RIGHT** cost

Products to Support MISP Implementation

- Inter-agency Emergency Reproductive Health Kits

OVERVIEW OF INTER-AGENCY REPRODUCTIVE HEALTH KITS TO SUPPORT IMPLEMENTATION OF THE MISP

Health Care Level	Kit Number	Kit Name
Community/Health Post	Kit 1 A	Male condoms
	Kit 2 A&B	Clean delivery (A – Mother, B – Birth Attendant)
	Kit 3	Post-rape treatment
	Kit 4	Oral and injectable contraceptives
	Kit 5	Treatment of sexually transmitted infections
Primary Health Care Facility (BEmONC)	Kit 6 A&B	Clinical delivery assistance – midwifery supplies (A – reusable, B - consumable)
	Kit 8	Management of complications of miscarriage or abortion
	Kit 9	Repair of cervical and vaginal tears
	Kit 10	Assisted delivery with vacuum extraction
Referral Hospital (CEmONC)	Kit 11 A&B	Obstetric surgery and severe obstetric complications kit (A – reusable and B - consumable)
	Kit 12	Blood transfusion

In-country supplies to meet demand?

- Local procurement
- Pre-positioning of equipment & supplies

Products to Support MISP Implementation

- Inter-agency Emergency Reproductive Health Kits

1. Community Level/ Health Post:

   10,000 people for 3 months

2. Primary Health Care Facility:

   30,000 people for 3 months

3. Referral Hospital Level:

   150,000 people for 3 months

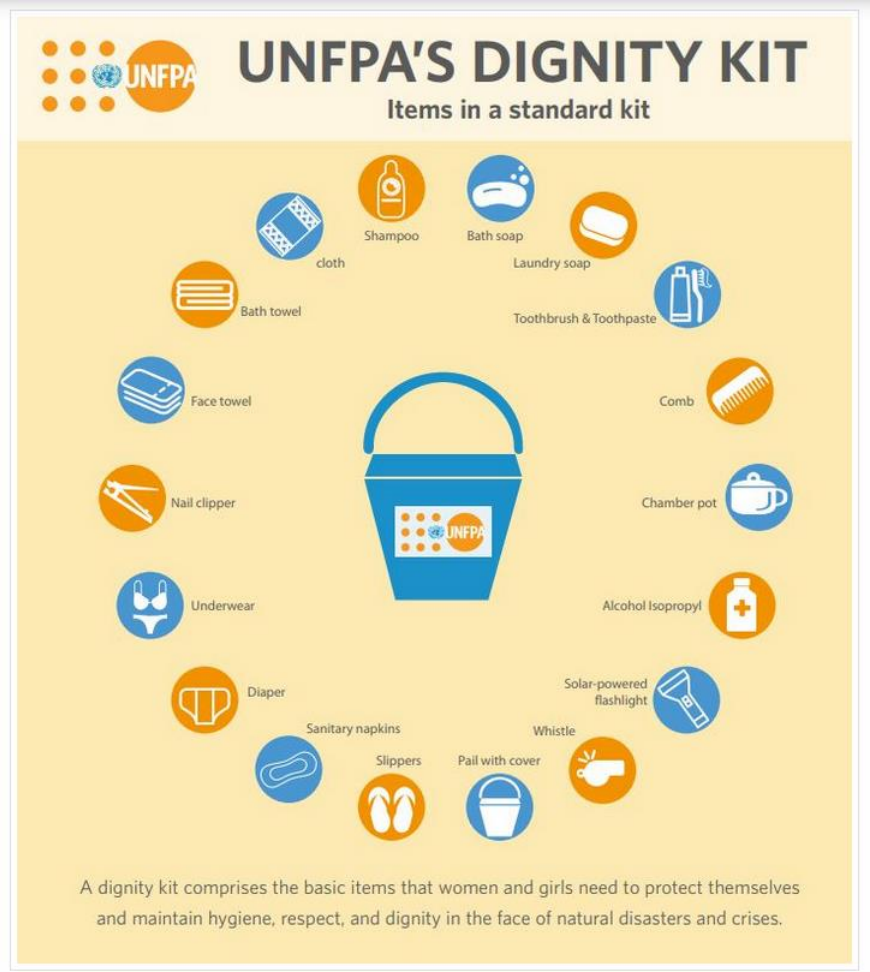
Products to Support MISP Implementation

- Complementary Commodities:

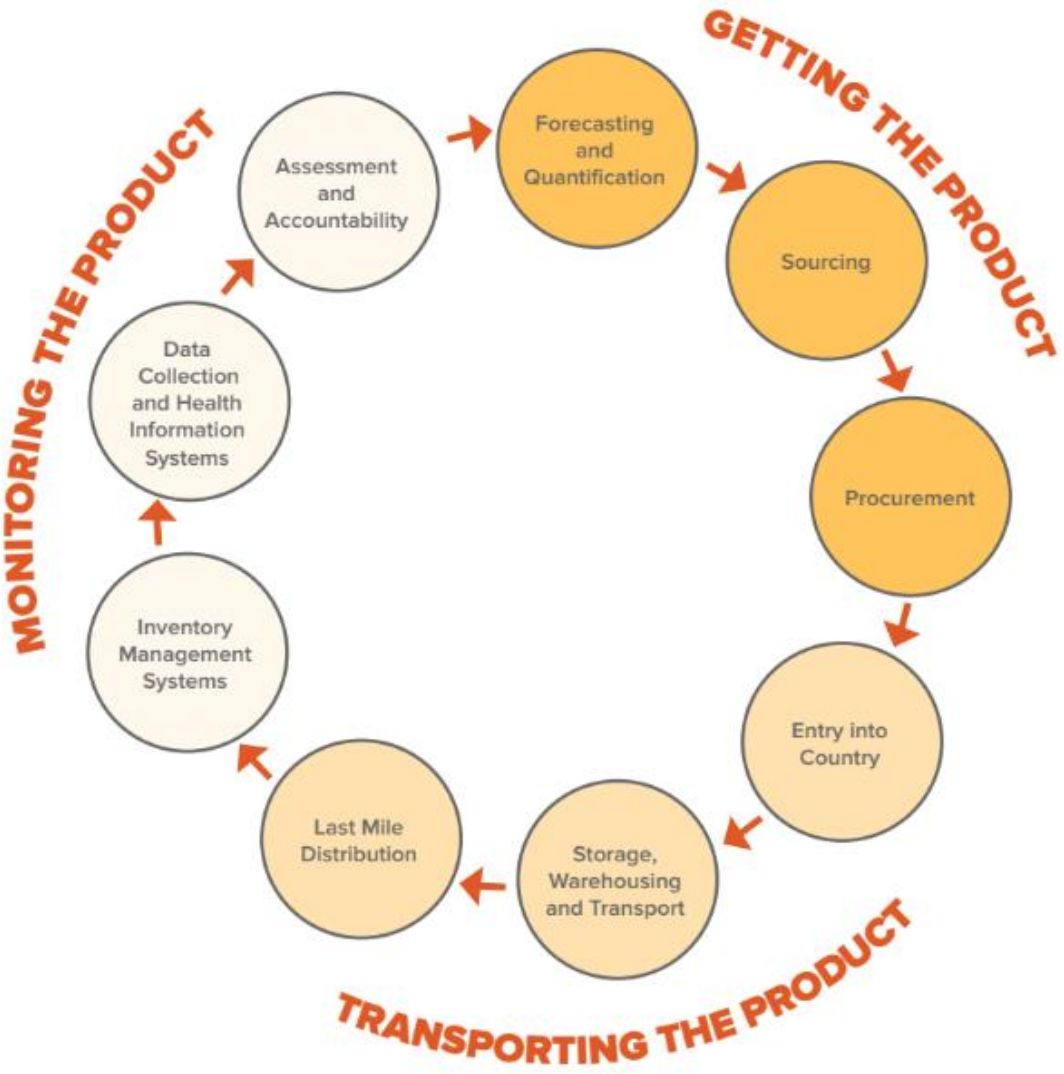
COMPLEMENTARY COMMODITIES:			
Level	**To complement**	**Item**	**Format**
Coordination	All Kits	Administration and training	Kit
Community/ Health Post	Kit 1A	Kit 1B - Female condoms	Kit
	Kit 2A	Chlorohexidine	Bulk
	Kit 2B	Misoprostol **	Bulk
	Kit 2A and 2B	UNICEF/Save the Children - Newborn care supply kit - community*	Kit
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)	Bulk
Primary Health Care Facility (BEmONC)	Kit 4	Kit 7A - Intrauterine device (IUD)	Kit
	Kit 4	Kit 7B - Contraceptive implant	Kit
	Kit 6A	Non-pneumatic anti-shock garment	Item
	Kit 6B	Oxytocin	Bulk
	Kit 6A & 6B	UNICEF/Save the Children - Newborn care supply kit - primary health facility*	Kit
	Kit 8	Mifepristone**	Bulk
	Kit 10	Hand-held vacuum assisted delivery system	Item
Referral Hospital (CEmONC)	11B	Interagency emergency health kit supplementary malaria module	Kit
	11A & 11B	UNICEF/Save the Children -Newborn care supply kit - *Hospital*)*	Kit

* At the time of printing this manual Newborn Care Supply Kits are not yet available
** Misoprostol can also be procured to complement Kit 6B and Kit 8 for the Primary Health Care Facility

- Other Supplies:
  - Culturally appropriate hygiene or dignity Kits



Supply Chain Management



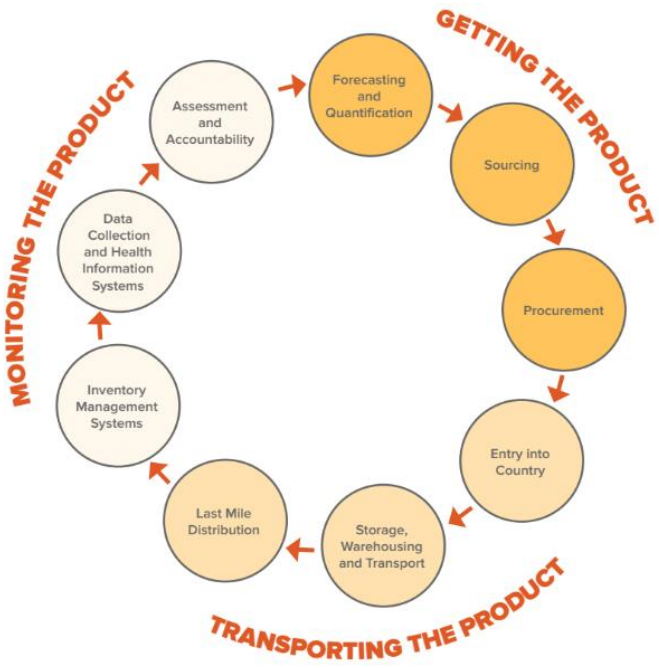
Led by:

- UNFPA
- In-country experts

Partner with:

- Logisticians
- Other sectors/ clusters
- Health sector/ cluster core commodity pipeline

Supply Chain Management



Principles:

- Meet immediate SRH needs
- Transition away from RH Kits as soon as situation stabilises
- Strengthen local supply chain capacity
- Support local economies
- Prepare in advance

Supply Chain Management

Step 1: Getting the product

Forecasting & quantification:

Estimating the quantities & costs of products required

Sourcing:

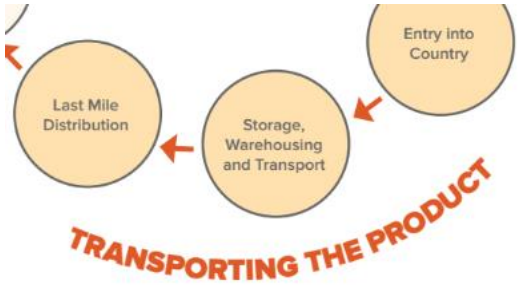
Determining brand/ manufacturer for each product

Procurement:

Purchasing the right product

Supply Chain Management

Step 2: Transporting the product



Entry into country:

Customs & clearances

Storage, warehousing & transportation:

Ensure distribution & maintain quality:

- Receive & arrange commodities: stock rotation, special storage conditions
- Prevent damage & contamination
- Waste Management

Step 2 Continued: Last Mile delivery

- Crucial but overlooked part of supply chain
- Moving goods to remote program sites
- Develop storage and distribution plans all the way to the end point

Supply Chain Management

Step 3: Monitoring the product

Inventory Management Systems:

Track products in warehouses & health facilities

Data collection & HIS:

Logistics information systems

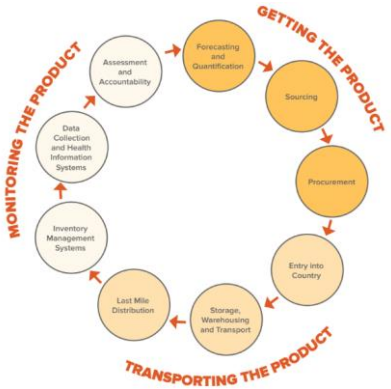
Assessment & Accountability:

Inventory to maintain & improve supply chains

Supply Chain Management

Inter-agency Reproductive Health Kits
at Sri Lanka Airport

Warehousing



Distribution
Planning

In-country Transport

Logistics Exercise

Group Work

Essential Program Information for Logistics

- Critical Information for Logistics:
  - Population size of catchment area
  - Number & scope of functioning health facilities
  - RH Kit product specifications
  - Government requirements
  - Partner agreements
  - Transportation & warehousing options
  - Inventory monitoring & reporting tools
  - Staff capacity & organisational logistics infrastructure along supply chain
  - Waste management

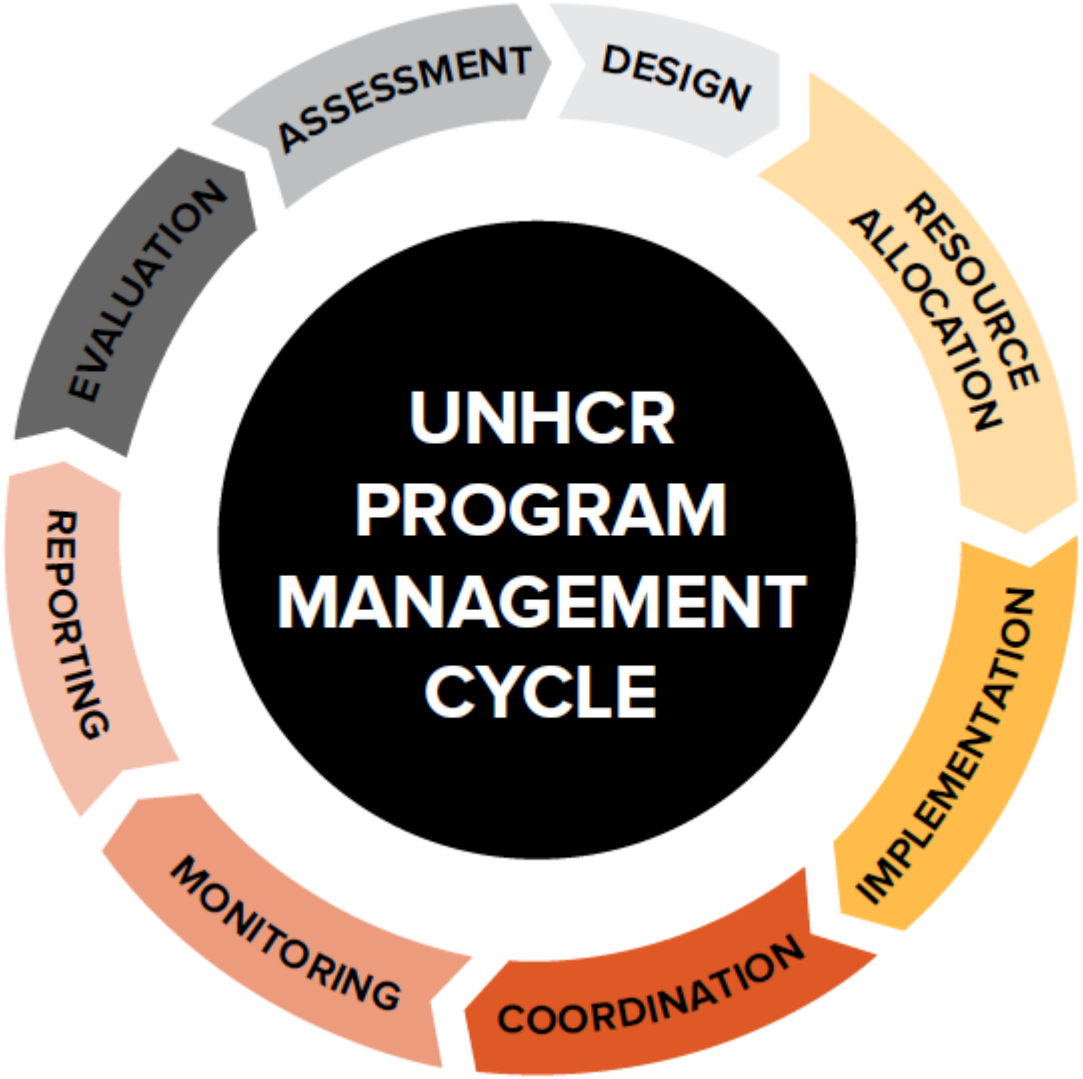
Concluding thoughts

- No supplies, no program.
- Inter-agency Reproductive Health Kits are designed to implement the MISP for SRH to complement existing national supplies.
- Kist should be ordered as needed, ensuring sufficient capacity is available to use their contents, and that storage is available and well managed.

Session 4.4: Assessment, Monitoring & Evaluation

Training for Program Managers

Assessment, Monitoring & Evaluation



Assessment: determining & addressing needs/ gaps

Monitoring: ongoing systematic collection of data

Evaluation: process for determining whether a program has met objectives

Assessment, Monitoring & Evaluation

Roles of Assessment, Monitoring & Evaluation in emergencies:

- Determine humanitarian needs & contributing factors
- Ensure effective & efficient use of resources
- Identify programmatic barriers & enablers to improve programming
- Determine the success or failure of the program
- Provide accountability & transparency to donors, beneficiaries & other stakeholders

Assessment

- To identify SRH needs of the population & contributing factors
- To determine the capacity of existing health system to respond
- When to conduct assessment depends on type of information needed & phase of emergency
- Remember: the causes of the most important SRH-related morbidity & mortality are already addressed by the MISP for SRH &

can be put in place without an in-depth assessment

Assessment

- Can provide important information for strategic planning:
  - Number & location of people
  - Number & location of health care staff for MISP components
  - SRH medical supply logistic opportunities
  - Health facilities affected
  - MISP funding possibilities
- Methods may include:
  - Desk review
  - Situational analysis
  - Key Informant Interviews
  - Focus Group Discussions
  - Participatory methods
  - Health facility assessments
  - Mapping
  - Surveys

Methods used depend on phase of emergency, time, resources & information needed

Assessment

Assessment

- Data analysed soon after collection
- Results as specific as possible
- Assessment reports shared with all stakeholders
- Findings & decisions shared with communities

Monitoring MISP Implementation

- Regular collection, analysis and reporting of SRH data
- Monitor performance & quality of health service delivery & changes in health status of population
- Onset: simple information system to collect minimal SRH data to monitor MISP implementation
- Timing depends on phase of emergency & needs of the organisation
- Service Providers: routine collection & reporting of data
- Clinical supervisor: aggregates reports & conducts quality assurance of data collection

Monitoring MISP Implementation

- Standardised monitoring tools
- Part of Health Information System if functioning
- Sex, age & disability disaggregated data
- Sources include:
  - Patient records/ charts
  - Registers & tally sheets
  - Maternal & perinatal death review forms
  - Community-based health worker/ midwife reports
  - Surveys
  - Commodities & supplies
  - Community feedback systems

Monitoring MISP Implementation

MISP Checklist

- Useful tool for monitoring progress of SRH response
- SRH coordinator supported by program managers
- Onset: weekly monitoring
- Gaps & overlaps addressed

FIGURE 3.2: SAMPLE MISP CHECKLIST

GEOGRAPHIC AREA:	REPORTING TIME PERIOD: __/__/20__ TO __/__/20__	START DATE OF HEALTH RESPONSE: __/__/20__	REPORTED BY:

1. SRH lead agency and SRH Coordinator			
		YES	NO
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly:	YES	NO
	National (MONTHLY)		
	Sub-national/district (BIWEEKLY)		
	Local(WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH Working Group meetings	YES	NO
	Ministry of Health		
	UNFPA and other relevant UN agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
	Civil Society including marginalized (adolescents, persons with disabilities, LGBTQIA people)		
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensures mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		
2.2	Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)		
2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population or estimated at 4% of the population)		
3. Prevent sexual violence and respond to the needs of survivors			
		YES	NO
3.1	Multi-sectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (Sex segregated latrines with locks inside, lighting around health facility, system to control who is entering or leaving facility, i.e., guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	YES	NO
	Percentage of health facilities providing clinical management of survivors of sexual violence (Number of health facilities offering care/all health facilities) x 100%)		%
	Emergency contraception		
	Pregnancy test		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/Tetanus immunoglobulin		

Monitoring MISP Implementation

- Enables program managers to analyse trends of specific indicators to determine whether the program serves the affected population
- Correct choice of indicators
- Feedback loop to lower-level managers and SRH staff

Evaluation

- Supports program managers to understand if and how objectives were met
- Need a sufficient amount of time to measure outputs and impacts
- 3-6 months post-acute phase: MISP process evaluation tools
- Integrate frameworks of evaluation as transition to comprehensive SRH

Evaluation

Evaluation questions can include:

- What were our goals?
- What was our logic frame?
- What did we do?
- What did we achieve?
- Did we achieve what we intended?
- What worked & why? For which target groups?
- What didn’t work & why? For which target groups?
- What lessons have we learned?
- What else is needed to achieve our desired impact?

Evaluation

- Results used to improve program planning & design
- Feedback as the program continues
- Final evaluation report shared with all stakeholders & the community

Participatory Methods

- Important that assessment, monitoring & evaluation processes are inclusive
- Engage community organisations & subpopulations in assessment, monitoring & evaluation process as soon as possible

Key Concepts

- Privacy
- Confidentiality
- Security
- Identifiable information
- Patient-identifiable data

Concluding thoughts

- Assessment, Monitoring and Evaluation systems support effective programming, decision making and accountability
- Methods used depend on phase of emergency, time, resources & information needed
- Sex Age Disability Disaggregated Data should be collected where possible
- Engage members of affected population and marginalised communities including adolescents from assessment to evaluation
- Disseminate learnings and findings with key stakeholders

Session 4.5: Next Steps

Training for Program Managers

Mapping & Planning

Group Work

Post-Test

Final Presentations