



Incorporating Sexual and Reproductive Health into Emergency Preparedness and Planning

Lessons learned from national-level efforts in Haiti, Uganda
and South Sudan



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Since 1989, the Women's Refugee Commission has advocated for policies and programs to improve the lives of refugee and displaced women, children and young people, including those seeking asylum—bringing about lasting, measurable change.

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Cover photo: Midwives sorting through reproductive health kits after the tsunami in Aceh, Indonesia, 2005. © WRC/Julia Matthews.

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Acronyms & Abbreviations

CBO	Community-based organization
DRR	Disaster risk reduction
HEM	Health Emergency Management
ISDR	International Strategy for Disaster Reduction
MISP	Minimum Initial Service Package
MOH	Ministry of Health
NGO	Nongovernment organization
PLWHA	People living with HIV and AIDS
RH	Reproductive health
SRH	Sexual and reproductive health
UNFPA	United Nations Population Fund
WRC	Women's Refugee Commission

Summary

This report reviews recent Women's Refugee Commission sexual and reproductive health activities (SRH) in Haiti, Uganda and South Sudan. It considers the impact of advocacy, training and planning activities related to emergency preparedness and planning specific to SRH. The report then offers lessons learned and recommendations for improving steps towards SRH emergency preparedness at the national level. As efforts to incorporate SRH activities into disaster risk reduction (DRR) are in their early phases, this report makes an important contribution to a knowledge base that could help to shape effective practices. It is essential that we expand this knowledge base to reduce reproductive health morbidity and mortality and ensure that women and girls have full access to response systems, during and post-disasters, by taking critical preparation steps.

Introduction

It is well documented that women are disproportionately affected by disasters: 90 percent of those killed in the 1991 cyclone in Bangladesh and 80 percent of those killed in the 2004 tsunami were women and girls.¹ Gender differences in loss of lives due to natural disasters are directly linked to a woman's economic and social rights before the crisis;² these rights affect one's ability to access warning systems, survival skills and rescue mechanisms. For women and girls who do survive these events, the immediate impacts of a disaster—displacement, sexual violence and exploitation, disruptions in health services and loss of financial security within a family unit—often lead to devastating, long-term effects, including SRH-related death and illness.

Planning and preparing for disasters can help to address these gender imbalances, as well as improve access to critical life-saving SRH services during an emergency.

To this end, the Women's Refugee Commission (WRC) has supported global-, national- and community-level

Key Definitions*

Disaster risk reduction: Reducing disaster risks through efforts to understand and manage the causal factors of disasters. This includes reducing exposure to hazards, reducing vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events. A comprehensive approach to reduce disaster risks is set out in the United Nations-endorsed Hyogo Framework for Action.**

Hyogo Framework for Action: The first plan to explain, describe and detail the work that is required from all different sectors and actors to reduce disaster losses. Its goal is to substantially reduce disaster losses by 2015 by building the resilience of nations and communities to disasters.

Contingency planning: A management process examining potential events or emerging situations that might threaten society or the environment. Contingency planning results in organized and coordinated courses of action with clearly-identified institutional roles and resources, information processes and operational arrangements for specific actors at times of need. Contingency planning is an important part of overall preparedness. Contingency plans need to be regularly updated and exercised.

UN International Strategy for Disaster Reduction (ISDR): Serves as the focal point in the United Nations system for the coordination of disaster reduction and to ensure synergies among disaster reduction activities.

* Based on definitions from the ISDR: www.unisdr.org/we/inform/terminology

** <http://wrc.ms/x4QMTD>

efforts to plan and prepare for disasters. The WRC facilitates the RH sub-working group of the International Strategy for Disaster Reduction (ISDR)³ at the global level, which is currently developing policy and programmatic tools that support the incorporation of SRH into Health Emergency Management (HEM). The WRC is also involved in national- and community-level activities to support a similar objective. During 2010 and 2011,

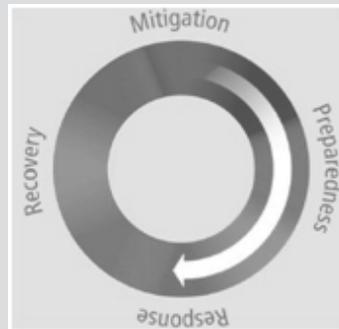
the WRC conducted activities in Haiti, Uganda and South Sudan in order to better understand essential steps, capacities and challenges when incorporating SRH into HEM. The WRC provided training and technical assistance for emergency preparedness and planning, in relation to SRH in each country, supporting the priority areas within the Hyogo Framework for Action. This document describes these activities and presents what was learned from these efforts.

Background

The importance of planning and preparing for disasters is understood as a critical step to reducing loss of lives during emergencies.

Over the past two decades, the number of recorded natural disasters has doubled.⁴ In addition, vulnerability is growing in many countries due to a variety of factors, including urbanization, population growth, unplanned settlements, poverty and HIV prevalence.⁵ The ISDR was adopted by the United Nations in 2000 as a strategic framework to build resilient nations and communities, so that they are better prepared for such disasters. This helped to institutionalize DRR as a global priority. The Hyogo Framework for Action is the key instrument and global blueprint for implementing DRR activities. It aims to build resilient nations and communities and reduce losses from disaster by 2015, through five priority actions: 1) ensuring DRR is a national and local priority; 2) identifying, assessing and monitoring risks and enhancing early warning systems; 3) building a culture of safety and resilience at all levels; 4) reducing existing vulnerabilities; and 5) strengthening preparedness and response at all levels.

Disaster Cycle



Mitigation: The lessening or limitation of the adverse impacts of hazards and related disasters.

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 of

disaster-affected communities—including efforts to reduce disaster risk factors.

Response: The provision of emergency services and public assistance during or immediately after a disaster. Actions are taken in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected.

Recovery: The restoration and improvement, where appropriate, of facilities, livelihoods and living.

WRC Activities

During 2010 and 2011, the WRC provided technical, in-kind and financial support for activities to help countries realize priority actions for emergency preparedness and planning as they relate to SRH. Planning efforts in South Sudan were timely given feared instability connected with the then-upcoming national referendum in January 2011. Efforts in Uganda were motivated by the cyclical political and social instability in the north, and the frequent influx of refugees from neighboring countries such as Sudan and the Democratic Republic of Congo. In Haiti, disaster risk reduction efforts fit naturally within the process of recovery and reconstruction following the 2010 earthquake. In-country activities implemented by the WRC focused on three key objectives:

- 1) **Building the knowledge base around the Minimum Initial Service Package (MISP)⁶ for RH** to ensure full understanding of the priority SRH interventions to be implemented during the initial phase of an emergency;

Table 1: Activities conducted in each country			
Country	Uganda	South Sudan	Haiti
Participants	(National Level & Providers)	(National Level & Providers)	(Providers & Community Level)
MISP and DRR Training	<p>April 2010</p> <p>SPRINT conducts MISP regional training of trainers (TOT) for Ugandan partners</p> <p>October 2010</p> <p>SPRINT and WRC support MISP training, conducted by the national team, for providers and national-level planners</p>	<p>April 2010</p> <p>SPRINT conducts MISP regional training of trainers (TOT) for partners from South Sudan</p> <p>October 2010</p> <p>SPRINT and WRC support MISP training, conducted by the national team, for providers, and national-level planners</p>	<p>May 2010</p> <p>Inter-agency MISP assessment</p> <p>June 2011</p> <p>WRC, UNFPA and CARE support MISP and DRR training for select community-based organizations (representing vulnerable populations) and key international organizations</p>
Advocacy and Planning	<p>Spring 2010</p> <p>WRC conducts advocacy on SRH emergency preparedness among national-level stakeholders and providers</p> <p>October 2010</p> <p>WRC facilitates the development of action plans by training participants (national-level stakeholders & providers)</p>	<p>Spring 2010</p> <p>WRC conducts advocacy on SRH emergency preparedness among national-level stakeholders and providers</p> <p>October 2010</p> <p>WRC facilitates the development of a national-level SRH contingency plan</p>	<p>June 2011</p> <p>WRC facilitates the development of action plans by community-based organizations to implement SRH activities in their communities</p>
Follow-up	April 2011	March 2011	December 2011

2) **Building knowledge, understanding and available resources around DRR activities** so that government officials, program managers and communities understand why risk reduction is important, what their role could be within planning and what steps should be taken in preparedness efforts; and

3) **Advocating SRH in emergency preparedness at the national level** and supporting the development of DRR plans (at the community, district and national levels) that would lead to stronger, more inclusive and effective contingency and preparedness plans at the national level.

Activities in each country (see Table 1) were implemented through a partnership between the WRC and the SPRINT Initiative—an International Planned Parenthood Federation regional initiative, designed to address gaps

in MISP implementation in the East and South East Asia and Oceania Region (ESEAO) and Africa. The SPRINT Initiative focused on providing MISP trainings in each identified country, while the WRC focused on advocating SRH within emergency preparedness and planning at each level. Lessons learned from one setting were applied to the next, aiming to efficiently evaluate the capacities and challenges of different approaches.

South Sudan

In South Sudan, MISP training with an additional two-day planning exercise for contingency planning was provided to national-level stakeholders and humanitarian actors in October 2010. Participants subsequently developed an SRH contingency plan in preparation for the January referendum. As a result of these activities



Reproductive health kits can be procured in advance to ensure capacity to respond to a possible influx of displaced people.

and additional advocacy, national-level SRH contingency plans were developed and integrated with the health cluster contingency planning. RH supplies were pre-positioned, SRH focal points were identified and a mapping of available skilled staff was completed. These activities, the first of their kind, appeared to be very successful with regard to preparedness.

Challenges to implementation were identified following unexpected circumstances with regard to the referendum. Mass displacement, violence and insecurity, which the plans had focused on, did not ensue. Instead, low-level insecurity occurred, resulting in gradual, massive population movements, which had not specifically been planned for. Additionally, plans that were designed for an emergency phase appeared to still be in the process of implementation months after the referendum as a means to address the high numbers of returnees to the area. Organized and/or planned evacuations (including the encouragement of extended leave and vacations) of key staff, as well as high staff turn-over, also introduced challenges to the implementation of plans developed.

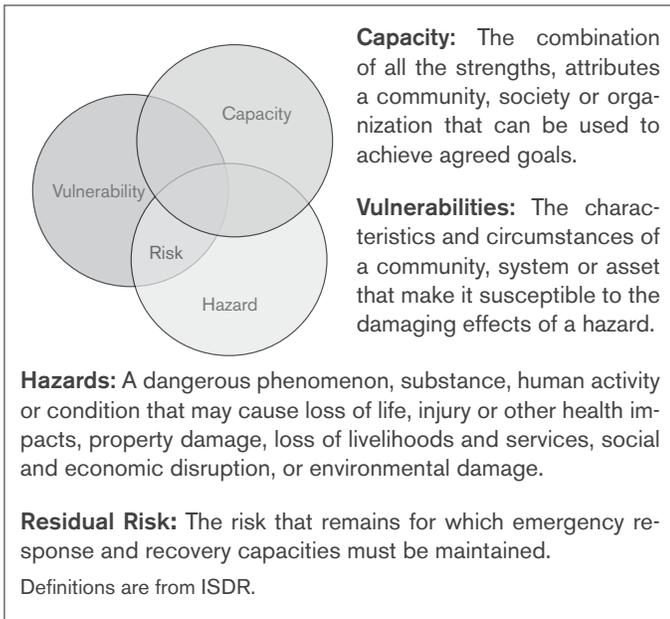
Plans did not appear to protect the pre-emergency planning structures from being overtaken by the humanitarian

response system. The WRC also noted that contingency plans and procurement lists had not been developed specific to the number of health facilities that were actually available and functioning in the various states. Calculations were based exclusively upon population size which served as a limitation during implementation. These factors are notable, and illustrate the importance of planning for specific circumstances: evacuations, parallel management structures, available capacity and various degrees of displacement and conflict. It is therefore recommended that planners:

- include community based organizations (CBOs) and local staff in planning and preparedness activities, to account for evacuations and staff turnover;
- develop contingency plans for different level emergencies and scenarios;
- ensure accurate procurement estimates based on population size, functioning facilities and available trained personnel;
- establish hand-over or communication structures between existing systems and the international humanitarian architecture.

Uganda

In Uganda, following months of advocacy at the national level for SRH incorporation into emergency preparedness plans, MISP trainings were implemented for key stakeholders. Those trained in the MISP by SPRINT subsequently developed action steps, with assistance from the WRC, that would promote the development of national contingency plans inclusive of SRH. While all action plans were not implemented, a number of steps were taken at the national level that facilitated the incorporation of SRH within emergency preparedness planning. As of March 2011, a draft National Policy for Disaster Preparedness and Management had been put on the agenda of the cabinet for a vote in April. Routine meetings were occurring within the DRR forum, led by the Office of the Prime Minister, with participation by training participants. Additionally, the Ministry of Health (MOH) had appointed an individual to focus on coordinating SRH in emergencies and a roll out plan for MISP



trainings to the Maternal and Child Health (MCH) “cluster” had been established. Also, several regions especially prone to natural disasters had been identified as priority areas for building the knowledge and capacity of district health teams. As an important preparedness action, RH kits⁷ were procured in advance of the referendum in South Sudan, to ensure capacity to respond to a possible influx of refugees into Uganda. These actions demonstrate the impact of advocacy and training efforts by SPRINT and the WRC with regard to the incorporation of SRH within emergency preparedness activities.

The challenges identified for this effort were time and money allocations for planned follow-up activities. It would therefore be recommended that:

- training activities themselves incorporate as much of the planning and collaboration activities as possible;
- knowledge regarding SRH preparedness could start to be incorporated within already existing education platforms (such as through schools of public health or within midwifery training curricula). Professionals could be trained in key activities for SRH emergency preparedness and response.

Haiti

In Haiti, observations from Uganda and South Sudan led to a slightly different approach to emergency preparedness and planning: the focus was put on efforts to build the capacity of civil society to prepare for and respond to SRH needs in an emergency. In a crisis, community members are frequently the first responders and therefore need information about priority SRH actions. Additionally, communities (and especially the most vulnerable groups) need to be involved in planning and preparedness efforts in order to ensure equitable access to effective warning systems.

In June 2011, the WRC conducted a MISP and DRR training for civil society groups, and specifically CBOs serving marginalized and vulnerable groups. The MISP training was followed by a training on DRR, including methods for conducting participatory rural appraisals, and a targeted activity to develop CBO-specific action plans. By incorporating organizations serving youth, persons living with HIV and AIDS (PLWHA) and persons with disabilities, ideas were generated during the training time itself about capacities and challenges for vulnerable communities during an emergency and how such groups could be better incorporated into national-level DRR activities and emergency preparedness plans. Due to the involvement of United Nations Population Fund (UNFPA), CARE and other key international NGOs in this training, many civil society groups were connected with the standing inter-agency RH working group led by the Ministry of Health and UNFPA at the national level. Upon returning to their communities, some CBOs were able to implement their action plans, including activities within their communities to improve education and awareness about the MISP and DRR. Through the training activities, CBOs consistently demonstrated their capacity to be involved in emergency preparedness and response, but were limited in their support to do so. Unfortunately, the inability to connect the CBO training to the national DRR planning exercises demonstrated a key weakness of the WRC’s collaborative effort. Additionally, CBOs lacked funds and support to implement small-scale preparedness activities at the community level. It is therefore recommended that:

- efforts to support and build the capacity for civil society should be linked to advocacy efforts at the national level to incorporate the strengths and capacities of civil society into emergency planning and response;
- CBOs be provided with funding and ongoing support to complete action plans developed.

Follow-up visits, which captured much of the information above, were conducted in all sites, five months on, to gauge the effectiveness of the activities in accomplishing planning and preparedness activities related to SRH.

Lessons Learned

Activities implemented in each country provide insight into practices that could be promoted to ensure the inclusion of SRH within emergency preparedness and response. Implications of emergency preparedness and planning efforts could only be evaluated in South Sudan (which faced a small-scale crisis), but each country offers lessons for the process going forward, including:

- Contingency plans are national-level, multi-sectoral documents for emergency preparedness that should articulate, at the very least, steps to maintain the minimum priority SRH services as noted in the MISP. These include plans to maintain functional referral hospitals, systems to refer and transport patients experiencing an obstetric emergency, systems to protect vulnerable populations (women, girls, disabled, PLWHA and the elderly) from sexual violence and the ability to provide post-exposure prophylaxis (PEP) and emergency contraception, as well as maintain standard precautions for the prevention of HIV transmission. Additionally, contingency plans should identify central locations and required quantities for RH kits to be pre-positioned before an emergency. Calculations for RH kits should be based on population size, number and type of health facilities and available trained personnel—numbers to be compiled prior to any crisis.
- Facilitated contingency planning exercises conduct-



Midwives hold up a clean delivery kit after the tsunami in Aceh, Indonesia, 2005.

- ed with national policy makers (RH focal points, Ministry of Health and NGOs) can be immensely productive when linked with a MISP training event.
- Trainings on the MISP that encourage participants to take next steps for DRR, but do not include time during the training for action planning, allocate funding or provide national-level support, are less likely to be effective.
- Contingency plans will face multiple challenges if all levels (inclusive of providers and CBOs) are not incorporated into planning and preparedness activities.
- CBOs, and those specifically working with vulnerable populations, have immense capacity to prepare for and respond to emergencies.
- Emergencies are complex, and response plans that do not account for many possible scenarios and challenges may not be realistic or applicable.
- First responders, including providers, are eager to learn steps that they can take to better prepare for and respond to emergencies.

Recommendations

- Trainings on the MISP and DRR, including contingency planning, should be conducted at all levels (national, sub-national and community) to build and maintain knowledge. Efforts should be made to ensure linkages between these systems.
- National-level policy maker training (RH focal points, MOH and NGOs) on the MISP can be combined with a specific activity to guide the development of a national contingency plan incorporating SRH.
- Steps should be taken to systematically include CBOs and groups representing vulnerable populations within emergency preparedness planning (ensuring warning systems are accessible, that education is widespread and unique vulnerabilities are considered) and response plans. Communities should be involved from the earliest phase of emergency preparedness and planning.
- Contingency plans should assume high staff turnover (including through standard evacuation) and an exacerbation of existing capacity limitations (facilities, supplies, equipment, staffing, transport, etc.). Plans should also consider multiple scenarios—both large-scale and smaller-scale crises.
- Plans and protocols for shifts in power and roles among already existing coordination bodies and those set up to respond to emergencies (cluster system) should be incorporated into disaster plans.

Conclusion

National, sub-national and community efforts to incorporate SRH into DRR are in their early phases. The implementation of activities across these three settings offers a base of knowledge, which must continue to be built upon. It is essential to continue to expand our knowledge base of effective practices that may help us to achieve more resilient communities and systems, to better respond to SRH needs in emergencies. This critical effort will ultimately reduce SRH morbidity and

mortality during disasters, and also ensure that all members of a population have equitable access to preparedness and response systems.

Notes

¹ 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.

² APWLD (2005) "Why are women more vulnerable during disasters?" Asia Pacific Forum on Women, Law and Development, NGO in consultative status at UN ECOSOC.

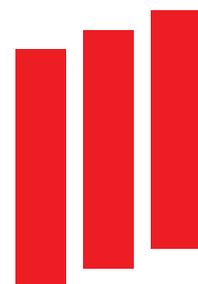
³ Neumayer E & Plumper T: 'The Gendered Nature of Natural Disasters: the impact of catastrophic events on the gender gap in life expectancy, 1981-2002': LSE available at: <http://www2.lse.ac.uk/geographyAndEnvironment/whosWho/profiles/neumayer/pdf/Disastersarticle.pdf>

⁴ UNISDR and UNOCHA (2008). Disaster preparedness for Effective Response: Guidance and indicator package for implementing priority five of the Hyogo Framework. Introduction, page 9. <http://www.preventionweb.net/english/professional/publications/v.php?id=2909>.

⁵ Ibid.

⁶ The Minimum Initial Service Package (MISP) for Reproductive Health is a widely accepted standard for SRH in humanitarian settings. It is a set of minimum priority actions, to be implemented in the earliest days and weeks following an emergency, to ensure a reduction in death and illness. www.misp.rhrc.org.

⁷ The RH Kits, procured through UNFPA, are intended for use at the onset of the humanitarian response and contain sufficient SRH supplies for a three-month period for different population numbers, depending on the population coverage of the health care setting for which the kits are designed.



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