SPRINT STAGE 2

CONCEPT NOTE

21 MARCH 2011

Introduction

Complications and problems related to sexual and reproductive health (SRH) are the leading cause of women's death and ill health globally. SRH, as defined at the UN International Conference on People and Development (ICPD) in Cairo, 1994 includes a wide variety of services such as family planning, safe motherhood, prevention and care of sexually transmitted infections (STIs) including HIV, and active prevention of harmful practices such as female genital cutting and sexual and gender-based violence. SRH was discussed at the Fourth World Conference on Women in Beijing in 1995. It concluded that some of the reasons why many of the world's people do not benefit from reproductive health services were:

"...inadequate levels of knowledge about human sexuality; inappropriate or poor-quality RH information and services; the prevalence of high-risk sexual behaviour, discriminatory social practices; negative attitudes towards women and girls and the limited power many women and girls have over their sexual and reproductive lives..."

Refugees and displaced populations are faced with even greater difficulties in obtaining SRH services, including the breakdown of pre-existing family support networks which mean that young men and women lose their traditional sources of information, assistance and protection; women becoming solely responsible for the welfare of their families which represents an emotional and physical burden that is not addressed by any services; and attention to immediate life-saving measures in which SRH is not considered a priority. That is, in a crisis, SRH needs and vulnerabilities increase at the same time as access to services decreases. The desperate circumstances of refugees and IDPs fleeing conflict or disasters places them at exceptional risk of pregnancy and sexual and gender based violence-related death, illness and disability.

Context

SRH in crises affects a large cross section of the population. Women bear the greatest burden of reproductive ill-health. Approximately 25% of women of reproductive age in any refugee population will be pregnant at one time. As with all women, 15% will suffer from unforeseen complications of pregnancy and childbirth. A study in selected camps in Pakistan in 1999-2000 indicated that maternal and neonatal deaths comprised 22% of all recorded deaths, more than any other category. The majority (60%) of infants born to women who died of maternal causes were either stillborn or died soon after birth.

Conflict and displacement increase people's vulnerability to sexually transmitted infections (STIs). Greater sexual violence or increased risky sexual activity, commercial sex, forced migration, psychological stress and the collapse of health services all imply a heightened risk of

infection. 17% of women who survived rape during the conflict in Rwanda tested positive for HIV.

Gender-based violence (GBV), in particular sexual violence, including domestic violence, rape, female genital cutting, forced marriage, sexual trafficking or sexual abuse, is especially problematic in complex emergencies and natural disasters, where women and children are often targeted for abuse, and are the most vulnerable to exploitation, violence and abuse because of their gender, age, lack of adequate protection and status in society.

An effective SRH program takes into account the different needs of men and women, and the different needs of various age groups. It must be accessible and available to all segments of society, including single women, widows, older women, adolescents, unaccompanied minors and men. In addition to the bio-psycho-social needs, it is important that SRH be consistent with moves in recent years that humanitarian assistance be provided within a human rights framework rather than a needs based approach. Increasing women's agency increases their own ability to lead safe lives, helping them to avoid those unsafe circumstances that put them at risk, such as exchanging sex for goods or protection.

International Framework

In addition to the three main international legal documents that make reference to an obligation to address SRH - the Universal Declaration of Human Rights, the Convention on the Rights of the Child and the Convention on Elimination of all Forms of Discrimination Against Women - there is a comprehensive international framework covering reproductive health. These have been developed over the past 17 years and include the International Conference on Population and Development Programme of Action, 1994, the Guiding Principles on Internal Displacement, the IASC Gender Handbook for Humanitarian Action, the IASC Guidelines on Gender-based Violence Interventions in Humanitarian settings, UNAIDS Guidelines for HIV/AIDS interventions in emergency settings, the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, Addressing Conflict-Related Violence: Analytical Inventory of Peacekeeping Practice, UN Security Council Resolution 1325 on Women, Peace and Security, 2000 and the International Strategy for Disaster Reduction. The MISP (Minimum Initial Service Package for Reproductive Health, see below) is also included as a minimum standard in the Sphere Project and meets the life-saving criteria for the UN Central Emergency Relief Fund. (A more comprehensive description of the international framework is at **Annex 1**)

The Minimum Initial Service Package (MISP)

In 1995, the Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations (now the Inter-Agency Working Group in Crisis Situations), a group of some 40 United Nations, academic, research, governmental and non-governmental organizations, came together to develop guidance on how to address SRH for refugees. The resulting field manual articulated the Minimum Initial Service Package (MISP) for Reproductive Health, a set of priority activities to be implemented during the onset of an emergency – both conflict or natural disasters.

The goal of the MISP is to reduce mortality, ill-health and disability amongst populations affected by crises, particularly women and girls. If it is implemented in the very early stages of a

crisis, the MISP saves lives and prevents illness by providing an agreed approach and set of guidelines to meet SRH needs in such environments. The MISP is not simply a set of kits comprising equipment and supplies but a structured set of actions that must be undertaken in a coordinated manner by trained staff. The MISP concept includes: human resources, guidelines and training for the implementation of the interventions, material resources, including essential drugs and basic equipment. (A full description of its components is at **Annex 2**).

The MISP comprises five key objectives :

- Identifying a lead SRH organization to facilitate implementation of the MISP;
- Preventing sexual violence and providing appropriate assistance to survivors;
- Reducing the transmission of HIV;
- Preventing excess maternal and newborn death and disability;
- Planning for the provision of comprehensive SRH services, integrated into primary health care as the situation permits

The MISP has also recently been revised to include three additional life-saving activities:

- The syndromic treatment of STIs
- Provision of contraceptives
- Provision of anti-retrovirals for existing users

The MISP cuts across all sectors, including the humanitarian response priorities of food security, water and sanitation and shelter. It should be provided within the context of these critical priorities. In addition, it should be coordinated with other sectors/clusters, particularly protection and early recovery.

The MISP therefore is specifically designed to facilitate the rapid and appropriate delivery of SRH services in the initial acute phase of an emergency situation and to plan for services as the situation develops. It is equally important that it be mainstreamed into national Disaster Risk Reduction policies and plans.

The Problem

Unfortunately, implementation of the MISP is far from universal and despite the fact that the MISP is an internationally accepted minimum standard of care, its implementation during crises has been inconsistent. Despite the international framework endorsing the need for SRH services in crises, considerable progress in defining the MISP, promoting awareness of it, and incorporating it in important standards, assessments undertaken by the Women's Refugee Commission and the IAWG have consistently demonstrated that the MISP is not implemented in emergencies. Despite the increased need for reproductive health care during crises and the greatly reduced access to care, the damages to infrastructure, displacement of skilled health workers and the focus on acute trauma that often characterize health responses during crises, critical SRH needs are not being met.

In 2004, the IAWG carried out a global evaluation of SRH in humanitarian settings and a number of assessments of SRH and MISP implementation in specific crises have been carried out including Haiti post earthquake response, May 2010; Jordan, Iraqi refugee influx – Sept 2007, February 2009;Northern Uganda, LRA rebel regional conflict – June 2007, August 2009; Kenya, in the aftermath of post election violence – October 2008;Thai/Burma border – April 2006; Aceh, post Tsunami response –February 2005; and Pakistan, Afghan refugee crisis – October 2003.

Overall, primary gaps were identified that revealed:

- SRH is not prioritized in an emergency
- Poor implementation of the priority SRH services outlined in the MISP
- Lack of responders qualified or trained to implement the MISP
- Response efforts often not well coordinated, particularly between national and international actors
- Lack of awareness of the MISP amongst humanitarian actors
- Dedicated funding to implement the MISP is often not pursued by humanitarian agencies nor adequately funded by donors

The SPRINT Initiative

The SPRINT Initiative was designed to address the gaps in MISP implementation at the regional and national levels identified in the 2004 IAWG global evaluation of SRH in humanitarian settings. The first three year stage was solely funded by AusAID.

Policy

The SPRINT Initiative is consistent with AusAID's Humanitarian Action Policy which notes the importance of protection of life, health, subsistence and physical security to counteract social instability, reduce vulnerabilities and strengthen local capacities. The policy has a particular focus on increased participation by beneficiary governments and communities in all levels of activities which coincides with the SPRINT approach of building the capacity of national actors. A key focus of SPRINT is ensuring coordination among the humanitarian agencies in the SRH response to a crisis.

The goal of AusAID's Disaster Risk Reduction Policy is to reduce vulnerability and enhance resilience of communities to disasters. Disaster risk reduction (DRR) forms a large part of the Initiative's work through building the capacity of national actors on the priority SRH activities to implement in a crisis and facilitating the development of national action plans to address national and local policies, health systems, human resources, and other key factors access to SRH services in crises.

AusAID's Peace, Conflict and Development Policy highlights humanitarian relief, support to refugees and internally displaced persons and support for women and children as key methods to address the negative effects of conflict and potentially influence lasting peace and stability. The M&E component of SPRINT includes an MOU with University of New South Wales (UNSW)

which supports four in-depth research projects to build the body of evidence around SRH in humanitarian settings.. Each of the research projects examines different aspects of the SPRINT Initiative and all findings are documented and fed back into SPRINT's ongoing programming and design. This links directly with AusAID's Development Research Strategy 2008-10.

SPRINT falls within the scope of the Australian Government support for regional and multi-country activities, and its commitment towards MDGs 4 and 5 on maternal and child health, in particular in Africa. SPRINT is also consistent with AusAID's policy on social inclusion and with AusAID's approach to the advancement of gender equality – a major underpinning of the aid program.

SPRINT Stage 1

The goal of the first stage of SPRINT was to increase access to SRH information and services for populations surviving crises and living in post-crisis situations in the East, Southeast Asia and the Oceania Region (ESEAOR).

SPRINT uses a three-pronged approach to achieve its goal:

1. Increasing national capacity to coordinate and implement MISP in conflict and natural disasters;
2. Supporting advocacy to governments and organizations to integrate SRH into their emergency preparedness and response plans; and
3. Providing funding and technical assistance for implementation of the MISP in crises.

That is, it provides the enabling environment. The essential elements of Stage 1 were advocacy and capacity building, particularly the training of field worker experts in the MISP through 5 day regional training courses, 3 day in-country trainings and the establishment of a regional network of field workers ready to be deployed. Over 4300 workers from 81 countries have been trained in the MISP. Policy changes have been completed or are underway in 14 countries to advance SRH in emergencies. UNFPA, IFRC and other humanitarian actors have started to integrate SRH in crises into their programming.

Capacity Building Strategy

Capacity building is integral to SPRINT's goal. The capacity building strategy aims to:

- Establish country coordination teams
- Provide the country coordination teams with the necessary knowledge, skills, tools and support to undertake preparedness activities and coordinate a response to SRH needs in crisis situations.

A core component of the capacity building strategy is training, undertaken at regional, national and local levels. Initial five-day regional training workshops are conducted by experienced trainers from the Initiative itself. Identified participants from these regional trainings subsequently become master trainers and roll out in-country trainings based on the SPRINT curriculum at the national level. Master trainers in turn identify local actors with expertise in

various aspects of the MISP to undertake in-country training. Participants at both regional and national training workshops are selected from the SRH, health, emergency management and gender sectors and include selected key staff from Ministries of Health, international NGOs UN agencies, national NGOs, national disaster management authorities and community based organizations. Participants are required to demonstrate that they meet prior knowledge and experience pre-requisites and have institutional support and are selected so as to form a comprehensive team of key actors best placed to respond to SRH needs in crisis situations.

However, while training is a cornerstone of the capacity building strategy, it is not a standalone capacity building activity. It requires work before and after training by both the SPRINT Initiative and trainees. SPRINT workshops are therefore buttressed by extensive pre-training and post-training interventions and informed by a continual research-feedback loop. These interventions help to identify and engage existing in-country actors and systems, build coordination mechanisms and relationships prior to and during the training, and provide links to the wider advocacy and policy change work of SPRINT. Following country coordination team training, the regional secretariats provide guidance and technical support to assist trainee advocacy work, preparedness activities and implementation during crises; and assist with the incubation of communities of practice amongst trainees and link trainees to global and regional communities of practice.

Country Coordination Teams

The original concept of simply establishing regional training programmes and in-country training in order to build the capacity of individual SRH workers in emergency responses quickly evolved into the development of country coordination teams. Country coordination teams are formed during SPRINT regional trainings on the MISP. Three to five representatives involved in SRH in emergencies are identified from each country throughout the region and constitute the core team. These representatives are selected from Ministries of Health/National Disaster Management Units, UNFPA, WHO, national Red Cross/Crescent, NGOs, IPPF Member Associations, academic institutions and other relevant organizations. Each country coordination team develops an action plan to advance SRH in their own setting. In Mongolia, for instance, the country coordination team held an in-country SPRINT training in 2009. As a result, the team led a working group on SRH in crises with a specific Terms of Reference outlining the parameters of their collaboration. The group has successfully advocated for the inclusion of the training on SRH into the National Disaster Preparedness Plan as part of routine preparedness.

The Millennium Project has pointed out that the recognition of the importance of SRH has been hindered by the complexity of the concept. Different components of SRH fall within the province of different sectoral Ministries, challenging coordinated national responses. Many SRH issues have also been distributed among various MDGs (maternal health, child mortality, gender equality, HIV/AIDS) and family planning was initially excluded from the Goals, reducing priority attention (now in MDG 5B).

The advantage then of the country coordination teams is that it brings together a group of people with responsibility in all such areas, including emergency and development areas, but who would not otherwise have met, building their skills in preparation and response and allows them to plan for the implementation of SRH in responses and in DRR plans. Such plans mean that when a response occurs, there is less delay. Everyone understands their role and tasks. Even more

importantly, it means the response is not dependent on outside help. For example, in Burma, after Cyclone Nargis hit in 2008, the country coordination team immediately established an SRH/HIV working group under the health cluster to coordinate the implementation efforts. The working group integrated the MISP in humanitarian appeals, including the Flash Appeal and CERF, and distributed RH kits throughout the affected area. UNFPA Myanmar has noted "Without the SPRINT Initiative, the reproductive health needs of vulnerable people would have been forgotten".

SPRINT therefore supports national capacity to respond to lifesaving SRH needs in crises as well as building future capacity of SRH service providers at the national and community level. A critical aspect of the functioning of the country coordination teams which ensures they have real influence and are not just another working group is that they are made up of people at a high enough level in their own organization to have sufficient authority to make the decisions to ensure SRH is implemented in crisis responses or in DRR plans. All this means systemic changes occur resulting in a high level of sustainability, illustrative of one of the most fundamental guiding principles of development.

Disaster Risk Reduction

A gap in global policy on SRH in crisis was identified at the May 2010 IAWG conference. Participants, in light of the Haiti disaster, recognized that while global policy and guidelines exist to be applied at the onset of crisis (the MISP) and during early recovery (the Granada Consensus) there is currently no global guidance on how to better mitigate life-threatening SRH risks *before* a crisis (man-made or natural) strikes. By focusing on risk mitigation and preparedness, participants felt response efforts would be greatly improved. Consequently, key global stakeholders including WHO, UNFPA, UNHCR, the Women's Refugee Commission, CARE International, IFRC, ICRC, and representatives from SPRINT came together to form a dedicated SRH sub-working group under the Health Thematic Platform of the UN International Strategy for Disaster Reduction (ISDR). The working group is tasked with developing global policy recommendations as well as field guidance on SRH during the mitigation and preparedness phases of the emergency management response cycle. Empowering women to have an increasing role in leadership, management and decision making positions is an essential element of disaster risk reduction. (See **ANNEX 3** for key recommendations.)

The SRH working group is looking to SPRINT as the global leader in implementing these recommendations on the ground and for technical advice and input on the effectiveness of global recommendations. The working group's forthcoming global policy brief and guidance note will showcase SPRINT case studies as models for global replication.

SPRINT sits on the International Strategy on Disaster Reduction's (ISDR) Task Force on SRH & DRR, along with UNFPA, UNHCR, WHO, IFRC, CARE and the Women's Refugee Commission, to develop the first global guidance on integrating SRH into DRR strategies. It also makes linkages between DRR, SRH and **climate change.** For example, in Bangladesh, one of the countries worst hit by climate change, the country coordination team has integrated SRH into its training for service providers, as part of its climate change survivors project.

The first phase of SPRINT highlighted the need to engage more holistically with the disaster management cycle in order to achieve its objectives. Initially, country teams were asked to identify and address certain aspects of DRR/Emergency Preparedness, (for example the ordering of supplies for emergencies), but other important areas also emerged as critical. As a result, SPRINT has started to situate its approach within a specific DRR/EP framework to address all the relevant factors before an emergency. In Stage 2, regional secretariats will engage with country coordination teams to develop strategies to assess and systematically address SRH/DRR issues in their national setting.

SPRINT Structure

The Initiative is coordinated by IPPF regional secretariats in East, Southeast Asia and Oceania Region (ESEAOR) based in Kuala Lumpur and Africa (AR) based in Nairobi (the latter funded by AusAID beginning in the second year of Stage 1 in response to Australia's expanded program of assistance to Africa). Key partners include UNFPA, UNHCR, University of New South Wales (UNSW) and the Women's Refugee Commission. (A full description of partners and their roles is at **ANNEX 4).**

It was envisaged that collaboration between IPPF (with its large number of Member Associations (national Family Planning / SRH Associations) throughout the world) and the IAWG, combined with technical guidance from UNFPA Humanitarian Response Branch, would push forward the agenda of SRH for vulnerable populations in crisis situations.

Levels of Engagement

The Initiative operates at three levels – country, regional and global.

The first stage of SPRINT was initially focused at the regional and national level with the regional secretariats providing support to the country coordination teams. However, through monitoring and analysis (particularly through the UNSW researchers), the need to establish strategic linkages with the global level (e.g. IAWG MISP Working Group, ISDR DRR and SRH Task Force) and other regional players (e.g. UNFPA regional humanitarian focal points) was identified. The regional secretariats began to engage at the global level to feed into policy development advocacy for the advancement of the MISP and share lessons learned from the field (see Indonesia Case Study plus the impact SPRINT has had on other regions at **Annex 5**).

At the country level, policy, capacity building and implementation activities are carried out by country coordination teams. The SPRINT regional secretariats in Kuala Lumpur and Nairobi work closely with the country coordination teams to support their work in-country by providing technical assistance and small funding during acute emergencies and in protracted settings, supporting and guiding the teams advocacy and DRR efforts, conducting monitoring, overseeing quality of in-country trainings, spearheading linkages between team members and regional and global agencies and individuals, developing and disseminating locally contextualized resources and ensuring teams are up to date with the latest developments and policies coming from the regional and global level (e.g. latest CERF guidelines, changes in the MISP, etc).

At the regional level the SPRINT regional secretariats collaborate closely with key regional partners such as UNFPA, IFRC and UNHCR to negotiate for the advancement of SRH in

emergencies at regional and global levels, and provide support to regional humanitarian agencies working to integrate SRH into their programming.

At the global level, SPRINT works within the already established international framework on SRH to carry out the, unfortunately still necessary, advocacy to incorporate SRH into crisis responses. To date, engagement at the global level has primarily been coordinated by the ESEAOR regional secretariat, as the original pilot model. As well as advocacy, work includes engaging the global level through the IAWG and other key partners to ensure lessons from SPRINT are fed into the development of new international guidelines and resources on SRH in emergencies. Strategic partnerships with advocacy agencies such as the Women's Refugee Commission, leading the UNISDR RH sub working group on DRR as well as the IAWG MISP sub working ensures SPRINT's experiences in the field inform the global SRH agenda. SPRINT's partnership with UNFPA's Humanitarian Response Branch is a symbiotic one; SPRINT field experience informs UNFPA's humanitarian global priorities, regional and national response plans while UNFPA HRB technical expertise supports SPRINT's country teams, training curriculum, and crisis response efforts.

At the national and regional level, SPRINT's strategic partnership with the Australian Reproductive Health Alliance (ARHA) supports awareness raising and advocacy of SRH in crisis amongst Australian Parliamentarians and the general public. In addition, SPRINT and ARHA have targeted trainings on SRH to the Australian Defence Forces who are increasingly becoming responders to crises in the region.

SPRINT Stage 2

Goal

The first stage of the SPRINT Initiative achieved a great deal in laying the ground work and developing a model for the further work needed to provide SRH services to crisis affected populations. The goal therefore remains much the same: that crisis-affected populations have timely access to life-saving sexual and reproductive health services.

Strategy

Stage 2 strategy will be to:

- Build onto best practices of SPRINT (capacity building, advocacy, technical assistance and funding);
- Further integrate the DRR framework into SPRINT;
- Focus and strengthen country coordination teams in priority countries;
- Strengthen partnerships at the global, regional and national levels;
- Fully develop the M&E framework

In order to fulfill the goal, it is proposed to scale up the delivery approaches that have been recognized to be promising or successful under Stage 1. These include:

a. Capacity building of country coordination teams through:

- Regional and national trainings using the SPRINT curriculum
- Ongoing remote and in-country technical assistance
- Surge capacity
- Development of clearer guidance for country coordination teams, including TORs and revision of the action planning matrix template
- Ongoing facilitation of a national and international community of practice to enhance South to South collaboration

b. Advocacy and standard setting activities to foster an environment supportive of SRH in crises, including:
   - Ongoing collaboration with IAWG partners
   - Continued participation in global standard setting mechanisms, including the ISDR SRH/DRR Task Force and the IAWG MISP Working Group
   - Ongoing participation in regional IASC
   - Technical support to other international humanitarian and development agencies to integrate SRH in crises into their programming
   - Advocacy to the Global Health Cluster and other clusters/sectors to prioritise MISP
   - Participation in national, regional and international forums

c. Research, monitoring and evaluation, including:
   - Strengthening of internal M&E systems
   - Assessments of country teams' coordination of the SRH response in emergencies
   - Ongoing partnership with UNSW and other research institutions associated with regional secretariats

Outcomes

Outcome 1: increased capacity at global, regional, national and local levels to coordinate the implementation of the MISP

- Building on the country coordination team approach and the development of a TOR outlining the roles and responsibilities of each member
- Improving the SPRINT capacity building model through a revised regional trainings curriculum designed to improve MISP coordination which in turn will train a national pool of humanitarian workers
- Strengthening the capacity building continuum by providing support before, during and after the regional and in-country trainings
- Advocating to other humanitarian agencies for SRH focal point training through the development of additional one or two day training to specifically train the overall SRH focal point who leads the SRH coordination mechanism
- Advocating for a rapid deployment/roster system, i.e. the development of a MISP Standby Capacity project modeled after the IASC Gender Standby Capacity (GenCap) project.

Outcome 2: The humanitarian policy and funding environment is increasingly supportive of SRH

Advocacy

- Inclusion of SRH into DRR processes to make them more resilient and able to absorb impacts, adapt and respond and recover more effectively to crises; using global platforms participate in developing policy guidance for inclusion of SRH into DRR
- Providing technical support to each country coordination team to assist in working towards an enabling environment for SRH in crises by advocating for the MISP in their respective agencies and at the national level; and my mainstreaming SRH into DRR processes
- With IAWG partners, meet with key representatives in the IASC Cluster System to prioritise the MISP in the Cluster System
- Support country coordination teams to include MISP in humanitarian appeals
- Continue to advocate and provide technical support to other international humanitarian agencies to integrate SRH in crises into their regular programming

Standard setting

- Provide continuous leadership on SRH in crises through active engagement with the IAWG, particularly through the already established IAWG regional chapters that bring together policy makers, humanitarian and development actors to work on SRH issues
- By working with the IAWG Training Partnership, work to integrate the SPRINT curriculum on MISP coordination into national pre-service, postgraduate and on-the-job curricula.

Outcome 3: An increased number of humanitarian settings put key coordination mechanisms in place in an emergency to ensure effective MISP implementation

- SPRINT will continue to serve as a convenor by supporting the operationalistion of the SRH country coordination teams in an emergency; country coordination teams to act as the basis of an SRH Task Force under the Health Cluster.
- Provide more in-person support for surge capacity – not a replication of the old humanitarian response model of international staff flying in for short periods of time without building or supporting local capacity - but a 'twinning' arrangement of staff at the onset of the crisis. SPRINT staff would provide technical assistance to country teams to establish an SRH Task Force under the Health Cluster, identifying an overall SRH focal point, etc but would not lead the actual response itself. This is distinct from the rapid deployment system of SRH coordinators outlined under Outcome 1.

Capacity Building

Capacity building will remain the cornerstone of the Initiative. Stage 2 will build on the country coordination team approach by formalizing the process of in-country consultations to identify training candidates with the experience, disposition, qualifications and organizational position that individually and collectively best matches the outcome expectations of SPRINT country

coordination team training; by systematizing pre-training advocacy efforts with targeted individuals and their organizations to maximize alignment of individual and organization expectations, needs, mandates and work time allowances with the trainings objectives; and by further developing pre-training activities, including joint vulnerability assessments on which action planning work during the training can be based; and joint problem based learning activities to engage prior knowledge of participants before the training.

In Stage 2, the regional secretariats will engage strategically with country coordination teams and will facilitate the development of a Terms of Reference for each country team, delineating both the role of the team and the role of each individual team member, as well as a country strategy to advance the MISP throughout the disaster management cycle.

Levels of Engagement - Inter-regional secretariat

In Stage 2, the different levels of SPRINT's engagement will be more clearly delineated by the establishment of an inter-regional SPRINT secretariat to coordinate and ensure cross fertilization among the regional secretariats as well as participate in global mechanisms. The inter-regional SPRINT secretariat will act as the focal point and main management hub for the Initiative. The regional secretariats will continue to collaborate with regional partners and provide support to country coordination teams. At the national level, the country coordination teams will be formalized through the development of a country strategy and TOR. The relationship between the different levels of SPRINT will be clearly articulated to ensure consistent communication and feedback loops.

Priority countries

SPRINT cast a wide net at the beginning of the pilot project in ESEAOR and trained people from 30 countries throughout the region. However, a more focused, strategic approach with select priority countries based on highest humanitarian need is essential in the next stage (e.g., five to six countries in ESEAOR and three to four countries in South Asia). This would allow the regional secretariats to develop clear strategies of engagement with each priority country coordination team to address SRH throughout the disaster management cycle. Suggested and indicative priority countries include: **ESEAOR** – Burma, Indonesia, Papua New Guinea, Philippines, Timor-Leste and Solomon Islands: **South Asia** – Afghanistan, Bangladesh, Pakistan and Sri Lanka: In case of an emergency striking other countries, SPRINT will also consider intervening to support the country coordination team in their implementation of the MISP. **Africa** - SPRINT has partners and Country Coordination Teams in 38 countries, from Zimbabwe to Maghreb. Those countries were already prioritized within the SPRINT Africa partners (IPPF, UNFPA and UNHCR). Given the high level of risk of each country, the Secretariat will rather adapt its support to those countries than select priority countries. For most of the countries not facing recurring humanitarian settings, the Secretariat will follow up on their emergency preparedness plans, provide remote technical support for MISP implementation and policy change initiatives. For the countries facing humanitarian situations, the support of SPRINT will be more in-depth, and would combine remote support with in-country missions. SPRINT Africa will also be available to support the Country Teams in any emerging crisis.

Human resources

Lack of human resources in the regional secretariats (with only 2 fulltime staff in ESEAOR and 2 other fulltime staff in the Africa Region) and the lack of an inter-regional coordinating body were primary factors constraining Stage 1 of the initiative. Stage 2 of SPRINT will address this through the development of the inter-regional SPRINT secretariat which will include administrative and finance support. Additional operational support staff are also essential for the regional secretariats. UNFPA in Geneva will continue to provide technical advice and training support to national Universities – particularly to train cadres of people (doctors, midwives, etc) who can be pulled in during emergencies. This arrangement will be formalized in Stage 2, both to ensure UNFPA HRB support continues and to help UNFPA HRB to better plan for its own activities. This would involve no financial cost to SPRINT.

Monitoring and Evaluation

In Phase I the SPRINT regional secretariat based in Kuala Lumpur has managed the monitoring and evaluation of the Initiative at the country, regional and global level.

At the country level, the SPRINT regional secretariat monitors the activities and outcomes of a total of 27 country teams in policy, capacity building and implementation through follow up with country team members, training reports and field assessments, the key achievements of which are documented in a Monitoring and Evaluation Matrix, donor reports and e-updates. Since the regional secretariat formed in Africa and the IPPF focal point in South Asia Region has taken on the role of SPRINT focal point these two regions have managed their own country level M&E. The ESEAOR regional secretariat though has been primarily responsible for overseeing monitoring of all regional and global level work.

The significant workload of monitoring global and regional level work in addition to the 27 country teams has meant the level of monitoring carried out by the ESEAOR regional secretariat has not adequately captured the impact of the SPRINT Initiative. In Stage 2 a more systematic Monitoring and Evaluation system will be implemented to monitor the impact of the SPRINT Initiative at the various levels at which it operates.

In Stage 2, SPRINT regional secretariats will focus on individual country monitoring plans for the priority countries (approx. five to six in ESEAOR) to capture impact at the country level. These plans will be closely tied to the country action plans developed by country coordination teams. Regional secretariats will also integrate more robust M&E systems into their daily work to ensure the impact of their regional and country strategy is captured.

The inter-regional SPRINT secretariat will ultimately be responsible for analysing and synthesising the lessons across the regions and feeding back into regional program strategies. It will also be the focal point for monitoring the impact of SPRINT's engagement at the global level.

In addition to these internal monitoring mechanisms SPRINT benefits significantly from the external research being carried out by 4 PhD students from University of New South Wales. Unlike other Initiatives the external research component is built into the Initiative's ongoing monitoring system. The feedback loop between researchers and the SPRINT Regional secretariat

has been crucial in informing the strategic direction of SPRINT over the last three years. For example, extensive engagement with SPRINT trainees and research into the impact of training models on transfer of learning has been key to refining the capacity building strategy and identifying what is needed to strengthen processes in Stage 2 of SPRINT.

Risks

The risks associated with this program are primarily associated with housing a humanitarian initiative within a development agency such as IPPF. These risks have been identified in the pilot phase and strategies to address them are outlined above (see 1.4 Lessons Learned/Organizational Support.) Other risks include the heavy reliance on partnerships through SPRINT's inter-agency country team approach. SPRINT does not have leverage with the members of a country team like it would if it were solely focused on IPPF Member Associations. However, the inter-agency approach is also the key to SPRINT's success. It is working to formalize these relationships through MOUs and TORs which will help build in leverage.

A further risk is that of having only one donor – AusAID. SPRINT is very conscious of this and is approaching other prospective donors to share funding.

Design Process

Timeline

The design will be carried out together with AusAID appointed consultants in collaboration with IPPF ESEAOR, Africa and South Asia with one representative from each making up the core team.

Proposed timeline (3 months – April, May, June). Starting date of the design to be negotiated with AusAID.

Budget

See Annex 6

ANNEX 1

International Framework

The International Conference on Population and Development (ICPD) Programme of Action: Australia was a signatory to the ICPD Programme of Action in 1994 and this was reaffirmed by the Prime Minister in 2004. At the 2005 UN Millennium Summit, heads of state agreed to work towards universal access to reproductive health by 2015.

The Guiding Principles on Internal Displacement: Issued by the Secretary-General's Special Representative on INDPs, they are intended to address the specific needs of IDPs and to provide valuable practical guidance to Governments, other competent authorities, intergovernmental organizations and NGOs in their work with IDPs. Principle 19 states "Special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproduction health care, as well as appropriate counselling for victims of sexual and other abuses." The Guiding Principles reflect, and are consistent with, international human rights law and international humanitarian law.

Inter-Agency Standing Committee Gender Handbook for Humanitarian Action: A handbook for field practitioners setting forth standards for the integration of gender issues from the outset of a new complex emergency or disaster.

Inter-Agency Standing Committee Guidelines on Gender-based Violence Interventions in Humanitarian Settings: A tool for field practitioners to establish a multi-sectoral coordinated approach to gender-based violence programming in emergency settings.

UNAIDS Guidelines for HIV/AIDS interventions in emergency settings: UNAIDS: The purpose of these guidelines is to enable governments and cooperating agencies, including UN Agencies and NGOs, to deliver the *minimum* required multisectoral response to HIV/AIDS during the early phase of emergency situations.

Sphere Humanitarian Charter and Minimum Standards in Disaster Response for humanitarian assistance providers (The Sphere Project): The Sphere Project Handbook 2004 has a section on SRH. It identifies the key concerns as being the coordination and implementation of the Minimum Initial Services Package (MISP); addressing issues related to gender based violence; the prevention of HIV/AIDS transmission; obstetric and emergency obstetric care, and the integration of reproductive health care services into primary health care.

Central Emergency Relief Fund (CERF): The MISP meets the life-saving criteria for the CERF.

UN Global Health Cluster: The Global Health Cluster system endorses the MISP as a minimum standard in health service provision in emergencies as outlined in the IASC Health Cluster Guide.

Addressing Conflict-Related Sexual Violence: An Analytical Inventory of Peacekeeping Practice: Authored by UNIFEM, UN Department of Peacekeeping Operations and UN Action Against Sexual Violence in Conflict, it is the start of a process to identify what works in preventing

sexual violence and improving women's security. Australia was a substantial contributor to the cost of the inventory.

Reproductive health services are also vital to realizing the full implementation of United Nations Security Council Resolutions 1325, 1820, 1888 and 1889 on Women, Peace and Security – both in reducing the impact of armed conflict on women but also, importantly, ensuring women are able to participate in peace processes at all levels and thereby ensure peace agreement and reconstruction processes include women's points of view and concerns and adequately address their needs.

International Strategy for Disaster Reduction (ISDR): There are numerous statements from the ISDR on mainstreaming gender into national disaster risk reduction policies and plans and the advantage this has, not just for the increased status and influence of women in their communities, but for the overall benefit of the communities and the sustainability of DRR.

ANNEX 2

Components of the MISP

(1) ENSURE the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:

- nominates an RH officer to provide technical and operational support to all agencies providing health services
- hosts regular stakeholder meetings to facilitate implementation of the MISP
- reports back to the health sector/cluster meetings on any issues related to MISP implementation
- shares information about the availability of RH resources and supplies

(2) PREVENT AND MANAGE the consequences of sexual violence:

- Put in place measures to protect affected populations, particularly women and girls, from sexual violence
- Make clinical care available for survivors of rape
- Ensure the community is aware of the available clinical services

(3) REDUCE HIV transmission:

- Ensure safe blood transfusion practice
- Facilitate and enforce respect for standard precautions
- Make free condoms available

(4) PREVENT excess maternal and newborn morbidity and mortality:

- Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:

At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications

- At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies
- Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and hospital
- Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible

(5) PLAN for comprehensive RH services, integrated into primary health care (PHC) as the situation permits. Support the health sector/cluster partners to:

- Coordinate ordering RH equipment and supplies based on estimated and observed consumption
- Collect existing background data
- Identify suitable sites for future service delivery of comprehensive RH services
- Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff

(6) *Note: It is also important to ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to child transmission (PMTCT). In addition, ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in "hygiene kits") are distributed to women and girls.*

ANNEX 3

Disaster Risk Reduction

Recommendations target both policy and practice. Key points include:

Policy

- Ensuring SRH is included in regional and national DRR and emergency preparedness strategies,
- Including SRH in regional and national vulnerability assessments
- Ensuring SRH is included in contingency planning and emergency response plans
- Pre- establishing SRH focal points and coordination mechanisms

Practice:

- Incorporating disaster risk reduction and emergency preparedness strategies into SRH programming
- Training on MISP implementation
- Pre-positioning supplies, identifying distribution routes
- Identifying emergency referral mechanisms

ANNEX 4

Strategic partnerships

- **IPPF** is a critical partner of the SPRINT Initiative. As a global federation of grassroots SRH organisations, IPPF is an acknowledged leader in advocacy and service delivery working in over 170 countries—providing and campaigning for sexual and reproductive health care and rights. In addition to providing SPRINT Initiative's institutional home, IPPF is essential as a partner providing direct access to its in-country Member Associations. Member Associations are an important constituent of country coordination teams as they are well positioned to be among the first responders to a crisis, know the local SRH context, and are frequently able to access insecure settings when international actors are not.

- **UNFPA** is the UN leader in SRH and is a leading agency on SRH in humanitarian response. However, expertise on SRH in crises has been mainly concentrated at UNFPA headquarter and has not trickled down to the regional and national levels. At the global level, UNFPA co-lead the design of the SPRINT training curriculum and provides technical and advocacy support to the Initiative. SPRINT has in turn built the capacity of regional and national UNFPA staff on SRH in crises. However, UNFPA is not an implementing agency and has not had trained implementing partners on SRH in crises on the ground. SPRINT-trained coordination teams have filled this gap. At the regional level, UNFPA humanitarian focal points coordinate closely with the SPRINT regional hubs regarding strategic engagement with country teams as well as advocacy to other agencies to prioritize SRH in emergencies. At the national level, UNFPA is a vital member of the country coordination team and SPRINT has been critical in enabling UNFPA national staff to champion and take is often the lead agency regarding advocacy and implementation related to SRH in crises. Most of SPRINT's champions at the country level are from UNFPA.

- **The Australian Reproductive Health Alliance (ARHA)**, established in 1996, works closely with parliamentarians, NGOs, media and civil society to garner political and public support for addressing sexual, reproductive and maternal health and rights issues. As the Secretariat for the parliamentary Group on Population and Development (a group of federal and state/territory parliamentarians committed to population, development and reproductive health issues) they have been a vital partner in promoting the issue of SRH in crises amongst Australian Parliamentarians. They have organised parliamentary study tours in the typhoon affected areas of the Philippines, held a parliamentary retreat in PNG where Senator Clair Moore highlighted to the work of SPRINT and Thailand along the Thai/Myanmar (Burma) border. They are also now working and building relationships with the Australia civil and Military Defence Force to address the issue of SRH in crisis. A training for the ADF is planned for March 2011.

ARHA has a history of engagement with parliamentarians and key stakeholders in sexual and reproductive health nationally and regionally and is therefore well placed to fulfil its role in the SPRINT initiative; establishing links with the SPRINT Initiative and parliamentary, regional policy makers, donors and the general public.

- **UNHCR** is a key partner of SPRINT, especially in Africa. UNHCR is part of the steering committee of SPRINT Africa. SPRINT has been building the capacity of regional and national UNHCR staff on SRH in crises. In refugee settings, UNHCR is a vital member of SPRINT coordination teams.

- **University of New South Wales (UNSW)** has carried out critical research on the SPRINT Initiative and the field generally. Four PhD students are exploring: 1) the effectiveness of the SPRINT training; 2) organizational transformation of IPPF as it moves into humanitarian response; 3) accountability and MISP implementation during an acute emergency; and 4) SRH as a platform for peace-building in post-crisis settings. This research linkage is unique and has been critical to inform the strategic direction of SPRINT as well as improve its capacity building model.

- **Women's Refugee Commission (WRC)** is the leading advocacy organization on SRH in crisis and the MISP in particular. The WRC has helped spearhead and develop the first policy on DRR and SRH, and has been a leader in the integration of the MISP into global policies and guidelines. The WRC is a key partner to strategically advance the MISP at a global level, particularly in regards to setting the agenda on SRH and DRR.

- **Inter-agency Working Group on Reproductive Health in Crises (IAWG)** promotes access to quality SRH care for people affected by crises. It is a loose network of UN agencies, governmental and nongovernmental organizations, universities, donors and others, and includes over 500 people on its list serv. IAWG has lead the global agenda on SRH emergencies since 1995. The SPRINT concept was developed by members of the IAWG Steering Committee, and the SPRINT Secretariat remains closely involved in the IAWG Steering Committee at the global level.

Relationship between SPRINT, IPPF and UNFPA

- IPPF has a dual role in the SPRINT Initiative: IPPF is a key partner and also responsible for the institutional arrangements for the SPRINT, i.e. its institutional home.

- UNFPA is a critical partner supplying one of the main trainers and ongoing technical advice

- SPRINT was, from the outset, conceived as a multi agency initiative and the original organisations were UNFPA, UNSW, Women's Refugee Commission and IPPF; where IPPF assumed the role of lead fundraiser and provided the institutional arrangements for

its secretariat.

- The IPPF contribution to the SPRINT initiative includes direct access to its network of 152 Member Associations, which are the national level Family Planning / SRH associations (e.g. FPOP in the Philippines, FPAP (Pakistan), AIBEF in Ivory Coast, ATBEF in Togo or RHU in Uganda).

- The institutional arrangement for the SPRINT Initiative in IPPF has provided access to resources and systems, and an organisational structure dedicated to SRHR. Operating under the IPPF banner lends legitimacy to the SPRINT activities.

- The SPRINT Initiative has had a strategic impact on IPPF. The increased involvement of IPPF in humanitarian structures such as the IAWG, direct collaboration with the UNFPA Humanitarian Response Branch and participation in regional workshops has meant that IPPF is effecting a repositioning of the organisation and expressing a desire to be seen as an organisation with capacity to be involved in SRHR disaster risk reduction and SRH interagency work in emergencies.

- Internally in IPPF, the involvement with the SPRINT Initiative implementation process has meant that there has been an increase of staff that have humanitarian experience. This new group of employees has championed performance improving changes within the IPPF, which has benefitted the organisation as a whole. (Examples include financial management routines, improved awareness of security measures and a process of clarifying IPPF's global role with regard to access to SRH.)

- The strategic changes to IPPF, due to the SPRINT implementation process, have the potential to transform IPPF in the longer term perspective and support IPPF to remain as an organisation that is credible, relevant and legitimate at the global level and at the grassroots level working for SRHR among the most vulnerable populations in the world.

ANNEX 5

Indonesia – case study

In 2009 the Humanitarian focal point from UNFPA Indonesia was trained on the MISP at the SPRINT regional training in Kuala Lumpur alongside colleagues from the IFRC, Indonesia Planned Parenthood Association (IPPA) and the MoH. Together they formed the Indonesia Country team. Following the training the UNFPA humanitarian focal point has initiated a number of activities to ensure the MISP is implemented in crisis and integrated into key government policies. At the onset of the West Sumatra earthquake which affected over 2.5 million people in the five worst affected districts she spearheaded and lead the MISP sub working group, coordinating regularly with the Health Cluster. She also integrated the services of the MISP into the CAP appeal. In addition to her immediate work on the crisis she went on to work closely with trainees from the MoH have the SPRINT training accredited by the MoH at the national level. The training is now a recommended part of the MoH training curriculum.

In June 2010 when the government decided to revise the National Technical Management Guidelines on Health and Disaster Management, used by all government crisis centres, SPRINT trainees' organised to feed into the process. Through their successful advocacy the MISP has been integrate and the revised guidelines will come into effect from 2011. The trainees are now working to have the same changes mirrored in the national Ministry of Health decree on health and disaster management. To complement the changes in the technical guidelines and minimize delays and costs in securing RH supplies in crisis trainee from UNFPA has been working to localize the RH kits and have them prepositioned within Indonesia. The establishment and development of a national procurement system for RH kits has been integrated into the UNFPA Country Programme for 2011-2014. The humanitarian focal point is working on these activities in parallel with her work on rolling out the SPRINT trainings at the provincial level.

Impact on other regions

The SPRINT model has had an impact on other regions. In South Sudan, MISP training was organized and supported both technically and financially by the SPRINT Secretariat; this training session was followed by a 2-day Contingency Planning exercise, bringing the partners to design a Reproductive Health contingency Plan that was included in the Health Cluster Contingency Planning for the 2011 January, 9 referendum. This was a major achievement in terms of incorporating SRH into national emergency preparedness initiatives and serves as a global model for others preparing for crisis. .In the South Asia Region (SAR), the IPPF focal point has integrated responsibility for SPRINT in South Asia into its work. The IPPF Regional Office has also started to mainstream humanitarian response into its regular programming through SPRINT trained humanitarian focal points in all Member Associations and including SRH in crisis in its programming budgets.

In the Middle East and North Africa region, UNFPA is taking the lead on the roll out of the SPRINT model in the region. On the Tunisian-Libyan border, UNFPA has deployed as SRH Coordinator one of its staff from Morocco who was trained by the SPRINT in 2010 in West Africa. The IPPF Member Association in Tunisia has a strong presence on the ground and is

working closely with UNFPA as an implementing partner for the emergency response. Under the auspices of the regional Latin America and Caribbean IAWG chapter established in 2010, IPPF Western Hemisphere Regional office in close collaboration with UNFPA Regional Office will take the SPRINT model further in the region.