SEXUAL AND REPRODUCTIVE HEALTH PROGRAMME IN CRISIS AND POST-CRISIS SITUATIONS IN EAST & SOUTH EAST ASIA AND OCEANIA REGION (ESEAOR)

SPRINT BRIDGE II PERIOD REPORTING

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Introduction

This report on the Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations for East, Southeast Asia and the Pacific, hereinafter referred to as the SPRINT Initiative, is submitted in accordance with the Grant Agreement Deed 61632 between AusAID and the International Planned Parenthood Federation - East and South East Asia & Oceania Region (IPPF ESEAOR). The report period covered is January to June 2012 and includes all activities undertaken by the SPRINT Initiative.

Executive Summary

Over the past six months, the SPRINT ESEAOR Secretariat has been maintaining regular activities in capacity building, advocacy and MISP implementation in response to crisis activities related to SPRINT objectives in SPRINT 1 project, whilst awaiting confirmation from AusAID regarding the approval of the SPRINT II project design. Due to the uncertain future, it was decided that no new activities should be initiated and all efforts would go towards progressing the on-going planned activities, gaining clarity regarding SPRINT II plans and laying the foundations for SPRINT II.

The concerns expressed by AusAID regarding IPPF's financial management systems were addressed through a financial audit conducted by KPMG in March 2012. Recommendations arising from the KPMG report have been incorporated into SPRINT II planning. Despite the availability of emergency response allocation, no emergencies arose in ESEAOR in the six month period to which funding support was requested. Funds were reallocated to support the Mae Tao Clinic in Thailand in improving access to SRH services for migrant workers on the Thai/Burma border, and to support Trainings of Trainers (ToTs) for about 100 persons on the MISP in Bangladesh, Sri Lanka and Pakistan.

The WASHI response sub-grant agreement between SPRINT and the Family Planning Association of the Philippines (FPOP) was followed up with technical support, advice and a post response review trip undertaken by the SPRINT team. One SPRINT supported in-country regional training was conducted in this period. The funding for this training in Papua New Guinea had already been allocated in 2011, but had to be postponed on several occasions. On-site technical support was available in Momase, Papua New Guinea for the week of the training.

Significant progress has been made on adapting the Facilitators Training Manual for Minimal Initial Service Package (MISP) for Sexual and Reproductive Health in Crises. IPPF has finalized the translation, and next steps in SPRINT II will be to circulate with IAWG network, and to print and distribute the document. Finally, the outstanding concerns regarding the set up and launch of SPRINT II were clarified during the AusAID SPRINT meetings held in Kuala Lumpur in early May and the grant agreement for continuation of SPRINT was signed.

Key outputs achieved to date

Over the past four years, the SPRINT initiative has met its goal of increasing access to sexual reproductive health information and services for crisis-affected populations in the Asia and Pacific regions through its capacity development model which focuses on training, advocacy, technical assistance and funding. Funding for populations affected by natural, conflict or protracted displacement in fifteen settings has ensured improved access to the services outlined the MISP and policy makers in eight countries have worked towards the integration of MISP into national response systems.

The model to be adopted in SPRINT II aims to advocate for integration of MISP, to further develop national capacity through emergency preparedness, response and review, and continues to provide funding opportunities for timely emergency response following crisis.

Objective 1: Capacity Building for SRH response in crisis and post-crisis situations

At the SPRINT Global Stakeholders meeting in Istanbul, November 2011, the Indonesian Planned Parenthood Association (IPPF Member Association) identified a significant gap in MISP services related to medical services for survivors of Sexual Gender Based Violence (SGBV) in country. With technical support from SPRINT and in collaboration with UNFPA, IPPA facilitated a training workshop for staff members from all Chapter offices across the country, on the provision of clinical services for SGBV survivors. The objective of the training was to increase capacity of IPPA clinical service providers to offer these essential services post crisis within their clinical setting.

In May, the second in-country regional training was conducted in Momase, Papua New Guinea, after being postponed on several occasions related to issues within UNFPA, who facilitated the training. There was some urgency in conducting the training at this time (prior to the end of the bridge funding period) and unfortunately the dates coincided with the final weeks of a mass vaccination campaign being conducted by Ministry of Health staff. This resulted in late changes in the list of participants, mainly made up of non-governmental organizational staff. The MISP was a fairly new concept to most of the participants and they highly valued the training. Two SPRINT ESEAOR Secretariat staff were present to provide on-site technical assistance, to informally assess the capacity of in-country facilitators and to improve cultural and contextual challenges facing the country regarding MISP implementation.

The SPRINT Initiative has continued to engage with relevant Reproductive Health networks which include IAWG and UNISDR Reproductive Health and Disaster Risk Reduction Platform. Case studies related to experiences with the SPRINT model in Myanmar and Indonesia were documented and shared with UNISDR to contribute to policy guideline development. On a monthly basis, participation with MISP group and the SGBV group has been maintained by SPRINT staff.

In response to a request from IPPF's Latin America and Caribbean region, remote technical support was provided to advance the integration of humanitarian work into their portfolio following collaboration with the UN regarding MISP implementation. Technical assistance was also provided to IPPF's European Network, as they are eager to contribute to the Reproductive Health in Emergencies policy guidelines for the European Commission raising the profile of the Minimal Initial Service Package for Sexual and Reproductive Health in Crises.

The update/revision of the Facilitators Manual has been completed and is IPPF internally finalized – this process has taken a significant period of time as it is based on the feedback of the MISP trainers and trainees over the past three years. The update has also been translated into French. The next steps in SPRINT II will be to circulate this updated manual within IAWG network for comments, and to print and distribute the document.

In mid March, as a follow up review to the WASHI emergency response, the SPRINT Secretariat visited Cagayan de Oro to meet with the Family Planning Organization of Philippines WASHI response team. Funding support had been provided by SPRINT following the submission of a proposal in December 2011. The five days spent in the field provided ample time to meet with all the key reproductive health partners and to broaden understanding with regards prioritization and MISP implementation post WASHI. Significant advances have been made with regards to coordination and implementation of the MISP in Cagayan de Oro, but having collaborative review process enabled SPRINT team, FPOP and other partners to discuss openly lessons learnt and recommendations for future MISP interventions.

FPOP have recently assumed a key role in the Humanitarian Response consortium at a National level and through this review process, SPRINT were able to highlight the importance of open coordination and realistic ambition in this regard in line with their current capacity.

Objective 2: To strengthen the coordination of SRH responses in crisis and post-crisis situations;

From March 12th – 14th, the SPRINT coordinator participated in the World Health Organisation WPRO's Informal Consultation on Health Service Preparedness in Response to Humanitarian Emergencies and Disasters held in Manila. The key points arising from this consultation were:

- WPRO region experiences a wide range of disaster scenarios
- Provision of health services to those affected by disaster remains a top priority
- MISP for sexual reproductive health in crisis is not fully implemented.

The future action proposed as a result of this consultation reflects the concepts of SPRINT II design:

- Incorporating sexual and reproductive health into disaster risk management activities
- Prioritization of emergency preparedness for health services during uneventful times
- Involvement of all relevant stakeholders using a collaborative and consultative process at national and local government level is recommended.
- Strengthening of local capacity is critical for routine health services and response to crisis
- Specific preparation is required to cope with the increased demand on health services.

Participation within this consultation was extremely beneficial in raising awareness regarding the MISP for National Government participants and this has generated interest and further planning with regards advocacy and training workshops which will be conducted later in the year in Vietnam, China and the Philippines.

Objective 3: To raise awareness on the importance of addressing SRH in crisis and post-crisis situations at the national, regional and international levels

The SPRINT Global publication titled 'SPRINTing towards change' developed and finalized in late 2011, has now been translated into French for distribution in the Africa Region. The English version of this publication has been distributed to donors and relevant stakeholders.

Objective 4: To respond in a timely fashion to SRH needs in crisis situations;

Tropical storm WASHI hit the island of Mindanao in the Philippines in mid December 2011. SPRINT and the Family Planning Organization of Philippines (FPOP) signed a sub-grant agreement based on a MISP proposal within two weeks of the disaster. During the period January to March 2012, the MISP for Reproductive health in response to tropical storm WASHI was implemented by FPOP in Cagayan de Oro (one of the worst affected cities). The key objectives of the project were focused MISP components, namely initiating and participating in the RH coordination mechanism, prevent and manage SGBV, reduce transmission of HIV and STIs, prevent excess maternal mortality and morbidity, and planning for the provision of comprehensive reproductive health services. FPOP showed enormous ambition and their achievements were significant in comparison to previous emergency response interventions.

As a result of previously established relationships between key reproductive health actors, the Reproductive Health Coordination Working Group (RHCWG) was formed timely and met regularly throughout the intervention. FPOP effectively assessed the gaps in response and service provision and consequently prioritized their support to the home based population (those residing outside the Evacuation centers) as certain areas had been neglected by local authorities and significant support was being provided by other partners to those within. Several barangays had no access to basic health services as their health clinics had been washed away in the typhoon.

As part of the RHCWG, FPOP coordinated with partners to provide outreach services and through their volunteers distributed hygiene kits. FPOP held a unique position working closely with the community and participating within the coordination group and they used this position to support and promote aspects of the MISP components. The WASHI response sub-grant agreement between SPRINT and the Family Planning Association of the Philippines (FPOP) was followed up with technical support, advice and a post response review trip undertaken by the SPRINT team.

Advocacy for appropriate and accessible medical services for survivors of SGBV was conducted at a local level by FPOP whilst other partners including UNFPA concentrated on the service provision through a 'One Stop Shop' (client focused services) – as a new concept within CDO, slow progress was made in setting up a OSS. Addressing the HIV component of the MISP also presented challenges as there is little integration between HIV and reproductive health in normal times – many opportunities to link NGO activities were recognized in the latter stages of the intervention. Issues surrounding accessibility and availability of family planning supplies (in particular for adolescent population) presented on-going challenges until the end of the intervention, mainly due to the complex religious and political norms pertinent in the region.

At a national level, FPOP is becoming an increasingly important player, leading the Humanitarian Response Consortium and actively participants in the National Reproductive Health working group. Moving ahead with their humanitarian agenda, they are motivated to build internal capacity to provide timely and appropriate humanitarian action in implementing the MISP post crisis, in country. The SPRINT ESEAOR Secretariat will further liaise with FPOP in the SPRINT II implementation phase to develop the role of the Member Association in the Philippines Country Coordination Team.

Despite the availability of funds for emergency response, no humanitarian emergencies arose in ESEAOR in the January – June 2012 period to which funding support was requested. Funds were reallocated to support the Mae Tao Clinic in Thailand in improving access to SRH services for migrant workers on the Thai/Burma border, and to support Training of Trainers (ToT) sessions for about 100 persons on the MISP in Bangladesh, Sri Lanka and Pakistan. Separate reports for these interventions are due by 31 October 2012, and will be managed by the SPRINT II team.

Finances

The Bridge Period II grant for the SPRINT ESEAOR Secretariat for the first half of 2012 was absorbed for 97%. Funds were used to maintain the SPRINT Secretariat in IPPF Regional Office, whilst awaiting confirmation from AusAID regarding the approval of the SPRINT II project design. Due to the uncertain future, it was decided that no new activities should be initiated and all efforts would go towards progressing the on-going planned activities, gaining clarity regarding SPRINT II plans and laying the foundations for SPRINT II. The salaries of one Project Officer and one Consultant were fully charged. The IPPF Director, Finance & Operations supported the SPRINT ESEAOR team after the departure of the IPPF ESEAOR Regional Director, and 50% of his salary (for four months) was charged, as well 20% of the salary of the IPPF Finance Officer (for two months).

Despite the availability of emergency response allocation, no emergencies arose in ESEAOR in the six month period to which funding support was requested. Funds were reallocated to support the Mae Tao Clinic in Thailand in improving access to SRH services for migrant workers on the Thai/Burma border, and to support Trainings of Trainers (ToTs) for about 100 persons on the MISP in Bangladesh, Sri Lanka and Pakistan. The implementing partners are requested to provide separate reporting for these interventions per 31 October 2012, which will be managed by the SPRINT II team.

The SPRINT ESEAOR Secretariat facilitated a Financial Review to examine its responses to recommendations of the 2010 Financial (and Operational) Review and the 2010 Independent Activity Completion Report of the SPRINT I initiative. The 2010 Audit identified six overlapping areas that required

immediate action to mitigate areas of financial risk for AusAID, and requested independent assurance that all recommendations contained in the reports were implemented. The Financial Review was conducted by KPMG in March 2012 and an extensive Financial Review report, including a set of 38 recommendations, was delivered. Recommendations arising from the KPMG report have been incorporated into SPRINT II planning and will, as far as not implemented already, be instrumental in the implementation of SPRINT II.

Conclusion

The past six months (January – June 2012) has provided the SPRINT ESEAOR Secretariat an opportunity to continue advocating and raising the profile of the MISP for Sexual and Reproductive Health in crisis and to maintain technical support to countries within the region focused on integrating and implementing MISP for SRH in crisis. Furthermore the Secretariat has been able to consolidate efforts and reflect on the lessons learnt over the past four years during SPRINT Phase I pilot.

The AusAID/SPRINT meeting in Kuala Lumpur in May 2012 clarified positions with regards the future plans of SPRINT II design. Efforts in the final months of bridge funding have also been focused on preparing for the inception phase of SPRINT II, documenting key information for handover purposes and strategizing plans for future intervention in priority focus countries.

The SPRINT Initiative is deeply thankful for AusAID's continued support and confidence in our work to increase access to quality SRH services for displaced women, men and youth. This support is critical for the SPRINT Initiative to continue engaging in capacity building, supporting implementation of the MISP in crises and advocating on behalf of displaced populations throughout the region.

Annex - Additional Report:

To enhance access to SRH information and services for populations surviving crisis and living in protracted post-crisis situations.

Setting: Southern Thailand from February 2011-February 2012
Partner: Planned Parenthood Association of Thailand (PPAT)

The SPRINT supported project in protracted setting in Southern Thailand was implemented from February 2011 for the period of 1 year. The purpose of the project was to implement, sustain and build upon the MISP towards comprehensive SRH services to be achieved through coordination, provision of clinical services, local capacity building capacity, advocating for integration of all components into existing services and increased community awareness.

The key outcomes reported at the conclusion of this project were related to the increased knowledge surrounding the MISP components amongst service providers and local community alike, the momentum generated by all to value the integration of services of the MISP which has consequently resulted in local government plans to replicate the project in other areas. There is a greater understanding amongst community members regarding Maternal Child health issues, sexual gender based violence and reducing the risk transmission of HIV and STI's. Government representatives are more familiar with the One Stop Crisis centre concept and its services and the local hospital (Yaring) significantly adapted their service provision model within the hospital to implement the MISP. Furthermore, the project has benefitted the wider community through its focus on community outreach activities.

The strengths were related partly due to timing as the PPAT project was introduced during a period when health care providers were trying to increase services despite the insecure setting with minimal support and guidance available. Community expectations for services were high. The commitment of participating staff from all three SDHPHs and their acceptance of the MISP principles were paramount to its success. Furthermore the volunteers were existing community health volunteers, young people religious leaders (Muslim), and all involved project and health care staff acknowledged that MISP volunteers were a key strength following training which increased their practical knowledge and enable them to disseminate information within their own communities. The clear goals of the MISP volunteers differentiated them from the existing health volunteers, which helped to focus their work.

Local authorities acknowledged that having a NGO implementing the project (PPAT) contributed to the successful implementation as they could operate swiftly and directly without being restricted by government regulations. They also noted the provision of SRH information has resulted in SGBV being prioritized as an issue. Additionally, PPAT were able to establish crucial links with health service providers and community members.

The period of only one year for project implementation was considered too short. In such a complex setting a longer implementation period would have been more optimal for lasting change to be achieved. Advocacy may also have had a more far reaching affect if the time frame had been extended.