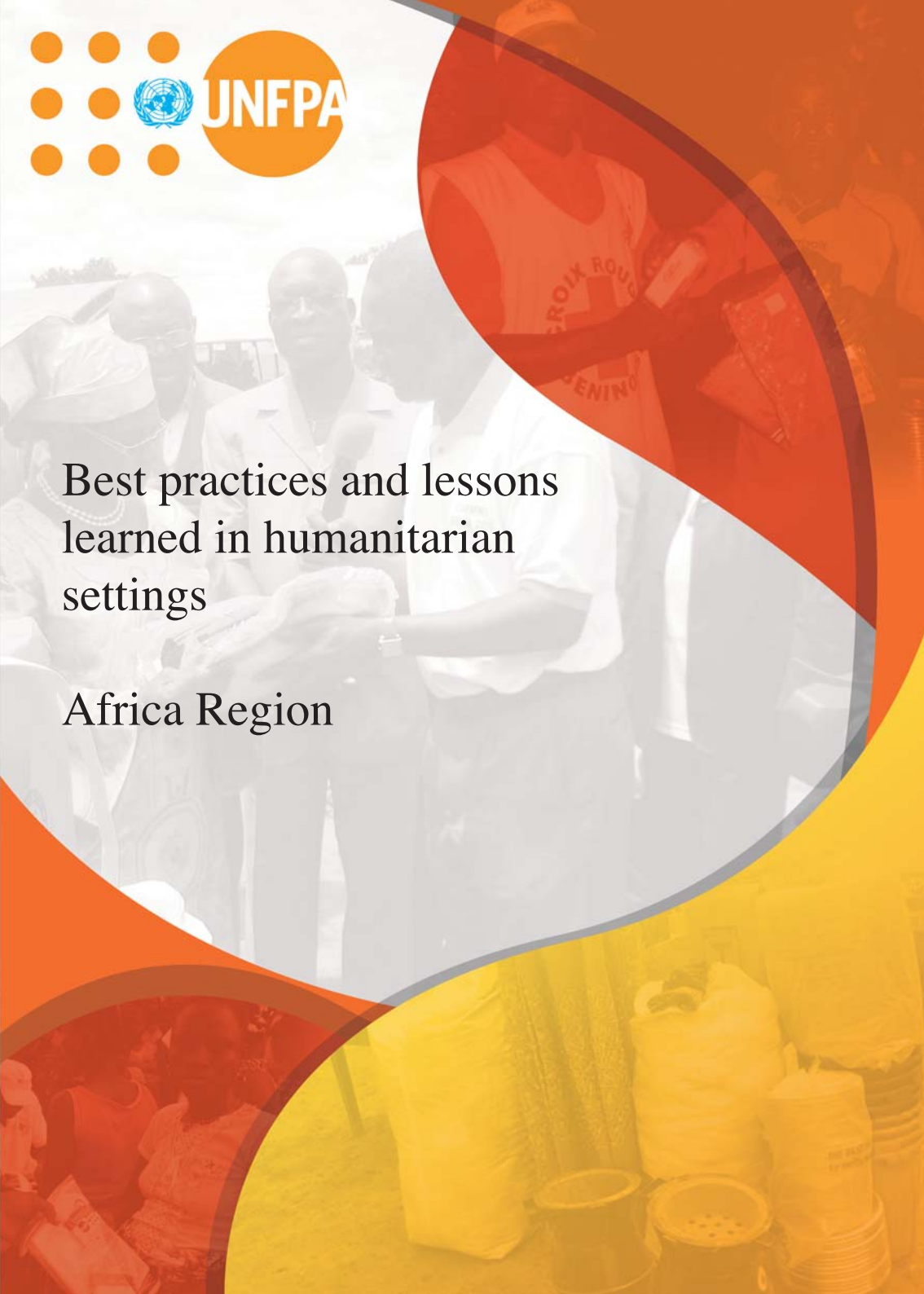

Best practices and lessons learned in humanitarian settings

Africa Region

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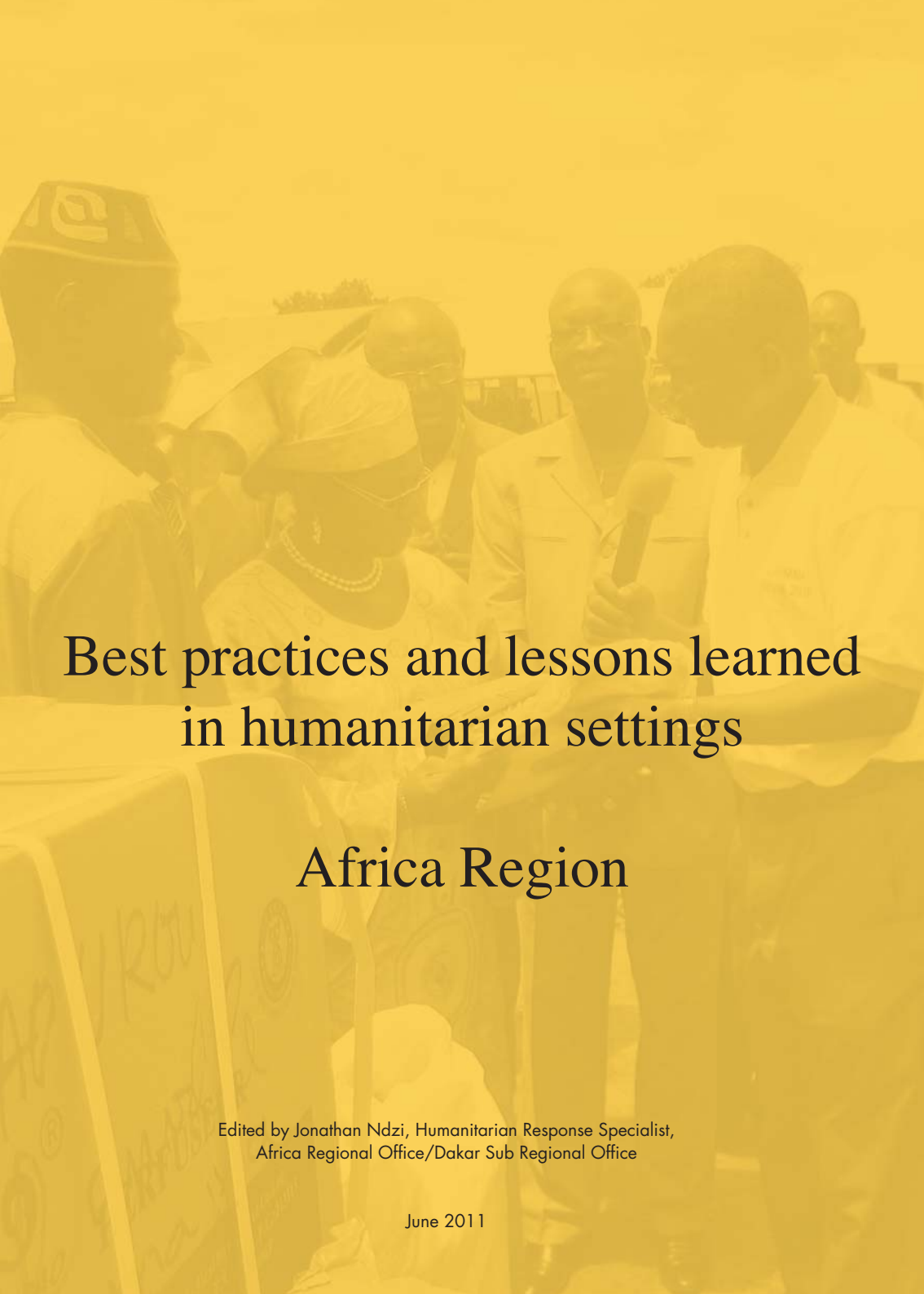

Best practices and lessons learned in humanitarian settings

Africa Region

Edited by Jonathan Ndzi, Humanitarian Response Specialist,
Africa Regional Office/Dakar Sub Regional Office

June 2011

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ABBREVIATIONS

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
ARO	Africa Regional Office
CBO	Community Based Organisation
CBS	Community Based Services
CERF	Central Emergency Response Fund
CO	Country Office
CPAP	Country Programme Action Plan
DYO	District Youth Officer
EHAP	Emergency Humanitarian Action Plan
HRB	Humanitarian Response Branch
IASC	Inter Agency Standing Committee
MISP	Minimum Initial Service Package
MoU	Memorandum of Understanding
MOSS	Minimum Operating Security Standards
NADMO	National Disaster Management Organisation of Ghana
NYCOM	National Youth Council of Malawi
OCHA	Office for the Coordination of Humanitarian Affairs
OMP	Office Management Plan
PNC	Post Natal Care
RH	Reproductive Health
RHR	Reproductive Health and Rights
SGBV	Sexual and gender based violence
SPRINT	Sexual and Reproductive Health Programming in Crisis and Post Crisis
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRO	Sub Regional Office
STI	Sexually Transmitted Infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organisation

FOREWORD

This first edition of lessons learned and good practices in humanitarian settings in the UNFPA Africa region is a collection of documented evidence of interventions that have been shown to make a difference in the lives of people affected by various crisis. The various documents are the outcome of collaboration between UNFPA Country office staff and key partners at country and regional levels.

The inspiration to collate these documents follows the first ever workshop on "Best practices in natural disaster settings" organised in Dakar Senegal, from 25-27 October 2010 by the UNFPA Africa Regional and the Sub regional Offices of Dakar and Johannesburg. The workshop was attended by 26 participants from 12 countries, Benin, Burkina Faso, Ethiopia, Ghana, Madagascar, Malawi, Mauritania, Namibia, Senegal, Sierra Leone, The Gambia and Zambia as well as from the ARO, SROs, Information and External Relations Division (Resource Mobilisation Branch) and Programme Division (Humanitarian Response Branch). The collection covers natural disasters common to the region including flooding, drought and food insecurity and earthquakes. The practices have covered vulnerable populations of women, girls, boys and men who each have special and different needs face to an emergency.

This publication on good practices and lessons learned are a collection of experiences of country offices in managing natural disasters. The experiences show how UNFPA guidelines in humanitarian situations have contributed to improving the ICPD (International Conference on Population and development) agenda. These experiences and practice make reference evidence-based tools, strategies, challenges and lessons learned in the course of life saving interventions in sexual and reproductive health and protection in different crisis settings in support of government efforts.

This publication is intended for use by humanitarian actors to improve standards of practice in crisis settings where, especially within the Africa region, the capacity for timely and appropriate response to the plight of disaster affected populations has remained a challenge. Excerpts of the documents can be used by media personnel, as an additional channel,

for buy-in, awareness creation, advocacy with the objective of achieving improved interventions. The ARO/SROs look forward to receiving comments that will help in improving future editions of the document on best practices in humanitarian settings.

This publication has benefited from the appreciable contributions of various groups and people. The authors acknowledge the efforts of: i) the participants at the Africa regional workshop on « good practices in situations of natural disasters », organised by UNFPA in October 2010 ; ii) the members of the review committee of the various submissions at UNFPA Country Office, Sub Regional Office, Regional Office and Head Quarter levels The Regional Communications Adviser at the SRO Dakar oversaw the quality of the good practices.

Your comments on the publication will help improve on future documentation of best practices, experiences and lessons learned not only in natural but also in man-made disasters. Send any comments and suggestions to ndzi@unfpa.org.

OVERVIEW OF THE HUMANITARIAN CONTEXT IN THE AFRICA REGION

The Africa region is plagued with many humanitarian situations that have had a significant impact on development in the continent and the lives of ordinary citizens. Natural and human-made disasters are frequent while epidemics which have been eradicated in other regions of the world abound:

- Seasonal rainfall has had devastating effects from Madagascar through Mozambique, Zambia, Zimbabwe and Angola to Nigeria, Ghana, and Gambia up to Senegal. In 2010, over 1.5 million persons were affected with 377 deaths by floods in West and Central Africa with many displacements in Nigeria and Benin; while in Southern Africa over 708,000 people were affected by storms and floods with 341,361 displacements.

- Occasional extreme drought especially in desert countries has resulted in food insecurity and its untold consequences in Niger, Ethiopia, Somalia, and Kenya down to Lesotho; Over 7.2 million persons in Niger were affected by the worst drought in 2009.

- Major epidemics of meningitis and cholera has affected parts of Burkina Faso, Cote D'Ivoire, Nigeria while ebola fever has been a cause of concern in Uganda (2011) and a relapse of poliomyelitis in Congo Brazzaville and Democratic Republic of Congo in 2010 and 2011; A poliomyelitis epidemic resurfaced in Congo Brazzaville affecting over 300 persons with 200 deaths.

- Major earthquake phenomenon has been recorded in the great lakes region lately as December 2010. It is estimated that in latest earthquake in Karonga region of Malawi in that month, over 1000 houses collapsed, further 2900 damages, 300 people wounded and four killed.

In all, these crises, issues of sexual and reproductive health including maternal health, HIV prevention and prevention and management of gender based violence are gradually been integrated in the emergency relief efforts. The interventions will appropriately target most vulnerable groups of crisis affected populations if disaggregated data is used in the design, planning, implementation and monitoring of humanitarian interventions.

1. BENIN

Title	**Strengthening partnership with humanitarian actors with non governmental organisations) providing services facilitates the implementation of humanitarian interventions for target groups**
Contact persons **Region : country**	Dr. Alexandrine Dazogbo : dazogbo@unfpa.org Mr. Pierre Klissou : klissou@unfpa.org Ms Diene Keita : keita@unfpa.org Africa Region: Benin
Thematic area	Reproductive Health / Management of humanitarian emergencies
Primary keywords	Partnership, NGOs, Humanitarian Response, Reproductive Health, Humanitarian situations, Beninese Red Cross (CRB)
Objectives	Contribute to reducing maternal mortality and morbidity, the propagation of HIV/AIDS and Sexually Transmitted Infections (STI), cases of gender-based violence (GBV) as well as preventing unwanted pregnancy among affected young girls and women. More specifically to : • Implement and monitor the Minimum Initial Services Package of reproductive health (MISP) • Improve access to quality health services in crisis and post-crisis situations.

Description and context	In Benin, floods occur on a cyclical basis and represent the most persistent hazard. Floods are due to overflowing of various riverbeds and their tributaries during the 2nd rainy season period in Benin covering the months of September and October. In Benin, like in the rest of the sub-region, the scale of flooding has increased progressively over the past four years, growing from a few affected communes in 2007 and 2008 to about twenty of the Country's 77 Communes in 2009 and 55 Communes in 2010. Enormous damage was done: about ten thousand homes and schools and close to a hundred health-care facilities were flooded and rendered non functional in 2010 ; thousands of hectares of cultivated rice, sorghum, maize and yam devastated. Forty-three deaths were registered. Every year, UNFPA provides support to the government in response to the devastating effects of the crisis. In view of the results obtained in 2008, UNFPA decided, with effect from 2009, to involve NGOs who are humanitarian actors, like the Beninese Red Cross and Caritas in order to step up disaster victims' access to the support provided to them. UNFPA support included, among others, the reproductive health (RH) needs assessment; the provision of essential drugs and RH kits and hygiene kits; support for the organisation of Reproductive Health/Gender-Based Violence/Sexually Transmissible Infections (RH/GBV/ STI) services and community-based services (CBS) on the sites, capacity building (preparatory phase) and strengthening partnership with humanitarian actors of the United Nations System, according to the comparative advantage within the health and protection clusters, and NGOs for the organisation of relief aid to the disaster victims. Two projects were developed and implemented in 2009 and 2010: BEN7R22C « UNFPA support to 2009 flood victims», and BEN7R22D « UNFPA support for 2010 humanitarian emergencies ».

Strategies, Key Challenges and Implementation	**Preparatory Phase** • Develop partnership with the Beninese Red Cross (CRB) and join forces with Doctors who are zonal coordinators, for the implementation of UNFPA community-based interventions. Within this framework, the Beninese Red Cross will train volunteers and midwives in the distribution of individual clean delivery packs, and also distribute kits and non-food items to the affected populations as soon as they are officially handed over. • Meetings were held outside the Health Cluster meetings to discuss the distribution plan for relief items to the affected population with a proforma invoice attached. • Train 25 CRB traditional birth attendants in flood-prone areas of south Benin in the use of individual clean delivery packs, with the view to facilitating packs distribution in inaccessible areas. • Strengthen the technical skills of service providers (Public sector and NGOs) with respect to the Minimum Initial Service Package in Reproductive Health in July 2010 to ensure that essential RH care is available to the affected populations. **During the crisis phase** • Offer RH services to affected populations in health care facilities. • Weekly coordination meetings within the Crisis unit and health cluster. • Immediate transfer dignity kits and individual clean delivery packs after the official handover to Beninese Red Cross officials for community based distribution. • Free condoms distribution at settlement sites for the internally displaced persons through Beninese Red Cross volunteers who provide community-based services and sensitize the populations about potential risks. • Strengthen technical capacity of maternity hospitals in affected areas and CRB clinics with RH medical supplies and equipment including emergency RH kits from UNFPA and the WHO (anti-malaria and anti-diarrhoea drugs) 2009 and 2010.

	• Improve the living conditions of the affected populations particularly pregnant women and nursing mothers (protection and security) through the provision of sleeping accessories and dignity kits by UNFPA. • Monitor, collect and forward data to UNFPA, to assess impact on beneficiaries as well as to the Monitoring and Evaluation unit of the Crisis management team (Government, United Nations System and NGO) to assess global response, under the leadership of the Prevention and Civil Protection Department.
Progress and Results	• Strengthened partnership with other humanitarian actors: Government, WHO, UNHCR, UNDP, WFP, NGOs (Caritas, Plan Benin and CRB). • Substantially improved quality of health care services provided to pregnant women by maternity hospital staff. • Improved quality of maternal and neonatal health with no maternal death or abortion among disaster victims reported during the intervention period compared to 2005 when with the Togolese refugees on the Agamè site where 50 cases of preterm labour were recorded in 3 months, including 28 in the first week alone. • In 2009, dignity kits were provided to 3000 beneficiaries that included pregnant women, nursing mothers and most vulnerable men in several Communes; • 100 safe deliveries with individual clean delivery packs in isolated villages and sites for the displaced population.

Lessons learned	• The involvement and collaboration of key actors familiar with the community, in the implementation and follow-up of the response is a key to the success of interventions in favour of persons in crisis situation. • The contribution of NGOs in sensitization and community distribution activities led to a better coverage of target groups by RH interventions with the availability of commodity distribution reports within the set timeframe. • Strengthening capacities of actors guarantees an effective and efficient coverage of target groups. • An efficient preparation of the response strategy (pre-positioning of logistics and capacity building) well in advance combined with the availability of financial resources facilitates meeting the social needs of crisis affected populations.
Conclusion and recommendations	Strengthening partnership with humanitarian actors, notably the Beninese Red Cross, for awareness raising and community distribution activities facilitated the effective and timely provision of individual clean delivery and dignity kits to beneficiaries in 2009 and 2010 contrary to 2008 when there was a delay in the distribution of relief items.
Partners	• CRB, Town Councils, social action technician of concerned Communes • Doctor, health zonal Coordinators • Departmental Health Directorate, Ministry of Family Affairs and National Solidarity, Ministry of Health, Town Councils. • Health Cluster (WHO, UNICEF, Ministry of Health, NGOs, USAID) • Other UN partners: UNAIDS, UNHCR
Sources and links	Report on UNFPA activities in support of the affected populations 2009 and 2010 (original in French) Meeting minutes, report on training of Traditional birth attendant Pictures
Reviewed by	SRO Dakar, ARO and HRB

2. BURKINA FASO

Title	**Partnership, gateway for UNFPA's positioning as a humanitarian actor**
Personne-contact **Region: country**	Mr. Siaka Traoré (traore@unfpa.org) Africa: Burkina Faso
Thematic area	Humanitarian emergency
Primary keywords	Partnership; Emergency;
Objectives	• Position UNFPA as a reliable humanitarian partner in Burkina Faso • Step up the integration of RH in emergency management documents • Improve the implementation of the Minimum Initial Service Package (MISP) for RH in the field.
Description & context	UNFPA interventions in the area of humanitarian emergency and, more specifically, in the implementation of the MISP for RH began quite recently. In connection with the management of Burkinabè returnees from Côte d'Ivoire in 2002, UNFPA intervened by providing condoms, emergency RH kits but did not stand out as a humanitarian partner. Thus in 2005, the country's humanitarian partners did not consider UNFPA as a humanitarian actor. Besides, the UNFPA country office staff is not yet familiar with the role of the organisation in the management of humanitarian emergencies. As a result, UNFPA does not sufficiently participate in meetings on emergencies held within the UN system, despite the fact that it is a member of IASC (Inter-Agency Standing Committee). In the Ministry of Health and Social Action, UNFPA is not recognized as an actor and is not invited to attend meetings. At the level of national structures in charge of managing humanitarian emergencies, four agencies of the UN system are recognized as humanitarian partners: UNICEF, WFP, WHO and UNDP through the coordination of the UN system.

	Thus, the multi-risk contingency plan, a reference document to deal with emergencies does not sufficiently take RH and GBV into consideration, despite the participation of the office in the drafting of this document. Actually, there has not been sufficient sensitization among humanitarian partners because UNFPA activities were particularly focused only on providing RH kits. Providing kits to the Ministry of Health proved insufficient for UNFPA's positioning as a humanitarian actor. In February 2008, the UNFPA Country Office humanitarian focal point underwent training in the MISP for RH. A debriefing session on this training was held for colleagues to make them aware of the role of UNFPA in emergencies. It was thus decided that UNFPA's position in humanitarian settings in Burkina Faso should be strengthened by consolidating partnership with actors already intervening in this area.
Strategy, key challenges and implementation	**Strategies** • Training of humanitarian actors • Advocacy meetings with actors • Active participation in meetings • Financing joint humanitarian initiatives within the UN system • Signing a MoU with Associations and NGOs who are humanitarian actors. **Challenges and constraints** • Interventions in the health sector were underpinned by the fight against epidemic diseases and the Early warning and surveillance system, and only the Disease Control Directorate was invited to coordination meetings. The Family Health Directorate in charge of RH was not invited to the meetings. • UNFPA did not incorporate humanitarian emergencies in its different programme components; hence no budget-line allocation of regular resources devoted to humanitarian activities (RH/HIV/GBV/ data collection was made; thus UNFPA interventions in humanitarian settings were limited with spontaneous response with no emphasis on preparedness.

- UNFPA staff were not equipped to defend the need to take into consideration the MISP for RH during coordination meetings;
- Humanitarian actors did not consider RH as a priority in humanitarian crises.

Activities

- Training/sensitizing the staff of the UNFPA office, sister agencies of the UN System, key figures of Ministries (health and social actions) and NGOs in 2009. The training was facilitated by the Johannesburg UNFPA Africa Regional Office and the Dakar Sub-Regional Office. It served as an opportunity to deliver key messages on the integration of the MISPfor RH and the role of UNFPA in humanitarian situations. This activity was the starting point of the recognition of UNFPA as a humanitarian partner.
- Training in MISP for RH in 2010: participation of the humanitarian officer in the UN Resident Coordinator's Office in the training on SRH programming in crisis and post-crisis situation (SPRINT) at the insistence of UNFPA; the participation of this key person in the coordination of humanitarian affairs within the UN system in Burkina led to the building of alliances.
- Advocacy meetings: two advocacy meetings were held: (i) with the Red Cross to see how UNFPA could provide support to this organisation which is deployed throughout the country, within the framework of sexual and reproductive health interventions; (ii) with the Department of family health to ensure that this department responsible for RH issues at the Ministry of Health is more involved in the management of humanitarian emergencies.
- UNFPA participation in the financing, preparation and implementation of the simulation exercise on the flooding scenario in 2009
- Interventions of humanitarian partners during meetings: the UNFPA staff intervened at several strategic meetings (i) the humanitarian coordination meetings were excellent forums for the promotion of sexual and reproductive health in emergency situation; (ii) UNFPA presented to the entire humanitarian partners, data it collected during the flooding simulation exercise in 2009; (iii) presentation of the MISP

	for RH, in 2010, at the quarterly meeting of health partners. This meeting was attended by the government (central, regional and district levels), technical and financial partners, NGOs and associations working in RH.
Progress and results	• UNFPA is invited to the different meetings of humanitarian partners. • UNFPA mobilised CERF resources in 2009 and 2010. • During the management of the 2009 floods, the Prime Minister mentioned UNFPA among the humanitarian partners that have supported the Government by providing dignity kits. • UNFPA proposed two projects in the 2010 Emergency Humanitarian Action Plan (EHAP). • UNFPA contributed to the preparation of all the documents on humanitarian emergencies between 2008 and 2010: revision of the contingency plan, preparation of the flash appeal, CERF, EHAP, preparation of the national civil protection policy, the revision of data collection tools.
Lessons learned	• Strengthening the capacities of key actors of the humanitarian sector on the MISP for RH makes it possible to better integrate RH in the documents produced and in the humanitarian space. • Partnership in the humanitarian sector facilitates the recognition of UNFPA as a humanitarian partner. • UNFPA's participation in different meetings helps improve resource mobilisation for RH and GBV in emergency situation.

Conclusions and recommendations	The partnership established with humanitarian actors led to the consolidation of UNFPA's positioning in Burkina Faso. The role of UNFPA in emergency management area has led to an increasing number of requests by partners. These requests are of a technical, operational and financial nature. The situation calls for the reorganisation of the office to better deal with growing requests particularly by ensuring that programme and operations staff integrates humanitarian action in their respective work plans with a view to setting up a humanitarian team in the office.
Partners	Ministry of Health, Ministry of Social Action and National Solidarity, UN System Coordination Unit, PS/CONASUR (Permanent Secretariat of the National Committee for Emergency Assistance), WHO, UNICEF, WFP, Burkinabe Red Cross, National Institute of Statistics and Demography (INSD).
Sources and links	• Multi-Risk Contingency Plan • CERF 2009 and 2010 Burkina • EHAP 2010 Burkina • Press releases
Reviewed by	SRO Dakar, ARO and HRB

3. ETHIOPIA

Title	**Integration of reproductive health services in nutritional programmes in Ethiopia (2006-2010)**
Personne-contact **Region: Country**	Mr. Benoit Kalasa, Country Representative, UNFPA Ethiopia kalasa@unfpa.org Africa: Ethiopia
Thematic Area	Humanitarian Interventions on Reproductive Health and Gender
Primary Keywords	RH, ANC , Food insecurity, Nutritional intervention, Southern Nations, Nationalities and Peoples' Region (SNNPR), Regional health bureau (RHB), GOAL, Action Contre la Faim (ACF), International Medical Corps (IMC), UNICEF, Ethiopia, UNFPA
Objectives	• Contribute to the reduction of maternal and neonatal mortality and morbidity by supporting maternal and reproductive health education and the identification of 92,619 malnourished pregnant and lactating women and referral for treatment of malnutrition, antenatal, and postnatal care from 2008 to 2010 with a total budget of US$ 601,744. • Enhance the capacity of 21 health institutions, 1,372 health extension workers and 93 nurses and midwives in 2008-2010 to provide quality Reproductive and Sexual Health Services with a total budget of US$ 238,256. Area of Intervention: Southern Nations, Nationalities and Peoples' Region (SNNPR), Ethiopia.
Description and Context	Ethiopia has had a long standing history of natural and human-made crises and emergencies. The country continues to face several humanitarian challenges with recurrent natural hazards, including cyclical drought, flooding and infectious human and livestock diseases compounded by community level clashes that provide the basis for chronic food insecurity, high mortality rates, population displacements and loss of livelihoods.

	About 5.2 million people in Ethiopia will require emergency food assistance in 2010. Ethiopia has some of the worst maternal mortality indicators in the world. Each year about 2 million women in Ethiopia give birth and more than 95% without the supervision of a skilled birth attendant. An estimated 573 mothers die for every 100,000 live births. Out of the total, an estimated 350,000 births are taking place in communities living under both acute and chronic emergency situations. Over 80% of maternal deaths occur due to preventable pregnancy-related complications that are attributed to limited and inadequately trained staff; limited equipment, supplies and drugs; and an inefficient health referral system. Recurrent crisis such as floods, drought, conflict and displacement, coupled with inadequate access to health facilities put pregnant women at risk in humanitarian settings.
Strategy, Key Challenges and Implementation	**Strategies** • Using nutritional interventions as an entry point for essential reproductive health services provision in humanitarian settings. • Working in partnership with other humanitarian and development partners (Government Offices, UN Agencies, NGOs). • Enhancing the capacity of health facilities and medical personnel through the provision of RH commodities and equipment and trainings. • Social Mobilization for awareness creation and information sharing for improved utilization of available RH services. • Although the CO doesn't have any sub-offices, efforts have been made to integrate humanitarian issues into the different development programs of the CO as well as its partners; to cite some examples, humanitarian interventions have now become part and parcel of each program component in the newly developed Country Program.

	Implementation • A rapid assessment was carried out to identify the gaps and needs of health facilities. • On average, 30 trainings were organized for Health Extension Workers (HEWs) and medical staff on clean and safe delivery techniques, modern family planning options, and treatment of sexually transmitted infections and prevention of HIV/AIDS, rape survivor treatment and gender concerns under humanitarian setting. • Information Education Communication (IEC) sessions conducted for community members in general, and women, in particular on maternal and Reproductive Health issues. • Health extension workers and health facilities supported to identify and refer malnourished pregnant and lactating women for antenatal and postnatal care treatment. • Malnourished pregnant and lactating women provided with FEFOL capsule. • Health facilities equipped with missing key reproductive health supplies and equipment. **Key Challenges** • Political instability and insecurity in some pocket localities • Inadequate understanding of humanitarian issues on the part of partners • Integrating RH and Gender in programs of GOs and NGOs.
Progress and Results	• Pregnant and lactating women screened for malnutrition were linked with ANC, delivery and PNC services (20,100 Fefol capsules distributed). • Health facilities equipped with RH equipment and drugs such as clean delivery Kits, Individual, clean delivery Kits, birth attendant, treatment of sexually transmitted infections kits, clinical delivery assistance kits, intrauterine devices (IUDs); management of miscarriage and complications of abortion kits, suture of tears (cervical and vaginal) kits and vacuum extraction delivery kits. • The use of RH commodities has increased. • 18,912 pregnant and lactating women referred for treatment of malnutrition, ANC and PNC.

	• Training provided to 616 health extension workers on safe and clean delivery, family planning, ANC,PNC and the risk of severe malnutrition for pregnant and lactating women. • 71644 women of reproductive age received health education on maternal and newborn health care including family planning and other aspects of reproductive health such as ANC, PNC, etc. • 721 traditional birth attendants received orientation on clean delivery, antenatal care including the recognition of danger signs, postnatal care, and family planning. • 16 health facilities equipped with supplies and equipment to manage obstetrical complications (clinical delivery assistance, suture of birth canal tears, management of miscarriage and complications of abortion, and vacuum extraction delivery). • 48901 individual clean delivery kits distributed to 48901 visibly pregnant women.
Lessons Learned	• Integrating humanitarian responses of RH and Gender with existing nutritional programs can be instrumental in terms of increasing access of women to essential RH services thus contributing to the reduction of maternal mortality that otherwise would have been escalated because of birth related complications. • Capacity building of partners working closely with communities contributes to improved preparedness and effective response. • Strengthening of partnerships for effective and coordinated preparedness and response is crucial.

Conclusions and Recommendations	Identification of malnourished pregnant and lactating women and referral for provision of curative and preventive treatment including supplementation of iron capsules for pregnant and lactating mothers suffering from low hemoglobin in chronically food insecure areas are important in saving maternal deaths attributed to bleeding during delivery. The linkage of RH services with nutritional programs has also been instrumental in reaching the unreachable. **Way Forward** • The integration of RH services in a humanitarian setting needs to be replicated in other parts of the country where chronic emergency situations prevail. • Need for advocacy on the importance of integrating RH and gender issues in regular programs.
Partners	• Beneficiaries, SNNPR RHB, IMC, Goal, ACF, and UNICEF
Sources and Links	• Project Documents • Progress Reports • Evaluation Reports
Reviewed by	Mr. Benoit Kalasa SRO Dakar, ARO and HRB

4. GHANA

Title	**Including and budgeting for humanitarian interventions in the 5th country programme (2006–2011)**
Contact person **Region: country**	M. Bawa Amadu,Assistant Representative (amadu@unfpa.org) Africa : Ghana
Thematic area	Humanitarian Intervention – Reproductive Health, Gender
Primary keywords	Humanitarian Interventions, Country Programme, Budgeting, Annual Work Plan
Objectives	• To mainstream humanitarian interventions into the CO programme o To provide quality and timely response to humanitarian situations at all times o To implement quality and effective humanitarian interventions
Description & context	Ghana has a high maternal mortality rate of 451/100,000. This may be exacerbated in humanitarian situations. Moreso, RH and SGVB are not recognised as priority in humanitarian settings. In view of this UNFPA Ghana in the development of the 5th Country program, (2006-2010) included strategies to address Reproductive Health and Sexual and Gender based violence in humanitarian settings and also build upon the capacities of national systems in this area. These interventions were addressed under Reproductive Health and Gender Components.

Strategy, key challenges and implementation	**Strategy:** • Sensitizing CO team on the importance of humanitarian response. • Advocacy for a inclusion of a budget line for humanitarian interventions in the Annual Work plan. **Key Challenges** • SRH and SGBV not considered as a priority by Humanitarian partners. • Limited evidence to back up the need for SRH and SGBV in humanitarian situations. • Limited awareness and capacity of National systems for SRH and SGBV interventions in humanitarian situations. **Implementation** • Budgeted for CO humanitarian interventions in the 2010 Annual Workplan under the RH and Gender components. • Advocated with National Disaster management Organisation to integrate SRH and SGBV interventions in National Contingency Plan. • Orientation of NADMO on RH and SGBV in humanitarian situations. • Prepositioned hygiene kits from budgeted funds to support affected population.

Progress and results	Through the allocation of core programme funds, UNFPA Ghana was able to implement its activities outlined in the contingency plan during the 2010 as follows: • Procurement of hygiene kits for women, girls and nursing mothers ; • Distribute RH kits procured with support from HRB to Health facilities in flood affected regions ; • Orientation and advocacy workshop for NADMO regional coordinators and operation officers on integrating SRH and Gender into disaster management. **Results:** • Increased Awareness of the National Disaster Management Organisation in giving priority to of SRH and SGBV issues in humanitarian coordination. • NADMO agreed to incorporate SRH and Gender concerns into the Regional disaster and management plans. • NADMO agrees to improve inter-sectoral dialogue and relationships with the Ghana Health Service and the Domestic Violence and Victims Support Unit (DOVVSU) / Ghana Police Service and ensure that all partners are adequately involved in disaster management. • The allocation of programme funds also facilitated the participation of CO and Sub Office (Tamale) in Rapid assessment exercises.
Lessons learned	• The involvement of the operations Unit facilitated the procurement of the RH and Hygiene kits. • The allocation of core funds to humanitarian interventions enhanced further resource mobilization from HRB. • Allocation of core funds to humanitarian interventions facilitates the development of the capacity of government, and other humanitarian partners to respond to Sexual Reproductive Health and Gender Based Violence. • The allocation of core funds leads to improved preparedness for humanitarian response.

Conclusions and recommendations	**Conclusion** The inclusion and budgeting for humanitarian interventions in the Annual Workplan improves country office preparedness and also serves as an entry point for increased resource mobilization. **Recommendations** • Regular Monitoring and Evaluation of humanitarian activities including utilization of RH and Hygiene Kits • Build the capacity of more humanitarian actors in SRH and SGBV with budgeted programme funds. • Build new partnerships with other humanitarian actors • Advocate for more core funds to address humanitarian preparedness • Advocate with Government to increase budget line for SRH in humanitarian response • Provide budget line in AWP for data collection in humanitarian situations.
Partners	National Disaster Management organization, Ministry of Health/Ghana Health Service, Domestic Violence and Victims Support Unit /Ghana Police Service, UNFPA HQ, RO and SRO.
Sources and links	UNFPA Ghana Annual Work Plan, UNFPA Ghana Strategic Plan, Country Office Report
Reviewed by	Mr. Jude Edochie, UNFPA Representative a.i Mr. Bawa Amadu,Assistant Representative Dr. Robert Mensah, Reproductive Health Specialist Ms. Bridget O.Asiamah – NPO-RH / Focal Point – Humanitarian Response Ms. Doris Mawuse Aglobitse - Advocacy and Communications Officer SRO Dakar, ARO and HRB

5. MADAGASCAR

Title	**Restore hope, save lives : UNFPA humanitarian response in the face of excessive risks of maternal and neonatal mortality, in three regions in the South Madagascar affected by recurrent food insecurity (2008-2010)**
Contact person	Mr. Cheikh Tidiane Cissé, UNFPA Representative, Madagascar (cisse@unfpa.org) Dr SOLOMANDRESY Ratsarazaka, NPO "Policy analyst and humanitarian assistance" (solomandresy@unfpa.org)
Region: country	Africa : Madagascar
Thematic area	Humanitarian interventions in reproductive health, gender equality and food security
Primary keywords	Reproductive health ; Vulnerable groups ; Food insecurity, Food; UNFPA ; World Food Programme (WFP) ; Joint response; Community ; Accessibility ; Gender.
Objectives	Contribute to the reduction of vulnerability among women of child-bearing age linked to recurrent food crisis in three regions of Southern Madagascar.
Description and Context	Southern Madagascar[1] particularly suffers from cyclical chronic drought which tends to be aggravated in time and space due to the fallouts of climate change; this results in recurrent food insecurity with risks of famine during the lean period. The people of these three regions represent 10% of the national population estimated at 20 million. With regard to socioeconomic vulnerability, only 70% of its households are ranked in the second poorest quintiles for a rate of 40% at national level. They health indicators are lowest compared to rest of the country[2]; the contraceptive prevalence rate for modern methods among 15-49 year old women is only 3.2 while the national average is 29.2.

1 Monitoring the Early Warning System
2 Results PHS 2008-2009 Madagascar

	As regards the use of maternal health services only 24%, on average of live births in health facilities were reported over the past 5 years while the national average is 35. 3[3]. The Reproductive Health situation of Teenagers and Youths confirms these warning signs: on the average, 48.7 % of 15-19 year old teenagers in these three regions have either been pregnant or are already mothers while the national average is 31.7. These different indicators "in red" attest to the existence of a high risk of excess maternal and neonatal mortality during the lean period, thus the prioritisation of a response facilitating the availability and access to RH and basic social services. In view of the challenges and resources available, UNFPA's response lays emphasis on the most vulnerable groups, namely teenagers and youths and pregnant women and lactating mothers.
Stratégies, principaux défis et mise en œuvre	**Strategy** • Resources mobilized from non-traditional donors in addition to the regular funds available[4]. • Strengthening the capacities of governmental institutions, namely the Ministry of Health at all levels[5]. • Development of partnership with WFP for the « food security » component, The local NGO SOMONTSOY which has expertise in social mobilization and an in-depth knowledge of cultural sensitivities of the target population and community leaders of target communes. • Social mobilization for the use of RH services in target communes; (v) Organisation of free quality RH services for the enhanced access of targets in the concerned communes.

3 On the decline in relation to the PHS 2003-2004
4 The project document is in annex
5 Training providers of target centres in emergency obstetrical and neonatal care (EONC), MLD/FP, SRA ; supervising the quality of services delivered ; supervising the management of the different tools used

Key Challenges

- Timely availability of required resources.
- Accessibility for populations living more than 10 km away from health centres.
- Storage of individual delivery and hygiene/ dignity kits in communes.
- Capacity of local and community-based NGOs to react rapidly in situation of crisis (since members of the community are affected by the lean period).
- Evaluation of results (quantitative and qualitative).

Implementation

Two months before the lean period

- Conduct a rapid assessment including the nominative census according to the place of residence of women of child-bearing age/visible pregnant in target communes. WFP provides food supplements on the list basis.
- Re-mobilization of members of the local NGO who have already undergone training in RH, sexual violence and gender issues.
- Institution of supervision mechanisms during sensitization activities covering all the fokontany (counties) of targeted communes: That of NGOs by UNFPA field teams and that of community workers by the different heads of the local NGO.
- Institution of mechanisms for the identification of and search for missing persons by community workers, of pregnant women or those who have recently delivered, for prenatal and post-natal care covering all the zones including those inaccessible.
- Institution of a mechanisms for the management of dignity or hygiene kits through collaboration with the NGO and heads of target communes as well as the mechanism dubbed « food after accessing RH services ».
- Provide RH supplies for free service delivery during the lean period[6].

6 Madagascar already has a health policy consisting in free supplies to the most vulnerable populations. It is simply recommended to have a transparent management of donations and the adequate tools to that end.

	At the beginning of and during the lean period • strengthening the technical capacity of health facilities for quality service by providing medical supplies and equipment and training /supervision of healthcare providers by UNFPA supported doctors . • Operationalize mechanisms for the use of free RH services in target centres, « *any woman of child-bearing age with emphasis on pregnant women or those who have recently delivered and who have had access to at least one RH service, receives food complements provided by WFP*» . • Providing individual kits (delivery, dignity/ hygiene) for women coming for RH consultation. • Facilitating the delivery of RH service through advanced strategies (out-reach approach) for pregnant women living far from the health centre, in close collaboration with community workers of concerned communes. • At all levels, strengthen the monitoring and coordination of implementation of the activities.
Progress and Results	• Community leaders of 14 targeted communes took ownership of the mechanism for the management of individual delivery kits; • Every year, thanks to the activities undertaken during the lean period in 14 level II health centres of health communes, more than 8000 women of child-bearing age benefited from adequate reproductive health management through better access to free quality RH services. The rate of contraceptive coverage rose from 3.6% to 31% in the target areas of Androy thanks to the availability of different methods on the site, on the one hand, and the active participation of community workers in the mobilization of the populations for the use of services and active search for missing clients. • More than 2500 pregnant women or those who recently delivered were provided with prenatal, delivery and postnatal care thus reducing the high risk of excess maternal mortality due to obstetrical complications. They thus received their dose of iron-folic acid tablets, at least one tetanus toxoid vaccination, sensitization on the danger signs during pregnancy and child birth. The

	number of deliveries for target centres tripled during the lean period and performance was maintained even 2 months after the interventions. • Thanks to an increased resilience in the face of food insecurity, hope was restored to more than 8000 women of child-bearing age and their families.
Lessons learned	• The integration of two programmes « RH and food programme" in the response was favourably accepted by all stakeholders and their implementation was facilitated through the close monitoring of activities and the strengthening of coordination at all levels. • Strengthening the capacities of community actors upstream led to an enhanced appropriation downstream which translated into an effective management of individual kits and the significant increase in the use of RH services by the most remote populations. However, since the community itself is constantly affected, it needs to be continually « boosted ». • The recruitment of a local NGO familiar with cultural sensitivities and with proven experience in working with the community is fundamental for the supervision of community leaders in social mobilization activities and the recuperation of missing clients. • The leadership of the management team of health districts is fundamental for the availability of human resources. • The correlated development of partnership between United Nations Agencies and local actors made it possible to better prepare and find a response to the lean period through efficient resource management. • Thanks to the development of IEC aid, taking into account the «joint » aspect of the approach, it was possible to better relay the message « Healthy pregnancy, healthy food », «Taking iron- folic acid and the prevention of anaemia among pregnant women», « The vulnerability of youths in acute food crisis » • The development of appropriate management tools helped establish a climate of confidence among the different stakeholders, especially in the recipient community

Conclusions and Recommendations	Considering the growing extension of communes affected by the impacts of climate change in the Southern Madagascar region, it is vital to embark on an ongoing resource mobilization to strengthen the network of partners at local level. The project's sustainability would only be possible if there is a firm political commitment by policy-makers for a lasting development programme in this area. However, the integrated approach was convincing and was adopted and extended to other UN sectors. This approach featured in the report of the Resident Coordinator of the UN system for Madagascar in 2010.
Partner	Ministry of Health, The United Nations Country Team (UNCT[7]), United Nations Office for the Coordination of Humanitarian Affairs (OCHA), WFP, Government[8] and Civil Society.
Sources and links	Project Document for the project financed by the principalities of Monaco and Andorra, Progress report for the project financed by the principalities of Monaco and Andorra, Joint mission report.
Reviewed by	Mr. Cheikh Tidiane Cissé, UNFPA Representative to Madagascar SRO Dakar, ARO and HRB

7 UNCT decisions facilitated the implementation of different interventions of this joint programme which is the first of its kind for Madagascar
8 The National Nutrition Board which works in close collaboration with WFP and which has validated and followed-up the activities

6. MALAWI

Title	**Timely provision of customized hygiene kits to families affected by an earthquake in Karonga-Malawi January, 2010**
Contact person **Region : country**	Dorothy Nyasulu (nyasulu@unfpa.org) Africa : Malawi
Thematic area	Emergency response
Primary keywords	Hygiene; Earthquake; Dignity; Vulnerable populations; Humanitarian response
Objectives	To ensure that women affected by Karonga earthquake maintain their dignity through provision of hygiene kits.
Description & context	Karonga experienced a series of earth tremors culminating in one strong quake measuring 6.1 on the richer scale on 21st December 2009. The earthquake led to destruction of houses, roads, schools and health facilities. A total of 145,436 people were affected and 1,557 houses collapsed. The destruction and displacements compromised the personal hygiene standards of the most affected persons. Furthermore, vulnerable groups such as women and girls of reproductive age found it increasingly difficult to meet their menstrual needs and move easily, especially to access the humanitarian assistance. The aim of the intervention was to address the right to dignity for 1000 most vulnerable household, each comprising of approximately six people. The affected population was put in a makeshift camp. Interviews with the affected population by UNFPA revealed the need for menstruation supplies, bathing and toilet supplies and dental hygiene supplies. UNFPA, in collaboration with Malawi Red Cross society, provided 1000 dignity kits to the affected population as part of the MISP response. Other stakeholders such as Oxfam, World Vision International, and Women community based organizations, and Government departments, provided shelter, food, water and sanitation.

Strategy, Key challenges and implementation	**Strategy** • A rapid assessment and focus group discussions with women, men, boys and girls was done for identification of needs of the affected populations through the deployment of staff at the onset of the disaster • Collaboration with Government and other NGOs for the timely response to the needs of the affected populations. The kits comprised of: Chitenje (cloth wrappers); toothbrush and toothpaste; bath soap; laundry soap and powder; men's shaving disposable blades; women's menstrual cloth; pads and cotton wool. Of the items included, the Chitenje was important for women movements within and outside the camp as it provides a sense of dignity in Malawi. In addtion, the mestrual cloth is a traditional menstration item for Malawian older women whilst the pads and cotton wool served the young women well. **Implementation** Following the rapid assessment, identification of beneficiaries was done based on vulnerability levels. • Collaboration with Malawi Red Cross Society • Procurement and assembly of hygiene kits and distribution by Malawi Red Cross Society volunteers and selected communty memebers of Karonga. UNFPA procured the items; Malawi Red Cross volunteers and selected members of the community in Karonga assembled the kits under the supervision of UNFPA. • Joint monitoring of activities by UNFPA and Malawi Red Cross Society. • Reporting by UNFPA **Key challenges** • The primary challenge was the lack of key RH indicators in the initial assessment report conducted by the District Team • Lack of operational partnership or signed MOU with the Malawi Red Cross.

Progress and results	• 1,000 customized packages were made and distributed to identified beneficiaries were identified by local village headmen and Malawi Red Cross volunteers and verified by the District Commissioners team.
Lessons learned	• An existing and long term agreement with Malawi Red Cross could have made the intervention better. • UNFPA Malawi to integrate disaster risk reduction including humanitarian issues in its programmes for future interventions will enhance preparedness, adequate funding and timely response. • UNFPA is now recognized as a humanitarian agency with specific key interventions to offer and a leadership role of the UN Humanitarian Group.
Conclusions and recommendations	UNFPA humanitarian response through the hygiene kits was seen as tangible response in the area of RH. Previously the Humanitarian response in Malawi had not included the hygiene kits. UNFPA should continue to advocate for its inclusiveness in the humanitarian response.
Partners	Malawi Red Cross Society; Women CBOs; Malawi Government and beneficiaries.
Sources and links	• Rapid assessment report • Monitoring report • Final report by UNFPA
Reviewed by:	SRO Dakar, ARO and HRB

7. MALAWI

Title	**Responding to the Sexual and Reproductive Health and rights (SRHR) needs for the internally displaced youths (girls and boys) and support to communities to provide psychosocial care for young people affected by an earthquake in Karonga-Malawi January- April, 2010**
Contact person **Region/country**	Dorothy Nyasulu/Nyasulu@unfpa.org Africa : Malawi
Thematic area	Emergency response
Primary keywords	Internally displaced Youths (IDY), Sexual and Reproductive Health and Rights services, Psychosocial support
Objectives	• To respond to the Karonga earthquake through provision of psychosocial support. • To provide youth-friendly SRH and HIV/STI services to young people i.e contraceptives and Voluntary Counseling and Testing (VCT) to ensure continued access to services and prevent HIV infection and unwanted pregnancies.
Description & context:	• Karonga experienced a strong quake measuring 6.1 on the Ritcher scale in January 2010. The earthquake led to destruction of houses, roads, schools and health facilities. Young people were affected as a specific group. A youth organization called Tupakisane had its youth centre completely devastated. The organization was serving more than 8,000 young people. It was providing SRHR services. The services included condom distribution, VCT, contraceptives and Information, Education and Communication (IEC) materials on SRHR. It was the main provider of these to young people and some adults as the nearest health facility was more than 15 km away. Following the earthquake, it meant that young boys and girls could not access these services anymore due to destruction of the centre. As such it meant that they would now have to move long distance to access SRHR services. The likelihood of them doing so, was less as they would have to prioritize looking for food or getting shelter. It was necessary to break this link and provide SRH services that could otherwise have been accessed in normal situations.

	• A situation analysis was conducted by the National Youth Council of Malawi with support from the communities leadership, young people and the district youth officer (DYO) for Karonga. It was reported that: i) traditional leaders and parents were concerned about the increased apprehension of young people as no one was talking to them while the prevailing situation could increase vulnerabilities through involvement in risky behaviors such as early and unprotected sexual activities; ii) young people would like to see continued provision of services but also need to put strategies that would help mobilize young people to access the services at the centre. • A total of 145,436 people were affected (35% were young people aged 10-24 years) and 1,557 houses collapsed . A total of $16,000 was advanced to NYCOM for the intervention. • Utilizing their track record in counseling and psychosocial support to young people, NYCOM has wide presence in all districts in Malawi making follow up easy through their member organizations such as the district youth office. UNFPA provided technical assistance in the area of emergencies which was new to NYCOM. • This community initiated intervention was first of its kind in the history of disasters in Malawi which aimed at providing a centre where young people could get correct information and SRH services during the crisis and recovery period.
Strategy, Key challenges and implementation	**Strategy** • UNFPA worked through National Youth Council of Malawi (NYCOM), an exisiting IP to undertake the needs assessment and setting up of the crisis centre. NYCOM partnered with two community based youth organisations in Karonga under the leadership of the District Youth Officer (DYO) to moblise the young people and undertake the interventions. • Training of 30 community counsellors selected based on a set criteria to ensure safty and protection of young people in the community.

- Peer education
- Establlish Voluntary Counselling and testing (VCT), free condom distribition and referral services.
- Training on of community counsellors on prevetnion of GBV.
- Recreational facilites included sports, full Digital Satellite Televion (DSTV)s and indoor games (acticities were identified with the participation of the affected yound people).

Key Challenges

- The primary key challenges were the long standing community beliefs and attitudes surrounding young people's SRH information.
- Less numbers of girls than boys attending the centre due to preoccupation with household chores.
- The minimal quality of the premises making them less attractive.
- Lack of resources to expand or sustain the services, non availability of trained human resources and disruption of continuum of the peer education.
- Delayed reporting by the CBOs with raw data not disaggregated by sex and age.

Implementation

- UNFPA assisted in developing the teaching materials for psychosocial support and identied experts from the Ministry of women and gender, Women and Development and Malawi Red Cross Society for facilitating the workshop. A total of 24 participants were trained from government, NGOs and CBOs for 5 days. The trainers were oriented on how to follow up the application of knowledge gained by participants to their respective communities. It was established that the district has structures linked from community to the district level which is represented by 62 active Community Based Organizations. These were linked to ensure sustainability of the interventions beyond the emergnecy period.
- NYCOM through DYO ontinues to support the intervetions through incoporation of the interventions in the district implementation plan of the DYO for karonga who reports to NYCOM and Ministry of youth on a quarterly basis.

Progress and results	• A functional SRHR centre was set up to assist young people access various SRH services. • The findings from the rapid assessment led to the setting up of the SRHR youth friendly centre. It was ailmed at addressing young people's SRH and psychosocial needs through provision of counseling services, information, recreation and HIV/STI prevention services in that they temporarily could not attend school, while parents were busy with livelihood and shelter issues leaving them idle and mostly on their own. • As reported and verified (through register review by NYCOM and DYO) by the Tupakisane youth organization and the community members), the site received more young people than before the site was struck by an earthquake. It was found that between July to September 2010, the site had received a total of 807 males and 577 females who came for counseling, IEC materials and recreation services. VCT services were accessed by 44 males and 26 females. A total of 344 pieces of condoms were distributed. These were only male condoms as they were no female condoms. Erratic supply of VCT test kits at the District Health Office (DHO) affected their VCT provision. However the numbers were reported to be higher than in the previous months before the earthquake. • The trained 30 counselors continue to provide information on prevention of GBV. The centre has since not reported any cases of sexual exploitation.
Lessons learned	• UNFPA Malawi to integrate humanitarian issues including disaster risk reduction in its programming processes for future interventions other than relying on initial support from elsewhere such as HRB. • Recreational activities in the center were an entry points for a continuation of ASRH services as young people would initially come to watch football games ending up getting information on SRH. • The interventions have now been incorporated in the district implementation plan to ensure sustainability.

	• The experience gained from this earthquake response will be used to guide future responses to natural disasters in Malawi. • Psychological support for staff in charge of the project coupled with regular supervision enhances their ability to cope with unusual levels of stress. • The relevance of UNFPA's intervention led to a recognition of UNFPA country office as member of the UN country humanitarian team with a leadership role in 2010 UNFPA is now recognized as a humanitarian agency with specific key interventions to offer for young people.
Conclusions and Recommendations	• Young people should be considered as a vulnerable group requiring special attention in emergency settings to prevent them from contracting HIV, unwanted pregnancies and to deal with high levels of stress. • Young people's needs and programs to be mainstreamed in humanitarian response right from rapid assessments to the response itself to avoid exclusion.
Partners	UNFPA, NYCOM, KASOBA and Tupaskiane youth CBOs, Malawi Government (District youth office) and beneficiaries.
Sources and links	2010 AWP, Newspaper articles, launch reports, progress reports and photos.
Reviewed by	• SRO, ARO, and HRB • Chisomo Zileni (NYCOM)zilenizileni@gmail.com

8. MAURITANIA

Title	**An efficient implementation of the Minimum Initial Service Package facilitates response to floods in the South West of Mauritania.**
Contact person **Region: Country**	Amar Mohamed Lemine (amar@unfpa.org) Africa : Mauritania
Thematic area	Sexual and reproductive health, Minimum Initial Service Package, flood victims
Primary keywords	Santé sexuelle et reproductive ; Dispositif Minimum d'Urgence; Sinistrés
Objectives	• To increase availability of quality reproductive health services in settlement sites of flood victims. • To strengthen knowledge, attitudes and practices of target groups (youth/Adolescents, women and men). • To contribute to the prevention of sexual abuse and violence to girls and women in the settlements for flood victims. • To reduce HIV transmission among the flood victims. • To reduce maternal and neonatal mortality and morbidity
Description & context	In Mauritania 18 cities are officially declared prone to flooding. Five other cities recorded floods in the last years. Between 1994 and 1997, bush fires destroyed 6,731 km^2 of pasture land. There are 11 breaks in the sand dune corridor which protects Nouakchott from the sea. Three huge invasions of locusts have been recorded in the last 30 years. Attacks of grain-eating birds on farms are a yearly occurrence. Rosso is the regional capital of the Trarza in the southern most part of the country situated along the Senegal River. The climate of this area is influenced by its proximity to the ocean

and records maximum rainfall than any other area of the country. Rainfalls can be heavy. The city does not have urban infrastructures adapted to flooding including the water drainage system. The soil is made of clay and the buildings are not resistant enough to these climatic changes. Ross city is surrounded by returnee sites of people repatriated following the three party agreement signed in 2007 between Mauritania, Senegal and the UN High Commissioner for Refugees (UNHCR) for voluntary return of 35 000 refugees. On the night of Thursday 27 to Friday 28 August 2009, Rosso recorded a rainfall of 104 mm and in the afternoon of 28 August another rainfall of 70 mm, so much rainfall within a 24 hour period, resulting in forced displacement of up to 12000 persons following flooding.

Rapid assessment

- Camp site for over 12000 displaced persons without prior preparations for water supply, latrines, lighting or protection precautions.
- Sudden disruption in health information and services; 2 health centres cut off by surrounding rainwater.
- An outbreak of diarrhoea and malaria cases reported by health services. Risks of cholera if the latrines are not quickly provided.
- Increase in acute respiratory tract infections and rheumatism.

UNFPA response

- Rapid Mobilization of the office for technical and financial support that was needed.
- Joint rapid need assessment on the basis of the harmonized template for use in humanitarian settings.
- Participation of the office in simulation exercises using the flood scenario (in May, 2008) proved to be key in the management of the flood response in this case.

Strategy and implementation	**Strategy and implelmentation** • Dialogue with the authorities and with implication of communities with fair representation of men and women in the management committee of the camp. • Respect confidentiality with consultations: (guarantee privacy, patients assigned a number code in the registers as well as another code for the diagnosis). • Based on the reports of meetings with the beneficiaries, a package of activities which corresponds to the specific needs of the populations and provide a minimum initial services for improved access to sexual and reproductive health to affected men, women, adolescents (boys and girls) are made available. • Establish and equip and render operational an advanced health post • Clean delivery packs available. • Prevention of HIV / AIDS transmission: respect for universal precautions; guarantee free condoms distribution. • Information Education Communication on Reproductive Health / HIV package of activities. • Referral system of neonatal and obstetrical complications throughout the day (24 hours) by shift duty for health staff. • Establish a health information system including data collection. • As activities for prevention and response to sexual violence, specific arrangements were negotiated with the local authorities that include: lighting of the site, women represented in the committees for distribution of food items and camp management, the distribution of water points and also patrols by security forces in the evenings. • In collaboration with UNICEF and in partnership with the local authorities and Non Governmental Organizations, the office supported an awareness raising programmes broadcasted over the local radio network on prevention and response to sexual abuse and sexual violence against girls and women.

	key challenges • Targeting beneficiaries. • Coordination with authorities, various partners, involvement of affected communities. • Procurement of supplies, distribution, reporting.
Progress and results	• Continuous provision of sexual and reproductive health care in a context of sudden disruption in health services as a result of recurring floods. • Planning for comprehensive reproductive health services. • Availability of disaggregated data.
Lessons learned	• The quality of emergency response is reliable on the level of preparedness. • Proper understanding, by operational staff, of key concepts of coordination and operational guidelines of MISP will increase impact of the intervention. • The quality of the emergency response also depends of the types of partnerships forged in the preparedness phase. • Coordination and implementation of the MISP in reproductive health has boosted UNFPA position within the Humanitarian Coordination as well as the health and protection clusters. • Quick resource mobilization from UNFPA Emergency Response Funds (50.000 dollars) facilitated response to the priority needs of affected communities within a short time frame. • The need to have a concise plan for the distribution of RH kits. • One key factor for satisfactory implementation is field supervision. • Data collection help in assessing the impact of an intervention.

Conclusions and recommendations	• The implementation of the MISP during floods will respond to respond to the priority needs of the affected populations. • The choice of an organization or individual in charge of coordination must be strategic. • The involvement of communities from the beginning including the design phase of preparation and transparency will facilitate implementation and monitoring of the project.
Partners	Implementing partners: Ministry of Health, UNICEF, World Food Programme, World Health Organization, Mauritania Association for the Promotion of the Family, SOS-Peer educators, the Camp Management Committee.
Sources and links	• Situation reports (Sitreps) • Report of the meetings with officials • Report of the meetings with the beneficiaries • Report on emergency medical assistance and sensitization of flood-affected populations in Trarza (Mauritania) • mauritania.unfpa.org
Reviewed by	mcoulibaly@unfpa.org ahmedsalem@unfpa.org SRO Dakar, ARO and HRB

9. ZAMBIA

Title	**Integration Of Security Measures As An Integral Part Of Programme and Budget Design**
Contact person **Region: Country**	Mr. DUAH OWUSU-SARFO, Representative, UNFPA, (owusu@unfpa.org) Africa: Zambia
Thematic area	Emergency Response
Primary keywords	Security, MOSS, Staff safety, Acute phase
Objectives	To comply with minimum operating security standards (MOSS) for staff deployed and on duty in case of an emergency
Description and context	According to UNFPA security policy all Country offices are expected to be MOSS compliant and staff are required to have security clearance when traveling from their duty stations. All basic communication equipment, training and procedures ie vehicle and radio or telephone should be in place. Travel authorizations are also a requirement for travelling outside duty stations on missions which includes travels undertaken in humanitarian interventions. The nature of security preparedness will vary from country to country based on the relevant security risk assessment and approved MOSS , and the UNDSS is ready and available to provide guidance and assistance through the UN Resident Coordinator system. Zambia country office is MOSS compliant and security phase Zero is in effect for the country. It has generally been a peaceful country, but in the event of a crisis situation, MOSS measures including communication equipment has to be in place, and staff needs to be security conscious and already MOSS compliant to respond without delay.

Strategies, Key Challenges and Implementation	**Strategy** • To build the capacity of staff on security measures • To provide training, equipment and supplies to enhance staff MOSS compliance and readiness. **Key Challenges** • Limited attention given to MOSS compliance in Country Offices • Security issues not integrated in budget for Country programmes including humanitarian interventions • Limited awareness of MOSS by Country Office Staff **Implementation** • MOSS measures, including communication equipment including codans, hand-held radios and satellite phones procured by the CO. • All UNFPA CO Staff trained in security measures and were allocated call signs. • A UNFPA team comprising of Key Management and programme staff undertook a mission to a relocated camp for flood affected populations to conduct a rapid assessment and to test security measures.
Progress and Results	• All CO staff are now aware of security procedures, how equipment work, codes/terminologies. • Advanced security course (ASITF) taken by all staff. • CO has in place relevant security equipment as per approved country-MOSS, including held radios, condoms on vehicles and satellite phones. • A budget has been included in the Country office to address security measures as recommended by the UNDSS office.

Lessons learned	• Putting security measures in place at all times contributes to quick response for humanitarian interventions, and the security of staff that respond. • Building Capacity of staff enhances integration of security into programming and operations.
Conclusion and recommendations	• MOSS to be strengthened in preparedness for Humanitarian response – after the event there is no time to do so.
Partners	• UNDSS, PNUD
Sources and links	• Zambia UNFPA Annual Work Plan and • Country Office Report
Reviewed by	ARO Security Adviser SRO Dakar, ARO, HRB

Knowledge sharing workshop: Dakar (Senegal), Ngor Diarama 25-27 October 2010

List of Participants

No	Name	Title/Function	Country	EMAIL
1	Alexandrine DAZOGBO	Chargée de Programme SRAJ	Benin	dazogbo@unfpa.org
2	Sarai B. MALUMO	NPO RH	Zambia	malumo@unfpa.org
3	Siaka TRAORE	NPO BCC	Burkina Faso	traore@unfpa.org
4	Solomandresy RATSARAZAKA	NPO Policy Analyst	Madagascar	solomandresy@unfpa.org
5	Dorothy NYASULU	Assistant Rep	Malawi	nyasulu@unfpa.org
6	Bridget ASIAMAH	NPO RH	Ghana	asiamah@unfpa.org
7	Benoit KALASA	Representative	Ethiopia	kalasa@unfpa.org
8	Meron TEWFIK	NPO P&D	Ethiopia	meron@unfpa.org
9	Amar Ould Mohamed Lemine	Medical Adviser	Mauritania	amar@unfpa.org
10	Teopolina M.HAITEMBU	GBV – Red Cross	Namibia	teopolinah@yahoo.com
11	Bintou SUSO	Programme Associate	The Gambia	suso@unfpa.org
12	Nyaibor NGOMBU	NPO	Sierra Leone	ngombu@unfpa.org

No	Name	Title/Function	Country	EMAIL
13	Jusu SQUIRE	Programme Assistant	Sierra Leone	squire@unfpa.org
14	Hugues KONE	Regional Communications Adviser	SRO Dakar	kone@unfpa.org
15	Penda NDIAYE	RHCS Technical Adviser	SRO Dakar	pndiaye@unfpa.org
16	Boubacar SOW	Technical Advisor P&D/Census	SRO Dakar	bsow@unfpa.org
17	Jonathan NDZI	Humanitarian Response Specialist	SRO Dakar	ndzi@unfpa.org
18	Maria Caterina CIAMPI-MBAYE	GBV Technical Specialist	SRO Dakar	Ciampimbaye@unfpa.org
19	Faustin YAO	Director/ SRO	SRO Dakar	yao@unfpa.org
20	Rose GAKUBA	UNFPA Representative	Senegal	gakuba@unfpa.org
21	Lucien SIMBA	Humanitarian Affairs Officer	OCHA	simba@un.org
22	Siti Batoul OUSSEIN	Humanitarian Programme Specialist	ARO Jo'burg	oussein@unfpa.org
23	Margaret AGAMA	HIV Adviser	SRO Jo'burg	agama@unfpa.org
24	Leon TERBLANCHE	Regional Security adviser	ARO Jo'burg	terblanche@unfpa.org
25	Kae ISHIKAWA	RMB /RM Specialist	UNFPA NY	ishikawa@unfpa.org
26	Samson LAMLENN	Humanitarian Response Branch	UNFPA NY	lamlenn@unfpa.org