This report summarizes the proceedings of the sensitization training on “Emergency Risk Management for Health sector partners” held in Bhubaneswar, Odisha, India on 16th & 17th October 2015 to explore and deliberate on approaches to sustainably integrate and put people’s Health at the centre of Emergency Risk Management in the state of Odisha with the proactive participation of the various humanitarian agencies. Led by the UN agency, World Health Organisation (WHO), New Delhi India, this workshop called together over 60 stakeholders of the state representing the humanitarian agencies, senior health managers, govt. functionaries, UN & civil society representatives and experts on Disaster Risk Reduction to discuss however small but effective interventions that could be taken forward towards DRR in health.

Report by:
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Report on Sensitization Training on Emergency Risk Management for Health Sector Partners

16th & 17th October 2015
Hotel Hindustan International, Bhubaneswar, Odisha, India

Host: State Health Mission, Odisha
Organized by: WHO, UNFPA, IAG Odisha & Sphere India
The Context:

There are ever increasing evidences that recent growth processes have generated new forms of vulnerability in health and has a potential to seriously affect certain sections of population at all levels. The economic and social costs of vulnerability are huge and thus cannot be ignored. Odisha’s performance in emergency risk management particularly for health sector is ranked higher than many Indian states because of many pioneering, innovative and sustained efforts in peace times so as to effectively respond in disasters.

Poverty rates in Odisha remain among the highest in the country. The state’s vulnerability with poverty is accentuated by the frequent disasters disturbing the livelihood of people forcing them to migrate though migration is primarily induced by extreme poverty, hunger, dearth of work opportunities and debilitating impacts on health. Thus these call for a coherent and sustained effort for emergency risk management with the focus on people’s health, which is defined by WHO as “a state of complete physical, mental and social wellbeing and not mere absence of disease or infirmity.” (WHO, 1946)

International instruments also reaffirm the issue of health as under:

- Everyone has the right to a standard of living adequate for health and wellbeing of himself and his family –Article 25 of Universal Declaration of Human Rights 1948
- “…no one should be discriminated against on any grounds of status, including age, gender….” – The Sphere Project 2011
Thus to enhance the understanding on the necessary elements of Emergency Risk Management in Health, in reducing and/or protecting the vulnerabilities of different age-groups and to discuss prioritization of minimum level of health preparedness required for emergencies, the sensitization training was organized where the participants discussed their role in supporting the formulation of policy actions and implementation of emergency preparedness in peace time and to develop a road map / future action to take forward the preparedness to effectively respond to any health emergency.

The sensitization training was held successfully on 16th & 17th October 2015 at Hotel Hindustan International, Bhubaneswar, Odisha, India. More than 60\(^1\) participants representing humanitarian agencies, senior health managers, govt. functionaries, UN & civil society representatives and experts on Disaster Risk Reduction actively participated as per the session plan\(^2\) and helped the programme to achieve its objectives towards ensuring better preparedness to respond to health emergencies in the state of Odisha.

\(^1\) List of participants given as Annex-1
\(^2\) Given as Annex-2
Inaugural Session:

The proceedings of the day began with the formal welcome address by the Mr. Manoranjan Behera, IAG Coordinator, Odisha.

Dr. Nilesh Buddha, Technical Officer, WHO, New Delhi, Dr. Ambika Prasad Nanda, CSR Head, Tata Steel, Mr. Manoj Dash, Senior Programme Officer, Sphere India, New Delhi, Ms. Seema Mohanty, State Programme Officer, UNDP/OSDMA, Dr. Chakradhar Panda, Honorary Secretary, Indian Red Cross & IAG and Dr. Deepa Prasad, State Programme Officer, UNFPA Odisha were welcomed with flower bouquets followed by lighting of the ceremonial lamp.

On behalf of the Inter Agency Group, Odisha, Mr. Manoranjan Behera, IAG Coordinator, Odisha welcomed the dignitaries to discuss and deliberate on Emergency Risk Management of Health in Odisha with the hope that the training session in the state of Odisha would be instrumental in addressing various issues of health in emergencies.

Welcoming the participants of the workshop, Mr. Behera laid out the objectives of organizing such a sensitization training with the agenda for the two days and looked forward to discuss challenges & opportunities for emergency risk management in health expecting whole-hearted support from Govt. of Odisha and the humanitarian agencies and the architects of various innovations in DRR and health in Odisha.
Mr. Manoj Dash, Senior Programme Officer, Sphere India:

Mr. Manoj Dash gave an account of the activities of Sphere India in Emergency Risk Management and informed of the national coalition of over 52 organizations including UN, Govt., civil society and humanitarian agencies and looked forward to the discussions on the situation of preparedness in Odisha over the two days and work out better ways of preparedness so as to respond effectively in case of any health emergency.

Sharing that Sphere India was working towards ensuring Quality and Accountability in humanitarian actions had six life saving sectors mentioned as below:

i. Health
ii. WASH
iii. Food & Nutrition
iv. Shelter
v. Education
vi. Protection

Further, there are Committees and Sub Committees for each sector and each Sub Committee has a Chair & Vice Chair and thus WHO leads the Health Sector Inter Agency Coordination Committee.

Besides, Mr. Dash informed that Sphere India was also working for Knowledge Management, developed varying knowledge products and are also into training and capacity building on DRR.
Sphere India is supporting to prepare for floods in 5 Indian states listed as below.

i. Odisha  
ii. West Bengal  
iii. Bihar  
iv. Assam  
v. UP

He expected that all the assembled health sector partners and agencies to come together to share their strengths and capacity to better manage health emergency.

Requesting all the members on the dias to speak on health preparedness by their respective agencies concluded his inaugural address.

Dr. Deepa Prasad, State Programme Officer, UNFPA:

Dr. Prasad was of the view that though different practitioners tried their ways in Disaster Risk Management, yet the health sector was confined to prevention of health outbreaks. Sharing that UNFPA was supporting the implementation of the Minimum Initial Service Package (MISP) programme targeting women and youth, particularly the adolescent girls hoped the workshop was going to give new insights on Disaster Risk Management with respect to health preparedness.
**Ms. Seema Mohanty, State Programme Officer, UNDP/OSDMA:**

Ms. Seema Mohanty, State Programme Officer, UNDP/OSDMA showing the different pictures of the disasters faced by Odisha defined hazard, vulnerability and its type and explained vulnerability at different levels. She also shared the role of Odisha State Disaster Management Authority in managing disasters in the state.

**Dr. Ambika Prasad Nanda CSR Head, Tata Steel:**

Dr. Nanda shared that disasters were not new to Odisha and the state has been facing various disasters and would commemorate the 150th year of the Great Famine. There has been change in the frequency of the disasters in the state. Lauding the efforts of Sphere India conveyed that the *rights based approach* originated from the Rwanda Conflict.

The humanitarian agencies have responded to crisis in Odisha and that it would be injustice to the people of Odisha if all wouldn’t work together.

Reminiscing the contribution of NIMHANS on psycho-social support during the super cyclone, Dr. Nanda reiterated the importance of the psycho-social support in crisis. He was of the view that normally it takes a back seat and hence stressed the need for a focused attention on psycho-social support besides health.

**Dr. Nilesh Buddha, Technical Officer, WHO, New Delhi:**

Dr. Buddha informed that WHO works with the central governments except in special situations like Polio, TB emergency supporting partners. Thus for Emergency Risk Management in Health, WHO wanted to emphasize that the health system needs to be strengthened during peace time. Health system continues to struggle – paucity of doctors, paramedics etc. and was of the view that every day was a disaster and that there was a need to prepare by strengthening the health system so the response to any disaster is better.

**Dr. Chakradhar Panda Honorary Secretary, Indian Red Cross, Odisha:**

Dr. Chakradhar Panda Honorary Secretary, Indian Red Cross, Odisha suggested that though traditionally disasters are classified as *man-made* and *natural*, now most of the disasters are
man-made. Even the climate related disasters could be attributed to climate change – resulting out of anthropogenic causes.

Dr. Panda further shared that the occurrence of disasters are common though we are shifting from the MDGs to the SDGs. He felt that the Sustainable Development Goal (SDG) is a task which has to be achieved so that it is sustainable in the long term and laid the importance of mainstreaming of all aspects of Disaster Risk Management for sustenance.

The necessity to map risks and planning for the same was also stressed by Dr. Panda.

Lamenting that though Odisha had managed to prevent deaths to a great extent, still a lot was needed to be done particularly for the marginalized and vulnerable – women & children, elderly and the disabled.

Sharing that Odisha had created many good examples of Disaster Risk Management and was of the view that Emergency Risk Management in Health would involve the identification of the health emergency and planning a series of actions to deal with the same.

Defining health as physical, mental, social & spiritual well-being, Dr. Panda restated the importance of psycho-social health as well as continuous monitoring with feasibility & evaluation needed for Emergency Risk Management in Health.

Mr. Manoranjan Behera, IAG Coordinator, Odisha concluded the inaugural session by thanking the guests for their valuable deliberations.

**Technical Session Day-I:**

Laying out the objectives of the workshop, Dr. Nilesh Buddha invited Dr. Deepa Prasad to talk about the Minimum Initial Service Package (MISP) and Sexual & Reproductive Health (SRH).

**Dr. Deepa Prasad, State Programme Officer, UNFPA:**

Sexual & Reproductive Health (SRH) according to Dr. Deepa Prasad was one area often overlooked during and after any disaster.

Starting with a background that Odisha had a lot of vulnerabilities to disasters like Earthquakes, Cyclones, Floods etc. she also felt that most affected by disasters are the poor
and the socially disadvantaged. Besides, disaster response alone yields temporary relief at a very high cost and that preparedness contributes to lasting improvement in safety.

Though Odisha has done quite well but still there are lots of challenges.

Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.

*(Cairo, ICPD Programme of Action, paragraph 7.2)*

**Describing why Reproductive Health services for populations in disasters?**

Reproductive Health is
A human right
A bio-psycho-social health need
Right to RH-ICPD Programme of Action, 1994

Further all migrants, refugees and displaced persons should receive basic education and health services.

Many International mandates & policies address RH rights & services.

- Universal Declaration of Human Rights, 1948
- Convention on the Elimination of All Forms of Discrimination Against Women, 1979
- Platform for Action, Fourth World Conference on Women, Beijing 1995
- CEDAW & DEVAW
- Convention on All Forms of Rational Discrimination
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Rights of the Child
- UN Security Council Resolutions 1325, 1820, 1308, 1888, 1889 *
- Reports of the UN Special Rapporteurs on (1) Violence Against Women and (2) Right to Health

**The Reproductive Health** needs continue. In fact, the need increases during emergencies and the reasons could be listed as under.

- Poor birth preparedness and complication readiness among vulnerable population - Childbirth wayside during population movements
- Disasters and epidemics can increase risk of pregnancy complications
- Lack of access to contraception increases risk of unwanted pregnancy — unsafe abortion/teenage parenthood
- Lack of access to comprehensive emergency obstetric care increases risk of maternal death
- Sexual violence may increase during social instability
- STI/HIV transmission may increase in areas of high population density — adolescents are at high risk

**What is the MISP?**

MISP is Minimum Initial Service Package.

**Minimum** basic, limited reproductive health

**Initial** for use in emergency, without site-specific needs assessment

**Service** services to be delivered to the population

**Package** supplies (e.g. RH kit) and activities coordination and planning

**Goal:** To increase access to RH information and services for populations affected by disasters.

**Objectives:**

i. increase the capacity of key stakeholders
ii. strengthen the coordination of RH responses in emergencies (2)
iii. raise awareness on RH needs in emergencies
iv. respond in a timely fashion to RH needs in emergencies

**Components of the MISP**
- **Identify a RH focal point/coordinator**
  - Organization (Ministry/Department)
  - Individuals
  - IAG ??

- **Prevent and manage the consequences of sexual violence**
  - plan camp design for protection of at risk groups
  - medical response (EC, STI/HIV prevention)
  - inform the community

- **Reduce HIV transmission**
  - Enforce respect for Universal precautions
  - Guarantee availability of free condoms
  - Ensure safe blood transfusion

- **Prevent excess newborn & maternal morbidity and mortality**
  - emergency obstetric and newborn care services (EmONC)
    - Basic EmONC in primary health care facilities (skilled staff and supplies for birth available at health facilities)
    - Comprehensive EmONC in referral hospitals (skilled staff and supplies available to manage obstetric and newborn care)
  - referral system (transport/communication) for emergencies
  - clean home deliveries (clean delivery kits to visibly pregnant women)
  - Clean and safe deliveries at health facility

- **Plan for comprehensive RH services (Family Planning, GBV prevention and management, STI/HIV prevention and management)**
  - collect background information
  - identify suitable sites
  - order supplies
  - train staff

6. **Provide other important supplies:**
   - **Meet pre-existing family planning needs**
     - Basic FP methods and contraceptive needs to meet spontaneous demand
   - **Meet needs for menstrual protection**
✓ “Hygiene” or “Dignity” kits

(One saree, salwar kameez with dupatta (adolescent girls), thirty sanitary napkins, two panties, two washing soap, two bathing soap, two packets of safety pins, one comb and old newspaper)

Key Challenges for RH in Emergencies:

- a) Lack of prioritization of RH in emergencies
- b) At times perceived as inappropriate (condoms) or denial of need
- c) Lack of awareness of the MISP amongst humanitarian actors
- d) Poor implementation, lack of responders qualified or trained to implement the MISP
- e) Young people do not have access to RH services

Availability of supplies, Distribution of kits; transport, storage and distribution

Lessons learnt:

- “Do not wait for an emergency to address the MISP”
- Need for strong coordination among NGOs and Govt. to improve the RH response
- Continuous advocacy for MISP can bring about a focus of RH needs
- Sensitization and training of all stakeholders
- Clean delivery kits provide essential supplies for deliveries outside health facilities
- People use condoms during an emergency
- Satisfactory implementation requires pre-planning

To conclude, it was said that MISP was practical, effective and saves life.

Interactive session:

Mr. Manoranjan Behera, IAG Coordinator informed the house that the Cluster Coordination approach was being mooted by IAG and sought UNFPA’s support in taking a lead role.

Dr. Ambika Prasad Nanda suggested coming up with some SOPs for the hospitals
Dr. Deepa Prasad responded that not just SOPs but ensuring availability of doctors, paramedics and their training was essential.

Mr. Sailendra Pattanaik, CRS Odisha volunteered that though they could pass on and/or support in pre-position the Dignity Kits for the affected population, wanted to know as to whom to be contacted for the same. To this Mr. Pattanaik was informed that for all these efforts on MISP, the Block Medical Officer would take the lead.

Dr. K.K.Rout responded that for the supplies side, all are defined and the nodal person for the same is the Block Medical Officer. Besides, there is a SOP for MISP.

Dr. Chakradhar Panda, Honorary Secretary IRC felt that the patients need to be classified based on Triage followed by First Aid and then Specialized Care. Thus this was how the sudden surge of patients could be efficiently handled.

Mr. Jayakrishna from CUTM wanted to know if the doctors already trained on MISP are carrying forward the objectives.

Dr. K.K.Rout responded that it would be taken up soon in Odisha.

**Conceptual Framework of Emergency Risk Management in Health**

**Dr. Nilesh Buddha, Technical Officer, World Health Organisation, New Delhi, India** gave his deliberation on the Conceptual Framework of Emergency Risk Management in Health.

**Historical issues in management of Emergency Response:**

- Lack of leadership related to qualification or judgment
- Lack of Coordination due to failures in cooperation
- Lack of Integration due to competition
- Lack or loss of Resources due to failures in Planning
- Lack of Media support due to all the above plus failures in risk & crisis communication

**Observations of Health Emergency Management:**

- **Ebola 2014-15**
  - Affected countries taking different Emergency Management approaches
  - “Unified Command” – not fully embraced
  - Concept of Operations – MOH and NDMA
  - 2nd & 3rd Order – Consequences beyond health
• Different terminology, reporting processes and products
• Public Health Emergency Management training lacking
• NO UNIVERSAL STANDARDS!!!

**Big picture in terms of emergencies:**

- Global burden due to emergencies
  - Increasing outbreaks
- 100 epidemic prone diseases annually
  - Humanitarian emergencies
- Largest number of displaced since World War II – 60 million people
- Since May 2014, WHO - three new Grade 3 emergencies:
  - the complex humanitarian crisis in Iraq
  - the Ebola virus disease outbreak in West Africa
  - the earthquake in Nepal (graded in April 2015).

- Major emergencies for SEAR 14-15
  - Ebola, Nepal earthquake, MERS CoV

**Current drivers: Global, Regional, new risks and hazards**

- International Health Regulations (2005)
- Global Health Security Agenda
- Regional Flagship on Scaling up emergency risk management capacities in health
- Regional Committee Resolution (RC 68)- response to emergencies
- Climate change and health
- Other risks and hazards : unplanned urbanization, migration

Dr. Nilesh Buddha added that WHO has prioritized emergency preparedness on health more so in view of the exponential rise in urban population.

Dr. Amibika Prasad Nanda felt that health would be in the hands of physicians if it is not explained in the language of common man.

Dr. Nilesh Buddha responded that ironically 70% of the doctors prefer to stay and work in urban areas while 70% of the population is in rural areas. He further added that the health
system itself is a disaster as there are numerous vacancies in different health institutions like PHCs/CHCs etc.

Besides, only less than 20% of the Indian population is covered by Insurance.

Further, the out of pocket expenditure on health and medicine is increasing as Indians lack access to high quality generic medicines. Technology that we are using at present also needs improvement.

Non-communicable diseases like diabetes, hypertension are also being treated on a daily basis. Thus understanding epidemiology of a district cannot be done overnight. Thus strengthening surveillance is the pillar of Emergency Risk Management.

Thus WHO has always been stressing on “Systems Strengthening” and health sector needs to prepare for emergency over a period of time.

Dr. K.K.Rout congratulating Dr. Nilesh for his deliberation on the topic thought that we must have a preparedness Micro plan and things would follow to a great extent.

Dr. Sandipani Pati, ASMO, IDSP Govt. of India, was concerned about the lack of cooperation from the private hospitals in sharing data for surveillance and lamented that it took more than a year to start getting data even from Govt. sources.

Dr. Nilesh Buddha responded that as per the Clinical Establishment Act all the hospitals are mandated to share epidemiological data and that only exceptional bodies like the armed forces are exempted.

Dr. Balwinder Singh, WHO New Delhi, responded that there was a lack of reporting system in place. In spite of all this, the private practitioners who report need to be awarded and recognized.

Ms. Seema Mohanty, State Programme Officer, UNDP/OSDMA:

Ms. Seema Mohanty, State Programme Officer, UNDP/OSDMA showing the different pictures of the disasters faced by Odisha defined hazard, vulnerability and its type and explained vulnerability at different levels like - Individual, family, community or village, state and at the national level. She also described the physical, social and economic vulnerabilities and also explained at length on the Hazard & Vulnerability Assessment and shared the following points to be considered while conducting the assessment.

1. Hazard Assessment:
• Origin: What are the causes and from where do they come?
• Frequency: How often do they occur?
• Speed of Hazard: How quickly the people will be affected?
• Warning: How much time will be there before the hazard strikes?
• Size: What area is likely to be affected?
• Intensity: How severe will be the effects?
• Predictability: Is it a hazard, which has occurred before?
• Controllability: Will it be possible to take anti hazard measures?

2. Vulnerability Assessment:

• Geography - location of the vulnerable communities?
• Size: How many people, how close together do they live?
• Infrastructure: What services or infrastructures will be affected?

To sum up she added the following.

\[
\text{Risk} = \text{Hazard} \times \text{Vulnerability} - \text{Capacity}
\]

Dr. Balwinder Singh from WHO, New Delhi wanted to know the structure of normal review during peace times and the frequency of the meetings and whether there are any independent or external monitoring & feedback mechanism.

Ms. Mohanty responded that there was only a Department wise review once in 6 months and a monthly review meeting for the Emergency Officers.

Dr. Chakradhar Panda also added that independent monitoring & feedback mechanism has not been implemented till now but is being actively considered.

Ms. Mithun Karmakar, Sr. Consultant, NHM Odisha:
Ms. Karamakar gave an elaborate presentation on the **Use of Health Information System for Emergency Risk Management.**

**Use of Technology in Disaster Management:**

**HMIS:**

Supports in pre-disaster assessment of health services and preparedness at facility level.

Health Management Information System is a user-friendly programme geared towards use of information for planning and action. The system captures Service delivery data from 8403 Govt. health institutions on a monthly basis.

**MCTS:**

Mother & Child Tracking System (MCTS) is a centralized web based application for improving delivery of health care services to pregnant women (ANC/PNC) and children up to five years of age through name based tracking of each beneficiary and monitoring service delivery (PNC/immunization).

**Key Data available during Emergency:**

- Name wise pregnant mother including High risk cases details.
- Expected date of delivery (whether it is expected during the disaster time)
- Phone number of the Pregnant women
- Phone number of the ANM who is providing services to her
- Phone number of ASHA for escorting the pregnant women to the safe delivery point

Mother & Child Tracking System provides data on target population at risk up to Sub Centre level. This helps in timely evacuation of people at risk, prior to any disaster.

**GIS:**

Geo Information System is used as a monitoring as well as assessment tool before, during and after any disaster.

**Use in disasters:**

- Identification of affected blocks
• Disease mapping
• Occurrence of different diseases like Diarrhoea, Measles etc.
• Flood or disaster specific maps
• Infrastructure Available to respond during disaster.
  - Location of Blood Banks & Blood Storage Units
  - Location of Drug Ware house
  - Location of Ambulance
  - Facility level mapping
  - Location of Janani Express and Mobile Health Units
  - Location of ILR points etc.
Mr. Manoj Dash Sr. Programme Officer, Sphere India welcomed the participants back to the post lunch session of the Day-1.

Mr. Manoranjan Behera, Coordinator, IAG Odisha:

Mr. Manoranjan Behera gave an account of the Journey of Inter Agency Group (IAG) Odisha and recalled how the Super Cyclone of October 1999 was managed and narrated the inception of IAG in March 2004 for intra and inter coordination. This was necessary in view of the lack of coordination amongst all the humanitarian agencies during the super cyclone.

Mr. Behera shared the activities of the Inter Agency Group (IAG) Odisha before, during and after any disaster that strikes Odisha and went on to highlight the initiatives during the cyclone Phailin in 2013 and Hudhud in 2014.

Community is the first responder to any disaster and they are the ones who suffer most in case of any emergency. Thus community preparedness for any disaster can help save lives and curtail staggering losses from natural disasters especially in states like Odisha which is multi-hazard prone, as it compromises development gains accrued over many years.

The Disaster Management Act 2005 lays down policies, plans and guidelines for disaster management and aims to ensure timely and effective response to disasters. Although life losses have decreased over time, more and more people are affected each year (FAO, 2003). Economic losses have multiplied seven times since the 1950s to $703.6 billion in the 1990s and have reached an all-time high of $210 billion in 2005 (Munich Re Group, 2005, 2006).

Investing in the most vulnerable communities reflects the intent of development partners to bring about sustainable resilience of the communities to face disasters that has become synonymous with the state of Odisha.

The Inter Agency Group (the coordinating agency of numerous national and international agencies and individuals involved in disaster management in Odisha) has not only acted during disasters but also at peace times to invest in studies and research on DRR. As such, IAG intends to prepare a comprehensive booklet called the Odisha Disaster Report.
The Odisha Disaster Report would be a reference for all DRR practitioners as it examines the following looking at disasters in a holistic manner rather than from a relief and response centric point of view. Besides, IAG also plans to prepare the following for effective disaster risk reduction.

- Database for Emergency
- Odisha WASH Forum
- Contingency Plan
- Book on Phailin
- RADR - Regional Alliance for Disaster Alliance.

**Minimum Initial Service Package (MISP):**

Dr. K.K. Rout laid out the objectives of Minimum Initial Service Package (MISP) as under:

**Objective 1**

*Ensure health cluster/sector identifies agency to LEAD implementation of MISP*

- RH Officer in place
- Meetings to discuss RH implementation held
- RH Officer reports back to health cluster/sector
- RH kits and supplies & used

**Objective 2**

*Prevent SEXUAL VIOENCE and assist survivors*

- Protection system in place especially for women and girls
- Medical services & psychosocial support available for survivors
- Community awareness of services

**Objective 3**

*Reduce transmission of HIV*

- Safe and national blood transfusion in place
- Standard precautions practiced
- Free condoms available
Objective 4

Prevent excess MATERNAL & NEWBORN morbidity & mortality

- Emergency obstetric and newborn care services available
- 24/7 referral system established
- Clean delivery kits provided to birth attendants and visibly pregnant women
- Community awareness of services

Objective 5

Plan for COMPREHENSIVE RH services, integrated into primary health care

- Background data collected
- Sites identified for future delivery of comprehensive RH
- Staff capacity assessed and trainings planned
- RH equipment and supplies ordered

Dr. Balwinder Singh, WHO, New Delhi, India:

Dr. Balwinder Singh gave an elaborate presentation on Emergency Preparedness and Response Plan (EPRP) citing the Polio Eradication Programme as an example.

Initiating the discussion with the significant decline in number of persons paralyzed by wild polio viruses globally from 1988-2015 and the actions that were taken as part of Emergency Preparedness and Response Plan (EPRP).

The term Public Health Emergency of International Concern is defined in the IHR (2005) as “an extraordinary event which is determined, as provided in these Regulations to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response”. This definition implies a situation that is serious, unusual or unexpected, carries implications for public health beyond the affected State’s national border and may require immediate international action.

On 5 May 2014, WHO declared the international spread of wild polio virus as public health emergency of international concern and subsequently extended on 31 July & 13 November 2014, 3 March & 5 May 2015.
Stages of Emergency Preparedness and Response (EPRP)

- Emergency Preparedness
  - Stage 1: before virus identification
- Emergency Response
  - Stage 2: from virus identification to mop up
  - Stage 3: mop up response implementation
  - Stage 4: from end of mop up to the beginning of the next campaign

State level actions:

- Formation of State Emergency Preparedness & Response Group (EPRG)
- Identify Rapid Response members and coordinate their training
- Identify high risk districts/areas
- Review plans that outline actions to improve coverage in these areas

Actions for state EPRG

- Identify high risk districts/areas and assign these to senior state officials for visits
- Ensure actions to improve RI and SIA coverage in these high risk areas
- Assess communication risks to develop communication and media response plan for use following the detection of a wild poliovirus
- Have plans for emergency procurement of logistics in case of WPV importation
  - Marker pens
  - Banners
  - Posters.
- Depute spokesperson at state level for media interactions
- Assess cold chain status and plan for contingencies

Role of RRT members:

- Ensure intensification of Routine Immunization in HRAs
  - Operationalization of District task force Immunization (DTFI)
  - Tagging of HRAs to RI session sites
  - Capacity building of frontline workers
  - Advocacy & integrated communication
  - Intensified RI monitoring
- Assess preparedness of districts to undertake urgent mop up
Besides, Dr. Singh also shared of the Continuous **vaccination of children at border crossing points** in India with focus on border population.

Indo-Pak border
5 vaccination posts
> 109,000 children vaccinated from Sep 2011 to Jul 2015

Indo-Nepal border
90 vaccination posts
> 7.5 million Children vaccinated from Aug 2010 to Jul 2015

Indo-Bangladesh border:
3 vaccination posts (> 53,000 children vaccinated from Mar 2013 to Jul 2015)

Indo-Myanmar border: 3 vaccination posts (> 25,000 children vaccinated from Apr 2013 to Jul 2015)

Indo-Bhutan border:
1 vaccination post (>50,000 children vaccinated from Jul 2013 to Jul 2015)

**Role of RRT members:**

- Program planning
  - Plan and operationalise DTFs/ TTFs/ BLTFs
  - Ensure timely fund, logistics and vaccine distribution
  - Support media planning

- Microplan review
  - Review of HR block/ HRA microplans & social mapping
  - Cold chain assessment and planning

- Trainings
  - Training of trainers
  - Plan and operationalize vaccinator and supervisor trainings
Plan for briefing of social mobilizers

**Activities:**

- Intensive monitoring of activity by RRT members and all partners
- Visits by State observers, District Magistrate, CMO/ DIO to high risk areas
- Mandatory evening meetings at block and district level to review quality of coverage
- Daily meeting of the State EPRG to review feedback on quality of mop up and support improvements

**Role of State EPRG during mop up:**

- Representatives of the state response group to visit the districts involved in mop up.
- State EPRG must meet daily to review the quality of mop up and suggest corrective actions

**Role of RRT members during mop up:**

- Involve District Magistrate, CMHO/ DIO and other senior state level officials in making visits to high risk areas
- Ensure daily review of activity
  - Block level – BDOs, monitors and MOs
  - District level - by DM, CMO, central and state monitors
- Daily feedback to the State Response group

**Activities after the mop up campaign:**

- Post activity District Task Force meeting to review quality & gaps in coverage in each district
- Report from District Magistrate to State EPRG
- Development of district timeline for the next round
- Meeting of state EPRG to review coverage in districts and support improvements in quality
Role of State EPRG after campaign:

- Review and compilation of the district reports and communicate to the Central EPRG
- Ensure the focus of the districts on polio activities before the next campaign
  - RRT members to ensure the same
- Scale up the IEC and social mobilization activities
- Conduct State steering committee meeting to share feedback and ensure corrective actions before the next campaign

Role of RRT members after campaign:

- Operationalize post activity District Task force meeting
  - Share key feedback with all partners
  - Ensure corrective actions
- Ensure report from District Magistrate to the State EPRG
- Develop district timeline for the next round

Ms. Bharati Chakra State Head, Help Age India, Odisha:

Ms. Bharati Chakra State Head, Help Age India, Odisha shared the concerns of the elderly and their health in Emergencies. She discussed disaster management with an elderly lens, the issues of senior citizens and how those could be integrated in Emergency Risk Management since the elderly are mostly invisible.

The UN defines older persons as those who are above 60 years of Age.

- 12% of world’s population is >60 yrs
- 17% is >55 yrs
- 22% is above 50 yrs
- As per census 2011 in India
- More than 10 crore are above 60 yrs i.e. 8.3%
- In next 20 yrs, the grey population will be double

The underlying determinants of health:

- As per The committee on Economic, Social and Cultural Rights for monitoring the International Covenant on Economic, Social and Cultural Rights”..
- Safe drinking water and adequate sanitation
- Safe food
- Adequate nutrition and housing
- Healthy working and environmental conditions
- Health related education and information
- Gender equality

**Basic principles of emergency-health interventions:**

- **Accessibility**
  - Physical Accessibility- location, transport, age friendly
  - Financial Accessibility –free/ subsidized
  - Availability of good quality essential drugs

- **Gender Equality**
  - Services for older men and women equally
  - Equal participation in design, implementation, monitoring and evaluation
  - Equal benefit from training/ Capacity Building. Specific Action.

**Health needs of older persons:**

- **Older people have**
  - Limited regenerative abilities
  - Health risks and needs
  - Multi-morbidity
  - Physiological, sensory and cognitive changes
  - Isolation

- **Chronic diseases**
- **Communicable diseases**

**Action Points:**

1. Access the health needs of older people
   1. Identify existing gaps in health system
   2. Collect Age, Sex disaggregated data
   3. Involve older people in need assessment

2. Strengthen health system so that it can cope with older people’s health needs
   1. Health service delivery
2. Human Resources
3. Drugs and medical supplies
4. Health Financing
3. Provide integrated essential health services to older people
   1. Prioritize health services
   2. NDC
   3. Mental Health
4. Build Partnerships
   a. Integrate care for older people in the general health system – building partnership with public and private health facilities
   b. Service delivery – training, provision of funds etc.
   c. Accountability for regular activity and financial reports
5. Advocate for older people’s right to health
   a. Present evidence and messages at coordination forums
   b. Coordination with key decision makers
   c. Coordinate with international and local partners
   d. Media engagement

**Advocacy Goals:**
- Inclusion in the humanitarian agenda
- Availability of health services
- Access to essential health services
- Availability of age-friendly health services
- Health policy

The concluding remarks were given by Mr. Manoranjan Behera, Coordinator, IAG Odisha.
The proceedings of the day began by the welcome address by Dr. Soumya Mishra from Save the Children Fund, Odisha.

**Dr. Soumya Mishra, Save the Children Fund, Odisha**

Dr. Mishra was concerned that there were critical areas under health and that we have an opportunity to identify those criticalities. One such area was Sexual & Reproductive Health.

Thus to address Sexual & Reproductive Health issues, its importance particularly during emergencies showed the Animated Film developed on Minimum Initial Service Package (MISP) with the testimonials from the field and message from celebrity Ms. Priyanka Chopra who gave a call to embrace MISP and the tag line was “Get Prepared and Be Prepared”.

The basic line of reasoning for reducing risk of infection and injury for Mother & Child was

- Prevent
- Prepare and
- Pre-position

Dr. Mishra citing the example of a pregnant mother in her last trimester enquired as to how many in the hall knew what was to be done and how. Thus explaining MISP and why it was so important for all especially during emergencies.

Lamented how even in urban areas like Bhubaneswar, educated mothers discard colustrum which is essential for the new-born child. Upset that though Govt. was doing tremendous work on Disaster Risk Reduction, still there was no corner for breast feeding in the multi-purpose cyclone shelters.

**Ms. Malaya Manjari Mishra, Adhikar** referred to her experience during past disasters when the Relief did not contain sanitary napkins as it was not considered important.

Dr. Mishra responded that was what is normally referred to as Sexual and reproductive health right. The humanitarian agencies must have that lens called MISP, sensitivity towards sexual violence and preserve maternal and neo-born health.

Sanitary education is critical during disasters.
Further, since the country was struggling to bring down IMR, the major contributor is early neonatal deaths.

Ms. Shanti Agarwal, CUTM:

Ms. Agarwal was concerned that normally adolescents couldn’t discuss sex and related issues as it was considered as a social taboo.

Dr. Soumya Mishra remarked that thus there is a necessity of creating a kind of space among parents, CBOs, youth, adolescents and they need to be sensitized and what MISP was all about.

MISP is

1. Advocacy for RH in crises
2. Apply coordination skills for the implementation of the MISP
3. Training and Capacity building for preparedness and response for MISP

Rights to Sexual & Reproductive health needs continue and in fact increase during disasters.

Reproductive Health is

- a human right
- a bio-psycho-social health need
- Right to RH-ICPD Programme of Action, 1994

All migrants, refugees and displaced persons should receive basic education and health services

Many International mandates & policies address RH rights & services

Key Challenges for RH in Emergencies:

a) Lack of prioritization of RH in emergencies
b) At times perceived as inappropriate (condoms) or denial of need
c) Lack of awareness of the MISP amongst humanitarian actors
d) Poor implementation, lack of responders qualified or trained to implement the MISP
e) Young people do not have access to RH services
   - Availability of supplies, Distribution of kits; transport, storage and Distribution
f) Lack of data on SRH  
g) Lack of capacity to plan and implement  
h) Lack of knowledge amongst service providers  
i) Lack of integration of SRH in Polices and Programmes.

Inviting Dr. K.K.Rout to take over Planning & Coordination concluded his deliberation.

**Dr. K.K.Rout**  
**Overall MISP Contingency Planning – Sharing of Odisha experience.**

Dr. K.K.Rout reiterated that the best practice of West Bengal Polio in 6 days was possible due to a Plan in place prior to the incidence.

Dr. Rout extensively described his experience of responding to the cyclone “Hudhud” in Odisha during October 2014 and how it was averted with no loss of life.

Dr. Rout is of the view that the following points must be part of a Contingency Plan which could be given as under.

- Cover page  
- Index  
- Maps  
- Introduction  
- Nodal Person  
- Human Resources  
- Establishment of Control Room  
- Rapid Response Team  
- Delivery points  
- Cyclone Shelters  
- Line listing of High Risk Pregnant Women  
- NGOs  
- Preparatory Activities  
- Transportation Services  
- Essential Drugs  
- List of all ILR points  
- Alternate Power Backup System
Group Work on Emergency Preparedness and Response:

Mr. Manoj Dash, Senior Programme Officer, Sphere India was of the view that there was a major role of the NGOs before, during and after any disaster thus facilitating the Group Work.

All the health sector partners attending the training were divided into 3 groups. Care was taken to ensure that each of the group was represented by the different humanitarian agencies. Three different topics were assigned to the groups formed and were suggested to deliberate based on two broad thematic areas of

- Health Preparedness and
- Response Activities

The topics assigned to the different groups are as under.

Group-I: Flood
Group-II: Disease Outbreak
Group-III: Cyclone

All the groups I to III assembled, deliberated and discussed over the topic assigned to prepare their respective presentations followed by presentation by each group.

The expert comments were provided by Dr. K.K.Rout to all the groups.

Mr. Dillip Biswal from Aaina presented the findings of Group-I on “Preparedness & Response activities for Health in Floods”.

I. Preparedness

- Pre Emergency meeting-Health department, ICDS, RWSS, CSOs, NGOs working on this issue along with PRI members
- Formation of rapid response team at different level
- Capacity building of RRT
- Preparation of micro plan, discussion and review and up to date
- Mock drill
II. **Response**

- Stock taking and positioning-man and material (including IEC)
- Logistics plan
- Coordination
- Monitoring, Review and Reporting modalities

Mr. Abani Kumar Nayak from Adhikar presented the findings of Group-II (on Health Outbreaks) as follows.

I. **Preparedness**

- Rapid response team
- Availability of necessary logistics
- Preliminary information on situational analysis
- Community need Assessment
- Household survey
- Development of micro plan where duties and responsibilities fixed with inputs from all stake holders
- Creation of control room for compilation and collation of data

II. **Response**

- Specific camp for the concerned out break
- Identify and Referral of High risk cases
- Treatment of the affected
- capacity building of stakeholders at every level
- Cause identification or source of out break
- Remedial steps for source
- Arrange alternate water source/ source reduction with concern dept or any concern people/ PRI member/ GKS of the village
- Community awareness through IEC, BCC
- Standard monitoring format to be developed with community participation for continued surveillance

The presentation of Group-III (on Cyclone) was done by Mr. Jaykrishna Behera from CUTM.
I. **Preparedness**

- Mapping of Infra, man power, HR and resources
- Identification of Nodal Person at different level
- Control room
- Formation of Rapid Response Team
- Delivery points
- Identification of Cyclone Shelter and arrangement of basic facilities
- Listing of pregnant women
- NGOs at different level
- Transportation services for logistics and drugs
- Procurement of essential drugs
- Vaccination points
- Alternative power back up
- Health Monitoring team – District and block
- Preparation of IEC materials
- Preparation of temporary toilets for men and women
- Evacuation plan
- Reporting format
- Capacity building
- Mock Drills
- Training on infant and young child feeding practices
- Media management – Draft press brief
- Evacuation of the most vulnerable persons
- Sharing of Guidelines

II. **Response**

- Emergency Health Coordination meeting at different level
- Rapid assessment with respect to health
- Distribution of responsibilities
- Deployment of health care team – PHC/CHC/ Shelter
Dr. Kamalakant Das, MISP Master Trainer:

Dr. Kamalakant Das presenting on MISP for sexual and reproductive rights during disasters stressed on the preparedness and prioritization of the needs. He was of the view that the priorities to be included in the Supplementary Budget if not included earlier and informed the house of the initiative of Govt. of Odisha to have already allocated 19.5 Lakhs INR for the same.

Dr. Das also laid emphasis on the role of **Surveillance** and defined it as Ongoing Systematic Process during:
- Pre-disaster
- Inter-disaster
- Post-disaster

**Mr. Manoranjan Behera, Coordinator, IAG Odisha** thanked each one of the participants for their active participation in the efforts on Emergency Risk Management.
<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Name</th>
<th>Designation</th>
<th>Department</th>
<th>Email/ Phone</th>
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<tr>
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### SENSITISATION TRAINING ON EMERGENCY RISK MANAGEMENT

**Date:** 16th - 17th October  
**Venue:** HHI, Bhubaneshwar

#### Program Schedule

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<tr>
<td>09:00 to 09:15</td>
<td>Registration</td>
<td>State IAG Odisha</td>
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<tr>
<td>09:15 to 09:30</td>
<td>Welcome &amp; Inaugural Speech</td>
<td>Mission Director, NRHM</td>
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<tr>
<td>09:30 to 09:45</td>
<td>Objectives of the workshop</td>
<td>Dr. Nilesh Buddha, WHO Country Office – India</td>
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<tr>
<td>09:45 to 10:00</td>
<td>Introduction to SRH in Disasters and MISP</td>
<td>Dr. Deepa Prasad, Programme Officer, UNFPA</td>
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<tr>
<td>10:00 to 10:30</td>
<td>Conceptual Framework of Emergency Risk Management in Health</td>
<td>Dr. Nilesh Buddha, WHO Country Office – India</td>
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<tr>
<td>10:30 to 10:45</td>
<td>Hazard, Risk &amp; Vulnerability Assessment / Analysis (HRVA) in the Health Sector</td>
<td>Odisha State Disaster Management Agency</td>
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<tr>
<td>10:45 to 11:15</td>
<td>Mapping of State Agencies (Govt and Non-Govt) Post Flood Health Response and Challenges at the State level</td>
<td>Manoranjan Behera, State IAG Coordinator, Odisha</td>
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### 11th October Day 1

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<tr>
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<tr>
<td>11:15 to 11:30</td>
<td>Tea Break</td>
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<tr>
<td>11:30 to 12:00</td>
<td>Health Information System</td>
<td>NHM Odisha</td>
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<td>12:00 to 13:00</td>
<td>Group work on Emergency Preparedness and Response – floods, earthquake, dengue and diarrhoeal disease outbreak</td>
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<td>13:00 to 13:30</td>
<td>Lunch Break</td>
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<td>13:30 to 14:00</td>
<td>Presentations on Group work</td>
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<tr>
<td>14:00 to 14:30</td>
<td>Health Sector EPR: National Polio Surveillance Program – showcase</td>
<td>Dr. Balwinder Singh NPO, WHO Country Office – India</td>
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<td>14:30 to 15:00</td>
<td>MISP Roll out in the State of Odisha</td>
<td>Dr. Khirod Kumar Rout, MISP Master Trainer</td>
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<td>15:00 to 15:30</td>
<td>International Health Regulations</td>
<td>Dr Niles Buddha, WHO-India</td>
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<td>Tea Break</td>
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<td>15:45 to 16:15</td>
<td>Emergency Preparedness and Response in Health Sector in Assam – experience sharing</td>
<td>SPHERE Member Agencies</td>
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<tr>
<td>16:45 to 17:00</td>
<td>Conclusions &amp; Agenda for Way forward</td>
<td>WHO Country Office, UNFPA, SPHERE – India</td>
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### 17th October Day 2

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<td>MISP Advocacy Films</td>
<td>Manoj Dash, Senior Programme Officer, Sphere India</td>
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<td></td>
<td>- Animation Film on MISP</td>
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<td>- Testimonies from the Field</td>
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<td>- Message from Priyanka Chopra</td>
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<tr>
<td>10:00-10:30</td>
<td>Introduction to SRH Interventions-Global perspective</td>
<td>Dr. Deepa Prasad, State Programme Officer, UNFPA</td>
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<tr>
<td>10:30-10:45</td>
<td>Tea Break</td>
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<tr>
<td>10:45-12:00</td>
<td>Overview of Sexual and Reproductive Health in Disasters in India</td>
<td>Dr. Khirod Kumar Rout, MISP Master Trainer</td>
</tr>
<tr>
<td>12:00-1:00</td>
<td>Minimum Initial Service Package for SRH in Disasters- Odisha Context</td>
<td>Dr. Kamlakant Das, MISP Master Trainer</td>
</tr>
<tr>
<td>01:00-01:30</td>
<td>MISP Action Plan for contingency planning- Sharing of Odisha experience</td>
<td>Manoj Dash, Senior Programme Officer, Sphere India</td>
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<tr>
<td>01:30-02:00</td>
<td>Lunch and Closing</td>
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