

13th Annual Meeting of the

Inter-Agency Working Group

IAWGW

on Reproductive  
Health in Crises



Istanbul, Turkey  
14-16 November 2011

# TABLE OF CONTENTS

<b>LIST OF ACRONYMS .....</b>	<b>iii</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>v</b>
<b>KEY AREAS OF COLLABORATION AND ACTION ITEMS IDENTIFIED .....</b>	<b>vi</b>
<b>MEETING EVALUATION SUMMARY .....</b>	<b>vii</b>
<b>SESSION NOTES.....</b>	<b>1</b>
<b>Opening Session .....</b>	<b>1</b>
<b>Session 1: Where Have We Come From and Where Are We Now? .....</b>	<b>2</b>
<b>Session 2: Global Updates.....</b>	<b>4</b>
<b>Session 3: Global to Local: Capacity Building in Crises.....</b>	<b>6</b>
<b>Session 4: Family Planning in Crises .....</b>	<b>7</b>
<b>Session 5: A: Research and Innovation .....</b>	<b>10</b>
<b>Session 5: B: Research and Innovation .....</b>	<b>11</b>
<b>Session 6: C: Approaches to Reproductive Health: Lessons Learned from the Field .....</b>	<b>13</b>
<b>Session 6: D: Approaches to Reproductive Health: Lessons Learned from the Field .....</b>	<b>15</b>
<b>Session 7: Disaster Risk Reduction and Contingency Planning.....</b>	<b>17</b>
<b>Session 8: Newborn Health.....</b>	<b>19</b>
<b>Session 9: Global to Local: Capacity-Building in Crises.....</b>	<b>22</b>
<b>Session 10: Thematic Working Group Meetings .....</b>	<b>24</b>
<b>Closing Session .....</b>	<b>24</b>
<b>APPENDICES .....</b>	<b>25</b>
<b>APPENDIX A: LIST OF PARTICIPANTS.....</b>	<b>25</b>
<b>APPENDIX B: EVALUATION RESULTS .....</b>	<b>28</b>
<b>APPENDIX C: TERMS OF REFERENCE.....</b>	<b>31</b>

## LIST OF ACRONYMS

AIBEF	Association Ivoirienne Pour Le Bien Etre Familial
AIDS	Acquired Immune Deficiency Syndrome
AMA	Afghan Midwives Association
ARC	American Refugee Committee
AusAID	Australian Government Overseas Aid Program
CDC	Centers for Disease Control and Prevention
CHW	Community Health Workers
CPR	Contraceptive Prevalence Rate
DRR	Disaster Risk Reduction
EC	Emergency Contraception
EECA	Eastern Europe Central Asia
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
ESEAOR	East South East Asia and Oceania Region
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
IAFM	Inter-agency Field Manual
IASC	Inter-Agency Standing Committee
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IDP	Internally Displaced Persons
IMC	International Medical Corps
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
ISDR	International Strategy for Disaster Reduction
IUD	Intrauterine Device
LAC	Latin American and Caribbean
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NASG	Nonpneumatic Anti-shock Garment
NGO	Non-governmental Organization
OBGYN	Obstetrician/gynecologist
PAC	Post Abortion Care
POC	Point of Contact
PPH	Post Partum Hemorrhage
PTSD	Post-traumatic Stress Disorder
Rahnuma-FPAP	Rahnuma-Family Planning Association of Pakistan
RBH	Rabia Balkhi Hospital
RH	Reproductive Health

RTI	Reproductive Tract Infection
SGBV	Sexual and Gender-based Violence
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
ToT	Training of Trainers
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WG	Working Group
WHO	World Health Organization

## EXECUTIVE SUMMARY

The thirteenth annual meeting of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises was held in Istanbul, Turkey, from 14-16 November 2011. More than 90 representatives from 39 agencies met to address ways to improve the reproductive health outcomes of crisis-affected populations. The meeting had three stated objectives:

- Review progress towards achieving the programmatic goals and future steps outlined in the Terms of Reference following the 2010 IAWG meeting held in Santo Domingo, Dominican Republic.
- Share information and identify key areas of common work. Plan next steps and areas of coordination and collaboration for 2011-2012.
- Establish a regional IAWG forum for Eastern Europe and Central Asia, which will serve to share information and lessons learned across projects in the region and enable synergistic partnerships to fill in gaps and minimize duplication of efforts.

The three-day meeting opened with keynote addresses which focused on lessons learned in integrating reproductive health into disaster management, and emphasized the importance of multi-sectorial coordination and scaling-up reproductive health training in humanitarian response. The meeting further covered an array of topics related to reproductive health in crises, including capacity building in humanitarian settings, lessons learned in the implementation of the Minimum Initial Service Package, as well as risk reduction and contingency planning efforts. Panelists also discussed research findings, identified new technologies, and explored promising practice in family planning, newborn health, and maternal and neonatal health. In addition, several case studies on the provision of reproductive health services among crisis-affected and hard-to-reach populations were presented.

While the first and second days were dedicated to oral presentations and panel discussions on reproductive health in crises, the third day was mainly dedicated to thematic working groups. Dividing into one of eight working groups, participants had an opportunity to share information, identify gaps, and prioritize activities for 2011/2012. The working groups included Advocacy/Minimum Initial Service Package, Reproductive Health Data and Research, Adolescent Reproductive Health, HIV/AIDS/STI/RTI, Maternal and Newborn Health, Family Planning and Logistics, Eastern Europe and Central Asia IAWG Regional Working Group, New Technologies, and Gender-based Violence.

## KEY AREAS OF COLLABORATION AND ACTION ITEMS IDENTIFIED

As one of its objectives, this meeting aimed to identify areas and activities for future collaboration, the following priority areas were addressed during discussions:

- **ENHANCED COORDINATION:** Participants identified the need to strengthen reproductive health coordination in preparedness and response, urging the establishment of comprehensive coordination mechanisms in conflict, post-conflict, and disaster settings.
- **RESEARCH AND DATA:** Participants described the need to develop a robust evidence base by promoting methodology that will allow for reliable data collection in crisis settings, developing standardized instruments to collect a minimum set of information, establishing collectively agreed upon research priorities, and expanding monitoring and evaluation efforts.
- **COMMUNITY ENGAGEMENT:** Participants identified the need to further engage stakeholders in ensuring national and local ownership of reproductive health initiatives at all stages of humanitarian preparedness and response, including increased involvement at the IAWG meetings. In addition, participants discussed the importance of developing training and guidance materials that reflect the complexity of disparate social institutions and cultures.
- **CAPACITY DEVELOPMENT:** Participants determined the need for capacity development at national and community levels with an emphasis on multi-sectoral trainings to establish a roster of trained reproductive health service providers.
- **RESOURCE DEVELOPMENT:** Participants discussed the importance of acquiring adequate funding to establish successful reproductive health service delivery systems, as well as the importance of strengthening institutional and human resources.

Along with the above listed priority areas, several **crosscutting thematic activities** emerged during the three-day meeting, these include:

- Developing comprehensive data collection mechanism to better explore maternal and neonatal health in humanitarian settings,
- reducing unintended pregnancy,
- exploring the impact of gender-based violence in refugee settings,
- and engaging adolescents and men in reproductive health services and programming.

Meeting participants also suggested several next-steps and action items to shape the work of the IAWG in the upcoming year, some of these include:

- Ensure timely and robust reproductive health coordination efforts that engage national and local authorities, including community-based organizations. Suggestions for expanding reproductive health coordination efforts include: 1) identifying best practice in engaging national governments in reproductive health response coordination, 2) engaging development communities in establishing reproductive health kit procurement mechanisms at the country level, and 3) improving collaboration with the International Strategy for Disaster Reduction, by establishing an IAWG disaster risk reduction working group.

- Setting immediate and longer-term research priorities. Participants noted the importance of engaging field partners in establishing research mechanisms. Suggested next steps include: 1) developing regional workshops to identify operational research questions at the field level, and 2) collecting evidence-based data on gender-based violence in crisis, and maternal and neonatal death in refugee settings.
- Engaging crisis-affected communities and field level responders by: 1) including national leadership in early planning and implementation stages, 2) preparing culturally and linguistically appropriate advocacy, training, and guidance documents and materials, and 3) adapting the reproductive health kits and Minimum Initial Service Package implementation guidance to make them more context specific.
- Expanding access to family planning and emergency contraceptives in crisis settings, through: 1) improving access to high quality family planning information, counseling, and services, including exploring community-based distribution of family planning, 2) ensuring adequate supplies, 3) undertaking efforts to increase awareness of and access to emergency contraception, 4) increasing access to skilled birth attendants and providers, 5) expanding efforts to engage adolescents in family planning initiatives, and 6) engaging men in family planning to aid in identifying and addressing barriers.
- Expanding efforts to improve emergency obstetric and neonatal care services in crisis; suggestions included: 1) collect evidence-based data on maternal and neonatal death in refugee settings, 2) advocating for and expanding strategies to introduce Misoprostol into humanitarian health systems and product pathways, 3) strengthening coordination in referral networks, and 4) identifying more formalized ways to engage traditional birth attendants.
- Exploring community-based efforts to address clinical care for survivors of sexual violence in the early stages of a humanitarian response.
- Exploring collaborative efforts to expand reproductive health services to greatly underserved populations, including sex-workers.
- Exploring ways to foster safe environments for first-responders and other front-line workers.

## **MEETING EVALUATION SUMMARY**

The evaluation for the 13th annual meeting of the IAWG was developed to assess the overall impression of meeting participants, and gain insight on ways to improve future meetings. Thirty-six meeting participants completed the evaluation survey. Most respondents thought all three meeting objectives were met well or very well; with 75.0% agreeing that the meeting achieved the objective of establishing a regional IAWG forum for Eastern Europe and Central Asia, 83.3% affirming that meeting participants were able to review progress toward programmatic goals established in 2010, 75.0% identifying that they were able to plan next steps and areas of coordination/collaboration for 2011-12, and 94.5% stating that they were able to share information. Through open-ended questions, respondents suggested a variety of topic areas and ways to improve future meetings. Complete evaluation results can be found on page 30 of this report.

# SESSION NOTES

## MONDAY, NOVEMBER 14

### *Opening Session*

Chairperson: **Nadine Cornier**, *United Nations High Commissioner on Refugees (UNHCR)*

**Fehmi Aydinli**, *Ministry of Health, Turkey, Deputy Director General of Mother-Child Care and Family Planning* described an increase in natural disasters within Turkey in recent years, and asserted the importance of contingency planning in ensuring adequate health services for populations in need. As a result of the 1999 earthquake, Turkey implemented a disaster management system, and adopted steps for emergency preparedness, including the preparation of the health institutions and access to essential drugs, allocation of funds, and an assessment of staff, transportation, and equipment available. Additionally, all hospitals have at least one emergency system in place. Ayadinli also noted that the United Nations Population Fund's (UNFPA's) regional office organized a training of trainers (ToT) in March of 2011. The minimum standard reproductive health (RH) services have been put in place and are accompanied by action plans. Future regional trainings will include the national medical team trainings. Aydinli closed by highlighting that lessons learned from recent earthquake in Van region of Turkey demonstrated improved response.

**Thea Fierens**, *UNFPA, Regional Director for the Eastern Europe Central Asia (EECA) Region* welcomed all participants to Istanbul, the merging point of the East and the West. Fierens acknowledged that last year's meeting highlighted many lessons learned from responses in Haiti and the floods in Pakistan. Since then, there has been a significant increase in the number of floods and political emergencies in the EECA region. UNFPA hosted their first EECA regional ToT in 2011, with the intent of building capacity to respond to disasters given the likelihood they will increase with the growing global population. Fierens specifically noted the vulnerability of women and girls to sexual violence during a crisis, its relation to HIV, and the importance of keeping this issue "sky high" on the global agenda. She raised the importance of providing separate living facilities for unaccompanied women and working to support these women to come forward in cases of sexual violence.

Fierens also presented on behalf of [Zahidul Huque](#), *UNFPA, Representative for Turkey and Country Director for Armenia, Azerbaijan and Georgia*. Fierens illustrated challenges in humanitarian coordination following the 2011 earthquake in Van, Turkey; highlighting difference in coordination by command, consensus, and default. Experiences in Turkey have demonstrated that coordination in humanitarian response has blurred lines between political and humanitarian actions, and illustrated that multiple responders are not always helpful. Fierens further expressed that UNFPA aims to live up to the expectations of the international community and will continue to focus on women and girls in humanitarian response.

## ***Session 1: Where Have We Come From and Where Are We Now?***

**Wilma Doedens**, UNFPA, illustrated that the IAWG meetings are dedicated to the exchange of information and collaboration between the agencies committed to RH in crises. Doedens provided the following brief history of the IAWG.

- 1991 UNHCR develops guidelines on the importance of protecting refugee women.
- 1994 The Women's Refugee Commission issues a report exploring the RH needs of refugee women, and the International Conference on Population and Development defines RH as a human rights issue; access to reproductive and sexual health services are extended to all people, including those affected by humanitarian emergencies.
- 1995 With funds from the United States State Department the first Inter-agency Field Manual (IAFM) was produced following the Inter-agency Symposium on RH in Refugee Situations held in Geneva, Switzerland. The symposium also spanned initial discussion for the development of the Minimum Initial Services Package (MISP).
- 1999 The IAFM is published, MISP is now a global standard (IASC, Sphere standard), and IAWG developed the RH kits.
- 2004 Various training materials are developed to address gaps in RH knowledge and services. To help foster regional working groups (WG), the IAWG steering committee moves its annual meeting to differing global regions.
- 2006 The IAWG meeting is held in Sydney, Australia, to help establish the East South East Asia and Oceania Regional (ESEAOR) WG.
- 2007 The IAWG meeting is held in Nairobi, Kenya to help establish the East and West Africa WG.
- 2008 The IAWG meeting is held in Cairo, Egypt, to help establish the Middle East and North Africa (MENA) WG.
- 2010 The IAWG meeting is held in Santo Domingo, Dominican Republic to help establish the Latin America and the Caribbean (LAC) WG. The revised version of the IAFM is launched.
- 2011 The IAWG meeting is held in Istanbul, Turkey to help establish the EECA WG.

**Sandra Krause**, *Women's Refugee Commission*, gave an introduction of this year's meeting, its purpose, terms of reference, and an overview of how IAWG operates. Krause noted that 121 people registered for this year's meeting from 69 agencies and 36 countries who represent governments, international and local Non-governmental organizations (NGO), and research and United Nations (UN) agencies. Annual IAWG meetings were established in 1995 to exchange ideas, develop partnerships, and institutionalize RH for populations in crises. The IAWG works in a spirit of collaboration and voluntary commitment to advance the agenda of global RH in crises. The IAWG has fluid membership, with a listserv comprised of over 1,000 individuals. The IAWG is guided by a steering committee comprised of 16 agencies at present. In addition, several thematic and regional WGss work independently throughout the year to inform areas relevant to the IAWG. In further illustrating the work of the IAWG, Krause stated that the IAFM was launched in multiple regions in 2011 while an IAFM review process is

underway, and IAWG members are planning another global evaluation of RH in crisis settings.

**Keya Saha-Chaudhury**, *International Planned Parenthood Federation (IPPF)*, *SPRINT Initiative*, gave an update on the ESEAOR IAWG regional network. SPRINT began as a pilot project to bring global issues down to the country level with the goal of increasing access to information and services in crisis and post-crisis settings. Since the last IAWG meeting in 2010, SPRINT trainings on the MISP have been one of the main means of building capacity. Six country teams have been formed in Iran, India, Bhutan, Maldives, Pakistan, and Afghanistan and three national trainings have taken place in India and Papua New Guinea. Fifteen countries have rolled out trainings at the sub national level. In October of 2011, SPRINT held its second regional meeting with 25 participants from the ESEAOR region. Ten countries are currently working on integrating sexual and reproductive health SRH into emergency preparedness plans and activities. Achievements include a Magna Carta for Women in the Philippines, a formalized RH WG in the Philippines and Myanmar, training of national disaster management authorities in Indonesia and India, and the establishment of National Committee on RH in Crises and district focal points in Timor Leste. Saha-Chaudhury closed by stating that SPRINT is working with national networks in engaging actors in humanitarian response, and with the increase in natural disasters, there is evidence that RH programs and services are better integrated in protracted crisis settings.

**Louise Ochanda**, *IPPF*, gave an update on the East and West Africa IAWG regional networks on behalf of **James Wanyama**, *UNFPA*. The East and West Africa WG grew out of SPRINT initiative in 2009 with support from UNFPA and Australian Government Overseas Aid Program (AusAID). Achievements include capacity building in 38 countries covered through six regional ToTs, which trained 204 individuals. Twenty-three countries have conducted in-country trainings. The regional WG most recently facilitated the inclusion of MISP into contingency planning for the South Sudan in the January 2011 referendum. Inter-agency response in East and West Africa since the last IAWG meeting has included the 2010 floods in Togo, 2010 political crisis in Cote d'Ivoire, 2010 returnees in Uganda, 2010 refugees from the Ivory Coast in Ghana, and the 2011 famine in the Horn. IAWG has been strong in pushing for coordination and ensuring that capacity is available to implement the MISP. Ochanda further noted that in order to strengthen the IAWG network in Africa, the group hopes to bring other players on board, coordinate with other WGs, establish a community of practice, and link with the larger IAWG with the overall goal of strengthening coordination for RH in humanitarian settings throughout Africa.

**Julie Taft**, *International Medical Corps (IMC)*, gave an update on the MENA regional WG. The region is prone to natural disasters and continues to experience political unrest and armed conflict in Tunisia, Egypt, Libya, Syria, Yemen, Sudan, and South Sudan. MENA was established in December 2008 at the 11<sup>th</sup> Annual IAWG meeting in Cairo and was co-chaired by UNFPA and IMC with support from UNFPA's Arab States Regional Office Secretariat. Action plans include capacity building through the development of a roster of trained experts, coordination and information sharing, and advocacy and raising awareness to integrate RH preparedness into national emergency preparedness plans. Since the 2010 IAWG meeting, MENA has translated the MISP ToT

manual into Arabic, and has held many trainings throughout the region. In addition, the WG exchanged information and valuable tools through e-mail during the onset of the Egypt and Libya crisis in January and February 2011. MENA has also held advocacy meetings with Ministries of Health (MoH) at the country level and has drafted a RH emergency plan for integration into Jordan's National Health Strategy Plan for Disaster Preparedness. Plans for 2012 include echo trainings scheduled for southern governorates in Jordan, Lebanon and Libya and updating the roster of experts in the region. MENA plans to hold the second Regional IAWG meeting in the spring, with the objectives of extending membership to more countries and partners, adapting the MISIP to specific country contexts, and to discuss organization and leadership of the WG.

## ***Session 2: Global Updates***

Chairperson: **Nguyen-Toan Tran, IPPF**

**Henia Dakkak**, UNFPA, presented the World of 7 Billion campaign. Nearly three billion (2.7 billion) people were affected by disasters between 2000 and 2010, and many more will be affected by disasters in the future. Dakkak emphasized that although UNFPA coordinates this campaign, they desire for participants to take action and embrace the campaign themselves. The campaign has seven themes: poverty, empowerment of women and girls, young people, RH and rights, healthy environment and healthy people, ageing, and urbanization/planning for growth. It is important to talk about poverty and who is most affected. We know that women are more affected by gender-based violence (GBV), and that 70% of women experience GBV in their lifetime. People under 25 make up 43% of the world's population. Dakkak further noted that social media is an important component of the campaign and participants were encouraged to post and promote their issues of concern via Facebook and twitter. Visit [www.7billionandme.org](http://www.7billionandme.org) to learn more.

**Lisa Thomas**, World Health Organization (WHO), opened by acknowledging the work of Lale Say and Doris Chou in the Department of Reproductive Health and Research who were meant to attend and present the following information. Thomas spoke about achieving Millennium Development Goal (MDG) 5. Overall, the global Maternal Mortality Ratio (MMR) has dropped, most notably in South East Asia, but not enough to reach the target by 2015. It is important to note that displaced populations may be excluded from these estimates and that no low-income fragile or conflict-affected country has yet achieved a single MDG<sup>1</sup>. Most of the countries with high MMRs are on the World Bank's list of fragile situations, including all of the countries with extremely high MMRs (greater than 1,000 maternal deaths /100,000 live births)<sup>2</sup>. We do not have reliable estimates of maternal mortality in humanitarian settings, making an assessment of progress towards MDG5 in these settings nearly impossible. There is a need to focus on methodologies that will provide reliable data in crisis settings, and there are a number of tools in development that could be adapted to the humanitarian context. WHO has developed rigorous methodologies through extensive group consultation and a draft plan

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<sup>1</sup> *World Development Report 2011*. The International Bank for Reconstruction and Development / The World Bank

<sup>2</sup> Trends in Maternal Mortality: 1990 to 2008: estimates developed by WHO, UNICEF, UNFPA and The World Bank. World Health Organization 2010

to address MMR measurement in humanitarian settings is under discussion. Thomas ended by emphasizing that measurement is visibility.

**Basia Tomczyk**, *Centers for Disease Control and Prevention (CDC)*, presented updates on the Inter-Agency Field Manual Review, a review initiated by the IAWG. The objectives of the review were to determine the relevance of the IAFM, review the applicability of technical sections, review the indicators, collect user recommendations, and assess chapter flow and organization. A multi-language survey (made available in French, Spanish, and Arabic) comprised of 46 open and close-ended questions, was distributed to field-level users of the IAFM via Survey Monkey. In addition, 18 focus group discussions were conducted among six sites to provide additional contextual information and observation of the operating environment. In total, 15 completed surveys were collected. Results indicate that overall the IAFM was clear, user friendly, and easy to understand. Most felt that the manual was useful and applicable to their crisis setting, and also applicable to development settings. Tomczyk further noted that the low response rate made it difficult to draw meaningful conclusions and may in part be due to the passive distribution of the survey. In the next six months, members of the IAFM Review WG will work on identifying survey distribution mechanisms and prioritization of indicators.

**Wilma Doedens**, *UNFPA*, provided an update on the Reproductive Health Kits. There are 13 kits to help with the provision of medical care for three months based on the MISP. Kits 0-5 are for use at the community and primary health care level with a population of 10,000 or less, kits 6-10 for larger health centers with a population of 30,000, and kits 11-12 are for referral hospitals dealing with obstetric emergencies and a population of 150,000. The kits are managed and ordered through UNFPA. The kits need to be reviewed and updated every few years. This necessitates a field review among users to inquire about implementation, training, logistics and a review to identify any new technologies relevant to RH response. Following the survey, meetings are held with technical focal points and recommendations are made, ensuring input from procurement experts. An effort has been made to keep the reviews as consistent as possible since 2005. Notable revisions in the kits include combining kits 3A and 3B, splitting kit 6, and adding Misoprostol for post-abortion complications.

**Sandra Krause**, *Women's Refugee Commission*, presented updates on the MISP distance learning module and the Mama: Together for Safe Births in Crises campaign. The MISP is a minimum set of priority services to be implemented at the onset of an emergency. The IAFM has a full chapter dedicated to the MISP and provides definitive guidance on implementation. In addition, the MISP distance-learning module provides additional contextual information on the provision of priority services. The module was last revised in 2011, takes approximately 4.5 hours to complete, and is available in English, French and Spanish (Arabic forthcoming). The module was revised by the Women's Refugee Commission with substantive inputs from Save the Children, UNHCR, UNFPA, and WHO and includes the following updates: 1) new information on the needs and capacities of adolescents, 2) the importance of establishing a complaints mechanism to handle sexual exploitation and abuse, 3) considerations for urban displacement, 4) additional information and messaging for communities, 5) additional information on RH coordination as a component of the health sector/cluster, and 6) priority activities in

addition to the MISP. Over 3,000 individuals have completed the module to date, and 155 have completed the revised module.

Mama is a social media and mobile short message service (text messaging) enabled community of practice for maternal health workers in crisis-affected settings. The initiative was launched in April of 2011 and to date has over 800 registered users. The network was developed with the goal of improving maternal health outcomes by overcoming gaps in knowledge and providing technical support. Users to date are from 28 countries, 13 of which are developing countries. Next steps will focus on improving the user experience by conducting a Facebook survey among front line responders, including more local experts as Mama mentors, and linking training materials with mobile applications to assist with provider decision making.

### ***Session 3: Global to Local: Capacity Building in Crises***

Chairperson: **Emma Simpson**, *Marie Stopes International (MSI)*

[Nguyen-Toan Tran](#), *IPPF*, spoke on developing national SRH capacity in humanitarian response. The SPRINT Initiative, a three-year pilot program (ending in 2011), was developed in December 2007 with funding from AusAID to address challenges such as lack of prioritization, training, coordination and qualified responders. The initiative works to increase access to SRH services and information for persons living in both emergency and protracted situations, with a focus on national response. IPPF is comprised of 150 locally led member associations. The strategic approach is to develop the RH capacity of those already in the field, focusing on country-level coordination. The aim is systemic change at the country level by addressing all areas of the emergency management cycle. The SPRINT initiative has included 150 national five-day trainings in 95 countries and 14 regional trainings, with a total of over 4,000 national coordinators and responders trained and 23 enabling policies enacted. As a result of these trainings, country coordination teams have been developed to move country action plans forward, but clear terms of reference are needed to affectively progress action plans. In closing, participants were urged to use ‘capacity development’ instead of ‘capacity building’, as capacity development refers to the process of unleashing, strengthening, creating, adapting, and maintaining capacity over time at the organizational and individual levels.

[Eziz Hellenov](#), *UNFPA*, spoke about the MISP rollout in seven emergency prone countries (Georgia, Moldova, Kyrgyzstan, Tajikistan, Turkey, Uzbekistan, Turkmenistan) within the EECA Region. The SPRINT model was used to develop national and regional preparation activities, and buy-in was solicited from national and government partners. In addition, UNFPA translated the IAFM into Russian, and intends to create a forum for all translated materials for the region. Hellenov further addressed the importance of involving government bodies early in efforts to gain endorsement of the MISP into national preparedness plans.

[Natalia Zakareshvili](#), *UNFPA*, spoke on UNFPA’s response to the armed conflict in South Ossetia, Georgia in 2008, which affected over 132,000 people and destroyed existing infrastructure. UNFPA had the capacity to meet the needs of internally displaced persons (IDP) in the areas of RH, hygiene, and sexual and gender-based violence

(SGBV). Immediately after the outbreak of the crisis under the leadership of the UN, the health cluster was activated to ensure effective coordination and information sharing amongst the different humanitarian actors. UNFPA was part of the health, WASH, and protection cluster coordination groups. Activities supported by UNFPA centered on the most urgent needs of IDPs, access to RH services, and hygiene. Since 2008, Reproductive Health Mobile Teams have been deployed providing quality RH services to internally displaced women. UNFPA Georgia's Mobile Teams reached an average of 200 displaced women on a daily basis. Youth friendly centers were established and 1800 youth kits (for those ages 15-25) were assembled and distributed by youth to youth. UNFPA also ensured distribution of RH emergency kits and contraceptives in health care facilities across the conflict-affected region. Zakareshvili closed by noting that UNFPA is involved in strengthening Georgia's health system by contributing to the contingency planning activities, coordinating humanitarian actions for the health sector, and providing recommendations for disaster preparedness, risk reduction and mitigation plans.

#### ***Session 4: Family Planning in Crises***

Chairperson: **Eziz Hellenov**, *UNFPA*

**Dhammika Perera**, *International Rescue Committee (IRC)*, spoke on using family planning as a tool to reduce maternal deaths in humanitarian settings. More than 350,000 women die during pregnancy each year and 150,000 of these are unintended pregnancies. This works out to 15 unintended pregnancy-related maternal deaths every hour. Demographic and Health Survey data shows a relationship between the percent of women using contraception and maternal mortality rates. If women wishing to postpone or to stop childbearing used effective contraception, 90% of global abortion related and 30% of obstetric-related mortality and morbidity could be averted. Meeting unmet need for family planning could reduce demand for already overstretched health services, reduce poverty and hunger, avert 32% of all maternal deaths, and 10% of childhood deaths (under 5). An estimated 200 million women want to delay or avoid pregnancy, but do not use effective family planning. The demand is expected to rise 40% by 2025. Perera challenged participants to focus on preventing unintended pregnancies.

**Angel Foster**, *Ibis Reproductive Health/University of Ottawa*, spoke on the use of emergency contraception (EC). EC includes medications or devices used post-coitally to reduce the chance of pregnancy. The most familiar modality of EC is progestin used within five days of intercourse and side effects are minimal. There are dedicated products, or in the absence of such products, birth control pills can be used. Updated guidance indicates that it is best to take a the full dose of progestin as soon after intercourse as possible, but the method is effective up to 120 hours after intercourse (not only 72 hours). Updated guidance also indicates that a full dose is more effective than taking the dose over two days. EC delays ovulation and the implantation of a fertilized egg, but does not cause an abortion. The method can be used multiple times without risk, even in the same cycle. If the EC does not work, it will not cause any harm to the fetus. Side effects include nausea and vomiting. If a woman vomits she should take the dose again. EC is available in pharmacies in 60 countries around the world. In the absence of progestin, the YUZPE method using regular oral contraceptives may be used. [www.Nottolate.com](http://www.Nottolate.com) provides dosage instructions for various brands of oral contraceptive pills as EC. YUZPE

reduces the chance of pregnancy by 75% and is not as effective as progestin only. Foster further noted that the data on the use of EC in humanitarian emergencies is limited. According to a report published by UNHCR, 54% of refugee women in camps were not receiving EC when eligible. Obstacles to the use of EC in humanitarian response include limited knowledge, viewing EC as appropriate only after sexual assault, confusion that EC is an abortifacient, concerns over repeated use and misuse of the method, the lack of dedicated products being registered (especially in Central Africa and the Middle East), and the failure to mainstream EC into family planning services. Foster ended with advocating for increased, widespread knowledge of EC, recommending that we increase the availability of dedicated EC products, and that we advocate for use of YUZPE when the products are not available.

[Ashley Wolfington](#), *IRC*, spoke on family planning and post-abortion care (PAC) in Chad (1200 MMR and 1-2% Contraceptive Prevalence Rate (CPR)), Democratic Republic of Congo (670 MMR, 6% CPR), and Pakistan (960 MMR and 18% CPR), with the objective of demonstrating that family planning and PAC can be delivered in crisis-affected settings. The IRC delivery model has three pillars to fight maternal mortality: 1) antenatal care and emergency obstetric care (EmOC) 2) family planning and 3) PAC services. IRC is working to build capacity of providers to provide long-term methods and post abortion care through competency based training and ToTs, equipping facilities to provide quality family planning and PAC services, and integrating men and religious leaders as promoters and educators, even in faith based clinics. In October 2009, family planning methods provided in Chad included pills and injectables and only 10-15% of the need was met. Now, 90% of the need is met and over 20% of users are choosing long-term methods like implants and inter-uterine devices (IUDs). The number of clients who are being treated for post-abortion complications has also greatly increased. At the start of the initiative in the Democratic Republic of Congo there were fewer than 200 family planning clients. Now, in 2011, there are over 8,000 clients and more women are choosing long-term family planning methods. This model is now being rolled out in Pakistan. Now that services are in place in Chad and the Democratic Republic of Congo, the focus will shift onto improving quality assurance and increasing the in-country capacity to train and supervise providers. Future challenges that are perceived include the taboos around family planning and PAC, provider attitudes and bias, and how to reach adolescents with family planning and PAC messages and services.

[Nadine Cornier](#), *UNHCR*, presented results from a multi-country family planning baseline survey that took place in Djibouti, Kenya, Uganda, Jordan, and Malaysia. The study aimed to document knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision in selected UNHCR operations. UNHCR, Women's Refugee Commission, and CDC collaborated on the study, which included a literature review, in-depth interviews with community leaders, surveys, and facility assessments. Findings revealed that modern contraceptive prevalence was lower in refugee settings than in the host communities in four out of the five sites. Individuals in camp settings tend to know about condoms and injectables, but often do not have knowledge of long-term methods or emergency contraception. Opposition to use, particularly religious opposition, is a key reason for women who are not using a method. Access to information and services is particularly difficult for adolescents. Emergency contraception is only available in the context of post-rape care. Limited availability of long-term and

permanent methods is compounded by the general weakness of referral systems for longer-term and permanent methods. Moreover, service providers are overwhelmed with other duties and family planning has low priority. The following recommendations emerged from the study; 1) enhance community information and acceptance, 2) improve service quality and availability, 3) and support effective programs. Additional information on this study can be found on the UNHCR and [Women's Refugee Commission](#) websites.

## TUESDAY, NOVEMBER 15

### *Session 5: A: Research and Innovation*

*Moderator: Wilma Doedens, UNFPA*

[Basia Tomczyk](#), CDC, spoke on the RH research priorities identified from the June 2011 workshop in Atlanta, GA, co-hosted by CDC and Columbia University. Members of the group identified 28 research questions from prior meetings and conferences. These questions were circulated among 36 respondents for feedback and to solicit additional questions, resulting in a total of 94 research questions. Criteria were then developed to prioritize questions systematically and questions received a research priority score with a cut off of 0.65. This process produced a short list of 28 questions that covered a broad range of RH issues. Four groups then selected one question from seven questions and applied criteria in a group discussion, reporting back to the larger group with the rationale for selection. The top ranked research questions were as follows: 1) global review of RH services in crises, 2) assessing contraceptive services obstacles and use among youth in a protracted emergency, 3) assessing the feasibility, acceptability, safety and adherence to self-administered Misoprostol for the prevention of post-partum hemorrhage through community-based distribution in conflict-affected settings, and 4) identify barriers and facilitators of EmOC implementation in an acute emergency setting as part of the MISP. The research questions were absorbed into the different thematic WGs within the IAWG. In closing, Tomczyk identified the following limitations: 1) time (the group needed more than two months to plan such a workshop), 2) low response rate, 3) some of the suggestions provided were ideas and not research questions, and 4) in the future, this process should include ethical considerations in criteria selection.

[Angel Foster](#), *Ibis Reproductive Health/University of Ottawa*, presented on key findings from a RH needs assessment on the Thailand-Burma border conducted in 2010. Research methods included collection and review of published and unpublished documents, key informant interviews, a service mapping exercise, and 18 focus group discussions with migrant adolescents, adults, and health care workers. Key findings included significant unmet contraceptive need, practice of unsafe abortions, lack of information and services among adolescents and unmarried populations, lack of access to skilled birth attendants and medications, and structural barriers in accessing services. Foster outline the following recommendations: 1) improving access to high quality family planning information, counseling, and services, 2) increase awareness of and access to emergency contraception, 3) increasing access to skilled birth attendants and providers, 4) develop strategies to reduce harm from unsafe abortion, 5) expand efforts to address adolescent RH needs, and 6) establish additional avenues for communication and coordination. The full report will be available in January 2012, and the executive summary will be available in English, Thai, Burmese, and Karen. Moreover, these findings will be available online, disseminated in workshops, and published in a peer reviewed journal.

[Mihoko Tanabe](#), *Women's Refugee Commission*, spoke on building the evidence for community-based medical care for survivors of sexual violence. A consultation on RH technologies in crisis settings in May of 2008 reaffirmed the challenges for survivors of

sexual assault in accessing medical care at the height of insecurity. In response, the Women's Refugee Commission, with the Global Health Access Program, Burma Medical Association, and Karen Department of Health and Welfare, designed and implemented a pilot project among IDPs in Karen State of Burma to examine the safety and feasibility for community health workers (CHW) to provide clinical care to sexual violence survivors as defined by WHO protocol. To overcome ethical and practical challenges, the project provided training and sensitization on the topic, focused on medical care as opposed to the multi-sectoral GBV responses, focused on the provision of minimum care according to the WHO protocol, reduced documentation in the field (no perpetrator information was documented due to security concerns), carefully communicated information sharing procedures, and kept the pilot small. Preliminary findings demonstrate acceptance of the program among health workers and traditional birth attendants (TBA). Moreover, health workers demonstrated knowledge of clinical care and understood the concept of confidentiality. However, no survivors of violence have utilized the program to date, perhaps indicating that awareness needs to be raised. Possible next steps include: sensitizing communities to increase the likelihood of survivors reporting to address questions of safety, possible replication of the pilot in other crisis-affected settings to further the evidence-base, exploring more than minimal care in Karen State in light of a feasible cold chain and, addressing the limited evidence of post-exposure prophylaxis initiation by CHWs in settings with higher HIV prevalence.

#### ***Session 5: B: Research and Innovation***

**Moderator: Julie Taft, IMC**

[Lisa Thomas](#), WHO, provided an overview of Misoprostol use. Misoprostol is inexpensive, and can be used with limited refrigeration and is particularly useful where skilled professionals and oxytocin (gold standard) may not be available. Routes of administration include oral, sublingual, buccal, vaginal, and rectal. The range of dosage varies (25-800 micrograms), and side effects of the drug are mostly dose related. Misoprostol is now included in WHO's *Model List of Essential Medicines* for early pregnancy termination (with mifepristone), induction of labor, medical management of miscarriage, and prevention of post-partum hemorrhage (PPH). Community based distribution is currently not recommended by WHO due to lack of evidence. WHO encourages additional research on the drug and its uses. For PPH prevention, an uterotonic drug (Oxytocin or Misoprostol) should be offered by a trained health worker for PPH prevention in the absence of active management of the third stage of labor. Misoprostol for the treatment of PPH guidelines are undergoing revision. Thomas displayed countries with the highest rates of maternal mortality and also countries where Misoprostol is registered, demonstrating the need to advocate for the drug and extend its evidence-based use. Thomas closed by discussing the strategy for introducing Misoprostol into humanitarian health systems, which included partnering with development organizations with technical expertise. Aspects of the strategy include method selection, developing product pathways (beyond kits), training, operations and implementation research, monitoring and evaluation efforts, and looking at other agents and devices for the treatment and prevention of PPH.

**Mohammad Masood Arzoiy**, *Jhpiego Afghanistan*, spoke on PPH prevention through CHWs. Afghanistan has a high MMR, 1,600 per 100,000 live births. PPH is responsible for 30% of maternal mortalities in Afghanistan. Health centers are often difficult to reach, and few alternatives exist for care if a woman experiences PPH. Jhpiego's project goal was to reduce the incidence of PPH and the contribution of PPH to maternal mortality in 20 districts in five provinces within Afghanistan. Community-level activities had complimentary activities at the national level (advocacy) and facility level (trainings on active management of third stage of labor and PPH). Jhpiego mobilized a trained network of CHWs to identify pregnant women in selected areas. Once selected, pregnant women were interviewed and received home visits from health workers who provided information and counseling to her and her household support members. Upon conclusion of the third trimester counseling visit, women were given three tables of 200 micrograms of Misoprostol to take if needed. 6,408 pregnant women have been registered in the pilot. Misoprostol packages were distributed to 4,190 of the registered women at the eighth month of pregnancy. Three thousand sixty eight of the registered women delivered at home or a health facility. One thousand, nine hundred and ninety seven of those who delivered at home correctly used the Misoprostol, and no women took the drug before delivery of the baby. There were no major drug related adverse outcomes. In closing Arzoiy stated the pilot was successful and community-level distribution of Misoprostol for the treatment of PPH may be a successful strategy for prevention of PPH, especially in rural and remote areas where the accessibility to facility based delivery services by skilled birth attendants is limited.

**Ernest Athumani**, *Tanzania Red Cross Society* and **Abdelhadi Eltahir**, *Pathfinder International* presented on the utilization of the Non-Pneumatic Anti-Shock Garment (NASG) in refugee camps and surrounding host communities in Tanzania. The NASG is a first-aid device made from a neoprene and Velcro material. It squeezes blood from the lower part of the body to the heart, reversing hypovolemic shock and keeping a woman alive at the most critical time to allow for her transfer and treatment. In March 2010, Pathfinder International introduced NASG into North Western Tanzania, in partnership with the Tanzania Red Cross Society and the MoH. The NASG was introduced in two refugee camps and their host community. Throughout the duration of this project, several women's lives were saved after use of the NASG. The presenters closed by suggest that the NASG be included in the MISAP as a First Aid device in postpartum care.

**Ouahiba Sakani**, *UNHCR*, presented a maternal deaths review in refugee settings. The analysis included data from 2008-2010 from 25 refugee camps in 10 countries: Bangladesh, Nepal, Chad, Ethiopia, Kenya, Sudan, Uganda, Rwanda, Tanzania, and Zambia. Selection criteria included a refugee population size  $\geq 25,000$ . 144 maternal deaths were identified through the Health Information System (HIS) and active inquires by the research team. Of these, 108 were investigated. Fifteen percent of cases were not reported in the HIS and 74% were investigated less than one week after the death occurred. Most reviews were facility-based with limited involvement of the community, and provided little information on the circumstances surrounding the death with no critical review. There were discrepancies and inaccurate information and no practice corrective actions. The average age of all women was 26.7 years with a range of 15 to 41

years of age; 11% of women were 18 years old or younger and 8% of the women were older than 35 years. The median gravida was four with a range of zero to 13, and the women had a median of three antenatal care visits with 90% attended by a nurse midwife. The top direct causes of death were similar to those found globally; obstetric hemorrhage (31%), hypertensive disorders (25%) and non-obstetric complications (19%). Ninety-nine cases listed indirect causes of death, including anemia (43%), multi gravida (41%), and history of hypertension (31%). In 56% of the cases, women died within 24 hours. Most maternal deaths occurred at health facilities (>80%). While this is an indication that many refugee women are reaching care, various delays and other avoidable factors may contribute to unsuccessful interventions. Limitations of the review include underreporting, possible missing data of deaths where women delivered at home or early in pregnancy, failure of the review team to mention other delays and avoidable factors that may have played a role in the deaths, omission of information in the reports, and difficulty in accessing family and birth attendants outside the health system to assist in the review. Sakani closed by providing recommendations, which include: 1) revision of the maternal mortality death review form and guidance note to strengthen the investigation process and content, 2) a re-orientation of the field staff on revised tools, 3) involvement of family and key community members in maternal death reviews, 4) clarification of stakeholders' role in improving emergency obstetric and neonatal care (EmONC) services, 5) stronger coordination in the referral networks, and 6) short-term practice actions and long-term recommendations to improve access to quality of EmONC services for refugees.

### ***Session 6: C: Approaches to Reproductive Health: Lessons Learned from the Field***

*Moderator: Mary Yetter, CARE*

[Sheikh Mohammed Shariful Islam](#), *International Centre for Diarrhoeal Disease*, presented on the pilot project in the Chittagonog Hill Tracts of Bangladesh aimed at improving RH in a remote, post-conflict population in which two-thirds of the population lack access to basic health care. To improve access to basic services, female CHWs were selected locally and trained to offer a range of RH services in their communities, including STI treatment. The CHWs were trained for two months at a tertiary hospital and were then provided with RH kits, logistical support, and supervision by a local health authority. The CHWs met once a week to create an action plan for service delivery in their area, collect supplies, and report on their work. The CHW program was part of a collaborative approach to health services involving government, NGOs, UN and private organizations. Workshops were organized to build local capacity of staff and to facilitate emergency referrals for women who could not be treated at the local level. Select results include an increase in facility births from 20% at baseline to 73% on follow-up. Moreover, the CPR rose from 43% to 95% and was partly due to community-based distribution of methods. Challenges included working in a hilly and remote area with a low-literacy rates and high-poverty. The health facilities were not offering quality services at the outset and there were high rates of absenteeism, as well as structural limitations. Islam closed by outlining that teamwork can be used in a remote region to

maximize utilization and CHWs are an important asset in meeting RH needs among hard to reach populations.

**Julie Taft**, *IMC*, presented on building the capacity of health providers at one of the largest maternity hospitals in Kabul, Afghanistan. Since 2004, IMC has implemented four projects to increase capacity of Rabia Balkhi Hospital (RBH) to improve supply chain and also clinical skills of providers. IMC and the RBH conducted a review of outcomes from capacity building carried out from 2004 to 2011. Methods included desk review, focus group discussions, key informant interviews, and observation. RBH was opened in 1986 with 259 beds; today the exclusively women's hospital is a 200-bed facility with 373 staff including 72 obstetrician/gynecologist (OBGYN) residents, and provides both outpatient and in-patient services, including obstetrics, gynecology, internal medicine and general surgery. RBH handles a large proportion of the caseload for deliveries in Kabul, more than 20,000 in 2011, and is used frequently by the most vulnerable populations due to free in-patient care and nearly free outpatient care. Since 2004 IMC has developed in-service curricula for OBGYN, midwives, nurses, pediatricians and allied staff. More than 200 providers benefited from IMC direct training from 2004 – 2009. Key accomplishments include: 1) training of midwives to perform full scope of work including active management of the third stage of labor, 2) infection prevention, such that rates have reduced from 7% in 2006 to 3% in 2010 for post-operative cases, 3) pharmaceutical management was strengthened and IMC provided \$1.6 million in essential drugs, equipment and rehabilitation to the hospital, and 4) the introduction of a medical record system and subsequent trainings on its use. Taft also highlighted challenges including staff turnover at the hospital, midwives leaving for private practice and weak primary health care services in Kabul. While investment in midwifery has been strong in Afghanistan in recent years, there has been little similar investment in nurses and doctors. Key lessons include promoting an active learning process for in-service training. A holistic approach to capacity building is recommended, which includes nurses and doctors in addition to midwives. Clinical skills building should be matched with availability of supplies so training can be put into practice and optimum patient outcomes achieved.

**Sarfarz Hussain Kazmi**, *Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP)*, presented on the role of grassroots civil society in implementing the MISP following the 2010 Pakistan Floods in which 1600 lives were lost. There were 5 million people displaced and 15 million affected. Rahnuma-FPAP is a grassroots organization that has been providing comprehensive RH services in Pakistan since 1953. They were involved in the flood response in Punjab, Khyber Pakhtunkhwa, Sindh, Baluchistan and other areas, working closely with other partners such as SPRINT, IPPF, CARE, AusAID, UNFPA, and the MoH. As a grassroots civil society organization they were able to begin providing SRH services within a week through mobile units. Rahnuma-FPAP provided all the MISP services and provided care to over 4,000 women affected by GBV. RH supplies were procured, distributed, and utilized in a timely manner. In identifying lessons learned, Kazmi noted that grassroots organizations with service delivery outlets providing RH services are effective for implementing the MISP. Moreover, trained

female service providers are key to implementing the MISP and to strengthening humanitarian response with Rahnuma-FPAP and other agencies in Pakistan.

### ***Session 6: D: Approaches to Reproductive Health: Lessons Learned from the Field***

*Moderator: Anne Golaz, United Nation's Children Fund (UNICEF),*

[Nadine Cornier](#), *UNHCR*, presented on an intervention responding to the multi-sectoral needs of sex workers (RH and protection in particular) in and around refugee camps in East Africa and the Horn, with an aim of reducing HIV acquisition and transmission in humanitarian settings. Sex work in refugee settings is an on-going and often unrecognized public health problem, linked to poverty, gender inequality, and vulnerability. The magnitude of the problem can be known only through behavioral surveillance. Key components of the program relate to the 10 steps on sex work interventions. After mapping out 'hot spots' where sex work was taking place, roll-out included an initial visit to assess existing interventions available for sex workers in one of the pilot camps (Kakuma), a one week training for multi-functional teams from six camps (two each from Kenya, Ethiopia and Uganda) on the steps and content of effective interventions for sex work and the protection of children, provision of support through field based visits to the camps and online mentorship to assist the teams to roll-out the interventions, and monitoring and evaluation activities. Cornier noted, the minimum package for sex work intervention includes determining service delivery points, identification of friendly health care workers for each service delivery point, and the provision of STI screening and treatment, as well as family planning and HIV testing methods. An initial lesson learned is that there are inherent systemic weaknesses in social protection structures that increase vulnerability of women and girls. The best approach for sustainable and ethical provision of services is for interventions for sex workers to be integrated within existing health and protection systems with gradual scale up. Next steps include a bio-behavioral survey to identify baseline parameters in sex workers in the camps, solving capacity gaps among implementing partners and UNHCR, fine tuning the sex worker-training module, including HIV behavioral change communication activities in messaging, in-country training for Uganda and Ethiopia and rolling out of the interventions in the remaining camps, linking sex worker interventions with national efforts and programs, and integrating interventions for sex workers into the broad humanitarian response. An annual review workshop will be held in March 2012 in Uganda and the publication of the sex worker intervention guide will follow.

[Kablifa Elmusharaf](#), *University of Medical Sciences and Technology Sudan*, spoke on an approach to advocate for and promote the health of hard-to-reach conflict affected women in Renk, South Sudan. Many health education approaches and advocacy strategies have been used to promote women's health in post conflict settings. Yet, most of these approaches had limited understanding of complexity of social institutions and cultures in which behavior is contextualized. Health education materials used are handed down from outside, are not rooted in the culture, lack ownership, and have repeatedly failed. In some cases, messaging interventions have done more harm than good. Elmusharaf discussed the Innovative Participatory Health Education Project. In this

project, members of a theatrical band worked together to identify the important issues related to women's health in their community and developed context-friendly materials, delivering the messages to their local community in the form of pictograms, songs, and drama. Later, a four-day training workshop was conducted on RH Project Management, targeting 10 senior officers in the MoH in the Renk County with advocacy on maternal health to increase their awareness and develop their knowledge and skills to help them develop, implement, assess, monitor and evaluate RH projects in post conflict settings. The learning and behavioral change happened during the process of developing and delivering of the educational materials. The local community understood, appreciated and enjoyed the delivered materials since they were tailored and conveyed by locals. Moreover, the innovative participatory health education approach engaged senior MoH officers with community members and promoted their knowledge about maternal health issues. Elmusharaf closed by reiterating that the involvement of local theatrical band members and employees from local women's organizations helped ensure the sustainability of this project.

**Deepmala Mahla**, *MSI*, spoke about responding to the RH needs of underserved women in Yemen. A Yemeni woman's risk of maternal death is one in 91 (365 MMR) and direct causes of 70% of these deaths relate to PPH, difficult labor, uterine rupture, toxemia, and puerperal sepsis. MSI provides a range of RH and family planning services through 10 static clinics, outreach and home visits, and community midwives. In 2011, MSI served 100,000 clients through clinics, outreach, and home visits. Future plans include expanding static clinics with mobile teams, serving through a community midwives network, capacity development of NGOs on RH and provision of family planning services, and offering support to the existing system through the provision of drugs, equipment, supervision, and capacity development. Gaps and urgent needs include adequate and timely humanitarian response, flexible, predictable, and impartial funding, technical assistance and financial assistance to enable continuation and expansion of social protection and welfare programs, and the facilitation of access by aid agencies to communities in need.

**Martin Migombano**, *SPRINT Initiative, IPPF Africa* and **Florent Kéi**, *Association Ivoirienne Pour Le Bien Etre Familial (AIBEF) - IPPF Côte d'Ivoire*, presented on implementing and building on the MISP for internally displaced persons in Côte d'Ivoire. MISP implementation started in February 2011 following post-election violence in January of 2011. It was important to build upon the MISP and coordinate with the WHO in developing a comprehensive RH program. In May 2011, an evaluation of MISP implementation was conducted and comprehensive SRH services were started. These services include increasing the choice of modern family planning methods (IUD, implants), paediatric consultations including immunizations, HIV prevention (including prevention of mother-to-child transmission), strengthening basic emergency obstetrics care (oxytocin and manual vacuum aspiration), extension of AIBEF clinics from one to three, and extend clinic users from IDPs only to include the local population. Challenges included, identifying sustainable sources of funding, weak coordination during crisis, difficulty securing qualified staff, and insecurity preventing easy access to implementation sites. In closing, the speakers noted that building comprehensive SRH

services upon MISP is critical during recovery and redevelopment. Lessons learned indicate that robust coordination mechanisms should be in place before, during and after the crisis phase. Local NGOs are well positioned in helping communities to transition from crisis to recovery in an effective, efficient, and culturally sensitive manner. Donors and humanitarian partners should invest in grassroots agencies to ensure continuity of services and strengthen local ownership.

### ***Session 7: Disaster Risk Reduction and Contingency Planning***

*Chairperson:* **Lisa Thomas**, WHO

**Jennifer Schlecht**, *Women's Refugee Commission*, spoke on integrating SRH into Health Emergency and Disaster Risk Management Systems. In the past two decades, recorded disasters have doubled, populations are becoming more vulnerable to hazards, and one in five women will be pregnant in an emergency. We have learned that services that are strong before an emergency are more likely to remain functional throughout an emergency. Relief workers and responders understand emergencies and priority areas, while local governments, communities and development actors know capacities. The International Strategy for Disaster Reduction (ISDR) was developed in 2000, after El Nino increased global attention to natural disasters. In 2009-2010, aware of the increased impact of natural disasters, the Women's Refugee Commission established and chairs a disaster risk reduction sub-WG that has become an official RH sub-WG within the Health Platform of the ISDR. Preparedness and planning checklists (broken down by activities at the national, sub-national, and community level) and a policy brief were put together by this sub-WG as a form of global advocacy. At the country level, national trainings in the MISP and DRR have been held in Sudan, Uganda, and Haiti, through partnerships with SPRINT. A community level training was held in Haiti to train community based organizations working specifically with vulnerable populations (youth, disabled, HIV positive) on MISP and DRR. Experience in Haiti demonstrates that local partners are eager to receive guidance on DRR to make their communities safer and that it is critical to link community actions with national efforts. Lessons learned from all activities include that successful DRR planning requires integration across all levels, MISP training alone is not sufficient for successful DRR preparation in SRH, and that contingency plans must account for known realities of crisis and regional capacity constraints.

Recommendations include training individuals at the national, sub-national and community level on MISP and DRR, developing a training curriculum for DRR and contingency planning to complement the MISP (for policy makers and community members), assume high staff turn over and international evacuation in disasters, and to involve vulnerable populations in preparedness and planning activities. Schlecht, ended by requesting participation in reviewing the draft checklists, disseminating and piloting the checklists and policy briefs in the near future, and increasing information sharing about DRR efforts.

**Lauren Heller Szafran**, *SPRINT Initiative, IPPF*, presented trends in SRH emergency preparedness and DRR initiatives in Asia. In order for response to be effective, work needs to be done in the non-crisis phase. Since 2007, SPRINT has trained 95 country coordination teams and 4,000 national coordinators and actors who have responded to 32

humanitarian crises. Common barriers to MISP implementation include logistical issues in coordination, an enabling policy environment, and procurement of supplies. Two case studies from Myanmar and Indonesia demonstrate how to address common barriers to MISP implementation. Country coordination teams formed during disaster response continued working together to create an enabling environment for MISP response by monitoring developments in crisis-prone areas and seasons, identify training needs, coordinate trainings, and sharing resources. Team members are varied, coming from organizations and individuals at the national, sub national, and community levels. The MISP and other guidelines were translated into local languages and the teams provided ongoing advocacy with MoH and government agencies regarding SRH in emergencies. The teams procured and maintained a stockpile of SRH supplies and strategized distribution systems. This approach may increase the speed and quality of national responses to SRH needs in crises. Challenges include knowing what to do when (e.g. focusing on kits versus system strengthening), ongoing struggles to successfully incorporate GBV into response and preparedness messaging and activities, linking to global efforts, the amount of time consumed by advocacy and policy work, and significant challenges in protracted crises. Innovations included the role of Red Cross volunteers in Myanmar, partnerships with national professional medical associations, and preparing to respond at community level. SPRINT continues to advocate for other countries to follow similar emergency preparedness DRR models, provide support to country coordination teams in priority countries to implement emergency preparedness activities, link national efforts to global resources and initiatives, and support documentation and research on preparedness and its impact on response.

**Jasim Anwar**, *University of Sydney, Australia*, presented data on RH and psychological trauma in the context of a natural disaster in Pakistan. More than half a million women die each year from pregnancy-related causes and mental disorders make up three of the 10 leading causes of disease burden in low- and middle-income countries. More than 73,000 people died in the 2005 earthquake in Pakistan, one of the worst disasters in South Asia. Objectives of Anwar's cross-sectional study were to estimate the frequency of long-term psychological trauma - post traumatic stress disorder (PTSD), anxiety and depression among married women of reproductive age who experienced the earthquake and stayed in Balakot, and to assess the association between psychological trauma, displacement, and RH events. Survey instruments included CDC's *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25. The majority of women were between 25-34 years old and there was a high prevalence of PTSD, depression and anxiety. Many were still living in prefabricated shelters five years after the earthquake. Separation from family members and sleeping in tents was a significant risk factor for PTSD, depression and anxiety. Poor RH including stillbirths, abortions, abnormal vaginal discharge and genital ulcers were risk factors for common mental disorders. Difficult access to health facilities is a risk factor from common mental disorders among disaster-affected women. Anwar recommends integrating RH with mental health into the disaster preparedness and response.

[Sophie Pecourt](#), *SPRINT Initiative, IPPF*, spoke on contingency planning and emergency response in SRH in South Sudan. In South Sudan, the MMR is extremely high (2,054 per 100,000 live births), the literacy rate is very low, and there is a critical shortage of health personnel and equipment due to over 30 years of conflict (chronic emergency). In 2010, 215,000 people were newly displaced by inter-tribal clashes and political violence resulting in activation of the health cluster that July. The 2011 Referendum led to massive returns from the North, low-intensity communal fighting and Militia-Sudan People Liberation Army clashes leading to more internal displacement. In October 2010, a five day MISP and Contingency Planning Workshop, endorsed by the National MoH, included 20 participants from States' MoH, NGOs, Red Crescent, UNICEF, and UN agencies. SPRINT, UNFPA and Women's Refugee Commission organized and financed the workshop. The contingency plan matrix from the health cluster was used, mapping was conducted to identify different actors' capacities, projections of anticipated caseload by sector were made, and various preparedness and response activities were designed. RH was integrated into the health cluster contingency planning. UNFPA prepositioned RH kits and preordered kits based on scenarios and figures. IRC provided mobile clinics in two States of high return. UNFPA released RH kits to partners at national and State levels. UNFPA and partners conducted trainings on clinical management of rape survivors and elaborated standard operating procedures for GBV response, targeting areas of high return. Lessons learned include that timing, coordination, staffing, quality of the plan, as well as advocacy and buy-in are critical. Prepositioning of kits is essential, but supplementary kits were ordered after the Referendum and figures were not reviewed, resulting in too large of quantities. Not enough time was given to build consensus or involve all key partners. Competing contingency plans created some confusion and lack of buy-in. Multi-level coordination must be included. The lack of an identified RH coordinator jeopardized the interagency coordination efforts. Logistics were not included in contingency planning decreasing operationalization. Integration in the contingency plan has to be specific and adapted to each context. The prepositioning of kits helped put RH onto the agenda and approval of the MoH at that time was key to success.

### ***Session 8: Newborn Health***

*Chairperson: Ouahiba Sakani, UNHCR*

[Maria Tsolka](#), *Save the Children*, presented on neonatal health in crisis situations. Major causes of neonatal death include preterm birth, asphyxia and infections. Afghanistan, Somalia, Democratic Republic of Congo, Mali, Sierra Leone, Guinea Bissau, Chad, Central African Republic, Burundi, and Pakistan have the top 10 neonatal death rates. Up to 50% of these deaths occur in first 24 hours, and 75% are in first week of life. Tsolka presented a summary slide on evidence-based interventions and then presented Save the Children's experience with some of these interventions. Community interventions include newborn baby kits and clean delivery kits delivered through a network of CHWs and auxiliary midwives, training of services providers, and supporting capacity of referral care and neonatal resuscitation. Tsolka provided examples from Myanmar and Bangladesh. Future plans include introducing neonatal resuscitation (*Helping Babies Breathe*) to emergency response, immediate prenatal care at the home level by

reinforcing messages to mothers and providers on use of kits and strengthening of pregnancy surveillance mechanisms, and capacity building and operational research for neonatal resuscitation.

[Anne Golaz](#), *UNICEF*, spoke on UNICEF's approaches to newborn health in humanitarian emergencies. Until recently, preventing newborn deaths has not been a focus of child survival or safe motherhood programs. Data needs to be disaggregated to look at newborn mortality in children under five mortality estimates. Although there has been some progress reducing child mortality between seven to 28 days, very little progress has been made in reducing deaths in first week of life. Neonatal deaths account for more than 40% of all deaths of children under five. A majority of neonatal deaths can be prevented with evidence-based interventions. We know what works to prevent neonatal death, but there are coverage gaps along the continuum of care; which include contraceptive prevalence, skilled attendant at delivery, postnatal visit within two days, exclusive breastfeeding, and case management of pneumonia. UNICEF is working to promote strategies to increase use and access to antenatal care and skilled birth attendants. UNICEF is also working to supply essential commodities and improve community-based home visits. Golaz gave several examples from the field include mapping of UNICEF RH activities in humanitarian emergencies, provision of RH supplies and support for basic and comprehensive EmONC, deployment of key health personnel in emergencies, provision of newborn care units to operate baby warmers and oxygen concentrators, early community mobilization through community health workers, promotion of breastfeeding, and health education sessions. Golaz closed by stating that newborn survival should be included in crisis work. In particular, RH kits should include newborn resuscitation supplies.

[Catrin Schulte-Hillen](#), *Médecins Sans Frontières (MSF)*, presented on pregnancy outcomes from a specialized cholera treatment unit for pregnant women in Haiti. A massive cholera epidemic occurred nine months after the earthquake, affecting close to 0.5 million people and resulting in 6,500 deaths (case fatality rate 1.3%). MSF assumed 60% of the caseload resulting from the epidemic. An alert came from the field in the beginning of the epidemic. Out of 17 deliveries, 14 resulted in stillbirths and three in live infants, demonstrating an increased risk of morbidity and mortality for the pregnant woman, the fetus, and the newborn. Limited documents and studies suggest associations between cholera and spontaneous abortion, premature delivery, fetal death, stillbirth and increased mortality in mature and pre-term infants. These problems are not due to the cholera toxin itself, but likely have a hemodynamic and metabolic cause. A treatment approach was decided upon in mid-December 2010 and included specific set-up of an isolated obstetric cholera unit with 20 beds capacity and care for pregnant women. Treatment protocol included aggressive fluid replacement, prevention of hypoglycemia, systematic antibiotics and strict hygiene precautions. Descriptive analysis included 264 pregnant women with cholera cared for by MSF's isolated obstetric cholera unit. The case fatality ratio was zero. 227 (86%) women were discharged cured with preserved pregnancy. Out of 15 deliveries, five were admitted to the intensive care unit and two resulted in neonatal deaths. There were 21 foetal deaths (8%), 11 were before admission. Results indicate that the greater the dehydration on admission the greater the risk of fetal

death. Limitations include that cholera cases were not laboratory confirmed and the study had no control group, therefore it is not possible to judge positive effect of the specialized unit or treatment protocol. This is the largest cohort with a description of cholera in pregnancy and indicates a positive outcome compared to the literature. Conclusions include that cholera and pregnancy patients are at risk, reduction of fetal mortality is possible with early identification and specific treatment protocols, and that special cholera units for pregnant women should be considered. New cholera guidelines will be available in 2012.

[Basia Tomczyk](#), CDC, presented on a survey of providers regarding neonatal health in humanitarian emergencies conducted by a subgroup of the IAWG. The survey included 53 open and close-ended pilot tested questions and was distributed in English to key organizations and participants working in maternal, newborn, and child health using a non-random snowball technique. Objectives were to assess the continuum of services, identify barriers to program implementation in the field, and to better understand policies and practices for newborn care. Fifty-six individuals from 29 organizations in 26 countries responded to the survey. Tomczyk presented specific results on the provision of antenatal care, childbirth services, preventative newborn care, therapeutic newborn care, and HISs. Reported barriers to providing maternal and newborn care include lack of funding, and lack of trained personnel. The following limitations were identified: 1) small sample size, 2) survey was not population based, 3) the survey did not measure the accessibility of services, and 4) possible selection bias. Tomczyk closed by stating that understanding the breadth of newborn care services can help identify areas for improvement, and interventions can be provided in the context of humanitarian emergencies. Recommendations include enhancing training, improve monitoring of newborn health data, increase the use of task shifting, and reaching out to donors to improve funding.

[Diane Morof](#), CDC, presented on identifying priority questions and gaps in neonatal health through a collaborative study with Save the Children. The goal of the study is to build the evidence base to improve newborn survival and prevent/reduce stillbirth in humanitarian settings. Saving Newborn Lives Program at Save the Children developed a list of 35 questions deemed critical to improving the evidence base in humanitarian settings. The initiative will utilize systematic methodology developed by the Child Health and Nutrition Research Initiative to set priorities in health research investments through a multiple step, flexible process that enables prioritization at any level (institutional, regional, national, international and global). The survey will be on going in complex humanitarian emergencies from now until 2020. Four criteria have been selected for evaluation of questions and include answerability, feasibility, relevance, and equity. Participants can help by completing the survey and disseminating the survey to field staff with expertise on neonatal health.

## WEDNESDAY, NOVEMBER 16

### *Session 9: Global to Local: Capacity-Building in Crises*

*Chairperson: Meghan Gallagher, Columbia University*

[Emma Simpson](#), MSI, spoke on MSI's experience with task-sharing in RH to meet the health worker shortage. The global shortage of health care workers is 4.3 million, and most physicians are in urban areas. Task-sharing contributes to sustainability and strengthening of health system. It requires training, finance, leadership and an enabling framework. MSI works in 43 countries worldwide, and can offer clinical skills training, technical assistance, quality control and in country support. Simpson gave as an example MSI's implementation efforts in Yemen, where PAC services were only performed by doctors providing D and C. Manual Vacuum Aspiration (MVA) was added into clinical guidelines through MSI's advocacy efforts. MSI then advocated for task sharing of MVA, training all midlevel providers in MVA and establishing basic services. Midwifery and medical schools integrated MVA into their training curriculums and established a peer network for trainees. A 24-hour helpline was created to provide technical assistance to trainees. The key messages for in-country advocacy efforts included an evidence base, use of WHO international standards, linking reality of maternal mortality with the lack of human resources, and dispelling fears with provision of back up support. Between 2005 and 2011, 212 midwives were trained. Midwives carried out 1,080 MVA procedures in 2011. Simpson closed by providing the following lessons learned: 1) the importance of building relationships and enlisting national and professional bodies to help with internal advocacy, and 2) using international best practice and national guidelines to shape policy. MSI's current developments include the establishment of an internal cross-departmental WG on task sharing and a WHO evidence review for task-sharing across comprehensive family planning methods.

[Sabera Turkmani](#), *Afghan Midwives Association (AMA)*, presented on the AMA's efforts in strengthening the midwifery profession through advocacy, education and regulation. The AMA was formed in 2005 to improve leadership and management of midwives in the country and to improve quality and access of RH services. The AMA has become known as a model for midwifery associations worldwide and as a prime partner of choice within national movements for safe motherhood. In 2002, the MMR in Afghanistan was 1,600/10,000, 40% of primary health care facilities had no female provider, and a skilled provider attended only 8% of births. The midwife became viewed as central to the provision of quality RH services, and it was decided that the professional association would advocate on behalf of midwives at the policy level and be active partners in all deliberations that affect the profession. The AMA started with 15 members and now has 2,600, with more than 50 honorary members around the world. The AMA has a board of directors from 32 provincial chapters and has established a mechanism for recognition of midwives who had significant contribution to maternal health. The AMA also initiated a safe motherhood initiative within the country, and established mentorship program. The AMA is actively engaged in policy and education despite the unstable political environment, and is actively building the capacity of midwives as leaders, trainers, and as competent and compassionate health care providers. Turkmani gave an

example on an AMA initiative where young women with basic education from villages were enrolled in a two-year midwife-training program. The women returned to their villages after graduation and had a direct impact improving maternal health. The AMA is currently evaluating this program and its impact.

**Mihoko Tanabe**, *Women's Refugee Commission*, presented on a pilot project on community-based distribution of family planning services in Malakal, South Sudan. There is documented evidence on the lack of attention to family planning in humanitarian settings, but there are also proven strategies to increase knowledge and use of family planning services in development settings. With the American Refugee Committee (ARC) and CDC, the Women's Refugee Commission set out to examine whether community based distribution of family planning was applicable and feasible in a humanitarian setting and if it would enhance people's access and use of contraceptives. Malakal, in upper Nile State with a total population of 126,500, was selected as the study site. The study began in 2009 and included household visits by outreach workers to discuss family planning methods, community meetings, development and distribution of educational materials, school talks and presentations, dramas in churches and mosques, radio sessions, and referrals to two standing health facilities. September 2011's end-line activities included a household survey using CDC's *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, focus group discussions with family planning users and community based distribution agents, and comparison of household interview data with facility-level data on antenatal care, family planning and other services. Preliminary results showed an increase in the CPR for any method from 3.2% (baseline) to 22.1% (end-line), CPR for modern methods also increased from 1.9% (baseline) to 5.3% (end-line), although any changes are not solely due to the community based distribution effort. Tanabe further noted that communities did not report conflict as heavily linked to challenges in obtaining family planning services, although this finding may be because the violence and conflict has become the norm. Tanabe closed by stating that more family planning outreach is needed, especially in rural areas. A functional supply chain and motivational factors are critical for success of community based distribution approaches in crisis-affected settings. Limitations include the limited reach of the project in the three payams, challenges to tracking as a result of conflict, end-line study sampling and limited perspectives from peer educators and RH promoters.

**Bill Powell**, *Ipas*, presented on capacity building through refresher training for MVA. Although reliable data are needed on spontaneous abortion, it is estimated to account for up to 25-50% of the MMR in crisis settings. Safe abortion services are especially needed in crisis settings due to the lack of security, sexual violence, disruption in contraceptive and other health services, and the possible desire to delay childbirth during a crisis. MVA is recommended by WHO for PAC services and induced abortion, is a signal function of any EmOC program, and is an IAWG training partnership focus. Ipas contextualized existing materials to crisis settings and condensed them from a five-day training to a two-day outreach module for MVA, appropriate for use in camp settings. This is considered a refresher training and is appropriate for clinicians with previous training, as it is

comprised of didactic classroom work with skill development using a pelvic model, but has no clinical component. UNHCR, UNFPA and Ipas worked together to pilot the refresher course in two camps in Kenya in May 2010 and one camp in Uganda in December 2010. The courses included six doctors, 37 nurses and midwives, and 11 clinical officers. Many trainees had never been exposed to MVA, so more foundational time was needed. Logistics and security issues made trainings longer than the intended two days, and there was not enough follow-up after the training. Recommendations and next steps include reiterating that the training is refresher and not a competency based training, including a review of local abortion law in the agenda, considering pre-training and follow-up assessments (field visits) to better understand the context and setting, and considering additional content around 2<sup>nd</sup> trimester PAC and Misoprostol for PAC and induced abortion.

### ***Session 10: Thematic Working Group Meetings***

*Chairperson:* Sandra Krause, Women's Refugee Commission

In session 10 of the meeting participants had an opportunity to break into thematic WGs. Dividing into one of eight WGs, participants had an opportunity to share information, identify gaps, and prioritized activities for 2011/2012. The WGs included Advocacy/Minimum Initial Service Package, Reproductive Health Data and Research, Adolescent Reproductive Health, HIV/AIDS/STI/RTI, Maternal and Newborn Health, Family Planning and Logistics, Eastern Europe and Central Asia IAWG Regional WG, New Technologies, and Gender-based Violence. Complete Terms of Reference for the WGs are available on page 33 of this report.

### ***Closing Session***

*Chairperson:* **Sandra Krause**, Women's Refugee Commission

**Nguyen-Toan Tran**, *IPPF*, gave conclusions and recommendations. In his closing remarks Tran urged members to take stock, consolidate, and scale-up their activities. Tran further integrated lessons learned from the meeting in asking participants to expand their collaboration efforts in bridging the divide between development and humanitarian communities, engaging and empowering national leadership, engaging donors, engaging child and adolescent health service providers and HIV/AIDS organizations, as well as positioning IAWG within the *World of 7 Billion* campaign, MISP and MDGs.

**Nadine Cornier**, *UNHCR*, provided the closing remarks and began by asking participants where the next meeting should be held. Cornier further discussed the importance of continuing to meet in, and developing, global regional networks. Cornier reiterated those lessons learned in the three days of the meeting, which include: actively engaging donors, scaling-up community projects and evidence-based projects, expanding access to underserved populations (including adolescents), promoting capacity development to better respond to emergencies, and working collaboratively in the face of new climate changes. Cornier closed by urging working group to engage the broader IAWG membership as they develop their Terms of Reference in the upcoming year.

## APPENDICIES

### APPENDIX A: LIST OF PARTICIPANTS

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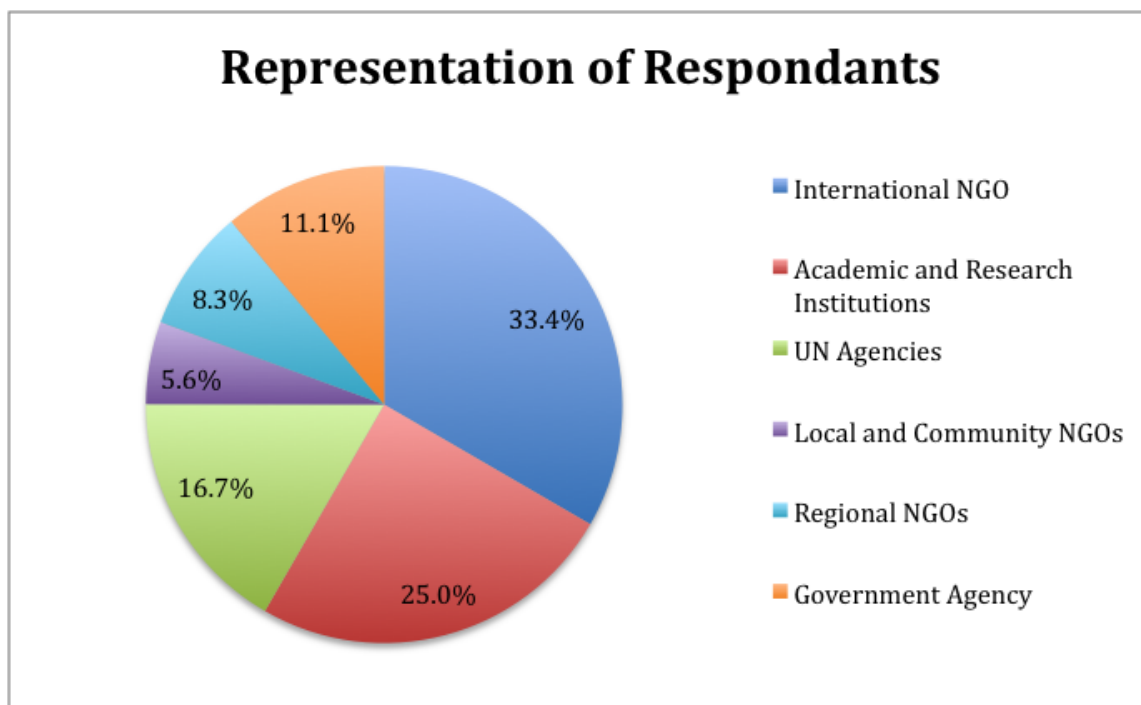
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## APPENDIX B: EVALUATION RESULTS

**METHODS:** The evaluation for the 13<sup>th</sup> annual meeting of the IAWG was disseminated to meeting participants via a hard copy at the meeting and an electronic version was sent out after the meeting through the IAWG listserv. Responses were collected through December 12, 2011. The survey included a total of 27 questions, and was developed to capture the overall impressions of meeting participants.

**RESPONDENT COMPOSITION:** Thirty-six of 92 meeting participants completed the survey, for a completion rate of 39%. Nearly half of the respondents (47.2%, n=17) indicated working for NGOs, while the remainder worked for research institutions (25.0%, n=9), UN Agencies (16.7%, n=6), and government agencies (11.1%, n=4). In addition, 52.8% (n=19) stated they had not previously attended an IAWG annual meeting. Eleven of the 36 respondents (30.5%) indicated that they received scholarships to attend the 13th annual meeting of the IAWG. The following graph highlights the representation of respondents who completed the evaluation.



**FINDINGS:** Using a Likert scale, participants answered questions regarding their overall impressions of the meeting content and materials covered. Response categories included *too detailed*, *about right*, and *not detailed enough*. Most participants, 69.4% (n=25) felt that the material covered was “about right”, while 11.1% (n=4) felt that the material was “too detailed” and 11.1% (n=4) felt that it was “not detailed enough.” When given the options of ranking each session as *excellent*, *good*, *fair*, or *poor*, participants consistently ranked sessions as ‘good’. All participants who rated the meeting logistics (83.3%, n=30) thought logistics were excellent (63.3%, n=19) or good (36.7%, n=11).

The following table displays the degree to which respondents thought the meeting objectives were or were not attained.

**TABLE 1: SURVEY ITEM LIKERT SCALE PERCENTAGES (N=36)**

Objective	Very well % (n)	Well % (n)	Poorly % (n)	Not at all % (n)	N/A % (n)	Missing % (n)
Progress towards achieving programmatic goals determined in 2010	47.2 (17)	36.1 (13)	8.3 (3)	0.0 (0)	5.6 (2)	2.8 (1)
Share information	66.7 (24)	27.8 (10)	0.0 (0)	0.0 (0)	0.0 (0)	5.6 (2)
Plan next steps and areas of coordination/collaboration for 2011-12	22.2 (8)	52.8 (19)	16.7 (6)	0.0 (0)	2.8 (1)	5.6 (2)
Establish regional IAWG forum for EECA	25.0 (9)	50.0 (18)	0.0 (0)	0.0 (0)	19.4 (7)	5.6 (2)

## SUGGESTIONS FOR FUTURE MEETINGS

Respondents made several suggestions for future meetings, which cut across several themes, including:

### *Participant Composition:*

- Invite more donors to future meetings
- Invite OCHA to join the forum
- Include more field and regional participation/representation

### *Meeting Focus and Structure:*

- Develop an overall vision and strategy for IAWG
- Identify stronger meeting objectives prior to each meeting
- Allow more time to plan the meeting
- Focus on an identified theme, or have thematic days
- Reduce the number of topics and stay focused on a specific theme
- Standardize meeting dates so that the meeting is held at the same time every year
- Increase the number of meeting days to five
- Provide opportunities for agencies to share their plans for the future and to identify potential areas of collaboration
- Include a special session for UN partners to discuss coordination/lessons learned
- Include all logistical information about the meeting in the opening session
- Present awards for best practices among partners to acknowledge their efforts
- Include one full day for recreation and informal discussions among participants
- Create an on-line forum for participants to share post meeting experiences

### ***Enhancing Meeting Sessions and Presentations:***

- Limit the number of presentations in each session to three
- Dedicate more time to discussions
- Include a formal abstract submission for presentations
- Disseminate session themes out through IAWG network in advance to solicit presentations from all participating organizations
- Limit the number of presenters from each organization for more equal representation
- Review PowerPoint presentations prior to the meeting to reduce duplication and assist presenters in improving their presentations
- Provide better guidance to presenters
- Include more sessions on current emergencies
- Solicit more presentations on experiences from the field (outside of research findings)

### ***Working Groups:***

- More emphasis on strengthening regional WGs
- Restructure WG meetings so that participants can attend more than one
- Split the WGs between two days
- Simplify the report back from WGs and utilize templates for the review and updating of Terms of Reference

In addition, respondents suggested that future meetings include more information on a variety of topics, including:

- Adolescent RH in and after crises
- Male involvement in family planning in humanitarian settings
- Coordination during crises
- Coordination among IAWG members/agencies
- Challenges, lessons learned, and roles and responsibilities regarding coordination of MISP
- Moving MISP to more comprehensive RH services
- Improving access to MISP in rural settings
- Updates on technologies
- Chronic, on-going emergencies
- Long-term implications for RH in crises
- Sexual violence as a tool of war
- Prevention and management of SGBV
- Gynecologic and traumatic fistulas
- Quality assurance/quality improvement in low resource and crisis settings
- Security issues for organizations that are not UN members
- RH rights advocacy and research
- Community capacity building

## APPENDIX C: TERMS OF REFERENCE

The IAWG Terms of Reference (ToR) is a tool for IAWG members to collectively identify annual progress, identify gaps and propose solutions to ensure women, men and young people in crisis situations have access to the MISP in the early days and weeks of new emergencies and comprehensive RH services as the situation stabilizes. While the full membership of the IAWG itself is not tasked with undertaking specific activities to address the gaps, it is expected that IAWG member organizations, either individually or in partnership with others, will voluntarily commit to undertaking them. Thus, the ToR serves as a collective guiding post for its members to identify and prioritize gaps, progress and appropriate solutions.

### IAWG WORKING GROUPS (WG):

\*Denotes WGs that have *not* submitted 2011/12 updates.

1. Adolescent Reproductive Health
2. Advocacy
3. Family Planning/Logistics
4. Gender-based Violence
5. HIV/AIDS/STI/RTI
6. Maternal and Newborn Health
7. Minimum Initial Services Package (MISP)
8. New Technologies\*
9. Reproductive Health Data, Health Information System (HIS), and Research
10. Regional Strategy: Eastern Europe and Central Asia (EECA)
11. Regional Strategy: Latin America and the Caribbean (LAC)\*
12. Regional Strategy: Middle East North Africa (MENA)

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## 1. Adolescent Reproductive Health

### 1.1. Advocate for quality adolescent SRH programming in humanitarian settings.

**STATUS:** Past efforts have focused around using YOUTH ZONES as an awareness-raising tool. Screenings included Women Deliver (June 2010); UN General Assembly's launch of international year of youth (New York City, August 2010); Mexico City Youth Conference (August 2010); refugee film festival (London); high-level meeting on youth (July 2011); and over 25 smaller screenings. Advocacy packages and DVDs have been sent to requests; website was created at: [www.youthzones.org](http://www.youthzones.org). YOUTH ZONES is being translated to Arabic, French and Spanish; the new language versions will be available in early 2012.

**RECOMMENDATIONS:**

1. Link adolescent SRH to MDGs while advocating to donors, humanitarian players, government bodies etc. and demonstrate how MDGs, especially MDG 5b: universal access to RH cannot be accomplished unless youth-targeted interventions are developed.
2. Advocate for adolescent SRH to be part of RH in developing protocol for emergency preparedness.
3. Design advocacy campaigns to focus on a certain topic of adolescent SRH (such as family planning or STI/HIV). A topic- and region- specific campaign helps to garner larger support and help the wider community understand the importance of targeting youth and integrating adolescents into RH interventions.
4. Attempt a bottom-up approach to advocacy to spark youth to initiate the campaigns around adolescent SRH.
5. WG facilitators to expand membership of the adolescent SRH WG by inviting stronger youth participation. This will start with extending an invitation to active Y-Peer groups.
6. WG facilitators to work more closely with the IAWG Family Planning WG to strategize on family planning programs to meet the needs for adolescents.

### 1.2. Build manager, provider, community leader and others' capacity to facilitate their recognition of and champion for adolescent SRH within their areas of work.

**STATUS:**

1. UNFPA/Save the Children are rolling out their *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* (ASRH Toolkit) developed in 2009. In-person trainings have included with IRC (September 2010), UNFPA West Africa Region (September 2010) and Save the Children staff. A ToT is scheduled for IMC staff in 2012 for six country programs. An e-learning tool has also been developed, with 195 completions as of November 2011. French and Spanish versions of the e-learning will be launched by the end of 2011.

2. The SPRINT Initiative has integrated training materials on adolescent SRH into their existing training curriculum. The manual was presented at the 2011 IAWG meeting.

**RECOMMENDATIONS:**

1. UNFPA/Save the Children to widely disseminate and translate the *ASRH Toolkit* into additional languages; UNFPA Indonesia to initiate and finalize Bahasa Indonesia translation by the end of 2012.
2. All service delivery agencies to increase programs that address adolescent SRH in humanitarian settings.
3. Implement youth mapping exercises that push for age-aggregated data collection.
4. WHO to roll-out recently published guidelines on preventing early marriage.
5. Develop “peer education” kit or “Peer Education in a box” which can be ordered and deployed in emergencies (outstanding from 2010 ToR; WG members needed).

**1.3. Increase programs that address adolescent SRH in humanitarian settings.**

**STATUS:**

1. Adolescent SRH textboxes and a template on Flash/Consolidated Appeals Process (CAP) were included in the MISP module available at <http://misp.rhrc.org>. Adolescent MISP fact sheet from adolescent SRH toolkit were further made available to RH managers and health cluster/sector members in humanitarian settings through PDFs.
2. UNFPA held discussions with colleagues working on the gender marker to see if a tool could be replicated for age. Rather than developing a new “age marker tool,” all persons consulted favored instead to amend the current gender marker.
3. The UNFPA Arab States Regional Office is launching a *Manual for Peer Education on Youth Reproductive Health in Humanitarian Settings*. The project is collaboration between UNFPA Arab States Regional Office and the Humanitarian Relief Branch. The manual follows the Y-PEER methodology and can be used for both training of Peer Educators, and ToTs. The Peer Educators training agenda was pilot-tested in July 2011 in Southern Tunisia with young refugees from Libya. A group of peer educators was formed at Choucha refugee camp and mobilized to sensitize other young people on HIV, SRH, gender and GBV. A pilot ToT is planned in Somalia in December 2011. The manual is scheduled for launched in early 2012.
4. Agencies worked to address adolescent SRH in current emergencies:
  - 4.1 Interagency Haitian Adolescent Girls Network led by Population Council was created, with funding from UN and Nike Foundations. Save the Children intends to support and strengthen the project through improving the SRH components and increase fundraising efforts for this purpose.
  - 4.2 IMC has integrated adolescent SRH into its emergency response in Dolo Ado, Ethiopia. This includes integration of MISP adolescent SRH interventions, including training of government Administration for Refugee and Returnee Affairs staff on youth friendly services, linking

pregnant girls to health care services and conducting an assessment for longer-term interventions.

- 4.3 IRC is developing its first SRH policy and guide for programming that calls for inclusion of adolescent-friendly services in all RH programs, and that directs programs to conduct annual assessment of their adolescent friendliness. IRC also has an agency-wide WG on adolescent girls that is developing a concrete plan/framework for all sectors to reduce teen pregnancy. For RH, the focus will likely be increasing access to family planning for adolescents. Further, in a family planning and PAC program across Chad, Democratic Republic of Congo and Pakistan, IRC is disaggregating data by age to capture family planning uptake among adolescents. This is coupled with specific plans to increase access/uptake of family planning and PAC services to adolescents and apply those lessons to other settings.

**RECOMMENDATIONS:**

1. Service delivery agencies to continue to increase adolescent SRH and adolescent-friendly programs in new and existing emergencies. CARE to take part.
  2. Field test tools in *ASRH Toolkit* and document lessons learned for future revisions. Organizations interested in field-testing: IRC, American Refugee Committee (Thai-Burmese Border, South Sudan), Save the Children (South Sudan), IPPF (Haiti), UNFPA (Bangladesh). (Outstanding from 2010 ToR)
  3. UNFPA to widely disseminate and translate the *Manual for Peer Education on Youth Reproductive Health in Humanitarian Settings*.
  4. UNFPA Arab States Regional Office to rollout trainings on Youth SRH in Humanitarian Settings in the region.
- 1.4.** Document and share best practices and lessons learned in addressing adolescents in humanitarian settings. Post documents and lessons learned on Adolescent RH WG list at IAWG.

**STATUS:** Very little documentation has been completed. In the past year, the WRC developed a four page brief and technical report from its joint 2010 Haiti MISP assessment that includes adolescent SRH.

**RECOMMENDATIONS:**

1. WG facilitators to specifically allocate a time during quarterly meetings for members to take turns in sharing best practices and challenges. These are to be documented and shared within the WG and adapted for working papers, proposals, advocacy, etc.
2. WG facilitators to call emergency meetings in new crises, including through MISP WG, to discuss how adolescent SRH can be integrated in the emergency.
3. Review recent humanitarian appeals to assess inclusion of youth, estimate budget requirements and mobilized funding on youth issues (outstanding from 2010 ToR).

## 1.5. Support research studies on the impact of crises on adolescents.

**STATUS:** Research priorities identified in 2007 include: 1) examining the characteristics that determine and influence adolescent transitions from childhood to adulthood in both non-conflict and conflict settings, so as to be able to identify ways to support a healthy transition in communities affected by crises; 2) influences leading to positive deviance; and 3) the effects of conflict and/or displacement on the construct of masculinities vis-à-vis the changing expectations of men and women in crisis settings.

1. Women's Refugee Commission conducted a qualitative study on early marriage in northern Uganda. The study documented conflict-affected adolescent and adult perspectives on marriage customs and changing norms, and examined service provider observations on addressing the consequences of early marriage.
2. John Snow and UNFPA planned to conduct research on urban refugee youth; however, this research did not materialize due to lack of funding.
3. Save the Children, Pathfinder and the Institute for Reproductive Health are conducting formative research as a part of an USAID program in Northern Uganda to explore gender norms as it effects RH and family planning decisions. The ethnographic qualitative research is being conducted with adolescents 10 to 19 years old and will be used to design a program in 2012. The formative research report will be available in 2012 on the Insitute for Reproductive Health website and can be circulated to the adolescent RH WG.
4. Women's Refugee Commission's youth program has embarked to build social agency in young adolescents.

**RECOMMENDATIONS:** Conduct practical operations research to show the effectiveness of specific strategies and process evaluations to document best adolescent RH practices in crisis settings.

1. Save the Children intends to design a qualitative study to study the impact of lack of access to youth-friendly services in emergency and protracted emergency settings and to also study the impact of capacity building of local organizations on adolescent SRH outcomes in 2012-2013.
2. CARE will continue their research on contraceptive choice with adolescents in post-conflict settings.
3. Other research ideas from 2010 include:
  - 3.1 The impact of the lack of access to youth-friendly services on adolescents.
  - 3.2 Broader study on impact of earthquake on youth in Haiti.
  - 3.3 Study the impact of capacity building of local NGOs on adolescent SRH outcomes.
  - 3.4 Operations research on communities with peer educators verses those that have not.
  - 3.5 Youth friendly health facility assessments.
  - 3.6 Comprehensive RH youth survey in Haiti or elsewhere for a cross sectional view of current situation.

## 2. Advocacy

### 2.1. Continue outreach to identify new members to engage with IAWG.

**STATUS:** Identify new members from donor agencies and stakeholders including European donors, International Federation of Red Cross and Red Crescent Societies, UN agencies, World Bank, medical societies representing providers that provide RH care, and governments, among other agencies.

**RECOMMENDATIONS:** Ongoing

### 2.2. Liaise on advocacy issues and initiatives within IAWG and other SRH agencies.

#### 2.2.1. Disseminate the IAWG family planning advocacy statement with cover letters to UN agencies, NGOs and governments to advance family planning programming within each agency.

**STATUS:** The cover letter to UNHCR is complete and an official response has been received. A cover letter to UNICEF among other agencies is in process.

**RECOMMENDATIONS:** Follow-up with UNICEF

#### 2.2.2. Invest in local SRH human resource capacity and assist local organizations with coordination and leadership on SRH service provision in crisis settings.

**STATUS:** SPRINT has trained over 4,000 coordinators across three regions. The SPRINT curriculum is under revision and will be available in English and French targeting health providers and first responders such as the Red Cross/Red Crescent. Separate modules will also be available for directors and direct implementers.

**RECOMMENDATIONS:** Undertake more translations of the SPRINT curriculum, including Spanish for LAC. Translations should be facilitated in the country itself. Strive to ensure the MISAP is integrated into curricula/text books for health providers, such as nurses, midwives and doctors.

## 3. Family Planning/ Logistics

### 3.1. Build in-country capacity for family planning and PAC family planning.

#### 3.1.1. Conduct mapping exercise of local, regional, and international expertise and capacity for family planning and PAC family planning training.

**STATUS:** Ongoing  
**POC:** Dhammika Perera

- 3.1.2.** Build family planning knowledge for program managers and RH implementers, by developing a list of family planning courses (online) that should be completed as a basic introduction to family planning. Distribute to program staff along with an explanation of whom the program is for.

**STATUS:** Ongoing since 2007, new family planning Counseling/ Overview  
**POC:** Janet Myers

- 3.1.3** Compile a package of family planning resources (inclusive of family planning, PAC family planning, family planning methods, quality assurance, supervision, male involvement, and community mobilization) which will be distributed to field offices and providers. Members of the family planning WG also complete suggested modules.

**STATUS:** Adapted recommendation from previous years  
**POC:** Maria Tolska

**RECOMMENDATIONS:**

1. Follow up with K4health to learn what resources are available for field offices, how they can be shared (consider Dakkar family planning conference, mailing, etc), and what languages are available (Jennifer).
2. Share available resources from each agency present to drop box online tool developed by Maria (Dhammika- IRC, Emma- MSI, Janet- CARE, Maria- Save the Children, Jennifer- Women's Refugee Commission).
3. Develop criteria for selecting tools (e.g. ease of use, developed by UNFPA or WHO, comprehensiveness, access in multiple languages)- point person needed.

- 3.1.4** Ensure integration of comprehensive (short term, long term and permanent methods and dual protection) family across RH services (adolescent, GBV, HIV and STIs, and maternal health care) and ensure that family planning data can be collected from each of these service delivery points. Collaborate with Adolescent RH WG on research question focused on adolescent family planning.

**STATUS:** Groups to discuss this point further  
**POC:** To be identified

- 3.1.5** Research has indicated the efficacy of community-based distribution of Depo-Provera. Agencies to integrate implementation of community-based distribution of Depo-Provera with trained promoters/CHWs as clients want or need. Research topic also on adolescent access to family planning- in collaboration with Adolescent WG.

**STATUS:** Ongoing  
Responsible for reporting back: Dhammika, IRC

### 3.2. Advocacy

- 3.2.1.** (Cross-cutting) Providers to give a one to three month resupply of oral contraceptives and barrier methods.

**STATUS:** Adapted – All agencies to work towards implementing this.

- 3.2.2.** (Cross-cutting) at the global level to reposition family planning as preventing maternal mortality and improving child health. Leverage existing family planning statement developed by IAWG. Reach out to UNFPA to endorse a statement supporting the repositioning, consistent with the evidence base.

**STATUS:** New; Group to revisit this point during the next WG call - discuss feedback during plenary regarding ways to use current family planning statement and need for “repositioning.”

### 3.3. Logistics

- 3.3.1.** Increase equity of supplies to multiple delivery sites. Agencies should take on attempting to have minimum three categories of methods at a time (i.e. barriers, pills, implants, injections, long-term methods) at their facilities and facilities they support.

**STATUS:** New

## 4. Gender-based Violence

- 4.1.** Provide technical support to field sites as requested and support the IAWG regional level chapters in coordination of GBV interventions with other coordination groups.

**STATUS:** The Inter-Agency Standing Committee (IASC) has formed a GBV Area of Responsibility under the Protection Cluster. This group addresses support to the field, knowledge building, norm setting and advocacy. However, they have identified a gap in providing clinical management of rape to survivors, which is not always guaranteed in emergency settings.

#### **RECOMMENDATIONS:**

1. Establish network with IAWG agencies and field staff to disseminate existing clinical post-rape care and related field guidelines, training and other resources.
2. Share best practices with regional IAWG field staff for implementing guidelines and identify challenges and opportunities to advocate for

implementing post-rape care within the GBV coordination structures at the regional level.

3. Reach out to IAWG regional groups to identify gaps in addressing clinical care and GBV coordination in emergencies.

**4.2.** Build capacity in post-rape clinical and psychosocial technical knowledge and maintain ongoing communication between IAWG GBV WG and global coordination bodies.

- 4.2.1.** Build capacity of practitioners on clinical and psychosocial management of rape survivors.

**RECOMMENDATIONS:**

1. Engage the IAWG Training Partnership, UNFPA regional coordinators, and IAWG Regional WGs to move forward with recommendation.
2. Maintain communication with Protection Cluster/GBV Area of Responsibility to promote synergies.

**4.3.** Set normative standards around key issues in relation to GBV prevention and response.

- 4.3.1.** Practical, user-friendly guides for best practices to provide clinical and psychosocial care for GBV survivors that integrate the IASC GBV guidelines and other resources.

**STATUS:** The GBV Area of Responsibility and IASC have developed a large number of guides and tools to support the implementation of GBV guidelines. There is a need to ensure that clinical and psychosocial care are available in all settings and GBV coordination groups are aware of strategies for implementing these guidelines.

**RECOMMENDATION:** Develop case studies describing best practices for addressing barriers in implementing clinical management standards for the following identified key issues:

1. Provision of post exposure prophylaxis and emergency contraception.
2. Completion of the police form in the clinical setting.
3. Community-based models for care seeking behavior.
4. Psychosocial interventions in humanitarian settings.

- 4.3.2.** Strengthen research on GBV in crisis settings to guide best practices in GBV prevention.

**STATUS:** Limited research exists on the scope and effectiveness of programs that prevent GBV in humanitarian settings including gaps in understanding the impact of GBV on the individual, family and community.

**RECOMMENDATIONS:**

1. Coordinate possible activities with the GBV prevention community.

2. Explore more rigorous evaluations on the effectiveness and safety of prevention programs in humanitarian settings.

**4.4.** Raise the profile of health care and psychosocial response to sexual violence in humanitarian action among policymakers, donors and other sectors.

**4.4.1.** Advocate availability of high-quality mental health services.

**RECOMMENDATION:** Advocate for availability of high quality mental health and social support services based on the IASC mental health guidelines.

**4.4.2.** Improve the linkage between the development/humanitarian community and Protection/ Health Clusters for GBV prevention and response.

**RECOMMENDATIONS:**

1. Convene a meeting to bring together GBV experts in the development and humanitarian (acute and protracted) community to explore applying existing strategies to provide clinical and psycho-social care for survivors to humanitarian settings. For example, the experience of the development community on community-based interventions, effective prevention strategies, addressing intimate partner violence, conducting research in sensitive settings, and establishing common indicators.
2. Identify clear guidance for the field on areas where protection and health cluster can work together on GBV.

**4.4.3.** “Best Practices” exchange via IAWG website and information exchange.

**RECOMMENDATION:** Using the IAWG website, include GBV tools and resources including links to other global GBV websites such as the GBV Area of Responsibility Community of best practice.

## **5. HIV/AIDS/STI/RTI**

**5.1.** Create a new WG, through contacting IAWG members, the current group being inactive. The proposed activities below will need to be modified or approved by the new group.

**5.1.1.** Coordination: reactivate the group in particular through networking at the onset of new emergencies. Link with the UNAIDS Division of Labor group “Addressing HIV during emergencies.”

**5.1.2.** Compile, review and share training materials and plans. Commit to put training on STI/HIV/AIDS in work plan and budget. As much as possible provide to the group self-explanatory training curriculum with lessons learned for roll-out.

- 5.1.3. Compile field briefs, best practices and other operation supporting documents. Provide inputs to “HIV IN Emergency” web platform (formerly managed by UNAIDS, currently managed by UNHCR/World Food Program).
- 5.1.4. Compile and update materials promoting and facilitation community involvement to improve quality and access and address stigma (review guideline developed by Pretoria University for UNFPA/ARC).
- 5.1.5. Increase use of “positive lives” exhibition and community guides.
- 5.1.6. Work on material and projects to increase access and information to young people (with parent’s involvement in message and strategy development).
- 5.1.7. Review the state of cervical cancer screening and prevention and investigate opportunities to introduce/scale up prevention in post crisis situations

## 6. Maternal and Newborn Health

High priority activities for the upcoming year: 6.2; 6.3; 6.5.2, and 6.9

- 6.1. Women’s Commission/Reproductive Health Response in Crises Consortium published field-friendly guide to integrate EmOC in humanitarian programs.

**STATUS:** Completed and on the Internet currently

**ACTION ITEM:** Additional advocacy

- 6.2. Document and share case studies, best practices and lessons learned on successful implementation of basic EmOC with the goal of sharing best practices

**STATUS:** Ongoing but incomplete

**ACTION ITEMS:** Reaffirmed need for lessons learned and sharing of field experiences. UNHCR (Ouahiba) will work on broad template and circulate it. Plan to send the templates to the IAWG group to obtain case stories. Plan for eventual printed document, shared with the group and put on IAWG Website.

- 6.3. Change commitment from “coverage” to “quality” in services; define quality and provide checklists for supervisors; link with increasing demand for services at the community level.

**STATUS:** Not completed. Discussion led to two outcomes:

1. To compile/collect and post the tools
2. To develop selected tools for use

**ACTION ITEMS:** Diane (CDC) to review banked tools. If tools do not exist, plan is to divide topic area by agency/individual for collection of tools. Bill (IPAS) to do Comprehensive and PAC. Wael (UNFPA Jordan) to do antenatal and prenatal care. Overall plan is to develop one review of quality tool that is flexible and can be modified for use in multiple settings.

#### **6.4.** Development and share of practical operational tools for Essential Newborn Care.

**STATUS:** Continue at global level; no designated lead

**ACTION ITEMS:** Disseminate SAVE training guide on newborn care (available on external website of Save the Children); Check in with UNICEF and Save the Children

#### **6.5.** Conduct a survey to better understand the magnitude of fistula among crisis-affected communities. Fistula is a recognized as a critical RH issue. The group discussed the case of Sudan, which has a International Federation of Gynecology and Obstetrics program on fistula that Atif Fazari has been involved in since 2005. Identified prerequisite is to have local assistance (NGOs on sites, donors' and MoH's support). The program is facility based at public hospitals.

**STATUS:** Not achieved

**ACTION ITEMS:**

1. Determine research plan/methods for determination of scope/magnitude of fistula problem in protracted emergencies. Ouahiba and Diane will work on survey design and then share with the group.
2. Atif Zafari and Laurence Elaine will work on summarizing fistula findings from respective programs.

#### **6.6.** Gaps in knowledge of PAC care are still unknown. MVA Calculator - web based calculator has been completed and is on-line at Ipas website. Misoprostol training for use in first trimester abortion is online.

**STATUS:** On-going

**ACTION ITEMS:**

1. Advocate for PAC and comprehensive abortion care caseload data to be included in the Global Review. Bill Powel to contact Nadine to assess whether this can be included.
2. Plan to release a Misoprostol for PAC training. Bill Powel will find out about posting on the Ipas website; Determine dissemination plan for calculator and Misoprostol training.

#### **6.7.** Advocate for mid-level health care providers to provide basic EmONC (task-shifting). It is found that agencies are doing this all the time. It is understood that this is an advocacy point and that it is the policy of all the countries though not endorsed by all the governments.

**STATUS:** On-going (combining 6.9 and 6.10 in previous ToRs)

**ACTION ITEMS:** Determine lead for this activity and develop a position statement/tool for advocacy.

- 6.8.** Country profile of Maternal and Newborn Care priorities for consideration in Flash Appeals. Similar to WHO Risk Assessment, IAWG will distribute the country profile within 24 hours of an emergency.

**STATUS:** Not achieved

**ACTION ITEMS:** Determine lead for this activity, develop a template, and elaborate a plan of action to ensure its inclusion in the appeal.

- 6.9.** Develop a template to investigate maternal mortality cases. UNHCR template is already included in the revised IAFM 2010.

**STATUS:** UNHCR is currently revising the maternal mortality audit form.

**ACTION ITEM:** Ouahiba, Diane and Atif to work on this.

- 6.10.** Advocacy for basic first aid (Detect and Refer) and psychosocial support for maternal health (new item).

**ACTION ITEM:** Develop a position statement; Weal Hatahet (UNFPA) to initiate.

## **7. Minimum Initial Services Package (MISP)**

- 7.1.** Improve the MISP response in real-time emergencies, with UN agencies fielding RH coordinators, and the MISP WG holding teleconferences to share information, coordinate activities and identify gaps.

- 7.1.1.** Provide headquarters and regional IAWG groups with support for a MISP response in real-time emergencies.

**STATUS:** Complications getting RH into Health Cluster reports.

**RECOMMENDATION:** Reach out to IAWG regional subgroups to describe areas of potential support from the MISP WG and how the partnership can be activated in an emergency. Send RH Situation Reports to both the Health Cluster and Office for the Coordination of Humanitarian Affairs (OCHA).

### 7.1.2. Facilitate MISP coordination at the field level.

**STATUS:** The IAFM includes a MISP calculator that can be used for estimating population numbers and RH kits. The calculator can be developed into a handheld application for quick and easy estimates to identify gaps in a real-time emergency and as population figures shift throughout the crisis.

**RECOMMENDATION:** CDC will work with their in-house technical experts to develop an application to be piloted in the field.

**STATUS:** Current Health Cluster guidance indicates it is the responsibility of the Health Cluster to identify a Focal Point for RH that has the most capacity on the ground to coordinate. This could be the government and/or a UN agency, international or local NGO.

**RECOMMENDATION:** Women's Refugee Commission to address field coordination in the MISP WG and within the Global Health Cluster to identify challenges and solutions. All WG members should work to disseminate and share current Health Cluster guidance on RH coordination, especially within the Health Cluster during emergencies. ToR for RH sub-cluster in Sudan shared with WG.

### 7.2. Advocate for better cross-sectoral/cluster preparedness and response on the MISP/Comprehensive Reproductive Health Program.

**STATUS:** An ISDR RH sub-WG comprised of WHO, Women's Refugee Commission, UNICEF, UNHCR, IPPF SPRINT Initiative and CARE have drafted a policy brief which provides policy makers with tools for advocacy, highlighting the importance of addressing SRH (integrating the MISP) and DRR in national planning. It has further drafted a planning and preparedness checklist.

**STATUS:** The humanitarian crisis in the Horn of Africa adds to a protracted refugee setting, thus having different implications for MISP response.

**RECOMMENDATION:** Convene virtual meeting or small WG to develop recommendations for MISP response in varying contexts to share with the humanitarian community in a publication.

### 7.3. Continue development of tools in support of MISP implementation and monitoring efforts.

#### 7.3.1. MISP Monitoring and Evaluation Tool

**STATUS:** Women's Refugee Commission plans to update its current MISP assessment tools. In June 2011, the IAWG Technical Workshop for Setting Research Priorities selected the following gap as a research priority, "Identify Barriers and Facilitators of EmOC Implementation in an

Acute Emergency Setting as Part of the MISP”. EmOC implementation is one component of the MISP that can be evaluated to better understand how to improve it in acute emergencies.

**RECOMMENDATION:** CDC will develop a concept for a prospective assessment of EmOC implementation in an acute emergency setting to identify and categorize bottlenecks to EmOC implementation. This will be shared with potential donors.

### 7.3.2. MISP Standard and Verification Tool

**STATUS:** Jhpiego is developing a MISP checklist based on its Standards Based Management and Recognition (SBM-R) process that can be used to monitor internal progresses, facilitate remote supervision and identify the reasons for gaps in services. The format is aligned with the Health Resources Availability Mapping Tool (HeRAMS).

**RECOMMENDATION:** Jhpiego will lead a task force to further develop and refine the tool.

**STATUS:** The need for more user-friendly tools on the MISP, written with less jargon and specifically for clinical professionals has been identified.

**RECOMMENDATION:** Explore the development of country-specific, culturally relevant “pocket portfolios” – one pagers in both electronic and hard copy form – and other aides on the provision of RH to girls and women.

## 7.4. Build capacity of RH coordinators and relevant actors to facilitate MISP implementation.

### 7.4.1. Develop a database on available RH personnel to be deployed in emergencies through consolidating existing databases (Columbia University, Norwegian Refugee Council, Danish Refugee Council) and determining where the list will be housed.

**RECOMMENDATION:** Work with IAWG Training Partnership and SPRINT Initiative to maintain such a list at the country level.

### 7.4.2. Identify a core set of training materials to support clinical training of field-based RH coordinators and clinicians, in addition to humanitarian coordinators.

**STATUS:** IAWG Training Partnership Initiative has been reviewing curricula since 2007.

**RECOMMENDATION:** Receive updates from the IAWG Training Partnership.

- 7.4.3.** Certify as many humanitarian actors, policy makers and donors in the MISP distance learning module. IAWG member agencies are encouraged to incorporate the MISP module into their orientation package for all new health staff and to advocate internally for staff certification.

**STATUS:** The MISP module has been revised and translated to address updates to the 2010 IAFM MISP chapter.

**Recommendations:**

1. Widely disseminate the revised MISP module.
  2. Increase the number of MISP trainings and provide as much advance notice on dates and locations of training through the IAWG list-serv and the *Mama* platform.
  3. Obtain update on the clinical training of field-based providers.
- 7.5.** Participate in IAWG opportunities to discuss uses for new and underutilized RH technologies that facilitate effective MISP implementation.
- 7.5.1.** Take part in the RH Kit review processes as they occur to ensure new and underutilized RH technologies are included in Inter-agency RH Kits.

**STATUS:**

1. On behalf of the Reproductive Health Response in Crises Consortium, the Women's Refugee Commission is developing and piloting "universal" adaptable Information, Education and Communication templates on specific objectives of the MISP.
2. Completed analysis of pilot-test data; awaiting opportunities to finalize. Women's Refugee Commission is also developing Information, Education and Communication templates on family planning. PATH has developed job aids on clinical management of rape and other themes.

**RECOMMENDATION:** Agencies to finalize tools and advocate for possible inclusion in RH Kits

## **8. New Technologies**

- 8.1.** Identify gaps, challenges, solutions, and opportunities where new or underutilized technologies could improve RH service delivery for populations in crisis settings.
- 8.1.1.** Conduct assessments to identify gaps and challenges in RH service delivery for populations in crisis settings (one means of allowing field staff to inform WG priorities).

**STATUS:** 2010/2011 Recommendation

**8.1.2.** Develop operations research guidelines: identify, adopt, adapt, develop & provide technical and ethical guidance on conducting assessments and research in crisis settings.

**STATUS:** 2010/2011 Recommendation

**8.1.3.** Develop donor strategies and donor scan to support WG efforts.

**STATUS:** 2010/2011 Recommendation

**8.2.** Identify new or underutilized RH technology solutions to improve RH and service delivery in crisis settings and gather operational evidence on their introduction.

**8.2.1.** Create a matrix framework on RH technologies and next steps.

**STATUS:** 2010/2011 Recommendation

**8.2.2.** Develop and test delivery systems for community-based immediate health care for rape survivors.

**STATUS:** 2010/2011 Recommendation

**8.2.3.** Document the field introduction of the NASG and its results to develop a case study that can serve as an example of how to introduce new technologies in crisis settings.

**STATUS:** 2010/2011 Recommendation

**8.2.4.** Conduct an assessment/scan on the use and potential for cell phone and other forms of Information Technology (IT) in crisis settings to improve RH and other health care service delivery.

**STATUS:** 2010/2011 Recommendation

**8.2.5.** Advocate for inclusion of new drugs on the Essential Medicines List (Misoprostol for PPH prevention and/or treatment).

**STATUS:** 2010/2011 Recommendation

**8.2.6.** Investigate making Oxytocin in Uniject and Depo in Uniject available in crisis settings.

**STATUS:** 2010/2011 Recommendation

**8.3.** Provide technical assistance for production and advocating for inclusion of new technologies in the interagency RH kit or through alternative supply channels.

**8.3.1.** Provide technical assistance on NASG manufacture to improve the price performance equation.

**STATUS:** 2010/2011 Recommendation

- 8.3.2.** Investigate supply options for misoprostol for PAC and Mifepristone/Misoprostol for medical abortion.

**STATUS:** 2010/2011 Recommendation

- 8.4.** Provide assistance to help prepare field staff and facilitate the implementation of new technologies (e.g. job aids, training, policy guidance on new technologies, etc.)

- 8.4.1.** Print new job aids: vacuum extractor in assisted vaginal delivery (poster), using steam sterilization (poster), and post-rape care checklist (pocket reference).

**STATUS:** 2010/2011 Recommendation

- 8.4.2.** Develop of job aids for magnesium sulfate and Misoprostol for PAC.

**STATUS:** 2010/2011 Recommendation

## **9. Reproductive Health Data, Health Information System (HIS), and Research**

- 9.1.** Maintain list of ongoing research activities to improve discussion and dissemination of data collection activities by IAWG subgroups/agencies and disseminate to IAWG and broader audience of researchers.

- 9.1.1.** Populate excel table of ongoing data collection activities updated quarterly.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Distribute standardized excel sheet for IAWG group members to generate a list of active data collection ongoing.

- 9.1.2.** Upload research activities on a website or database and share with IAWG partners.

**STATUS:** Pending location of website

**RECOMMENDATION:** Create website/database searchable by time, topic, organization, country, time in crisis, and point of contact for research conducted within the last five years.

- 9.1.3.** Following identification of research gaps and newly generated ideas, prioritize areas for future research.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Evaluate ongoing research gaps and present gaps to other subgroups.

**9.2.** Conduct prospective data collection on selected indicators.

**9.2.1.** Evaluate a select group of indicators prospectively.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Choose two or three indicators and ask all agencies to collect over the next year. Assess how indicators were collected, the ease of collection and quality of the data.

**9.2.2.** Link RH indicators to modifications in programs based on those indicators. This would be done to see if the measured indicator changes/there is an effect on programs (dependent on whether process versus impact indicators are selected).

**STATUS:** Not yet initiated

**RECOMMENDATION:** Conduct this as a follow up portion to the two or three indicators collected over the year.

**9.3.** Conduct retrospective analysis of data to assess consistency of indicators used within different data sources (overlap or lack of overlap in measured indicators).

**9.3.1.** Analysis of indicators found in existing data sets (population based surveys, CDC toolkit, HIS, MoH data). Determine which indicators are comparable across data sets using the IAFM as the basis for comparison.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Develop methodology for selecting population based data, HIS data, and MoH data (where feasible) to proceed with the comparison.

**9.3.2.** Utilize collected data and indicators that overlap to provide program and policy changes.

**STATUS:** Not yet initiated

**RECOMMENDATION:** UNHCR HIS assess numbers and types, use and quality of indicators and link to program linked decision making. IASC could be a potential user of comparable population based data.

**9.4.** Conduct retrospective assessment of multiple sources of data (triangulation of data) from one location to compare and analyze data elements.

- 9.4.1.** Identify strengths and limitations of population-based surveys, HIS, and other sources of data in one location.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Identify site where data sources exist and determine protocol for undertaking the assessment. To determine available sites, conduct a meta analysis of sites which have population based data and surveillance data.

- 9.4.2.** Triangulate existing data and make recommendations for policy and programs.

**STATUS:** Not yet initiated

**RECOMMENDATION:** Obtain and review data according to identified protocol then develop a comprehensive picture of one site by triangulating all data available. Make recommendations for using data based on findings.

- 9.5.** Resource for IAWG and non-IAWG groups to provide technical assistance for research methodological issues, sample design, data analysis and interpretation.

- 9.5.1.** Increase knowledge on RH epidemiology; utilize existing (and build additional) internal capacity to conduct desired research.

**STATUS:** Pending date

**RECOMMENDATION:** Collect curriculum vitae of subject matter experts and plan to make available to agencies as needed to plan robust operational research.

## **10. Regional Strategy: Eastern Europe and Central Asia (EECA)**

UNFPA Regional Office will take leading role on coordination and communication for 2011- 2012. This function should be rotational starting 2013.

- 10.1.** UNFPA EECA Regional Office/Sub-regional Office will take the lead in establishing EECA regional WG and will initiate information sharing among countries about the formation of the group. Country representatives, (government, Civil Society Organizations, academia) and representatives of international NGOs, UN agencies and professional associations will be invited to be part of the EECA IAWG.

**10.1.1.** Objectives of EECA Regional WG

1. Knowledge sharing
2. Partnership synergy (strengthening and creating new partnerships on all levels)
3. Coordination of efforts
4. Technical assistance to countries (tools, expertise, etc.)

- 10.2.** Initiation of ToR drafting in December 2011; EECA Regional Office responsible.
- 10.3.** Situation analysis and mapping of partners working in RH in crisis and emergency preparedness; January-June 2012; EECA Regional Office, Country Offices and all partners responsible.
- 10.4.** ToT Regional MISP; March 2012; UNFPA Regional Office, Humanitarian Response Branch, and IPPF responsible.
- 10.5.** In country roll-out of MISP training; April-June 2012; Country Offices responsible.
- 10.6.** First EECA Regional IAWG Forum: participation of regional and international partners; September 2012; UNFPA Regional Office responsible
  - 10.6.1.** Objectives
    - 1. Share experience and analysis of the mapping exercise
    - 2. Finalize ToR for the EECA IAWG
    - 3. Set the priorities for the region
    - 4. Draft a work plan for 2012 and 2013
    - 5. Discuss funding, roles and responsibilities

## **11.Regional Strategy: Latin America and the Caribbean (LAC)**

- 11.1.** Identify gaps and challenges in reproductive health and rights for populations in crisis settings in the LAC region.

**STATUS:** 2008/2009 Recommendation

- 11.2.** Identify networks in LAC working in this area (regional, sub-regional, country).

**STATUS:** 2008/2009 Recommendation

- 11.3.** UNFPA, Pan American Health Organization, and IPPF can coordinate how to implement survey tool to conduct mapping exercise.

**STATUS:** 2008/2009 Recommendation

- 11.4.** Use information from survey to analyze results and create next steps (identify prioritize area, determine next steps).

**STATUS:** 2008/2009 Recommendation

## **12.Regional Strategy: Middle East North Africa (MENA)**

**12.1.** Identify gaps and challenges in reproductive health and rights for populations in crisis settings in the MENA region.

**STATUS:** 2008/2009 Recommendation

**12.2.** Provide a platform to share information and lessons learned across projects in the region and enable partnerships to minimize duplication of efforts and to fill gaps.

**STATUS:** 2008/9 Recommendation

**12.3.** Establish a system of communication to facilitate effective and coordinated response to emergencies affecting women and young girls in the region.

**STATUS:** 2008/9 Recommendation

**12.4.** Improve access to information, services and support partnerships to encourage capacity building of actors providing reproductive health services in the region.

**STATUS:** 2008/9 Recommendation

**12.5.** Advocate and implement the MISIP in the region through support of the SPRINT initiative.

**STATUS:** 2008/9 Recommendation

**12.6.** Advocate for response to unmet needs in reproductive health in the region.

**STATUS:** 2008/9 Recommendation