

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 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 MISP 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 MISP 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