

Terms of Reference

TERMS OF REFERENCE (TOR)

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 MISRP in the early days and weeks of new emergencies and comprehensive reproductive health 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:

(*Denotes working groups that have submitted 2010/11 updates.)

1. Advocacy*
2. RH Data, Health Information Systems (HIS) and Research*
3. Adolescent Reproductive Health (Best Practices and Quality of Care)*
4. Minimum Initial Services Package (MISP)*
5. HIV/AIDS/STIs (Best Practices and Quality of Care)
6. Maternal and Newborn Care (Best Practices and Quality of Care)*
7. Gender-based Violence (Best Practices and Quality of Care)
8. Family Planning (Best Practices and Quality of Care)*
9. Logistics (Best Practices and Quality of Care)*
10. Training (Best Practices and Quality of Care)
11. Regional Strategy: Middle East North Africa (MENA)*
12. Regional Strategy: Latin America and the Caribbean (LAC)*
13. New Technologies*
14. Urban Displacement*

1. ADVOCACY

- 1.1 Continue outreach to identify new members to engage with IAWG.

Status: Identify new members from the IOM, NRC, UN OCHA and WFP, among other agencies.

2010/11 Recommendations: Ongoing

- 1.2 Liaison on advocacy issues and initiatives within IAWG and other SRH agencies.

- 1.2.1 Disseminate the IAWG family planning (FP) advocacy statement with cover letters to UN agencies, NGOs and governments to advance FP programming within each agency.

2010/11 Recommendations: Target agencies include Global Health Cluster, IFRC, IOM, OCHA, UNAIDS, UNFPA, UNHCR, UNICEF, U.S. Government (BPRM/OFDA); letter to UNHCR in process.

- 1.2.2 Invest in local SRH human resource capacity and assist local organizations with coordination and leadership on SRH service provision in crisis settings

2010/11 Recommendations: The SPRINT Initiative will continue to address these issues; Jhpiego will introduce the MISP in country programs where feasible for pre service training.

2. REPRODUCTIVE HEALTH DATA AND RESEARCH

- 2.1. 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

- 2.1.1. Populate excel table of ongoing data collection activities updated quarterly **Status:** Not yet initiated

- 2010/11 Recommendation:** Distribute standardized excel sheet for IAWG group members to generate a list of active data collection ongoing
- 2.1.2. Upload research activities on a website or database and share with IAWG partners.
Status: pending location of website
2010/11 Recommendation: Create website/database searchable by time, topic, organization, country, time in crisis and point of contact for research conducted within the last 5 years.
- 2.1.3. Following identification of research gaps and newly generated ideas, prioritize areas for future research.
Status: not yet initiated
2010/11 Recommendation: Evaluate ongoing research gaps and present gaps to other subgroups.
- 2.2. Conduct prospective data collection on selected indicators
- 2.2.1. Evaluate a select group of indicators prospectively.
Status: not yet initiated
2010/11 Recommendation: Choose 2-3 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.
- 2.2.2. 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
2010/11 Recommendation: Conduct this as a follow up portion to the 2-3 indicators collected over the year.
- 2.3. Conduct retrospective analysis of data to assess consistency of indicators used within different data sources (overlap or lack of overlap in measured indicators)
- 2.3.1. Analysis of indicators found in existing data sets (population based surveys, CDC toolkit, HIS, Ministry of health data). Determine which indicators are comparable across data sets using the IAFM as the basis for comparison.
Status: not yet initiated
2010/11 Recommendation: Develop methodology for selecting population based data, HIS data, and ministry of health data (where feasible) to proceed with the comparison.
- 2.3.2. Utilize collected data and indicators that overlap to provide program and policy changes.
Status: not yet initiated
2010/11 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.
- 2.4. Conduct retrospective assessment of multiple sources of data (triangulation of data) from one location to compare and analyze data elements.
- 2.4.1. Identify strengths and limitations of population based surveys, HIS, and other sources of data in one location.
Status: not yet initiated
2010/11 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.
- 2.4.2. Triangulate existing data and make recommendations for policy and programs.
Status: not yet initiated
2010/11 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.
- 2.5. Host interagency meeting to discuss gaps in operational research
- 2.5.1. Increase knowledge on RH epidemiology; utilize existing - and build additional- internal capacity to conduct desired research
Status: pending date
2010/11 Recommendation: CDC plan to host interagency meeting to discuss gaps in

operational research.

3. ADOLESCENT REPRODUCTIVE HEALTH (BEST PRACTICES AND QUALITY OF CARE)

3.1 Advocate for quality adolescent RH programming in humanitarian settings

Status: Ongoing. UNFPA and Women's Refugee Commission are launching YOUTH ZONES, an advocacy video on young people in emergency settings.

2010/11 Recommendation:

- 1) Disseminate YOUTH ZONES as widely as possible (screenings, blogs, youtube, etc.) and host Q&A sessions / discussions to raise visibility of youth in emergencies
- 2) Continue dissemination of relevant advocacy material

3.2 Develop and disseminate technical tools to address Adolescent Sexual and Reproductive Health in humanitarian settings.

Status: UNFPA/Save the Children developed an *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* (the —ASRH Toolkit), which is being rolled-out in 2010. First training was held at the IAWG meeting in the Dominican Republic. The toolkit was also introduced to 15 UNFPA CO's via webinar and at UNFPA HQ.

2010/11 Recommendation:

- 1) UNFPA to keep track of organizations and regions where hard copies of the ASRH toolkit is sent.
- 2) IRC interested in training senior health staff with the ASRH toolkit in September 2010
- 3) UNFPA West Africa region interested in training youth focal points in the ASRH toolkit in September 2010
- 4) MSF Spain (Olivia Hill) interested in including ASRH training materials during their annual meeting
- 5) Introduce (45 minute presentation) ASRH toolkit at Save the Children's annual health meeting in June 2010
- 6) Integrate ASRH into Save the Children's 3 to 5 day RH training currently being developed to train up SC's emergency health and nutrition staff.
- 7) SPRINT Initiative (Sarah Chynoweth) possibly interested in including training materials on ASRH into their existing training
- 8) Save the Children and UNFPA to develop an e-learning module for the ASRH toolkit which will be posted and disseminated through the RHRC Consortium and IAWG websites
- 9) Develop guidance on youth and community mobilization in humanitarian settings and how to quickly recruit and training peer educators in emergencies (WG members needed)
- 10) Develop a peer education toolkit for humanitarian settings (Y-Peer and UNFPA Arab States region)
- 11) Develop "peer education" kit or "Peer Education in a box" which can be ordered and deployed in emergencies (WG members needed)

3.3 Increase programs that address adolescent SRH in humanitarian settings

Status: Ongoing. The Women's Refugee Commission provides small grants to adolescent RH networks on the Thai-Burma border. IPPF/Promfamil ordering pre-fab youth centers for Haiti and working with peer educators.

2010/11 Recommendation:

- 1) Advocate with MISP revision group for inclusion of adolescent focused interventions in the revised MISP distance learning tool.
- 2) Disseminate Adolescent MISP fact sheet from ASRH toolkit to RH managers and health cluster/sector members in humanitarian settings.
- 3) Develop an "age marker tool," similar to the IASC "gender marker tool," in order to assess and strengthen the age-responsiveness of projects in any humanitarian appeal or funding mechanism, including CAPs, CERFs and pooled funds.
- 4) Actively seek funding for and support programmes on ASRH and/or adolescent girls in the aftermath of the Haiti earthquake

5) Develop project (Flash Appeal/CAP/CERF) templates to help organizations appeal for adolescent-focused interventions even in acute phase of crisis. As a WG, brainstorm a list of feasible and acceptable interventions that can be included on such template (i.e, prefab youth centers, first time mother tents where adolescent mothers get extra breastfeeding support and education about LAM and transitions to new FP methods, etc) (UNFPA/Save the Children in collaboration with WG)

6) Field test tools in ASRH toolkit and documents lessons learned for future revisions.

Organizations interested in field testing parts of the ASRH toolkit: IRC, ARC (Thai-Burmese Border), Save the Children (South Sudan), IPPF (Haiti), UNFPA (Bangladesh).

3.4 Documents and share best practices and lessons learned in addressing adolescents in humanitarian settings. Post documents and lessons learned on ARH WG list at IAWG.

Status: Very little documentation being completed. Adolescent focus groups included in the inter-agency MISP assessment in Haiti in May 2010

2010/11 Recommendation:

1) Women's Refugee Commission to possibly document key highlights of the adolescent focus groups from Haiti MISP assessment

2) IPPF to work with Profamil in Haiti to develop case studies of youth who were involved in their youth centers which were destroyed and the effects on youth and their peers.

3) Review recent humanitarian appeals to assess inclusion of youth, estimate budget requirements and mobilized funding on youth issues. (JSI and UNFPA)

3.5 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.

2010/11 Recommendation: Conduct practical operations research to show the effectiveness of specific strategies and process evaluations to document best adolescent RH practices in crisis settings.

Ideas developed for the research working group include:

1) The impact of the lack of access to youth-friendly services on adolescents

2) Broader study on impact of earthquake on youth in Haiti

3) Study the impact of capacity building of local NGOs on ASRH outcomes

4) Qualitative study on the impact of conflict on the adolescents' transition from the youth perspective, multi- country/ look at different settings

5) Disaggregate RAISE data by age

6) Operations research based on communities with peer educators vs. those that have not

7) Girls' response to crisis situations

8) Youth friendly health facility assessments

9) Comprehensive RH youth survey in Haiti or elsewhere for a cross sectional view of current situation

4. MINIMUM INITIAL SERVICES PACKAGE (MISP)

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

4.1.1. Provide headquarters support for a MISP response in real-time emergencies

Status: The Women's Refugee Commission had created a template in 2008 for HQ-level RH coordination to be completed by agencies, but the matrix was never employed given the time constraints faced by country and field-level staff. In the wake of Haiti, IAWG also received a request to serve as an information-sharing platform and offer a WWW matrix for RH. Given lack of field response, concerns for duplication and IT issues, the concepts were never launched.

2010/11 Recommendation: Continue conversation on how IAWG can better support information sharing in real-time emergencies. Monir Islam/WHO to discuss with directors of HAC and the WHO Assistant Director General to learn how GHC/HAC reports on MISP implementation in emergencies

2010/11 Recommendation: Basia Tomczyk/CDC to determine why USAID updates often do not address RH; Sandra Krause/Women's Refugee Commission to learn from UNFPA why RH is seldom covered in sit-reps.

4.1.2 Facilitate MISP coordination at the field level.

Status: Haiti response provided lessons for advocacy including the need to sustain MISP coordination for at least one year, the importance of subnational coordination and the need for local counterparts/partnerships.

2010/11 Recommendation: The Chief of UNFPA's Humanitarian Response Branch and BPRM will follow-up on issues. The MISP SWG will consider options to achieve adequate coordination, including through local counterparts/partnerships.

4.2 Advocate for better cross-sectoral/cluster preparedness and response on the MISP/CRH.

Status: Janet Meyers/CARE and Chen Reis/WHO have been developing a matrix on the MISP as it cross-cuts other sectors/clusters including shelter, food security and water/sanitation. Janet is leading a sub-working group for the matrix.

Status: Janet Meyers/CARE and the Women's Refugee Commission have been examining how RH can be integrated into existing programs, through emergency preparedness and disaster risk reduction (DRR). Lauren Heller/Women's Refugee Commission is leading a sub-working group to address these issues.

2010/11 Recommendation: Advance the above two initiatives

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

4.3.1 MISP Monitoring and Evaluation Tool

Status: CDC and the Women's Refugee Commission have been developing quantitative facility-based self-assessment tools for field based staff to monitor and evaluate MISP implementation.

2010/11 Recommendation: CDC, Jhpiego, the Women's Refugee Commission among other agencies will further develop and refine tools.

4.3.2 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 progress, facilitate remote supervision and identify the reasons for gaps in services. The format is aligned with the HeRAMS tool.

2010/11 Recommendation: Jhpiego will lead a task force to further develop and refine the tool.

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

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

2010/11 Recommendation: Work with IAWG Training Partnership Initiative to maintain such a list at the country level.

4.4.2 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.

2010/11 Recommendation: Receive updates from the IAWG Training Partnerships.

4.4.3 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 new staff and to advocate internally for staff certification.

Status: The module is being revised to address updates to the IAFM MISP chapter.

2010/11 Recommendation: The Women's Refugee Commission, IPPF, Jhpiego, Save the Children, UNHCR and WHO will revise and finalize the MISP module for strengthened outreach on the MISP using the module.

4.5 Participate in IAWG opportunities to discuss uses for new and underutilized RH technologies that facilitate effective MISP implementation.

4.5.1 Take part in RH Kit review processes as they occur to ensure new and underutilized RH technologies are included in Inter-agency RH Kits.

Status: On behalf of the RHRC Consortium, the Women's Refugee Commission is developing/piloting —universal & adaptable IEC templates on specific objectives of the MISP. PATH has developed job aids on clinical management of rape and other themes.

2010/11 Recommendation: Agencies to finalize tools and advocate for possible inclusion in RH Kits; request UNFPA to clarify the RH Kit review process.

4.5.2 Develop short film on interviews with humanitarian actors championing the MISP and/or an animated short film on RH coordination.

Status: On hiatus due to time and funding constraints.

2010/11 Recommendation: IPPF may have funds to contribute to this project.

5. HIV/AIDS/STI/RTI

5.1 Compile a list of training materials and supporting documents

Status: still recommended to be on the agenda UNHCR/ARC to take lead on making available a list of practical field oriented training materials and other supporting documents.

5.2 IAWG agencies must put training on STI/HIV/AIDS in their work plan and budget

Status: training to continue being on the agenda

5.3 Develop a set of two-day refresher trainings for in-service training

Status: Most IAWG Agencies have refresher trainings for in-service training Organizing 2 regional workshops for the East and Central Africa on HIV among sex workers (UNHCR)

5.4 Inter-Agency Standing Committee (IASC) Guideline on HIV/AIDS in Emergencies (advocate for inclusion of RH)

Status: on going

Recommendation: Continue advocacy for inclusion of RH in and the related materials. IAWG agencies to ensure HIV programming to improve or upscale RH programs.

5.5 Better involve community to improve quality and access and address stigma

5.5.1 **Status:** Compiling and update materials to be availed

Recommendation: guideline developed by Pretoria University will become available (UNFPA/ARC)

5.5.2 Increase use of —positive lives exhibition & community guides

Status: [materials] Discussion guides developed and are available: being distributed (ARC)

5.6 Access and info to young people (parents weren't involved in what messages to children)

Status: 2 films developed by UNHCR (on stigma, HIV and STIs). ARC is developing "Through Our EYES" participatory video program (community based): Liberia, South Sudan, and Rwanda... UNCHR developing documentary film in Burundi on grass root level initiative on HIV

5.7 Programmatic guidance on humanitarian settings.

5.7.1 Develop programmatic guidance on newly emerged (RDTs) technology. (UNFPA)

5.7.2 Cervical Cancer screening/prevention (UNFPA/UNHCR/JHPIEGO). Investigate opportunities to introduce cervical cancer screening and vaccine in post crisis screening

5.7.3 Follow up on the UNFPA UNHCR JPHIGO initiative.

PRIORITIES

1. List Serve for working group members:

2. MEETINGS (regional and workshops)

3. Organize a regional meeting on protection and working with most at risk groups on access and for stigma address (UNHCR, UNFPA and Refuge e Egypt

4. Give input and feedback on the Global guidance notes on Sex work in Humanitarian situations (developed by UNFPA and UNHCR)

5. WAY FORWARD: email people in the first meeting to know whether still interested (UNFPA/UNHCR).

6. Mail IAWG members to seek interest and updates on meetings

6. MATERNAL AND NEWBORN HEALTH

6.1 Women's Commission on behalf of RHRC Consortium published *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*

Status: Completed

Follow-up: encourage use, evaluate and feed-back

6.2 UNHCR and Save the Children publish and present case stories on successful implementation of basic EmOC in health units at the peripheral level. Document and share feasibility and effectiveness as an example that it can be done.

Status: (on-going)

2008/9 Recommendation: continue

2010/11 Recommendation: The Working Group will share a template for collecting lessons learned. UNHCR (Ouahiba) is focal point. All partners involved in providing EMOC will be encouraged to collect lessons learned and share with the group.

6.3 UNHCR compiles and publishes best practices and lessons learned from basic EmOC services at the peripheral level (globally)

Status: (on-going)

2008/9 Recommendation: continue

2010/11 Recommendation: continue

6.4 Change commitment from "coverage" to "quality" in services such as ANC. Define quality and provide checklists for supervisors. Link with increasing demand for services at the community level.

Status: (not achieved)

2008/9 Recommendation: encourage use of Focused ANC (WHO)

Looking for an agency that can commit to share lesson learned next year

2010/11 Recommendation: The Working Group will collect RH (ANC, PNC, CAC, FP) quality supervision tools/ checklists to be centralized on the IAWG website. An announcement will be sent to all IAWG members upon completion.

6.5 Save the Children develops and shares practical operational tools for Essential Newborn Care

Status: (completed) Available on external website of SC

2008/9 Recommendation: SC to advocate for inclusion of NB resuscitation kit in IEHK.

2010/11 Recommendation: The working group will disseminate SAVE training guide on newborn care (available on external website of SC). The IEHK kit does not contain a NB resuscitation kit but the RH kit is recommended to have it.

6.5.1 Group will further work to advocate for inclusion of antibiotics and materials (for sepsis, LBW, etc.) for newborns in the IEHK.

6.6 Conduct a survey to better understand the magnitude of fistula among crisis-affected communities

Status: (not achieved)

2008/9 Recommendation: partners to be identified

2010/11 Recommendation: Fistula is a recognized as a critical RH issue.

6.6.1 Working Group members will identify partners who will be encouraged to assess availability of fistula treatment services, and set up an identification and referral system in protracted emergencies.

6.7 UNHCR, Save the Children pilot Misoprostol for prevention of post-partum hemorrhage

Status: (not achieved)

2008/9 Recommendation: Save the Children and CARE will work with RAISE

2010/11 Recommendation: More evidence and inclusion of Misoprostol in national protocols is needed. WHO guidance is that if Oxytocin is not available, Misoprostol is provided through trained personnel (revision scheduled for 2010).

6.7.1 Group to advocate for Misoprostol if the substance is listed in the national protocol and registered in-country.

6.8 IPAS addresses gaps in PAC data and service provision

Status: (on-going)

2008/9 Recommendation: MVA not part of IEHK 2006 (Interagency Emergency Health

Kit) will be discussed in December 2008 forum. IPAS will follow-up

Status 2010/11: MVA equipment is included in the RH kit, but not in the IEHK.

6.8.1 Group to disseminate the MVA calculator (available online for supply calculations) well used by IPAS offices. A web-based training for Misoprostol will be available next year through IPAS University.

6.9 Advocate for mid-level health care providers to provide basic EmONC (taskshifting)

Status: 2008/9 Recommendation

2010/11 Recommendation: The Working Group will advocate for the training of mid-level professionals as a phase-out strategy of TBAs.

6.10 Develop a TBA phase-out strategy: from TBA at the onset of an emergency to skilled birth attendants, and training of TBAs to women and children health promoters

Status: 2008/9 Recommendation

2010/11 Recommendation: The Working Group will advocate for the training of mid-level professionals as a phase-out strategy of TBAs.

6.11 MOH Yemen commitment: Advocate for inclusion of refugees and IDP reproductive health into national policies and strategies

Status: 2008/9 Recommendation

For training working group: Training in Essential newborn care and newborn resuscitation with or separately from EmOC training

6.12 Country profile of Maternal and Newborn Care priorities for consideration in Flash Appeals.

6.12.1 Similar to WHO Risk Assessment, IAWG will distribute the country profile within 24 hours of an emergency.

Status: 2010/11 Recommendation

6.13 Develop a template to investigate maternal mortality cases.

6.13.1 UNHCR template is already included in the revised version of the IAFM. The working group will discuss the template and opportunities for its use in the field.

Status: 2010/11 Recommendation

6.14 Group will communicate through an e-mail listserv, and scheduling bi-monthly teleconference; additional teleconferences will be scheduled as needed (Led by UNHCR).

Status: 2010/11 Recommendation

7. GENDER-BASED VIOLENCE

7.1 Capacity-building in the form of TOT for GBV Coordinators at a regional level

Status 2007/8 Ghent training, gencap training, caring for survivors, IRC Clinical care of sexual assault training

7.1 a. Enhanced coordination capacity of relevant stakeholders (including around situation analysis and data collection) i.e.; sharing and learning on initiatives on data collection around trafficking and GBV

7.1 b. Build capacity of practitioners on GBV

2008/2009 Recommendation: mechanism should be in place to monitor the benefits, impacts and efficacy (research and evaluation team could look into this) IASC gender and GBV guidelines trainings in Nairobi and Johannesburg

7.2 User-friendly info sheet from UNFPA for how to access/obtain PEP in emergencies, on-going conflict, and post-conflict settings

Status: 2007/8: RH kit booklet updated and printed (4th edition printed)

2008/9: recommendation not kept

7.3 Ensure roll-out of and promote adherence to IASC GBV Guidelines by Regional GBV Task Force with input from in-country RH Coordinators/GBV Focal Points

Status: 2007/8 Continuous roll out and awareness raising on the guidelines. (i.e. Kenya crisis, South Africa, DRC coordination, Comoros, Uganda)

2008/9 Ensure roll-out of and adherence to IASC GBV Guidelines by all relevant stakeholders

7.4 Advocate availability of high-quality mental health services

Status: 2007/8 All actors have (i.e. during Kenya crisis)

2008/9 Advocate availability of high-quality mental health services based on the IASC mental health guidelines

7.5 Practical, user-friendly guides to best practices for organizations specifically working to prevent and respond to GBV to supplement IASC GBV guidelines

Consistent M&E tools developed;

Status 2007/8 GBVIMS roll out in Kenya and Uganda.

7.6 Situation Analysis to be encouraged before GBV programs are implemented in order to ensure community participation, ownership, and sustainability;

Status 2007/8 GBV assessments were conducted in response to the Kenya crisis and in South Africa after the xenophobic attacks

7.7 Establishing community-based GBV Working Groups and community safety action group

Status: 2007/8 During Kenya crisis this was done.

Recommendation and changes for 2008/29

7.7.1 Practical, user-friendly guides to best practices for organizations specifically working to prevent and respond to GBV to supplement IASC GBV guidelines. Consistent M&E tools continue to be rolled out.

7.7.2 Situation Analysis to be encouraged before GBV programs are implemented in order to ensure community participation, ownership, and sustainability. Action Point – CARE will develop draft guidelines by end of March 2009

7.7.3 Encouragement of community based GBV coordination Action Point: All members of the group present will send Carmen de los Rios from IRC references to documents around engaging communities around GBV (useful guides might include work on community protection committees) by the end of November 2008 to be posted on the IBP network

7.8 Continue examining and advocating improved legal support and/or redress for survivors of GBV (including advocacy on legislation reform through national conferences and other means)

Status: 2007/8 Continuous support to the ICLGR by the regional GBV TF – including UNFPA support to ICLGR for the Goma declaration.; UNICEF invited the ICGLR to present on their protocol during the Gender Justice Colloquium in Ethiopia; UNICEF authored expert paper on GBV for AU ADF 6

2008/9 Continue engaging in above

7.9 “Best Practices” Intranet Exchange via regional discussion boards and information exchange

Status: 2007/8 Recommendation

2008/9 Ensure exchange of discussion and information via the IBP network. Action Point: Chelsea (ARC) and Etobssie (CDC) will send an email to IAWG members encouraging them to post and share GBV related information via this network

7.10 Increased awareness among donors regarding realistic timeline of programming to ensure sustainable, community-driven, and survivor-centered GBV interventions are implemented (organizations must have the capacity to implement best practices quickly)

Status: 2007/8 Donor briefings. Trainings etc..(all done during Kenya), review of GBV subcluster. Donor briefings in Europe

2008/9 Encourage organizations to keep donors educated on GBV Action point: reference to RAISE fact sheet, does and don't in GBV data collection by UNFPA and UNICEF

7.11 Link to ILO or other MED/IGA groups to decrease vulnerability to sexual exploitation among community members

2008/9 Reduce vulnerability to SEA by promoting links /access to livelihoods groups

7.12 SEA codes of conduct examined and reinforced in all organizations implementing GBV interventions:

7.12.1 Ensure trainings for staff and stakeholders on SEA and codes of conduct

7.12.2 SEA focal points to ensure SEA policies/codes of conduct are followed and monitored

Status: 2007/8 UNDP and OCHA are focusing globally on SEA. UNDP developing senior managers training on SEA and OCHA has organized a review of existing focal point trainings and are rolling it out. Gencaps have also been deployed in Kenya and in Somalia to work on SEA issues. UNICEF and UNFPA have trained approximately 300 individuals from a variety of organizations on PSEA in Kenya

2008/9 Promote use of the code of conduct of IAWG members Action points; collect code of conducts of IAWG members and GBV group to provide support to members if needed.

8. FAMILY PLANNING

8.1 Technical Excellence

8.1.1 Reproductive Health Access, Information, and Services in Emergencies (RAISE) Initiative established by Columbia University Mailman School of Public Health and Marie Stopes International. RAISE has been conducting FP trainings at Eastleigh Maternity Center and will continue to conduct trainings this year. They are also trying to conduct follow up trainings in the individual participating countries.

Status: Ongoing

POC: Louise Lee Jones

8.1.2 One provider from each refugee camp or IDP setting takes the Global Health FP101 and Family Planning Counseling course. FP working group members have taken the course and new members have committed to take the course and share with others. This and other FP courses may be found on the GHC course website at

www.globalhealthlearning.org

Status: Ongoing since 2007, new FP Counseling

POC: Udaya Thomas and all

8.1.3 Providers to utilize the FP Wall methods counseling chart and anatomic models (when feasible) in their FP counseling, including clarifying misconceptions. FP working group to make a list of countries/agencies to submit to K4H so that K4H could send wall charts. Sarah from IRH to follow up with K4H.

Status: Adapted recommendation from previous years.

POC: Sarah Terlouw

8.1.4 (Cross-cutting) Providers need technical updates on FP-HIV care and integration and reference to care is included in the Family Planning: A Global Handbook Providers for consideration of HIV status during FP counseling. Countries need more handbooks and link to website included in the revised field manual. www.fphandbook.org

Status: Adapted from previous years

POC: Sarah Terlouw

8.1.5 (Collaboration) Utilize resources online to increase access to IUD updates and information on IUD as there are still many misconceptions regarding this method. Collaborate with INGOs (development agencies) that are conducting IUD trainings. www.iudtoolkit.org

Status: New

POC: Catherine-Marie St.Urbain (Quality of services) Implement PFP, including LAM, depending on the context and the woman's choice.

Status: New

POC: Ernest Desir

8.1.6 Increase capacity of local NGOs to provide family planning services in 4 crises-affected settings to provide quality FP services, reporting on the status of at least 4 initiatives/countries.

Status: New

POC: Meriwether Beatty and Udaya Thomas

8.1.7 (Quality of services) Provide post abortion care family planning within service delivery.

Status: New

POC: Lucito Jeannis

8.2 Advocacy

8.2.1 Family Planning Advocacy Tool

Status: Women's Commission with RAISE has develop an advocacy document this past year as planned and this year will disseminate to UN agencies and others to advocate for more FP in humanitarian settings. Refer to Advocacy group on development of this.

8.2.2 (Cross-cutting) Providers to give a minimum of three month resupply of oral contraceptives and barrier methods and even up to 12 months as supplies are available to those who are using those methods.

Status: Adapted to make more specific

8.2.3 (Cross-cutting) Create awareness on what family planning methods is available, including targeting male involvement and awareness on family planning. Take advantage of captive audience in tent cities that are emerging with promoters/CHWs.

Status: New

8.2.4 Increase awareness to providers and clients that the new female condom is available (FC2). Jewel to follow up on how to get this to countries/agencies. It is included in the revised RH kit.

Status: New

POC: Jewel Gausman

8.3 Community Outreach

8.3.1 Make available references on working with communities (e.g. pictorial IEC) found on website <http://www.k4health.org/k4h>

Status: Adapted to include website here.

8.2.3 (Cross-cutting) Create awareness on what family planning methods is available, including targeting male involvement and awareness on family planning. Take advantage of captive audience in tent cities that are emerging with promoters/CHWs.

Status: New

8.3.2 Research has indicated the efficacy of CBD of DMPA. Agencies to integrate implementation of CBD of DMPA with trained promoters/CHWs as clients want or need.

Status: New

Responsible for reporting back: Dhammika Perera, IRC

8.4 Logistics

8.4.1 Increase equity of supplies to multiple delivery sites. Agencies should take on attempting to have minimum 3 categories of methods at a time (i.e. barriers, pills, implants, injections, long-term methods) at their facilities and facilities they support.

Status: New

Responsible for reporting back: Meriwether Beatty

9. LOGISTICS

9.1 Conduct evaluation of logistics/commodity needs issues in refugee settings. Also, determine how NGOs can integrate RH logistics/commodity planning with other logistics/commodity planning in emergency settings.

Status: 2007/8 Recommendations. JSI is in the process of a review of major challenges/issues with the goal of improving quality RH supplies and commodities at all stages of the crises through improved logistics and supply management and will seek input from IAWG members and RAISE partners. UNFPA has appointed a Logistics Specialist who has reviewed UNFPA's logistics capacity and designed a two year strategy to improve this capacity

Status 2010/11: MSI conducted in DRC, Uganda, S. Sudan, preliminary report available

9.2 Re-establish Commodity/Logistics Committee, which will include: JSI, UNFPA, and WHO. Request/recommend membership of USAID, MDM, CARE (implementing agency), UNFPA Global Commodity Security, World Bank and WHO/EDM

Status: Not implemented. IAWG working group forming and discussion on role of formal committee (outside of IAWG) to take place at meeting.

9.3 Deployment of a logistics person in large operations to the field to facilitate the distribution of RH kits

Status: Unknown - Using companies to distribute kits in the field, but logistics person has not been discussed. For all RH programs, The implementing agency should consider putting in place a logistics person. The REH coordinator can also get support from a logistics person for a few months. Regional logisticians are part of the UNFPA strategy though there is no funding at this time. One suggestion is to make it part of the RH coordinators SOW and ensuring the RH coordinators have the appropriate skills/necessary training to make sure kits are procured and distributed quickly, or delegate. This raises the concern about how much and how long would it take to train the RH Coordinator to have additional logistics knowledge and skills.

Status: Within UNFPA discussions are ongoing about a standard surge team that is deployed to any new emergency, including an RH coordinator and a logistics person. It is

not clear yet whether this will be possible for all large emergencies. We also have to discuss alternative options, like using companies or ensuring recruitment of an RH logistician from a pool through NRA for instance.

9.4 Using systematic reviews, a small group including representatives of WHO, UNHCR, MSF, UNFPA and UNICEF will meet biannually and suggest changes in the content of the RH Kits

Status: Done in November 2005 by UNFPA. Suggested changes shared with IAWG in April 2007. In 2001, female condoms were added to kit #1, and small changes were made to other kits. In 2003, PEP was added to kit 3B. In 2007 child dosage of STI medicines were included in kit 5 and azithromycin replaced doxycycline for the treatment of chlamydia. Review undertaken in 2010: Misoprostol for PAC will be added to kit 8. The 5th edition of the RH Kit brochure will become available early in 2011.

9.5 Establish a working group to look at kit positioning and evaluate the distribution of the kit

Status: Will be done as part of the next kit review in late 2007/early 2008; not yet implemented. A UNFPA logistics study in 2006 recommended that repositioning of the kits would be too costly and difficult in most settings. UNFPA has a report of distribution of the RH Kits to emergencies in 2007 and 2008.

Status 2010/11: Not implemented

9.6 Identify the specific areas for capacity building. Recognized needs include: existing RH kits; in-country distribution; ordering (what, how much, transition from "push" to "pull"; components (consumption based). Provide two places for field staff working in conflict settings for JSI (DELIVER) training on supply chain management

Status: UNFPA and JSI in the early stages re: identifying and addressing capacity building needs in RHR logistics. JSI will do a better job advertising the trainings and coordinating with UNFPA to ensure participation by UNFPA and others. Need to consider a module for RH coordinators, if this is the way to proceed.

Status 2010/11: Not implemented

9.7 Identify the specific areas for capacity building. Recognized needs include existing RH kits; in-country distribution; ordering: what, how much, transition from "push" to "pull" RH kit; components (consumption based).

Status: Not implemented

9.8 Develop a training module (linked to the training partnership) for field staff addressing some of the key capacity building gaps/needs.

Status: Needed/funding dependent

9.9 Adapt existing tools (developed by DELIVER and other organizations) as needed for crisis setting to be part of a toolkit.

Status: Needed

9.10 Integrate logistics and supply chain management into other appropriate IAWG Sub-working groups.

Status: Started

10. TRAINING PARTNERSHIP

10.1 Provide clinical training and follow-up, both in the field and at Marie Stopes International's comprehensive RH centre in Nairobi, Kenya, to improve quality of care as part of the RAISE initiative.

Status: Clinical centre operational and trainings ongoing. Currently, trainings are for RAISE-related partners and over time, this resource might be more available to the field more broadly.

10.2 Develop an inventory/list of training materials

Status: Save the Children US to initiate and follow-up with IAWG Training Partnership working group. CARE reviewed and updated list. This will be made available on IAWG TP web page.

10.3 Create a matrix framework of training needs and target audiences

Status: In progress (CARE International & UNFPA)

10.4 Establish an IAWG TP secretariat

Status: Secretariat now formed by UNFPA and CARE International (the steering committee is a much wider group). The secretariat will organize the fifth IAWG Training Partnership Meeting in November 2010. The meeting convened in Geneva where IAWG training partners met and exchanged information and determined next steps. The

outcome of this meeting was presented to donors and a strategy paper was developed taken their comments into consideration

- 10.5 Develop a virtual communication platform, including an e-learning platform and a community of practice for trainers

Status: In progress (Women's Refugee Commission, CARE International and UNFPA)

- 10.6 Continuation of SPRINT roll-out (RH Coordination Training)

Status: Ongoing regional and in-country SPRINT (RH Coordination) trainings (IPPF and UNFPA). ToTs have taken place in Asia, Middle East and Africa. The in-country roll-outs are ongoing. IPPF created SPRINT "secretariats" in Nairobi and in Kuala Lumpur. Next step: A SPRINT roll-out is planned in Southern America and Eastern Europe/Central Asia.

- 10.7 Develop/pilot four refresher clinical outreach training modules (MVA, Vacuum Extraction, Standard Precautions and Signal functions of BEmONC)

Status: MVA and VE modules have been finalised, peer reviewed and piloted, Standard Precautions module has been finalised and Signal Functions of BEmONC is under development. Next step: Develop other refreshers trainings for moving towards comprehensive RH services, based on analysis of the IAWG partners.

- 10.8 Linking IAGW partners and training institutes with potential researchers

Status: New recommendation

- 10.9 Standardisation of training materials and measurement of effectiveness of training package

Status: New recommendation

11. REGIONAL STRATEGIES FOR MIDDLE EAST NORTH AFRICA (MENA) REGION

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

Status: 2008/9 Recommendation

- 11.2 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

- 11.3 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

- 11.4 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

- 11.5 Advocate and implement the MISIP in the region through support of the SPRINT initiative.

Status: 2008/9 Recommendation

- 11.6 Advocate for response to unmet needs in reproductive health in the region.

Status: 2008/9 Recommendation

12. REGIONAL STRATEGIES FOR LATIN AMERICA AND THE CARIBBEAN (LAC) REGION

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

Status: 2008/9 Recommendation

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

Status: 2008/9 Recommendation

- 12.3 UNFPA, PAHO, and IPPF can coordinate how to implement survey tool to conduct mapping exercise.

Status: 2008/9 Recommendation

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

Status: 2008/9 Recommendation

13. NEW TECHNOLOGIES

- 13.1 Identify gaps, challenges, solutions, and opportunities where new or underutilized technologies could improve RH service delivery for populations in crisis settings.

- 13.1.1 Conduct assessments to identify gaps and challenges in RH service delivery for populations in crisis settings (one means of allowing field staff to inform NTWG priorities).
- 13.1.2 Develop operations research guidelines: identify, adopt, adapt, develop & provide technical and ethical guidance on conducting assessments and research in crisis settings.
- 13.1.3 Develop donor strategies and donor scan to support NTWG efforts.
- 13.2 Identify new or underutilized RH technology solutions to improve RH and service delivery in crisis settings and gather operational evidence on their introduction.
 - 13.2.1 Create a matrix framework on RH technologies and next steps.
 - 13.2.2 Develop and test delivery systems for community-based immediate health care for rape survivors.
 - 13.2.3 Document the field introduction of the non-pneumatic anti-shock garment (NASG) and its results to develop a case study that can serve as an example of how to introduce new technologies in crisis settings.
 - 13.2.4 Conduct an assessment/scan on the use and potential for cell phone and other forms of IT in crisis settings to improve RH and other health care service delivery.
 - 13.2.5 Advocate for inclusion of new drugs on EML (Misoprostol for PPH prevention and/or treatment).
 - 13.2.6 Investigate making Oxytocin in Uniject and Depo in Uniject available in crisis settings.
- 13.3 Provide technical assistance for production and advocating for inclusion of new technologies in the interagency RH kit or through alternative supply channels
 - 13.3.1 Provide technical assistance on NASG manufacture to improve the price performance equation
 - 13.3.2 Investigate supply options for misoprostol for PAC and mifepristone/misoprostol for MA
- 13.4 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.)
- 13.5 Print new job aids: vacuum extractor in assisted vaginal delivery (poster), using steam sterilization (poster), and post-rape care checklist (pocket reference).
- 13.6 Develop of job aids for magnesium sulfate and misoprostol for PAC.

14. URBAN DISPLACEMENT

During the IAWG meeting in Santo Domingo, May 2010, the TORs of the Sub-working Group of on RH in Urban Displacement were discussed. The Sub WG was initiated in November 2008 and further discussions continued during 2010. Two new co-chairs, UNHCR and UNFPA, were identified to lead the Sub WG. UNHCR has a valuable experience in the provision of health care for urban displaced populations, and has recently issued its policy on urban refugee health. UNFPA has the comparative advantage of RH expertise and working with national health systems. These TORs are the basis for the Sub WG activities.

Context of Urban Displacement

Urban displacement has emerged as a new dimension to the challenges we face in meeting the humanitarian needs of IDPs and refugees. Besides disrupting the family life of the displaced and the social fabric of communities, the movement of people to non-camp, urban settings is further exacerbating the vulnerability of the already resident urban poor. The arrival of new IDPs and refugees further stresses already inadequate water and sanitation infrastructure, shelter and access to land. Competition for resources and livelihoods among the urban displaced and host populations increases social tension and can result in new conflict.¹

Recent UNHCR studies have found that almost half of the world's refugees now reside in non-camp settings including urban areas.² Furthermore, a larger proportion of refugees are now fleeing from middle-income countries. In the latter setting, the demographic and disease epidemiologic profiles are that of an older population with chronic diseases. Recently, UNHCR published its Policy on Refugee Protection and Solutions in Urban Areas (2009). The Policy is based on the principle of expanding protection space beyond camp-settings.³

It is important to focus on reproductive health in urban displacement and start bridging relief and development divide, to understand the gaps and set priorities for affected populations to access quality reproductive health services through strengthening and supporting national health systems and NGO/CBO sector. Group set the following objectives, activities, and mechanisms for monitoring progress:

14.1 To follow-up on progress of RH delivery in urban displacement to meet affected population's needs.

Status: 2010/11 Recommendation.

14.2 To identify gap/solutions and set RH priorities for displaced populations during emergencies and stable humanitarian situations

Status: 2010/11 Recommendation

14.3 To update IAWG members on research initiatives on RH in urban displacement

Status: 2010/11 Recommendation

14.4 To share information on up to date RH technologies and tools developed by agencies and organizations.

Status: 2010/11 Recommendation.

14.5 To identify gap/solutions and set RH priorities for displaced populations during emergencies and stable humanitarian situations

Status: 2010/11 Recommendation

14.6 Collection of documents on current/past models, lessons learned and recent researches findings related to urban displacement and reproductive health;

Status: 2010/11 Recommendation

14.7 Identification of differences, opportunities, and mapping vulnerabilities in urban settings, as well as assessing access to and availability of quality RH services and caseload.

Status: 2010/11 Recommendation.

14.8 Identification of knowledge gaps and practices, and up-to-date tools in order to

(a) build the capacity of local health systems and organizations to provide quality RH services;

(b) advocate for policies change and the inclusion of displaced populations under SRH national programs, and adapt these programs to context;

(c) develop a strategy and set SRH priority interventions for emergency in urban settings.

Status: 2010/11 Recommendation

14.9 Develop an annual work plan.

Status: 2010/11 Recommendation

14.10 Update and maintain email list for sub-working group.

Status: 2010/11 Recommendation

14.11 For monitoring and communication purposes, the email listserv will be used to coordinate group communication. Information will be shared with WG members through quarterly teleconferences and meeting notes on agencies/organizations specific activities and events related to RH in urban displacement. Documents will be shared and review before submission and posting on IAWG website.

Status: 2010/11 Recommendation

¹ Forced Migration Review : Adapting to Urban Displacement , Refugee studies centre, Oxford university, 2010

² UNHCR. Statistical Yearbooks (1994-2007). <http://www.unhcr.org/pages/4a02afce6.html>. Geneva.

³ UNHCR policy on refugee protection and solutions in urban areas. Geneva, 2009.