Acronyms

ACABEF— Association Centrafricaine pour le Bien-Etre Familial
AMDA – Association of Medical Doctors of Asia
ANC—Antenatal Care
BCC – Behavior Change Communication
CAR—Central African Republic
CBO—Community-Based Organization
CCSAS—Clinical Care for Sexual Assault Survivors
CDC – U.S. Centers for Disease Control and Prevention
CFI—Childfund International
CHW—Community Health Worker
C-section—cesarean section
D&C— Dilation and curettage
DDRM— Disaster Risk Reduction Management
DFAT – Australian Aid, Department of Foreign Affairs and Trade
DRC – Democratic Republic of the Congo
DRR—Disaster Risk Reduction
EC—Emergency Contraception
EECA—Eastern Europe and Central Asia
EmOC—Emergency Obstetric Care
ERC—Ebola Virus Disease Response Consortium
ESEAOR—East and Southeast Asia and Oceania Region
ETC—Ebola Treatment Center
EVD—Ebola Virus Disease
FP—Family Planning
FTS—Financial Tracking System
GBV—Gender-Based Violence
GBV AoR—Gender-Based Violence Area of Responsibility
GHC—Global Health Cluster
HIS—Health Information Service
HPV—Human papillomavirus
IA –Interim Approach
IAWG—Inter-Agency Working Group on Reproductive Health in Crises
ICPD—International Conference on Population and Development
IDP—Internally Displaced Person
IEC—Information education communication
IFRC—International Federation of the Red Cross
IMC—International Medical Corps
IPC—infection prevention and control
IPPF—International Planned Parenthood Federation
IRC—International Rescue Committee
IUD—intrauterine device
JHSPH—Johns Hopkins School of Public Health
MENA—Middle East and North Africa
MISP—Minimum Initial Service Package for Reproductive Health
MNH –Maternal and Newborn Health

MoH—Ministry of Health
MoHS—Ministry of Health and Sanitation
OCHA—Office of Coordination in Humanitarian Affairs
ODA—Official Development Assistance
PAC—Post-Abortion Care
PHO—Provincial Health Office
PNC—Postnatal Care
PRM—U.S. State Department Bureau of Population, Refugees, and Migration
RH—Reproductive Health
RHHS—Reproductive Health in Humanitarian Settings
RP/RH Law—Responsible Parenthood/Reproductive Health Law
SAVE—Save the Children
SCMP—Supply Chain Master Plan
SPRINT—Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
SRH—Sexual and Reproductive Health
STI—Sexually Transmitted Infection
ToR—Terms of Reference
ToT—Training of Trainers
UNFPA—United Nations Population Fund
UNHCR –United Nations Refugee Agency
UNRWA—United Nations Relief and Works Agency for Palestinian Refugees in the Near East
VHT—Village Health Team
WHO—World Health Organization

Executive Summary

The fifteenth annual meeting of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises was held in the Dead Sea, Jordan from 25-27 February, 2015. One hundred and forty participants representing 72 agencies, organizations and institutions met to address ways to improve the sexual and reproductive health (SRH) outcomes of crisis-affected populations. The meeting had three stated objectives:

- To review progress towards achieving the programmatic goals and future steps outlined in the Terms of Reference (ToR) following the 2013 IAWG meeting in Kuala Lumpur.
- To share information and identify key areas of common work and plan next steps and areas of coordination and collaboration for 2015-2016; and
- To revitalize or establish regional IAWG forums for the Middle East and North Africa and West and Central Africa regions that will serve to share information and lessons learned across projects in the region and enable synergistic partnerships to fill gaps and minimize duplicative efforts.

The three-day meeting opened with a warm welcome from representatives from the United Nations Population Fund (UNFPA) Jordan, who hosted the meeting. Opening remarks were also made by the Jordanian Ministry of Health and the U.S. Department of State, Bureau of Population, Refugees and Migration (PRM), whose generous support of IAWG made the meeting possible.

The theme of this year's meeting was addressing the gaps identified in the 2012-2014 IAWG Global Evaluation of Reproductive Health in Crises. Following the welcome and introductory sessions, a panel of

IAWG members presented select findings from the Global Evaluation, which provided background and context for presentations and discussions that followed. Other topics included SRH responses in current emergencies, transitioning from the Minimum Initial Service Package (MISP) for SRH to comprehensive SRH; adolescent SRH, maternal and newborn health; family planning; community engagement; as well as a variety of other new and emerging topics. Panelists discussed research findings, case studies and promising practices in SRH for crisis-affected populations.

The majority of Day two was dedicated to working group meetings, during which participants broke into one of five technical sub-working groups:

- MISP for Reproductive Health
- Adolescent Sexual and Reproductive Health
- Voluntary Contraception
- Maternal and Newborn Health
- Gender-Based Violence

The objectives of the sub-working group discussions were to review the updated ToR to identify progress and remaining gaps and to identify priority actions for 2015-2016.

Participants next broke into one of five cross-cutting thematic discussions:

- Quality of Care
- Reproductive Health Data and Research
- Logistics
- Capacity Development
- Urban Contexts

Drawing upon the previous technical sub-working group discussions, participants were encouraged to identify challenges, promising practices, key stakeholders, etc. around the specific cross-cutting theme, as well as identify three to five actions and areas of collaboration for 2015-2016. Lastly, the plenary came together and representatives from each technical and cross-cutting sub-working groups presented on their discussions.

The meeting concluded with a plenary discussion on priorities for the coming year. These included:

- A reliable steering force supported by multi-year predictable funding and dedicated human resources.
- Improved coordination, including through the IAWG secretariat, the surge capacity roster of SRH coordinators, and new partnerships with development agencies and national partners, among others.
- Empowering and equipping local, regional and global partners by systematically engaging communities in all program phases, including disaster risk reduction (DRR) and emergency preparedness; reviving the IAWG capacity development partnership initiative; and strengthening and better supporting regional IAWGs.
- Funding that matches the needs.

Feedback Survey

An evaluation of the 15th annual meeting of the IAWG was developed to capture participants' thoughts on the sessions, overall impressions, and suggestions for future meetings. Hard copy responses were collected from meeting participants directly following the closing session on Friday, 28 February and an

electronic version of the survey was also circulated via the IAWG listserv with responses collected through 1 April. Ninety-four meeting participants completed either the paper or electronic version of the survey, for a completion rate of 67%. The majority of respondents felt that the meeting objectives were accomplished well or very well. Ninety-six percent felt that the goal to review progress towards achieving the programmatic goals determined in 2013 was accomplished well or very well; 98% felt that the goal of sharing information was accomplished well or very well; 89% felt that planning next steps and areas of coordination and collaboration for 2015-2016 was accomplished well; and lastly, 71.43% felt that the goal to establish a regional IAWG forum for West and Central Africa and Middle East and North Africa regions was accomplished well. In addition, 81% of participants felt that the material covered was about right, as compared to 10.47% who felt the material covered was too detailed, and 8.14% who felt the material covered was not detailed enough. When participants were given a choice between excellent, good, fair, or poor, all sessions received a majority score of good or excellent. Through open-ended questions, respondents suggested several ways to improve future meetings. Four broad themes that emerged from that process include increasing time for discussion and networking, particularly in the sub-working group discussions; encouraging a broader range of participation including from donors, development agencies, community-based organizations and youth; improving the participation and linkages of regional IAWGs; and lastly, focusing more on action-oriented or implementation level priorities for 2015-2016, with clear mechanisms for follow-up after the meeting. These suggestions will be incorporated into planning for the next annual meeting, as well as into continued follow-up from this meeting.

Background and Annual Meeting Objectives

Formerly the Inter-agency Working Group on Reproductive Health in Refugee Situations, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises was formed in 1995 to promote access to quality reproductive health (RH) care for refugee women and others affected by armed conflict. It was originally comprised of over 30 groups, including United Nations (UN) agencies, universities, governmental and nongovernmental organizations (NGOs), and was led by the UN High Commissioner for Refugees (UNHCR), the World Health Organization (WHO) and the UN Population Fund (UNFPA). Today, the IAWG has grown to over 1,800 individual members from more than 450 agencies under the aegis of 18 Steering Committee member agencies—representing the UN, governments, NGOs, universities and donors. Since its formation, the IAWG has met annually to exchange information, identify challenges, gain from the experience of others, build partnerships and collectively work toward the institutionalization of RH care for refugees and internally displaced persons (IDPs). Membership in IAWG is open to organizations and individuals interested in actively contributing to the advancement of the RH of women, men and adolescents in humanitarian settings. With support from the U.S. Department of State, Bureau of Population, Refugees and Migration (PRM), the fifteenth annual IAWG meeting was held in the Dead Sea, Jordan, from 25-28 February, 2015. The objectives for this meeting were to:

- Review progress towards achieving the programmatic goals and future steps outlined in the Terms of Reference (ToR) following the 2013 IAWG meeting held in Kuala Lumpur, Malaysia.
- Share information and identify key areas of common work.
- Plan next steps and areas of coordination and collaboration for 2015-2016.
- Strengthen the regional IAWG forum for the Middle East and North Africa (MENA) and West and Central Africa regions, which will serve to share information and lessons learned across projects in the regions and enable synergistic partnerships to fill in gaps and minimize duplication of efforts.

One hundred and forty participants attended the meeting, representing 72 agencies, organizations and institutions. The agenda for the meeting and the list of participants are included in Annex III: Meeting Agenda and Annex IV: List of Participants.

Welcome and Opening Session

Dr. Shible Sahbani, UNFPA-Jordan

Dr. Sahbani opened the conference noting that this year's theme – responding to the gaps identified in the 2012-2014 Global Evaluation – is important to UNFPA and the Jordan country office. Since 2012, UNFPA, together with the Jordanian Ministry of Health (MoH), has been responding to the increased sexual and reproductive health (SRH) needs in Jordan resulting from the Syrian crisis. UNFPA Jordan also participated in the Global Evaluation; namely, the Minimum Initial Service Package (MISP) for RH Assessment that was conducted in Za'atari Camp and Irbid City in February 2012. Furthermore, two weeks prior to the IAWG Annual Meeting, UNFPA Jordan and several other members of the IAWG Secretariat met in Abu Dhabi for the *Every Woman Every Child* experts' consultation, which provided a forum to discuss constraints and challenges to addressing the SRH of displaced women and children in humanitarian contexts. These discussions and the resulting Abu Dhabi Declaration highlight the critical importance of addressing SRH *everywhere*, including in fragile and humanitarian contexts. This IAWG meeting is another opportunity to discuss progress to date, identify the remaining gaps and build upon

the momentum of the Abu Dhabi meeting. Dr. Shible offered warm thanks to PRM for their longstanding support to the IAWG and for supporting this important meeting in Jordan.

Ms. Susan Olsen, U.S. State Department, Bureau of Population, Refugees and Migration

Ms. Olsen welcomed the delegate and sent regards from Margaret Pollack, Senior Advisor on Population Issues at PRM – who is one of the greatest champions of IAWG. She noted that this is the largest IAWG meeting to date, and as a proud supporter of the IAWG and the Annual Meeting, PRM is happy to see such a large commitment.

Dr. Ahmad Al-Hiari, Directorate of the Ministry of Medical Tourism, on behalf of the Minister of Health

Dr. Al-Hiari reiterated that RH is a human right. The MoH, together with UNFPA, has seen significant reductions in maternal and infant mortality in Jordan, with 99% of births given at health facilities since 2009. He extended his sincere thanks to UNFPA for continued support to Jordan and to the regional and national organizations for their work on these important issues. He closed by wishing the delegates well in their work on RH over the next three days and beyond.

Session 1: Where have we come from and where are we now

History of IAWG, Henia Dakkak, UNFPA

IAWG is a broad-based, highly collaborative network that is dedicated to advancing RH for those affected by conflict and natural disaster. In the early 1990s, two landmark events helped shape this field. In 1993, the Women's Refugee Commission (WRC) published *Refugee Women and Healthcare: Reassessing Priorities,* which showed that RH was severely neglected for refugees, and in 1994, the International Conference on Population and Development (ICPD) formally recognized the rights of RH for crisis-affected persons for the first time. The IAWG was formed shortly afterward and today, we are celebrating 20 years of collaborative work.

Initially drafted in 1997 and finalized in 1999 with funding from PRM, the first edition of the *Reproductive Health for Refugee Situations: An Inter-Agency Field Manual* guided the field of RH response for roughly a decade. The MISP--a set of priority activities to be implemented at the onset of a new emergency--was also developed as a standard of care at that time along with RH kits to complement the MISP. To address the changing nature of humanitarian crises and reflect a decade of learning, the IAWG revised the 1999 Field Manual, resulting in the current 2010 edition for field-testing. The first *Sphere Standards*, a set of guidance that dictates the minimum standards in humanitarian contexts, were published in 2004 and did not include any standard for RH.
In 2013, in order to better manage the expanding membership and best support fundraising and advocacy functions, the IAWG, with generous support of PRM, created a secretariat and a full-time IAWG coordinator position. IAWG also formalized its membership structure and created a formal steering committee of 18 dues-paying member agencies.

Most recently, UNFPA received funding from the Government of Belgium to develop a pilot roster of three-five SRH experts to deploy to emergencies for 6-12 months to work with the Health Cluster Coordinators to facilitate SRH mainstreaming in emergencies. Together with UNFPA, the Norwegian

Refugee Council and a steering committee of IAWG members, a roster of SRH experts were recruited, trained and deployed to emergencies in Sierra Leone and Guinea.

Changing nature of humanitarian contexts, Sandra Krause, WRC

There is an increasing number of refugees and displaced persons in the world today – the most since World War II. The world is faced with more level three complex emergencies (in Iraq, Syria, Central African Republic (CAR), and South Sudan), while lesser crises and protracted crises (Libya, Honduras, Sahel, Ukraine, Somalia, Afghanistan etc.) are falling off the radar. Viruses have become a global health issue, and there are new threats and higher levels of insecurity, for example Boko Haram in Nigeria and ISIS. The tremendous needs are outstripping resources, and NGOs and donors are stretched to capacity. Furthermore, policies and guidance are outpacing practice and are mismatched with skill sets, available time and capacity. There is increasing specialization and expertise, but in many cases, we are still not getting the basics right. As we move forward, it is important to think: "How do we advance SRH in these new contexts and what will IAWG's role be?"

Purpose of the meeting, Sarah Knaster, IAWG

In the past 20 years, the IAWG has grown into a broad-based network with representatives from 120 countries and territories, led by a Steering Committee of 18 dues-paying agencies. Collectively, we evaluate RH quality and availability in crisis-affected settings, develop technical standards, build the evidence-base, and advocate for the inclusion of crisis-affected persons in global development and humanitarian agendas. Much of this work is accomplished through technical and regional sub-working groups. In addition to our Steering Committee and sub-working group members, we have nearly 1,800 IAWG members that are a part of our listserv. This meeting provides an opportunity for this unique community to come together to share, collaborate and build partnerships.

Updates from the regional networks

Mollie Fair, UNFPA MENA Region

Since 2012, the MENA region has been hectic, with conflicts in Libya, Iraq, Palestine and Syria, among other countries. As a result, this regional IAWG remains very response-oriented. The regional IAWG leads—Save the Children (Save), International Medical Corps (IMC) and UNFPA—met to discuss next steps for this regional IAWG, particularly around coordination. They identified the need for more information sharing, especially sharing lessons learned and resources, and inter-regional learning. MENA is also working towards formalizing preparedness efforts, even if most countries in the region are working on response. To accomplish these goals, the regional IAWG will need to secure dedicated resources to support the regional IAWG.

West and Central Africa, Judicael Elidje, UNFPA

In the West and Central African region, actors are focusing on the food crisis, which spans nine countries from Senegal to Chad. There is also the Northern Mali crisis; the Boko Haram crisis, which is affecting four countries; the Central African Republic (CAR) crisis affecting five countries; the Ebola crisis affecting three countries; and a variety of risk-factors, including six countries that are facing upcoming elections. West and Central Africa does not yet have a regional IAWG; however there is collaboration around preparedness activities. For example, the region is focusing on capacity building of the MISP through academic institutions based in the region. Several institutions have graduated MISP-trained midwives for field deployments, but there is still a need to broaden the base and identify further opportunities to raise awareness around crises and the MISP. The next phase is to have a regional meeting with academic institutions that have MISP certification programs.

Eastern Europe and Central Asia (EECA), Emmanuel Roussier, UNFPA
Integrating the MISP into national emergency preparedness plans is a top priority for this region. Historically, the EECA regional IAWG has had very strong leadership and commitment at the highest levels, with dedicated resources to support the regional IAWG and colleagues in the field. Regional IAWG meetings have been held every year, most recently in Istanbul in October 2013. There is very strong coordination at all levels. The EECA regional IAWG has identified 20 actions for follow-up in four areas (technical assistance, coordination, knowledge sharing and advocacy). Each country will focus on five indicators.

East and Southeast Asia and Oceania Region (ESEAOR), Jaya Samuel, International Planned Parenthood Federation (IPPF) – Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations (SPRINT) Initiative
Over the past year, the SPRINT Initiative-ESEAOR provided regional, national, provincial and community level trainings, as well as MISP emergency response in the Philippines, Indonesia, Solomon Islands and Myanmar. One particular challenge in the field includes overstretched SRH champions. The ESEAOR IAWG was revitalized during the IAWG Annual Meeting in Kuala Lumpur and SPRINT-ESEAOR is working to engage national and regional partners.

South Asia, Nimisha Goswami, IPPF SPRINT Initiative
The SPRINT Initiative-South Asia, funded by the Australian Department of Foreign Affairs and Aid (DFAT), is currently working in Pakistan, Bangladesh, Afghanistan and Sri Lanka. The countries in this region are disaster prone and conflict-affected. SPRINT provides regional and in-country MISP trainings, rapid assessments, emergency response and post-emergency review. SPRINT is also focused on integrating the MISP into government disaster risk reduction (DRR) policies. In coordination with IAWG and UNFPA, SPRINT is working to develop a South Asia regional IAWG, leveraging the existing country coordination teams. In the coming year, the regional IAWG lead intends to define roles and responsibilities and mobilize dedicated resources for sustainability of a regional IAWG.

Session 2: Taking Stock of Taking Stock of Reproductive Health in Humanitarian Settings: Findings from the IAWG 2012-204 Global Evaluation of Reproductive Health in Crises
Chairperson: Nguyen-Toan Tran

The objectives of the 2012-2014 IAWG global evaluation were to 1) assess progress 2) document gaps and 3) determine future directions for programming, advocacy and funding. In other words, where are we now, where are we going and how do we better implement in the field? The Global Evaluation consisted of seven complementary studies:

- Systematic literature review;
- Assessment of agency commitment and capacity;
- Assessment of availability, use and quality of RH services (in-depth study) in South Sudan, Democratic Republic of the Congo (DRC) and Burkina Faso;
- Assessment of the use/efficacy of the MISP conducted in Irbid City and Za'atri Refugee Camp in Jordan;
- Analysis of funding trends for RH in crises; and
- Review of UNHCR Health Information System (HIS) RH data.

This global snapshot showed overall progress and maturity in the field, a growth in institutional capacity, increased implementation and increased funding for SRH in humanitarian settings. It also captured clear

opportunities for improvement—revealing uneven, inequitable MISP implementation; gaps in emergency obstetric care (EmOC), clinical care for sexual assault survivors (CCSAS), family planning (FP), particularly long-acting and permanent methods and emergency contraception (EC), and safe abortion care services; access barriers; and inequitable and inadequate funding to meet existing needs.

Mihoko Tanabe from the Women's Refugee Commission, presented findings from two complementary studies. The first study, *Tracking Reproductive Health Funding in Official Development Assistance (ODA)* led by Kings College London, tracked ODA for RH in order to provide longer-term trends in patterns of disbursement for RH activities in 18 conflict-affected countries between 2002 and 2011. The findings showed a 298%increase in ODA for RH. Over half (56.3%) of the 298% increase in total reproductive health disbursements during the study period is due to the substantial increase in HIV/AIDS funding. The study also found a 57% discrepancy between funding for conflict-affected countries ($2.3 per capita) and non-conflict-affected countries ($3.4 per capita), despite the fact that the conflict-affected least-developed countries appear to have generally worse RH indicators (with the notable exception of HIV/AIDS) and lower gross domestic product (GDP) than the non-conflict-affected least developed countries. One notable limitation of this study is that ODA is tracked at the country level, rather than at the specific conflict-affected region within a country.

The second study, *Tracking Humanitarian Funding Appeals for Reproductive Health* led by the Women's Refugee Commission, examined the extent to which agencies have appealed to implement various RH activities in humanitarian health and protection appeals, and the extent such appeals were funded for the 2002-2013 period. The study analyzed publicly available data from the UN Office for the Coordination of Humanitarian Affairs' (OCHA) financial tracking service (FTS) and systematically reviewed each health and protection proposal. Among the 11,347 proposals, 34.5% were relevant to RH. While only 43% of the total request for relevant RH proposals was met, trends still show a 17.9% average annual increase in the proportion of requests received per year. Among RH components for 2009-2013 proposals, maternal newborn health (MNH) comprised the largest proportion (56.4%), followed by RH-related gender-based violence (GBV) (45.9%), HIV/sexually transmitted infections (STI) (37.5%), general RH (26.2%) and lastly, FP (14.9%). There was very little mention of abortion care in the proposals.

Next, **Sathya Doraiswamy from UNHCR** presented on *a Retrospective Analysis of UNHCR's Health Information System's (HIS) RH and HIV/AIDS Indicators in UNHCR's Post-emergency camps*. Together with the U.S. Centers for Disease Control and Prevention (CDC), UNHCR analyzed the RH indicators collected in the HIS to assess whether the indicators met benchmarks. This study analyzed monthly camp data between 2007 and 2013 from 56 refugee camps in 10 countries across seven RH indicators. Significant increases were observed in

- percent of births attended by a skilled birth attendant, although most (8 of 10) countries did not meet the 100% target;
- the percentage of births performed by Caesarian section, despite the average monthly rates within refugee camps being below the recommended target minimum every year for 8 of 10 countries;
- the percentage of women screened for syphilis across years; and
- the percentage of women who received post HIV exposure prophylaxis.

There was no significant change in the condom distribution rate. Overall significant positive trends were observed, demonstrating progress in RH programming in refugee settings. Many of these indicators were better than those in host populations. Recommendations to improve RH outcomes include

increased community mobilization to create demand for services and to improve reporting, combined with regular program evaluation to address the quality of maternal and perinatal mortality reporting and care. Integrated community care for mothers and newborns with targeted home visits during pregnancy and post-partum periods, combined with improved referral to health facilities could further improve rates of skilled attendance at birth.

Next, **Janet Meyers from the International Medical Corps (IMC)** presented on the *Institutional Capacity Assessment for RH in Humanitarian Settings (RHHS)*. This descriptive study used a questionnaire tool to examine the following elements of capacity:

1) Institutional policy
2) Accountability mechanisms
3) Delivery strategy
4) Financial, human and technical resources related to RHHS

This descriptive study was distributed to IAWG, the Global Health Cluster (GHC) and CORE group listservs. Eight-two institutions from 48 countries responded to the online self-reporting survey, and the results indicate an overall growth in institutional capacity in RHHS over the past 10 years. Twenty-five percent of institutional respondents had a primarily humanitarian focus, 25% had a primarily development focus, and 50% had a dual focus revealing that RHHS is no longer the exclusive remit of humanitarian actors. Seventy-eight percent of respondents were working in camp settings, 83% in rural settings and 83% in urban settings compared to the primarily camp-based settings in the previous global evaluation. Sixty-eight percent of respondents reported that their institution has an RHHS-related policy or guideline or other official support document, such as a board mandate. This is notable as only one institution had a policy in 1994 and only 43% had a policy at the time of the last Global Review in 2004. A general increase in the overall organizational expenditure has been observed from 1995 to 2004, and this trend continued after 2004 for half of the respondents (49%), while 20% did not report substantial change and 13% reported a decrease. An increasing number of institutions had a dedicated budget for RHHS over the past decade, from research to all the different phases of the emergency management cycle, and in particular, DRR and response. This is a positive finding in spite of the global financial crisis of 2008 and its aftermath, and demonstrates the importance and commitment given to RHHS by institutions, including donors. The results showed increased activity in almost all clinical areas of work, both for the MISP and comprehensive RH. Despite this, there were still major gaps in abortion-related services, permanent methods of FP and cervical cancer screening and treatment. A large number of respondents also reported challenges with procurement of RH supplies. Further research is needed to look at the quality and extent of progress at the field-level. It is critical that we address identified gaps and continue the momentum of ongoing improvement.

Dr. Nguyen then reflected on the IAWG Global Evaluation. The evaluation shows IAWG at its best – a model of collaborative partnerships between institutions. We now need to reflect as a community on the future direction of the field, and what should prioritize over the next five to ten years so that:

1) All crisis-affected populations have access to quality SRH services in both acute emergency and during recovery that are effectively coordinated by all implementing partners;
2) 2) Human resources, supplies and funding for SRH match the needs and are efficiently used; and 3) IAWG members are empowered and equipped to respond to the SRH needs of affected populations?

Some additional questions for reflection over the course of the next three days include:

- How do we disseminate these findings?

- How do we garner more attention and funding from donors and other partners for the gaps that were identified?
- How do we deal with the changing humanitarian context?
- How do we accelerate progress on ownership and engagement of the "South"?
- How are we engaging emerging donors?
- How do we best transition from humanitarian response to development?

Some suggested key priorities mentioned included:

- Effective coordination
    - How do we improve UN agency coordination and strengthen the current surge capacity for SRH coordinators?
    - Who is missing from the discussion (UN Development Programme, development NGOs, donors, etc.)?
- Empowering and equipping local partners
    - Reviving IAWG Training Partnerships Initiative
    - Including MISP in curricula for midwives, doctors and nurses
    - Strengthening regional IAWGs
- Funding that matches the needs
    - Do we need dedicated resource mobilization and communications teams to close the RHHS funding gap?
    - How can we better engage development donors?
    - How can we efficiently use available funding through innovative delivery models?

The audience discussion that followed included questions for thought over the next three days:

1. Why are there still gaps in FP and comprehensive abortion care ten years after they were documented in the last Global Evaluation?
2. The contexts are changing rapidly and quickly that we remain focused on process, rather than on technical components.
3. Why is community engagement and adapting to the context "low on the totem-pole"?
4. Where is the national and local partner voice on the IAWG Steering Committee?
5. Where are the other donors at the IAWG meeting?
6. We need to engage development organizations and donors in order to build longer term capacity following disasters. How can we secure longer-term multi-year funding for emergencies in order to build longer-term capacity?

Session 3: New and Ongoing Emergencies
Chairperson: Sandra Krause – Women's Refugee Commission

Omar Ballan from UNFPA presented on a program to *Improve Women's Access to Emergency Reproductive Health in Violence-Affected Areas in Syria through an RH Voucher Program*. Women in Syria face a number of challenges accessing RH care including security conditions, increasing militarization of health care, economic barriers, shortage of financial services, destruction of hospitals, gender considerations and social norms, to name a few. The RH voucher program gave women the ability to access free services, including safe delivery, cesarean-section (c-section), pre/post-natal care (PNC), and FP consultation (however FP services themselves were provided by another program) from 29 hospitals. In total, 18,000 women received services through vouchers, and an increase was observed in the use of antenatal and postnatal care and institutional deliveries. RH vouchers allowed women to

choose providers and improved equitable access to RH services. There were also reported improvements in staff and client satisfaction. Remaining challenges include targeting the women most in need, controlling overbilling, security concerns, confusion that vouchers are intended only for deliveries and limited resources.

Dr. Ballan closed with key lessons learned, namely:

- The RH voucher program reduced the delays to RH services at the community and institutional levels.
- The RH voucher acted as a catalyst for improvements in quality of maternity care in both public and private sectors health facilities.
- It is important to enter into partnership with local and international organizations.
- Third party monitoring of the RH voucher is key for system improvement and accountability.

Next **Dr. Ali Shaar from UNFPA-Palestine** presented on a *Post-crisis RH Assessment in Gaza*. Gaza is faced with many challenges included a high fertility rate, poverty, unemployment, limited health services and no freedom of movement. The health system is already over-stretched and the existing blockade has resulted in stock outs of approximately half of the necessary drugs. In this most recent military operation--the third in six years--2,133 = people were killed, included 183 women, 16 of them pregnant; 11,000 were injured; and 500,000 were displaced. The qualitative RH assessment looked at pregnant and lactating women, children, men, and health care providers in both rural and urban settings. Findings revealed that UNFPA, the MoH, WHO and UN Reliefs and Works Agency for Palestine Refugees in the Near East (UNRWA) were losing gains on RH; in particular, improvements to the maternal mortality rate made in 2012. Findings revealed more pre-term deliveries and infant case fatality (hospital capacity was exhausted and priority was being given to injured persons). FP uptake was reduced and antenatal visits also dropped significantly. Furthermore, homes that originally held four people were now holding up to 70; shelters were crowded, and access to water was limited to 1.5 liter per day. Women were not able to bathe for weeks at a time and had no access to menstrual hygiene supplies. All of this often led to violent behavior, resulting in increased reports of household GBV and violent sexual crimes. In addition to ending the ongoing violence in Palestine, recommendations from these findings include the need to rebuild the health care system and roll out the MISP immediately.

Next, **Dr. Beyam Edith Narcisse from UNFPA Central African Republic (CAR) and Ndotiga Biansere Alphonse from the Association Centrafricaine pour le Bien-Etre Familial (ACABEF)/ IPPF** presented on the *SRH response in CAR*. CAR is a country deeply in crisis, with social and health services completely destroyed and 2.7 million people displaced. The CAR conflict was declared a Level Three emergency in December 2013, and is ongoing. The early SRH response included creation of a MISP/SRH Working Group chaired by UNFPA. In 2013, the Working Group was linked to the health cluster and received technical support from IPPF. Key achievements of the early program intervention include the provision of emergency RH kits and additional equipment to functional health facilities, a focus on MISP implementation and mobile clinics for SRH, including FP and GBV clinical care. The Working Group was able to improve service quality and reduce duplication of services. Planned next steps include gaining support for a regional IAWG, reinforcing readiness to maintain MISP implementation, especially with upcoming elections, prepositioning SRH kits, monitoring more risky areas, deploying trained staff in advance and supporting strong M&E and knowledge management systems. They will also continue capacity-building on the MISP, including training of senior staff and Training of Trainers (ToT) for staff at the country level.

Challenges include:

- Overall funding for SRH within humanitarian interventions remains low.

- Security threats (supplies blocked outside of the country, resulting in delays in the implementation of the MISP).
- Fragmented implementation of MISP components due to limited resources.
- Natural constraints on travel, etc.

Key lessons learned include:

- A functional coordination mechanism leads to a better and harmonised response, minimising duplication and increasing efficiency.
- The joint IPPF/SPRINT, ACABEF and UNFPA program increased efficiency.
- In a country with insufficient health facility equipment, the intervention has improved quality of services and paved the way towards comprehensive SRH services.
- Contributions of the National Midwives Association for community-based services and partnering in advance with the Red Cross for community interventions contributed to successes.

Lastly, **Dr. Shible Sahbani from UNFPA-Jordan** presented on the *SRH response for Syrian refugees in Jordan*. The response began in early 2012 with 1,500 refugees and one SRH clinic inside the camp. Today, more than 620,000 Syrian refugees are residing in five camps and urban areas (85% are outside of the camps), including approximately 155,000 women of reproductive age and 15,500 pregnant women. The IAWG MISP assessment in Jordan—as part of the IAWG Global Evaluation--sought to identify and assess the availability of SRH services for this population. Recommendations from the assessment included: strengthening coordination in the urban settings; mapping RH services; increasing community awareness around available services; and providing better linkages with NGOs, MoH and GBV working groups.

UNFPA, the MoH and their partners have worked to address all of the recommendations from the MISP assessment; however, remaining challenges include involving men, addressing youth SRH needs, and limited distribution of condoms among refugees. There was also a MoH decree in November 2014 that primary health care is no longer free to refugees, which will have huge implications on the transition to comprehensive SRH services, including for cervical cancer screening and treatment and breast cancer screening.

Session 4: Objective 5 of the MISP: Moving Towards Comprehensive SRH services—When and How
Chairperson: Wilma Doedens, SRH consultant

Dr. Doedens opened with a brief overview of some of the issues around transitioning from the minimum to more comprehensive services. She mentioned an increase in demand to create a "MISP Plus" because the minimum is not accurate for every setting. Will we be able to find a one size fits all model? We should encourage planning for integrating SRH as soon as the situation allows, but there are no clear guidelines.

Next, **Ibraheem Abu-Siam from UNHCR** presented on *Innovations in Assessing Reproductive Health Access and Utilisation Among Non-camp Refugees in Low to Middle Income Countries: Experience from Jordan and Lebanon.* Since the beginning of the Syrian conflict, 3.2 million refugees have fled to neighbouring countries, including 1.1 million to Lebanon and 623,000 to Jordan. All refugees in Lebanon live outside of camps, and 84% in Jordan live outside of camps, mostly in major urban centres. Challenges in data collection for this population include frequent population movement and identifying the refugee population living among the host population. Reliable data on health service needs of non-camp refugees can be difficult and costly to collect on a routine basis. In an effort to develop a cost-

effective and efficient mechanism for regular monitoring of health access and utilisation among non-camp refugees, UNHCR, in collaboration with local partners, carried out a household telephone survey among registered Syrian refugees. that the survey found that the context has a major impact on SRH indicators and that repeat telephone surveys provide relatively rapid, reliable and cost-effective access to population level SRH data.

Next, Mollie Fair from UNFPA – MENA presented on *Emergency RH in the Arab States region from MISP to Comprehensive RH*. UNFPA carried out a review of RH services in the MENA region from 2012-2014 in order to understand recent RH in emergency programming experiences in the region, especially transitions from MISP to comprehensive RH, and in particular, in protracted emergencies in middle-income settings. Further, the findings would result in a set of recommendations to guide efforts to strengthen RH in emergency programs in the region and gain a consensus for those recommendations and priorities. The review took place in Tunisia, Sudan, Palestine, Syria, Jordan and Somalia. They found that all responses included aspects of comprehensive RH even when full the MISP package was not fully implemented– most common services were antenatal care (ANC), PNC and community outreach. They also found that timely and rational expansion to comprehensive RH services was a common challenge, as well as a lack of comprehensive RH assessments and data to inform transitions/expansion of services. In middle-income countries with more developed health systems, it is possible to plan immediately for comprehensive services; however, there is still a need to ensure that the minimum is still being met. In countries with less developed health systems, the response is more reliant on NGOs and there is a need for continuous capacity building due to high staff turnover.

The review resulted in a set of recommendations that include:

- Support comprehensive RH needs assessments.
- Focus on Objective 5 of the MISP as soon as possible.
- Focus on preparedness strengthening systems, capacity building, including “shock-absorbing capacity”.
- Strengthen communications/advocacy around the MISP.
- Engage donors to bridge the humanitarian/development divide.

Next, **Abdelhadi Eltahir from the International Rescue Committee (IRC)** presented on *IRC’s Experience Transitioning from the MISP to Comprehensive RH Service Delivery in Southern Chad*. In April 2014, the IRC launched a MISP response for CAR refugees residing in three transit camps in Southern Chad. Major achievements of the response include implementation of all the pillars of the MISP, with plans to transition to comprehensive RH services from the beginning. Furthermore, the response was pulled together very quickly because the team in Chad recognized the importance of RH (and had been providing RH services for ten years). Other factors of success include:

- Dedicated staff, including an experienced RH coordinator, and pre-positioned RH supplies set the foundation for successful MISP implementation and allowed for immediate planning for comprehensive RH services;
- Capacity-building and on-the-job trainings for health staff helped to build service quality and facilitated scale-up of the MISP;
- Community Health Workers (CHWs) worked with the community to generate increasing awareness of and demand for RH services.

The response transitioned successfully into comprehensive RH, emphasizing community outreach and a well-functioning health information system from the beginning. Other key ingredients for transition to comprehensive RH included:

- MISP integrated into the existing primary health activities of IRC in Southern Chad.
- On-the-job training for humanitarian service providers.
- Advocacy for MISP in cluster and coordination forums.
- Established bilateral working relationship with RH focal points.

Lastly, Michelle Dynes from the Centers for Disease Control and Prevention (CDC) presented on *Lessons Learned from Reproductive Health Surveillance in Za'atari Refugee Camp — Jordan, 2013-2014.* The UNHCR Health Information System (HIS) is a standardized tool to design, monitor and evaluate refugee public health and HIV programs. The HIS is implemented in over 18 countries and targets over 2.1 million refugees in camp and non-camp settings. Za'atari had nine health providers, all with varying degrees of exposure to health information systems. Following the 2013 MISP assessment, UNHCR and UNFPA invited CDC to review RH health surveillance and to assist in addressing shortcomings. Qualitative methods were used to evaluate the HIS, including key informant interviews; facility site visits; review of reproductive health documents, tools and indicators; and stakeholder meetings at the national, organizational and camp levels.

Findings showed that RH data collection was particularly complex due to the presence of multiple non-traditional health actors. Data collection was further complicated by the fact that women could seek services with multiple providers and there was poor documentation of consultations early on. In addition, three of the health actors were military facilities, which entailed long negotiations and compromise. Each health actor used different data collection methods, including varying health forms and different levels of charting on patient care. Health actors also following their own program-specific reporting mechanisms and requirements. High staff turnover, as frequent as every 3 weeks in some facilities, further compounded complications. And finally, a process was not in place to share individual patient health information across provider sites; this lack of access to patient records impacts the ability of clinicians to gather relevant health and care history data to provide high quality services. These factors all contributed to incomplete and inconsistent reporting of RH data. The team also found that few health actors reported FP data, and no sexual violence case had been reported to HIS, even though service providers reported anecdotally that they had seen cases.

Recommendations include: standardizing RH data collection across health actors and sites, and simplifying daily data collection. To improve information sharing across sites, a Pregnancy Card was implemented. The card remains with the pregnant woman and is carried to each visit where the provider can review and update information.

Lessons learned from this evaluation include:

- A flexible, systematic approach to data collection and reporting is needed.
- All relevant health actors--including non-traditional actors--should be engaged with and provided training on key RH data to be collected at different phases;
- Agreement on and development of a standardized approach to data collection at a global level would facilitate implementation.
- Using RH registers early in a crisis helps highlight the key RH outcomes and guide interventions for the establishment of a comprehensive RH response.
- Health care provider involvement in the development and adoption of quality improvement tools enhances commitment, collaboration and information sharing from health actors.

- Data sharing between services that are provided inside and outside the camps is essential for accurately capturing health outcome data in a timely manner.
- It is critical to evaluate the quality of HIS data early and work in close collaboration with health actors to develop and implement a detailed action plan to guide improvements and respond to emerging challenges.

Questions and Discussion

- How do we build the government's capacity to provide RH services?

Panelists reflected that the advocacy will be contextual. We will need to work with the government to make sure that SRH is a priority, certain drugs are available, protocols are in place (for CCSAS for example) and we are building knowledge and advocates at the government level. It is also important to work with professional organizations in-country.

- How are data generated from refugee camps in Jordan reflected in national government systems (since ultimately, the MoH is responsible for all refugees)?

Panelists responded that the data are shared on a weekly-basis at meetings. The refugee camp data are managed by UNHCR in collaboration with the MoH. The CDC evaluation addressed the needs of refugee in camps.

- What was the impact of MISP implementation in Chad on maternal mortality?

Chad has one of the highest maternal mortality ratios in the world. The IRC program is not measuring maternal mortality ratio as part of the program, but by providing services, the program is reducing maternal death.

Dr. Doedens closed the session with a few thoughts on how to successfully transition from the MISP to comprehensive RH. Namely, the transition will require lateral thinking, collaboration with the MoH, NGOs and development agencies. We need to look at the existing infrastructure, human rights, existing RH data and the political and cultural contexts to determine which aspects of comprehensive RH should be prioritized while ensuring that quality MISP services remain in place.

Session 5A: Addressing SRH Needs during EVD Response and Recovery
Chairperson: Carolyn Baer, CARE International

Michelle Dynes from the U.S. Centers for Disease Control (CDC) presented on the *Perceptions of the Ebola Virus Disease (EVD) and Health Facility Use among Pregnant and Lactating Women and Community-level health workers in Kanema District, Sierra Leone*. In May, 2015 the Sierra Leone MoH confirmed the presence of EVD, with a third of confirmed cases in Kanema District facing one of the highest maternal mortality ratios in the world. In collaboration with IRC, and the Kenema District Health Management Team, the CDC carried out focus group discussions with health center and health post staff, and pregnant and lactating women. The ultimate goal of the collaboration was to identify ways to increase use of maternal and child health services.

Health care workers reported a sharp decline in facility use for routine health services immediately after the EVD outbreak, although deliveries were the least impacted because of fines imposed on women who deliver at home. There was consensus that the primary reason for decreased use of health facilities was fear of contracting EVD at a facility. Several common misconceptions were reported. For example, it was thought that every person who went to a health facility was presumed to have EVD and would be taken

to the Kenema EVD Treatment Unit, because the community believed that the staff was paid for each patient referred. Another common misconception was that health facility staff injected patients with EVD or took their blood for financial gain or magical power. These misconceptions were particularly strong early in the outbreak. Some staff acknowledged that they had discontinued certain services, such as the provision of injectable contraception, due to fear of increasing their own risk of contracting EVD. Despite ongoing fear, health care workers reported a reduction in their own fear of EVD since they had received an infection prevention and control (IPC) training. The staff agreed, however, that there were gaps in the provision of infection prevention equipment. Fear among and for traditional birth attendants (TBA) was particularly strong because the TBAs had not received the trainings and did not have access to protective equipment.

Participants in the focus group discussions proposed sharing messages in the communities about the recent IPC trainings so that facilities were seen to be safe. Health workers and community members also suggested offering incentives such as food or clothing to encourage registration and use of the facility for care, as well as having women share their positive experiences around visiting a health facility. Both health care workers and women thought TBAs could help spread messages about EVD and the importance of coming to the facilities for care.

Next**, Laura Miller from the IRC** presented on the *Continuity of SRH Service Provision and Uptake during the 2014 EVD outbreak in Kenema District*. To ensure that cleaners, TBAs and every staff member who would come in contact with EVD patients, knew how to protect themselves and others around them, The IRC, WHO, and the Ministry of Health and Sanitation (MoHS) developed a training package on IPC based on the six IPC principles: Social distancing; hand washing; screening; isolation; waste management; and clinic management.

The particular challenges for RH during the outbreak included a lack of access to RH services for those under quarantine, insufficient quantities of FP commodities and the risks of EVD to pregnant women. As a result, FP use, ANC and facility-based delivery declined. Despite this, the Sierra Leone health system did not collapse, and only 4.1% of primary health care facilities closed.

Partnerships between seven international NGOs of the EVD Response Consortium (ERC), the MoHS, UNICEF and CDC accomplished the following:

- Development of a nationally approved IPC training package for primary health care.
- Training of over 4,500 health care workers from 1,180 primary health care facilities in 6 weeks.
- Provision of IPC supplies to all facilities.
- Ongoing supportive supervision from international NGOs and MoHS.

Dr. Miller closed by reiterating that health workers are true heroes—they continued to care for women and children on the front lines. Four hundred and forty four health workers have been infected and over 50% have died, with most infections happening outside of EVD care facilities.

Next, **Jessica Izquierdo from Childfund International (CFI)** presented on the *EVD Response in Guinea, Liberia and Sierra Leone and the Role of Local Partners*. Childfund is primarily a development organization that supports local partners to create child-focused community-based programs that are sustainable and contribute to achieving equity. They responded to the EVD outbreak with a community awareness and hygiene campaign. They then scaled up social mobilization activities, followed by emergency care and psychosocial support to vulnerable children, and lastly, community health and child protection programming. Organizational reasons for ChildFund to respond included the fact that CFI's

communities were affected, they had a commitment to the communities and they were planning a continued presence after the emergency.

Key lessons learned include:

- Emergency response organizations need to work with international development organizations in the response to the EVD epidemic.
- Funding flexibility is needed to adequately respond to EVD so that teams can mobilize rapidly.
- Preexisting partnerships are important for the EVD response, as engaging the community is one of the most effective ways to control EVD.

Lastly, **Janet Meyers, on behalf of Elizabeth Benga-De, from** IMC presented on *Community Engagement in Providing Quality SRH Care in Liberia and Sierra Leone*. There were many EVD-related stressors and psychosocial support was critical. These include: disruption of routines and livelihoods; fear and uncertainty; isolation for; anxiety; loss and grief; and fear and community stigma for health care workers. IMC activities included community education and awareness raising; information about EVD and Ebola Treatment Centers (ETC); partnerships with local organizations, promotion of community inclusion and community support groups, including for survivors.

Psychosocial support teams also communicated with patients and affected families and communities to promote well-being and emotional support, which created an entry point for explaining how to stop the spread and chain of transmission. They also provided support to vulnerable populations, such as separated children and very young heads of households; carried out activities to support discharged patients; and involved families in acceptable and meaningful mourning practices (i.e. bereavement kits).

IMC intervention strategies included:

- Engaging local leaders, stakeholders, traditional leaders at all levels with positive messages about EVD.
- Involving survivors in all outreach activities.
- Providing soap and water for hand washing.
- Demystifying the ambulance.
- Changing the IPC control strategy at the community level.
- Tailoring weekly live phone-in radio programs.

Conclusions from this project include: Psychosocial support interventions facilitate community engagement and social behavior change, and that EVD survivors are key actors in community engagement.

Discussion

- In all the three countries there has been a recovery assessment done by the UN. What should we strengthen in order to go develop a resilient health system?

Panelists commented that the government reaction in Sierra Leone and Liberia were very different. The key to resilience is the government being accountable for trained health workers, health workers receiving a salary, and ensuring the availability of supplies.

Partnerships are also important between all emergency response teams, humanitarian actors and development actors. In order for resilience to be effective, we need to work with the community.

- What are the causes of the spike in teenage pregnancies?

The data is not well understood. One possibility is that children are out of school in all three countries, but there has also been a decline in sexual behavior.

- How can we make supervision of IPC really work in this crisis?

In Sierra Leone, there is an IPC national ministry focal point and IPC focal points in districts. Each hospital has one MoH IPC point person, one NGO IPC point person and one WHO IPC point person.

IPC is not only about behaviors, it is also about supply chain management. When a health staff needs to change gloves, another pair of gloves is available for use.

Session 5B: The kids are not alright: Challenges and promising practices for improving adolescent sexual and reproductive health in humanitarian settings.
Chairperson: Sathyanarayanan Doraiswamy, UNHCR

Y-peer experience – voice of youth from Zaatari refugee camp, Jordan

A youth presenter from Za'atari refugee camp elaborated on a program created by Save the Children to increase child protection called "Safe you Safe me". The child protection program works in collaboration with community based organizations (CBOs). The overall purpose of the program is to integrate child protection services into the community, as well as foster youth development, and shift ownership and responsibilities of services to the community. The normalcy within the communities of child marriage and GBV are major vulnerabilities the program attempts to address. Therefore, "Safe you Safe me" targets children exposed to GBV (physical and/or sexual violence) to develop their self-protection mechanisms. Results from the intervention have shown an improvement in the communication skills of children and an increase in the number of children reporting incidents of violence within the communities. Negatively attributed habits have also subsided and positive coping mechanisms have increased. The program has created child protection committees, which receive and share information on various topics, including on sexual harassment and early marriage.

Next, **Sandra Krause from the Women's Refugee Commission** spoke on the risks and needs of very young adolescents in humanitarian contexts. In an attempt to parcel out the needs and risks of very young adolescents, research was conducted in Mae Sot town and Mai La refugee camp in Thailand; Kobe refugee camp in Ethiopia; and Barelias and Qabe-Iias in Bekka Valley in Lebanon. Through exploratory interviews, household surveys and participatory activities, adolescents expressed concern around poverty, physical violence, forced labor, limited schooling, early marriage and pregnancy. Beyond these concerns, the adolescents expressed a desire for menstrual hygiene products and knowledge around puberty as their knowledge stemmed only from friends and family members. This study provided valuable lessons on working with very young adolescents, highlighting the importance of catering research methodologies to the community, placing focus on healthy bodies instead of sexual health, and connecting with parents and other sectors to reinforce the knowledge children receive.

Hailu Bekele from IMC gave a presentation that built upon the research Sandra Krause presented, focusing specifically on the findings of very young Somali refugee adolescents in Ethiopia's Kobe Refugee Camp. Data were gathered from 14 focus group discussions with adolescents and four focus group discussions with adults. For very young adolescents, the most important sources of sexual health knowledge were parents. The segregation of sexes after the age of ten was shown to be a prohibiting factor in direct questioning between sexes concerning sexual relationships. The survey results

emboldened the divide between boys and girls, as most adolescents reported no opposite sex close friends and less than half feeling it appropriate to have close friends of the opposite sex. The six major risk factors for very young adolescents were identified as poverty, forced work, violence, and lack of education, marriage and pregnancy. For adolescent girls specifically the major risks were early marriage, sexual violence and female genital cutting. While knowledge around SRH ranged, with 20% of girls unaware of menarche and 20% of girls educated about pregnancy. Finally, in terms of maturing, 96% of adolescents felt comfortable becoming adults, demonstrating the lack of connection between SRH knowledge and how comfortable they feel becoming adults.

Lastly, **Erin Wheeler from Columbia University** discussed attitudes towards adolescent FP by health care providers and NGO staff in Pakistan and DRC. In 2013 and 2014, the RAISE Initiative evaluated partners' Pakistan and DRC FP and post-abortion care (PAC) programs. During this time, the RAISE Initiative was also able to conduct an assessment of health care workers and NGO staff attitudes toward FP and abortion.

Results indicated that few DRC respondents held favorable attitudes toward adolescent access to the intrauterine device (IUDs) and injectables. In Pakistan, most respondents held favorable attitudes towards adolescents having knowledge about pregnancy prevention, with fewer respondents finding adolescent access to FP favorable. For Pakistan and DRC, most respondents' held favorable attitudes toward parental consent and notification of adolescent use of FP. Services are likely to be affected by unfavorable attitudes, though attitudes are not a predictor of behavior.

Discussion

- *Y-PEER representatives shared that in Jordan, Y-PEER is currently implementing strong youth-led programming in Za'atari camp and is also work in urban settings. Furthermore, within the Za'atari camp itself, Y-PEER works within clinics where SRH services are provided, in coordination with the Nur Al Hussein Foundation, Jordan Health Aids Society and UNFPA. A representative from the International Federation of the Red Cross (IFRC) hospital in Azraq camp invited Y-PEER to work with them, an idea that was welcomed by Y-PEER representatives.*
- *Ms. Wheeler mentioned that DRC and Pakistan were selected for the study on attitudes from among four RAISE programmatic countries (DRC, Pakistan, Yemen, Myanmar) since DRC and Pakistan had the largest sample size. She also explained that the project in fact engaged several representatives from the local government through their program improvement workshop last year.*
- *A participant reiterated that we are missing a serious opportunity of reaching adolescents in refugee camps, when health facilities are not providing awareness-raising on puberty or on adolescent-targeted services.*
- *Panelists emphasized how attitudes of health providers can greatly affect quality of services. There is a need for values clarification and supportive supervision of health provides to facilitate provision of youth-friendly services.*
- *Participants further discussed the importance of increasing knowledge and awareness on sexual violence against boys.*
- *A participant raised concern that the humanitarian response for Syrian refugees has been largely focused on Za'atari and Azraq camps, while refugees living in other areas are in significant need of services. Panelists answered that several NGOs are working in urban areas, but agreed that organizations need to coordinate more to identify gaps and implement programs accordingly.*

Sub-Working Groups Discussions:

The following sub-working groups meet for approximately one hour on Thursday morning.

- Minimum Initial Service Package (MISP) for Reproductive Health
- Adolescent Sexual and Reproductive Health
- Voluntary Contraception
- Maternal and Newborn Health
- Gender-Based Violence

The objectives of the sub-working group discussion were to review the updated ToR to discuss progress; identify remaining gaps and solutions; set the agenda for further collaboration in 2015-2016; identify priority actions for 2015-2016; and determine modes of communication for further discussion. The sub-working groups reported back to the plenary on the following priority actions for 2015-2016.

MISP

1. Smooth transition from MISP to comprehensive RH.
2. Improve logistics and RH supply chains.
3. Pilot and finalize the MISP assessment tools.

Voluntary Contraception (or FP)

1. Integrate FP into the humanitarian response (adapting to cultural context) and supply chains.
2. Endorse all recommended changes in repositioning FP within the MISP and ensure this is reflected in other resources, such as SPHERE Standards.
3. Develop standard operating procedures (SOPs) for integrating FP into humanitarian settings.

Maternal and Newborn Health (MNH)

1. Update field-friendly Emergency Obstetric Care (EmOC) guidelines.
2. Share lessons learned on how to implement in the changing humanitarian context.
3. Pool resources on neonatal and perinatal audits.

Gender-Based Violence (GBV)

1. Support existing efforts to include SRH in the GBV Area of Responsibility (AoR) and the revised guidelines.
2. Invest in GBV clinical guidance in countries prior to emergencies in order to create a community demand.
3. Gather the evidence on GBV, prevention and clinical care and provide a “one stop-shop” on resources.

Adolescent SRH

1. Engage adolescents
    a. Build capacity of/for youth groups (e.g. organizing, fundraising, quality).
    b. Provide more opportunities to participate/engage.
2. Training:
    a. Develop master trainers for adolescent SRH.
    b. Use lessons learned from MISP/SPRINT training.
    c. Share more info on trainings and focus on Training of Trainers (ToT).
3. Cross-sectoral (in field and in IAWG)
    a. Engage development actors more strongly.

Cross-Cutting Thematic Discussions

The following cross-cutting thematic discussions followed the sub-working group discussions on the afternoon of Thursday, 26 February.

- Quality of Care
- Reproductive Health Data and Research
- Logistics
- Capacity Development
- Urban Contexts

These discussions drew upon the previous sub-working group discussions in order to identify challenges, promising practices and key stakeholders around the cross-cutting themes. Participants were asked to identify three to five priority action and areas of collaboration for 2015-2016, which they subsequently shared with the plenary.

Urban Settings

1. Develop advocacy strategies based on reviews of existing operational guidance.
2. Strategize and develop Information, Education and Communication (IEC) materials.
3. Strengthen financial support to national governments and increase demand-side financing.
4. Ensure that data from HIS feeds into national health systems.

Quality of Care

1. Define Quality of Care in an emergency and identify barriers: funding, institutional capacity, supply chain etc.
2. Create a simple guidance document firmly embed in DRR.
3. Develop a human resources plan template that adequately plans for human resources needs.
4. Develop trainings at pre-service and service level.
5. Create good indicators for quality and develop checklists.
6. Coordinate across all sub-working group to make this successful.
7. Develop one quality indicator tied to each objective of the MISP.

Research and Data

1. Keep members informed of current and recent research.
2. Provide resources to IAWG membership, technical assistance (institutional review boards, methodology, identifying funding opportunities, etc.).
3. Share information on standardized indicators; systems.

Capacity-Building

1. Engage policymakers and academia to support all levels of capacity-building.
2. Further develop surge capacity (coordination capacity).
3. Integrate into DRR efforts and bring development and humanitarian actors together.
4. Think beyond current models for capacity development, and build capacity at the community-level.

Logistics

1. Examine bottlenecks in-depth to identify priorities for the group.
2. Create guidance on transitioning from RH Kits to the national supply chain (guidance note).

3. Update global forecasting guidance from UNFPA.

6A: Looking Outside the Box
Chairperson: Nadine Cornier, UNHCR

Florence Tayzon from UNFPA spoke about the Philippines's vulnerability to natural disasters and an example of how steps have been taken to mitigate that risk. In the Philippines, the Disaster Risk Reduction Management (DDRM) Law of 2010 worked to create a holistic, rights-based approach to DRR. When looking specifically at SRH, the Women's Magna Carta of 2010 and the Philippines's Responsible Parenthood and Reproductive Health (RP/RH) Law of 2012 gave a platform for the integration of the MISP into DRR. Though UNFPA conducted MISP trainings for health service providers and social workers in all 10 UNFPA-assisted provinces, the most comprehensive Philippine Disaster Risk Reduction and Management Law that incorporated SRH services was found in Sultan Karat province. The lead agency, Provincial Planning and Development Office and the Disaster Risk Reduction and Management Office, worked to mainstream and integrate MISP into the Philippine Development Plan, as well as incorporating the MISP into the Government's Annual Investment Plan and other budget sources. By preparing Integration in the form of sustained local funding, teams were able to shift from humanitarian mode during disasters to comprehensive RH services after the disaster.

During MISP implementation the provincial health office (PHO) and the Pangasinan Social Welfare Development Office provided RH medical missions, kit distribution and health, as well as psychosocial support services to reduce STI transmission, sexual violence and maternal and neonatal mortality. Within the disaster rehabilitation and recovery, the MISP objective was to integrate RH services into primary health care through PHO providing integration workshops.

Looking towards the future, challenges remain in the MISP not being integrated into the national health emergency package, the lack of standardization of the MISP module for local government units and a lack of understanding on how to bring MISP to the community or barangay levels. To overcome these hurdles, working towards community level MISP integration, standardizing the MISP II training module and garnering support for the inclusion of the MISP into various national and DDRM protocols can help prepare communities to provide lifesaving SRH care in emergency settings.

Next **Sophie Pecourt representing UNFPA and Lena Luyckfasseel from IPPF Eastern Europe** presented on a *MISP readiness assessment conducted in 18 countries in Eastern Europe and Central Asia (EECA)*. This MISP Readiness Assessment tool was developed by the EECA Regional IAWG in 2013, with a pilot in four countries. An assessment in 18 countries with 90 organizations took place in 2014 and the final results were presented at the EECA IAWG Forum in October 2014. The tool measured indicators describing an ideal state of preparedness to provide the MISP. On average, most of the indicators showed only partial achievement, leaving room for improvement. Results are slightly better for HIV/STIs (linked with the Global Fund for AIDS, Tuberculosis and Malaria in most countries) and MNH (considered "core work" of most SRH specialists). Key findings include:

- MISP Objective 1 – Coordination and Disaster Management System
    - Thirteen of 18 countries have Health Disaster Coordinator with roles and responsibilities shared with the Health Coordinator.
    - Seven countries out of 18 have non-formalized working groups.
    - Eleven countries have no SRH working group.
    - Poor preparedness for safety of medical structures in 2 out of 18 countries.
- MISP Objective – 2 Prevention and Response to Sexual Violence

    - Lack of knowledge of non-medical structures and networks involved in prevention and response to sexual violence at national and sub-national levels.
    - Fifty-five percent of countries have part of the services of MISP Objective 2 planned, other 45% have no such services integrated in a health disaster response plan.
- MISP Objective 3 – Reduction of HIV Transmission and Meeting STI Needs
    - Seventy-seven percent of countries have part of the services of MISP Objective 3 planned.
    - The other 23% have no such services integrated in a health disaster response plan.
    - Only seven of 18 countries have HIV services planned, but no STI services have been planned.
- MISP Objective 4 – Prevention of excess maternal and neonatal mortality and morbidity
    - Fifteen of 18 countries plan for EmONC services.
    - Ten countries include provisions for post-abortion care.
    - Eight countries plan for contraceptive services.
    - Eight countries access a list or mapping of existing 24/7 referral systems.
- MISP Objective 5 – (partial) Planning for comprehensive RH
    - Only five countries have SRH indicators in their HIS.
    - Provisions to use MISP Checklists from the onset of the response are poor.
    - Provisions to measure MISP Indicators from the onset of the response are poor.

Key success factors in this study include the cooperation of Ministries, the UN and NGOs, as well as the endorsement of the tool by the Ministries of Health and country teams maintaining their commitments through the annual EECA IAWG forum.

Next, **Mihoko Tanabe from the WRC** presented the findings from a study looking at the intersection of SRH and individuals with disabilities. Partnering with the IRC in Kenya at the Kakuma Refugee Camp; Association of Medical Doctors of Asia (AMDA) Nepal and organizations of persons with disabilities in Damak, Nepal; and with the Refugee Law Project in Kampala, Uganda. Group activities, individual interviews and focus group discussions were implemented among individuals (aged 15-49 years old) with physical, intellectual, sensory and mental impairments and caregivers/family members to determine specific risks, needs and barriers for refugees with disabilities surrounding SRH. Results showed varying degrees of awareness around HIV and condom use, as well as a range of knowledge around SRH, especially around reproductive anatomy, FP and STIs. Overall, refugees with disabilities, no matter the age or impairment group, showed interest in learning more about SRH. In terms of barriers, provider attitudes were the greatest hurdle to refugees seeking care. Other barriers reported included long wait times, cost, refugee status and lack of accessibility of health services. While the ability of women with disabilities to exercise their SRH rights was mixed, marital status was a large factor in determining treatment of women who became pregnant. Pregnant women also reported discrimination by medical providers and increased instability in their relationship with their partner. In terms of safety, high risk areas for sexual violence in Kenya were the bush and latrines, the forest and jungle in Nepal and toilets and the neighborhood in Uganda. Participants expressed desire for increased training of health providers, retaining sign language and other interpreters at health facilities, as well as the creation of a space for peer learning and SRH awareness activities. Suggestions for the future include incorporating disability inclusion in current programs and supporting agencies to empower refugees with disabilities.

Lastly, **Sathyanarayanan Doraiswamy from UNHCR** spoke on UNHCR's work screening pre-cancerous lesions of the cervix in Uganda. As the rate of cervical cancer rises and maternal mortality decreases,

UNCHR has become increasingly committed to cervical cancer prevention. From a foundational level, fostering healthy lifestyles and providing the Human Papillomavirus (HPV) vaccine form the basis of prevention. Beyond this foundation, screening, pre-cancer detection and treatment are considered the secondary or tertiary levels of prevention. For Uganda, cervical cancer is the first cause of female cancer deaths, with around 2,275 new cervical cancer deaths annually. As the most common form of female cancer in Uganda, combatting cervical cancer is addressed through advocacy to include refugees in national HPV vaccination campaigns, training of service providers in screening, procurement of necessary equipment, as well as referral care. Implementing these interventions allowed 13,539 girls to be vaccinated in 2014, as well as 1,330 women to be screened and 35 women receive treatment. Challenges to providing these services concerned monitoring the intervention and determining how to scale up the project. A lack of supplies and staff turnover also created barriers to implementation. Cervical cancer prevention interventions are possible in refugee settings, with the assistance of partnership organizations and the knowledge that inclusion of refugees in national cancer programs creates added benefit to the whole program.

Discussion:

- *A panelist shared applauded the work in the Philippines and shared that the Women's Refugee Commission has developed a curriculum on integrating gender and SRH into DRR at the community level. The organization is piloting the curriculum in the Philippines, which has a very robust RH and DRR effort at the national level.*
- *A panelist asked about the cost of disability inclusion amidst competing priorities in emergency settings. The presenter shared that some refugee settings have documented high numbers of persons with disabilities reporting cases of sexual violence. Further, disability inclusion can be done within existing programs, especially addressing providing attitudes and making specific accommodations.*

Session 6B: Emerging models and tools from Humanitarian SRH field
Chariperson: Jaya Samuel, IPPF-SPRINT

Jennifer Miquel from UNFPA presented on the development of safe spaces for women in Jordan, Iraq, Lebanon, Turkey and Syria. Defined as a formal or informal place where women and girls feel physically and emotionally safe, safe spaces were created as women have limited access to meeting spaces and services. To create a safe space, an initial assessment of the community must occur to tailor services to the needs of the community and guarantee the safety and accessibility of the center. Beyond the assessment, staffing and services are implemented and monitored, with the end goal of placing the women's safe space in the hands of the community. The process was operationalized differently in Syria, Turkey, Lebanon, Iraq and Jordan. Partnering with existing organizations, UNFPA in Syria provided safe spaces in RH clinics. Women who attended the clinics preferred social workers from the community, but from different camps or towns. Alternatively in Iraq, UNFPA ran existing safe spaces. UN Women also provided economic empowerment expertise, such as providing women with the skills to make and sell clothing. Women in these communities also preferred social workers to come from the community, but from the same camp. Finally, UNFPA in Jordan initially performed a safety audit and partnered with existing organizations to allow for an easier transition to the community running the safe spaces. By tailoring services to the specific locations, women reported a decrease in stress and anxiety, as well a general sense of support and access to necessary material goods.

Kate Morris from Save the Children presented on the effect of supportive supervision on key program indicators and on FP and PAC service delivery from Save the Children and the MOH's project in the

Democratic Republic of the Congo (DRC). Since 2011, Save the Children and the MOH have worked to increase access and utilization of FP and post-abortion care services for IDPs and host families in North Kivu. Within the DRC, the contraceptive prevalence rate is 8%, and 28% of married women have an unmet need for FP. To provide FP and PAC services, the key program components have focused on offering competency-based training to all MOH providers and Save the Children staff to provide a complete method-mix of modern contraceptives and link individuals to quality comprehensive PAC services. Currently, 40 facilities provide FP methods with 2 trained MOH providers at each facility. As of 2015, there were 28,000 new FP acceptors and over 2,000 PAC clients. A supportive supervision model is in place to monitor program implementation, offer constructive feedback and on-the-job training to service providers. Save the Children staff, nurse supervisors are trained to provide supervision with a MOH representative. Though challenging due to security and motivation issues, the goal is to provide monthly visits to all health facilities. Reports and findings are written up to provide a qualitative component to monthly data.

In terms of feedback, results from 415 exit interviews showed that overall, clients were very satisfied, with a correlation between themes of supervision and areas of client satisfaction. Currently, the focus is on creating a tool to allow supervisors to better track needed supervision visits, routinely evaluate services provided in challenging locations, create incentives for supervisors, create support for the supervisors, and finally, to develop new supervision themes. Looking towards the future, Save the Children plans to conduct further research around supportive supervision and the impact on services.

Next Hannah Tappis from Jhpiego / Johns Hopkins Bloomberg School of Public Health presented on UNHCR's RH Scorecard. The balanced scorecard approach is a common performance management tool in a variety of fields, ranging from business to education and health care. Balanced Scorecards have been used to measure and manage both health service and public health programs in a variety of settings. In 2010-11, UNHCR collaborated with Johns Hopkins Bloomberg School of Public Health's Center for Refugee and Disaster Response (JHSPH) to develop a Balanced Scorecard to assess the quality of care provided in primary health care facilities in refugee camps, which has been successfully implemented in twelve countries. In 2014, UNHCR identified r RH as an area where additional monitoring and evaluation of services is required, and partnered with JHSPH to develop an RH Scorecard to supplement to the existing Balanced Scorecard. Indicators were developed based on UNHCR guidelines for RH programming, and aligned to the extent possible with the WHO's Service Availability and Readiness Assessment (SARA) tool and recommendations of the 2013 Consultation on Improving Measurement of the Quality of Maternal, Newborn and Child Care in Health Facilities and 2014 Every Newborn Action Plan. Draft data collection tools were then developed and field-tested in October-November 2014. General findings from the field-test in Thailand and Rwanda include:

- The RH Scorecard is an effective and acceptable method for assessing the quality of services in protracted refugee settings.
- Overall service quality in the two refugee settings is good, but areas that need attention vary across and within countries.
- Detailed results (sub-items for each indicator) may not be reported in the scorecard, but are important for programming.

Recommendations for implementation include:

- Take time to review tools in advance.
- Carefully consider selection of data collectors to minimize bias and maximize learning opportunities.
- Practice observations.

- Encourage data collectors to work in pairs.
- Consider including assessment as part of routine program review (1x/year or more).

For additional information about the UNHCR Balanced Scorecard Toolkit, please visit http://twine.unhcr.org.

Michelle Dynes from U.S. Centers for Disease Control and Prevention presented an evaluation conducted in Haiti on handheld solar lights for internally displaced individuals in two camps between August 2013 and April 2014. The evaluation of the use and benefits for handheld solar lights was the product of the US National Action Plan's focus on addressing GBV in humanitarian settings. Through household surveys, direct observations and focus group discussions, the IRC in collaboration with the US government, evaluated the impact of the handheld solar lights. They asked women about their activities outside of the home at night and were able to compare changes in activities from baseline and endline. They found that more women and girls in both camps had greater odds of reporting going out at night to buy goods at endline compared to baseline and that there were greater odds of reporting going out at night for personal reasons, such as using the latrine, at the endline compared to the baseline. Generally, it was found that within the camps there is a need to improve the physical camp environment in order to affect the security and safety of women and girls, as well as more closely monitor protection issues. Donors and humanitarian organizations should increase their support towards the handheld solar light distribution.

Discussion

- Since staff retention is important, did that come into play in the supportive supervision project in DRC? Was that an issue and if not, what played a role in keeping staff?

The panelist answered that staff retention is always an issue; poaching happens, but for the most part, staff have stayed.

- Which protocol do you apply to PAC—local or national in DRC?

The use of misoprostol depends on the clinic; Save the Children stayed within national framework for PAC.

- In the CDC solar light project, were GBV cases assessed in the setting before starting implementation of evaluation. It would have been good to see if there was a difference from beginning to end.

Dr. Dynes reported that no, as a first step, this project aimed to see if women would use the lights, and if the lights would last. There is little research on lighting and how it helps women and girls. It is challenging to obtain the most relevant data. The study examined perceptions of safety rather than actual safety. Moving forward, research can connect lighting to violence. Anecdotally, women shared that when they shone a light down a path and saw a group of men, they would go down a different path.

- Why were certain indicators selected for the RH Scorecard?

UNHCR did not want to limit indicators to the MISP, but selected indicators following global standards and what is measurable in low resource settings. The indicators were selected to understand quality of services, and for implementing partners to use to advocate for funding.

- Is this a useful tool?

It was tweaked so teams can use it in participatory way and tie it in with action planning.

Session 7A: Increasing Access to LARC and EC
Chairperson: Nancy Harris - JSI, Inc.

Dr. Harris opened the session by mentioning that the International Conference on Family Planning will be in Indonesia in the fall of 2015, with youth and faith-based programs as two major themes. JSI, Inc. is leading efforts to secure a UNHCR tent to highlight what it is like to be a refugee. She hopes this exhibit will attract FP donors and others working in the development sector to engage more in humanitarian settings.

Faduma Gure from the University of Ottawa presented on an *Assessment of Awareness and Needs of Emergency Contraception (EC) in Post-conflict Somalia*. The study found a notable lack of awareness of EC: Only 2 out of 10 key informants and 1 out of 20 pharmacists interviewed were aware of EC. Similarly, focus-group discussions among women revealed no knowledge of EC. However, once the idea was explained, women shared broad support for this method across all groups. EC has the potential to fill a major gap in Somalia; however, no registered product is currently available. Some pharmacists believed that higher illiteracy rates would prevent women from being able to accurately take the Yuzpe method in the absence of a dedicated EC product, but also noted that the general lack of regulations in Somalia might in fact facilitate EC availability. Ms. Gure noted that while there is no clear opponent to EC and no pervasive rumors or misconceptions, there is a lack of knowledge and no clear champion in Somalia. Dr. Harris closed by noting that this presentation was a good example of how one can conduct strong research *and* awareness raising at the same time.

Next **Dr. Abdelhadi Eltahir from the International Rescue Committee** presented on a *Program to Increase Access to EmOC and Long-term and Permanent FP methods in Kiryandongo Refugee Settlement Camp in Uganda*. In April 2014, IRC conducted a rapid RH assessment, followed by an emergency RH response in May 2014. The objective of the emergency response was to support implementation of the MISP by strengthening the capacity of three health facilities in the Kiryandongo settlement and the referral hospital. In order to stimulate demand and awareness of improved safe delivery and FP services, the IRC Identified 40 refugees to become Village Health Team (VHT) members who were trained in community outreach. The VHTs conducted RH education sessions, mapped pregnant women and referred women to the appropriate facilities. As a result, the proportion of women delivering in a health facility increased from 42% pre-intervention to 62% in December 2014. Between May and December, the program received 638 new FP acceptors, and 41% of those new acceptors adopted a long-term or permanent method (LTPM). Early challenges included stock outs and low levels of staff competency in LTPM and EmOC. The program found that an initial investment in FP commodities, staff and infrastructure was needed to jump-start the program, followed by community outreach to stimulate demand and dispel common misbeliefs. Dr. Hadi also noted that MoH support and buy-in and strong partnerships with other agencies on the ground was critical to success.

Lastly, **Minnnie Sirtor Bowier from JSI, Inc.** presented on the *Interim Approach (IA) for Health Commodities Distribution in Liberia*. During the EVD epidemic, Liberia was hit very hard and struggled to implement the National Supply Chain Master Plan (SCMP), which provided accountability for commodities, commodity security and data availability for decision making. This led to the development

of the interim approach (IA), a modified top-up commodities distribution system in which a team of health care workers determines quantities of commodities based on physical inventory at the facility to then develop logistics data reports. The IA can ensure commodity security, accountability, transparency and availability of data for decision making in the absence of the SCMP. The IA was used during the EVD outbreak with modifications, including use of PPE during commodity delivery, and limited entry into health facilities. The IA had a tremendous impact on the health system. Despite many challenges, the IA resulted in consistent decline in stockout rates, greater visibility of data and greater accountability.

Discussion

The discussion that followed the panel presentation focused on EC. Sandra Krause from the Women's Refugee Commission noted that the IAWG Global Evaluation found that EC continues to be a major gap in humanitarian settings, and that the International Consortium for Emergency Contraception (ICEC) is a new associate member of the IAWG. Ms. Gure mentioned that in Mogadishu, an NGO contracted women to visit house to house to raise awareness about breastfeeding and basic hygiene. The model could serve useful to raise awareness of EC and the Yuzpe method, if further developed and is funded. Ms. Gure further noted that her study looked at the availability and awareness of FP services in Mogadishu, and very low levels of availability and awareness were found.

Dr. Harris closed by advocating that agencies use the lessons learned from these presentations in their own FP programs. For example, they should make sure to include EC, consider strengthening the forecasting of commodities to avoid stock-outs, and ensure that programs engage the community.

Session 7B: Quality and Creative Interventions to Enhance Utilization of MNH Programs in Emergency Settings
Chairperson: Sarah Ashraf, Save the Children

Hannah Tappis from Jhpiego, on behalf of UNHCR and CDC, presented the results of *Verbal Autopsy Studies in Farchana Camp in Chad and Nyarugusu Camp in Tanzania*. The study looked at neonatal mortality in post-emergency refugee camps and measured the causes and risk factors of mortality. Specifically, the team wanted to know the proportion of neonatal deaths that were captured by UNHCR's HIS, the main contributing factors related to neonatal deaths, and ways to improve neonatal health programming. Using the WHO verbal autopsy tool, trained clinicians identified births and deaths using capture-recapture methodology, listing all "probable" or "highly suspect" neonatal deaths. The study team identified 25 and 20 probable or highly suspect deaths in Chad and Tanzania, respectively. Using the study outcomes, the team developed operational guidelines. The issue now, with clinical and operational guidelines, field manuals and tools, is how to best put this into practice. As 2015 is "The Year of the Newborn," the IAWG can help accelerate reduction of preventable newborn deaths.

Sathya Doraiswamy from UNHCR presented on *Caesarean Section (c-section) among Syrian Refugees in Lebanon*. A highlight of the Syria crisis is a very high c-section rate (45-60% vs. WHO's recommended 5-15%). Of the 1.1 million Syrian refugees in Lebanon, UNHCR is supporting 75% of total delivery services. This study examined unmet and excess c-section rates among the Syrian population supported by UNHCR in Lebanon. Between December 2012 and June 2013, c-sections accounted for 35.3% of deliveries; despite qualitative findings showing that women preferred normal deliveries. Furthermore, c-section rates were higher in public hospitals. Service providers cited low ANC coverage and higher rates of complications as reasons for the high rates. The study found that the decision was often prompted by lack of adequate female service providers and the automatic financial guarantee associated with c-

sections. Following the study, UNHCR developed a standard ANC and PNC package and introduced a clearance procedure; whereby, a company was contracted to pre-approve every planned C-section. Preliminary follow-up showed a declining trend. UNHCR concluded that the pre-existing, highly privatized health care system was resulting in expensive health care delivery for refugees. SOPs can help to rationalize c-section rates, and future studies should compare c-section rates to the national rate.

Next, **Dr. Syed Rizwan Ali from the IRC** presented on the use of *Misoprostol to Improve Client Access and Choice for PAC in Nowshera District, Pakistan*. Pakistan's maternal mortality ratio is 276 maternal deaths per 100,000 live births, with 6% of all maternal deaths caused by complications of unsafe abortion. Since 2011, IRC Pakistan has been supporting 41 health facilities in the crisis-affected Nowshera District to reduce unintended pregnancy and address risk of injury and death from abortion complications. Key elements of the program include building staff capacity; ensuring zero stock outs of FP commodities and PAC supplies; and increasing demand for long-acting FP services and PAC. The program ensures 24/7 availability of services at select health facilities and has trained staff to replace Dilation and Curettage (D&C) with the WHO-standard, manual vacuum aspiration (MVA) for PAC. In 2014, the IRC supported all facilities to offer misoprostol as an option for treatment of incomplete first trimester abortion. Provider capacity to counsel and administer misoprostol for PAC was an initial challenge, as well as the low understanding of the legal context. Another challenge was client apprehension around efficacy of medical abortion compared with MVA. Initiating the use of misoprostal involved a multi-pronged strategy that included advocacy, capacity-building, improved quality of counseling and follow-up, as well as addressing attitudes and biases. Since the initiation of the program, 431 of 680 PAC clients chose misoprostal. The initial experience resulted in high rates of acceptability and satisfaction among clients. Use of misoprostol is simple, cost-effective and can be implemented in settings with high rates of abortion-related mortality. Misoprostol can increase access to and uptake of PAC at lower level health facilities. FP counseling must be strengthened for all PAC clients and tailored to those patients treated with misoprostol versus MVA.

Lastly, a representative from **WARDI Relief and Development Initiatives** presented on *Emergency Preparedness and Response for Pregnancy and Childbirth Complications through the Use of Maternity Waiting Homes in South and Central Somalia*. In 2012, WARDI, in partnership with UNFPA, supported a project to establish seven maternity waiting homes in Mogadishu and Hiran regions. Health promoters were hired to provide counseling and enroll pregnant women. Midwifes provided safe delivery in the maternity waiting homes or referred complicated cases to the hospital. A community health care committee was responsible for selecting the health promoters and providing logistical support for referrals. From January 2014 to January 2015, the maternity waiting homes provided 8,817 consultation for pregnant women—an increase of 25% from 2013. In total, 2,630 women delivered at a maternity waiting home, while 220 pregnancy and childbirth complications were identified and referred for further management and care. The presenter closed with a quote from a religious leader from the Rabitug/Nafis IDP camp: "*The number of funerals I have administered after this maternity waiting home came to our settlement has reduced very much, which is a clear show of the positive change that has been created by the project*"

Discussion

In Syria, c-section rates have reached 60%, which may be over-weighted by security concerns. In Jordan the c-section rate is 17%; a clear disparity exists among Syrian refugees. In Lebanon, there was an over medicalization, private sector approach that existed before the emergency and was extended to refugees, possibly increasing the rates.

The presenter shared that the success of misoprostol for induced abortion is 80%, as providers gain confidence as efficacy increases. The time limit used to assess efficacy in the IRC Pakistan program was three days. FP uptake was an important indicator for this program. If the client does not come back within seven days, they are considered a lost patient in terms of measuring indicators.

A participant shared that Save the Children has good experience with maternity waiting homes and suggested pulling from the organization's experience to measure lives saved by the maternity waiting home intervention in Somalia. The participant suggested moving waiting homes to health facilities, which may be more relevant in some communities.

Session 8: Community Engagement
Chairperson: Kamlesh Giri, Care International

The first presentation was from **Maryline Nyaboda from IMC** on *Improving Access to Maternal and FP Programs through Community Participation in Wau, South Sudan*. South Sudan has many challenges due to the civil war, and there is limited acceptance of FP services. Various cultural barriers exist, including the preference of women to deliver at home and the need for their husband's approval to use FP. The project aimed to increase access to quality RH services including FP, EmOC, adolescent SRH and other maternal health services. It also aimed to increase human resource capacity to satisfy unmet RH needs and expectations. The project components included:

- Renovation of health facilities for women to access ANC and safe deliveries.
- Capacity building of health workers.
- Equip health facilities to provide minimum standards of RH services.

Next, **Ashley Wolfington from IRC** presented on behalf of Jessica Kakesa on *Communication and Service Campaigns to Increase Uptake of Modern Contraception in South Kivu, DRC*. The overall objective of the program was to increase the demand and use of services of FP in North and South Kivu. Unmet need is estimated at 25%), while the contraceptive prevalence rate (CPR) nationally is at 8%. IRC has worked in North Kivu to increase the use and quality FP and PAC services in four zones in eastern DRC. Although the facilities existed services were offered, providers were trained and community outreach was completed, IRC saw very few FP acceptors per month from June 2011 to March 2013.

In 2013, IRC began working with the MoH on behavioral change communication (BCC) strategies to raise awareness of FP. Staff began raising awareness in churches about health benefits of FP, developed radio messages and worked with the local radio stations and theater groups i to dispel myths. IRC further made sure that health center staff were dedicated to FP services on campaign days and increased contraceptive stock in anticipation of demand. IRC worked very closely with the MoH in order to provide these services. As a result, the uptake of FP increased greatly from June 2011 to January 2014.

Next **Nadine Cornier from UNHCR** presented on *SRH Care and Protection for Sex Workers and Sexually Exploited Children in the Humanitarian Context of Masisi, DRC*. This project took place in four IDP camps in Masisi health zone, alongside the local population. Sex work is often a means for displaced girls and women to meet their socioeconomic needs; however sex-work under the age of 18 is defined as sexual exploitation. During UNHCR's pre-project assessment, 86% of participants had never been tested for HIV. Women and girls knew very little about HIV, even though they were sexually active with multiple partners and often not using condoms. The subsequent project was designed to address the problems associated with sex work and sexual exploitation, taking into account both medical and protection aspects of the intervention.

The project employed a peer-led approach (UNHCR did not hire anyone and only worked with and through sex workers). This type of project requires sensitization and buy-in; hence it cannot be rushed. The intervention took place in the general population and employed a multi-functional team (i.e. protection workers, health workers, beneficiaries, sex workers etc.).

Challenges included numerous local languages and the need to carefully translate key messages and appropriately deliver them to clients; very low client acceptance of condoms; and the presence of sometimes violent clients. However, there were also opportunities and achievements. Awareness was raised for 880 sex-workers and sexually abused children. Twenty-four sex workers are expected to graduate as SRH promoters. Sex work and sexual abuse will always exist in humanitarian settings; it is important to empower women and girls and create innovative, appropriate and adapted solutions, recognizing the power of peer education.

Lastly, **Felipe Rojas Lopez from Save the Children** presented on designing a community mobilization strategy to increase uptake of FP and PAC services in North Kivu, DRC. Save the Children supported 40 facilities; however the organization had no systematic strategy for community engagement. The objective of the project was to increase knowledge and uptake of PAC and FP services by emphasizing training, management and focalized messaging to the community.

Training on theoretical basis, discussion techniques, community engagement and messaging was implemented among CHWs, satisfied clients, peer educators, community leaders and TBAs. Messages were targeted to sub-populations in a variety of languages. Sub-population included women, men, adolescents and pregnant and lactating women.

Conclusions and lessons learned include the importance of involving all relevant actors; creating specific messages per target group; aadapting to the context; and coaching, motivating and following-up after trainings.

Plenary Discussion - Identifying Key Themes and Priorities for 2015-2016
Chairperson: Toan Nguyen Tran

Dr. Nguyen shared that in 2004, awareness of the MISP was very low in the field, but ten years later a change has been observed. In the coming years, the RH community needs to consolidate successful strategies, initiatives and programs. The community needs to create space for effective referrals, linkages and partnerships, and put the needs and rights of affected populations at the core. To do so may require pushing the boundaries within organizations, challenging funding competition and securing agency visibility.

The key priorities for IAWG for the coming year include:

- A reliable steering force supported by multi-year predictable funding and dedicated human resources.
- Improved coordination, including through the IAWG secretariat, the surge capacity roster of SRH coordinators, new partnerships with development agencies and national partners, among others.
- Empowering and equipping local, regional and global partners by systematical engaging communities in all program phases, through DRR and emergency preparedness; reviving the IAWG capacity development partnership initiative; and strengthening and better supporting regional IAWGs.

Dr/ Nguyen invited participants to contribute to our wall of reflection. Submissions can be found in Annex I.

Discussion

A participant commented that FP needs to be repositioned within the MISP. There is a need to learn how to put FP into practice in emergencies in culturally sensitive ways, and to focus on quality of care. Humanitarian situations are becoming chronic, better support is necessary to transition from the MISP to comprehensive RH.

Other participants shared that the IAWG community should:

- *Hold a donor meeting to think creatively about how to move gaps and solutions forward.*
- *Consider developing a communications strategy to support fundraising efforts for IAWG.*
- *Secure dedicated IAWG staff at the regional level.*

Closing from Margaret Pollack – U.S. State Department, Bureau of Population, Refugees and Migration

Ms. Pollack began by commending the IAWG Steering Committee and leaders of the sub-working groups for organizing a successful meeting, thanking them for volunteering so much of their time to this effort. She also thanked the Jordanian hosts for their warm welcome and noted that PRM was happy to be able to provide financial support for this meeting and ongoing financial support for the secretariat. Ms. Pollack noted that the current administration is firmly committed to the protection and empowerment of women and girls and understands the importance of universal access to SRH services. Over the past six years, the US government has increased funding for RH in both development and humanitarian settings. The Safe from the Start Initiative is helping to build core capacity of partners to address GBV from the earliest days of an emergency. PRM is leading the Call to Action and hopes this will be a vehicle for including SRH in emergencies. While we should celebrate the tremendous progress made on the Millennium Development Goals, MDG 5 still lags behind. Addressing MDG 5 is even more challenging in emergency settings. Ms. Pollack shared that she applauds IAWG's advocacy to date and encourages the IAWG to accelerate efforts to include crisis-affected populations in the post MDG agenda.. She further mentioned that she is happy to see IAWG continue to formalize its structure, and she applauds the IAWG's long-standing efforts to raise awareness of the MISP and conduct trainings to strengthen capacity. Ms. Pollack closed by encouraging participants to build upon the learning and partnerships developed at this meeting in the coming year.

Closing from Wilma Doedens

Dr. Doedens shared that rich and diverse presentations were made during the three days, which will inspire us when we return to our work. We have made new friends and reconnected with colleagues. We should not hesitate to keep these relationships alive after the meeting. Dr. Doedens encouraged: IAWG is not merely a handful of agencies on the Steering Committee, IAWG is you, IAWG is us – reach out with your challenges, share your ideas, and initiate new programs. She closed by thanking UNFPA for hosting and organizing, particularly on such short notice; PRM for funding the meeting and for its long-standing support of the IAWG; the IRC and the Women's Refugee Commission for helping with the

meeting logistics and planning; the translators and the Kempinski staff, and lastly the participants for making the meeting so successful.

ANNEX I: