UNIT 2: ENSURE THE HEALTH SECTOR/CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP

Coordination of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) activities as part of the overall health sector/cluster response is essential at multiple levels, including within each agency responding to the emergency, as well as at sub-national, national, and international levels. Coordination within and among these various levels and across sectors is crucial to ensure the effectiveness of the SRH response. This is because coordination helps to identify and fill gaps in service delivery, prevent overlapping programming, strengthen advocacy, and support the application of standards and accountability to ensure crisis-affected populations access to lifesaving SRH services.

From the beginning of the response in each humanitarian setting, the health sector/cluster must identify a lead SRH organization to ensure coordination. This can be the Ministry of Health, a United Nations agency, and/or a national or international nongovernmental organization (NGO). The nominated organization, which is the one identified as having the greatest capacity to fulfill this role, immediately dedicates a full-time SRH Coordinator for a minimum period of three to six months. The SRH Coordinator provides operational and technical support to health partners and facilitates coordinated planning to ensure the prioritization of SRH and the effective provision of MISP for SRH services. It is important that this individual has sufficient technical knowledge of all MISP for SRH components and coordination skills to provide this support.

At the end of the unit, learners will be able to:

- describe the importance of having a lead SRH agency and SRH Coordinator and
- identify the roles and functions of the SRH Coordinator.

MISP for SRH objectives and activities

ENSURE THE HEALTH SECTOR/CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services;
- hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP;
- reports back to the health cluster, gender-based violence (GBV) sub-sector/cluster, and/or human immunodeficiency virus (HIV) national coordination meetings on any issues related to MISP implementation;
- in tandem with health/GBV/HIV coordination mechanisms, ensures mapping and analysis of existing SRH services;
- shares information about the availability of SRH services and commodities in coordination with the health and logistics sectors/ clusters; and
- ensures the community is aware of the availability and location of SRH services.

What are the activities of the SRH Coordinator?

At the onset of a humanitarian response, the health sector/cluster must identify a lead SRH organization. The lead SRH organization should then put into place an SRH Coordinator who functions within the health sector/cluster.

The following are broad terms of reference to be undertaken by the SRH Coordinator:

SRH Coordinator: Terms of Reference

The SRH Coordinator is responsible for supporting health sector/cluster partners to implement the MISP for SRH and plan for the provision of comprehensive SRH services. The SRH Coordinator's role is to:

- coordinate, communicate, and collaborate with the health, GBV, and HIV sector/ cluster/actors and actively participate in health and other intersectoral coordination meetings, providing information and raising strategic and technical issues and concerns;
- host regular SRH coordination meetings at national and relevant sub-national/ regional and local levels with all key stakeholders, including the Ministry of Health, local and international NGOs (including development organizations working on SRH), relevant United Nations agencies, civil society groups, intersectoral (protection, GBV, and HIV) representatives, and community representatives from often-marginalized populations, such as adolescents, persons with disabilities,

and lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) individuals to facilitate implementation of the MISP for SRH;

- compile basic demographic and SRH information of the affected populations to support MISP for SRH advocacy, implementation, and planning for comprehensive SRH service delivery;
- identify, understand, and provide information about the elements of national and host-country policies, protocols, regulations, and customary laws that:
  - support SRH services for the affected population and
  - create barriers and restrict access to SRH services;
- with health, GBV, and HIV coordination mechanisms, support a mapping exercise/situation analysis of existing SRH services (including specialized local service providers that are already working with sub-populations such as LGBTQIA individuals and those engaged in sex work); identify SRH program needs, capacities, and gaps; and conduct a planning exercise in coordination with all relevant stakeholders for effective, efficient, and sustainable SRH services;
- support health partners in seeking SRH funding through humanitarian planning processes and appeals, including the flash appeals process (Central Emergency Relief Fund [CERF] and Country-based Pooled Funds) and the Humanitarian Response Plan, in coordination with the health sector/cluster;
- provide technical and operational guidance on MISP for SRH implementation, as well as orientation for health partners on the MISP for SRH, Inter-Agency Emergency Reproductive Health (IARH) Kits,[31] and other resources; and
- support coordinated procurement and distribution of IARH Kits and supplies, support partners in basic data collection on consumption of supplies and plan for long-term, stable SRH procurement and distribution systems.

The SRH Coordinator works within the context of the overall health sector/cluster coordination mechanism to obtain and use information to:

- ensure MISP for SRH services are monitored to facilitate quality and sustainability; utilize the MISP for SRH Checklist (see Appendix B) to monitor services;
- ensure regular communication among all levels and report back on key conclusions and challenges requiring resolution to the overall health coordination mechanism;
- collect and apply service delivery data, analyze findings, identify solutions to service gaps, and plan for the provision of comprehensive SRH services;
- facilitate planning meetings with all stakeholders to identify synergies, needs, gaps, and opportunities; and
- support the establishment of client-centered comprehensive SRH services as soon as possible and within three to six months of the onset of the emergency.

31 See Unit 9 for more information about IARH Kits.

Adolescents

The MISP for SRH may not address all adolescents' needs, and it may not be possible to incorporate all adolescent SRH principles when implementing the MISP for SRH. Given this situation, the SRH Coordinator should meaningfully engage adolescents in SRH coordination, project design, and implementation and should support the provision of adolescent-friendly SRH services. One helpful resource to refer to is the *Adolescent SRH Toolkit for Humanitarian Settings* developed by Save the Children and the UNFPA for additional guidance on the establishment and provision of adolescent-friendly MISP for SRH services.[32] See Appendix E for an updated version of the adolescent-friendly SRH service checklist from the toolkit.

Why is putting an SRH Coordinator in place a priority?

Evidence shows that without appropriate technical expertise and coordination to support the SRH response, the critical services of the MISP for SRH are often ignored, deprioritized, or isolated in their implementation.

Who should participate in SRH working group meetings?

Regularly hosting SRH coordination meetings is one of the responsibilities of the SRH Coordinator. Relevant actors in the humanitarian health response should participate in these meetings, including:

- the Ministry of Health and any other relevant ministries;
- local and international development, humanitarian, and civil society organizations and private sector actors with SRH expertise and experience;
- donors;
- the protection working group or cluster and its GBV Area of Responsibility;
- representatives from the affected communities; and
- United Nations agencies, such as the United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), United Nations Office on the Coordination of Humanitarian Affairs (UNOCHA), and the World Health Organization (WHO).

As partners in the coordination mechanism, agencies are responsible for raising SRH-related issues for discussion within the overall health sector/cluster meetings.

32 *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Save the Children and UNFPA, September 2009), https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf.

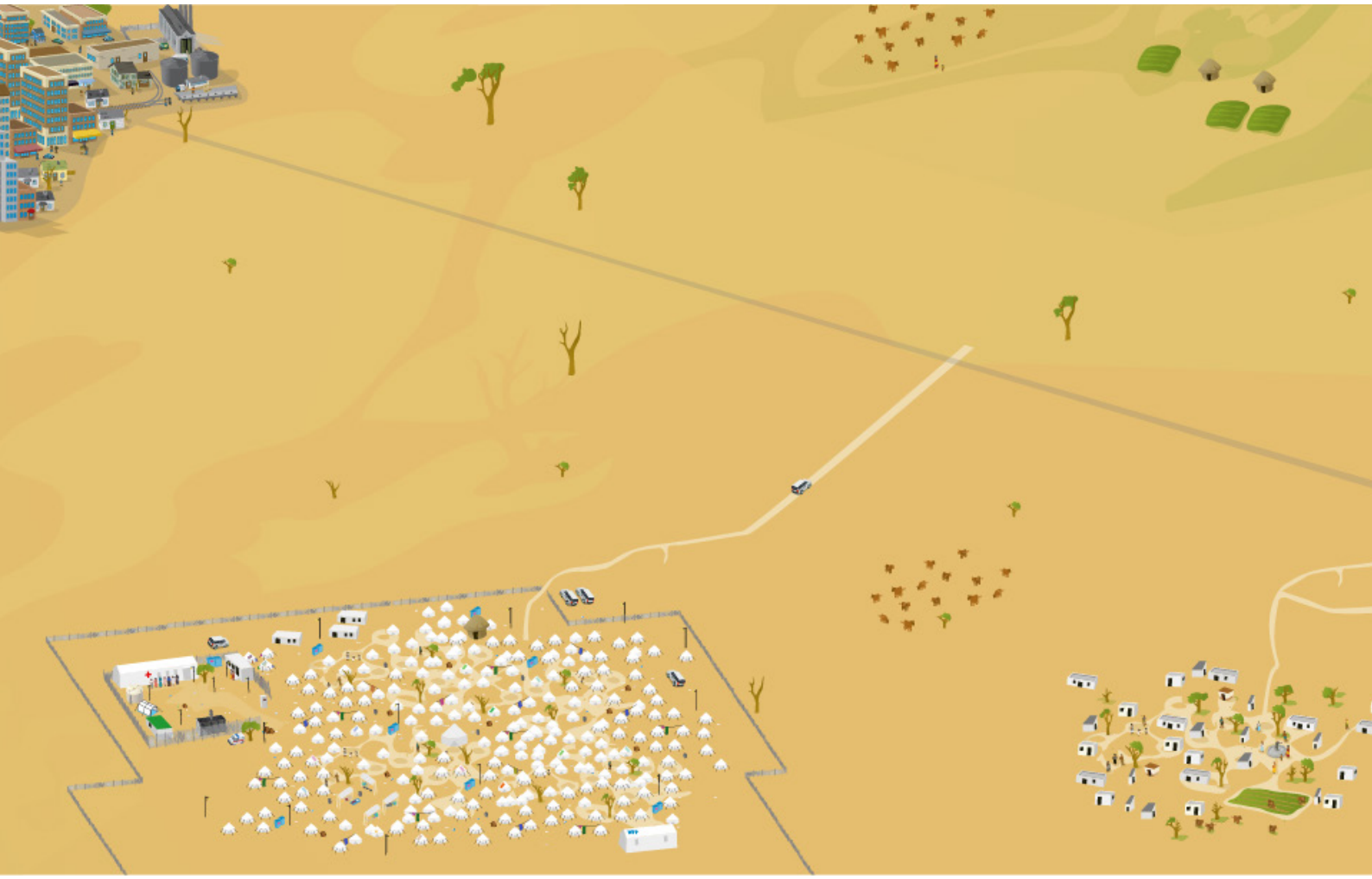
SRH coordination at the national and sub-national levels

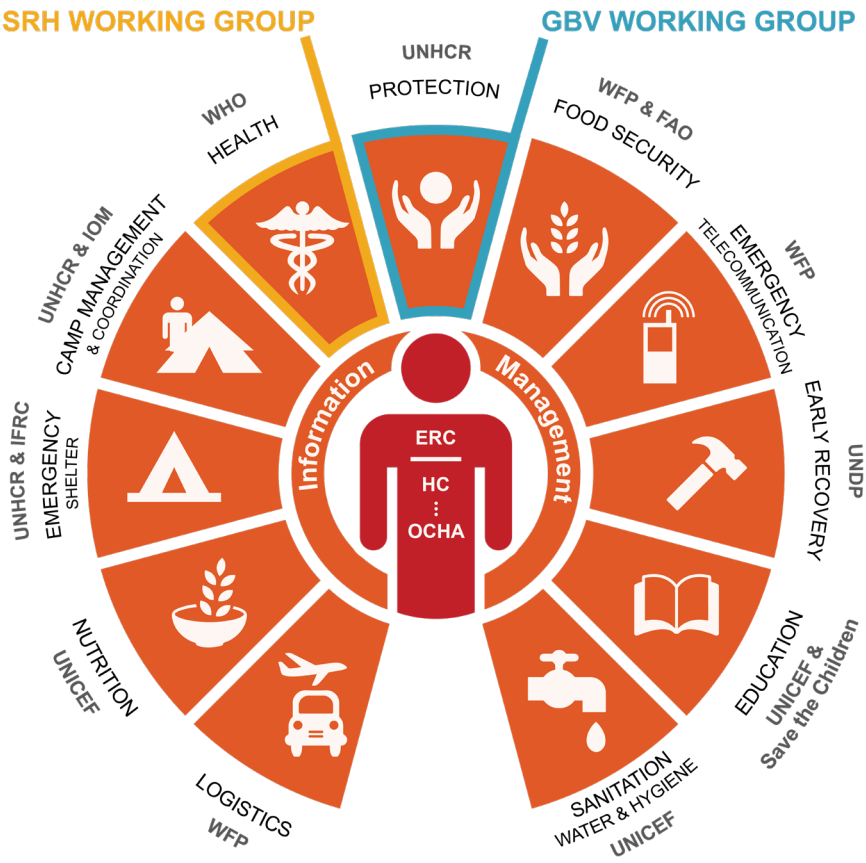
In order to understand SRH coordination at the national and sub-national level, it is important to remember that coordination mechanisms in a refugee setting are different from those in an internally displaced populations setting.

- If you are operating in a **refugee setting**, UNHCR is responsible for the overall coordination of the response.
- If you are operating in an **internal displacement setting**, UNOCHA is responsible for the overall coordination using the 'Cluster Approach' (described on page 26).

While these coordination structures differ operationally, it is important to remember that the obligations for partners to ensure the implementation of the MISP for SRH at the onset of every emergency remain the same.

For more information on the differences between the coordination mechanisms of refugees and internally displaced populations responses please see the *Building A Better Response* training on humanitarian coordination (https://www.buildingabetterresponse.org) or go to the UNOCHA and UNHCR websites.





Source: "What Is the Cluster Approach?" Humanitarian Response, accessed April 8, 2019 https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach.

Global cluster lead acronyms	
FAO	Food and Agriculture Organization
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
OCHA	Office for the Coordination of Humanitarian Affairs
UNAID	Joint United Nations Program on HIV/AIDS
UNDP	UN Development Program
UNEP	UN Environment Program
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
WFP	World Food Program
WHO	World Health Organization

Note that at the national level, responsibility for leadership and coordination may be placed with different agencies that have more competencies on the ground.

What support does the SRH Coordinator need?

The SRH Coordinator should be supported with administration, communications, and logistics personnel to:

- help arrange SRH coordination meetings;
- identify and ensure meaningful inclusion of local civil society groups including networks and organizations representing women, adolescents, LGBTQIA individuals, people living with disabilities, and other crisis-affected community members;
- maintain and post meeting minutes;
- share situational updates, trainings, and related resources; and
- work with the health and logistics sectors/clusters to order, stockpile, and distribute SRH supplies.

Useful MISP for SRH-related resources for the SRH Coordinator and others can be found at iawg.net.

What are some of the attributes of strong and successful SRH coordination meetings or working groups?

Strong and successful SRH coordination meetings or working groups:

- have agreed-upon terms of reference (focused on implementing and building upon the MISP for SRH);
- are well-facilitated and used for strategic planning and problem-solving to ensure service coverage of the MISP for SRH;
- have active engagement of the Ministry of Health in leading or co-leading the coordination effort;
- are advertised to all stakeholders and open to all relevant agencies and members of affected communities—including representation from often-marginalized populations (e.g., adolescents, persons with disabilities, LGBTQIA individuals);
- are held in an accessible location and hosted on a regular basis—usually once per week at the onset of an emergency; and
- are time efficient and based on an action-oriented agenda to ensure equitable and comprehensive coverage of MISP for SRH activities.

Facilitation of the meetings should:

- support equal participation, effective listening, and notetaking;
- be reinforced through the distribution of minutes post-meeting; the meeting minutes should also be posted on the Humanitarian Response website (humanitarianresponse.info), and the SRH Coordinator should ensure that key points are included in the health cluster situation reports (sitreps) and communicated to UNOCHA for its sitreps as part of the health sector/cluster contribution;

- accommodate new agencies and the rotation of staff by reviewing the MISP for SRH and the action plan for the working group at the start of each meeting; different organizations could take the lead at the beginning of the meeting to distribute and review the MISP for SRH advocacy sheet and synopsis (also referred to as the "cheat sheet") (Appendices E and F).

How can SRH coordination be sustained through post-acute/protracted crises?

International SRH Coordinators should, at the onset of their work, actively engage the Ministry of Health or identify a local counterpart to lead or co-lead the coordination effort. This will ensure a smooth transition during any staff turnover that occurs while aiming for the Ministry of Health to assume SRH coordination.

Nepal Post-2015 Earthquake(s): Preparedness and Coordination of the MISP for SRH

Before the 2015 earthquake(s) in Nepal, the Government and partners had made commitments to and investments in SRH, and the MISP for SRH was included in preparedness activities, including the coordination and pre-positioning of IARH Kits. Within two days of the devastating earthquake, an SRH coordination mechanism was initiated under the health cluster in Kathmandu.[33] This effort was led by the Department of Health Services, Family Health Division, and UNFPA.

Leadership and collaboration among partners occurred immediately to successfully secure donor support and reach the affected communities. At the national level, Nepal designated its SRH working group as an RH sub-cluster. The meetings in Kathmandu were reported to have had a rapid start; key stakeholders, including the Department of Health Services, United Nations agencies, local and international NGOs, and adolescents, were involved in the RH sub-cluster coordination meetings. In rural areas, the District Public Health Office led the response efforts, including establishing temporary hospitals, mobile RH camps, and supplies distribution mechanisms, which allowed the MISP for SRH to be integrated into efforts to reach more rural and remote communities.

33 Myers, et al., "Facilitators and Barriers in Implementing the Minimum Initial Services Package."

What global mechanisms provide policy and technical support for the MISP for SRH?

Global Health Cluster: The Global Health Cluster, led by the WHO, comprises approximately 700 partners at the country level, 55 of which engage strategically at the global level. These organizations work collaboratively to ensure predictable and accountable health action, including for SRH in crises settings.[34] For refugee crises, UNHCR is the lead coordinating agency, including for SRH.

IAWG on RH in Crises: The IAWG on RH in Crises is a broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for people affected by conflict and natural disasters. The group is led by a 19-member Steering Committee comprised of United Nations agencies and nongovernmental humanitarian, development, research, and advocacy organizations. With over 2,800 individual members from 450 agencies in 2018, the group collaborates with members through biennial meetings (as of 2017) where local and international partners share activities and resources, initiate collaborative efforts, and analyze issues in the field to be addressed.[35] The IAWG on RH in Crises has 12 active sub-working groups through which members address critical SRH topics. Sub-working groups develop their own terms of reference, which are updated annually. The MISP for SRH sub-working group meets regularly by teleconference to address its terms of reference, share findings, and identify areas for improvement. The findings from these meetings and actions implemented from the terms of reference support a more coordinated and effective MISP for SRH response in new emergencies. This is an example of how action at the global level can support activities in the field. For more details on joining the IAWG on RH in Crises, please go to iawg.net.

Logistics Cluster: The Logistics Cluster, led by the World Food Programme (WFP), provides coordination and information management to support operational decision-making and improve the predictability, timeliness, and efficiency of the humanitarian emergency response. Where necessary, the Logistics Cluster also facilitates access to common logistics services.

GBV Area of Responsibility (The GBV AoR): The GBV Area of Responsibility, led by UNFPA, brings together NGOs, United Nations agencies, academics, and others under the shared objective of ensuring life-saving, predictable, accountable, and effective GBV prevention, risk mitigation, and response in humanitarian contexts. It also works to strengthen system wide preparedness and the technical capacity to respond to humanitarian emergencies. The GBV Area of Responsibility sits within the Global Protection Cluster.[36]

34 The Global Health Cluster website is found at http://www.who.int/hac/global_health_cluster.

35 More information on the IAWG meetings can be found at http://iawg.net/event_type/annual-meeting.

36 "What we do" Gender-Based Violence AoR (website), accessed June 19, 2019, http://gbvaor.net.

The Reality of Implementing the MISP for SRH in Jordan

In March 2011, civil unrest in Syria led to a mass exodus of Syrians into neighboring countries, including Jordan.[37] Relief agencies ensured the SRH needs of refugees were factored into the humanitarian response, relying on the Jordanian Ministry of Health guidelines on maternal, newborn, and post-abortion care; HIV prevention and treatment; and family planning.

In 2013, a joint evaluation of MISP for SRH services was conducted by the Women's Refugee Commission, UNFPA, and the Centers for Disease Control and Prevention to determine the status of MISP implementation for Syrian refugees in the Zaatari refugee camp and the urban area of Irbid, Jordan, as part of a global evaluation of RH in crisis-affected settings. The results revealed that lead health agencies addressed the MISP by securing funding and supplies and establishing RH focal points, services, and coordination mechanisms.

UNFPA held weekly coordination meetings in Zaatari, which focused specifically on refugees within the camp, and monthly meetings in Amman, Jordan, which focused on the refugee influx and the crisis as a whole. However, coordination was lacking in Irbid and other urban areas, which had larger numbers of refugees. Maternal and newborn health services, including safe blood transfusions, were functioning in urban areas. This was possibly due to the pre-existing level of maternal and newborn care in Jordan.

The challenge was that refugees hosted in the urban areas were not as visible as those in Zaatari camp, which made them more vulnerable. For example, there was a lack of information about the types and locations of services that were available to them. In Zaatari, regional partners offered advanced maternal and newborn care, but there were gaps in the prevention of sexual violence and the provision of clinical care for survivors. This was thought to be due to health providers' lack of attention to preventing and responding to sexual violence.

Overall, this assessment revealed that there was an increased awareness of the MISP for SRH in the response at the field level. It also highlighted the challenges of working in an urban context and the importance of ensuring all crisis-affected people have knowledge of and access to services.

37 Krause, et al., "Reproductive Health Services for Syrian Refugees."

Unit 2: Key Points

- It is important to have a lead SRH agency and SRH Coordinator because without appropriate technical expertise and stakeholder coordination to support the SRH response, the critical, lifesaving services of the MISP for SRH are often ignored, and interventions are isolated or deprioritized. This can lead to life-threatening consequences for affected populations.
- The role of the SRH Coordinator, with the support of the SRH lead agency, is to provide operational and technical support, host regular meetings with all relevant stakeholders, share information about the availability of SRH services and commodities, ensure the community is aware of SRH services, work with the health and logistics sectors/clusters for supplies, and with the health/GBV/HIV coordination mechanisms ensure a mapping and analysis of existing SRH services and gaps and challenges related to MISP for SRH implementation.
- All relevant actors in the humanitarian health response should participate in the SRH coordination meetings (Ministry of Health, international NGOs, civil society organizations, the private sector working in SRH, donors, the protection working group/cluster—including the GBV Area of Responsibility—representatives from the affected communities, and United Nations agencies).

Challenges and Solutions

Challenges	Solutions
Sometimes a lack of understanding and/or prioritization of SRH by humanitarian actors can make implementation of the MISP for SRH within the overall health response difficult. How can one ensure that SRH and the MISP for SRH are prioritized and integrated appropriately?	Emphasize that the MISP for SRH is an accepted international minimum standard reflected in *The Sphere Handbook*, the CERF lifesaving criteria, the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, and the *Health Cluster Guide*. Encourage all technical and managerial staff involved in humanitarian response to complete the MISP for SRH distance learning module and share relevant resources, such as the MISP for SRH Advocacy and Synopsis Sheets (Appendices C and E). Conduct trainings on the lifesaving SRH services of the MISP for SRH as part of preparedness efforts and collaborate with the Ministry of Health and other relevant governmental organizations prior to an emergency, if possible. Undertake a MISP for SRH emergency preparedness assessment.
At the beginning of an emergency, UNFPA and other SRH specialist agencies may not yet be operational in the field. Security may be poor and staff capacity may be weak. In such a setting, what can an agency do to address SRH?	If your agency is involved in the health response, it should ensure the MISP for SRH is included in its programming. Your agency or another agency could volunteer in the health sector/cluster meetings to lead on SRH and to establish regular SRH working group meetings to facilitate implementation of the MISP for SRH. If your agency cannot provide all MISP for SRH recommended activities, assess other health/SRH actors' service capacity, and establish an effective referral system for those services that your agency cannot provide.
How can a local counterpart be identified to lead or co-lead the SRH coordination effort?	If capacity exists, the Ministry of Health should lead or co-lead the coordination effort. The Ministry of Health could advise on existing local organizations and their capacities. Conduct a mapping of existing local actors implementing SRH programming to identify candidates to lead or co-lead the coordination effort.

How can marginalized populations be included in coordination initiatives?	With the SRH working group, identify representatives of local adolescents, women, persons with disabilities and LGBTQIA, and other often marginalized groups from among the crisis-affected populations. Extend an invitation for representation in the SRH working group meetings to these leaders.
What can be done about members of the SRH working group who have never heard of the MISP for SRH?	In the early weeks and months of the SRH working group meetings, begin with a brief orientation to the MISP for SRH. Share the MISP for SRH Synopsis (also known as the “cheat sheet”) and explain that the overall objective of the SRH working group is to work collaboratively to ensure the full MISP for SRH is accessible to all crisis-affected populations. If there is a high rotation of staff and new agencies joining the SRH working group meetings, review the MISP for SRH and the action plan for the working group at the start of each meeting.

MISP FOR SRH MONITORING CHECKLIST: COORDINATION

The MISP for SRH Monitoring Checklist below, can be used to monitor SRH service provision in humanitarian settings.

1. SRH Lead Agency and SRH Coordinator			
		Yes	No
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly[38]	Yes	No
	National (MONTHLY)		
	Sub-national/district (BIWEEKLY)		
	Local (WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH working group meetings	Yes	No
	Ministry of Health		
	UNFPA and other relevant United Nations agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
	Civil society organizations, including marginalized (adolescents, persons with disabilities, LGBTQIA people)		
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensure mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		
2.2	Number of women of reproductive age (ages 15–49, estimated at 25% of population)		
2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population, estimated at 4% of the population)		

38 Meetings are more frequent at the immediate onset of a crisis.

MATERIALS AND SUPPLIES

Which supplies are needed for coordinating the implementation of the MISP for SRH?

IARH Kits (2019)

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Complementary commodities

The first objective of the MISP does not have an IARH Kit associated with it. However, there is an administration and training complementary commodity kit available that should only be procured where administrative supplies can not be procured in-country.

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Coordination	Kit 0 Administration and training	All Kits

Unit 2 Quiz: Coordination of the MISP for SRH

1. The lead SRH agency should immediately dedicate a full-time SRH Coordinator for a minimum period of one year to provide operational and technical support to the health partners and facilitate coordinated planning to ensure the prioritization of SRH and effective provision of MISP for SRH services.

   True or **False**

2. In the MISP for SRH, the lead SRH organization is responsible for all the below **except**:

   a. Hosting regular meetings with all relevant stakeholders
   b. Mapping existing SRH services alone and separate from health/GBV/HIV coordination mechanisms
   c. Nominating an SRH Coordinator
   d. Sharing information about the availability of SRH services and commodities
   e. Ensuring the community is aware of the availability and location of SRH services

3. Who should participate in the SRH working group meetings?

   a. Representatives from the affected community
   b. NGOs
   c. Civil society organizations
   d. GBV coordinator
   e. All of the above

4. Components of successful SRH coordination include all **except:**

   a. Having an agreed-upon terms of reference
   b. Engaging the Ministry of Health in leading or co-leading the coordination effort
   c. Having appropriate administrative, communications, and logistics support
   d. Meeting on a monthly or bimonthly basis at the beginning of an emergency

5. The MISP for SRH Checklist can be used to monitor SRH service provision and coordination in humanitarian emergencies.

   True or **False**