SHAPING THE NEW COVID-19 REALITY

Creating Evidence-based Solutions to Sustain Family Planning in Humanitarian Settings & Across the Nexus

IAWG Inter-Agency Working Group on Reproductive Health in Crises

WOMEN'S REFUGEE COMMISSION

FP FAMILY PLANNING 2020™

CONSULTATION OBJECTIVES

- **Share findings** from WRC's two-year landscaping of family planning in humanitarian settings and across the humanitarian-development nexus.
- **Agree on recommendations** in key gap areas to improve access to FP in humanitarian settings and across the humanitarian-development nexus.

AGENDA

Time	Topic
8:00-8:10am	Welcome and Introductions
8:10-8:50am	Presentation of key findings (Lily Jacobi, WRC)
8:50-9:20am	Discussion of findings • Remarks from panel discussants (Gathari Ndirangu, Pathfinder International – MOMENTUM IHR Team and Abdiqani Hirsi Shire, Save the Children International - Somalia) • Q&A
9:20-10:40am	Break out groups: Each group develops 2-3 recommendations based on identified gaps.
10:40-11:00am	Next steps and closing

MAKE SURE YOU ARE SIGNED UP FOR A SMALL GROUP!

If you haven't selected a small group, select NOW. Go to:

iawg.net/fp-group

Global snapshot of contraceptive services across crisis-affected settings

Lily Jacobi, Sara Casey, and Sarah Rich

GLOBAL LANDSCAPING OBJECTIVES

- Improve knowledge on the state of contraceptive services in humanitarian settings
- Assess progress and challenges to the successful implementation of contraceptive service delivery in humanitarian settings
- Identify key recommendations to accelerate access to contraception for crisis-affected populations across the humanitarian-development nexus

Methods

- Literature review
- Global coverage survey
- Key informant interviews
- Case studies in three humanitarian settings

COVID-19 AND CONTRACEPTIVE SERVICES ACROSS THE HUMANITARIAN-DEVELOPMENT NEXUS

WRC conducted an additional series of KIIs with stakeholders across the nexus to document:

- The **impact** of COVID-19 on contraceptive service delivery
- **Innovations** to ensure that contraceptive services remain **available and accessible**
- **Facilitators and barriers to** contraceptive services and SRH in COVID-19 preparedness and response

Methods across components

LITERATURE REVIEW

- Identified publicly available peer-reviewed literature via PubMed
- Identified grey literature via Google, ReliefWeb, and by visiting organizations' websites
- **Identified 75 peer-reviewed articles and 22 grey publications (2010-2019)**
- Did not assess quality of the research/data or exclude items on the basis of quality

GLOBAL COVERAGE SURVEY

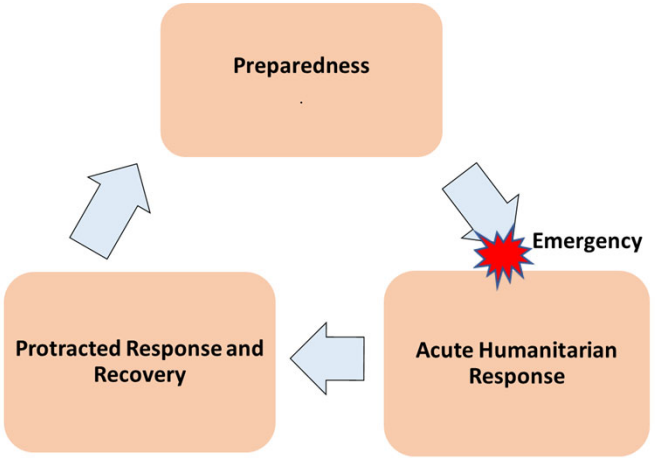
- Completed Spring 2019
- Purposive sampling
- 20 organizations participated:
  - 7 INGOs
  - 12 national/regional NGOs
  - 1 UN agency
- Data represents 84 programs across 42 countries/territories

Data should not be treated as a complete picture of the current state of contraceptive coverage in humanitarian settings, or representative of programs - there are likely many organizations, especially local and community-based organizations, providing contraceptive services that are not captured.

KEY INFORMANT INTERVIEWS (N=17)

Breakdown of informants

- 14 interviews with 17 informants
  - 1 UN agency; 6 INGOs; 1 national NGO
  - 10 humanitarian; 7 development
  - 8 field-based; 9 HQ
- Focused on transition periods
- Explored collaboration across the nexus



Graphic credit: Sarah Rich (WRC)

CASE STUDIES

Settings

- Cox's Bazar, Bangladesh
- Maiduguri, Borno State, Nigeria
- Cyclone Idai-affected Mozambique

Data collection

- KIIs with key stakeholders
- Facility assessments
- FGDs with affected communities

Image credit: Cassondra Puls (WRC)

KEY THEMES ACROSS THE ASSESSMENT

- Quality of care, particularly method mix
- Adolescents and marginalized groups
- Supplies
- Data collection and use
- Preparedness
- Localization
- COVID-19 disruptions and innovations

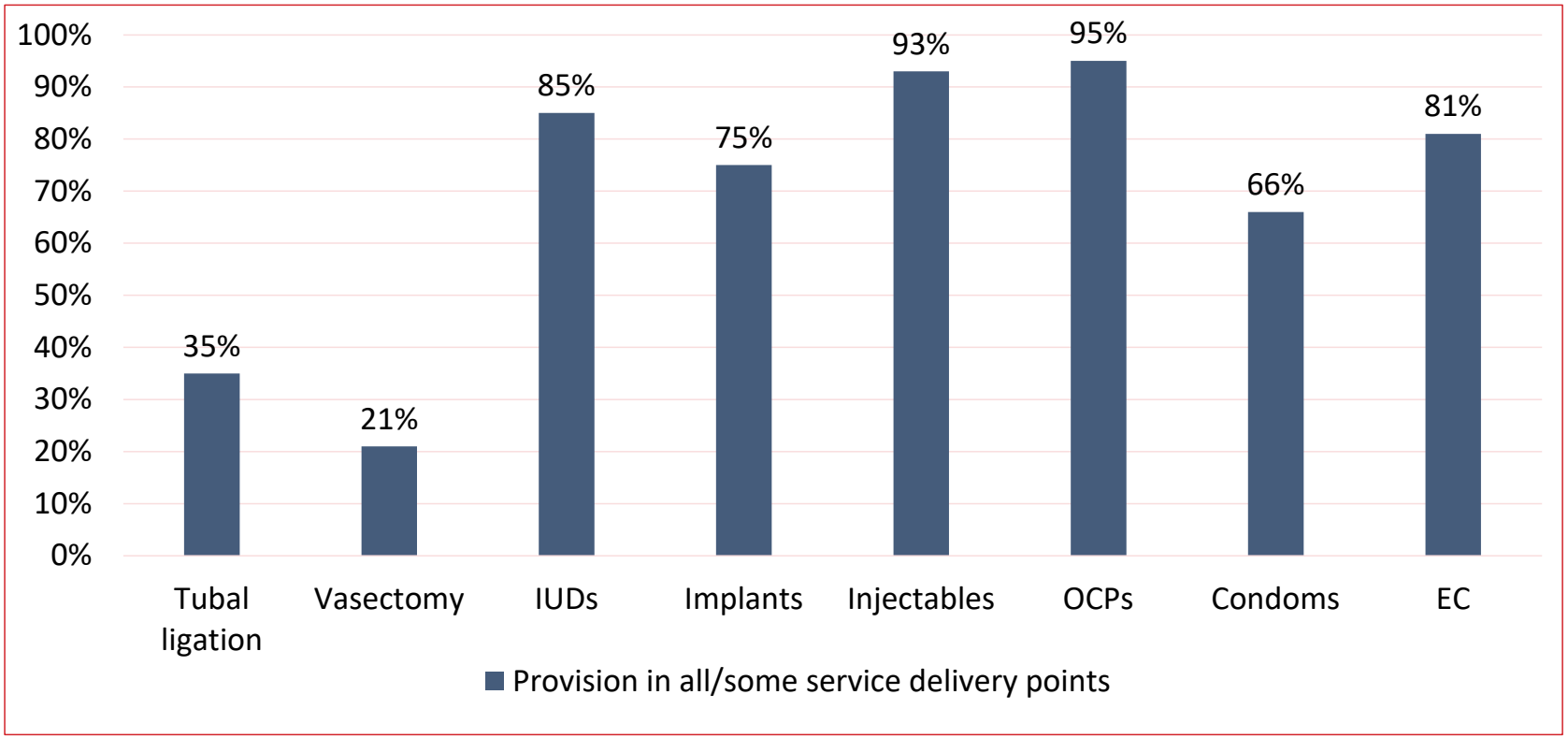
Image credit: Arturo Sanabria

Quality of care with a focus on method mix

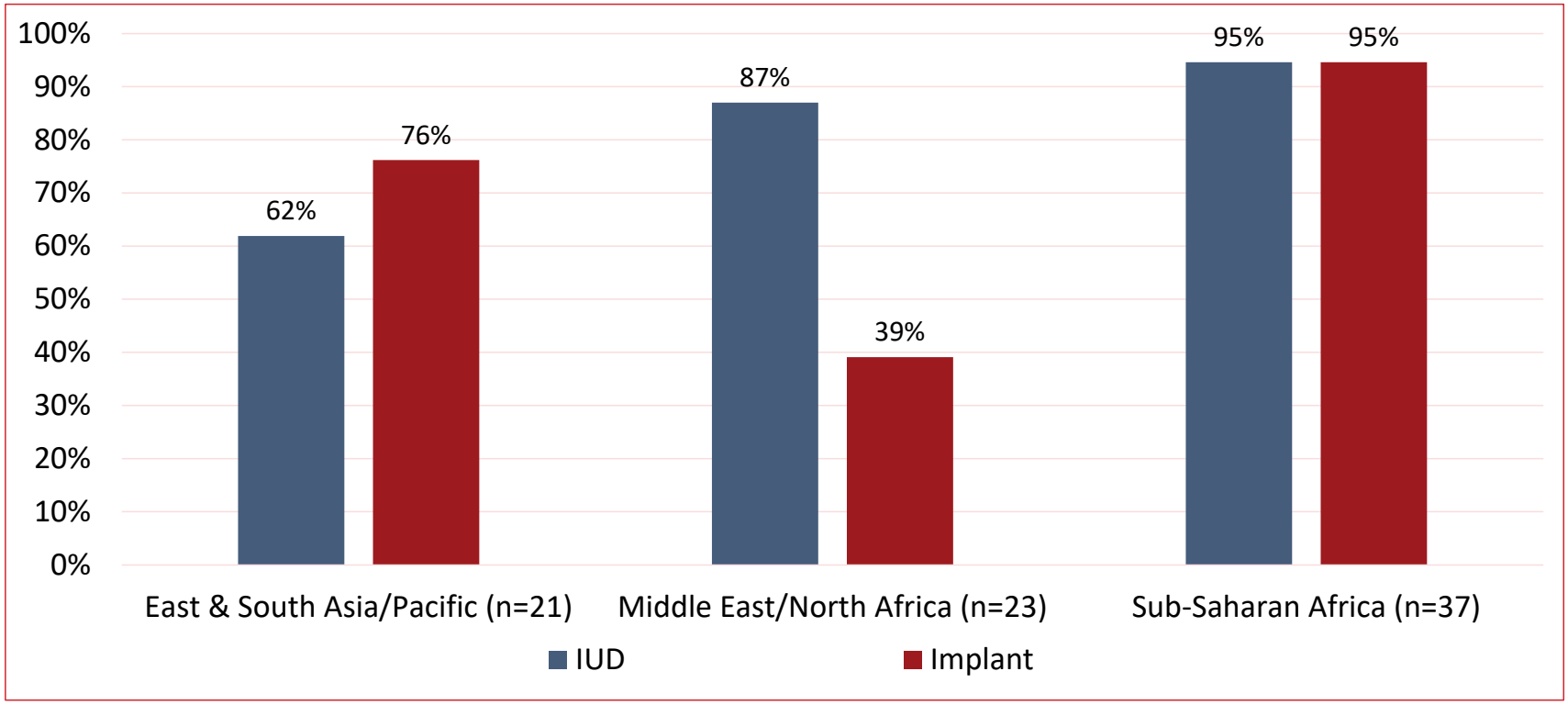
LITERATURE REVIEW

- LARCs and EC are less available as compared to other methods across diverse settings, often due to a lack of trained providers
- Providers may be less knowledgeable about LARCs and EC, and be more likely to have misconceptions and negative attitudes towards LARCs and EC
- Providers across settings expressed a desire for additional training and skills building opportunities
- Provision of EC continues to be limited to clinical management of rape in many settings
- Knowledge of EC is extremely low across settings, even where populations reported a reasonably good knowledge of other methods

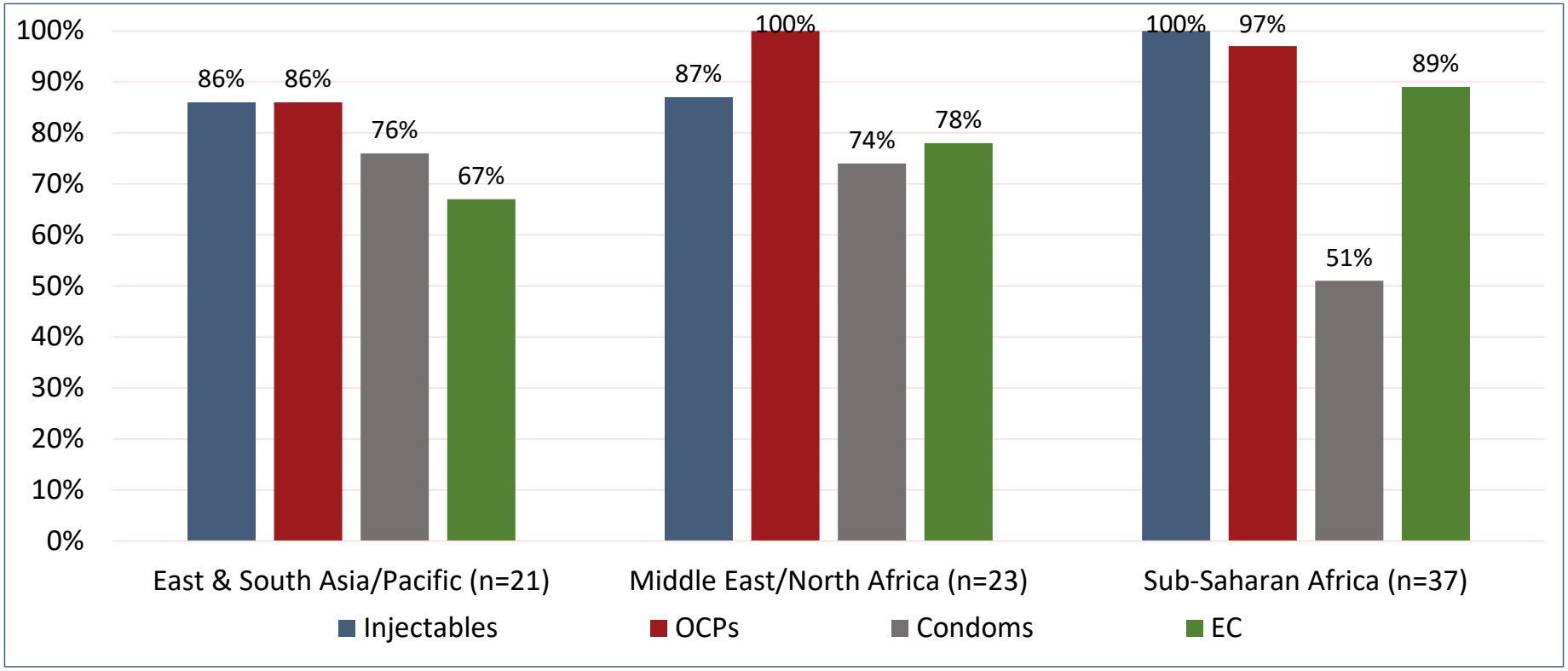
% OF COUNTRY PROGRAMS PROVIDING CONTRACEPTIVE METHODS IN ALL/SOME SERVICE DELIVERY POINTS (N=84)



PERCENTAGE OF COUNTRY PROGRAMS PROVIDING LARCS BY REGION (N=84)



PERCENTAGE OF COUNTRY PROGRAMS PROVIDING SHORT ACTING METHODS BY REGION (N=84)



ACROSS CASE STUDIES

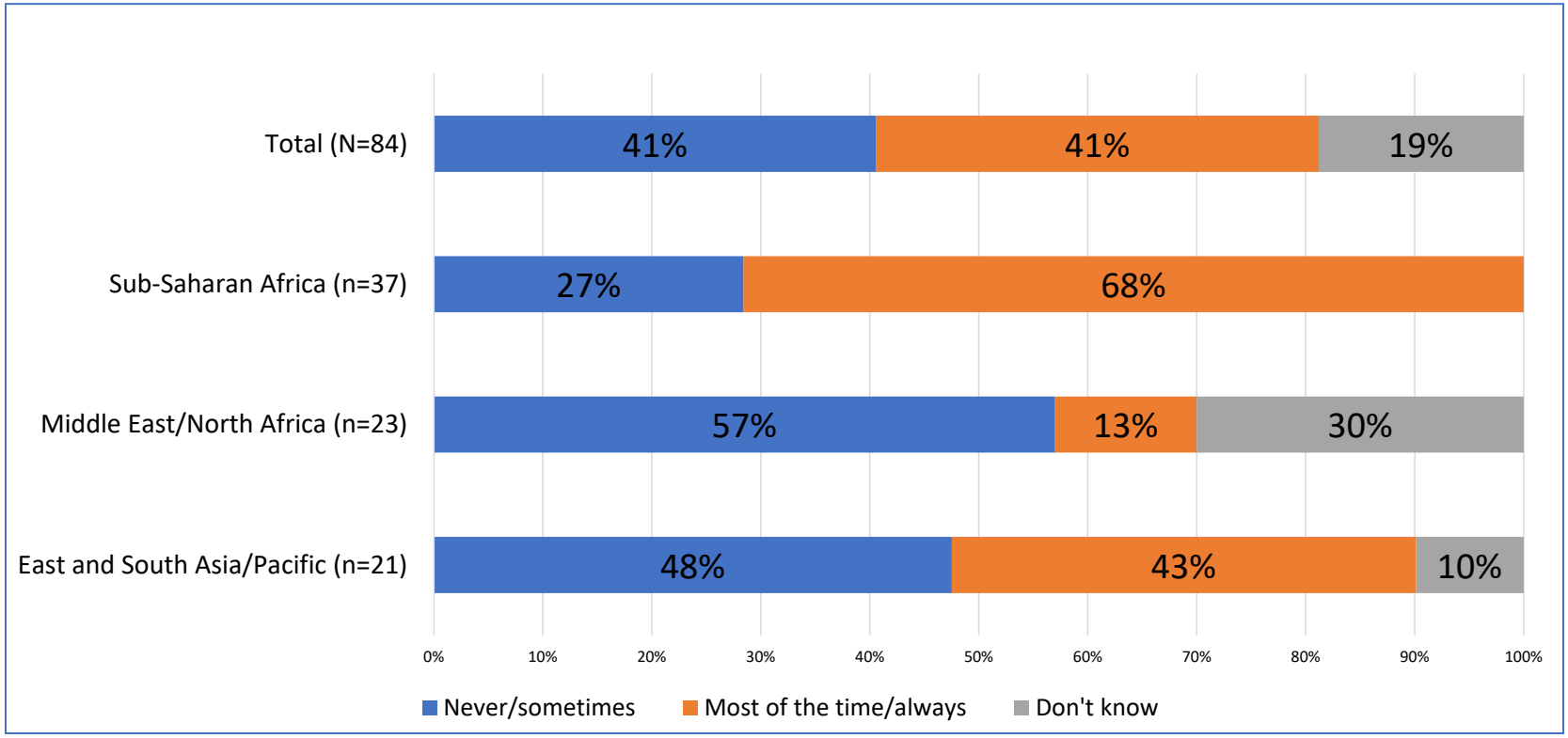
- LARCs and EC were consistently less available as compared to other methods
- A lack of trained providers and stockouts of supplies and equipment contributed to lower availability of LARCs
- FGD participants were less familiar with LARCs as compared to short-acting methods
- FGD participants were unfamiliar with or had extremely low knowledge of EC

Adolescents and marginalized populations

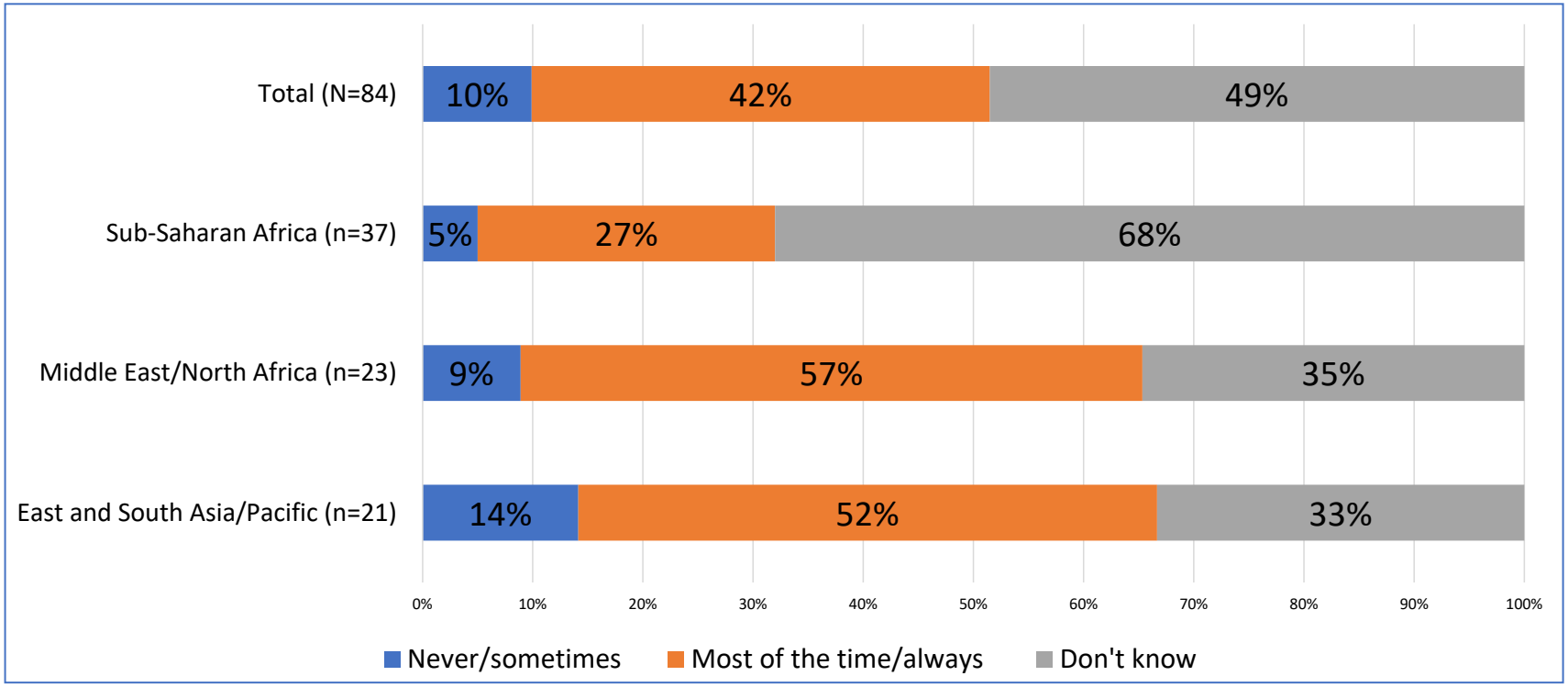
LITERATURE REVIEW

- Adolescents across settings want access to SRH and contraceptive information and services, and will use contraception when it is available
- There is limited availability of adolescent-focused contraceptive programming in humanitarian settings
- Very limited evidence on access, barriers, and programing for persons with disabilities and members of other marginalized populations

CONTRACEPTIVE SERVICE ACCESSIBILITY AND AVAILABILITY TO UNMARRIED ADOLESCENT GIRLS BY REGION



CONTRACEPTIVE SERVICES ACCESSIBILITY AND AVAILABILITY TO PERSONS WITH DISABILITIES BY REGION



ACROSS CASE STUDIES

Adolescents:

- Expressed interest in and need for access to contraceptive and SRH services
- Faced heightened barriers to accessing contraceptive services, particularly for unmarried girls
- Experienced higher levels of community stigma and negative attitudes, and opposition from parents and/or spouses
- Experienced higher levels of stigma and negative attitudes from providers

Persons with disabilities:

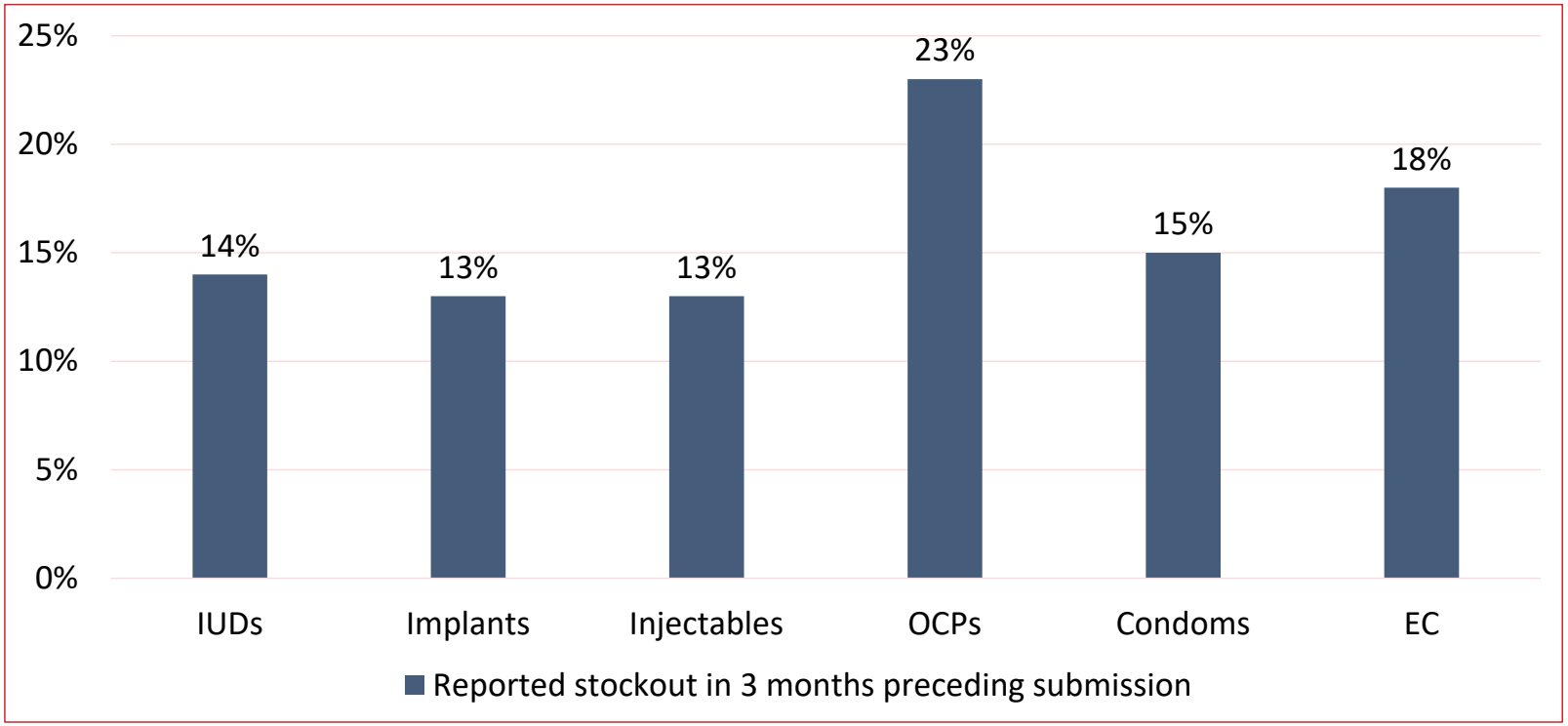
- Faced greater barriers when accessing contraceptive services, including due to distance, lack of transportation, and inaccessible facilities

Supplies

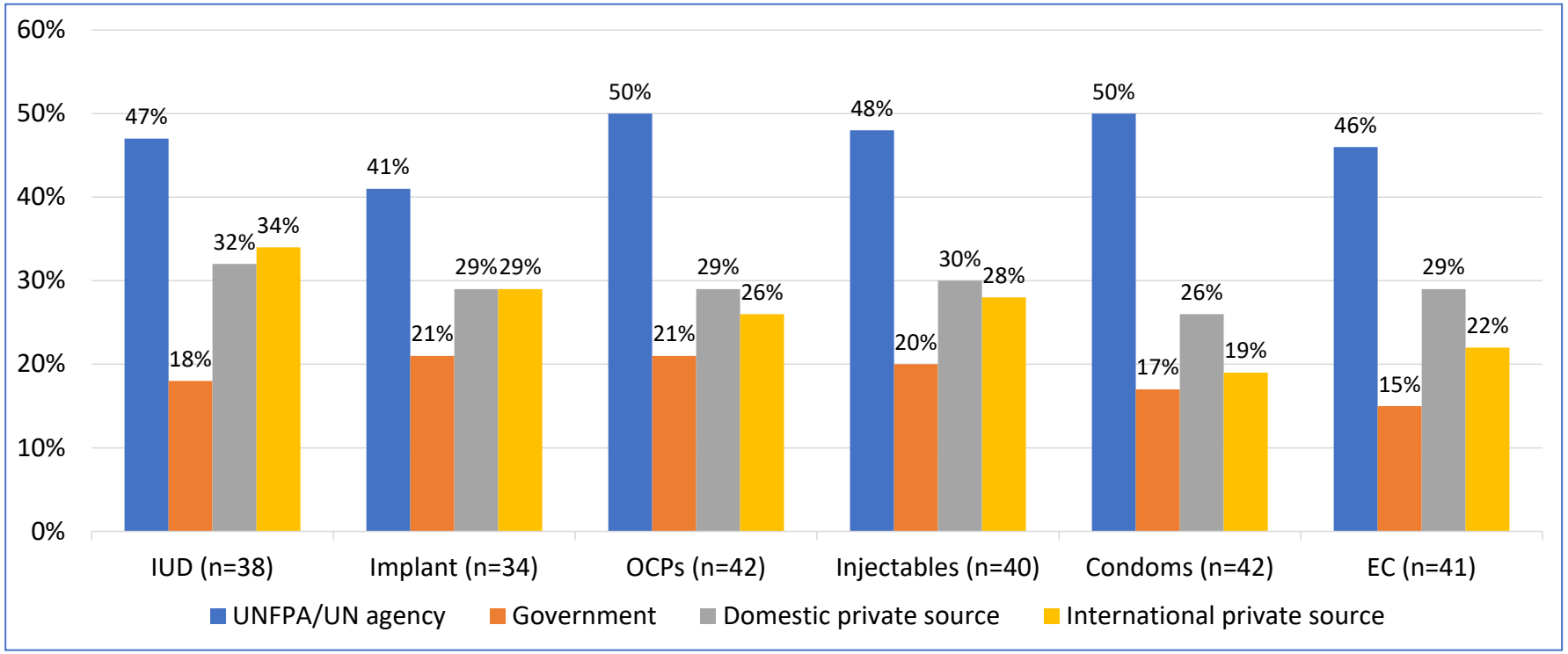
LITERATURE REVIEW

- Gaps in the availability of contraceptive supplies and IARH kits were documented across many settings, including stockouts
- Poor data collection negatively impacts supply chain management
- Supplies challenges are exacerbated when products are not registered in country, as is sometimes the case with ECPs

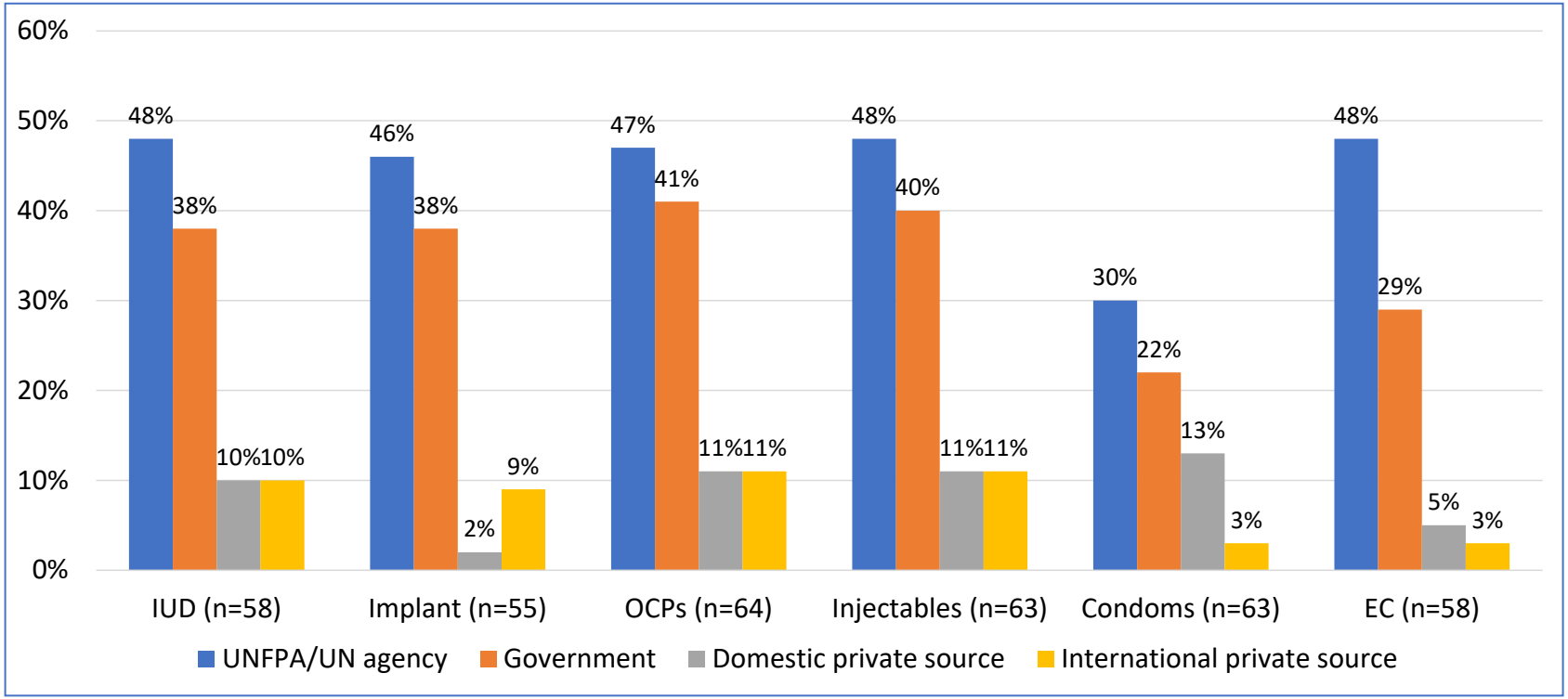
% OF COUNTRY PROGRAMS REPORTING A STOCKOUT IN PRIOR 3 MONTHS (N=84)



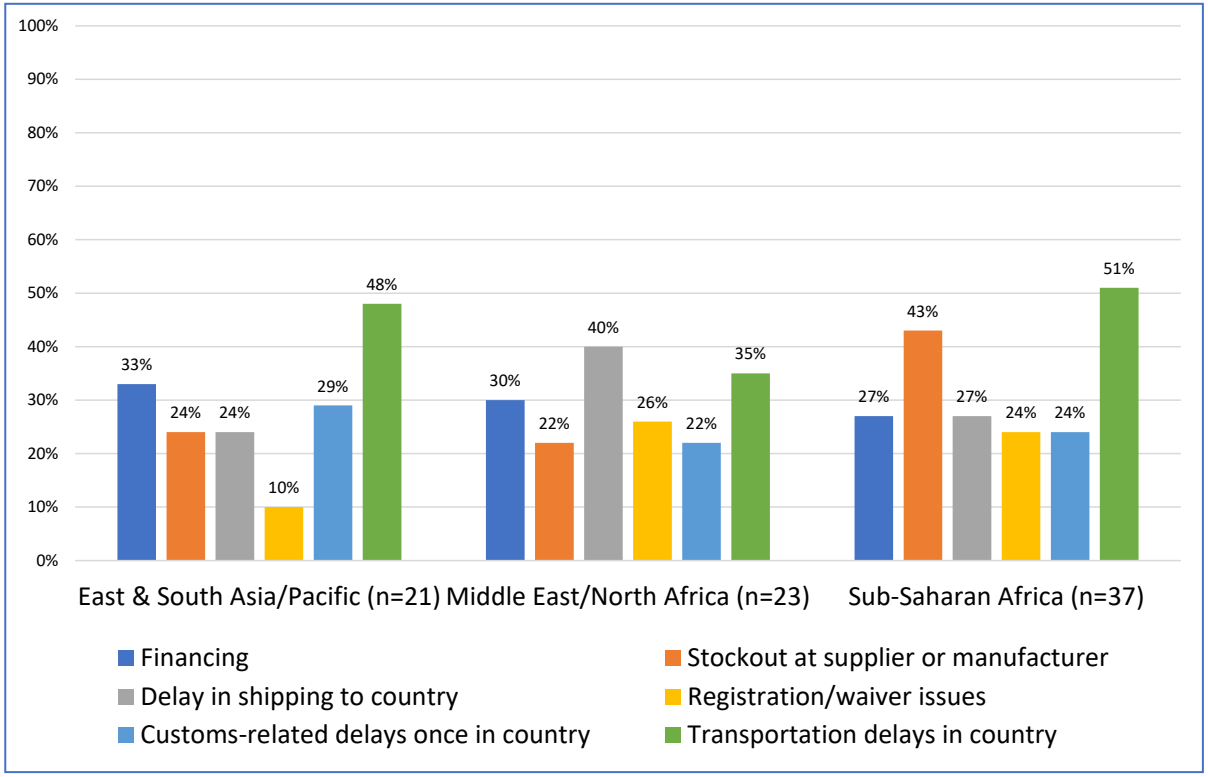
PROCUREMENT BY METHOD IN ACUTE SETTINGS



PROCUREMENT BY METHOD IN POST-ACUTE SETTINGS



COMMON DELAYS IN OBTAINING SUPPLIES BY REGION



ACROSS CASE STUDIES

- Facility assessments across all settings documented stockouts of contraceptive commodities
- Respondents in Borno State and Mozambique reported challenges related to supply chain management and stockouts that negatively impacted the availability of services
- Challenges in Borno State and Mozambique also included last mile delivery, storage conditions, wastage, and quantification
- IARH kits were in use across settings, and played a significant role in the supply chain for contraceptive commodities in Cox's Bazar and Borno State

Data collection and use

CASE STUDY – COX'S BAZAR, BANGLADESH

- Respondents reported that data collection was improving, but not all partners reported data each month
- Providers from multiple organizations often worked out of shared facilities which could lead to double-counting
- Partners were working to standardize indicators and definitions, but inconsistent definitions complicated efforts to review and compare data
- Data across partners were presented and reviewed at SRH coordination meetings on a regular basis

CASE STUDY – MAIDUGURI, BORNO STATE, NIGERIA

- Mechanisms were in place to collect data from implementing partners, but challenges included overreporting, and late, incomplete, and missing data
- Most organizations reported reviewing data on a regular basis
- Multiple program managers reported having quarterly data review meetings including government health agencies, community members, providers, and NGO staff
- Health facility assessments indicated limited displays of data, limited capacity to describe trends in contraceptive service delivery data, and incomplete completion of registers

CASE STUDY – CYCLONE IDAI-AFFECTED MOZAMBIQUE

- The cyclone destroyed many paper-based registers and client cards, disrupting data collection and reporting
- MOH respondents reported challenges with late reporting and variable data quality
- Respondents reported that a change in the definition of “new user of family planning” and lack of clarity between partners led to challenges with accuracy
- National systems for collecting contraceptive service delivery were fragmented across cadres
- Respondents reported that data was shared in coordination meetings at national and sub-national levels and used to inform prioritization and resource allocation
- Health facility assessments indicated limited data visualizations on display, but providers were generally able to describe actions taken as a result of reviewing data

LITERATURE REVIEW

Evidence on effective interventions for contraceptive service delivery in humanitarian settings is limited.

Programmatic literature

- Multi-pronged programs addressing method mix, provider capacity, supplies, and M&E
- Community-based service delivery mechanisms, including mobile units and CHWs
- Alternative financing, including subsidies and vouchers
- Acceptance of contraception in PAC

Preparedness

KEY INFORMANT INTERVIEWS

Program transitions across the emergency response cycle

- Existing national systems and capacity, including preparedness, was a key factor in successful transitions
- Respondents also cited organizational preparedness as being beneficial for successful program transitions
- Investing in local capacity supported resilient/sustainable programs

Coordination across the humanitarian-development nexus

- Preparedness phase is an opportunity to strengthen coordination between humanitarian and development actors

CASE STUDY – COX'S BAZAR, BANGLADESH

Effective preparedness strategies and enabling factors that supported contraceptive service delivery and uptake included:

- UNFPA-Bangladesh had consistent funding before and during the emergency, which contributed to pre-positioning of contraceptive supplies, availability of supplies from the onset of the emergency, and presence of a dedicated SRH coordination team
- UNFPA reported having supplies from early in the emergency, in part because IARH kits were pre-positioned in Bangladesh as part of preparedness for cyclone season
- UNFPA's early support to organizations that were already present and registered in Bangladesh, as well as a strong NGO sector in Bangladesh, ensured availability of contraceptive services early in the response

CASE STUDY – CYCLONE IDAI-AFFECTED MOZAMBIQUE

- Multiple respondents noted a lack of emergency preparedness, including for health and SRH
- Respondents reported that awareness of the MISP was low among government staff and providers at the outset of the response
- UNFPA provided and led distribution of IARH kits and provider training on use, but respondents reported challenges due to lack of familiarity with kit management
- Lack of capacity for supply chain management prior to the cyclone exacerbated challenges with availability of supplies during the response
- Multiple respondents explicitly expressed the need for more training on emergency preparedness, including for SRH
- Respondents reported that the presence of FP focal points at the district level prior to the cyclone supported the inclusion of contraceptive service delivery in the response

Localization

KEY INFORMANT INTERVIEWS

- Health systems strengthening activities and building local ownership were critical for successful program transitions over the course of the emergency response cycle
- Respondents emphasized local/national actors' capacity for immediate response
- Localization supports efficient and sustainable humanitarian response
- Current humanitarian funding apparatus disadvantages national/local actors
- Operationalizing localization requires shifting funding flows and investing in national/local actors

“This is something we overlook as implementing partners or international organizations. We think that the first response to a humanitarian crisis is what we provide, what we bring…No. When people are fleeing, when people have been displaced, the first response is not coming from international organizations. Not even [from] the government. The first response is coming from local communities, coming from local organizations.”

CASE STUDY – CYCLONE IDAI-AFFECTED MOZAMBIQUE

- AMODEFA was recruited to coordinate MISP implementation in accommodation centers
- Conducted outreach and sensitization on available SRH services
- Leveraged existing services, networks of CHWs, and strong relationships with communities to launch activities immediately
- Reported they were the only national NGO that participated in the SRH working group, and played a critical role in linking communities with humanitarian actors
- Reported that securing funding was a challenge, and a key barrier to participation of other national NGOs in the response
- Committed to build internal capacity and support other national NGOs to prepare to participate in humanitarian response, including by training on the MISP

COVID-19 and contraceptive services across the humanitarian-development nexus

Lily Jacobi, Sarah Rich, Cady Nyombe Gbomosa

WOMEN'S REFUGEE COMMISSION
RESEARCH. RETHINK. RESOLVE.

METHODS (N=29)

Breakdown of informants

29 interviews representing:

- 1 UN agency
- 3 Ministries of Health
- 11 INGOs
  - 12 HQ
  - 8 regional/country level
- 5 NGOs

- 23 in English and 6 in French

Interviews explored:

- Disruptions and adaptations in contraceptive service delivery
- Barriers for communities
- Facilitators and barriers to contraceptive services and SRH in COVID-19 preparedness and response
- The impact of COVID-19 on the funding environment for contraceptive services and SRH

CONTRACEPTIVE SERVICE DELIVERY DISRUPTIONS AND CHALLENGES

Service delivery, programming, and provider availability

- Movement restrictions
- Lack of PPE
- Facilities and staff diverted to COVID-19 treatment
- Impact on LARCs, especially early on, related to PPE and telemedicine
- Training disrupted by movement restrictions and social distancing measures
- Community sensitization activities were severely affected
- COVID-19 infections, quarantines, and deaths

CONTRACEPTIVE SERVICE DELIVERY DISRUPTIONS AND CHALLENGES

Contraceptive supplies

- Movement restrictions disrupted the supply chain, from manufacturing, to getting the product in country, to last mile delivery
- Shipping and transportation costs increased
- Decreased availability of IARH kits

Data collection and reporting

- Disrupted by movement restrictions in some settings
- Challenges related to lack of technology/connectivity in some settings

CONTRACEPTIVE SERVICE DELIVERY DISRUPTIONS AND CHALLENGES

Barriers facing communities

- **Fear of COVID-19** and visiting facilities
- **Movement restrictions**
- Increased transportation **costs**
- **Loss of livelihoods**
- Products **stocked out** at facilities
- Respondents discussed **concerns about adolescents** being out of school, and facing risks of increased GBV, including CEFM, and pregnancy

ADAPTATIONS AND INNOVATIONS

Technology and telemedicine

- Feasibility and suitability of telemedicine varies across settings
- Use of calling and WhatsApp to provide counseling and follow-up, and to direct clients where to obtain methods
- Reporting data electronically, including via WhatsApp
- Using Zoom for provider training and WhatsApp groups for provider support

ADAPTATIONS AND INNOVATIONS

Community-based service delivery and distribution

- In some cases, respondents were forced to stop community-based service delivery, at least early in the pandemic
- Other respondents described community-based mechanisms being introduced or strengthened to:
  - **Deliver commodities**
  - **Share information** on COVID-19 prevention and available services
  - **Encourage communities** to continue seeking services

ADAPTATIONS AND INNOVATIONS

- **Multi-month supplies** for OCPs, DMPA-SC, and condoms
- **Task-shifting and sharing**, including shifting delivery of some contraceptives to pharmacies/dispensaries
- Supporting **self-administration of DMPA-SC**
- **Integrated service delivery**, including with other essential health services like immunization

FACTORS AFFECTING CONTRACEPTIVE ACCESS AND AVAILABILITY AMIDST COVID-19

- Differences in disruptions and adaptations between humanitarian, fragile, and development settings
- Preparedness
- Prioritization of contraceptive and SRH services during COVID-19 response

DIFFERENCES IN DISRUPTIONS AND ADAPTATIONS ACROSS HUMANITARIAN, FRAGILE, AND DEVELOPMENT SETTINGS

- Multiple respondents perceived humanitarian actors and programming to be more responsive and agile for COVID-19 adaptations
  - Many respondents working in fragile/humanitarian settings reported using the MISP to inform prioritization of SRH service delivery
- Conversely, some respondents felt development programs were better resourced and thus able to better able to absorb shocks

PREPAREDNESS

- Humanitarian and development respondents largely reported that both governments and organizations did not have health/SRH preparedness plans prior to the pandemic
- Respondents acknowledged that existing government and organizational preparedness plans did not anticipate a global pandemic
  - Respondents perceived that settings with experience responding to Ebola were more prepared for COVID-19 response
- Respondents reported that preparedness activities conducted prior to the pandemic supported adaptations and response:
  - Training staff and providers on the MISP for SRH
  - Supply chain strengthening activities

PRIORITIZATION OF CONTRACEPTIVE AND SRH SERVICES DURING COVID-19 RESPONSE

- Perceptions of prioritization of contraception/SRH by governments and stakeholders varied
  - Some respondents noted that governments included contraceptive and SRH services as essential services, or were receptive to advocacy
  - Other respondents perceived prioritization to be very low
- Advocacy included:
  - Long-term consequences of increases in unintended pregnancy
  - Lessons learned from the impact of Ebola on maternal mortality and morbidity
- Several respondents noted that even where SRH was prioritized, contraception was neglected as many do not yet understand it is life-saving
- Multiple respondents reported challenges due to the large volume of guidance documents generated, particularly for frontline staff and emphasized the expertise of frontline staff in determining which adaptations best suited their environment

COORDINATION

Challenges

- Shifting to virtual coordination caused delays and challenges with uneven access to technology
- Coordination was challenged due to the high number of demands facing stakeholders, including government partners

Successes

- Strong coordination mechanisms prior to the pandemic supported fast and effective response
- Organizations leveraged existing relationships to address supplies challenges, including transportation and sharing/loaning supplies
- Existing relationships with ministries supported the prioritization of contraception and SRH

FUNDING FOR SERVICE CONTINUITY

- Respondents largely reported that donors allowed flexibility to reallocate funds to ensure service continuity
- The majority reported that their organizations did not have to reallocate funding away from SRH to COVID-19 activities
- Some respondents reported that governments had reallocated funding away from SRH as a result of COVID-19
- Multiple respondents reported seeking additional funding to support adaptations and service continuity, including for PPE
- Small number of development respondents reported tapping humanitarian funding streams
- Several respondents reported incidences in which donors were not able to follow through on planned funding due to COVID-19
- Concern and high levels of uncertainty about SRH funding environments over the coming years

RESPONDENTS' LESSONS LEARNED

Preparedness

- COVID-19 has underscored the importance of and revealed gaps in preparedness at every level across the humanitarian-development nexus
- Development actors have a key role to play in preparedness – but may not see preparedness as being part of their remit

RESPONDENTS' LESSONS LEARNED

Localization

- INGO respondents expressed that successful remote work and collaboration reinforced the importance and feasibility of shifting resources closer to the field
- Design and evaluation of programming should incorporate preparedness and systems strengthening activities to build resilience
- Operationalizing localization will depend on donor prioritization and investing accordingly

KEY TAKEAWAYS FROM ALL STUDY COMPONENTS

We have identified the need to:

- Meet the clear demand for contraception in humanitarian settings, and address barriers for adolescents and marginalized populations
- Improve quality of care, including the availability of LARCs and EC
- Improve data collection and use, and build the evidence base on effective contraceptive service delivery programs in humanitarian settings
- Strengthen supply chains and improve commodity security
- Ensure diverse stakeholders, including governments and development actors, invest in preparedness for SRH to mitigate the impact of crises, and
- Invest in local stakeholders to ensure efficient, effective SRH response and support sustainable recovery.

DISCUSSANTS

- Gathari Ndirangu, Pathfinder International – MOMENTUM IHR Team
- Abdiqani Hirsi Shire, Save the Children International – Somalia

Questions and Answers

SMALL GROUP DISCUSSIONS

Each group will develop 2-3 recommendations. Be as specific as possible.

- Adolescents and other marginalized groups
- Quality of care with a focus on method mix and supply chains
- Data collection and use
- Preparedness and Localization
- FP during the COVID era

REPORT OUT: SMALL GROUP DISCUSSIONS

- Adolescents and other marginalized groups (1/2)
  - Utilize tested social accountability tools (eg PDQ-Y, Community Score Card, Citizens Voice & Action)
  - Co-analysis & co-facilitation in presenting the data during meetings and workshops
  - Involve adol/youth in humanitarian planning & decision-making (creating space for their participation)
  - Use participatory methods to collect and share data (story-telling/vignettes to make things more personal and relatable)
  - Provide opportunities for parents & adol/youth to look at values, attitudes, beliefs (looking at normative changes together
  - Engage religious & traditional leaders to become champions of ASRH
  - Mainstream inclusion tools & approaches into broader assessments

REPORT OUT: SMALL GROUP DISCUSSIONS

- Adolescents and other marginalized groups (2/2)
  - Building evidence base in humanitarian contexts & disseminating that information
  - better collaboration and coordination between humanitarian & development actors
  - Equipping adolescents (both girls & boys) with language, efficacy & knowledge to be able to speak to their needs
  - Empowering girls and boys to make their own SRH decisions (agency)
  - targeting SRH messages for 10-14 for social norms
  - Covid-lens: making digital and/or self-care approaches are available for adolescents
  - Seek out organizations serving these populations and partner with them and build capacity

REPORT OUT: SMALL GROUP DISCUSSIONS

- FP during the COVID era
  - Institutionalize task-shifting/sharing, multi-month provision, and telemedicine protocols
  - proactively identify in-need clients based on existing health records
  - create online info forums (if tech. is accessible) to reach people with movement restrictions

REPORT OUT: SMALL GROUP DISCUSSIONS

- Data collection and use (1/2)
  - Health facility staff should be allocated adequate time for data collection activities
  - Train health workers how to collect and use data and why accurate timely data are important
  - Need consistent and clear definitions for key indicators
  - Need for agreed upon standard indicators (UN/IAWG)
  - Using standard disaggregating info (eg age)
  - Need standard tools (eg registers) to collect range of common indicators

REPORT OUT: SMALL GROUP DISCUSSIONS

- Data collection and use (2/2)
  - Implementation research on how best to delivery comprehensive FP in different stages of emergency cycle
  - Research looking at how to best reach underserved pops
  - Engage with implementation partners and others on the ground, including local groups
  - Include capacity strengthening of local/in-country partners to conduct research - practical skills training!
  - Use range of research methods; openness to different types of evidence
  - Publish what doesn't work;failures

REPORT OUT: SMALL GROUP DISCUSSIONS

- Preparedness and Localization (1/2)
  - Investments in integrating FP/SRH into government and organizational preparedness
  - Identify and engage local groups in advance
  - Organizational capacity (leadership, management) should be strengthened in preparedness phase
  - Technical working group within govt, led by high level govt member, who are ready to respond with other actors
  - Engage with clusters (health and others)
  - Build capacity of local organizations to engage with cluster systems

REPORT OUT: SMALL GROUP DISCUSSIONS

- Preparedness and Localization (2/2)
  - More funding needed for country level working groups who are local decision makers
  - Develop standardized supply-specific preparedness plans
  - Simplify the systems
  - Address the systems that do not support local NGO engagement
  - Build capacity of local organizations to engage with preparedness activities

REPORT OUT: SMALL GROUP DISCUSSIONS

- Quality of care with a focus on method mix and supply chains (1/4)
  - Mass media campaigns to raise awareness of EC in humanitarian settings
  - Work with organizations already worked in communities to reach community members with messages about EC
  - Make it available in kits that woman take on the go, like dignity kits, hygiene kits - so that women have it on hand when they need it
  - EC should be freely / widely available in local pharmacies, markets, safe spaces (recognize that people prefer to get services from a variety of outlets)
  - During preparedness, need to address misconceptions about EC; EC must be integrated into development programs
  - Remove policy restrictions that limit access to LARCs and EC, such as residence requirements, prescription requirements, age-related requirements
  - Disseminating relevant guidance and checklists along with training

REPORT OUT: SMALL GROUP DISCUSSIONS

- Quality of care with a focus on method mix and supply chains (2/4)
  - Clinical and refresher WITH practicums, supportive supervision mechanisms needed on LARC insertions and removals including infection prevention
  - During acute response, use training for LARC tailored to these settings such as the S-CORTS
  - Even when there's not a training space, can train on counseling, can do practical on-the-job training
  - Consider task-shifting/sharing on training to mid-level providers so that the people who are available to train are allowed to do the training [success in Nepal - Kusum]
  - Training and values clarification needed on how to counsel and address attitudes on LARCs and EC, respect for client choice [success example - CARE in DRC, Nigeria - Sylvie]

REPORT OUT: SMALL GROUP DISCUSSIONS

- Quality of care with a focus on method mix and supply chains (3/4)
  - Supply chains must be addressed during preparedness - need to collaborate with development sector
  - To make the case for devt agencies to integrate preparedness, research / disseminate evidence on the costs (economic costs, health costs)
  - Recommend / disseminate specific supply chain data collection tools that have been adapted for humanitarian settings
  - Improve data visibility to the last mile inc for the kits
  - Integrate data collection systems in humanitarian settings in govt LMIS; how to track IARH Kits in LMIS
  - Deploying human resources for pharm supply chain management - specific expertise
  - Connect to HMIS to improve communication between programs and logistics

REPORT OUT: SMALL GROUP DISCUSSIONS

- Quality of care with a focus on method mix and supply chains (4/4)
  - Partnering with private sector manufacturers and big institutional buyers to incentivize setting up manufacturing in places where it's not currently being done; guarantees to companies that they will be able to sell those products
  - Need to understand what the barriers, opportunities are to rights-based, client-centered services and counseling. What works??
  - Need to train and do values clarification with providers on counseling and client interactions, including addressing power dynamics between providers and clients, confidentiality, and ensuring two-way understanding
  - Provide guidance / tools on how to adapt client-centered counseling to humanitarian settings
  - Integration of FP counseling with other services (i.e. during pregnancy, post-partum); ensuring those providers are ready to offer FP counseling
  - Linking with civil society groups to reach marginalized populations

NEXT STEPS

- WRC will develop an advocacy brief summarizing the recommendations. The brief will be disseminated widely to key stakeholders, including all participants in today's consultation.

WOMEN'S REFUGEE COMMISSION

RESEARCH. RETHINK. RESOLVE.

For any questions, please email lilyj@wrcommission.org