Inter-Agency Working Group on
Reproductive Health in Crises

PLANNING FOR COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH (SRH) IN CRISIS-AFFECTED SETTINGS:

A Participatory Workshop Toolkit to Transition from the Minimum Initial Service Package (MISP) for SRH

Workbook for Participants Attending the Facilitator Training

UNFPA World Health Organization HEALTH CLUSTER

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Inter-Agency Working Group (IAWG) on Reproductive Health in Crises

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Table of Contents

Acknowledgments

This toolkit is the result of an inter-agency collaboration led by members of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, World Health Organization (WHO) Global Health Cluster, and the United Nations Population Fund (UNFPA). The following colleagues have made invaluable contributions to this resource: Mohira Boboeva and Hilde Cortier (WHO Global Health Cluster), Clare Lofthouse (WHO), Janet Meyers (Save the Children), Sandra Krause (Women's Refugee Commission), Catrin Schulte-Hillen (Médecins sans Frontières), Josep Vargas (UNHCR), and Jonathan Ndzi and Eziz Hellenov (UNFPA).

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- In Bangladesh: Dr. Balwinder Chawla, Ms. Diana Garde, Dr. Mukesh Prajapati, Dr. Hassan Abdi, Dr. Sayantan Chowdhury
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This complementary workbook to the toolkit was informed by stakeholders from Niger, Syria, and Iraq, who participated in the training of workshop facilitators and contributed to its design.

Nguyen-Toan Tran, Wilma Doedens, Kristen Harker, and Alison Greer oversaw the development of this toolkit and the final text along with the IAWG Training Partnership Initiative Steering Committee and MISP Sub-Working Group. Nadia Ahmed, Sara Casey (Columbia University), Katie Meyer and Erin Worden (IAWG), and Meghan Obermeyer (UNHCR) provided a review of the final text. Rec Design designed this toolkit with guidance from Rose Bender.

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List of Acronyms

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretrovirals
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
EC	Emergency Contraception
EmONC	Emergency Obstetric and Newborn Care
GBV	Gender-Based Violence
HPV	Human Papillomavirus
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Asexual
MISP	Minimal Initial Service Package
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Background of the Facilitator Training Process and Materials

In March 2020, the COVID-19 pandemic drastically limited in-person convenings, travel, and direct in-country technical support. These restrictions impacted the preparations for and roll out of participatory planning workshops for comprehensive sexual and reproductive health (SRH) scheduled to take place in Syria, Niger, and Iraq. Prior workshops conducted in the Democratic of Congo, Yemen, and Bangladesh involved a team of external facilitators and support staff.

Within this context, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises Training Partnership Initiative, World Health Organization (WHO) Global Health Cluster, United Nations Population Fund (UNFPA), and partners piloted a cascading capacity development approach. The WHO Global Health Cluster first developed the training methodology and tools to train in-person a cadre of workshop facilitators in Yemen due to travel restrictions. Given the different circumstances, the original materials were revised to incorporate a blended training approach, which combines pre-training independent study, in-person small group study, and a virtual interactive training session. The process results in a training that equips a core group of in-country experienced facilitators with the knowledge and skills to rollout participatory SRH planning workshops at the national or subnational level.

This workbook was conceived to support participants in the facilitator training by guiding them through the participatory planning toolkit and process. For this reason, it is built into the toolkit. Beyond the COVID-19 pandemic restrictions, the training strategy and this workbook could be adapted and used in other contexts where travel is severely limited.

TRAINING OVERVIEW

TRAINING OBJECTIVE: To equip facilitators with the necessary knowledge and skills to facilitate participatory planning workshops for comprehensive SRH services and programming at the national or subnational level.

METHODOLOGY: Blended learning based on reverse classroom[1] principles and organized in three parts:

1. Independent study (at least 2 weeks before the training)
2. In-person group study (in the morning of the training)
3. Virtual interactive training session with facilitators (in the afternoon of the training)

See Annexes for an example of the agenda for the one-day training with in-person group study and virtual session.

1 A teaching or training approach where students or participants study the theory ahead of time and outside of class or an in-person training. Afterwards, class or in-person time is used for group work, application of knowledge, directed problem solving, contextualization, validation, and discussion.

CRITERIA FOR PARTICIPATION:

Selection criteria for facilitators to participate in the training may include:

- Advanced knowledge and experience in SRH programming in crisis-affected settings, including knowledge of the Minimum Initial Service Package (MISP) for SRH
- Advanced knowledge and understanding of the country context
- Prior experience facilitating trainings or workshops involving diverse stakeholders
- Demonstrated commitment to SRH programming and inclusion of marginalized communities

LEARNING OBJECTIVES:

At the end of the training, participants will be:

- Familiar with the workshop toolkit and its steps, including preparations and follow-up.
- Able to prepare the practical aspects of the workshop and adapt the pre-designed documents to the context.
- Able to facilitate a workshop utilizing the methods and techniques described in the workshop toolkit.
- Able to summarize the outcomes of the workshop and compile the evaluations and other documents and information necessary for proper documentation of the workshop.

Note to Training Participants

You are about to join the facilitator training on the participatory planning process for comprehensive SRH services and programming. To get the most out of the training, you are strongly encouraged to read and reflect upon this workbook at least two weeks in advance (independent study). Depending on your level of familiarity, you may need to study additional documents to have as much context as possible, including on international standards such as the MISP. We also encourage you to coordinate with other training participants and meet at least four hours before the training (in-person group study). Some of the activities during the training will have to be prepared in the meeting room before the start of the virtual session with facilitators (see training agenda).

When undertaking independent study using this workbook, please pay attention to the **gray-colored boxes.** These boxes are intended to help you reflect upon the toolkit's steps and resources and prepare for the training.

Lessons Learned from Iraq:

Two weeks before the facilitator training, the Ministry of Health of Iraq created a WhatsApp group for participants and invited the facilitators to join. The WhatsApp group allowed participants and facilitators to introduce themselves, share experiences, motivate one another during the independent study phase, and ask questions about the technical contents of the workbook and workshop logistics. This communication platform has the potential to serve as a community of practice when preparing for and facilitating SRH planning workshops.

Resource Overview

Providing comprehensive sexual and reproductive health (SRH) care to all, including those affected by crises, is an overarching goal of the health sector. However, during a crisis, SRH services that are more critical in preventing death and illness are often prioritized over others. These priority lifesaving SRH interventions are bundled into what is known as the Minimum Initial Service Package (MISP) for SRH. The MISP, which is a global standard in humanitarian response, has six objectives and one additional priority. Objective 6 of the MISP consists of planning for comprehensive SRH services that are integrated into primary health care as soon as possible. Over the years, implementing this planning process has proven to be a challenge.

The objective of this toolkit is to provide a step-by-step guide for SRH coordinators, or staff with equivalent responsibilities, to facilitate an in-country workshop to catalyze participatory planning among stakeholders and partners.

This toolkit will enable facilitators to foster a systematic, engaging, interactive, and inclusive planning process among participants over a two-day workshop. Five key steps move workshop participants towards developing a shared work plan with consensus around priority activities for transitioning from MISP to comprehensive SRH services while strengthening the health system in settings affected by crises.

The toolkit is part of a three-phase process, which includes:

1. Pre-workshop preparations (collecting the necessary data to inform the workshop, identifying key stakeholders, and soliciting feedback in advance from key stakeholders unable to attend the workshop),
2. The participatory planning workshop, and
3. Post-workshop follow-up to fine-tune the work plans and undertake the necessary additional preparations and steps to move forward the prioritized activities.

This toolkit has been piloted in close collaboration with colleagues in the Democratic Republic of Congo, Bangladesh, and Yemen. Lessons learned from partners and participants in these three countries have been integrated throughout this resource.[1] Additionally, tips and variations of activities are included to support the use and contextualization of the toolkit.

> This training resource was rolled out in close collaboration with colleagues in Niger, Syria, and Iraq. Lessons learned from partners and participants in these countries have been integrated into this workbook.

1 Tran NT, Greer A, Kini B, Abdi H, Rajeh K, Cortier H, Boboeva M. Integrating sexual and reproductive health into health system strengthening in humanitarian settings: a planning workshop toolkit to transition from minimum to comprehensive services in the Democratic Republic of Congo, Bangladesh, and Yemen. Conflict and Health. 2020 Dec;14(1):1-2. Available at: https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-020-00326-5

Note to Training Participants

Are you up to date on the MISP? Have you read or re-read Chapter 3 of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (2018), which describes the MISP? Have you completed the *Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module* and obtained a certificate of completion? If not, start your study as soon as possible (approximate study duration: 5-7 hours).

Checklist Before the Training

☐ I have studied Chapter 3 of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (visit www.iawgfieldmanual.com)

☐ I have completed the MISP Distance Learning Module (visit www.iawg.net/misp-dlm)

Introduction

Background

Twenty-five years after the conception of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH), it is still a challenge to plan for comprehensive SRH services that are integrated into primary health care as soon as possible after a crisis and work with the health sector/cluster partners to address the six health system building blocks. These blocks encompass service delivery, health workforce, health information system, medical commodities, financing, and governance and leadership.

Planning for comprehensive SRH forms the core of Objective 6 of the MISP. Misjudging the importance of planning in the early phase of a crisis could delay the programming of expanded and quality SRH information and services. Such a delay would, in turn, compromise timely access to comprehensive SRH programming for communities having survived crises or living in protracted, complex emergencies.

To support the planning process to transition from MISP to comprehensive SRH programs and services and bridge the nexus between the acute response and recovery phase, a workshop toolkit was developed to support SRH coordinators and stakeholders in their efforts to implement Objective 6. This process, which began in 2017 and ended in 2020, was led by the Inter-Agency Working Group (IAWG)on Reproductive Health in Crises Training Partnership Initiative, World Health Organization (WHO) Global Health Cluster, United Nations Population Fund (UNFPA), and partners.

What is the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)?

The MISP is a priority set of lifesaving SRH interventions to be implemented at the onset of every emergency response. The MISP has six objectives and an additional priority activity. Each of the objectives has its own related activities:

OBJECTIVE 1: Ensure the health sector/cluster identifies an organization to lead the 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, gender-based violence (GBV) sub-cluster/sector, and/or 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
- Ensures the community is aware of the availability and location of SRH services

OBJECTIVE 2: Prevent sexual violence and respond to the needs of survivors by:

- Working with other clusters – especially the protection or GBV sub-cluster – to put in place preventative measures at the community, local, and district levels, including health facilities to protect affected populations, particularly women and girls, from sexual violence
- Making clinical care and referral to other supportive services available for survivors of sexual violence
- Putting in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

OBJECTIVE 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections (STIs) by:

- Establishing safe and rational use of blood transfusion
- Ensuring application of standard precautions
- Guaranteeing the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population before the crisis), ensure the provision of female condoms
- Supporting the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an antiretroviral therapy (ART) program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs
- Providing post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure
- Supporting the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensuring the availability in health facilities of syndromic diagnosis and treatment of STIs

OBJECTIVE 4: Prevent excess maternal and newborn morbidity and mortality by:

- Ensuring availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - » At the referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC)
  - » At health facility level: Skilled birth attendants and supplies for uncomplicated vaginal births and provision of basic emergency obstetric and newborn care (BEmONC)
  - » At the community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
- Establishing a 24 hour per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensuring the availability of lifesaving post-abortion care in health centers and hospitals

- Ensuring availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

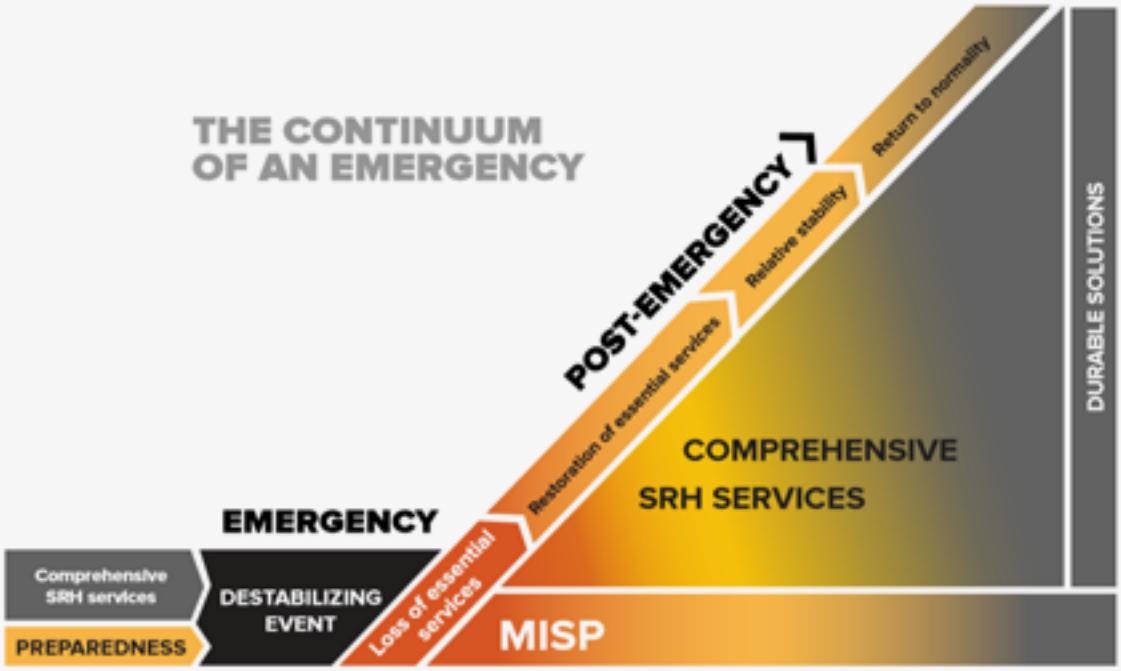
OBJECTIVE 5: Prevent unintended pregnancies by:

- Ensuring availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
- Providing information, including existing information, education, and communications materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
- Ensuring the community is aware of the availability of contraceptives for women, adolescents, and men

OBJECTIVE 6: Plan for comprehensive SRH services integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks, including service delivery, health workforce, health information system, medical commodities, financing, and governance and leadership.

OTHER PRIORITY: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

The goal of the MISP is to prevent SRH-related morbidity and mortality while protecting the right of the affected community to life with dignity. Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn death; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV. Therefore, the MISP was designed to form the starting point for SRH programming.



NOTE: Crisis seldom take a linear, clear-cut path from emergency, stability, recovery to development. Often, they are complex, with settings experiencing varying degrees of improvement or deterioration that can last decades. The provision of RH services must therefore take into account the non-linear trajectory of a crisis, and the gaps in services due to insecurity, competing priorities or dwindling funds in protracted settings. The IAFM is applicable for all settings, wherever an agency finds itself on the emergency continuum.

As highlighted in Objective 6 and in the previous graph, MISP services should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises and the recovery and reconstruction phases.

Implementation of the MISP does not only entail making lifesaving SRH services available. It also entails the essential process of starting to address comprehensive SRH as soon as possible.

For more information, see "Chapter 3: Minimum Initial Service Package (MISP)" of the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

What Are Comprehensive SRH Services?

For this planning process, it is important for stakeholders to understand what SRH services are prioritized in the MISP during a crisis and what is defined as comprehensive SRH programming. Achieving comprehensive SRH services could include the broadening and strengthening of the quality of MISP services as well as the inclusion of SRH services that fall outside of the MISP. According to a report from the Guttmacher-Lancet Commission, comprehensive SRH services are "essential sexual and reproductive health services that must meet public health and human rights standards, including the 'Availability, Accessibility, Acceptability, and Quality' framework of the right to health. The services should include:

- accurate information and counseling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counseling, and care related to sexual function and satisfaction;
- prevention, detection, and management of gender-based violence and coercion;

- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care, to the full extent of the law;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers."[2]

Comprehensive SRH Example: HPV and Cervical Cancer

Human papillomavirus (HPV) is a very common infection. More than three-quarters of sexually active women are estimated to be infected at least once in their lifetimes. The risk of acquiring HPV infection is highest soon after sexual activity begins. Most of these infections are self-limiting and harmless, but a persistent infection over a number of years can cause cervical cancer in women, especially among those living with HIV. Screening and treatment of early stages of cervical cancer (cervical dysplasia or pre-cancer) are effective in reducing morbidity and mortality. The dynamic of cervical cancer development makes it a non-vital and non-essential clinical service to be prioritized during the acute phase of a crisis. Therefore, cervical cancer screening is not part of the MISP. However, due to the high burden of disease among women, such screening and early treatment services (e.g., through a "single visit approach" using visual inspection and acetic acid combined with immediate cryotherapy) should be part of the comprehensive SRH services package to strengthen health systems after an emergency.

Note to Training Participants

Reflect on your experience.

What do you think about the implementation of the MISP objectives in the crisis-affected setting(s) in your country?

What MISP objective(s) should be strengthened?

2 Starrs AM, et al. "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission." The Lancet 391.10140 (2018): 2642-2692. Available at: https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

Do you have other examples of comprehensive SRH services that have been implemented in crisis-affected settings in your country? If yes, describe.

Considerations When Planning for Comprehensive SRH Services

To fully achieve Objective 6 of the MISP and support local and international stakeholders in planning for the delivery of comprehensive SRH services, several critical aspects need to be considered. These include:

- communication among decision-makers, including national governments and implementing partners;
- enabling laws and policies related to SRH and rights;
- adequate financing;
- effective coordination;
- commodity availability and supply chain management;
- human resources management;
- monitoring and evaluation; and
- a system of information sharing, feedback, and accountability to the affected community.

Note to Training Participants

Does this list remind you of something? Yes, the components of the health system that are at the heart of the planning work.

Checklist before the Training

- ☐ I am up to date with the health system building blocks framework (if necessary, read Templates E and F in the Annexes).

As is the case for MISP services, comprehensive SRH services must be accessible for all crisis-affected populations, including adolescents; unmarried as well as married women and men; persons living with disabilities; lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) people; and ethnic and religious minorities. Comprehensive SRH services should be designed to be inclusive and meet the needs of these and other often marginalized populations.

Note to Training Participants

Reflect on your experience.

Who are the people or communities that have the most difficulty accessing SRH services? Why?

Application to Different Humanitarian Contexts

While primarily designed to support the transition from the MISP to comprehensive SRH programming after an acute emergency, this toolkit can be adapted and used in protracted and complex humanitarian settings to expand the range and enhance the quality of available SRH services, which are often limited to a set of minimal services that may not reach all members of the crisis-affected population. Limited resources often constrain SRH planners to focus on easily accessible populations. However, this reality should not narrow the scope of planning and fundraising efforts, which must include adequately budgeted services to reach all communities.

Objective of the Workshop Toolkit

The objective of this toolkit is to guide SRH coordinators (or where not available, health coordinators or managers) in facilitating a national (or subnational, depending on the context) workshop to catalyze participatory planning among stakeholders and partners. The goal is to improve the availability, accessibility, acceptability, and quality of MISP services and integrate comprehensive SRH services into health system strengthening efforts through the development of a **shared work plan for comprehensive SRH programming.**

Participatory Planning and Prioritization Methodology Used in this Toolkit

The workshop is shaped by the understanding that meaningful participation and engagement of relevant stakeholders is essential to inform the design of solutions and interventions that are centered on the diverse needs of different populations, context-oriented, effective, feasible, and sustainable. The proposed methodology will give ample space for key stakeholders to exchange ideas and good practices, jointly

identify gaps and opportunities, and – through individual reflection and group deliberations – reach a consensus on a set of prioritized comprehensive SRH activities to be implemented.

Note to Training Participants

Reflect on your experience as a trainer.

How would you encourage the active engagement of adult participants?

What are the basic principles or techniques you have used to stimulate adult learning?

Health System Building Blocks Framework

The toolkit is grounded in the WHO health system building blocks framework. This framework is used to facilitate a discussion and action around the inclusion of comprehensive SRH services into a primary health care package and higher levels of care, and strengthen health systems in humanitarian contexts. The blocks encompass service delivery, health workforce, health information system, medical commodities, financing, and governance and leadership.

Although the health system building blocks serve as the primary framework for the planning process outlined in this toolkit, a systems thinking approach should be applied to the fullest extent possible. Applying systems thinking to health requires looking at the interactions of other systems, sectors, and factors that contribute to public health in a holistic manner. This can include, but is not limited to: education; household to national and global economics; water, sanitation, and hygiene; transportation; agriculture and food security; and public safety and security.[3]

3 Peters DH. The application of systems thinking in health: why use systems thinking?. Health Res Policy Sys 12, 51 (2014). Available at: https://doi.org/10.1186/1478-4505-12-51

The COVID-19 Pandemic and Planning for Comprehensive SRH

The COVID-19 pandemic has highlighted the critical need for a holistic and whole-society response that leaves no one behind, including those living in humanitarian and fragile contexts. The global response to a pandemic is as strong as the weakest health system.[4] SRH services can strengthen health systems and, therefore, must be part of outbreak preparedness and response as poor health outcomes will surge from the lack or disruption of priority SRH interventions.[5] For instance, gender-based violence and sexual exploitation and abuse may increase during outbreaks due to confinement, increased exposure to perpetrators at home, economic precarity, and reduced access to protection services. Maternal mortality and morbidity will increase if women can no longer have access to emergency obstetric and newborn care, contraception to prevent unintended pregnancies, and services to manage abortion complications, among other factors. Depending on the scenario, consider the following actions to ensure MISP services and comprehensive SRH planning and programming.

In anticipation of health resource reshuffling toward outbreak prevention and control measures, SRH working groups must actively advocate for the maintenance or implementation of a priority set of SRH services as defined in the MISP.

Where plans for comprehensive SRH are underway, SRH working groups will need to review and adapt them to the situation, which could mean cycling SRH programs back momentarily to the MISP while ensuring its wide coverage and access for the populations most at risk.

As soon as the situation and resources allow, SRH working groups should convene all key stakeholders to use this toolkit to plan for the transition from MISP to comprehensive SRH services. If such exercises were conducted before the outbreak, SRH working groups and key stakeholders should revisit the plans for comprehensive SRH services. Such reviews will help consolidate initial plans and make them relevant to the post-pandemic era by integrating local and international lessons learned and best practices that have emerged from outbreak preparedness and response.

How Does the Work Plan Developed Fit into Overall Health Planning and Programming?

The shared work plan for comprehensive SRH that will be developed at the end of this participatory planning process can be used to:

4 Quinn SC, Kumar S. Health inequalities and infectious disease epidemics: a challenge for global health security. *Biosecur Bioterror.* 2014;12(5):263-273. doi:10.1089/bsp.2014.0032. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4170985/

5 Tran NT, et al. Not a luxury: a call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic. The Lancet Global Health 8.6 (2020): e760-e761. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30190-X/fulltext

- strengthen existing SRH implementation,
- help focus attention on problem areas,
- be used as an advocacy tool to garner support and funding for programs, and
- feedback into the overall sexual and reproductive health program review.

The goal of this process is to better support the transition from minimum to more expanded SRH services in protracted, recovery, or fragile settings and further address the SRH needs and rights of women, men, gender nonconforming people, adolescents, and newborns in these situations.

When Should the Workshop Take Place?

Although initial planning for comprehensive SRH is started at the onset of the response, this formal participatory process should begin as soon as MISP services are available and accessible, and progress towards reaching MISP indicators is underway. It should also take place when agencies begin longer-term planning and funding processes, such as the Humanitarian Response Plans, and in preparation for humanitarian appeals processes. The integration of comprehensive SRH services into these processes will help to avoid service delays and ensure sustainability.

In addition to the resources required for the process and workshop, it is recommended to identify seed funding to kick start the implementation of the activities that will be prioritized in the comprehensive SRH work plan. Facilitating the rapid operationalization of activities in the work plans as part of the follow-up process builds trust in the planning process and demonstrates that investments into comprehensive SRH services and programming are a priority. When considering the timing and budget for the workshop, it is important to keep these factors in mind.

Audience for this Toolkit and Workshop

FACILITATOR: SRH coordinator (or health coordinator or manager) in collaboration with national counterparts.

In addition to the lead facilitator, it is recommended that there be a:

- co-facilitator
- workshop assistant to help with logistics and during group work
- notetaker/rapporteur
- support person available for technology needs

TARGETED AUDIENCE FOR PARTICIPATION IN THE WORKSHOP: National (or sub-national, depending on the context) health system strengthening team and key partners (see the section titled "Pre-Workshop Preparation" for more information).

How Many People Should Attend the Workshop?

Although the workshop should be open to and inclusive of all key stakeholders, the participatory planning methodology is best suited for a maximum of 30 participants.

Given the limitation of 30 participants, see the guidance in the following "Pre-Workshop Preparation" section for suggestions as to how other stakeholders can feed into the planning process.

Timeline

WEEK	1	2	3	4	5	6	7	8 ONWARD
PREPARATION	X	X	X	X	X	X		
WORKSHOP								
POST-WORKSHOP FOLLOW-UP & IMPLEMENTATION OF PRIORITY ACTIVITIES								X

*This timeline includes a 2-day stakeholder workshop and 1-day for immediate post-workshop activities (e.g., meeting notes, synthesizing action plans, reporting, etc.). Monitoring and follow-up will be coordinated by the SRH coordinator.

Outline of the Process and Steps

Phase I: Preparation

Estimated Time Frame: 6 weeks

STEPS	OBJECTIVES	METHODOLOGY
Pre-workshop preparation by the SRH coordinator in collaboration with local partners	To prepare background documents to inform the discussions during the workshop and identify key stakeholders	Collection of background SRH data and mapping of key stakeholders

Phase II: Workshop

Estimated Time Frame: 2 days

Note:If the workshop requires translation, plan for more time during the workshop and budget for translation services. Preparations also should factor in the time and budget needed for translating materials in advance.

STEPS	OBJECTIVES	METHODOLOGY
WORKSHOP DAY 1		
Introductions and expectations	To break the ice among participants and agree on the objectives of the workshop	Interactive plenary discussion
Step 1 - Setting a common understanding	To set the scene for the workshop with an overview of the essential information that participants need to be aware of in order to effectively plan for comprehensive SRH	Interactive PowerPoint presentations
Step 2 - Mapping needs and opportunities related to comprehensive SRH	To reflect upon, discuss, and map current needs and opportunities in relation to comprehensive SRH programming	Personal reflection and group work
Step 3 - Setting planning priorities for comprehensive SRH	To agree on a set of planning priorities related to comprehensive SRH	Group discussion
Step 4 - Teamwork on agreed planning priorities for comprehensive SRH	To produce a detailed and practical work plan to implement the top three SRH priorities	Teamwork

STEPS	OBJECTIVES	METHODOLOGY
Workshop Day 2		
Step 5 - Reporting back and finding synergies	To establish a consolidated national (or subnational, depending on the context) work plan to implement priority interventions related to comprehensive SRH	Group discussion

Phase III: Follow-up and Implementation of Activities

Estimated Time Frame: Ongoing

STEPS	OBJECTIVES	METHODOLOGY
Post-workshop follow-up	To ensure that plans are followed through and challenges are addressed	As needed: follow-up meetings, email, etc.

Pre-workshop Preparation

WHEN: Start at least 6-8 weeks before the workshop.

WHAT: The SRH coordinator, in collaboration with local partners, will undertake the following steps to prepare background documents to inform the discussions during the workshop, and identify key stakeholders.

Lessons Learned from the Toolkit Pilots: **Preparation Is the Stepping Stone for a Successful Workshop**

Experience has shown from pilots in the Democratic Republic of the Congo, Bangladesh, and Yemen that the pre-workshop preparation is critical to ensure that the workshop meets its objective in producing a concrete and fact-based work plan. With careful planning, facilitators will have the data and information assembled and, when possible, shared with all participants at least a week in advance. This allows participants the time to reflect on the SRH situation before the workshop starts. The more detailed information that can be provided for advanced review, the more effective the planning process will be during the brief two-day workshop.

HOW: The preparation for the workshop should focus on two elements: mapping the status of current MISP implementation and SRH programming before the crisis, and mapping key stakeholders.

A. Map the status of current MISP implementation and SRH programming before the crisis (Templates A, B, and C):

1. The status of MISP implementation (Template B and accompanying Excel workbook)

Collect data generated by the MISP indicators (or similar), including on SRH supplies availability. The analysis should address the following questions:

- To what extent did MISP interventions reach all women, men, gender nonconforming people, adolescents, and newborns?
- Were there unserved or underserved populations? If so, has there been a mapping or formative assessment to inform the workshop that has considered the voices of these communities?
- Has the MISP improved the health status of all women, men, gender nonconforming people, adolescents, and newborns?
- What MISP objectives and activities were implemented? Where, when, and by whom?
- What was the quality of the services provided?
- What were the successes in MISP implementation?

- What are the main barriers causing gaps in the implementation of the MISP?

  Note: Solutions and recommendations for these problems will be discussed in the stakeholder planning workshop.
- Is there available information to share on the costs of services and funding opportunities?

Note to Training Participants

Reflect upon and try to answer the above questions on your own.

Notes:

Available Tools and Resources for Mapping the Status of MISP Implementation

To assess the status of the SRH activities included in the MISP, you may reference the following tools that have been created by IAWG and are available on www.iawg.net, as well as others:

- MISP Process Evaluation Tools (2017, to be updated in 2021)
- MISP Checklist (2018)
- MISP Readiness Assessment (revised version available in 2020)

Another helpful forthcoming resource in 2021 is *Community Capacity Assessment Tools*, developed by the Approaches in Complex and Challenging Environments for Sustainable SRHR (ACCESS) Consortium.

2. The status of the SRH program before the crisis

Provide an overview of the SRH program goals and objectives before the crisis (Template C). The analysis should focus on:

- The SRH status of women, men, gender nonconforming people, and adolescents and information on newborn health in the host country and the country of origin.
- SRH service delivery in the host country and the country of origin.

Note: For internally displaced populations, the population comparisons should be between the host community and the different regions of origin.

Resources for the SRH Program Analysis May Include:

- Ministry of Health documents and protocols that exist or are under development (such as those regarding SRH, contraception, post-abortion and safe abortion care, gender, etc.)
- Demographic and health surveys
- United Nations and nongovernmental organization reports

Note to Training Participants

Checklist:

☐ I have reviewed Template A and have the following questions:

☐ I have reviewed Template B and have the following questions:

☐ I have reviewed Template C and have the following questions:

☐ Other resources for the analysis of SRH programs could include:

B. **Map key stakeholders who need to be part of the workshop. List separately those involved before the crisis and those involved during MISP implementation to see where gaps may be.**

Lessons Learned from the Toolkit Pilots: **Ensuring an Inclusive Planning Process**

If key stakeholders – including representatives of communities that have been marginalized – are unable to attend the workshop, every effort should be made to include them in the preparation and follow-up processes. In advance of the workshop, this can be done through key informant interviews, focus group discussions, and surveys as part of the data collection process. After the workshop, participation can occur during follow-up consultations on the work plans developed. Voices from marginalized and affected communities are critical to developing an inclusive and comprehensive plan for SRH.

Note to Training Participants

Reflect on your experience.

What are some other ways to engage the communities you have identified as marginalized so that their voices and perspectives are heard and represented in this planning process?

Stakeholders to consider include representatives of the following institutions and communities:

- Ministry of Health (planning and implementation of SRH services)
- Ministry of Finance (financing of health services)
- Ministry of Education (training and certification of health staff, comprehensive sexuality education)
- Ministry of Home Affairs (refugees and internally displaced persons)
- Ministry of Policy, Planning, and Information
- Humanitarian and development organizations, including nongovernmental organizations and United Nations agencies working on SRH in the country (local, national, as well as international)
- Humanitarian and development organizations working on SRH-related services (e.g., water, sanitation and hygiene, gender-based violence, camp management, economic empowerment)
- Women's organizations (working in refugee, internally displaced, and host communities)
- Community-based and civil society organizations (working in refugee, internally displaced, and host communities)
- Universities / research centers (working on health or SRH with refugee and internally displaced persons)
- Midwifery, nursing, and medical schools
- Professional associations (e.g., midwifery, nursing, obstetrics and gynecology, etc.)

- Communities of concern (women, men, adolescents and youth, persons living with disabilities, LGBTQIA, ethnic and religious minorities, sex workers)
- SRH service providers (e.g., frontline, referral-level)

OUTPUT: A short summary (1-2 pages) of key background information for workshop stakeholders (Templates A, B, and C) and a PowerPoint to be presented in the session on "Setting a Common Understanding."

Lessons Learned from the Toolkit Pilots: **Prepared and Present Participants**

It is important to have all participants present from the very beginning of the workshop to not disturb the participatory process or interrupt the group dynamics. Those who are in attendance should be asked to take the MISP Distance Learning Module (available at www.iawg.net/misp-dlm) in advance to establish a clear understanding of the SRH services included in the MISP for those who may not be familiar.

Recommended to be Shared with Participants at Least a Week in Advance of the Workshop:

- ☐ Description of expectations for attendees: Participants must have the time, capacity, and organizational support to attend the workshop and commit to investing in its follow-up. This critical information should be emphasized by the workshop coordinator in the invitation email to participants and their supervisors and shared with the information below.
- ☐ Summary of the MISP implementation and SRH background information (completed Templates A, B, and C)
- ☐ List of key stakeholders/participants (completed stakeholder mapping)
- ☐ Workshop agenda (revised Template D)
- ☐ Background and overview of the WHO health system building blocks (Templates E and F)
- ☐ MISP reading materials and resources (available on www.iawg.net):
  - ☐ *Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module*
  - ☐ Chapter 3 of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
  - ☐ MISP Reference (also known as the "Cheat Sheet")

Lessons Learned from the Toolkit Pilots: **Establishing Early a Community of Practice**

In 2020, Niger, Syria, and Iraq started planning for participatory workshops in their respective countries. To support the pre-workshop preparation phase, in addition to regular email exchange, each country focal point found it useful to set up formal weekly teleconference calls with the IAWG Training Partnership Initiative. In addition, unscheduled WhatsApp messaging and calls were regularly used for quick questions and answers whenever the need arose. The two-way communication in its weekly and spontaneous, and written and oral formats allowed for a timely and effective resolution of questions from workshop organizers. It also enabled the IAWG Training Partnership Initiative to remotely support the countries and collaborate around identifying the contextually appropriate solutions.

Workshop Supplies and Preparation

Facilitators should bring with them or ensure the following supplies are available for the workshop.

ITEM	UNITS	CHECK
Laptop	At least 1	☐
Projector	1	☐
Flip charts	At least 2	☐
Markers in different colors		☐
Tape or pins	Several packs	☐
Post-its or cards in several colors	Several packs	☐
Name tags		☐
Pens	1 per participant	☐
Notebooks	1 per participant	☐
Participant folders with hard copy handouts	1 per participant	☐
USB keys	1 per participant	☐
Prepared charts and tables for display during Steps 2 and 3		☐
Sticky dots for voting		☐

Workshop Day 1

Introductions and Expectations

OVERVIEW	This session opens the workshop. After welcoming remarks, participants will introduce themselves and state their expectations for the workshop.
OBJECTIVE	By the end of the session, participants should: - Be familiar with fellow participants and facilitators. - Have stated their expectations and be aware of if expectations will be met during the workshop.
HOW LONG	30 minutes
HOW	Interactive plenary discussion
MATERIALS	☐ Flip charts or whiteboards ☐ Markers ☐ Pins or tape to display materials on the wall ☐ Cards/Post-its in several colors ☐ Name tags ☐ Packets for participants containing: • a folder with hard copies of the following: • key SRH background documents (Templates A, B, and C) • agenda (Template D) • health system building block overview (Templates E and F) • handouts for group work (Templates G, H, and I) • workshop evaluation form (Template J) • list of participants • PowerPoint handouts • MISP Reference • a pen and notebook

Lessons Learned from the Toolkit Pilots: **Establishing a Safe Space**

Based on experience in pilot testing this toolkit, the workshops will gather among its participants responders and program staff who have been impacted by the crisis and likely experienced trauma. From the start of the workshop, facilitators must remind participants about this issue. Encourage all of those present in the room to co-create a safe, caring, respectful, confidential, and non-judgmental space where participants can share and process their experiences. Facilitators should encourage participants to take care of themselves physically and emotionally and support one another throughout the workshop.

Note to Training Participants

Reflect on your experience as a trainer. In addition to creating a safe space, how will you concretely put into practice other teaching strategies to encourage adult learning? For example:

- ☐ Help learners to **identify their learning objectives**
- ☐ **Build on the personal experience** of each learner and encourage **personal reflection** and **exchange of experiences among learners**
- ☐ Enable learners to be **active contributors** to their learning
- ☐ Encourage **collaboration** among participants
- ☐ Ensure **relevance** of the content to the learner's job or occupational function
- ☐ Adopt a **problem-solving (and innovative)** approach

- ☐ **Support** learners in a caring way
- ☐ Enable learners to **observe the exemplary behavio**r of facilitators and their peers
- ☐ Enable learners to **practice** what they have learned
- ☐ Encourage learners to **receive feedback** from and **give feedback** to peers and facilitators

Process

1. Welcome all participants as they arrive. Invite them to sit wherever they would like but encourage them to mix with one another.
2. While waiting for all participants to arrive, ask those who are already present to write down one main expectation on the cards or Post-its (e.g., what they would like to get out of the workshop).
3. Invite the head of the organization hosting the event, or others as necessary, to give opening remarks (suggested time: 3 minutes maximum).
4. Ask participants to take a maximum of 15 seconds to stand and introduce themselves to the large group, by name, function or title, and organization. One of the facilitators can break the ice and start by saying, "My name is (name) and I am a (function or title) at (organization)."

Variations of this activity:

Provide 30 seconds for participants to introduce themselves to a partner. Then, each member of the pair introduces their colleague to the larger group.

Ask participants to arrange themselves in a line according to alphabetical order. Going down the line, ask participants to share their name, function or title, and organization with the group.

5. Invite participants to finish writing their main expectation for the workshop on the cards.
6. A co-facilitator will collect the cards, group them by theme, and display them on the wall by similar

expectations.

7. Read out loud the most commonly expressed expectations to all participants.
8. Present the overall outcomes of the workshop and use these to respond to the expectations, stating clearly which are and which are not likely to be addressed. Keep outcomes and expectations displayed on a wall of the room for the remainder of the workshop, as you will need to come back to these on the last day.
9. Invite participants to open their folders and remove the workshop agenda from the packet of materials. Review the agenda together as a group.

Note to Training Participants

Get ready to role-play the process involved in the introductions and expectations workshop step during the **virtual training session**.

Tip:

It is recommended to give all participants a USB key with the workshop information and materials. However, it is advised to wait until the end of the workshop to give participants the USB key. Documents can be added throughout the course of the workshop, including notes, photos, and draft work plans. Participants will then receive the USB key with the entire packet of materials before leaving. The workshop assistant, facilitators, and co-facilitators can help with this process during breaks.

Note to Training Participants

Please write down your questions and suggestions regarding the workshop session on *Introductions and Expectations:*

Step 1 - Setting a Common Understanding

OVERVIEW	This session sets the scene for the rest of the workshop. It offers an overview of the essential information that participants need to be aware of to effectively plan for comprehensive SRH services.
OBJECTIVE	By the end of the session, participants will have a common understanding of the following topics: - MISP and comprehensive SRH services - Definitions of quality SRH services - Health system building blocks (service delivery, health workforce, medical commodities, health information system, financing, and governance and leadership) - Current situation of SRH service provision in the affected areas, marginalized populations, and needs
HOW LONG	90 minutes
HOW	Interactive PowerPoint presentation
MATERIALS	☐ Health system building blocks sign attached to the wall ☐ Health system building blocks overview and description (Templates E and F) ☐ SRH background information (Templates A, B, and C) ☐ MISP Reference ☐ Markers ☐ Flip charts or whiteboards ☐ Audio visual material to project a video clip, if using

Process

1. Present the PowerPoints which cover the following topics:
    - MISP and comprehensive SRH services, and what it means to integrate comprehensive SRH services into primary health care
    - Definitions of quality SRH services
    - Health system building blocks
    - Current national or subnational SRH situation

Note to Training Participants

During your **independent study**, review the PowerPoint and write down your thoughts and questions.

During the **in-person study group**, discuss this step and designate a volunteer willing to role-play this step **during the virtual training session**. (An example includes the slides with information on MISP and comprehensive SRH programming, or the health system building blocks. Note that the presentation on the current status of SRH programming will require much more preparation time.)

2. Facilitate a discussion. To reinforce the different health system building blocks that are required to be addressed during the planning process, try to link participants' feedback to each of these components. For example, state "the need to improve service providers' skills that you described relates to the human resources building block." Or, ask participants, "the funders that you mentioned are linked to which health system building block?" (Answer: financing).

Note to Training Participants

Please write down your questions and suggestions regarding *Step 1 - Setting a Common Understanding:*

Step 2 - Mapping Needs and Opportunities Related to Comprehensive SRH Priorities

OVERVIEW	This session engages participants to reflect upon, discuss, and map current needs and opportunities in relation to comprehensive SRH programming. The health system building blocks will serve as the framework for this exercise.
OBJECTIVE	By the end of the session, participants will have established a mapping of comprehensive SRH needs and opportunities within a health system framework.
HOW LONG	90 minutes
HOW	Personal reflection and group work
MATERIALS	☐ Post-its or cards of two different colors (one color for needs, another color for opportunities) ☐ Markers and flip charts or whiteboards ☐ A replica of the table below, using A4 or A3 format paper for the headings, prepared on a wall of the meeting space ☐ Current SRH needs and opportunities (Template G)

Remember: Systems Thinking

This toolkit uses the health system building blocks as a framework. However, encourage participants to think about other critical contributing factors to SRH outside of the health system. How can these factors (e.g., education, livelihoods, safety and security, water, hygiene, and sanitation) be addressed in the planning process for comprehensive SRH services and programming? Do other key stakeholders need to be involved?

Note to Training Participants

Reflect on your experience.

What are some of the systems factors you know of or have incorporated to facilitate the implementation of SRH programs and services? How did you engage with different sectors?

HEALTH SYSTEM BUILDING BLOCK	CURRENT NEEDS	OPPORTUNITIES
Service delivery • Adolescent SRH • Contraceptive services • Maternal and newborn health, including safe abortion care and fistula care • Gender-based violence • Prevention and treatment of STIs/HIV • Gynecology/urology services • Reproductive cancers • Management of infertility • Others:		
Health workforce		
Medical commodities		
Health information system		
Financing		
Governance and leadership		

Note to Training Participants

During the **in-person group study**, prepare the necessary materials and role-play each of the process points described below. Build together the table shown above on the wall of the meeting room (see pictures below for inspiration).

- A training participant plays the role of facilitator
- The others play the role of workshop participants
- Designate a volunteer who will report **during the virtual session** on how you role-played this step as well as any questions or comments you may have about it

Process

1. Invite each participant to individually reflect upon the presentations of the previous session and list their perceived:
   - current needs related to comprehensive SRH (e.g., comprehensive family planning programming, cervical cancer screening services).

- current and future opportunities related to comprehensive SRH (e.g., linkages, expertise, pooling of resources).

2. Ask participants to write their perceived needs and opportunities on Post-its or cards. Please note that there should only be one item written on each; *needs* should be written on Post-its in one color and *opportunities* on another color.
3. Review the table on the wall and give a few examples.
4. Invite participants to stick their Post-its on the table according to needs, opportunities, and the different health system building blocks.

Variation of this activity:

For smaller groups: Individuals can post their responses onto the table provided and share their thoughts with the group.

For larger groups: During the pilots – especially where translation was required – requesting individuals to share their responses one-by-one took too long; participants lost focus. Instead, invite small groups of participants (around 5 people at a time) to post their responses on the tables provided. Instead of the facilitator reading and sharing back the written individual reflections, ask the whole group of participants to move to the front of the room to observe the Post-its responses.

5. When all the Post-its are attached to the table, invite participants to review and discuss the contributions amongst one another and add more ideas, if necessary. At this stage, explain that all ideas are welcome and that this is not the time to question participants' inputs.
6. Ask participants to return to their seats.
7. Clarify the proposed items and group them into similar themes based on the discussions and feedback. Create broader umbrella categories within each building block if necessary (e.g.,"contraceptive implants" and "intrauterine devices" under "long-acting contraceptive methods" or under "family planning program").
8. Facilitate a discussion about the contents of the table with the whole group.
9. Before the break, explain that a prioritization exercise will be facilitated in the next session. Show the proposed prioritization table (Template H) and facilitate a discussion to see whether participants agree on this prioritization framework and criteria. Take into account feedback from participants and the overall emerging consensus and modify the criteria and table as needed.

Step 2: Example of a table built on the windows in the workshop room. The empty table is pictured above and the completed table below. (Kinshasa, DRC, August 2018. Photo credit: Nguyen Toan Tran)

Note to Training Participants

Please write down your questions and suggestions regarding *Step 2 - Mapping Needs and Opportunities Related to Comprehensive SRH Priorities:*

Step 3 - Setting Planning Priorities for Comprehensive SRH

OVERVIEW	This session will allow participants to prioritize the SRH activities and interventions that have emerged from the previous exercise. This activity is based on pre-determined criteria for prioritization.
OBJECTIVE	By the end of the session, participants will have identified the top planning priorities related to comprehensive SRH programming.
HOW LONG	60 minutes
HOW	Group discussion
MATERIALS	☐ Sticky dots (five per participant) ☐ Prepare and attach to a wall of the meeting space a replica of the table below, using A4 or A3 format paper for the headings ☐ Flip charts or whiteboards ☐ Markers ☐ SRH priorities mapping (Template H)

SETTING SRH PRIORITIES*

Priority	Importance of the problem	Efficacy of the intervention	Program requirements	Costs	Health system capacity	Opportunities and resources already available
Higher ↕ Lower	High	High	Low	Low	High	High
	Medium	Medium	Medium	Medium	Medium	Medium
	Low	Low	High	High	Low	Low

*The priorities for decision-making in each setting may be different. Consult in advance of the workshop with key stakeholders to identify these factors and how to consider opportunities and synergies. Then, edit this template accordingly in advance of the workshop or at the end of Step 2.

Note to Training Participants

What prioritization criteria is important for your setting? Are there other factors to consider?

Tip:

Ensure there is enough time for ample discussion and reflection during all group activities.

Note to Training Participants

During the in-person group study, prepare the necessary materials and role-play each of the process points described below. Build together the table shown above on the wall of the meeting room (see pictures below for inspiration).

- A training participant plays the role of facilitator
- The others play the role of workshop participants
- Designate a volunteer who will report **during the virtual session** on how you role-played this step as well as any questions or comments you may have about it

Process

1. Divide participants into working groups of 6 to 10 (maximum) people. Each group should make its own table. Ask participants how they would like to be grouped. For example, teams could be divided according to the following criteria:
   - *Subnational or local level:* participants providing services in the same geographic area should be grouped together.
   - *National level:* participants working at the national or central level should be grouped together in another team.

Variation of this activity:

Experience has shown there are different ways to divide participants, including by area of expertise or geography. Each has a trade-off. Consult with the participants if they have a preference as to how they would like to be grouped.

2. Based on their understanding of national or subnational priorities, ask each team to stick to the table of the different activities or interventions identified during the previous session that are relevant to their contexts.

3. Be sure to discuss the following points:

   - When there are more opportunities, the costs or the resources required may be less.
   - Cross-cutting interventions have great impacts on SRH. These include: skills-based midwifery training, integration of health services (e.g., STI screening and management in antenatal care, STIs and contraception in adolescent SRH services, mental health and psychosocial support services in SRH programs, GBV and water, sanitation, and hygiene services), interventions to address gender inequalities, and investments in effective delivery channels that could positively influence different levels of services.
   - Cross-cutting priorities should be considered, especially for the national teams. This would allow the locally based teams to focus on local priorities.

4. Walk around the room and observe the groups. Respond to any questions and encourage reflection and discussions within the groups as you see fit.
5. When it seems that the groups have completed the prioritization exercise, invite them to review the other groups' work and share their thoughts before returning to their tables. Based on their observations and conversations, groups can make changes to their own tables.
6. Distribute five sticky dots to each participant. These will be used to cast individual votes.
7. Explain to participants that this "voting" technique is not designed to identify majority winners. It is a technique for the group to visualize overall trends, and to consider and further discuss what others are thinking. This process allows for all participants to share their thoughts, including those who are shyer to express themselves orally.
8. Invite participants to stick their five dots on what they think are the most important activities or interventions. Explain that the dots can be divided between different choices within each of the categories, or all added to one activity or intervention. They are free to be used as each person prefers.
9. After the process concludes, each team should count the votes and identify the top three prioritized activities or interventions. Comparisons and justification between the prioritized options should be further discussed until consensus is reached. If there is any disagreement, encourage further discussion among group members until all teams arrive at consensus. Explain that these main priorities will be kept by each team for the rest of the workshop. The other priorities will be addressed at a later stage by key national actors as needs, resources, and priorities evolve.

Variation of this activity:

In Bangladesh, participants were first divided into five groups during this activity. In addition to voting, each of these groups reached consensus through members' comparison and justification of the selected SRH priority areas. Then, the five groups merged into two groups. These two larger groups presented the priorities they had agreed upon in their smaller groups. Together, they discussed the rationale for selecting the priority areas until all were in agreement. Next, the two groups merged into one group of all workshop participants. The discussion of the priorities and their rational continued until the entire group of participants agreed on the same priority areas to focus on.

An example of a table created for Step 3 and built on the windows of the workshop space. Note the Post-its and circles representing votes. Kinshasa, DRC, August 2018 (Photo credit: Nguyen Toan Tran)

Note to Training Participants

Please write down your questions and suggestions regarding *Step 3 - Setting Planning Priorities for Comprehensive SRH:*

Step 4 - Teamwork on Agreed Planning Priorities for Comprehensive SRH

OVERVIEW	Each team will work on the three principal priorities identified in Step 3. Each team will discuss and establish a practical workplan that identifies who will do what, where, when, and how.
OBJECTIVE	By the end of the session, participants will have produced a detailed and practical work plan to implement the top three priorities.
HOW LONG	3-4 hours
HOW	Teamwork
MATERIALS	☐ Markers and flip charts or whiteboards ☐ Workplan for Comprehensive SRH - hard and soft copies (Template I)

Lessons Learned from the Toolkit Pilots: **Defining Principles for Collective Action**

Participants in the Democratic Republic of Congo found it essential to collectively define and agree upon guiding principles for collaboration. This activity occurred before discussing the details of the work plans. The principles encompassed coordination between actors, non-duplication of efforts, evidence-informed programming, equity in population coverage, and continuous learning through communities of practice. It is recommended to discuss with workshop participants how they would define the core principles for collective action and to build consensus around a shared definition at this phase in the planning process.

Note to Training Participants

During the **in-person group study**, designate a volunteer willing to role-play this step in the afternoon **during the virtual training** (e.g., giving instructions, explaining the matrix, etc.).

Process

1. Explain how to fill the pre-established matrix, taking into consideration the following tips:
   - Work with existing resources and opportunities.
   - Be specific, realistic, and ensure the achievability of the proposed steps.
2. Allow participants sufficient time to complete the matrix. Rotate around the room to answer questions and be of any support to the teams.

Place /context: _____

ACTIVITIES	Next steps	Focal points	Additional groups/people to involve	Timing	Resources needed	Comments
PRIORITY 1						
PRIORITY 2						
PRIORITY 3						

Tip:

Facilitators should actively walk around the room and be of support to all groups during this step. Participants should also be encouraged to visit other groups and share thoughts and their work plans with each other, especially if they have finished early. This continuous sharing and these discussions will facilitate with finding synergies across work plans during Step 5.

Lessons Learned from the Toolkit Pilots: **Shared Accountability**

To ensure the timely and effective implementation of the work plan, participants must be encouraged during the workshop to commit to its operationalization and agree upon responsibilities (who will do what, when, where, and how). Each of the activities of the work plan must have at least one focal point to lead on its implementation. Remember that a requirement for participants is that they have the time, capacity, and organizational support to attend the workshop and commit to investing in its follow-up.

Note to Training Participants

Do you have any questions about the table?

What difficulties could you anticipate in completing the table? What would be the solutions?

Please write down your questions and suggestions regarding *Step 4 - Teamwork on Agreed Planning Priorities for Comprehensive SRH.*

END OF DAY 1

Workshop Day 2

Step 5 - Reporting Back and Finding Synergies

OVERVIEW	In this session, each team will share and build on their proposed work plans for comprehensive SRH programming. Synergies will be explored by all participants and groups, particularly by the cross-cutting work teams (see Step 3, Process point 3).
OBJECTIVE	By the end of the session, participants will have established a consolidated draft of the national (or subnational, according to the context) work plan to implement priority interventions related to comprehensive SRH.
HOW LONG	6 to 8 hours
HOW	Group discussion
MATERIALS	☐ Markers and flip charts or whiteboards ☐ Evaluation forms (Template J)

Building Support for the Work Plans and Planning Process

To encourage personal and organizational investment in the process and work plan, key stakeholders and decision-makers, such as the heads of organizations, must be in the room together at this time. If they were not present throughout the workshop, invite them back to participate in this critical session. Additionally, ensuring there is seed funding for the rapid implementation of some of the activities builds trust in the process. If investments are made strategically, they can catalyze additional funding and operationalization of other activities within the work plan.

Note to Training Participants

During the **in-person group study**, designate a volunteer willing to role-play this step in the afternoon **during the virtual session** (e.g., giving instructions on how the session will run).

Process

1. Each team presents their work plans for comprehensive SRH programming (maximum 30 minutes per presentation).

2. Facilitators should then facilitate a discussion and encourage teams to find complementary activities in each work plan.
3. Ensure that agreement is reached for each of the steps within the work plans and who will do what, when, where, and with which resources. This will help with developing a detailed matrix, which can be consolidated after the workshop.
4. Before ending the workshop, review the participants' expectations that are displayed on the wall. Reflect as a group as to whether they have been met.
5. Thank all participants for their work and collaboration.
6. Ask all participants to complete an evaluation form and return it to the workshop organizers.
7. Upon submission of the evaluation form, organizers should hand each participant a USB key with the imported materials from the workshop. Encourage participants to share this information with colleagues who were unable to attend.

Note to Training Participants

Please write down your questions and suggestions regarding *Step 5 - Reporting back and finding synergies:*

END OF WORKSHOP

Post-workshop Follow-up

WHEN: Right after the workshop and until an agreed-upon time frame to allow the implementation of the work plans

WHAT: The workshop was a critical step to gather stakeholders and help them collectively plan for comprehensive SRH programming. The SRH coordinator, in collaboration with designated local partners, needs to ensure that the work plans are implemented. The following post-workshop activities can contribute to maintaining continuous buy-in for the work plans and troubleshoot for potential challenges faced by SRH coordinators and partners:

- Consolidate the work plan and share it with participants and selected stakeholders in a timely manner.
- Offer to facilitate regular follow-up meetings to report back on intermediate results and adjust the implementation plan as needed. Offer to work with the different teams to fundraise at the national, regional, or international level for activities.
- Facilitate the linkage with regional or international champions working on similar issues (e.g., other IAWG partners).
- Share existing IAWG resources on the topics that can help to facilitate further planning and implementation of comprehensive SRH programming.

OUTCOMES: Teams are motivated, engaged, and have the necessary resources to implement their work plans.

Lessons Learned from the Toolkit Pilots: **Maintaining Momentum and Progress Throughout Follow-up**

The actions taken within this step help to ensure the transfer of knowledge, roles, and responsibilities to new colleagues who join the collective effort at a later time. There is often a high turnover of staff during an emergency response and during the transition to the recovery phase. Regular follow-up meetings, consistent reporting, and clearly defined roles and responsibilities will help maintain momentum and progress towards the transition to comprehensive SRH programming.

Note to Training Participants

Please write down your questions and suggestions regarding post-workshop follow-up.

Please complete the Training Evaluation Form and return it to the training organizers.

Notes:

Resources

- World Health Organization. **Analyzing disrupted health sectors**. 2009. Available at: http://www.who.int/hac/techguidance/tools/disrupted_sectors/en/
- Inter-Agency Working Group on Reproductive Health in Crises (IAWG), Sub-Working Group on Adolescent Sexual and Reproductive Health (ASRH). **ASRH Toolkit for Humanitarian Settings: 2020 Edition.** New York City: 2020.
- World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). **Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings**. 2020. Available at: https://apps.who.int/iris/bitstream/handle/10665/331535/9789240001411-eng.pdf?ua=1
- Approaches in Complex and Challenging Environments for Sustainable SRHR (ACCESS) Consortium. **Community Capacity Assessment Tools**. 2021.
- World Health Organization: **Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action**. Geneva: 2007. Edited by the World Health Organization.
- Inter-Agency Working Group on Reproductive Health in Crises. **Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery.** 2009. Available at: www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf
- Inter-Agency Working Group on Reproductive Health in Crises. **Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.** 2018. Available at: www.iawgfieldmanual.com
- Inter-Agency Working Group on Reproductive Health in Crises. **MISP Checklist: Monitoring of MISP Implementation, Figure 3.2.** 2018. Available at: www.iawgfieldmanual.com/manual/misp
- Inter-Agency Working Group on Reproductive Health in Crises. **MISP Considerations Checklist for Implementation During COVID-19.** 2020. Available at: www.iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19
- Inter-Agency Working Group on Reproductive Health in Crises. **Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Settings: A Distance Learning Module**. 2019. Available at: www.iawg.net/misp-dlm
- Inter-Agency Working Group on Reproductive Health in Crises. **Minimum Initial Service Package (MISP) Process Evaluation Tools**. 2017. Available at: www.iawg.net/resource/misp-process-evaluation-tools-2017/
- World Health Organization. **Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.** 2010. Available at: https://www.who.int/healthinfo/systems/monitoring/en/
- United Nations Children's Fund, Save the Children, World Health Organization. **Newborn health in humanitarian settings field guide.** New York: 2018. Available at: https://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide/
- Inter-agency Working Group on Reproductive Health in Crises**. Quick Reference for the Minimum Initial Service Package for Sexual and Reproductive Health ("Cheat Sheet")**. 2018. Available at: www.iawg.net/resources/misp-reference
- Family Planning 2020, Inter-agency Working Group on Reproductive Health in Crises, International Planned Parenthood Federation, John Snow Inc, United Nations Population Fund, Women's Refugee Commission**. READY TO SAVE LIVES: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies.** 2020.

Other references on SRH in crises are available at www.iawg.net.

Annexes

All up-to-date templates and complementary resources can be found on www.iawg.net.

Template A: Summary of SRH Background Information

This template is used to collect the necessary SRH information about the location where you are working. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

Key current SRH and demographic statistics	
Current situation of MISP implementation	
Key existing SRH policies and protocols	
Relevant legal definitions and guidance related to SRH (e.g., age of consent, definition of rape, abortion laws)	
Health infrastructure, including SRH delivery points	
SRH staff availability and training status (including functioning professional schools)	
SRH commodities and supply line(s)	
Expenditure and financing (primary health care, including SRH)	
Status of the integration of SRH indicators within the national health information system	

Template B: Goals and Objectives for the SRH Program Before the Crisis

This template is used to layout the goals and objectives of your program before a crisis occurs. It is broken down by SRH area. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

PROGRAM GOALS	PROGRAM OBJECTIVES
Maternal and Newborn Health	
(Example: To reduce the rate of maternal mortality)	(Example: To increase the proportion of pregnant women who receive antenatal care to 75% by 2021.)
Contraceptive Services	
Safe Abortion Care / Post-Abortion Care	
HIV and Other Sexually Transmitted Infections	
Gender-Based Violence	
Adolescent Sexual and Reproductive Health	
Other Areas:	

Template C: MISP Implementation During the Crisis

This template helps you map the implementation status of MISP activities and what barriers exist to achieving each MISP objective. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

MISP Objectives	MISP Activities	MISP implementation status: Who, What, Where, When, Why & How	Barriers
1. Coordination *The lead SRH Organization:*	Nominates a 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 MISP implementation		
	Reports back to the health sector/cluster, gender-based violence (GBV) subsector/cluster, and/or 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		
	Ensures the community is aware of the availability and location of SRH services		
2. Prevent sexual violence and respond to needs of survivors by:	Working with other clusters, especially the protection cluster and GBV sub-cluster, to put in place preventative measures at community, local, and district levels, including health facilities, to protect affected populations, particularly women and girls, from sexual violence		
	Making clinical care and referral to other supportive services available for survivors of sexual violence		
	Putting in place confidential and safe spaces within health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral		
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs by:	Establishing safe and rational use of blood transfusion		
	Ensuring application of standard precautions		
	Guaranteeing the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population before the crisis), ensure provision of female condoms		
	Supporting the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an antiretroviral therapy (ART) program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs		
	Providing post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure		
	Supporting the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV		
	Ensuring the availability in health facilities of syndromic diagnosis and treatment of STIs		

4. Prevent excess maternal and newborn morbidity and mortality by:	Ensuring availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services, including: • at **referral hospital level**: skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC); • at **health facility level**: skilled birth attendants and supplies for vaginal births and provision of basic emergency obstetric and newborn care (BEmONC); • at **community level**: provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities; clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible		
	Establishing a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital		
	Ensuring the availability of lifesaving post-abortion care in health centers and hospitals		
	Ensuring availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable		
5. Prevent unintended pregnancies by:	Ensuring availability of a range of long-acting, reversible and short-acting contraceptive methods (including male and female [where already used] condoms and emergency contraception [EC]) at primary health care facilities to meet demand		
	Providing information, including existing information, education, and communication materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and nondiscrimination		
	Ensuring the community is aware of the availability of contraceptives for women, adolescents, and men		
6. Plan for the transition to comprehensive SRH services by:	Working with the health sector/cluster partners to address the six health system building blocks: • Service delivery • Health workforce • Health information system • Medical commodities • Financing • Governance and leadership		
Safe abortion care	It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities		

SRH supply chain			

Inclusion of priority populations & impact of events on them	Adolescents Hard-to-reach Individuals living with disabilities LGBTQIA people Older persons		

Expenditure and financing (primary health care, including SRH)			

Template D: Workshop Agenda

This template provides an example of a workshop agenda that you can adjust and provide to participants. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

Day 1

Time	Session	Expected Outcome
0800 – 0815	Welcoming and opening remarks	
0815 – 0845	Introduction of participants, expectations, logistics, and ground rules	Agree on the objectives of the workshop
0845 – 1015	Step 1: Setting a common understanding	To set the scene with an overview of MISP implementation and SRH program prior to the crisis
1015 – 1030	**Break**	
1030 – 1200	Step 2: Mapping needs and opportunities related to comprehensive SRH priorities	To map current needs and opportunities in relation to comprehensive SRH programming
1200 – 1300	**Lunch**	
1300 – 1400	Step 3: Setting planning priorities for comprehensive SRH	To agree on a set of planning priorities related to comprehensive SRH
1400 – 1500	Step 4: Teamwork on agreed planning priorities for comprehensive SRH	To produce a plan to implement the top three SRH priorities
1500 – 1515	**Break**	
1515 – 1645	Step 4 (continued): Teamwork on agreed planning priorities for comprehensive SRH	To produce a plan to implement the top three SRH priorities
1645 – 1700	Q&A, preparation for Day 2	To provide clarity on the task of Day 2
1700	End of the day	

Day 2

Time	Session	Expected Outcome
0900 – 1030	Step 5: Reporting back and finding synergies (groups 1 – 3)	A consolidated national (or subnational, according to the context) work plan to implement priority interventions related to comprehensive SRH
1030 – 1045	**Break**	
1045 – 1200	Reporting back and finding synergies (group 1 – 3) - continued	A consolidated national work plan to implement priority interventions related to comprehensive SRH
1200 – 1300	**Lunch**	
1300 – 1500	Agreeing on next steps	Identify focal points for action items and agree on next steps
1500 – 1515	**Break**	
1515 – 1600	Q&A, comments, and closing	
1600	End of the workshop	

Template E: Overview of the Health System Building Blocks and Comprehensive SRH Considerations

This template provides a list of what should be considered for each building block of the health system and a checklist for self-reflection. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

Health system building block	When planning for comprehensive SRH services, collaborate with all stakeholders to:	Checklist for self-reflection:
SERVICE DELIVERY	Identify SRH strengths and needs in the community Identify suitable sites for SRH service delivery	☐ What demand generation activities exist for communities and how are they prioritized? ☐ What are the barriers faced by hard-to-reach populations when accessing services? ☐ How are health care delivery services organized to ensure services are close and accessible to the population? How does the referral system work? ☐ When designing new facilities, how are buildings planned, including their locations and equipment; utilities, such as power and water supply; waste management; transport; and communication and information systems?
HEALTH WORKFORCE	Assess staff capacity Identify staffing needs and levels Design and plan staff training	☐ How are health workers organized for effective service delivery at the different levels of the system (primary, secondary, tertiary)? Is there a system to monitor and improve their performance? ☐ How are training programs designed? Are they standalone trainings or integrated into a training larger strategy or program? ☐ If the emergency escalates suddenly in your setting, is there a plan as to how to scale-up the workforce? ☐ Is there a retention plan for an effective workforce, within dynamic local and international labor markets?
HEALTH INFORMATION SYSTEM	Build upon estimated demographic data to collect more specific SRH information Include SRH information in the health information system	☐ Is it possible to generate population and facility-based data: from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g., human resources, health infrastructure and financing)? ☐ Do operations have the capacity to detect, investigate, communicate, and contain events that threaten public health security at the place they occur, and as soon as they occur? ☐ Is there capacity to synthesize information and promote the availability and application of this knowledge?

Health system building block	When planning for comprehensive SRH services, collaborate with all stakeholders to:	Checklist for self-reflection:
MEDICAL COMMODITIES	Identify SRH commodity needs Strengthen sustainable SRH commodity supply lines	☐ Does the health system that you work in ensure equitable access to essential medical products, vaccines, and technologies of assured: - Quality, - Safety, - Efficacy and -cost-effectiveness, and - Scientifically sound and cost-effective use? ☐ Are there efforts to strengthen local supply lines for SRH commodities that meet the criteria listed above?
FINANCING	Identify SRH short and long-term financing possibilities	☐ Are there any plans for raising additional funds where health needs are high, and where revenues have been insufficient? ☐ Do populations you cater to spend out-of-pocket for health services? Is there an estimate of how much? ☐ Do vulnerable and low-income groups have access to needed services, in the form of social protection/ health insurance? ☐ How would you rate efficiency of resource use in your operations by focusing on the appropriate mix of activities and interventions? ☐ What mechanisms do you have in place to monitor health expenditure?
GOVERNANCE AND LEADERSHIP	Review SRH-related laws, policies, protocols Coordinate with the Ministry of Health Engage communities in accountability	☐ Are all specific technical policies/guidelines to guide partners available and up to date? ☐ Are trends analyzed periodically to study patterns? ☐ Are there regular national-level discussions on policy issues? ☐ How are regulations relevant to your settings enforced? ☐ Is there duplication of services in your setting which can be avoided? ☐ Are there any mechanism for hearing feedback from clients on services provided?

Template F: Description of Health System Building Blocks

This template provides a description of each of the health system building blocks. It is available at https://iawg.net/misp-to-csrh/templates. Extracted from the *Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module* available at: www.iawg.net/misp-dlm.

Service Delivery

Collaborate with national and local authorities, the affected community, and, where appropriate, camp management experts to identify possible new and existing sites to deliver comprehensive sexual and reproductive health (SRH) services, such as family planning clinics, sexually transmitted infection (STI) outpatient rooms, or focused adolescent-friendly SRH services. Consider the following factors, among others, when selecting suitable sites:

- Feasibility of communications and transport for referrals
- Number, type, quality, and distance to existing health facilities, SRH services, and other health services
- Accessibility to all potential users, in all their diversity, including the affected populations and the target group
- Possible integration with other services versus standalone services
- Security at the point of use as well as while moving between home and the service delivery point

Health Workforce

Assess staff capacity to undertake comprehensive SRH services, establish plans to train or retrain staff, and ensure supportive supervision. Staff capacity can be measured through supervisory activities (e.g., monitoring checklists, direct observation, client exit interviews) or through formal examinations of knowledge and skills.

When planning for training or retraining of staff, work with national authorities, academic institutes, and training institutes and take into consideration existing curricula. Where possible, use national trainers and plan training sessions carefully in order not to leave health facilities without in-service staff. Training health workers on patients' rights and the provision of respectful, unbiased, equitable care is critical and should be incorporated into trainings, training schedules, and/or supportive supervision.

Consider ongoing capacity development opportunities outside of trainings, such as supportive supervision, mentorship programs, and opportunities to practice learned skills.

Provide protocols and job aids to support quality service delivery according to evidence-based best practices.

Health Information System

In order to move beyond the Minimum Initial Service Package (MISP) for SRH and start planning for comprehensive SRH service delivery, SRH program managers – in close collaboration with the partners in the health sector/cluster – must collect existing information or estimate data that will assist in designing such a program.

Examples of information that assists with planning for comprehensive SRH include:

- Ministry of Health policies and protocols for standardized care (e.g., STI syndromic management, family planning protocols, and laws and regulations surrounding safe abortion care).
- MISP service indicators that are monitored and evaluated. The MISP for SRH Checklist and process evaluation tools are useful for ensuring the MISP components are in place. For gathering data as part of needs assessments, Reproductive Health Assessment Toolkit for Conflict-Affected Women can be helpful.
- Services and supply consumption data at health facilities.
- SRH demographic information collected about the affected population, number of women of reproductive age, number of sexually active men, crude birth rate, age-and sex-specific mortality data, newborn mortality rate, and maternal mortality rate.
- STI and HIV prevalence, contraceptive prevalence and preferred methods, prevalence of unsafe abortion, and SRH knowledge, attitudes, and behaviors of the affected population.

Medical Commodities

The Inter-Agency Emergency Reproductive Health (IARH) Kits are not intended as re-supply kits and, if used long-term, may result in the accumulation of items and medicines which are not needed. Although supplying medicines and medical devices in standard pre-packed kits is convenient early in an emergency, specific local needs must be assessed as soon as possible and further supplies must be ordered accordingly. This will help ensure the sustainability of the SRH program and national supply chain, reduce unnecessary costs, and avoid shortages of particular supplies, as well as the wasting of others not typically used in the specific context.

When basic services have been established, work with the SRH Coordinator and other health partners to assess SRH needs and attempt to re-order bulk medicines, devices, and equipment based on consumption of these items, in order to ensure that the SRH program can be sustained and expanded. To make this shift, the SRH Coordinator should:

- strengthen or develop a medical supplies logistics management information system as soon as possible, in coordination with the United Nations Population Fund (UNFPA), WHO, United Nations Children's Fund (UNICEF), and other health supplies partners;
- estimate the use of SRH supplies based on consumption, services, and demographic data and conduct a forecast; assess the changing SRH needs of the population and how this may affect supply needs; and
- reorder supplies as needed based on a supply plan; this can be a mix of IARH Kits and bulk item procurement.

When ordering supplies for comprehensive SRH services, coordinate SRH commodity management with health authorities and the health and logistics sectors/clusters in order to ensure uninterrupted access to SRH services and to avoid creating multiple health supply chains.

Some suggestions to strengthen national supply chains include the following:

- Hire staff trained in supply chain management and medical logistics.
- Develop the capacity of existing staff on supply chain management.
- Establish a health-logistics coordination sub-group under the health cluster in close partnership with the logistics cluster.
- Estimate monthly consumption and utilization of SRH commodities.

- Support the creation of or reinforce an existing (if one exists) national logistics management information system.
- Identify medical supply channels. If local supply chains are inadequate (e.g., cannot confirm quality standards), obtain SRH commodities through recognized global suppliers or with support from UNFPA (through the Procurement Services Branch), UNICEF, or the WHO, which can facilitate purchasing bulk quantities of high-quality SRH supplies at lower costs.
- Place timely orders through identified supply lines.
- Store supplies as close to the target population as possible.

Financing

To ensure ongoing access to affordable, high-quality comprehensive SRH care, long-term financing mechanisms must be considered during the initial response to a crisis. A good health financing system is critical to sustaining comprehensive SRH care. Several financing options include, but are not limited to:

- Community financing and community-based health insurance
- Conditional and unconditional cash transfers
- Out-of-pocket payments or user fees
- Results-based financing
- Voucher subsidies to clients and reimbursements for health care workers
- Social marketing and franchising

Governance and Leadership

Leadership and governance for integrating SRH into health systems strengthening efforts can be driven from international, national, and community levels.

International and national levels: By identifying existing policies, guidelines, and protocols that do not support SRH and rights or meet international standards, international actors can advocate and support national leadership to implement a health systems strengthening plan to address excess SRH-related morbidity and mortality.

Community level: Communities should understand their rights and participate in the design and implementation of SRH services, creating demand and enforcing accountability (e.g., register complaints and seek remedies). They must be provided with the necessary resources to support these efforts.

Template G: Current SRH Needs and Opportunities

This template helps you to think through the current needs and opportunities related to each health system building block. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

HEALTH SYSTEM BUILDING BLOCK	CURRENT NEEDS	OPPORTUNITIES
Service delivery • Adolescent SRH • Contraceptive services • Maternal and newborn health, including safe abortion care and fistula care • Gender-based violence • Prevention and treatment of STIs/HIV • Gynecology/urology services • Reproductive cancers • Management of infertility • Others:		
Health workforce		
Medical commodities		
Health information system		
Financing		
Governance and leadership		

Template H: Setting SRH Priorities

This template helps you to prioritize SRH needs of your situation. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

SETTING SRH PRIORITIES

PRIORITY	Importance of the problem	Efficacy of the intervention	Program requirements	Costs	Health system capacity	Opportunities and available resources
HIGHER	High	High	Low	Low	High	High
↕	Medium	Medium	Medium	Medium	Medium	Medium
LOWER	Low	Low	High	High	Low	Low

Template I: Workplan for Comprehensive SRH

This template helps you to organize the activities of your workplan and note related details like focal points and timeline. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

EXPECTED RESULT :

ACTIVITIES*	Focal points	Additional groups/ people to involve	Timeline	Resources Needed	Comments

*Include activities for the six health system building blocks, if relevant for your expected result

Template J: Evaluation Form

This template is an evaluation form that participants can use to assess the workshop. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

MISP to Comprehensive SRH Planning Workshop Evaluation Form

Thank you for taking time to fill this evaluation form. It will allow us to evaluate the workshop and improve the organization of future similar workshops.

Please rate the following from 1 to 5

0= not applicable **1=** strongly disagree **2=** disagree **3=** neutral **4=** agree **5=** strongly agree

1. The workshop was well prepared and organized	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
2. The objectives of the workshop have been reached	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
3. The general methodology used was efficient	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
4. The workshop met my expectations	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
5. Step 1 was useful (setting a common understanding)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
6. Step 2 was useful (Mapping needs and opportunities related to comprehensive RH)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
7. Step 3 was useful (Prioritization)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						

8.	Step 4 was useful (teamwork on work plans for agreed priorities)	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
9.	Step 5 was useful (presentation and discussion of the work plans)	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
10.	The time allocated for each session was adequate	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
11.	There were sufficient opportunities for exchange and participation	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
12.	The facilitation of the workshop was of quality	**0**	**1**	**2**	**3**	**4**	**5**
Comment							

I participated:

- □ In the entire workshop
- □ In part(s) of the workshop

I identify as:

- □ A woman
- □ A man
- □ Other / Prefer not to respond

Given the topic, the workshop was

a) Too long b) Too short c) Right length

Other comments or recommendations:

Thank you very much for participating in this workshop!

Please email info.iawg@wrcommission.org with any questions, concerns, or feedback

Template K: Training Agenda

This template provides an example of a training agenda that you can adjust and provide to participants. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

Example of an Agenda for the Face-to-Face and Virtual Facilitator Training: MISP to Comprehensive SRH Planning Workshop

Time	Session	Methods, focal person, materials	Expected results
9:00-11:30	Group study & preparation. Participants meet to: □ Discuss any major questions or concerns regarding the toolkit and their role as facilitators (participants can list their main questions on a flipchart paper to facilitate with reporting) □ Discuss and briefly role-play each of the steps; note that participants will need to build wall charts for Step 2 and Step 3 and populate it with the Post-its □ Discuss who will volunteer for the role-play or reporting of each of the steps during the afternoon Zoom session: □ Role-play the facilitation of the introduction: ..... □ Role-play the facilitation of Step 1 (presenting a few slides of the PowerPoint): ..... □ Summarize the role-play and outcomes of Step 2 (needs and opportunities): ..... □ Summarize the role-play and outcomes of Step 3 (prioritization): ..... □ Role-play the facilitation of Step 4 (give instructions for the planning process and describe the planning template): ..... □ Role-play the facilitation of Step 5 (introduce the teamwork presentations): ..... □ Discuss Templates A, B, C: What data will be a challenge to obtain, questions about the templates and process □ If time allows, start discussing the roll-out of the 2-day planning workshop that participants will be facilitating post training	□ Post-its or color cards □ Flipchart / whiteboard □ Markers □ Laptop & projector & screen □ 1 laptop with Zoom/2-3 participants □ A3 or A4 sheets & white adhesive paper to prepare the charts on the wall □ Sticky dots	Developing a team spirit Questions about the training and materials discussed among participants Steps 1-5 have been role-played Distribution of roles for the afternoon meeting Room and technology ready and functional for the training
11:30 - 12:15 (45 min)	**Lunch break**		
12:00-12:30 (30 min)	Video Zoom line will open during lunch time to test connection: audio-video & microphone Get participants familiar with Zoom (mute, unmute, post a chat in the discussion box)	The Zoom link will be shared in advance	
12:30 - 12:45 (15 min)	Welcome Introduction of participants and facilitators Expectations Logistics and ground rules	Led by facilitators, organizers, and volunteer participants	Ice broken Collaboration established Expectations defined
12:45 - 12:50 (5 min)	Review and adoption of the agenda	Interactive discussion	Agree on the objectives and training program
12:50 - 13:10 (20 min)	Reflection: Questions & answers on the Facilitator's Guide and resources	Participants report their independent study experience before the training	Overview of the main themes and issues to be discussed and resolved
13:10 - 13:30 (20 min)	Facilitator's Guide: Introduction& adult learning principles	Interactive discussion Participants share their personal experiences as trainers	Participants familiar with: - introduction - adult learning principles

13:30 - 14:00 **(30 min)**	Facilitator'sGuide: Pre-workshop preparation	Review and interactive discussion of Templates A, B, C	Participants familiar with: - pre-workshop preparation steps - Templates A, B, C and how to complete them
14:00 – 14:15	**Break**		
14:15 - 14:30 **(15 min)**	Facilitator's Guide: Step 1 (setting a common understanding)	PPT presentation by a participant (projector & screen) Feedback from participants	Participants able to facilitate: - presentation of PPT
14:30 - 14:50 **(20 min)**	Facilitator's Guide: Step 2 (mapping needs & opportunities)	Presentation of the table and instructions by a participant Summary of the morning process	Participants able to facilitate: - Step 2
14:50 - 15:10 **(20 min)**	Facilitator's Guide: Step 3 (prioritization)	Presentation of the table and instructions by a participant Summary of the morning process	Participants able to facilitate: - Step 3
15:10 - 15:20 **(10 min)**	Facilitator's Guide: Step 4 (planning)	Presentation of the template and instructions by a participant	Participants able to facilitate: - Step 4
15:20 - 15:30 **(10 min)**	Facilitator's Guide: Step 5 (teamwork presentation)	Presentation of instructions by a participant	Participants able to facilitate: - Step 5
15:30 - 15:45 **(15 min)**	Facilitator's Guide: Post-workshop follow-up & post-training follow-up	Interactive discussion	Participants have concrete strategies for post-workshop follow-up Participants have a plan for the post-training follow-up after the facilitator training and the steps for the preparation of the workshop
15:45 - 16:00 **(15 min)**	Questions & answers Review of expectations Oral feedback/evaluation on the training by each participant Instructions for the written evaluation	Interactive discussion	Answers given to key questions Review of expectations & feedback on training methodology Training evaluated
16:00 - 16:30 **(30 minutes)**	*Optional* after the Zoom call: If not yet completed, continuation of planning among participants for next steps		
End of Facilitator Training			

Template L: Training Evaluation Form

This template is an evaluation form that participants can use to assess the training. A fully editable version of this template is available as a Word document or Excel worksheet online at https://iawg.net/misp-to-csrh/templates.

Training Evaluation Form: MISP to Comprehensive SRH Planning Workshop

Thank you for taking time to fill this evaluation form. It will allow us to evaluate the workshop and improve the organization of future similar workshops.

Please rate the following from 1 to 5

0= not applicable **1=** strongly disagree **2=** disagree **3=** neutral **4=** agree **5=** strongly agree

1. The training was well prepared and organized	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
2. The training objectives have been reached	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
3. The general methodology used was efficient (independent study and Zoom videoconference)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
4. The training met my expectations	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
5. In general, the activities proposed in the workbook were useful	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
6. Training activities for Step 1 were useful (setting a common understanding)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
7. Training activities for Step 2 were useful (mapping needs and opportunities related to comprehensive SRH)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						
8. Training activities for Step 3 were useful (prioritization)	**0**	**1**	**2**	**3**	**4**	**5**
Comment						

9.	Training activities for Step 4 were useful (team work on work plans for agreed priorities)	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
10.	The time allocated was adequate	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
11.	There were sufficient opportunities for exchange and participation	**0**	**1**	**2**	**3**	**4**	**5**
Comment							
12.	The facilitation of the training was of quality	**0**	**1**	**2**	**3**	**4**	**5**
Comment							

I identify as:

- □ A woman
- □ A man
- □ Other / Prefer not to respond

Given the topic, the workshop was

a) Too long b) Too short c) The right length

Other comments or recommendations:

Thank you very much for participating in this workshop!

Please email info.iawg@wrcommission.org with any questions, concerns, or feedback

Inter-Agency Working Group on
Reproductive Health in Crises