A PREPAREDNESS TOOLKIT

Ready to Save Lives

Sexual and Reproductive Health Care in Emergencies

Field Test Version

PRODUCED BY

Family Planning 2020, International Planned Parenthood Federation, John Snow, Inc., Women's Refugee Commission, and United Nations Population Fund

IN COLLABORATION WITH

Inter-Agency Working Group on Reproductive Health in Crises

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In Memoriam

This toolkit is dedicated to our beloved friend and colleague, Jennifer Schlecht. Jenn was the driving force behind this resource and instrumental in advancing family planning (FP) and sexual and reproductive health (SRH) preparedness work to meet the global crisis of increasing humanitarian emergencies and ever more people living as refugees and internally displaced. She had a vision to expand shared learning and guidance for preparedness, and thus strengthen SRH response and help achieve FP goals, through this body of work. This effort is in her honor and in hopes of moving her vision forward.

"Good preparedness is a prerequisite for a good response! This was confirmed during the arrival of refugees and migrants in 2015. Thanks to the sensitization of our stakeholders on the MISP and the preparedness work conducted since 2012, the mobile gynecological clinics were the first to be on the site offering services for the affected population. The Ministry of Health recognized their importance and put them into practice, even before health units for general medical services were established."

—MEMBER OF THE SRH WORKING GROUP, NORTH MACEDONIA, 2018

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Glossary of Terms

The following term is adopted directly from the ICPD Programme of Action (1994):[1]

sexual and reproductive health: sexual and reproductive health (SRH) is a state of complete physical, mental, and social well-being (not merely the absence of disease and infirmity) in all matters relating to the reproductive system and its functions and processes. SRH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are people's rights to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice, as well as other interventions and strategies for fertility regulation that are not against the law. People should also have the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide individuals and couples with the best chance of having a healthy infant.

The following terms are adopted directly from the WHO Glossary of health emergency and disaster risk management terminology (2020):[2]

preparedness (emergency): the knowledge and capacities developed by governments, response and recovery organizations, communities, and individuals to effectively anticipate, respond to, and recover from the impacts of likely, imminent, or current disasters. Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good links with early warning systems, and includes such activities as contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal, and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required.

Note: The WHO terminology uses preparedness and readiness interchangeably and this has been adopted in this Toolkit.

resilience: the ability of a system, community, or society exposed to hazards to resist, absorb, accommodate, adapt to, transform, and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management.

disaster risk reduction: [activities] aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.

disaster risk governance: the system of institutions, mechanisms, policy and legal frameworks, and other arrangements to guide, coordinate, and oversee disaster risk reduction and related areas of policy.

disaster risk management: the application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk, and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses.

hazard: A process, phenomenon, or human activity that may cause loss of life, injury or other health impacts, property damage, social and economic disruption, or environmental degradation.

Note: This may include the latent property or the inherent capability of an agent or substance which makes it capable of causing adverse effects to people or the environment under conditions of exposure.

Inass Zeineddine is a youth educator and Arab World Region Regional Youth Representative working with young Syrian refugees inside the Saadanayel camp, Bekaa Valley, Lebanon. Image credit: IPPF/Peter Caton/Sri Lanka

Foreword

Family Planning 2020 is deeply honored to have facilitated the development of *Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies* as part of FP2020's commitment to fostering collaboration among humanitarian and development actors. At the 2017 London Family Planning Summit, members of the Inter-Agency Working Group on Reproductive Health (IAWG) in Crises insisted that a dialogue on scaling up access to quality family planning services must include consideration of women in humanitarian settings. IAWG called for partnerships between humanitarian and development organizations to ensure the fundamental right to family planning is not lost to people who are displaced by conflict, natural disasters, environmental degradation, and epidemics.

FP2020 heeded this call, under the leadership of Jennifer Schlecht. Jenn devoted her career to ensuring that women and girls in crisis situations have access to the best possible medical care, including family planning and other reproductive health care. She was a vital part of the FP2020 family until her death in 2019. In honor of her mission to extend family planning to displaced people as a part of comprehensive sexual and reproductive health care, FP2020 continues to partner with governments, humanitarian, and development actors around the world to raise the profile of and access to voluntary contraception everywhere. FP2020 exists as a platform for the exchange of ideas and making commitments that change lives for the better.

We are grateful to all the sexual reproductive health and emergency response experts who contributed their expertise to the development of the toolkit. We could not have completed this first version of the toolkit without the financial support of the Foreign, Commonwealth & Development Office and the invaluable contributions of IPPF, John Snow, Inc., Women's Refugee Commission, UNFPA, and IAWG. We remain grateful to CARE for funding the original fellowship that brought Jennifer Schlecht to FP2020, and helped us to build this partnership with humanitarian colleagues.

Beth Schlachter
Executive Director
Family Planning 2020

Overview

Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies provides country-level actors with guidance and resources to ensure that quality, essential SRH services are available at the onset of an emergency[i] response and remain available until the situation stabilizes. It was developed by FP2020, IPPF, JSI, WRC, and UNFPA in collaboration with IAWG.

i "Emergency" refers to natural hazards, armed conflict and civil unrest, epidemics and pandemics, drastic changes in socio-economic environment, serious violations of international human rights or humanitarian law, and environmental hazards (see the IASC Emergency Response Preparedness Guidance in *Resources*).

About This Toolkit

The purpose of the toolkit is to bring together existing learning and guidance as a starting point for stakeholders to begin SRH preparedness work. Within the SRH sector the field of preparedness is relatively new and growing. More collective effort is required to further evaluate the impact of preparedness efforts and push the field forward. This effort is a first attempt at a draft guidance for SRH preparedness, and is intended for field testing. The toolkit recognizes the longstanding work of the field of emergency and disaster risk management, and endeavors to bridge that work with the human rights-oriented and people-centered field of sexual and reproductive health.

The work for this toolkit began in early 2019 and wrapped up in June 2020, long after the COVID-19 virus outbreak became a pandemic. COVID-19 has highlighted both the importance of preparedness as well as the painful cost of facing hazards unprepared. Looking beyond our current, urgent focus on COVID-19 preparedness and response, this toolkit takes an all-hazards approach.

Intended Users of This Toolkit

The toolkit is meant to be used by country-level decision makers and stakeholders—whether in government, national and local organizations (including those led by women and youth), or international agencies—who want to ensure the provision of quality, appropriate SRH services during an emergency. This includes SRH actors looking to become more familiar and engaged with national and subnational emergency preparedness efforts and systems, as well as disaster risk management (DRM) actors who wish to better understand and integrate SRH into emergency management and preparedness work. The toolkit is intended to align with the workstreams of the Grand Bargain, particularly those connected to localization of humanitarian action, participation of affected communities, and collaborative work between humanitarian, development, and government actors.[3]

How to Use This Toolkit

This toolkit is structured in five sections:

Section 1: Introduction to SRH preparedness to familiarize users with key concepts, advocacy points, and frameworks.

Section 2: Outline of stages to initiate, assess, and implement SRH preparedness actions, with links to relevant Learning Briefs and select resources.

Section 3: A series of Learning Briefs capturing country-level SRH preparedness activities from multiple countries and contexts.

Section 4: Recommendations for comprehensive SRH preparedness.

Section 5: Resources for SRH preparedness, including guidance and tools.

Introduction to SRH Preparedness

SRH preparedness reflects the actions undertaken so that, at a minimum, timely and quality essential SRH services will be provided at the onset of an emergency. SRH preparedness must be linked to wider health emergency preparedness efforts.

What is SRH preparedness?

Preparedness in general encompasses actions that are intended to improve operational readiness to respond to a disaster or destabilizing event, and that contribute to a more efficient and effective recovery. Preparedness actions may include developing disaster management plans and policies, conducting risk assessments, strengthening infrastructure and logistics, and building human resource capacity.

Preparedness is only one stage of the emergency management cycle, which requires complementary and reinforcing activities at all stages to minimize impact and ensure a more efficient and effective recovery (see Figure 1). Preparedness is frequently undertaken as part of disaster risk reduction and management, and is an integral part of the cycle of building resilience (see Figure 2).

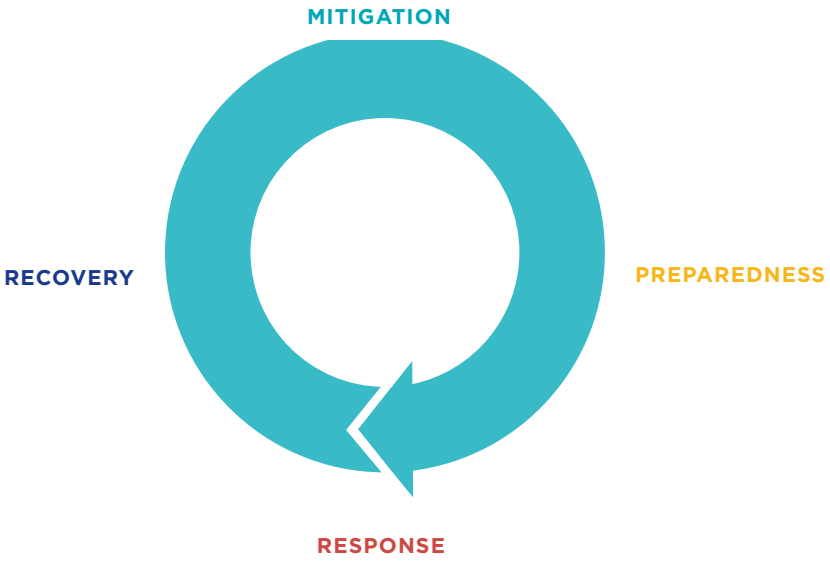
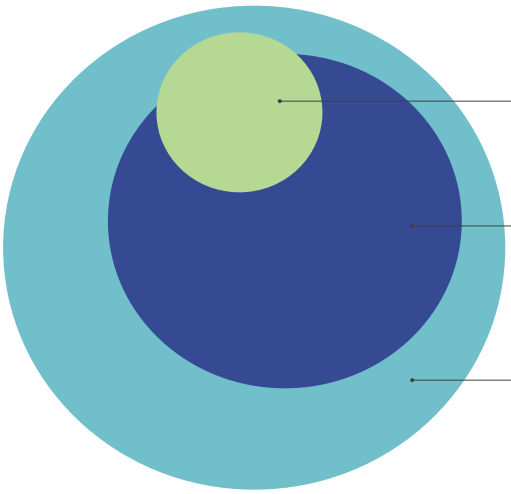


FIGURE 1. Emergency Management Cycle
Adapted from Sprinting Towards Change: Sex and Pregnancy in Emergencies, IPPF, 2011.

Why SRH preparedness?

In the past decade humanitarian needs have expanded at an unprecedented pace. Violent conflicts are causing widespread mortality, morbidity, displacement, and devastation. The increasingly visible effects of climate change are compounding risks and exacerbating vulnerabilities.[4] Even before COVID-19, nearly 168 million people were estimated to be in need of humanitarian assistance and protection, or about 1 in 45 people globally—the highest number in decades.[5,6]

Emergencies—whether from natural hazards or conflict—threaten the capacity of governments to respond and recover. They can cause long-term damage to health systems, even those that may have been operating at a relatively high capacity. Precious development gains can be lost, and the effects of poverty and inequality intensified.[7] The failure to prepare and respond to emergencies threatens to undermine hard-won progress on the 2030 Agenda for Sustainable Development and limit the possibility of achieving universal health care.[8] Preparedness is thus a key part of the humanitarian-development-peace nexus, and is a prime example of multiple stakeholders working together for "collective outcomes," as called for in the *New Way of Working* adopted at the World Humanitarian Summit in 2016.[9] As emergency preparedness work becomes increasingly prioritized across countries and contexts, it is time to ensure that SRH is fully integrated.



PREPAREDNESS: Aims to build capacities to anticipate, respond to, and recover from the impacts of *any hazard.*

DISASTER RISK REDUCTION (DRR): Wider than preparedness, includes prevention and mitigation. Aims to reduce potential disaster losses caused by *natural hazard*.

RESILIENCE PROGRAMMING: Wider than DRR. Aims to strengthen the ability to resist and recover from the effects of *any hazards*, both natural and human-induced.

FIGURE 2. Emergency Preparedness within DRR and Resilience Programming
Adapted from similar graphics produced by UNFPA and UNICEF.

The cost of disaster: Natural disasters cost the global economy nearly three trillion dollars over the past decade, and US$232 billion in 2019 alone.[10] The funding gap for humanitarian response remains wide; even in 2019, when funding for inter-agency coordinated responses reached a record high of US$16 billion, only 54% of the total need was met.[11] Preparedness efforts can mitigate these impacts: not only do they protect development gains and cushion the impact of emergencies, they are also cost-effective. A 2017 Inter-Agency Standing Committee (IASC) report found that "every US$1 invested beforehand saved more than US$2 in future response costs." In some cases, more than US$7 was saved for every US$1 invested. The average gain in response time was ten days.[12]

A woman after receiving a contraceptive implant at the IPPF/FPAN clinic in Ekamba Sansari, Nepal.
Image credit: IPPF/Tom Pilston/Nepal

Impact on women, girls, and other marginalized groups

As of 2019, an estimated 67 million women and girls worldwide require humanitarian assistance.[13] Emergencies have a disparate effect on the poorest and most marginalized or underserved members of a community. This can include women, children and adolescents, and elderly persons; people with disabilities; people of diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC);[ii] and those in migrant or refugee communities.[14,15] Existing pre-crisis gender disparities, such as limitations on access to schooling and livelihoods, are known to be exacerbated in emergencies.[16] For example, women and girls may not have access to early warning and evacuation information, may lack survivor skills, or may stay behind in an emergency to look after family members.

With the disruption of social structures and health systems associated with emergencies, existing SRH needs and inequalities not only continue but are heightened. Women and girls face increased risk of unintended pregnancy, maternal death and disability, sexual and gender-based violence (GBV), unsafe abortions, and sexually transmitted infections (STIs), including HIV. Though data in fragile settings are limited, research suggests that one in five refugee or displaced women experiences sexual violence.[17] In two locations in South Sudan, a country facing ongoing civil conflict, up to 65% of women and girls experience physical or sexual violence in their lifetime.[18]

A note on inclusion: This toolkit recognizes that emergencies and SRH risks are overwhelmingly experienced by women and girls in all their diversity, but also experienced by men, boys, and gender non-conforming people. Therefore, this toolkit refers to "women, girls, and other marginalized groups" for the sake of brevity but with the intention of acknowledging that everyone has intersecting identities and that holding marginalized identities can lead to further SRH risks. These identities could include—but are not limited to—unmarried women or married girls; adolescents or the elderly; people with disabilities; people of diverse sexual orientation, gender identity, and sexual characteristics; persons of marginalized ethnic, racial, religious, or linguistic identities; persons of refugee or migrant status; and persons of low socio-economic status. When referring to inclusion and using "women, girls, and other marginalized groups," we are referring to everyone in their intersecting identities who need or seek SRH care.

ii The term SOGIESC was selected in accordance with the Asia and the Pacific Call for Action in the Humanitarian System, in recognition that not everyone is represented by variations of the LGBTIQ+ acronym. See the Pride in the Humanitarian System: Consultation Report in *Resources*.

MISP Objectives to Implement at the Onset of an Emergency

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care, as soon as possible.

FIGURE 3. MISP Objectives

Source: IAWG, Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018

Note: 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 Continuum of an Emergency

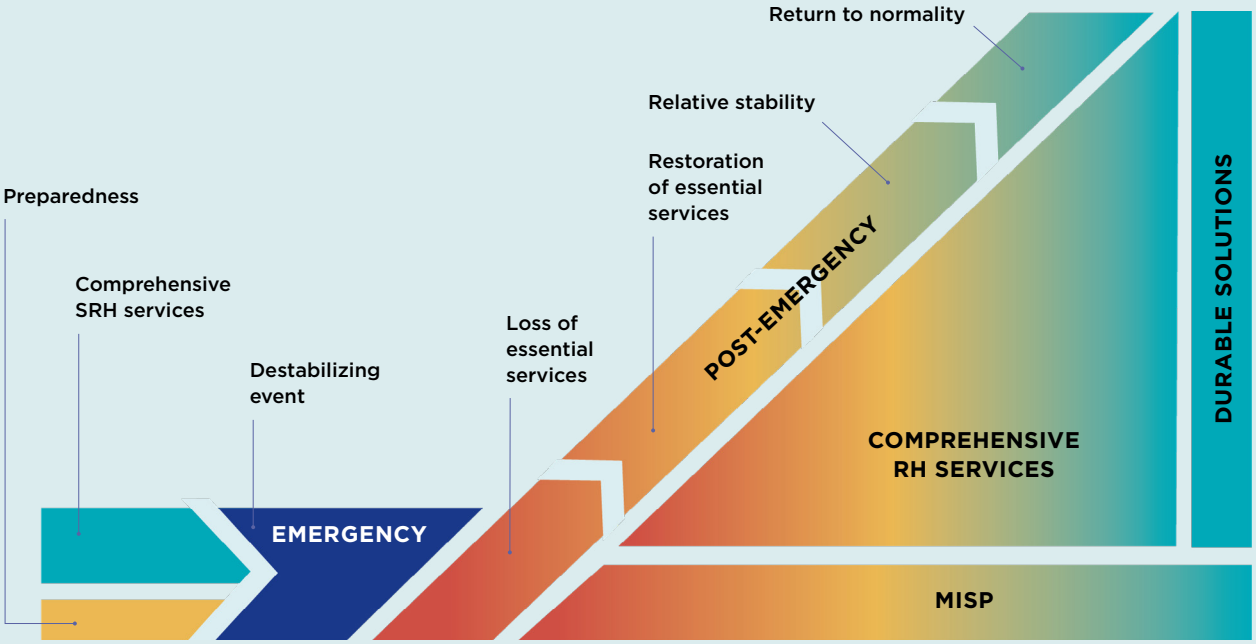


FIGURE 4. The continuum of an emergency

Adapted from the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, IAWG, 2018.

Respecting rights and saving lives

In the 1994 ICPD Programme of Action, the world acknowledged that reproductive rights are human rights, and that sexual and reproductive health and rights are central to health, well-being, and development.[19] The provision of quality SRH care saves lives. It is estimated that if all women in low and middle income countries who want to avoid pregnancy were to use modern contraceptives and all pregnant women were to receive care that meets international standards, each year there would be 76 million fewer unintended pregnancies, 26 million fewer unsafe abortions, and 186,000 fewer maternal deaths each year (a decline of 62% (from 299,000 to 113,000 per year)). Among women who want to avoid a pregnancy, adolescents have a higher unmet need for modern contraception than do all women of reproductive age (43% versus 24%). An estimated 27,000 adolescent women per year in LMICs die from complications of pregnancy (including unsafe abortion) or childbirth, according to 2019 data. Investing in contraceptive services and recommended pregnancy-related health care would reduce adolescent maternal deaths by 63% from the current level to 10,000 per year.[20]

Recognizing the unique risks women, girls, and other marginalized groups face during emergencies, preparedness to mitigate SRH-related morbidity and mortality is crucial. SRH preparedness has been found to be instrumental in enabling timelier SRH services in emergencies and is integral to achieving a faster recovery.[21]

ICPD Reproductive Rights Framework:

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence."

—ICPD PROGRAMME OF ACTION, 1994

Minimum Initial Services Package (MISP) for SRH

When an emergency occurs and comprehensive SRH care is disrupted, lifesaving SRH services must be implemented to mitigate mortality and morbidity. The set of priority SRH activities to be implemented at the onset of an emergency is known as the Minimum Initial Service Package (MISP) for SRH, hereafter referred to as the MISP (see Figure 3).

The MISP was developed by the Interagency Working Group (IAWG) on Reproductive Health in Crises, and the priority lifesaving activities are included in the Sphere Humanitarian Charter and Minimum Standards in Disaster Response and the Inter-Agency Standing Committee Health Cluster Guide.[iii] Because of its lifesaving nature, the MISP is eligible for Central Emergency Response Fund (CERF) funding.[22] The MISP is detailed in the Inter-agency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings, the authoritative source for global guidance on addressing SRH in emergencies.[23] The Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings is a companion to the IAFM that underscores the importance of reaching adolescents with SRH services during an emergency. As documented in the IAFM and illustrated in Figure 4, SRH preparedness takes place alongside, and arguably is a part of, comprehensive SRH services, before an emergency occurs.

iii A cluster is a group of agencies that gather to work together toward common objectives within a particular sector of emergency response. The cluster approach, instituted in 2006 as part of the UN Humanitarian Reform process, is an important step on the road to more effective humanitarian coordination.

Closing the Gaps

Despite the widespread recognition of the lifesaving nature of SRH services in emergencies, women, girls, and other marginalized groups living in humanitarian settings continue to face severe SRH-related risks. The IAWG 2012–2014 Global Evaluation identified gaps in care stemming from attitudes related to SRH, weak data, inadequate funding, poor commodity management and security, and compromised health systems. Additional gaps included weak implementation of the MISP at the onset of emergencies, insufficient services for marginalized groups, and limited access to emergency contraception, long-acting and permanent methods, GBV prevention measures and clinical care for survivors, and safe abortion care.[24]

A more rigorous and comprehensive approach to SRH preparedness can help close these gaps by integrating SRH into emergency risk management and capacity-strengthening efforts. This will require better collaboration and coordination between SRH and DRM stakeholders, with SRH actors becoming familiar and engaging with existing risk management efforts and systems. Recent international frameworks emphasize the importance of preparedness to safeguard health—and health systems—as well as improve care during emergencies:

The Sendai Framework for Disaster Risk Reduction 2015-2030 calls upon stakeholders to invest in approaches that build capacity to prevent, mitigate the impact of, and prepare for emergencies. It recognizes the gendered impacts of disasters, particularly on the sexual and reproductive health of women and girls. The framework outlines four priority areas, with SRH included under Priority #3 as a critical health service and Priority #4 focusing on improving preparedness for a stronger response.

The Health Emergency and Disaster Management Framework (Health-EDRM) was developed by WHO to offer a comprehensive approach to mitigate health risks and negative outcomes from emergencies. The framework applies to all types of settings and captures the broad intersection of health emergency preparedness and disaster risk management. The framework ties together work on humanitarian action, disaster management, emergency preparedness, readiness and response for health emergencies, and health systems strengthening. SRH is included as an essential health service to be implemented in all stages of the humanitarian cycle.

This SRH toolkit is meant to build on the Sendai Framework and applies the structure of the Health-EDRM Framework. Increased attention to SRH preparedness is moving forward on the country level—often in the form of collaborations between government, national institutes and organizations, UNFPA, IPPF, INGOs, and community-based organizations—as preparedness gains more traction within the humanitarian-development-peace nexus.[iv]

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iv The IASC Emergency Response Preparedness Guidance (see *Resources*) is also formative. Although the guidelines do not specifically mention SRH, or health for that matter, they have been adopted by UNFPA to develop actions for preparedness within country offices, considerably informing the SRH preparedness work UNFPA does in partnership with governments.

Women and girl Rohingya Refugees participate in International Women's Day at a Women's Center in Balukhali camp, March 8, 2018 in Cox's Bazar, Bangladesh. Image credit: UN Women/Allison Joyce/Flickr

Stages of SRH Preparedness

Initiating, Assessing, and Implementing

This section outlines stages to consider when undertaking SRH preparedness efforts. The stages draw on information collected through a literature review and key informant interviews (see *Acknowledgments* and *List of Key Informants*). Links to Learning Briefs and resources are included where applicable. This section is divided into the following stages: Initiating, Assessing, and Implementing SRH preparedness.

STAGE 1

Initiating SRH Preparedness

It is important to ground all SRH preparedness work in the ultimate goals of:

ensuring, at a minimum, that quality, inclusive, and timely essential SRH services are available at the onset of an emergency;[v] and

contributing to overall health system strengthening and resilience building.

To begin SRH preparedness work, consider the following points:

1. Adopt a systems approach to SRH preparedness.

Connect individual SRH preparedness activities on all relevant levels (national, subnational, and community) to collectively build capacities to manage risks and withstand hazards.

2. Treat SRH preparedness as a component of health system strengthening and resilience building.

As part of the humanitarian-development-peace nexus, SRH preparedness work can benefit from and contribute to activities designed to strengthen health systems, including efforts to achieve universal health care. SRH preparedness efforts can be considered a component of comprehensive SRH, with shared responsibility across government, humanitarian, peace, and development actors and support from different funding streams.

COUNTRY SPOTLIGHT

The interconnectedness of preparedness, resilience building, and health system strengthening is evident in **Pakistan**, where a community-level preparedness project resulted in a general increase in health facility visits. The project was conducted in Jhang District by UNFPA, Muslim Aid, the District Disaster Management Authority, the Department of Health, Rescue 1122, and local communities. It focused on reducing maternal and newborn mortality by providing health facilities with RH kits and other supplies (medical and non-medical) and raising community-level awareness of SRH and GBV. Antenatal visits, postnatal visits, and facility-based deliveries all increased, and there was an observed improvement in quality of care.[25]

v Note: Although continuity of comprehensive SRH services is ideal, this toolkit is intended to also be relevant to those countries that can focus on essential services only.

3. Use the MISP and Health-EDRM Framework to guide SRH preparedness activities.

In 2018 the MISP was updated and in 2019 the WHO Health-EDRM Framework released (see IAFM for the updated MISP and WHO Health-EDRM Framework in *Resources*). Both provide a useful frame to consider when developing preparedness activities. The MISP clearly outlines what is needed, at minimum, during an emergency, and so provides important guidance to the areas that SRH preparedness should focus on. The Health-EDRM Framework is broader and outlines 10 priority components and functions that are helpful to ground SRH and the MISP in the overall health system and in broader emergency risk mitigation, management, and capacity development. For SRH preparedness background and summary documents, see the IAWG DRM-H Fact Sheet and the IAWG SRH and EDRHM Policy Brief in *Resources*.

Many countries have started their SRH preparedness work by conducting MISP trainings and orientations. (For resources on the MISP, including trainings and advocacy sheets, see MISP Training Materials in *Resources*.) MISP training offers an opportunity to bring together SRH and DRM actors from the government, humanitarian, and development sectors, often for the first time. Ensure that MISP trainings and orientations are localized and include existing DRM structures and SRH policies. Following a MISP training with a coordination meeting can launch or reinvigorate SRH preparedness. (See the *Coordination* brief for country examples.)

4. Contextualize and tailor preparedness based on the health system capacity and on the types of hazards and degrees of risk.

Preparedness activities must be defined by what makes sense in the context, in careful consideration of existing health system capacities as well as community resources and capacities. Risk assessments can clarify the different types and degree of hazards faced and the level of preparedness required.

For more information on assessing risks and designating roles for government and humanitarian agencies, it might be helpful to consult the IASC ERP Guidance in *Resources* or explore the Rapid Response Approach to Disasters in Asia-Pacific (RAPID).

5. Build rights-based, people-centered, and inclusive SRH preparedness.

Work from a rights-based and people-centered approach. Recognize that SRH is a human right and that everyone has the right to access quality SRH care. Care should be available across all communities and be people-centered.

Recognize that everyone has multiple and intersecting identities that lead to a diversity of needs and affect their access to services. Inclusion refers to the inclusion of *everyone*, particularly those who are marginalized or underserved. (See the *Inclusion* brief for specific country examples and the note on inclusion.)

Maysam Shouman and Inass Zeineddine are youth peer educators working at the Salma Clinic, conducting comprehensive sexuality education sessions with Syrian refugee youth inside the Saadanayel camp, Bekaa Valley, Lebanon. Image credit: IPPF/Hannah Maule-ffinch/Lebanon

People-centered health care: "Integrated people-centered health services means putting people and communities, not diseases, at the center of health systems, and empowering people to take charge of their own health rather than being passive recipients of services. Evidence shows that health systems oriented around the needs of people and communities are more effective, cost less, improve health literacy and patient engagement, and are better prepared to respond to health crises."

—WHO, *WHAT ARE INTEGRATED PEOPLE-CENTRED HEALTH SERVICES?*[26]

Ensure inclusion is seen as a priority at every stage and level of preparedness. Emergencies disproportionally impact the most marginalized members of communities, and often the most underserved regions of a country. At every stage and level of preparedness, include representatives from marginalized groups on the coordination and planning body to ensure that the MISP will meet the specific needs of those groups during an emergency. Consider inclusion at each step—from policies to coordination, from health workforce trainings to community engagement—to ensure more equitable SRH care and access across the humanitarian-development-peace nexus. Stakeholders might benefit from training on values clarification to eliminate bias or discrimination. (See *Inclusion* brief and Inclusion Guidance for a range of inclusion materials and the values clarification toolkit in *Resources*.)

Engage and follow the leadership of marginalized groups. As first responders, local communities are critical to timely, inclusive, effective response as well as to transition and recovery. All too often these communities are excluded from humanitarian planning and response mechanisms and activities, especially when they are led by women or young people. SRH preparedness should be undertaken in collaboration with leaders and organizations representing the specific needs and priorities of marginalized groups. Work to ensure that the wide-ranging needs of the group are represented; for example, ensure that women with disabilities are adequately represented within a disabled persons' organization (DPO) if it is not women-led. (See *Inclusion* brief and Inclusion Guidance in *Resources* for tools to engage different marginalized communities.)

After flash floods in 2018, the National Transgender Network of Sri Lanka (NTNSL) and the Family Planning Association of Sri Lanka (FPASL) distributed dignity kits to affected transgender persons in the Gamapha District in Sri Lanka. Image credit: IPPF/Ellena Ashley Williams

STAGE 2

Assessing SRH Preparedness

1. Identify and collaborate with key stakeholders to jointly assess preparedness.

The delivery of lifesaving SRH care during emergencies requires collaboration and coordination among various stakeholders. This is also true of preparedness. Identifying the different actors—from community-based organizations to health and protection actors to policymakers—is critical to ensuring comprehensive coverage of preparedness activities and shared responsibility. When assessing SRH preparedness, identify the range of stakeholders to engage.

2. Use available tools to assess preparedness.

In each country (and even in different parts of the same country) the readiness to provide SRH services in an emergency will be different. Starting with an assessment of national, subnational, and community readiness can help prioritize resources for preparedness. The following tools can be used to assess SRH readiness and are included in *Resources*:

The MISP Readiness Assessment is designed to evaluate MISP preparedness on national and subnational levels and identify necessary steps to strengthen readiness to implement the MISP during an emergency.

The ACCESS Community Capacity Needs Assessments is designed to assess community assets and needs for MISP preparedness on a community level.

3. Inform assessments using available SRH-related data and relevant previous or regional learning.

Collect and analyze SRH-related data to identify gaps and needs that will inform SRH preparedness actions, including advocacy and planning. Data should draw from or include SRH indicators, facility assessments, sex- and age- and disability-disaggregated data (SADD+), and other health and population data, such as the health information management system or the demographic health survey. (See *Resources* for the MISP calculator, which can assist with data analysis for advocacy, fundraising, and planning). Reflect on learnings from previous emergency responses and from neighboring countries facing similar risks.

STAGE 3

Implementing SRH Preparedness

This stage covers steps for implementing SRH preparedness actions. The steps are categorized under the ten Health-EDRM Framework components and functions to assist users in structuring their SRH preparedness within the Framework.

1. Policies, Strategies, and Legislation

Integrate the SRH/MISP into existing health, DRR, and emergency health policies, strategies, and legislation at both national and subnational levels.

Integration is a long and iterative process that requires considerable advocacy on the importance of SRH. Map out the relevant policies, strategies, and legislation, and assess whether they would enable or hinder the MISP during response. Identify policies, strategies and legislation to target for SRH/MISP integration. SRH and DRM actors often collaborate on this when undertaking the MISP Readiness Assessment. The effort is strengthened when gender and GBV/ protection actors are also involved. If integration is possible only at the subnational level, move forward with that and then advocate later for national-level policy. (See *Resources* for the IAWG DRM-H SRH Fact Sheet for advocacy points, the MISP Readiness Assessment for overall assessment questions, and the IFRC Disaster Preparedness and Response Law Checklist and Handbook for assessing laws. See the *Policy Integration* brief for country-level examples).

Monitor the revision schedule of targeted policies, strategies, and legislation.

Become familiar with the policy review process to identify opportunities to integrate SRH/MISP language when revisions are scheduled. (See *Policy Integration* brief).

Integrate the MISP into the relevant national SRH or GBV policies, strategies, and laws to ensure SRH in emergencies is properly covered across the humanitarian-development-peace nexus.

Identify any further policies or strategies, such as those for youth, that could be targeted for integration. (See *Inclusion* and *Policy Integration* briefs.)

Trupti Rani Manapatra, Programme Officer at the Family Planning Association of India (FPAI), gives a sexual and reproductive health awareness session to women whose communities were affected by Cyclone Fani. Image credit: IPPF/Kathleen Prior/India

Additional Considerations

- Efforts can be as large as integrating the MISP into national SRH policy, as in Malawi and the Philippines, or as specific as integrating preparedness and response into FP country action plans, as undertaken by several FP2020 commitment countries.
- Global commitments such as the Sendai Framework, Health-EDRM, Sphere Guidelines, or Sustainable Development Goals can be referred to when advocating for integration.
- Champions are valuable assets in pushing policy integration forward. (For detailed learning from different country experiences integrating MISP/SRH into policies, see the *Policy Integration* brief.)
- Ensure that planning and funding allow for implementation of the revised national policies at a subnational level.

2. Planning and Coordination

Foster multi-agency and multi-sectoral collaboration for SRH preparedness.

Activities to advance SRH preparedness require multi-sectoral collaboration. Identify stakeholders relevant to the context, the types of risks and hazards faced, and the structure of the existing DRM system. Consider representatives from:

SRH (from all MISP technical fields) and overlapping sectors such as gender and protection;

DRM and emergency health decision makers;

government finance, education, and youth departments;

relevant humanitarian and development INGOs and UN agencies and humanitarian response clusters;

relevant local NGOs and civil society, including those representing marginalized groups (see Advancing Gender-Transformative Localization in *Resources* and the *Community* brief);

the private sector, where applicable; and

first responders (such as health providers, the army, emergency service providers, and the National Red Cross/Red Crescent society).

In **Colombia**, Profamilia (the local IPPF Member Association) struggled to gain participation in the Interagency Group for Mixed Flow Migration, which is coordinating the response to the Venezuelan migrant crisis. After producing several research pieces regarding the SRH and general health needs of the Venezuelan migrant population and host communities, they started to be accepted. They are now the only Colombian organization participating in the group, which includes UN agencies, INGOs, and members of the Red Cross Movement.

Establish or strengthen coordination bodies to advance SRH preparedness.

New coordination bodies can be established or SRH preparedness can be integrated into existing bodies, such as national SRH technical working groups, humanitarian preparedness and response forums, or committees in charge of DRM. Coordination bodies should be institutionalized if possible to assure sustainability and avoid challenges with staff turnover. Members should represent a range of relevant stakeholders, notably SRH and DRM representatives (see previous step above for expansive list). Consider opportunities to link with other coordination groups to build MISP awareness across different sectors or strengthen overlapping goals.

A review of the Ebola response in DR Congo found that SRH was not well integrated into the Ebola Working Group, despite attempts by SRH actors who argued its importance. This led to a siloed SRH response that was less effective than it would have been had it been a part of the larger Ebola response effort.[27]

Use joint action plans and/or terms of references (TORs) to advance SRH preparedness work.

Preparedness efforts are best supported by multi-stakeholder coordination and a collaborative model that enables different actors to contribute to different aspects of preparedness. Having joint TORs or action plans that clearly outline the roles and responsibilities of stakeholders can help clarify and advance preparedness work. These plans should be monitored for accountability and consulted when activating a response. (See *Coordination* brief for examples. In *Resources*, see the MISP Readiness Assessment for action planning and the Inter-Agency Field Manual for a sample SRH Coordinator TOR).

Coordinate at all relevant levels of the health system.

Establish and connect coordination bodies at the national, subnational, and community levels. On the community level, engage local government officials (including those focused on disaster and health) as well as health providers, women's groups, community leaders, schools, religious leaders, youth networks, and other organizations representing marginalized populations.

When her husband was arrested during the 2015 coup d'etat, Luscie Baragurana and her eight children fled the Bujumbura province in Burundi. They are now refugees at the Lusenda camp in Uvira, in the Democratic Republic of the Congo. Image credit: UN Women/Flickr

3. Human Resources

Invest in subnational and community actors.

In countries that face frequent disasters at subnational levels, such as Indonesia and the Philippines, it might be district authorities and community members who respond and manage the response and recovery. Investing in their leadership for preparedness and response is essential.

Support local champions. Local champions can be instrumental in advancing SRH preparedness work, such as by facilitating the integration of the MISP into medical professional curricula or advocating attention to SRH by district health officials. Once champions are identified, provide meaningful support for their continued engagement to help them carry their work forward. (See *Policy Integration*, *Coordination*, and *Curriculum Integration* briefs for examples of local champions).

Build workforce capacity.

Prepare the health workforce to be quality first responders. Health providers, even those working outside the scope of SRH, should understand the importance of SRH in emergencies, and SRH providers should be trained to provide the MISP when challenged by resource or mobility constraints. Identify, where possible, opportunities for SRH/emergency response simulations and other trainings. Attend to the safety, health, and wellbeing of first responders to support their work and reinforce their commitment.

In the **Indonesian province** of Aceh, a high-risk area for disasters, a survey found that only 74.6% of nurses scored at a moderate level of self-perceived readiness to practice in the event of a disaster.[28]

It is important for stakeholders to identify the appropriate role of international organizations in strengthening the national health system for preparedness. In a recent case study assessing the Typhoon Yolanda response in the Philippines, it was found that humanitarian INGOs failed to work with the existing preparedness mechanisms and "sidelined" government agencies in the response.[29] In a study exploring preparedness in South Sudan, findings showed that focusing on the roles and readiness of national staff for emergencies was especially critical given that international staff were evacuated.[30] IPPF and UNFPA, key partners in bolstering preparedness in the Asia Pacific region, have worked to avoid these shortfalls by focusing attention on strengthening the national systems.

Develop surge capacity. Countries should consider whether building a national roster or linking to a regional roster for surge capacity is appropriate, how trained providers will be deployed to affected regions (from within or outside the country), and who will ensure that providers are ready. Providers must be trained on the MISP, including follow-up trainings (in person or online) to ensure quality service provision. National medical associations should be leveraged to build surge capacity and maintain rosters at both the national and regional level of all those trained.

Countries such as Indonesia and Bangladesh have developed national surge capacity of midwives to respond to emergencies, while in regions like the Pacific and Latin American, UNFPA has developed a regionally based surge capacity.

Integrate the MISP into pre-service and in-service curricula. In collaboration with relevant ministries, identify training curricula where the MISP can be integrated. Consider opportunities for the accreditation of trained health providers on the MISP. (For detailed learnings from different countries, see *Curriculum Integration* brief. For more information about IAWG's Training Partnership Initiative that supports MISP refresher trainings in risk-prone countries, see SRH Service Delivery Training Materials in *Resources*).

Invest in national networks. National networks that have members in communities should be included in preparedness and engaged for surge and coordination during emergencies. These may include national midwives associations, the association of nurses, medical and health associations (obstetricians/gynecologists, pediatricians, general physicians, public health specialists), and networks representing women, youth, and people of diverse SOGIESC.

Idri, a youth volunteer with Indonesia Planned Parenthood Association, is supporting young people affected by the Sulawesi disaster through youth activties and information about services. Image credit: IPPF/Kathleen Prior/Indonesia

4. Financial Resources

Identify government and external funding sources.

Funding for national readiness often depends on a combination of domestic government investment and external resources. The Asia Pacific region has seen considerable attention to preparedness because of the Australian government's support for IPPF and UNFPA initiatives, which in turn has led national governments such as the Philippines and Indonesia to allocate funding for SRH preparedness (see *Coordination* brief). In the Eastern Europe and Central Asia (EECA) and Latin America and the Caribbean (LAC) regions, UNFPA's support has been instrumental. Given the burden on humanitarian funding for existing emergencies, funding for preparedness should be identified through various streams across humanitarian, development, and peace sectors.

In 2015, only 5% of humanitarian funding went toward preparedness.[31]

Tap funding for coordinated activities.

Identifying MISP readiness gaps without identifying the funding to address them can reduce government buy-in and momentum for SRH preparedness work. When possible, use existing funding to support the joint activities specified in the MISP readiness assessment. Where resources are constrained, focus on cost-effective and high-impact activities such as advocacy and partnership building.[32]

Additional Considerations

- Advocate using national and subnational budgets for SRH preparedness.
- Explore cost-effective opportunities to integrate SRH into existing preparedness funding, activities, and mechanisms.
- In contexts with cyclical hazards, ensure funding obligations are flexible enough to respond to emergencies as required.
- If specific contingency plans exist, ensure that emergency funds are available for their implementation.
- Estimates of economic and societal costs from prior emergencies, including losses of life from lack of SRH preparedness as well as overall preparedness, can be used to engage with donors.
- Help donors understand that SRH preparedness requires flexibility and long-term investment.
- Seek out joint program funding from different actors, including local and international actors and the private sector.
- For cases such as a pandemic, where lack of essential health services might lead to even more indirect deaths than those caused by the infectious disease, remind donors that SRH preparedness and response funding can safeguard access to safe and quality SRH in times of crisis and that this access is critical for reducing related morbidity and mortality.[33]

5. Information and Knowledge Management

Ensure that SRH and related gender considerations are integrated into DRM information and knowledge management systems, including surveillance systems and related monitoring and research efforts.

Include community-level early warning systems that leverage women and youth networks or local DRM committees, and link community leaders to SRH/DRM mechanisms to stay up-to-date and informed. (See *Community* and *Inclusion* briefs.)

Integrate SRH into DRM assessments on risks, vulnerabilities, and capacities at the national, subnational, and community levels.

Identify opportunities with relevant stakeholders to integrate SRH into any risk assessments and vulnerability assessments carried out during the preparedness stage. These can be as small as IFRC's vulnerability and capacity assessment or as large as OCHA's multiple large-scale assessments. As these are often employed when developing response strategies or emergency funding appeals, it is important to ensure that SRH is integrated.

Many early warning systems remain gender blind and must be updated with gender-sensitive indicators. This should be undertaken in close collaboration with women's groups. UN Women's Gender-Responsive Early Warning: Overview and How-to Guide (see *Resources*) outlines the process of selecting gender-sensitive indicators for community-based early warning systems and planning, implementing, monitoring, and evaluating early-warning mechanisms. This guide also offers examples from a variety of contexts, including a project that developed indicators of conflict-related sexual violence to be integrated into different early warning systems.

After flooding occured in Sri Lanka in 2017, the Family Planning Assoication of Sri Lanka (FPA-SL) created GBV and child protection awareness groups, which operated out of community members' houses. Image credit: IPPF/ Peter Caton/Sri Lanka

6. Risk Communications

Develop an effective communication strategy.

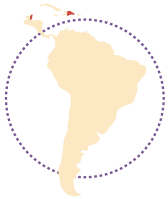
Ensure that affected communities receive accurate and timely information. Communities must be informed on current risks, the importance of seeking care for essential SRH services, where to seek care, and ways to stay safe and healthy. When developing the risk communication strategy, gather data on knowledge and perceptions related to SRH, communication patterns, at-risk populations, language, religion, influencers, and available health services. Coordinate and collaborate with other stakeholders to guarantee consistent messaging. Ensure effectiveness by using influencers, a variety of mediums, and tailored approaches for specific populations. Collaborate with different members of the community to design and pilot communication approaches. Different approaches and mediums can be adopted for different populations, and all should be monitored. (See *Resources* for WHO's Risk Communication and Community Engagement Action Plan Guidance.)

Ensure communications are accessible.

Engage with different community mechanisms to guarantee that all community members—regardless of language, abilities, literacy, or age—have access to information. Explore with each community group (for example, adolescents, women, people living with HIV, people of diverse SOGIESC, women and girls with different disabilities) how they both receive and communicate emergency health information. Consider radio, text messages, peers, community health workers and leaders, posters, leaflets, and information boards.

7. Health Infrastructure and Logistics

Assess facilities at every level of the health system to ensure that they can "remain intact, accessible and functioning" during emergencies.[34]



In the **Dominican Republic** and **Belize**, Engineers Without Borders-USA and IPPF Western Hemisphere Region are developing resilience guides and pre-emergency and post-emergency infrastructure checklists to help local clinic managers assess the operational capacity of health facilities. (See *Resources* for PAHO Health Sector Self-Assessment Tool.)

Create an enabling environment for supply chain preparedness.

Advocate policies, political will, and financing to include SRH commodities on essential medicine lists and standard treatment guidelines. Streamline processes to allow for easy importation, fast-tracking, and prepositioning, both during routine deliveries and in preparation for emergencies. If the country is at high risk for emergencies,[vi] work with national authorities on preauthorizing the import of Inter-Agency Reproductive Health kits.[vii] Improve coordination among government, NGOs, donors, and the private sector to support and align supply chain preparedness activities by engaging existing coordinating bodies. Make sure that all strategies include a preparedness component and that key organizations are added to coordinating bodies to discuss strategies, help improve policies, and mobilize funding to support preparedness. Advocate the inclusion of SRH and commodity security in the country's existing disaster preparedness activities for the wider health sector and beyond.

Develop continuity of operations for essential supply chain functions.

Create a continuity of operations plan (COOP) for the supply chain. This includes a plan to secure the availability of key RH/FP products in case of an emergency by: 1) maintaining essential supply chain functions and the key resources that support them, 2) carrying out risk assessments, and 3) developing contingency plans for specific risk scenarios and processes to build redundancy and resilience into the supply chain. The COOP should be the overarching plan that includes all preparedness plans and actions, including indicators and standard operating procedures (SOPs), to ensure the continuity of all logistics operations. Update and disseminate the COOP on a regular basis to all key stakeholders.

Identify key health products that will be secured. In addition to adding key SRH products to existing essential medicine lists and standard treatment guidelines and streamlining processes for importation, review all the products required to maintain comprehensive SRH services through existing programming. Determine the ideal list of products that will be provided during an emergency, with upper and lower thresholds of the range of products that will be managed. The inclusion of EC and long-term methods in these lists can help protect the rights of all women in emergencies.

Make plans to maintain critical resources for all essential supply chain functional areas that need to be maintained in an emergency. The key operations or functions that need to be maintained include product selection, quantification, procurement, inventory strategy, distribution, and warehousing, as illustrated in Figure 5. For each of these functional areas, develop plans to secure the following critical resources: people, processes, tools, information, assets/supplies, and financing.

Carry out risk assessments for functional and resource areas. As part of the COOP, conduct risk assessments for each of the functional areas and resource areas. The risk assessments should identify any actual or potential weaknesses or threats (internal or external) to the supply chain. If formal risk management is practiced as part of the supply chain's routine operations, use this documentation to build on for disaster preparedness. Define the context and scope for the risk assessment and follow these steps: 1) set performance objectives and identify relevant stakeholders, 2) identify sources of risk in collaboration with stakeholders, and 3) determine likelihood and impact of risk events. Sources of risk will typically be discussed and identified in a workshop setting, where stakeholders are present to give feedback on a variety of scenarios. Risks are then scored by likelihood and impact, giving managers a single score for prioritization.[35]

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vi See the INFORM Global Risk Index: https://drmkc.jrc.ec.europa.eu/inform-index

vii See the MISP Distance Learning Module, Unit 9: Ordering IARH Kits: https://iawg.net/resources/minimum-initial-service-package-distance-learning-module/unit-nine-ordering-reproductive-health-kits

Develop and continuously update contingency plans. Based on the risk priorities from the assessment, identify strategies for managing risks, such as reducing or hedging risks, and develop a small number of specific contingency plans to address vulnerabilities from most likely scenarios. Include ways to reduce impact to the supply chain, such as by creating redundancy through multiple sources of products, identifying varying routes of access to points of distribution, prepositioning products closer to vulnerable populations, or by securing investment through insurance. Contingency plans should also map the actions that staff need to take, as well as timelines, risk monitoring metrics, and response protocols.

The Logistics Cycle

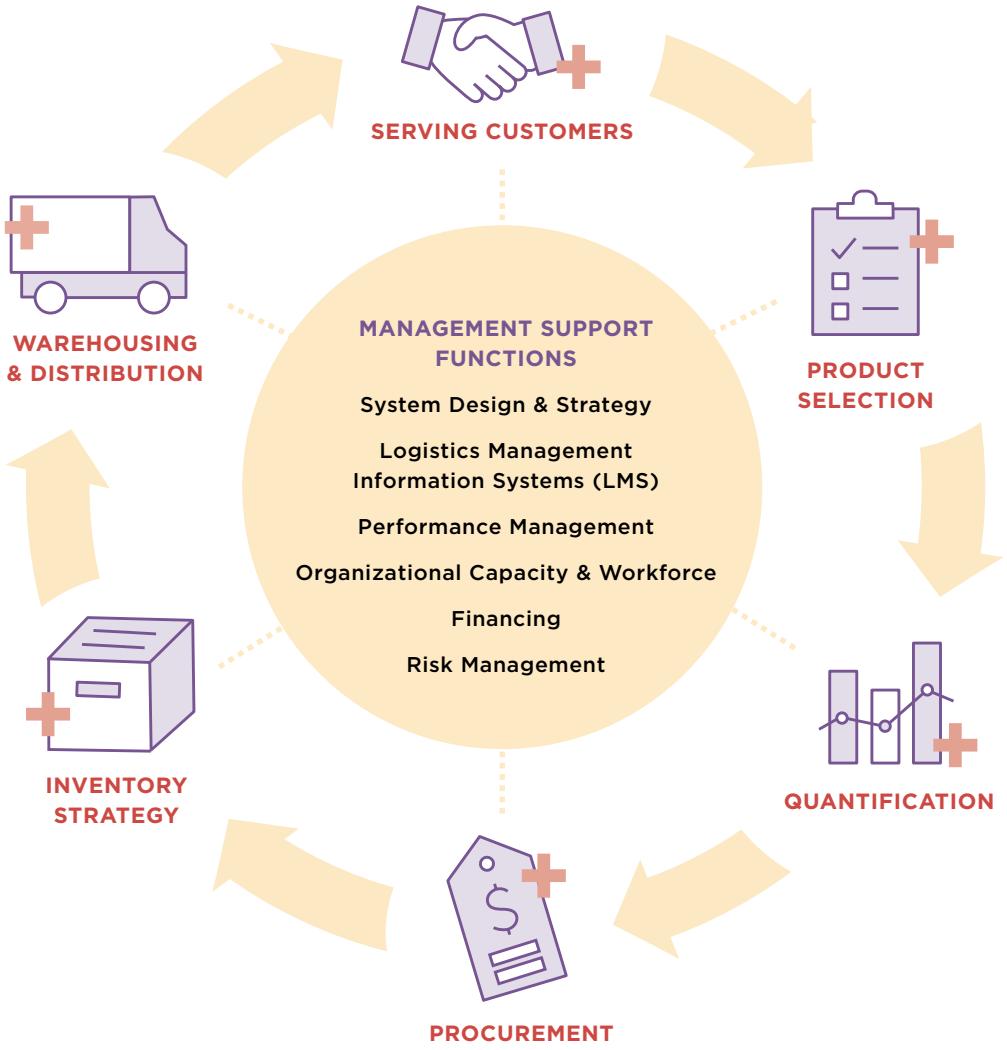


FIGURE 5.
Adapted from The Supply Chain Manager's Handbook: A Practical Guide to the Management of Health Commodities, John Snow, Inc., 2017.

8. Health and Related Services

Address service delivery availability.

It is vital to maintain continuity of essential SRH services. Ensure that women seeking care for time-sensitive lifesaving services, like delivery, do not face additional delays such as new checkpoints or mobility restrictions. Prepare for MISP provision in consultation with other health facilities, including the private sector, recognizing that during an emergency all services will be overstretched and some facilities will be closed or destroyed. It may be necessary to re-sensitize health providers on the MISP and plan how SRH services might be modified to ensure continued delivery of care.[36]

During the Ebola outbreak in Liberia, in urban areas only 22.9% of women who sought prenatal care and 22.3% of women who sought obstetric care received it.[37] In Monrovia, there was an increase in births at private facilities while public facilities were closed or directed toward Ebola response.[38] In Sierra Leone, in the year 2014-2015, it is estimated that the reduced utilization of SRH services led to an additional 4,700-5,000 maternal, neonatal and stillbirth deaths.[39] In DR Congo, women faced additional significant delays in traveling to seek facility-based care.[40]

Plan for service adaptation for each MISP component in view of potential risks.

Consider task shifting/sharing policies and the training required. To increase access to SRH services in hard-hit, hard-to-reach, or underserved communities, consider task-shifting. Task-shifting/sharing allows lower-level health workers to provide certain health services (see WHO's task sharing guidance for FP/contraception in *Resources*).

Recognize the role of community health workers.[viii] Many countries have strong networks of community health workers who are often frontline responders in emergencies. Their role should be formally recognized and preparedness activities should address any barriers that would limit their participation, such as policies or limited remuneration.

Consider service delivery shifts. Depending on risks and hazards faced, preparedness actions might include planning for modifications to services, such as transitioning to community-based delivery, identifying new service delivery points such as pharmacies, or shifting to remote care and offering telemedicine where possible.

Consider self-care and self-management. Self-care or self-management of options should be considered during the preparedness stage to ensure that enabling policies and necessary health products, information and communications technologies (ICTs), training materials, and information are in place. (See WHO's consolidated guideline on self-care interventions in *Resources*.)

viii In some countries this role might be referred to as village health worker, lady health worker, health extension worker, or health assistant.

Volunteers with Direct Relief supplying midwife kits as part of relief efforts after Typhoon Haiyan, a Category 5 storm that struck the area in 2013. Photo credit: Direct Relief/Flickr

Address service delivery quality and access.

SRH care must be of high quality during emergencies. Beyond clinical MISP trainings, sessions on people-centered care, addressing disrespect and abuse, supportive supervision, values clarification exercises, and refresher trainings can further equip health providers to provide high-quality care without discrimination to all community members. The IAWG global evaluation found that adolescent girls, people of diverse SOGIESC, sex workers, and people with disabilities are frequently underserved.[41] Efforts that address root causes of low-quality service delivery are not just part of preparedness, but complement broader health system strengthening initiatives. (See *Inclusion* brief and Inclusion Guidance for a range of inclusion materials and see the values clarification toolkit in *Resources.*)

A 2015 study assessing service provision in South Sudan, DR Congo, and Burkina Faso found that inadequate quality standards and insufficient service delivery were due to weak clinical knowledge and personal biases.[42] In the same year, an evaluation of RH programs in humanitarian crises found that men and women will seek services if the quality is adequate.[43]

Address service delivery gaps in the MISP components.

During emergencies, all MISP components, to the full extent of the law, must be enacted. To overcome barriers to service provision across MISP components, preparedness efforts should consider direct and indirect factors that lead to uneven care. Services to prevent GBV and offer clinical care for survivors, safe abortion care, and the provision of long-acting and permanent contraceptive methods are examples of MISP components that frequently receive insufficient attention during emergencies. These gaps lead to higher risks of morbidity and mortality.[44]

9. Community Capacities for Health-EDRM

Engage and build relationships with communities as critical first responders.

Before external assistance arrives, it is the community that responds, and the degree to which the community has developed preparedness plans and mechanisms will influence its ability to address immediate concerns. Identify community leaders and organizations and build relationships based on trust and collaboration, keys to fostering more sustainable and effective preparedness. Undertake all community-level activities in close collaboration with different community stakeholders, recognizing the diversity of community members, their respective SRH needs, and their own capacities to manage risks and respond to hazards.

In close partnership with community members, develop a community assessment of risks and capacities and create an action plan.

Identify key stakeholders. In collaboration with local SRH stakeholders, identify local, subnational, and national civil society groups that address SRH (including GBV and HIV) to learn more about their existing capacity and needs and get to know their networks. These might include community civil society representatives who engage on health issues with adolescents and youth, people with disabilities, people living with HIV, people of diverse SOGIESC, and/or sex workers. In addition, identify the community health work force, which might include community health workers, home visitors, public health workers, social welfare workers, and first responders.

Conduct a community capacity needs assessment. In collaboration with local stakeholders, assess the community's needs, capacity, and readiness to implement the MISP. (See *Resources* for ACCESS community capacity needs assessment tools.)

Conduct a MISP/DRR training. Once the community capacity needs assessment is complete, a local lead agency or coordinating body can utilize the findings to undertake and support a DRR and MISP training. (See *Resources* for the Facilitator's Kit: Community-based Preparedness for Reproductive Health and Gender. See *Inclusion* and *Community* briefs for examples of women-led and youth-led DRR work.)

Develop a community action plan based on the needs assessment. It is recommended that action planning be combined with training on community preparedness for SRH. (See *Resources* for the Facilitator's Kit: Community-based Preparedness for Reproductive Health and Gender.) Use this process to identify and prioritize key activities, identify and secure funding, and implement monitoring (including monitoring for sustainability). Actions should focus on the priority activities of the MISP and can include awareness-raising to mitigate GBV and gender risks in emergencies, establishing and sensitizing the community to referral mechanisms for obstetric emergencies and sexual violence survivors, working with pregnant women to develop birth plans and petty savings, prepositioning supplies, working with local hospitals on blood donor lists, expanding access to contraception (including emergency contraception), developing or bolstering women and youth committees for disaster risk reduction, conducting simulations, and establishing an emergency fund (see *Community* and *Inclusion* briefs for community-preparedness examples and see *Resources* for ACCESS Community Capacity Needs Assessment Tools).

Rahnuma-Family Planning Association of Pakistan (FPAP) supported six community trainings on the MISP in three disaster-prone districts of Pakistan. The evidence demonstrated that community members, including young people, were empowered to identify solutions. Young people were involved in developing a list of cheaper local emergency transporters for emergencies and proposing locations for contact information to be shared and posted in the community. Adult community members identified houses where hygiene and clean delivery kits could be stored and where condoms and emergency contraception would be more accessible in the event of emergency.

The health center in Hajizai refugee camp in Charsadda district, Pakistan, is staffed exclusively by female officers, and is one of two facilities that are open round-the-clock to offer assistance to mothers and their children, in addition to general consultations. Photo credit: EU Civil Protection and Humanitarian Aid/Flickr

Seize opportunities to advance preparedness quickly at local levels.

Local level preparedness efforts are sometimes more efficient than national-level efforts. In some countries it is easier to foster collaboration between SRH and DRM actors on subnational or community levels, and these efforts can then be showcased to inspire national efforts (see *Coordination* brief).

The significance of community-level care: In the Ebola response in Guinea, Liberia, and Sierra Leone, it became clear that communities place the most trust in their own community health workers, who speak their language and understand their social context. Community health workers, traditional birth attendants, and community health committees were instrumental during the Ebola response.[45] In Guinea, FP users dropped by up to 75% during the Ebola crisis, and in two locations facility-births dropped 87%.[46] It was found that FP-seeking behavior proportionally dropped far more at higher levels of the health system than at the community-based health clinics, likely because of trust in the care and safety of accessing a community clinic.[47]

As the COVID-19 outbreak expands globally, anecdotal reporting points to smaller health clinics as being the last to shorten their hours or close, reminding us that investment in community health centers and their staff is essential during preparedness.[48]

Link communities to national preparedness systems.

Community-level preparedness efforts and community-based organizations and networks will be more effective and sustainable if linked to national preparedness efforts for strengthening, collaboration, support, and follow up. Foster national and subnational support for community-level preparedness initiatives (see *Community* brief).

Leverage community networks.

In addition to leveraging the networks of community members who are part of national networks (see this previous step), leverage community-based networks (such as women, youth, or people of diverse SOGIESC networks) to plan and undertake community preparedness activities.

A team of community-based health volunteers at work in a client's home in Gidan Igwai area in Sokoto, Nigeria. Image credit: POPCOM Albay Province & Legazpi City for RTI International

10. Monitoring and Evaluation

Monitor action plans and TORs.

Establish systems and indicators to monitor preparedness efforts, including any action plans and TORs. Include community members, such as youth, in monitoring the programs that engage them.

Collect and manage SRH-related data.

Integrate SRH indicators into existing health data management systems during the preparedness phase, and strengthen data management systems to include SRH and ensure agility to adapt to emergency response systems. Ensure that SADD+ and essential SRH data are included in risk assessments for preparedness, rapid assessments for response (such as Multi-Cluster/Sector Initial Rapid Assessment), and health information management systems (HIMS). (For more information on SRH-related indicators and the MISP checklist for monitoring, see the Inter-Agency Field Manual MISP Chapter listed in *Resources*.)

A case study assessing the 2013 Mount Sinabung eruption response in **Indonesia** found a lack of SRH preparedness. This led to insufficient systems to document, report, analyze, and maintain the confidentiality of SRH-related information during emergency response. Having learned from this lesson, the Ministry of Health partnered with UNFPA and members of the SRH sub-cluster to create a list of SRH indicators that are linked to the country's health information system. These were tested and used during data collection, analysis, and reporting of the 2018 tsunami response in Central Sulawesi.[49]

Document and share preparedness learnings.

It is important to share and learn about experiences with SRH preparedness globally and regionally.

Document learnings from responses to inform and strengthen preparedness. Countries are encouraged to conduct reviews of previous responses to inform and strengthen preparedness efforts as well as to document the impact of preparedness on response. More reflective learnings like these would greatly contribute to the SRH preparedness field.

Learning from past responses: In Vanuatu and Tonga, after emergency responses exposed a demand for LARCs that could not be met, providers were trained on LARCs and supply chains were updated to ensure that LARCs were part of preparedness and response going forward. The results were most recently evidenced in the response to Tropical Cyclone Harold in Vanuatu.[50]

In Kenya, a case study examined lessons learned from the 2007 post-election violence regarding care for HIV-affected communities. Following reflection on the response, in 2008 Kenya established a disaster management agency that incorporated HIV care into its response plan and a steering committee dedicated to HIV care during emergencies.[51]

In Nepal, a review of the 2015 post-earthquake response found that the country's coordination mechanism was instrumental in the effectiveness of the response.[52]

Document learnings from different contexts and types of hazards. Globally, more learning is needed from diverse regions and different types of emergencies. In the limited documentation of SRH preparedness, most examples are from the Asia Pacific and EECA regions. It would be invaluable to hear more from other regions operating with different health systems or facing exposure to different types of hazards: slow onset disasters, such as drought and/or impacts of climate change; conflict-related crises; political turmoil, such as election violence; or other types of seasonal or cyclical natural disasters.

Document cases when preparedness did not impact response. Documented learning is also helpful on when preparedness did not facilitate stronger or effective responses, or contingency plans did not anticipate the subsequent emergencies.

Reports from South Sudan, Iraq, and a regional review in West Africa (including Mali, Burkina Faso, Côte d'Ivoire, Ghana, Liberia, and Sierra Leone) offer critical lessons on missed opportunities. In South Sudan, procurement was planned around population but did not consider the number of health facilities or international staff evacuations.[53] In Iraq and West Africa, leadership buy-in underscored effective preparedness work, but external considerations such as security-restricted mobility and limited funding weakened efforts and hindered responses.[54]

Research or develop further guidance on SRH preparedness. Further development of resources, research, and guidance to support SRH preparedness is needed. This toolkit is ready for field testing to assess its utility and link it to complementary implementation research to determine how SRH preparedness efforts influence health outcomes.

A client brings her child to meet with a healthcare worker in Afghanistan.
Photo credit: IPPF

Learning Briefs

The Learning Briefs in this toolkit focus on specific topics in SRH preparedness and provide real-world examples of actions taken to improve readiness. They build on available literature, case studies, key informant interviews, and experiences and learnings from a selection of countries. The briefs are designed to provide decision makers in countries with starting points to initiate or scale up preparedness work to improve access to SRH care during emergencies.

The examples cited in the Learning Briefs are not meant to be exhaustive or normative, but rather to highlight some promising practices that led to strengthened SRH readiness. As each context is specific, decision makers will have to identify the lessons that best fit their environment in terms of risk level, available resources, policy setting, and more. The Learning Briefs, like the whole toolkit, are intended to inspire countries and agencies to develop additional briefs and examples and contribute to the learning in this space.

The *Learning Briefs* are sequenced in order of the Stages of SRH Preparedness: Initiating, Assessing, and Implementing.

LEARNING BRIEF ON INCLUSION

"Leave No One Behind"—Developing inclusive SRH preparedness strategies, plans, and activities

Key Takeaways

Communicate and collaborate with community-based organizations. Identify key women-led, youth-led, and other community-based organizations at national and subnational levels and build relationships. Get to know each other's networks and collectively identify the specific SRH needs of vulnerable and marginalized populations. (See the note on inclusion.)

Go beyond tokenistic inclusion, apply the principles of "do no harm," and be creative. Use tailored strategies to ensure informed decisions, meaningful involvement, and representation of marginalized and underserved groups in all SRH preparedness activities.

Train first responders on stigma-free attitudes. Conduct values clarification and attitude transformation exercises, and provide information on human rights (of women and girls, people with disabilities, people of diverse SOGIESC, and others) and on sexual and gender-based violence to ensure first responders are prepared to provide stigma-free and rights-based services in emergencies.

Advocate for inclusive emergency preparedness policies and their effective implementation. Advocate at the national and subnational level for inclusive SRH emergency preparedness strategies, policies, and plans, and ensure these are being budgeted, implemented, supervised, and monitored.

Provide visibility to different marginalized groups in key policies. Ensure different marginalized and underserved groups (such as women with disabilities, adolescents, and people of diverse SOGIESC) are explicitly mentioned in policy documents to ensure no one is left behind.

Building an inclusive approach to disaster preparedness

"To deliver impartial and accountable humanitarian assistance that responds to vulnerability in all its forms, and reaches the most marginalized people, an inclusive approach to the design, implementation, monitoring and funding of humanitarian assistance is required."

—INCLUSION CHARTER, AGENDA FOR HUMANITY[55]

Emergencies affect everyone, but the impact is particularly great on those who are the most vulnerable, marginalized, and discriminated against in society. Vulnerability is a complex concept, depending on a range of factors that include sexual and gender identity, sexual orientation, age, disability, health, marital status and parity, social and legal status, ethnicity, faith, and nationality. Each person has multiple, overlapping identities that affect their degree of vulnerability.[56] The IFRC World Disaster Report 2018 notes that "too many affected people are 1) out of sight, 2) out of reach, 3) left out of the loop, or find themselves in crises that are 4) out of money, or deemed to be 5) out of scope because they are suffering in ways that are not seen as the responsibility of the humanitarian sector."[57]

By recognizing that different populations face specific risks and have specific needs, emergency preparedness and response can be better tailored to meet those needs. In planning for preparedness activities and strategies, it is essential to meaningfully include diverse groups and build community-driven preparedness and response to ensure inclusion of marginalized and underserved populations. As highlighted in the Pride in the Humanitarian System Consultation Report (2018): "relationships with all stakeholders need to be in place ahead of time, in order for the network to be ready to respond rapidly and efficiently when called upon. This requires engaging early with community leaders as people who know their own communities, and as a means of establishing trust-based relationships."[58]

Communities and grass-root organizations are also very often the first responders. They have the best knowledge about their context and are a vital complement to the national and international humanitarian community. Even if not experienced humanitarian actors, they nevertheless allow meaningful care to reach people who might otherwise fall through the cracks.

Key elements for inclusive SRH preparedness strategies

Work on meaningful inclusion of marginalized and underserved groups during SRH preparedness is still in its early stages. Active participation of youth groups in the Nepal earthquake and Sulawesi response demonstrate the immense value an inclusive approach can have in emergency response. However, engagement during stages of preparedness is still evolving and needs more attention. Ongoing discussion with marginalized communities is needed to better understand the diversity and challenges faced in humanitarian response. The work described in this brief, based on grey literature and key informant interviews, is intended to serve as an inspiration for inclusive action.

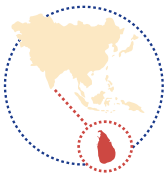
Celestine, a refugee at the Lusenda camp, leads a dance performance organized by youth at a multipurpose center in October 2015. Image credit: UN Women/Catianne Tijerina

Creating a space for constructive dialogue with marginalized groups

One of the most critical factors is building relationships, particularly between humanitarian actors, diverse civil society organizations and networks (including women-led and youth-led groups), government entities, religious leaders, ethnic groups, minorities (including refugees and migrants), and donors.[59] For many community groups working on issues of gender identity, disability, youth, or HIV, the humanitarian sector (national and international) remains a foreign system, from which they have been largely excluded. Similarly, for many SRH and humanitarian actors the experiences of these community groups are poorly understood even in stable times, let alone in emergencies.

As noted in *Down By The River: Addressing the Rights, Needs and Strengths of Fijian Sexual and Gender Minorities in Disaster Risk Reduction and Humanitarian Response:* "Working with sexual and gender minorities who have experienced discrimination and marginalization requires trust-building that is hard to accomplish in the rush of humanitarian response, especially for external actors if they descend in the aftermath of disasters. It takes time to map local CSOs and to build working relationships. It takes time to connect with informal networks and build trust with individual community members."[60]

Investing in constructive dialogue and opportunities for people to come together (such as meetings, workshops, and trainings) enables both sides to learn from each other, and helps reduce the impact of emergencies on marginal and underserved groups.



In **Sri Lanka**, the Family Planning Association of Sri Lanka (FPASL) was exposed to issues facing people of diverse SOGIESC and people living with disabilities through various regional events. FPASL identified representatives from these communities who could serve on their SPRINT[ix] project steering committee, thus bringing these groups into dialogue with the Ministry of Disaster Management and other ministries. While many issues are still sensitive, ongoing representation and funding support has resulted in disability-inclusive MISP materials (such as IEC videos in sign language and leaflets in braille) and consultation in DRR planning.

In **Nepal**, a 2018 consultation on SOGIESC issues in humanitarian settings supported by the Family Planning Association of Nepal (FPAN), UN Women, the Red Cross, and Blue Diamond led to an ongoing series of events as well as a workshop to share these issues with the Disaster Preparedness Network Nepal. Building on the 2015 earthquake response, FPAN consulted with various SOGIESC organizations (Blue Diamond Society, Mitini Nepal, Inclusive Forum) to identify challenges they faced in accessing public health facilities. This input was used to formulate suggestions for making district disaster management policies more inclusive of SOGIESC needs. The Ministry of Home Affairs and the Ministry of Women, Children, and Senior Citizens welcomed this initiative and will consider revising their policies.

In **Indonesia**, the SRH sub-cluster includes representatives from people living with HIV (Indonesia AIDS Coalition), which is key for ensuring their needs are not overlooked in preparedness activities.

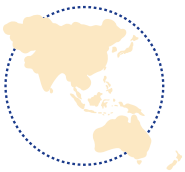
Destruction to infrastructure from the September 2018 earthquake and tsunami that hit Palu, Indonesia.
Image credit: IPPF/Kathleen Prior/Indonesia

ix The SPRINT (Sexual and Reproductive Health Program in Crisis and Post Crisis Settings) initiative, led by IPPF in collaboration with UNFPA and other national and international partners, aims to improve health outcomes of crisis-affected populations by reducing preventable sexual and reproductive ill health, disability, and death.

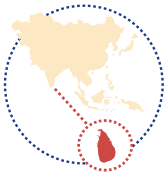
Applying the principle of "Nothing about us, without us"

The inclusion of organizations or leaders from marginalized groups can help identify actions to improve SRH and prevent GBV during emergencies. MISP trainings need to include sensitization to the rights of marginalized groups, such as people of diverse SOGIESC, to ensure that bias or discrimination does not impact service provision.

In **Indonesia**, consultations with communities resulted in the design of different hygiene kits for elderly people and pregnant adolescents, and different dignity kits were designed for different religious groups. Existing networks, such as youth networks and women-led NGOs, were leveraged during preparedness planning. Through Perkumpulan Keluarga Berencana Indonesia (PKBI-Indonesia Planned Parenthood Association), youth volunteers assisted with the Central Sulawesi response.



In the **Pacific Region**, UNFPA and IPPF Member Associations have been actively working with disabled people's organizations (DPOs) at regional and national levels. Under the Asia Pacific Regional Prepositioning Initiative, UNFPA, IPPF, and the Pacific Disability Forum have created a partnership to support the inclusion of disability in preparedness, with a focus on GBV in emergencies. A regional workshop brought together six countries to discuss national priorities and develop action plans for UNFPA country offices, IPPF Member Associations, and national DPOs to take forward. The work at national levels builds on existing relationships cultivated during stable times. IPPF and UNFPA have included DPOs in MISP trainings, invited them to SRH events, and advocated greater inclusion in cluster meetings. In Tonga, people with disabilities have been trained on the MISP and were part of the response team. In Solomon Islands, the Solomon Islands Planned Parenthood Association worked together with DPOs to rebuild the clinics, ensuring they would be accessible for all in stable times as well as emergencies.



In **Sri Lanka**, FPASL recognized that people of diverse SOGIESC have a variety of needs, and worked with the National Transgender Network of Sri Lanka (NTNSL) to develop transgender-friendly dignity kits. During the October 2018 floods, members of the NTNSL distributed these kits to their community, which was highly appreciated.

Fostering women leaders at the community level in DRR and SRH preparedness activities

Social roles and gender inequalities can exclude women from preparedness planning, but experience has shown that women can act as agents of change and play an instrumental role during emergencies. Building their capacity, providing the opportunity to participate in decision making, and including community concerns in emergency preparedness plans show the potential for responses that meet the needs of women.

In **Pakistan**, UNFPA and Muslim Aid organized women and youth reproductive health disaster risk reduction (RHDRR) committees in Punjab province. The objective was to build the capacity of youth and women on disaster management and provide them with the necessary skills to be ready to respond during an emergency. The activities led to village-driven preparedness plans and context-specific RHDRR measures. Activities for young people included blood group listing (if needed for transfusion of pregnant women during emergencies), tailored IEC material, training to liaise with health officials to enable access to care for adolescents, and more. The women and youth committees also contributed to improve the district health department contingency plan.[61,62]

In **Samoa**, the Samoa Family Health Association (SFHA) invested in work at the community level and established focal points among women leaders in villages. Under the leadership of the National Disaster Management Office (NDMO), SFHA and the Red Cross go from village to village and conduct SRH preparedness work and simulations with the communities. This created an opening for the NDMO to establish contacts with women leaders, who felt empowered and took ownership of the interventions. As a result, more women joined the village disaster committees to better represent the needs of women and girls in emergency preparedness planning.

Engaging meaningfully with youth groups, networks, and leaders

Children and young people can assume a change-maker role in village-led preparedness.[63] The key informant interviews and literature review reveal that very little has been done so far to include young people in preparedness strategies, coordination, and activities. A few examples of meaningful engagement with young people during responses can serve as inspiration for similar inclusion in preparedness phases.

In **Indonesia**, PKBI-Indonesia Planned Parenthood Association collaborated with IPPF and UNFPA Indonesia after the 2018 Lombok earthquake to establish a model for youth participation and accountability. It was originally difficult to ensure that young people were included in the coordination mechanisms, and it came to light that they did not always feel comfortable sharing their experiences due to stigma and lack of acceptance. PKBI youth volunteers set up a youth forum managed and led by young people themselves, which allowed the group to come together to identify specific needs, barriers, and strategies for meeting their SRH needs during the response. The youth forum included specific action items and recommendations that could then be formally raised to the SRH sub-cluster by PKBI staff. While it is important to include young people in coordination mechanisms, PKBI found that a youth forum led and managed by young people themselves, where they feel comfortable and have a platform free from stigma, is a key driver of success.

In the **Philippines**, youth committees in two high-risk areas (Metro Manila and Mindanao) were established for preparedness after young people assisted with response to Typhoon Washi (December 2011).[64] Since then, UNFPA has also supported the engagement of young people as part of the mobile teams to distribute dignity kits and discuss with peers issues related to SRH and GBV.

Ensuring "Do No Harm" approaches

In some countries sexual diversity is illegal or heavily stigmatized. Similar issues are faced by sex workers, drug users, and marginalized ethnic groups. They often rely on their formal or informal networks for information and care to avoid the risk of discrimination or stigma, and seek discretion to ensure safety. When working on inclusive participation, it is critical to ensure people are not being forced into any preparedness or response action which would put the group or an individual at risk. The "Do No Harm" principles are also supported by various international commitments, such as the IASC Guidance on GBV in Humanitarian Action, UNICEF IASC Protection from Sexual Exploitation and Abuse, and the IASC Policy on Protection in Humanitarian Action.

A volunteer staff nurse from the Vanuatu Family Health Association (VFHA) created contraceptive boards to help showcase to clients the available options. Image credit: IPPF/Kathleen Prior/Vanuatu

LEARNING BRIEF ON POLICY INTEGRATION

Integrating SRH into disaster risk management policies and plans

Key takeaways

Refer to global commitments and frameworks for MISP policy integration. Use global commitments that endorse SRH or MISP, such as the Sendai Framework, Health-EDRM Framework, Sphere Guidelines, and the Sustainable Development Goals, to make the case for integration of SRH and the MISP in national policy.

Know your context and your policies. Analyze the legislative environment regarding disaster risk management, emergency health responses, and restrictive policies (e.g., access to care for adolescents, refugees, etc.) to identify where provisions for SRH exist and which policies need to be revised.

Leverage existing supportive policies. Ensure policies supportive of MISP are implemented at all levels and that resources for its implementation are allocated.

Moving towards SRH-inclusive disaster risk management policies and plans

The impact of conflicts and natural hazards on human health is indisputable and often devastating, and highlights the urgent need for more comprehensive approaches to disaster risk management (DRM).[65] The Sendai Framework urges the design of inclusive policies that position access to basic health care, including SRH care, as an essential element of disaster management.[66] The Health-EDRM Framework also clearly emphasizes the importance of integrating health considerations into relevant policies and strategies.

But while some progress has been observed, the integration of health, and particularly SRH, into national disaster risk reduction policies and strategies remains a challenge.[67] The main obstacles include lack of knowledge of existing and missing policies, complex governance structures (such as a strongly decentralized system), inadequate funding, and poor coordination with other sectors.[68]

Key elements leading to SRH integration into DRR strategies

Efforts to integrate SRH into DRR policies are still in the early stages, but attention to this approach is growing and initiatives have been conducted in several countries. This learning brief outlines some of the approaches that have been successful, based on literature review, case studies, and key informant interviews. The advocacy strategies vary depending on the context, but all have in common the fact that policy change is a long-term process and requires continued commitment and dedication.

Identifying strategic entry points to advance inclusive SRH disaster risk management policies

Identifying policy gaps in collaboration with DRR bodies through a joint assessment and action planning processes

The MISP Readiness Assessment (see *Resources*) provides a detailed picture of gaps for SRH in emergencies, and is a key entry point for policy change. Countries that have conducted the assessment have found that it creates a process to bring together SRH and DRM actors, and can lead to the development of meaningful joint action plans to improve policies and plans.

In **Albania**, the MISP assessment conducted in 2013 (part of the region-wide EECA assessment) led to the 2015 integration of the MISP into the Ministry of Health's Platform on Disaster and Risk Reduction and into the contingency plan for possible mass influx of migrants and asylum seekers at the Albanian border. This was achieved through the committed efforts of the SRH working group, including UNFPA, the Albanian Center for Population and Development (IPPF Member Association), and the Ministry of Health and Social Protection.

In **Kenya**, UNFPA organized a workshop in 2018 to conduct the MISP readiness assessment with the Ministry of Health, the National Council for Population and Development, the National AIDS Control Council, UN Women, the Red Cross, and World Vision. The exercise helped identify the key policies needed to include SRH provisions and kicked off advocacy work to include MISP in relevant plans.

In **DR Congo**, CARE has worked with government partners at multiple levels to integrate the MISP into emergency preparedness planning. In 2019, CARE organized a national workshop in Kinshasa that brought together the Ministry of Health, the Ministry of Solidarity and Humanitarian Action, the Ministry of Social Affairs, UNHCR, the IPPF Member Association, the International Rescue Committee, Save the Children, UNFPA, and others. Prior to the workshop, CARE conducted a MISP readiness assessment with the Ministry of Health to evaluate the legislative environment for emergency preparedness and DRM and determine the extent to which SRH was integrated. The assessment proved to be a very useful exercise to get people thinking about what did and did not exist and how to address gaps. Six months after the workshop, representatives from the Ministry of Health's National Adolescent Health Program and National Program for Emergencies and Humanitarian Action, together with CARE and UNFPA, launched a plan to revise the National Strategic Plan for Adolescent Health for humanitarian contexts and to integrate SRH into the National Contingency Plan.

Tracking policy revisions and being opportunistic

When working on policy integration, SRH actors need to have a good understanding of the legislative environment. Key informant interviews reveal how SRH partners build on current work and use the existing relationships and visibility they have in the country to advocate for SRH integration. An ideal time to integrate SRH language is when policies come up for review. As this happens only every few years, a comprehensive grasp of the policy review agenda and process is critical.

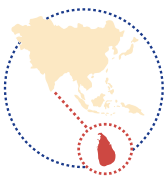
In the **Pacific region**, IPPF created a database mapping all policies and guiding documents in their countries. The database includes information on whether SRH is mentioned in relevant policies and when these policies are planned for review. This database enabled the Kiribati Ministry of Health, the Kiribati Family Health Association, and UNFPA to advocate for SRH language and have it integrated in the *Strategic Roadmap for Emergency Management in Kiribati 2019–2022* and the National Public Health Emergency Response Plan.

In **Nigeria**, CARE conducted a MISP readiness assessment workshop in Borno State with key partners, including the State Emergency Management Agency, the Primary Health Care Development Agency, and the Medical Relief and Humanitarian Services. In the course of the exercise it emerged that the Borno State Health Development Strategic Plan had been recently revised. Although this plan addressed emergencies such as disease outbreaks, it did not mention the MISP or include any specific considerations for SRHR in emergencies. Recognizing the need to have a better understanding of existing policies and the timelines for revision, CARE and the other partners developed a recommendation and advocacy letter to the government to influence the next revision of the strategic plan.

Maasai tribe young mothers gather for a forum about family planning and other sexual reproductive health options.
Image credit: Jonathan Torgovnik/Getty Images/Images of Empowerment

Using local integration initiatives to influence national policy changes

Key informants confirm that it is essential to establish supportive policies at the national level, as this will ensure sustainability and a government mandate for SRH in emergencies. In reality, getting the needed buy-in at the national level can be challenging. A possible pathway is to start working at the subnational level. Piloting local initiatives, developing videos on the MISP in local language (such as in India and Nepal), and documenting the results can help influence national level policies.



In **Sri Lanka**, FPASL established a formal collaboration in Badulla District and provided MISP training to stakeholders, including the District Disaster Management Center staff and first responders at the village level. Continued advocacy and training led to the integration of MISP components into the preparedness plans at the divisional level. Thanks to persistent advocacy and the positive impact demonstrated in the region, stakeholders at the national level started to take interest in the importance of providing SRH care during emergencies.

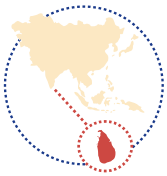
Building on existing structures, systems, and policies

When working on SRH integration, it is essential to have a good understanding of the existing structures and policies in the country, as this will define the needed advocacy strategies. In countries with a strong and comprehensive legal framework on disaster risk management, such as the Philippines, Indonesia, Sri Lanka, and Pakistan, targeted advocacy actions led to MISP integration into national emergency and response systems.

Adopting long-term and multi-pronged advocacy approaches with dedicated government staff

Policy change is very often an iterative process, and needs long-term commitment as well as a dedicated team to work on it. Key informants stress that the preparedness phase is ideal for building capacity, ensuring inclusivity of SRH response, and adapting international guidelines to local conditions. Having policies and guidelines in place gives weight to the importance of SRH in emergencies and confirms a mandate to work on it.

In **Indonesia**, the integration of elements of the MISP into emergency preparedness and response guidelines has been progressive. Advocates realized that buy-in from the government was essential for the institutionalization of SRH preparedness. One challenge was staff turnover within ministries and the need to invest continuously in knowledge building and advocacy. By adopting a long-term advocacy strategy—under the leadership of UNFPA and with strong commitment from the Ministry of Health's Family Health Directorate and close coordination with PKBI-Indonesia Planned Parenthood Association, Indonesia's Midwives Association, the Indonesian National Nursing Association, and Yayasan Pulih—the SRH sub-cluster succeeded in integrating the MISP into the national emergency and response system.[69]



In **Sri Lanka**, FPASL faced similar issues with high turnover at the MOH, and adopted an advocacy strategy that targeted not only high-level policy makers but also mid-level management who were less subject to turnover. This helped sustain knowledge at the MOH and retain internal advocates. FPASL also advocated integration of the MISP into national action plans as an intermediate step toward national policy change.

Indri, a youth volunteer with Indonesia Planned Parenthood Association, is sharing information with young people affected by the Sulawesi disaster. Image credit: IPPF/Kathleen Prior/Indonesia

Rolling out the implementation of national policies and guidelines at the subnational level

Some countries have strong national policies in support of SRH in emergencies, but face challenges in implementing them at the local level. In countries where power is highly decentralized, such as in the Philippines and Indonesia, it is essential to advocate at local levels and develop local policies and plans.

In the **Philippines**, UNFPA and the Family Planning Organization of the Philippines (FPOP) played an instrumental role in ensuring the local institutionalization of the MISP. In 2016, a Joint Memorandum Circular[70] was adopted which set out guidelines on implementation of the MISP and its integration into national and local disaster risk reduction management plans. The Circular was signed by four key national agencies, including the Department of Health, the Department of Social Welfare and Development, the Department of Interior and Local Government, and the Office for Civil Defense. It applies to all sub-regional and local entities as well as all partners working on SRH and GBV, including NGOs, local government units (LGUs), and the private sector. The implementation of the Circular has been slow and only a few local government units have initiated the local Reproductive Health Coordination Teams called for in guidelines. Despite the slow progress, the existence of the policy mandates work at the subnational level and supports advocacy efforts. For instance, FPOP has used this policy to target and encourage LGUs to implement it. After FPOP conducted MISP training with the local disaster risk management council in Masbate City, the mayor committed to allocating approximately US$20,000 for cascade trainings down to the village level.

In **Pakistan**, Rahnuma-FPAP organized sensitization sessions in six provinces. They invited the Provincial District Management Authorities, including parliamentarians and decision makers, to discuss the importance of the MISP and its inclusion in disaster management plans. This work resulted in the issuance of SOPs stating the need for MISP inclusion in all contingency plans in the targeted six provinces.

Advocating for MISP integration into SRH non-emergency policies

As called for in the Health-EDRM Framework, integrating SRH provision into national, subnational, and local health policies as well as DRR policies helps mitigate the risk of SRH being neglected in response strategies. This approach also ensures that SRH (and the MISP) is recognized in a national policy that is operative at all times. For some advocates, using the SRH angle to influence policy is preferable as they already have strong existing partnerships at the national and subnational level.

In the **Pacific region**, SRH language has been integrated into policies in Kiribati, the Solomon Islands, Tonga, and Fiji (for example, the National DRR Policy 2018-2030 in Fiji and the National Public Health Emergency Plan in Solomon Islands). IPPF Member Associations and UNFPA have advocated using two different angles for securing SRH in emergencies, targeting health emergency preparedness plans on the one hand and national reproductive health policies on the other.

In the **Philippines**, the MISP has been integrated into various policies that operate in both normal and crisis situations. Provisions for SRH or the MISP have been included in the Responsible Parenthood Reproductive Health Law,[71] the Magna Carta of Women,[72] the LGU Disaster Preparedness Manual (Operation Listo),[73] and the Joint Memorandum Circular.

LEARNING BRIEF ON COORDINATION

Building national SRH coordination during emergency preparedness

Key Takeaways

Build a robust knowledge base on SRH/MISP: Ensure that key stakeholders have a common understanding of SRH in emergencies and internationally recognized SRH standards of care. MISP trainings and orientations can be used to raise awareness.

Build multi-sectoral partnerships: Adopt a multi-sector team approach by getting the right partners on board from the health and disaster management sectors, technical fields (family planning, maternal health, HIV, GBV), and community-based organizations (including women, youth, people of diverse SOGIESC, and people with disabilities).

Develop joint action plans for the SRH working group: Identify as a group the key gaps in SRH preparedness (such as through a MISP readiness assessment) and agree on a joint action plan with clear accountability lines and monitoring processes.

Consider coordination at all levels: Adapt the coordination mechanisms to the government structure and build relationships at national, subnational, and community levels.

Learn from peers: SRH preparedness activities have been implemented in many different countries, and opportunities exist to learn and share experiences with countries with similar situations.

Advocate for sustainable SRH emergency preparedness coordination: Institutionalize SRH coordination mechanisms to ensure sustainability. Create an enabling environment through supportive policies and budget allocations.

Walaa Abu Monshar, 29, is a Youth Centre Coordinator/Vitol Coordinator with IPPF's Member Association in Palestine, the Palestinian Family Planning and Protection Association. Image credit: IPPF/Hannah Maule-ffinch

Coordination saves lives: building relationships during preparedness for improved responses

The humanitarian sector agrees that "*coordination saves lives.*"[74] In the past decade it has been widely recognized that effective coordination contributes significantly to coherent humanitarian response. It saves resources, efforts, and time, and reduces the likelihood that efforts will be duplicated or essential services omitted.[75] Inadequate coordination, on the other hand, impedes the delivery of essential care during emergencies, and contributes to a cycle in which the focus is continually on reaction rather than prevention.

Coordinated preparedness planning is one of the 10 key components of the Health-EDRM Framework, and the first MISP objective clearly stipulates that a coordinated approach is essential. The IAFM also highlights the need for respectful partnerships between different humanitarian actors (government, UN, INGOs, NGOs, and community organizations). While coordination has been globally accepted as an essential part of SRH response, it is not yet consistently implemented before or during a response. It needs to be advocated globally and within countries.

"Establishing clear mechanisms for accountability and coordination is critical to effective humanitarian response. These mechanisms need to be discussed and agreed before the crisis strikes."

—EMERGENCY RESPONSE PREPAREDNESS, IASC, 2015

Key elements leading to strong partnerships for coordinated SRH preparedness planning

Coordination does not happen overnight or spontaneously. Building strong and robust relationships takes time and commitment, and a sensitivity to the country context and enabling environment. There is no one right way to build coordination; the examples presented in this learning brief all have in common the need for tailored and contextualized approaches and strategies that are aligned to existing national coordination mechanisms. Key informant interviews indicate that there is a need to be creative and explore different pathways to get the needed buy-in and commitment to work on coordinated SRH preparedness.

Identifying strategic entry points to obtain buy-in for the development of SRH coordination bodies

Making SRH emergency preparedness coordination relevant to key stakeholders

In many countries, knowledge of lifesaving SRH care in emergencies is low. The topic of SRH can be very sensitive, particularly in conservative societies. It is important to find the right entry points to demonstrate the need for coordination on SRH-related topics.

In **North Macedonia**, the SRH working group—comprised of UNFPA, HERA (Health Education and Research Association), and the Institute of Public Health—focused on maternal health in natural disasters as an entry point to sensitize the Ministry of Health and secure their participation in a coordination body. By starting with a focus on healthy pregnancies and the prevention of violence against women in emergencies, the group was able to establish common ground for reaching agreements. From there the group was able to raise awareness and advocate for all components of the MISP and for comprehensive SRH care in emergencies. The working group has succeeded in integrating the MISP into national policies and continues to meet on a regular basis with dedicated involvement of the Ministry of Health. They were also active in the SRH response to the refugee crisis in 2015.

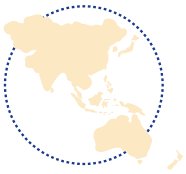
Using recent disasters to bring attention to the need for SRH coordination

Coordination often starts as an ad hoc activity in the aftermath of a national disaster or crisis when the response does not meet expectations. This can offer a unique opportunity to bring forward the diversity of SRH needs and the importance of preparedness.

In **Pakistan**, the need for a comprehensive and proactive Disaster Risk Management (DRM) system was recognized after the Kashmir earthquake in 2005. The government established the National Disaster Management Authority and began investing in preparedness activities. With support from WHO, the Ministry of Health established the National Health Emergency Preparedness and Response Network (NHEPRN) in 2010. This was the first step towards institutionalizing the concept of health emergency preparedness and response in Pakistan. In 2010 Pakistan suffered devastating floods; inspired by the UN cluster approach to that crisis, the national Reproductive Health Working Group (RHWG) was established in 2013. The RHWG operates with an annual workplan and has been very active in training district level staff on the MISP.

Capitalizing on SRH meetings or MISP trainings to create coordination bodies

In countries where SRH preparedness coordination is non-existent, the first steps are to get buy-in from key partners and educate them on the importance of SRH in emergencies and the MISP. Face-to-face training on the MISP is an excellent entry point. Training participants often form the nucleus of new coordination bodies, which means they should be selected strategically. Representatives from government, service providers, INGOs, NGOs, community-based organizations (see the note on inclusion), technical experts (family planning, HIV, GBV, maternal health), and other first responders should be included.



In the **Asia Pacific region,** MISP trainings have been implemented since 2007. These trainings have helped make the case for the importance of SRH in emergencies and served as successful entry points to coordination. In the Cook Islands in 2019, for instance, a staff member from the national disaster management office participated in all of the training modules, and went on to become a key SRH champion and influencer in driving forward the agenda. The result was a network linking the disaster management office with the relevant government ministries, the Red Cross, and the IPPF Member Association to advance preparedness activities.

In the **Eastern Europe and Central Asia (EECA) region,** the regional IAWG forum created in 2011 brought together 18 countries to discuss the need to build capacity for SRH in emergencies and work in a coordinated way on preparedness. The forum was the starting point for the establishment of SRH country teams (or working groups), comprised of representatives from UNFPA Country offices, SRH CSOs (mostly IPPF Member Associations), and Ministries of Health. The country teams also joined forces to get additional partners on board, particularly non-SRH actors such as Ministry of Interior and DRR authorities. The yearly EECA IAWG meetings create a unique opportunity to invite DRR authorities to the event and secure their further buy-in.

Using MISP readiness assessment results to initiate work on SRH preparedness coordination

The MISP Readiness Assessment (MRA) was developed by the EECA IAWG in 2013 to help country teams assess their readiness to implement the MISP in the event of a humanitarian crisis. The MRA was updated in 2020. (See the MISP Readiness Assessment in *Resources*.) A sub-set of questions focuses on coordination, and use of the assessment tool has been instrumental in prompting the establishing of SRH preparedness coordination bodies.

In the **EECA region**, a region-wide assessment conducted in 2014 revealed a general lack of coordination; 11 countries out of 18 had no SRH working groups.[76] A second assessment conducted in 2017 showed significant improvement, with 16 countries now having SRH working groups.[77] This was achieved because the members of the regional IAWG agreed to prioritize coordination, and because country teams were supported to develop clear TORs for their groups and yearly action plans to improve national coordination. IPPF and UNFPA supported the development of sound action plans, provided remote technical support, and monitored progress. Each country team committed to identifying their own local financial resources to implement their action plans.

Kiribati Family Health Association (KFHA), an IPPF Member Association, has created Humanitarian Youth Clubs, which meet regularly to plan rapid needs assessments of their communities during a disaster. Image credit: IPPF/ Hannah Maule-ffinch/Kiribati

In **North Macedonia**, an interdisciplinary team was established to coordinate MISP preparedness and response activities. After assessing the country's preparedness level through the MISP Readiness Assessment tool, the team developed a clear road map with priority interventions to advance SRH preparedness. Thanks to persistent advocacy and a membership roster of influential leaders (from the Ministry of Health, the National Institute of Public Health, HERA, the Red Cross, the University Clinic for Obstetrics and Gynecology, and UNFPA), the group has successfully advocated a number of key policies: incorporating a chapter on SRH (including the MISP) in the 2017 National Preparedness Plan for the Health Sector, training medical and non-medical staff on the importance of integrating SRH care into health care services in emergencies, establishing guidelines for managing GBV prevention and response in migrant transit centers (in response to the 2015 crisis), implementing standard operational procedures (SOPs) for responding to GBV in emergency settings, and defining medical protocols for mobile SRH clinics in crises (based on experience with refugee women).

Leveraging the existing coordination work on DRM, health preparedness, and SRH networks

In countries where there is a strong disaster risk management infrastructure and emphasis on health preparedness, opportunities often exist to leverage SRH coordination. Another path to coordination, which is still in very early stages, is through technical RH working groups; partners in Afghanistan, the Philippines, and Myanmar are exploring these possibilities.

In **Indonesia**, the National Disaster Management Authority (NDMA) coordinates the cluster system, with the Health Crisis Center of the Ministry of Health managing all health-related responses. UNFPA and local NGOs successfully advocated the adoption of the SRH-MISP guideline as the National MISP Operational Guideline and the inclusion of the SRH sub-cluster under the health cluster. The sub-cluster was initiated during an emergency response, but was subsequently maintained during preparedness work—thanks in large part to dedicated staff at various organizations (including UNFPA, PKBI, the Indonesian Midwives Association, and Yayasan Pulih) and introductory work on SRH in emergencies, such as MISP trainings, conducted with the Ministry of Health since 2003. The work of the SRH sub-cluster eventually led the Ministry of Health to issue a statement urging consideration of SRH at subnational levels, including the empowerment of provincial health offices to coordinate the SRH sub-cluster in the regions. The sub-cluster continues to meet on a quarterly basis with the support of the national budget for sub-clusters (50%) and UNFPA.

In the **Philippines**, the MISP is integrated into the 2012 Responsible Parenthood and Reproductive Health law. Coordination bodies—the National Implementation Team (NIT) and Regional Implementation Teams—are responsible for overseeing its implementation. A national Reproductive Health Coordination Team (RHCT) is in charge of managing MISP implementation at all levels and phases. Discussions are ongoing to better streamline these working groups, and a directive has been issued to integrate the RHCT into the NIT and create possible MISP sub-committees.

In **Pakistan**, the national Reproductive Health Working Group (RHWG) meets quarterly. The RHWG develops annual workplans focused on increasing coordination among SRH field actors to create synergies and avoid duplication during preparedness, response, and recovery. Members of the RHWG include active SRH actors such as Rahnuma-FPAP, Muslim Aid, International Medical Corps, and UNFPA, who have been working in the country for many years and are considered experts and leaders in the field. Because these organizations have strong existing relationships with the government, their voices are taken seriously during important discussions. Rahnuma-FPAP, for example, is very engaged in regional and national advocacy and is an active member of the RHWG. At the provincial level, branches of Rahnuma-FPAP conduct coordination meetings with the Provincial Disaster Management Authority (PDMA) to discuss strategies for MISP integration in response plans.

Driving national coordination through regional support

In the Asia Pacific and EECA region, much of the national preparedness work has been supported by regional initiatives through the SPRINT Initiative, IPPF regional offices, UNFPA regional offices, and regional IAWG. Regional support has helped to build the knowledge on the MISP, allowed for networking, facilitated support to national SRH coordination bodies, and connected different SRH and DRM actors.

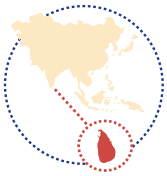
The **EECA region** pioneered a pro-active and systematic approach to SRH preparedness by establishing a functional regional IAWG in 2011, as described above. The regional IAWG's efforts to assess and promote SRH readiness led to the establishment of new SRH working groups in nine countries from 2014 to 2017.

Many island nations in the **Pacific Region** are too small to maintain their own coordination mechanisms for SRH preparedness. Instead, much of the work is conducted through a regional cluster coordination system, with representatives from UNFPA and IPPF attending the relevant regional clusters (for example, the health and nutrition cluster and the protection cluster). The regional approach facilitates the sharing of country examples to demonstrate to national-level actors what other partners are doing. SRH regional actors also convey key messages to humanitarian and government actors on the importance of SRH in emergencies and the need for coordination.

In the **Asia Region**, many of the MISP trainings conducted through the SPRINT Initiative and UNFPA have employed a multi-agency approach of strategically selecting the partners and champions to be trained. Other countries in the region have adopted this approach as well, including those not supported by SPRINT.

Ensuring meaningful participation of community groups for inclusive coordination mechanisms

Communities and grass-root organizations, particularly women-focused and women-led organizations, are often the first responders in a crisis and the most knowledgeable about the local context. They play a pivotal role in preparedness actions, especially in areas where disasters are frequent or cyclical. Including these communities in coordination bodies empowers them to manage their own risk, and aligns with the World Humanitarian Summit pledge to "leave no one behind."[78]



In **Sri Lanka**, FPASL added representatives from the SOGIESC community (National Transgender Network of Sri Lanka) and disabled persons' organizations (Disability Resource Center) to the SPRINT project steering committee (which also includes representatives from the Disaster Management Centre, the Disaster Relief Service Centre, the Australian High Commission, the Ministry of Health Disaster Response and Preparedness Unit, the Family Health Bureau, the Ministry of Women and Child Affairs, UNFPA, WHO, and the Sri Lanka Army). As a result of their input, dignity kits were adapted for transgender communities and IEC material was developed in sign language (video) and braille (leaflets).

Building sustainable coordination mechanisms

Experience shows that a functional partnership plays an important role in improving coordination for SRH preparedness.[79, 80] The type of partnership adopted varies from country to country; what seems to matter most is the level of commitment and engagement by the working group. Institutionalizing coordination within the Ministry of Health or disaster management systems is often a lengthy process that requires time and commitment. Nevertheless, key informants agree that the effort is worthwhile, as institutionalization helps ensure the sustainability of the work. Formalized working groups also have standing to hold governments accountable. Official terms of reference (TOR) are useful for structuring the scope and implementation of the work, and help mitigate risks linked to staff turnover by clearly defining the competencies needed in the working group. A robust source of funding can also help institutionalize preparedness work.

The **EECA** regional IAWG was very active from 2011 to 2018, thanks to financial support from UNFPA. During this time the regional IAWG forum was established and a dedicated regional coordinator provided support to country SRH working groups. In addition to developing the MISP Readiness Assessment tool and conducting a region-wide assessment, the EECA IAWG created a standard TOR template for SRH working groups. This helped institutionalize the groups in each country. Since 2019, securing funding has been particularly challenging. Continuous advocacy and resource mobilization are needed to be able to continue implementing preparedness activities.

Katherine Mafi hands a dignity kit to Etka Lotaki on Eua Island, Tonga. Etka lost her home to Tropcial Cyclone Gita.
Image credit: IPPF/Alana Holmberg/Tonga

LEARNING BRIEF ON CURRICULUM INTEGRATION

Integrating the MISP into national pre-service and in-service education of health professionals

Key Takeaways

Build relationships with relevant ministries. Identify the key government ministries and training institutions in charge of building the capacity of health care professionals and sensitize them on the importance of the MISP to get their buy-in and support.

Identify the most relevant curriculum to include the MISP. Consider your local context and target the most relevant curriculum for revision (midwifery, nursing, doctor, etc.).

Use the opportunity of curriculum revisions to integrate the MISP. Know when curricula are being revised, as this is ideal timing to advocate MISP integration.

Explore alternatives (if needed) for MISP outside the formal curriculum. Assess what fits best in the national context and look at alternatives if curriculum integration does not seem to be the best option or is difficult to pursue.

Look into options for accredited training for in-service health professionals on the MISP. Ensure health professionals can get access to MISP trainings by advocating formal recognition of such trainings.

Building the capacity of frontline health workers to ensure readiness to respond to SRH needs

Effective disaster management strategies require skilled human resources ready to respond to an emergency at the onset of the crisis. In most cases, the initial response starts at the community level, and nurses and midwifes are often the frontline workers providing SRH care.[81] Having a pool of trained medical professionals is essential to respond quickly to SRH needs during an emergency.

Midwives form an important part of the health care workforce in many countries, and work most closely with the affected population. Midwives are key contributors to sexual, reproductive, maternal, newborn, and adolescent health care, and qualified midwifery care contributes to sustained reduction of newborn and maternal mortality. The International Confederation of Midwives recognizes that the role of midwives is vital in emergencies as well as during stable times, and recommends the integration of modules on disaster and emergency preparedness into the midwifery educational program.

Members of the Youth to Youth program during a meeting about family planning and sexual and reproductive health, where they demonstrate condom usage and options for contraceptives. Image credit: Jonathan Torgovnik/ Getty Images/Images of Empowerment

Key elements leading to more sustainable approaches for trained first responders

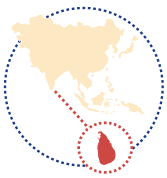
To build the capacity of health professionals in a systematized and sustainable way, countries have undertaken both pre-service and in-service approaches to education. Given the available literature and based on the key informant interviews, the section of this learning brief on pre-service education focuses on the integration of the MISP into midwifery curricula, as this has been the most documented and successful approach to date. Integrating the MISP into medical curricula seems to be a more complex and lengthy process that has not yet been achieved, according to the interviews conducted for this learning brief.

The initiatives highlighted here have in most cases been complemented by MISP trainings provided to first responders such as national disaster management officials, Ministry of Health staff, police, army, and civil society organizations. Some of these processes call for long-term commitment and strategies; all of them require robust collaboration and buy-in from the government and sustained follow-up.

Integrating the MISP into pre-service education for health care professionals

Using curriculum revisions as an opportunity for MISP integration

Some national partners, such as UNFPA country offices and IPPF Member Associations, have advocated the inclusion of the MISP in national midwifery curricula. In countries where this was successful, the integration came at a time when the training curriculum needed to be revised. The revision created a unique opportunity to build on the already existing relationship with the government and sensitize them on the importance of having modules on the MISP.



In **Sri Lanka**, FPASL advocated the integration of a MISP module into the Public Health Midwives (PHM) training curriculum. FPSAL built on their already strong established collaboration with the government and their active involvement on SRH preparedness, particularly through the SPRINT initiative. They worked with the Ministry of Health's Family Health Bureau and the Education, Training and Research Unit to identify which elements of the MISP training package were missing and where these could be integrated into the PHM training curriculum. FPSAL conducted advocacy with both entities to ensure buy-in and commitment for the implementation. The process took over six months and, as of the time of publishing, is in its finalization phase. In parallel, FPSAL initiated contacts with the University of Colombo to have the MISP integrated into the medical curriculum. This process takes longer and requires an investment of several years.

In **DR Congo**, the training curriculum for midwives was not aligned to the Bachelor's-Master's-Doctorate system and needed to be revised. The UNFPA country office supported the government in the overall revision of the curriculum and, in partnership with IAWG, took that opportunity to advocate the inclusion of the MISP in the training package. The midwifery curriculum in DR Congo is under the responsibility of the Ministry of Higher Education (MoHE), while the Ministry of Health (MOH) is in charge of employing midwives. Close collaboration with both ministries was needed to ensure buy-in and support for the revised curriculum. The process was led by a steering committee of experts from the MOH, MoHE, and a medical training institution in Kinshasa. Thanks to earlier established partnerships as well as technical and financial support from UNFPA, the process was completed in one year and the new module approved in 2019. The module on the MISP is part of the third-year program, allowing midwives to acquire necessary skills and competencies in the earlier part of their training and be better prepared to integrate the requirements of the MISP. The first class of midwives trained on the new MISP curriculum will graduate in 2020. In the meantime, UNFPA has trained a pool of humanitarian surge midwives on the MISP and has started the popularization of the curriculum in targeted medical institutions.

In **South Sudan**, the MISP was integrated into the Curriculum for the Diploma Midwifery Education Programme in 2011 (and updated in 2016) as the result of a UNFPA program to strengthen midwifery in the country. Since then the MOH and UNFPA have continued to lead on this initiative, with international NGOs such as the International Medical Corps also playing an instrumental role as implementing partners in managing midwifery schools and building the capacity of future midwives.

Exploring alternative pathways to provide MISP training during pre-service education

Influencing medical curricula is considered especially challenging, since the revision process is lengthy and complex. Some countries have been exploring different pathways to provide trainings on the MISP for medical students.

In **Fiji**, a representative from the Reproductive and Family Health Association of Fiji participated as a guest lecturer in universities and schools of medicine to discuss priority SRH care in emergencies, reaching an audience that included medical students, nurses, and public health students. This allowed future doctors to receive training on the MISP without it being formally embedded in the curriculum.

In **Samoa**, the Samoa Family Health Association organized the first MISP training in 2017, and one of the participants was a senior lecturer from the medical university. She went on to act as an influencer at the university and began working internally at the school to drive changes in the curriculum. While no official integration of the MISP has been achieved yet, these initiatives have helped sensitize future health care professionals on the MISP.

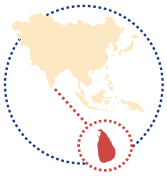
Offering MISP trainings for in-service education of health professionals and first responders

Advocating MISP training as a nationally recognized module for health professionals and first responders is another way to build the capacity of service providers during preparedness. These initiatives have been undertaken in many countries, including the Philippines, Indonesia, Sri Lanka, Kyrgyzstan, Albania, Nepal, and others.

Obtaining formal accreditation of MISP training for health care professionals to be trained during preparedness

As part of their formal recognition of the importance of providing SRH in emergencies, some countries have invested in official accreditation for the MISP training. This helps sustain the availability of such capacity building and can be used to incentivize MISP training for health professionals and first responders. It can also serve as an intermediate step before having the MISP integrated into official curricula.

In **Nepal**, UNFPA has collaborated with the National Health Training Center (NHTC), Family Health Division (FHD), Epidemiology and Disease Control Division (EDCD), Department of Health Services, Ministry of Health and Population, and RH partners to lead the adaptation of MISP training material into the local language. The Nepali training package was approved in 2010 and trainings were rolled out to rapid response team members, health care providers, and key stakeholders at the community, district, regional, and national levels. The formally accredited 2-day MISP training has been conducted regularly since then through the National Health Training Center and remains an official training under the NHTC. It was updated after the 2015 earthquake and is in the process of being aligned to the revised MISP. Around 500 service providers have been trained so far. UNFPA in Nepal is now advocating to have the MISP module included as part of the mandatory 2-month induction package for health workers (including doctors, nurses, midwives, and paramedics) recruited by the government. This would ensure that all health care providers working for the public system have received training on the MISP.



In **Sri Lanka**, an accredited training course on SRH services in crises has been part of the Health Emergency and Disaster Management Training of the University of Peradeniya Faculty of Medicine since 2005. The initiative is supported by UNFPA, FPSAL, and the Ministry of Health. The training course targets medical professionals from NGOs and INGOs, mid-level administrative officers of the Ministry of Health, university lecturers, medical officers (including medical officers of maternal and child health and medical officers in sexually transmitted disease clinics), regional epidemiologists, and officers in the Disaster Management Centre.

In **Kyrgyzstan**, a module on SRH in crises was integrated into the Kyrgyz Medical Continuous Post Graduate Training Institute program for all health care providers 2016. Because of high turnover of staff, UNFPA and the Red Crescent Society of Kyrgyzstan have continued to advocate regularly for this module to remain part of the official trainings. In 2020 they initiated discussions with the University of Osh to have the MISP integrated into the medical curricula.

In **Indonesia**, the MISP training package has been incorporated into the Midwifery Local Curricula by the Indonesian Midwives Association and is included as one possible training module for midwifery schools. As of 2020, UNFPA and the MOH are working on developing an accredited national training package to be endorsed by the MOH for nationwide implementation.

In **Albania**, the SRH working group under the leadership of the IPPF Member Association and UNFPA succeeded in having the MISP package accredited by the National Center for Continuous Medical Education to strengthen capacities of primary health care providers.

Offering MISP trainings for health care professionals through alternative pathways

To update and reinforce clinical providers' knowledge and skills on the services included in the MISP, IAWG developed four training courses called the SRH Clinical Outreach Refresher Trainings (S-CORT), designed for humanitarian contexts. The MISP Distance Learning Module was updated in 2018 and offers the opportunity for people to learn about the MISP online at their own pace and free of charge through the IAWG site. Many countries have found the learning module a useful resource and made it a prerequisite for the face-to-face MISP trainings. (See MISP Training Materials in *Resources*.)

In the **Pacific Region**, where distance learning is widely used to provide continuing medical education, the IPPF is exploring the option of integrating the MISP Distance Learning Module into online platforms.

A nurse from the Vanuatu Family Health Assoication provides a sexuality awareness session under a mango tree to community members before mobile clinic operations commence. Image credit: IPPF/Kathleen Prior/Vanuatu

LEARNING BRIEF ON SUPPLY CHAIN PREPAREDNESS FOR SRH COMMODITIES

Building a flexible supply chain that can respond to SRH needs in emergencies

Key Takeaways

SRH supply chain preparedness is similar to preparedness for other health products, but advocacy and planning are needed to secure SRH products and contraceptives, particularly in disasters when priorities shift quickly and the range of services and products narrows.

Overall, supply chain preparedness involves development of back-up plans so program and supply chain managers can quickly plan for changes in demand and source, finance, and deliver supplies in times of crises.

Countries that are best prepared are those that experience disasters regularly and build preparedness continuously. Learning from past events can help to develop and institute new and better preparedness practices. Preparedness hinges on commitment and funding and should therefore go hand in hand with system strengthening efforts to build resilient systems.

Coordination and leadership are critical components for maintaining a continuity of all essential operations in both stable times and during disasters. Countries can learn from each other and work in concert with UN agencies and local organizations to align their goals, objectives, and investments. Ultimately, success hinges on widespread understanding that preparedness is not the sole responsibility of humanitarian actors but of everyone who is committed to protecting the health of all people and satisfying unmet needs for SRH services and supplies.

A map of up-to-date information on all supply chain resources that can be mobilized in a disaster empowers a country to make decisions quickly and to find options that best suit the situation. This includes human resources, suppliers, commodities, financing, transportation, and warehousing within all sectors (international, regional, NGOs, public, and private sectors, as well as the military and national guard). Partnering with non-traditional organizations, such as faith-based and civic organizations, can yield new ways to distribute SRH products during emergencies.

Epi is receiving prenatal care at one of the mobile camps set up in internally displaced persons sites during the Sulawesi response. It is the first time she has received prenatal care throughout any of her six pregnancies.
Photo credit: IPPF/Kathleen Prior/Indonesia

Key elements of supply chain preparedness

As discussed in other sections of the toolkit, a literature review and a broad range of stakeholder interviews found that, beyond disease outbreaks, little knowledge or understanding exists of what constitutes good preparedness and resilience for supply chain practices for preventative health programs. There are even fewer examples of preparedness for SRH supply chains specifically.[x] This learning brief and toolkit aims to take a first step at filling this gap, although more work is required to further evaluate, test, and document this learning. This brief covers broad actions that countries can take to bolster their supply chains in preparation for emergencies to make them more agile and resilient, especially SRH supply chains. Some key country examples illustrate practices that can be employed to improve preparedness efforts. It is important to note that SRH commodities can be managed with the same principles and concerns as other health products, but special advocacy is needed to ensure that SRH is always a priority on the health agenda. General guidance is provided in this brief that can apply to any health program supply chain, but special emphasis is made throughout to make sure that SRH is included as a priority in all supply chain preparedness efforts at a country level.

x The literature review lists more than 25 resources that can aid in preparedness and resilience planning for health supply chain management.

The examples shared throughout this document illustrate that to be prepared for disaster, it is not enough to rely solely on the humanitarian architecture for disaster response. The systems and resources in place in a country must be leveraged for an effective response because it is these systems and supply chains that exist before and after a disaster. Even in a worst-case scenario when local systems collapse, it is these same resources that must be built back for recovery and to avoid becoming overly dependent on intermittent external support.

Countries can start by strengthening national-level organizations involved in supply chain management, such as central medical stores, local and international NGOs, civil society organizations, associations, commercial distributors, and pharmacies. By reaching out to all local sectors, countries can better prepare to leverage all available support in an emergency. In the event of a major disaster where countries need assistance from UN organizations and other international partners, ministries of health with their emergency response team and their supply chain management staff will likely need to collaborate with UN health and logistics clusters to bring in humanitarian supplies in the form of kits and equipment. During stable times, countries and partners should engage humanitarian actors in technical working groups for commodity security whenever possible to establish these connections early and often.[82]

As outlined in the MISP, a set of minimum SRH services must be provided to crisis-affected populations during humanitarian disasters, and as soon as possible comprehensive services should be offered to those in need. These life-saving services cannot be provided without commodities. Supply chains must be robust and reliable during normal operations, and flexible during emergencies so they can respond to a variety of disaster scenarios, whether they are localized events that can be managed with national resources or large-scale conflicts or disasters that require intervention by international organizations.

Before beginning an intensive preparedness effort in a country, it is necessary to establish an enabling environment for supply chain preparedness. Once buy-in and political will has been secured, a country can begin the operational steps of developing a continuity of operations plan (COOP). The key parts of a continuity of operations plan (COOP) are the same for any health program:

- Map functions and resources, and develop emergency protocols to maintain operations
- Conduct risk assessments
- Develop contingency plans for probable risks

Leilani Faingaia Lopes, a member of the Tonga Leiti Association, holding IPPF Condoms, which were distribued to clients attending the mobile health clinic after Tropical Cyclone Gita hit Tonga in 2018. Image credit: IPPF/ Alana Holmberg/Tonga

Establishing an enabling environment for supply chain preparedness

To initiate effective preparedness for health supply chains, leaders at the highest levels of government, ministries, and donor organizations must commit to supporting preparedness activities as a routine part of system strengthening activities. These leaders must secure resources, know-how, and political will to establish or strengthen public health emergency operations centers and national emergency response teams.[83] They must also ensure that health supply chain management staff and preventative health program managers, such as for FP, SRH, MNCH, immunization, nutrition, etc., are included in these and other relevant coordination bodies and emergency teams.

Prioritizing and financing SRH and FP supplies

To ensure the continuity of FP programs specifically, it is paramount to guarantee a range of contraceptive methods, including short-term and long-acting methods, self-injection, EC, and condoms. This protects the right of all women to access a range of methods irrespective of their background or ability to pay. For long-acting methods, guidance is available that ensures their proper administration and removal, and preparedness efforts can further reinforce these capabilities so first responders can be adequately equipped to provide services during emergencies.

Ministries of health and other stakeholder organizations will need staff who understand the maximum and minimum levels of service needed to maintain continuity of operations and minimize unnecessary loss of life, exacerbation of inequities, and de-prioritization of SRH programs and supplies in the case of a disaster.

Just as advocates often support the ring-fencing of financing for SRH services and supplies in stable times, specific funding for FP products must be secured ahead of time so these products are not left out of the package offered during an emergency. Specific guidance on how to set up emergency funding for SRH has not yet been developed, but advocates can adapt compelling arguments from the development sector to demonstrate the economic and health benefit of SRH, especially to internally displaced and refugee populations. They can also adapt existing tools and methods, such as supply chain costing, to estimate what it will cost not only to procure SRH commodities but to distribute them to the last mile, and the added benefits of planning ahead versus waiting until the last minute to plan.[84]

Ensuring access to IARH kits

For the products themselves, if the country intends to provide Inter-Agency Reproductive Health (IARH) kits, cost estimates can be made using pricing data from the UNFPA catalog. Countries that do not intend to provide kits can estimate the cost of individual products by reviewing past procurement history or price reference catalogs, such as the MSH International Medical Products Price Guide or the UNFPA catalog.

SRH commodities must be added to national essential medicine lists and to standard treatment guidelines in stable times. All products needed to provide SRH services should be registered, including those in the IARH kits,[85] and countries must streamline regulations to allow for easy importation of humanitarian supplies as well as routine SRH supplies, both during routine deliveries and in preparation for emergencies.

If partners anticipate that they will import IARH kits or other new products during emergencies, they must work with national authorities to get preauthorization to import, supply, and deliver them to those in need.

It is helpful to advocate for waivers to any policies that block access to FP services, such as residency requirements or eligible couple registration.[86] In some cases, where contraception is not prioritized or is opposed by government leaders, these services will sometimes still be supplied to those in need during disasters. In these cases, humanitarian actors operating outside the public sector or in the absence of national systems should be prepared beforehand to import these products through humanitarian structures and in line with global guidance, WHO essential medicine lists, and quality assurance standards.

Coordinating preparedness among all participating actors

Government, NGOs, donors, and the private sector must also work together to align their objectives and supply chain preparedness activities in coordination. Emergency preparedness efforts may consider engaging reproductive health commodity security coordinating committees, reproductive health coordinating committees, the supply chain strategic planning coordinating body, emergency preparedness coordination mechanisms and teams, and others. All development, program, and system strengthening strategies should include a preparedness component, and key organizations that will play a role during an emergency should be included in the development of all policies and strategies to ensure a harmonized and effective approach, including local and international NGOs from various levels of the system, such as the community level. Community actors can contribute greatly to preparedness efforts by providing insight into private and communal resources and volunteer networks that can be accessed beyond the public sector in case reinforcements will be needed. Long-term or stand-by agreements with partners, including governments, UN agencies, humanitarian and development organizations, donors, civil military organizations or national guard, local and international vendors, and community organizations can add capacity in various areas of the supply chain that can be mobilized in a disaster.[87]

A mobile clinic providing women in rural areas with family planning options like contraceptive implants and cervical cancer screenings, at a rural village on the outskirts of Mombasa. Image credit: Jonathan Torgovnik/Getty Images/ Images of Empowerment

Creating a continuity of operations plan

This brief focuses on creating a COOP at the national level. Initial learning indicates that to prepare for disasters, it is advisable to develop a comprehensive COOP for the public health supply chain, with SRH included at the broad health system level and government leadership. A tool for developing a COOP is forthcoming and this and other materials are included in the Resources section. Rather than setting up a parallel humanitarian response or focusing on a specific hazard or health program, it is important to prepare for all hazards and to work at the national level so that local leaders can be involved in the humanitarian response in the case of a disaster. Risk assessment and contingency planning for specific scenarios and products can be a part of this process. A COOP looks at existing supply chain operations and includes emergency protocols to maintain basic supply services for the health sector during a crisis. A COOP gives overarching guidance and contains all emergency actions and plans that have been prepared in advance of any possible emergency.

COOPs are tailored to local contexts and should be developed in collaboration with all relevant supply chain management and program stakeholders. Country lessons illustrate that it is important to integrate SRH into these plans. Before the COVID-19 pandemic, for example, many countries had prepared for an infectious disease outbreak, but very few considered the importance of planning for continuity of other health services and supply chains during such a crisis. There are initial anecdotal reports that indicate that SRH products are out of stock due to competing priorities and a lack of planning.

Preparedness should include coordination at all levels and creation of an enabling environment for SRH supply chain preparedness, which eliminates barriers and puts in place levers that can quickly be engaged to fast track delivery of supplies in the event of a disaster. Finally, the COOP should be updated and disseminated to all key stakeholders on a regular basis (yearly); if a disaster is imminent, this can be escalated. When disasters take place, countries and international partners should learn from them and share these lessons broadly to help update and improve future plans.

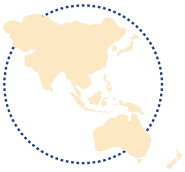
Mapping functions and resources, and developing emergency protocols to maintain continuity of operations

Before developing emergency protocols for disaster response, a country should map the key operations or functions that need to be maintained to ensure a continuity of supply chain operations. These include product selection, quantification, procurement, inventory strategy, distribution, and warehousing. To support the continuity of these functional areas, countries can scan each of the resources that support these basic supply chain operations: assets and supplies, financing, people, processes, tools, and information. For each of these areas, countries can put in place emergency protocols that guide how these resources should be managed in case of disruption. Below are some examples of protocols and country experiences by resource area.

Assets and supplies

Establish credits, standby agreements, and backup suppliers for priority products, both from NGOs and the private sector. If an emergency is likely, consider stockpiling and prepositioning these products near the potential emergency, and ensure that storage capacity is sufficient and stock can be rotated or used before it expires. If a significant amount of stock is being held for preparedness, it is important to establish methods for circulating stock back into the system and refreshing the stored stock to avoid wastage due to expiries.

Map existing assets, including trucks, vehicles, warehouses, and facilities, as well as likely needs, challenges, and contingencies. Identify alternate storage facilities and logistics providers, and plan for alternate routes and transportation. Identify alternate distribution channels to get supplies to clients and plan to dispense larger amounts of product if needed.

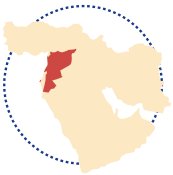


In the **Asia Pacific Region**, the most disaster-prone region in the world, UNFPA's Regional Prepositioning Initiative has established hubs in Australia and Fiji that can quickly provide supplies to 11 countries when typhoons and tsunamis strike or conflicts erupt. In 2018, the initiative made lifesaving supplies available for 17 emergency responses in nine countries.[xi] Prepositioning has dramatically improved the humanitarian response in Asia and the Pacific in terms of speed, quality, and efficiency, and has also reduced transportation costs. Prepositioned supplies have been delivered within 48 hours in accordance with SPHERE and MISP guidelines, or immediately in case of national prepositioning, and can be customized for the country context.

In **South Sudan**, where instability is ongoing, UNFPA has played a key role in coordinating the prepositioning of SRH supplies to reduce stockouts. In five locations within the country, the creation of humanitarian hubs has improved access to reproductive health supplies throughout the region. The hubs provide RH supplies and are staffed to also give quick access to technical assistance for the more than 30 partners that help distribute supplies to the last mile, both in stable times to prepare for flare ups in the conflict and in emergencies.[88]

The International Rescue Committee is using a new practice to secure and preposition safety stock with suppliers at their warehouses. Based on monthly consumption, they will preposition products with three international suppliers to prevent stockouts, which also ensures that stock is stored and rotated by suppliers, shifting responsibilities upstream and reducing risk to the organization of expiries, theft, and improper storage conditions.

In **Rwanda**, during the current COVID-19 outbreak, the MOH has a disaster response team and plan in place, and they are shoring up the FP supply chain by planning for the maximum stock level of 13 months, while monitoring and revising stock data, looking at pipeline, and working with donors to manage orders of FP supplies. During this pandemic, the distribution of FP is continuing with infection prevention precautions, and since some workers may not be able to get to work, the country is estimating that distribution costs may increase.



Working in five field locations in the **Middle East (Syria, Lebanon, Jordan, the West Bank, and Gaza)** that include 140 health facilities, the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) established their own internal procurement system with high quality and cost effective suppliers. With rigorous prequalification through a competitive tender process for each of the 1,200 health products they stock, UNRWA established 15 three-year long-term agreements with suppliers. They also created a performance feedback loop to inform routine evaluations and accountability for the quality of supplies and performance of the supplier. This rigorous process resulted in high quality and affordable medicines from multiple sources, allowing for quick procurement and distribution to the programs they support. The level of redundancy in the system, and risk shifted to suppliers, minimizes the need to hold stock in their own pipeline while still being responsive to emergencies.

xi Fiji, Indonesia, Kiribati, Lao PDR, Myanmar, Papua New Guinea, Philippines, Tonga, and Vanuatu.

The 2013 class of the School of Midwifery in Makeni, Sierra Leone, received midwife kits at their graduation ceremony. Image credit: Direct Relief/Flickr

Financing

Plan and fundraise for two budgets relating to emergencies: an ongoing preparedness emergency supply chain budget to strengthen the system and a response reserve fund to be used during a disaster. Determine protocols for activating these funding mechanisms quickly and accessing these funds easily, especially for timely procurement in the case of an emergency; budget for these funds to support the full cycle of humanitarian response from preparedness to response to recovery. Budget for both the procurement of products and the cost of distribution, and include the cost of insurance to maintain key resources in the case of an emergency. In some cases national or provincial funds can be raised to cover these needs, but in other cases there will be gaps and a country will need to make humanitarian appeals. Countries can prepare by gaining familiarity with the relevant coordination mechanisms and making sure that budget supplies and distribution are included in these international appeals.[89]

In **Bangladesh**, Cox's Bazar houses Rohingya refugees in a protracted crisis that needed to transition from using RH kits to procuring individual SRH supplies. UNFPA and JSI provided assistance to the MOH at both the national and regional levels and the UNFPA office by helping to map and strengthen the existing supply chain, and by providing a forecast and a supply plan for individual products.[90] The team also mapped funding streams, as budget gaps had caused breaks in the supply chain, illustrating the importance of diversified funding to achieve sustainable and resilient RH commodity security in a protracted emergency setting.[91]

In the early phases of **Sierra Leone**'s Ebola epidemic, a lack of documentation for use of emergency funds undermined public trust and inhibited proper staffing and supply chain management, demonstrating the importance of proper documentation for emergency supply chain financing. The National Ebola Response Center (NERC) later developed an effective payment system that used mobile phones to transfer salaries to Ebola Response Workers who managed the supply chain and provided health services to the population. This not only improved system performance, but allowed the NERC to track payments, which generated public trust at a time when community support was essential to the emergency response effort.[92]

People

Define roles and responsibilities for emergency situations within the routine supply chain system and the RH program for each of the key supply chain functions. Consider adding a position responsible for emergency preparedness, or make it part of an existing position, at the national level. Create staff notification mechanisms so people can be contacted, and define meeting protocols for emergencies. Develop support and safety systems to prepare staff and protect them during emergencies. Cross-train staff to create redundancy of capabilities within the supply chain, specifically with regards to SRH commodities. Define the role the health and logistics cluster will play, as well as participation from local and international NGO staff, in a humanitarian response, and define how these entities will be linked to teams within the government and community in the case of an emergency.

In the **Philippines**, the MOH has a disaster and risk reduction plan in place and can mobilize quickly at the national level to preposition supplies, engage partners, and coordinate among different levels and actors in the supply chain. The Health Emergency Management Bureau (HEMB) worked with the Supply Chain Management (SCM) division to look at sourcing and procurement of personal protective equipment for the COVID-19 outbreak, and engaged police and military to support transportation of supplies. A survey by USAID's ReachHealth Project, through RTI International, gauged the outbreak's impact on SRH services, which showed some decline in both demand and service provision. The government has since issued guidance on how to get FP products to clients, which includes adding condoms to food packs, providing nurses with bicycles to make house calls, and engaging community volunteers to distribute condoms house to house.

In **Niger**, refugees from areas in Nigeria affected by Boko Haram are flowing into the eastern part of the country around Diffa, where Boko Haram terrorists launch sporadic attacks from Nigeria. With no preparedness plans in place, the MOH is working with humanitarian organizations such as IFRC, UNFPA, UNICEF, and UNHCR to provide assistance, including provision of SRH products. Partners are using various strategies to deliver services, including collaborating with the military to distribute commodities. Also, a multi-functional center has been created in the refugee camp that serves more than 17,000 refugees and displaced persons, and a number of midwives have been recruited to work there.

Processes

For each of the essential supply chain logistics functions, develop streamlined alternate routine processes that can be employed at the time of an emergency. Develop standard operating procedures (SOPs) that outline when and how emergency procedures should be ramped up or down. Conduct practice exercises of the SOPs and update them with what is learned in those exercises.

Indonesia is currently working to develop guidelines and procedures for managing contraceptive supplies in crisis situations, with support from UNFPA under leadership of the Indonesian government, to strengthen the supply chain and be better prepared for emergencies. Learnings from past response to tsunamis and earthquakes indicate that more buffer stock is needed, perhaps two or more months' worth. Recent efforts have focused on strengthening program manager capacity to estimate local needs, while future plans include national prepositioning of contraceptives. FP provision is currently restricted to married couples, which means that forecasting of FP supplies can only be done according to such data. These restrictions complicate the ability to properly prepare for the coverage of all people in need in the case of a disaster.

In **India**, various partners worked on preparedness after the 2007 war in Sri Lanka and the 2004 tsunami. During the current COVID-19 outbreak, Plan International India is working with local organizations and the government to plan for contingencies in the supply chain for HIV, including getting medicines to people at home through hubs and dispensing for two months at a time.

Tools and systems

Develop logistics management information systems (LMIS) for emergency supplies, including contraceptives and IARH kits, within existing systems or stand-alone modules or tools. Make sure if adding emergency supplies to existing systems that there is a way to manage the flow of that information separately to avoid creating confusion or duplication with the routine system for the same product categories. Consider how to track SRH supplies if those systems fail. Assess continuity of operations for information technology tools, such as alternate streamlined systems or modules that can be adapted within existing LMIS, warehouse and inventory control management information systems, and transportation management systems. Review the reliability and accessibility of underlying systems, servers, and networks, access to vital records through backup systems, and ability to provide records electronically or in hard copy.

To gain an overview of the humanitarian response in **Iraq**, UNOCHA developed the Humanitarian Response Dashboard, a comprehensive view of the humanitarian response supporting internally displaced persons, returnees, and affected host communities, as well as the humanitarian presence of more than 100 partners. Users can filter the data to view progress and activity information by geographic area, including data on health supplies distributed by partners. The dashboard is updated continuously and improves coordination and decision-making among participating partners. This collaboration gives UNOCHA visibility into the supply chain downstream and enables them to prepare their suppliers for the ups and downs of the protracted crisis.

Women from a young mothers group receiving family planning information from a community health worker.
Image credit: Jonathan Torgovnik/Getty Images/Images of Empowerment

Information

Prepare to collect critical logistics data through existing systems or alternate tracking mechanisms, including paper-based reports, in case ICT systems or tools are not available. Monitor and evaluate this information with supply chain key performance indicators and routine calls or meetings. Develop communication metrics and phone charts between all key parties for critical data sharing at various levels and beyond the public sector, when possible.

In two different areas of **Nigeria**, one affected by terrorist attacks and the other by floods, JSI implemented Impact Team Meetings to ensure uninterrupted delivery of FP supplies to affected communities. The meetings were held at the state level and FP coordinators from local government areas came together with partners and state ministries of health to pick up several months of supplies, report on stocks, and receive information so they would be prepared with sufficient stock in the case of an emergency. If access to certain locations would be cut off for longer periods, larger amounts of stock were provided to cover that period. In between meetings, health facilities received supportive supervision and reported into the LMIS through WhatsApp groups.

In **Pakistan**, the government and partners, such as the USAID Global Health Supply Chain Program (GHSC) program, used demographic and logistics data at the onset of the COVID-19 response to create forecasts for both COVID-19 and other health products. The country experienced major flooding in 2010 and has since kept key logistics data accessible. They have also mapped risk areas and populations, which has helped to accelerate the response. Other key learnings included keeping 5–10% buffer stock and advocating for contracts that allow donors and implementers to shift focus to disaster response if needed.

Conducting risk assessments

Risk assessments are a fundamental part of creating a COOP, as they create an inventory of potential risk to the continuity of the functions and resources identified in the mapping exercise. The risk assessments preemptively identify any actual or potential weaknesses or threats both internal and external to the supply chain. Organizations that implement formal risk management processes as part of their supply chain's normal operations can build on this existing documentation to assess risks for disaster preparedness. For examples and tools to conduct a risk management assessment, see Risk Management for Public Health Supply Chains: Toolkit for Identifying, Analyzing, and Responding to Supply Chain Risk in Developing Countries.[93]

Risk assessments should be conducted for each of the functional areas and resource areas within the supply chain, in collaboration with all relevant stakeholders. This may necessitate multiple workshops to discuss sources of risk and potential scenarios with staff and external partners. Performance objectives will be defined for each function and resource area, and stakeholders will estimate the likelihood and impact of risk events. Using the likelihood and impact parameters in combination can give managers a single score for prioritization.[94] Risk monitoring metrics should be included in the COOP.

The prioritized list of risk scenarios with scores can be used by the emergency preparedness team to determine strategies for managing risk, such as reducing or hedging risks, and the types of preparedness actions needed. While mitigation and preparedness measures should be outlined for all risks, the most likely scenarios warrant elaboration into contingency plans, which contain a greater level of detail for preparedness and response actions.[95] Countries will need to consider where and how to invest preparedness funds to optimize limited resources. Learning from existing experiences and best practices is therefore essential.

Developing contingency plans for key identified risks

Contingency plans define how a supply chain will continue to operate during a certain set of adverse circumstances. While contingency plans can be specific to natural disasters or an infectious disease outbreak, they can also be more general to address any number of hazards that might interrupt one or more functions of the country's health supply chain. Contingency plans may include information, actions, timelines, checklists, and protocols that enable the response and reduce impact to the supply chain, for example by creating redundancy, greater flexibility, or by having insurance.

The **International Rescue Committee**, which operates in 26 countries, is investing in preparedness efforts that enable country programs to establish contingency plans for emergencies that affect the health supply chain. Based on an in-country pharmaceutical assessment and best practices from UNICEF, MSF, and others, IRC provides coaching and capacity building for preparedness through a 2–3 day training for health teams on all SCM components, including finance. Over several months, IRC works with the team to design a practical country plan that includes assets, functions, tools, contracts, warehouse space, and sources.

CARE is developing preparedness tools and resources for staff in country offices who may need to source and manage SRH and other health commodities, particularly the IARH kits, during emergencies. The tools include a practical, user-friendly guidance document with suggested checklists that countries can readily begin to develop ahead of an emergency. It is written for people without specialized knowledge or experience with pharmaceutical and medical supply chain management.[xii] These tools refer to the MISP, IARH kit calculator, and IARH forecasting tool so countries can develop contingency plans for forecasting the need for these supplies in the case of an emergency.

The **Solomon Islands**, frequently hit with earthquakes, cyclones, and flooding, has an active national disaster management office, with dedicated staff at the national and provincial levels. A working group is currently developing an SRH preparedness plan.

xii The guidance document is derived from John Snow, Inc.'s Supply Chain Manager's Handbook: A Practical Guide to the Management of Health Commodities (see *Resources*).

LEARNING BRIEF ON COMMUNITY PREPAREDNESS

Incorporating SRH into disaster risk reduction for communities affected by crises: A case study from Pakistan

Key Takeaways

Undertake a comprehensive assessment of existing community capacity and needs for SRH and gender preparedness, ensuring inclusion of the most marginalized and underserved populations, such as women and girls, adolescents, sex workers, people with disabilities, and people of diverse SOGIESC. See the note on inclusion.

Foster national and subnational policy commitments in support of community action plans.

Engage policy makers, the community health workforce, and civil society representatives with a health background.

Ensure that participants are familiar with the MISP prior to the training.

Secure sustained funding to support implementation, monitoring and evaluation of action plans, and to generate new evidence on the efficacy of SRH and gender preparedness at the community level.

Communities affected by disaster have needs and solutions that require support

As mentioned in the toolkit introduction, the Sendai Framework for Disaster Risk Reduction 2015–2030 calls upon stakeholders to invest in approaches that build community and country capacities to prevent, mitigate the impact of, and prepare for emergencies. The Sendai Framework recognizes the gendered impacts of disasters and the critical roles that communities play as first responders. It defines four priorities for strengthening resilience: 1) understanding priority disaster risks; 2) strengthening disaster risk governance to manage disaster risk; 3) investing in emergency preparedness and disaster reduction; and 4) enhancing disaster preparedness for effective response and to "Build Back Better," which means ensuring that recovery efforts build resilience and reduce a community's vulnerability to future emergencies.[96] This brief highlights insights gained from a variety of locations, with a particular focus on lessons learned from a pilot project in Pakistan.

A nurse from the main KFHA clinic on the island of Tarawa, Kiribati, provides contraception to a client.
Image credit: IPPF/Hannah Maule-ffinch/Kiribati

Considerations for successful application of SRH and DRR curriculum

In 2010 the Women's Refugee Commission (WRC) initiated work on national and community-level disaster risk reduction (DRR), with a focus on emergency preparedness for gender and SRH. The WRC developed and piloted the Facilitator's Kit: Community-based Preparedness for Reproductive Health and Gender (SRH and DRR Curriculum) in collaboration with UNFPA and local partners in the Philippines. Its development was based on eight trainings across five diverse settings in 2013, and it has been further applied in three additional sites in the Philippines, northern Iraq, and in disaster-prone communities in Pakistan. The highly participatory curriculum consists of a three-day training that brings communities together to understand local disaster risks and their impacts on gender and SRH and to make community action plans in line with the MISP.

Early piloting of the SRH and DRR Curriculum identified several key considerations for success:

- **Ensure that there is national and subnational commitment** to integrating SRH and gender into disaster risk management and that community-level action plans are supported up to the national level.
- **Engage participants with the recognition that SRH priorities are challenging** to understand for those without a health background. Suggested participants include health policy makers, program managers and coordinators, first responders, midwives, and representatives of community-based organizations (women, youth, people with disabilities, people of diverse SOGIESC, and others).
- **Ensure that participants are familiar with the MISP prior to the training** (through the MISP Distance Learning Module, for example). Local health and SRH actors in stable development contexts are more familiar with addressing comprehensive SRH, and can benefit from learning about the limited lifesaving priorities of the MISP. Recognizing what is included in the MISP and what is not requires targeted reinforcement throughout the training, and in community action planning, monitoring, and evaluation.
- **Strengthen the integration of supplies and supply chain management into the curriculum.** Ensure that steps are taken to address commodity risk management, supply prepositioning or stockpiling, and plans for obtaining emergency SRH supplies.
- **Before developing the action plan, identify actions that require funding and those that do not** (or have minimal costs). Initially prioritize the most feasible actions until funding is secured for more costly activities.
- **Invest in monitoring, evaluation, and evidence generation** to measure the efficacy of SRH and gender preparedness at the community level.

These considerations informed the design and implementation of the Pakistan project described below. This case study presents one approach to community engagement for SRH and gender preparedness in health emergencies.

In 2017, after incessant rains affected more than half a million people across seven districts in Sri Lanka, midwives stationed in the FPASL Clinic in Nagoda, Southern Province, provided SRH care to those affected.
Image credit: IPPF/Peter Caton/Sri Lanka

Case Study from Pakistan: Incorporating SRH into DRR for communities affected by crisis

With funding and support from the US Centers for Disease Control and Prevention (CDC) through a five-year cooperative agreement (September 2015–2020), the WRC partnered with IPPF and Rahnuma-FPAP to build the evidence base and tools for incorporating SRH into disaster risk reduction for communities affected by crises. The pilot project in Pakistan focuses on:

- **Building the community-level health workforce** to prepare and respond to SRH risks using the WRC's SRH and DRR Curriculum and establishing a supportive and coordinated environment for community-level MISP preparedness in Pakistan
- **Developing the evidence base and tools** for communities affected by crises to incorporate SRH into DRR activities, based on achievements and lessons from this pilot.
- **Scaling up interventions for SRH integration within disaster risk management for health** to institutionalize inclusion of SRH into existing disaster risk management efforts.

The frequency of natural disasters in Pakistan and the conducive environment for supporting SRH in DRR at national and subnational levels, in combination with the prior experience and expertise of IPPF's SPRINT initiative and Rahnuma-FPAP to leverage the SRH coordination platform at national, provincial, and district levels, made Pakistan an ideal location for this multi-pronged initiative to build community resilience for SRH and gender preparedness.

A client receives an ultrasound in Syria. Photo credit: IPPF/Chloe Hall/Syria

Project Activities

The WRC initiated its work in Pakistan by undertaking a desk review of the SRH and disaster risk management for health infrastructure in Pakistan, as part of three case studies on building national resilience for SRH. Findings showed that following the earthquake in 2005, Pakistan made extensive progress in advancing DRR through the establishment of its 2010 National Disaster Management Plan, which was subsequently updated in 2019.[97] It also developed a 2013 DRR strategy with disaster management structures that support preparedness at national and subnational levels.[98] In 2010 Pakistan established a National Health Emergency Preparedness and Response Network (NHEPRN) under the Ministry of National Health Services, which leads health-related emergency response and disaster risk management and chairs the national RH working group (with UNFPA as co-chair).[99] In addition, Pakistan has implemented specific policy guidelines on gender through the National Disaster Management Authority's (NDMA) *Child and Gender Cell and National Policy Guidelines on Vulnerable Groups in Disasters.*

In 2010 the Constitution of Pakistan was amended (18th Amendment) and government powers related to disaster management were devolved to the provinces. The 2015 DRR legislation in Pakistan sought to further decentralize DRR responsibilities to provincial and district levels. Recognizing gaps in institutional capacity on SRH and gender at the local union council/community levels, Rahnuma-FPAP selected three disaster-prone provinces and districts (Khyber Pakhtunkhwa–KP province, Nowshera district; Punjab province, Muazffargarh district; Sindh province, Badin district) to focus this initiative. Rahnuma-FPAP aimed to support the institutionalization of SRH and gender through advocacy, training, and workshops for public and private stakeholders at national, provincial, and district levels. It also trained law enforcement and Rescue 1122 frontline responders; established and

supported RH working groups at national, provincial, and district levels; and facilitated the formation of community groups and leaders to build capacity around SRH and gender.

To initiate the training of trainers (ToTs) on SRH and gender, the SRH and DRR Curriculum was adapted to the Pakistan context to address the national disaster risk management infrastructure and local disaster, gender, and SRH risks. The project aimed to build community resilience for SRH and gender, with resilience understood as the ability of the community to resist, accommodate, and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.

The first ToT was hosted by the WRC and Rahnuma-FPAP in Islamabad in September 2016 for representatives of federal and provincial DRR agencies from the three select provinces, UN agencies, and NGOs. The first day of the workshop provided an overview of community-based DRR and SRH priorities in emergencies. The second day covered all areas of the MISP, including GBV, HIV prevention, maternal and newborn care, and family planning. On the third day, participants developed action plans, one for the national level and one for each of the three provinces. The four action plans focused on integrating SRH and gender preparedness into existing disaster risk management policies and RH working groups, organizing follow-up ToTs at district and community levels, and facilitating community awareness.

The cascade of trainings—supported by 18 Rahnuma-FPAP master trainers—included training and refresher trainings on community preparedness for SRH and gender in six union councils/communities, with action planning and follow-up monitoring and evaluation. Participants included male and female, adolescent and youth community members; elected representatives of local government; field staff of health and population departments; and teachers and other community influencers. Community action plans with indicators and methods of measurement were created in alignment with MISP priority activities. Planned activities included raising community awareness on SRH in crises and discussing the role of the community in DRR; mapping and informing the community about referral mechanisms for emergency obstetric care and care for survivors of sexual violence; establishing birth plans for every pregnant woman and providing women with boxes to collect petty savings for use at the time of delivery to reduce delays in seeking care at health facilities due to economic or logistical reasons; planning for the provision of clean delivery kits to all pregnant women by stockpiling supplies; compiling and sharing information with local hospitals about blood donor lists; facilitating the availability of contraception and emergency contraception through direct distribution and referrals for long-acting methods; raising awareness on STIs and HIV; and improving the availability of condoms in communities in advance of emergencies.

Rahnuma-FPAP advocated the integration of SRH and gender into disaster risk management policies, standard operating procedures, and assessment tools for DRR with a wide range of government stakeholders: parliamentarians, DRM agencies (national, provincial, and district), NHEPRN, and Departments of Health, Population Welfare, and Social Welfare. It also worked with the GBV Task Force, UNFPA, WHO, and international and local NGOs in the RH working groups.

Project Outputs

Rahnuma-FPAP sensitized more than 20 members of parliament and policy makers on the MISP and trained more than 300 members of the community. Trainings reached local health and social welfare government representatives, health service providers, first responders known as Rescue 1122, lady health workers, and traditional birth attendants. Awareness-raising events reached 700 community members: girls, boys, women (including mothers-in-law), men, youth, activists, shop owners, teachers, students, and community transporters. The community health workforce trainings and community awareness-raising sessions included before-and-after tests on knowledge about DRR and priority SRH needs and actions, with an average of 60-70% increase in knowledge.

Project outcomes

While community action plans are currently under final evaluation in year 5 of the pilot project, preliminary findings show the communities' preparedness efforts are strengthening their resilience and even improving the SRH and gender situation in stable times. For example, community members have established groups and volunteered to support the community health workforce in addressing SRH and gender priorities.

A blood donor group list was used in at least two emergencies, and a new local emergency transport list was activated for a woman suffering complications of pregnancy and childbirth. Additional project successes and challenges shared by union council/community representatives participating in a project monitoring workshop in Islamabad in August 2019 include the following.

Successes

- **Community members know where to go for safety in the event of flooding, such as designated relief camps.**
- **Helplines have been established.**
- **200 clean delivery kits have been prepositioned at each of the six community/union council locations.**
- **Referral systems from communities to health facilities have been established or strengthened.**
- **Contraceptive uptake of both long-acting reversible methods and short-term methods has increased.**
- **Blood donor grouping volunteer lists have been developed in each of the six locations.**
- **Lady health workers and Rahnuma country outreach workers are now maintaining records of pregnant women.**
- **Mother-in-law and male support groups have been formed; they hosted community sessions in their homes, which led to community ownership.**
- **District health forums with a focus on SRH have been established with the District Disaster Management Agency and local organizations in all three districts.**
- **Champions of SRH and gender preparedness have been identified, including parliamentarians and members of Rescue 1122.**

Challenges

- Cultural sensitivities around SRH and HIV/STIs, and the need to use language such as "family health." Youth reported talking with their peer groups to remove stigma associated with STIs and HIV. Sensitivities were also noted around condom dissemination, and local shop keepers and community houses for guests were identified as sites for free condoms in the event of a disaster.
- Frequent transfers of training public sector managers.
- Limited free delivery kits, which prompted a follow-up discussion on local production and plans to procure more kits from UNFPA.
- Shortage of post-exposure prophylaxis (PEP) kits, prompting follow-up with NHEPRN, WHO, and UNFPA.
- Gaps in shelter support and legal aid for survivors of sexual violence.
- High levels of child marriage and early forced marriage.
- Gaps in information, education, and communication (IEC) materials, which led to follow-up discussions on the availability of universal, adaptable IEC materials for the MISP.

Conclusion

Lessons learned from the Pakistan project will be reflected in the next edition of the SRH and DRR Curriculum, which is being prepared by the Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights (ACCESS) Consortium. The revision will strengthen the focus on building community capacity and better address the inclusion of marginalized and underserved populations. The Consortium is also examining scalable, evidence-based approaches to mobilize marginalized and underserved populations across the humanitarian-development contexts of Lebanon, Mozambique, Nepal, and Uganda.

This community preparedness for SRH and gender initiative in Pakistan supports global policy developments—including the Sendai Framework—that recognize the need to collectively enable local communities to reduce SRH and gender risks and vulnerabilities, and enhance community resilience in disasters, conflicts, and even pandemics. It also highlights the need to ensure support from leadership at the local, regional, and national levels. Emergency preparedness and recovery are two entry points within the continuum of an emergency that provide an opportunity to strengthen local capacity to prepare for and respond to future emergencies.[100]

Recommendations

The following recommendations are sequenced in order of the Stages of SRH Preparedness: Initiating, Assessing, and Implementing.

1. **Consider MISP preparedness a key component** of SRH resilience building and health system strengthening efforts, enabling a quick transition to MISP during an emergency and a faster recovery to comprehensive SRH.

2. **Use the MISP and its assessment and training tools** to structure, monitor, and evaluate preparedness efforts.

3. **Undertake SRH preparedness work in consideration of the specific context:** the operating environment, existing health and disaster management systems, type of hazards and risks faced, and existing capacities.

4. **Build rights-based, people-centered, inclusive SRH preparedness** across all activities and levels, recognizing the importance of leadership and representation from diverse groups and the necessity of tailoring preparedness to ensure SRH services are accessible and of quality for everyone, particularly the most marginalized and underserved.

5. **Integrate SRH into relevant DRM and/or health emergency policies, strategies, and legislation** at national and subnational levels, and integrate DRM into SRH policies, strategies, and legislation.

6. **Establish or strengthen coordination bodies** (such as the SRH working group or sub-cluster) to advance SRH preparedness, bringing together emergency and disaster management, SRH, and other relevant stakeholders.

7. **Build a trained and readied workforce for MISP implementation** with agile systems available to provide the full MISP components regardless of type of emergency.

8 **Source sufficient, appropriate, and flexible funding** for preparedness action planning and implementation through a variety of means: national and subnational DRM and health emergency budgets, contingency or emergency funds, and external donors across the development and humanitarian sectors.

9 **Develop communication mechanisms and IEC materials** to ensure affected communities are receiving accurate, timely, and appropriate communication on SRH care and risks, and equip first responders to reinforce communication messages.

10 **Enable resilient supply chains by developing plans** for continuity of operations, ensuring that a full range of contraceptives and reproductive health supplies are prioritized and prepositioned as appropriate.

11 **Recognize the role of community groups, their leaders and networks, local government, health workforce, and civil society as first responders.** Invest time and resources to build community-level health preparedness by fostering collaboration and partnerships, building community-based mechanisms, and bolstering coordinating bodies to build community-level capacity and operations. Use joint action plans before emergencies to ensure they are better equipped to contribute to preparedness, response, and recovery efforts.

12 **Strengthen the collection and management of SRH-related data**—including sex-, age-, and disability-disaggregated data—to aid in preparedness efforts and the monitoring and evaluation of response efforts.

13 **Establish systems to monitor, evaluate, and share learning** on SRH preparedness activities and how they affect response.

Resources

The following resources are recommended for SRH preparedness and include:

- Tools to assess SRH preparedness and develop action plans
- SRH/preparedness frameworks, briefs, and guidances
- Tools to support preparedness for health infrastructure, supplies, and logistics
- MISP training materials
- Relevant operational guidance for inclusive MISP implementation
- SRH service delivery training materials
- Inclusion guidance

Tools to assess SRH preparedness and develop action plans

IPPF/FP2020. 2020. MISP Readiness Assessment (MRA). The MISP Readiness Assessment (MRA) brings together government, UN, civil society, and private sector actors to assess their country's readiness to implement the MISP during an emergency. The assessment outlines a process for identifying and prioritizing the areas to work on during preparedness to improve the ability to implement the MISP during response. The assessment can be used at both national and subnational levels to develop action plans.

ACCESS Consortium. 2020. Community Capacity Needs Assessment Tools (CCNA). *(currently in draft form)* The Community Capacity Needs Assessment Tools encompass four tools for use at the community level to assess community assets and needs for MISP preparedness. The tools include: two key informant tools for policy makers and health providers with an accompanying health facility assessment, and two focus group discussion tools for community health workers and community members.

WRC/UNFPA. 2015. Facilitator's Kit: Community-based Preparedness for Reproductive Health and Gender. *(currently being updated)* In 2015 WRC and UNFPA developed a facilitator's guide for community resilience-building for preparedness, piloted in the Philippines, Iraq, and Pakistan. An updated revision integrating lessons identified and pandemic preparedness was undertaken in mid-2020.

IAWG. MISP Calculator. The MISP calculator is a spreadsheet that can be used to determine the demographics of an affected community and calculate its SRH needs, producing estimates that can be used for advocacy, fundraising, and program purposes.

SRH/preparedness frameworks, briefs, and guidance

UNDRR. 2015. Sendai Framework for Disaster Risk Reduction (2015–2030). The Sendai Framework for Disaster Risk Reduction is a seminal framework on disaster risk reduction and management and includes emergency preparedness. The framework outlines four priority areas, with SRH included under Priority #3 as a critical health service. All priority areas feed into emergency preparedness, with Priority #4 focusing on improving preparedness for a stronger response. Although not specific to SRH/health, the brief Enhancing Disaster Preparedness for Effective Response: Words in Action (2020) delves into preparedness implementation for response.

WHO. 2019. Health Emergency Disaster Risk Management Framework (Health-EDRM). This framework was developed by WHO to assist country level actors and illustrates principles, key components, and functions to achieve health emergency preparedness. SRH is listed as an essential service under "Health and other services." There is also the WHO Glossary of health emergency and disaster risk management terminology.

IAWG. 2020. Integrating sexual and reproductive health into emergency and disaster risk management for health: Policy Brief. *(currently in draft form)* This policy brief outlines the importance of SRH in

health emergency and disaster management and offers recommendations and next steps for SRH preparedness. This brief is an updated version of the 2012 WHO Integrating sexual and reproductive health into emergency and disaster risk management for health.

IAWG. 2020. Disaster Risk Management for Health: Sexual and Reproductive Health: Fact Sheet. *(currently in draft form)* This fact sheet argues the importance of SRH care in emergencies, and describes all essential SRH components for disaster risk management and emergency preparedness. This fact sheet is an updated version of the 2011 WHO Disaster risk management for health: sexual and reproductive health.

IASC. 2020. Emergency Response Preparedness (ERP) Guidance. *(currently being updated)* IASC ERP is guidance intended for international humanitarian actors in different countries to assess levels of risk to hazards and develop minimum multi-hazard preparedness or step-by-step contingency planning for an expected hazard (that can include the RAPID approach). The ERP is not sector-specific. Although not targeting country-level actors and not health or SRH-focused, the guidance can be an excellent resource for DRM actors within countries and for SRH actors becoming more engaged with the broader preparedness landscape and developing national preparedness systems. This guidance is an updated version of the 2015 version for field testing, IASC Emergency Response Preparedness Guidance.

IFRC. Law and Disaster Preparedness and Response. This online resource includes links to the Handbook on Law and Disaster Risk Reduction and the Disaster Preparedness and Response Law Checklist that can aid user when assessing how assess laws and integrate MISP to ensure inclusion in response.

WHO. March 2020. Risk Communication and Community Engagement Action Plan Guidance: COVID-19 Preparedness and Response. Although geared toward COVID-19, this guidance is a helpful resource for developing an effective and appropriate risk communication strategy in any emergency response.

UN Women. 2012. Gender-Responsive Early Warning: Overview and How-to Guide. This guide outlines the process of selecting gender-sensitive indicators for community-based early warning systems and planning, implementing, monitoring, and evaluating early warning mechanisms in close collaboration with women leaders and women's groups.

Tools to support preparedness for health infrastructure, supplies, and logistics

PAHO. 2010. Health Sector Self-Assessment Tool for Disaster Risk Reduction. This tool assists users in identifying priorities for national-level health system risk reduction and disaster management work for the purposes of risk mitigation and emergency preparedness. It includes a monitoring tool and can be adapted to a variety of settings.

IAWG. 2019. Strengthening Supply Chains for Sexual and Reproductive Health. This information brief on the importance of collaboration identifies entry points and calls for action to invest in two critical transition points along the humanitarian-development continuum: pre-crisis preparedness and transitioning after acute emergencies to more stable supply chains.

John Snow, Inc. 2019. The Supply Chain Manager's Handbook: A Practical Guide to the Management of Health Commodities. Chapter on Supply Chain Management for Healthcare in Humanitarian Response Settings. This guide is a starting point for anyone interested in learning the key principles and concepts of supply chain management for health commodities. Concepts described in this handbook will help those responsible for improving, revising, designing, and operating a supply chain. The chapter on humanitarian response settings discusses how to manage risks to supply chain performance.

UNFPA. Country Inter-Agency Reproductive Health (IARH) Kit Forecasting Tool. The Country IARH Forecasting Tool is an Excel-based planning tool for country-level forecasting of IARH kits. It estimates the number of IARH kits needed for the acute phase (first 3 months) of a humanitarian crisis up to a maximum of 9 months. The tool also provides an advocacy dashboard to help mobilize resources for services and supplies during an emergency.

USAID Global Health Supply Chain. 2018. Best Practices in Supply Chain Preparedness for Public Health Emergencies. This document compiles best practices in emergency supply chain preparedness to help countries respond rapidly and effectively to epidemic and pandemic threats. By planning for a range of possible scenarios and outlining stakeholder roles, countries can mitigate the impact of these challenges.

MISP training materials

WRC/IAWG. 2018. MISP for Sexual and Reproductive Health in Crisis Settings: A Distance Learning Module. The MISP distance learning module (DLM) is based on the 2018 revision of the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises' Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, "Chapter 3: Minimum Initial Service Package," and allows the user to read each unit, complete eLearning activities, test knowledge with unit quizzes, and earn a certificate in the MISP.

IPPF/IAWG. 2019. MISP Training for Policy Makers/ Program Managers and Service Providers. This face-to-face training package is based on the 2018 revision of the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises' Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, "Chapter 3: Minimum Initial Service Package," and related resources including the previous SPRINT training packages. There are three packages in total targeted at different country level audiences: policymakers, program managers, and service providers. Each package consists of a facilitator's manual, practical exercises/handouts, and an accompanying slide deck. They vary in length from one to four days. They are intended to complement the Distance Learning Module and provide an opportunity for actors in the SRH and Disaster Management field to become more familiar with the MISP.

IAWG. MISP Advocacy Sheet and MISP Cheat Sheet. *(currently being updated)* The MISP advocacy sheet offers a select list of advocacy points on the lifesaving nature of SRH and its importance. The MISP cheat sheet summarizes the MISP objectives. These are both useful tools for advocacy, fundraising, training, and programming and are located on the IAWG website alongside other MISP resources.

Relevant operational guidance for MISP implementation

IAWG. 2018. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) is the authoritative guidance on SRH in humanitarian settings. It includes a chapter on the MISP, a set of priority activities to be implemented at the onset of an emergency (within 48 hours) and up to 3–6 months or until it is possible to transition to comprehensive SRH. Preparedness is referenced throughout, with specific actions for preparedness outlined in the GBV, logistics, and HIV chapters.

IAWG. 2020. Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings. *(currently being updated)* This guidance is a companion guide to the IAFM on adolescent sexual and reproductive health (ASRH) and includes preparedness actions for ASRH in the following areas: coordination; assessment and monitoring; facility-based ASRH services; community-based ASRH services; protection and human rights; information, education, communication. This toolkit is based on the 2009 UNFPA/Save the Children Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings.

IAWG. 2016. Universal & Adaptable Information, Education & Communication (IEC) Templates on the MISP. IAWG has developed IEC templates to ensure clear communication with communities on the importance of seeking care, where and how to seek care, and what services are available.

IASC. 2015. Guidelines for Gender-Based Violence Interventions in Humanitarian Settings. The IASC GBV Guidelines offers humanitarian actors and affected communities guidance to implement, monitor, and evaluate GBV prevention and response activities by sector. Emphasis is also placed on inclusion of marginalized groups.

IASC. 2005. Guidelines for HIV/AIDS interventions in emergency settings. This guidance reviews HIV/AIDS programming in humanitarian settings and includes preparedness actions in the introduction and in a matrix outlining different thematic areas.

Save the Children/UNICEF. 2018. Newborn Health in Humanitarian Settings: Field Guide. This companion to the IAFM provides information related specifically to newborn care during the neonatal period (days 0-28).

FP2020. 2020. High-Impact Practices in Family Planning (HIPs). Family Planning in Humanitarian Settings: A Strategic Planning Guide. This document leads national and subnational decision-makers through a strategic process to identify actions that improve family planning access in places at risk of, experiencing, and recovering from crisis events. It includes some tips on supply chain management.

WHO. Task sharing to improve access to FP/contraception. This summary brief outlines opportunities to task-share FP services, identifies which cadres of health providers can provide different contraception methods, and offers recommendations for the implementation of task-sharing initiatives.

WHO. 2019. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. This manual shares guidance across select SRH components on opportunities for self-care interventions, including select MNCH, contraception and preventing unsafe abortion, HIV/STI, and promoting sexual health.

IPAS. 2018. Abortion Attitude Transformation: Values Clarification toolkit for humanitarian audiences. This toolkit is for humanitarian workers and their colleagues to explore and assess attitudes toward abortion to lead to improved access to meet abortion-related needs and address service delivery gaps, to the full extent of the law, in humanitarian settings.

WHO/UNFPA/UNHCR. 2020. Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings. This guidance is designed for health care providers to be able to develop protocols in emergencies for the clinical care of survivors of rape and intimate partner violence. The guidance includes considerations such as resources, supplies and logistics, and national policies, and the materials can be used to develop provider trainings.

IRC/UCLA. 2014. Clinical Care for Sexual Assault Survivor Multimedia Training Tool. *(currently being updated)* This online training tool is designed for health care workers to provide quality clinical care for sexual assault survivors in low-resource settings.

IRC/UNICEF. 2012. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings. This guidance document is for caring for children and families affected by child sexual abuse in humanitarian settings and can inform collaborative work between SRH and protection sectors.

OCHA. Protection against sexual exploitation and abuse (PSEA). This site houses a number of resources, including the Summary of IASC Good Practices on PSEA, the IASC Strategy on PSEA, and other statements and approaches. These can be good resources during the critical period of policy development, staff training, and the development of accountability mechanisms, including robust complaint mechanisms.

SRH service delivery training materials

IAWG. IAWG Training Partnership Initiative SRH Clinical Outreach Refresher Trainings and other Training Resources. In response to a growing need for MISP clinical refresher trainings in risk-prone contexts, IAWG launched the Training Partnership Initiative (TPI) in 2006 to develop and disseminate a series of SRH Clinical Outreach Refresher Trainings (S-CORT) modules on select clinical components of the MISP for an audience of trained clinical providers. To support planning early in a response for comprehensive SRH services after the implementation of the MISP, the IAWG TPI, WHO Global Health Cluster, and IAWG members and partners developed a toolkit to guide a participatory workshop with key stakeholders and to develop workplans to facilitate SRH service expansion. The S-CORT modules and the Transition from MISP to Comprehensive SRH toolkit have been field tested in crisis-affected settings.

Inclusion guidance

IASC. 2019. Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action. The guidelines outline the actions for humanitarian workers to reach out and engage persons with disabilities in humanitarian action, including during the identification of needs and provision of services. The guidelines include specific actions to undertake during preparedness to ensure inclusion and appropriate service provision for the diverse community of persons living with disabilities.

WRC. 2015. "I See That It Is Possible" Gender-Based Violence Disability Toolkit. This toolkit is for GBV practitioners to adapt for their settings and particular programs and integrate into GBV tools. The purpose of this set of tools is to train GBV staff and utilize qualitative tools to thoughtfully and appropriately engage the disability community in GBV programming.

Women Enabled International/UNFPA. 2018. Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. These guidelines and tools are for humanitarian practitioners to enable GBV and SRH programming to be inclusive of and responsive to the diversity of women and girls with disabilities.

WHO/CBM/UNISDR/UNICEF/IFRC/IOM. 2013. Inclusion Guidance Note on Disability and Emergency Risk Management for Health. This guidance note outlines the importance of programming for disability and access in all stages of emergency risk management, covering the EDRM components such as policies, coordination, supplies, and service delivery, and including a helpful checklist for disability and emergency risk management: Checklist of minimum actions required by the health sector.

UNSDRR. 2020. Words in Action: Engaging Children and Youth in Disaster Risk Reduction and Resilience-Building. This document is part of a series of guidelines to improve DRR. This brief is focused on engaging children and youth and centering them in the DRR work. Attention is paid to including children and youth in all their diversity and ensuring access to care for SRH, including GBV-related needs.

IFRC. 2020. Protection and Inclusion: The Importance of Disaster Law and Policy. This fact sheet offers recommendations to ensure that disaster management laws and policies address protection and inclusion of marginalized populations.

IFRC. Minimum standards for protection, gender and inclusion in emergencies. This guidance document offers steps to integrate protection, gender, and inclusion across all humanitarian sectors, including emergency health.

Humanitarian Advisory Group. 2018. Taking Sexual and Gender Minorities out of the Too-Hard Basket. This guidance is a rebuttal to any avoidance of inclusion or service provision for sexual and gender minorities. Although not SRH-specific, it offers recommendations to engage and include sexual and gender minorities in humanitarian action.

IPPF/APCOM/Asean SOGIE Caucus/UNWomen/ AsiaPacific Transgender Network/Edge Effect. 2018. Pride in the Humanitarian System: Consultation Report. This report is based on a consultation that took place in the Asia Pacific region on how best to include and follow the leadership of people of diverse SOCIESC. The report identifies key barriers and enablers to participation, and offers tools and recommendations for a more inclusive humanitarian sector.

Women Deliver. 2020. Advancing Gender-Transformative Localization. This report documents key challenges faced by women-led civil society organizations to their meaningful engagement, leadership, and participation in humanitarian action. In support of localization in humanitarian action, this report offers recommendations for donors, international organizations, and women-led CSOs.

Annexes

ANNEX 1

Acknowledgements

This toolkit was developed with the generous contribution of time and insights from more than 80 government, humanitarian, and development actors from around the globe. In particular, we thank the individuals listed in Annex 2 for allowing us to interview them about their experiences implementing various aspects of SRH preparedness. We are also grateful to the 35 SRH and emergency and disaster management experts (see Annex 3) who reviewed the toolkit, especially since they made time to provide thoughtful comments while responding to the COVID-19 pandemic. These dedicated professionals are paving the way for other actors to strengthen their own health systems to be able to robustly respond to all types of emergencies and meet the SRH needs of affected populations.

The toolkit was conceived and initiated by Jennifer Schlecht, who recognized the tremendous potential for country actors to be better prepared to provide access to quality SRH care during emergencies if they invest time and effort in preparation.

Anna Myers, FP2020 consultant, was the lead author on the toolkit, with substantial input by Keya Saha-Chaudhury (IPPF), Nesrine Talbi (IPPF consultant), and Lorelei Goodyear (FP2020). The Learning Briefs were authored by Nesrine Talbi (IPPF consultant), Nadia Olson (JSI), Anne Marie Hvid (JSI), Sandra Krause (Women's Refugee Commission), and Dr. Anjum Akhter (Rahnuma-Family Planning Association of Pakistan). The toolkit writing and production teams were managed by Lorelei Goodyear (FP2020). A special thanks goes to FP2020 Executive Director Beth Schlachter, the Communications Team, and the Country Support Team for strategic guidance on the toolkit and for extending the FP2020 platform as a bridge between development and humanitarian actors at country and global levels.

The toolkit was designed by Eighty2degrees and edited by Suzanne Scoggins.

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ANNEX 2

Key informants interviewed for the SRH preparedness toolkit

Name	Organization	Location
Adewole Adebola Adefa	JSI	Nigeria
Dr. Shilu Adhikari	UNFPA	Solomon Islands
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Dr. Henia Dakkak	UNFPA	USA
Akanisi Dawainavesi	IPPF	Pacific
Dr. Robyn Drysdale	IPPF	Pacific
Parfait Edah	Global Health Supply Chain Program–Procurement and Supply Management (GHSC PSM)	Burkina Faso
Richie S Encillo	Ministry of Health, Philippines	Philippines
Mollie Fair	UNFPA Myanmar	MENA and Myanmar
Nimisha Goswami	IPPF	South Asia
Dr. Viola Grace	UNFPA Philippines	Philippines
Alison Greer	Interagency Working Group on Reproductive Health in Crisis	USA
Dima Hamasha	UNFPA	Jordan
Naikmal Shah Hamdard	Afghan Family Guidance Association	Afghanistan
Chris Hamon	Ipas	USA
Dr. Issoufou Harou	Ministry of Health and Traditional Medicine, Niger	Niger
Dr. Rizwanullah Hassan	Ministry of Public Health, Afghanistan	Afghanistan
Dr. Sheikh Md. Nazmul Hassan	CARE Bangladesh	Bangladesh
Ezizgeldi Hellenov	UNFPA Kenya	Kenya
Dr. Janitha Hettiarachchi	Family Health Bureau, Sri Lanka	Sri Lanka
Ahmad Hidayat	PKBI-Indonesia Planned Parenthood Association	Indonesia
Maria Hotslberg	UN Women	Asia/Pacific
Brunilda Hylviu	Albanian Center for Population and Development	Albania
Jordan Supply Chain Team	UNRWA	Syria, Lebanon, Jordan, West Bank, Gaza

Bojan Jovanovski	HERA (Health Education and Research Association)	North Macedonia
Danielle Jurman	UNFPA	Switzerland
Meba Kagone	JSI	Burkina Faso
Anushka Kalyanpur	CARE USA	USA
Hari Karki	UNFPA Nepal	Nepal
Manju Karmacharya	UNFPA Bangladesh	Bangladesh
Sandra Krause	Women's Refugee Commission	USA
Dr. Kyaw Wai Aung	UNFPA Myanmar	Myanmar
Achu Lordfred	UNFPA Democratic Republic of Congo	DR Congo
Dr. Om Maharjan	Family Planning Association of Nepal	Nepal
Dr. Nadeem Mahmood	Rahnuma-Family Planning Association of Pakistan	Pakistan
Dr. Nadeem Mahommod	Rahnuma-Family Planning Association of Pakistan	Pakistan
Chuda Mani	Health Emergency and Disaster Management Unit, Nepal	Nepal
Indah Nugraheni Mardhika	Ministry of Health, Indonesia	Indonesia
Chris Martin	IRC	USA
Henriette Eke Mbula	UNFPA Democratic Republic of Congo	DR Congo
Lindsay McCormack	IPPF	Western Hemisphere Region
Ian McKnight	IPPF	Western Hemisphere Region
Branwen Millar	UNFPA Asia Pacific Regional Office	Thailand
Mervis Patience Muvuringi	IMC	South Sudan
Dr. Myint Moh Soe	Ministry of Health and Sports, Myanmar	Myanmar
Jane Newnham	IPPF Consultant	Global
Dr. Yin Yin Htun Ngwe	UNFPA	Myanmar
Elizabeth Noznesky	CARE USA	Benin
Dr. May Chan Oo	Myanmar Maternal and Child Welfare Association	Myanmar
Dr. Rina Rani Paul	CARE Bangladesh	Bangladesh
Sophie Pécourt	IPPF Consultant, now with Humanity & Inclusion	MENA, EECA, and Haiti
Naomi Printz	GHSC PSM	Tanzania
Abdul Qader Raza	UNFPA Afghanistan	Afghanistan
Sarah Rich	Women Refugee Commission	USA
Keya Saha-Chaudhury	IPPF	Global
Nandy Senoc	Family Planning Organisation of Philippines (FPOP)	Philippines
Teymur Seyidov	UNFPA	Turkey
Syed Kamak Shah	Rahnuma-Family Planning Association of Pakistan	Pakistan
Elisabeth Adelina Sidabutar	UNFPA	Indonesia

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Mihoko Tanabe	Independent Consultant	USA
Dr. Muhammad Tariq	GHSC PSM	Pakistan
Isabella Thafvelin	UNFPA Asia Pacific Regional Office	Thailand
Ralph Titus	GHSC PSM	USA
Dorina Tocaj	UNFPA Albania	Albania
John Wafula	UNFPA Kenya	Kenya
Wambui Waithaka	IRC	Kenya
Olivier Wane	Ministry of Health, Rwanda	Rwanda
Erin Wheeler	IRC	USA
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ANNEX 3

Toolkit reviewers

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ANNEX 4

Acronyms

ASRH	Adolescent sexual and reproductive health
CBO	Community based organization
COOP	Continuity of operations plan
DRM	Disaster response management
DRR	Disaster risk reduction
EECA	Eastern Europe and Central Asia
FP	Family planning
FP2020	Family Planning 2020
GBV	Gender-based violence
HEDRM	Health emergency and disaster risk management
IAFM	Inter-Agency Field Manual on RH in Humanitarian Settings
IARH	Inter-Agency Reproductive Health kits
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
ICPD	International Conference on Population and Development
ICT	Information and communication technology
IEC	Information, education, and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International nongovernmental organization
IPPF	International Planned Parenthood Federation
JSI	John Snow, Inc.
LGBTQI	Lesbian, gay, bisexual, trans, queer, and intersex
MISP	Minimum Initial Service Package
MOH	Ministry of Health
NGO	Nongovernmental organization
RH	Reproductive health
SADD+	Sex- and age- disaggregated data
SCM	Supply chain management
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
SOP	Standard operating procedures
SRH	Sexual and reproductive health
TOR	Terms of reference
ToT	Training of trainers
UNFPA	United Nations Population Fund
WHO	World Health Organization
WRC	Women's Refugee Commission

ANNEX 5

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Karo performing a health check on Tarairosa, a single mother in Naivakarauniniu, Fiji.
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