Sexual and reproductive health during protracted crises and recovery

Escuela Andaluza de Salud Pública
CONSEJERÍA DE SALUD

WHO/HAC/BRO.2011.2

Sexual and reproductive health during protracted crises and recovery

World Health Organization

UNFPA

Escuela Andaluza de Salud Pública
CONSEJERÍA DE SALUD

© World Health Organization 2011

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press through the WHO web site (http://www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

This publication contains the collective views of an international group of experts and does not necessarily represent the decisions or the policies of the World Health Organization.

Printed in Spain

Table of contents

Acknowledgements v
List of acronyms vi

Introduction 1

Background paper 2

Introduction 2
Challenges and needs in sexual and reproductive health during protracted crises and recovery 2
Scope of sexual and reproductive health in crisis situations 2
Sexual and reproductive health interventions in emergency situations 5
Comprehensive sexual and reproductive health services 6
Planning for comprehensive reproductive health services 7
Different needs in different contexts 9
Constraints to comprehensive sexual and reproductive health services 9
Health system issues related to sexual and reproductive health 9
Service delivery 10
The basic package of health services 11
Health workforce 12
Information 12
Medical products, vaccines & technologies 13
Financing 14
Leadership 14
Humanitarian platform 15
Humanitarian reform 15
Prioritization of sexual and reproductive health interventions in the CAP process 15
Towards a framework for action 16
Comprehensive reproductive health services 17

Lessons learned from case studies on sexual and reproductive health in health recovery 23

Sexual and reproductive health service delivery 23
Use of the MISP 23
Priority to the MISP or comprehensive services 24
Information 24
Human resources 24
Medical products 25
Financing 25
Leadership and governance 25
General issues emerging from the case studies and conclusions 26

Report on the expert consultation held in Granada, 28–30 September 2009 28

Plenary sessions 28
Introduction 28
Framework on sexual and reproductive health during protracted crises and recovery 28
Purchasing and financing sexual and reproductive health services during protracted crises and recovery 29
Human resources for sexual and reproductive health during protracted crises and recovery 30
Field experiences 30
International funding and advocacy 31
Advocacy for sexual and reproductive health 32

Working groups 32
Service delivery 32
Health workforce 32
Assessment 33
Financing 34
Governance, policies and leadership 35
Closing remarks 36
Ministry of Health of Spain 36
Concluding remarks 36
Annexes
Annex 1. Agenda of the Consultation 37
Annex 2. List of participants 39
Annex 3. Sexual and reproductive health (SRH) including HIV: from minimum initial response to comprehensive services 47

Granada Consensus on sexual and reproductive health in protracted crises and recovery 42

From consultation to action 44

Granada Consensus points 44
Recommendations 45

Acknowledgements

A planning committee was established in the preparations for the Consultation. The members were: Iain Aitken, Laila Baker, Ivana Boko, Doreen Caroll, Henia Dakkak, Wilma Doedens, Laura Guarenti, Daniel López-Acuña ,Jemilah Mahmood, Maria Augustina Pando Letona, Chen Reis, Lisa Thomas, Dörte Wein and Nevio Zagaria.

The following case studies were prepared as background for discussion during the Consultation by the following people:

- Afghanistan: Iain Aitken, Management Sciences for Health and School of Public Health, Granada
- Côte d'Ivoire: Armand Abokon Kanon
- Democratic Republic of the Congo: Kyombo Mbela, University of Kinshasa, School of Public Health
- Liberia: Naomi Nyangetha Nyitambe, Reproductive Health Coordinator, Merlin
- Nepal: Indira Basnett, Country Director, Ipas, and Chie Nagata, intern, WHO
- Southern Sudan: Dragudi Buwa, Deputy Representative UNFPA

This publication has been edited by:

- Manuel Carballo, Executive Director, International Centre for Migration and Health
- Daniel López-Acuña, Director, Strategy, Policy and Resource Management, Health Action in Crises, WHO
- Jemilah Mahmood, Chief Humanitarian Response Branch, Programme Division, UNFPA
- Dörte Wein, Public Health Officer, Strategy, Policy and Resource Management, Health Action in Crises, WHO
- Nevio Zagaria, Coordinator, Strategy, Policy and Technical Development, Health Action in Crises, WHO

Several participants have kindly provided comments during the review of this publication.

List of acronyms

ART	Antiretroviral therapy
ARV	Antiretrovirals
CAP	Consolidated Appeal Process
CERF	Central Emergency Response Fund
CRHC	Comprehensive Reproductive Health in Crises Programme
CRS	Creditor Reporting System
DRC	Democratic Republic of the Congo
EC	Emergency contraception
EmONC	Emergency obstetric and newborn care
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
GDP	Gross Domestic Product
ICPD	International Conference on Population and Development
IDP	Internally displaced person
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
ODA	Official Development Assistance
PEP	Post-exposure prophylaxis
PLWHA	Person living with HIV
PMTCT	Prevention of mother to child transmission
SGBV	Sexual and other forms of gender based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TT	Tetanus toxoid
TTM	Traditional trained midwife
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

During a protracted crisis, the first priority is the provision of humanitarian relief. For the health sector, this means focusing first on life-saving activities. Only when the immediate needs of the affected populations are addressed can activities to strengthen the health system be initiated. At that moment, such activities become not only possible but also necessary. Strengthening the institutional capacity to pursue longer-term health development goals can begin while responding to humanitarian needs continues in parallel.

Conflict has a major impact on the entire health system. The first and most obvious effect is the destruction of infrastructure. Consequences also include reduced financial and human resources, as well as weakened capacity for policy-making. Health service delivery is often fragmented and uncoordinated because of the numerous nongovernmental organizations (NGOs) that have filled in the spaces vacated by the State. Furthermore, there is usually tension between the need to quickly achieve results and the need to ensure health system sustainability through capacity-building and planning.

There are clear existing strategies to provide health services during complex humanitarian emergencies. This is for example reflected in the development of the Minimum Initial Service Package (MISP). However, the provision of sexual and reproductive health services (SRH) and international assistance in the transition period that follows a conflict, particularly the transition from the MISP to comprehensive SRH services, is not as clearly defined.

Recognizing this gap in SRH service provision during protracted crises and recovery, the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the Andalusian School of Public Health convened a global consultation in September 2009 in Granada, Spain. The meeting brought together approximately 50 participants from countries in crisis or recovering from protracted crises, representatives from United Nations agencies active in health recovery, humanitarian partners from the Health Cluster providing health services in crisis situations, as well as academic experts and donors.

The consultation produced the "Granada Consensus", a statement that highlights four priority areas to be addressed in order to facilitate the sustainable provision of SRH services in protracted crises. It also agreed on a matrix to support decision-makers plan the progress from minimum initial response to comprehensive response for SRH services.

In order to promote the implementation of the Granada Consensus, WHO and UNFPA organized a follow-up meeting of 20 experts in July 2010 in Geneva, Switzerland. During this meeting, recommendations were made particularly on how international actors can best support countries for the promotion of SRH services.

The present publication is a compilation of the key documents that guided the consultation process as well as reports from the above mentioned meetings:

- The first part presents the background paper that was developed for the global consultation in September 2009, and the lessons learned from six case studies that had been prepared for the working groups during the Granada Consultation.
- The second part gives an overview of the proceedings of the Granada Consultation, summarizes the presentations and discussions and presents the key conclusions and recommendations.
- The last part (From consultation to action) presents the outcomes and recommendations of the follow-up meeting that took place in Geneva in 2010, and agreed on a strategy for the implementation of the Granada Consensus.

We hope that the outcome of the consultation, particularly the Granada Consensus, will be instrumental in gathering international support and political commitment for the sustainable provision of SRH services in countries in protracted crises and recovery. However, affected countries themselves will have to take responsibility for bringing the provision of SRH services at facility and community level forward.

Background paper*

INTRODUCTION

Sexual and reproductive health services in protracted crises and recovery have long been neglected. Maternal mortality seems to be higher in countries with recent conflict than in countries that have not experienced conflict. While the dangers to which women are exposed in pregnancy in conflict situations are not necessarily different from non-conflict situations, war or natural disasters jeopardize health systems to respond to these dangers. Pregnancy-related outcomes appear to depend primarily on the availability and use of SRH services.[1]

During the past 15 years, the coverage of SRH services in conflict situations has increased substantially. While in 1994 there were virtually no such services, in 1998 one could find programmes for safe motherhood and family planning. Since then the number of agencies offering SRH services has increased and their range of services provided has expanded.[2] However, today, there are still barriers to the full and effective implementation of these services. Case studies showed that even the Minimum Initial Service Package (MISP) for SRH in emergency situations often does not get implemented completely, and scaling up to more comprehensive SRH services does not seem to take place systematically.

One difficulty in the implementation of SRH services in protracted crises and recovery is the lack of a universal understanding of health recovery in general, not only in terms of SRH. WHO is currently in the process of developing a guidance note on health recovery for the Health Cluster, which will provide more insight into these issues. In addition, the report of the Global Consultation on Health Recovery in Transition, held in Montreux in December 2007, provides further information.[3, 4]

There is no one definition of recovery that is universally used. This section provides a working definition of recovery and protracted crisis to facilitate a common understanding for this Consultation. Recovery is the process of "restoration of the capacity of the government and communities to rebuild and recover from crisis and prevention of relapses. In so doing, recovery seeks not only to catalyze sustainable development activities but also to build upon earlier humanitarian programmes to ensure that their inputs become assets for development" (adapted from UNDP (DP/2001/14, Paragraph 48). There is no clear-cut boundary between the relief and the recovery periods. It is important to emphasize that the disaster-management cycle is an unbroken chain of humanitarian actions whose phases overlap.

While a natural disaster usually comes with an immediate prospect of recovery and reconstruction the transition is typically not clear during a prolonged conflict. The uncertainty as to the duration and outcome of the conflict often paralyses thinking about recovery. This often results in missed opportunities to work on recovery already during the conflict period.

One major challenge during protracted crises and recovery lies in the absence of technical assistance and knowledge for recovery planning and programming in affected countries. Often capacity building activities at national level addressing issues such as human resources and policy arrangements are inadequate. Moreover, the rush to return to normality in the absence of policies to direct recovery efforts can jeopardize the reconstruction process.

In protracted crises and recovery it is important to build systemic capacity for comprehensive service provision. A "system" is a set of interconnected components working together for the same purpose. An action affecting one component will affect all the others. Thinking "systemically" means anticipating and considering the systemic effects of actions targeting one or few system components. This approach underpins the framework of this background paper: SRH interventions need to be linked to health systems development actions, with the objective of dealing with SRH in an integrated and holistic way, as opposed to simply taking a vertical approach.

CHALLENGES AND NEEDS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES DURING PROTRACTED CRISES AND RECOVERY

Scope of sexual and reproductive health in crisis situations

More than a third of maternal deaths worldwide occur in fragile states.[5] When comparing 42 countries in Sub-Saharan Africa, O'Hare et al.[6] found the median adjusted maternal mortality rate in conflict settings to be 1000/100 000 births versus 690/100 000 birth in countries without conflict. Almost all 34 countries considered

* Prepared for the Global Consultation in 2009.

"fragile states" by the World Bank,[7] are on the priority list of the MDG5 countdown, which includes 68 countries.[8] Most of them are categorized as having "very high maternal mortality", ranging from 660 to 1800 deaths in 100 000 live births.[8]

TABLE 1. MATERNAL MORTALITY RATES IN PROTRACTED CRISIS AND RECOVERY SETTINGS (2008)[9]

Country	Maternal mortality rate (/100 000)
Sierra Leone	2100
Southern Sudan	2054
Afghanistan	1800
Angola	1400
Somalia	1400
Rwanda	1300
Liberia	1200
Burundi	1100
DRC	1100
Zimbabwe	880
Nepal	830
Côte d'Ivoire	810

These high mortality rates are related to a number of factors: a small proportion of deliveries are attended by a skilled health provider and women do not have access to emergency obstetric services, due to delays in recognizing the problem, lack of transport and delayed services once they reach a facility. Access to SRH services is particularly restricted for women and girls living in countries experiencing armed conflict or natural disasters.[10] Lack of access to emergency obstetrisc services leads to prolonged obstructive labours, which is the primary cause of obstetric fistula.[11, 12] Fistula can also be caused by trauma to the genital area through sexual and other forms of gender-based violence (SGBV), which will be discussed below.[13] If untreated, fistula leads in most cases to life-long isolation, shame and stigma.

Family planning is another important component of safe motherhood. Unmet needs for family planning pose a problem, as they may lead to unsafe abortions, which frequently result in complications or death.[14] An evaluation in conflict affected sites showed that 90% of sites have at least one method of family planning available; however, intrauterine devices (IUDs) are available on only half of the sites and implants are not even mentioned.[15] In addition to intermittent supply of contraceptives, few staff are trained in family planning or might be reluctant to promote a high profile family planning service.[16] Even where contraceptives might actually be available over the counter, they may not be affordable; also, in some cultures pharmacists may also refuse to sell contraception to younger or non-married women.[17]

Other sexual and reproductive health issues important in crisis situations are SGBV and sexually transmissible infections (STI) and HIV prevention and treatment. Violence, especially intimate partner violence and sexual violence against women and girls is increasingly documented in crisis settings. Macklin[18] cites displaced women in Southern Sudan who "fear rape by militia, rape by men who distribute aid in exchange for sex and rape by husbands who demand that they replace dying children…". The risk of SGBV can be increased for internally displaced people (IDPs) due to crowded conditions, separation from their family as well as trauma and alcohol abuse.[16] Studies showed that between 23 and 44% of women have experienced intimate partner violence in crisis settings such as Uganda, Thailand and Columbia[19] About one in four women experienced violence by someone outside their family during the conflict in Timor-Leste; after the crisis, displacement to a camp showed a significant association with SGBV.[20]

In armed conflict rape also is often used as a means of intimidation or ethnic cleansing.[10] In Rwanda, the Democratic Republic of the Congo (DRC) and Darfur deliberate and widespread use of rape as a means to control and demoralize the population has been employed.[19] This means that SGBV in conflict settings can result from the breakdown in social and moral systems, but can also be systematic and commanded or condoned. International courts now recognize rape as a war crime. However, women are likely to be reluctant to report cases due to lack of personal security, lack of adequate services as well as shame and stigma.[16, 17]

While some characteristics of conflict settings, such as increased prevalence of casual or commercial sexual activity, increased interactions among civilians and combatants or military personnel, as well as sexual violence

as mentioned above, suggest the possibility of a high transmission of HIV, HIV seems to be often overestimated in conflict settings. Instead, most countries that have experienced conflict appear to have lower levels of HIV infection than those that have experienced relative peace. As documented in Burundi, Sierra Leone, Rwanda, DRC and other countries the absolute HIV prevalence has not increased significantly.[21, 22] This indicates that exposure opportunities may in fact be lower during conflict. However, when conflict subsides, exposure opportunities may increase, which might lead to an increased transmission of HIV.[23] Widespread rape may still pose an increased risk to a woman's acquisition of HIV on an individual basis. Attention to HIV prevention should therefore be part of SRH services in recovery.

Sexual and reproductive health needs of adolescents also require attention in protracted crises and recovery. While children have been recognized as vulnerable in conflict settings, adolescents are less the focus of attention even though STIs, unplanned pregnancies and unsafe abortion have been identified as major health risks for this age group.[24] Conflict settings can deprive adolescents of their traditional social structures, making them more vulnerable to sexual abuse and exploitation. There is often an increase of unprotected sex, early pregnancies, sexual exploitation and the spread of STIs in crisis settings.[19] Moreover, there is indication that young unmarried women face barriers to accessing SRH services due to their social status.[25]

Three of the eight Millennium Development Goals (MDGs) are directly related to SRH: reducing child mortality, improving maternal mortality and combating HIV, malaria and other diseases. In 2007, universal access to reproductive health by 2015 has been added as New Target 5b. The indicators for this target are the following:

1. adolescent birth rate;
2. antenatal care coverage;
3. unmet need for family planning;
4. contraceptive prevalence rate.

Many low income countries will not achieve the MDG health targets by 2015, those countries that have the worst health status being least likely to make considerable progress.[26] Countries in protracted crises and recovery are particularly concerned.

As discussed in the previous section, SRH is challenged in a number of ways in protracted crises and recovery, which can be divided into two categories. First, there are additional factors such as SGBV and sexual exploitation that increase the risk of STIs, unplanned/unwanted pregnancies and abortions. Second, the health system does not have the capacity to respond to the need of pregnant and childbearing women. While health problems in conflict situations and health service strategies during the acute humanitarian emergencies have been well developed, strategies for effective international assistance in transition periods, including for SRH are not yet well established.[27]

During protracted crises and recovery there seem to be tensions between development-oriented agencies and governmental entities and emergency-oriented service providers, the first aiming at comprehensive SRH services, and the latter focusing on saving lives. Even in conflict the acute emergency phase is relatively short lived. For this reason the recovery approach, which tries to bridge this gap, needs to be taken into account by all partners.

BOX 1. SEXUAL AND REPRODUCTIVE HEALTH ISSUES
IN PROTRACTED CRISES AND RECOVERY

- High maternal mortality due to lower number of attended deliveries;
- Unmet needs for family planning, being either unavailable or non affordable, leading to unsafe abortions;
- Increased risk of sexual and other forms of gender-based violence due to breakdown in social and moral systems or due to systematic use as a means to control populations;
- Transmission of HIV possible to increase when crisis subsides; rape as risk factor for HIV transmission;
- Lack of sexual and reproductive health services targeting adolescents despite adolescents being deprived from traditional social structures in conflict settings.

Box 1 captures the main SRH issues in protracted crises and recovery. The following sections discuss the response to SRH needs in emergency and recovery situations.

Sexual and reproductive health interventions in emergency situations

The Minimum Initial Services Package for Reproductive Health in Crisis Situations (MISP) is a coordinated set of priority activities designed to prevent and manage the consequences of SGBV, reduce HIV transmission and prevent excess maternal and newborn morbidity and mortality in acute humanitarian settings. The package was first formulated in the 1999 *Reproductive health in refugee situations: An inter-agency field manual* and was recognized as a Sphere standard in 2004 as a priority intervention to be implemented at the onset of every new emergency.

While there are some publications regarding single interventions which are part of the MISP, the little literature available regarding the implementation of the MISP as a whole consists mainly of grey literature. These publications indicate that there is still a need to institutionalize the MISP in humanitarian crises.

Experiences from different settings, including Indonesia after the tsunami, Kenya, Myanmar, Jordan but also protracted crises such as DRC, Darfur and Timor-Leste showed that health staff did not always know about the MISP, particularly its activities and objectives and even when awareness had risen, the MISP was not fully implemented. This seemed to be due to managerial and policy barriers but also donor influence. Often, components of the MISP were not adequately provided, due to lack of supplies, equipment and skilled staff; some components, such as HIV were not considered an emergency issue, or condoms were not considered to be culturally appropriate. It was further observed that other components, which are not part of the MISP, such as ante natal care were prioritized before the entire MISP was implemented. SGBV and HIV seem to be particularly sensitive issues, leading to insufficient implementation of protection from SGBV and standard precautions of HIV. Emergency obstetric care (EmOC) and referral systems were often not in place. Overall, the implementation of the MISP seems to be limited in most crisis situations. Underlying reasons appear to be lack of awareness among humanitarian actors and donors, but also different priorities and the belief of some humanitarian actors that the MISP should not be implemented until the situation stabilizes. The degree to which MISP is implemented varies considerably per site.[16, 28, 29, 30, 31] Furthermore, not all agencies seem to use the MISP to guide their activities, but define their own packages of SRH to be provided in emergencies, such as the "SRH Core package of activities in MSF projects".[32] This package includes a much wider range of SRH services than the MISP. Box 2 provides an overview of the SRH services included in the MISP.

BOX 2. SCOPE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES INCLUDED IN THE MISP (CURRENTLY BEING REVISED, NOT YET PUBLISHED)

1. Prevent and manage the consequences of sexual violence:
    - Put in place measures to protect affected populations, particularly women and girls, from sexual violence
    - Make clinical care available for survivors of rape
    - Ensure the community is aware of the available clinical services
2. Reduce the transmission of HIV by:
    - Ensure safe blood transfusion practice
    - Facilitate and enforce respect for standard precautions
    - Make free condoms available
3. Prevent excess maternal and neonatal mortality and morbidity by:
    - Ensure availability of emergency obstetric and newborn care services (EmONC) including:
    - skilled staff and supplies to facilitate skilled attendance at births in health facilities,
    - skilled staff and supplies to manage obstetric and newborn emergencies,
    - a referral system to facilitate transport and communication from the community to the health centre and between health centre and hospital,
    - clean delivery kits for visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

Note: Ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child-transmission.

Comprehensive sexual and reproductive health services

One component of the MISP is planning for comprehensive SRH services.[33] While it is necessary to prioritize the MISP activities before providing comprehensive SRH services, planning and implementation of comprehensive SRH services should begin when the humanitarian planning process moves from short term (Flash Appeal) to longer-term (CAP, etc.); implementation should begin incrementally as soon as the MISP is assured.

Since the International Conference on Population and Development (ICPD) in 1994, governments and NGOs have faced the challenge to implement the new agenda of comprehensive SRH on the ground. There exist few models from resource poor settings, and even less from post-conflict settings for providing these services, indicating the need for a common understanding of both comprehensive SRH services and the planning process itself.

There is general agreement on certain services to be included as comprehensive SRH service provision, which are also proposed by the MISP as comprehensive SRH services. However, there is some discrepancy regarding abortion (safe abortion or only post-abortion care after unsafe (illegal) abortion) and SGBV (only medical response or prevention and management). Abortion and SGBV are both politically and culturally sensitive topics, which might explain this discrepancy. Further, services for HIV/AIDS lack specificity (only standard precautions, prevention of mother to child transmission (PMTCT), only free condoms, or also antiretrovirals). Finally, adolescents' SRH services are increasingly demanded by advocates but this group is not automatically included in the list of comprehensive SRH services. Infertility treatment is mentioned by the ICPD but not discussed in crises settings.

It is also necessary to look at what is considered comprehensive in national planning processes as well as at the implementation phase. Overall, it seems that the term comprehensive SRH is used very differently by different actors and countries. It seems that the comprehensive definition has been used mainly in developing national strategy documents, while at the operational level, each country has tackled the elements where improvement seemed most likely.[34] Moreover, there does not necessarily seem to be agreement on what is meant by SRH. There appear to be barriers to linking SRH and HIV,[35, 36] or SRH and family planning, as was the case in Bangladesh.[37]

There is a range of lists with various SRH services prioritized in different countries. Priorities seem to be different in non-conflict settings, where services such as infertility or menopausal treatment seem to be often included in the list, and post-conflict settings, where SGBV receives more attention. However, it is also considered appropriate that service delivery models proven among settled populations should continue to be adapted for refugees, including issues such as fertility, family planning, safe motherhood, STIs and HIV and SGBV.[38]

Comparison of different national strategies for SRH show that each country (both conflict and non-conflict) includes some of the services highlighted in the MISP definition of comprehensive services but leaves out others and adds different ones. For example, in India, nutrition, gynaecological problems and breast cancer are part of the comprehensive list, while HIV treatment, SGBV and EmOC are not mentioned.[39, 40] Similarly, priority areas in Pakistan, Bangladesh or Thailand do not include HIV treatment and management of SGBV, but Pakistan and Thailand do include infertility and menopausal services.[37, 41, 42, 43] The WHO-UNFPA-UNICEF-World Bank Joint country support plan aims at ensuring universal access to reproductive health, focusing on family planning, ante-natal care, skilled attendance and delivery, EmOC, as well as linkages with HIV/AIDS treatment and prevention, but does not mention SGBV.[44]

After a consultation process in 2008 and the beginning of 2009, the Global Health Cluster agreed upon a health service check list (see Table 2), which should be available in protracted crises and recovery. This checklist includes all MISP and additional SRH (see Box 3).

This list needs to be taken as a framework for both, scaling-up of the minimum response during protracted crises and recovery as well as the expansion to comprehensive SRH services according to the specific country situation and health system challenges.

TABLE 2. HEALTH SERVICE CHECK LIST
GLOBAL HEALTH CLUSTER, 2009

	Health sub sectors		Health Services (RH MISP Services in bold)		Yes / No
C. Community Care	C0	Collection of vital statistics	C01	Deaths and births	
			C02	Others: e.g. population movements; registry of pregnant women, newborn children	
	C2	Child health	C21	IMCI community component: IEC of child care taker + active case findings	
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute diarrhoea	
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/treatments	
	C3	Nutrition	C31	Screening of acute malnutrition (MUAC)	
			C32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	
			C33	Community therapeutic care of acute malnutrition	
	C4	Communicable diseases	C41	Vector control (IEC + impregnated bed nets + in/out door insecticide spraying)	
			C42	Community mobilization for and support to mass vaccinations and/or drug administration/ treatments	
			C43	IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others)	
	C5	STI & HIV/AIDS	C51	Community leaders advocacy on STI/ HIV	
			C52	IEC on prevention of STI/HIV infections and behavioural change communication	
			C53	**Ensure access to free condoms**	
	C6	Maternal & new-born health	C61	Clean home delivery, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioural change communication, knowledge of danger signs and where/when to go for help, support breast feeding	
	C8	Non communi-cable diseases, injuries & mental health	C81	Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems	
	C9	Environmental health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities	
P. Primary Care	P1	General clinical Services	P11	Outpatient services	
			P12	Basic laboratory	
			P13	Short hospitalization capacity (5-10 beds)	
			P14	Referral capacity: referral procedures, means of communication, transportation	
	P2	Child health	P21	EPI: routine immunization against all national target diseases and adequate cold chain in place	
			P22	Under 5 clinic conducted by IMCI-trained health staff	
			P23	Screening of under nutrition/malnutrition (growth monitoring or MUAC or W/H, H/A)	
	P3	Nutrition	P31	Management of moderate acute malnutrition	
			P32	Management of severe acute malnutrition	
	P4	Communicable diseases	P41	Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARS)	
			P42	Diagnosis and treatment of malaria	
			P43	Diagnosis and treatment of TB	
			P44	Other local relevant communicable diseases (e.g. sleeping sickness)	
	SEXUAL & REPRODUCTIVE HEALTH AREA	P5 STI & HIV/AIDS	P51	Syndromic management of sexually transmitted infections	
			P52	**Standard precautions:** disposable needles & syringes, safety sharp disposal containers, Personal Protective Equipment (PPE), sterilizer, P 91	
			P53	**Availability of free condoms**	
			P54	Prophylaxis and treatment of opportunistic infections	
			P55	HIV counselling and testing	
			P56	Prevention of mother-to-child HIV transmission (PMTCT)	
			P57	Antiretroviral treatment (ART)	
		P6 Maternal & newborn health	P61	Family planning	
			P62	Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition & breastfeeding, self care and family planning, preventive treatment(s) as appropriate	
			P63	Skilled care during childbirth for **clean and safe normal delivery**	
			P64	**Essential newborn care:** basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breastfeeding	
			P65	**Basic emergency obstetric care (BEmOC):** parenteral antibiotics + oxytocic/anticon-vulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery **24/24 & 7/7**	
			P66	Post partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, promote family planning	
			P67	Comprehensive abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion com-plications, counselling for abortion and post-abortion contraception	
		P7 Sexual violence	P71	**Clinical management of rape survivors** (including psychological support)	
			P72	**Emergency contraception**	
			P73	**Post-exposure prophylaxis (PEP) for STI & HIV infections**	
	P8	Non communi-cable diseases, injuries & mental health	P81	Injury care and mass casualty management	
			P82	Hypertension treatment	
			P83	Diabetes treatment	
			P84	Mental health care: support of acute distress and anxiety, front line management of severe and common mental disorders	
	P9	Environmental health	P91	Health facility safe waste disposal and management	

	Health sub sectors		Health Services (RH MISP Services in bold)		Yes / No
S. Secondary & Tertiary Care	**S1**	**General clinical services**	S11	Inpatients services (medical, paediatrics and obstetrics and gynaecology wards)	
			S12	Emergency and elective surgery	
			S13	Laboratory services (including public health laboratory)	
			S14	Blood bank service	
			S15	X-Ray service	
	S2	**Child health**	S21	Management of children classified with severe/very severe diseases (parenteral fluids and drugs, O2)	
	S6	**Maternal & newborn health**	S61	**Comprehensive emergency obstetric care:** BEmOC + caesarean section + **safe blood transfusion**	
	S8	**Non communi-cable diseases, injuries & mental health**	S81	Disabilities and injuries rehabilitation	
			S82	Outpatient psychiatric care and psychological counselling	
			S83	Acute psychiatric inpatient unit	

BOX 3. SEXUAL AND REPRODUCTIVE HEALTH SERVICES INCLUDED IN THE HEALTH SERVICE CHECKLIST, GLOBAL HEALTH CLUSTER, 2009

1. Syndromic management of STIs
2. Standard precautions
3. Availability of free condoms
4. Prophylaxis and treatment of opportunistic infections
5. HIV counselling and testing
6. Prevention of mother to child transmission
7. Antiretroviral therapy
8. Family planning
9. Antenatal care
10. Skilled care during child birth for clean and safe normal delivery
11. Essential newborn care
12. Basic emergency obstetric care
13. Post partum care
14. Comprehensive abortion care
15. Clinical management of rape survivors
16. Emergency contraception
17. Post-exposure prophylaxis for STI & HIV infections

Planning for comprehensive reproductive health services

The Women's Commission for Refugee Women and Children defines planning for comprehensive SRH services as activities that must be undertaken to expand MISP services when the situation stabilizes, prioritizing the collection of data regarding morbidity and mortality, identification of sites where SRH services can be delivered in the future, assessment of staff capacity and planning of training, as well as the identification of SRH supplies.[45] It also indicates specific services that should be provided as comprehensive SRH. However, as discussed above, this is not a universally agreed list.

Planning for comprehensive SRH services is not only a challenge in post-conflict settings, but in resource-poor countries in general. India recognized that its health system was not capable of implementing comprehensive services everywhere at the same time. For this reason, an "essential package" was defined to be implemented nationwide, while a "comprehensive package" only had limited application in selected urban areas, highlighting the incremental addition of services in a phased manner and a detailed plan about staff training and gradual expansion of (laboratory) facilities.[39]

It is also not evident that there is agreement about the need to plan for comprehensive RH services so soon in a post-conflict setting. Some authors advocate for a targeted implementation of priority programmes in Timor-Leste.[46] Similarly, Merlin focuses on an "Essential package of maternal care", which includes EmOC, post-natal care and family planning,[47] USAID and CARE implemented a Family Planning Project in DRC[48] and the IPPF, while acknowledging that crisis situations require a comprehensive SRH response, focus on family planning and safe abortion services.[49] This indicates that one challenge to the planning and implementation of comprehensive SRH may be the vertical nature of programmes, as historically competing bureaucracies in family planning, maternal and child health, gender and HIV are not easily unified as SRH.[16]

Different needs in different contexts

There is not always a linear transition from MISP to comprehensive SRH services. Often times, a crisis can hit a country where previously comprehensive SRH services have been provided. In this case the challenge lies in sustaining these services. While in settings such as Darfur or DRC, the lack of SRH services and the inadequacy of the health system reflect a chronic situation, the situation is of more transient and temporary nature in conflicts as seen in Lebanon or Georgia. In the latter, it is important to be able to provide the same services that had been available before the conflict as soon as possible, while in protracted crisis, one needs to assure the minimum services first. This means that the health system needs for SRH service provision differ depending on the crisis context.

Constraints to comprehensive sexual and reproductive health services

Planning and implementation of comprehensive SRH services still faces some barriers, not only in post-conflict settings. These barriers include bureaucratic divisions and poor communications between health and women's affairs, health providers' attitudes (who are often underpaid and overworked), inadequate attention to social context and governments' reluctance to confront controversial issues. Even more important are inadequacies in the health system with weak infrastructure and lack of qualified human resources, lack of national systems for reporting and accountability. Moreover, improvement of service delivery requires training and retraining of personnel, which is time consuming.[2, 34, 40] This is one of the underlying reasons for the gaps seen in STI/HIV and SGBV management, as well as the implementation of components of comprehensive SRH services before assuring the full implementation of the MISP.

There is a need for a definition of comprehensive SRH services and how to manage the transition from the MISP to gradually expand to comprehensive SRH, in situations where services were inadequate before the crisis, as well as how to reach the previous situation in countries that had provided comprehensive SRH services. Filling the gaps in SRH will require strong policies. It should not focus on project level only but on health system strengthening, addressing issues such as stock shortages, training and supervision of staff and monitoring.

HEALTH SYSTEM ISSUES RELATED TO SEXUAL AND REPRODUCTIVE HEALTH

After extensive destruction, recovery may offer a unique opportunity to reconsider the whole of the health sector and plan it on a comprehensive, rational basis. In some instances, large amounts of capital become available to address the lack of resources or major allocative distortions; the atmosphere of change may reduce resistance aimed at preserving the status quo; massive destruction and dilapidation make the abandonment of unwanted facilities easier. Thus, building an equitable and sustainable (in the long term) health system may become a realistic, although difficult target.[50]

While it is important to focus on a defined set of interventions to be provided during an acute emergency, as defined by the MISP, it is necessary to then plan for enabling elements within the health system that allow the sustainable provision of comprehensive SRH services in the long term. Major constraints to improving SRH service delivery are human resources, drugs and supply and information systems.[51, 52]

While the immediate health needs in crises require quick inputs and urgent actions, it is important to incorporate this fast response into a systematic medium and long-term response in order to guarantee a successful reconstruction of the national health system. This means, that fast relief responses need to be accompanied by the simultaneous anticipation of future policies and programmes to develop an efficient and equitable health system in order to guarantee that good quality services are consistently available and accessible and are sustainable.[53]

This section shows the importance of developing a coherent policy framework to coordinate recovery efforts using a health systems approach during protracted crises and recovery. Strengthening of the entire health system is a prerequisite for success in specific priority areas.

WHO has defined six building blocks that make up a health system:

1. service delivery;
2. health workforce;
3. information;
4. medical products, vaccines and technologies;
5. financing;
6. leadership and governance (stewardship).

These distinct blocks help clarify essential functions of a health system. However, they require an integrated approach, taking their interdependence into consideration.[54] The following gives an overview of the six building blocks of health systems and their implications for SRH.

Service delivery

SRH services are not uniformly provided in protracted crises and recovery. As discussed in the previous section, family planning, antenatal care and condom distribution seem to be the most established and first to be adopted services. Areas of more concern are response to SGBV, emergency obstetric care, service provision for adolescents and STI services other than condom distribution.[19]

Scaling-up of services after acute crisis has two dimensions. On the one hand, it involves the scope of services, on the other hand the coverage of service availability. An assessment of the availability of EmOC in protracted crises and post-conflict settings as well as in refugee camps in stable settings showed that most health facilities lack adequate infrastructure, essential medicines, equipment and supplies, qualified staff as well as gaps in communication and emergency transport systems and insufficient data collection.[55] This indicates that both dimensions require mechanisms of the entire health system to be improved.

Gericke et al.[56] highlight the importance of intervention complexity in expanding access to and utilization of, health interventions. By intervention complexity they mean the quality and quantity of non-financial resources required to implement and sustain an intervention – such as the availability of skilled human resources.

The Countdown to 2015 for maternal, newborn and child survival showed that in 2008 interventions for maternal health that can be routinely scheduled, such as antenatal care, had much higher coverage than those that rely on functional health systems and 24-hour availability of clinical services, such as skilled or emergency care at birth and care of ill newborn babies;[8] this underlines the relevance of intervention complexity. Gericke et al.[56] identified four areas of intervention complexity: intervention characteristics, delivery characteristics, government capacity and usage characteristics. Based on the literature on SRH services provision in both post-conflict and non-conflict settings, possible barriers might include the following:

TABLE 3. INTERVENTION COMPLEXITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES (ADAPTED FROM GERICKE ET AL.[56])

Intervention complexity	Requirements for sexual and reproductive health services
Intervention characteristics (stability of product, ease of storage, equipment issues)	• Storage of post-exposure prophylaxis (PEP) and emergency contraception (EC) • Use and equipment of manual vacuum aspiration (MVA), vaccines (cold chain)
Delivery characteristics (requirements for facilities, human resources, transport, communication)	• Trained staff for basic EmOC • Referral system for complications • Water, electricity • 24/7
Government capacity (legislative and regulatory capacity)	• Legal and safe abortion, management of complications after abortion
Usage characteristics (ease of usage, pre-existing demand for intervention)	• SGBV services, skilled birth attendance, referral/transport

Oftentimes, initiatives addressing SRH have a strong service-specific focus with separate planning, staffing and financing systems that do not work through existing health system structures.[26] In crises and recovery situations where health systems are weak, this is even more likely to happen. However, concentrating on disease priorities may compromise already weak systems.[26]

While priorities should not be abandoned, they should not be tackled by parallel approaches but by taking a system-wide perspective, as parallel approaches run the risk of:

- duplication (parallel drug delivery, increased number of forms to be filled out by health workers…);
- distortion (training of staff in specific areas – may lead to less attention to other key areas);
- disruptions (uncoordinated training of staff takes them away from their job etc.);
- distractions (uncoordinated reporting and training etc.) .

In contrast, a systemic approach, which addresses the health system as a whole instead of focusing on single interventions tackles the root causes with potentially long-term improvements in coverage and quality of care.[26]

The basic package of health services

The definition of a basic package of health services implemented either by public service providers or by NGOs may play an important role in service delivery in health recovery. These packages are a limited list of public health services at primary and secondary level; they suggest a guaranteed minimum of services to be provided, therefore supposing that human resources, drugs and equipment for these services are available. During the past years, this concept has been adopted by a number of countries.

Roberts et al.[57] see a number of risks for the availability and quality of SRH services, particularly services in the case of SGBV and services for adolescents, as they claim that these services are usually not included in basic packages. However, as presented in Table 4 below, most basic packages include services for SGBV victims as well as sexuality education in school and out of school programmes. This means, in most countries, from a policy making point of view, these issues seem to be mostly taken into consideration. Yet, one needs to look at the actual implementation of these policies, as for example, obstetric care remained limited in Afghanistan, despite being part of the basic package.[57] Overall, it is important that the basic health packages, which guide the health service implementation in protracted crises and recovery adequately incorporate core SRH services and that they further include clear guidance on how these services will be implemented.

TABLE 4. REPRODUCTIVE HEALTH IN DIFFERENT HEALTH SERVICE PACKAGES
(STI & HIV, MATERNAL HEALTH, SEXUAL VIOLENCE)

Country	SRH content of basic package
Afghanistan[58]	• STI/HIV education for adolescents
	• Antenatal care • Delivery care (EmOC/ referral) • Postpartum care • Family planning • Care of the newborn
Southern Sudan[59]	• HIV/AIDS control
	• Reproductive health promotion (safe motherhood, including safe pregnancy and family planning) • EmONC and free MNRH services including Caesarean sections • HIV prevention and control, as well as condom use promotion and social marketing • Sexuality and maternal, neonatal and reproductive health teaching for young people in out-of-school activities
	• Awareness activities for SGBV (clinical staff and mass media), clinical care, rape kits, PEP
Uganda[60]	• HIV prevention and control (standard precautions not specified), safe blood transfusions, condom use promotion
	• Management of obstetric emergencies, operationalization of EmOC services at HC III, IV and hospital level, referral for high risk pregnancies, family planning • Sex education, counselling and life skills in schools
	• GBV prevention and control, integrated strategy on GBV in the health sector
Liberia[61]	• STIs education for adolescents, STIs/HIV control, PEP, condoms promotion and distribution
	• Antenatal care, labour and delivery care, management of pregnancy complications, including incomplete or complicated abortions, emergency obstetric care, postpartum care, newborn care, family planning, family planning for adolescents, referral system
	• Mental health support for rape or other sexual assaults as well as rape exam
Nepal (not a basic package)	• Awareness raising on STI/HIV/AIDS among everyone, especially government officials and migrants • Prevention of heterosexual transmission of HIV by promoting safe sexual activity through advocacy and condom promotion • Promotion of health-seeking behaviour among STI patients, skilled manpower & services • Provision of hospitals and other institutions services for people living with HIV/AIDS • Education for family and community members to provide all possible support and care to people living with HIV/AIDS

Country	SRH content of basic package
Nepal (not a basic package)	• Universal precaution and proper disposal of instruments and equipment (e.g. syringes) • Family health • Maternal health care services, including family planning • Quality and consistent care during pregnancy and childbirth • Antenatal, delivery, postnatal and neonatal care (health staff trained on essential obstetric care)
	• Referral systems between peripheral health facilities and district hospitals • Advocy for legal reforms that would reduce the incidence of maternal deaths resulting from factors such as unsafe abortions and early marriages • Distribution of iron tablets to reduce anaemia in pregnant women • Increased coverage of TT2 immunization for women of reproductive age • Infertility management

Contracting

Governments are usually the major providers of SRH services. However, the non-governmental sector may play a vital role in expanding access to quality SRH services through its resources, expertise and infrastructure. For this reason, governments often contract with non-governmental providers to deliver health services in order to expand coverage and improve quality of care.[62] Contracting-out implies the mechanism of purchasing a specific service at an agreed-on price from a specific provider for a specified period. The rationale behind contracting-out for health services is the assumption that health services delivered by the public sector may not reach the entire population. Contracts that set clear expectations and predefined objectives for providers are supposed to improve efficiency, quality and cost-effectiveness of health services delivery.[63] This strategy was first applied in Cambodia, later, among others, in Afghanistan, Rwanda, Timor-Leste and Haiti and more recently in Southern Sudan and Liberia.

NGOs can play an important role in SRH service delivery, reaching relatively high coverage.[64] Governments have contracted-out for virtually all areas of SRH. Most common are family planning and maternal care; in Bangladesh abortion-related care and in Colombia emergency obstetric care have also been contracted-out, but contracting for these services are rare.[65] Instead, NGOs often limit their service provision to ante-natal care, skilled attendance, tetanus toxoid vaccinations, post-natal check-up and modern contraception. Studies assessing maternal and child health usually only analyse this set of services.[64, 66]

Experiences in Afghanistan suggest that the use of contracting for basic health service provision is appropriate in the short term. Findings from Afghanistan and Cambodia support the idea that the establishment of a basic package of health shapes sector priorities and influenced allocation of resources towards primary healthcare.[67, 68] The implementation of a basic package by contracting out seemed to improve coverage within the contracted districts; this seemed to be particularly the case for SRH services, as for example in Cambodia coverage of antenatal care increased more than four times.[67] However, the question of sustainability in the medium to long term has been raised.[69] Standardization for ensuring quality of service delivery is another issue.[70] Moreover, the mechanism of contracting out health services requires a strong regulatory and enforcement capacity within the government.[68] Contracting has become more and more popular during the past years, but this popularity is based on theoretical advantages rather than on evidence of its effectiveness, while lacking evidence particularly in terms of quality and efficiency.[71] Contracts may have advantages as the basis for health service delivery in theory, in practice it is not clear that these advantages will be realized where infrastructural pre-conditions are absent.[72] This needs to be taken into account particularly in fragile states. Specific skills are needed for the management of contracts at all levels. Particularly, if the process of contracting is used to respond to a crisis with civil service retrenchment and public expenditure cuts, it is unlikely that adequate consideration will be given to the development of such skills and the retention of key personnel.[72]

Where contracts subsume SRH within a broader set of services, this poses the risk that contractors neglect SRH care, indicating the need for adequate monitoring.[65] This is important to keep in mind, as most interventions involve the provision of a combination of primary heath care services, including maternal health, child health and treatment of high prevalence diseases, with little information about the coverage for SRH services.[63]

Health workforce

Prolonged conflict has major negative effects on a country's health workforce, such as an imbalanced composition of health workers, deteriorating skills and training capacities along with different types of health staff who have been trained in different settings with different competencies.[73] The majority of health workers are in need of intensive and sustained retraining and skill upgrading after a protracted crisis.[74] The lack of qualified staff and its uneven distribution is one major obstacle to the provision of SRH services, contributing to inadequate SRH services and high maternal mortality and morbidity rates in most low-income countries; this situation is aggravated in crisis settings.[75]

One important reason for the shortage of skilled health workers besides death, migration and relocation during the crises, is the disruption of education and professional training and loss of qualified teachers. The training network is often disrupted by conflict due to closure or destruction of training facilities in unsecure areas and underfunding of remaining facilities. Further, training standards are often low.[74] The (re-) establishment of a human resource system is often undermined by a concentration on provision of ad hoc in-service trainings and employment of health workers in parallel to the health system. This parallel system of training health workers for specific tasks may lead to distortions to the health system by creating a cadre of health workers with very specific tasks. Further, uncoordinated trainings may not only disrupt work by taking health workers away for training but it may lead to a large number of different categories of health workers trained to meet immediate needs by different NGOs and donors.[26, 76] While ad hoc trainings in a vertical way might be the only possibility during acute emergencies, it will be important to have a more integrated and sustainable approach during protracted crises and recovery, particularly, as short term emergency approaches may have a negative impact on the human resources at a later stage.[73]

Smith at al.[73] list a number of steps to take in order to (re-)establish human resources in a post-conflict setting, adopting a development approach rather than a short-term emergency approach. These steps include the identification of available staff, development of human resource management structures, and clarifying roles and responsibilities. These steps apply to SRH and should be adopted instead of planning project based in-service training.

Task shifting

Another strategy to improve access to health care services and to overcome shortage in staff is task shifting: training less costly health workers to provide health service delivery tasks. Already in the 1990s, midwives in Ghana were trained to perform manual vacuum aspiration to control uterine bleeding and in Mozambique medical doctors trusted trained assistant medical officers to conduct certain surgical tasks.[77] A similar strategy was applied in Eastern Burma, where health workers were trained in basic emergency obstetric care, blood transfusion, antenatal care and family planning. These "maternal health workers" subsequently trained local health workers and traditional birth attendants in their communities on a sub-set of these services. The rationale for this rather vertical approach is the lack of a functioning health system in Burma, rendering the emphasis on facility-based delivery with skilled attendants unfeasible.[78]

It needs to be assessed whether this strategy is more of a short term solution or whether it has the potential to contribute to long-term health system strengthening. For this, political and financial commitment, and ensuring a regulatory framework is required.[79] Lack of country-level coordination of health training among donors, partners, ministries and other actors can impede successful implementation of task shifting; it needs to be aligned with the broader strengthening of the health system in order to be successful.[80, 81] This was observed in South Asia, where task shifting of anaesthesia has been effective in improving access to emergency obstetric surgery. But these programmes were not part of an overall human resource strategy.[82]

Information

A functioning health information system should ensure reliable and timely provision of information about health determinants, health systems performance and health status at all levels of the health system.[54] This system however deteriorates during a protracted crisis with data collection closing down or becoming dysfunctional and therefore meaningless. At the same time, most aid agencies launch their own information collection initiatives, often not disseminating or sharing the information.[83] As a result, in protracted crises and recovery there is often no information system as such, but rather a number of information storage by each agency. Instead of continuing this separate collection of information, efforts need to be made to build up a national health system, and SRH information needs to be integrated into this overall health information system.

Medical products, vaccines & technologies

The provision of reproductive health commodities faces several challenges such as increasing demand, insufficient and poorly coordinated donor funding and inadequate logistic capacity in the countries, not only in crisis settings. Supply not only depends on the availability of commodities, but also on a country's capacity to forecast, finance, procure and deliver them.[84] This is further challenged by a sharp decline in donor funding since 1993.[85] In order to improve this situation, an increase in funding as well as lower unit costs is required. Further, the delivery system needs to be strengthened, supported by better donor and country coordination and possibly pooled procurement. Existing logistic systems often separate contraceptives from other supplies, which in the long term will not be efficient.

In addition to the supply system, it is also important to have a consensus regarding the commodities to be included in an essential list of supplies during the recovery phase. While comprehensive lists of SRH commodities with an exhaustive inventory of required supplies and equipment exist, they do not set priorities, as would be important in crisis settings and recovery. A survey in 2000 conducted by Population Action International showed that most contraceptive supplies are considered to be essential by implementers. Other services include condoms for STI/HIV prevention, Information, education and communication materials, material to diagnose and treat STIs, emergency contraception as well as manual vacuum aspiration for abortion and post-abortion care.[86]

Reports by UNFPA from post-conflict settings such as Côte d'Ivoire and Liberia showed that the situations, which developing countries face in terms of SRH commodities are further complicated by lack of warehouse facilities to store supplies safely and manage them accountably and weaknesses in supply chain management. Further, the capacity for logistics and operations management does not seem to be adequate in crises settings, requiring training in order requisitioning processes, warehousing and inventory standards and transport management.[87, 88]

Financing

The main reasons that prevent people from seeking health care in any subsystem are financial; in order to achieve equity within health systems, the scale and the distribution of public health expenditure are of importance.[89] In (post-) conflict settings most of the time there is no national health financing system in place. It is important to target financing and policy in order to have an impact on access and quality of sexual and reproductive health services, as in developing countries out-of pocket expenditures are the largest source of financing of SRH services.[90]

Out-of-pocket payments seem to have a negative impact particularly on women who find it more difficult to pay for health care than men. In addition, other informal costs for maternity care, such as gloves, syringes and drugs may even be higher than user fees. This means that women who are only able to pay the user fee may still receive poor attention.[91, 92]

External funding plays a major role in protracted crises and recovery. Despite an initial increase after the ICPD in 1994, funding for SRH has never reached the required amount. It seems that HIV funding has been increasing significantly over the past ten to fifteen years, while other areas of SRH, such as family planning have remained the same or even decreased. The underfunding of contraceptives, leads to large numbers of unwanted pregnancies, induced abortions and maternal death.[93]

Governments give importance to SRH in their overall health financing; most basic packages of health include a wide range of SRH services. However, the difficulty seems to lie in the negotiation of the use of external funds at country level in order to provide comprehensive sexual reproductive health services despite the concentration on HIV/AIDS activities and the overall reduction of funds available for other aspects of SRH.[94]

Leadership

Many countries that experience conflict were poor countries with poorly developed health services, particularly SRH services, before the conflict. Recovery provides both the opportunity and the challenge to envision and go beyond what was available before the conflict. That vision and the rate at which it can be implemented will depend upon the human and resource capacities of the country and the strength of the leadership. A challenge in health service provision in transition situations is to balance the need to meet the immediate demands for health service delivery and the need to adopt a long-term view for health systems development.[95]

One critical decision to be taken in protracted crises and recovery is the role of the ministry of health as either the service provider or as a steward of the health system, as during recovery, an important process is the change in engagement by the international community. In protracted crises humanitarian relief may hardly be connected to government services or may even operate in areas outside government control. Recovery aims

to restore the lead role of the government; though (re)building the capacity of the government may take considerable amounts of time and effort. This indicates that during protracted crises and recovery, decentralized entities, such as district health teams have a critical role to play in order to assure the implementation of SRH services in peripheral areas. District health teams should have a leading role in the assessment of needs and the planning process. This also means that SRH programmes should be planned and aligned in an integrated manner with overall health sector policies and regulations in a bottom-up approach in order to secure a large coverage of service availability.

HUMANITARIAN PLATFORM

Humanitarian reform

In 2005, an independent review commissioned by the United Nations Emergency Relief Coordinator identified a number of gaps in the humanitarian response. For this reason, a humanitarian reform was launched in order to guarantee greater predictability, accountability and partnership, leading to improved effectiveness of the humanitarian response.

The main components of this reform are:

- the cluster approach;
- the humanitarian coordinator system;
- adequate, timely, flexible and effective financing;
- partnership between United Nations and non-United Nations actors.

The cluster approach is a means of coordination and cooperation among humanitarian actors to facilitate joint strategic planning. There are eleven clusters in total, one of which is the Health Cluster. At global level, cluster leads have been designated by the Interagency Standing Committee (IASC). At country level, the cluster approach implies the establishment of a cluster lead agency, assuring a clear system of leadership and accountability for international response, as well as a framework for effective partnership among national and international humanitarian actors. The lead agency for the Health Cluster is usually WHO.

The cluster serves as a mechanism for coordinated assessments, joint analyses, the development of agreed overall priorities, objectives and a health crisis response strategy, and the monitoring and evaluation of the implementation and impact of that strategy. This means that participating organizations are expected to be proactive partners in assessing needs, developing joint strategies and plans for the overall health sector response, implementing agreed priority activities, ensuring attention to priority cross cutting issues and adhering to agreed standards, to the maximum extent possible. In order to facilitate the joint assessment, the Global Health Cluster developed the Health Resources Availability and Mapping System (HeRAMS) using the health service checklist mentioned above (see also Table 2).

To ensure adequate coverage of SRH services, an organization that is a partner in the Health Cluster and has specific expertise and capacity in country must be assigned the responsibility to support, promote, advocate for and lead actions in this area.

The assignment of a SRH area focal point agency should be discussed and agreed within the Health Cluster with all partners agreeing on the terms of reference, and the organization concerned committing to fulfilling the agreed terms of reference.

Coordination of gender based violence prevention activities needs specific, joint arrangements between health and other clusters – primarily the protection cluster. These arrangements should be inclusive and health aspects of these cross cutting issues have to be discussed and addressed within the Health Cluster.[96]

Adequate, timely, flexible and effective financing is one component of the humanitarian reform. The Flash appeal, which is supposed to clearly articulate humanitarian needs, is a tool for structuring a coordinated response during the initial three to six months of a crisis. In addition, projects addressing life-saving activities from the flash appeal can be submitted to the Central Emergency Response Fund (CERF), which is intended to complement existing humanitarian funding mechanisms. If the crisis continues beyond six months, a CAP can be launched, which is a tool to plan, coordinate, fund, implement and monitor the activities of aid organizations.[97]

Prioritization of sexual and reproductive health interventions in the CAP process

In order to assure provision and funding of SRH services in conflict and post-conflict settings, they need to be part of the CAP. The types of SRH services in CAPs differ from one country to another, indicating that the these do not aim for provision of comprehensive SRH services. While the CAP of the Central African Republic has a high number of SRH projects, with a stress on response to SGBV, other countries, such as Afghanistan, Somalia, Uganda and Sudan, have no or very few projects on SGBV. It seems that most SRH projects in CAPs

are related to HIV. Only very few projects deal with adolescents SRH. In addition, health is rather underfunded, which means that only a small percentage of the SRH projects listed in CAPs actually get implemented.

Not only in protracted crises and recovery, funding of SRH is largely directed towards HIV/AIDS activities, resulting in a reduction in external funds available for other areas of SRH.[94] In addition, health is overall underfunded in CAPs with less than half of the requested funding in all CAP countries. In Afghanistan, the health sector received only 4% of the required funding. Moreover, an assessment of donors assistance to maternal health between 2003 and 2006 showed that while funding for maternal and newborn health increased by 66%, this did not seem to be targeted towards countries with higher need.[98] Most countries affected by conflict, such as DRC, Iraq, and Sudan, saw an increase in funding for maternal health. However, others, such as Afghanistan and Sierra Leone received less funding in 2006 than in 2003. A study tracking Official Development Assistance (ODA) for SRH particularly in conflict affected countries, analysing ODA disbursed for SRH activities in conflict settings between 2003 and 2006, using the Creditor Reporting System (CRS), claims that non-conflict-affected least developed countries received more than 50% more ODA for SRH activities than countries affected by conflict, despite having less need.[99] The study also showed that almost half of ODA disbursed for SRH funded direct HIV/AIDS projects and an increase in ODA disbursement for SRH was only due to a substantial increase in HIV funding, while ODA disbursed for other SRH activities actually declined.

Spiegel et al.[100] underline the lack of data on actual SRH needs and required funding associated with these needs in conflict and post-conflict settings. A comprehensive study quantifying needs, costs and required resources will be useful in order to channel donor funding appropriately.

Overall, SRH concerns need to be mainstreamed into the work plan of the Health Cluster, in order to bring it higher up on the agenda than is currently the case. One important issue is the lack of funding for capacity building and training during the early phase of recovery, which is required to successfully implement SRH services.

TOWARDS A FRAMEWORK FOR ACTION

The main challenge for SRH in the relief operations lies in the achievement of optimal coverage of all the components of the MISP. This is unfortunately not often the case, as documented in this paper. Consequently, during recovery and protracted crisis, it is necessary to assess and document the coverage of the minimum SRH services and to fill the gaps in terms of optimal coverage of the MISP interventions. Once optimal coverage of the MISP in all crisis areas is achieved, services need to be expanded in a systematic and sustainable way. This transition from the MISP to comprehensive SRH services – on which there exists no universal definition needs to be guided by a list of expanded basic SRH services as an intermediate step. While the MISP is supposed to be implemented without prior assessment, implementation of expanded SRH services will require an assessment of the context, needs and local behaviour, in order to orient the planning in crisis areas. The planning process includes development of training curricula for health personnel, strengthening of infrastructure and financing mechanisms with elements of solidarity and a procurement system for equipment and supply. In order to avoid fragmentation of health service delivery, this planning should not be done individually by each agency. Procurement of equipment, data collection and training of health personnel require a bottom-up approach with strengthened district health teams who are actively involved in the national assessment and planning process.

This process needs to take place in a sustainable way through strengthening of the local health system and local actors as opposed to international actors. This is also reflected in the "two track approach" of the joint United Nations agencies country support, focusing on rapidly scaling up highly cost-effective interventions and on strengthening national health systems.[44] It implies the need to deliver basic services through the six building blocks, addressing the bottlenecks within each of the blocks.

Key issues to move forward include:

1. Assessment of available SRH services and monitoring of SRH coverage;
2. Assessment of the local context for detailed planning;
3. Scaling-up SRH services in a systematic manner taking a health system approach;
4. Mainstreaming SRH in training curricula of health personnel;
5. Reduce segmentation and fragmentation of health service provision by strengthening the role of district health teams;
6. Implement financing mechanisms with elements of solidarity.

This paper calls for a holistic health systems approach developing a sustainable infrastructure with local resources. A prolonged reliance on foreign health care personnel, technologies and supplies may undermine the reconstruction of a local healthcare system. Instead, there is a need for change in health system planning and management for reconstruction by donors, NGOs and governments.[101] This requires a paradigm shift by NGOs in their engagement with the health system recovery, including capacity building of national actors

and a plan to eventually phase out activities. Phasing out needs to be well planned, taking into account that international actors cannot leave from one day to the other without having put national actors in the position to take over, but also considering that they need to leave at some point in order to give the opportunity to the government to take the lead.

COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

	ICPD	CRHC [102]	Comprehensive MISP	UNFPA	WHO[103]	HeRAMS	Areas not shared by all programmes
STI & HIV/AIDS	• Management of reproductive tract infections, including STIs and barrier methods to prevent infection • HIV prevention, particularly for pregnant women	• Sexually transmitted infections: prevention and treatment • HIV/AIDS: prevention, voluntary counseling & testing, prevention of mother-to-child transmission & referral • Family planning: all methods, including long-term and permanent, & emergency contraception	• Comprehensive STI prevention & treatment services, including STI surveillance systems • Comprehensive HIV services as appropriate • Care, support & treatment for people living with HIV/AIDS • Awareness of prevention, care & treatment services for STIs, including HIV • Community education	• Prevention & treatment of reproductive tract infections & STIs including HIV/AIDS	• Management & prevention of STIs, including HIV, reproductive tract infections, cervical cancer & other gynaecological morbidities	• Syndromic management of STIs • Standard precautions • Availability of free condoms • Prophylaxis & treatment of opportunistic infections • HIV counselling & testing • PMTCT • ART	• HIV counselling & testing • PMTCT • ART • Standard precautions
Maternal & newborn health	• Pregnancy, delivery & neonatal care • Skilled birth attendants • Widest achievable range of safe & effective family planning methods	• Emergency obstetric care: basic & comprehensive emergency obstetric care, including post-abortion care	• Antenatal care • Post natal care • Skilled attendants (midwives, nurses, doctors) in performing EmONC	• Family planning/ birth spacing services • Antenatal care, skilled attendance at delivery, and postnatal care • Management of obstetric & neonatal complications and emergencies • Prevention of abortion & management of complications resulting from unsafe abortion	• Antenatal, peri-natal & postnatal care/skilled birth attendance • High quality services for family planning including infertility services • EmOC	• Family planning • Antenatal care • Skilled care during child birth for clean & safe normal delivery • Essential newborn care	• Legal & safe abortion • Prevention & treatment of infertility • Adolescents' RH services • Treatment of obstetric fistula

	ICPD	CRHC [102]	Comprehensive MISP	UNFPA	WHO[103]	HeRAMS	Areas not shared by all programmes
Maternal & newborn health	• Safe, legal abortion • Maternal nutrition • Essential obstetric care • Prevention • Prevention of infertility		• Incrased access to basic EMoNC & comprehensive EmONC • Sourcing & procurement of contraceptive supplies • Staff training • Comprehensive family planning programming • Community education	• Early diagnosis & treatment for breast & cervical cancer • Promotion, education & support for exclusive breast feeding • Prevention & appropriate treatment of sub-fertility & infertility • Active discouragement of harmful practices such as female genital cutting • Adolescent sexual & reproductive health	• Effective referral system • Management of complications of unsafe abortion/ safe abortion; eliminating unsafe abortion	• Comprehensive essential obstetric care • Post partum care • Comprehensive abortion care	• Prevention & treatment of female genital mutilation
Sexual & gender based violence		• Gender-based violence: medical response & referral	• Expanded medical, psychological social & legal care for survivors • Prevention and management of other forms of GBV, including domestic violence, forced/ early marriage, female genital mutilation • Community education • Men and boys engaged in GBV programming	• Prevention & management of gender-based violence		• Clinical management of rape survivors (including psychological support) • EC • PEP	• Prevention & management of GBV: EC and PEP

REFERENCES

1. McGinn T. Reproductive health of war-affected populations: what do we know? *International Family Planning Perspectives*, 2004, 26(4):174-180.
2. McGinn T, Purdin S. Reproductive health and conflict: looking back and moving ahead. *Disasters*, 2004, 28(3):235-238.
3. Health Action in Crises, ed. *Health recovery in transition. Report of a WHO global consultation*. Geneva: World Health Organization, 2008.
4. Interagency Standing Committee. *Health cluster guidance note on health recovery*. Geneva: World Health Organization, 2008.
5. Newbrander W. Rebuilding health systems and providing health services in fragile states. In M.S.f. Health, ed. *Occasional Papers*. Cambridge, MA: USAID, 2007.
6. O'Hare B, Southall AM and DP. First do no harm: the impact of recent armed conflict on maternal and child health in sub-saharan Africa. *Journal of the Royal Society of Medicine*, 2007, 100:564-570.
7. International Development Association. *List of fragile states 2007* (http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,contentMDK:21389974~pagePK:51236175~piPK:437394~theSitePK:73154,00.html).
8. Countdown Coverage Writing Group. Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions. *Lancet*, 2008, 371:1247-58.
9. United Nations Population Fund. Monitoring ICPD goals – selected indicators. In *The state of world population 2008*. United Nations Population Fund, 2008.
10. Cottingham J, Garcia-Moreno C, Reis C. Sexual and reproductive health in conflict areas: the imperatitve to address violence aganist women. *International Journal of Obstetrics and Gynaecology*, 2008, 115:301-303.
11. Shefren, JM. The tragedy of obstetric fistula and strategies for prevention. *American Journal of Obstetrics and Gynecology*, 2009, June:668-671.
12. Tebeu, PM et al. Risk factors for obstetric fistula in the Far North Province of Cameroon. *International Journal of Gynecology and Obstetrics*, 2009, 107:12-15.
13. Peterman A, Johnson K. Incontinence and trauma: sexual violence, femal genital cutting and proxy measures of gynecological fistula. *Social Science & Medicine*, 2009, 68:971-979.
14. Lee RB. Delivering maternal health care services in an internal conflict setting in Maguindanao, Philippines. *Reprod Health,* 2008, 16(31):65-74.
15. Interagency Working Group on Reproductive Health in Refugee Situations. *Report of an inter-agency global evaluation of reproductive health services for refugees and internally displaced persons.*Geneva: United Nations High Commissioner for Refugees, 2004.
16. Wayte K et al. Conflict and development: challenges in responding to sexual and reproductive health needs in Timor-Leste. *Reproductive Health Matters*, 2008, 16(31):83-92.
17. Chynoweth SK. The need for priority reproductive health services for displaced Iraqi women and girls. *Reproductive Health Matters*, 2008, 31(16):93-102.
18. Macklin A. Like oil and water, with a match: militarized commerce, armed conflict and human security in Sudan. In Giles W, Hyndman J, eds. *Sites of violence: gender and conflict zones*, Berkley: University of California Press, 2004:82.
19. Austin J et al. Reproductive health: A right for refugees and internally displaced persons. *Reproductive Health Matters*, 2008, 16(31):10-21.
20. Hynes M et al. A determination of the prevalence of gender-based violence among conflict-affected populations in East Timor. *Disasters*, 2004, 28(3):294-321.
21. Mock NB et al. Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-affected settings in Africa. *Emerging Themes in Epidemiology*, 2004, 1(6).
22. Anema A et al. Widespread rape does not directly appear to increase the overall HIV prevalence in conflict-affected countries: So now what? *Emerging Themes in Epidemiology*, 2008, 5(11).
23. Strand RT et al. Unexpected low prevalence of HIV among fertile women in Luanda, Angola. Does war prevent the sperad of HIV? *International Journal of STD & AIDS*, 2007, 18:467-471.
24. McGinn T et al. Reproductive health for conflict-affected people. In H.P. Network, ed. *Network Paper*. London: Overseas Development Institute, 2004.
25. Al-Adili N et al. Deaths among young, single women in 2000-2001 in the West Bank, Palestinian Occupied Territories. *Reproductive Health Matters*, 2008, 16(31):112-121.
26. Travis P et al. Overcoming health-systems constraints to achieve the Millennium Development Goals. *Lancet*, 2004, 364:900-906.
27. Nagai M et al. Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka. *Health Policy*, 2007, 83:84-93.
28. Women's Commission for Refugee Women and Children, *Lifesaving reproductive health care: ignored and neglected. Assessment of the Minimum Initial Service Package (MISP) of reproductive health for Sudanese refugees in Chad*. New York: Women's Commission for Refugee Women and Children, 2004.

29. Krause S, Matthews J. *Reproductive health priorities in an emergency. Assessment of the Minimum Initial Service Package in tsunami-affected areas in Indonesia*. New York: Women's Commission for Refugee Women and Children, Feb-Mar. 2005.
30. Hakamies N, Geissler P, Borchert M. Providing reproductive health care to internally displaced persons: barriers experienced by humanitarian agencies. *Reproductive Health Matters*, 2008, 16(31):33-43.
31. Interagency Working Group (IAWG) in Reproductive Health in Crises. *IAWG 2008 Meeting Report*.
32. International Working Group on Sexual and Reproductive Health. *Sexual and reproductive health core package of activities in MSF projects*. Edited by Médecins Sans Frontières. Geneva: Médecins Sans Frontières, 2009.
33. Matthews J. *Minimum Initial Service Package (MISP) for reproductive health in crisis situations: a distance learning module*. New York: Women's Commission for Refugee Women and Children, 2006.
34. Ashford L, Makinson C. *Reproductive health: policies and practices. Case studies: Brazil, India, Morocco, and Uganda*. Washington D.C.: Population Reference Bureau (PRB), 1999:32.
35. Berer M. HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy and Planning*, 2004, 19(Suppl. 1):i62-i70.
36. Oliff M et al. Integrating reproductive health services in a reforming health sector: the case of Tanzania. *Reprod Health*, 2003, 11(21):37-48.
37. Jahan R. Securing maternal health through comprehensive reproductive health services: lessons from Bangladesh. *American Journal of Public Health*, 2007, 97(7):1186-1191.
38. McGinn T. Reproductive health of war-affected populations: what do we know? *International Family Planning Perspectives*, 2000, 26(4):174-180.
39. Pachauri S. Defining a reproductive health package for India: A proposed framework. In Maithreeji K, Ratna MS, Abusaleh S, eds. *Gender, population and development*. SNDT Churchgate: Oxford University Press, 1998:310-339.
40. Rao KS Ranebennur V, Joshi B. Comprehensive reproductive health: an operations research study. *Journal of Family Welfare*, 2002, 48:49-65.
41. Tangcharoensathien V et al. Universal coverage and its impact on reproductive health services in Thailand. *Reproductive Health Matters*, 2002, 10(20):59-69.
42. Abrejo FG, Shaikh BT, Saleem S. ICPD to MDGs: Missing links and common grounds. *Reprod Health*, 2008, 5:4.
43. Teerawattananon Y, Tangcharoensathien V. Designing a reproductive health services package in the universal health insurance scheme in Thailand: Match and mismatch of need, demand and supply. *Health Policy and Planning*, 2004, 19(SUPPL. 1):i31-i39.
44. World Health Organization et al. *WHO-UNFPA-UNICEF-World Bank joint country support plan for accelerated implementation of maternal and newborn continuum of care*, 2009.
45. Women's Commission for Refugee Women and Children, *Reproductive health coordination gap, services ad hoc: Minimum Initial Service Package (MISP) assessment in Kenya*. New York: Women's Commission for Refugee Women and Children, 2008.
46. Henfry LA. Women in East Timor: health crisis and aid priorities. *Development Bulletin*, 2004. 65:105-108.
47. Merlin. All mothers matter. Investing in health workers to save lives in fragile states. In *Hands up for health workers*. London: Merlin, 2009.
48. Toth C. Meeting needs for reproductive health services in post-conflict environments: CARE's family planning project in the Democratic Republic of the Congo. In *Voices from the village: Improving lives through CARE's sexual and reproductive health programs*. Atlanta, Georgia: Cooperative for Assistance and Relief Everywhere, May 2007.
49. International Planned Parenthood Federation. IMAP statement on family planning and safe abortion - the missing components of sexual and reproductive health services in crisis situations. *IPPF Medical Bulletin*, 2008, 42(4).
50. Pavignani E. Formulating strategies for the recovery of a disrupted health sector. In Pavignani E, Colombo S. eds. *Analysing disrupted health sectors - A modular manual*. Geneva: World Health Organization, 2009.
51. Hanson K et al. Expanding access to priority health interventions: a framework for understanding the constraints to scaling-up. *International Journal of Development*, 2003, 15:1-14.
52. O'Heir J. Pregnancy and childbirth care following conflict and displacement: care for refugee women in low-resource settings. *Journal of Midwifery & Women's Health*, 2004, 49(4, Suppl.1).
53. Waters H, Garrett B, Burnham G. *Rehabilitating health systems in post-conflict countries*, edited by W.I.f.D.E. Research. Baltimore: United Nations University, 2007.
54. World Health Organization. *Everybody's business - strengthening health systems to improve health outcomes - WHO's framework of action*.Geneva: World Health Organization, 2007.
55. Reproductive Health Response in Conflict Consortium. *Emergency obstetric care: critical need among populations affected by conflict*, edited by W.s.C.f.R.W.a. Children. New York: Women's Commission for Refugee Women and Children, 2004.
56. Gericke C et al. Intervention complexity - a conceptual framework to inform priority-setting in health. *Bull World Health Organ*, 2005, 83:285-293.
57. Roberts B et al. A Basic package of health services for post-conflict countries: implications for sexual and reproductive health services. *Reproductive Health Matters*, 2008, 16(31):57-64.

58. Transitional Islamic Government of Afghanistan, Ministry of Health. *A basic package of health services for Afghanistan*. Kabul, Ministry of Health Afghanistan, 2003.
59. Government of Southern Sudan, Ministry of Health, Southern Sudan. *Maternal, neonatal and reproductive health stategy action plan 2008-2011*. Djuba: Government of Southern Sudan, 2007.
60. Ministry of Health of the Republic of Uganda. *Health Sector Strategic Plan II 2005/06 – 2009/2010 Volume I*. Kampala: Ministry of Health of the Republic of Uganda, 2005.
61. Republic of Liberia Ministry of Health and Social Welfare. *The basic package of health and social welfare services*. Monrovia: Ministry of Health and Social Welfare.
62. O'Hanlon B. *The vital role of the private sector in reproductive health, in PSP-One Policy Brief*. Washington. D.C.: USAID, 2009.
63. Liu X. *Contracting-out reproductive health and family planning services: contracting management and operations*. PSP-One Primer for Policy Makers, 2006.
64. Mercer A et al. Effectiveness of an NGO primary health care programme in rural Bangladesh: evidence from the management information system. *Health Policy and Planning*, 2004, 19(4):187-198.
65. Rosen JE. Contracting for reproductive health care: a guide. In *HNP Discussion Paper*. Washington DC: The World Bank, 2000.
66. Berman P, Rose L. The role of private providers in maternal and child health and family planning services in developing countries. *Health Policy and Planning*, 1996. 11(2):142-155.
67. Bhushan I, Keller S, Schwartz B. Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia. In A.D. Bank, ed. *ERD Policy Brief Series*. Manila: Economics and Research Department, 2002.
68. Sondorp E. *Contracting health services in Afghanistan: Can the twin objectives of equity and efficiency really be reached?* London: London School of Hygiene and Tropical Medicine, 2005.
69. Palmer N et al. Contracting out health services in fragile states. *British Medical Journal*, 2006, 332:718-721.
70. Sabri B et al., Towards sustainable delivery of health services in Afghanistan: options for the future. *Bull World Health Organ*, 2007, 85:712-718.
71. Liu X, Hotchkiss DR, Bose S, The impact of contracting-out on health system performance: A conceptual framework. *Health Policy*, 2007, 82:200-211.
72. McPake B, Hongoro C. Contracting out of clinical services in Zimbabwe. *Social Science & Medicine*, 1995, 41(1):13-24.
73. Smith J, Kolehmainen-Aitken R-L. Establishing human resource systems for health during postconflict reconstruction. *Management Sciences for Health* 2006, Occasional Papers(3):1-28.
74. Pavignani E, Colombo S. eds. *Analysing disrupted health sectors - A modular manual*. Geneva: World Health Organization, 2009.
75. Serour G I. Healthcare workers and the brain drain. *International Journal of Gynecology and Obstetrics*, 2009. article in press.
76. Smith J. *Guide to health workforce development in post-conflict environments*. Geneva: World Health Organization, 2005.
77. McPake B, Mensah K. Task shifting in health care in resource-poor countries. *Lancet*, 2008, 372(9642):870-871.
78. Mullany L et al. The MOM project: delivering matrnal health services among internally displaced populations in Eastern Burma. *Reprod Health*, 2008. 16(31):44-56.
79. Lehmann U et al. Task shifting: the answer to the human resources crisis in Africa? *Human Resources for Health*, 2009, 7(49).
80. Gaye PA, Nelson D. Effective scale-up: avoiding the same old traps. Human Resources for Health, 2009, 7(2).
81. Samb B et al. Rapid expansion of the health workforce in repsonse to the HIV epidemic. *New England Medical Journal*, 2007, 357(24):2510-2514.
82. Mavalankar D, Sriram V. Provision of anaesthesia services for emergency obstetric care through task shifting in South Asia. *Reproductive Health Matters*, 2009, 17(33):21-31.
83. Pavignani, E. and S. Colombo, Making (rough) sense of (shaky) data. In Pavignani E, Colombo S. eds. *Analysing disrupted health sectors - A modular manual*. Geneva: World Health Organization, 2009.
84. Population Action International. The need for security in reproductive health supplies. In Interim Working Group on Reproductive Health Commodity Security, ed. *Meeting the challenge: securing contraceptive supplies*. New York: United Nations Population Fund, 2001.
85. United Nations Population Fund. *Donor support for contraceptives and logistics*. New York: United Nations Population Fund, 2000.
86. Population Action International. Defining reproductive health supplies: a survey of international programmes. In Interim Working Group on Reproductive Health Commodity Security, ed. *Meeting the challenge: securing contraceptive supplies*. New York: United Nations Population Fund, 2001.
87. Steele P. *UNFPA Côte d'Ivoire global logistics assessment report*. New York: United Nations Population Fund, 2008.
88. Steele P. *UNFPA Liberia Supply Chain Report*. New York: United Nations Population Fund, 2008.
89. Pan American Health Organization (PAHO). The right to health and the Millennium Development Goals. In United Nations, ed. *The Millennium Development Goals: A Latin American and Caribbean perspective*. Santiago, Chile: United Nations Publications, 2005:135-169.

90. Montagu D, Graff M. Equity and financing for sexual and reproductive health service delivery: current innovations. *Journal of Family Planning and Reproductive Health Care*, 2009, 35(3):145-149.
91. Nahar S, Costello A. The hidden cost of 'free' maternity care in Dhaka, Bangladesh. Health Policy and Planning, 1998, 13(4):417-22.
92. Nanda P. Gender dimensions of user fees: implications for women's utilization of health care. *Reproductive Health Matters*, 2002, 10(20):127-134.
93. Senanayake P, Hamm S. *Sexual and reproductive health funding: donors and restrictions*. *Lancet*, 2004, 363(70).
94. World Health Organization. *Financing sexual and reproductive health-care services*. Geneva: World Health Organization, 2006.
95. American Council for Voluntary International Action. *Health in crises: Programming for transition*. Washington, D.C.: American Council for Voluntary International Action, 2008.
96. Interagency Standing Committee and Global Health Cluster. *Health Cluster Guide. A practical guide for country-level implementation of the health cluster*. Geneva: World Health Organization, 2009.
97. Interagency Standing Committee. *Introduction of Flash, CERF and CAP*. Humanitarian Reform, Resources and Tools (http://www.humanitarianreform.org/humanitarianreform/Portals/1/Resources%20&%20tools/Flash%20CERF%20and%20CAP.doc).
98. Greco G et al. Countdown to 2015: assessment of donors assistance to maternal, newborn and child health between 2003 and 2006. *Lancet*, 2008, 371:1268-75.
99. Patel P et al. Tracking official development assistance for reproductive health in conflict-affected countries. *PLoS Medicine*, June 2009.
100. Spiegel P, Cornier BN, Schilperoord M. Funding for reproductive health in conflict and post-conflict countries: A familiar story of inequity and insufficient data. *PLoS Medicine*, 2009, 6(6).
101. Clunan AL. *Sustaining healthcare systems in post-conflict environments. In Center for Stabilization and Reconstruction Studies, ed. Sustaning healthcare systems in post-conflict environments*. Monterey, California: International Medical Corps, 2009.
102. McGinn T, Guy S. Comprehensive Reproductive health care in crises: from vision to reality. *Forced Migration Review*, 2007, January(27):70-71.
103. World Health Organization. *Reproductive health strategy*. Geneva: World Health Organization, 2004.

Lessons learned from case studies on sexual and reproductive health in health recovery

Six case studies were prepared for the Granada Consultation held in 2009. They were:

- Afghanistan
- Côte d'Ivoire
- Democratic Republic of the Congo (DRC)
- Liberia
- Nepal
- Southern Sudan

(The occupied Palestinian territory and Sierra Leone were discussed during the consultation, but no written documents were provided).

All six have experienced protracted conflicts of varying duration and intensity. In Afghanistan, a long series of conflicts since the late 1970s have killed, injured and displaced millions of people and eroded much of what was already a weak and poorly financed health care infrastructure. By comparison, the conflict in Côte d'Ivoire was relatively brief but between 2002 and 2004, it destroyed about half of all of the country's health care facilities. In the DRC, more than 20 years of conflict and instability have killed more than 5 million people, eroded food and health security and seriously damaged the infrastructure. The health care system of the eastern provinces was particularly affected, significantly reducing its capacity. In much the same way, the 14-year-long civil war in Liberia devastated the country's health care system while causing the loss of approximately 250 000 lives and displacing over a third of the population. Between 1996 and 2006, Nepal was affected by a civil war that killed an estimated 13 000 people and displaced 200 000, many in rural areas where the insurgents prevented people and staff from accessing health facilities.

All are developing countries and had under-financed and weak health care systems prior to the conflicts. The conflicts weakened those systems even further and in all countries. Except in Nepal and Liberia, national governments did not appear to be in a position to respond to the health crises of their countries in a structured way. Particularly the weak infrastructures challenged the reconstruction of the health care systems. This task has been increasingly taken up by foreign NGOs using external funding. However, this dependence on external partners and funding can pose a risk to the recovery process.

The case studies present similarities in terms of challenges and facilitators for SRH, but also differences in the way of dealing with these challenges.

SEXUAL AND REPRODUCTIVE HEALTH SERVICE DELIVERY

In all six, the pre-war health systems were poorly resourced and inadequate for the size of the populations they were supposed to serve. The few existing SRH services were concentrated in urban areas, leaving rural areas underserved and service-quality was poor. Financing was irregular everywhere and most staff outside the capital city had poor training and were badly equipped. The main challenge as described in all case studies is the depleted infrastructure. The entire health system was often further challenged by vertical programmes and fragmented funding for selected diseases.

The war significantly worsened health service delivery in all the countries which were studied. SRH services that had previously existed rapidly deteriorated, having a negative impact on the outcomes of pregnancy and delivery.[1, 2, 3, 4, 5]

Major challenges in all countries are high fertility rates combined with a low percentage of skilled birth attendance. Family planning and prevention of STIs and HIV/AIDS have long been overlooked in times of conflict and recovery. Particularly family planning has not been a priority.

In most of the six countries SRH needs of young people seem to be unmet, resulting in high prevalence of teenage pregnancies and STIs among young people. The perennial problem of SGBV in times of acute social disorganization remains apparent in most of the countries. In Liberia and DRC SGBV assumed almost epidemic proportions and was used as a tool of ethnic cleansing. This also reflects the breakdown in law and order in these countries. In addition to the increased risks and the lack of services, widespread malnutrition has further eroded the health of women, especially the health of pregnant women.

Use of the MISP

There is little in the case studies to indicate that the MISP was taken up either by humanitarian organizations or national governments. This may reflect the relatively low priority given to reproductive health by many hu-

manitarian relief organizations and countries but also the poor distribution of information and education on the MISP. This is an important observation, as it indicates that the MISP does not seem to serve as a guiding instrument during the acute crisis nor the recovery process. The only exceptions seem to be DRC and Liberia, where minimum health packages are formulated around the MISP.

Priority to the MISP or comprehensive services

Most planning for reproductive health services as described in the case studies was focused on introducing comprehensive services rather than using the MISP. For example, in South Sudan, where a Basic Package of Health Services (BPHS) was formulated, the MISP was not referred to either and the reproductive health plans aimed again to bring in a comprehensive SRH package. Afghanistan, Liberia and Southern Sudan formulated a BPHS and DRC developed a minimum package of SRH activities. None of these packages explicitly refer to the MISP but for the main part the services correspond to the MISP and beyond, indicating that planning goes towards comprehensive services. The Liberia BPHS clearly gives priority to SRH services. The possibly premature planning for comprehensive SRH services might be challenging as there is no infrastructure on which these comprehensive services could be built upon in order to provide any high degree of coverage. This neglect of the MISP as the first step in responding to sexual and reproductive health in emergencies has therefore had a number of implications. Planning for comprehensive services for which there are few funds, personnel and equipment can contribute to the neglect of basic services that the MISP helps to ensure. In addition, it is unlikely that any good coverage by comprehensive services will be achieved within a medium term timeframe.

In Côte d'Ivoire of the 526 facilities in 30 health districts that were assessed as part of a survey, 466 (84.4%) needed rehabilitation and were in no condition to sustain the delivery of reproductive health or any other services.[6] In DRC where fighting continues, health personnel losses and destruction of health care facilities continue to be a problem and together with the broader insecurity, have become major stumbling blocks to any progress.

INFORMATION

One important impact of the conflicts suffered by all the countries has been the extensive damage to vital statistics and information systems. This has been further exacerbated by the massive and frequent forced movement of people, both internally and to neighboring countries, making it difficult to obtain good denominator data. Thus, mortality rates being used today tend to be based on population estimates that in some cases may be out of date. Data for SGBV are even more inconclusive because women and girls, men and boys, even if specialist agencies were available victims are inevitably reluctant to report incidents of rape. In most of the six countries, the national health information system in is just developing and most information gathering is still being done by NGOs and United Nations organizations using small surveys. From the perspective of health planning, especially for sexual and reproductive health, this absence of good data is a major obstacle to recovery or reconstruction of services. However, the available data estimates point to an overall situation of social penury and poor SRH.

HUMAN RESOURCES

In all case studies, the loss of trained health care workers appears to have been another key factor in the deterioration of health care services and the reduced capacity of countries to meet the SRH needs of their populations. Trained health personnel at all levels, including community based primary health care workers were lost to a combination of forced displacement, injury and death. Lack and uneven distribution of health workers, particularly female health workers have been described as an important challenge in all case studies. For SRH services of particular importance is the lack of certified midwives but also medical doctors. This situation is exacerbated by the destruction of training facilities as well as the lack of adequate trainers. As a result, most SRH services remain poorly staffed resource limitations, jeopardize rapid recruitment and training of new personnel.

In Afghanistan, in 2004 the percentage of all health care facilities estimated to have a trained female health worker had dropped from 60% to 21%, due to the rapid expansion of facilities. The situation has improved to the extent that by mid-2009 61% of health centres were said to have at least one female midwife.[7] Furthermore, in 2006 16 new midwifery schools were opened and a further 6 were opened by 2009. The small ratio of doctors and nurses to people (0.5 and 7/ 10,000 respectively), nevertheless continues to present major challenges, and much remains to be done by both national government and international groups.

In Liberia where prior to the war there were 200 doctors and 600 physician assistants, now there are only 51 doctors and a few skilled birth attendants. One of the consequences of this is that only 20% of deliveries are assisted by a skilled birth attendant. The distribution of remaining personnel is highly uneven and outside the capital city, the ratio of midwives to women falls dramatically.[8]

Similar challenges exist in South Sudan where conflict has created a large inter-generational gap among Southern Sudanese health workers, making long-term local initiatives difficult to plan and develop. Of the health workers in the region, few have had any adequate training to meet the reproductive health needs of the population which is growing quickly as a result of the encouraged return of refugees.

In Nepal the Ministry of Public Health has developed a plan to achieve the MDG goal of 60% of deliveries by a skilled birth attendants by 2015, but is unlikely to achieve this, as the training of health care staff is favouring doctors who are unlikely to work in rural areas or in the field of reproductive health.[9] The situation in Côte d'Ivoire is challenged by the current ratio of 1 doctor for 9739 people, one nurse for 2374 people and one midwife for 2081 women of reproductive age; again outside urban areas few women have access to the care they require.[10]

MEDICAL PRODUCTS

In most of the studied countries, there continues to be a high dependence on external sources for most medical products and technology and the capacity in these countries in terms of planning, procurement, storage and distribution remains highly limited. Reproductive health products and technology are particularly precarious. The recovery of the logistic system and the management of supplies takes a significant amount of time, resulting in fragmented supplies. SRH commodities are often not integrated in the overall supply system.

In most cases, medical products, equipment and health facilities were looted or destroyed during the conflict which significantly hinders the re-establishment of a functional health care system. In Afghanistan for instance, after the conflict less than 25% of all the primary care centres in the country were adequately equipped for antenatal and delivery services, and only 29% were providing three or more methods of contraception.[11]

In South Sudan the Multi-Donor Trust Fund is the largest financier of drugs and equipment and UNFPA is the sole supplier of SRH commodities. UNFPA is working with the Ministry of Health to ensure better commodity security by assisting in the development of a warehousing system. Despite these large donors and the progress they are making, there remain major and widespread deficiencies in the physical and human resources that are essential to effective procurement, supply and management systems. Prepositioning of supplies, in particular, is difficult.

In Nepal national authorities are creating a Logistics Management Information System (LMIS) unit which, in combination with a free drugs policy, is already resulting in better stock availability and improved public accessibility to contraceptives and other commodities. Even so, funding and contraceptive security remains a problem.

FINANCING

In most of the case studies financing of health care services in general, and reproductive health services in particular, remains fragile and highly dependent on external resources while the national budget allocates only a small portion to SRH. For most of the countries under study it is unlikely that, without continued external funding SRH will be adequately addressed.

In terms of policies, there are positive measures taken in Nepal and Liberia. Nepal formulated a free drug policy as well as support for transport costs. Liberia abandoned user fees in all health facilities which resulted in a quick increase in services uptake.

LEADERSHIP AND GOVERNANCE

The extend to which the governments of the countries under study were able or willing to tackle the numerous challenges in the provision of SRH services varied. Even in cases where the government took on a strong leadership role, service provision depended highly on international NGOs. It is important to highlight that in all countries SRH seemed to be on the agenda. In most countries policies where outdated at the end of the conflict. But in all of them the development of new national standards, programmes and roadmaps addressing different reproductive health issues documents that some importance is given to SRH at policy level. Yet, even with the help of external actors, the lag time between the end of conflict and the reconstruction of health care services has been long, facing severe difficulties in the implementation of existing policies and plans. For example, in

South Sudan, the government collaborating with outside partners has developed relatively elaborate health plans and objectives, including plans for comprehensive sexual and reproductive health. But there is little evidence that South Sudan has the manpower, the finances or the organizational system required to implement the plans that have been formulated.

However, progress has been documented in some of the countries. In Liberia the government and its ministries have given high priority to SRH and the country's plans for harmonization of resources and strategies are proving useful to the recovery process and the mobilization of resources.

At the end of the conflict, Nepal developed proactive policies geared towards poverty reduction and promotion of maternal health in vulnerable populations. The Interim Constitution has legalized abortion and recognized maternal health rights, including safe motherhood, as a fundamental human right. Similarly in Côte d'Ivoire there has been increased investment in emergency obstetric care and prevention of HIV/AIDS. There has also been a reinforcement of SRH services through rehabilitation and training of service providers.

GENERAL ISSUES EMERGING FROM THE CASE STUDIES AND CONCLUSIONS

A number of key points emerged from the six case studies that provide an insight into the challenge of promoting SRH in protracted crises and recovery situations. Countries coming out of crisis do give importance to SRH as seen in numerous policies and guidelines concerning SRH services, but are not in the position to adequately implement these policies. The case studies indicate that all the work that has gone on over the past decade to generate interest and commitment to SRH in conflict and recovery situations is showing some positive results in terms of policy formulation, but the challenge of implementation has still not been taken up systematically by all stakeholders – including countries and humanitarian relief as well as development agencies.

One of the most common features of the six countries was the weakening of already inadequate pre-conflict health services and further post-conflict degradation. Most of the countries in the study had poor health infrastructures which contributed to the poor health of their populations reflected in persisting high rates of maternal mortality. In all of these countries the number of women delivering with the assistance of a trained health care provider was very low and this became even more so as a result of the conflict.

With respect the MISP the case studies suggest that many humanitarian relief agencies, United Nations agencies and government bodies still do not appear to be aware of the scope and value of the MISP and are not taking it systematically on board in their relief and post-conflict recovery activities. More work therefore needs to be done to inform the key people involved in planning and executing crisis and recovery work about the MISP and how it can best be implemented.

If SRH services and the sexual and reproductive health of women is to be improved and maintained in countries in protracted crisis and recovery, governments and the international community will have to find new ways of introducing minimum SRH services. Here the MISP can play an important conceptual and operational role. Assistance from external sources will also be important to foster sustainable provision of SRH services during recovery.

It seems that many national and international partners tend to move quickly to planning for comprehensive SRH services irrespective of the availability of a financial base, human resources and infrastructure that could support these services. Instead, countries in crisis and recovery situations should ensure MISP as the entry point, which in some cases may need to become the long-term basis for SRH activities.

The last half century has seen a major increase in the number of complex emergencies around the world. Many of them have occurred in economically poor countries; others have erupted in countries trying to move quickly from one politico-economic system to another. In almost all cases, they have occurred in countries and in settings where national health, educational and public service systems were already under-financed, under-staffed and largely unable to meet the needs of their constituents. In many cases large proportions of the populations within these countries were not well covered by quality health care services.

The case studies that were prepared for the Granada Consultation show that SRH is on the agenda of health recovery, but much will have to be done to achieve good sexual and reproductive health practices in these contexts. Much will depend on the extent to which the overall health system, especially human resources, infrastructure and supply systems can be strengthened. Sustainable external assistance of the size currently being allocated will remain crucial.

NOTES

1. Bartlett, LA et al. (2005) Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999-2002. *Lancet* 365: 864-70.

2. *Liberia Demographic Health Survey 2007/8*. Government of Liberia.
3. *Sudan Household and Health Survey (SHHS) 2007*.
4. Ministry of Health and Public Hygiene, Côte d'Ivoire (2007). Evaluation mission.
5. Devkota, M.D. (2005) *An assessment on impact of conflict on delivery of health services*. Nepal Health Sector Program. The World Bank Health, Nutrition and Population (NHP) Nepal Country Office.
6. Ministry of Health and Public Hygiene, Côte d'Ivoire (2007). Evaluation mission.
7. Estimation of community midwifery schools.
8. MOHSW (2006). *Rapid assessment of the health situation in Liberia*.
9. Ministry of Health and Population (2005). *National policy on skilled birth attendants*.
10. Ministry of Health and Public Hygiene, Côte d'Ivoire (2007). Evaluation mission.
11. *Afghan National Health Resources Assessment 2002*.

Report on the expert consultation held in Granada, 28–30 September 2009

PLENARY SESSIONS

Introduction

The objectives of the Granada Consultation were:

- to review experiences, challenges and lessons learned on SRH service provision in protracted crises and transition situations;
- to identify critical health system issues for facilitating the transition from the MISP to comprehensive SRH services in different crisis contexts;
- to build a consensus on the modalities of SRH service provision during protracted crises and recovery;
- to identify areas in need of additional research and assessment.

The meeting started with presentations on key sexual and reproductive health (SRH) issues during protracted crises and recovery. This was complemented by specific country presentations to highlight experiences in different settings. Participants then split in small groups to review selected topics related to the six health system building blocks defined by WHO and to compile recommendations. Following-up on the Consultation, the participants reached the Granada Consensus, which conveys priorities for action in order to address the challenges of SRH during protracted crises and recovery in an effective and sustainable way (see the Granada Consensus on page 42 and Annex 1 for the agenda of the Consultation).

Framework on sexual and reproductive health during protracted crises and recovery

Due to non-sustainable interventions, protracted crises and recovery periods are oftentimes characterized by a regression of service coverage as humanitarian activities put in place during the acute relief has come to an end. Chronic underdevelopment, weak ownership by national actors and overwhelming influence of international actors further jeopardize the situation. Governments are not necessarily committed to health, whether politically or financially, which means that while it is important to secure service provision and fill gaps, it is crucial to build national capacity and to strengthen the health system as a whole. This is important as leadership and management skills are often lacking. Leadership and governance, while being the most difficult and therefore the last to be dealt with, are also the most important areas in recovery.

Another difficulty during protracted crises and recovery is the low and slow funding of Consolidated Appeal Processes (CAPs) and transitional appeals, while regular instruments of developmental funding are not yet fully operational. This implies the need to have a greater link between humanitarian and development actors. In addition, it is also important to take into consideration the changes that have taken place over the past few years, following the humanitarian reform, and that call for increased partnership between agencies, whether from the United Nations or not, and governments.

Short-term health recovery objectives are to restore and to maintain health service delivery in affected areas and long-term objectives to build institutional capacity for improving health system performance. Planning and implementation need to take place as a bottom-up approach, starting at local and district level rather than national level. This approach fosters sustainability and helps implementing focused strategic actions in affected areas. At the same time, this approach requires local capacity building at all levels.

During emergencies, the Minimum Initial Service Package (MISP) focuses on a limited set of priority life-saving interventions. In addition, it forms the starting point for all SRH programming. While during the acute phase of an emergency, SRH interventions are supposed to be implemented without any assessment, a demographic and epidemiological profile is required for planning health interventions during protracted crises and recovery so as to contextualize and adapt planning and implementation to the specific circumstances. This should include an assessment of:

- status of SRH services;
- population indicators;
- economic situation;
- health system issues, such as policies, supply, etc.

The importance of this process is to tie data to action, base interventions on a demographic and epidemiological profile and design interventions according to needs and opportunities. When scaling up the MISP, it is important to first strengthen what works. The difficulties lie in the fact that while there are standards for emergencies, there are none for post-conflict situations.

The transition from relief to development calls for a recovery strategy before full-fledged services can be provided. The transition from the MISP to comprehensive SRH services requires steps in between in order to be able to scale up in a sustainable way. SRH-related challenge during this period goes along two axes: on the one hand, it is important to secure quick, equitable and sustainable scaling up of health service provision both in terms of coverage and type of services, and on the other hand, it is necessary to strengthen the health system, which implies an increase of national capacity building. This dualism could be referred to as the "recovery imperative".

Before scaling up SRH services, it is important to guarantee universal access to the full MISP (all services listed in the package), by assessing gaps in service availability and documenting the capacity of service delivery. Once the MISP is fully implemented, more services can gradually be added. This process needs to take place in a sustainable way, taking into account health system strengthening activities, as shown in the matrix presented in Annex 3.

Purchasing and financing sexual and reproductive health services during protracted crises and recovery

There have been two main service delivery trends with regards to SRH:

- Vertical programmes, with earmarked resources designated to attack one or a few health problems;
- Increasing interest in shifting from vertical programmes to a horizontal multi-problem approach, by implementing SRH services through an integrated programme. A large number of elements belonging under the umbrella of reproductive health services require such an approach.

The rationale for moving from a vertical to an integrated approach is that the integrated programmes (basic package of services) are likely to better meet the needs of the population, being more effective, efficient and equitable. However, this paradigm shift still faces significant challenges:

- Engaging multiple donors with varying orientations may challenge the package content;
- Translating genuinely integrated SRH into national policy through an implementation strategy requires political will, motivation and capacity;
- Striking a balance between the expansion of reproductive health services and the improvement of quality of care;
- Providing an integrated approach is contingent on the adequacy of existing health infrastructure;
- Providing continuous supply of commodities and equipment to all service delivery levels is required;
- Expanding services can complicate the retraining of staff and supervisors.

The concept of basic health service packages has been increasingly popular in post-conflict countries; oftentimes governments contract out to NGOs to provide their define health packages. However the content of the packages is usually decided by the country's government with assistance from donors, the United Nations and NGOs. Interventions typically include maternal and newborn health and some components of reproductive health, but often leave out sexual and gender based violence (SGBV), safe abortion, mental health, and youth-specific topics. The general debate surrounding the contracting-out of services was centred on the aim of rapidly increasing the scale-up of services while simultaneously improving the quality of care. Contracting out SRH services to NGOs was seen as a strategy to improve effectiveness and equity, considering that the NGOs have the necessary experience and expertise to scale-up coverage and greater flexibility and capacity to respond effectively. However, there may be some limitations to contracting-out SRH services. The need to focus on reducing death and disability can lead to prioritization of restricted SRH services – while overlooking less tangible services such as SGBV. In this case, NGOs may feel they cannot criticize governments or donors for fear of losing contracts. The competitive bidding process leads to ambitiously small budgets (resulting in reduction of less popular services) and services may be adversely affected by the influence of conservative political, religious or cultural forces (including faith-based organizations). Furthermore, general health NGOs with limited knowledge and experience of specific SRH may not be able to provide quality services and advocacy for SRH rights. Another possible limitation to contracting out basic SRH services may be the difficulties encountered when scaling-up in areas with significant shortages of skilled health professionals. It is not sure that SRH elements, as they are currently implemented, actually address women's basic health needs, particularly with regard to essential obstetric care and appropriate method mix for family planning. Overall, the health information systems are weak and the range of SRH indicators often narrow.

Other financing options discussed during the meeting were cost recovery and users fees. Though it remains the largest financial contribution to SRH services, evidence from a range of sources note the negative impact of users fees on service uptake. Lack of finance is the major reason given by individuals as to why their household members could not access health facilities even though they needed to.

SRH is usually included as part of the package of several universal health care schemes; however, due to funding constraints some expensive interventions may be explicitly excluded, for example, highly active antiretroviral therapy (HAART) for HIV/AIDS, or infertility treatment and abortion.

There has been increasing calls from a range of bilateral as well as multilateral donors for free at point of access services for woman and children. It is not clear what this package of free care would support and how comprehensive it would be in terms of SRH; this approach has been criticized for being rather gender-biased as it excludes men.

Overall, greater clarification and flexibility is needed on what constitutes comprehensive SRH within a basic health care package contracting approach. Given the paucity of data on the impact of contracting on SRH services, it is imperative to strengthen evidence base. This will inform scaling up effective, efficient and equitable SRH services in post-conflict countries.

It is necessary to mobilize resources, test alternative financing mechanisms as well as explore innovative financing initiatives – this will require lobbying to convince donors to commit more money to health and governments to promote access to services for mothers and children in particular. Further, alternatives such as community-based insurance should also be tested.

Human resources for sexual and reproductive health services during protracted crises and recovery

Protracted crises and recovery have a profound impact on the health workforce. Human resources for health are affected by death, migration or relocation (internal and cross border). The primary, secondary and tertiary education system is disrupted and/or degraded while training institutions for health professionals are destroyed. Ad hoc training of health cadres practicing beyond their scope of practice can result in the proliferation of false certification.

Teachers are isolated from updated scientific knowledge in the health field. To restore health services, it is necessary to rebuild the human resources systems. This is commonly undermined by ad hoc emergency approaches to produce health workers to meet immediate needs which do not take into account the effects of the protracted crises on the education system, health sciences and the basic knowledge of the health workers. This emergency approach to producing persons to deliver reproductive health services is usually applied to meet targets defined by available donor funding timetables. There is lack of coordination of provision of training among the many agencies providing training. Training is usually unlinked to redevelopment human resource system and educational standards. The lack of standardization of training results in lack of accreditation of training.

In addition to parallel trainings, the employment of large numbers of health workers outside the health systems to achieve targets frequently undermines the ability of the existing health systems to address SRH service delivery.

Human resource is an important component in the re-establishment of the health system during protracted crises and recovery. Failure to attend this component could severely compromise the quality and scope of SRH service delivery. It is imperative to address the deficiencies in health worker competencies despite donor funding time frames requiring quick results, as well as to promote a healthy balance between meeting the immediate human resources needs in SRH and longer-term system development to ensure sustainability.

Field experiences

Case studies from Afghanistan, Côte d'Ivoire, the Democratic Republic of the Congo (DRC), Liberia and Nepal were discussed during the Consultation. Although geographically and demographically different and affected by crises of widely varying form and duration, a number of commonalities regarding health recovery and SRH could be identified.

In most settings, pre-war health infrastructure was poor and showed great inequities, with health services concentrating in urban areas. Further, vertical programmes seemed to prevail, focusing on selected diseases. Due to interrupted educational services, health staff had been missing out on international developments. For this reason, and also due to emigration, qualified health staff was rare. Further, leadership skills were lacking. This indicates that there was a great need for technical support and capacity building from international actors both at central and at provincial level. Task shifting was identified as an opportunity to scale-up preventive aspects of SRH services especially in remote and underserved areas; however, concern was raised that training of cadres lower than midwives will not contribute to the reduction of maternal and neonatal mortality.

Health recovery was further challenged by weak administrative structures and planning capacity; the large number of different actors may further lead to fragmentation of the health system. It has also been observed that special mandates by donors can lead to rapid changes in priorities and strategies for SRH.

Key recommendations that could be deducted from the case studies are to reinforce the role of the state and to strengthen the health system at all levels while pursuing integrated activities. Moreover, funding should be aligned with overall capacity-building of the health system. Improved predictability of health sector funding will ensure that this information can be exploited in advance during the health planning process.

International funding and advocacy

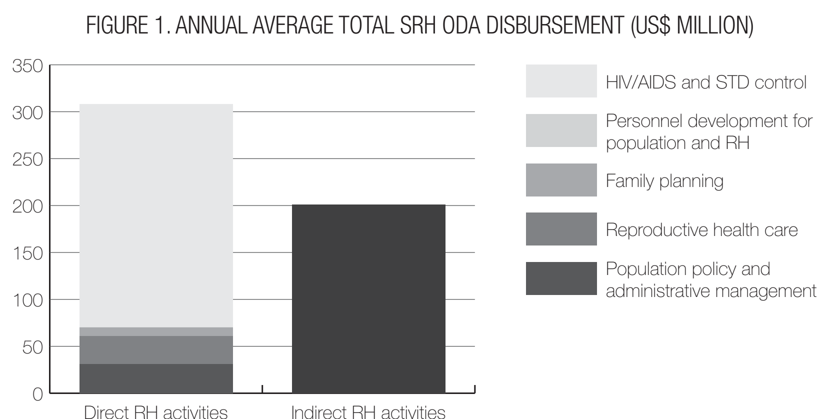
A study analysing the absolute amounts of official development assistance (ODA) spent on SRH using the Creditor Reporting System (CRS) and Financial Tracking Systems (FTS) as data sources, was conducted for the period of 2003-2006. Recipient countries included in the study were: Afghanistan, Angola, Burundi, Central African Republic, Chad, Colombia, DRC, Eritrea, Iraq, Liberia, Myanmar, Nepal, Sierra Leone, Somalia, Sri Lanka, Sudan, Timor-Leste and Uganda. A comparative analysis was conducted on non-conflict-affected least developed countries.

The results revealed that an ODA average of US$ 20.8 billion had been disbursed to the 18 conflict-affected countries. The annual average disbursed for SRH activities to the 18 conflict-affected countries is US$509.3 million, which corresponds to 2.4% of the total ODA and an annual average of US$1.30 disbursed for SRH per capita. Between 2003 and 2005, an increase in SRH ODA of 78% could be observed. However, this was due to a major increase in HVI funding, which takes up a major part of SRH funding, as shown in Figure 1. This is a reason for concern, as this funding mainly goes to ARVs, but not to health system development. In order to revitalize funding for family planning, general advocacy using demographic data is required.

A country comparison showed that the highest ODA per capita went to Uganda (US$ 4.80), Timor-Leste (US$3.20) and Central African Republic (US$ 2.90); the lowest to Colombia (US$ 0.10), Sri Lanka (US$ 0.30) and Myanmar (US$ 0.30). It is important to note that Somalia (US$1.00 per capita) and DRC (US$0.80 per capita) get less SRH ODA per capita than Iraq (US$ 2.20 per capita) and Timor-Leste (US$ 3.20 per capita) despite generally worse health indicators (with the notable exception of HIV).

The comparison with non-conflict affected countries revealed that non-conflict-affected least developed countries received 53% more ODA per capita despite having generally better indicators for reproductive health than those affected by conflict: US$ 1.50 compared to US$ 2.30.

FIGURE 1. ANNUAL AVERAGE TOTAL SRH ODA DISBURSEMENT (US$ MILLION)



Note: Patel P, Roberts B et al.Tracking official development assistance for reproductive health in conflict-affected countries. *PLoS Med* 2009, 6(6): e1000090

The study observed a relatively short time period and made only approximate estimates for proportions from indirect activities. It was recommended to continue the analysis for the last three years, taking into consideration common humanitarian funds. Moreover, data only showed donor disbursement data rather than actual expenditure, national expenditure data were not included in the analysis. In addition, not all donors, especially philanthropic donors, report to CRS. It was noted that there are increased efforts to funding SRH bilaterally. Overall, 60% of SRH funding is provided through programmatic approaches.

The study could not track certain specific SRH sub-sectors (e.g. SGBV), as the FTS does not have specific categories for SRH. Moreover, there might be some limitations in terms of data completeness and accuracy. Further, for better comparison, it would be interesting to analyse how much money of ODA goes into health in general to have a better idea of the percentage of SRH within this domain. Overall, there is evidence of substantial funding gap for conflict-affected countries compared to non-conflict-affected countries.

Advocacy for sexual and reproductive health

Past experience in advocating for sexual and reproductive health in protracted crisis and recovery showed that the use of data and findings from the field combined with concrete recommendations are a strong advocacy tool. It has further shown to be successful to establish strategic alliances and to identify "champions", i.e. success stories from countries.

It is recommended to take opportunities to link in with those issues that have the attention of the international community, such as the millennium development goals. An early engagement of the development community in recovery processes is crucial. Here it is important to find common grounds and reach out to non-SRH communities, including those who are not directly implicated in health. Advocates need to think outside of their own comfort zone and engage other actors and make them understand why it is in their interest to invest in SRH in emergencies.

In order to communicate a stronger message, it is necessary for advocates to get clarity about some of the key concepts being used and to translate them effectively and with one voice.

Data are important to identify gaps/opportunities for advocacy. While donors are particularly interested in numbers and results, it is important to inform them about what is possible to reach. Sometimes, process indicators may be more useful than impact measurements.

The concept or notions of SRH determine the funding or interest related to support such kind of programme. This implies the need for "donor education" regarding SRH. There is for example little funding for family planning issues.

One challenge in advocacy in the area of SRH is the demand generation. Considering that the actual victims are dead or disabled, other groups such as husbands and children need to be used in the communication.

WORKING GROUPS

Service delivery

The MISP plays a vital role in ensuring the sexual and reproductive health of women during and after emergencies and must be a key first step in ensuring sexual and reproductive health in conflicts and in the recovery phase. It is also a way of moving towards universal coverage and establishing SRH as a national goal. Promoting SRH as a key part of post conflict recovery and reconstruction calls for a new role on the part of the humanitarian and development sectors and will require a re-assessment of international and national responses to health development in general. The MISP offers a uniquely designed way of taking up this challenge and opening path to more comprehensive SRH development. It can serve as an initial tool in SRH strengthening and planning. When planning fore more comprehensive SRH services, it is essential to assess what was there before and what worked well in terms of SRH service provision, and to identify gaps in what is available and what is required for full implementation of the MISP and additional SRH services. Further, a demographic profile is necessary, and an assessment of availability of human resources, equipment and health facility needs. During this process it is crucial to involve national authorities and donors at all times. The aim is not only to ensure MISP, but also to sustain it through health system strengthening and to build on it. MISP is the foundation when moving towards comprehensive SRH. This requires that also humanitarian actors need to change their mindset to ensure a sustainable service availability with a well planned exit strategy. This requires changes in the mind set of humanitarian actors, but also in politics and structures of humanitarian action and approach in relief.

Recommendations

- SRH must be an integral part of all post-conflict recovery.
- Health system strengthening and community participation must be stressed.
- The role of humanitarian actors and action must be reviewed and possibly modified in light of the SRH and health system strengthening need.
- The SRH and health system strengthening initiative must be promoted to donors as well as local and national authorities.
- Evidence based approaches must be stressed and ways of strengthening local capacities must be sought through the vehicle of the MISP and comprehensive SRH services.

Health workforce

Health workers are "human beings" whose psychosocial needs and overall well-being should be addressed. In order to establish human resources in a post-conflict setting, a development approach is required, which implies the establishment of health worker registration systems to capture the number of workers and their

levels of training. This will require institutional mapping of health care and training institutions. One needs to consider that building a strong health work force requires collaboration across sectors. This requires the establishment of a human resource information system (qualitative and quantitative) which can be linked to health information systems to determine health force recruitment, deployment/distribution and workload. The main problem is that there is no reporting, nor assessment of gaps.

Diaspora models that have worked in other contexts might need to be applied, involving the International Organization for Migration (IOM) and the United Nations Development Programme (UNDP) and ministries in conversations about how to promote the return of qualified workers in the diaspora; this includes the creation of policies that foster appropriate roles for diasporas and best approaches for transfer of technology learned while overseas.

It might be necessary, as a short-term measure, to consider intensive training to fill gaps, as foreseen in the MISP. However, in the long term, one needs to develop clear job categories including what specific education and skills are required for each level, with clear job descriptions. Stand alone trainings are not sustainable and should be mainstreamed into pre-service education, while strengthened. This will require minimum standards for training modules and materials set by the ministry, while donors and external agencies should encourage joint working on professional issues. Further, the taxonomy of the training audience needs to be determined in terms of their training levels, as well as the content of the curricula, including issues such as gender and human rights, and the supportive environment in terms of clinical sites. All this will require support by regulatory frameworks regarding recruitment, retention and performance management. All donors should be aware of the ministry of health training modules and curricula. Training will need to be implemented in partnership with local organizations following standards as defined by the ministry of health. It is crucial not to develop a parallel system but instead to strengthen the ministry of health with competent staff. The MISP is one good example of how to start thinking about sustainable mechanisms. The MISP will only be sustainable if its training is mainstreamed in overall training curricula.

It will be necessary to create professional partnerships between the Ministry of health and professional associations to establish health professional issues, such as task shifting, accreditation of training institutes, issues related to professional conduct. This will require placing a human resource unit highly within the government/ministry of health which coordinates all human resource functions as well as performance management and supervision. To support this, donors should be required to include supervision plans, monitoring and training of trainers in any training at the local level.

The Health Cluster, Education Cluster and Early Recovery Cluster must recognize that human resources are a cross-cutting and multi-sectoral issue and not just a health issue, to support the process described above. At the same time, ministries of health, finance, education and justice must collaborate on human resource issues to build a common workforce.

Recommendations

- Reposition human resource development as an imperative to delivering SRH services by a competent and effective workforce. Particularly because human resources are the most expensive resource and can absorb 80% of the health budget.
- Recognize that health workers are "human beings" whose psychosocial needs and overall well-being should be addressed.
- Take a development approach to establishing HR in a post-conflict setting.
- Consider that building a strong health work force requires collaboration across sectors.
- Establish human resources development policies to support human resource planning and systems development.
- Develop regulatory frameworks to support implementation of the policies.
- Consider management, roles and responsibilities in recruitment process.
- Consider issues of safety and security when planning placement, distribution and deployment.
- Ensure appropriate supervision, monitoring and evaluation for performance management.
- Determine key functions and competencies required to deliver SRH – consider the strategy of "task shifting" as a mechanism to fill in the gaps, given the poor quality or lack of workforce.

Assessment

Assessment in protracted crises and recovery should include the policy environment, such as the existence of standards policies and guidelines and their relevance. Other areas to be assessed are human resources mapping, with a specific focus on SRH, by cadre and district as well as a mapping of facilities, including their readiness to provide SRH services.

This process requires the capacity for data collection, analyses, interpretation and dissemination in the country. However, it is often undermined by lack of funds for data collection, analysis and dissemination and therefore utilization.

One difficulty in recovery is the limited availability of qualitative data on a number of topics, such as utilization of services or coping mechanisms of the population. This implies that there is a need to look beyond health and take food security, livelihoods, nutrition, etc. also into consideration. This is further challenged by the fact that governments may restrict data collection on certain topics such as SGBV or abortion. Another challenge is the use of multiple assessment tools of varying quality in combination with large quantities of data not being used. The capacity to produce knowledge out of available data is often not in place. It is therefore important to find a way of data disaggregation, analysis and their inclusion in planning processes. Often, existing monitoring and evaluation systems are not being utilized. In general, throughout the assessment process, it is crucial to involve stakeholders from the outset.

Data should be used to document evidence, as well as to formulate policies. This will require increased documentation regarding SRH. Further, data should serve advocacy and evidence for best practices.

In every crisis the value of indicators needs to be reviewed and refined. In some cases, some indicators are not useful, as for example infant mortality rate and maternal mortality rate in the oPt, where they are always rather low. In this case, other indicators to assess the humanitarian response are required, such as access to care or psychosocial aspects and morbidity as well as looking beyond these kinds of indicators, looking at health system information. It is further useful to look at process indicators instead of impact, such as for example training curricula and training institutions.

Often in protracted crisis and recovery the question is who will take the responsibility in coordinating, analysing and interpreting collected data. This decision should be done in the Health Cluster with contributions of all cluster members.

Recommendations

- Ensure SRH is included in all post crisis assessments.
- Strengthen and enhance health management information systems, including human resources.
- Conduct an inventory of all SRH data and sources.
- Develop culture of data sharing, transparency and dissemination.
- Build capacity for SRH data collection, analysis, interpretation, and use.
- Identify opportunities for strategic use of data, specific planning processes such as recovery plans, health strategies, poverty reduction strategy papers.

Financing

The main challenge in protracted crises and recovery is to maintain funding during the transition phase. This requires to work with donors to agree on mechanisms to prolong CAP (or alternative) funding. This can be challenged by lack of coordination and harmonization. Further, it will be helpful to have multi-year versus one year funding cycles.

Funding mechanism need to ensure the inclusion and performance of SRH in the recovery and development phase, which requires SRH to be included in comprehensive health service policies. One possible way may be performance-based financing for a comprehensive health package with SRH indicators, to ensure SRH service provision. This in turn requires technical assistance in the contracting processes. Funds are often conditioned depending on donor preferences. This can be a difficulty in the area of SRH. There is need for increased recognition of SRH as an important part of the health sector.

Fundraising can be undermined by insufficient data analysis or impact studies for planned and efficient advocacy, institutional corruption.

Challenges in terms of SRH are the fact that humanitarian agencies do not use a health system approach. In order to guarantee sustainability, an entirely new role for humanitarian intervention is required, which may initially be more costly. Support needs to aim at health system strengthening as well as strengthening of financial institutions in the countries.

Recommendations

- Promote conceptual/paradigm shifts in humanitarian interventions with increased long-term perspective.
- Advocate for financing recovery rather than transition.
- Address the lack of absorptive capacity of some countries.

Governance, Policies and Leadership

Leadership needs to be seen at three levels:

- international leadership aiming at strengthening a "joint approach" to push for SRH dialogue with the government to ensure their ownership;
- national leadership leading to national recognition of areas of excess morbidity and mortality;
- Community leadership to create demand and accountability (e.g. social audit).

At all three levels the following guiding principles should be adopted:

- SRH is the right of all people in all circumstances;
- SRH is a fundamental component of individual and community well-being and recovery;
- continuity of appropriate SRH services can only be guaranteed through harmonized (coherent), cross sectoral policy, planning and action;
- SRH is an integral part of health systems development;
- communities have the right to participate in the design and implementation of SRH programmes and hold key stakeholders to account.

International leadership must advocate for increased resource mobilization for SRH as well as for effective harmonization of planning and funding instruments in support of SRH. The use cultural preferences' in a positive manner is a good tool to promote SRH.

The aim is to mainstream SRH in all health policy and all strategies for health system strengthening instead of isolating it from wider health system development. Separate mechanisms or isolated policies and fragmentation should be avoided. This can easily happen due to fragmented donor policies towards SRH and health system strengthening. Therefore, the humanitarian, transition and development communities should ensure continuity through a coordinated and joint actor approach to dialogue, assessment and planning.

The international community needs to support the government and the civil society to develop accountability mechanisms for SRH (including early participation). Further, an early interagency and national dialogue needs to be promoted as well as sensitive interactions within and between the Health Cluster, humanitarian country team, across clusters and interaction with national authorities.

In order to be able to guarantee sustainable provision of SRH services during protracted crises and recovery, improved links between the humanitarian architecture with transition/development mechanisms are needed. It is further necessary to agree on key SRH deliverables, and to ensure that the system is equipped for these services. This will require a clear implementation strategy which addresses critical support functions such as human resources and financing, as well as intensified support to the main foci of delivery, such as the district health teams. It is further important that international agencies adopt this approach and have a realistic exit strategy after handing over to the government.

When developing an implementation strategy, a bottom-up approach should be taken, focusing on gaps such as human resources, equipment, logistics etc. It is crucial that the cost of the strategy be assessed before its implementation begins.

Recommendations

- International leadership must jointly advocate with government to recognize SRH rights.
- Global actors must jointly support government to develop and implement appropriate SRH programmes/planning.
- International leadership must advocate for increased resource mobilization for SRH (educate donors to let them know that it's a cost effective investment)
- International leadership must advocate for effective harmonization of planning and funding instruments in support of SRH.
- SRH must be mainstreamed in all health policy and all strategies for health systems strengthening .
- International community must support government and civil society to develop accountability mechanisms to SRH (including early planning).
- The humanitarian, transition and development communities should ensure continuity through a coordinated and joint actor approach to dialogue, assessment and planning.

Ministry of Health of Spain

Throughout the world, SRH is affected by ignorance and neglected in developed and developing countries alike, in normal circumstances and in crisis situations equally. Good information and sexual education are scarce. In many parts of the world, including developed countries – such as Spain comprehensive SRH suffer from system constraints. These constraints are more present in protracted crisis and post-conflict situations. During acute crises, when health systems are weak, some interventions implemented during humanitarian action cannot be sustained in the medium term.

NGOs need to look at how to implement their activities in developing partnerships and developing health systems more efficiently.

Health resources for SRH are insufficient and will continue to be insufficient especially in terms of skilled personnel.

Wars are made against women and children. Focusing also on global solutions such as the reduction of weapon use and trade is therefore important.

In addition, policies that drain resources from developing countries, especially skilled professionals, need to be avoided, as aimed for by the WHO initiative on elaborating a code of good practice for human resource migration.

Concluding remarks

This meeting should be the beginning of a new partnership between UNFPA and WHO in the field of SRH. It is only through this kind of partnership that outcomes for beneficiaries can be improved. The United Nations humanitarian reform and the Health Cluster provide a useful platform for this process. WHO's mandate in humanitarian settings is to convene all actors for health in all items in agenda.

The Health Cluster provides a good opportunity to boost the agenda on SRH, which can only happen if all partners and clusters (global, country and training and all) are involved. For this reason it is important to communicate the outcomes of this meeting as widely as possible and to foster discussions with partners and donors. The next steps will be to brief the Global Health Cluster on this meeting, to advocate for support in moving forward and to include SRH in national health cluster training plans in order to increase understanding of SRH issues in the context of health system strengthening in protracted crises and recovery.

Annex 1. Agenda of the Granada Consultation

<table>
<tr><th colspan="2">Monday 28 September</th></tr>
<tr><td>9.00–9.45</td><td>OPENING SESSION
• Chair: José Ignacio Oleaga, Chairman of the Department of International Health, Escuela Andaluza de Salud Pública</td></tr>
<tr><td>9.00–9.30</td><td>WELCOMING REMARKS
• WHO: Daniel Lopez-Acuña, Director, Recovery and Transition Programmes, Health Action in Crises
• UNFPA: Jemilah Mahmood, Chief, Humanitarian Response Unit
• Andalusian Regional Ministry of Health: José Luis Rocha Castilla, General Secretary of Quality and Modernization</td></tr>
<tr><td>9.30–9.45</td><td>Introduction of Participants</td></tr>
<tr><td>9.45–11.00</td><td>1ST PLENARY SESSION
• Chair: Linda Bartlett, Johns Hopkins University</td></tr>
<tr><td>9.45–10.05</td><td>Disrupted health systems in protracted crises and recovery: challenges and opportunities
• Presentation: Daniel Lopez-Acuña, HAC, WHO
• Discussant: Iain Aitken, Management Science for Health, Escuela Andaluza de Salud Pública</td></tr>
<tr><td>10.05–10.25</td><td>Nature of needs in protracted crises and recovery
• Presentation: Wilma Doedens, Senior Reproductive Health Coordinator, UNFPA
• Discussant: Basia Tomczyk, CDC</td></tr>
<tr><td>10.25- 10.45</td><td>From MISP to comprehensive reproductive health services/sustaining comprehensive SRH services
• Presentation: Nevio Zagaria, Coordinator, Recovery and Transition Programmes, Health Action in Crises, WHO
• Discussant: Sandra Krause, Director, Reproductive Health Program, Women's Commission for Refugee Women and Children</td></tr>
<tr><td>10.45–11.00</td><td>PLENARY DISCUSSION</td></tr>
<tr><td>11.20–13.30</td><td>2ND PLENARY SESSION
• Chair: Alexis Ntabona, Coordinator, Technical Cooperation with Countries for Sexual and Reproductive Health, WHO</td></tr>
<tr><td>11.20–11.40</td><td>Purchasing and financing of SRH services in protracted crises and recovery
• Presentation: Linda Doull, Director of Health and Policy, Merlin
• Discussant: Louise Lee-Jones, Marie Stopes International</td></tr>
<tr><td>11.40–12.00</td><td>Human resources for SRH service provision in protracted crisis
• Presentation: Joyce Smith, Consultant
• Discussant: Anna Whelan, Associate Professor, School of Public Health and Community Medicine University of New South Wales, Sydney</td></tr>
<tr><td>12.00–13.30</td><td>Presentations of case studies
• Afghanistan: Dr. Nader Hassas, Ministry of Public Health
• Nepal: Dr Indira Basnett, Ipas Country Director
• oPt: Umayyaeh Khammash, Chief of Health, UNRWA Jerusalem
• Côte d'Ivoire: Abhe Gnagoran, Directeur Coordonateur du Programme National de la Santé de la Reproduction, Ministry of Health
• DRC: Marie Louise Mbo, Director, National Health and Reproduction Programme, Ministry of Health
• Liberia: Naomi Nyitambe, Merlin
• South Sudan: Makur Kariom, Director of Reproductive Health
• Sierra Leone: Peter Sikana, UNFPA</td></tr>
<tr><td>13.30–15.00</td><td>Lunch break</td></tr>
</table>

15.00–18.00	1ST GROUP WORK SESSION • Organization of groups, clarifying objectives of group work; group work • Service delivery: MISP–comprehensive reproductive health (also: medical products/supply chain) • Health workforce • Assessment, ways of prioritizing, collection and use of information • Financing • Leadership/Governance/ Policy
	Tuesday 29 September
9.00–13.30	3RD PLENARY SESSION • **Chair:** Rosa Elcarte López, Director Sectorial and Multilateral Cooperation, Spanish Agency for International Cooperation for Development
9.00–12.30	Group presentations and discussion
12.30–12.45	Trends in external aid for SRH services in protracted crises and recovery • Bayard Roberts, Research Fellow in Conflict and Health, London School of Hygiene and Tropical Medicine
12.45–13.00	Advocacy and resource mobilization for sexual and reproductive health • Marlou den Hollander, RAISE
13.00–13.30	PLENARY DISCUSSION
13.30–15.00	Lunch break
15.00–18.00	2ND GROUP WORK SESSION
15.00–18.00	Working groups • Consensus on reproductive health service interventions in protracted crisis and recovery
	Wednesday 30 September
9.00–10.30	4TH PLENARY SESSION • **Chair:** Manuel Carballo, Executive Director, International Centre for Migration and Health
	Recommendations and consensus on sexual and reproductive health in protracted crises and recovery • Group presentations
10.50–12.30	5TH PLENARY SESSION • **Co-Chairs:** Jemilah Mahmood, HRU, UNFPA and Daniel Lopez-Acuña, HAC, WHO
12.00–12.30	CLOSING CEREMONY • Alberto Infante Campos, Director General for Organization, Coverage and High-level inspection of the National Health System, Ministry of Health and Social Policies • Daniel Lopez Acuña, HAC, WHO • Jemilah Mahmood, HRU, UNFPA

Annex 2. List of participants

Governmental institutions

Laurence Eliane Abhé Gnangoran
Director Coordinator National Reproductive Health Programme
Ministry of Health
Côte d'Ivoire

Dina Abu Shaaban
Director Women's Health Dept.
Ministry of Health
West Bank Gaza

Rosa Elcarte López
Director of Sectorial and Multilateral Cooperation (AECID)
Ministry of Health and Social Policy
Spain

Sergio Galan
Responsible Area of Health
Directorate for Multilateral and Multisectoral Cooperation (AECID)
Ministry of Health and Social Policy
Spain

Alberto Infante Campos
Directorate General for Inspection and Coverage
Ministry of Health and Social Policy
Spain

Mohammad Nadir Hassas
Ministry of Public Health
Afghanistan

Marie Louise Mbo
Director Coordinator of the National Reproductive Health Programme
Ministry of Health
Democratic Republic of the Congo

Carmen Perez Samaniego
Supra-regional Project "Strengthening the German contribution to the global AIDS response"
Deutsche Gesellschaft für Technische Zusammenarbeit (gtz)
Germany

José Luis Rocha Castillo
Gen.Sec. Quality & Modernization
Regional Andalusian Health Ministry
Spain

Basia Tomczyk*
International Emergency and Refugee Health Branch
Centers for Disease Control and Prevention Centers for Disease Control and Prevention (CDC)
United States of America

International agencies

United Nations Population Fund

Laila Baker*
Humanitarian Liaison Specialist, Humanitarian Response Branch, Programme Division
Switzerland

Luc Debernis°
Senior Maternal Health Advisor
United States of America

Pam DeLargy
Acting Representative
Sudan

Wilma Doedens*
Senior Reproductive Health Coordinator, Humanitarian Response Branch
Switzerland

Dennia Gayle
Sexual and Reproductive Health Advisor
United States of America

Jemilah Mahmood*
Chief Humanitarian Response Branch, Programme Division
United States of America

Peter Sikana
Technical Specialist Reproductive Health
Sierra Leone

United Nations International Children's Fund

Anne Golaz
Senior Health Advisor
Switzerland

United Nations High Commissioner for Refugees

Ouahiba Sakani*
Reproductive and Child Health Officer, Public Health and HIV Section
Switzerland

Marian Schilperoord°
Senior HIV and AIDS Advisor, Public Health and HIV Section
Switzerland

United Nations Relief and Works Agency for Palestine Refugees in the Near East
Umayyaeh Khammash
Chief of Health
occupied Palestinian territory

World Health Organization
Islene Araujo°,
Technical Officer, Gender, Women and Health
Switzerland

Ivana Boko
Administrative Assistant, Strategy, Policy and Resource Management
Health Action in Crises
Switzerland

Rayana Bouhakah
Medical Officer, Emergency and Humanitarian action
Regional Office for the Eastern Mediterranean
Egypt

Claudia Garcia Moreno
Medical Officer, Department of Reproductive Health
Switzerland

André Griekspoor°
Medical Officer, Strategy, Policy and Resource Management, Health Action in Crises
Switzerland

Daniel Lopez-Acuña*
Director of Strategy, Policy and Resource Management, Health Action in Crises
Switzerland

Alexis Ntabona
Coordinator, Department of Reproductive Health
Switzerland

Chen Reis°
Technical Officer, Strategy, Policy and Resource Management, Health Action in Crises Switzerland

Lisa Thomas*
Medical Officer, Department of Reproductive Health
Switzerland

Dörte Wein*
Public Health Officer, Strategy, Policy and Resource Management, Health Action in Crises
Switzerland

Nevio Zagaria*
Coordinator, Strategy, Policy and Technical Development, Health Action in Crises
Switzerland

Ahmed Zouiten°, Medical Officer, Strategy, Policy and Resource Management, Health Action in Crises
Switzerland

Academic institutions

Escuela Andaluza de Salud Pública
Granada, Spain
Iain Aitken
Management Sciences for Health

Doreen Carroll
Administrative Assistant

Maria Gracia Roca

Liliana Palacios García
Consultant

Maria Agustin Pando Letona

Natxo Oleaga Usategui
Director Area of International Health

Other academic institutions
Linda Bartlett
Johns Hopkins Bloomberg School of Public Health, Department of International Health
United States of America

Marleen Bosmans
ICRH Focal Point SRH Research and Knowledge Transfer
International Center for Reproductive Health Ghent University
Belgium

Bayard Roberts
Department of Health Services Research and Policy
London School of Hygiene and Tropical Medicine
United Kingdom

Anna Whelan
Associate Professor School of Public Health and Community Medicine
University of New South Wales
Australia

Non governmental organizations

Indira Basnett
Country Director Ipas
Nepal

Manuel Carballo*
Executive Director, International Centre for Migration and Health
Switzerland

Amjad Iraqui°
Intern, International Centre for Migration and Health
Switzerland

Marlou den Hollander*
Marie Stopes International (MSI)
United Kingdom

Linda Doull
Director of Health & Policy Merlin
United Kingdom

Naomi Nyangetha Nyitambe
Reproductive Health Coordinator Merlin
Liberia

Sandra Krause
Reproductive Health Program Director
Women's Commission for Refugee Women and Children

Amy Watts (Collins)
Programme Coordinator, SPRINT
Malaysia

Ashley Wolfington
International Rescue Committee
United states of America

* *participant at both consultations*
° *participant at follow-up meeting only*

Granada Consensus on sexual and reproductive health in protracted crises and recovery

More than a third of maternal deaths worldwide occur in crisis settings. In protracted crises and recovery there is a lack of access to basic and comprehensive emergency obstetric services and only a small proportion of deliveries in these situations are attended by skilled health providers. There is further a lack of adequate services for victims of sexual violence, insufficient services for prevention and treatment of sexually transmitted infections/ human immunodeficiency virus (HIV) as well as unmet needs for family planning.

To address these challenges, a consultation on sexual and reproductive health in protracted crisis and recovery was convened in Granada, Spain, the 28 to 30th September of 2009, bringing together practitioners directly involved in the provision of services in affected countries, representatives from United Nations organizations and other humanitarian partners from the Health Cluster, academic experts and donors. The participants identified the following priorities for action:

1. MAINSTREAM SEXUAL AND REPRODUCTIVE HEALTH IN ALL HEALTH POLICIES AND STRATEGIES THAT AIM TO REVITALIZE THE HEALTH SYSTEM DURING THE RECOVERY PERIOD AND/OR A PROTRACTED CRISIS. One fundamental objective during protracted crisis and in the recovery after conflict and natural disasters is a quick, equitable and sustainable scaling-up of sexual and reproductive health services. This can only be guaranteed through health systems strengthening occurring within the framework of harmonized and coherent cross-sectoral policy, planning and action. Sustainable interventions are essential to ensure the right to health of affected populations, to prevent regression of coverage during the recovery period and to strengthen the health system to better withstand any future crises.

2. ACHIEVE SUSTAINABLE CONSOLIDATION AND EXPANSION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN PROTRACTED CRISES AND RECOVERY. The Minimum Initial Service Package of sexual and reproductive health (MISP) is a priority set of life-saving activities to be implemented at the onset of every emergency. It forms the starting point for all reproductive health programming. Full implementation and coverage of the MISP in a sustainable way needs to be assured as a solid foundation for a wider scope of interventions during protracted crises and recovery. This is a gradual process that requires critical interventions for strengthening the performance of the often weakened health system, especially in affected areas. It needs to be contextualized and adapted to the specific circumstances. This necessitates better assessment of the needs both in terms of health outcomes and of coverage of services; scaling up service provision through comprehensive primary health care emphasizing the local district operations using evidence based approaches; addressing the human resources dimension, including standardized training for health workers and strengthening the capacity of local staff, governmental and private sector stakeholders, including non-governmental organizations.

3. SECURE THE COMMITMENT OF HUMANITARIAN AND DEVELOPMENT ACTORS TO BRIDGE THE CURRENT SERVICE DELIVERY AND FUNDING GAPS. Greater synergy between humanitarian and developmental actors and institutions are required as early as possible in order to prevent the drop of coverage of services and to sustain health system recovery. This needs a true partnership approach which demands a concerted effort of all national and international stakeholders. This will entail breaking the humanitarian and development compartments and bringing all stakeholders, national and international, including donors, into a more concerted support of more solid and sound health recovery policies, strategies and action plans that can create the necessary economies of scale during these long and difficult periods. Existing platforms of humanitarian and recovery action through the different cluster or sectoral groups and the consolidated and transitional appeal processes need to be fully utilized so sexual and reproductive health is adequately addressed within crisis settings. Currently, essential efforts to strengthen health systems and sustain sexual and reproductive health response remain systematically underfunded. To address this, flexible and sustained funding, that recognizes the long-term investment necessary to meet sexual and reproductive health needs of populations in protracted crises and recovery is necessary.

4. RECOGNIZE AND SUPPORT THE LEADERSHIP ROLE OF NATIONAL AND LOCAL AUTHORITIES, COMMUNITIES AND BENEFICIARIES IN ENSURING SEXUAL AND REPRODUCTIVE HEALTH. This should begin from policy and strategy formulation for prioritizing and developing action plans and programmes to scale-up services. Partnerships at global and country level have a fundamental responsibility to support and strengthen the capacity of national and local actors to ensure involvement and ownership of communities and individuals.

From consultation to action

In July 2010, a second smaller meeting was hosted by WHO and UNFPA in Geneva, Switzerland, to discuss the follow-up to the Granada Consultation and the implementation of the Granada Consensus. Participants agreed on the following points:

- The Consensus should be brought quickly to the attention of stakeholders, including governments, United Nations agencies and NGOs. It is essential both as an information document and a framework on which countries and agencies can scale up their work in this area.
- The Consensus should serve as an advocacy tool to better target policies and programmes designed to strengthen SRH in protracted crises and "transition to recovery" situations. Donor and recipient governments alike should be encouraged to give more attention to the special needs of women and girls affected by conflict and post-conflict transition processes.[1]
- SRH is fundamental to the achievement of broader public health goals and to post-conflict social recovery and reconstruction. Therefore more information must be made available on the promotion and protection of SRH in crisis and recovery situations, and on the role of humanitarian and development partners in the process.

Different definitions of "transition to recovery" and "reconstruction" challenge the effective implementation of SRH services during protracted crises and recovery, making it difficult to position SRH and to define what should be done and by whom.

A second challenge is that even when countries recognize the importance of SRH, many tend to give over responsibility to external groups such as international NGOs whose involvement is often time-limited by their mandate and by a lack of financial continuity. In some cases the long-term involvement of external groups has undercut the perceived need for national governments to invest in SRH, which undermines a sustainable approach by national authorities.

GRANADA CONSENSUS POINTS

Participants to the follow-up meeting reviewed the four points endorsed by the Granada Consensus and drew the following conclusions:

Point 1: Mainstream SRH in all health policies and strategies that aim to revitalize the health system during the recovery period and/or protracted crises.

- The range of agencies working in the area of SRH is large. They have to be identified in order to mainstream SRH work.
- SRH policies are seen by many key stakeholders as optional rather than essential. SRH has to be promoted as an integral component of humanitarian relief and recovery action, and as a key to broader sustainable development.
- Policy-makers have to define SRH policies that are geared to the special needs of the specific crises and recovery situations.
- The promotion of SRH in crisis and recovery processes lacks precision regarding the range of implementation options available to governments and agencies. More work is called for to identify and inform stakeholders on the steps that can be taken to move SRH from policy to practice.
- The structure of the CAP does not do justice to SRH and its components. SRH should be seen as and planned as an integral part of the relief and recovery process.
- Infrastructure is a crucial prerequisite for SRH service provision. CERF and other criteria have to include details on the type of commitments required to create and sustain adequate infrastructure for SRH activities.

Point 2: Achieve sustainable consolidation and expansion of SRH services in protracted crises and recovery situations.

- Health Cluster leads and other key health partners have to be conversant with SRH and to address adequately the challenges associated with its implementation.
- Insufficient attention has been given to explaining to countries how and when (and when not) to move from the MISP to comprehensive SRH services.
- MISP coverage has to be strengthened already during crises to facilitate the sustainability of MISP services during recovery.

- The gathering and use of data on needs and coverage by key interventions such as emergency obstetric care must be promoted.
- To achieve the sustainability of SRH services, their introduction must be done selectively. Both, the expansion of services and the evolution of needs must be carefully monitored.
- Countries should achieve and maintain a good MISP coverage before aiming at comprehensive SRH services. Simultaneously, investments should be sought to make the transition to more comprehensive SRH services as soon as possible.
- More information on the SRH situation in fragile states is needed. UNFPA, UNHCR and the International Planned Parenthood Federation (IPPF) are working on this issue, but much needs to be done to define criteria and help countries strengthen their capacity in this area, including policies, strategies and plans and their implementation.

Point 3: Secure the commitment of humanitarian and development actors to bridge the current service delivery and funding gaps.

- Humanitarian and development partners should be aware of the Granada Consensus and the details of the actions required for its implementation.
- WHO and UNFPA should continue the promotion of SRH in protracted crises and recovery settings and where necessary convene key actors for briefing on the roles that each of them can fill.
- Health Cluster personnel have to be briefed on SRH issues and provided with necessary information and guidelines.

Point 4: Recognize and support the leadership of national and local authorities, communities and beneficiaries in ensuring SRH.

- National ownership of SRH actions during protracted crises and recovery is essential to the promotion and protection of SRH. National governments and ministries of health must be the main authorities on SRH care at a national level.
- Not all national partners are likely to be convinced of the importance of SRH. Potential opponents such as religious and cultural groups have to be educated in the importance of MISP and comprehensive SRH services.
- The number of partners available to work on SRH issues at national level needs to be broadened. The Health Cluster should work with local NGOs and with community-based actors such as community leaders, women's groups, community and other health care workers, and private sector people.
- Capacity-building at national level as well as disaster preparedness and pre-deployment of SRH-related commodities, pre-crisis training of personnel should be a priority.

RECOMMENDATIONS

Advocacy

Although there is an urgent need for more research data on the dynamics of SRH in the context of crisis and in the transition from crisis to recovery, much can and should already be done to support governments in more sustained action to provide sound SRH services to women and girls, men and boys.

Advocacy for SRH in protracted crises and recovery calls for a number of approaches, if the unique nature of the problem and the challenge is to be promulgated. Advocacy for SRH in protracted crises and recovery should include investment in SRH issues in peacetime as well. Both the Granada Consultation and the follow-up meeting highlighted the fact that for countries going into crisis with already weak SRH (and other) health service systems, the outcome is likely to be far worse than for countries that have allocated human and financial resources to the challenge as part of their development agendas.

Country support

Many of the countries that are most vulnerable – from an SRH perspective – to the impact of protracted crises are developing countries with low Gross Domestic Product (GDP), limited qualified human resources to draw upon, and severe limitations in terms of equipment and other resources. Providing support to these countries will be essential if SRH issues are to be given the priority ranking the two consultations agreed was necessary. The form of this support will differ considerably from one country to another, but in general it can be assumed that donors and external operational groups such as United Nations agencies and NGOs, will be called on to play an instrumental role in helping countries to define the magnitude of needs, their location and optional ways of reaching people with special needs and vulnerability.

WHO and UNFPA, in collaboration with the other partners in this initiative will work with countries and all stakeholders in advocating internally for action, defining the size and specific nature of the SRH problem, helping devise responsive plans, mobilizing the resources needed and implementing and monitoring the progress made. As seen in the case studies, the major challenge at country level is the development sound and realistic implementation plans of newly developed policies related to SRH during recovery. Country support should therefore focus on the formulation of realistic policies and facilitation of their implementation.

Technical support

UN agencies such as WHO and UNFPA and technical NGOs are a position to provide technical support to countries and other United Nations agencies and NGOs so that the theme of SRH can be taken up in a technically sound fashion. Where necessary WHO and UNFPA will organize briefings and workshops to both national and international actors on themes such as moving from MISP to Comprehensive SRH services, and under what conditions this is possible. WHO and UNFPA, in collaboration with other actors, are also in a position to assist national and international actors working in the area of SRH to put in place monitoring and evaluation schemes designed to measure process and impact, and provide all stakeholders with explanatory result reports.

Not all protracted crisis and recovery situations will be simple to define or manage and all organizations involved in this SRH initiative should be in a position to help countries and other actors to solve problems that fall outside the expected realm of field-level issues. This will require a rapid response capacity and staff well trained in SRH and emergency relief and recovery issues.

From MISP to Comprehensive SRH Services

The fact that many countries in protracted crises and recovery do not explicitly use the MISP suggests that much more needs to be done to make the MISP known and understood. Some countries try to move to comprehensive SRH services well before they have the capacity to do so, suggesting that many do not have a good understanding of what it entails – from a human, technical and financial resources and infrastructure perspective – in setting up and sustaining such services.

WHO, UNFPA and other technical partners are taking the lead in setting out more clearly not only the rationale and content of the MISP, but also what is involved in moving from the MISP to include other services. They do this through both technical documentation and briefings and training aimed at national authorities, other United Nations agencies and NGOs. They also seek to ensure that this theme is taken up in health planning in general, and that it is acknowledged in all relevant United Nations agency, donor and NGO planning.

Preparedness

Both consultations highlighted the need for countries, regional groups and external actors to be better prepared to respond to SRH needs in protracted crises and recovery. Training national and international groups in preparedness with special reference to SRH services is also urgently called for. Preparedness should encompass comprehensive SRH planning with fragile states and other countries that are prone to be affected by crises. As part of this, more attention should be given to forward planning and warehousing of SRH (and other) supplies. This is in turn should be accompanied by training in themes such as warehousing and the management of pre-deployed SRH and other materials. Much could be done through the systematic pre-deployment of the SRH kits.

As part of preparedness exercises countries that are considered to be "at risk" of man-made and natural disasters should be encouraged and helped to develop as-good-as- possible data bases on key SRH issues so that these can become the basis on which SRH plans can be developed, and actions monitored and evaluated.

NOTES

1. During the Granada Consultation, participants also emphasized the importance of SRH for men, families and society in general.

IASC
Inter-Agency Standing Committee

Sexual & Reproductive Health (SRH) including HIV: from Minimum Initial Response to Comprehensive Services

Global Health Cluster

Relief

Protracted crisis/Recovery

Minimum initial service package for SRH (MISP) including HIV

Area	MISP
STIs including HIV	Standard precautions (supplies and guidance)
	Free condoms available (including female condoms if already used in affected population)
	Safe blood supply and rational use of blood transfusion
	Syndromic treatment of STIs
	Co-trimoxazole prophylaxis for HIV related illnesses
	ARV drugs for PMTCT where mother is known to be HIV positive
	ARV continued for people already on ARVs (ART & PMTCT)
Maternal & newborn health	Contraceptives available
	Clean home delivery kits available
	Skilled care during childbirth for clean and safe normal deliveries in health facilities
	Essential newborn care
	Basic emergency obstetric care (BEmOC) 24/7
	Comprehensive emergency obstetric care (CEmOC) 24/7
Sexual violence	Prevention and management of consequences of SV including presumptive STI treatment, EC, PEP and psychosocial support and protection system

How to evolve from the minimum initial to the comprehensive response

Ensuring quick, equitable and sustainable scaling up and expansion of SRH and HIV health services requires strengthening of all six health system building blocks, according to local context and health system capacities.

Source:
Everybody's business: strengthening the health systems to improve health outcomes. WHO's framework for action. Geneva: World Health Organization, 2009.

Comprehensive services and their link to the minimum initial response *

Category	Comprehensive services
MISP services to be maintained in a sustainable way during all the phases of the crisis	Skilled care during childbirth for clean and safe normal deliveries in health facilities
	Essential newborn care
	Basic emergency obstetric care (BEmOC) 24/7
	Comprehensive emergency obstetric care (CEmOC) 24/7
MISP services to be expanded as soon as a proper assessment of the local context and needs has been done	Standard precautions with appropriate HF waste managements options
	Condom promotion including female condoms
	Blood bank services
	STI programme for women, men and adolescents
	Prophylaxis and treatment of all opportunistic infections
	Full PMTCT
	ART, including ART adherence counselling & support
	Clean home delivery by skilled birth attendant
	Family planning programmes for women, men and adolescents
	Comprehensive abortion care & post-abortion care
	Full medical, psychosocial and legal assistance and prevention for rape survivors and other forms of SGBV (domestic violence, female genital mutilation, and others)
Services to be introduced in order of priority according to the needs and capacities of the local health systems	Antenatal care
	Post-partum care services
	HIV counselling and testing services
	Home-based care services including patient self-management training, palliative and end-of-life care
	Prevention and treatment of fistula, including physiotherapy and psychosocial assistance
	Gynecological care, including management of menopause, surgical and oncological management of female reproductive cancers, cervical and breast cancer screening, infertility management, etc.
	Urological care, including management of female and male SRH malfunctioning, surgical and oncological management of male RH problems (circumcision, cancers, infertility, etc.)

* Synergies across the sub sectors within the expanded comprehensive response.

July 2010

Sexual & Reproductive Health (SRH) including HIV: from Minimum Response to Comprehensive Services

How to evolve from the minimum initial response to the comprehensive response

Ensuring quick, equitable and sustainable scaling up and expansion of SRH and HIV services requires the following: 1) Consolidate full coverage of all services defined by the minimum initial response, 2) Transfer governance responsibilities to the national health authorities and strengthening the local health system; 3) Plan for the expansion towards comprehensive services, while maintaining performance of all services from the minimum initial response and ensuring availability, accessibility, acceptability and quality of SRH and HIV services.
This requires strengthening of all six health system building blocks, according to local context and health system capacities. Critical issues to be considered in planning and mana-ging the consolidation of the minimum initial response and its expansion include:

1. Leadership/governance

- Are all the minimum initial services delivered in a sustainable way through the local health system and do delivery strategy(ies) move from a humanitarian to recovery?
- Are there policies and a legal framework in place that support the full and sustainable implementation of the minimum initial response and envision its expansion?
- Are there any policies and/or legal frameworks that obstruct the provision of SRH & HIV services, including sensitive and/or controversial issues?
- Have regulation functions of the national health authorities been strengthened, for example through contracting mechanisms with service providers?
- Is the humanitarian coordination mechanism being phased out and has health sector coordination resumed under national leadership, and has its capacity been strengthened at central and peripheral levels?
- Do humanitarian/recovery agencies support decentralization and handover of responsibilities to sub-national health authorities, local NGOs and communities?

2. Information

- Is the availability of health services and human resources assessed and monitored in the crisis area (HeRAMS)?
- Are key health indicators, including SRH & HIV, generated, disseminated, analysed and used to inform planning, particularly at sub-national level?
- Has integration of humanitarian information systems in and/or the strengthening of the national/local HIS been part of the preparation of the expansion of services?
- Are planning and implementation of the expansion of quality SRH &HIV services based on a detailed analysis of health system functions?

3. Service delivery

- Have all potential barriers to access to the minimum initial response for the entire population affected by the crisis been analysed and addressed (including geographic, financial, quality, information, and cultural barriers)?
- Has the minimum initial response been fully integrated in the defined package of health services to be available at the different levels of the primary health care system?
- Is the infrastructure network adequate according to the norms of BEmOC and CEmOC and to local conditions and is a functioning referral system in place?
- Will the adding of a service(s), as envisaged by the expansion of services, have a negative impact on the coverage of the minimum initial response?

4. Human resources

- Do the different categories of health workers have the required skills, the appropriate mix at the different levels of care and the appropriate distribution across the country to implement the minimum initial response?
- Do the skills and numbers of the existing health workforce have to be upgraded to expand from minimum initial response to the comprehensive services, such as through in service training or task shifting?
- Has planning been done for the expansion of a balanced workforce (in terms of numbers, categories and sex), that includes sufficient capacity for the expansion of SRH services?
- How are the training institutions strengthened to increase numbers and competencies as required for the minimum initial response and its expansion?
- Are accreditation systems appropriately applied for training institutions as well as for individual health workers to ensure quality as required for the minimum initial response and its expansion?
- Are the appropriate managerial and supervision capacities in place to expand services?

5. Medical products and technology

- Do national policies and list of essential medicines and equipment include the medicines and equipment required for SRH expansion?
- Are all the medicines and equipment required for provision of the minimum initial response and its expansion integrated in the national standard procurement and delivery system as a pre requisite of a sustainable expansion? (in order to reduce fragmented supply chains and to phase out reliance on SRH/HIV kits)?
- How are constraints in the national procurement system, the warehouse capacity and supply chain management being addressed?

6. Financing

- Are financial resources available for the provision of the minimum initial response and is funding sustainable for implementation by the local health system?
- Have the costs of the expansion of services and/or coverage been estimated and are they covered by sustainable funding mechanisms?
- Does the financing policy include sufficient social protection to reduce inequalities in access and to avoid catastrophic expenditures for health care?
- What are the strategic options to address non service related costs to access SRH services and to encourage women to deliver in a health facility?

List of acronyms

ART	anti retroviral treatment
ARV	anti retroviral
BEmOC	basic emergency obstetric care
CEmOC	comprehensive emergency obstetric care
EC	emergency contraception
GHC	Global Health Cluster
HIS	health information system
MISP	Minimum Initial Service Package
PEP	post exposure prophylaxis
PMTCT	prevention of mother to child transmission
SGBV	sexual and gender-based violence
SRH	sexual and reproductive health
STI	sexually transmitted infections
SV	sexual violence