

UNIT 7: PLAN TO INTEGRATE COMPREHENSIVE SRH SERVICES INTO PRIMARY HEALTH CARE



The implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) not only entails coordination to make lifesaving SRH services available, it is also essential to start addressing comprehensive SRH as soon as possible. This requires vision, leadership, effective coordination skills, and a sound understanding of the local situation and opportunities related to health system reconstruction. This section outlines the steps to take to be ready to expand to comprehensive SRH services integrated into primary health care.

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

- ▶ explain the importance of planning for comprehensive SRH services;
- ▶ understand the process for expanding SRH services toward achieving comprehensive care; and
- ▶ explain the World Health Organization (WHO) health system building blocks.

MISP for SRH objectives and activities

PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE, AS SOON AS POSSIBLE.

This includes working with the health sector/cluster partners to address the six health system building blocks:

- ▶ Service delivery
- ▶ Health workforce
- ▶ Health information system
- ▶ Medical commodities
- ▶ Financing
- ▶ Governance and leadership

Why is planning for comprehensive SRH services a priority?

Providing comprehensive SRH care to all members of a crisis-affected population is an overarching goal of the health sector. If neglected, gaps in the provision of comprehensive SRH services will lead to increased morbidity and mortality. By collecting data, selecting appropriate service sites, preparing staff, ensuring the availability of supplies, and identifying long-term funding mechanisms, comprehensive SRH services can be more quickly and efficiently operationalized once the MISP for SRH has been implemented.

What are comprehensive SRH services?

According to a report from the Guttmacher-Lancet Commission, comprehensive SRH services are “essential sexual and reproductive health services that must meet public health and human rights standards, including the ‘Availability, Accessibility, Acceptability, and Quality’ framework of the right to health.”¹¹⁶ The services should include the following, as quoted in the commission’s report:

- ▶ Accurate information and counseling on SRH, including evidence-based, comprehensive sexuality education.
- ▶ Information, counseling, and care related to sexual function and satisfaction.
- ▶ Prevention, detection, and management of sexual and gender-based violence and coercion.
- ▶ A choice of safe and effective contraceptive methods.
- ▶ Safe and effective antenatal, childbirth, and postnatal care.
- ▶ Safe and effective abortion services and care, to the full extent of the law.
- ▶ Prevention, management, and treatment of infertility.
- ▶ Prevention, detection, and treatment of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), and of reproductive tract infections.
- ▶ Prevention, detection, and treatment of reproductive cancers.

Who should have access to comprehensive SRH services?

As with the MISP for SRH, all people (women, girls, men, and boys) should have access to comprehensive SRH services. The best way to ensure that SRH services meet the needs of the affected population is to involve the community in every phase of the development of those services; only then will people benefit from services specifically tailored to their needs and demands and only then will they have a stake in the future of those services.

¹¹⁶ *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission* (The Lancet, May 9, 2018), <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>.

What are some considerations for specific populations when planning for comprehensive SRH services?

SRH services must be accessible for all crisis-affected populations, including often-marginalized populations such as adolescents, persons with disabilities, unmarried and married women and men, the elderly, sex workers and clients, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) persons, ex-combatants, uniformed staff, and injecting drug users. This chart demonstrates some of the special considerations for specific populations.

Adolescents	Adolescents in humanitarian emergencies face increased risks of sexual violence, abuse and exploitation, unintended pregnancy, and unsafe abortion. Health staff should be aware that adolescents requesting contraceptives have a right to receive a full range of contraceptive services, including emergency contraception (EC), regardless of age or marital status. Adolescents presenting to facilities for voluntary contraception should be asked about STI symptoms and HIV, and voluntary contraception should be discussed with those who come to STI clinics.
Persons Engaged in Sex Work	It is important to be mindful that persons engaged in sex work have the same SRH needs as their peers who are not engaged in sex work. It is important to ensure their needs are addressed through discussion and counseling on available methods of contraception, safe sex and STI/HIV protection, and instructions on the proper use of male and female condoms and lubricants. Service providers should also screen for HIV and other STIs, promote and provide condoms and lubricants in sufficient quantities, prescribe the client's preferred contraceptive method, and make EC available.
Persons with disabilities	The diverse SRH needs of persons with disabilities are rarely understood or addressed through SRH programming in emergency contexts. The SRH needs of persons with disabilities, their family planning intentions, increased risk of sexual violence in emergencies, and access to voluntary contraceptive services should be understood and mainstreamed within comprehensive SRH programming.
LGBTQIA Persons	Discriminatory laws, attitudes, and practices often produce health disparities and compromise the ability of LGBTQIA individuals to access quality SRH services. SRH care should focus on a person's specific needs, determined by their behavior rather than their identity. Providers should adopt a respectful and nonjudgmental attitude when providing contraceptive services, being mindful of the particular barriers that LGBTQIA persons may face when seeking care and should strive to address any concerns that may be specific to this population.

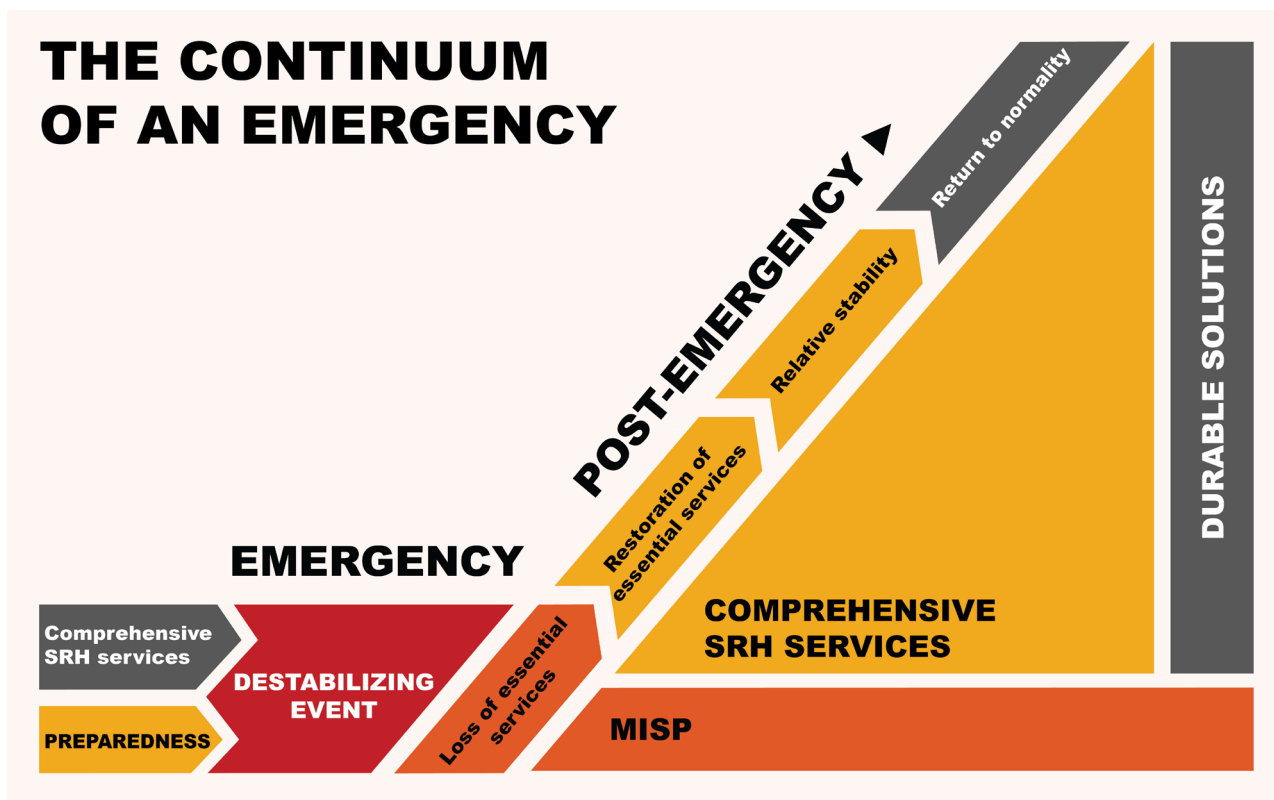
What aspects need to be considered when supporting local and international stakeholders in planning for delivery of comprehensive SRH services?

Providing comprehensive, high-quality SRH services in humanitarian settings requires a multisectoral, integrated approach. Protection, health, nutrition, and education, as well as water, sanitation, and hygiene and community service personnel all have a part to play in planning and delivering services. When planning, it is therefore important to consider the following:

- ▶ Communication among decision-makers and implementing partners
- ▶ Adequate financing
- ▶ Effective coordination
- ▶ Supply chain management
- ▶ Human resource management
- ▶ Monitoring and evaluation
- ▶ System of information sharing, feedback, and accountability to the affected community
- ▶ An exit strategy for humanitarian partners

When should planning start for comprehensive SRH services?

It is essential to start planning for the integration of comprehensive SRH activities, with health sector/cluster partners as well as with affected women, adolescents, and men, as soon as possible. This includes obtaining input/feedback on the initial response in order to identify gaps, successes, and avenues for improvement. When planning for the delivery of comprehensive SRH services, the priority services put in place as part of the MISP for SRH should be built upon, sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction.



How should planning for comprehensive SRH services take place?

Planning for comprehensive SRH services should take place through a participatory planning process among national stakeholders, national and international partners, relevant partners at provincial, regional, or local levels, and the affected population.¹¹⁷ The objective of the participatory planning process is to integrate comprehensive SRH programming into health system reconstruction efforts through a collective work plan for comprehensive SRH. As part of the participatory planning process, key stakeholders should do the following:

1. Assess the current situation, including the status of MISP for SRH implementation and the state of SRH among affected populations.
2. Based on this information and using the health system building blocks (see more information below) as a framework, identify SRH service needs and opportunities for expansion and integration into primary health care.
3. Referring to the activities and interventions seen as a group to be gaps and opportunities, identify and decide on planning priorities. Priorities for achieving comprehensive SRH services could include the broadening and strengthening of existing MISP for SRH services, as well as inclusion or strengthening of SRH services that fall outside the MISP for SRH.

¹¹⁷ A toolkit for implementing this participatory planning process is under development by the IAWG Training Partnership Initiative: "Integrating Sexual and Reproductive Health into Health System Reconstruction: A Workshop Toolkit to Catalyze Participatory Planning to Move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to Comprehensive Sexual and Reproductive Health Programming."

4. Develop a collective work plan for comprehensive SRH services to:
 - strengthen and build upon existing SRH implementation;
 - address service gaps and challenges;
 - be used as an advocacy tool to garner support and funding for programs; and
 - feed back into the overall reproductive, maternal, newborn, child and adolescent health program review.

Although initial planning starts at the onset of the response, this formal participatory process should begin as soon as the MISP for SRH indicators are reached and when humanitarian appeals processes and agencies begin longer-term planning processes. To avoid delays and ensure sustainability, it is essential that comprehensive service components are integrated into the national longer-term funding and planning processes, such as the Humanitarian Response Plans. *It is important to note that the implementation of comprehensive SRH programming should not negatively affect the availability of MISP for SRH services; on the contrary, it should improve and expand upon them.*

What should be assessed and planned for under the WHO health system building blocks?

1. Service delivery

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

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

2. Health workforce

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

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

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

Provide protocols and job aids to support quality service delivery according to evidence-based best practices. For examples, see iawg.net/resource/job-aids-health-care-providers-humanitarian-settings/.

3. Health Information System

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

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

- ▶ Ministry of Health policies and protocols for standardized care (e.g., STI syndromic management, family planning protocols, and laws and regulations surrounding safe abortion care).
- ▶ MISP for SRH service indicators that are monitored and evaluated. The MISP for SRH Checklist in Appendix B and process evaluation tools are useful for ensuring the MISP for SRH components are in place.¹¹⁸ For gathering data as part of needs assessments, *Reproductive Health Assessment Toolkit for Conflict-Affected Women can be helpful*.¹¹⁹
- ▶ Services and supply consumption data at health facilities.
- ▶ SRH demographic information collected about the affected population, number of women of reproductive age, number of sexually active men, crude birth rate, age- and sex-specific mortality data, newborn mortality rate, and maternal mortality rate.
- ▶ STI and HIV prevalence, contraceptive prevalence and preferred methods, prevalence of unsafe abortion, and SRH knowledge, attitudes, and behaviors of the affected population.

118 IAWG. (2017). MISP Process Evaluation Tools. Retrieved from: www.iawg.net/resource/misp-process-evaluation-tools-2017.

119 Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention, & Department of Health and Human Services. (2007). *Reproductive Health Assessment Toolkit for Conflict-Affected Women*. Atlanta, GA. Retrieved from: https://www.unscn.org/web/archives_resources/files/ToolkitforConflictAffectedWomen.pdf.



Integrating Comprehensive SRH Services into Primary Health Care in the Rohingya Humanitarian Response in Bangladesh

A needs assessment was conducted with sound sampling, which allowed for analysis of real-time data and evidence to guide planning and programming.¹²⁰ However, one of the major challenges to integrating comprehensive SRH care was related to funding. Funding was for short, joint-response cycles, which made long-term planning difficult and the risk of service withdrawal high. This highlights a need to aim to identify long-term funding sources as soon as possible.

4. Medical commodities

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

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

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

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

¹²⁰ Site visit follow-up, Women's Refugee Commission, November 2018.

Some suggestions to strengthen national supply chains include the following:

- ▶ Hire staff trained in supply chain management and medical logistics.
- ▶ Develop the capacity of existing staff on supply chain management.
- ▶ Establish a health-logistics coordination sub-group under the health cluster in close partnership with the logistics cluster.
- ▶ Estimate monthly consumption and utilization of SRH commodities.
- ▶ Support the creation of, or reinforce an existing (if one exists) national logistics management information system.
- ▶ Identify medical supply channels. If local supply chains are inadequate (e.g., can not confirm quality standards), obtain SRH commodities through recognized global suppliers or with support from UNFPA (through the Procurement Services Branch¹²¹), UNICEF, or the WHO, which can facilitate purchasing bulk quantities of high-quality SRH supplies at lower costs.
- ▶ Place timely orders through identified supply lines.
- ▶ Store supplies as close to the target population as possible.



Always keep in mind the importance of utilizing and strengthening sustainable medical supply chains when planning for comprehensive SRH services. For more information and guidance, see Unit 9 in this publication and Chapter 4 in the 2018 Inter-Agency Field Manual (IAFM).

5. Financing

To ensure ongoing access to affordable, high-quality comprehensive SRH care, long-term financing mechanisms must be considered during the initial response to a crisis. A good health financing system is critical to sustaining comprehensive SRH care.^{122,123} Several financing options include, but are not limited to:

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

¹²¹ www.unfpaprocurement.org.

¹²² Kutzin J., Witter S., Jowett M., Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Geneva: World Health Organization; 2017. (Health Financing Guidance No 3) Licence: CC BY-NC-SA 3.0 IGO, accessed: <https://apps.who.int/iris/bitstream/handle/10665/254757/9789241512107-eng.pdf?sequence=1>.

¹²³ *Health financing in post-conflict settings – a literature review*, (ReBUILD Consortium, 2011), <https://rebuildconsortium.com/media/1124/health-financing-in-post-conflict-settings-a-literature-review.pdf>.



UNHCR's Health Financing Efforts

- ▶ UNHCR has begun to implement successful cash-based interventions for health programs in refugee settings, such as a program offering Syrian refugee women short-term cash payments to offset the cost of maternal health care.¹²⁴
- ▶ The UN agency has had further success in integrating crisis-affected populations into the national health insurance structure of the country in which they are residing.

6. Governance and leadership

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

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

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

Unit 7: Key Points

- ▶ Gaps in the provision of comprehensive SRH services to all members of a crisis-affected population will lead to increased morbidity and mortality.
- ▶ It is essential to start planning for the integration of comprehensive SRH activities with health sector/cluster partners, as well as affected women, adolescents, and men, from the onset of the humanitarian response.
- ▶ The implementation of comprehensive SRH programming should not negatively affect the availability of MISP for SRH services; on the contrary, it should improve and expand upon them.
- ▶ As with MISP for SRH services, comprehensive SRH services must be accessible for all crisis-affected populations, including adolescents, persons with disabilities, unmarried and married women and men, the elderly, sex workers and clients, LGBTQIA individuals, ex-combatants, uniformed staff, and injecting drug users.
- ▶ SRH must be integrated into public health packages and linked to other service sectors, including when strengthening SRH supply chain management.
- ▶ When planning for comprehensive SRH services, use the six WHO health system building blocks as a framework: service delivery, health workforce, health information system, supplies and medical commodities, financing, and governance and leadership.

¹²⁴ *Cash-Based Interventions for Health Programmes in Refugee Settings: A Review*, (UNHCR, 2015), <https://www.unhcr.org/568bce619.pdf>.

Challenges and Solutions

Challenges	Solutions
<p>What if there appears to be a lack of female health workers?</p>	<p>Efforts should be made to identify and engage female health workers, particularly in contexts where restrictive religious or cultural norms bar male health workers from examining female patients. Where feasible, engage and train female health workers in the emergency preparedness phase.</p> <p>The lack of female staff, however, should not prevent women and girls from accessing care. Another option is to ensure a female attendant or friend accompanies the woman seeking medical care.</p>
<p>What can an agency do to obtain reliable data on the crisis-affected population (e.g., background information on maternal, infant, and child mortality, HIV/STI prevalence, and contraceptive use)?</p>	<p>This information should be collected through the health sector/cluster and should be available to its members, including the Ministry of Health. In addition, the agencies that attend health sector/cluster and SRH working group meetings may be able to collectively obtain reliable data online from agencies such as UNFPA, WHO, United States Agency for International Development (USAID), the World Bank, the Demographic and Health Survey, and the Ministry of Health.</p> <p>If possible, try to collect data from credible online resources, or request headquarters to assist and ensure that data is shared and compared with that available to the health sector/cluster more broadly. Where there are inconsistencies in data, there should be discussions within the health sector/cluster to agree on which should be used.</p>
<p>How can I initiate a participatory planning process to expand services from the MISP for SRH to comprehensive SRH?</p>	<p>Field experience has shown that this MISP for SRH objective remains challenging to implement. In order to help address this gap, the IAWG on SRH in Crises Training Partnership Initiative is developing a workshop toolkit to support SRH Coordinators and key national and international stakeholders in their efforts to expand services from the MISP for SRH to comprehensive SRH services. This toolkit will be available on the IAWG website in 2020.</p>

MISP FOR SRH MONITORING CHECKLIST: PLANNING FOR THE TRANSITION TO COMPREHENSIVE SRH SERVICES

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

7. Planning for Transition to Comprehensive SRH Services			
7.1	Service delivery	Yes	No
	SRH needs in the community identified		
	Suitable sites for SRH service delivery identified		
7.2	Health workforce	Yes	No
	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		

MATERIALS AND SUPPLIES

Which supplies are useful for planning for comprehensive SRH services integrated into primary health care?

This objective does not have a kit associated with it.

Unit 7 Quiz: Plan to Integrate Comprehensive SRH Services into Primary Health Care as Soon as Possible

1. Which of the following is a core component/building block of the health system?
 - a. Health information system
 - b. Health workforce
 - c. Community awareness
 - d. Service delivery
 - e. a, b, and d
2. In order to ensure ongoing access to affordable comprehensive SRH care, long-term financing mechanisms must be considered at the initial response to a crisis.

True or False

3. Which one of the following should **not** be considered when selecting a site to deliver comprehensive SRH services?
 - a. Distance to existing health facilities, SRH services, and other health services
 - b. Accessibility to all potential users
 - c. Ability to have a standalone SRH service
 - d. Privacy and confidentiality during consultations
 - e. Feasibility of communications and transport for referrals
4. When planning for comprehensive SRH services, you must continue to order the prepackaged IARH Kits.

True or False

5. Which information or data should be collected to plan for comprehensive SRH services?
 - a. Individual organizations' protocols for standardized care
 - b. MISP for SRH service indicators that are monitored and evaluated
 - c. General health data and statistics on noncommunicable and communicable diseases, malnutrition rates, etc.
 - d. Chronic disease prevalence and health knowledge of the affected population
 - e. All of the above