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Zenebech, mother of three, with her youngest at an emergency food assistance gathering. August 7, 2020. Ethiopia.*

READY: GLOBAL READINESS FOR MAJOR DISEASE OUTBREAK RESPONSE

Maternal, Newborn, and Reproductive Health and COVID-19: Adaptations, Successes, Challenges, and Next Steps. An Expert Consultation.

November 2020

READY Initiative

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Acronyms

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CASS	Cellule d'Analyse des Sciences Sociales (Social Science Analysis Cell)
CDC	Center for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHWs	Community Health Workers
DRC	Democratic Republic of the Congo
FIGO	International Federation of Gynecology & Obstetrics
GOARN	Global Outbreak Alert and Response Network
HIV	Human Immunodeficiency Virus
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IPC	Infection Prevention and Control
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
ITCs	Isolation and Treatment Centers
ITM	Institute of Tropical Medicine
LMICs	Low and Middle Income Countries
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations
MMR	Maternal Mortality Rate
MNRH	Maternal, Newborn and Reproductive Health
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGOs	Non-Governmental Organizations
OCHA	Office for the Coordination of Humanitarian Affairs.
PHC	Primary Health Care
PNC	Postnatal Care
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
RCOG	Royal College of Obstetricians and Gynaecologists
SAC	Safe Abortion Care
SARI	Severe Acute Respiratory Infection
SBA	Skilled Birth Attendant
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SC	Save the Children
STI	Sexually Transmitted Infections
TBAs	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSLAs	Village Savings and Loan Associations
WHO	World Health Organization
WRC	Women's Refugee Commission

Executive Summary

Introduction: In early 2020, the COVID-19 pandemic spread across the world in a few months and caught the humanitarian community unprepared. Despite lessons learned in previous outbreaks (Ebola in West African and the Democratic Republic of Congo, Cholera in Yemen, etc.), Maternal, Newborn, and Reproductive health (MNRH) priorities were not included in Country Preparedness Plans and the global community feared that these were deprioritized during the COVID-19 response.

In October 2020, the READY initiative[1] and the Inter Agency Working Group on Reproductive Health in crises (IAWG) organized a four-day remote expert consultation where key Maternal, Newborn, and Reproductive health and infectious disease stakeholders came together to review MNRH in the infectious disease preparedness/outbreak response and identify priorities for the ongoing pandemic. The purpose of these consultations was to share and compile experiences and lessons learned, and to identify the challenges and gaps in implementing humanitarian MNRH services in COVID-19 across the world. COVID-19 guidelines and tools most used by implementers were analyzed in terms of their successes, challenges, and gaps. The interactions between global and field levels were analyzed and lessons learned have been drawn out to improve ways of working moving forward. The recommendations developed from these consultations are intended to support MNRH services and actors to improve access and quality of care to vulnerable populations in future waves of COVID-19 and in future outbreaks.

Methods: A series of four discussion-based workshops were organized around the three phases of an outbreak: preparedness, response, and recovery, with an additional workshop for francophone participants.

To ensure a diversified group, the Steering and Technical Support Committees compiled a list of possible participants from which the consultants selected and invited 68 participants to meet the following criteria:

- Diversity of institution: different non-governmental organizations, donors, United Nation's organizations, Ministries of Health (MoH) and research institutions
- Combination of field and global level experts
- Diversity of contexts and countries
- Diversity of background on Maternal/Newborn/Reproductive Health and Infectious Diseases

There were 19 participants for the Francophone session on October 1st. For the Anglophone sessions, there were 27 participants on Day 1 (October 5th), 28 participants on Day 2 (October 7th), and 19 participants on Day 3 (October 9th).

Within each session, participants were further divided into three breakout groups to discuss different thematic areas: Maternal, Newborn, and Reproductive Health. Facilitators used discussion tools that were iteratively developed to guide brainstorming. The notes taken from these conversations were then compiled into master documents and coded to identify themes across days/groups. This analysis formed the basis of this report.

[1] The READY initiative exists to augment global capacity to respond to outbreaks of infectious disease with epidemic or pandemic potential that rise to the level of a humanitarian emergency. Led by Save the Children, READY is implemented in partnership with the Johns Hopkins Center for Humanitarian Health, the Johns Hopkins Center for Communication Programs, UK-Med, EcoHealth Alliance, and Mercy Malaysia.

Key Findings: Participants were asked to reflect upon their experiences with implementing MNRH interventions during the COVID-19 outbreak response. Identified adaptations, successes, and challenges were analyzed via the health system building blocks framework:

1. *Health workforce*: Routine and COVID-19-specific trainings and supervision of staff went remote and online causing logistical challenges. Midwives were often overlooked for COVID-19 trainings and trainings of trainers, thus overseeing the specific needs of maternity units. The increased workload, fear of infections, and increased stigma resulted in unsustainable levels of stress and lowered motivation. Community-level providers were generally excluded from service adaptations such as personal protective equipment (PPE) trainings, increasing their risk of contracting and spreading the virus.

2. *Service Delivery*: MNRH adaptations to COVID-19 included restructuring the service layout (routes and patient flow); maintaining social distance; pivoting to low/no-touch services; allowing smaller groups of patients in at a time (eg. antenatal care [ANC]); reducing hospital visits by providing commodities for longer periods (eg. family planning); and offering telephone follow-ups (eg. postnatal care). According to anecdotal evidence, the quality of services suffered, as MNRH was not prioritized in the outbreak response. Efforts to improve community networks and feedback have improved since the onset of the pandemic, and should be mobilized to improve MNRH services. Due to a decrease in demand for and access to facility-based services, the need to provide acceptable MNRH services at community level is becoming increasingly apparent.

3. *Health Information Systems*: COVID-19 prevention measures, such as movement restrictions and social distancing, broke down many of the data collection, compilation, and analyses systems in place prior to the pandemic. While adaptations were put in place, including online data collection systems and online data analysis meetings, they were not suited to every context. Both MNRH and outbreak data collection tools did not adapt to each other, limiting the availability of data to investigate the interaction between MNRH and COVID-19 and the impact of COVID-19 on MNRH services.

4. *Finance*: Preparedness Plans were not systematically developed nor adequately funded; when they were developed, MNRH was frequently absent, causing resources to be diverted from MNRH services toward the COVID-19 response. However, the pandemic has diversified sources of funding (philanthropies and non-traditional donors that do not usually fund MNRH), which could be capitalized upon to strengthen MNRH programs moving forward.

4. *Medical commodities*: The incredible demand for PPE at global scale was unique and unprecedented and impacted international and local markets, causing stock-outs across services, and diversion of commodities towards areas in hospitals with perceived higher COVID-19 risk. As a result, MNRH staff and patients were forced to adopt high-risk behaviors and were put at increased risk of COVID-19 transmission, thus affecting the quality of services.

5. *Governance and Leadership*: The lack of coordination between the COVID-19 response structure and the MNRH response structure at every level (global, regional, national and local) led to contradicting guidelines and created confusion and tensions. Additionally, lack of coordination between MNRH partners and governments led to difficulties in identifying common priorities.

According to participants, the World Health Organization (WHO) and IAWG issued the most commonly used guidelines to operate and adapt MNRH programs during this COVID-19 pandemic. However, some guidance gaps remained, such as home-based care and the management of newborns in

COVID-19, and thus some organizations developed their own tools or relied on guidance from professional bodies (e.g. Royal College of Obstetricians and Gynaecologists).

The overload of (sometimes conflicting) guidance, and the necessity to adapt documents to ever-changing contexts, created tensions during implementation. Frontline staff experience needs to be better reflected in future guidance development and roll-out processes. Most global level tools get disseminated down to the implementation level through national Ministries of Health. However, specific MNRH guidance developed by IAWG reached implementation levels via IAWG member organizations, thus causing tensions in some contexts for MNRH implementation teams receiving separate guidance from local and internal authorities.

Recommendations:

1. **Health Workforce and Service Delivery**:
    - Invest in the training of frontline staff (including how best to prioritize essential MNRH services during a pandemic) before and during a response and investigate approaches to retain essential services at both facility and community level and identify the training programs that worked best.
    - Invest in workforce wellbeing and ensure that staff experience informs guidance for future outbreaks.
    - Ensure Infection Prevention & Control (IPC) supplies are included in MNRH kits (e.g. Inter-Agency Reproductive Health Kits) and MNRH supplies are included in outbreak response procurement plans and essential medical lists.

2. **Community Level MNRH Services**:
    - Ensure appropriate research and evidence-based guidance is developed and disseminated to improve community level care, including research for safe home birthing, guidance on community distribution of reproductive health commodities, and community health worker protection.
    - Develop suitable modalities to invest, train, and support community level workforce before and during an outbreak, and ensure their inclusion in lessons learned exercises.
    - Capitalize on new communication approaches (including risk communication and community engagement approaches) and networks to strengthen MNRH service demand.

3. **Guidance and tools**:
    - Develop a comprehensive MNRH tool to help frontline staff adapt their services to different types of epidemics (respiratory, water-borne, viral haemorrhagic, etc.) at the onset of new epidemics while more specialized tools are being developed. Breakdown new guidance into checklists, one-pagers, and other rapid adaptation tools and dissemination methods to enable easy assimilation of new guidelines.
    - Ensure MNRH tools are disseminated through national channels in appropriate local languages.
    - Provide guidance and technical support from Health Clusters to operationalize tools to the local context.

4. **Coordination**:
    - Rework or develop and invest in country-level Preparedness Plans that include MNRH as an essential service.
    - Improve the collaboration between the MNRH and the outbreak sectors at all levels.
    - Advocate for a multisectoral outbreak response and capitalize on new stakeholders (donors, research institutions, suppliers, private sector etc.) to improve on MNRH services.
    - Lead gender impact analyses to ensure that MNRH programs are reaching the most vulnerable.

Introduction

The COVID-19 pandemic, caused by a novel coronavirus first identified in China in December 2019, spread across the globe in a matter of months and brought the world to a standstill in March 2020.[2] Health, economic, and social impacts were felt everywhere and compounded pre-existing inequalities in maternal, newborn, and reproductive health (MNRH) outcomes. Humanitarian contexts report considerably worse MNRH indicators than developing or developed settings,[3] and efforts to improve these have been impacted by the pandemic response. Despite a plethora of lessons learned exercises from previous public health crises,[4] such as the 2018–2020 Ebola epidemic in the Democratic Republic of Congo (DRC), the 2014–2016 Ebola epidemic in West Africa, and the 2016–2020 cholera outbreak in Yemen, the global community feared that MNRH priorities and outcomes were deprioritized during the COVID-19 preparedness and response phases.

COVID-19 is a novel disease, and the scale of the spread is unprecedented in modern times, yet there have been missed opportunities at every stage to both stop transmission and to reduce the impact on vulnerable groups, including those served by MNRH programming. This report reviews and challenges certain aspects of the COVID-19 response globally and at the national level, without expressing judgement on any one organization or body. The pandemic has stressed and strained all aspects of the global health structure and system, and the huge efforts made by individuals, organizations, governments, and multi-national bodies to manage this pandemic and save lives are acknowledged.

In September and October 2020, the READY initiative[5] and the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises organized a four-day remote expert consultation where key MNRH and infectious disease stakeholders came together to review MNRH in the infectious disease preparedness/outbreak response and to identify priorities for the ongoing pandemic. The purpose of these consultations was to share and compile experiences and lessons learned and to identify the challenges and gaps in implementing humanitarian MNRH services in COVID-19 across the world. COVID-19 guidelines and tools most used by implementers were analyzed in terms of their successes, challenges, and gaps. The interactions between global and field levels were analyzed and lessons learned have been distilled to improve ways of working moving forward and prioritize efforts. The recommendations are intended to support MNRH services and actors to improve provision, access and quality of care to vulnerable populations in future waves of COVID-19 and potentially in future outbreaks. Some of the reccommendations and findings could also be considered for outbreaks of other origins.

Aims and Objectives

1) To describe the landscape for MNRH services during the COVID-19 pandemic in health facility and community-based settings in a range of humanitarian contexts

2) To mobilize the expertise of implementation and global technical experts to gather existing guidance, lessons learned, and challenges for providing MNRH services during the COVID-19 pandemic and identify gaps in guidance for MNRH services during the preparedness, response, and recovery phases of

[2] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline#event-0
[3] https://www.unfpa.org/sites/default/files/resource-pdf/MMR_in_humanitarian_settings-final4_0.pdf
[4] https://www.rescue.org/report/not-all-bleeds-ebola-how-drc-outbreak-impacts-reproductive-health
[5] The READY initiative exists to augment global capacity to respond to outbreaks of infectious disease with epidemic or pandemic potential that rise to the level of a humanitarian emergency.

the pandemic

3) To develop an action plan including recommendations to strengthen the MNRH health system during the COVID-19 pandemic

Adapting the Minimum Initial Service Package (MISP)[6] in the Democratic Republic of Congo (DRC) in North-Kivu

In a context that has known decades of civil unrest and a recent large Ebola epidemic, the DRC was able to rapidly pivot its Ebola response to COVID-19. The International Rescue Committee (IRC) ran a MISP program to provide essential MNRH services to women and girls in North Kivu. Adaptations were required for each pillar of the MISP:

- **Coordination**: Regular coordination meetings could no longer occur face-to-face and were shifted to online platforms.
- **Prevent and Manage Consequences of Sexual Violence**. Access to services for survivors became more difficult as the population feared going to healthcare facilities. IRC continued sensitizing women and men through mass media about the importance of seeking clinical care after sexual abuse. PEP kits were provided in facilities and psychosocial services were offered in safe spaces.
- **Reduce Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs)**. Access to treatment became more challenging for men and women as the population feared going to healthcare facilities. The IRC continued its sensitization messages while providing sufficient condoms to last clients for six months. Treatment was offered in facilities, while respecting infection, prevention, and control (IPC) measures.
- **Prevent Maternal and Newborn Mortality**: To decrease the risk of COVID-19 transmission in maternity wards, the IRC set up triages and IPC in all supported maternity units and organized more regular ANC/postnatal care (PNC) consultations with a maximum of five clients to ensure social distancing.
- **Prevent Unintended Pregnancy**: IRC increased sensitizations through mass and social media; provided additional short term methods to clients to reduce visits; coached providers to offer socially distant services and collected data through tablets and Whatsapp.
- **Plan for Comprehensive Sexual Reproductive Health (SRH)**: The IRC is planning on analyzing the capacity of facilities to start up regular services once IPC measures are well integrated.

Methods

The expert consultation process was led by two consultants, in collaboration with a Steering Committee (made up of the two consultants and representatives of Save the Children's MNRH unit, the READY Initiative, and IAWG) and in consultation with the Technical Support Committee (made up of eight volunteers from different organizations within IAWG).

[6] https://iawg.net/resources/minimum-initial-service-package-misp-resources#:~:text=The%20minimum%2C%20life%2Dsaving%20sexual,within%2048%20hours%20wherever%20possible).

Following an initial steering committee meeting, a series of four workshops were organized:

1. Francophone Group on October 1st: 27 participants
2. Day 1: Preparedness (Anglophone) on October 5th: 28 participants
3. Day 2: Response (Anglophone) on October 7th: 19 participants
4. Day 3: Recovery (Anglophone) on October 9th: 19 participants

The consultants developed the objectives for the consultations and an agenda for the workshops, which were reviewed by both committees. The agenda was similar for all four days, and included presentations from the field, breakout discussions in three groups (Maternal health, Newborn health, and Reproductive health) and a plenary discussion. See Annex A for a generic agenda.

Participants

Participation in these workshops was by invitation only. A table was uploaded on Google Drive for members of the Steering and Technical Support Committees to contribute suggestions for participants. A list containing 75 Anglophone experts and 18 Francophone experts was compiled. The consultants then selected participants to fulfill the following criteria:

- Diversity of institution: different non-governmental organizations (NGOs), donors, United Nation's (UN) organizations, Ministries of Health (MoH), and research institutions.
- Combination of implementation and global level experts.
- Diversity of contexts and countries.
- Diversity of background on Maternal, Newborn, Reproductive Health and Infectious Diseases.

A total of 68 experts were selected: 41 from the global level and 27 from the national level. In total, 35 participants were from NGOs, 11 were from the UN, 14 were from research institutions, 4 were from donor institutions, 3 were from MoHs, and 1 was an independent consultant. Invitations were sent to all 68 selected experts; some invitations were forwarded to colleagues and based on response rate additional invitations were sent. There were 19 participants for the Francophone session on October 1st. For the Anglophone sessions, there were 27 participants on Day 1 (October 5th), 28 participants on Day 2 (October 7th), and 19 participants on Day 3 (October 9th).

Tools

The consultants iteratively developed three tools to guide the breakout discussions of each session; these were reviewed by the Steering Committee.

1. Tool 1 was based on the Preparedness phase and structured around the pillars of the Health system (Human Resources; Service delivery; Heath Information System; Financing; Access to Essential Medicines; Leadership and Governance) was developed for the Francophone session and the first day of the Anglophone session.
2. Building on these discussions, Tool 2 was developed for the Response discussion, with a specific lens on the process between the development and the use of guidelines.
3. Following the progression of the discussions and to conclude the series of workshops, Tool 3 was developed for the Recovery discussions and was built around lessons learned and recommendations. The tool templates can be found in Annex C.

The facilitators of each breakout group (selected from the Technical Support Committee) displayed these tools to their group by sharing their screen and typed out the key points under discussion within the word document. These documents were then shared with the consultants after the day's session.

Analysis

The completed tools were then compiled into one "master" document, consolidating the inputs from all three groups: Maternal health, Newborn health, and Reproductive health. There were three master documents, one for each day. These were then coded to pull out new/unique ideas as well as themes across groups and days. These themes have formed the basis of this report.

The report was drafted between October 12th and 19th October, and reviewed between the October 19th and November 20th by the members of the Technical Support Committee and volunteers from IAWG and the READY initiative.

Integrating MNRH in Isolation and Treatment Centers in Bangladesh

Bangladesh has a Maternal Mortality Rate (MMR) of 179/100,000, with high rates of home births and a shortage of trained midwives. UK-Med introduced MNRH services in two Severe Acute Respiratory Infections Treatment Centers (SARI ITCs) in Cox's Bazaar.

The main challenges surrounded timelines (with an unknown trajectory of the pandemic), physical constraints (space and climate), and contextual factors (with low community engagement and service uptake). However, there was a pool of trained midwives in local Primary Health Care (PHC) facilities, and a proactive SRH working group and SRH partners.

SARI ITC Maternal Health Standard Operating Procedures (SOPs) were created and a high and low transmission phase approach was adopted. As a result, UK-Med created 24 maternity beds across two camps (Camp 20: 6 beds and Leda Camp 24: 18 beds); set up a basic emergency obstetric and newborn care services (BEmONC), including trained midwives and obstetricians, with a clear referral to comprehensive emergency obstetric and newborn care services (CEmONC).

Findings

A. Program Adaptations: Successes and Challenges

This report makes reference to the MNRH community and the Outbreak or COVID-19 response community. The MNRH community refers to the stakeholders that research, develop guidelines, and implement MNRH services in humanitarian crises. This community is led by the United Nations Population Fund (UNFPA) and IAWG at global level, and the Reproductive Health Sub-Working Group of the Health Cluster (usually chaired by the MoH at country level) coordinate the MNRH sector at national and implementation levels. The Outbreak or COVID-19 response community refers to actors and stakeholders who research, develop guidelines, and implement outbreak responses in humanitarian settings. COVID-19 leadership at global level is split between the World Health Organization (WHO), the Office for the Coordination of Humanitarian Affairs (OCHA), and the Global Outbreak Alert and Response Network (GOARN). The MOHs of each country lead the response at national and implementation level with or without the Health Cluster.

This section describes program adaptations, analyzed via the Health System Building Blocks framework.

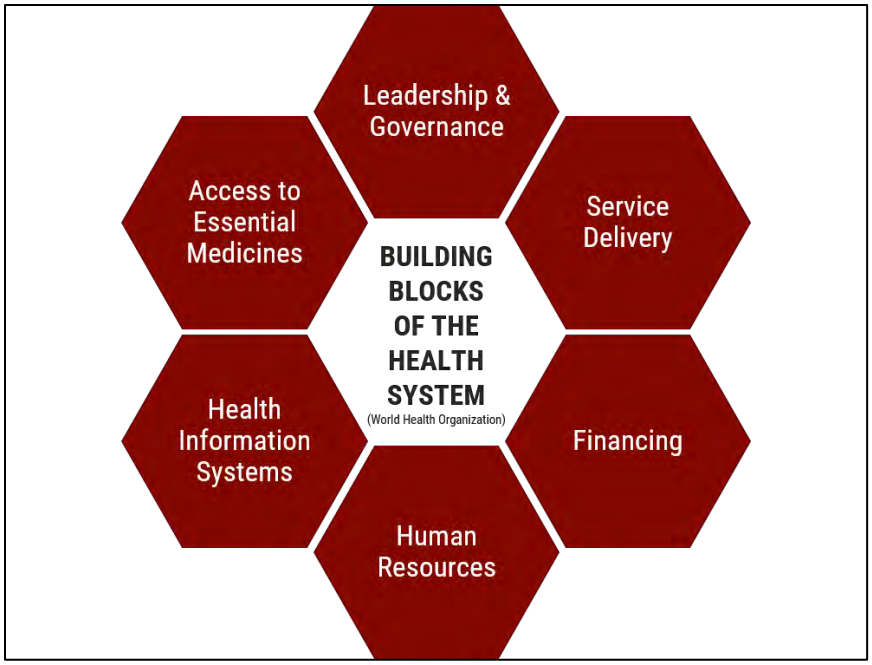

Figure 1: Building Blocks of the Health System (epimetrics.com)

1. Human Resources

Training staff on COVID-19, Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) use was essential in adapting to the COVID-19 pandemic. However, to minimize the spread of the infection, maintaining social distancing was imperative and remote/online trainings had to be adopted. This approach increased the time it took to train the workforce, required increased logistics (such as access to computers and reliable internet network) and in some cases cost more, as explained by a participant from Democratic Republic of the Congo (DRC) who had to increase incentive pay for trainings that took longer due to the online format. Routine MNRH teachings were also adapted to avoid transmission, such as Family Planning trainings in the DRC that was divided into several separate modules, thus increasing the time and cost for the program. Some organizations, such as Save the Children, adopted a "blended" approach, whereby they provided a combination of online and one-on-one in-person trainings by supervisors in clinics.

The World Health Organization and other actors conducted training of trainer (ToT) sessions, often selecting doctors to train others. As a result few members of other cadres, such as midwives, were selected as trainers, though these cadres are generally responsible for overseeing the specific needs of maternity units, an oversight that is slowly being rectified. However, in contexts where there had been previous large outbreaks such as Ebola in the DRC, trainers increasingly included midwives in the training process, and MNRH was more likely to be included in the training modules, demonstrating the application of lessons learned from previous experiences.

Supervision and quality assurance of healthcare provision was difficult to undertake due to social distancing rules, lockdowns and border closures. Different adaptations took place, such as increased use of social media (e.g. WhatsApp) to share experiences and data and for the workers to ask questions. Scorecards were used to monitor improvements in IPC in some facilities following training efforts.
In many cases, training efforts were unable to be properly evaluated for efficacy as it was not possible to check that trainees adopted the measures encouraged in the training and therefore a level of trust was required between supervisees and their supervisor.

Frontline Staff Wellbeing was highly affected during this pandemic. The increased workload and known or feared staff infections were compounded by the stigma that some healthcare workers faced. All of these elements contributed to unsustainable levels of stress and lowered motivation. One respondent from South Sudan spoke about a lack of coordination between partners impacting frontline staff in one health facility: some were provided with PPE and others not, causing tensions and resignations. Some positive adaptations included reworking shift patterns, reducing hours, and "bubbling" workers so that any infections in the bubble would limit who needed to be quarantined.

Community level providers, such as community health workers (CHWs) and traditional providers, were generally excluded from trainings or from the process of deciding how to rework programming and health care delivery in COVID-19. Since they are often the first port of call for community members, they are therefore at increased risk of contracting and spreading the virus.

"Traditional healers were neglected when it came to training and provision of equipment."

2. Service Delivery

Service adaptations had to be made in all MNRH services to integrate IPC and prevent contamination. These adaptations included restructuring the service layout (routes and patient flow), maintaining social distance, increasing hand-washing in facilities, pivoting to low/no-touch services, allowing smaller groups of patients in at a time (eg. antenatal care), reducing hospital visits by providing commodities for longer periods (eg. family planning), offering women in their third trimester with "Laisser-passer" to access hospitals during lockdowns, and offering telephone follow-ups (eg. postnatal care). Field level participants expressed the need to share lessons learned across contexts, however teams in the DRC did mention adopting adaptations based on lessons learned from the previous Ebola outbreak. Many participants stated that outbreak response guidance, for instance on Infection Prevention and Control (IPC),[7] did not initially include MNRH technical inputs, which led to delays in addressing maternity-specific needs, contributing to detrimental outcomes.

Tele-health, while available pre-COVID-19, was rarely used in humanitarian settings. While adopted in some contexts, this approach faced challenges, particularly due to poor connectivity, lack of equipment such as tablets and smart phones, lack of funding, staff-training requirements, and difficulties reaching the most vulnerable or remote communities.

COVID-19-positive maternity patients were dealt with differently in different contexts: either referred to a "red-zone" or to a secondary facility, which required additional resources such as ambulances, toll-free lines, triage and well-established referral pathways, not always available in emergency contexts. Severe Acute Respiratory Infection (SARI) isolation and treatment centers (ITCs) did not consistently include MNRH services and inclusion tended to depend on the lead organization.

Quality of services suffered during COVID-19 according to anecdotal evidence, as many contexts did not prioritize MNRH in the outbreak response. In some instances, such as in Pakistan, outpatient departments, including MNRH services, were forced to close for several weeks. In other contexts, policies in direct contradiction of global best practice[8] were put in place (such as denying birth partner presence during birth) and affecting respectful maternal care. However, the pandemic also offered the

[7] https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-2020.4

[8] https://www.who.int/reproductivehealth/publications/emergencies/Pregnancy-3-1200x1200.png?ua=1

opportunity to tackle quality issues that had not been prioritized earlier, such as reducing waiting times of women seeking antenatal care services.

Demand for MNRH services has decreased due to a generalized loss of trust in the health system because of COVID-19.[9] Community mobilization strategies were criticized for placing too much emphasis on providing information and not enough focus on community feedback. Risk Communication and Community Engagement (RCCE) strategies were therefore adopted by many MoHs and NGOs, following lessons learned in previous outbreaks, to ensure community awareness, engagement, and uptake of services.[10] These approaches grew and have improved significantly since the beginning of the pandemic, mobilizing new approaches, technologies, and networks. Innovative approaches include mobilizing taxi-drivers in Uganda, training CHWs on IPC in Nigeria, and leveraging other community structures, such as village savings and loan associations (VSLAs) in Cox's Bazaar. Demonstrating a flexible health-system, adaptable to respond to the needs of the community was also mentioned to build patient trust, and thus demand for services – however this was sometimes difficult with an over-worked, demotivated workforce. While MNRH messages were not systematically included in these RCCE strategies, especially at the onset of this crisis, mobilizing these new resources could improve community engagement in MNRH in the future.

Community-level services have shifted since the onset of the pandemic. As many contexts observed a decrease in access to basic services at facility-level[11] (ANC, PNC, family planning, births attended by Skilled Birth Attendants [SBAs]), the need to provide quality MNRH services at community level has become increasingly important. While much effort was made to encourage institutional and health facility-based care, the COVID-19 pandemic made it clear that community and home-based services do need to be supported (in a safe way) when the barriers to accessing facility care are too great. Identified evidence based, good practices included supporting reproductive health self-care practices, community-based distribution of commodities and training of community providers (e.g. traditional birth attendants [TBAs]) in IPC measures. Further research is needed to identify safe ways to provide intra-partum care in community settings when there is limited facility access, reduced staffing, risk of nosocomial infections, etc.

"In South Sudan a lack of coordination between partners impacted front line staff in one health facility where some [departments] were provided with PPE and others not, thus causing tensions and resignations"

3. Health Information System

Data Collection tools were not systematically adapted to the COVID-19 pandemic. In humanitarian emergencies, the tools used are negotiated with the MoH and standardized by the health cluster, and therefore were difficult to adapt to the new outbreak. While WHO and UNFPA collaborated on joint indicators at the global level (such as the inclusion of SRH data points in the Global Health Response Plans), implementation-level MNRH data collection tools were not always amended to account for COVID-19. Equally, data collected by the outbreak response system at implementation level did not

[9] UNICEF. Understanding the interruption of essential health services by COVID 19 to guide recovery. Programme brief: Based on cross regional analysis of COVID-19 impact on health services. 10 October 2020.
[10] Ochega A. Ataguba & John E. Ataguba (2020) Social determinants of health: the role of effective communication in the COVID-19 pandemic in developing countries, Global Health Action, 13:1, DOI: 10.1080/16549716.2020.1788263
[11] UNICEF. Understanding the interruption of essential health services by COVID 19 to guide recovery. Programme brief: Based on cross regional analysis of COVID-19 impact on health services. 10 October 2020.

systematically include MNRH data. For instance, in Yemen, pregnancy was recorded in the COVID-19 register as a co-morbidity, and the COVID-19 response coordination remained inflexible to adapt the register. As a result it was difficult to measure the interactions between COVID-19 and MNRH or the impact of COVID-19 on MNRH services. Better dissemination of global tools, more collaboration between MNRH and outbreak response communities at every level, and triangulation of data will provide a better picture of women's experiences in this response, and positively inform policy. An example of this process is taking place in Pakistan at the time of writing, as the MoH collaborated with other actors to lead a Coordinated Gap Analysis of its data, whereby data pertaining to COVID-19 and other thematic areas are being cleaned and filtered so as to inform analysis and a report.

The structure of the Health Information System was negatively impacted by the restrictions set by the COVID-19 response. Pre-COVID-19, a standard (well-functioning) Monitoring and Evaluation (M&E) approach involved healthcare workers collecting data in registers and filling weekly/monthly data collection tools (often hard copies) that were sent to the local MoH office. This data was analyzed in stakeholder meetings and corrective actions were taken and communicated back to facilities. With the onset of COVID-19 and public health measures, such as movement restrictions and social distancing, this process broke down. Supervisors could not travel to remote facilities and collect data and face-to-face stakeholder meetings could no longer take place. As a result, many organizations worked with the authorities to set up online data collection systems (either on tablets or through Whatsapp) and supported stakeholders to continue these data analysis meetings online. However, the logistics of ensuring connectivity and access to devices posed a challenge and were often not accessible by remote facilities.

Data quality is often an issue in humanitarian contexts, and this was compounded by the COVID-19 pandemic. In Pakistan, the National Census was not updated for a decade; therefore, there was no baseline data to set the scene for COVID-19 numbers. However, the resources provided by this crisis created an opportunity to improve systems. For example in South Sudan, UNFPA set up a new database system which could improve the systematically poor data quality in this country.

"In Pakistan the MoH collaborated with other actors to lead a Coordinated Gap analysis of its data."

4. Financing

Crisis Preparedness Plans should be developed in all countries to plan for a response to any (public health) crisis, however this was not systematically done according to consultation participants. Ideally, these plans should include comprehensive budgets and the funds allocated to these plans should not be diverted elsewhere for other reasons. In the few countries that did have solid plans in place, such as the DRC, MNRH was usually not included as part of the planning or budgetary process. As a result, these plans did not include projected MNRH needs, such as program adaptations, trainings, PPE, etc.

Diversion of funds and resources from MNRH services towards COVID-19 was observed in many settings, including in Cox's Bazaar. Respondents stated that MNRH services are often funded through block grants to the Ministry of Health (often with funds from large multi-lateral organizations like the World Bank) while other donors and partners support vertical programs such as Malaria or HIV. As a result, MNRH resources were the first to be diverted at the onset of COVID-19 as they could be reallocated easily. Consequently, the MNRH sector had to fundraise to fill funding gaps, while simultaneously trying to minimize harm to end-users and staff.

Opportunities to diversify donors and sources of funds have appeared as more philanthropies and non-traditional donors, including national-level donors, expressed interest in supporting MNRH services in the midst of the COVID-19 pandemic.

"The Government has plans but it is not used. The actors responsible for each element of the plan do not take their responsibility."

5. Access to Essential Medicines

The demand for PPE at global scale was unique and unprecedented. Consistent use of PPE and IPC supplies in all services (including MNRH) became difficult as forecasted emergency stocks were used up in the early days of the pandemic and were unable to be adequately replenished as a result of the numerous challenges in the procurement process. Some donor requirements precluded procurement of some items with their funds, market closures impacted the quality and price of locally available materials, pushing organizations to procure internationally. Big PPE manufacturing companies, usually located in the global north, were under pressure by their governments to prioritize their own countries, leaving less stock available for low and middle income countries (LMICs). International border closures and flight disruptions delayed shipments and prevented the pre-positioning of equipment in harder-to-reach emergency contexts. Health services were left with little to no protective supplies, forcing staff to adopt high-risk behaviors such as reusing single-use masks and gloves.

Inter-Agency Reproductive Health Kits, usually provided by UNFPA, did not provide adequate PPE for an outbreak scenario, thus leaving MNRH services reliant on a highly stressed international procurement system. In some instances, the PPE provided in these kits were removed and sent to higher-risk departments, rather than used for provision of maternity care. However, local manufacturing of PPE ramped up, which in turn relieved the pressure on international procurements, positively impacted local economies, and improved preparedness for future outbreaks.

The prepositioning of MNRH commodities was inadequately done, as Preparedness Plans (when they existed) were rarely acted upon. As a result, some actors witnessed stock-outs of essential supplies in MNRH services, and there were cases where MNRH providers were required to turn over their (often meager) stocks of PPE to hospital departments with higher COVID-19 risk, or when community level MNRH services had their commodities taken to stock up COVID-19 MNRH wards (e.g. in SARI ITCs). However, some agencies noted that mitigation measures were put in place early in the response to avoid stock-outs, and these stock-outs occurred in contexts with pre-existing supply chain difficulties, such as the DRC. Some participants noted the opportunities to capitalize on COVID-19 investments, such as leveraging COVID-19 oxygen supplies and infrastructure for newborn care.

"The general medical supplies of the SARI did not include RH supplies"

6. Leadership and Governance

Poor coordination between the COVID-19 response structure and the MNRH structure was observed at every level (global, national, and implementation) and in many contexts. For instance, Yemen saw the health cluster system (including the SRH working group) separated from the COVID-19 response (which did not include any MNRH representation). This resulted in lack of interaction and coordination between the two, leading to different and sometimes contradicting guidelines, creating confusion and tensions. Following a similar experience in DRC during the recent Ebola outbreak, the COVID-19 response system was under the MoH leadership, who lead the local health clusters, demonstrating an improvement on coordination challenges.

Lack of coordination between MNRH partners and between the MNRH community and governments led to difficulties in identifying common priorities and developing clear messages and "asks" of governments and donors to ensure prioritization of MNRH and its recognition as an essential service.

"People want coordination, but they don't want to participate."

B. Guidance

Tools Used

Many organizations issued MNRH tools in response to COVID-19, but according to participants, WHO and IAWG issued the most commonly used guidelines and tools to operate MNRH programs during the COVID-19 pandemic. WHO tools included documents on maintaining essential health services, which were general and not MNRH-specific; Community Health services; IPC oxygen-assessment tools; newborn care tools; and breastfeeding and treatment of COVID-19 positive pediatric cases.

To cover gaps, organizations also developed their own tools that benefitted the wider community such as the newborn guidance by Médecins Sans Frontières (MSF)[12], ASRH and FP guidance in COVID-19 by Save the Children. [13,14] Organizations also rediscovered existing guidance such as tools on self-care practices by Ipas and Gynuity[15], and SRH service continuity by the IRC[16]. Agencies also saw the pandemic as an opportunity to better integrate humanitarian approaches across their programming, for example CARE-International published and implemented their Minimum Commitments for Gender and Inclusion[17].

IAWG tools were more MNRH-specific and included the MISP COVID-19 adaptation tool[18], which was developed with input from UNFPA, WHO, and the United Nations High Commission for Refugees (UNHCR). However, this tool was issued when the response had already begun in most countries and was not disseminated as widely as would have been ideal. The transition from the MISP to comprehensive SRH services during the recovery phase of the pandemic is likely to prove challenging. However, IAWG is working on a new tool to support this transition to comprehensive programming, which was piloted in DRC, Yemen, and Bangladesh before COVID-19 and in Niger, Iraq, and Syria during COVID-19.[19]

Other agencies published guidelines used by MNRH actors during this pandemic including the United States Center for Disease Control (CDC); Africa CDC; United Nations Children's Fund (UNICEF) (breastfeeding and newborn care, however not always adapted to COVID-19); UNFPA (maternity guidance); and UNHCR (emergency supply chain handbook). Tools from non-humanitarian settings were also adapted from actors including the United States American College of Obstetricians & Gynecologists

[12] Tools not made publicly available
[13] Save the Children. COVID-19 Adaptation Guidance for My Sexual Health and Rights. Last updated 8 April 2020
[14] Save the Children. COVID-19 Adaptation Guidance for Contraception by choice. Last Updated 14 April 2020
[15] https://www.ipas.org/resource-search-results/?wpv_post_search=&wpv-topic%5B%5D=self-managed-medical-abortion&wpv_sort_orderby=post_date&wpv_sort_orderby_as=string&wpv_sort_orderby=post_date&wpv_filter_submit=Search
[16] https://covid-rescue-org-app.azurewebsites.net/wp-content/uploads/2020/10/IRC-Minimum-Initial-Service-Package-SRH.pdf
[17] https://insights.careinternational.org.uk/in-practice/gender-equality-in-emergencies
[18] https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic
[19] IAWG: "Planning for comprehensive SRH in crisis-affected settings: A participatory workshop toolkit to transition from the Minimum Initial Service Package (MISP) for SRH." Will be available in late 2020 / early 2021 at www.iawg.net

(ACOG), the International Federation of Gynecology & Obstetrics (FIGO), the United Kingdom Royal College of Obstetricians & Gynecologists (RCOG), WHO guidelines for infectious disease prevention and Rights-based approach guidance from the HIV sector (particularly to tackle issues of stigma). Tools from other epidemics, including the 2018–2020 Ebola epidemic in DRC, the 2014–2016 Ebola epidemic in West Africa and the 2016–2020 cholera outbreak in Yemen, were drawn on for this pandemic. These tools allowed for a rapid pivot and response but the care provided was not always appropriate given the major differences in terms of mode of transmission and risks for MNRH groups between the diseases. At the time of writing, eight months into the pandemic, lessons learned are starting to be consolidated into tools, such as UNHCR's emerging practice document for SRH continuity of care during the pandemic.

"Most guidelines provide information on WHAT needs adapting, without focusing on HOW this is to be done, especially in resource-poor contexts."

Tool Gaps and Challenges

Several key programmatic areas do not have adequate guidance for implementation in COVID-19. For instance with the decrease in facility-births, there is still no guidance on how to make home-births (and immediate post-partum care) as safe as possible for mothers who are unable to access facilities due to COVID-19 restrictions (e.g. national lockdowns), newborns, CHWs and other workers or family members who may be supporting such births. While guidance exists on obstetric care in COVID-19, WHO has not published guidelines on the management of newborns in COVID-19 (leading MSF to develop their own). This guidance should link with Child Health guidance to avoid disrupting that continuum.

COVID-19 specific guidance was not adapted to the MNRH context rapidly enough. For example, clear guidance on the use of masks in maternity wards or COVID-19 testing for newborns was developed late in the response, when such guidance should have been readily available and adapted from guidance for pandemic flu and other respiratory infections.

Many tools developed at global level do not take into account the extent to which they need to be adapted to context-specific realities. Realizing this, MSF (among other organizations) aligned its operations to national guidance and adapted its response country-by-country. Most guidelines provide information on *WHAT* needs adapting, without focusing on *HOW* this is to be done, especially in resource-poor contexts. This led to difficult decisions when facilities could not meet the basic criteria or expectations of this guidance. For instance, maintaining a two-meter (six feet) distance in very cramped labor wards and waiting rooms or wearing PPE during stock-outs is not realistic in many small rural health facilities. So while the guidelines do exist, they may be unrealistic to operationalize in certain contexts.

An important delay in the implementation of tools was their translation into local languages. Global level institutions such as WHO should work with MoHs and translation organizations to ensure all tools are available in local languages, and thus useful for frontline staff.

Consultation participants felt that the continuously changing COVID-19 landscape led to ever-evolving guidance and far too many tools. This guideline-overload overwhelmed implementation-level or implementation-support staff, with no clear system to filter and triage guidance. Implementation teams did not have the time to research, read, breakdown, contextualize, and disseminate guidelines for their teams. As a result, teams continued to implement approaches that might no longer represent best practices, further affecting quality of services and putting patients and staff at risk. Simplifying long

complex tools into one-page documents rapidly digested by implementation-level teams is required, although difficult in a dynamic, ever-changing environment.

Participants believed that agencies put too much emphasis on technical guidance, while many (if not most) of the challenges were systemic in nature. The fact that the humanitarian sector relies heavily on external technical support, often from the global north, led to a breakdown of the whole response system as borders closed and technical experts were no longer able to travel, with some programs feeling set adrift during this crisis. De-colonializing aid and placing more emphasis on localization by building capacity at national level to reduce reliance on external aid should be prioritized as a lesson from this crisis.

Frontline clinical staff have the most "hands-on" experience dealing with COVID-19 and required adaptations to prevent onwards transmission and harm. Yet, the voices and experiences of these front-line workers did not seem to be heard at global levels, and thus are not able to influence global guidelines. Those responsible for treating cases and developing response systems at national level are not the same people developing the global guidance, and systems need to be put in place to elevate the voices and feedback from the country-level upwards, thus contributing to advocacy, planning and resilience-building. While frontline teams are over-burdened and at risk on the ground, there is a fine line to tread between not wanting to burden them with extra work, while still collecting their inputs and analysis of tools and contexts.

"The guidance was useful, there was just too much. We needed a system to help filter."

Tool Development and Dissemination

Figure 2 illustrates the process in which guidance is translated from big global institutions to implementation level. Global institutions such as WHO, CDC, etc. develop tools and guidelines and share them to country level Ministries of Health. The Ministries of Health collaborate with these institutions to use the guidance to inform their policy. Once their policy is finalized and funded, these guidelines and tools are then communicated to local-level MOH offices who usually chair Health Clusters. The Health Clusters then work with implementation partners to ensure the guidance is followed and a harmonized approach is adopted.

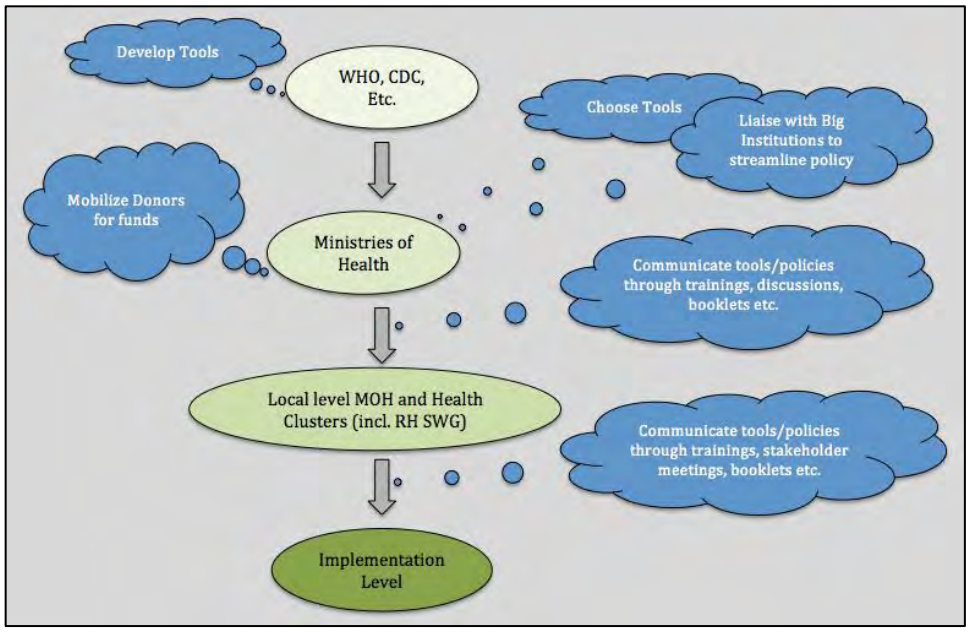

Figure 2: Structure of Guidance Dissemination from Global to Implementation levels.

During the consultations, it was noted that MoHs were faced with some confusion as to which guidance to select between institutions, with some contradictions between them. This process was delayed in some countries, such as Tanzania, where the epidemic was not declared. In many contexts, the MoH did not consider MNRH an essential service to maintain during the response, therefore the guidance they endorsed did not necessarily include MNRH-specific guidance. Additionally, in some settings, such as Sierra Leone, the MoH would only collaborate with the COVID-19 response pillars, thus side-lining MNRH related discussions in the response.

The IAWG developed "Programmatic Guidance for SRH in Humanitarian and Fragile Settings During COVID-19 Pandemic"[20], the MISP Considerations Checklist[21] and an advocacy pack[22], drawn from mappings of resources and tools from WHO and other agencies. However, IAWG and other INGOs led a different process to translate the tools from global to implementation level, as illustrated in Figure 3. Once these tools were developed, they filtered down to regional and implementation level through the technical units of the different member organisations of the IAWG.

[20] https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic
[21] https://iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19
[22] https://iawg.net/resources/advocating-for-sexual-and-reproductive-health-services-in-covid-19-response

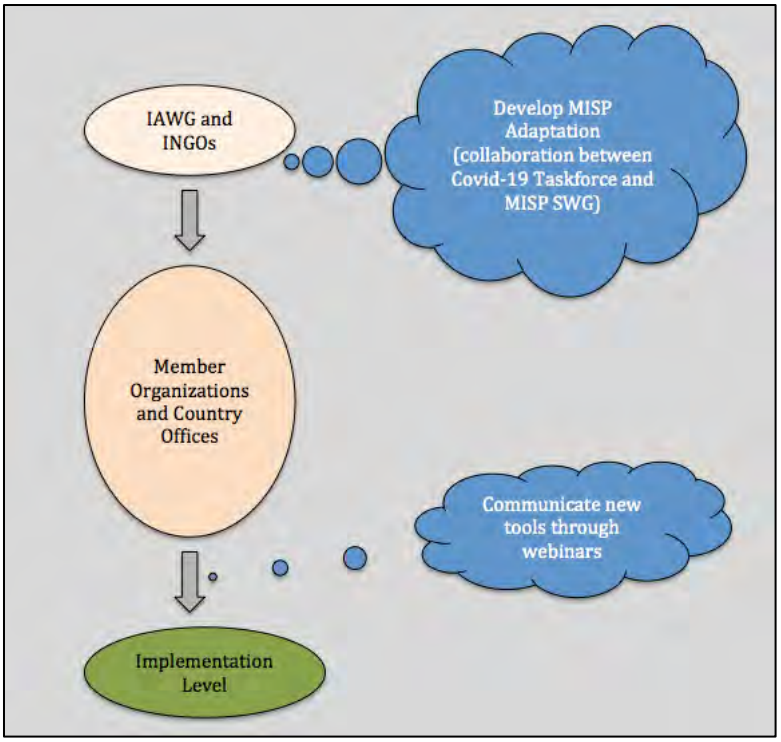

Figure 3: Dissemination of IAWG Guidance from Global to Implementation levels.

In countries that still do not implement the 2018 version of the MISP that includes family planning and safe abortion care (SAC) to the extent of the law, not all priorities of the new MISP were implemented in the COVID-19 response. It is also to be noted that some implementation-level representatives in these workshops had not heard of the MISP considerations checklist, implying that dissemination all the way to implementation level was incomplete. The IAWG COVID-19 taskforce is now working on documenting and compiling lessons learned to adapt the tool and evaluate the dissemination process.

National participants reported that they occasionally received contradicting guidance between those sent through from their internal technical unit at regional and/or global level, and those mandated by the Health Cluster and MOH in-country. Figure 4 demonstrates the conflict that occurs at implementation level when separate guidance is advocated for by different authorities (Ministry of Health or NGO headquarters).

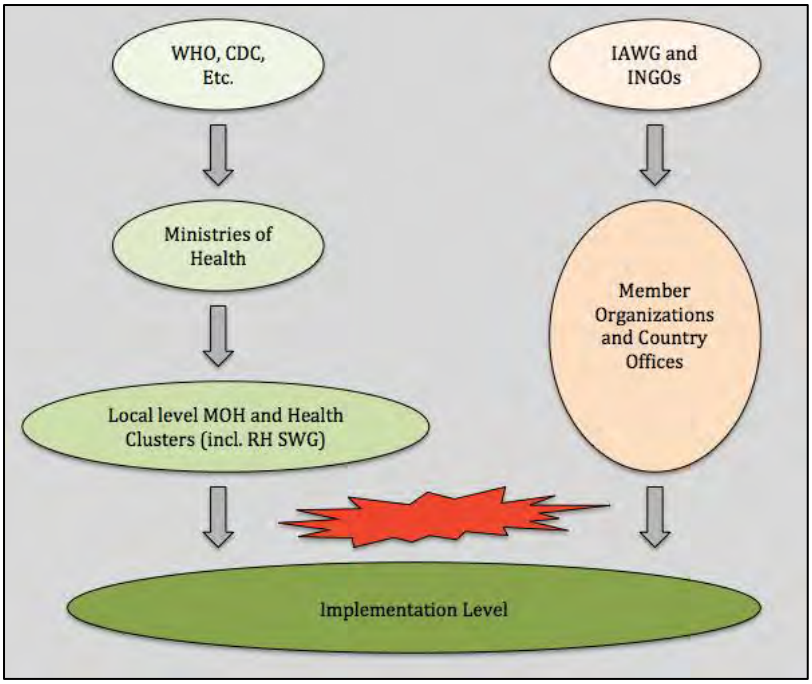

Figure 4: Parallel streams of guidance dissemination

As a result, MNRH implementation teams received separate guidance and advice from local authorities and internal authorities, creating confusion and tension as to which guidance to follow. In some countries, such as Nigeria, some partners did not follow MoH guidance, but chose to follow specific global guidance advocated by their own organization, creating a discrepancy at ground level and undermining MoH authority.

"Maintaining a two-meter distance in many labor wards or waiting rooms or wearing PPE during stock-outs is not realistic in many small rural health facilities. So while the guidelines do exist, they may be unrealistic to operationalize in certain contexts."

Recommendations

The following recommendations were either directly informed by the panel of experts or were assembled as a result of the challenges and issues voiced during the workshop discussions. A more in depth table of the recommendations, identifying key actors and the implementation phase (preparedness, response, or recovery) is detailed in Annex D.

1. **Health Workforce and Service Delivery**:
    - Invest in the training of frontline staff (including on how best to prioritize essential MNRH services during a pandemic) before and during a response and investigate approaches to retain essential services at both facility and community level and identify the training programs that worked best.
    - Invest in workforce wellbeing and ensure their experience informs guidance for future outbreaks.
    - Ensure Infection Prevention & Control (IPC) supplies are included in MNRH kits (eg. Inter-Agency Reproductive Health Kits) and MNRH supplies are included in outbreak response procurement plans and essential medical lists.
2. **Community Level MNRH Services**:
    - Ensure appropriate research and evidence-based guidance is developed and disseminated to improve community level care, including research for safe home birthing, guidance on community distribution of reproductive health commodities, and guidance on CHW protection.
    - Invest, train, and support community level workforce before and during an outbreak, and ensure their inclusion in lessons learned exercises.
    - Capitalize on new communication approaches (including Risk Communication and Community Engagement (RCCE) approaches) and networks to strengthen MNRH service demand.
3. **Guidance and tools**:
    - Develop a comprehensive MNRH tool to help frontline staff adapt their services to different types of epidemics (respiratory, water-borne, viral haemorrhagic, etc.) at the onset of new epidemics while more specialized tools are being developed. Break down new guidance into checklists, one-pagers and other rapid adaptation tools and dissemination methods to enable easy assimilation of new guidelines.
    - Ensure MNRH tools are disseminated through national channels in appropriate languages.
    - Provide guidance and technical support from Health Clusters to operationalize tools to the local context.
4. **Coordination**:
    - Rework or develop and invest in country-level Preparedness Plans that include MNRH as an essential service.
    - Improve the collaboration between the MNRH and the outbreak sectors at all levels.
    - Advocate for a multisectoral outbreak response and capitalize on new "allies" (donors, research institutions, suppliers, private sector etc.) to improve on MNRH services.
    - Lead gender impact analyses to ensure that MNRH programs are reaching the most vulnerable.

Limitations

1. The sessions were structured around the three phases of an outbreak response: preparedness, response, and recovery. Most countries are still within the Response phase of the COVID-19 crisis, and can draw conclusions on what was not done to prepare, therefore most discussions centered on the difficulties of the Response phase and lessons learned of the Preparedness

phase. However, as few countries are facing Recovery, it was challenging to elicit many experiences centered on that phase.

2. The breakout sessions were structured around three separate services: Maternal Health, Newborn Health, and Reproductive Health. While there were some service-specific challenges that were discussed, it was apparent that these are on a continuum of care and there were few differences as the issues centered on system challenges rather than service challenges.
3. The sessions were conducted in English and French, with an under-representation from regions of the world speaking other languages, such as Arabic or Spanish. This could have limited representation from regions with a high COVID-19 caseload.
4. The sessions were carried out online, and were therefore reliant on good internet connection. This may have prevented some participants to attend or to properly articulate their points.
5. Few frontline staff, such as clinical care providers, attended the sessions, thus limiting their own perspective in the discussions.

Conclusion

An outbreak response is not a linear process, but a continuum. It is imperative that the humanitarian community applies the lessons learned during recovery phases to prepare for future outbreaks. The oversight of MNRH in preparedness plans and outbreak responses has been noted in previous outbreaks[23], however MNRH services were again deprioritized during this response and negatively affected by measures taken to tackle COVID-19.

Most of the guidance to adapt MNRH services to COVID-19 now exists. However, the development of the guidelines is not the end-point but only the beginning. Efforts must be placed in dissemination, adaptation, and operationalization of these tools to properly support implementation on the ground. The importance and value of frontline staff is too often overlooked though they are the experts of their context. Adopting localization strategies by elevating and reflecting the voices, experiences, and needs of frontline staff in the guidelines, and supporting these staff to respond and prepare for the next crisis will improve both the quality and access to MNRH services.

[23] https://www.rescue.org/report/not-all-bleeds-ebola-how-drc-outbreak-impacts-reproductive-health

Annex A: Generic Agenda

Time	Activity
1300	Introduction
1320	Field presentation 1
1340	Field presentation 2
1350	Instructions for Breakout Sessions
1355	Breakout Groups
1515	Feedback from Breakout Groups
1530	Discussion following Breakout Groups
1550	Next Steps

Annex B: List of Participants

	Francophone Group	Day 1	Day 2	Day 3
1	Cady Gbomosa (U Ottawa)	Angel Foster (IAWG)	Angel Foster (IAWG)	Angel Foster (IAWG)
2	Jerry Jonas-Mbasha (WHO Burkina Faso)	Marilyn Nyaboga (International Planned Parenthood Federation [IPPF])	Marilyn Nyaboga (IPPF)	Marilyn Nyaboga (IPPF)
3	Lucien Kikwayaba (IRC - Chad)	Alice Oyuko Awuor (SC - ESA)	Alice Oyuko Awuor (SC - ESA)	Alice Oyuko Awuor (SC - ESA)
4	Bibiche Malilo (SC-DRC)	Sanni Bundgaard (IRC)	Sarah Collis (UK MED)	Geoffrey Luttah (IRC)
5	Llevin Bangali (IRC-DRC)	Sarah Collis (UK MED)	Kathleen Mayer (OFDA)	Smita Kumar (USAID)
6	Fanny Misengabu (Cellule d'Analyse des Sciences Sociales [CASS]), DRC)	Isabel (CASS, DRC)	Anushkar Kalyanpur (CARE Int.)	Sharifa Khan (SC)
7	Dr Jeremie (DRC-WHO)	Smita Kumar (USAID)	Daniel Martinez (MSF)	Janet Meyers (SC)
8	Jacques Emina (Uni Kinshasa)	Daniel Martinez (MSF)	Opwoku Sukere (UNFPA)	Alison Greer (IAWG)
9	Pierrot Mbela (SC)	Ornella Lincetto (WHO)	Sharifa Khan (SC)	Sandra Krause (WRC)
10	Philemon Musavuli (UNFPA DRC)	Opwoku Sukere (UNFPA)	Anne Harmer (ELHRA)	Alina Akhyar (IRC-Pakistan)
11	Janet Meyers (SC)	Sharifa Khan (SC)	Hilary Wartinger (WRC)	Emily Monaghan (SC)
12	Gillian McKay (Consultant)	James Okara Wanyama (UNFPA South Sudan)	Janet Meyers (SC)	Alice Janvrin (Consultant)

13	Alice Janvrin (Consultant)	Racheal Cummings (SC)	Gillian Butts Garnett (UNFPA)	Gillian McKay (Consultant)
14	Blami Dao (Jhiepgo)	Lily Jacoby (WRC)	Emily Monaghan (SC)	Virginie Jounaicot (SC)
15	Cyprien Masaka (IRC, DRC)	Janet Meyers (SC)	Mel Johnson (UK-Med)	Elaine Scudder (SC)
16	Emily Monaghan (SC)	Alison Greer (IAWG)	Shehu Dasigit (IRC-Sierra Leone)	Lisa Noguchi (JHPIEGO)
17	Virginie Jouanicot (SC)	Emily Monaghan (SC)	Aline Semaan (Institute of Tropical Medicine [ITM])	Okpwoku Raphael (UNFPA-South Sudan)
18	Laura Romig (SC)	Shehu Dasigit (IRC – Sierra Leone)	Elaine Scudder (SC)	Emma Clark (USAID)
19		Katie Moore (Anthrologica)	Alice Janvrin (Consultant)	Temitope Oyelade (IRC-Nigeria)
20		Lisa Noguchi (JHIEPGO)	Prince Banya (IRC Sierra Leone)	
21		Emma Diggle (SC)	Temitope Oyelade (IRC-Nigeria)	
22		Gillian McKay (Consultant)	Ashley Wolfington (IAWG)	
23		Alice Janvrin (Consultant)	Emma Clarke (USAID)	
24		Elizabeth Noznesky (CARE Int.)	Emma Diggle (SC)	
25		Ashley Wolfington (IAWG)	Lisa Noguchi (JHPIEGO)	
26		Sarah Ashraf (SC)	Maria	
27		Laura Romig (SC)	Maureen Ayako	
28			Pete Sykes (SE)	

Annex C: Breakout Group Tools

Break Out Group Tool Day 1:

For the day's focus (preparedness, response, or recovery) for your assigned group (Maternal, Reproductive, or Newborn), please work together to complete the below table in the context of COVID-19.

Table 1: MNRH in COVID-19 Landscape & Available Guidance

NOTE: We do not expect that you'll fill all these boxes! They are simply here to guide you as you discuss ☺

Day's Focus:						
Breakout Group Assignment:						
Facilitator Name:						
	Column 1	**Column 2**	**Column 3**	**Column 4**	**Column 5**	**Column 6**
	Examples of Good (or Not Good) Practice	**Challenges/ Lessons Learned**	**Guidance Name & Link (if available)**	**Comment on Guidance**	**Gaps in Guidance**	**Recommendations**
Guiding Questions	Do you have any experience of an MNRH intervention that has worked well in COVID-19?	What challenges and what lessons have you learned while adapting/intervening in MNRH in COVID-19?	What key tools/guidelines have supported your interventions? Was this guidance specific to COVID-19? Or were you adapting other guidance (eg. Ebola)? Was it very context specific? Note: some	How useful/not useful was guidance that you used? How could it be made better?	What areas of your intervention were not supported by tools/guidelines?	Any recommendations you'd make for this health system pillar to support MNRH in COVID-19?

			guidance will likely span multiple health system pillars			
Health Workforce						
Service Delivery						
Health Information Systems						
Financing						
Medical Commodities						
Governance and Leadership						

Table 2: Additional Notes (any other information of interest that arises in the discussion that is relevant to MNRH in COVID-19)

Break Out Group Tool Day 2:

Days Focus:
Breakout Group:
Facilitator Name:

1. Can you give us an example of Good Practices to adapt MNRH services in COVID-19?

2. What Global Guidelines were used to adapt MNRH services to COVID-19 in your context? Why and how were those guidelines chosen amongst so many others?

3. How much did we use guidelines from other (eg. non-humanitarian) sectors?

A. Development of Global guidelines (WHO/CDC/IAWG etc.):

1. How did these guidelines get translated from Global Level to Operational (local) Level to implement/adapt MNRH services? (*Describe the PROCESS: Who/which group(s) were involved? Was it done in meetings/committees? Were guidelines contradictory/aligned to each other? Was it the same/different between contexts? How long did the process take?*)

2. How did different actors interact? (*ie. HQ, Field (national or sub-national), MoH, partners, COVID-19 Response Committees etc.*)

3. What were the facilitators to this process?

4. What were the barriers/challenges to this process?

5. What are ways to improve this process?

B. Adaptation of existing National-level Guidelines (eg. from a different disease):

1. How is the above process different when you are adapting existing guidelines? (*eg. Adaptation of Cholera or Ebola guidelines) At what level was this adaptation done? Who was consulted in this process?*

2. If you could go back in time 8 months, what would you do differently?

3. At this stage, what do we think would be most useful way to organize/present guidelines for future outbreaks?

Break Out Group Tool Day 3:

Days Focus:
Breakout Group:
Facilitator Name:

1. **Case study a country which is already in recovery phase or which has recovered from a first "peak" of the pandemic?**

2. **How can we capitalize on the current COVID-19 crisis to rebuild a better MNR Health system in emergency settings? Please also list any tools already available to do that.**

   (*don't worry if you do not cover every pillar*)

- **Health workforce**:

- **Service Delivery**:

- **Health Information System**:

- **Financing**:

- **Medical Commodities**:

- **Governance and Leadership**:

3. **How can we rebuild stronger trust between the community and the MNRH health system post-COVID-19 ?**

4. **How and what should we prioritize when transitioning from the MISP to Comprehensive SRH programs in the recovery phase of COVID-19?**

5. **4. How can we pull from national level experience to improve the Recovery from COVID-19?**

Annex D: Recommendations

		Preparedness	Response	Recovery
Health Workforce and Service delivery:	Capacity Development	• **NGOs**: Invest in training (including alternative modes of training) and support for frontline and national-level staff, in an effort to de-colonialize aid and better prepare for future (Health) emergencies. • **MoH and donors**: Create national level rosters that are able to mobilize and respond to (health) crises. These teams should include MNRH expertise. • **UN agencies**: Create guidelines on how to conduct remote/virtual and blended training programs.	• **MoH and/or Outbreak response coordination**: Ensure MNRH staff is among the first wave of teams trained on IPC and outbreak response.	• **Donors, NGOs, and MoHs**: Investigate approaches to retain trained healthcare workers and create a pool to respond to second waves or future health crises. • **MoH and NGOs**: Build on IPC training and supply provision to build confidence and reinforce MNRH services. • **MoH and NGOs**: Collaborate with research institutions to identify the training programs that worked best, where and why, so as to strengthen future approaches. Invest in professional associations and local clinical training institutions (midwifery, nursing, medical) to build preparedness and response capacity.
	Wellbeing	• **NGOs and Research Institutions**: Conduct research collaboratively with frontline clinical staff (including midwives) on factors affecting career satisfaction and use this for lobbying efforts. • **NGOs and Multi-lateral agencies**: Actively lobby MoHs and donors for better compensation and career development for MNRH staff in humanitarian settings.	• **All stakeholders**: Invest in workforce wellbeing through time-off, self-care, stress management, sick leave policies, mental health and psychosocial support (MHPSS) etc. to avoid burnout, especially during a long, widespread response. Ensure adequate staffing and back-up staffing if health care providers become sick.	• **All stakeholders**: Evaluate and document frontline workforce experience, promising practices, challenges, lessons learned etc. so as to inform guidelines for future outbreaks.

	Medical Commodities	• **IAWG and UNFPA**: Add an additional *MISP in Outbreaks* kit to the selection of Inter-Agency Emergency Reproductive Health Kits, which includes adequate IPC supplies for different types of epidemics (respiratory, water-borne, viral haemorrhagic etc.). • **Outbreak response agencies**: Include MNRH supplies in procurement plans.	• **NGOs, MoHs, Outbreak response agencies**: Ensure facility and community-based MNRH services are included PPE prioritization.	• **IAWG, UNFPA and implementing agencies**: Analyse the need for IPC supplies and equipment in maternities to inform future health crises. • **Outbreak Response agencies**: Analyse their MNRH supply usage and projected future need to inform future health crises.
		• **NGOs, MoHs, Outbreak response agencies**: Try to identify MNRH suppliers in-country to reduce the risk that community-level supplies will be taken for "higher profile" emergency response facilities, and support sustainable local supply chains and reduce the reliance on Inter-Agency Kits.		
Community Level MNRH Services	Guidance	• **UN agencies, Research Institutions, and MoHs**: Invest in research and tools to improve community level care, including research on safe home birthing and guidance on community distribution of commodities and CHW protection. • **MoHs and implementing partners**: Ensure appropriate dissemination, translation and training of new guidance.		• **NGOs and Research Institutions:** Conduct an After Action Review to identify what positive practices were put in place to manage home and community-based MNRH care provision to feed into new tools.
	Workforce	• **MoH and Implementing partners**: Invest, train and support community level workforce (HCWs, TBAs, etc.) to provide support to facility staff and increase trust between communities and the healthcare system.	• **MoH and Outbreak response agencies**: Ensure the inclusion of community level workforce in response trainings, and include them in the response approaches (Eg. Home based care).	• **MoH, Implementation partners, and Research Institutions**: Ensure the inclusion of community level workforce in analysis of the response and development of lessons

				learned.
	Community Engagement	• **MoH, NGOs, and Research Institutions**: Build the network of RCCE contributors (local organisations, religious leaders, market trader associations) to share information about MNRH service, who can act as intermediaries in future outbreaks.	• **NGOs, MoHs**: Conduct regular community-based research to rapidly recognize the increased barriers to health-facility access and adapt response accordingly (for instance be prepared to pivot quickly to community-level services to reduce the risk of poor outcomes).	• **MNRH actors and MoH**: Capitalize on new RCCE approaches and networks to strengthen MNRH service demand.
Guidance and tools	Adaptation	• **IAWG and UN Agencies**: Develop a comprehensive MNRH tool to help frontline staff adapt their services to different types of epidemics (respiratory, water-borne, viral haemorrhagic etc.) These tools can then be used to ensure rapid adaptations during the initial phase of future outbreaks, while more specialized tools are being developed. • **MoH (in collaboration with Global institutions)**: Ensure tools are translated into local languages.	• **IAWG, UN Agencies, and Implementation partners** Develop simple tools that breakdown new guidance and enable implementation teams to assimilate the information quickly and easily. Reinforce dissemination methods and provide continuous virtual and face-to-face support with adaptation to frontline teams.	• **Research Institutions and NGOs:** Conduct evaluations of MNRH tool adaptation, dissemination and operationalization at national and local levels to identify lessons learned for future outbreaks. Share lessons learned and/or connect with advocacy teams to bring attention to under/un-served areas of MNRH.
		• **All Stakeholders:** Improve communication channels between implementation-levels and HQ levels regarding guidance tool development to ensure it's "fit for purpose" at the implementation level. Shift the power and working dynamics to national or local actors by elevating guidance, recommendations, and lessons learned from the national/local level, to the global level. Create forums for frontline, national, and regional stakeholders to share lessons learned, adaptations, etc.		

	Dissemination	• **IAWG**: Liaise with WHO and UNFPA at global level and Health Clusters (incl. the SRH Working Groups) at national levels to advocate for the endorsement of the MISP and other IAWG guidance by the MoH and the dissemination to implementing teams through the national channels.		
	Operationalization	• **Health Cluster**: Provide guidance and technical support to implementation partners (through checklists, flowcharts, training guides etc.) to operationalize tools to the local context.		
Coordination	Preparedness Plan	• **MoH, UN Agencies (WHO), and donors**: Develop (or rework existing), fund and implement Country-level Preparedness Plans, which include MNRH as an essential service. These plans should cover MNRH workforce, MNRH trainings, MNRH policies and prepositioning of MNRH stocks (with in-built buffer and replenishing systems to keep stock moving and avoid waste). They should also prioritise the continuation of MNRH services (and not only case management). • **MoH and donors**: Ensure Preparedness Plans are simulated and updated regularly.	• **MoH and donors**: Hold partners accountable for the implementation of the response as per the Preparedness Plans.	• **MoH and Implementation Partners (MNRH and Outbreak)**: Conduct collaborative After Action Reviews to identify challenges to outbreak response efforts and impacts on MNRH at national levels to inform Preparedness Plans for future outbreaks.
	MNRH/Outbreak interaction	Improve the collaboration between MNRH and Outbreak sectors. • **IAWG and MNRH partners**: Advocate for the inclusion and funding of MNRH in outbreak response plans to donors, WHO, MoHs etc. • **MoH**: Ensure that MNRH and	• **UN Agencies, IAWG**: Ensure guidance for Outbreak response & MNRH response is developed in a collaborative manner with experts from MNRH & infectious disease specialities. • **MoH, Health Cluster, Outbreak response agencies**: Ensure guidance contextualisation	

		Outbreak data collection tools have the flexibility to adapt and incorporate essential data points (eg. disaggregate data for pregnant and breastfeeding women)	processes include representation from the MNRH and the infectious disease specialties.	
	Multisectoral approach	• **MNRH and Outbreak response partners** (to the extent of their capacity): Advocate to donors and MoHs for multisectoral outbreak response that takes into account broader societal, cultural and economic impacts.		• **IAWG and National Health Clusters**: Capitalize on newly found "allies" (donors, research institutions, suppliers, private sector, etc.) of the humanitarian and/or MNRH sectors (during the COVID-19 outbreak) to mobilize resources and improve on MNRH services.
	Gender		• **Implementation Partners and Research Institutions**: Lead Gender Impact Analyses during and following outbreak response to learn and adapt responses to ensure MNRH services are reaching the most marginalised and vulnerable. Ensure guidance, programming and funding are considered.	