HEALTH CLUSTER
GHC SRH Task Team

REPORT

Baseline Assessment on Sexual and Reproductive Health Coordination

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Acronym List

BEmONC	Basic Emergency Obstetric and Newborn Care
CCPM	Cluster Coordination Performance Monitoring
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CERF	Central Emergency Response Fund
CMR	Clinical Management of Rape
CoP	Community of Practice
EmONC	Emergency obstetric and newborn care
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GHC / HC	Global Health Cluster / Health Cluster
HCC	Health Cluster Coordinator
HeRAMS	Health Resources and Services Availability Monitoring System
HNO	Humanitarian Need Overview
HRP	Humanitarian Response Plan
IARH kits	Inter-Agency Emergency Health Kits
IEC	Information Education Communication
IEHK	Interagency Emergency Health Kits
INGO	International Non Governmental Organization
IAWG	Inter-Agency Working Group for Reproductive Health in crisis
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KII	Key Informants Interviews
MISP	Minimum Initial Service Package for Sexual and Reproductive Health in crisis
MOH	Ministry of Health
MNH	Maternal and Newborn Health
MRA	MISP Readiness Assessment
MSF	Médecins Sans Frontières (doctors without borders)

NGO	Non Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
PEP	Posts Exposure Prophylaxis
PIN	People in Need
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRH - TT	Sexual and Reproductive Health Task Team (within the Global Health Cluster)
SRHWG	Sexual and Reproductive Health Working Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund/The United Nations Sexual and Reproductive Health Agency
WHO	World Health Organization

Executive Summary

Background

The Sexual and Reproductive Health Task Team (SRH-TT)[1] was established in November 2022 under the Global Health Cluster (GHC), to ensure that Sexual and Reproductive Health (SRH) priorities are systematically addressed in all phases of the humanitarian response and that SRH is consistently included in cluster coordination, both at global and country levels. In its first year, the SRH-TT undertook a series of foundational activities to align its work with the needs and priorities of the field. Within this framework, the main objectives of the Baseline Assessment conducted in June 2023, are to **map and describe the existing SRH coordination mechanisms in countries with an activated health cluster (HC)**. This assessment investigates challenges, successes, enablers and opportunities, with the overall goal of making **recommendations to support and improve the coordination of SRH in emergencies (SRHiE)**.

This assessment was conducted in two phases:

1. The first phase consisted of a desk review and remote interviews of 65 key informants during 57 key informant interviews, including **HC and SRH coordinators**.
2. The second phase involved an in-depth assessment of SRH coordination in four countries: Central African Republic, Colombia, South-Sudan, and Somalia. This included **17 focus group discussions** (FGD) with a total of 139 informants, **51 interviews** with 62 informants, **29 observations,** and **4 visits.**

Main Findings

Functional status of SRH Working groups (SRHWGs) and other forms of SRH coordination

At the time of the assessment, **20 (71%)** of the **28 countries** with an activated HC had **SRHWGs**. In **12 (43%) countries, the SRHWGs were fully established**, in **8 (28.5%)** countries, the **SRHWGs were partially-functioning**, lacking regularity and/or clear structure; and in the final **8 (28.5%)** countries, **no SRHWGs were established** under the HC. Of the 20 countries with an SRHWG, 19 (95%) had written terms of reference, though these varied widely in form and completeness, from fully validated and published documents to drafts and working versions, while only 11 (55%) had action plans, assuming different forms and levels of structure and follow-up. All 28 countries had some form of SRH coordination, pre-existing and or in parallel to the one established under the HC. The assessment clearly identified the **added value in covering gaps and reducing duplication of the SRHiE coordination established under the HC** (20 countries), particularly where groups were fully functional (12 countries). The articulation between the humanitarian coordination mechanisms and the SRH sector coordination that pre-existed the crisis has important areas of improvement : strengthened synergies should be considered as part of NEXUS-related reflections. Moreover, **60% of SRHWGs existed at sub-national level.** Generally useful and in line with area-based and localized coordination, this 'decentralization' does not always align with the establishment of the HC at sub-national level, resulting in coordination and communication challenges that need to be addressed for more effective response.

Human resources and leadership of SRH coordination

The availability and continuity of clearly-tasked human resources for coordination and information

[1]https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team

management for SRH emerged as a crucial enabler and the lack of it as a key challenge. At the time of the assessment, **UNFPA led 17 (85%) of the SRHWGs**, while the Ministry of Health (MOH) led 2 and Expertise France led 1. Five SRHWGs were co-led by the MOH, 4 by an international NGO, 2 by UNFPA, 1 by WHO, while only 2 were co-led by a national organization. All staff tasked with the SRH coordination functions, both those specific to humanitarian response and others (total staff in 28 countries), were **double-hatting**, and most of them **do not possess significant humanitarian experience and/or specific training.**

Quality and effectiveness of SRH coordination

Informants consistently voiced the need to improve the quality and effectiveness of SRH coordination, proposing three areas for significant investments.

First, **ongoing capacity building and technical support,** with SRH coordination training extending beyond the technical aspects of SRHiE to incorporate management, planning, negotiation, communications, interpersonal skills, and guidance on navigating the humanitarian architecture.

Second, **a clear functional framework for SRHWGs or alternative forms of SRH coordination**, for enhanced regularity and effectiveness, as stakeholders reported frequent disruptions, creating a cycle of "starting and restarting working groups".

Third, **establishing formal linkages between the HC, Ministry of Health, and gender-based violence (GBV) actors at national and sub-national levels**.

In addition, current contextual challenges limit access to and the quality of SRH services, and existing coordination efforts often accept these limitations as "status quo", thereby restricting the scope and impact of interventions.

Expanding on the above overreaching feedback, specific observations and recommendations emerge for most SRH-TT workstreams and can be summarized as follows:

Use of data for a strategic and evidence-based response

An evidence-based approach to SRH coordination is identified as an area needing important improvement to ensure strategic and effective actions. The access to and use of data is generally valued by informants as a key enabler, who consistently highlighted shortcomings in access, management and analysis of information. Issues cited include: the lack of clear and ready to use **needs assessment templates**, the lack of **harmonized tools** and/or their excessive length and complexity, and the difficulty encountered in gathering and cross-referencing information across **multiple existing platforms** and **systems** (both in the humanitarian and development space). Respondents also highlighted the lack of standardized **SRH indicators** and related objectives in humanitarian needs overview, response plans, and cluster's information products.

Harmonization of clinical training and programmatic standards for SRHiE

Capacity building has achieved many successes, but requires reflection and more strategic investment. Countless efforts on the support for programmatic and clinical capacity building were reported by SRH teams in acute and protracted emergencies. **The delivery of training and technical guidance are amongst the most often mentioned successes** of SRH coordination. However, informants concurrently reported the **low availability** and **high turnover** of human resources, and the lack of updated **rosters of trained personnel** as important barriers to the continuity and scale up of capacity building efforts and

improvements in quality of care. Additional challenges included the **lack of harmonized protocols and guidelines** across organizations and the need for contextual adaptation of guidance and training content.

SRH Service Delivery Implementation: the Minimum Initial Service Package (MISP) and beyond

De-prioritization and inadequate funding for SRHiE, resulting in inequitable service coverage, were identified as major challenges. Improvements are needed to strengthen the monitoring of assistance to ensure access to the Minimum Initial Service Package (MISP) for all people in need and early expansion to comprehensive SRH services. Consultations and observations highlighted the **fragmentation of interventions** and **disproportionate concentration of partners** and interventions in the most accessible and/or most funded areas, thereby leading to **significant gaps** in lifesaving SRH services in other, less accessible/funded areas.

Recurrent feedback is outlined as such:

First, **mapping interventions** and partners helped the prioritization of the MISP, improved referral, supported resource mobilization, and promoted continuity of services and transition to comprehensive SRHiE. However, this practice is neither common nor standardized.

Second, the question remains on how to ensure adequate **information flows with the HC and other reporting mechanisms**, without duplicating. It also emerged that **not all components of the MISP are equally implemented or prioritized**, and the MISP is not well known by all SRH actors.

Third, in stronger or more centralized health systems, implementers expressed major challenges in service delivery due to high national standards in terms of clinical protocols and/or limitations imposed on the scope and tasks of frontline workers.

Fourth, informants mentioned **cultural barriers** as one of the major challenges in delivering SRHiE, particularly contraception services. Lack of community acceptance and **significant protection risks for frontline providers** (retaliation, imprisonment, etc.) were reported by several partners.

Finally, inter-agency reproductive health (IARH) kits see significant use in emergencies, but **procurement and distribution** were seen as major challenges. Although service delivery partners have robust systems to plan and follow up distribution, **the mapping of availability and gaps** of emergency SRH supplies **is not reflected at coordination level**. Despite different attempts at better coordination, the lack of a comprehensive overview to avoid wastage and gaps remains a challenge

Linkages between Sexual and Reproductive Health (SRH) and Gender-based Violence (GBV)

The **need for a more formalized coordination between SRH and GBV** actors, both at national and local levels, clearly emerged from the assessment. Joint SRH and GBV task forces are in place in several contexts, but they are not regular. Moreover, they tend to respond only to specific and operational needs, predominantly focused on the Clinical Management of Rape and Intimate Partner Violence (CMR-IPV). Successful collaborations were reported in addressing SRHiE-related harmful practices in collaboration with GBV, and in ensuring continuity of GBV services during outbreaks and access limitations of other nature, by using health as entry point. These practices should be further explored and replicated.

Technical support for emergency preparedness

Faced by cyclic, protracted, and complex crises, all categories of informants described the humanitarian response as '*much more reactive than proactive*'. Technical support from the GHC and the SRH-TT is

expected to strengthen SRH emergency preparedness and provide guidance on how to tailor it to specific crises (outbreaks, conflict, natural disasters, etc), both at service delivery level (objectives 2 to 5 of the MISP) and through coordination.

Reflections and Recommendations

Functional status of SRHWGs and other forms of SRH coordination

The formal establishment of an SRHWG under the Health Cluster, equipped with dedicated and adequately prepared staff emerges as the most effective way to ensure SRH coordination.
The SRH-TT can play a key role in advocating for such set-up and ensure needed support. When an SRHWG and dedicated coordination is not yet envisaged as part of an activated HC, the SRH-TT should ensure SRH coordination is systematically addressed. Under the guidance of the GHC, the SRH-TT can play a key role in promoting reflections for **better articulation of SRH coordination efforts** (WG or other forms of SRH coordination) with the HCs, other technical areas (mental health, primary care, community mobilization, etc.), with other clusters (GBV sub- cluster, nutrition, etc.), and with relevant national and local actors within and outside of humanitarian architecture. The SRH-TT can support HCs in mainstreaming formalized linkages with development efforts and national groups for SRH and the different geographical levels of coordination (national, sub-national, and cross border as applicable). Further, it can support better articulation and integration of SRH coordination in refugee responses

The SRH-TT must be the space for inter-agency dialogue to examine and support **formalization of SRHWG co-leadership responsibilities** at global, regional and country level, as well as promoting collaborations between Health Cluster members to ensure coordination of SRH at country level. Additionally, it should foster reflection at the global level, in coordination with the GHC, regarding **mobilization of resources for clearly mandated positions** to ensure effective coordination in the countries. The SRH-TT should also support induction and continuous capacity building, involving and extending to coordinators where appropriate and recommended. Capacity-building efforts are to address both soft and managerial skills, and plan for hybrid modalities to increase access and ensure sustainability. Finally, the SRH-TT should lead efforts to call upon a plurality of stakeholders to contribute to an **enabling environment** for effective SRH coordination in emergencies, which includes firm commitments to the funding and appointment of and support to dedicated human resources.

Quality and effectiveness of SRH coordination

It is necessary to promote ***'institutionalization'* of SRH coordination**, with better definition of roles and responsibilities - both at lead and co-lead levels. Central actions to this effort include developing and organizing specific SRH coordination training in close collaboration with the GHC capacity building efforts for cluster coordinators.
Therefore, producing, piloting, translating, and disseminating a toolkit for SRHiE coordination is essential. This should include templates for: contact directories, information sharing platforms, terms of reference, work plans and monitoring frameworks, tracking tools, trained providers lists and trainers' rosters, advocacy tools, for national and sub-national levels. Additionally, it is crucial to provide **strategic guidance** on **linkages with other sectors, clusters and sub clusters, localization** opportunities, **negotiation of access** and services for specific groups, **resource mobilization** and **transition along different phases of the crisis,** including cluster system deactivation. Furthermore, producing, piloting, translating, and disseminating technical guidance on mainstreaming SRHiE and ensuring multi-sector and

GBV/SRH linkages is necessary.

Finally, the creation of a **'helpdesk'** to continuously support coordinators is strongly encouraged. This should be accompanied by the establishment and maintenance of a **community of practice of SRH coordinators** and support field visits and experience sharing missions**.**

Use of data for a strategic and evidence-based response

Support to country teams with a **structured framework for SRHiE information gathering and utilization**, including specific templates and a minimum set of indicators, technical guidance and specialized advice is warranted. Further, good practices showcase the power of evidence based SRHiE advocacy, coordination and response, and should be leveraged.

Investment in the area of data also has the potential to help overcome or at least mitigate implementing organizations' significant reluctance regarding data sharing and 'reporting fatigue', and allow for more solid understanding and representation of SRH needs in emergency contexts.

Harmonization of clinical trainings and programmatic standards

Supporting the training of trainers, piloting innovative practice for capacity building, and technical guidance for **harmonization and dissemination of guidelines and tools should be prioritized** by the SRH-TT**.** Coordination at all levels should ensure the streamlined implementation of agreed upon standards and align with programmatic priorities and quality of care standards. Finally, support to the area of capacity building will improve the sustainability of capacity enhancement initiatives and strengthen quality of care and services in emergencies.

SRH Service delivery Implementation: the MISP and beyond

MISP Prioritization

The low prioritization of SRH and lack of funding emerged as central concerns for informants. SRH actors expressed high expectations for backup and support from the GHC and SRH-TT during engagements with decision makers and donors. The SRH-TT should work to **strengthen awareness within the humanitarian architecture about SRH needs in emergencies, advocate for specific allocation of funds for SRH and promote more flexible funding mechanisms.**

Additionally, **better knowledge of the MISP is needed** at all levels among SRH actors and beyond to ensure a **more rational and equitable delivery of SRH services** in acute and protracted crises. The **full implementation of the MISP** needs to be promoted and understood as a **non-negotiable package**. Finally, context specific needs and potential for transition to comprehensive services should be systematically examined and planned.

Humanitarian access and implementation

In a humanitarian response, upholding pre-emergency national standards and processes in health care provision can represent a barrier to the organization of immediate and life-saving services. A recurrent proposal voiced during the interviews sought a temporary derogation and shift to more adapted modalities in humanitarian contexts. In order to do this, there needs to be consensus around the existing evidence-based criteria for the delivery of lifesaving services with humanitarian approaches (e.g. syndromic management, etc). The SRH-TT can play a pivotal role by collecting experiences, consulting relevant experts and supporting negotiations at national level.

Family Planning and prevention of unintended pregnancies

Access to adapted messaging for communities and authorities was seen as helpful, but there is an expressed need for **more strategic reflection and investment into innovative approaches to address contextual barriers to contraception services.** This includes sharing of tools and experiences, initiating a dialogue to overcome protection challenges related to the provision of contraception and family planning information and services, capitalizing on comparative advantages of different implementing partners in accessing specific communities, and liaising with community health working groups.

Country teams requested global technical guidance and leverage to support the resolution of specific challenges. In the longer term, it will be helpful to provide advocacy points and support collective efforts to influence the **legal and normative frameworks** that guide SRH efforts in different contexts. While more in the development domain, shifting the normative frame is seen as fundamental to increase access to the MISP and reduce risks for health providers.

Supplies for SRH service delivery

Important support is expected from the global level to raise awareness about and solve bottlenecks along the supply chain (especially excessive lead time and general stock outs) and other supply related concerns. These include context-adapted packaging, support to country teams in transitioning from a kit to a bulk system, and advocacy towards donors for more flexible funding that takes into account logistic challenges and last mile delivery costs. Prioritization of support for SRH commodities in emergencies will allow for a more timely and robust response and increase the credibility and leadership role of the mandated pipeline agencies.

Linkages between SRH and GBV

Close collaboration between the SRH-TT, the GBV AoR and their counterparts at the local level should focus on **clarifying roles and responsibilities** in providing care for survivors (including supplies), **streamlining and aligning service mapping and indicators**, and improving communication among country teams. GBV advisors are increasingly appointed within the HCs, and this opportunity should be fully leveraged. A **formalized framework between SRH and GBV** will help avoid dispersed and irregular platforms and conflicts of agenda, increasing participation and inclusion of SRH and GBV partners. A well-designed collaboration will allow for the exploration of the **extensive potential of SRH/GBV linkages** beyond CMR and provide holistic and respectful care not only for survivors, but for all populations with SRH needs. Further, as GBV is an area of responsibility, at the coordination level, efforts should be made **to strategically mainstream SRH** in platforms where it cannot be duly represented due to architecture (such as in the Inter-Cluster Coordination Groups) or resources (sub-national level, area-based coordination groups). This should not be an alternative to the responsibility of HCs to give voice to their technical areas, of which SRH is part. Finally, **technical support for emergency preparedness** continuing to mainstream the MISP readiness assessment exercise is seen as essential, and additional efforts should be made to integrate and support contingency planning into coordination functions. This will translate into a more forward-looking response seeking to increase resilience of both responders and affected communities.

Conclusions and way forward

The road to ensuring effective SRH coordination in emergencies, to support adequate, timely and quality SRH response is still long, but the demands from country teams and stakeholders are clear and coherent, underpinning the direction proposed by the SRH-TT through its work plan.

This report's **recommendations** are mainly **addressed to the SRH-TT,** validating several actions already proposed under different workstreams for 2024 and raising awareness of actions that may be needed but are not yet addressed.

Some recommendations and reflections go beyond the SRH-TT's scope, requiring discussion and alignment with the GHC team. This report also aims to **raise awareness** of issues all stakeholders, beyond the SRH-TT, should commit to and engage with to create an **enabling environment** for SRH coordination in all phases of emergencies. This starts with sector **lead organizations (UNFPA, IRC, etc.),** making the necessary internal arrangements to operationalize their commitment and fully embrace their responsibility as SRH leads for emergency preparedness and humanitarian response.

This report recommends **increasing transparency and inclusivity and facilitating the engagement of additional key interlocutors**. These include local organizations, civil society and development platforms, donors, stabilization actors, organizations with observer status in the clusters (ICRC, MSF, etc.), and agencies specialized in HIV/STIs and in refugee responses.

SRH presents unique challenges in stable settings and even more so in emergencies, requiring collective efforts to respond adequately. Effective and continuous **coordination can be a game-changer** in achieving timely and quality **SRH service provision in emergencies, and to set the basis for contributing to sustainable changes in the sector's future development.**

The establishment of an SRH-TT at the global level is regarded as an encouraging step forward, and raises expectations for increased support to SRH coordination in emergencies. For the SRH-TT, it will be crucial to work closely with all stakeholders, including the GHC and HC teams, to build on the momentum and ensure concrete support and action through an inclusive and community-focused lens.

Summary recommendations to strengthen SRHiE coordination		
Action	**Responsible**	**Collaborators**
Produce, pilot, translate, and disseminate a toolkit for SRHiE coordination. This should include templates for: contacts directories, information sharing platforms, terms of Reference, work plans and monitoring frameworks, tracking tools, trained providers list and trainers' rosters, mapping tools and advocacy tools, for national and sub-national levels..	SRH-TT	Global SRH coordinators and focal points from countries
Establish a helpdesk and backup support for SRH coordinators and focal points.	SRH-TT	Global SRH lead agencies
Provide induction and continuous capacity building for SRH coordinators, involving coordinators where appropriate. Include soft and managerial skills in the coordinators' training and plan for hybrid modalities.	SRH-TT	Global SRH lead agencies, SRH coordinators from countries
Establish and maintain a community of practice of SRH coordinators and support in-person visits and experience-sharing missions.	SRH-TT	Global SRH lead agencies, SRH coordinators, and focal points from countries
Produce, pilot, translate, and disseminate technical guidance on mainstreaming SRHiE and ensuring multisectorial and GBV/SRH linkages.	SRH-TT (all workstreams)	Global SRH lead agencies, GBV AoR, GBV and SRH coordinators, and from countries
Support efforts and partake in negotiations for strategies to provide better access to SRH services for affected populations. This includes overcoming challenges (from cultural barriers to derogation to national protocols). This needs to be done in close collaboration with the technical streams.	SRH-TT (all workstreams)	Global SRH lead agencies, OCHA
Ensure adequate, clearly tasked, and duly supported SRH coordinators and co-coordinators and strengthen resources for information management for SRH.	SRH lead and co-lead agencies	SRH-TT/GHC, donors

Introduction & Acknowledgments

The Sexual and Reproductive Health Task Team (SRH-TT)[2] was established in November 2022 under the Global Health Cluster (GHC). The goal of the SRH-TT is to ensure that Sexual and Reproductive Health (SRH) needs are **systematically considered and addressed and that SRH rights are fulfilled** in acute and protracted crises through **coordinated and standardized preparedness and response approaches.**

The SRH-TT is mandated to provide support and guidance to national and delocalized clusters and technical working groups at the country level while bringing main issues and concerns on SRH into the global agenda, raising awareness, supporting advocacy, and mobilizing resources.

In 2023, the SRH-TT was organized into 7 workstreams and related sub-groups[3]:

1. Conduct a baseline assessment on SRH coordination in health cluster countries
2. Assemble and pilot an SRH Coordination Training
3. Mapping mechanisms and strengthening of data for adequate information management
4. Conduct a process evaluation of MISP
5. Harmonize and disseminate SRH Training Standards
6. Preventing unintended pregnancies with Family Planning and Contraception
7. Systematize and strengthen SRH-GBV linkages in emergencies.

The main objectives of this baseline assessment, conducted in June 2023, were to map and describe the existing SRH coordination mechanisms in countries with an activated health cluster and to investigate challenges, successes, enablers, and opportunities to make recommendations on supporting and improving SRH coordination.

The assessment was also an opportunity to raise awareness among all relevant stakeholders on opportunities to create an enabling environment for SRH coordination and emergency preparedness and response.

The baseline assessment was led with an interagency approach that allowed for the comprehensive data collection and the joint analysis and formulation of recommendations presented in this report.

Gratitude goes to the Global Health Cluster for enabling and accompanying the process and to all members of the SRH-TT, who provided contacts with field-based colleagues and shared thoughts and suggestions. Deep gratitude goes to UNFPA, International Rescue Committee, UNICEF, and WHO/health cluster country teams and management, which have supported the in-person visits in many ways, and to UNICEF and UNFPA that, in addition to providing technical support and guidance, provided funding for this work.

Special acknowledgments are due to Kadra Noor (South Sudan), Ifrah Yousuf (Somalia), Jessica Kakesa (CAR) and Bibiana Wagner (Colombia) from IRC, Khawaja Aftab Ahmed and Simon Morgan Dada (South Sudan) from UNICEF, and Cecilia Lopez (Colombia) from Medical Teams International, who have joined the in-person missions as observers and contributed to the findings and recommendations. The full length of the document would not be enough to thank everyone who contributed to the assessment, and first and foremost, the brave coordinators, focal points, and implementers who strive every day to ensure the needs of women, girls, and all populations for Sexual and Reproductive Health are met amidst emergencies. We sincerely hope that this report and the actions that will stem from it will support you in your mission.

[2] https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team
[3] Obtained from the SRH-TT Terms of Reference and work plan

1. BACKGROUND & METHODOLOGY

1.1. Objectives and Scope of Work

Important efforts were undertaken in the past to understand and improve coordination for SRH in specific contexts and crises. This baseline assessment is the first comprehensive exercise to provide a deeper understanding of SRH coordination as part of the cluster system.

The assessment lasted 8 months - from May to December 2023 – targeting countries with an **active health cluster** in June 2023 (corresponding to the remote phase of the exercise).

Criteria to ensure diversity in the sample – including culture, language, type, the scale of crisis, and the level of existing coordination mechanisms for SRH – guided the selection of countries for deeper focus (through in-person and online visits). Country selection was discussed in the GHC partner meeting, where partners requested to expand the sample for the county visits from two to four.

Important note: In the ever-evolving situation of humanitarian crises and response, this assessment may not fully reflect the situation on the ground in terms of the presence and level of activity of the cluster. By the time the report will be published, certain elements may have changed. Nonetheless, the lessons learned, and recommendations made remain valid.

1.2. Methodology

1.2.1 Data Collection Methodology

Data collection was conducted in English, French, and Spanish to facilitate adherence to and understanding of the exercise by all informants. Assessment tools were validated first within the sub-group 1, responsible for the baseline assessment and then with the rest of the SRH-TT members.

The data collection phases included:

1. An **online desk review** of key documents and sources such as: Humanitarian Needs Overviews (HNO), Humanitarian Response Plans (HRP), field mission and assessment reports, Health Resources and Services Availability Monitoring System (HERAMS) products, and key documents of the SRH coordination groups (terms of reference, work plans, meeting minutes, etc).
2. **Remote, semi-structured interviews with key informants**[4]. Deviating from the initial Terms of Reference (ToR), the subgroup 1, as commissioner of the assessment, preferred live, semi-structured interviews rather than a structured, online, self administered survey. This required the adaptation and a slight extension of the assessment's timeline. The interview guide was piloted in 3 languages, with a small group of coordinators whose feedback was integrated. Of the 57 interviews, 50 were conducted with a single individual. In 7 interviews, key informants preferred to have collective interviews with relevant colleagues, involved in the coordination. This was considered in the analysis. The interviewer systematically asked questions on challenges, successes, and enablers for SRH coordination, desired attributes of SRH coordinators and working groups, and desired support from the SRH-TT. Specific themes of interest for all workstreams of the SRH-TT were also asked during interviews following a sampling scheme, where each interviewee was pre-allocated 3 out of the 7 main specific themes. This allowed us to 'assess' how coordination impacts an actionable response.

[4] Key informants include Health Cluster Coordinator, SH coordinators and focal persons tasked with SRH coordination and WG coordination, and Ministry of Health staff involved in the SRH coordination for the humanitarian response, staff from national and international partners.

3. **Country-focused Activities - Three in-person visits were conducted to South Sudan, Central African Republic, and Colombia, and a remote country-focused analysis was carried out for Somalia[5].** Key activities including working group, health cluster and other coordination meetings were also attended online when the opportunity was presented to enrich data collection. The countries-focused activities consisted of observations, FGD, and KII. During the focus groups, different profiles were segmented for discussions: the composition of each group depended on the context, but in general, the main distinctions were between the coordination team, cluster observers, and members. When possible, additional segmentation between INGO and local organizations and between central and subnational levels was applied. A non-probabilistic, purposive sample of Health Cluster Coordinators (or co-leads) and SRH working group leads, SRH focal points, MoH focal points, donors, and other coordinators of humanitarian platforms (ICCG, logistic, GBV, etc.) was identified using snowballing techniques. In each country, one or more experts nominated by organization members of the SRH-TT were included in the data collection activities, either in person or online, and contributed to identifying the preliminary findings and recommendations, which were then shared in a debriefing with the country team. This allowed for a more transparent and inclusive analysis.

In total, the following were conducted:

- **During the remote phase:**
  - A desk review for 28 countries
  - 57 KII with 65 informants
- **During the in-person visits/country-focused activities (aggregated):**
  - 17 FGD with a total of 139 informants
  - 51 interviews with a total of 62 informants
  - 23 observations (9 were in person and 14 online)
  - 6 site visits.

To preserve confidentiality, information is presented in an aggregated form and not by country.

1.2.2 Data Analysis Methodology

The information collected during the **desk review** was summarized in a 'synoptic sheet' and verified with coordinators prior to or during key informants' interviews and in-person visits when applicable as well as triangulated with sources from the desk review. The variables of interest were then consolidated in a frequency table for the overall analysis.

In addition, key documents such as meeting minutes, reports, and response plans were examined, and the information was triangulated with the results of interviews, focus groups, and observations.

Through textual analysis of **interviews** from the remote phase, key themes and patterns of SRH coordination in emergencies were identified. After the first coding, interview transcripts were read a second time, and the coding system was adjusted. Frequencies were then calculated and presented.

Key informant interviews and focus group discussions during the in-person visits and **country-focused activities** were summarized based on audio recordings and notes[6] to identify and compile main tendencies on challenges, successes, opportunities, and recommendations for support by the SRH-TT.

[5] The in person mission was canceled the day of planned departure de to security reasons/lockdown
[6] A thorough textual analysis was not performed for the in-person visits and country-focused FGD and additional KII, due to limited resources and time

The analysis resulting from the country-focused activities was shared and validated with the accompanying expert from another member organization of the SRH-TT for each country.

Quotes were extracted and anonymized for communication purposes. They were translated into English if it was not the original language.

1.2.3 Ethical considerations

The baseline assessment was conducted with a **neutral and unbiased** outlook, with a **solution-oriented**, non-judgmental approach: this was clearly explained to informants, and the principle of *do no harm* was followed at each stage.

Interviews and FGD were video or audio recorded upon receiving informed consent for recording, storage, and utilization of the collected data (in aggregated form). Where consent to video or audio recording was not given, the interviews continued with note-taking.

The database with individual interviews will remain the property of the commissioner of the assessment (UNFPA).

Aggregated data will be shared with SRH-TT members upon demand. The assessment consultant remains available to clarify and respond to any questions.

1.3. Baseline Assessment Products

The data collected was gathered and systematized with the potential to be used as a **repository of key information and documents** to support future specialized assessments and accompany the SRH-TT of country teams in the response, and in particular:

- The mapping of SRH coordination in countries with health clusters.
- The synoptic sheets are a list of key documents and key contacts for each country, including best practices and tools.

Several interim presentations on specific topics (capacity building, maternal and newborn health, etc.) were also held for specific audiences and remain at the disposal of the SRH-TT.

2. FINDINGS

2.1. Baseline Assessment: Status of SRH Coordination in Countries with a Health Cluster

2.1.1. Presence and Denomination of SRH Groups within the Health Cluster

At the time of the assessment, in the 28 countries with an activated health cluster, **20 (71%)** had a **working group** for SRH.

These groups had different denominations according to cultural context (where the word 'sexual' was considered problematic), technical preferences (RMNCH was considered to have broader coverage than SRH), and position in the humanitarian architecture (task force, working group, or sub-cluster level).

SRH (Technical) Working Group was the most frequent denomination (9, 45%). Others include:

- Maternal, Sexual and Reproductive Health Group
- RMNCH - Reproductive Maternal Newborn and Child Health working group
- Reproductive Health sub-working group
- Reproductive Health (RH)/Minimum Initial Service Package (MISP) Working Group within the National Health Cluster
- Reproductive Health, Family Planning, Maternal, Newborn and Child Health + Nutrition Technical Group
- Reproductive, Maternal, Newborn and Child Health including Adolescents (RMNCH+A) Sub-Task Force (STF)
- Reproductive Health Working Group (RH WG) in Emergency
- Reproductive Health Interagency working group
- Sexual and Reproductive Health Task Force
- Sexual and Reproductive Health Technical Working Group in humanitarian settings
- Sexual and Reproductive Health Sub-cluster

Most groups were supposed to hold biweekly or monthly meetings in relation to the health cluster calendar. However, adherence to the schedule and regularity was a challenge in practice.

Of the 20 existing groups, 19 had at least a draft of terms of reference, and **11 (55%) had an action plan**. The action plans take different forms, from a simple list of priorities for the year to a clearly developed framework with follow-up indicators.

Of the 20 existing groups, 12 **(60%) existed at sub-national level.** This 'decentralization' of SRH coordination did not always align with the health cluster configuration (which had sub-hubs in 17 countries); in fact, it was most often linked to the location of UNFPA sub-offices or the presence on the ground of UNFPA's implementing partners.

2.1.2. Level of Functionality of the Groups

Out of 28 countries with an activated health cluster, **12 (43%) had an SRH WG** that could be considered **fully established;** 8 **(28.5%) had a WG partially functioning, and 8 (28.5%) had no SRH WG at all.**

The criteria to assess the functionality of the groups included: regularity of meetings, clear structure, and functional framework with terms of reference and action plan or at least strategic priorities, and credibility and reputation of the working group by the health cluster, SRH partners, and other actors.

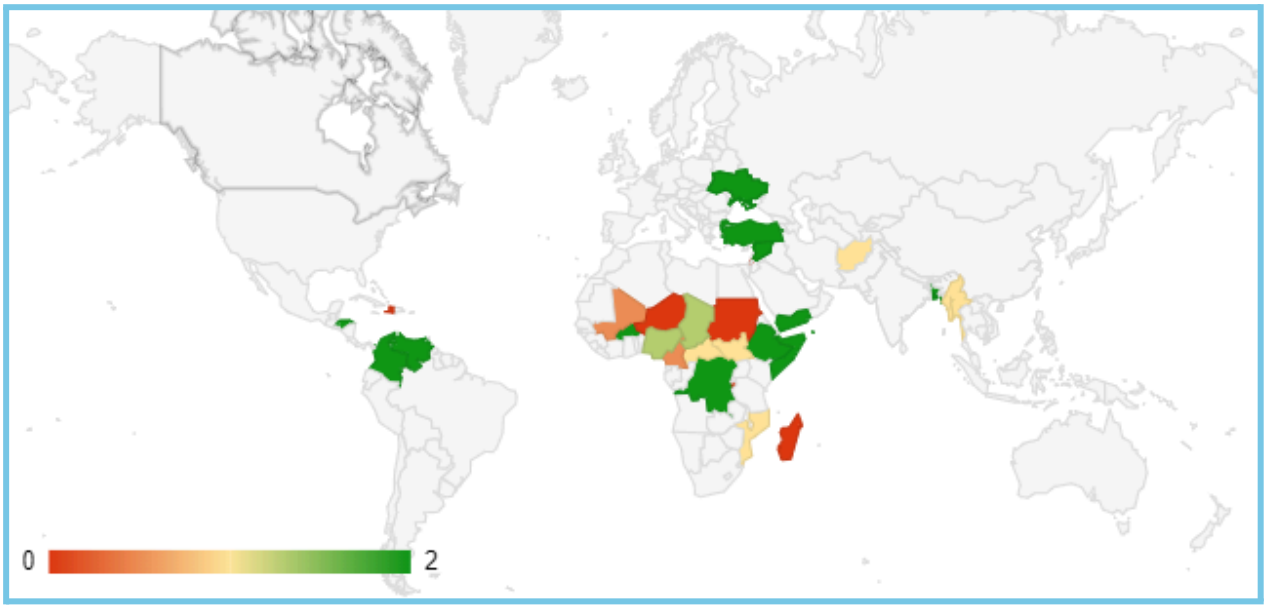


Figure 1: presence and level of functionality of SRHWG under the health cluster. 0 (red) indicates the non-existence of the group, yellow and orange (1- 1.5) different degrees of partial functionality, and green (2) fully established groups.

2.1.3. Other Forms of Coordination

Across all 28 countries, different arrangements for SRH coordination, either led by UNFPA or the national health authorities, existed. In general, the establishment of a specific humanitarian coordination mechanism has been demonstrated to bring added value to ensure the continuation of services during crisis situations, particularly in covering gaps and reducing duplications.

In the 8 **(28.5%)** countries **with no established working group** under the health cluster, alternative platforms and mechanisms included:

- **Development Reproductive Health Groups** (with varied denominations) either systematically included an emergency preparedness and response component or integrated humanitarian discussions according to arising needs. These groups, however, tended to meet on a quarterly basis and were not regular or able to promptly respond with SRH in emergency interventions. Such platforms also existed in countries with established SRHWG under the health cluster, and formalization of linkages between the two appears necessary to avoid duplication and maximize resources.
- **UNFPA partners' coordination mechanisms, in the framework of specific projects and initiatives,** are by nature limited in the type and number of actors who can be included.
- **Other forms of bilateral coordination** with strategic SRH actors are carried out by UNFPA and WHO or by discussing SRH - to some extent - in health cluster meetings. However, this was found to be insufficient to overcome technical, operational, and strategic bottlenecks to ensure a timely and quality response.

2.1.4. Leadership and profile of SRH coordinators and focal points

UNFPA is the lead organization for 17 out of the 20 existing SRH working groups (**85%**) under health clusters, the Ministry of Health (MOH) technical departments lead 2, and Expertise France (1).
UNFPA is co-lead of 2 groups, while five groups (25%) are co-led by the MOH (in 3 cases, the MOH shares the co-leadership with a national or international NGO); 4 groups are co-led by an international NGO (3

of them by IRC), the local branch of IPPF co-leads 2 groups and WHO 1.

6 groups (30%) do not have an official co-lead, and **only 2 groups are co-led by a national organization.**

Table 1 Leadership and Co-Leadership of SRHWGs.

Leadership of SRHWG								
UNFPA			EXPERTISE FRANCE			National Authority (MOH)		
17			1			2		
Co-leadership of SRHWG								
no co-lead	UNFPA, MOH + IPPF or NGO	UNFPA	MOH	IRC	WHO	IPPF branch	Other International NGO	National NGO
6	3	2	2	3	1	1	2	1

Out of the 65 key informants in the remote phase, **38 SRHWG coordinators and focal points** were interviewed[7]. Information on workload, training, and background is presented below.

Table 2a: background description of informants of the remote phase

Gender		Role related to		Organization				Multiple hatting	
Women	Men	SRH	Health Cluster	WHO	UNFPA	MOH	Other	SRH	Health Cluster
25	40	**38**	27	27	31	6	1	**38** (100%)	12 (44%)

Table 2b: background description of informants of the remote phase

	Clinical background related to SRH (midwife, gynecologist, etc.)	Other clinical background	Non-clinical	Public Health specialization
SRH	**11 (29%)**	**25 (66%)**	**2 (5%)**	**25 (66%)**
Health Cluster	3 (11%)	19 (70%)	5 (19%)	24 (89%)

Of the **SRH coordinators** and focal points (n=38), 36 (95%) have clinical training: 1 is a midwife, and 10 are gynecologists. Two (5%) are non-clinical and 25 (66%) have a public health specialization. Among them, 17 (45%) are women and 21 (55%) are men. All coordinators and focal points **are double or multiple hatting**, meaning they handle SRH coordination alongside another, potentially full-time assignment. Examples include roles such as SRH unit team leader, SRH supplies pipeline manager, national health advisor, and fistula program manager.

All are carrying out both programmatic and coordination responsibilities within SRH, either only in the humanitarian space or across humanitarian and development. Some are humanitarian coordinators, specialists, or analysts who are **stepping in to cover the lack of specialized SRHiE staff**. The title within the organizations varies from coordinator, specialist, officer, analyst, and consultant. The range of years of experience related to current assignments is also very broad, going from a few months to decades.

[7]31 from UNFPA , 6 from MOH and 1 from Expertise France. The difference between SRH coordinator and SRH focal point relates to the formal appointment as coordinators and the existence or non-existence of a formalized SRHWG.

Most have declared one form or another of humanitarian experience and informal training that they sought at the onset of the crisis or when tasked with humanitarian responsibilities. The type of undergone **training is non-homogeneous,** and, as detailed in the qualitative analysis in the next section, the majority of coordinators and focal points asked for specific training and tools for SRH in emergency coordination and response.

2.2. Baseline assessment qualitative findings

2.2.1. Barriers and challenges to effective SRHiE coordination (and response)

Barriers and challenges to effective SRHiE coordination and response were discussed in 55 remote interviews[8] and country-focused activities (KII and FGD). Observations made during participation in meetings and other country focused-activities were triangulated with these two methods.

Context-related challenges

Context-related challenges were mentioned in 36 interviews (63% of informants) for 57 entries.

> *"The challenges to be raised are primarily related to access. If we have to talk about these difficult access areas or compromised security, the first problem is access. How do people access care in these areas, especially in reproductive health?"* (Health Cluster Coordinator)

Insecurity and access constitute the most mentioned barrier (28% of entries). While not a direct barrier to coordination, it represents a major challenge that coordination should address, as it directly impacts the capacity to ensure adequate coverage in service delivery. The second most mentioned challenges are difficulties in **dealing with national, subnational, and de facto authorities** (25% of entries) due to international sanctions and cultural norms and taboos around SRH. Finally, the **size of the country, with multiple types of emergencies** happening simultaneously was also mentioned as an important challenge (16%).

Less mentioned during the remote phase but strongly highlighted during the in-person visit activities were human resource challenges (specifically the **brain drain and resulting lack of qualified human resources for SRH** in affected areas), the high level of maternal mortality, language, and cultural barriers.

Barriers and challenges directly linked to coordination

The barriers directly related to effective coordination were mentioned in 54 interviews for a total of 322 entries and concerned:

- **Information management** (by 50% of informants, 17% of entries). Difficulties included: SRH actors' reluctance to share data, obstacles in collecting SRH indicators (mostly linked to needs assessment and difficult access to public databases), lack of information management support for SRH, and barriers to mainstreaming and representing SRH data in humanitarian products (health cluster bulletin and others). Informants highlighted the plurality of sources and systems of information management and the difficulty of cross-referencing data. These barriers hinder data analysis and data-informed decision-making. Donors also expressed the need for better availability and quality of the data presented on SRH in emergencies, calling for more evidence-based approaches.
- **Funding and the role of donors** (by 56% of informants, 15% of entries) in setting priorities and modalities of intervention. The limited resources available for SRH in humanitarian contexts and the difficulties in positioning SRH in the CERF and other humanitarian allocations stood out as an important concern. When funds for SRH are available, they are generally strings attached: challenges include lack of flexibility, short grant duration, and restrictions on the area of intervention

[8] 2 informants did not mention any challenges, although asked

and the funded actors. Short grant duration also emerged as a barrier to the consolidation of service provision and smooth transition to comprehensive care and handover to national systems after the acute phase.

Difficulties in obtaining funding support for an essential package of SRH services, rather than selective prioritization of SRH components (‘cherry picking'), were also mentioned. The resulting incomplete service provision in SRH, which may not address even the 4 service provision objectives of the MISP, is seen as a negative impact of a *'donor-driven'* response.

> *“See the biggest constraint here at present what I see is that again fragmentation within the working group itself. We don't have specific partners or partners who are motivated to focus on one aspect of MISP. It's so donor-driven. People want to do everything that they have in their hand. The moment they run a SRH clinic, the moment they get funding close to or near to nutrition, they just come and say, oh, we will do nutrition, nutrition, nutrition, integration of nutrition.” (SRH coordinator)*

- **Turnover, multiple hatting, and lack of adequate training** of the SRH coordinators and focal points (45 % of informants, 14% of entries). These challenges were reported to have a grave impact on the continuity and quality of coordination. In particular, informants mentioned the limited time available for the designated focal point due to conflicting responsibilities, the type of contract, and the lack of specific humanitarian skills and knowledge. Informants also mentioned the absence of a specific reference framework and discontinuity in support from regional and global level. This was strongly corroborated during the in-person visits.
- **Lack of documentation** of the activities of the working group was seen as hindering forward thinking and the strategic role of the coordination. In other words, linked to discontinuity of coordination, all categories of stakeholders reported a pattern of '*starting and restarting of working groups*' so that by the time the mechanism is re-established, another disruption happens, and all discussions have to restart from zero. The need for a stronger *'institutionalization'* of coordination, with a better definition of roles and responsibilities - both at lead and co-lead levels - emerged strongly from the country-focused activities.
- **Weak ownership and capacity of national authorities** (9%) and their discontinuous implication in the SRH in emergency coordination. This is linked with the non-prioritization of SRH in emergencies (8.5%) at the national level. Corroborated by the findings of the in-person visits, this difficulty also includes the frequent change of interlocutors at every change of political administrations, as well as the type of positions (contract, leverage) of the SRH focal points appointed by the MOH for humanitarian activities. Barriers to conducting effective advocacy, with a clear need to raise the level of incidence towards decision-makers, were also mentioned.
- **Coordination for procurement and distribution of supplies** (8%) and shortcomings of the pipeline agency's capacity to ensure timely availability of SRH supplies stand out as important concerns. The lead time, delivery delays, and frequent stockout of lifesaving medical supplies emerged as the greatest obstacles. During in-person visits, stakeholders reported concerns about a specific situation, which leaves them with little alternative: since the pipeline agency (UNFPA) is mandated to ensure SRH supplies for emergencies, many partners are fully dependent and no longer allowed by their donors to procure through other channels. When the pipeline is dysfunctional, it creates major service gaps, and they can last for weeks and months. Although some good practices were mentioned, the last mile delivery and rapid mobilization of commodities remain major hurdles and are also influenced by the limited flexibility of program/funding rules in re-orienting resources and supplies to face sudden emergencies/scale-ups.
- **Lack of continuity and commitment of SRH actors** in the coordination platforms (8%), even in contexts with established and fully functional SRH working groups. A number of actors only participate when funding opportunities present themselves. In some cases, this motivated the

coordinators to request an 'adherence pledge' to the members, with a clear indication of focal points and engagement in joint activities of the group. However, this was mentioned for isolated cases and is not standard practice. During the in-person visits, the perspective of implementing organizations, national authorities, and other key actors was integrated to better understand participation-related challenges. Faced with the multiplication of coordination platforms, members and observers pointed at a *" meeting fatigue*" and their own need to prioritize. To fully engage, they claim the need to see the "usefulness" and "attractiveness of coordination." Indeed, desk reviews and observations indicate a trend to allocate most meeting time to plain and unilateral information sharing by the main agencies, leaving no space for discussion of other organizations' input. Some informants, during the remote phase, also mentioned a lack of capacity to prioritize agenda points and limited time to prepare for coordination meetings. The preference for online meeting modalities was seen to remove the *'human dimension*' of coordination and hinder the creation of a group spirit, which, on the other end, was considered an enabler for cooperation and trust. The need for more strategically oriented coordination with clear action points and follow-up action and a more inclusive and participatory' coordination style' emerges as a demand.

Other challenges mentioned by informants include:

- The need to **better formalize and entertain relations with the Health Cluster,** clarify roles and responsibilities, and ensure more connectedness between the local and the central levels. These aspects emerged much more strongly from the country-focused activities, where the perspectives of implementers, decentralized coordinators, and other stakeholders were included. Some informants reported an absence of a clear framework for SRH coordination/response in localized emergencies and occasional confusion about the agency's respective mandate. In some cases where the assessment identified area-based SRHWG in collaboration with technical and development groups of local authorities, the humanitarian health cluster counterparts were unaware of and disconnected from such platforms. In other cases, linkages with MOH platforms were weak or nonexistent, generating another type of duplication and dysfunction.
- The **lack of harmonization of guidelines, protocols, and clinical training modules** was directly linked to insufficient coordination and gaps in information sharing.

  As observed in the in-person missions, this also included **challenges in the adaptation of service delivery** modalities for people on the move, particularly in contexts with a lack of clear demarcation between humanitarian response and development activities. The need for improved quality of care emerged particularly from donors and was corroborated by observations.

  Informants also mentioned the necessity for stronger and more collective reflections on cultural norms, gender inequalities, and social taboos surrounding SRH topics that may hinder service utilization and limit community engagement and that require sensitive and context-specific approaches.

> *"'Because another element is…like an extreme context where the women, even when they are on the table and they need a C-section, cannot get one until there is a male member, like a husband or a father, gives permission. So the women, their autonomy is completely absent, and it's very difficult for medical staff now to deal with that because they cannot just say, deal with the woman and say, okay, let's do it. Because then even if the woman says like, yeah, it's okay, do it, they will go after the surgeon who then does it if things go wrong. So medical professionals are really bound by all sorts of cultural rules and limitations."* (Health Cluster Coordinator)

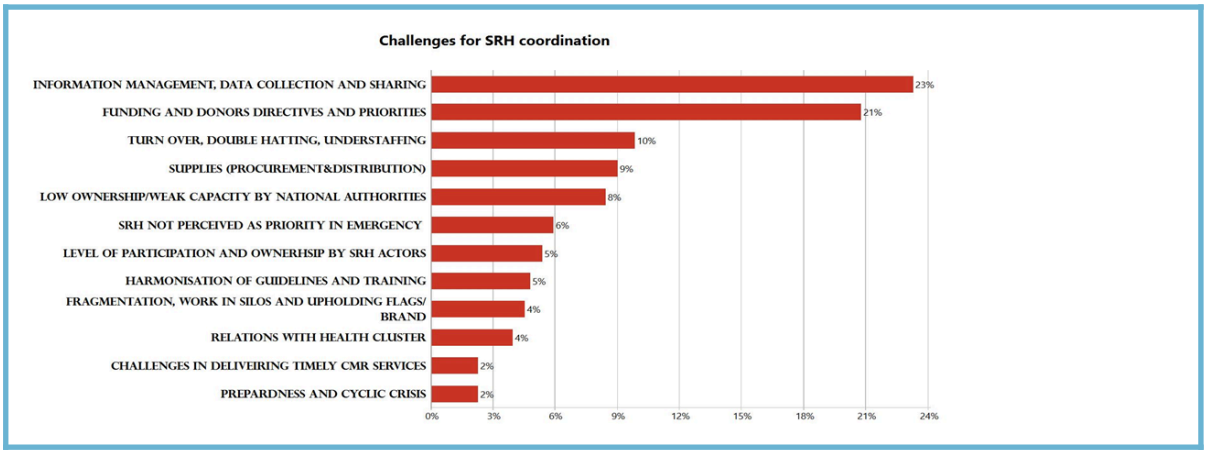
- A **tendency for implementers to work in silos** and promote their own visibility in a sort of *"competition mode"* emerged both from the remote phase and the country-focused activities, with a

direct impact on coverage of services and a lack of understanding of 'who does what', where, and with whom. In some contexts, the **lack of a common understanding of the MISP within and beyond SRH actors led to the prioritization of non-essential interventions, gaps, duplications, and 'irrational' distribution of interventions and services in the same geographical area**, and in low prioritization of specific components in the emergency response (FP, STI/HIV, AYSRH).

> *"'The problem is that in big cities you do have hospitals, you do have different agencies, you do have a lot of capacity, but in the regions and remote areas such services or chances are not there. So we do suffer actually…so it's not evenly distributed in terms of staff and capacity."* (SRH Coordinator, National Authority)

- **The lack of systematic SRH-GBV linkages results in failing to ensure timely clinical management of rape (CMR) services** due to difficulties in coordination and referral. As mentioned by some informants during the remote interviews, this aspect emerged strongly from the country-focused activities. Cases were observed where SRH groups worked on developing guidance and protocols on sexual violence without the necessary collaboration with GBV platforms. Conflicts of agendas for partners working both in SRH and GBV are frequent, and there is non-alignment or double reporting of indicators on CMR. Bottlenecks and duplications were also reported on the provision of post-rape kits. Particularly in the FGDs, partners reported vertical SRH and GBV programming, with difficulty in ensuring adequate referral pathways due to fragmentation of services, with several organizations covering just a small component, resulting in dispersion of resources and a high number of referrals needed to ensure holistic care for one person.

- A **response of a more reactive nature, rather than proactive and preventive**, was linked with **weak preparedness** even in the case of cyclic crises. This was mentioned by all categories of informants, but in particular by health authorities. In the desk review, well-structured plans for preparedness and contingency were mapped. However, in the remote and local consultations, informants reported barriers to promptly operationalizing them.



Graph 2. Summary of challenges for SRH coordination, from the remote KII.

2.2.2. Successes and enablers for SRH coordination in emergencies

Success and achievements of SRH coordination in emergencies were mentioned during 44 interviews[9], for a total of 106 entries, and triangulated with country-focused activities findings.

[9] Although the question was systematically asked, not all informants could mention results, particularly where coordination was unstructured.

> *"Yes, to keep us alive. To keep alive is complex. I think that being alive is already a great gain. Because in the last restructuring that they wanted to do in December, one of the first things they wanted to do was to end the working groups."* (SRH Coordinator)

The following categories of achievements were the most often reported:

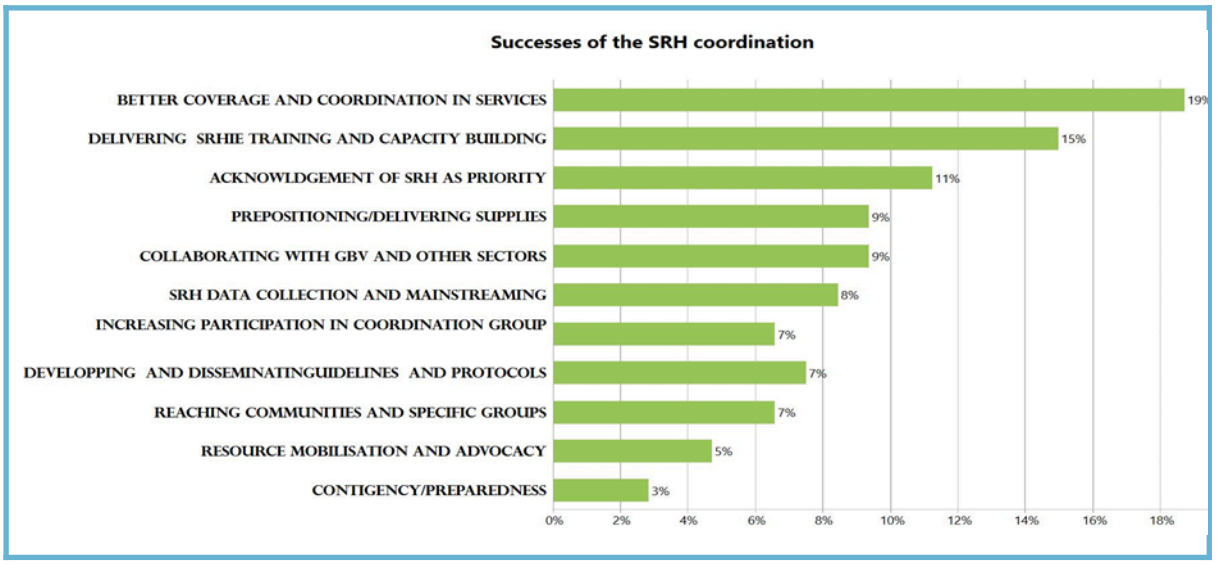
- **Better coverage of interventions**, including continuity of SRH services during crisis (45% of informants, 19% of entries). This included being able to map interventions and services in order to fill gaps through interagency collaboration and prioritization of locations or types of services through evidence-based advocacy. The example of *positioning SRH for continuity of services during COVID-19* was the most recurrent. During country-focused activities, good practices of continuation of services for comprehensive SRH were also observed: the up-to-date mapping of interventions and partners creating strong referral pathways for STI testing and follow-up for pregnant women, as well as timely redistribution of responsibilities among implementers when programs ended.
- **Delivering SRH in emergency training** and capacity building (45% of informants, 15% of entries). In the vast majority, the topics were related to the Minimum Initial Service Package for SRH in crisis situations (MISP) and Clinical Management of Rape and Intimate Partner Violence (CMR/IPV). As emerged during observations, in addition to structured ad hoc training, key messages were also delivered in coordination meetings and joint activities of the working groups. This component needs to be strengthened in all contexts, with support through training, increasing the availability of trainers, and increasing the visibility of trained professionals (through the establishment and regular update of rosters).
- **Acknowledgment of SRH as a priority in emergencies** (27% of informants, 11% of entries). This included making SRH a standing point in the health cluster agenda, managing to keep the SRHWG as a specific group within the health cluster during restructuring processes, and obtaining dedicated objectives in the Humanitarian Response Plan.

The following achievements were also mentioned:

- **Transparent and inclusive leadership** of pipeline agencies – which are providing joint warehouses and transport services - proved to be effective in managing supplies. Challenges, however, remained at the local level in terms of tracking and follow-up of last-mile delivery and within the point of service, where specific items (from gloves to PEP) were reported to be withheld by decision-makers at the decentralized level, who were worried about misuse or wastage.
- **Prepositioning and delivering of supplies** (23% of informants, 9% of entries). UNFPA's leading role in streamlining the acquisition process and coordinating the expression of interests for RH kits by partners and SRHWG members was acknowledged. In particular, during in-person visits, it was observed how the inclusion of development program focal points in the discussions on forecasting, allocation, and distribution of supplies (and strong links of lead SRH agencies with logistic cluster teams) allowed them to promptly fill in gaps and mobilize contributions.
- **Collaborating with GBV and other sectors** to provide holistic care to affected populations (23% of informants, 9% of entries). This included data sharing, advocacy, and referral pathways. Some good practices in working with WASH clusters and MHPSS and community health working groups were also mentioned. Successes also included leveraging health as an entry point for protection services, for instance, during COVID-19, when limitations on movements and service provision allowed the continuation of activities only for a few sectors.
- **SRH data collection and mainstreaming** (20% of informants, 8% of entries). Different types of achievements were reported: succeeding in systematically including SRH indicators in the health cluster bulletin, developing infographics, adding maternal mortality data in the regular epidemiological presentations, and carrying out needs assessments. It can be noted that the

reported successes in this respect appear to be "small gains," but they required important efforts.

- **Developing, updating, and mainstreaming guidelines and protocols** (18% of informants, 7.5% of entries) and increasing participation by SRH actors and engagement of national authorities (16% of informants, 6.5% of entries) were mentioned as important achievements in 'building forward' in a sustainable way while responding to the crisis.
- **Reaching communities and specific groups** such as adolescents and refugees (16% of informants, 6.5% of entries) through mobilizing partners in advocacy and outreach activities.
- **Resource mobilization** and donors' advocacy achievements that led to the continuation of services or funding of strategic activities (11% of informants, 5% of entries).
- **Preparedness and contingency** (3% of entries) were mentioned, as informants were training and developing an emergency coordination team selected among SRH providers to be activated in case of emergency scale-up. This involves integrating SRH in humanitarian contingency planning and being able to quickly respond to refugee influx thanks to the previous efforts in establishing the group.



Graph 3. Summary of successes of SRH coordination from the remote KII.

Enablers for SRH coordination were discussed during 38 interviews[10], with a total of 66 entries.

The most frequently mentioned enablers were:

- **Good relationships between SRHWG and the health cluster team.** This included support or demand from the health cluster coordinator to activate the working group (71% of informants, 40% of entries) and the role of OCHA for endorsement and acknowledgment of the importance of SRH. The importance of teamwork with the health cluster was confirmed during the in-person missions. Conversely, bottlenecks in the relationships between SRHWG and health clusters that hinder good coordination were identified and should be addressed with the support of management at regional or global levels.

> *"These are topics that we discuss, but unfortunately, If the working group is not really functional, it poses a problem. For us, if the working group is functional, it helps us to improve."* (Health Cluster Coordinator)

[10] due to time or difficulties of informants in identifying factors for successful coordination

- **Having a shared vision and plan as a group**, with clear objectives and a team spirit (37% of informants, 21% of entries). This also emerged during the country-focused activities either as best practices or as a request for the way forward in the consolidation of the group (for instance, to finalize the work plan and ensure monitoring of the group's activities).

> *"That a group is made visible and not that individual actions are made visible. That is a whole network. So I think that is a... One maintains the spirit alive, the initiative, the correlation, accompanies the team."* (SRH Coordinator)

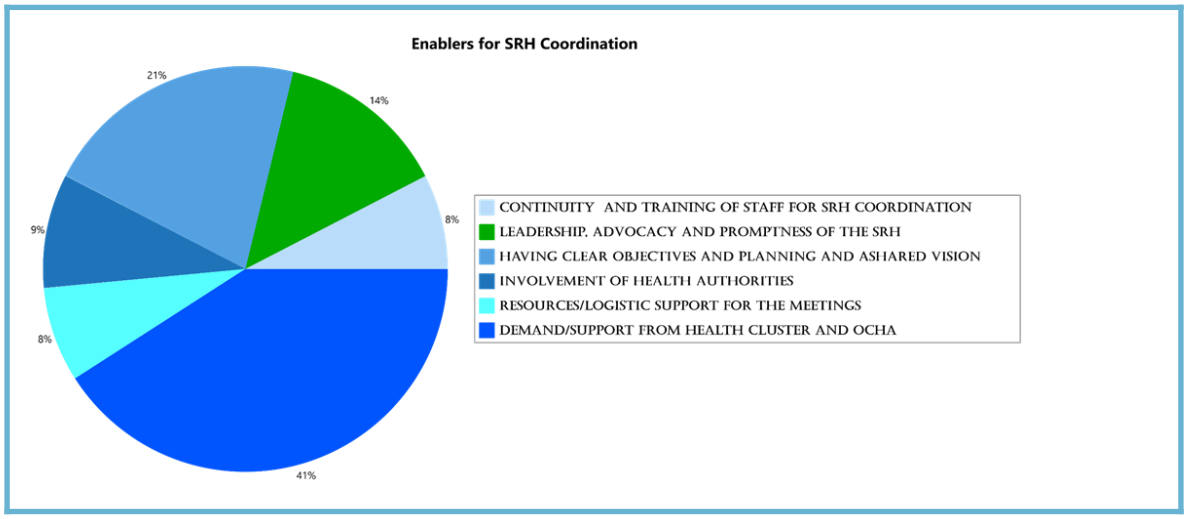
- The **qualities of the SRH coordinators** (24% of informants, 14% of entries), such as leadership skills, promptness in responding and attending to matters, ability to advocate, and presence and collaboration in other coordination platforms.

- The **active involvement of the health authorities in the coordination group**.
  This was confirmed in the country-focused activities, particularly in the cases where MoH focal points have roles of leadership or co-leadership. Nonetheless, their contribution, accountability, and ownership need to be consolidated.

- The **continuity in office and the level of training of the SRH coordinators** about humanitarian issues. The online resources available on the IAWG platform were highly appreciated, although some language barriers persist, and, as we will see in the next section, coordinators expressed the desire for a more holistic toolkit.

- Having financial and logistical **resources to carry out coordination** activities in a conducive environment.

- Country-focused activities allowed the observation of good practices of well-structured, **continuous, and inclusive coordination, with established, supportive connections between central and sub-national levels** acknowledged and recognized by the majority of SRH stakeholders.
  - **Co-leaderships** were seen as a crucial aspect of successful coordination.
  - Although the formalization of roles and responsibilities to determine accountability and ownership needs to be strengthened, **active involvement of civil society organizations and national authorities** brought added value to the coordination, as did the passion and commitment of members and observers, good communication and reactiveness of the lead.
  - Continuous **communication** was an important factor mentioned. Instant messaging platforms (such as WhatsApp) and direct and transparent access to documents and tools of the SRH group through a well-organized information-sharing platform played an important role in the communication flow.



Graph 3. Summary of enablers for SRH coordination, from the remote KII

2.2.3. Attributes, skills, and competencies of SRH coordinators

The desired attributes, skills, and competencies of SRH coordinators were mentioned by 19 informants in a total of 39 entries. These are:

- To be **technically sound in SRH in emergencies** (69% of informants, 32.5 % of entries), including being able to establish and strengthen inter-sectoral linkages with GBV and other areas of intervention.
- To have **managerial, planning, communication, and advocacy skills** (68% of informants, 32.5% of entries) and to be able to establish and maintain meaningful partnerships and alliances.
- They must be **clearly mandated** by the lead agency and have the time and space to exercise their coordination responsibilities (47% of informants, 22.5% of entries). No predominant preference was expressed for the full-time or part-time nature of the position (informants had varied opinions). The key message was the need for the coordinators to be clearly tasked **and accountable and to have enough time and support from the lead organization** to fulfill their inter-agency responsibilities.
- To be able to **understand and navigate the humanitarian architecture** (26% of informants, 12.5% of entries), including respecting humanitarian principles and understanding and adjusting to the peculiar characteristics of specific crises (outbreaks, conflicts, floods, etc.).

> *"But given the importance, especially in these areas…we need to have a fairly effective working group, not only someone who has notions in terms reproductive health, but also who can have much more capacity as a program manager and more of these capacities..these sound and programmatic ones, and that we have clear mechanisms of collaboration and exchange for all of us to try to boost a little more the SRH"* (Health Cluster Coordinator)

2.2.4. Desired support from the SRH-TT

The **establishment of the SRH-TT** at the global level was warmly welcomed by health clusters and SRH coordinators and actors. It also **triggered efforts to launch or revitalize SRHWGs** and to strengthen collaboration between UNFPA and IRC (the two lead organizations of the SRH-TT). It also generated high expectations from country teams on help and accompaniment from the global level.

> *"'The big expectation is the one related to learning, recycling, sharing documents, updating, which is at a global level, and training to allow the actors or coordinators are up to date with global information, whether it's information on the SRH, evaluations, and to build bridges, bridges for sharing experiences between countries, because we have things to share, we also have things to learn from each other. I think building these bridges needs to be built."*
>
> (SRH Coordinator)

In the remote phase, the desired **support by the SRH-TT** was mentioned in **44 interviews**, for a total of 112 entries. The most recurrent were:

- **Training, guidance, and coaching** on how to ensure effective humanitarian coordination for SRH (77% of informants, 48% of entries). Modalities were discussed with 52% of informants (28 entries), and no particular preference emerged among virtual in-person or blended activities. Three main suggestions were made:
  - Provide capacity building through a **community of practice** of SRH coordinators and experience-sharing visits between country teams
  - **bring together health cluster teams and SRH coordinators** for discussions and reflections and for specific modules on SRH in emergencies
  - ensure **multi-lingual support** in coaching, training, and production of guidelines and tools

  In addition to formal **training**, informants asked for **adaptable tools and templates**. The most listed were terms of reference for the different levels of coordination, action plan, monitoring and evaluation framework, service mapping, advocacy supports, and needs assessment tools. Some informants specifically mentioned the desire for an '*SRH coordination manual.*'

> *"For example, I have the manual of the coordination of the GBV group: it is super complete with what is expected, with the activities, with what implies the coordination of the group of GBV. I think that foR SRH, it is up to us to respond to needs without having a specific thing that can be guided at the level of the region or global."*
>
> (SRH Coordinator)

- Needs for **strategic guidance** were also clearly expressed. This included how to **ensure linkages with other sectors,** how to better **negotiate access** and services for specific groups (e.g., adolescents, refugees), and how to conduct **resource mobilization** and **transition along different phases of the crisis,** including in the framework of cluster system deactivation. Moreover, SRH coordinators and focal points presented the demand for **stronger and continuous support** and for the possibility of **reaching out to experts at the global or regional level for coaching** and discussing practical challenges and bottlenecks.
- Support in **positioning SRH in the humanitarian architecture and formalizing linkages,** in particular with the health clusters, was also an important demand (30% of informants, 13.5% of entries).
- 27% of informants (12.5% of entries) mentioned **strengthening resource mobilization and advocacy** for SRH at the global level. This aspect was corroborated by the findings of the country-focused activities.
- 16% of informants specifically mentioned the importance of receiving visits from global and regional levels to **create momentum** and provide on-the-job coaching and advice to coordinators.

"'How do we coordinate? How do we make the link with the health cluster, with the other clusters? You see, all these aspects in the country, the governance, how it goes with the partners, all these aspects, I think that people do it like that, I don't know if there are any global or regional capacity boosts. I don't know..were there some when you were there?" (SRH Focal Point)

- **The provision of technical guidance and training in specific areas of SRH** in emergencies was also mentioned (30% of informants, 13.5% of entries). This concerned in particular the need for more training of trainers. CMR was the most requested topic, along with how to ensure **more comprehensive SRH services** in protracted emergencies.
- **Support for information management was mentioned during the remote phase** (16% of informants) and was more strongly expressed during the in-person visits.

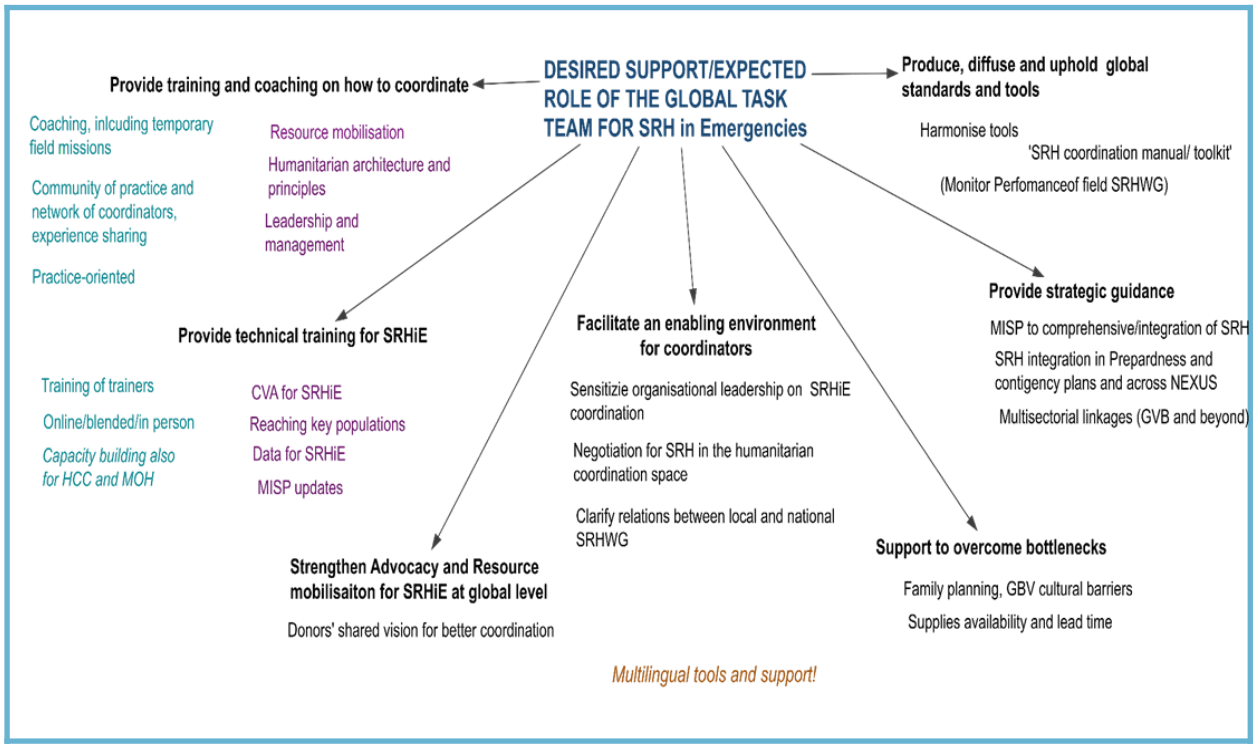


Figure 2: Summary of desired support from the SRH-TT

2.2.5. Specific themes in relation to SRH coordination

Data Collection and Reporting for SRH

Observation

Aspects related to data collection and reporting for SRH in emergencies were discussed with 25 informants in the remote phase and addressed during country-focused activities. The main findings are presented below. Primary **challenges** reported and observed were:

- Availability of information and **reluctance to share** by implementers or national authorities. This was also linked to '*reporting fatigue*' by partners and existing duplications in data collection from different agencies and coordination groups;
- Existence of **multiple platforms and reporting mechanisms** and the need for better articulation across them along the humanitarian and development spectrum;

- Multiplication of **needs assessments and lack of standardized tools** for SRH: informants highlighted the need to agree and focus on a manageable number of indicators across different phases of the crisis, from rapid evaluation to follow-up of MISP implementation and beyond, to tackle the major challenges to reduce morbidity and mortality related to SRH;
- The **lack of dedicated and experienced staff for SRH information management at the level of the lead agencies** to collect, manage, and analyze SRH indicators. This created dependency, discontinuity, and issues of sustainability in carrying out evidence-based coordination and advocacy; SRH focal points also pointed out the need to constantly negotiate for space for SRH data in information products of the humanitarian response. As a mitigation factor, **good collaboration with the health cluster team for information management** was reported to be conducive to the representation and analysis of SRH data.

Among **good practices**, informants mentioned examples of evidence-based advocacy, using the '*power of data*' for resource mobilization and positioning of SRH in response and contingency planning. The systematic inclusion of maternal death indicators in the epidemiological situation, which was regularly presented in health cluster meetings by the health authorities, was also considered a success.

In the desk review, a rapid analysis of the Health Resources and Services Availability Monitoring System (HERAMS) was performed, and it emerged that:

- **HERAMS pages existed only for 14 of the 28 countries (50%)** with an active health cluster at the time of the assessment[11]
- 4 additional countries (without an active health cluster) have a functional HERAMS page[12]
- Of the 18 HERAMS, 17 **(99%) had information on the availability of SRH services** and related barriers to service provision. These services are standardized in the system and include:
    - STIs/HIV services (Availability of free condoms, IEC on STIs/HIV, Syndromic Management of STIs, HIV advocacy, HIV Counseling and Testing, PMTCT, ART)
    - Maternal and newborn health (Family Planning, Antenatal Care, Clean Deliveries, Skilled Care during Childbirth, BEMOC, CEMOC, Postpartum Care, Comprehensive Abortion Care)
    - Sexual Violence (CMR)

HERAMS definitely represents an opportunity for SRH in emergency information management and should be leveraged more by coordinators. Nonetheless, the level and the type of information presented in the system are not always sufficient to follow up interventions and conduct strategic analysis.

Other platforms exist, such as the IMAPP-supported Report Hub in 5 countries and the ActivityInfo page, where space and a deeper level of analysis for SRH are negotiated with the health cluster. Strategic reflections should be supported on how to ensure harmonization across these and other existing platforms without creating duplicates.

In terms of health indicators, a variety of realities exist in the availability of public data (DHIS1, DHIS2, national health institutes, national statics institutes, SRH observatories, etc.), and coordinators and implementers reported difficulties in accessing such platforms and in puling and cross-referencing the different data necessary to conduct adequate analysis.

In the framework of the Humanitarian Project Cycle, **64% of the examined Humanitarian Needs Overviews and 60% of the Humanitarian Response plans contain reference** (indicators and or objectives) to SRH.

Most objectives and indicators revolve around **obstetric care and skilled birth attendance**. There is, however, an important lack of **homogeneity**, which results in underrepresentation and prioritization of

[11] No HERAMS was available for Burundi, Cameroun, Colombia, Haiti, Hondouras, Myanmar, Palestine, Somalia (not functioning), South Sudan, Gaziantep and Damascus hubs, Ukraine and Venezuela
[12] Iraq, Libya, Pakistan and Philippines.

non-life-saving SRH services (e.g., menstrual health and dignity kits labeled as SRH interventions and no mention of the MISP).

> *"We need data. Without data, we cannot make good planning. We cannot make good decision-making. So there are tools that are put in place in a parallel way at the moment to compile the information. And as we go along, we work to put our information collection system, and we are in the process of digitization of information. So, one thing after another, I think we can put these tools in place, our primary tools, to compile the data. But right now, it's done in parallel." (SRH Coordinator)*

Recommendations

The need for better **prioritization and harmonization** of data for SRHiE is valid at all stages of the humanitarian cycle in order to enable strategic analysis and decision-making for an effective and equitable response.

It is key to support country teams with a structured **framework for SRH in emergency information gathering and utilization, including specific templates, technical guidance, and coaching.** Best practices show the power of evidence-supported SRHiE advocacy, coordination, and response, and they should be leveraged.

Goal

This will possibly help overcome or at least mitigate the significant challenges of reluctance and 'fatigue' in sharing and reporting and allow for a more solid understanding and representation of SRH needs in emergency contexts.

SRH capacity building and training: programmatic and technical standards

Capacity building for SRH in emergencies was discussed during the remote phase with 24 informants.

Observation

Countless efforts are made by SRH teams in acute and protracted emergencies to provide technical capacity building as a means to increase the availability and quality of services.

However, important **challenges** were reported in the interviews and corroborated by the findings of the in-person activities.

- Shortcomings in the **harmonization of guidelines and protocols across interventions.** Although good practices exist, in most contexts, difficulties in alignment remain and are often linked with a lack of availability of updated national guidelines or the absence of proper coordination among implementers.

> *"We do not have a standardized and updated supply and drug list. We do not have standardized protocols that are shared by everyone…Different partners use their own protocols, their own supply lines, their own minimum packages, their own local linkages."(SRH coordinator)*

- When the guidance is clear, important **differences in training** tools, curricula, and design are observed, making it difficult to identify and uphold standards. Informants also lamented the shortage of trainers and difficulties in post-training follow-up:

> *"We are not able to have a critical mass of trained people on the different themes for sexual and reproductive health." (SRH coordinator)*

- Another complication is related to the already mentioned **high turnover** of human resources and challenges in selecting the right audience, in context with evolving task shifting and loss and displacement of health professionals, away from the crisis to safer areas or abroad. **Only a few** informants reported the existence of structured and updated **rosters of trained personnel** in their context.

> *"So integration of SRH into primary healthcare is very difficult and requires a lot of effort... Meaning that the family doctors or general practitioners and most of them are elderly, particularly those who are in conflict zones, and they do not have this, how to say, willingness or desire, you know, to start integration of SRH activities here were trying to capacitate nurses and midwives to do kind of task shifting and to be able to provide like SRH because SRH is not integrated into primary healthcare and most of primary healthcare facilities they were reporting not availability."* (Health Cluster Focal Point)

Some **good practices** were reported: delivering training on the job (at the facility level) and creating a 'core team' of SRH in emergency professionals to mobilize in case of new, cyclic, and scale-up emergencies. Informants, however, mentioned persistent difficulties in the actual and timely operationalization of such strategy due to the mobility of professionals, availability of flexible funding resources, and security issues.

Recommendations

The need for **standardization of protocols, guidance, and training packages, as well as better visibility and follow-up of trained professionals,** was clearly expressed by informants and was indicated among the expected objectives of SRH coordination.

Support in training of trainers, piloting innovative practices for capacity building, and technical guidance for **harmonization and dissemination of guidelines and tools** should be prioritized.

Coordination at all levels should also ensure streamlining and appeal to all implementers for alignment and respect of standards.

Goal

This will allow for better sustainability of capacity enhancement initiatives and strengthen the quality of care in emergencies.

Service delivery, including MISP, comprehensive SRHiE, and quality of care

> *"The word « MISP » is not ready. I think. And so, when people don't listen to the words of MISP, when there are a lot of colleagues who haven't taken the courses, then everything is dealing with a reality that is not mature."* (SRH Focal Point)

The role of coordination to ensure adequate service delivery for SRH in emergencies was discussed with 21 informants during the remote phase and explored in the in-person visits activities, with dedicated KII, FGD, and field visits.

Observations

Equitable coverage of services emerged as a main **challenge.**

Consultations and observations highlighted issues of **fragmentation** and **high concentration of partners** and interventions in the most easily accessible or most funded areas. This led to **major gaps** in life-saving SRH services in underserved geographical areas.

Referral was also amongst the most frequently mentioned challenges, linked with both infrastructural (roads, security) and health systems issues (resources, services per level of care).

A high variety emerged across contexts in terms of implementation and follow-up of MISP objectives in relation to the health system and the set priorities. In particular, in higher-income and more developed countries, family planning, CMR, and abortion care were prioritized by the partners and more often addressed by coordination, while EmONC services were prioritized in lower-resource contexts. STIs and HIV services were less mentioned and covered, and stronger links in coordination with specialized agencies, particularly for HIV, are needed.

In general, it clearly emerged that **not all components of the Minimum Initial Package for SRH in crisis (MISP) are equally implemented or prioritized** and that the MISP is not well known by all SRH actors.

Moreover, adapted services for adolescents and youth and the need for stronger sexual education interventions were raised on several occasions during interviews and focus group discussions as essential to enable the implementation of MISP across all categories of affected populations.

> *"There are many needs, for example, for young people who are not covered. There are many needs in terms of birth and reference to obstetric care that are not allowed. Access to safe abortion care… the law is also a problem."* (SRH Coordinator)

Finally, in stronger or more centralized health systems, implementers expressed the need to work on **criteria to allow delivery of life-saving services with humanitarian approaches**, in temporary derogation of national gold standards and protocols, for instance, in rural areas and with populations on the move.

> *"What kind of syndromic approach to STIs can the government accept? Because it's not easy, the government currently is not accepting a syndromic approach, right? They have a laboratory, and patients can go to the laboratory. But in more affected areas, it's not possible."* (SRH Coordinator)
>
> .....
>
> *"And family doctors are mainly referring patients, even for normal ANC, PNCs, they have been referring to secondary health care, to the hospital and to tertiary health care. And what we are trying to negotiate and advocate now to make sure that at the level of primary health care, those patients are getting certain level of treatment, especially when we are talking about rape victims, right? And referring them to second, to third health facilities, it's not always good, and we may just lose them on the way."* (SRH Coordinator)

Good practices were reported on conducting and keeping an updated **mapping of interventions** and partners. This allowed prioritization of MISP, improved referral, supported resource mobilization, and promoted continuity of services and transition to comprehensive SRHiE. Nonetheless, this practice is not disseminated nor standardized. The question remains on how to **ensure adequate information flow with the health cluster** and other reporting mechanisms without duplicating.

In areas of high concentration, issues related to subsidies and incentives for community volunteers and health workers were also reported to be tackled and regulated thanks to coordination.

> *"'And the community health workers at the time were with preference. Preference to work with NGOs that pay a lot. With competition, at the time, NGOs paid a lot of money for community health workers. But we discussed that here, we can use the same table for all health workers. We decided this. We do the rules, how we can run the mobile brigades. I take this example for mobile brigades, but we had the training for TBAs, traditional birth attendants."* (SRH Coordinator)

Recommendations

To **strengthen referral pathways in countries with pre-existing EmONC networks**, these should be better exploited at the coordination level and supported in a "NEXUS approach" across humanitarian and development sectors. Strategies could be developed on how humanitarian actors working in SRH could leverage pre-crisis mapping and monitoring of SRH services and cooperate with parallel ongoing efforts on the development side. Developing a strategy to systematically implement such linkages within and beyond EmONC could be an important piece of support at the global level (SRH TT), both at the technical and coordination levels.
Coordination also has a key role to play in ensuring adequate **mapping and follow-up of MISP interventions and in supporting negotiations with health authorities** around temporary task shifting or mobile modalities to ensure services reach the affected populations.

As proposed by a variety of stakeholders during in-person consultation, the relevance and possibility of working on **criteria** to allow the delivery of life-saving services with humanitarian approaches in the temporary derogation of national gold standards and protocols should be explored.

Such effort requires both programmatic and coordination actions, as joint negotiations with health authorities around temporary task shifting and mobile modalities are crucial to implement such changes.

Goal

This will help increase access to SRH services in rural areas and with populations on the move and will contribute to improving knowledge and coverage of the MISP among and beyond SRH actors.

Community Mobilization and Health Promotion

Feedback focused on family planning and the prevention of unintended pregnancy.

> *"'The family planning is not actually... the regular family planning is not a part of the MISP, you know that, but it's only the emergency. But of course we're also trying to emphasize on the importance of family planning as well. Not only as part of the emergency, but also like in the regular pieces, because we know that it's associated with reductions in maternal mortality and morbidity."* (SRH focal point)
>
> **** This statement is inaccurate: all modern contraception methods are within the scope of objective 5 of the MISP. We added this quote to exemplify the need for better understanding of MISP including within the SRH community.*

Family planning, prevention of unintended pregnancies, and community-based approaches were discussed with 18 informants during the remote phase and addressed during country-focused activities.

Observations

As demonstrated by the quote above, even expert and engaged SRH focal points seem to not have fully understood the pivotal role that contraception plays in the revised MISP. There is a clear **need for better understanding and promotion** of objective 5.

Cultural barriers in communities were mentioned as one of the major **challenges** in delivering SRH in emergencies, and in particular family planning and contraception services, with reports of **significant protection risks for frontline providers** and community health workers (retaliation, imprisonment, etc.) and 'instrumentalization' of intervention for political goals.

> *"To talk about condoms over there is a problem, to talk about sexuality is dangerous.. It's not easy."* (Local organization working in SRH- FGD)
>
> …
>
> *"But the government, they have very serious concerns about family planning. They are looking for data for family planning because they are thinking especially now we are coming to election and there is political tension, there is some kind of agitation against the refugees... And they are insisting on having, trying to have data… pressing even more on the national partners."* (SRH Coordinator)

Moreover, informants highlighted the **difficulty in designing and carrying out effective behavioral change interventions**, linked to limitations and short durations of funding.

> *"There is always a barrier. In most cases, it is a cultural barrier. Humanitarian interventions are limited in time. Because, look…it's about a duration of three to six months, and developing interventions for behavior change in that duration, it's not things that are addressed in a clear way, because you have to do analysis, social norms, have messages adapted for the transformation of negative norms, all that. And it's not easy, even though it's really important. But we focus more on the offer of services…The duration of the interventions does not offer enough opportunities. That is why it is important, as I was saying, to always link development and humanitarianism."* (SRH Coordinator)

Good practices show that when due diligence and respect for humanitarian principles and human rights are ensured by the coordination team, it is possible to address and overcome such challenges.

> *"Just one last example to contextualize it, it would be in the case of family planning. That's a big priority right now. The government has its own ambitions of how it wants to do it.... the SRH working group as a technical body supported by UNFPA developed a strategy. We looked at it at a strategic advisory group, and agreed to go with this, then now that goes to the government for their endorsement." (Health Cluster Coordinator)*

The need for **better counseling** in providers closer to communities and better availability of **commodities** also strongly emerged. Access to **safe abortion** care continues to be a major challenge.

> *"'I can say it like that, even if the country has validated the Maputo protocol, it is still a dynamic issue. But there is a national law that prohibits abortion. There is this other law that authorizes officially, beyond the Maputo protocol. So there are still limits. And there are also socio-cultural barriers in*

relation to the question of abortion, which still requires more awareness of the actors, especially the continuing leaders, the religious leaders, so that they can join." (SRH Coordinator)

….

"Nonetheless, successes have been reported through strong advocacy and involvement of national authorities, and are lessons learned that should be capitalized on. The Ministry also has the lead on access to the safe abortion care of the process according to the law." (SRH Coordinator)

In general, good practices show that **coordination can help by sharing tools and experiences, initiating a dialogue to tackle protection challenges** related to family planning, capitalizing on comparative advantages of partners in **accessing specific communities**, liaising with community health working groups, and **supporting the collective effort to influence the legal and normative framework** for FP, contraception and abortion care, to the possible extent.

Recommendations

While adapted messaging for communities and authorities is always regarded as helpful, there is a clear need for **more strategic reflections and piloting of innovative approaches for the prevention of unintended pregnancies in emergencies**.

As shown by best practices, coordination at all levels can help tackle such barriers. This includes sharing tools and experiences, initiating a dialogue to overcome protection challenges related to family planning, capitalizing on the comparative advantages of partners in accessing specific communities, and liaising with community health working groups. At a higher level, it will be helpful to provide advocacy points and support collective efforts to influence the legal and normative framework.

Goal

This will increase access to services, reduce risks for health workers, and promote behavioral change for better SRH outcomes and fulfillment of SRHR.

Linkages and synergies between SRH and GBV in emergencies

Observations

Linkages and synergies between SRH and GBV have been discussed with 35 informants in the remote phase and addressed during specific FGD and KII and through observation during the country-focused activities.

Through the assessment, a variety of arrangements were identified in terms of collaboration between SRH and GBV, both in coordination and programmatic aspects, but systematic and formalized linkages and synergies are lacking.

For instance, joint SRH and GBV task forces are in place in several contexts, but most of them are not regular and come together only to tackle specific issues and respond to punctual needs, particularly around Clinical Management of Rape (CMR).

Moreover, in the absence of a **formalized coordination between SRH and GBV** actors, these arrangements are left to the vision and preferences of the SRH and the GBV coordinators (and sometimes management of the lead agencies), resulting in discontinuity and constant changes (also linked to turn over of coordinators).

"To me when I came on board and thinking about the partners interests I decided not to split the CMR

task force and SRH sub-working groups. So to me SRH working group could be the working group and the platform where the CMR… and all these services can also be discussed and you know because you know the CMR service are already SRH working group members. So we should not split these two teams." (SRH Coordinator)

.....

"Even within UNFPA, you know, it was difficult to establish links with GBV colleagues because, you know, the system was, how to say, they were working based on projects. So in order to implement something it was very difficult to reach people involved because you didn't know who is doing what and who is responsible for what." (SRH Coordinator)

In terms of operational and programmatic linkages, during interviews and focus group discussions, informants reported **challenges** related to:

- Taboo and cultural barriers related to GBV and, in particular, sexual violence.
- Difficulties in ensuring **adequate and respectful referrals** for survivors of sexual violence, in particular in contexts with the highest fragmentation of services among the partners and absence of clear mapping of interventions. This was also linked to the difficulties in providing timely (within 72 hours) and free-of-charge care. It was reported that despite policies, guidelines, and protocols, survivors still have to pay for part of the services.
- **Stockout of supplies** and, in particular, PEP for survivors; at the same time, informants reported issues of 'unclear roles and responsibilities' and overlapping between health and protection actors in administering the kits, signaling a strong need for better coordination and formalization of responsibilities.
- **Overlap** was also observed in data collection on CMR services, with cases where different numbers were reported by the two sectors, linked with data sharing challenges between the team, sometimes justified with 'confidentiality reasons.'
- During observations, it was also noted that GBV and SRH teams tended to **work mostly in silos and in parallel** (organizing meetings at the same time, creating a conflict of agenda or working on CMR and GBV protocols separately), and would come together only for punctual issues (often around supplies).

"We are far from where we should be, particularly assistance within 72 hours due to obligation to refer to provincial, 'bureaucratic impediments' and as humanitarian we should find ways around this! 'Multi Sectoriality is also very challenging, the populations might receive assistance from one sector at one point in time, and then three months later form another sector because they did not have the funds or projects before." (Humanitarian Coordinator)

Successes and examples of good collaboration were also highlighted:

- The provision of **holistic care** for survivors, in particular, where health was acknowledged and strengthened as an entry point.
- Collaboration of SRH and GBV teams in **advocacy** to end harmful practices and in **resource mobilization** by systematically integrating SRH and GBV in proposals.

- Representation of key SRH messages through the participation of the GBV team in **inter-cluster** and other strategic platforms[13].
- Integrated **mobile services** and community mobilization activities.

"So we were thinking about an innovative approach, service delivery points to bring a multi-sectoral approach, meaning physically integrating GBV into health facilities, you know, like making health facilities an entry point for GBV. In capacity building, we always look at synergies and integration. Where can we help most? For instance, GBV is now integrated into our HIV prevention programming. So we've trained our counselors and care providers in HIV, GBV, and CMR. There are several areas where we can interlink. For example, they have something called confidential corners within the hospitals, where they provide integrated case management. It's not merely health intervention." (SRH Coordinator)

Better coordination should also consider other key interlocutors, namely:

- Leverage inter-agency coordination as a bridge to **strengthen synergies and dialogue** between the respective national institutions and ministries on protection and health**.**
- Reinforce collaboration with **observer organizations** such as MSF and the Red Cross and Red Crescent movement, who are key actors in providing GBV and SRH services in humanitarian contexts.

In terms of desired support from the global level (SRH TT), the following emerged:

- Clarifying and formalizing **roles and responsibilities** in providing care for survivors (and particularly management of kits for CMR).
- **Streamlining and aligning service mapping and indicators**, avoiding creating multiple platforms and conflicts of agenda.
- Provide guidance on how to further explore the **extensive potentialities of SRH/GBV linkages** beyond CMR, including reinforcing collaboration and joining in-person missions and needs assessments.
- Provide guidance on how to reinforce **integration in resource mobilization and advocacy.**

"'I think we should multiply the opportunities of having joint missions to the field. But also, another thing is that we need to clarify the coordination on the GBV theme. Because at some point there is a kind of... I would say, especially when we talk about the national authorities. On the health side, it is the Ministry of Health that is actively engaged in the framework of the SRH WG. On the GBV side, it is the Ministry of Gender, Family and Child. So, these are the actors. Because sometimes you have the impression that the people's health care workers are in the front line. I say we have the impression that the health care workers are complaining that they should do this and that. So it's about how to classify the roles and responsibilities of each leading party and make those bridges. Beyond the working group, we would need to make clear these points between the health care workers and the actors at the national level.'' (SRH Coordinator)

[13] This should not however be an alternative to the responsibility of health clusters to give voice to their technical areas, of which SRH is part.

Good practices exist, where protection aspects of SRHiE were tackled in alliance with GBV actors, particularly for specific groups. Other opportunities are constituted by the increasing appointments of **GBV advisors within the health clusters**.

Recommendations

Stronger coordination between SRH and GBV should focus on **clarifying roles and responsibilities** in providing care for survivors (including supplies), **streamlining and aligning service mapping and indicators**, and improving communication among country teams. GBV advisors are increasingly within the health clusters, and this opportunity should be fully leveraged.

Coordination can support better articulation with the GBV AoR by creating a collaborative framework at all levels that will build on comparative advantages and common objectives in caring for survivors, tackle harmful practices, and ensure holistic and respectful SRH care by mutually amplifying and maximizing resources and competencies.

Finally, as GBV is an area of responsibility, at the coordination level, efforts should be made to strategically mainstream SRH in platforms where it cannot be duly represented due to architecture (such as in the Inter-Cluster Coordination Groups) or resources (sub-national level and area-based coordination meetings). This should NOT, however, substitute the health clusters responsibility to reflect needs and concerns and advocate for support of the different technical areas, one of which is SRH.

Goal

A formalized framework between SRH and GBV will help avoid dispersed and irregular platforms and conflicts of agenda, increasing participation and inclusion of SRH and GBV partners. A well-designed collaboration will allow the exploration of the extensive potentialities of SRH/GBV linkages beyond CMR and provide holistic and respectful care not only for survivors but for all populations with SRH needs.

SRH medical supplies

Observations

The role of coordination in ensuring timely and adequate distribution of SRH supplies was discussed during the remote phase with 29 informants and with partners and key informants (including logistic cluster teams) during country-focused activities when observations and site visits were also carried out.

> *"'Actors' capacity on the supply chain of SRH, that is really a need to be able to improve. But these are things that are discussed at the working group level.. but I think that currently it is not systematic. In the same way we discuss the data on maternal deaths, we should also have a specific place to come back to the availability of kits, even the use of kits in general, the need for kits, all that. But it is not systematic."* (SRH Coordinator)

Although **inter-agency reproductive health kits** (IARHK) are largely distributed in emergencies, with few exceptions, supplies are **not systematically discussed** in SRH coordination platforms or at the health cluster. Specific task forces do exist, but they tackle more general issues of regulations and access and do not meet regularly. **Mapping** of needs and availability of supplies, and particularly RH kits, exist to some extent either at the level of the working group, the health cluster, the pipeline agency (often UNFPA), or the designated provider.

Nonetheless, as reported by informants, **visibility is limited,** and keeping these tools up to date is difficult due to challenges in reporting and information sharing by health services and partners.

"We ask our partners and then we try to inform the team that we have. It's true, it's been a long time since we've done the update, but we have this cartography to know where these kits are, because the kits can be in the capital, the others in the regions that are the most affected by this kind of catastrophe. But the update was not made long ago." (Health Cluster Coordinator)

Most of the inter-agency mapping efforts on the kits focus on IARHK 3, for CMR, which is also one of the most mentioned in terms of gaps, shortages, and wastage (due to the short shelf-life of the ARVs)

"No, we don't have a mapping, and that's a challenge. And as we have more pressure from our friends at GBV, we prioritize at times the mapping of the kits for this rape. We don't have a cartography of the different… We know that the UNFPA is available, we know that, but there are other factors. We were invited to share information about the availability of PEP kits. Honestly, I can tell you that we don't have all the information. We have the information from the UNFPA, but there are others like (NGO name), which are available, but we don't have all the information. So that's a weakness'." (Health Cluster Coordinator)

Among the main challenges regarding SRH life-saving supplies, informants reported:

- **Acquisition time and cost of procurement and shipment** of the commodities

"'But till July and August, I'm just praying that we don't have any kind of an unanticipated emergency…if you are planning to procure any kind of commodity, you are very lucky to have it in like seven, eight months." (SRH Coordinator)

- Earmarking of funding and donor's procedures, which **limits flexibility** in response and re-allocation of emergency supplies when needed. This also relates to 'last mile' or 'service point delivery' challenges, which, as lamented by coordinators and implementers, are often limited by the high costs in comparison to the percentage allowed in programmatic budgets.

"So that means most of the kits we are procuring, almost all of the kits we are procuring is targeted to a certain project areas in which we are really having a challenge on its flexibility because partners are asking UNFPA to provide those inter-agency RH kits to different regions and UNFPA is not able to respond to that request because we, the kits we are procuring are targeted to a specific project areas, regions or other facilities in which we are committed and accountable to the donor." (SRH Coordinator)

The discrepancy between the **composition and packaging** of the IARHK and the need on the ground often results in attempts to 'break the kits' in ways that create wastage and inefficiency (particularly for Kit 3[14]).

"We have been living here for 20 years in an emergency…let's go beyond that. We can develop the Ministry of Health as well. It's like okay, what is it that we need for a clinic that does 30 deliveries in a month? What is it? How is that adapted? How is that, like of course, the kits, nice, but kits are kits'.. " (Health Cluster Coordinator)

[14] Kit 3 corresponds to Clinical Management of rape, particularly the provisions of post exposure prophylaxis for STIs, including HIV, and emergency contraception. Access to the IARH kit Manual Version 6 can be found here.

There were few reported **successes**. These included **prepositioning** of supplies in the most affected areas, workshops, **capacity building** for partners and staff on the use and management of commodities, and the development of a ***'requisition supply pathway'*** with the shared responsibility of the SRHWG and the health cluster. In some contexts, there appear to be specific challenges related to the SRH commodities, compared to other health supplies, which are also linked with the role of the mandated pipeline agency.

> *"It is very difficult to defend the position of UNFPA, because if UNICEF and WHO are safe in their procurement process, what is so unique with the procurement and logistics supply chain system of interagency productive health kits?"* (SRH Coordinator)
> ....
>
> *"So really, really, it does not give a clear and good image for UNFPA. Because every two weeks, you keep on repeating the same reasons. We don't have RH kits, we are out of stock, and yet you have really requested one month ago, two months ago, and you are unable to receive the kits."* (SRH Coordinator)

Recommendations

As listed by informants, the global level could provide support to solve bottlenecks along the supply chain (in particular addressing delayed lead time and general stock out), in designing locally adapted packaging, and in accompanying country teams in transitioning from a kit to a bulk approach. Advocacy towards donors for more flexible funding that takes into account logistic challenges is also key.

Goal

Prioritization of support for SRH commodities in emergencies will allow more timely and robust responses and increase the credibility and leadership role of the mandated pipeline agencies.

3. REFLECTIONS & RECOMMENDATIONS

3.1. Reflections: An enabling environment for effective SRH coordination in emergencies

Good coordination allows for the saving of more lives and the prevention of excess morbidity and catastrophic consequences on affected populations while **maximizing resources and capitalizing on collective learning**. Even in emergencies, **coordination can be transformative,** by leading advocacy and impacting legal and normative frameworks. For topics like SRH, this is paramount but requires dedication, skills in management, planning, negotiation, communication, teamwork, knowledge, and *savoir-faire* in navigating the humanitarian architecture and the humanitarian-development spectrum.

Currently, all SRH in emergency coordinators or focal points are **double or multiple hatting**. Most of them do not have a humanitarian background, and often work isolated from other sectors and programs within and outside of their organization.

In order for SRH coordination to be an effective part of emergency response, several conditions are necessary. Before moving to the support that the SRH-TT can and must bring to country teams, this section examines responsibilities at the country and organizational levels.

3.1.1. The lead and co-lead organizations

Organizations with the willingness and mandate to ensure SRH coordination in emergencies are responsible for ensuring an enabling environment.

This includes adequate **human resources**, being clearly tasked and prepared for the role, having enough time to dedicate to such responsibilities, and having a **clear demarcation between their duties as staff members of the agency and their coordination role**. Moreover, each "SRH coordinator" should have at least an alternate to carry on the tasks if needed. For coordination to be effective and sustainable, the 'team approach' should be followed. This includes logistic and information management support to the coordination team. Documentation and handover processes related to coordination groups also need to be improved and systematized.

> *"I'm saying, yeah, if (agency name) wants to take the lead on SRH globally as it is, they have to have resources for the staff from the core budget. OK, if other agencies want to do it, because at the end it's about the capacity to lead, not just because of the mandate."* (SRH Coordinator)

Co-lead organizations are also accountable and seek improvement measures, as the same challenges of turnover and workload exist at their level. **The roles and responsibilities of the co-leading organizations** must be formalized and respected, and clearly identified co-coordinators should benefit from allocated time to fulfill their role. This can be supported in negotiations and internal advocacy from the lead organization at the global level, but it is the right and the responsibility of country-level leadership to enable and enact such mechanisms. Moreover, local, women-led, and civil society organizations are increasingly active in the humanitarian response and should be given more space and responsibilities in the core coordination team.

As observed, subnational and area-based coordination is often present only where the lead agency has sub-offices and often does not match with the health cluster hubs. Strategies of '**delegating' coordination to implementing partners or other agencies present on the ground** have been successfully piloted and should be replicated. Nonetheless, better formalization and interconnectedness with the central level and clear ultimate accountability of the lead agency need to be ensured. Decentralized SRH coordination can also be strengthened through focal points by integrating existing mechanisms led by local health authorities, according to the context.

Finally, the **management** of lead organizations could encourage the different sectors and programs coordination to breach silos and support, to a great extent, positioning of SRH in the humanitarian architecture, including, as demonstrated in some context, by taking a more prominent role in **Strategic Advisory Groups** of the health clusters, accompanying advocacy toward national authorities (when applicable), and vocalizing SRH need in the highest instances.

3.1.2. Other SRH actors

Members and observers of the Health Cluster active in SRH have important **responsibilities in ensuring continuous and meaningful participation in coordination efforts**. They are, therefore, encouraged to appoint clearly mandated focal points on their side and to share information and inputs on how coordination can be more inclusive, effective, and transparent.

SRHWG and other platforms can be opportunities to make the needs of institutions visible to all partners, and to encourage and accompany ownership by local authorities.

Linkages with development, stabilization, and NEXUS actors should also be ensured, and whenever interested and available, donors should be invited to participate.

3.1.3. Health Cluster

Support from the health cluster appears to be the strongest enabler for effective SRH coordination. This includes **advice, coaching, and support in humanitarian negotiations and resource mobilization**. SRHWGs are not competitors of the cluster, and efforts should be made to ensure clear and smooth information flow, avoiding duplicates and 'competition' in dealing with partners. The health cluster can also encourage and support multi-sectoral SRH interventions with other technical areas and beyond

health. On their end, SRH leading agencies have to 'earn' and demonstrate credibility and continuity of coordination, provide strategic and technical orientation and advice to health-encompassing exercises, and ensure transparency.

3.1.4. Donors

Donors can improve the SRH landscape through **strategic investments in a holistic package of essential SRH services.** Flexible support can help organizations to carry out preparedness and contingency activities or to **rapidly re-orient resources and supplies when facing acute emergencies**. Short or restricted grants make it challenging to implement quality SRHiE programs.

The Humanitarian Sector can and should offer the rationale behind humanitarian timeframes and procedures. In donor forums, a specific discussion should be on how to facilitate flexibility and promote broader coverage of services. This must be brought forward and encouraged by SRH-led organizations, and the SRH-TT with support from health clusters and humanitarian coordination.

3.2. Recommendations: Strengthen SRH coordination in emergencies

To fulfill all coordination objectives at best, SRH coordinators and focal points demand **continuous capacity building and technical support**, **a clear functional framework** and toolkit, **and formalized linkages** with the Health Cluster, Ministry of Health, GBV actors at central and sub-national level, as well as backstopping and **positioning of SRH in crisis for better resource mobilization and advocacy**. The SRH-TT has a crucial role to play in all these dimensions.

3.2.1. SRH positioning the humanitarian architecture

At the global level and under the aegis of the health cluster, the SRH-TT has a key role to play in promoting reflections for better articulation of **SRH working groups and other platforms with the health cluster and its other technical areas** (such as mental health, primary care, community mobilization, etc.), GBV sub-cluster and other sectors (e.g. Nutrition), within the framework of the humanitarian architecture. The task team can also support the mainstreaming formalization of linkages with development and national groups for SRH and the different geographical levels of coordination, from local to national and cross-border, when applicable. Better articulation and integration of **SRH coordination in refugees' response**s should also be supported.

Inter-agency dialogue promoted by the task team should also examine and support the formalization of co-leadership responsibilities at the country level and foster reflection at the global level in terms of mobilization of resources for clearly mandated (fully or partially dedicated) positions to ensure effective coordination in the countries.

3.2.2. Advocacy and resource mobilization

The need for a **larger promotion and better explanation and justification of the MISP** clearly emerged from the assessment. This should be addressed towards SRH actors, donors, health cluster teams, and other key stakeholders and be tailored according to the audience. Appropriate tools and strategies in different languages should also be created and/or disseminated for the use of the SRH advocates on the ground. Advocacy efforts could be made by the task team towards the donor community, sensitizing for policies and funding mechanisms that prioritize SRHR in emergencies with a holistic approach and allow for more flexibility, longer-term interventions, and human resources positions for SRH coordination.

The activation of a specific SRH-TT sub-group for advocacy and resource mobilization or stronger linkages with the IAWG on this workstream should be considered.

3.2.3. Capacity building and technical support

Ideally, **capacity building on SRH coordination should not be limited to lead agencies' focal points** but rather offered to health cluster teams (to some extent) and national health authorities who are willing to engage.

Moreover, **continuous accompaniment, mentoring, and coaching with practical and solution-oriented support** needs to be ensured, in addition to punctual training.

Capacity building for coordinators should aim to promote a more strategic role of the SRHiE coordination at all levels, directing prioritization (according to MISP and needs-based) and supporting resource mobilization efforts. The training curriculum should include the humanitarian architecture and principles, building management capacities, planning and monitoring skills, and adequate interpersonal attitudes.

A **'toolkit' for SRH coordination in emergencies should be the core and reference material for the capacity-building initiatives**, and templates and tools should be made available for all coordinators and focal points. At the very least, this should include standardized templates for working group ToR, an Action Plan and Monitoring framework, needs assessment services and interventions and service mapping, and a roster of trained professionals and trainers.

Continuous support for information management is crucial, particularly during the humanitarian cycle planning exercises.

Coordinators reported '*feeling like an island*,' isolated and disoriented, and their strong request for the creation of a community of practice and organization of support in experience-sharing activities should be seconded to empower them as professionals and leverage collective knowledge.

3.2.4. Technical guidance and programmatic support

A great variety of technical guidance and programmatic support is needed for SRH in emergencies. Some examples are:

- **Guidance on how to adapt responses to emergencies in highly centralized or structured systems** that are experiencing shocks, in order to find the right measure between national protocols (too elaborate and not applicable in hard-to-reach areas and people on the move) and global humanitarian standards (too basic for what the context can offer)
- **Strategies and funding for south-south/cross-border cooperation** to facilitate coverage and capacity building of human resources in humanitarian contexts
- Guidelines on how to ensure **linkages with GBV and other sectors**
- Guidance on SRH during a protracted crisis (between MISP and comprehensive)
- Guidance and accompaniment on how to tailor emergency preparedness and support for SRH to different emergencies (including leveraging MISP readiness assessments)
- Lessons learned and good practices on cash voucher assistance for SRH in emergencies
- Support **harmonization for data collection for SRHiE across partners,** identification of priority indicators, and analysis to orient and coordinate action
- Guidance and support on **tackling cultural barriers and protection risks of providers** and service users related to taboos around sexual and reproductive health
- Support to overcome specific bottlenecks, particularly for **life-saving supplies** (the **activation of a specific SRH-TT sub-group for supplies** or stronger linkages with the IAWG on this workstream should be considered

4. CONCLUSION

The road to ensuring effective SRH coordination in emergencies to support adequate, timely, and quality SRH response is still long, but the demands from country teams and stakeholders are clear and coherent and underpin, at large, the direction proposed by the SRH-TT.

The **recommendations** of this report are **addressed to the SRH-TT** and may validate already proposed action under different workstreams, raise awareness on actions that may be needed but are not yet addressed, and may even challenge assumptions made in the ToR of the SRH TT and the 2024 work plan.

In addition, the report aims to raise awareness of issues all stakeholders should commit to and engage in to create an **enabling environment** for SRH coordination in all phases of emergencies. This should start with the **sector-lead organizations** making the necessary internal arrangements to operationalize their commitment and fully embrace their responsibility.

It is equally important to increase transparency and inclusivity and facilitate the engagement of additional key interlocutors such as local organizations, civil society, and development platforms, as well as donors, stabilization actors, organizations with the status of observers of the clusters, and agencies specialized in HIV/STIs and in refugees' response.

SRH presents very specific and unique challenges in stable settings and even more so in emergencies. **Collective efforts are needed** to achieve timely and quality **SRH service provision in emergencies and contribute to sustainable changes for future development** in the sector. Coordination is central to this effort. Building on the 'well of knowledge and experience' of existing coordination groups, empowerment, harmonization, and standardization of coordination, together with the establishment of a 'help desk' for coordinators is key: **coordination can be a game changer**.

5. REFERENCES

1. SRH-TT GHC. *Sexual and Reproductive Health Task Team - Terms of Reference*. 16 February 2023. Available at https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team#:~:text=The%20Global%20Health%20Cluster%20SRH,the%20global%20and%20country%20levels. Last accessed: 31.12.2023.
2. Global Health Cluster. *Country Health Cluster Countries and Regions*. URL: https://healthcluster.who.int/countries-and-regions Last accessed on 31.12.2023
3. Global Health Cluster. Country Health Cluster Dashboard. 2023;(March). URL: https://healthcluster.who.int/publications/m/item/health-cluster-dashboard-q1-march-2023 Last accessed: 31.12.2023
4. Global Health Custer. *Health Cluster Annual Cluster Coordination Performance Monitoring Report 2022*. 25 October 2023. Available at https://healthcluster.who.int/publications/m/item/cluster-coordination-performance-monitoring-report-2022. Last accessed: 31.12.2023.
5. World Health Organization (WHO). *Integrated Programming for Better Health Outcomes, a Multisectoral Approach*.; 2020. Available at https://www.who.int/health-cluster/resources/publications/hc-guide/HC-Guide-chapter-8.pdf?ua=1 Last accessed 31.12.2023
6. Global Health Cluster. *Health Cluster Coordination Course*. Available at: https://healthcluster.who.int/our-work/capacity-development/e-learning. Last accessed: 31.12.2023
7. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). *OCHA Reports, Health Needs Overviews and Humanitarian Response Plans*. Available at: https://www.unocha.org/publications. Last accessed: 31.12.2023.
8. Global Health Cluster. *Health Resources and Services Availability Monitoring System* (HeRAMS). Available at: https://herams.org/session/create. Last accessed: 31.12.2023.
9. Durand MA and Tracey C, editors. *Principles of Social Research*. Second. Pr. Maidenhead, England: Open University Press; 2014.
10. Bellinger A, Elliott T. *What are you looking at? the potential of appreciative inquiry as a research approach for social work*. Br J Soc Work. 2011;41(4):708-725. doi:10.1093/bjsw/bcr065
11. Saunders B, Sim J, Kingstone T, et al. *Saturation in qualitative research: exploring its conceptualization and operationalization*. Qual Quant. 2018;52(4):1893-1907. doi:10.1007/s11135-017-0574-8
12. Trajkovski S, Schmied V, Vickers M, Jackson D. *Implementing the 4D cycle of appreciative inquiry in health care: A methodological review*. J Adv Nurs. 2013;69(6):1224-1234. doi:10.1111/jan.12086
13. Inter-Agency Working Group on Reproductive Health in crises (IAWG). General Sexual and Reproductive Health (SRH) *Key Informant (KI) Questionnaire: MISP Process Evaluation*. 2022. Available from: https://iawg.net/resources/minimum-initial-service-package-misp-process-evaluation-tools-revised-2022. Last accessed: 31.12.2023
14. Tran NT, Dawson A, Meyers J, et al. *Developing institutional capacity for reproductive health in humanitarian settings: A descriptive study*. PLoS One. 2015;10(9):1-18. doi:10.1371/journal.pone.0137412
15. Daoudi H, Frankin S, Some AN, et al. *Baseline and evaluability assessment on generation, provision and utilization of data in humanitarian assistance*. UNFPA Evaluation Office Assessment Reference Group. Published online 2021. Available at: https://www.unfpa.org/baseline-and-evaluability-assessment-generation-provision-and-utilization-data-humanitarian. Last accessed: 31.12.2023.
16. Global Health Cluster. *Information Management Task Team Toolkit*. Available at: https://healthcluster.who.int/our-work/task-teams/information-management-task-team/public-health-information-services-toolkit. Last Accessed: 31.12.2023.

17. Inter-Agency Working Group on Reproductive Health in crises (IAWG). *Taking Stock of Reproductive Health in Humanitarian Settings: Key Findings from the IAWG on Reproductive Health in Crises*. 2012-2014 Global Evaluation. 2014; (September 2009):2-4. Available at: https://iawg.net/resources/taking-stock-of-reproductive-health-in-humanitarian-settings-key-findings-from-the-iawg-on-reproductive-health-in-crises-2012-2014-global-evaluation.Last accessed: 31.12.2023

18. Tanabe, M., Schaus, K., Rastogi, S. et al. *Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013*. Confl Health 9 (Suppl 1), S2 (2015). Available at https://doi.org/10.1186/1752-1505-9-S1-S2. Last accessed: 31.12.2023

19. Vu A, Adam A, Wirtz A, et al. *The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis*. PLoS Curr. Published online 2014. doi:10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7

20. Gender-Based Violence Area of Responsibility (GBV AoR). *Coordinating Gender-based Violence Interventions in Emergencies*. Published online 2019. Available at: https://gbvaor.net/sites/default/files/2019-07/Handbook%20for%20Coordinating%20GBV%20in%20Emergencies_fin.pdf. Last accessed: 31.12.2023

21. Gender-Based Violence Area of Responsibility (GBV AoR). *Women-Led Organizations' (WLOs) Leadership in GBV Coordination Resource Package – 2023*. Available at: https://gbvaor.net/node/1834 Last accessed: 31.12.2023.

22. Inter-Agency Standing Committee (IASC). *Guidance on Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms*. 5 July 2021. Available at: https://interagencystandingcommittee.org/operational-response/iasc-guidance-strengthening-participation-representation-and-leadership-local-and-national-actors. Last accessed: 31.12.2023.

6. ANNEXES

All annexes can be made available as documents and excel sheets.

Annex 1: SRH TT. Concept note SRH Coordination Baseline Assessment (June 2023 update)

Concept note

SRH Task Team | Global Health Cluster

SRH Baseline Assessment

June 2023

Context

In December 2022, the formal establishment of a Sexual and Reproductive Health Task Team (SRHTT) as part of the Global Health Cluster (GHC) was approved by the Strategic Advisory Group of the GHC. The SRH Task team is co-chaired by UNFPA and International Rescue Committee (IRC), and has been joined by strong SRH-oriented colleagues from a number of GHC partners.

The establishment of a SRH Task Team goes back to discussions held with the Interagency Working Group for Reproductive Health in crisis (IAWG) members and secretariat in September 2020, during which IAWG members supported greater leadership of UNFPA in the Global Health Cluster as a means to strengthen the attention to and visibility of SRH in humanitarian crisis e and to prioritize SRH in the response.

The Global Health Cluster SRH Task Team will serve as a **formal entity** within the GHC that ensures **SRH priorities are systematically addressed** in all phases of humanitarian response and that SRH coordination is consistently included in cluster coordination at both the global, sub-regional and country levels.

A **baseline assessment,** including mapping of currently activated health clusters at the (sub)regional, national and, where possible, sub country level, will provide a concrete picture on how SRH-related **concerns and needs are identified, discussed, and addressed** within the health cluster. Particular emphasis on the role of the SRH contribution to continuity of services during the pandemics and outbreaks will also be considered.

This assessment will provide valuable insight into **good practices** as well as needs for improvement**.** Findings will directly feed into the **SRH Task Team priority setting** for the work ahead, inform all relevant **stakeholders** including donors, and create a baseline to build on and assess progress against.

Purpose

The aim of the baseline assessment is to understand to what extent SRH related **needs, concerns and capacities** are addressed across various activated country health clusters and, where established, specific SRH working groups under the Health Cluster. The baseline assessment will involve **identifying examples of best practices** as well as needs for improvement , and engage in a dialogue with health clusters on needed support. The final report will inform our understanding of how to **strengthen, systematize, and standardize SRH coordination** at the country level.

Objectives

The main objectives of the SRH baseline assessment are to

1) map and assess current SRH coordination activities within countries that have activated Health Clusters;

2) identify coordination challenges, enablers, and opportunities; and

3) propose solutions for strengthening SRH coordination and response.

The above will be realized through the following specific objectives:

- Identify key opportunities and challenges for SRH coordination at the sub-regional national and subnational levels

  - Identify key interlocutors for future collaboration on SRH coordination and systemization ● Propose priority areas of action compatible with the SRH TT mandate (see ToR)

Methodology

The **baseline assessment** will be conducted by applying the following methods:

1. Desk review (reports, minutes, etc etc)

2. Mapping (overview)

3. Key informants interview among Health Cluster coordinators, SRH WG focal points and MoH at country level

4. Field-based qualitative interviews, focus group discussions, observation activities

The **desk review** will focus on gathering and reviewing all resources available online, such as HNO, HRP, and Situation Reports. For example, these sources might point to the extent the Humanitarian Country Team (HCT) is addressing SRH, indicating the quality and position of SRH Working Groups.

The **Online/Remote Survey/Key informant interviews** will gather information on how the Health Cluster and SRH working group function. Interviews for the survey will focus on health cluster coordinators, SRH working group focal points/coordinators and , where possible, relevant MoH staff involved in the SRH humanitarian response. A survey tool (structured interview) will be developed and piloted, as part of the consultancy. The findings from this method will be triangulated with information from the desk review collected through in-depth interviews and

focus group discussions during missions to provide a more in-depth understanding of how effective the SRH response has been in various countries and what role the Health Cluster has played in this. The online survey will also provide information needed to select the countries for the field visits.

The survey is NOT self administered, but rather structured interviews, using online technology (Zoom, google meet)

The **Field Visits** will take place in two different countries, one English speaking and the other French speaking, with an activated health cluster. The data collection team will conduct **Key Informant Interviews (KII) and FGD with health and SRH coordinators, managers, relevant staff from NGOs in capital and field settings**, and carry out participant observation activities.

Preliminary findings will be presented to the GHC during the yearly partner meeting, as well as to regional and country stakeholders through webinars and other means of consultation, resulting in a comprehensive final report to be presented to the SRH Task Team and Global Health Cluster.

Roles & Responsibilities

- The **International Consultant (IC)** will lead the technical components of the mapping exercise, which includes but is not limited to:
    - developing the assessment tools,
    - conducting the assessment,
    - drafting the report and supporting dissemination materials,
    - and presenting the findings to the SRH Task Team.

The IC is expected to provide recommendations based on the assessment findings. The IC will have weekly contact with the Sub Group lead. Please find a detailed description of the assignment in the IC's ToR.

- The **Sub Group Lead** (UNFPA) is responsible for facilitating the Sub Group meetings, as well as being the direct focal point for the IC and other stakeholders.
- The designated **Sub Group** (Sub Group 1: SRH Coordination Mapping) is responsible for leading the preparation, dissemination and follow-up components of the exercise. The focal points will lead the recruitment of the IC and ensure adequate information and updates to the Health Clusters, following the GHC appropriate reporting lines. The Sub Group will also nominate the panel for the IC recruitment process.
- The **SRH Task Team** will review the assessment tools, reports and provide feedback and assume responsibility for the final result.

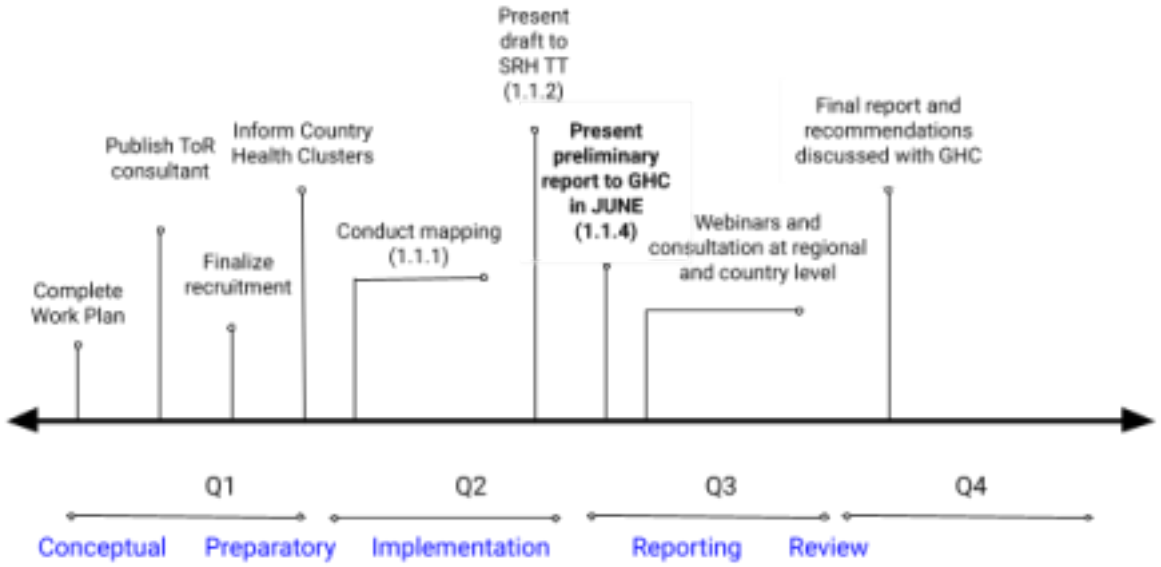
Element of interaction with other workstreams

Requirements and support offered

The following list indicates the required items to ensure appropriate action, and also provides information about the support offered by the SRH TT and Sub Group.

- Adequate funds to carry out the mapping (Obtained: UNICEF and UNFPA) ● Technical oversight by sub working group, and if possible, one of the sub group members to join the missions
- GHC to inform the respective Health Clusters, using the letters drafted by the sub group / SRH TT secretariat
- Health Cluster's participation at national and sub-national level
- SRH Working Group participation at national and sub-national level
- UNFPA and partners country level support

Process & Timeline



This timeline is based on the SRH Task Team Action Plan, approved by the GHC SAG. To ensure the milestones are met in time, the sub group will follow a separate work plan. Through this work plan, the sub group will be aware of the required actions. The sub group will keep the Task Team and GHC informed on the progress.

Want to know more?

1. Link to SRH Task Team Global Health Cluster web-page, at: [insert link]
2. Link to Terms of Reference SRH Task Team approved by GHC SAG, click here
3. Link to the Action Plan of the SRH Task Team approved by GHC SAG, click here
4. Link to the IAWG website for more information of the IAWG background and areas of work, at

   https://iawg.net/
5. Link to all Health Cluster countries, at https://healthcluster.who.int/countries-and-regions

Annex 2: Country Synoptic sheet template

SRH COORDINATION BASELINE ASSESSEMENTS RHTT/GHC 2023						
COUNTRY SYNOTPIC SHEET						
1. City	2. Country		3. Region		4. Type of Crisis	
5. Type of Emergency	6. Grade of crisis		7. People in Need (Health)		8. People Targeted (Health)	
9. Funding needs (Health)	10. % Funded (Health) at Q1 2023		11. Frequency of Health Cluster meetings		12. Modalities (virtual, hybrid, in person)	
13. Country Health cluster webpage	14. HERAMS (if existing)		15. HC meetings minutes online? (if yes, link)		16. HC workplan online (if yes, link)	
17. Last cluster coordination performance monitoring (CCPM) carried out (month, year)	18. Link to last CCPM report		19. Last joint needs assessement carried out (month, year)		20. Last joint needs assessement carried out (link)	
21. Health Cluster activated in (year)	22. Cluster COORDINATOR (name)		23. Cluster COORDINATOR (email)		24. Cluster COORDINATOR (phone, with country code)	
25. Cluster CO-LEAD (organization)	26. Cluster CO-LEAD (name)		27. Cluster CO-LEAD (email)		28. Cluster CO-LEAD (phone, with country code)	
29. Decentralised HC/Sub National hubs (YES/NO)	30. If YES, number of decentralised cluster (s)		31. If YES, site (s) decentralised cluster (s)			
32. Cluster Members (TOTAL)	33. UN agencies (number)		34. INGOs (number)		35. National NGOs (number)	
	36. National Authorities (number)		37. Donors (number)		38. Observers	
39. Existing Working groups (YES/NO) write YES to next to those that apply)	40. Non communicable diseases		41. Primary Care/Referral		42. Trauma	
	43. Mental Health		44. Infectious Diseases/ Epi		45. Risk communicaiton and community Engagement (RCCE)	
	46. Health Emergency supplies/kits		47. Other(s): specify		48. Other(s): specify	
49. Is SHR a standing agenda point in the Cluster meetings? (YES/NO)	50. Who is responsible for Sexual and Reproductive Health coordination, preparedness (contigency) and reponse within the cluster?			51. Are there other platforms for SRH coordination outside the cluster (MoH, NGOs, other): if yes, please specificy		
52. SRH working group exist (YES/NO)	53. SRHWG activated in (monht, year)		54. SRHWG ToR (link)		55. SRHWG Action Plan (link)	
56. SRHWG COORDINATOR (organization)	57. SRHWG COORDINATOR (name)		58. SRHWG COORDINATOR (email)		59. SRHWG COORDINATOR (phone number)	
60. SRHWG CO- LEAD organization	61. SRHWG CO- LEAD (name)		62. SRHWG CO-LEAD (email)		63. SRHWG CO-LEAD (phone number, wiht country code)	
64. SRHWG Members (TOTAL)	65. UN agencies (number)		66. INGOs (number)		67. National NGOs (number)	
	68. National Authorities		69. Donors (number)		70. Observers (number)	
71. Frequency of SRHWG meetings	72. Modalities of SRHWG meetings (virtual, hybrid, in person)		73. Last joint cluster needs assement including SRH or standalone SRH assessment (month, year)		74. Last SRH needs assessement carried out (link)	
75. Are there any decentralised SRHWG? (YES/NO)	76. If yes, number of decentralised SRHWG		77. If yes, site(s) of decentralised SRHWG			
78. Latest MISP Evaluation conducted (year/ not conducted)	79. Latest MISP Readiness Assessement (year/not conducted)		80. Latest MISP to comprehesive workshop conducted (year/not		81. Are Inter-gency Emergency Health kits distributed in the	
Link to document	Link to document		Link to document		82. Are Inter-gency Reproductive Health kits/complementary	
If there are any activities that could be relevant for the assessement on SHR coordination scheduled for July or August 2023 and you would accept researcher participation,						
If there are any sites or projects that could be relevant for the assessement on SHR coordination and you would accept researcher visit, please least below. Examples:						
				DATE COMPLETED:		
				By Contributer		

Annex 3: Interview Guide for Coordinators

SRH Task Team | Global Health Cluster
Baseline Assessment on Sexual and Reproductive Health Coordination in humanitarian settings with active health cluster

INFORMANT INTERVIEW

Interview information

Survey Code		Country:	
		Interview date:	
Language:		Interview time	
Place of interview:		Consent signed:	

Section 1: Introduction (5 min)

Dear XXX,
My name is XXX, and I am a Consultant mandated to carry out the baseline assessment on *Sexual and Reproductive Health Coordination in countries with active health clusters,* on behalf of the SRH task team, within the Global Health Cluster.
It is a pleasure to discuss with you today, and thank you very much for your availability for this interview.
You have been contacted as a key informant on how Sexual and Reproductive Health is organized and managed within humanitarian coordination, and how specific key themes are addressed through coordination.
With this interview, we intend to collect your inputs and recommendations, as well as verify pre-gathered information about your context.
There is no right or wrong answer, as this is a neutral, inquisitive and appreciative process to understand and map the current situation. It is also ok if you prefer not to answer a specific question. *This is not a performance evaluation.*
Our meeting will last *approximately 45 minutes*, and the information received will be treated confidentially:
I do kindly ask your permission to record it, for data analysis purposes.
You should have received a copy of the informed consent form, please let me know if you have any questions or objections to any of the points, before we proceed.
Please also let me know if you would like me to clarify anything about the SRH task team nature and mission, and the specific objectives of the baseline assessment, before we proceed.

(Notes)

Q1 a) Could you please introduce yourself and briefly share your academic/professional background?

Q1b) Is there anything about your current operational context that you would like to share before we begin?

Section 2: SRH Coordination in emergencies (15 min)

This section is meant to collect your views and recommendations on effective coordination to respond to SRH needs in your context. If that is ok with you, we will start from 'what is going well', and then move to how you would like to see it evolve and improve, and what would be necessary for the desired change. For the sake of time, I shall be grateful if your answers could be under 5 minutes, but we can discuss longer on few topics that you feel are more important.

Q2. Could you please tell me how the SRH coordination for humanitarian response is organized in the country?
Prompts -What are other key stakeholders for SRH coordination in the context? (Does the SRH WG report back to other groups? Which ones? (Cluster, Development Group, others…) -How are the interactions between the SRH WG lead and the Health Cluster regulated/formalized (What works well? What opportunities to improve exist)? -What would be the biggest achievement of the SRHWG this year or last year? -Are there working groups outside the cluster systems/led by the Ministry of Health? -Are Civil Society /Women led/local organizations participating in the SRHWG?How is leadership and co-leadership of the SRH working group organized? -Are members sharing responsibilities in fulfilling the MISP objectives?
Q3. What else would you wish to be done in terms of SRH coordination? What could enhance effectiveness or scope to the already existing strengths?
Prompts - Which support is needed to strengthen humanitarian SRH coordination in the context? - What kind of capacity building would SRH coordinators need to fulfill their role? - What common competencies could be identified for SRH coordinators in crisis? What knowledge and skills would they need? (What would be ideal for an SRH coordinator to do/to know)? - What kind of capacity building would Health Cluster coordinators need to support SRH?
Q4. How could we obtain this desired change? Could you provide practical examples/specific actions? **What challenges could exist?** How could they be overcome?
Prompts -In which time frame do you see this happening? Who would be responsible for it? -Is there a best practice? -What would be your individual/collective contribution to these changes? -How could we secure sustainability of coordination achievements (including in transition/cluster de-activation phase)?
Section 3: Key themes reflection (5 min)

Thank you very much for sharing these precious insights! Now, if you agree, I would like to dive deeper into some key themes that the SRH Task Team has pre-identified as potentially needing support, to have a better sense of the situation, of the needs on the ground and ways to support, and to identify together existing best practices. Again, I shall be grateful if your answers could be under 5 minutes, but we can discuss longer on a few topics that you feel are more important. We already discussed SRH Coordination architecture and leadership, but please feel free to share anything you might want to add, at any point. Amongst the broader list,the additional key themes we would like to focus on with you are XXX We would appreciate in particular any best practice or need for support you would like to flag, and recommendations you might have. (only 3 pre-allocated questions will be asked) I. SRH capacity building and training, including coordination, programmatic and technical standards (*go to Q6*) II. Data Collection and Reporting for Sexual and Reproductive Health (*go to Q7*) III. Service delivery, including MISP, MISP to comprehensive services and quality of care (*go to Q8*) IV. Community Mobilization and Health Promotion, in particular for Family Planning and prevention of unintended pregnancies (*go to Q9*) V. Linkages/Coordination/Synergies between Sexual and Reproductive Health and Gender-Based Violence in emergencies (*go to Q10*) VI. Life-saving SRH supplies such as IAEH, IARH, etc. (*go to Q11*) VII. Advocacy, funding and resource mobilization (*go to Q12*)
Q6. Is the SRH coordination for humanitarian response within the health cluster addressing capacity building /delivering training for SRH in emergency/MISP, SRH/GBV common areas in the country? If yes, could you tell me about it? (What challenges and opportunities exist?) Please list any needs for support in coordination, programmatic and technical areas and do not hesitate to share any best practice
Prompts -Do cluster/SRH WG members coordinate among themselves in organizing/delivering training for SRH in emergency/MISP/SRH/GVB common areas? And with the MoH/local health authorities? (are curricula shared/validated? -Do rosters of SRH trainers and of trained health providers , including to mobilize in scale up, exist? (MISP, CMR/IPV, AYSRH…) Are these rosters shared with the MoH? -Do standardized clinical SRH protocols exist? Are they adapted to the available supplies and the national protocols? -Is there any best practice?
Q7. Is the SRH coordination for humanitarian response within the health cluster addressing data collection and reporting for SRH (particularly Maternal and Neonatal) in the country? If yes, could you tell me about it?(What are the challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice

Prompts -What core indicators are measured/What SRH indicators (including clinical management of rape) are in the Health Cluster indicators Dashboard? With which frequency are they collected? -What systems of data collection, monitoring and reporting are in place? Who is responsible for it? How is this coordinated with existing national Health Information Systems? -Are there standardized reporting templates for SRH? Integrated or stand alone? -Are joint needs assessments that include SRH carried out in? Are there any known gaps in terms of SRH indicators?
Q8. Is the SRH coordination for humanitarian response within the health cluster addressing service delivery, in terms of access, coverage and quality of services? If yes, could you tell me about it? (challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice
Prompts -Are SRH services integrated into 3-5 W? -Is referral among levels of care discussed in HC/SRHWG meetings? -Is the support to EmONC rationally distributed ? -Are coordinators familiar with the MISP, MISP Evaluation, MISP readiness assessment ? -Is there any joint activity on quality of care for SRH in context? -Is there any adolescent/SOGIE/LGBTQI/minority friendly services joint initiative in context? -Have MISP Evaluation/MRA/MISP to comprehensive workshops being carried out in context? When? -Is there any best practice?
Q9. Is the SRH coordination for humanitarian response within the health cluster addressing community mobilization and health promotion and in particular prevention of unintended pregnancies If yes, could you tell me about it? (challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice
Prompts -Are SRH in emergency activities at community level, including family planning harmonized/discussed in HC/SRHWG meetings? Do they follow national or inter-agency standards? (for instance profile/curricula for Community Health Workers)? -Are there platforms/coalitions within and outside of the cluster/SRHWG engaged to generate demand for contraception/FP and to prevent unintended pregnancies? -Does the Health Cluster in general have an agenda item on Information Education and Communication activities? -Did the cluster/cluster partners produce any tool relevant to health promotion for SRH/FP/ contraception? Is there any best practice?
Q10. Is the SRH coordination for humanitarian response within the health cluster addressing linkages, coordination, synergies between Sexual and Reproductive Health and Gender-Based Violence? If yes, could you tell me about it? (Challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice

Prompts -Does the HC focal point for SRH/the SRH coordinator participate in the GBVSC? -Do the GBV coordinators participate in the HC/in the SRHWG? -Is there a dedicated (multi-sectoral) task force for CMR/IPV? -Are there functioning referral pathways between SRH and GBV? Are there examples? -Are there joint advocacy notes or proposals? Are there examples? -Are other linkages addressed such as with MHPSS, Nutrition, Early Childhood Development, HIV vertical programmes)? -Which support would be needed for SRH coordinators to reinforce these linkages? -Is there any best practice?
Q11. Is the SRH coordination for humanitarian response within the health cluster addressing procurement and delivery of humanitarian/life- saving supplies (including contraception)? If yes, could you tell me about it? (Challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice
Prompts -Are there regular/formal coordination mechanisms for Inter-agency Emergency Health Kits or Inter Agency Reproductive Health kits?If yes, how is the decision made on prioritizing allocation of limited supplies? -Is there any particular challenge with SRH life-saving supplies? -What support would be needed for SRH coordinators to better address life-saving supplies components of the SRH response? -Is there systematic communication/coordination between the health and the logistic cluster for delivery of SRH life-saving items? -Is there any best practice?
Q12. Is the SRH coordination for humanitarian response within the health cluster addressing advocacy and resource mobilization for SRH in emergency? If yes, could you tell me about it? (Challenges and opportunities) Please list any needs for support and do not hesitate to share any best practice
Prompts -Are SRHR integrated in advocacy done by the Health Cluster or the SRH working group? Are there examples? -Are SRH needs systematically integrated in flash appeal? -What percentage of funded humanitarian needs for health for 2022 corresponded to SRH? -Do Humanitarian Pool funds, CERF and main humanitarian donors prioritize Sexual and Reproductive Health? -Are there discussions within the cluster/the working group on how to combine/coordinate proposals to cover gaps and avoid duplications? -Is there any best practice?
Section 4: fact checking (if applicable) (10 min)
Thank you for all the information and recommendations you have provided so far.

Please allow me now to ask you a few follow up questions on the characteristics of the Health Cluster/SRH Working Group in your context. I will share on screen the synoptic sheet that summarizes the information we have so far. It will not take long.
Section 5: conclusion (5 min)
Dear XXX, Once again thank you very much for your time and contribution during this interview today. If I may summarize the main recommendations you made, these are: • • • Is this correct? Would you like to add or clarify anything? Do you have any further questions for me?
Please know that you can reach out to me and the SRH Task Team colleagues at the contact details provided in the consent form, both in case you would like to rectify anything or share additional documentation that might be useful for the assessment purposes. You will be kept informed of the process and invited to the final validation webinars, toward September/October. Once again, I sincerely thank you.

Annex 4: Templates for KII and FGD consent forms

SRH Task Team | Global Health Cluster - SRH Baseline Assessment

INFORMED CONSENT FORM – FOCUS GROUP DISCUSSION

In December 2022, a Task Team for Sexual and Reproductive Health (SRHTT) was formally established within the Global Health Cluster (GHC). This task team is led by UNFPA (United Nations Population Fund, the UN agency for Sexual and Reproductive Health), and IRC (International Rescue Committee).

Its mission is to ensure that Sexual and Reproductive Health rights and needs are systematically considered and addressed in acute and protracted crises, through coordinated and standardized preparedness and response. The task team will provide support and guidance to national and delocalized clusters and technical working groups at country level, while bringing main issues and concerns around SRH into the global agenda and carrying out advocacy and resource mobilization.

In order to better respond to country needs in terms of SRH coordination, a deeper understanding of the operational contexts is needed.

This is the objective of the baseline assessment for which you are kindly asked to grant an interview to Ms Alice Rosmini, International Consultant recruited to conduct the assessment.

For any additional information you can contact Ms Rosmini at rosmini@unfpa.org and Ms Schulte-Hillen (lead of the baseline assessment sub-group of the SRHTT) at schulte-hillen@unfpa.org.

Grateful for your availability to participate in the Focus group discussion, we invite you to fill in the consent form in the next page, to be able to include the information you will provide (in aggregated form) in the assessment findings.

SRH Task Team | Global Health Cluster - SRH Baseline Assessment

INFORMED CONSENT FORM – FOCUS GROUP DISCUSSION

- I (name and surname)..... in the role of *(eg cluster coordinator, SRH expert, etc..)* ..... voluntarily agree to participate in this baseline assessment exercise
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I have had the purpose and nature of the baseline assessment explained to me and I have had the opportunity to ask questions about it.
- I understand that participation in the FGD can take up to 3 hours time
- I understand that there are no direct individual benefits to taking part in this assessment.
- The risk in participating in the focus group discussion is related that if people know that you have participated in a focus group, it could lead to rumors in the community. To minimize this risk, we ask that, if you are to participate in a focus group, all participants in the focus group respect each other's confidentiality.
- I understand that I am no under obligation of answering any questions, if I do not wish to
- I agree for the focus group to be audio recorded
- I understand that the fact that I participated in the FGD and other activities of the assessment will not be fully confidential, but that all information I provide for this assessment will be treated in an aggregated matter, my name will not be directly linked to the information I provide, and the assessment team will do everything possible to protect my confidentiality
- I understand that disguised/anonymous extracts from my contribution during the FGD may be quoted in reports and presentations about the baseline assessment.
- I understand that if I inform the interviewer that myself or someone else is at risk of harm they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.
- I understand that signed consent forms and original recordings will be retained by UNFPA as in a password protected Drive folder,
- I understand that I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the assessment to seek further clarification and information.

I commit to respect the privacy and confidentiality of other focus group members by not disclosing any content discussed during the activity.

Date and place:

Signature of FGD participant

Annex 5: Focus group discussion outline (example)

SRHiE coord BA- Field Visits- Template for FGD /COORDINATION/			
I.	**INTRODUCTION**	**10 minutes**	
Good morning/good afternoon and welcome, I hope you are all well! My name is Alice Rosmini and I am an international consultant with the SRH TT under the GHC, tasked with carrying out a baseline assessment on Sexual and Reproductive Health in emergencies coordination, in countries with an activated health cluster .. and they are (intro for all other facilitators) and, as member organisations of the TT, will support today's activity.			
II.	**PRESENTATION OF FGD FRAMEWORK AND OBJECTIVES +Q&A**	**10 minutes**	
Aes we mentioned, and as indicated in the invitation letter, this activity is carried out in the framework of the SRHiE coord BA, please let us tell you briefly about the TT and the assessment (5 slides max about context and objectives of assessment + definition of SRHiE and coordination). Do you have any questions, before we proceed?			
III.	**INFORMED CONSENT**	**10 minutes**	
We are very grateful for your participation in this discussion, and please know that the information you provide will be treated in an aggregated/anonymised way, this is a safe space for discussion, and in a moment we will set some ground rules to ensure that. Your name will not appear with direct reference to the information you share, however, we will mention the location and type of participants in the FGDS, in the final report. You should have received a paper with a consent form to participate in this FGD, please fill it in and give it to my colleague XXX. For data analysis purposes, we would also like to audio record this FGD. The people who will have this recording are XXX. Does everyone agree with that? Thank you. Do you have any questions or comments, before we move to the next section?			recording/proceeding will depend on consent obtained (record just with note taking, excuse participants..
IV.	**GROUND RULES**	**5 minutes**	
Before we begin, we should agree on some principles to follow during our time together. As we mentioned, from the assessment team, confidentiality will be respected. We invite all FGD participants to do the same, and not share outside of this room what is discussed here, including other participants' personal information. There is no right or wrong answer, and all opinions and questions are welcome. If you prefer not to answer a specific question, that is also ok. Please put your phone and computer away, and please do not record this session. Also, please listen to each other, engage freely and respectfully in conversation and avoid side talks. If after the group discussion you would like to share something bilaterally with us, it is totally possible. We will try to stay within the time, and to give everyone the opportunity to express themselves. We will have a coffee break (details); if you need to use the restrooms, they are (details). How do you feel about these rules? Would you like to clarify/change/add anything?			Rules can be already listed in a flipchart and co-facilitator/note taker will add/modify according to group's inputs
VI.	**PARTICIPANTS PRESENTATION + ICEBREAKING QUESTION**	**15 minutes**	just to be notes-taking recorded
Ok, let's get started. We will not audio record yet. We would appreciate it if we could have a round of introduction where you could let us know how you would like to be called (first name, or nickname, or other), what is your role and organisation and also, what is your favorite color/animal/food. My favorite animal is cats. Over to you, thanks!			
Participants introduce themselves			
	COFFEE BREAK	**10 minutes**	***1 hour***
			START RECORDING
VI.	**CONTEXT**	**15 minutes**	
Thank you very much and again, very nice to meet you all. Now, **we will start the audio recording** *(if applicable)*. The first question for the group is if you could describe how SRHiE Coordination is organised in the context where you operate (be it national or sub-national)			
Participants answers			
VII	**SUCCESSES AND ENABLERS**	**15 minutes**	
Thank you very much for describing the current context. Now, what would you say it is working well in terms of SRHiE coordination? What could you achieve trhough it? And what do you think are the factors that allow for this result? What is making good coordination possible?			
Participants answers			
[**PROBE:** does it change according to different phases of the crisis?] [**PROBE:** if there is an SRHWG how are its relations with the HC/with other WG?] [**PROBE**: how is coordination across different geographical levels organised?] [**PROBE:** If there is no SRH working group, is there another WG that ensures SRHiE mainstreaming?] [**PROBE**: What are other key interlocutors for SRH coordination in the context?] [**PROBE**: Are Civil Society /Women led/local organizations participating in the SRHWG?]			
VII	**AREAS FOR IMPROVEMENT**	**15 minutes**	
Thank you very much and congratulations on the successes!Now what would you say it would still be important to strengthen/develop/improve?In other words, what would you like to see happening in terms of SRHiE coordination?			
Participants answers			

VIII	CHALLENGES		15 minutes	*2 hours*
Thank you very much for this information, if I understand correctly, the main needs for improvement concern (list main points) now what would you say are the challenges and the barriers that prevent this desired change from taking place?				
Participants answers				
IX	OPPORTUNITIES		15 minutes	
Thank you for listing challenges and barriers, now do you see/forsee/imagine any opportunities, to improve the situation and overcome barriers? What would they be?				
Participants answers				
X	SUPPORT		15 minutes	*2,5 hours*
Thank you very much for sharing so exhaustively, the last question would be, from your perspective, what kind of support could be provided from national, regional and global level to improve SRHiE coordination in your context?				
Participants answers				
[**PROBE:** What kind (content and modalities) of capacity building would SRH coordinators need to fulfill their role?And health cluster coordinators to support SRHiE?] [**PROBE:** What common competencies could be identified for SRH coordinators in crisis?What knowledge and skills would they need? (What would be ideal for an SRH coordinator to do/to know?]				
XI	ADDITIONAL COMMENTS		15 minutes	
Ok, this was our last question, but before we finish, is there anything about SRHiE coordinaiton ethat we have missed and you would like to discuss? or anything you would like to add? Any final recommendations?				
Participants answers				
XII	CONCLUSIONS (WRAPPING UP?)		15 minutes	
This has been great, we thank you very much for your time and engagement: you have greatly contributed to the assessment! Please be reminded that we committed to common rules, including confidentiality of what we discussed together today. Please also be reminded that if you wish to speak with us further, you can stay here or we can make an appointment. We might also reach out to some of you and ask if you would be available for an individual interview. Thank you very much!				*3 hours*

Annex 6: Observations general template

SRHiE Coord BA - Field Visit - Observation grid				
Date and time:			Place:	
Compiled by (name and role)			Contact:	
Type of activity		Meeting	Specify type of meeting (eg: Health cluster, SRHWG, other SRH platform, S.A.G, ICCG, humanitarian funds allocation meeting, GBVSC, CMR IPV TF, Logistic cluster or supplies TF, MHPSS WG, other ...):	
		Training	Specify type of training (CMR/IPV, SRHiE, preparedness, supplies, other)	
		Workshop	Workshop title:	
		Site visit/needs assessment	Purpose of visit:	
		Other	Specify:	
Relevance for SRH in emergencies	(circle which applies)	MAIN (SRHiE is or should be among the main topics, eg Health cluster, SRHWG other SRH activity)	SECONDARY/INTEGRATED (reference is or should be made, eg multisectorial meeting/needs assessment..)	NONE (explain)
Number of participants				
Describe participants (national/international, agencies, gender, profile/role)				
Describe activity				
Does the activity start on time?		A shared agenda was sent beforehand? How are items in the agenda organized? Is the order/importance respected?		
Who leads/facilitates?		Do people seem to have prepared for the meeting? How?		
Are there agreed upon ground rules on speaking intervening, confidentiality, etc?		Are the objectives of the activity respected? How?		
Are all participants engaged/paying attention? Is everyone given a chance to speak/ask questions if they wish?		To what proportion would you say the meeting/activity is about: a) information sharing b) transfer of knowledge/capacity building, including Q&A and experience sharing c) decision making/identification of solution (indicate % or low to high)	a) b) c)	
Is everyone willing to share information/share their opinion (even if not common) or do you sense reluctance/difficulty (prodive details, without names or identification of participants)		Pleases ummarise any decision/take away message relevant for SRH that was made:		
Would you say there is a general environment of trust/collaboration? (were there indicators of trust and collaboration? For example, did discussion include 'challenges' or 'bottlenecks', or if organisations were only sharing their own 'achievements'?)		Are everybody roles' and responsibilities clear?		
Please identify any good practice you observed during the meeting/activity		Please identify any obstacle/areas of improvement you observed during the meeting/activity.		
Were action points from previous meetings followed up?		What is the next step of this activity? Was it clearly communicated to participants?		