HEALTH CLUSTER
GHC SRH Task Team

REPORT

Executive Summary | Baseline Assessment on Sexual and Reproductive Health Coordination

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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.

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

Human resources and leadership of SRH coordination

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