PRIORITIZING SEXUAL AND REPRODUCTIVE HEALTH COORDINATION IN HUMANITARIAN RESPONSE

Sexual and Reproductive Health Task Team

Introduction

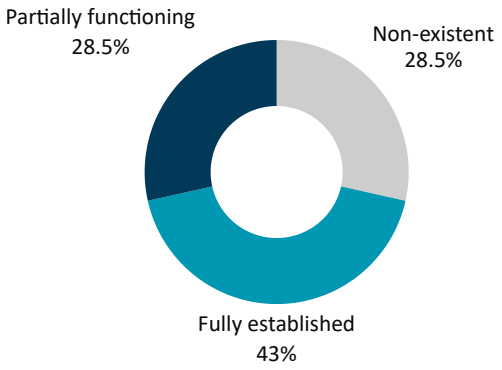
The Sexual and Reproductive Health Task Team (SRH-TT) was established under the Global Health Cluster, with the aim to ensure that sexual and reproductive health (SRH) priorities are systematically addressed in all phases of humanitarian response and that SRH is consistently included in cluster coordination at both the global and country levels.

In line with the SRH-TT's objectives, ***this baseline assessment aimed to map and describe existing SRH coordination mechanisms in countries with an activated health cluster***. In doing so, it identified challenges, successes, enablers, and opportunities, and served to provide recommendations for enhanced SRH coordination in emergencies.

KEY MESSAGES

- **SRH is currently de-prioritized, with significant gaps in funding and insufficient funding flexibility.**
- **There is a lack of continuity in SRH services, insufficient staff preparation and support, and only half of activated Health Clusters have fully established SRH working groups.**
- **The establishment of a SRH Task Team at the global level raises expectations for enhanced SRH coordination and support.**
- **Effective SRH coordination is crucial and life-saving.**

Findings



- The functional status of SRH working groups (SRHWGs) varied across countries. Specifically, 43% of SRHWGs are fully established, 28.5% are partially functioning, and 28.5% are non-existent. This variability underscores the **challenges in regularity and structure of SRH coordination in emergencies**.

- The **availability and continuity of human resources for SRH coordination have emerged as crucial yet challenging**. Most staff responsible for coordination functions are fulfilling multiple roles and lack humanitarian experience or specific training, highlighting gaps in capacity and expertise, particularly at the country level.

- **A need to improve SRH coordination quality and effectiveness emerged**, advocating for continuous capacity building and lead agency support, clear and documented functional frameworks, and formalized linkages within the Health Cluster (HC), as well as with the Ministries of Health, and gender-based violence (GBV) actors at both national and subnational levels.

- Respondents consistently highlighted **shortcomings in data access, management and analysis**, hindering effective evidence-based planning and needs-based response in SRH coordination.

- Barriers such as **low availability and high turnover of human resources, lack of updated rosters, and challenges in harmonizing protocols and guidelines** have impacted the ability to scale-up capacity-building efforts and quality of care.

- A series of consultations and observations demonstrated **inequities in access to services**, particularly regarding Minimum Initial Service Package (MISP) interventions. Fragmentation of interventions and the high concentration of partners and interventions in most accessible and/or most funded areas further accentuated the lack of access to affected populations.

- Timely supply of lifesaving SRH medicines and commodities was flagged as a major challenge by many.

- Joint SRH and GBV task forces are in place in several contexts. However, they tend to respond to specific operational needs, demonstrating the **need for more formalized coordination between SRH and GBV actors** at both the national and the local levels.

- Informants described the current humanitarian response as being **more reactive than proactive**.

Recommendations

1. Establishing an SRHWG under each Health Cluster, staffed with trained personnel, emerges as the most effective way to ensure SRH coordination.

2. Institutionalization of SRH coordination is imperative, with a clear definition of roles and responsibilities at lead and co-lead levels.

3. Providing country teams with a **structured framework for SRH in emergencies information gathering and utilization**, including templates and technical guidance is warranted.

4. Prioritizing training of trainers, innovative practice for capacity building and **harmonizing and dissemination of guidelines and tools** is crucial.

5. Promoting **better understanding and implementation of the MISP across all levels** is needed to strengthen awareness of SRH needs and evidence-based response.

6. Innovative approaches and advocacy are needed to **address contextual barriers** to needed family planning services and prevention of unintended pregnancy.

7. Global-level support is required to raise awareness and **solve bottlenecks along the supply chain** (e.g. excessive lead time and general stock outs) and other **supply related concerns.**

8. The SRH-TT, GBV AoR and field level counterparts must **clarify roles and responsibilities, streamline and align service mapping and indicators & improve communication** among country teams (e.g. to strengthen the prevention of sexual violence and response to survivors).

9. A **formalized framework between SRH and GBV** is required to provide a more holistic approach to meeting the needs of women and girls in emergencies**.**

10. Strengthen emergency preparedness efforts (e.g. MISP readiness assessments) to improve the capacity to respond, thus enhancing the resilience of both responders and affected communities.

HEALTH CLUSTER
GHC SRH Task Team