



EVALUATION REPORT

Evaluation of the Global Health Cluster and WHO sexual reproductive health project in Bangladesh (Cox's Bazaar), Yemen, and Democratic Republic of Congo (Kasai)

Conducted by:

Veronique De Clerck, June 2021

Acknowledgement

This evaluation could not have happened without the contribution and participation of multiple stakeholders, including the GHC, WHO SRH and partners at the HQ, regional offices, and in Cox's Bazar, Yemen, and the Democratic Republic of Congo. The evaluation has benefited greatly from the guidance and support of GHC team members Linda Doull, GHC Coordinator and Mohira Boboeva, SRH Program Manager. I would also like to recognize the contribution of the beneficiaries of the project I was able to interview by telephone. I am grateful for all participants' time and flexibility throughout the remote data collection process during the COVID-19 pandemic.

Table of Contents

1. Introduction	6
2. Subject of the evaluation and context	6
3. Approach and evaluation framework	9
4. Findings	11
5. Conclusions	28
6. Recommendations	31

Abbreviations

BeMONC	Basic emergency Obstetric and Neonatal Care
SAC	Safe abortion care
CaLP	Cash Learning Partnership
CeMONC	Comprehensive emergency Obstetric and Neonatal
CBO	Community based organisation
CS	Caesarean section
CSO	Civil society organisation
CSRH	Comprehensive Sexual and Reproductive Health Care
CVA	Cash & Voucher Assistance
DRC	Democratic Republic of Congo
EQ	Evaluation question
FP	Family planning
GBV	Gender Based Violence
GHC	Global Health Cluster
HC	Health Cluster
HCC	Health Cluster Coordinator
HNO	Humanitarian Needs Overview
IASC	Inter-Agency Standing Committee
IAWG	Inter-agency Working Group on SRH in Crisis
IOAC	Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
L3	Level 3 emergency
HeRAMS	Health Resources Availability Mapping System
HDMIS	Health data management information systems
HRP	Humanitarian response plan
HCT	Humanitarian Country Team
KII	Key Informant Interview
MISP	Minimum Initial Service Package
MR	Menstrual Regulation
SRHR	Sexual and Reproductive Health Care and Rights
SRH	Department of Sexual and Reproductive Health and Research
TOR	Terms of Reference
ToT	Training of Trainers
UNFPA	United Nations Population Fund
WHE	WHO Emergencies program
WHO	World Health Organisation
WHO RHR	WHO Department of Reproductive Health and Research

Key Evaluation Information

Evaluation title	Evaluation Global Health Cluster and WHO project: Delivering integrated Sexual and Reproductive Health Rights services in emergencies through the Health Cluster in Bangladesh (Cox's Bazaar), Yemen, and Democratic Republic of Congo (Kasai)
Project Timeframe	January 2018 - June 2021
Evaluation Date	May 2021 - July 2021
Type of evaluation	Endline, accountability & learning
Countries included	Bangladesh (Cox`s Bazar), Yemen (Aden, Ibb, Dhammar), Democratic Republic of Congo (Kasai region)
Evaluation Management	Linda Doull, GHC Coordinator Mohira Boboeva, SRH Project Manager
External evaluator	Veronique de Clerck

1. Introduction

Purpose, objectives, and scope of the evaluation

The purpose of the external evaluation is to determine Global Health Cluster Sexual Reproductive Health (SRH) Project results and performance within the health and SRH coordination architecture and its impact on the wider Level 3 (L3) humanitarian response.

Objective 1: assess the utility of the collaboration with WHO's SRH department, WHO's regional and global focal points, as well as the role of the GHC unit.

Objective 2: assess strengths and challenges of working within the country, SRH WG, WHE Country Incident Management Systems and the role of WHO as Cluster Lead Agency (CLA) in support of the country-level reproductive health sector deliverables.

Objective 3: learning lessons and provide utility focussed recommendations to strengthen future response and for similar emergencies

The evaluation emphasizes on both learning and accountability and informs on the GHC's approach to SRHR emergency response in humanitarian crises. The areas of inquiry include the design, implementation, and results of the program. The evaluation is framed within the complex environment of the three countries, as well as the impact of the COVID-19 pandemic.

2. Subject of the evaluation and context

Summary of the subject of the evaluation

The WHO Emergencies Programme and Global Health Cluster established a strategic partnership with the Government of the Netherlands through the Ministry for Foreign Trade and Development Cooperation since January 2018 to implement the pilot project "Delivering integrated Sexual Reproductive Health Rights Services in emergencies through the Health Cluster". The original duration of the SRH project was from January 2018 to December 2019 with additional two no-cost extensions including 6 months from January to June 2020, and a second no-cost extension of 12 months from July 2020 till June 2021. The total project budget was USD5,555,555.

This project was implemented in three targeted humanitarian settings experiencing Level-3 humanitarian crises, as designated by the Inter-Agency Standing Committee (IASC) – Bangladesh (Cox's Bazar), the Democratic Republic of the Congo (DRC/ Kasai Region) and Yemen (Ibb, Dhamar and Aden). In each country, available evidence indicated substantial burden and critical service gaps in acute sexual and reproductive health needs. These needs were identified through systematic and robust reproductive health assessments and reports, including the annual Humanitarian Needs Overviews (HNO). Important gaps

included Comprehensive Abortion Care (SAC), HIV prevention and attention to gender-based violence (GBV). Humanitarian contexts also present an opportunity for reaching more women, young people and those who have been hardest to reach, with limited access to quality SRH services.

Key interventions to increase access to and use of SRH services are known¹. However, there is an urgent need to build capacity among Health Cluster partners, not only to respond during crisis onset (e.g. through implementing the MISP, fully and correctly), but also to support the transition towards comprehensive SRHR through the primary health care system for the longer-term. Capacity building needs emphasise on establishing political agreement to provide the full package of services as recommended in the MISP; ensure that health providers, especially those working at community and primary levels, are trained in delivering services according to WHO guidelines appropriate for humanitarian settings; ensure that barriers on the demand side are properly understood and addressed so that services are accessible and acceptable to women of reproductive age; and guarantee that the minimum infrastructure, supplies and commodities are always available. Moreover, data collection, monitoring and accountability mechanisms for SRHR need urgent adaptation and use by Health Cluster partners, not only to ensure effective and efficient management, but also to learn and share lessons for SRHR in other humanitarian settings.

Following this, the project piloted two main components: (1) the introduction of a SRH project under the Health Cluster; (2) respond during onset, through implementing the MISP, but also support the transition towards comprehensive SRH² through the primary health care system for the longer-term as soon as possible by Health Cluster partners. The project focussed on 3 main output deliverables:

- 1) Strengthened capacity among health cluster partners and local health providers in 3 select countries to enhance provision of SRH services
- 2) Systematically strengthen the delivery of SRH services in 3 selected countries to reduce unmet need for services
- 3) Harmonization of Health Data Management Information System (HDMIS) including: process indicators at global level and in 3 select countries to enable performance monitoring and learning lessons for sustainable implementation of a full package of services; conduct feasibility assessments to assess service delivery and demand side barriers; assess implementation of innovations in service delivery in emergencies, such as health financing mechanisms

The 2020 WHO “Health Cluster Guide: a practical handbook” describes the coordination mechanism of SRH and GBV as follows. *“At the onset of a humanitarian emergency where the (IASC) cluster system is activated, the WHO as health cluster lead agency must ensure that an agency is identified to lead and guide provision of sexual and reproductive health interventions within the health cluster. In a humanitarian setting where the cluster system is*

¹ The global strategy for women's, children's and adolescents' health (2016-2030), *Survive, Thrive, Transform*. Sustainable Development Goals

² MISP Objective 6 of 'Planning and transitioning to comprehensive SRH services, integrated into primary health care'

not activated, a lead agency for sexual and reproductive health should still be identified. Usually that agency is UNFPA. The sexual and reproductive health lead agency will identify a coordinator for the health cluster or sector coordination mechanism to ensure that coordination, technical and operational support is provided to all health cluster partners, initially in scaling up coverage of emergency sexual and reproductive health services in the crisis areas, and then in supporting the provision of comprehensive sexual and reproductive health services. Prevention of sexual and gender-based violence and responding to the needs of survivors are key components of sexual and reproductive health programming (objective 2 of the Minimum Initial Service Package). To ensure programming beyond the clinical aspects of the response to gender-based violence, the sexual and reproductive health coordinator and the health cluster coordinator should actively participate in the wider inter-cluster coordination group discussion on prevention of and response to gender-based violence, and coordinate with the gender-based violence sub-cluster (under the protection cluster) to ensure effective referral pathways, standardized data collection and well-articulated management and preventive measures.”³

In Bangladesh, since the beginning of the crisis in August 2017, an estimated 909,000 stateless Rohingya refugees reside in Ukhiya and Teknaf Upazilas in Cox's Bazaar⁴. The vast majority continue to live in 34 extremely congested camps with severe limitations on their movement and income generation activities. Coordination mechanisms were quickly set up and stabilised, but services remain significantly constrained with protection funded at 7.2% and health funded at 16.9% in 2021⁵. The Rohingya people have faced decades of systematic discrimination, statelessness and targeted violence in Myanmar with little likelihood of a safe return to Myanmar in the coming years.

In DRC, violence initially flared in the Kasai region in August 2016, sparked by tensions between customary chiefs in Kasai-Central Province and the government. The violence spread rapidly in early 2017. Existing intercommunity tensions became part of a wider conflict involving militias, armed groups, and security forces. Beyond Kasai, the humanitarian situation in the Democratic Republic of the Congo has deteriorated dramatically over the past two years. The L3 emergency was activated for the Kasai region, Tanganyika and South Kivu provinces and more than 2.5 million people were reported to have been displaced. Between 2014 and 2020 the number of people identified in need has increased from 6.4 to 25.6 million people.⁶

Yemen remains a protracted crisis with the civil war starting in 2014. Since then, the scale of the humanitarian crisis increased. The HRP 2021 reports 20.7 million people are in need with 16 million people targeted for humanitarian and protection assistance⁷. Years of conflict has

³ <https://apps.who.int/iris/handle/10665/334129>, page 56

⁴ <https://www.unocha.org/rohingya-refugee-crisis>

⁵ <https://fts.unocha.org/appeals/1046/summary>

⁶ https://reliefweb.int/sites/reliefweb.int/files/resources/hrp_2021-vf_28_janvier_web_ok-links.pdf

⁷ https://reliefweb.int/sites/reliefweb.int/files/resources/Final_Yemen_HRP_2021.pdf

placed overwhelming strain on the country's health and social systems. Only 50 % of health facilities (HeRAMS) are functioning, and face severe shortages in medicines, equipment, and staff. The lack of access to appropriate reproductive health services in particular Family Planning (FP) and SAC but also antenatal care, safe delivery, postnatal care, emergency obstetric and newborn care places women and girls at higher risks. It remains a difficult operational environment with 78.7% of people targeted identified in hard-to-reach areas caused by a mix of administrative, operational, and political challenges. Conflict creates complex challenges for humanitarian delivery owing both to insecurity and arbitrary regulations and restrictions imposed by local authorities⁸.

3. Approach and evaluation framework

Evaluation approach, and rationale

The evaluation is **inductive and summative**⁹, providing opportunities for learning and accountability, and is based on validation and participatory principles. The process followed a **phased approach**: (1) inception, (2) qualitative data collection, (3) data analysis, and (4) reporting.

The evaluation framework (see Annex 1) was developed and was framed around the three areas of enquiry with six high-level evaluation questions and a series of sub-questions. It categorised the evaluation questions according to OECD/DAC criteria and focussed on **effectiveness, efficiency, coherence, and impact**. The three main areas of enquiry are:

- 1) Design (model and strategy)
- 2) Implementation (outputs, processes, and partnerships)
- 3) Performance (results, outcomes, sustainability)

All qualitative audio data was coded in Dedoose® data management software. The process was designed to systematically and transparently, minimize bias and maximize evidence. Despite the adoption of a pragmatic, but systematic, approach to analysing a substantial volume of data, field visits were not feasible due to ongoing Covid-19 restrictions, an important limitation in providing robust insights of the project.

⁸ https://reliefweb.int/sites/reliefweb.int/files/resources/Final_Yemen_HRP_2021.pdf page 45

⁹ an inductive approach starts with a set of observations and then moves to a more general set of propositions about those experiences. In other words, they move from data to theory, and aims at developing a theory while deductive reasoning aims at testing an existing theory. Summative refers to trying to understand why a program works or does not, and what other factors (internal and external) are at work during a project's life.

Evaluation methodology

The methods of data collection, analysis and reflection included review of documents and literature, semi-structured key informant interviews (see Annex 2), Focus Group Discussions (FGD) with training participants, and analysis of activity progress data, a validation workshop:

Table 1. Data Collection & Sources

DATA COLLECTION & SOURCES	
Document analysis	Internal and external documents were reviewed (see Annex 2)
Semi structured KIs	38 individuals (22 Female) interviewed including 15 global level stakeholders, 11 from Cox's Bazar, 5 from DRC, and 7 from Yemen. Informants represented GHC staff, GBV AoR coordination, IAWG, UNFPA, WHO, UNHCR, IRC, Ipas, IOM, independent consultants, representatives from Ministries of Health, Brac University, Amsterdam Royal Tropical Institute (KIT), Population and Health Research Institute (DRC), Programme National de Santé de l'Adolescent (DRC), National Association of Yemeni Midwives Association, Donors (Netherlands MOFA),
Focus Group Discussions (Remote online)	3 FGDs with training participants including nurses, midwives, and doctors in each country
Quantitative coverage	Quantitative data using existing project monitoring databases, implementing reports, project infographics, partners and UNOCHA focus reports
Participatory virtual validation workshop and presentation of final report	Workshop was conducted on 14 June 2021, with internal GHC project staff. Presentation final report 20 July

Limitations and risks to the evaluation

The evaluation had several limitations. Firstly, the evaluator was unable to travel to the field locations due to ongoing Covid-19 restrictions. As a result, all KIs and FGD had to be conducted remotely and there were no opportunities to include perceptions of health service users.

Quantitative project data was limited to measuring outputs and was largely activity-based. There was insufficient Monitoring and Evaluation (M&E) data available to assess contribution towards the desired population health results (e.g. how did the project influence SAC uptake).

While availability and overall response rates of stakeholders was satisfactory (61%), response rates and the number of KIIs conducted for Yemen (50%¹⁰) and DRC (25%¹¹) were low. Informants from Yemen and DRC included government representatives while KIIs from Cox's Bazar did not include government representatives. This has limited robust and sufficient data represented by a variety of country representatives.

Additionally, there is a selection bias regarding the FGDs conducted with training participants, as program staff identified them.

A co-creation exercise was initially proposed to give the recommendations more granular detail and to check the feasibility of the recommendations. Upon donor request, it was removed to keep the report truly independent. The absence of this step risks reducing the specificity of the recommendations to the WHO departments and the donor.

Quality Assurance

The evaluation was conducted in close collaboration with the GHC Coordinator and the SRH Project Manager and was overseen by the SRH Project Committee – which includes the Department of Sexual and Reproductive Health and Research (SRH). The evaluation adhered to the WHO Code of Conduct, UN Ethical Guidelines for Evaluations, and respected WHO's confidentiality requirements. As a result, interviews were undertaken upon oral consent, and based on agreement that details would not be attributed to a specific person or agency.

4. Findings

1) Design - model and strategy

EQ1: To what extent are the GHC SRH project strategies relevant in guiding the SRH response.

The pilot project design to test new approaches and tools was appropriate and a relevant stepwise practise. There is strong consensus among respondents on the need to improve health cluster partners delivery of comprehensive SRH services in humanitarian crisis. The gaps identified in the initial concept note¹² are important and recognised as hard challenges within the sector.

The strategy to strengthen capacity, service delivery and address health data management among HC partners and local health providers was pertinent and quite ambitious. Seeking to address SRH in L3 crises is ambitious because assuring the lifesaving and harm reduction

¹⁰ 6 KIIs conducted

¹¹ 4 KIIs conducted

¹² Lack of full and systematic implementation of MISP; Limited transition to integrated comprehensive SRH services within primary health care as situation stabilizes; Lack of availability of safe abortion care to the full extent of the national law; Limited contraceptive method options available, including emergency contraception; Little attention to the particular sexual and reproductive health needs of adolescents..

capacity requires many specific skills and assets in settings which are already under resourced. The three selected sites: Kasai (DRC), Yemen, Rohingya camps in Cox's Bazaar are, as recognised by their L3 designation, in the top tier of operational complexity and need. The proposal had elements which, given the operational complexity of these settings, were going to be challenging to be attained within the initial project timeline. Examples of these complexities are the strong host government policy alignment in Bangladesh to the Rohingya camps despite them being quite culturally different communities, the obstructive importation restrictions for humanitarian agencies in Yemen, or the severe geographical barriers in DRC. These situational constraints inhibit timely and best practice being achieved effectively.

Despite the initial project timeline being short (2 years), there was an overall fit-for-purpose intent, particularly as it was a pilot. The three-pillar approach of combining i) capacity building, ii) service delivery and iii) research is a powerful way to address current needs with an eye to assuring an evidence base for pilot scale up and further implementation.¹³ The increased emphasis on SAC, FP, GBV, and EMONC was pertinent following global recommendations¹⁴. The strategy is fully aligned with the priorities of the SDGs and builds on the evidence of what is needed and what works including in hard-to-reach communities like humanitarian settings. The piloting of this SRH project in these three contexts has allowed to build knowledge on how to provide accessible and quality SRH care services in protracted crises and thus compliments the '*leaving no one behind*' global 2030 Agenda for Sustainable Development¹⁵. Improving HDMIS for SRH has been a valuable ambition of this pilot. It is aligned with commitment 1.2 of the Grand Bargain Transparency Workstream and this "*can then be used to support and make evidence-based decisions around response planning activities, such as the allocation of often-limited resources by coordinators and inform programme activities of implementers on the front lines of the response*"¹⁶. It is identified as Strategic Priority 3 in the Global Health Cluster Strategy 2017-2019¹⁷ and 2020-2023.

The collaboration between the GHC, IAWG TPI, UNFPA and WHO was strategically relevant - key outputs from which - the inclusion of the IAWG TPI Toolkit¹⁸ for Planning for Comprehensive SRH in Crises proved to be foundational and invaluable to Transition from the Minimum Initial Service Package (MISP) for SRH (further referred to as the Participatory Workshop). The participatory workshop was perceived as very effective in providing a systematic approach to planning SRH response aligned with the 6th objective of the MISP¹⁹. Both the Tool, the workshops and the end product, a country specific workplan were highly relevant and contributed to a tailor-made, coordinated, complementary and a prioritisation approach. Across the three countries these workshops had the ability to engage a variety

¹³ <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-020-00280-2>, <https://gh.bmj.com/content/4/6/e001870>

¹⁴ The global strategy for women's, children's and adolescents' health (2016-2030), Survive, Thrive, Transform. Sustainable Development Goals

¹⁵ 2030 Agenda for Sustainable Development

¹⁶ <https://www.alnap.org/system/files/content/resource/files/main/Humanitarian-Research-Brief-2.pdf>

¹⁷ <https://www.who.int/health-cluster/about/work/strategic-framework/GHC-strategy-2017-2019.pdf>

¹⁸ https://iawg.net/resources/planning-for-comprehensive-sexual-and-reproductive-health-srh-in-crisis-affected-settings?utm_source=insider&utm_medium=email&utm_campaign=misp-csrh&mc_cid=323f3a4ed1&mc_eid=641a607c6c

¹⁹ Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the Health Sector/Cluster partners to address the six health system building blocks.

of stakeholders, including health authorities and local NGOs, and define the context specific implementation strategy and the responsibility matrix to assure delivery of the expected planned activities. The workshops were considered crucial in promoting effectiveness, efficiency but also coherence in a humanitarian environment where duplication is common. National and local health ministries were invested in all three country workshops, and this promoted government ownership. Feedback from DRC and Yemen stated the workshops helped build capacity through improving knowledge around MISP and comprehensive SRH. Also, the systematic approach to planning were good lessons learned that can be applied beyond SRH.

2) IMPLEMENTATION - outputs, processes, and partnerships

EQ2: How effective was the SRH project in meeting the objective to strengthen the capacity among health partners and local providers in the three countries.

The recruitment of a Project Manager and 3 country based SRH officers was regarded as a prerequisite for the program implementation effectiveness and to strengthen the capacity of health partners and local providers. In the initial project design the WHO/GHC had budgeted for three country-based project officers but this was not accepted by the donor. Health Cluster Coordinators could not absorb the additional day to day management of the SRH project and reported not to have program implementation experience. This resulted in delays in implementation. Following this, and in negotiation with the donor, country SRH officers were then recruited. While the recruitment took time, the SRH officers were recognised as providing three benefits for implementation: i) proximity to the implementing partners with the ability to manage the challenges, ii) more time to contribute to coordination across the HC and SRH WG partners, and iii) opportunity to prepare for SRH advocacy messaging to the HCT. Some respondents questioned whether the in-country position provided best value for money and whether integration of this position under the SRH WG led by UNFPA would be more cost efficient. However, coordination between the HC, the SRH WG and the country SRH officer was described mostly as collaborative and highly complementary. The GHC Project Manager and country SRH officers were effective in promoting follow up, driving the project forward and keeping up communication and collaboration across SRH partners.

The IAWG TPI Toolkit and workshops were piloted and found to be highly effective in enhancing SRH response planning under the Health Cluster coordination. The workshop was conducted in each country and was described as highly participatory in planning a transition from MISP to CSRH. The participatory workshops resulted in a well-coordinated and a complementary workplan amongst SRH partners. The workplan became the main reference document for the SRH WG coordinator and partners. Informants strongly agreed the workshops and trainings undertaken in this project have strengthened technical capacity of the HC and SRH WG partners and local providers to enhance the transition from MISP to CSRH. Gaps in SRH technical capacity was identified in the IAWG 2012-2014 Global

Evaluation as a key issue to be addressed. These workshops were conducted by external SRH experts between September 2018 and February 2019. Respondents presented that the workshop increased knowledge around SRH in the HC coordination and SRH WG partners, although some noted that greater focus on local skillset could have further increased its value. It did bring together partners and produced a plan, for instance Cox's Bazaar had 110 participants from 31 organisations out of the more than 130 organisations working in this setting. In Yemen, 94 participants from 29 implementing partners attended. In DRC, 27 participants representing 27 partners participated. While the workshops were highly valued, the proportion of staff who were trained by this one-off workshop reduced over time with the high turnover of coordination staff. Some key informants that had not participated in the workshop did not seem informed about this event and the purpose. Some were also not aware of the intent of transitioning from MISP to comprehensive SRH services activity. To sustain the momentum, the HC and SRH WG coordinator in Cox's Bazar conducted a second follow up one-day workshop in 2020 which was considered as contributing to enhanced knowledge and refocusing on the common goals.

Integrating the SRH project under the Health Cluster Coordinator increased SRH visibility and capacity in the Health Cluster. The participatory workshops were necessary to improve awareness and develop the skillset to assure that the first objective of MISP – to identify an organisation to lead implementation - was met. Roles and responsibilities were reported to be unclear mostly between WHO leading the Health Cluster and UNFPA leading the SRH WG. This was mostly at the onset of the project and at country level due to limited communication. With the arrival of the country SRH officer, the teams reduced the friction points successfully. The role of the country SRH officer was also important in clarifying roles, mitigating risks for duplication. This was particularly evident in Cox's Bazar. The UNFPA SRH WG coordinator focused on daily management of service delivery and capacity building. The HC kept the oversight of the SRH project which included the research component in collaboration with WHO SRH. The country SRH officer played a pivotal role in linking the HC and the SRH WG and assured problem solving and availing resources. KIs retained the perception that the HC remains significantly under-resourced, has large workload challenges and prioritisation difficulties and the increased prioritisation of SRH comes with a consequent reprioritisation of another important health topic. While the GHC SRH project contributed to more visibility of SRH in the Health Cluster, Covid-19 became a competing health priority and skewed to an extent the attention away from the SRH project.

EQ3: How effective has the SRH project strengthened SRH service delivery in the three countries to reduce unmet need

Capacity building and strengthening of CHWs to increase awareness in SRH was implemented to the required output and improved demand. It might not have reached the scale of the needs in Yemen and DRC. Trainings were undertaken with a Training of Trainers (ToT) cascade of knowledge approach (see Annex 3), but it has not been demonstrable that this cascade was achieved within the targeted communities. Several Trainings of

Trainers for Community Health Workers (CHWs) were conducted as part of a large commitment to strengthening service delivery uptake (see table 2). This included building institutional capacity through the involvement of local health authorities and cultural leaders in the planning and follow up of this CHWs training program. KIs in Yemen and DRC noted that they wished this component would be increased in coverage. For instance, in Kasai/DRC 126 CHWs were trained on SRH health promotion topics and 18 ToT community communication agents were trained on SRH community engagement activities which cascaded in 198 CHWs oriented on SRH topic by them²⁰. But these CHWs cover a cohort of 426,726 women of reproductive age. In DRC, despite the purchasing of motor bikes to facilitate transport, ensuring the training cascade was hampered by financial and geographical access barriers. The visit of an international consultant to conduct a baseline assessment and inform the training program priorities and agenda was important to set the scene. Local health authorities and cultural leaders were also briefed and coached on the inclusion of SRH in the CHWs program promoting local and government ownership.

Table 2. TOT training outputs for CHWs and CHW supervisors

Country	Topic	Participants trained	Partner organisations	Total TOT trained
Cox's Bazaar	SRHR messaging, TBA orientation labour room	CHW and CHW supervisors	CHW WG and partners	132
Yemen	SRHR training to CHW	CHW and CHW supervisors	MOPHP	88
DRC/Kasai Central	CHW/RECO ²¹ SRH training	CHW and CHW supervisors, local authorities, community communication agents	PNSR local provincial authorities	144

Cox's Bazaar has an estimated 300,000 women of reproductive age and the facility-based deliveries by skilled birth attendants were very low at onset of the crisis. In close collaboration with SRH WG and the Community Health Working Group (CHW WG), the HC organized a ToT training for community health volunteers, midwives, and traditional birth attendants (TBAs). The merging of these different health cadres clarified roles between the clinical work by midwives and community health workers and the importance of TBA's in non-clinical labour room support, referral, and health promotion. A tailored facilitator and training guide were co-developed, translated and 132 participants were trained and provided with 1 600 training flip charts (translated in Burmese)²². They would then train other CHWs and TBAs in the camps. This training allowed for both midwives and community health worker supervisors to engage with one another, for midwives to understand better the community health context, and for

²⁰ GHC SRH project Infographic May 2021

²¹ Relais Communautaire

²² GHC SRH project Infographic May 2021

CHWs and TBAs to learn more about the labour room and what midwives do. Pre and post test results demonstrated an improved knowledge from 71% to 95%²³. The training included orientation around the delivery rooms and was pertinent in overcoming health facility hesitancy issues. Informants reported that the CHWs training, in particular involving TBAs in delivery support, increased the health facility-based deliveries but also FP uptake during the project life cycle.

SRH WG data demonstrates an increase of facility-based deliveries from 2907 (2018 quarter 1) to 4463 (2019 quarter 4) in a relative stable population. In 2019 quarter 4, 9% were reported to be deliveries among women under 18 years of age. In that same quarter in 2019, 5% of health facility deliveries were reported to be by caesarean section²⁴ which is low. A total of 142,509 (101.7%) first-time family planning visits were reported in 2020 against a set annual target of 140,180 visits. Generally, the number of first-time visits for family planning continued to increase steadily from July to December 2020²⁵. Absolute numbers for Menstrual Regulation (MR)²⁶ increased from 740 (2018 quarter 1), to 3889 (2018 quarter 3) to 5208 (2019 quarter 4). The absolute number for rape survivors who report receiving PEP within 72 hours increased from 90 (2018 quarter 1) to 142 (2019 quarter 4). This data demonstrates a steady increase in uptake for health facility delivery, SAC, FP and CMR in absolute numbers.

Trainings of health workers were conducted and contributed to improved quality of service delivery through enhanced health worker skill and knowledge across the three countries.

The participatory workshops contributed to appropriately identifying skill and knowledge gaps among health workers. Each setting prioritised specific SRH topics in conducting ToTs. Most trainings were on SAC, and long-acting reversible family planning methods (LARC) aligned with the IAWG TPI (see table 3). There was also good adaptability to context and the changing environment. Covid-19 awareness and IPC trainings, and developing Standard operational procedures (SOP) ensured service providers and users were safe and SRH services could continue. The SRH WG coordinator prioritised topics and planned together with the HC the training program. In Cox's Bazar, 87 obstetrical training models were procured for a Midwifery Skill Lab in collaboration with the local health authorities promoting longer term government ownership. While trainings of health cadres in Cox's Bazar seemed to have reached good coverage, the Yemen and Kasai ToT masters faced challenges to reach lower-level health facilities to conduct trainings due to insecurity, difficulties in access but also due to the large geographical areas to cover (see Annex 3).

²³ Technical Report for Training/Workshop-WHE CX, March 2020

²⁴WHO standards recommend 10-15%.

²⁵ <https://www.who.int/health-cluster/countries/Bangladesh/Bangladesh-HS-Bulletin-July-Dec-2020.pdf?ua=1>

²⁶ Refer to SAC

Table 3. TOT training outputs for health cadres

Country	Training topic	Participants trained	Partner organisations	Total TOT trained
Cox's Bazaar	LARC, SAC, TBA orientation labour room, SOP maternal health during Covid-19, non-pneumatic anti-shock garment, EmONC, LSS, GBV/IPV	midwives, nurses, doctors, program support officers, NGO health cluster partners	CIRPB, WHO, UNFPA, UNHCR, RTMI, Care Bangladesh, IRC, IOM	389
Yemen	LARC, SAC, IPC in SRH, BEmONC	Midwives, medical assistants, nurses, physician, lab technicians, medical officers, HGO health cluster partners	MOPHP, Marie Stopes International, NYMA (National Yemen Midwifery Association)	143
DRC/Kasai Central	LARC, SAC, GBV/IPV, post-partum FP, SRH/IPC during Covid-19	Midwives, Doctors, nurses, PNSR supervisors, teachers & students of ISTM Mbujimayi/Tshikaji university Women's Division, NGO health cluster partners	ISTM Mbujimayi/Tshikaji university, Health cluster NGO partners	154

A main emphasis in strengthening service delivery was directed through supply that complimented UNFPA's SRH commodities in all three countries. The procurement and supply of SRH Kits represented 38% of the planned budget (see Annex 4) and resulted in a 99% absorption rate²⁷ by mid-June 2021. These stocks complemented UNFPAs procurement of the same kits. The workshop and country plan had assessed the commodity needs across the different health facilities in collaboration with local health authorities and partners at baseline. The follow up of stocks was a collaborative process with the SRH WG coordinator and SRH partners and this was reported to be relatively efficient.

In Yemen, 453 reproductive health kits were procured serving 60,000 beneficiaries across the 13 health facilities. In DRC, 399 IARH kits, 28 PEP kits, and 21 manual vacuum aspirations²⁸ kits were procured and targeted 60.000 beneficiaries. In Cox's Bazar, 781 reproductive health kits and essential supplies were procured including 50,000 doses of life-saving oxytocin, and 40 anti-pressure garments to stabilize post-partum haemorrhage.

The procurement and deployment of SRH kits was achieved and complimented the UNFPA supply but arrived later than intended in Yemen. The implementation of this output (2.3) remained one of the most difficult to achieve efficiently. KIs reported some uncertainty between GHC and UNFPA on the procurement of the IAWG kits at onset of the program.

²⁷ Interim Managerial Report as at 14 June 2021

²⁸ AMIU kit: Aspiration Manuelle Intra-Utérine

UNFPA is the SRH kit custodian and reported they have in country procurement and importation agreements with government ensuring fast track supply mechanisms. The coordination of SRH supplies seemed effectively managed in Cox's Bazar between the HC and the SRH WG coordinator. The SRH WG coordinator took the lead to monitor all SRH supply of all partners. While WHO and UNFPA stocks remained separately stored, stock management and delivery to health facilities was centralised at SRH WG coordinators level effectively reducing the risk for duplication or gaps. Cox's Bazar did not report significant stock ruptures. The GHC procurement and supply of SRH kits was considered of value in being complimentary to UNFPA's supply. Some informants questioned the role of the GHC in supply in a stable setting like Cox's Bazar. Some were of the opinion the SRH kits benefit the acute stages of an emergency only and local purchase would have been a preferred option in the current Cox's Bazar setting. DRC and Yemen had more difficult barriers to overcome that hampered timely delivery. Those included security and poor road and transport conditions. Yemen had difficulties importing SAC, CMR and FP items in the contested areas. Lengthy drug importation procedures resulted in certain items having a short shelf life upon arrival in the health facilities. Informants reported such barriers resulted in waiting times of 18 months for delivery in some settings.

Rehabilitation of health facilities (output 2.3) was conducted in DRC and is ongoing in Yemen but was not approved and seen as an appropriate activity for Cox's Bazar refugee context.

In Yemen 11 health facilities were assessed for rehabilitation and 13 were under procurement process with basic furniture during the evaluation period. In DRC, 22 health facilities were identified and costed for rehabilitation and 10 were rehabilitated by the SRH project. The other 12 health facilities are being rehabilitated by NGO partners. Rehabilitation came in late in the project due to challenges in finding appropriate contractors, transport to hard-to-reach locations and later the mobility restrictions of Covid-19. While this activity contributes to strengthening the existing health system, and while there was not always immediate benefit within the project timeline it was found to be appropriate to support longer terms needs as these are protracted crises settings.

Some responders stated more focus on joint supervision visits that support the quality of SRH would have benefitted the project. Joint supervision was conducted in collaboration with UNFPA, WHO or local health authorities in all three countries. These visits concluded on further identifying and prioritising SRH gaps and response. This process seemed very efficient and regular in Cox's Bazar with clear reporting and responsibility matrixes as a result. In Yemen, and to an extent in DRC, these visits were at times hampered by security, access barriers, and latterly by Covid-19 restrictions. Yemen informants expressed that such visits should include national health ministry representatives and standard national assessment tools should be used.

The pilot tested the coordination mechanisms both at global and country level and demonstrated strong partnership coordination and collaboration involving a large variety of stakeholders across capacity building, service delivery and research. Stakeholder feedback

described the nature of the partnerships overall positive and stated that coordination was particularly effective, inclusive, transparent, and problem solving. Many supported the idea of the Health Cluster taking on additional SRH programming. The project could have done better at clarifying roles and responsibilities between the HC, the WHO country office, the WHO regional teams, and UNFPA leading the SRH WG. While regional WHO emergency managers were included in all communication when the project proposal was developed the SRH technical counterparts were not directly involved, but there was an assumption the regional managers would engage them. Turnover of staff was an additional factor that influenced effective sharing of information on the project. Several external global actors stated more involvement in the design phase could have benefited the project implementation. Others stated the lack of clarity across the HC and SRH WG was a timebound issue only, not uncommon in humanitarian response, and was quickly resolved. UNFPA and IAWG partners at global level were particularly appreciative of the collaborative and transparent partnership with the GHC.

Partnerships necessitated and encouraged stakeholder engagement across several related initiatives and made efforts to harmonize activities and avoid duplication. Global and country level partnerships and efforts of collaboration included:

- *Partnership on piloting the IAWG Training Partner Initiative with IAWG, UNFPA and WHO*
- *Partnership on CVA with the Amsterdam KIT Royal Tropical Institute and WHO/GHC Cash Task team and its partners*
- *Collaboration with the WHO SRH department implementing GBV activities in Cox's Bazar and DRC with BPRM funding, which included additional countries like Syria, Afghanistan, and Iraq.*
- *Partnership between the WHO SRH and Maternal, Newborn, Child and Adolescent Health and Aging (MCA) departments, in collaboration with the GHC, for developing a common core framework for monitoring sexual, reproductive, and maternal, neonatal, child and adolescent's health services (SRMNCAH) and outcomes in humanitarian settings.*
- *Country partnerships with Research institutions including BRAC University, PHRI in DRC, and NYMA in Yemen.*

Efficiency in implementation was hampered by a low absorption rate in the first project year and later by Covid-19. In the first project year, budget absorption was low with an average of 13% by September 2018²⁹. The participatory workshops were mostly completed in the first year and the outcomes of these helped to accelerate expenditures during the rest of the project. The slow absorption rate resulted in a no cost extension of 6 months till June 2020. During 2020, the COVID-19 pandemic caused further limited access hampering the implementation of the project. The project therefore received a second no cost extension of 12 months till June 2021. Within the two no cost extensions, the team was able to

²⁹ October 2018 progress report (002) finances

successfully manage the underspend, while continuing the project's ambitions and by June 2021, the project absorbed 97% of its budget equally over the three specific objectives (see Annex 5). Linked to efficiency in implementation there were organisational issues within the WHE and specifically identified in Yemen. This impacted delivery of programming and has been addressed through the IOAC mechanism.³⁰

Informants reported that the initial timeline of two years was short for the ambitions in particular for the research component and the rehabilitation activities. Both activities came with significant preparatory work, including the establishing of appropriate partnerships. The research component comes with lengthy review and approval procedural requirements. In Yemen, the negotiations took time due to sensitivities around sexual health research in the contested areas. In DRC, negotiating the rehabilitation activities took time in finding competitive contractors and there were limitations in transport and geographical barriers in accessing some of the sub districts. In Cox's Bazar, informants reported that timely service delivery implementation depends heavily on the capacity of the implementing partners. Importing the SRH kits were significantly delayed in Yemen due to national or sub-national authorities and importation regulation.

Human resources challenges hampered the timeline and the sustained results for capacity building. The SRH project had challenges of retaining international and national human resources and at times finding appropriately qualified international staff. The turnover in project management after the first project year was perceived as an improvement. Finding the right country SRH officer profiles took some time but the decision to have country-based officers was viewed as effective in moving the project forward. Cox's Bazar reported high turnover of implementing partners and their staff which impacted the capacity building results of the trainings. There was also a large-scale loss of midwives to the national health system in Bangladesh which reduced the skilled SRH health staff and prior training investment made in this cadre.

EQ4: How effective and efficient has the GHC SRH project supported the research and data needs within the different specific topics in humanitarian settings?

The research component of the SRH project (project objective 3), was successfully managed by the WHO RHR department and consisted of two different research streams. The first stream included country situational analysis to inform on SRH demand and service delivery, as well as feasibility studies on the use of CVA. The second research stream was the harmonisation of HDNIS data and SRH core indicators.

A mixed method situation analysis was carried out in each of the three countries, involving appropriate partnerships with national research institutions but did not inform the project as such. Research objectives were found to be contextually pertinent in studying SRH demand

³⁰ <https://www.who.int/publications/m/item/twenty-first-meeting-of-the-committee-18-september-2019>
https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_16-en.pdf

and service delivery. The HC partnered with BRAC, PHRI-Kinshasa, NYMA-Yemen, and national MoH and WHO partners. Stakeholders reported this was a transparent and inclusive process. While the research did not intend to inform the SRH project within the timeline, informants reported on interesting findings that were shared among partners and health cadres which might have affected on service delivery. For example, in Yemen the baseline assessment concluded 69% of the women did not have general awareness on the benefits of seeking SRH services and there was low awareness around STI. During interviews different stakeholders were aware of these research findings and stated they try and address this at service delivery level. The assessment results provided district authorities with information around the extent of service delivery which they were unaware of. Research was also undertaken in the politically contested areas (Taiz & Abian) in Yemen. These research outcomes are valuable in providing a foundation for further and evidence informed programming.

In collaboration with the KIT, the GHC conducted literature reviews, feasibility studies around CVA in Yemen, and a collaborative workshop and this provided further evidence that CVA to support SRH services is relevant and feasible in humanitarian settings, and effective in addressing financial and other demand-side barriers. These activities involved collaboration with the WHO/GHC Cash Task Team and other relevant partners. Informants stated once services are made available of adequate quality, SRH projects should integrate a CVA component that looks at financing of services and explore context appropriate financing modalities that can help address the demand side barriers. From onset of program design, both supply and demand side barriers need to be assessed, and response can be integrated alongside supply side interventions. This can include but should not be limited to CVA. FGDs with health workers from Kasai in DRC indicated that women who underwent a caesarean section are detained in the hospital until they pay the bill (100-150USD). Specific CVA modalities are likely to address such financial barriers in these situations but the objective of the CVA research was not to implement CVA within the SRH project timeline. The CVA activities met the planned project outputs including: three deliverables in collaboration with the KIT, being a case study on Afghanistan and Yemen, a literature review on CVA in humanitarian settings, a partners participatory workshops to discuss findings, and the development of 'Tools and guidelines compendium' on CVA for SRH in humanitarian settings. This activity added to the workplan of the WHO/GHC Cash Task Team and adds on to the CaLP Programme Quality Toolbox, a set of common standards and actions for quality CVA³¹ and it is designed as a step-by-step list of actions to define what needs to happen for quality CVA. The project also progressed CVA by holding workshops to present the feasibility case which has been met and now it is important to embed this into implementation. A presentation in the Hague on the CVA work was planned, but due to Covid19 this was cancelled.

³¹ A Compendium of Tools and Guidelines, July 2020, Royal Tropical Institute, Amsterdam.

The different research partnerships for the situational analysis resulted in pertinent research outputs that are likely to inform current and future SRH programming. The success of adopting will depend on the ongoing dissemination processes being: (1) how they incorporate continuous stakeholder engagement for dissemination and utilization, (2) a comprehensive dissemination strategy, and (3) the tailored dissemination tools for various target audiences³². Both the GHC and the WHO SRH teams are engaged in the drafting of policy briefs, providing open access through publication and the GHC/WHO and IAWG websites, and conducting briefing workshops. Some previously planned dissemination activities with IAWG and the regional WHO offices (output 1.3) were cancelled due to Covid-19. At country level, dissemination of learnings from the situational analysis were delayed due to Covid-19 but were conducted during June 2021. The effectiveness of this activity could not be evaluated as this activity is still ongoing. At this stage it is unclear how the situational analysis will be incorporated in the future work plans of the SRH project. The following publication results are currently available:

- **With BRAC James P Grant School of Public Health, BRAC University;** *Situation Analysis for Delivering Integrated Comprehensive Sexual and Reproductive Health (SRH) Services for Rohingya Refugees in Cox's Bazar, Bangladesh*
- **With the Population and Health Research Institute & Programme National de Santé de l'Adolescent;** *Situation Analysis for Delivering Integrated Comprehensive Sexual and Reproductive Health Services for displaced population of Kasai, Democratic Republic of Congo*
- **With the National Association of Yemeni Midwives Association;** *Situation analysis for delivering Integrated Comprehensive Reproductive Health Services for Adolescent girls and women in the three selected districts: Al Sheikh Othman in Aden, Lawdar in Abian, and Almaafer in Taiz, Yemen*
- **Publication in BMJ;** *Situation analysis for delivering integrated comprehensive sexual and reproductive health services in humanitarian crisis condition for Rohingya refugees in Cox's Bazar, Bangladesh: protocol for a mixed method study*³³
- **Publication in Conflict and Health;** *Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Bangladesh*³⁴
- **International Journal of Information, Diversity & Inclusion;** *Ethics and Methods for collecting Sensitive Data: Examining Sexual and Reproductive Health Needs of and Services for Rohingya Refugees at Cox's Bazar, Bangladesh*³⁵
- **PLOS One;** *Situation analysis for delivering integrated comprehensive sexual and reproductive health services for displaced population of Kasai, Democratic Republic of Congo: Protocol for a mixed method study*³⁶

³² WHO Dissemination the research findings at https://www.who.int/tdr/publications/year/2014/participant-workbook5_030414.pdf

³³ <https://bmjopen.bmj.com/content/9/7/e028340>

³⁴ <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-020-00329-2>

³⁵ <https://jips.library.utoronto.ca/index.php/ijidi/article/view/33150>

³⁶ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0242046>

- **With the Amsterdam Royal Tropical Institute (KIT); Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies: A Compendium of Tools and Guidelines**³⁷
- **With the Amsterdam Royal Tropical Institute (KIT); Case studies: Afghanistan and Yemen, Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies**³⁸
- **With the Amsterdam Royal Tropical Institute; Literature review: Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies**³⁹

The harmonisation of HDMIS data provided relevant foundational work that can inform recommendations to strengthen data management at country level but has not yet improved performance monitoring and learning in the countries. This activity was led by the WHO SRH team with mutual efforts from the GHC team. The research objective was to develop a monitoring and evaluation framework for Sexual, Reproductive, and Maternal, Neonatal, Child and Adolescents Health Services (SRMNCAH) and outcomes in Humanitarian Settings. This was aligned with the GHC strategy (2017-2019) and the GHC Information Management Task Team. They focused on scaling up SRMNCAH monitoring and evaluation, as reflected within the strategic priority 3 on “Strengthen our collective and respective health information management and use”⁴⁰ through improved standardization, and quality of Public Health Information Standards and demonstrating the impact and effectiveness of the Health Cluster at country and global level. This research would also further inform the GHC set of core indicators⁴¹ and integration into the Health Resources Availability Mapping System (HeRAMS)⁴².

The research activities started with a systematic review of monitoring and evaluation indicators for sexual and reproductive health in humanitarian settings; and development of a draft framework of indicators building on this review. A large global technical stakeholder consultation was carried out⁴³ (December 2018) which agreed on a total of 59 SRMNCAH indicators across 9 SRH domains (45 were identified as core indicators)⁴⁴. Country assessments were carried out in Cox's Bazar and DRC which were perceived as relevant in identifying strengths and gaps in existing HIS and resources for collecting SRMNCAH indicators were carried out. This research did not involve Yemen as approval processes were too long. They also identified which current SRMNCAH indicators were useful to inform decision making, feasible in collecting, and that health facility data was preferred over population level data.

³⁷ <https://www.who.int/health-cluster/about/work/task-teams/CVA-SRH-Compendium-Tools-Guidelines.pdf?ua=1>

³⁸ <https://www.who.int/health-cluster/about/work/task-teams/CVA-Case-studies-Afghanistan-Yemen.pdf?ua=1>

³⁹ <https://www.who.int/health-cluster/about/work/task-teams/Literature-review-CVA-for-SRH.pdf?ua=1>

⁴⁰ <https://www.who.int/health-cluster/about/work/strategic-framework/GHC-strategy-2017-2019.pdf>

⁴¹ https://healthcluster.who.int/docs/librariesprovider16/meeting-reports/ghc-coreindicators-list-05-08-2020.pdf?sfvrsn=5943941d_3

⁴² <https://herams.org/session/create>

⁴³ First consultation was conducted on 11-13 December 2018, the second consultation was conducted on 15-17 June 2021.

⁴⁴ Report: Technical consultation for monitoring and evaluation of sexual, reproductive, and maternal, neonatal, child and adolescents health services and outcomes in humanitarian settings, 11-13 December 2018.

These assessments were harmonised with a WHO SRH-led DFID grant to compliment similar assessments in Afghanistan and Jordan.

The indicators were assessed between 2019-2020 in order to determine their feasibility, relevance, and acceptability for inclusion in routine data collection systems. This study was conducted in collaboration with the University of Ottawa (Canada)⁴⁵. The study results informed a second global Technical Consultations (June 2021) to conclude on a final set of core indicators. Both global technical consultations included a large variety of stakeholders from UN agencies, IAWG, NGOs and academia. This activity was regarded as a strong initial step in planning for strengthening SRH M&E and evidence-based programming in humanitarian settings.

3) Results - performance, outcomes, sustainability

EQ5 How effective and efficient has the overall GHC SRH project approach strengthened internal and external stakeholder collaboration to meet the project objectives and expected outcomes

The current GHC monitoring and evaluation framework tracked activity progress successfully (inputs and outputs level), though did not capture changes at the outcome or impact level.

The project tracked efficiently progress towards planned activities over time through the global workplan spreadsheet⁴⁶ (see Annex 4). By the end of June 2021, most activities (11) were recorded as 'achieved'. The Regional Meetings on SRHR in crises with EMRO and SEARO (activity 1.3) was postponed due to Covid-19 and the external endline evaluation (activity 3.2) is ongoing. The feasibility assessments related to provision of comprehensive package of SRH services in crises (activity 3.3) was cancelled due to Covid-19. Conducting implementation research on documentation of effective approaches to deliver SRH services (activity 3.5) was merged with activity 3.3. Each country had developed their own more granular workplan, but these were evaluated as inadequate on indicator targets or set benchmarks.

The project monitoring and evaluation framework was inadequate to assess contribution towards the desired population health results (outcome or impact level). The evaluation was therefore not able to assess coverage against the target of 60,000 women accessing services in each country, as cited in the project proposal. Measuring contribution to outcomes and impact is known to be challenging particularly in humanitarian settings due to the number of actors involved, the unprecedented nature of such contexts, the lack of baseline data, and difficulties in measuring morbidity and mortality.

⁴⁵ Report: Exploring the feasibility of establishing a core set of sexual, reproductive, maternal, newborn, child, and adolescent health indicators in humanitarian settings, executive summary, 12 June 2021.

⁴⁶ Work Plan progress report June 2021

There was consistent narrative quarterly reporting from countries upwards as well as annual reporting to the donors. These reports demonstrate continuous efforts on adaptation to context and the changing environment including due to Covid-19. The project also produced a midline and endline infographics displaying the main achievements over the project outputs⁴⁷.

Realtime self-evaluation was in place and contributed to continuous adaptation of the programme. Joint supervision and monitoring visits were conducted in all three countries and identified priority gaps and response across partners. During the supervision, the country workplan was the main reference document. While in Cox's Bazar and Kasai joint supervision was reported to have been done in strong collaboration with local health authorities, Yemen indicated joint supervision visits with authorities could have been better. While local health authorities participated, national representatives indicated visits should have been more inclusive of regional authorities and should have a stronger focus on quality of SRH care.

Regular supportive field visits from headquarters and expert consultants were conducted and supported the planning, strategizing and supervision. While these were mostly at the start of the program and contributed significantly to the implementation of the participatory workshop and the development of the country workplans, further visits were hampered by Covid-19 travel restrictions. As a result, the GHC team adapted its supportive role and intensified the frequency of regular communication through online meetings and WhatsApp calls.

There is variety in implementation of MISP to CSRH service delivery across the three countries but also within each context. While in theory the transition to CSRH is clear, the extent of CSRH implementation is influenced by local adaptation including mandatory alignment to country policy, the feasibility under country law or socio-political sensitivities, the capacity of implementing partners and financial constraints. In all three countries, the participatory planning workshop and workplan was an important contributor to setting the CSRH scene but the objective of implementing CSRH lost some emphasis over time. This was mostly impacted by the high turnover of partners and the loss of institutional knowledge, ongoing limited knowledge around MISP and CSRH amongst partners, and Covid-19 skewing the focus of response. Cox's Bazar reported to have conducted a refresher workshop to overcome this challenge successfully. Due to this implementation variety, understanding clearly to what extent each country has transitioned to CSRH has been difficult and was mostly informed through the key informant interviews. But informants state there has been a clear shift in mindset within the health cluster. The below section describes to an extent the variety and level of CSRH in each country.

In Cox's Bazar, ANC/PNC and comprehensive FP were implemented during the acute phase of the emergency following the Bangladesh SRH policies. Informants state the SRH project

⁴⁷ SRH infographics May 2021

contributed significantly to the expansion of SRH services including, SAC⁴⁸, GBV prevention, CMR and safe spaces, HIV testing and treatment, and Cervical cancer screening. There is also a referral pathway for sexual and reproductive cancer treatment. However, focus group discussions with clinician's state there are ongoing challenges with referral to CeMONC and particularly to accessing equitably quality blood transfusion. There are varying reports around how many CeMONC referral clinics are in the camp that operate 24/7 (from 1 to 7) and whether this meets the Sphere/GHC core standards (>1 CeMONC per 500,000⁴⁹). CeMONC referral out of the camps is challenged by lengthy administrative processes, the lack of surgical capacity upon arrival, and there is a perception that host communities are prioritized above refugees.

In Yemen, informants state that the SRH project has complemented comprehensive FP, SAC, quality BeMONC to what was previously limited to ANC, few FP methods and poor-quality delivery services. The project also strengthened the referral to CeMONC, and this was described as effective through FGDs with health cadres. However, there are socio-political sensitivities around GBV, FP and SAC in the contested areas that have hampered comprehensive scale up. Informants reported there are challenges in coverage and 24hr care is only available in few BeMONC hospitals. STI treatment is not well developed and there is limited understanding from the demand side. HIV testing and treatment was reported not be available apart from in one central referral hospital in Aden or Saana. Women are reporting that SRH services are of poor quality and there is limited communication around adolescent and youth health, but it is not clear whether this is targeting the SRH project as such.

Through the FGD with DRC health cadres, informants state there are SRH quality improvements at health facility level because of the SRH project. Contributors were the joint quality technical audits with the MoH, the uptake of the partogram, and improved competencies and supplies on SAC, LARC's, ANC and PNC. However, supply and stock management at health centre level remained challenging due to delayed importation, and difficulties in accessing the lower-level health centres due to access barriers (roads). Collaboration, with IRC, supervision of maternity red zones at PHC level to expand referral hubs / transportation system to address the gap between the home and the primary level facility was perceived as effective. The province also reports challenges in referral to CeMONC and access to quality blood transfusion across all provinces. FDG participants report that CeMONC costs are high⁵⁰, and hospitals detain patients who fail to pay their bill (e.g., the cost of CS in Kasai is approx. 150-200USD)⁵¹. While such contextual access barriers present a case for CVA interventions, the CVA component of the SRH project remained emphasised on assessments only.

⁴⁸ Referred to as MR – Menstrual regulation

⁴⁹ GHC Core Indicators

⁵⁰ 100-150USD for a caesarean section

⁵¹ <https://apnews.com/article/health-north-america-ap-top-news-africa-international-news-86372d0fec5c44bf9760ffa5fe75c2de>

Across the variety of stakeholders' interviews, there is a strong consensus that despite the implementation challenges the SRH project had impact and contributed to improved access and quality of SRH services in each of the three settings. The main contributors were the participatory workshop resulting in a common goals workplan, more effective coordination and collaboration with SRH partners on ground, joint supervision and monitoring to identify gaps informing program adaptation, capacity building activities improving capacity of health workers, CHWs and local health authorities and strengthening supply.

Sustainability concerns have not been embedded adequately in the SRH project strategy or implementation plans. Evidence from document review and interviews shows that there is no solid strategy in place to guarantee programmatic and financial sustainability, nor a plan to monitor sustainability actions. The project does not have a Theory of Change and there are no formal procedures for exit/transition plans in place to maintain capacity building and service delivery. However, the GHC strategic goals (2017-2019 and 2020-2023) are aligned to the localisation agenda and to the humanitarian-development nexus (HDP-Nexus). The project should be commended on its capacity building efforts of local systems including local health authorities, health cadres and local NGOs and associations, plus the research components aimed towards managing the implementation gaps.

But there is a significant sense that despite the protracted nature of each these crises, the activities initiated through this project remain heavily donor dependant. The uncertainty of future programme funding, in combination with the low capacity of governments remain the biggest barriers to sustaining SRH outcomes in each of the three settings. Cox's Bazar has significantly stabilised, has many international and local actors, including development actors and Bangladesh is a lower income country. In contrast, the DRC⁵² and Yemen⁵³ remain critically underfunded, remains unpredictable, and SRH needs have not decreased. Countries report that capacity building results, and the strengthened partnerships with a range of partners, and authorities can carry forward some results, but ongoing resources are required to extend the coverage of ToTs, address the continuous brain drain, well as sustaining the ongoing supportive supervision and supply.

CVA, particularly when embedded in overall health financing, can be a significant entry point to the HDP Nexus promoting the bridging between humanitarian and development funding, and as such is more likely to provide prospects for sustainability. The voucher program in Yemen was established before the crisis and managed to continue. Capacity of the health workforce is a significant factor for sustainability, but another one is ongoing support with resources, and this remains heavily on government capacity. SRH programming could actively look into assessing development actors and identify opportunities for CVA improving sustainability prospects.

⁵² DRC Health cluster funding coverage was 5,7% during 2020. Source: <https://fts.unocha.org/appeals/1026/summary>

⁵³ Yemen Health cluster funding coverage was 31,6% during 2020: Source: <https://fts.unocha.org/appeals/925/summary>

5. Conclusions

This section of the report synthesizes the findings with a focus towards Strategy/Design, capacity building, service delivery, coordination, and M&E. The recommendations will be directed towards strengthening future responses.

C1: The project strategy of piloting of new SRH approaches under the Health Cluster was seen as fit for purpose and highly relevant to the beneficiaries, global humanitarian strategic policy and recommendation, and SRH priorities. Several of these approaches warrant further and systematic scale up, these being the use of the participatory planning workshop methodology, the data quality improvements, delivering context specific capacity building, improving cluster coordinators knowledge on SRH and the outputs from the operational research such as CVA. The project did aim to direct attention and activities towards increasing access to quality SRH services to populations living in crisis. The participatory planning workshop and the development of country work plans was considered a main contributor in highlighting the importance of SRH in crises response and developing a coordinated, complimentary, and systematic approach to improving SRH outcomes. The strategy to advance SRH into the Health Cluster Coordination increased coherence and SRH visibility, and specifically to SAC, FP and GBV, but also faced operational challenges.

C2: The operationalisation of the SRH project under the Health Cluster Coordination promoted strong operational linkage with the SRH WG coordinator and contributed to improved coherence in planning and responding to priority SRH needs amongst the different SRH partners in all the three countries. As a result of the IAWG participatory planning workshops, the workplans became the guiding document for SRH implementation. Together with the combined capacity building approaches the project was impactful in strengthening capacity for HC coordinators, the SRH WG, local authorities and organisations, and health cadres. There was strong coordination between the HC and the SRH WG in planning the capacity building and service delivery implementation. The case study of Cox's Bazar is an important lessons model that demonstrates strong joint planning, implementation supervision and adaptation in capacity building and supply. As a result of high staff turnover and competing health priorities (mostly Covid-19), there was some loss of momentum of the workshop outcomes amongst implementing partners with not all partners being aware of the country work plans. Capacity building was effective in being demand driven, and while some mechanisms were put in place to ensure long term training cascading, there are uncertainties on how ToTs will take training forward in the long term if there are no financial resources. The recruitment of a global Project Manager within the Global Health Cluster and the country SRH officers were instrumental in driving the pilot project forward, establishing the partnerships on ground with the SRH WG and research partners.

C3: The SRH pilot project demonstrates that a transition from MISP to CSRH is a feasible recommendation in humanitarian crises, but it is a gradual process with implementation variety across countries and within project settings. The SRH service delivery package was

expanded within the project timeline in all three countries. The main contributors to this were strong coordination between the HC and the SRH WG, the country workplan, the tailored trainings of health authorities, health cadres and CHWs, as well as the support to supply. But the transition to CSRH was also heavily influenced by mandatory alignment to country policy, the country law, or socio-political sensitivities (in particular SAC, LARCs and GBV), and the capacity of implementing partners or the existing health system.

C4: Regular joint supervision visits monitored service delivery and identified priority gaps but had inadequate emphasis on quality of care from the onset. The joint supervision visits were effective in further identifying service delivery gaps and response. However, the project would have benefited from a standardised and consistent focus on 'quality of care' from onset onwards. While Cox's Bazar made use of standard and tailored assessment tools, DRC and Yemen seemed to have less focus on this. ToTs were thoroughly trained in all three countries but there are uncertainties in DRC and Yemen how they will ensure the training of their health workers covering large geographical areas without ongoing resources. In Cox's Bazar there are uncertainties how the training results will overcome the high turnover of staff in the long term.

C5: The external constraints (political environment, security, geographical access) and the complex environment of these three settings remain significant barriers influencing the project outputs and outcomes.

C6: The GHC coordination role in relation to the SRH project was perceived as efficient and effective at global and country level in all three countries. At global level, the SRH project was effectively coordinated and managed but leadership capacity during the first year of implementation was perceived as weak. At country level, there were opportunities to clarify roles and responsibilities better at onset between the HC, the SRH WG coordinator and the country SRH project officer. While there was no country agreement/MoU, the responsibilities around capacity building, service delivery and supply between these parties were resolved with proactive communication. The coordination of the research component between the WHO SRH department, the HC, WHO country teams and local research institutions was a strength. There is opportunity to increase the involvement of the regional WHO SRH teams in the design phase and the research component. Overall, the GHC was able to effectively manage this pilot project within the larger SRH strategic planning and there is a strong sense this effort of coordination has been a success in striving towards common planning and outcomes of SRH programming in humanitarian settings.

C 7: Efficiency fell short from the start and was further heavily challenged by Covid-19 during 2020 but the project did achieve most of its planned outputs within the two no cost extensions timeline. Budget absorption was low during the first year, but the recruitment of a diligent Project Manager and the donor agreement to recruit a project officer per country were instrumental in moving the project forward. Significant delays included the recruitment of qualified staff, procurement and supply and the rehabilitation of health structures. Yemen's

construction started during the evaluation and needs completion. The project was also impacted by larger WHE organisational issues beyond the project manager's control.⁵⁴ During 2020, Covid-19 heavily impacted the efficiency of the implementation.

C 8: The research component of the SRH programme was innovative and pertinent following global recommendations and practice and resulted in outcomes that may be of strong influence providing ongoing dissemination and sharing is done effectively. It established appropriate partnerships between the WHO SRH, GHC and national research institutions, health authorities and explored research questions that are pertinent to vulnerable populations and their sexual and reproductive health needs. The results from the situational analysis, and the CVA feasibility studies and literature review provide important components to inform future programming that should improve coverage. CVA to support SRH services is relevant and feasible in humanitarian settings, and effective in addressing financial and other barriers and there is a need to assess and address demand side barriers. The HDMIS harmonisation seemed ambitious within the project timeframe and it did not benefit the SRH implementation monitoring as such but with strong ongoing investment and dissemination, has potential to strengthen SRH M&E policy and practice for humanitarian settings at global level. This strategic research contribution of this pilot brought a more common understanding and collective buy-in to agreed indicators and was in alignment with the GHC global strategy on PHIS and the HeRAMS project.

C9: Respondents stated that the SRH project had impact and contributed to improved access to SRH services, but this was not effectively captured in the M&E of the project. While it effectively monitored activity progress, through periodic monitoring reports, it did not adequately capture changes at the population outcome or impact level which would have been pertinent in measuring the pilot results to inform scale up. However, there were strong levels of self-evaluation and continuous contextual program adaptation. Humanitarian crises and their complex and changing environment need such high levels of adaptability and flexibility across administration, financial and operational choices.

C10: The project did not adequately address mechanisms to improve prospects for sustained results like e.g. handover or exit plans. There is high uncertainty how far results will be carried forward without a dedicated project team and funding. The research results could benefit future policy and practice providing effective and sustained dissemination is conducted.

⁵⁴ https://cdn.who.int/media/docs/default-source/dco/independent-oversight-and-advisory-committee/ioac-meeting-report-1809201966e51b8a-e07c-49e1-ae51-49f06a13ace3.pdf?sfvrsn=105cd82f_1&download=true

6. Recommendations

1. Global: strategize and plan for CSRH scale up:

- 1.1. GHC to draft a global policy and advocacy plan to improve CSRH visibility in emergency settings. Map and align to recent global commitments prioritising gender &/or SRH (World Health Assembly, WHO Transformation core principles, IOAC recommendations⁵⁵)
- 1.2. GHC to utilise 1.1 to advocate for operational resource commitments towards CSRH policy in humanitarian crises.
- 1.3. GHC to build the evaluation recommendations into key WHO process documents, for example:
 - 1.3.1. The WHE IOAC Monitoring Framework⁵⁶ for embedding into WHO practise. For instance, aim to insert this advocacy plan into the internal and external communication mechanisms of the WHE; build in SRH into the Operationalising WHO's support for Universal Health Care Coverage in Fragile, Conflict-affected and Vulnerable (FCV) settings document.
 - 1.3.2. The Health Cluster Capacity Development Strategy 2020-2023⁵⁷, for instance into the Health Cluster Coordination Learning Programme (HCCLP), the Health Cluster Competency Framework and the activities linked to the 4 strategic priorities of the 2020-2023 plan.
- 1.4. The GHC to develop a scale up plan in collaboration with IAWG, WHO and UNFPA with the recommendation to scale up the IAWG TPI toolkit. The target audience to be internal WHO and external SRH partners (as based on recommendation 1.1). Use the WHO/ExpandNet "Practical Guidance for scaling up health service innovations"²¹.
- 1.5. Prepare a donor concept note and proposal⁵⁸ for SRH in emergencies to disseminate amongst member-states with a stated ambition towards SRH to fund the scaling up process⁵⁹.
- 1.6. Develop a global agreement with UNFPA and clarify roles & responsibilities between WHO and UNFPA in emergency settings with particular focus on country level coordination for SRH. It is recommended to have the SRH WG Coordinator for the scaling up period in complex settings to aid the transition.
- 1.7. Develop a plan to strengthen technical capacity to surge SRH expertise to have a faster deployment of National Professional Officer (NPO) staff in cases of gap-filling

⁵⁵ https://cdn.who.int/media/docs/default-source/documents/summary-analysis-of-the-ioac-recommendations-and-implementation-by-the-who-secretariat.pdf?sfvrsn=319bd150_1 The IOAC for instance recommends that « IOAC recommended that WHO secure funds to strengthen technical capacities in the WHE Programme, with the inclusion of social scientists and gender equality experts to address the socioeconomic and gender-related implications of public health emergencies. » page 9

⁵⁶ <https://www.who.int/publications/m/item/a74-16-independent-oversight-and-advisory-committee-for-the-who-health-emergencies-programme> Annex: Monitoring framework 15th March 2021 This document references opportunities like the World Bank's investment to equip 72 hospitals with Minimum Service Package.

⁵⁷ <https://www.who.int/health-cluster/capacity-building/cap-dev-strategy-2020-2023-web.pdf>

⁵⁸ Donor concept and proposal

⁵⁹ https://cdn.who.int/media/docs/default-source/documents/summary-analysis-of-the-ioac-recommendations-and-implementation-by-the-who-secretariat.pdf?sfvrsn=319bd150_1 page 12, reference EB142/8

or additional support. They should have pre-requisite learning achievements related to SRH ^{60 61}

- 1.8. Promote the IMO training and capacity building (while assuring it has SRH information) as it will strengthen accountability and measuring impact.
- 1.9. Assure coordination with UNFPA on supply or supply funding. Use the IOAC proposed supply chain benchmarking analysis to check WHO performance against UNFPA performance on kit delivery⁶² to determine best practise for continuing SRH kit supply in emergencies.
- 1.10. Undertake a coordinated communications strategy through social media to increase dissemination and uptake of the IAWG TPI Toolkit. Including senior WHO figures on social media to promote the commitment.

2. Health Cluster: operationalise the scale up at country level:

- 2.1. Undertake a mapping exercise of Health Cluster members in humanitarian settings with SRH activities and inform on the policy of CSRH in humanitarian crises. Directly contact them to promote they facilitate their own plan to transition to CSRH.

3. Health cluster: increasing CSRH service delivery in country:

- 3.1. Ensure CSRH in every HC activation is the SRH ambition
- 3.2. Request HC and SRH WG coordinators to arrange annual participatory planning workshops on SRH in locations with protracted conflict.
- 3.3. Following the annual participatory workshops, source financial support to undertake the ToT trainings according to a schedule matching the local situation and ensure effective cascading to health workers.
- 3.4. Develop alternative strategies targeting hard to reach populations not currently covered (leave no one behind) by the health cluster response, including mobile clinics and develop capacity of local partners to support delivery at country level⁶³.

4. Health cluster: assess and invest in sustaining quality of care in country:

- 4.1. Utilise the Health Cluster Guide: A practical handbook⁶⁴ to frame the quality of care discussion and establish a quality of care process with standard tools.
- 4.2. Update the Health Cluster Guide: A practical handbook 's section 5.3.2 MISP page 202 to become MISP to CSRH

5. Recommendation on external constraints

- 5.1. At country level, where national standards or conduct are not in line with the latest global recommendations and hindering quality CSRH service delivery then, with

⁶⁰ <https://iawg.net/resources/minimum-initial-service-package-distance-learning-module>

⁶¹ <https://healthcluster.who.int/publications/m/item/quality-of-care-in-humanitarian-settings>

⁶² <https://www.who.int/publications/m/item/a74-16-independent-oversight-and-advisory-committee-for-the-who-health-emergencies-programme>. Annex : Monitoring framework matrix 15 March 2021, page 9

⁶³ Recommended in the 'Evaluation of the Health Cluster and World Health Organization Coordination Architecture in Northeast Nigeria and Mozambique', January 2020.

⁶⁴ <https://apps.who.int/iris/handle/10665/334129>

UNFPA, WCO and through the HCT, take this on as an advocacy topic to the Humanitarian Coordinator and other relevant targets.

- 5.2. GHC &/or UNFPA to provide advocacy guidance for Heads of WCO, ensuring comprehension of roles and responsibilities to the HCT. Consider including an SRH advocacy question into the Key Monitoring questions for periodic review of the health response⁶⁵.

6. Recommendation on GHC communication

- 6.1. Include the WHO regional offices into the workshops (1.1) and mapping exercise (2.1).

7. Recommendation on project efficiency

- 7.1. At global level in collaboration with country level, ensure from the start that the project has a realistic timeframe and resources to deliver its outputs and absorb its budget. Two of the three selected L3 contexts are skewed to the most challenging end of the humanitarian implementation challenge spectrum.
- 7.2. Ensure a participatory project design phase with country relevant stakeholders

8. Recommendation on the research component of the project

- 8.1. WHO SRH and GHC to accelerate dissemination and find a solution to ensure continued development of these research products.
- 8.2. WHO SRH to expand and build upon the existing research partnerships with southern research institutes to further localisation efforts and 'fit-for-context' adaptation.
- 8.3. Build upon GHC partnership to promote implementation research of SRH in humanitarian crises.

9. Recommendation on capturing improved access

- 9.1. Accelerate the completion of the harmonization of the health cluster HDMIS and core indicators and ensure country level implementation that captures SRH service delivery on a routine basis.

10. Recommendations on improving sustainability of the project

- 10.1. At country level, explore from onset connections with development programming and financing, both addressing the supply and demand side.
- 10.2. Integrate CVA in all future programming, complementary to supply side interventions
- 10.3. At country level, ensure exit/handover strategies are embedded from the start of the program.

⁶⁵ <https://apps.who.int/iris/bitstream/handle/10665/334129/9789240004726-eng.pdf?sequence=1&isAllowed=y> Table 12.1 page 406

ANNEX 1: Evaluation framework as per the inception report

EVALUATION OBJECTIVES and QUESTIONS [OECD/DAC criteria]	Indicative criteria for judging performance	Evidence Sources	Analytical approach
AREA 1: DESIGN			
Area 1: Investigate the relevance of the GHC/WHO SRH response in the L3 emergency in the three country contexts			
EQ 1 How relevant are the GHC/WHO SRH L3 emergency strategies/models in guiding the response? [RELEVANCE]	• Extent of participatory baseline assessments • Extent of alignment to critical needs and vulnerabilities of populations • Extent of alignment to the country HNO/HRP identified needs and response priorities	• Country HNO/HRP • Baseline data • Primary data sources through KIIs, meetings, FGDs, etc. • Other policies and international criteria (IASC, IWAG, WHO, UNFPA etc.)	• Desk review • KIIs and meetings
AREA 2: IMPLEMENTATION			
Area 2: Investigate the effectiveness and time efficiency of the GHC/WHO SRH response in the L3 emergency in the three country contexts			
EQ 2 How effectively/efficiently did the SRH pilot project meet the objective to strengthen capacity among health partners and local providers in 3 selected countries to enhance provision of SRH services? [EFFECTIVENESS, EFFICIENCY, COHERENCE]	• Extent of achieved outputs as intended • Extent of adequate resources (HR, funding, guidelines) • Extent of effective advocacy to the HCT • Overview of identified gaps	• Result of 1.1 Training package & Toolkit (MISP to CSRH) • HC coordination planning /3W's • Intervention logical framework • M&E framework;	• Desk review • Key informant interviews • Triangulation • Timeline/milestone mapping
EQ 3 How effectively/efficiently has the SRH pilot Project strengthened the delivery of SRH services in 3 selected countries to reduce	• Extent of achieved outputs as intended • Timeline of key events and response activities • Extent of effective Coordination mechanisms	• Result of EQ 1 • Cluster Reporting (incl. Health, SGBV, etc.); • Quantitative analysis of Health data (HIS)	• Desk review • Key informant interviews • Timeline/milestone mapping • Triangulation;

EVALUATION OBJECTIVES and QUESTIONS [OECD/DAC criteria]	Indicative criteria for judging performance	Evidence Sources	Analytical approach
unmet need for services (including GHC/WHO's coordination role) [EFFECTIVENESS, COHERENCE]	- Extent of SRH service delivery partners - Extent of complementarity, duplication - Overview of identified gaps	Perceptions from members of cluster and coordination groups.	
EQ 4 How effectively/efficiently has the GHC SRH pilot project supported research and data needs within different specific topics in humanitarian settings? [EFFECTIVENESS]	- Extent of research outputs - Extent of established partnerships with national/local research institutions - Extent of HDMIS harmonisation & indicators - Evidence of baseline/feasibility assessments	- Review of EQ2, 3 - HDMIS - Research publications - Dissemination & learning plans	- Desk review - Key informant interviews - Triangulation
AREA 3: RESULTS Area 3: Investigate the results and impact (higher level effects⁶⁶) of the GHC/WHO SRH response in the L3 emergency in the three country contexts			
EQ 5 How effectively/efficiently has the overall GHC SRH pilot project approach strengthened internal and external stakeholder collaboration to meet the pilot project objectives and expected outcomes? [EFFECTIVENESS, IMPACT]	- Extent of outputs' contribution to outcomes - Nature and extent of partnerships and engagement (IAWG, WHO, GBV, implementing partners) - Overview of partnership successes and challenges	- Results from EQ2, 3, 4 - Partnership collaboration agreements - Perceptions from internal and external partners	- Desk review - Key informant interviews - Triangulation
AREA 4: LESSONS LEARNED Area 4: What are key lessons learned to inform the GHC/WHO SRH response in the L3 emergency in the three country contexts and future similar response			

⁶⁶ OECD definition of Impact: The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects

EVALUATION OBJECTIVES and QUESTIONS [OECD/DAC criteria]	Indicative criteria for judging performance	Evidence Sources	Analytical approach
EQ 6 What have been the key success stories in the GHC SRH L3 program response?	• Overview of good practices • Overview of gaps in operations • Training outcomes (pre-post testing, FGDs with training participants)	Review lessons learned from implementing partners	• KII/FGD with training participants • Triangulation

ANNEX 2: Key informant interviews

Type of stakeholder	Organisation	Name	Sex
Global/Regional	IAWG TPI consultant	Alison Greer	F
Global/Regional	IAWG TPI consultant	Hilde Cortier	F
Global/Regional	IAWG TPI consultant	Nguyen-Toan Tran	M
Global/Regional	KIT Royal Tropical Institute, Netherlands	Fernando Maldonado	M
Global/Regional	WHO FCV	Andre Griekspoor	M
Global/Regional	WHO SRH	Ian Askew	M
Global/Regional	WHO SRH	Loulou Kobeissi	F
Global/Regional	WHO SRH	Lale Say	F
Global/Regional	WHO SRH	Saba Zarif	F
Global/Regional	UNFPA	Wilma Doedens	F
Global/Regional	WHO RHR	Elisabeth Roesch	F
Global/Regional	WHO Regional	Meera Thapa	F
Global/Regional	WHO Regional	Gholbzouri, Karima	F
Global/Regional	UNFPA	Nadine Cornier	F
Global/Regional	Donor	Janneke Rijnart	F
Country COX Bazar	WHO	Dr. Mukesh Prajapati	F
Country COX Bazar	UNFPA	Dr. Sathya	M
Country COX Bazar	UNFPA	Hassan Abdi	M
Country COX Bazar	IOM	Dr Carolyn Nalugwa	F
Country COX Bazar	IRC	Dr Abu Shahin	M
Country COX Bazar	IPAS	Dr. Kaneez Hasnain	M
Country COX Bazar	WHO	Evers, Egmond	M
Country COX Bazar	WHO	Diane Garde	F
Country COX Bazar	WHO	Tabu Francis	M
Country COX Bazar	UNHCR	Allen Maina	M

Country Yemen	WHO	Dr. Fawad Khan	M
Country Yemen	WHO	Dr. Manal Baaees	F
Country Yemen	WHO	Dr. Kariman	F
Country Yemen	UNFPA	Dr. Afrah Thabet	F
Country Yemen	MOPH	Dr Hamida	F
Country Yemen	MOPH	Dr. Eshraq Al-Subaee	F
Country DRC	WHO	Dr Brigitte KINI	F
Country DRC	WHO	Dr. Joseph Fataki	M
Country DRC	MOPH	Dr Celestin MAMBA	M
Country DRC	MOPH	Dr. Cecile	F
Research partners Yemen	NYMA	Nagiba Alshawafi	M
Research partners Bangladesh	BRAC	Bachera Akhtar	F
Research partners DRC	PHRI	Jacques Emina	M

ANNEX 3: Training program outputs per country

N	Training Targeted Areas	Training Subject	Nb participants	Category of trained staff	Date of trainings	Name of SRH Partners involved (MOPH, NGO, etc)
1	CXB	LARC TOT	16	Medical Officers	Feb 9 - 13, Feb 23 - 27 2020	Care Bangladesh, UNFPA (participant representation from 6 NGO / INGO and government partners)
2	CXB	TBA - TOT orientation to the labour room	30	12 midwives, 12 CHWs, 6 program support officers	March 4-5 2020	UNFPA, Community Health Working Group (participant representation from 22 NGO and government partners)
3	CXB	SOP training for maternal health during COVID-19	45	Program Officers	July 1-2 2020	UNFPA, UNHCR, RTMI
4	CXB	SOP training for maternal health during COVID-19	114	Midwives, nurses and Medical Officers	July 15, 16 and 19 2020	UNFPA, UNHCR, RTMI
5	CXB	Emergency stabilization: Non-pneumatic Anti-shock garment	44	Medical Officers and midwives	Aug 30 - 31, Sept 1-2 2020	WHO (participant representation from NGO / INGO and government partners)
6	CXB	SRHR messaging	80	CHW and CHW supervisor	March 3 - 6 2020	CHWG and partners
7	CXB	SRHR messaging	40	CHW and CHW supervisor	September 30 - October 1 2019	CHWG and partners
8	CXB	EmONC and LSS	97	SRH staff	8 July till 31 July 2019	by CIRPB (participant representation from NGO / INGO and government partners)
9	CXB	GBV-IPV	55	SRH staff	févr-21	jointly with SRH WG (participant representation from 6 NGO / INGO and government partners)
10	Yemen/ Sana'a (Utoma, Al Oydan)	IPC in SRH HF's	35	Midwives, medical assistant, nurses, physician, lab technician	4-6 May 2019	by NYMA (National Yemen Midwifery Association) and MOPHP
11	Yemen/Aden (Al-Shieck-Othman)	IPC in SRH HF's	25	Midwives	2- 4 July 2019	by NYMA (National Yemen Midwifery Association) and MOPHP
12	Yemen/Dhamar (Utoma district)	BEmONC	18	Midwives	15-25 Oct 2019	by NYMA (National Yemen Midwifery Association) and MOPHP

13	Yemen/ Aden (Al-Shieck- Othman)	BEmONC	16	Midwives – medical officer	26 Oct- Nov v.2019	by NYMA (National Yemen Midwifery Association) and MOPHP
14	Yemen/Ibb Al- Oydan	BEmONC	16	Midwives	28 Dec 2019.- 7 Jun 2020	by NYMA (National Yemen Midwifery Association) and MOPHP
15	Yemen/Aden	SRHR training to CHW	22	CHW and CHW supervisor	23-26 February 2020	By MOPHP Health promotion for health cadres
16	Yemen/Dhamar	SRHR training to CHW	33	CHW and CHW supervisor	26-29 April2020	By MOPHP Health promotion for health cadres
17	Yemen/Ibb	SRHR training to CHW	33	CHW and CHW supervisor	23-27May 2021	By MOPHP Health promotion for health cadres
18	Yemen/Aden	LARC	12	Midwives	20 Sept-7 October .2020	by NYMA (National Yemen Midwifery Association) and MOPHP
19	Yemen/Aden	PAC- TOT	10	Medical Officers	10-15 October 2020	Jointly with MSI for health cadres
20	Yemen/Sana'a	PAC- TOT	11	Medical Officers	5-10 June2021	Jointly with MSI for health cadres
21	DRC/Kasai	LARC/PAC Directive on provision of SRH services in context of COVID-19/ Briefing on GBV/IPV	31	15 women and 16 men including 4 Doctors and 27 nurses (IT, ITA, Midwives, PNSR Supervisor)	29 May to 03 June 2020	2 weeks after the PNSR Provincial training
22	DRC/Kasai	Briefing on postpartum FP	29	5 teachers of ISTM Tshikapa, 2 field supervisors, 2 SANRU staff, FP 20 students ISTM Tshikapa.	13 to 22 August 2020	2 weeks after the training "SANRU - Woman of ISTM Tshikapa PNSR Provincial "
23	DRC/Kasai Central	LARC/PAC Directive on provision of SRH services in context of COVID-19/ Briefing on GBV/IPV	28	14 women and 14 men including 2 Doctors and 26 nurses (IT, ITA, Midwives)	08 to 12 June 2020	2 weeks after the PNSR Provincial training
24	DRC/Kasai Central	Briefing on postpartum FP	27	5 teachers from ISTM Tshikaji, 1 internship supervisor, 21 students of Woman section of ISTM Tshikaji	26 August to 1 September 2020	2 weeks after the PNSR Provincial training, Sage - Woman Section of ISTM Tshikaji
25	DRC/Kasai Oriental	LARC/PAC Directive on provision of SRH services in context of COVID-19/ Briefing on GBV/IPV	25	14 women and 11 men including 4 doctors and 21 nurses (IT, ITA, midwives, midwives)	18 to 27 May 2020	2 weeks after the PNSR Provincial training

26	DRC/Kasai Oriental	Briefing on postpartum FP	17	5 teachers ISTM Mbujimayi, 12 students Woman section of ISTM Mbujimayi	2 to 9 September 2020	2 weeks after the PNSR Provincial training, Woman Section of ISTM Mbujimayi
27	DRC/Kasai	CHWs/RECO SRH trainings	69	59 RECO Community, 15 RECO customary authorities	August/Sept 2020	Strengthen community engagement on SRH within 6 sessions
28	DRC/Kasai Oriental	CHWs/RECO SRH trainings	66	52 RECO staff, 14 NGO health cluster partners	August/Oct 2020	Strengthening community engagement in favor of SRH
29	DRC/Kasai Central	CHWs/RECO SRH trainings	6	6 RECO staff	mars-20	Safe motherhood at AS Musangilayi in LUKONGA
	Total:		1050			

ANNEX 4: Outputs and activity progress workplan, May 2021

Activity	HQ	Cox's Bazaar	Yemen	Kasai	Remark
Output 1: Strengthened capacity among health cluster partners & local health providers in 3 select countries to enhance provision of SRHR services					
1.1 Recruitment and posting of 1 FTE WHE	Achieved	Achieved	Achieved	Achieved	4 Staff are on board
1.2 Update and standardize a training package on SRHR	Done	-	-	-	In collaboration with IAWG and UNFPA
1.3 Regional Meetings on SRHR in crises (EMRO and SEARO)	Postponed	-	-	-	Postponed due to Covid-19 restriction. IAWG in 2022
1.4 SRHR trainings for cluster coordination teams (3, 1 per region)	Achieved	Planning workshop with 110 participants across 31 partner organisations in attendance	Planning workshop with 94 participants across 29 partner organisations in attendance	Planning workshop with 27 participants across 27 partner organisations in attendance	All trainings, workshops and completed and country workplan produced
1.5 Feasibility assessment of innovative financing to reduce cost barriers	-	-	Achieved	-	Work completed and Guidance & Toolkit under dissemination
Output 2: Systematically strengthen the delivery of SRHR services in 3 select countries to reduce unmet need for services.					
2.1 Capacity building and strengthening of CHW in 3 countries to increase awareness on SRHR (1x3 trainings)		132 CHWs and Supervisors trained in ToT	88 CHW and Supervisors trained in ToT	144 CHWs, supervisors and Communication Agents trained in ToT	CHWs trainings completed
2.2 Community awareness in 3 countries on SRHR (2x3)		1600 training flipcharts disseminated to CHWs	IEC materials disseminated	HDMIS and Community Awareness assessments done, included authorities and CHWs on SRH Topics	Completed and bulk of IEC materials distributed
2.3 Procurement and deployment of RH kits		781 kits delivered, including 50,000 Oxytocin doses and 40 anti-pressure garments	453 kits delivered to 13 HFs	399 IARH kits, 28 PEP kits, 21 AMIU kits delivered	Around 1700 IARH kits procured, delivered
2.4 Procurement of minimum infrastructure and supplies required in 3 countries to enhance SRH services		35 cold chain fridges, 6 air conditioners distributed to HFs, 87 models for MW skill Lab	13 out of 13 under process	22 HFs assessed, of which 10 HFs rehabilitated by WHO.	Rehabilitation of 10 HF in DRC, ongoing for Yemen

2.5 Capacity building of cluster partners and local providers on provision of SRH services		389 MDs, midwives, nurses, project officers ToT trained	143 MDs, midwives, nurses	154 MDs, nurses, midwives	1050 health cadres trained on SRH topics
Output 3: Harmonization of Health Data Management Information System (HDMIS), including process indicators at global level and in 3 select countries to enable performance monitoring and learning lessons for sustainable implementation of a full package of services					
3.1 Conduct baseline/endline needs assessment data for SRH needs in 3 countries	Achieved	Feasibility analysis undertaken	Feasibility analysis undertaken. SRH situation analysis done in 3 governorates	Feasibility analysis undertaken	All SRH assessments were done, dissemination process is ongoing
3.2 Conduct end of the project external evaluation	Achieved	-	-	-	Desk only, no field visits undertaken
3.2 Feasibility assessment related to provision of comprehensive package of SRH services in crises	Cancelled	-	-	-	Cancelled and merged into 3.1 due to Covid limitation
3.3 Harmonization of existing health cluster HDMIS to systematically capture SRH service delivery on a routine basis	on-going	Achieved & ongoing	Not feasible	Achieved & ongoing	Completed in CXB and DRC, dissemination ongoing
3.4 Conduct implementation research on documentation of effective approaches to deliver SRH services in crises	on-going	-	-	-	Joined with 3.3 Research protocol revised with Covid-19 context

ANNEX 5: Budget planning and spending, 14 June 2021

		Approved Budget	Utilization	Balance	% Absorb
O1 -	Capacity strengthening	1 282 000	1 245 272	36 728	97%
1,1	Project manager				
	Staff cost	662 000	625 272	36 728	
	Travel to countries and regions	150 000	150 000	-	
	Consultant / APW for country work implementation	280 000	280 000	-	
1,2	Training package on SRHR	30 000	30 000	-	
1,3	Regional meetings on SRHR	-	-	-	
1,4	Training for cluster coordination	90 000	90 000	-	
1,5	Feasibility assessment for innovative financing	70 000	70 000	-	
O2-	Delivery of services in countries	3 063 340	3 000 519	62 821	98%
2,1	Capacity building and strengthening of CHW	60 000	53 229	6 771	
2,2	Community awareness	60 000	37 131	22 869	
2,3	Procurement and deployment of kits	2 100 000	2 079 447	20 553	
2,4	Procurement of infrastructure and supplies	738 340	725 712	12 628	
2,5	Capacity building of cluster partners and local providers	105 000	105 000	-	
O3-	Harmonization of data management, info system	571 080	559 280	11 800	98%
3,1	Baseline/endline needs assessment data	60 000	60 000	-	
3,2	End of project external eval	50 000	38 200	11 800	
3,3	Feasibility assessment for provision of package of services	75 000	75 000	-	
3,4	Harmonization of existing health cluster HDMS to capture SRH service delivery	272 080	272 080	-	
3,5	Implementation research on documentation of approaches	114 000	114 000	-	
	Total without PSC	4 916 420	4 805 071	111 349	98%
	PSC 13%	639 135	562 260	76 875	
	Total incl. PSC	5 555 555	5 367 331	188 224	97%