



Workshop on Sexual and Reproductive Health Research Priorities in Humanitarian Settings

10-12 September 2018 | Copenhagen, Denmark

Meeting Report



INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

Summary

Building upon the documented need for further sexual and reproductive health (SRH) research in humanitarian settings and the successful track record of the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) to utilize research meetings to help steer their work, the IAWG held a workshop on SRH research priorities on September 10-12, 2018.

In advance of the workshop, an IAWG task team created an initial list of potential research questions from existing reviews and solicited additional questions from IAWG members through the steering committee and sub-working groups. The questions focused on implementation and impact research that would directly benefit SRH programming. IAWG members were asked to complete a ranking exercise of an edited list of questions. During the workshop, participants further refined a sub-set of research questions and developed a sample of concept notes, the process and results of which are detailed in this report. The work summarized in this report is intended to serve as a launching point for SRH implementation and impact research ideas and collaboration around identified key areas of need, both within and beyond IAWG members.

The workshop was hosted by the Danish International Development Agency (DANIDA) in Copenhagen, Denmark. DANIDA is supporting IAWG through a grant to the Women's Refugee Commission for 2018-19 with a focus on the research and data and voluntary contraception sub-working groups as well as the IAWG secretariat. The workshop received additional financial support from Elrha's Research for Health in Humanitarian Crises (R2HC) Programme, which aims to improve health outcomes by strengthening the evidence base for public health interventions in humanitarian crises.

Background

In 2018, the United Nations Office for the Coordination of Humanitarian Affairs estimates that 136 million people will need humanitarian assistance and protection, largely due to conflict.¹ The United Nations Population Fund (UNFPA) estimates that of this population in need, 34 million are women of reproductive age and 5 million are pregnant.² In humanitarian settings, women and girls face increased challenges in accessing good quality, and oftentimes life-saving, sexual and reproductive health care.

The Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) is a coalition of UN Agencies, Governmental, Non-Governmental, Academic, and Donor institutions, as well as individual members, that was established in 1995. IAWG works to expand and strengthen access to SRH services for people affected by conflict and natural disaster through provision of technical standards on delivery of SRH services, documentation and dissemination of evidence and accomplishments in the field, and advocacy on behalf of crisis-affected persons.³ In 1996, IAWG introduced the Minimum Initial Service Package (MISP) and the Inter-Agency Field Manual on Reproductive Health in Crisis, both of which were most recently revised in 2016-2018. The MISP is a coordinated set of priority activities that should be implemented at the onset of an emergency and the Field Manual is a guide that covers SRH interventions for all phases of emergency response for humanitarian responders. The IAWG is structured with a steering committee, ten technical and cross-cutting sub-working groups, and individual and organizational members. Since its inception, IAWG has increasingly engaged in and advocated for research to be conducted on the SRH burden in humanitarian contexts and the implementation of programs and policies.

IAWG has held several research meetings since its first in 1998. In 2011, a Technical Workshop on Setting Research Priorities for Reproductive Health in Crisis Settings was held. The workshop, which brought together 25 experts on SRHR in crisis settings, prioritized four research topics including community-based distribution of misoprostol to prevent postpartum hemorrhage, contraceptive services for adolescents, emergency obstetric and newborn care (EmONC) implementation as part of the MISP, and a global review of SRH services in crises.

1 OCHA Global Humanitarian Overview 2018: <https://www.unocha.org/sites/unocha/files/GHO2018.PDF>

2 UNFPA Humanitarian Action 2018 Overview: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2018_Jan_31_ONLINE.pdf

3 IAWG “About Us” website: <http://iawg.net/about-us/>

Following the 2011 Technical Workshop, IAWG and its members undertook a Global Evaluation of SRH in Humanitarian settings between 2012 and 2014.⁴ Seven complementary studies were conducted to assess the state of the field, document progress, and identify gaps in practice, funding, and research. The Global Evaluation found that substantial progress had been made in increasing awareness of the need for SRH response in humanitarian settings including the MISRP and its implementation. However, it concluded that there remained key service gaps, specifically in long-acting and permanent contraception, clinical care for sexual assault survivors, comprehensive EmONC, and safe abortion services. Operational gaps were also highlighted, particularly engagement with local NGOs and surrounding communities and systems strengthening. Since its publication, the global evaluation findings have provided a roadmap for organizations and donors working on SRHR in humanitarian contexts, which has led to progress within the field.

Several systematic reviews related to humanitarian settings have been published over the last two years. All conclude that despite increased need and attention, the evidence base for public health interventions, particularly SRH, in humanitarian settings remains limited.^{5,6,7} These reviews highlight that while there is increasing recognition that rigorous, timely, and high quality research is needed, this has not led to a corresponding increase in the body of good quality evidence. This is particularly the case when looking at the effectiveness of SRH interventions.

- 4 Global Evaluation papers [Casey S. Evaluations of reproductive health programs in humanitarian settings: a systematic review. *Confl and Health*. 2015; 9(Suppl 1):S1. <https://doi.org/10.1186/1752-1505-9-S1-S1>]
- 5 Singh NS, Aryasinghe S, Smith J, et al. A long way to go: a systematic review to assess the utilisation of sexual and reproductive health services during humanitarian crises. *BMJ Glob Health* 2018;3. doi:10.1136/bmjgh-2017-000682
- 6 Singh NS, Smith J, Aryasinghe S, Khosla R, Say L, et al. **Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review.** *PLOS ONE* 2018;13(7). <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199300>
- 7 Blanchet K, Ramesh A, Frison S, et al. Evidence on public health interventions in humanitarian crises. *The Lancet* 2017;390(10109) doi: 10.1016/S0140-6736(16)30768-1

Prior to the Workshop

Preliminary Research Question Selection Process

In advance of the Workshop on SRH Research Priorities in Humanitarian Settings, members of the IAWG Steering Committee and the research and data sub-working group formed a workshop task team, which compiled a list of research topics and questions for initial review. The questions were collected from a variety of sources including the 2011 research priority-setting workshop, the IAWG global evaluation publications, and systematic reviews published within the last 3-4 years. In May and June of 2018, the IAWG steering committee members and sub-working groups reviewed the questions, provided feedback and suggested additional priority research questions within their sub-sector. In July, the workshop task team consolidated all the feedback into a list of 84 questions covering 12 technical areas (Adolescent SRH, Contraception, Disability, DRR/preparedness, gender based violence, general SRH, HIV/AIDS/STIs, LGBTQIA+, Logistics, Maternal and Newborn Health, MISP, and Safe Abortion Care).

Ranking process

After multiple methodologies were reviewed, the Child Health and Nutrition Research Initiative (CHNRI) approach was chosen to identify top priority research questions.⁸ In August 2018, IAWG steering committee and sub-working group members were asked to rank the 84 questions on the following five criteria: answerability, effectiveness, feasibility, impact, and need (Table 1). Respondents ranked each question by criteria using the scale 1 (not at all), 2 (somewhat), or 3 (very). Forty-two members of IAWG completed the ranking exercise.

8 Rudan I, Yoshida S, Chan KY, et al. Setting health research priorities using the CHNRI method: VII. A review of the first 50 applications of the CHNRI method. *Journal of Global Health*. 2017;7(1). doi:10.7189/jogh.07.011004.

Table 1: Ranking Criteria for the Prioritization of Proposed Research Questions

Criterion	Definition
Answerable	Is it likely that this research question can be answered? Can it be collected in a complete, reliable, and valid manner that ensures good data quality? Can this research be conducted ethically?
Effective	Is it likely that the new knowledge would lead to an effective intervention or program?
Feasible	Can data on the research question be collected given safety considerations, language consideration, human resources (local capacity), funding, and logistical constraints?
Impactful	Does the research have the potential to protect existing SRH outcomes (i.e. in acute situations) or improve them?
Need	To what extent is this research needed in the humanitarian context? Does this question address a critical research gap?

An overall (unweighted) average was calculated for each question. To identify the most highly ranked questions, a cutoff of greater than 12.0 was used.

Thirty questions were ranked with a score above 12.0. The top-ranked 30 questions reflect the broad array of technical areas included within the SRHR field. Twelve topic areas were included in the ranking exercise and all 12 areas had at least one question that was included in the top 30. See Appendix A for the entire list of questions and their rankings.

Research Priority Setting Workshop

Workshop Objectives

The workshop had three objectives:

1. Refine a subset of research questions from the list of prioritized research questions so that they:
 - » Represent key areas of program impact and implementation science
 - » Are appropriate for individual research studies across multiple humanitarian contexts
 - » Reflect the ranking criteria
2. Develop draft concept notes of 5-10 prioritized and selected research questions for use by IAWG members
3. Strategize on concrete next steps to take forward the research priorities and concepts with IAWG and the SRH humanitarian field more broadly

Workshop Participants

Thirty-six participants attended the workshop, representing 26 non-governmental, government, UN, and donor organizations (See Appendix C). Participants were primarily IAWG members and donors, including representatives from regional IAWGs.

Workshop Process

The workshop built on the preliminary work undertaken to prioritize research questions in the field with IAWG members and sub working groups from May to August 2018. Over the course of three days in September during the workshop, participants collaborated in small groups to refine research questions and draft detailed concept notes for a subset of the refined questions. During the question refinement process, written feedback was provided to the small groups by the participants and discussions were held after each small group presented their concept notes.

The ranking methodology and results were presented to provide a foundation for the work to be accomplished during the workshop. The top 30 research questions were divided into seven groups, some of which included multiple topics (Maternal and Newborn Health, Marginalized Populations/Gender-Based Violence, Disaster Risk Reduction/Minimum Initial Service Package, Contraception, Safe Abortion Care, General SRH, and Logistics). Participants self-selected which group they would join based on interest and expertise. Each group was asked to review the research questions within the group's topic area(s), consider the ranking exercise results, and choose two questions to work on. For each, they were to refine the research question and draft a problem statement explaining its potential impact on programmatic work. Groups were encouraged to revise the questions as necessary, which could include merging questions or drafting new questions. They were not limited to the wording or language provided in the ranking exercise.

Each question and problem statement was reviewed by the workshop participants and feedback was provided via post-it notes. The small groups were then given time to review and incorporate the feedback they received. The final 14 questions are listed in Table 2.

Prior to beginning the concept note development, workshop participants shared current and recent research within each topic area. They also identified the areas in which they had expertise or current research projects in process. This allowed participants to see what relevant research is underway and to connect with each other during the remainder of the workshop if technical or field input was needed.

Refined Research Questions

Table 2. Refined Research Questions

What are feasible, effective, and cost-effective strategies for CHW-delivered, home-based postpartum maternal and neonatal care in established and/or protracted emergency settings?
What interventions are effective to prevent mistreatment and promote respectful care during pregnancy and childbirth in humanitarian settings?*
What are the strategies to move from MISP to comprehensive SRH programming in post-crisis settings?*
How does capacity development of key stakeholders (decision makers, program managers, service providers, CBOs) on the MISP for disaster risk reduction and emergency preparedness, including contingency planning, lead to improvements in implementation of MISP?*
How can we improve SRH/GBV interventions by better understanding and responding to the needs of populations placed at increased risks in humanitarian settings?*
What is the impact of cash transfer (CT) programs on intimate partner violence (IPV) through women's health and wellbeing, economic security, and intra-household conflict in the post-acute phase of an emergency?*
What are the most effective and efficient strategies for integrating LARC in contraceptive services during initial emergency response, for populations on the move, and in protracted crisis settings where infrastructure, capacity and awareness of methods are all limited?*
How can we expand the availability, provider knowledge and capacity, and mechanisms of distribution of EC in humanitarian settings?*
What are feasible and effective approaches to increasing access to SAC in legally restrictive humanitarian settings and how can we replicate these approaches?*
What are feasible and effective strategies for facilitating uptake (as a matter of policy) and implementation (as a matter of service delivery) of the global guidelines regarding SAC and PAC as outlined in the MISP chapter of the 2018 IAFM?*
What are effective strategies to improve the quality of selected SRHR services (ie FP, MNCH, SAC, GBV) in various phases of humanitarian crises? (providers, communities, and standards of care)
How can we strengthen evidence-based decision-making through ongoing data utilization to inform SRHR programs in humanitarian settings during the preparedness, acute, protracted, and transition periods?*
For SRH supply chain management in emergencies what are the most feasible preparedness and planning approaches that improve the ability to fully implement the MISP? (Approaches may include: pre-positioning, security, training, etc.)
What are the key SRH supply chain management components to successfully transition from MISP to comprehensive SRH service provision?

* Indicates the question was developed into a concept note

Concept Notes

To determine which of the refined research questions would be developed into concept notes, each participant was asked to indicate the top three questions they would be interested in working on during the remainder of the workshop. The workshop task team then assigned participants to 9 concept note groups based on their selections.

Ten questions were developed into concept notes as one group worked on two questions. The workshop task team provided an outline to assist with guiding discussion and drafting the concept note. Groups worked collaboratively to further refine their research question and describe a potential study design. Participants were asked to elaborate on the problem and justification for the research, identify research objectives and study methods, and give thought to appropriate phases of emergency that research could be undertaken, and potential study locations, partners, and funding opportunities. After presenting their draft concept notes, each group received feedback from the plenary, which they had the opportunity to incorporate before the end of the workshop.

The concept notes were developed to be used by anyone working on SRH research in humanitarian settings. The concept notes vary in level of detail, depending on the research question and topic. They suggest potential approaches to move these research questions forward but should be adapted as necessary to specific contexts and populations. The workshop participants recognize researchers and organizations have their own areas of expertise and preferred methodologies and may only use the concept notes as guidance or a starting point.

In the interests of transparency, if you or your organization utilizes the concept notes from this workshop, please let the organizers know by emailing Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu). Please also reach out if you have questions about the concept notes. Each has a point of contact that you can be put in touch with.

The concept note questions are italicized in Table 2, and the full concept notes can be found in Appendix B. It is important to keep in mind that these ten concept notes represent key priority areas identified through the ranking exercise and this workshop, however, these are not the only ten research questions that the workshop participants, or IAWG, believe need to be addressed.

Those interested in adapting the concept notes are encouraged to contact (info for me an Sara) for additional information and points of contact for the concept developers.

Limitations

It is important to recognize that the list of ranked questions do not represent the universe of key SRH research questions in humanitarian settings. While every effort was made to use a participatory process during the preliminary work and during the workshop, the level of participation varied. For example, only 42 reviewers ranked the research questions and feedback indicated that some reviewers were not comfortable ranking questions outside their area of expertise. Additionally, some questions were submitted for the ranking exercise after it had been distributed. These questions were not ranked but have been included in the overall list (Appendix A). Also, while efforts were made to include the maximum number of participants in the workshop with a variety of expertise and perspectives (programmatic and research, field office and headquarters, advocates and donors), the workshop did not have experts in attendance for every technical area.

This work is meant to be a launching off point for those who conduct SRH research in humanitarian settings. It is our hope that these questions and concept notes will help to focus the field on key issues and help generate additional ideas for addressing these topics in across humanitarian settings and populations globally. No one research question or project can provide definitive answers, but working towards common goals and across different humanitarian settings, the SRH field can advance and more effective programming can be provided to those we serve.

Next Steps

Participants identified concrete steps to ensure that the ideas and products generated during the workshop would prove useful to the wider SRH community working in humanitarian settings. These are outlined below.

- Distribute the results of this workshop widely within the SRH field, particularly taking advantage of upcoming conferences and events. It is the group's hope that the research questions and concept notes will be used and built upon by any organization that wishes to do so. Potential opportunities to publish the process and workshop results will be examined.
- Share the results of this workshop with donors so that they are aware of the work that has been produced with the hope that it will help spur funding for SRH research in humanitarian settings.
- Ensure that the ranking exercise results and the refined research questions will be included in an ongoing effort by the World Health Organization to identify priorities on sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH).
- Seek opportunities to develop partnerships or consortia of IAWG members to move the identified priority research questions forward. IAWG sub-working groups will increase communication between members and groups to help identify and collaborate on impactful research opportunities, as well as track research projects of interest.

All participants agreed to assist with the dissemination of the workshop products within their own organizations as well as the wider community.

Appendices

Appendices

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Appendix A: List of research questions, IAWG SRHR Research Priority-Setting Workshop

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer- able	Effect- ive	Feasible	Impact- ful	Need	SUM
1	What are sources and modalities of information to best reach adolescents with SRHR information?	ASRH	2.5	2.5	2.3	2.5	3.0	12.8
2	What interventions are effective (including cost effective) to prevent early marriage and early childbearing? (program evaluation)	ASRH	2.1	2.4	2.0	2.6	3.3	12.4
3	In a setting where insecurity and other challenges act as barriers to facility-based care, how can community-based care for survivors of sexual violence be conducted in a safe and feasible way? What are the challenges to providing care in this manner?	ASRH	2.2	2.6	2.1	2.7	2.6	12.2
4	How effective is the use of technology/social media in increasing access and utilization of GBV services among adolescent girls?	ASRH	2.4	2.4	2.4	2.4	2.3	11.8
5	How does SRH services access and utilization differ among sub-groups of adolescent girls (married/widowed/divorced, LGBTQIA, younger/older, etc.)? What are the cost-implications of this?	ASRH	2.3	2.4	2.3	2.3	2.3	11.5
6	What is the impact of engagement with parents and caregivers, boys, and the community in increasing safety for girls?	ASRH	2.1	2.4	2.2	2.4	2.3	11.4
7	How can mixed gender group-based programming be effective to improve access to and use of SRH services for a variety adolescents (i.e., un/ married girls, girls with disabilities, in/out of school, girls of different ages and backgrounds, mobile and IDPs)?	ASRH	2.2	2.2	2.1	2.3	2.2	11.0
8	What interventions are effective (including cost effective) in delaying a second birth, including PPFP?	ASRH	2.2	2.2	2.1	2.3	2.1	10.9
9	How does GBV prevalence differ among sub-groups of adolescent girls (married/widowed/divorced, LGBTQIA, younger/older, etc.)?	ASRH	2.1	2.1	1.9	2.3	2.2	10.6
10	What is the role of siblings and other household members in SRH service access and utilization? Are sibling-based intervention models supportive of enhanced protection and SRH outcomes in adolescent girls?	ASRH	2.1	2.1	2.1	2.1	2.0	10.4
11	What are the economic costs of sexual violence (the costs of providing SRH/ GBV services/access to adolescents compared to the cost of sexual violence prevention programs)?	ASRH	1.8	2.0	1.8	2.1	1.9	9.6
12	In what ways do existing programs for adolescents in crisis-affected contexts engage adolescents across the program cycle? What strategies and best practices do these programs use to promote adolescent engagement from design, implementation, feedback, data collection and evaluation?	ASRH	<i>Added by ASRH SWG after prioritization process</i>					

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer- able	Effect- ive	Feasible	Impact- ful	Need	SUM
13	Given the unique needs of different group of adolescents, who are the most at-risk in acute crises and what are the best strategies to improve access to quality SRH services? (Specifically consider pregnant adolescents, married adolescents, adolescent survivors of GBV, etc)	ASRH	<i>Added by ASRH SWG after prioritization process</i>					
14	What are the behaviors, attitudes and logistical barriers disabled people face when accessing and using SRH services in humanitarian settings?	Disabil-ity	2.5	2.6	2.5	2.6	2.6	12.7
15	Can group-based programming be effectively delivered to account for the heterogeneity of disabled people to increase effectiveness, relevance, and retention?	Disabil-ity	2.0	2.2	2.2	2.4	2.2	11.0
16	Does disaster risk management/community preparedness for SRH activities improve response to a humanitarian emergency?	DRR/ prep	2.4	2.7	2.4	2.6	2.6	12.6
17	What is the best way to engage in community resilience building on SRH (but not limited to) in seasonal / predictable crises?	DRR/ prep	2.2	2.4	2.3	2.6	2.4	11.8
18	What are best practices for investing in adolescents as part of preparedness efforts to serve as SRH first responders when an emergency occurs?	DRR/ prep	2.3	2.5	2.2	2.4	2.4	11.7
19	What are effective strategies for implementing LARCs in acute emergencies?	FP	2.5	2.7	2.3	2.8	2.7	13.0
20	Is community-based distribution of family planning services, including injectables, applicable and feasible in humanitarian settings and does it enhance people's access to and use of contraceptives?	FP	2.7	2.6	2.5	2.6	2.5	12.8
21	What are best practices (most cost effective and high quality) for delivering and scaling-up service delivery of contraceptives in humanitarian emergencies (from crisis to protracted emergencies)? (i.e. task shifting and mobile clinics)	FP	2.4	2.6	2.4	2.6	2.6	12.7
22	What is the availability, acceptability, provider capacity, and use of EC (oral contraception and IUDs) in humanitarian settings?	FP	2.6	2.5	2.5	2.5	2.5	12.6
23	What are most effective interventions for involving men in family planning?	FP	2.3	2.5	2.3	2.6	2.2	11.9
24	How can Sayana Press be used as part of emergency preparedness (eg for flooding/ cyclones)? It's more stable in certain circumstances (like floods) than OCPs, and not provider dependent	FP	2.5	2.4	2.3	2.4	2.3	11.9
25	What actions are effectively assuring quality of care in the delivery of LARC, in humanitarian contexts and what are the implications of removal in the absence of a functioning health system?	FP	2.2	2.4	2.3	2.5	2.4	11.8
26	Can we use traditional birth attendants to improve contraceptive prevalence in remote settings?	FP	2.5	2.3	2.3	2.4	2.2	11.6
27	How do contraceptive uptake trends differ or vary during a crisis (from non-crisis, across different types of crises, length of displacement, type of displacement, etc.? (i.e.: is there a tendency towards LARC, Sayana Press, etc.); what is acceptability and impact of self-administration of Sayana Press?	FP	2.2	2.4	2.2	2.3	2.4	11.5

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer-able	Effect-ive	Feasible	Impact-ful	Need	SUM
28	What are ways to build capacity and knowledge base to increase PPFP? (For women who indicate that they are interested in post-partum contraception, assess whether they follow-through on that intention, what methods they use, and if they do not receive contraception, why not. For those who do not report intent to use contraception, assess their actual behavior, and identify the factors that contributed to their choice.)	FP	2.3	2.2	2.2	2.3	2.1	11.2
29	What is the impact of new and innovative approaches to FP counseling, such as balanced counseling as well as BCS+ (including HIV/AIDS)?	FP	2.2	2.2	2.3	2.2	2.1	11.0
30	In what ways do conflict and/or humanitarian emergency situations impact individuals' childbearing intentions and fertility-related decision making, as well as fertility-related attitudes more broadly at the societal level?	FP	2.1	2.0	2.0	2.1	2.0	10.2
31	What are the longitudinal impacts on broader health (i.e. MMR and child survival) when family planning is implemented in an acute emergency?	FP	1.8	1.9	1.8	2.2	2.2	9.9
32	What are the most effective ways to integrate sexual violence interventions within broader humanitarian efforts in order to maximize safe uptake of services and ultimately deter sexual violence?	GBV	2.1	2.5	2.1	2.5	2.6	11.8
33	What is the impact of promising GBV prevention interventions: a) safe spaces for women/children?	GBV	2.3	2.3	2.3	2.4	2.4	11.8
34	What is the impact of promising GBV prevention interventions: b) cash transfer or livelihood interventions?	GBV	2.2	2.4	2.2	2.4	2.3	11.5
35	What is the impact of promising GBV prevention interventions: c) the impact of the placement of a GBV specialist advisor in acute crisis settings on the delivery of GBV services across the humanitarian clusters?	GBV	2.2	2.3	2.2	2.4	2.3	11.4
36	What is the impact of sexual violence interventions that follow current best practices (i.e. see: Spangaro, J., et al. (2015). "Mechanisms underpinning interventions to reduce sexual violence in armed conflict: A realist-informed systematic review." Conflict and health 9(1))?	GBV	2.1	2.3	2.2	2.3	2.4	11.3
37	What are the best practices for identifying and reducing violence risks for people selling sex in humanitarian settings, especially novice/initiate sex workers who are selling sex for the first time, owing to disrupted income?	GBV	2.0	2.3	1.9	2.4	2.5	11.2
38	There is no evidence base to understand the effectiveness and long-term impact of interventions for sexual violence survivors in the early crisis stage. What programming is feasible and effective?	GBV	2.0	2.2	2.0	2.4	2.4	11.0
39	What capacity building approaches and supportive mechanisms are effective at strengthening capacity of health workers for different SRH components in humanitarian settings? How does training and capacity-building of health workers impact on the quality, timeliness and effectiveness of emergency SRH response?	General SRH	2.4	2.5	2.6	2.6	2.6	12.7
40	What are effective quality improvement techniques to strengthen SRH programming?	General SRH	2.3	2.5	2.3	2.7	2.5	12.3
41	How can we improve use of data to improve SRH programs in humanitarian settings (can look at different phases)?	General SRH	2.3	2.4	2.2	2.6	2.7	12.3

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer- able	Effect- ive	Feasible	Impact- ful	Need	SUM
42	How effective are CHWs (including TBAs) in delivering specific interventions (To be specified) in community-based programs in humanitarian settings? How can CHWs be adequately trained, supervised and supported + what technologies can be used to support their work?	General SRH	2.3	2.4	2.4	2.5	2.4	12.1
43	What strategies are effective at reaching marginalised populations with SRH services (e.g. people with disabilities, men, adolescents, elderly, urban refugees, unregistered displaced people, SOGI)?	General SRH	2.2	2.5	2.1	2.6	2.6	12.0
44	What is, or could be, the role of new (media) technologies (to be specified, eg arcmapi/GIS, Cell phone technologies, Social media) for improving access to and use of SRH services in crises ?	General SRH	2.4	2.4	2.4	2.5	2.3	11.9
45	How can conditional cash transfers effectively increase access to and use of SRH services of humanitarian settings? How do cash-based interventions influence SRH outcomes in humanitarian settings?	General SRH	2.4	2.4	2.2	2.4	2.3	11.7
46	What strategies for community mobilization are effective to increase access to and use of SRH services?	General SRH	2.4	2.2	2.3	2.4	2.3	11.6
47	What are innovative strategies for strengthening capacity of local NGOs/CBOs to provide and/or scale up SRH service provision in conflict settings?	General SRH	2.0	2.4	2.1	2.5	2.6	11.6
48	What effect does emergency SRH activity in humanitarian response on SRH health system development within a country - in each phase of a crisis (natural disaster, acute conflict, chronic and post-emergency)?	General SRH	1.8	1.8	1.7	1.9	2.0	9.3
49	What is an effective community based approach for PMTCT follow-up in humanitarian settings?	HIV/AIDS/STI	2.3	2.4	2.3	2.6	2.5	12.2
50	What are effective programs to increase use of HIV/STI prevention methods?	HIV/AIDS/STI	2.4	2.3	2.3	2.3	2.2	11.6
51	What are the behaviors, attitudes and logistical barriers LGBTQIA+ persons face when accessing and using SRH services in humanitarian settings?	LGBTQIA+	2.3	2.5	2.3	2.5	2.5	12.1
52	What are the evidence based best practices to provide good quality SRH LGBTQIA+ persons in humanitarian settings?	LGBTQIA+	2.2	2.5	2.2	2.5	2.5	11.9
53	How can humanitarian actors better enable access to health and psychosocial care for LGBTQIA+ sexual violence survivors?	LGBTQIA+	2.2	2.5	2.1	2.4	2.4	11.5
54	What is the evidence base and/or best practices for implementing preparedness measures, such as pre-positioning SRH supplies, to improve SRH supply chains and SRH commodity security in emergencies?	Logistics	2.4	2.5	2.5	2.6	2.6	12.7
55	How often and how frequently are currently available commodities being used in emergencies? (I.e. how frequently is each component of RH kits being used? How can they be made more efficient?)*	Logistics	2.6	2.5	2.5	2.5	2.5	12.5
56	What is the evidence base and/or best practices for implementing SRH supply chains and ensuring SRH commodity security in acute emergency response or protracted crises?	Logistics	2.4	2.4	2.5	2.5	2.7	12.5

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer- able	Effect- ive	Feasible	Impact- ful	Need	SUM
57	What is the evidence base and/or best practices for transitioning a supply chain management system from relying on RH Kits for MISP implementation, toward developing sustainable SRH supply lines for comprehensive SRH service delivery?	Logistics	2.2	2.3	2.3	2.5	2.5	11.7
58	Does training and supporting health facility staff on the MISP and MISP contingency planning for emergency preparedness and disaster risk reduction lead to improvements in implementation of the MISP?	MISP	2.5	2.6	2.6	2.5	2.6	12.8
59	Does training and supporting community-based organizations on the MISP and MISP contingency planning for emergency preparedness and disaster risk reduction lead to improvements in implementation of the MISP?	MISP	2.5	2.6	2.5	2.5	2.5	12.6
60	What are most effective actions for moving from MISP to comprehensive SRH?	MISP	2.3	2.5	2.3	2.6	2.5	12.2
61	How can maternal mental health care be integrated into ANC, delivery and post-partum care in humanitarian settings?	MNH	2.4	2.5	2.4	2.5	2.5	12.3
62	What are effective strategies for home-based post-partum care to reduce maternal and neonatal morbidity and mortality in humanitarian settings?	MNH	2.3	2.6	2.3	2.6	2.5	12.3
63	How can Basic EmONC be shifted more to and better integrated into primary level health facilities to improve access to and use of EmONC at primary level and reduce mortality for women referred to higher level?	MNH	2.3	2.6	2.2	2.6	2.6	12.2
64	What interventions are effective to prevent mistreatment and promote respectful care in childbirth in humanitarian contexts? How are these similar to/different from the elements of successful interventions to promote RMC in developing countries?	MNH	2.4	2.6	2.3	2.5	2.5	12.2
65	What are effective and cost-effective strategies for providing maternal and newborn health services in settings with infectious disease outbreaks?	MNH	2.3	2.5	2.2	2.6	2.6	12.2
66	What is the impact of distribution of birth kits on home-based birth practices (eg correct use) and on newborn and maternal outcomes?	MNH	2.4	2.3	2.3	2.5	2.4	11.8
67	How effective is adding treatment of sepsis and birth asphyxia to a home-based neonatal care model?	MNH	2.2	2.5	2.1	2.4	2.4	11.5
68	What is the safety, feasibility, effectiveness and cost of managing severe neonatal infections at or close to home (eg requiring injectable antibiotics)?	MNH	2.1	2.4	2.1	2.5	2.4	11.5
69	What innovations in managing life threatening conditions such as (pre-) eclampsia and PPH can improve maternal and/or neonatal health outcomes?	MNH	2.1	2.4	2.2	2.4	2.3	11.4
70	What are the drivers of mistreatment in pregnancy and childbirth in humanitarian contexts, across the types of humanitarian settings (acute, protracted, fragile, recovery)? How are these similar to/different from the drivers documented in developing countries?	MNH	2.2	2.3	2.3	2.3	2.3	11.4
71	How can use of maternal and perinatal death and near-miss reviews reduce incidence of adverse outcomes?	MNH	2.1	2.3	2.2	2.3	2.4	11.3

	Question	Topic	Criteria (score 1-3, Average 42 responses)					
			Answer-able	Effect-ive	Feasible	Impact-ful	Need	SUM
72	What is the correlation/impact of mental health and nutrition status of adolescent pregnant women on the maternal and newborn health outcome?	MNH	2.3	2.2	2.1	2.3	2.3	11.1
73	What abortion technologies are being used (MVA, sharp curettage, miso-only, mife+miso, etc)? What are the supply issues and training needs?	SAC	2.6	2.3	2.5	2.4	2.5	12.4
74	What is the provider awareness/understanding of local abortion laws?	SAC	3.3	2.2	2.4	2.2	2.2	12.3
75	What are effective strategies to improve FP uptake after PAC / SAC in humanitarian settings?	SAC	2.4	2.5	2.2	2.5	2.5	12.2
76	What are effective strategies to improve harm reduction approaches (information on correct use of misoprostol) for SAC in humanitarian settings (especially urban settings, where miso for PPH is CBD, etc)?	SAC	2.3	2.5	2.2	2.5	2.5	12.0
77	What are the most effective / cost effective approaches for provider training and support during an acute emergency?	SAC	2.3	2.4	2.4	2.4	2.4	12.0
78	How does the inclusion of SAC in the MISP influence its availability in acute emergencies? What are the most effective strategies for expanding access to SAC during the transition from MISP to comprehensive?	SAC	2.2	2.4	2.2	2.5	2.5	11.8
79	What service delivery models are most effective in acute emergencies? (i.e., use of harm reduction strategies, referrals, franchising, nonstate or informal providers)?	SAC	2.1	2.4	2.0	2.6	2.5	11.6
80	What are the most effective approaches for increasing access to SAC in legally restrictive humanitarian settings?	SAC	2.1	2.4	1.9	2.6	2.7	11.5
81	Is safe abortion available for rape survivors in crisis settings? Under what circumstances? By whom?	SAC	2.2	2.3	2.1	2.4	2.6	11.5
82	What is the magnitude of unsafe abortion and its actual contribution to maternal mortality in the refugee/IDP context?	SAC	1.9	2.4	1.8	2.6	2.7	11.4
83	Is safe abortion available to all women in humanitarian settings in accordance with country law - e.g., to save the life of the woman, on grounds of health, on grounds of mental health? Under what circumstances? By whom? Is PAC always available?	SAC	2.3	2.2	2.2	2.3	2.4	11.3
84	How can abortion services in humanitarian settings screen for and support women experiencing sexual violence?	SAC	2.0	2.3	2.0	2.4	2.4	11.1
85	What are the consequences of unsafe abortion and the subsequent need for safe abortion care?	SAC	2.0	2.1	1.9	2.1	2.1	10.2

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Concept Note 1: Strategies to Expand Access to Emergency Contraception in Humanitarian Settings

Problem Statement

Humanitarian settings are characterized by high levels of sexual violence and exploitation, weak health infrastructure, disruptions in access to SRH services, and assumed low levels of emergency contraception (EC) knowledge, availability, and demand. Need for EC is assumed to be higher than in stable settings, while supply is assumed to be lower when used primarily for post-rape care. Access to EC is particularly important during crisis as the risks for disability and death related to unsafe abortion, pregnancy, and childbirth rise, and therefore preventing unplanned/unwanted pregnancies can be a lifesaving intervention. Additionally, as women and girls lose access to income generating activities they may engage in transactional and survival sex, where they are unlikely to have the power to negotiate condom use.

Justification

EC can be provided through multiple distribution channels, it is safe, portable, discreet, easy to implement, inexpensive, it can be provided prophylactically, it can be created from OCPs. Therefore, EC has the potential to address unmet need for women's ability to control their fertility in crisis settings where access to formal health services are often disrupted. Considering all the other potential approaches to preventing unplanned pregnancy following unprotected sex, emergency contraception is the most cost effective way to prevent unintended pregnancy, when compared to safe or unsafe abortion, miscarriage, or birth.(See Path Toolkit under Resources). In this project we propose to collect information on the utilization and practices related to EC provision specifically in humanitarian settings. Additionally, we propose interventions to address the under-utilization of EC in fragile and conflict-affected settings.

Research question

How can we expand the availability, provider knowledge and capacity, and mechanisms of distribution of EC in humanitarian settings?

Research objectives

- To update the global body of knowledge around the cost, availability and use of EC in humanitarian settings
- To test the feasibility and effectiveness of three implementation strategies on availability, acceptability, distribution and knowledge among providers and recipient populations

Study Design & Analysis Approach

Methods

Formative work on this study will begin with a systematic review of peer-reviewed articles and articles in the grey literature on emergency contraceptive (EC) use, availability, cost and interventions conducted among fragile and conflict-affected populations. Contributing to the results of the systematic review, researchers will conduct a global online survey with approximately 50 global and national sexual and reproductive health (SRH) experts and 10-15 semi-structured key informant interviews (KIIs) with SRH technical experts among humanitarian practitioner organizations. The survey and KIIs will explore organizational training practices, ongoing or existing research or interventions, supply practices and experiences, cost issues and service statistics related to emergency contraception. Data collected should be limited to utilization in disaster, fragile and conflict-affected settings.

To expand and contribute to evidence related to effective EC models and use in humanitarian settings, we propose to implement and investigate three models of EC provision in protracted emergency settings to contribute to increased availability and utilization of EC amongst migratory and under-served groups. The three interventions have been strategically chosen for their opportunity to contribute to evidence on the feasibility of use among populations during movement or migration, underserved adolescents and a population without access to a designated EC product due to a lack of registration, the case in 49 countries around the world. Lessons learned from the implementation and documentation of the intervention and results will contribute to broader knowledge on the feasibility of EC strategies most commonly used in stable development settings but rarely implemented in fragile settings among hard-to-reach populations. Additionally, the lessons and capacity built during implementation could be used to introduce these strategies earlier in a crisis as well as scaling up the models in protracted emergencies. In all health facility-based intervention strategies health service providers will be trained to offer a choice in EC methods using hormonal pills or the Copper-T IUD insertion. Allied community health promoters will be introduced and trained only on the use of medication to prevent pregnancy. The three models for care include the following concepts and suggested areas for implementation.

Do-it-yourself (DIY) EC to prevent unintended pregnancy in country contexts where the designated EC product is not available due to policy barriers around drug registration in 49 countries or prescription-only access. In this intervention we propose an intervention based on training and supplying community promoters, community health workers, community-based distribution agents and health service providers in the current evidence-based regimen for in- and out-of-facility education and provision of DIY EC using available hormonal contraception. Evaluation of the intervention will be conducted with a mixture of service statistics introduced at the time of training and semi-structured interviews with provider and community participants 3 months and 6 months following the training events.

Pre-positioning and prophylactic distribution of the designated product EC along the migration route of a mobile population. This strategy introduces community actors, promoters and service providers to EC through trained service providers, peacekeepers and allied community and social service providers. Preparing a multiplicity of actors with knowledge and products to answer questions and meet the anticipated increased need along the migratory path of women to reduce the possibility of unintended pregnancy. Evaluation of this strategy will be performed via the enrollment of women with their own mobile phones who access the product and are followed up with What's App follow-up messages about the use or non-use of the product at 2, 4 and 6 weeks following access.

Providing EC through youth and peer educator networks and established community-based distribution agents with an introduction and focus on youth-friendly services. This strategy focuses on increasing supply to and demand for EC among young people 10-19 years of age in a high density underserved urban area where designated EC is registered and can be provided legally without a prescription. Community education accompanying the introduction and supply of EC to designated youth promoters will focus on increasing knowledge of peer promoters, increasing awareness about the length of the effective period and name recognition of the chosen EC product, and building a safe youth-focused network for referral and peer-to-peer provision of EC. While EC may be provided by peers, the network will also contribute to increased utilization of and access to all SRH services in facilities by improving linkages between youth and providers and creating a mechanism for referral that bypasses difficult service delivery barriers for young people desiring SRH services. Evaluation of the intervention will be conducted with a mixture of service statistics introduced at the time of community-level training and orientations, semi-structured interviews with peer promoters on skill utilization and the social acceptability of the intervention 3 months and 6 months following the training events and a low-cost social networking study to monitor the diffusion of information in the community.

Analysis

Feasibility will be assessed by analyzing quantitative data on the output and outcome measures alongside qualitative data collected over the course of implementation.

Effectiveness will be assessed by analyzing quantitative data collected across all five measured variables and determining if an increase can be associated with the intervention under study

Descriptive bivariate and multivariate analyses will be conducted to contribute to findings related the availability, acceptability, supply, provider and population-based knowledge according to the following variables.

- **Availability:** quantity of ECP and copper IUDs held by providers and dispensers working under the intervention program, collected at baseline and monthly over the course of the study period
- **Acceptability:** Net promoter score among recipients of EC
- **Distribution:** Number of physical sites offering ECP and IUD insertion as EC plus number of trained and active individual distributors
- **Provider knowledge:** pre/post test knowledge assessments of providers and distributors by intervention
- **Population-level awareness of key messages:** social network study to assess name recognition, awareness of availability and timeframe of effectiveness (3-5 days).
- **Cost effectiveness:** The amount of CYP, births averted, pregnancies averted and the cost of provision.

Potential regions/countries

The three suggested intervention strategies will be designed to meet the needs of populations within distinct humanitarian settings: migration, resident displaced populations (e.g. camps) and countries with restrictive laws/importation policies on EC

Intervention	Proposed Setting
Pre-positioning and prophylactic distribution of the designated product EC along the migration route of a mobile population	Migration contexts with large scale population movements - e.g. Central America/Northern Triangle: Guatemala, El Salvador, Honduras
Do-it-yourself (DIY) EC to prevent unintended pregnancy in country contexts where the designated EC product is not available	Of the 47 countries where EC is not registered, nine are currently in the midst of humanitarian crisis - e.g. Afghanistan, Libya, Somalia, South Sudan
Providing EC through the formation of youth and peer educator networks	Settled, crisis-affected populations in densely populated areas: Central African Republic, Northeast Nigeria

Resources

https://www.popcouncil.org/uploads/pdfs/2014RH_EC-CrisisSettings.pdf

[Emergency Contraception for Crisis Settings - Key Resources \(ICEC\)](#)

[Emergency Contraception in War Zones \(WRC\)](#)

[Emergency Contraception in Conflict-Affected Settings - Distance Learning Module \(IAWG\)](#)

<https://www.path.org/resources/resources-for-emergency-contraceptive-pill-programming-a-toolkit/>

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 2: Improving MISP Implementation through Capacity Development of Key Stakeholders on Disaster Risk Reduction and Emergency Preparedness

Problem Statement

Given the increased need for humanitarian assistance including SRH response, resources are invested in capacity development of key stakeholders for MISP disaster risk reduction and emergency preparedness. There is a gap in evidence on the effectiveness of capacity development approaches for MISP implementation and their respective return on investments.

An appropriate evaluation of these interventions could lead to better resourced locally driven responses and ownership coupled with more effective implementation of the MISP in humanitarian crises. It will also provide a better understanding of what enables an effective implementation of all MISP six objectives.

Research question

How does capacity development of key stakeholders (decision makers, program managers, service providers, CBOs) on the MISP for disaster risk reduction and emergency preparedness, including contingency planning, lead to improvements in implementation of MISP?

Research objectives

- To evaluate the impact of MISP-related capacity development across the different stakeholders: decision makers, program managers, and service providers in different disaster vulnerable settings.
- To explore the barriers and facilitators of capacity development initiatives enabling an effective implementation of MISP in disaster vulnerable settings.

Study Design & Analysis Approach

A group comparison (cross-sectional study employing mixed methods design) will be conducted in two disaster settings that have recently witnessed a recent natural disaster (within the past two years): For example, Fiji corresponding to Cyclone Winston in 2016 and Tonga corresponding to Cyclone Gita in 2018. Fiji is an example of a country where no MISP capacity development efforts were undertaken prior to when the disaster hit. Tonga is an example of a country where considerable MISP capacity development efforts had occurred as part of emergency preparedness prior to the disaster.

Other Examples of countries with No MISP in DRR: Caribbean's 2017; Peru 2017 flooding

Examples of countries where MISP capacity development on DRR: Nepal; Pakistan and Sri Lanka

Target Population

Three main target populations (stakeholders) are of interest to this research in the two countries: decision makers, program managers, and service providers. A total (n) of each target group will be selected, to be determined and based on the countries that will be selected for this research. In addition, staff of agencies/organizations involved in facilitating the different capacity development efforts will also be selected. Again, the number of which will be determined based on the countries' selection

Sampling

A purposive sample of decision makers, program manager, service providers as well as facilitators of capacity development will be conducted. The exact sample size will be determined based on the selection of the countries of interest.

Design

Mixed method design will be employed. They are described below

A survey will be administered using the MISP readiness assessment tool to assess the outcomes of capacity development across the different stakeholders' groups of interest in this research. The MISP readiness tool consists of 38 indicators across the six different MISP objectives. In addition, key informant interviews will be carried out with capacity development facilitators to document the nature and types of capacity development efforts undertaken.

Desk review of key documents including policies, strategies and guidelines addressing disaster preparedness and response, will supplement these data collection efforts.

Data collection will be real-time. Only the PIs involved in this research will have access to the data who will be solely involved in supervising the data management and analysis.

Ethical Considerations

We foresee no particular risks for participants taking part in this research. All collected data will be anonymous. Informed consent will be sought from all participants detailing the study objectives, ensuring confidentiality of information collected, and the ability to withdraw from the research at any time, even after consent, without jeopardizing their role at their institutions.

Analysis

The [MISP Readiness Assessment Tool](#) will be used. It includes 38 indicators, and accompanying questions, to assess the state of emergency preparedness. Evaluation will also capture whether the following outcomes were achieved for the different types of stakeholders of interest in this research:

Decision makers

- Incorporation of MISP in DRR and contingency plans
- Establishing Accountability mechanisms
- Establishing coordination mechanisms
- Ability to advocate on SRHR
- Allocating budget and other needed resources

Program managers

- Establishment and/or engagement in coordination mechanisms
- Establishment of the needed partnerships/collaborations across different agencies' jurisdictions
- Allocation of resources both human and financial; commodities; prepositioning
- Developing MOUs and SOPs to guide MISP implementation
- Establishing referral networks (GBV, EMoC, HIV- ARV)
- Coordination of MISP training and readiness
- Dissemination of needed technical guidance for service delivery
- Mapping and/or Analysis of service delivery points, stakeholders, staffing and respective capacities

Service providers

- Ability to provide the service- in line with MISP training, CMR training, etc.
- Ability to offer Service Referral
- Use Technical guidance on adapted tools for use in humanitarian settings
- Ensuring the needed Commodities to support services provision

Generalizability

This research offers the platform for demonstrating facilitators and enablers of effective MISP implementation due to capacity development during emergency preparedness

Limitations

- Internal validity: recall bias, information bias, social desirability
- External validity: limited generalizability, recommend replicating the research elsewhere in other disaster vulnerable settings

Potential regions/countries where research would be most appropriate/impactful

Disaster vulnerable regions/countries: specifically, in countries where there has been a significant investment in capacity development around MISP implementation during DRR and contingency planning.

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 3: Understanding and Responding to the Needs of Populations Placed at Increased Risk (PAIR) in Humanitarian Settings

Problem Statement

In the acute stage of a humanitarian crisis responders are under incredible pressure to start services, as such, marginalized populations may be left out of the response at the onset. As aligned with MISP Objective 5 (plan for comprehensive reproductive health services integrated into primary health care), all humanitarian actors should ensure SRH/GBV services for populations placed at increased risk (PAIR) should be a priority on day two of the response. There is limited evidence on the particular SRH needs of these populations. There are groups of individuals who fall under the PAIR acronym, these may include people living with disabilities (physical and/or mental); LGBTQIA+; adolescents (LGBTQIA+, living with HIV, married/unmarried); people with substance use problems; and many other under-researched populations).

There is wide variance of needs, beliefs, and attitudes both within and between these populations, and it is important to note that intersectionality exists from being marginalized, which may result in common barriers and enablers to SRH service access.¹ No marginalized groups are homogenous, and to best understand the variance within these groups, formative research is a key first step. Formative research can inform the design and implementation of an intervention that may improve access to and quality of SRH/GBV services for PAIR. Access to and utilization of SRH/GBV services are shaped by diverse factors and social structures, and often vulnerability is exacerbated in humanitarian crises/contexts. These intersectional factors that need to be taken into consideration when responding to the SRH needs and rights of all marginalized populations include sex, age, gender, SOGI, religion, ethnicity, and family structure.

Justification

In humanitarian settings, marginalized and vulnerable people face multiple barriers in accessing and using SRH and GBV services. Structural, socio-economic and cultural factors are key influencers and need to be understood in each context. Additionally, including those marginalized in the development of solutions, should be a standard. Including a member (or group) from the marginalized group in all stages of research (from design to dissemination) is invaluable and necessary for more inclusive decision-making in the humanitarian context. Additionally, many times during conflict and crisis settings there is potential for positive shifting of social norms, during which opportunities may arise that can reduce the extreme risks some marginalized populations face, creating a window of opportunity for social change. The absence of data on marginalized and vulnerable groups remains a key barrier to tailor services that are **Accessible**,

¹ https://www.agendaforhumanity.org/sites/default/files/resources/2017/Aug/AP_3G_0.pdf

Acceptable, Affordable, and of good Quality. This concept note provides a rigorous research template, with a socio-ecological (SE) theoretical base, that could be relevant for a number of populations placed at increased risk that may relate to a number of SE factors (barriers at the individual, familial/interpersonal, community, policy levels). As such this concept note is divided into three phases, and an organization/researcher could enter in any of the three phases below.

Goal

Ensure that marginalized populations have access to comprehensive SRH services and rights. To reach the goal we need to ensure there are interventions that meet AAAQ measures.

Research Question

How can we improve SRH/GBV interventions by better understanding and responding to the needs of populations placed at increased risks² in humanitarian settings?

Overarching Principles throughout

- **Gender lens:** To be applied across all stages of the research from design to dissemination.
- **Inclusion/Authentic participation of population(s) of focus:** To be applied across all stages of the research from design to dissemination.

Study Design & Analysis Approach

We have identified three key phases, allowing for research to start at any phased, based on their existing research and/or operations. It is feasible that organizations could start at either phase.

Phase 1: Formative Research (~month 1-6): Identify the barriers and facilitators that [insert Population here] experience when accessing and using SRH services, including GBV services, in humanitarian settings?

Phase 2: Implementation research (~month 7-24): Design a contextualized SRH/GBV intervention and conduct a pilot study to measure **Accessibility, Acceptability, Affordability, and Quality** for SRH/GBV services for [insert Population here].

Phase 3: Scale-up of proven models (~month 24 onwards): Scale up contextualized SRH/GBV intervention and for [insert Population here] to continue to improve **Accessibility, Acceptability, Affordability, and Quality**.

2 Also known as marginalized populations, vulnerable populations, populations at risk.

Theory

Informed by socio-ecological theory, with barriers and facilitators and intervention aligned to the levels (e.g individual, family/interpersonal, community, policy).

Approach

Participatory Action Research, to achieve depth and breadth of knowledge based on the population of interest, using an inclusion approach-starting with identifying a co-investigator from [insert Population here] as possible. Together we will uncover practical knowledge and co-create an understanding of facilitators and barriers to an intervention or intervention(s).

Target Population

- Populations placed at increased risk (not an exhaustive list)
- People living disability (physical and/or mental);
- LGBTQI;
- Adolescents-living w HIV, married, unmarried, sexually-active, in/out school, 12-14/15-19 ages;
- People who engage in transaction sex/sex work;
- People who use drugs;
- People living with HIV;
- Under-researched populations/settings.

Sampling Process (Multiple)

For hard to reach/hidden populations: Snowball sampling, chain sampling, chain-referral sampling, referral sampling.

A range of options for larger, more visible populations (e.g. adolescents in some contexts).

Type of Data: data should be collected in a manner to allow for gender and age disaggregation

- Simple **demographic** data
- **Formative research:** collect information on barriers and facilitators at different levels of the socio-ecological model (individual, family, community, policy).
- **Implementation research:** collect information on variables Accessible, Acceptable, Affordable, and Quality of intervention (at provider and client level), using standardised and validated measures as much as possible. Guided by the information from the formative research (barriers and facilitators).

Data Collection Procedures

- Simple **demographic** data
- **Formative research:** collect information on barriers and facilitators at different levels of the socio-ecological model (individual, family, community, policy).
- **Implementation research:** collect information on dependent variables Accessible, Acceptable, Affordable, and Quality of intervention (at provider and client level), using standardised and validated measures as much as possible. Guided by the information from the formative research (barriers and facilitators).
- **Scale up research:** collect information on dependent variables Accessible, Acceptable, Affordable, and Quality of intervention (at provider and client level) in multiples sites, using standardised and validated measures as much as possible. Guided by the information from the Implementation research.

Data Approach

Mixed methods, formative is qualitative, implementation and scale up is quantitative with some qualitative.

- **Intervention Fidelity-**
- **Provider-**acceptability and feasibility of the training/intervention.
- **Populations (context dependant)-**acceptability and feasibility of intervention, satisfaction with intervention.
 - » Individual
 - » Family
 - » Community

Ethical considerations

These are incredibly vulnerable population(s), all efforts must be made to identify and mitigate any risk to participants.

Questions to ask should explore:

- Benefits: (what are the scientific/evidence generation benefits from doing this research? what benefits beyond the physical might arise (emotional, psychosocial, spiritual, other)? are there different benefits for individual participants compared to their communities?)
- Risks: (what are all the risks participants could be exposed to? Short-term/long-term risks? Are anyone's rights being put at risk?)
- Balancing the two to optimize
- Ensure confidentiality, privacy, and data protection

Analysis Plan

Pre/post control in multiple sites (within country-consider a phased approach, and/or between countries)

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 4: Identifying and Addressing the Drivers of Disrespectful Care during Pregnancy and Birth in Humanitarian Settings

Problem Statement

Given the growing knowledge base on the drivers of and how to address mistreatment during pregnancy and childbirth in non-humanitarian settings, there is concern that the resource constraints, security challenges, displacement, and health systems disruption found in humanitarian settings may exacerbate the systematic causes of mistreatment in pregnancy and childbirth. We need to understand what interventions would be most appropriate and/or adapted to humanitarian settings.

Justification

Known drivers of disrespect and abuse during childbirth in non-humanitarian settings include underlying social determinants and gender norms that perpetuate violence against women, weak health systems, poor/lack of managerial oversight, provider demotivation, lack of equipment, supplies and adequate personnel, and weak or non-existent legal redress, all of which are likely exacerbated in emergency settings.

In humanitarian response, not enough attention is given to the quality of care. If women find themselves mistreated while seeking SRH care, they have two options: seek health services elsewhere or don't seek care at all. People in crisis settings typically don't have the choice to change their health providers. If a woman in a humanitarian emergency experiences abuse or feels disrespected in childbirth, she is much more likely to stay home the next time she gives birth (and recommend that her family and neighbors stay home too, or they may experience the same poor treatment). In these situations, the care that is supposed to save lives becomes a barrier. Thus, ensuring access to health services that are safe, timely, respectful, and culturally appropriate is not only a right for all humans, but it is imperative to realize the life-saving mandate of humanitarian missions. Respectful maternity care is an integral element of quality of care.

Research question

What interventions are effective to prevent mistreatment and promote respectful care during pregnancy and childbirth in humanitarian settings?

Research objectives

1. Identify the drivers of disrespect and abuse during pregnancy and childbirth in the study setting* to inform a package of interventions
2. Test an intervention adapted from non-humanitarian settings, to determine what is effective in humanitarian settings* to reduce mistreatment and promote respectful care during pregnancy and childbirth
3. Determine which interventions or packages of interventions are most appropriate for the study setting

*ideally conducted in various types and phases of emergency settings

Study Design & Analysis Approach

Ideally, a mixed-methods approach would be undertaken to adapt and evaluate an intervention or package of interventions to improve respectful maternity care in the study setting. The target population is women of reproductive age, health facility providers and administrators. The socio-ecological model is an appropriate orienting framework for developing and analyzing the research.

The Maternal and Child Survival Program (MCSP; www.mcsprogram.org) has researched respectful maternity care in many developing countries. From this work, a body of validated tools and proven interventions have emerged. MCSP approaches and tools should be utilized as a starting point for researching respectful maternity care in humanitarian settings.

Phase 1: Formative research to understand drivers specific to the setting (qualitative - in-depth interviews ([IDIs - women who have given birth in a facility in the past 3 months](#)), key informant interviews (KII - health care providers) nurse/midwives involved in labor and delivery; health administrators).

For the qualitative interviews with patients, purposive sampling with possible snowball sampling will be used to achieve maximum variation of patient experience (positive/negative); among health providers and administrators, purposive sampling will be used to achieve maximum variation of roles, seniority, and years of professional experience.

When adapting the MSCP tools, be sure to consider that social and gender norms or the state of the humanitarian setting may normalize/accept violence. Review tools and considering adding questions about what people see as violence, since violence may be normalized, as it is important to understand what is and is not acceptable at baseline in order to design/adapt the intervention. For example, consider asking, “Describe examples of disrespect” or “Describe examples of abuse” instead of listing types of disrespect/abuse so that the respondents are informing what rises above the range of normal in their setting.

Phase 2: Implementation and Evaluation of an intervention or package of interventions (see MSCP RMC Operational Guidance document, Appendix 2, for list of promising approaches). Baseline and endline would be evaluated quantitatively (baseline could possibly be conducted while formative analysis is ongoing).

Patient measures (adapt MSCP Client Exit Survey):

- Non-confidential care
- Non-dignified care
- Neglect
- Non-consented care
- Physical abuse
- Inappropriate demands for payment / detainment for nonpayment
- Violations of confidentiality and privacy
- Abandonment
- Perceived satisfaction and quality of care
- Experience of disrespect

Provider measures: (adapt MSCP Provider Survey tool)

- Attitudes toward disrespect and abuse
- Systems factors that make it difficult to provide good care
- Work environment
- Job satisfaction
- Experience of disrespect and abuse in the workplace

Facility/system assessment: [Adapt from MSCP Facility Readiness Assessment tool](#)

For the quantitative baseline/endline, convenience sampling will be used among women being discharged from the postpartum ward, as well as with labor and delivery providers and health care administrators. Health facility assessments should be conducted at each facility in which the intervention is implemented.

Endline assessment should also include FGDs among both women and health care providers to elicit feedback on the intervention to inform future iterations.

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 5: Assessing Data for Decision Making to Inform SRHR in Emergencies

Purpose

Data usage for decision-making is widely applied globally; however, little attention is given to data use for programming in emergency setting, this concept note discusses on how to strengthen evidence-based decision-making through ongoing data utilization to inform SRHR programs in humanitarian settings during the preparedness, acute, protracted, and transition phases. It is expected that data usage will lead to programmatic adjustments that will lead to better outcomes and greater impact.

Problem Statement

Though the use of data to make programmatic decisions is viewed as important for ensuring program quality in humanitarian settings, there is not an evidence-base to show that this is an effective means of improving SRHR programs.

There are various challenges that influence the ability to effectively use data to improve programs. These include a **lack of capacity** for understanding data (data literacy around generation, collection and analysis); **inadequate organizational systems** that prevent the establishment of a culture around data use; **insufficient data capturing systems** that do not allow for easy access; and **a lack of harmonization** across indicators, tools, and databases. Further, there are often **data use protocols that could be incorporated into developing countries** as a means of preparedness, but are not.

This problem addresses a widespread need in humanitarian SRHR to not only collect quality data, but to ensure that the data are being used across programs and functions to allow for real time adjustments in programmatic activities to deliver interventions with the highest possible quality to the largest and broadest population. Currently, we have anecdotal evidence to suggest that data use, when applied effectively, can improve service delivery; however, there is no strong evidence base to support this, notably in humanitarian settings. If this evidence base can be established, it could improve the effectiveness of programs and be used to advocate for strengthening a culture of data use.

Research Question

How can we strengthen evidence-based decision-making through ongoing data utilization to inform SRHR programs in humanitarian settings during the preparedness, acute, protracted, and transition periods?

Research objectives

To demonstrate how data for decision-making can inform SRHR programming across various phases of emergency by:

- Identifying key actors in the data landscape and their capacity
- Document data systems being used (i.e. HMIS, LMIS)
- Determine the current status and drivers of data use among managers and decision-makers across humanitarian actors (NGOs, UN agencies, etc.)
- Identify factors contributing to active data utilization
- Identify effective ways to strengthen data utilization

Study Design & Analysis Approach

Target Population: key humanitarian actors: first-line managers (including providers), program and HMIS officers, UN staff, etc.

Sampling: We will employ a convenience sample, with referrals to other key actors in SRHR in humanitarian response in the research setting (using existing working groups, including the Global Health cluster, IAWG, etc.)

Data:

- Data flow
- Data feedback mechanisms
- Data systems
- Programmatic decisions taken based on evidence
- Collaboration
- Timely data accessibility
- Knowledge and skills of the user
- Shared policies and strategies

The data will be collected and verified from the following sources:

- Existing documentation: Data use frameworks, training materials, policies, etc.
- Surveys to key actors: first-line managers (including providers), program and HMIS officers, UN staff, etc.)
- Key informant interview with SRHR experts
- Focus group discussions with key actors

Design: A mixed methods approach using qualitative and quantitative data will be applied.

Means of Control of Data Quality:

- Triangulation of sources and methods
- Validation of the tools (pre-testing and piloting)
- Training of data collectors
- Debriefing

Ethical Considerations:

- Ethical Approvals: i.e. Ministry of Health, local research institution, IRB, etc.
- Consent forms (including right to withdraw)
- Confidentiality; data deidentified
- Anonymity of organizations

Analysis

Will employ a mixed methods approach as elaborated upon previously to answer the research question. This will include the review of background documentation, interviews, focus group discussions, and surveys with key actors involved broadly in data use for SRHR programs in humanitarian settings.

General Implementation Protocols:

Data collection → data processing → cleaning → transcription / translation → analysis → interpretation

Interpretation:

Descriptive statistics and analysis will be used to interpret qualitative variables. Content analysis will be used to code thematic variables across various transcripts. Survey data will be analyzed through descriptive statistics (proportions, averages, etc.) to examine the relationships between variables using inferential statistics. Each phase of humanitarian response will be examined individually before comparisons are made across phases and actors.

The results could potentially be applied to other emergency responses of the same context. Replication of the study can be applied to various settings; results of the study are generalizable only to similar contexts.

Limitations:

- Nature of emergency settings
- Impact of data use is not quantifiable in the context of quality
- Generalizability to multiple settings
- May not reach all key actors
- Funding

Potential regions/countries where research would be most appropriate/impactful

- To assess data use in all phases of emergency, there is a need to highlight countries focused on preparedness, acute response, protracted emergency, and transition.
- It is key to identify countries in each of these phases that are of interest to researcher
- An acute emergency may need to be identified on a case-by-case basis

Additional Resources

- Global Digital Health Forum: <https://www.mhealthworkinggroup.org/content/global-digital-health-forum>
- WHO has initiative on data in emergencies; UN (Geneva) very interested in this concept and should be approached for key stakeholders
- MISP-related components of UNHCR database

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 6: Understanding the impact of Cash Transfer (CT) programs on Intimate Partner Violence (IPV)

Problem Statement

Cash Transfer (CT) programs are increasingly used globally including in humanitarian settings. IPV is pervasive and may be exacerbated by the stressors associated with displacement and those present in emergency contexts. However, there is little evidence on the impact of cash transfer programs on IPV.

Justification

The research that does exist suggests that cash transfers influence across three pathways (economic security, intra-household conflict, and health and wellbeing). The most strongly supported pathway is a direct link between economic security and the reduction of IPV, although these data come from Low- and Middle-Income Countries (LMICs) (UNICEF, 2018)¹. More research is needed to explore the relationships between cash transfers programs, IPV, and the proposed pathways, and their intersections within humanitarian contexts.

Cash transfer programs may be unconditional in nature or linked to have programming (ie livelihoods, school attendance) but have rarely been directly linked GBV or IPV programming. Therefore it is unclear of their primary or secondary impact on IPV.²⁻³ While it is possible that CT may reduce IPV there are also the potential for harms including the entrenchment of traditional gender norms, increased household conflict over the use of CT funds, and security risks related to the receipt and transfer of cash,

Research question

What is the impact of cash transfer (CT) programs on intimate partner violence (IPV) through women's health and wellbeing, economic security, and intra-household conflict in the post-acute phase of an emergency?

1 Buller, Ana Maria; Peterman, Amber; Ranganathan, Meghna; Bleile, Alexandra; Hidrobo, Melissa; Heise, Lori (2018). *A mixed-method review of cash transfers and intimate partner violence in low and middle-income countries*, Innocenti Working Papers no. 2018-02, UNICEF Office of Research - Innocenti, Florence

2 DFID, <https://reliefweb.int/report/world/violence-against-women-and-cash-transfers-humanitarian-contexts>, retrieved September, 11, 2018

3 Protection Cluster, <http://www.cashlearning.org/downloads/erc-cash-and-protection-literature-review-web.pdf>, retrieved September 11, 2018

Research objectives

- Demonstrate the impact of CT programs on IPV over 12 months
- Examine 3 potential pathways through which IPV is impacted by CT programs

Study Design & Analysis Approach

Methods

Target Populations: Partnered persons (men and women identifying as heterosexual). The target population is delimited to non-mobile populations experiencing humanitarian emergencies.

Sub-populations to consider in the design phase include: polygamous partners, partnered adolescents, LGBTQIA+ persons. These populations may be oversampled.

Mixed-methods phased approach with control and comparison groups. Measurements taken at baseline and endline; control group receives CT programming following endline if the intervention is not harmful. A 12-month project cycle is anticipated.

Possible data collection methods: Household based survey, qualitative In depth interviews with women or both partners³, possible focus groups discussions with men.

Primary Domains of Interest

- IPV incidence (retrospective time period TBD on the basis of emergency duration).⁴
- Intra-household conflict types and causes
- Economic security, household spending, and decision-making
- Women's health and wellbeing (including measures of women's empowerment, gender norms)

³ Care should be taken if interviewing partner dyads to ensure that the personal safety of female participants is not compromised.

⁴ The WHO definition of IPV will be utilized.

Other considerations include attention to the variability in CT programs. These include CT program type (unconditional and conditional), delivery modes (cash, cards, vouchers, mobile), sector (food and livelihoods, health, protection).

Ethical and Contextual Considerations: Few CT programs, including those that are conditional in nature include a GBV, IPV or gender components. Given the state of the research and mixed findings on the impact of CT programs on IPV an important ethical consideration would be whether CT programs should be linked with complementary protection or IPV programming.

Additionally, there is wide variability on the mode of CT delivery which should be considered in program design. Gender norms vary by context and should be included as part of measurement to adequately measure baseline mores and gender norms change, if any. The study design should consider the geographic and cultural variability across and between the implementation sites. Because of the possibility of IPV disclosure referral services for participants must be available. WHO guidelines for conducting research on Violence Against Women should also be used.

Analysis

We would ideally do a pre/post over 12 months of intervention and then phased approach with a control group. We propose a comparative analysis post endline, then implement the CT intervention (adapted with any lessons learned) in the control group following the 12 month study. If a control group is not possible, other options could include a difference of difference methodology. Methodology choices will be based on the adaptation of this concept note.

Data from a wide range of countries and contexts is necessary to bolster the evidence base around the impact of CT on IPV, and GBV more broadly. Both the impact of CT programs as well as the pathways for how effects are derived are equally important.

Potential regions/countries where research would be most appropriate/impactful

Given the evidence base, we would encourage a wide range of regions and locations in order to contribute towards the wider methods of delivery, contextual factors, and sectors. Consider Post-acute, non-mobile population settings. Consider how location choice/region will influence the CT delivery method, Sector of Delivery (Relationship between Health and Protection Clusters/Sector)

Additional Resources/Information

- Need to tap into the lessons learned from other sectors
- UNHCR has done a bit on health, more broadly, and cash transfer programming- documentation started on this and could be a resource.
- Health Cluster published guidance on cash transfer programming for health service delivery (conflict and health)
- Look at the research on economic empowerment activities in emergency settings such as DRC, as lessons learned to transfer to CT services (alone or incorporated) CALP is working on this too
- Cash programming could have a positive impact on IPV, but is it the most efficient (or have a greater effect) by having other programs (non-cash based). CT programming can be very expensive to operate. So, this is an important question to ask.
- Community Participation might be considered as an outcome/domain of interest as well as school attendance of participant's children
- Define the context, if it is widespread cash program for many purposes or a targeted program, additional targeting methods to include more people, and other settings where there is less use of CT modality for programming
- Child marriage project with CT programs
- CT linked to specific outcomes have expectations, but is the IPV variable in addition to it?

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 7: Accelerating Integration of Long-Acting, Reversible Contraceptive Method Choices in Reproductive Health Services for Crisis-Affected Populations

Purpose

The prevention of unintended pregnancies is now a priority objective within the Minimum Initial Service Package (MISP) for reproductive health in emergencies. Activities under this objective include the provision of an adequate contraceptive method mix, including long-acting reversible contraceptive methods (LARC), and ensuring the crisis-affected community is aware of services and those wishing to space or limit pregnancies are able to access information and contraceptive services to meet their needs.

This research will examine the effectiveness of approaches for introducing or expanding LARC options within contraceptive services across diverse crisis settings.

Problem Statement

Contraceptive service delivery in humanitarian settings has advanced significantly over the past 10 years, due to reliable and sustained financial investment. However, approaches have varied within and across organizations, and many have not yet mainstreamed contraceptive services, in line with the MISP objective, within their initial emergency response efforts.

Decision makers lack evidence-based strategies to implement contraceptive services, inclusive of LARC, at scale during emergency response. Introducing or scaling up LARC methods may require coordinating with a wide range of health and non-health actors to address policy, financing, and logistics constraints; train clinical service providers; and raise awareness of methods and method availability among both health system actors and potential client populations. It is critical to now invest in research to identify effective strategies for scale up, mobilization and provision of LARC during crisis response, taking into account the time, cost and coordination required to ensure quality services in diverse operating environments.

Justification

Evidence-based strategies for integrating LARC in reproductive health services will enable humanitarian actors to accelerate implementation of programs to prevent unintended pregnancies and reduce maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities among crisis-affected populations. This research is designed to go beyond project specific learning to examine conditions and actions within and outside of the health sector (including policy, financing and coordination) that contribute to effective, replicable contraceptive service delivery strategies for different settings.

Research question

What are the most effective and efficient strategies for integrating LARC in contraceptive services during initial emergency response, for populations on the move, and in protracted crisis settings where infrastructure, capacity and awareness of methods are all limited?

Research objectives

1. Understand factors affecting strategies for provision of LARC as part of a broad package of contraceptive services in diverse operating environments, including:
 - » In acute emergencies with established infrastructure, capacity and awareness of methods
 - » In acute emergencies with established infrastructure and capacity but limited awareness of methods among displaced/affected population
 - » In acute emergencies with limited infrastructure and capacity but moderate or high awareness of services among displaced/affected population
 - » For populations on the move
 - » In crisis-affected settings with limited infrastructure, capacity and awareness of services
2. Compare effectiveness and efficiency of strategies for rapid technical/clinical capacity building (*combinations of classroom training, on or off site practice, mentoring, e-learning, etc*) and task shifting/sharing in settings with:
 - » limited clinical practice opportunities
 - » access constraints
 - » high turnover/rotation
3. Evaluate effectiveness and efficiency of strategies to address supply challenges (*regional / national / subnational prepositioning, -interagency coordination to manage stock outs / surplus*) across different regions/geographies

Study Design & Analysis Approach

Generating sufficient evidence to inform program planning and implementation in future emergencies will require multiple multi-faceted studies. Study designs will vary according to the setting and population of concern, and may include:

- **Program evaluations and descriptive case studies** documenting promising strategies for LARC provision to populations on the move and strategies to address supply challenges in diverse crisis settings
- **Comparative case studies** exploring how policy constraints influence design and implementation of strategies for clinical capacity building, supply availability, awareness creation and service provision in diverse crisis settings
- **Quasi-experimental studies** comparing effectiveness of clinical capacity-building content, frequency, format, setting and follow-up in different settings with acute emergencies
- **Economic evaluations** of clinical capacity building interventions and strategies to address supply challenges
- **Multi-disciplinary implementation research** to understand facilitators and barriers that support or diminish the effectiveness of LARC introduction and scale-up efforts

For example, research focus and study designs may vary across contexts as follows:

	Existing capacity and previous access/use	Limited capacity, existing awareness	Existing capacity, limited awareness	Populations on the move	Limited infrastructure, capacity and awareness
Objective 1: <i>Understand factors affecting strategies for provision of LARC in diverse operating environments</i>	Comparative, multi-country/context case studies			Descriptive/ analytical case studies	Program evaluations, implementation research
Objective 2: <i>Compare effectiveness and efficiency of strategies for rapid technical/clinical capacity building and task shifting/sharing</i>	---	Quasi- experimental studies, economic evaluations, implementation research		Program evaluations and descriptive case studies	---
Objective 3: <i>Evaluate effectiveness and efficiency of strategies to address supply challenges</i>	Program evaluations, implementation research				

All studies testing interventions will have robust quality assurance mechanisms to ensure that efforts to increase efficiency of service provision do not compromise quality of services available.

If resources allow, all studies will include multiple program sites and countries to maximize generalizability of results and translation of evidence into practical guidance for implementation in ongoing and future emergencies.

Analyses will focus on understanding what strategies work, where, how and why. Use of a common implementation research framework and standardized metrics will facilitate comparison and synthesis of findings across settings.

Analysis considerations for all studies
(research addressing objectives 1, 2 and 3)

- Previous service availability/utilization
- Policy context (method approval, provider scopes of practice, procurement/supply restrictions, etc)
- Supply context
- HRH context
- Service provision networks (public/private)
- Facility readiness
- Met need and demand for family planning
- Awareness of services and social norms in specific demographic groups (age, marital status, marginalized populations, etc)
- Humanitarian and development actors, roles and coordination

Illustrative outcomes of interest for effectiveness studies and program evaluations

(research addressing objectives 2 and 3)

Effectiveness of capacity building strategies

- Provider competency and skills retention
- Provider attitudes and motivation
- Facility service provision / uptake
- New users by method
- Total users by method
- Removals by method
- Complications/adverse events reported
- Time/cost to provision of services
- Cost per provider
- Cost per insertion

Supply challenge strategies

- Time/cost to location along supply chain
- Stock levels over time
- Facility service provision
 - » New users by method
 - » Total users by method

Potential regions/countries where research would be most appropriate/impactful

Initial focus on efforts to introduce contraceptive implants may be more practical than focus on intrauterine devices (IUDs), although research is needed on strategies to introduce and scale-up both method options in diverse settings.

Comparative studies using the same interventions and research methodologies in multiple settings will be most impactful. Comparing strategies across different types of settings is critical to this research question, and studies should seek to include multiple sites from one or more of the following:

- In acute emergencies with established LARC infrastructure, capacity and awareness of methods
- In acute emergencies with established LARC infrastructure and capacity but limited awareness of methods among displaced/affected population
- In acute emergencies with limited LARC infrastructure and capacity but moderate or high awareness of services among displaced/affected population
- For populations on the move
- In protracted crisis-affected settings with limited LARC infrastructure, capacity and awareness of services

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 8: Strategies for Transitioning from MISP to Comprehensive SRH Services in Post-Crisis Settings

Problem Statement

Transitioning from the Minimum Initial Services Package (MISP) to comprehensive sexual and reproductive health (CSRH) programming in humanitarian settings is often challenging. Very few countries have demonstrated a timely transition and according to the country standards or international standards where country standards are below the Inter-agency Working Group (IAWG) on Reproductive Health in *Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*-recommended services. It is critical to understand factors impeding or enhancing the transition from the MISP to CSRH to assist countries in scaling up to comprehensive programming. Differences between countries might be linked to exit strategies, sustainability plans, humanitarian-development nexus, funding, limited local human resources, language, networks, access to large influential actors. The Health System Building Blocks (Service delivery, Health workforce, Health information system, Medical commodities, Financing, Governance and Leadership) will be used as the framework for a systematic review of the problem.

Justification

By providing only the MISP when a situation has stabilized, crisis affected populations are deprived of their fundamental right to comprehensive SRH services and their SRH needs are not addressed. The research is most feasible and relevant in countries where there was a single disrupting event (post-election violence, natural disaster, refugee situations...), versus country context with recurring emergencies. The research will provide examples of successful interventions to move from MISP to comprehensive SRH for post-crisis settings.

Research question

What are the strategies to move from MISP to comprehensive SRH programming in post-crisis settings?

Research objectives

- Compare the processes followed in each country to transition from MISP to comprehensive SRH based on the six building blocks for health system strengthening
- Describe the pre-conflict/pre-natural disaster status of SRH indicators at country level
- Describe barriers and enablers transitioning from MISP to comprehensive SRH
- Identify successful interventions and key resources for each of the six building blocks for health system strengthening
- Identify key stake-holders engaged in successful transition
- Draw lessons learned and provide recommendations for successful transition

Study Design & Analysis Approach

Step 1: SRH focal points or coordinators should be located and identified through mapping and contacting all health clusters/sectors (via the Global Health Cluster or UNHCR).

Step 2: A combined closed and open questionnaire will be developed that includes MISP and comprehensive SRH services as well as the health system building blocks. The closed will be a checklist of services currently provided. The open part will be on steps taken to address the health system building blocks.

Step 3: SRH focal points/coordinators will be provided with the questionnaire to answer which MISP to comprehensive SRH services are currently provided in their settings. A validation process will be included.

Step 4: Analysis of the questionnaire will inform the selection of three countries to be included in the research including: one country setting that did not move beyond the MISP although post-crisis; one country setting that partially transitioned to comprehensive SRH services; and, one country setting that fully implemented comprehensive services.

Step 5: Mixed method research tools will be developed for the selected countries. They will consist of:

1. Country specific literature review.
 - » Pre-crisis indicators
 - » Legal framework
 - » Ministry of Health policies
 - » Disaster Risk Management and inclusion of SRH
 - » Minutes of Health Cluster/Sector and SRH working group meeting minutes
2. Key informant interviews (Government Ministry of Health, Disaster Risk Management agencies/departments, UN Agencies, Donors, (I) NGO's, CBO's, health facility managers and staff) to include the components of SRH services available and progress towards the six Health System Building Blocks:

Topics for INGO's, health facility managers, governments include:

- » Service delivery
 - ◇ Were RH needs identified?
 - ◇ Were suitable sites for SRH services delivery identified?
- » Health workforce
 - ◇ Were the necessary human resources need identified?
 - ◇ Were needs for training identified?
 - ◇ Were budgets allocated?
- » Health information system
 - ◇ Was SRH information included in the health information system (HIS)?
- » Medical commodities
 - ◇ Was a sustainable supply chain identified?
 - ◇ Were funds secured?
 - ◇ Were the logistics organized?
 - ◇ Were staff trained to manage the supply chain?
- » Plans for financing comprehensive RH
 - ◇ Were SRH financing possibilities studied?
 - ◇ Did you get the funding you needed? If not why?
- » Leadership & Governance
 - ◇ Were SRH related laws known?
 - ◇ Were policies enabling all aspects of comprehensive SRH?
 - ◇ Were protocols in place?
 - ◇ What key stake-holder facilitated/prevented comprehensive SRH?

Topics for CBOs and development INGOs

- » What was your capacity in term of SRH to support the response?
- » How were you engaged and involved in the SRH response (during the emergency phase, after)? If not, why not?
- » Did you access humanitarian funding? If not why? If yes how?
- » Topics for donors
- » What are your general policies around support of SRH in acute onset humanitarian emergencies?
- » What are your general policies around support of SRH in stable post-crisis humanitarian settings?
- » What are your general policies around support of SRH to transition from humanitarian to development?
- » What are your general policies around support of SRH in development?

3. Private and public health facility assessments by direct observation

- » Check-list of services
- » Check-list of a few essential material as proxies
- » Check-list of staffing

4. Routine data/user statistics

- » SRH basic indicators (list)

Step 6: Data analysis

Step 7: Report and dissemination. A country-based report should be share as soon as possible with the participants. An article compiling and analysis the 3 case-studies should then be published in a peer-reviewed journal.

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 9: Approaches to Increasing Safe Abortion Care (SAC) in Legally Restrictive Humanitarian Settings

Purpose

The purpose of this study is to document the lessons learned from different approaches to increasing access to safe abortion care (SAC) in legally restrictive humanitarian settings. This documentation is needed in order to provide humanitarian actors with practical examples and guidance for increasing access to safe abortion care in legally restrictive humanitarian settings.

Problem Statement

Safe abortion care is a lifesaving intervention and a basic human right. Yet, the IAWG Global Evaluation identified that safe abortion care was rarely available in humanitarian settings and we have limited evidence about how best to provide access to SAC in humanitarian settings. Further, the historic lack of prioritization of this service in humanitarian settings means that many humanitarian actors lack experience working on this service. Most humanitarian crises occur in countries in which abortion is legally restricted, meaning that innovative approaches are needed to increase access to safe abortion care.

Justification

Addressing this problem is important because safe abortion care is a need for women and girls in crisis and safe abortion care is part of the global guidelines outlined in 2018 IAFM.

Research Question

What are feasible and effective approaches to increasing access to SAC in legally restrictive humanitarian settings and how can we replicate these approaches?

Research objectives

- Describe successful and promising approaches to increasing access to safe abortion care in humanitarian settings in which abortion is legally restricted.
- Identify the factors that influence the extent to which these approaches can be replicated in different humanitarian settings.
- Compare the feasibility and effectiveness of different approaches to increasing access to safe abortion care in legally restricted humanitarian settings.

Study Design & Analysis Approach

We are proposing to document experiences and lessons learned from innovative approaches to increasing access to safe abortion care in legally restrictive, humanitarian settings.

Phase 1: Comprehensive case studies of approaches to safe abortion care in legally restrictive humanitarian settings already conducted or in progress.

Humanitarian actors will document the context, program, data collection methods, results and lessons learned from implementing safe abortion care in legally restrictive, humanitarian settings. We are interested in case studies of programs implemented in a variety of abortion legal contexts (e.g. life only indication, life + health indication, life + health + rape/incest indications and countries that have recently reformed their abortion laws), geographic settings, and emergency phases (acute and protracted, conflict and natural disaster). Innovative approaches to safe abortion care service delivery can include, but not be limited to:

- **Safe abortion care to the full extent of the law:** In this approach, humanitarian actors make safe abortion care available for the indications permitted by law. This approach will likely include expanded definitions of the legal indications to increase access and potentially revision or development and implementation of local policies and protocols on safe abortion care.
- **Harm reduction:** This approach includes the provision of information with or without commodities on safe self-induction of abortion to reduce harm from unsafe abortion. This approach may include interventions at the health facility and/or community level.
- **Referral for safe abortion care:** The approach involves a health response in which supported health facilities systematically refer and follow-up clients seeking safe abortion care to organizations/providers already offering high quality services.
- **Provision of safe abortion care for all indications, regardless of legal contexts:** This approach would involve providing safe abortion care on request, despite the restricted legal context, likely based on the humanitarian imperative to provide life-saving services. This may also include provision “to the full extent of the law” in which the law is purposefully interpreted to permit abortion on request, as a matter of a woman’s life and health.
- **Post-abortion care as a gateway to safe abortion care:** This approach would document the extent to which a post-abortion care program enables the provision of safe abortion care under the auspices of PAC. Documenting this would require the triangulation of data collection methods over time to determine changes in the provision of SAC over time in a PAC program.

Phase 2: The replication and comparison of promising and successful approaches for increasing access to safe abortion care in legally restrictive, humanitarian settings.

Part A: Replication of successful and promising approaches

Based on the experiences and lessons learned from approaches in Phase I, humanitarian actors will replicate one or more successful or promising approaches in a different legally restrictive, humanitarian setting. The implementers would then document the context, program, data collection methods, results and lessons learned from their experiences, while referencing and comparing their experience to that of the previous case study they replicated.

Part B: Comparing successful and promising approaches

Based on the experiences and lessons learned from approaches in Phase I, humanitarian actors will implement two or more promising and successful approaches alongside one another in the same settings to determine the comparative feasibility and effectiveness. The implementers would then document the context, program approaches, data collection methods, results and lessons learned and describe the factors that influenced the feasibility and effectiveness of each approach.

Methods

For the first phase of the project, project specific teams will use case study methodologies to explore and document programmatic efforts, outcomes, and lessons learned. These will likely involve a number of data collection methods and will be aided by a template.

The second phase of the project (both Parts) is dependent on the Phase 1 results and thus the methods cannot be determined at this time. However, all efforts at replication and comparison will involve rigorous monitoring and evaluation plans that will be developed at the outset of the initiative.

Past experience of researchers on abortion in humanitarian settings indicates that it will be possible to get ethics approval.

Ensuring diversity based on region, type of emergency, and the legal status of abortion is critical for the findings from this project to be transferable.

Analysis

The analysis plan for each case study in Phase 1 will likely include both descriptive statistics and content and thematic analyses using inductive and deductive techniques. The final phase of the analytic plan will involve triangulation of information with particular attention to concordant and discordant findings. We will later combine the findings from all case studies to provide a more comprehensive picture of feasible and effective models for SAC in legally restricted humanitarian settings. This will enable development of a tool kit that will help advance Phase 2 of the initiative.

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Concept Note 10: Strategies for Facilitating Uptake and Implementation of Global Guidelines Regarding Safe Abortion Care and Post Abortion Care

Purpose

The purpose of this study is to document the policy and service delivery uptake of the global guidelines regarding the provision of safe abortion care (SAC) and post-abortion care (PAC) at the onset of a humanitarian emergency.

Problem Statement

The 2018 Inter-Agency Field Manual (IAFM) outlines new global guidelines regarding the provision of SAC and PAC at the onset of an emergency. These guidelines focus on 1) provision of SAC or referral for SAC to survivors of sexual violence, to the full extent of the law (under Objective #2); 2) provision of PAC (under Objective #4); and provision of SAC to the full extent to the law (other priority activity). Uptake of new global guidelines is always a process and merits assessment. However, the historic lack of prioritization of SAC at the onset of an emergency means that these guidelines differ significantly from current policies and practices. More information is needed about effective strategies for encouraging uptake and use of these guidelines to support humanitarian actors to affect institutional change.

Justification

Addressing this problem is important because SAC and PAC are lifesaving interventions for women and girls in crisis and are now incorporated into the MISP chapter of the 2018 IAFM. Specific strategies are needed to ensure the new guidance translates to services on the ground.

Research Question

What are feasible and effective strategies for facilitating uptake (as a matter of policy) and implementation (as a matter of service delivery) of the global guidelines regarding SAC and PAC as outlined in the MISP chapter of the 2018 IAFM?

Research objectives

1. Establish baseline SAC and PAC policies and practices at the onset of a humanitarian emergency;
2. Document changes in policies and practices over a five year period that reflect uptake of the SAC and PAC guidelines;
3. Attempt to quantify the extent to which SAC and PAC are offered during acute crises at baseline and following implementation of the global guidance;
4. Identify the factors that influenced changes in policies and practices; and
5. Share findings with international, regional, national, and local stakeholders to facilitate further uptake of and adherence to the guidelines.

Study Design & Analysis Approach

This is a longitudinal mixed-methods study based on a concurrent explanatory design. The project will engage with three specific populations: Ministries of Health, donors, UN agencies and international non-governmental organizations, and field-level practitioners.

1. We will conduct a baseline assessment of current policies and recent practices regarding SAC and PAC at the onset of an emergency. This includes a global online survey, key informant interviews, and a review of policy statements, organizational guidelines, and relevant institutional documents. We will also purposively select 10 countries that have recently implemented the MISP for field-level assessment.
2. We will conduct an assessment after 1-2 years to understand any changes in policies (as reflected in organizational documents, an online survey, and key informant interviews) and practices (as reflected in in-depth assessments in a sample of countries where acute emergencies that have taken place). We will explore any trainings or programmatic interventions that have taken place since the launch of the IAFM that have focused on the MISP, in general, or SAC and PAC in the MISP, in particular. We will explore those case studies in-depth. We understand that policies and practice can change for a variety of reasons. Assessments will consider external factors and not assume causality.
3. We will conduct a final assessment at 5 years to explore changes in policies (at the MOH, donors, UN agency, and international NGO levels) and practices (at the field-level). This mixed methods study will again combine document review, a global survey, key informant interviews, and case-study methodology to explore facilitators, barriers, and lessons learned.

At the end of the five-year study period we expect to have a comprehensive understanding of the factors that influence the implementation of SAC and PAC in the acute phase of emergencies.

Methods

Target Population

- Ministries of Health
- UN Agencies
- International non-governmental organizations
- Field-level practitioners

Sampling Process

1. For the baseline, 1-2 year, and 5 year global surveys we will invite representatives from donors agencies, UN agencies, and international NGOs to participate. This will include those agencies focused on sexual and reproductive health and MISP implementation as well as those focused on health and protection in humanitarian settings more generally. As individual staff change over time, we will use the organization as the unit of analysis. We will ask representatives from these same agencies to participate in key informant interview during all three study stages.
2. For the baseline assessment of Ministries of Health and of field-level implementation we will purposively select 10 countries that have recently (within 3 years of the launch of the global guidelines) experienced an acute crisis and implemented the MISP. In order to support the transferability of results, we will select a diverse range of countries with respect to region, legal status of abortion, and type of emergency. At 5 years, we will follow-up with the Ministries of Health in the same 10 countries.
3. For the 1-2 year and 5 year assessments of field-level practices, we will focus on countries that have experienced an acute crisis and implemented the MISP since the launch of the 2018 IAFM. We will select a sub-set of countries that have implemented the guidelines and/or changed practices for in-depth analysis using case study methodology.

Types of data to be collected

- Document and policy statement review (MOH, UN agencies, international iNGO)
- Global online survey (UN agencies, international NGOs)
- Key informant interviews (MOH, UN agencies, international NGOs)
- Field-level assessments (multiple data collection methods including facility and provider surveys, review of institutional data, key informant interviews, focus group discussion)
- In-depth assessment to document field-level change (case study methodology)

This type of assessment requires a mixed methods approach. Results integration and triangulation will occur during each stage as well as the end of the 5 year project.

We will assemble an advisory board from members of the Safe Abortion Care Sub-Working Group, the MISP Sub-Working Group, and Steering Committee of IAWG to provide feedback on instruments. One multi-disciplinary team combined with local partners will collect all primary data. We will also ensure that this project is coordinated with the Training Partner Initiatives.

We do not anticipate there being challenges obtaining ethics approval to complete this study. We will receive provisional approval with the understanding that specific sites will be specified as emergencies arise.

Ensuring diversity based on region, type of emergency, and the legal status of abortion is critical for the findings from this project to be transferable.

Analysis Plan

We will use a combination of quantitative and qualitative analytic techniques to engage with our data. As this is a concurrent explanatory study we intend to analyze data for each component they are acquired and have identified multiple points of interface.

This study has the potential to provide essential information about the uptake of SAC and PAC at the onset of a humanitarian emergency. Working with the IAWG SAC Sub-Working Group, we will develop and implement a multi-dimensional knowledge translation and mobilization strategy.

For questions, contact: Michelle Hynes (mhynes@cdc.gov) and Sara Casey (sec42@columbia.edu)

Appendix C: Workshop on Sexual and Reproductive Health Research Priorities in Humanitarian Settings - Participant List

#	Name	Organization
1	Allie Doody	PAI
2	Angel Foster	Cambridge Reproductive Health Consultants
3	Ann Moore	Guttmacher Institute
4	Anne Harmer	Elrha's Research for Health in Humanitarian Crises (R2HC) Programme
5	Bergen Cooper	Center for Health and Gender Equity (CHANGE)
6	Cristina De Carvalho Eriksson	UNICEF
7	Dabney Evans	Emory University
8	Erin Wheeler	International Rescue Committee
9	Grady Arnott	Center for Reproductive Rights
10	Hannah Tappis	Jhpiego
11	Heather Howard	American Refugee Committee
12	Henia Dakkak	UNFPA
13	Hussein Had	Save the Children Somalia
14	Jennifer Schlecht	Family Planning 2020
15	Kate Meehan	US Centers for Disease Control and Prevention
16	Kathleen Myer	Office of U.S. Foreign Disaster Assistance
17	Kathryn Roberts	IPPF - Latin America and the Caribbean Region
18	Katinka Moonen	Oxfam Novib
19	Klara Christensen	Danish International Development Agency
20	Lara Martin	Emory University
21	Lene Aggernæs	Danish International Development Agency
22	Loulou Kobeissi	World Health Organization
23	Meghan Gallagher	Save the Children
24	Melissa Sharer	John Snow, Inc. (JSI)

#	Name	Organization
25	Miranda Meys	Independent Consultant for SRH and SRH in Emergencies
26	Michelle Hynes	US Centers for Disease Control and Prevention
27	Monica Onyango	Boston University
28	Nadine Cornier	UNFPA
29	Qamar Mahmood	International Development Research Centre (IDRC)
30	Robyn Drysdale	International Planned Parenthood Federation (IPPF)
31	Sandra Krause	Women's Refugee Commission
32	Sara Casey	Columbia University, Reproductive Health Access Information and Services in Emergencies (RAISE) Initiative
33	Shible Sahbani	UNFPA - Middle East and North Africa Region
34	Shirin Heidari	Independent Consultant/Senior Fellow, Global Health, the Graduate Institute of International and Development Studies
35	Tamara Feters	Ipas
36	Lale Say	World Health Organization



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