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2gether 4SRHR

Handbook for
Conducting Multi-stakeholder Vulnerability Assessments
for SRHR, HIV, and GBV in Humanitarian Settings

UNAIDS

UNFPA

unicef
for every child

World Health Organization

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Abbreviations

ESA	Eastern and Southern Africa
ESARO	Eastern and Southern Africa Regional Office
GBV	Gender-Based Violence
HESPER	Humanitarian Emergency Settings Perceived Needs Scale
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
HIV	Human Immunodeficiency Virus
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning
OCHA	Office for the Coordination of Humanitarian Affairs
MISP	Minimum Initial Service Package for Sexual and Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WRC	Women's Refugee Commission

Foreword

In our rapidly changing world, humanitarian crises—whether sudden or slow in onset—pose complex challenges that affect the most vulnerable in our communities disproportionately. Among those bearing the brunt of these emergencies are women and girls, people living with HIV, individuals in key populations at risk of HIV, and persons with disabilities. These groups often face heightened risks to their sexual and reproductive health and rights (SRHR), are exposed to an increased threat of gender-based violence (GBV), and encounter systemic barriers in accessing crucial health services. Displacement, disrupted social networks, and service breakdowns only compound these vulnerabilities, underscoring the critical need for more inclusive and responsive vulnerability assessments.

This handbook, developed under the 2gether 4 SRHR programme by four leading United Nations agencies—UNFPA, UNICEF, UNAIDS, and WHO—seeks to address this urgent need by introducing a harmonized framework for integrating SRHR, GBV, and HIV into vulnerability assessments across humanitarian settings. Rooted in the findings of an extensive study conducted from 2021 to 2023, it represents a milestone in collaborative humanitarian work, informed by consultations across regional, national, and community levels.

The tools and guidance within these pages are designed to empower humanitarian agencies, national governments, and community-based organizations to integrate SRHR, GBV, and HIV considerations into their assessments with greater nuance and flexibility. By facilitating the collection of local, community-based perspectives, the handbook ensures that those most affected by crises are no longer passive recipients but active contributors in identifying and addressing their own needs.

We invite humanitarian practitioners, government stakeholders, and local organizations to leverage this handbook as a comprehensive guide for conducting vulnerability assessments that prioritize resilience, inclusion, and the rights of the most vulnerable. May this resource support your vital work to ensure that humanitarian responses are truly reflective of, and responsive to, the voices and needs of those at the heart of the crisis.

1 Introduction

Vulnerable groups, including women and girls (especially adolescent girls and young women), people living with human immunodeficiency virus (HIV), key populations at risk of HIV, and persons with disabilities, are affected disproportionately in both slow- and sudden-onset emergencies, as well as in conflict and post-conflict situations (OCHA, n.d.). They face multiple sexual and reproductive health and rights (SRHR) challenges, such as early or unwanted pregnancy and an increased risk of gender-based violence (GBV) and HIV infection.[1]

[1] Extensive information on food insecurity in the context of climate-related hazards is available on the websites of the principal humanitarian agencies such as OCHA (https://reliefweb.int/countries). Specific information on SRHR, GBV and HIV in humanitarian situations can be found on the UNFPA website (https://www.unfpa.org/data), the GBV Information Management System website (https://www.gbvims.com/what-is-gbvims/) and the WHO Maternal, Newborn, Child and Adolescent Health portal (https://platform.who.int/data/maternal-newborn-child-adolescent-ageing).

Vulnerable groups face obstacles to exercising their sexual and reproductive health (SRH) rights due to stigma and discrimination within the community and from health service providers. They may be hard to identify and reach through health and outreach services, and stigma or discrimination makes them reluctant to use services. Changes resulting from emergencies can sever their support systems, reduce access to services and increase their vulnerability. These groups require additional support and heightened awareness of their needs, as well as opportunities to make their voices heard in planning for slow- and sudden-onset emergencies and in programmes to strengthen community resilience and reduce vulnerabilities (UNICEF, n.d.).

Vulnerability assessments in emergencies and slow-onset humanitarian situations are a key element in providing support and strengthening resilience. While women, girls and affected populations face complex and varying vulnerabilities, existing standard vulnerability assessment tools do not include a systematic review of the potential impact of humanitarian crises on SRHR needs, including the heightened risk of GBV and other harmful practices. Efforts have not been made to harmonize vulnerability assessment tools for SRHR, GBV and HIV among humanitarian agencies. Although many United Nations agencies have been working on humanitarian response for decades with well-established coordination mechanisms, there are still important gaps in responding to the SRHR, GBV and HIV needs and priorities of vulnerable groups, and in working closely with the communities to ensure vulnerability assessment that focuses on perspective of their changing needs. Harmonization of SRHR, HIV and GBV in vulnerability assessments is an important step to address these gaps.

In order to address these gaps, a study was commissioned by four United Nations agencies (UNFPA, UNICEF, UNAIDS and WHO) working in the 2gether 4 SRHR programme in Eastern and Southern Africa (ESA).[2] The study took place between 2021 and 2023. It was a highly participative, consultative process and involved United Nations and other stakeholders at regional, country and community levels.[3] It highlighted how SRHR, GBV and HIV relate to the integral needs of people in humanitarian

[2] *Harmonization of Vulnerability Assessment Tools for Sexual and Reproductive Health and Rights, HIV and Gender-Based Violence in Humanitarian Settings* (Final Report 2023).
[3] The people interviewed as part of the different deliverables during the process are listed in the respective deliverables.

situations and aimed at harmonizing the United Nations agencies' own vulnerability assessment tools in slow and sudden-onset humanitarian settings. It also aimed at providing a framework to integrate SRHR, GBV and HIV assessments within the context of the national health sector and the work of other humanitarian response agencies.

This handbook builds on the findings obtained from the study referenced previously and presents a module to harmonize vulnerability assessment tools for SRHR, GBV and HIV among humanitarian agencies. A core objective is to integrate these areas into the principal vulnerability assessments carried out in other sectors such as food security, livelihoods, and water, sanitation and hygiene (WASH). Each humanitarian situation has its own characteristics, so flexible tools are needed to respond different types of emergencies and different community contexts, incorporating SRHR issues in 23 countries in ESA.

The handbook and the flexible tools in the module are designed for humanitarian response agencies and practitioners within and outside the United Nations who want to integrate SRHR, GBV and HIV into their vulnerability assessments, for national governments, community-based organizations and stakeholders who want to strengthen resilience.

This handbook is a practical tool that is designed to be user-friendly for vulnerability assessment managers, planners and fieldworkers, and has been streamlined to focus clearly on essential information for using the tools in the field. It includes a summary of some key results of the study that explain the reasons for the content and structure of the tools. Users who require more details are referred to the final study report (UNFPA, 2023).

The handbook includes the following sections:

Why is the module needed?	**What can the module do?**	**What does the module cover?**	**Guidance on how to use the module**

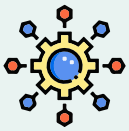
The tools themselves are presented in Annex 1. Ethical considerations are included in Annex 2. Annex 3 provides a glossary of key terminology used in English and French. Instructions for interviewers are included in Annex 4. Annex 5 provides an example of the data collection sheet.

[3] The people interviewed as part of the different deliverables during the process are listed in the respective deliverables.

Why is the module needed?

As outlined previously, the study commissioned by UNFPA, UNICEF, UNAIDS and WHO identified a set of gaps in existing vulnerability assessments for responding to the SRHR, GBV and HIV needs and priorities of vulnerable groups, and in working closely with the communities to ensure the vulnerability assessment that focuses on perspective of their changing needs.

The following needs were identified by the study for existing vulnerability assessments.



Need for harmonization and integration with existing tools.

In the fields of SRHR, GBV and HIV, tools have already been designed to assess vulnerability to changes in service delivery, access to services, supplies and resources, and community knowledge of rights. Tools are also available for vulnerability assessment in food security, WASH and primary health, and some of them include aspects of SRH and GBV. Most existing tools work from a supply-side perspective rather than a community perspective. The tools in this module are based on existing tools developed by the Women's Refugee Commission (WRC, 2021) and the World Health Organization (WHO, 2011) that do collect information from communities and vulnerable groups.[4]

Need to fill gaps in existing vulnerability assessment through collection of local and community information and perspectives on vulnerability.

Communities and individuals in vulnerable groups have different perspectives and priorities from decision makers. Their own assessments of their vulnerabilities are a key entry point for effective support, and their voices must be heard in identifying priorities. Few existing tools and processes focus on the communities' and vulnerable groups' own perceptions of their SRHR, GBV and HIV priorities and needs and how these are affected by slow- and sudden-onset crises. Their input complements information from other vulnerability assessments and involves the community in identifying challenges and planning for resilience.

Need to highlight to decision makers the importance of input from community members (men, women, boys and girls) to identify priorities and specific needs of vulnerable groups.

Decision-making on the allocation and management of resources for humanitarian response and strengthening resilience is constrained by policy, resource availability and decision makers' own perceptions, among other factors. Decisions will respond better to real needs and foster community participation when communities and vulnerable groups themselves participate in assessments.

[4] This adaptation was not created by WHO. WHO is not responsible for the content or accuracy of this adaptation. The original edition shall be the binding and authentic edition.

Need for flexible tools and processes for use in different contexts and types of humanitarian situations (slow and sudden onset, natural disaster, human-made disaster, conflict).

Every context has its own characteristics that affect vulnerabilities and priority needs. Tools are required that can be adapted to contextual factors but are still able to harmonize and integrate vulnerability assessment of diverse actors and stakeholders.

Need to strengthen the integration of SRHR, GBV and HIV at the nexus of humanitarian and development work.

Humanitarian response and development are closely linked and should dovetail closely. Information on underlying vulnerabilities is an important input for both humanitarian response and ongoing sector planning to meet needs, and it can strengthen work to build resilience at community level. Incorporation of this information into sector planning processes will support the institutionalization of vulnerability assessment.

What can the module do?

This module aims to contribute to addressing the needs outlined previously. It can do the following:

Give a voice to the people affected by humanitarian situations, including the most vulnerable groups.

The module includes tools that explore the SRHR, GBV and HIV needs of vulnerable groups in depth, and clarify their own priorities in humanitarian response.

Identify female and male community members' and specific vulnerable groups' own perception of their vulnerabilities, as the first step in meeting their needs and strengthening their resilience.

This information from the module will contribute to better preparedness on SRHR, GBV and HIV in emergencies and slow-onset humanitarian situations at the local level. A better understanding of vulnerabilities will strengthen existing national disaster preparedness and response plans and strengthen resilience.

Identify the differences between groups' perceptions of their needs.

Some of these may not be aligned to national priorities or health service providers' perspectives. The tools highlight the different responses of community members, vulnerable groups, policymakers and service providers to a range of questions covering SRHR, GBV and HIV topics, enabling a comparison of responses between and within groups (e.g., between service providers in health facilities and community health workers; between men and women; between different vulnerable groups).

Compare and contrast differences between localities and countries.

The tools are community based to ensure vulnerability assessment identifies people's needs in their specific locations. Comparison of the information from different zones and diverse humanitarian situations will contribute towards both strengthening resilience at the local level and formulating policy to increase resilience in a range of contexts.

Strengthen participative processes with buy-in from a wide range of stakeholders.

The module was developed through participative processes. It responds to and integrates the interests and priorities of a range of institutional stakeholders. And it builds on the challenges and opportunities identified by stakeholders on the ground.

Provide flexible tools and processes that can be adapted and integrated by practitioners doing ongoing vulnerability assessments.

The design of the tools as a separate module allows users flexibility in decision-making on the following:

- Which questions should be selected to cover priority themes for each specific context?
- Who are the key participants in SRHR, GBV and HIV vulnerability assessment?
- Who should lead the process for harmonization and integration with other vulnerability assessments, and with which other sectors and programmes (food security, health, emergency response, etc.)?
- Who will provide the human and financial resources? These are low-cost tools and will need few additional resources when integrated with other vulnerability assessments?

Users can focus on the elements of each tool that cover their own area of work and also include selected questions on the other SRHR, GBV and HIV themes to maintain the capacity to harmonize and integrate with other stakeholders. The handbook

indicates specific areas where local adaptations may be needed – for example, language and terminology should reflect community usage. Field staff can be trained by United Nations agencies, skilled local organizations, or consultants conversant with SRHR, GBV and HIV (non-governmental organizations, community health workers) and can be contracted for data collection.

Complement ongoing regional and national assessments or used as a stand-alone module.

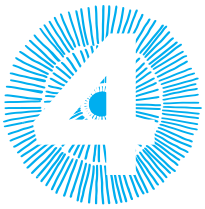
The module can be used to complement ongoing national and regional vulnerability assessments of all types. It provides qualitative information that relates SRHR, GBV and HIV priorities to those in other sectors, and focuses on the specific SRHR, GBV and HIV needs of those affected by humanitarian situations. It also provides information for in-depth exploration of vulnerable groups' needs at specific local levels. Although it was designed for countries in ESA, it can be adapted for use in other countries and regions.

Support national in-country and regional discussions for promoting the integration of SRHR, GBV and HIV into vulnerability assessment.

By focusing on the SRHR, GBV and HIV vulnerabilities of people most affected by humanitarian situations, information from the tools will highlight needs in order to strengthen the links between policy and practice in SRHR, GBV and HIV, and to integrate these areas into vulnerability assessment of other sectors (infrastructure for access, food security, protection, WASH, etc.).

Table 1. How the module addresses the needs identified by the study

Needs identified	How the module addresses these needs
Need for harmonization and integration with existing tools.	● Complements ongoing regional and national assessments or used as a stand-alone module.
	● Provides flexible tools and processes that can be adapted and integrated by practitioners doing ongoing vulnerability assessments.
	● Supports national in-country and regional discussions for promoting the integration of SRHR, GBV and HIV into vulnerability assessment.
Need to fill gaps in existing vulnerability assessment through the collection of local and community information and perspectives on vulnerability.	● Gives a voice to the people affected by humanitarian situations, including the most vulnerable groups.
	● Identifies female and male community members' and specific vulnerable groups' own perception of their vulnerabilities as the first step in meeting their needs and strengthening their resilience.
Need to highlight to decision makers the importance of input from community members (men, women, boys and girls) to identify the priorities and specific needs of vulnerable groups.	● Gives a voice to the people affected by humanitarian situations, including the most vulnerable groups.
	● Identifies the differences between groups' perceptions of their needs.
Need for flexible tools and processes for use in different contexts and types of humanitarian situations (slow and sudden onset, natural disaster, human-made disaster, conflict).	● Provides flexible tools and processes that can be adapted and integrated by practitioners doing ongoing vulnerability assessments.
	● Compares and contrasts differences between localities and countries.
Need to strengthen integration of SRHR, GBV and HIV at the nexus of humanitarian and development work.	● Strengthens participative processes with buy-in from a wide range of stakeholders.
	● Motivates community participation for building resilience.
	● Supports national in-country and regional discussions for promoting the integration of SRHR, GBV and HIV into vulnerability assessment.



What does the module cover?

The module is a set of six questionnaires to assess the vulnerability of different groups of respondents. Together they can provide a perspective on community vulnerabilities and priorities from both the demand side (service users) and the supply side (service providers). The questionnaires and guidance for using them are designed for use at the community level.

The module was compiled by selecting and adapting questions from the Women's Refugee Commission (WRC) *Capacity and Needs Assessment Tools to Build Community Resilience* (WRC, 2021a), the WRC Facilitators Kit that accompanies the tools (WRC, 2021b), and the WHO/King's College *Humanitarian Emergency Settings Perceived Needs Scale* (HESPER) tool[5] for determining community and individual vulnerabilities in humanitarian situations.[6] They were complemented with new questions to cover additional points identified by the 2gether 4 SRHR partners and other stakeholders. The tools in the module focus on ongoing vulnerability, particularly vulnerability to slow-onset and long-term humanitarian situations, including those resulting from climate change. They explore communities' and individuals' own priorities and perceptions of vulnerability. The tool selection and adaptations were validated in participative stakeholder workshops and pilot-tested in the five study countries.

Tools 1 to 5 are questionnaires for the following:

- **Policymakers:** district disaster management staff, mayor or chief medical officer
- **Health service providers:** health facility manager or clinical staff
- **Community health service providers:** community health workers, outreach workers, peer educators and other community resource persons
- **Community based organizations:** representatives of civil society organizations or networks, community leaders, and teachers
- **Community respondents from vulnerable groups:** women, adolescent girls, and at-risk groups including LGBTIQ, people with disabilities, sex workers and other minority groups

Tool 6 identifies community perceptions and priorities for SRHR, GBV and HIV in comparison with other humanitarian needs. It uses the WHO/HESPER methodology, with additional questions focusing on SRHR, GBV and HIV. It can be used with people from SRHR-, GBV- and HIV-vulnerable groups, including women, adolescent girls, and at-risk groups including LGBTIQ, people with disabilities, sex workers and other minority groups. It aims to relate SRHR, GBV and HIV to other priority needs, and will be especially important for integration with vulnerability assessment work in other sectors such as food security, infrastructure and WASH.

The module was developed through a multi-stakeholder participative process of design and field testing, with input from United Nations agencies, humanitarian organizations, local and community organizations, policymakers, service providers, and service users. The final versions of the tools and guidance include input and suggestions from all these actors.

The tools are presented in Annex 1.

[5] This is an adaptation of an original work: *Humanitarian Emergency Settings Perceived Needs Scale* (Geneva: World Health Organization). This adaptation was not created by WHO. WHO is not responsible for the content or accuracy of this adaptation. The original edition shall be the binding and authentic edition.

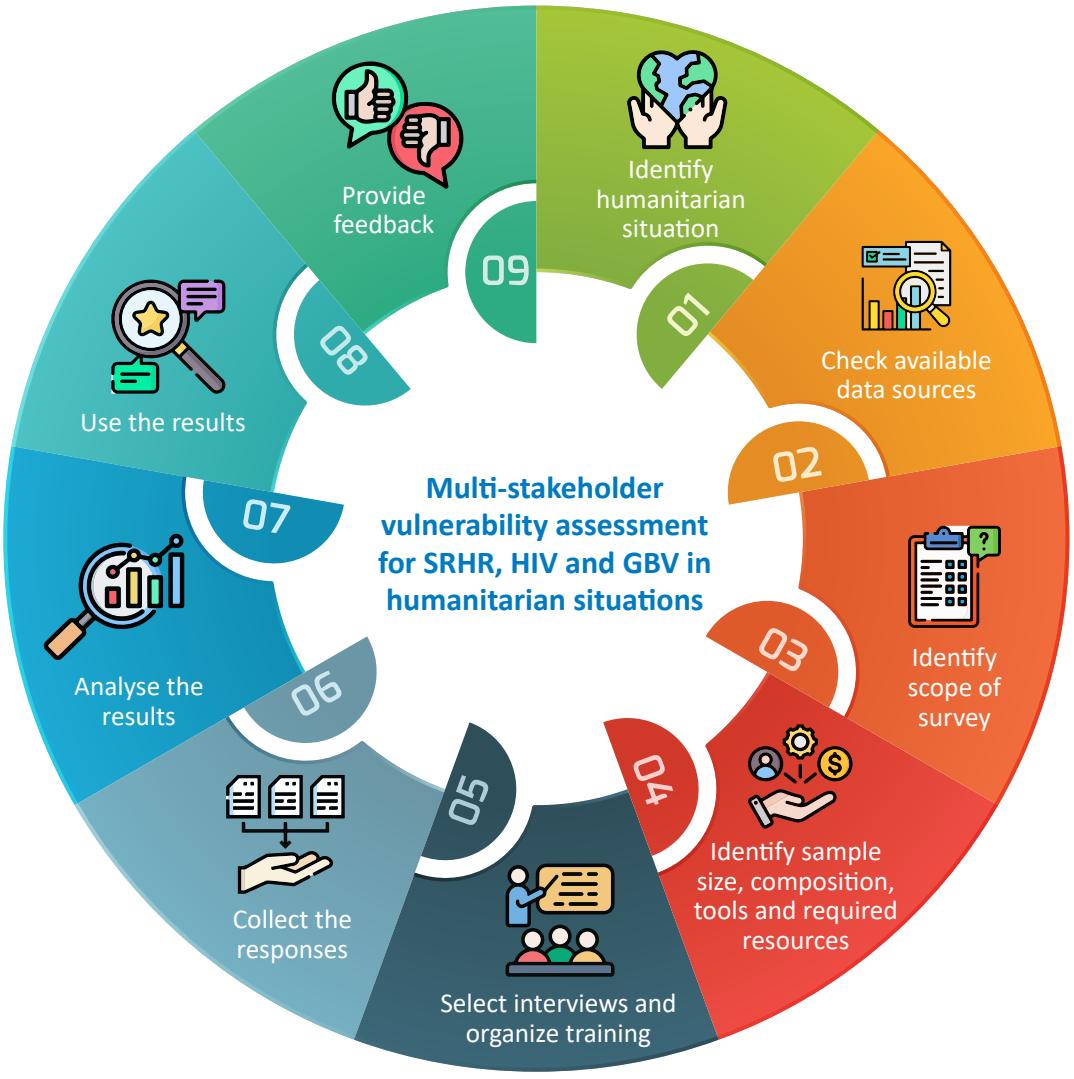
[6] These tools were identified as being the most appropriate ones for adaptation and modification during the study commissioned by UNFPA, UNICEF, UNAIDS and WHO working in the 2gether 4 SRHR programme in eastern and southern Africa. The study reviewed and assessed 31 existing tools in terms of the type of crises; coverage of SRHR, GBV and HIV; target groups covered; and integration with other sectors.

Guidance on how to use the module

This guidance is for planners and managers of vulnerability assessments, for field staff carrying out interviews, and for people using the information. It encourages planners and managers of vulnerability assessments to consider integrating tools and questions related to SRHR, HIV and GBV into ongoing vulnerability assessments or – in case it is not possible and decision makers want to collect qualitative information on SRHR, HIV and GBV – the tools can also be used as self-standing assessments. The guidance includes the six questionnaires (Annex 1), ethical considerations (see Annex 2), a glossary of SRHR, GBV and HIV terminology (Annex 3), instructions for interviewers (Annex 4), an example of a data collection sheet (Annex 5), and reflections on how the data can be used for advocacy at the national level and for decision-making.

The steps for using the tools are present in Figure 1 and the following sections.

Figure 1. Steps for undertaking vulnerability assessment on SRHR, HIV and GBV in humanitarian settings



5.1 PRIOR TO USING THE MODULE

As a starting point, it is important to identify how questions on SRHR, GBV and HIV can be integrated with other existing vulnerability assessments being planned or taking place on a regular basis or at the onset of a humanitarian situation in your country.

To do this, it is suggested that you do the following:

Map the scope and timing of existing vulnerability assessments where inclusion of SRHR, GBV and HIV is appropriate at country or regional levels.

Advocate for the **integration of SRHR, GBV and HIV** into ongoing vulnerability assessments with decision makers and national, regional and international coordination mechanisms.

Share the handbook widely, particularly with existing inter-agency coordination mechanisms.

Develop plans to use the tools in specific situations (such as post-emergency recovery and resilience building and preparedness/response planning).

Identify how to address potential obstacles to taking the work forward.

5.2 PREPARATION PHASE

5.2.1 Identify the humanitarian situation for which you want to assess the vulnerability

The humanitarian situation you select will affect the time and resources needed, challenges you may have to address, and partnerships you will need.

Take the following into account:

- The type of humanitarian situation (slow/sudden onset, protracted). For example, in slow-onset and protracted situations people may have already adapted by strengthening their existing support mechanisms or developing new ones. Vulnerability assessment teams will also have more time to organize and prepare. In contrast, vulnerability may be more acute in sudden-onset situations. The resources needed for vulnerability assessment in sudden-onset situations will differ too – sudden-onset crises may cause access problems for interviewers, and it may take longer to locate respondents. It is preferable for teams to be organized in advance and be ready to operate at short notice.

- The location and geographical accessibility. These should be taken into account and anticipated as much as possible. Remote areas with difficult access will require more time and incur more transport and staff costs.

- The reason for the vulnerability assessment (e.g., to dovetail with development work; to strengthen resilience; to prepare for emergencies; for advocacy). For example, if the purpose is to dovetail with development work, vulnerability assessment teams will need to spend more time on coordinating with development partners; if the purpose is to strengthen resilience, more time may be needed on community interviews. As the tools emphasize on the community perspective, they can also complement information collected by other assessments in humanitarian emergencies.

5.2.2 Check for existing complementary data

There may be existing data on key SRHR, GBV and HIV indicators such as skilled birth attendance, use of pre- and post-natal services, family planning users, antiretroviral users, and GBV services.

Quantitative data is available from the national health information system and should be disaggregated to community or health facility levels. The Demographic and Health Survey and other surveys such as the Multiple Indicator Cluster Survey (MICS) may not be sufficiently disaggregated to be useful at the local level. Municipal and district governments, local authorities for health, education and community development, and local community-based organizations also collect data that you may be able to access.

The data can be triangulated with information from the module questionnaires, and can also be used to compare and contrast results.

5.2.3 Identify the scope of the survey

In this step, we identify who will conduct the survey; whether it can be included in an existing assessment or should be used as a self-standing survey; and who will provide resources.

If you are integrating the module with other assessments, it is important to check whether the existing lead organization has field staff who can be trained in SRHR, GBV and HIV work. Although the module is a low-cost solution for the integration of SRHR, GBV and HIV, it is important to estimate the additional time and effort that will be required, as well as the transport and other costs that will be needed, and check if the lead organization can supply these resources. This type of survey can be conducted by a small team of two or three interviewers with a vehicle in each community. If the lead organization is working in the same locations as the SRHR, GBV and HIV vulnerability assessment, transport costs should be reduced. If lead agency staff can be made available, the only additional costs will be for staff training and extra working time for field staff to carry out the SRHR, GBV and HIV interviews.

For stand-alone surveys, estimate all the resources needed for staff, training, transport and data processing. A small team of two or three can also be used for the stand-alone surveys. If you need to carry out the work faster or cover a larger number of communities, you can use more interviewer teams, who will need transport. Identify whether your organization has field staff or will contract a

local organization. It may be more cost-effective to contract a local organization, given the added advantage of their local knowledge and contacts.

For both methods, the budget should include costs for the hiring of comfortable, safe spaces for interviews, along with travelling costs and refreshments for respondents.

5.2.4 Identify which tools to use and whether adjustments are needed

The module is flexible, and users can select tools and questions that reflect their interests. For example, if your focus is GBV you may not need to include all the questions on SRHR or HIV; if you are working only with specific key populations or vulnerable groups, you may select respondents from those groups and omit the others. If you are aiming to integrate SRHR, GBV and HIV with vulnerability assessment of other sectors, you may want to emphasize the use of Tool 6, which is designed to identify links and relative priorities between SRHR, GBV and HIV, other health needs, and vulnerabilities in other sectors.

Check with local leaders, community-based organization members and/or health facility staff for specific sensitivities or taboos in the discussion of SRHR, GBV and HIV topics, as well as the local words used for SRHR, GBV and HIV themes and services. You may also find it helpful to discuss with the stakeholders ways to introduce questions on sensitive topics that are important in SRHR, GBV and HIV vulnerability assessment but may not align with national policy or the legal environment (such as safe abortion and adolescent access to services). You may need to adjust the wording of the questions to take these points into account.

Finally, it is also important to check if translation to a local language is needed.

5.2.5 Identify the sample composition and size, and how respondents will be contacted

The questionnaires are not designed to collect quantitative data or carry out statistical analysis – the module is aimed at providing qualitative insights on community perspectives to help respond better to community needs.

The tools are directed towards policymakers (Tool 1), health providers (Tool 2), community health workers (Tool 3), community members (Tools 4 and 6), and community-based organizations (Tool 5). It is important to identify the most relevant stakeholders to include in the vulnerability assessment. Criteria to consider for policymakers and community-based organizations are their level of involvement and influence in the response to the humanitarian situation and their role/activities in SRHR, GBV and HIV. Similarly, involvement in humanitarian response could be an important criterion for health workers and community health workers, and their level of integration with the community is a key factor. It is important to include a range of community members. These may include (but should not be restricted to) traditional and religious leaders, teachers, vulnerable groups, and key populations you are interested in (e.g., adolescent girls, young women, pregnant women, elderly persons, less-abled people, HIV key populations, etc.). It is recommended that you map out the various types of community inputs you need to ensure good coverage.

Samples should be structured to include several respondents from each of the target groups. The overall sample size will depend on resources available. If you have enough resources, you can aim for 'saturation' and continue interviewing until you are not getting any important additional information.[7] The number of interviews for saturation will vary between locations and community characteristics. Respondents from close-knit communities may have more shared vulnerabilities and priorities than more dispersed populations; larger samples may be more convincing for decision makers if the results are to be used for advocacy, but may not provide more useful information and will be costlier. Even if the sample is small, it should include a minimum of five community respondents from different vulnerable groups to reduce the risk of atypical responses. The same minimum of five respondents can be used for local and community decision makers and service providers (health facility staff and management,

[7] "Saturation is achieved when any further data collection would not result in the identification of a new theoretical category that would be useful for understanding and explaining the analysed occurrence." https://www.researchgate.net/publication/349872963_DETERMINING_THE_SAMPLE_SIZE_IN_QUALITATIVE_RESEARCH.
For more formal qualitative research, sample sizes for saturation are small, with a total of between 9 and 17 interviews. https://www.sciencedirect.com/science/article/pii/S0277953621008558.

community leaders), ensuring that the samples include both female and male respondents.

Methods for selecting respondents include purposive, quota, snowball and convenience sampling.[8] By designing each questionnaire for a specific group of respondents, the module implicitly uses purposive sampling. As we are working with vulnerable groups who are often hard to reach, selection and contact with respondents should be done in partnership with local groups and networks who can find the right people and help ensure that they are comfortable and willing to participate. Local government, teachers, health sector staff, non-governmental organizations and community leaders should also be able to assist in identifying suitable people. You can also request additional contacts from interviewees, using a 'snowball' approach.

5.3 DATA COLLECTION PHASE

5.3.1 Select interviewers and organize training

You can build on opportunities such as the availability of trained fieldworkers in your own organization or in others that are participating in the vulnerability assessment. Teams should include female and male fieldworkers, with a larger proportion of women, who are often more sensitive to women's and girls' inhibitions in discussing sensitive SRHR, GBV and HIV topics. Female fieldworkers may be more successful in reassuring respondents and opening up discussion.

Even experienced fieldworkers will need additional guidance and training for SRHR, GBV and HIV interviews, as some of the topics are sensitive and respondents may be uncomfortable speaking about them. Training should cover basic themes of SRHR, GBV and HIV so staff can answer questions and clarify points if necessary. A glossary of technical terms is included as an annex to this handbook and can be adjusted to use local terminology for SRHR, GBV and HIV topics where appropriate. Training should also include methods to conduct the interviews and ethical considerations.

In small communities, one fieldworker may be able to carry out all the interviews. This will have the added advantage of the fieldworker gaining an in-depth understanding of shared community priorities and the best way to present and discuss sensitive issues with respondents, but it may present the risk of interviewer bias. In larger communities and urban areas, it will be preferable for field staff to work in teams to ensure adequate coverage.

A model for interviewer instructions is presented in Annex 4. The tools themselves include guidance for the interviewers on specific questions.

5.3.2 How to collect the responses

The tools in the module are currently paper based, but could be digitized in the future to facilitate fieldwork and analysis.

Data collection sheets or digital methods for recording responses should reflect the purpose and scope of each vulnerability assessment. The design should be as simple and user-friendly as possible, so interviewers can avoid losing time in the field or after completing the interviews.

A sample Excel data collection sheet used for piloting the tools is presented in Annex 5 and can be used as a template. It enables key points from the responses of all interviewees in a specific group to be consolidated in one sheet. This facilitates review of the datasets, comparisons between individual responses, and identification of the problems and priorities mentioned most frequently. The design can be adapted for specific vulnerability assessments.

During data collection, ethical principles such as 'do not harm' will be applied to identify and avoid any harm that may be inadvertently caused by the survey. The survey budget should cover any additional expenses for respondents, such as transport and refreshments. The data collection sheet and the questionnaires themselves draw interviewers' attention to the key ethical principles and the protection required for respondents, especially those from the most vulnerable groups.

[8] For a simple explanation of these terms, see https://pressbooks.pub/scientificinquiryinsocialwork/chapter/10-2-sampling-in-qualitative-research/.

5.4 DATA ANALYSIS AND USE PHASE

5.4.1 How to analyse the responses

This qualitative research provides information on community perspectives and priorities in humanitarian situations. Its purpose is to ensure that the communities' point of view and the needs of the people most affected by humanitarian situations are taken into account for decision-making on humanitarian support and for building resilience. The data may not be representative of opinions of a wider group and are not designed for consolidation to provincial or national levels. Methods for analysis should be simple to reflect the non-representative nature of the responses and the overall purpose and value addition of this type of qualitative data.

Qualitative data analysis[9] is the process of interpreting qualitative data to understand what it represents. For the type of qualitative data collected by the tools, it is recommended to use a combination of the following types of analysis:

- **Content analysis:** This refers to coding, categorization and thematic analysis of the data collected.
- **Narrative analysis:** Some data collected, particularly from the community level, may contain a story. Narrative analysis helps to understand the underlying events and their effect on the overall outcome, and is also effective for disseminating results and highlighting key messages.
- **Discourse analysis:** This type of analysis looks at what people say in social and cultural contexts. This may be of interest when it is clear that the stakeholders have significantly divergent opinions on similar topics.

For these types of analysis, it is important to code the information collected. If qualitative analysis software is available, this will facilitate the coding and analysis. If it is not available, you can upload the interview notes into a spreadsheet type of software, such as Excel, to easily add and filter using the available codes.

Before starting to code the dataset, you should decide whether to use inductive or deductive coding. The main difference between inductive and deductive coding is that inductive reasoning aims to develop a theory, whereas deductive reasoning aims to test an existing theory.

Deductive coding starts with a predefined set of codes, whereas inductive codes are developed based on the data itself. We recommend using a combination of deductive coding (listing the major topics that were included in the questionnaires, such as SRHR, HIV, GBV, management, resources, etc.) and inductive coding (to allow for nuances to be added). While coding, it is important to develop a codebook to keep track of the codes, to cover as many survey responses as possible, to avoid commonalities among codes, to capture both positive and negative opinions on similar topics, and to avoid having either too few or too many codes.

During the analysis of the codes, it is important to analyse the data from an overall perspective – for example, what were the opinions on the SRH services provided during the onset of the humanitarian situation? It is also important to break it down by stakeholder group – for example, are there differences reported by community members versus health providers?

The analysis can be written up by thematic area or by stakeholder group. This decision should be made after reviewing the dataset and also in light of how the information will be used (e.g., for stocktaking, for decision-making or for advocacy).

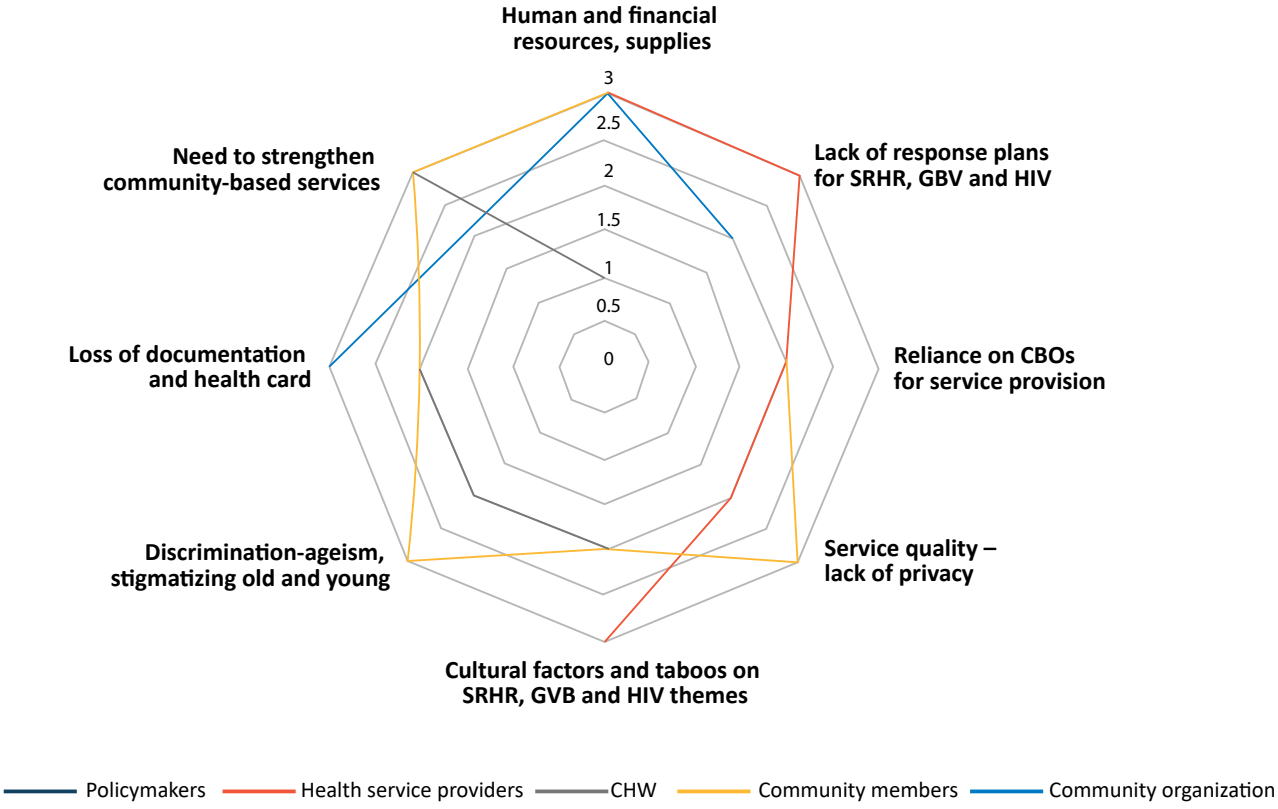
The data should be shared with the community for validation and to motivate community participation in building resilience. It should also be shared with decision makers for incorporation into their planning and humanitarian response. The analysis should focus clearly on responses to the issues of most interest to these groups.

[9] For those unfamiliar with qualitative data analysis, there is an excellent free online resource at Coursera: https://www.coursera.org/learn/qualitative-methods

Presentation methods should be kept as simple as possible, using simple graphics such as word clouds to show the relative importance of topics, along with diagrams that show where groups face several issues and challenges. Figure 2 shows a word cloud that highlights frequent responses. Figure 3 presents a spider web diagram that illustrates which issues are important for different groups. It also highlights the intersectoral nature of issues for the respondents by showing how frequently respondents from vulnerable groups mentioned the same two or more challenges (e.g., stigma/discrimination and lack of access to services). As the responses are qualitative and the samples are not designed to be representative, it is better to avoid presentation formats that show numbers.

Figure 2. Word cloud: respondents' perceptions of the relative importance of different problems

Figure 3. Spider web diagram: issues identified by respondent group[10]



[10] Note: This is based only on the pilot responses. It is not a representative sample and is included to illustrate an alternative for analysis and presentation.

5.4.2 How to use the data

One hundred per cent buy-in from the stakeholders (humanitarian workers, community members and specific vulnerable groups, with representation of men and women) in the planning and implementation of the module is essential if the results are to be used. In order to obtain this buy-in, it is important that those who participated in the data collection are also given feedback on the results of the vulnerability assessments. As mentioned above, feedback should be accompanied by community validation of the results, for example, through feedback sessions with key participants. If the tools are digitized in the future, it may also be possible to provide feedback through internet platforms.

Qualitative data can offer valuable insights and feedback on the understanding of involved stakeholders of the effects of the humanitarian situation, as well as the effectiveness and appropriateness of the response.

Use of the data will depend on the interests of those undertaking the vulnerability assessments:

- Communities, local networks and other organizations may use it to understand the gaps in the current response mechanisms and to identify measures for strengthening their resilience. They may also use it for advocacy with government and other decision makers to include and institutionalize SRHR, GBV and HIV service provision during humanitarian situations or for increased resource allocation.
- Decision makers may use it as input for planning resilience, for providing better responses to emergencies (e.g., through placement of stocks of essential supplies or through strengthening protection and support mechanisms), for mitigation of risks, to fine-tune the allocation of resources, and to motivate community participation in vulnerability assessment, humanitarian response and resilience building. It may also be useful for identifying needs for capacity building in SRHR, GBV and HIV on the supply side, and for increasing community awareness on the demand side. As the data collected helps to identify underlying vulnerabilities and the needs of especially vulnerable groups, it can also provide insights that contribute to strengthening work at the humanitarian–development nexus. This may include post-disaster recovery work, relocation of displaced people to new sites and preparedness/resilience planning.
- International organizations may use the information to identify how best to support decision makers, communities, local networks and organizations in their efforts to address the humanitarian situation and strengthen resilience.

Taking action: recommendations

The following are the recommendations for complementary actions to support the use of the module, to take advantage of the opportunities, and to begin to address the challenges identified in this study:

- Define how the module will be integrated with other vulnerability assessment planning and implementation in the ESA region and for each country prioritized in this study, and identify how to address potential obstacles to taking the work forward in each location. At the country level, this may include the following: mapping the scope and timing of existing vulnerability assessments where inclusion of SRHR, GBV and HIV is appropriate; strengthening existing inter-agency coordination mechanisms; and developing plans to use the tools in specific situations (such as post-emergency recovery and resilience building, and preparedness/ response planning) and to analyse learning from these experiences.

- Develop advocacy plans at regional and country levels to promote inclusion of SRHR, GBV and HIV in humanitarian response and vulnerability assessments. Identify relevant policies and decision makers. Identify focal points in each decision-making agency to facilitate the process. At the country level, advocacy may also be needed at the district level for allocation of resources for SRHR, GBV and HIV vulnerability assessment.

- Disseminate the handbook and start awareness-raising with a wider audience, in these and other countries in the region. Participatory processes where stakeholders can make specific inputs to planning and decision-making for vulnerability assessment will be essential to ensure their full commitment.

- Identify who can take up the leadership of this process at regional and national levels. Identify possible organizational structures to take the work forward – for example, inter-agency forums, coordination mechanisms and national government.

- Define a realistic action plan to share knowledge and experiences in the harmonization of SRHR, GBV and HIV, and in the use of the module with other countries in the region, taking into account limitations due to time availability and organizational mandates (e.g., in United Nations agencies). The plan could include virtual and in-person meetings and seminars, webinars, the development of an information hub, etc.

- Review the type and level of resources needed for use of the handbook or adaptations of it in different country contexts, as well as possible constraints (e.g., cultural taboos, local context) in specific countries and locations.

- Promote national reviews of analyses, and promote the use of data in decision-making. This is an integral part of the vulnerability assessment process and should be built into processes and use of tools from the concept and planning stages. Capacity building of partners and of data users may be needed.

For further details, it is recommended to consult the study report.[11]

[11] *Harmonization of Vulnerability Assessment Tools for Sexual and Reproductive Health and Rights, HIV and Gender-Based Violence in Humanitarian Settings* (Final Report 2023).

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ANNEXURES

ANNEX 1: QUESTIONNAIRES

TOOL 1. POLICYMAKER INTERVIEW

COUNTRY:	
COMMUNITY NAME:	
(District disaster management staff or chief medical officer)	
Instructions for interviewer	
Date of interview	
Job title of interviewee	
Start time	
Finish time	
Informed consent obtained?	
Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer.	
You may need to provide additional explanation of SRHR, GBV and HIV topics to respondents.	
Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)	
You were identified for this interview since you are involved in policymaking on SRHR, GBV and HIV in this zone, and we would very much appreciate your input.	
The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.	

	QUESTIONS	INTERVIEWEE RESPONSE
1.	What is your role around emergency preparedness and disaster risk reduction?	
2.	What were some of the health and sexual and reproductive health challenges in the most recent emergency (outbreak of violence, natural disaster)?	
	Explain what we mean by challenges: e.g., reduced access to services, lack of supplies, impacts on service quality, etc.	
3	To what degree are you aware of the Minimum Initial Service Package for Sexual and Reproductive Health? *If respondent is not familiar with the MISP standard, please review the objectives of the MISP. A short description is available at*: https://fp2030.org/sites/default/files/ready_to_save_lives/MISP_readiness_assessment.pdf.	
4.	Who within your community may be most at risk or vulnerable when a crisis occurs?	

	QUESTIONS	INTERVIEWEE RESPONSE
	Probe for persons with disabilities, the elderly, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents, orphans and vulnerable children, pregnant women. Probe: How and why are such persons more vulnerable?	
	Are such persons currently consulted to ensure health services, especially sexual and reproductive health services, best meet their needs? How so, and to what extent?	
5	What were the main challenges the district experienced when responding to the community's sexual and reproductive health needs in past emergencies? What services were disrupted, and how?	
6	Did that affect the community? What attempts were made to continue providing disrupted services?	
7	Which of these challenges could have been addressed before the emergency and in what way?	
8.1	Does the district routinely review the supply chain commodity risk management and pre-positioning?	
8.2	Does the review include SRH and HIV supplies? *These would include supplies for women to manage their menstruation, delivery kits for pregnant women, newborn kits for newly born babies, and hygiene kits.*	
9.1	Are there national or subnational policies, laws, protocols and strategies that hinder the provision of comprehensive SRH services to at-risk groups, including vulnerable women and girls, at the district level at any given time?	
10.1	Has the district identified an SRH, GBV and HIV focal point for emergencies?	
10.2	Does the district allocate a budget for SRH preparedness and contingency planning specifically?	
10.3	Does the district routinely implement disaster-response simulations/drills and include SRH, HIV and GBV issues?	
10.4	Does the district have staff trained specifically in the MISP?	
11	Does the district work with groups serving at-risk populations to ensure their voices are heard in processes to build community resilience in SRHR, GBV and HIV?	
	Probe for persons with disabilities, the elderly, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents, etc.	
12	Has the district pre-positioned supplies and equipment to provide MISP for SRH services should an emergency occur? What do you think needs to be strengthened or improved for this district to better address preparedness for sexual and reproductive health in emergencies?	
13	Do you foresee any barriers that could impede efforts to strengthen or improve the district's capacity to address preparedness for sexual and reproductive health in emergencies? If so, what are they?	
14	What are your priorities for preparedness for this district?	

Thank you for your excellent work. We applaud all that you do.

TOOL 2. HEALTH PROVIDER INTERVIEW

COUNTRY:	
COMMUNITY NAME:	
(Health facility manager or clinical staff)	
Instructions for interviewer	
Date of interview	
Job title of interviewee	
Start time	
Finish time	
Informed consent obtained?	
Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer.	
Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)	
You were identified for this interview since you are a clinical provider of sexual and reproductive health services in this facility.	
The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.	

	QUESTIONS	INTERVIEWEE RESPONSE
1.1	What is your role in this health facility?	
1.2	Do you provide SRHR services?	
2.	What were the health and sexual and reproductive health-related challenges that people in this community faced during the most recent emergency?	
	Explain what we mean by challenges: e.g., reduced access to services, lack of supplies, impacts on service quality, etc.	
3.	Who within your community may be most at risk or vulnerable when a crisis occurs?	
3.1	Are persons from the following at-risk groups (persons with disabilities, elderly people, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents, etc.) able to access health services, especially sexual and reproductive health services?	
3.2	Do persons belonging to an at-risk group face any particular challenges to access health and reproductive health information and services? What are these challenges?	
3.3	Does your health facility have any special measures in place to ensure that these persons can access services, despite these challenges? (e.g., mobile outreach teams to reach persons with disabilities and/or elderly people.)	
3.4	How can people from specific at-risk groups currently be best served with quality reproductive health services? (e.g., working with persons who are engaged in sex work as outreach workers to reach other persons engaged in sex work.)	

	QUESTIONS	INTERVIEWEE RESPONSE
4.	What are the sexual and reproductive health services that your facility provides in practice?	
5.	What were the main challenges that you experienced when responding to the community's sexual and reproductive health needs in the last emergency? (Specifically focusing on vulnerable women and girls.)	
	Explain what we mean by challenges here: e.g., reduced access to services, lack of supplies, impacts on service quality, etc.	
6.1	What SRH services were disrupted, and how did that affect the community?	
6.2	What caused these disruptions?	
7.	What attempts were made to continue providing disrupted SRH services? Were these attempts successful? Why or why not?	
8.	Are there any preparations that you think could have been made in advance to prevent or help with these challenges?	
9.	How is this facility addressing emergency preparedness for sexual and reproductive health in particular?	
10.	What training(s) have you had, if any, to build your current capacity in responding to sexual and reproductive health needs in emergencies (MISP for SRH training, inter-agency guidelines, etc.)? *If respondent is not familiar with the MISP standard, please review the objectives of the MISP. A short description is available at: https://fp2030.org/sites/default/files/ready_to_save_lives/MISP_readiness_assessment.pdf.*	
11.	Has the facility identified an SRH, GBV and HIV focal point for emergencies?	
12.	Does the facility allocate a budget for SRH preparedness and contingency planning specifically?	
13.	Does the facility routinely implement disaster-response simulations/ drills for SRHR specifically?	
	Explain that simulations are exercises in a fictional scenario to ensure staff and systems are prepared for real-life disasters and to strengthen training and processes where necessary.	
14.	Does the facility work in partnership with groups serving at-risk populations to ensure their voices are heard in processes to build community resilience? *(Persons with disabilities, elderly people, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents.)*	
15.	Has the facility pre-positioned supplies and equipment to provide MISP for SRH services should an emergency occur? *These would include supplies for women to manage their menstruation, delivery kits for pregnant women, newborn kits for newly born babies, and hygiene kits.*	
16.1	What do you think needs to be strengthened or improved for this facility to better address preparedness for sexual and reproductive health in emergencies?	
16.2	What barriers could prevent the facility from strengthening or improving its capacity to address preparedness for sexual and reproductive health in emergencies?	
	Probe for institutional support, time, and financial, logistic (equipment and supplies/commodities) or policy barriers, especially to providing maternal and newborn care, family planning, care for sexually transmitted infections and HIV/AIDs, comprehensive abortion care, and GBV, etc.	

Thank you for your excellent work. We applaud all that you do.

TOOL 3. COMMUNITY HEALTH WORKER INTERVIEW

COUNTRY:	
COMMUNITY NAME:	
(Community health worker)	
Instructions for interviewer	
Date of interview	
Job title of interviewee	
Start time	
Finish time	
Informed consent obtained?	
Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer. If abortion is legal, give a brief explanation to help respondents open up about the theme. If they are not comfortable talking about LGBTIQ or sex workers, you can have a short discussion and use the local terms to help them open up. If there are questions on topics or services that your respondent does not cover, omit the question.	
Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)	
We would like to understand better the SRH, GBV and HIV issues of women and adolescents, and the problems they face in this community. You were suggested for this interview due to your experience as a community health worker and your knowledge of the community's health needs, and we would very much appreciate your input.	
The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.	

	QUESTIONS	INTERVIEWEE RESPONSE
	First, I would like to ask about your role in the community.	
1.	What kind of work do you do in this community to help members with their health concerns? Specifically women and girls?	
2.	What was the last big emergency, such as an outbreak of conflict or a natural disaster, where there was a major disruption to your daily activities?	
3	***Are there challenges and capacities related to the Minimum Initial Service Package (MISP) for sexual and reproductive health (SRH)?*** *If respondent is not familiar with the MISP standard, please review the objectives of the MISP. A short description is available at:* https://fp2030.org/sites/default/files/ready_to_save_lives/MISP_readiness_assessment.pdf.	
3.1	In the last emergency, what role did you play for pregnant women and adolescent girls?	

	QUESTIONS	INTERVIEWEE RESPONSE
3.2	What challenges did pregnant women/adolescent girls face as they prepared for delivery or delivered their babies? *Probe if any populations, such as unmarried women and adolescents, LGBTIQ persons, persons with disabilities or other marginalized groups, faced additional challenges and what those challenges were.*	
3.3	What role did you play as community health resource persons in addressing these challenges?	
3.4	If a pregnant woman/adolescent girl faced a complication during pregnancy, what challenges did she face in accessing care?	
3.5	What if she was from an at-risk group?	
3.6	What role did you play as community health resource persons in addressing these challenges?	
4.	In the last emergency, what role did you play if women and adolescent girls in the community wished to prevent pregnancy or postpone becoming pregnant? *(Probe for awareness-raising sessions, community-based distribution, etc.)*	
4.1	Where did female (and male) community members go to access family planning/contraceptive services?	
4.2	What challenges did female (and male) community members face in accessing family planning and contraceptive services?	
	Probe if any populations, such as unmarried women and girls, adolescents, LGBTIQ persons, persons with disabilities, or other marginalized groups, faced additional challenges and what those challenges were.	
4.3	What role did you play as community health resource persons in addressing these challenges?	
4.4	In your specific role, can you directly provide:	
	a. Male and female condoms	
	b. Oral contraceptive pills	
	c. Injectable contraceptives (Depo-Provera)	
	d. Injectable contraceptives (Sayana Press)	
	e. Emergency contraceptives	
	f. What other methods, if any?	
5.	In the last emergency, what role did you play if women/adolescent girls in this community were pregnant but did not wish to be?	
5.1	What challenges did women/adolescent girls face if they wanted to seek services so that they did not remain pregnant?	
	Probe if any populations, such as unmarried women and girls, adolescents, LGBTIQ persons, persons with disabilities, or other marginalized groups, faced additional challenges and what those challenges were.	
5.2	What role did you play as community health resource persons in addressing these challenges?	
5.3	What role did you play to inform community members of the benefits of seeking care and where to access services after a spontaneous or induced miscarriage?	

	QUESTIONS	INTERVIEWEE RESPONSE
5.4	If a pregnant woman needed a referral, what role did you play, and how did you follow up on the care they received?	
5.5	In your specific role, can you directly provide:	
	a. Mifepristone	
	b. Misoprostol	
6.	In the last emergency, what role did you play to prevent the spread of HIV or other sexually transmitted infections?	
6.1	What challenges did the community face in accessing free condoms?	
6.2	In the last emergency, what role did you play to help persons living with HIV access or continue accessing treatment? (Probe for outreach via cell phone, etc.)	
6.3	What challenges did the community face in accessing antiretroviral treatment?	
	Probe if any populations, such as unmarried women and girls, adolescents, LGBTIQ persons, persons with disabilities, or other marginalized groups, faced additional challenges and what those challenges were.	
6.4	What role did you play as community health resource persons in addressing these challenges?	
7.1.	In the last emergency, what role did you play to protect community members from violence, including sexual violence?	
7.2	What role did you play to inform community members of the benefits of seeking care and where to access services after sexual violence? *(Probe for awareness-raising sessions, outreach via text messaging, etc.)*	
7.3	What challenges did the community face in accessing care after sexual violence? *(Probe if any populations, such as unmarried women and girls, adolescents, LGBTIQ persons, persons with disabilities, or other marginalized groups, faced additional challenges and what those challenges were.)*	
7.4	What role did you play as community health resource persons in addressing these challenges?	
7.5	In your specific role, can you directly provide: a. Emergency contraception to prevent pregnancy. b. Pregnancy test to confirm pregnancy. c. Post-exposure prophylaxis (PEP) to prevent HIV (including PEP initiation). d. Antibiotics to prevent and treat sexually transmitted infections.	
8.1	In the last emergency, did you take part in distributing any sexual and reproductive health supplies to women or girls in the community? These would include supplies for women to manage their menstruation, delivery kits for pregnant women, newborn kits for newly born babies, and hygiene kits.	
8.2	What supplies did you distribute?	
8.3	What did the community think about these distributions?	
8.4	Were there any challenges to note with regard to distribution?	

	QUESTIONS	INTERVIEWEE RESPONSE
9.1	Overall, how was access to sexual and reproductive health services affected during the last emergency? By sexual and reproductive health, we mean all of the issues we have discussed, including pregnancy, family planning, sexually transmitted infections and HIV/AIDS, and violence.	
9.2	Did adolescents (girls and boys) have the same level of access as adults? Why or why not?	
9.3	Did unmarried adolescents (girls/boys) have the same level of access as married adolescents? Why or why not?	
9.4	How about unmarried adult women or widows? Why or why not?	
9.5	How about persons with disabilities? Why or why not?	
9.6	How about persons who have a different gender identity or expression, or a different sexual orientation (LGBTIQ persons)? Why or why not?	
9.7	Were there other groups of people in the community who had a hard time accessing SRH services, and if so, in what way? *(Probe for persons who engage in sex work, persons from minority groups, adolescents, etc.)*	
10	How was the quality of sexual and reproductive health services affected during the last emergency?	
	If necessary, explain aspects of service quality, such as waiting times, availability of supplies, respectful treatment of users, etc.	

Thank you for your excellent work. We applaud all that you do.

TOOL 4. COMMUNITY MEMBER INTERVIEW

COUNTRY:	
COMMUNITY NAME:	
COMMUNITY MEMBER NAMES	
(Women, adolescent girls and at-risk groups, including LGBTIQ persons, people with disabilities, sex workers and other minority groups)	
Instructions for interviewer	
Date of interview	
Occupation of interviewee	
Sex	
Age group (adolescent or adult)	
Start time	
Finish time	
Informed consent obtained?	

Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer.

If abortion is legal, give a brief explanation to help respondents open up about the theme.

If they are not comfortable talking about LGBTIQ or sex workers, you can have a short discussion and use the local terms to help them open up.

You may need to provide additional explanation of SRHR, GBV and HIV topics to respondents.

Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)

We would like to understand the concerns and health needs for women, adolescent girls and other at-risk groups in the community to improve access to services and better prepare for emergencies, and would very much appreciate your input.

The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.

	QUESTIONS	INTERVIEWEE RESPONSE
	I would like to ask you some questions about health services for women and girls, including women/girls with disabilities, LGBTIQ women/ girls, women/girls who are engaged in sex work, now and in the last emergency (outbreak of violence, natural disaster, or another event that participants can pinpoint).	
1	What was the last big emergency, such as an outbreak of conflict or a natural disaster, where there was a major disruption to your daily activities?	
2.1	Where do women/adolescent girls seek health care when they are pregnant? How about when they are giving birth? How about after they give birth?	
2.2	In the last emergency, what challenges did pregnant women/ adolescent girls face as they prepared for delivery or delivered their babies?	
2.3	Were these challenges different for women/girls with disabilities, LGBTIQ women/girls, and women/girls who engage in sex work, etc.? If so, how?	
2.4	How were the challenges overcome?	
2.5	In the last emergency, if a pregnant woman/adolescent girl faced a complication during pregnancy or delivery, what challenges did she face in accessing care?	
3.1	What do women and men do to prevent or postpone having babies?	
3.2	Where would they find trusted sources of information about contraception and family planning?	
3.3	In the last emergency, what challenges did women/adolescent girls face in accessing contraceptives and family planning services?	
3.4	Are there places in this community where free male and female condoms can easily be found?	
3.5	What barriers do women and girls face in accessing them?	
3.6	What additional barriers did women and girls, including those with disabilities, LGBTIQ women/girls and women/girls who engage in sex work, face in accessing condoms in the last emergency?	
3.7	What would you like to see improved around access to contraceptives and family planning services when an emergency occurs?	
3.8	Are there any improvements that would be especially important for women/girls with disabilities, LGBTIQ women/girls, women/girls who engage in sex work, etc.?	

	QUESTIONS	INTERVIEWEE RESPONSE
4.1	What do women/adolescent girls in this community do when they think or know they are pregnant but do not want to be?	
4.2	In the last emergency, were there additional difficulties that women and girls faced when they knew they were pregnant and did not want to be?	
5.1	What measures are currently in place to protect all women and girls from violence in this community, especially those living with disabilities, LGBTIQ women/girls, women/girls who engage in sex work, etc.?	
5.2	What issues or challenges did all women and girls face in accessing this support or these services in the last emergency?	
6.1	In the last emergency, were any sexual and reproductive health supplies distributed to women or girls in the community? These would include menstruation supplies, delivery kits and hygiene kits. Who distributed these supplies?	
7.1	Was access to sexual and reproductive health services affected during the last emergency? How?	
7.2	Did adolescents have the same level of access as adults?	
7.3	Did unmarried adolescents have the same level of access as married adolescents?	
7.4	How about unmarried adult women or widows?	
7.5	How about women/girls with disabilities, LGBTIQ women/girls, women/girls who engage in sex work, etc.?	
7.6	Were there other groups of people who had a hard time accessing services, and if so, in what way?	
8.1	Was the quality of sexual and reproductive health services affected during the last emergency? How?	
	If necessary, explain aspects of service quality such as waiting times, availability of supplies, respectful treatment of users, etc.	
8.2	What services suffered the most loss in quality?	

Thank you for your participation and for sharing this information with us.

TOOL 5. REPRESENTATIVE OF COMMUNITY-BASED ORGANIZATION OR COMMUNITY LEADER INTERVIEW

ESARO VA PROTOTYPE TOOLS – INTERVIEW SHEETS FOR THE PILOT TESTING		
COUNTRY:		
COMMUNITY NAME:		
REPRESENTATIVE OF COMMUNITY-BASED ORGANIZATION OR COMMUNITY LEADER		
(Representative of civil society organization or network, community leader, teacher)		
Instructions for interviewer		
Date of interview		
Job title of interviewee		
Start time		
Finish time		
Informed consent obtained?		

Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer. If organizations do not have a specific health focus, you may need to provide additional explanation of SRHR, GBV and HIV topics to respondents.
Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)
You were identified for this interview since you represent a community-based organization that works in the health sector, or you are a community leader and have experience in emergency response, and we would very much appreciate your input.
The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.

	QUESTIONS	INTERVIEWEE RESPONSE
	First, I would like to ask you about community-based organizations' role in emergency response.	
1	What does your organization do in the community to prepare for and respond to emergencies?	
1.1	Do you do vulnerability assessments? If so, what tools do you use?	
2	Who within your community may be most at risk or vulnerable to problems of SRH, GBV and HIV when a crisis occurs?	
	Probe for women, adolescent girls, persons with disabilities, LGBTIQ persons, persons who engage in sex work, persons from minority groups, etc.	
3.	What norms or perceptions in the community may be perpetuating violence, vulnerability or inequality in your community?	
4.	What resources and capacities would you say your organization has to respond to a crisis in this community?	
4.1	How about in health specifically, especially sexual and reproductive health? *(If the respondent is unsure of what comprises SRH, briefly review the scope of SRH in the MISP.)*	
4.2	What resources and capacities related to health and to SRH currently exist within the community for the community to respond to a crisis? *Probe for community networks for persons with disabilities, women and minorities, as well as community leaders, social networks, sports and religious groups, etc.*	
5.1	What were the main challenges in responding to the community's SRH, GBV and HIV needs in the last emergency?	
	Explain what we mean by challenges: e.g., reduced access to services, lack of supplies, impacts on service quality, etc.	
5.2	What SRH/HIV/GBV services and supplies were disrupted, and how did that affect the community?	
5.3	How could the community have better prepared for these challenges before the emergency?	
5.4	What barriers might prevent efforts to strengthen or improve capacity to adequately respond to the community's sexual and reproductive health needs in a crisis?	

Thank you for your excellent work. We applaud all that you do.

TOOL 6. COMMUNITY MEMBER INTERVIEW – PERCEPTION AND PRIORITIES

COUNTRY:	
COMMUNITY NAME:	
(Women, adolescent girls and at-risk groups, including LGBTIQ persons, people with disabilities, persons who engage in sex work and other minority groups)	
Instructions for interviewer	
Date of interview	
Occupation of interviewee	
Sex	
Age group (adolescent or adult)	
Start time	
Finish time	
Informed consent obtained?	
Notes to interviewer: If you have found that there are any legal restrictions or local taboos related to sensitive topics such as safe abortion or adolescent access to services, or if you are aware that key populations may be discriminated against or stigmatized, respondents may be uncomfortable with some questions. Please approach these questions sensitively and make sure respondents know they are not in any way obliged to answer. If abortion is legal, give a brief explanation to help respondents open up about the theme. If they are not comfortable talking about LGBTIQ or sex workers, you can have a short discussion and use the local terms to help them open up.	
Hello and thank you for making yourself available for this interview. My name is _____. I am working with the United Nations agencies to develop assessment of community vulnerability in SRHR, GBV and HIV in humanitarian situations. (Explain SRHR, GBV and HIV if necessary.)	
We would like to understand the concerns and health needs for women, adolescent girls and other at-risk groups in the community to improve access to services and better prepare for emergencies, and would very much appreciate your input.	
The information you share will not be connected with your name or position. The information may be shared in a general, non-identifiable way with interested agencies and organizations that can address preparedness in this community. Your participation is completely voluntary. You are welcome to stop this interview at any time.	
Explain clearly what we mean by SRH/GBV/HIV (see interviewer's instructions)	
Rating:	
0 = no serious problem; **1 = serious problem;** **2 = somewhat serious problem;** **9 = does not know /not applicable/declines to answer**	

	QUESTIONS	RATING:
0 = no serious problem 1 = serious problem 2 = somewhat serious problem 9 = does not know/not applicable/declines to answer		
I am going to ask you about the serious problems that you and others in your community experienced in the last emergency. We are interested in finding out what you think – a serious problem is a problem that you consider serious. There are no right or wrong answers.		
1. Drinking water	Did you have a serious problem because you did not have enough water that is safe for drinking or cooking?	
2. Keeping clean	**For women:** Did you have a serious problem because in your situation it was difficult to keep clean? For example, because you did not have enough soap, sanitary materials or water, or a private and suitable place to wash.	
	For men: Did you have a serious problem because in your situation it was difficult to keep clean? For example, because you did not have enough soap or water, or a suitable place to wash.	
3. Toilets	Did you have a serious problem because you did not have easy and safe access to a clean toilet?	
4. Physical health	Do you have a serious problem with your physical health? For example, because you have a physical illness, injury or disability.	
5. Health care	**For women:** Did you have a serious problem because you were not able to get adequate health care for yourself? For example, treatment or medicines, family planning supplies, or health care during pregnancy or childbirth.	
	For men: Did you have a serious problem because you were not able to get adequate health care for yourself? For example, treatment or medicines.	
6. Safety	Did you have a serious problem because you or your family were not safe or protected where you lived? For example, because of conflict, violence or crime in your community, city or village.	
7. Safety or protection from violence for women in your community	Was there a serious problem for women, children and adolescents in your community because of physical or sexual violence towards them, either in the community or in their homes?	
8. Support for GBV survivors	Was there a serious problem for women, children and adolescents in your community because they did not get support from health workers or the police after physical or sexual violence?	
9. Care for family members	Did you have a serious problem because in your situation it was difficult to care for family members who live with you? For example, young children in your family or family members who are elderly, physically or mentally ill, or disabled.	
10. Being displaced from home	Did you have a serious problem because you were displaced from your home country, city or village?	
11. Separation from family members	Did you have a serious problem because you were separated from family members during the emergency?	

	QUESTIONS	RATING:
12. Support from others	Did you have a serious problem because you were not getting enough support from people in your community? For example, emotional support or practical help.	
13. Information	**For displaced people:** Did you have a serious problem because you did not have enough information about SRH/GBV/HIV health services and supplies? (e.g., because you did not have enough information about where they were available.) Or because you did not have enough information about what was happening in your home country or home town?	
	For non-displaced people: Did you have a serious problem because you did not have enough information about SRH/HIV/GBV health services and supplies? For example, because you did not have enough information about where they were available.	
14. The way aid is provided	Did you have a serious problem because of inadequate aid? For example, because you did not have fair access to the aid that is available, or because aid agencies were working on their own without involvement from people in your community.	
15. Respect	Did you have a serious problem because you did not feel respected or you felt humiliated? For example, because of the situation you were living in, or because of the way people treated you when you looked for SRH, HIV or GBV services and supplies.	
16. Moving between places	Did you have a serious problem because you were not able to move between places? For example, going to another village or town for SRH/HIV/GBV health services or supplies.	
17. Care for people in your community who are on their own	Is there a serious problem in your community because there is not enough care for people who are on their own? For example, care for unaccompanied children, widows or elderly people, or for unaccompanied people who have a physical or mental illness or disability.	
	Was this a serious problem during the last emergency?	
Other serious problems:	Did you have any other serious problems that I have not yet asked you about? *Write down the person's answers.*	
	Read out the titles of all questions you have rated as '1', as well as any other serious problems listed above. Write down the person's answers (write down the number and title of the questions).	
	1. Out of these problems, which one is the most serious problem?	
	2. Which one is the second most serious problem?	
	3. Which one is the third most serious problem?	

ANNEX 2: ETHICAL CONSIDERATIONS

The team and stakeholders maintained two overarching ethical principles throughout the whole study and piloting of the module:

- **Do no harm** – ensuring confidentiality and anonymity, gaining permission to collect data, and ensuring alignment with international human rights conventions.

- **Protection and empowerment** – respecting attitudes and behaviours of informants during data collection; ensuring privacy, objectivity, transparency and cultural sensitivity.

These principles should also be applied in implementing the module and the questionnaire tools. They are particularly important when gathering data from the women, children and marginalized or vulnerable groups who were the focus of the study's proposals and fieldwork. Risks related to stigmatizing key informants (individuals, families, communities or stakeholders from other levels) should be identified and mitigated through careful planning and implementation of interviews and discussion groups. As vulnerable groups are included in data collection activities, interviewers must ensure they can express themselves in a setting in which they feel comfortable and safe, and in which their dignity is respected. The data collection tools do not include any biased or affirmative questions, and all field staff should maintain a neutral position during data collection activities to ensure impartiality. They should be fluent in the languages in which the beneficiaries are at ease. As the tools cover sensitive topics, questions have been designed to be culturally acceptable – and this was checked during the tool pilot.

The guiding principles during interviews and discussions are respect, comprehension, sensitivity and protection.

Prior to the start of the fieldwork for comprehensive piloting, all members of the field team should be thoroughly briefed on these ethical principles, the national ethical compliance requirements in any given country, and approaches for specific respondent groups. Stakeholders participating in the assessment activities must be informed about their right to withdraw from activities or refuse to answer questions at any time. Field staff should explain that collecting data does not mean that participants' feedback will be identifiable as theirs or that it will lead to changes, thereby managing informants' expectations.

ANNEX 3: GLOSSARY OF SRH TERMINOLOGY

This list is an extract of information accessed from the websites of WHO, UNFPA, UNICEF, the International Planned Parenthood Federation (IPPF), the Guttmacher Institute and the Population Reference Bureau (PRB).

Adolescent sexual and reproductive health and rights

Adolescence[12] is the period between 10 and 19 years of age (early adolescence is 10–14 years; late adolescence is 15–19 years; post-adolescence is 20–24 years). Young people are those aged 10–24 years. Adolescents and young people have the right to accurate information and appropriate reproductive health services (UNFPA). A UNFPA document and an *International Journal of Gynaecology and Obstetrics* document provide a good overview of the work on adolescent SRHR.[13] [14]

Comprehensive sexuality education

A rights-based approach to comprehensive sexuality education[15] seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views sexuality holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

Family planning and access to modern family planning methods

Access[16] to safe, voluntary family planning is a human right. Family planning is central to gender equality and women's empowerment, and it is a key factor in reducing poverty. Yet in developing regions, an estimated 218 million women who want to avoid pregnancy are not using safe and effective family planning methods, for reasons ranging from lack of access to information or services to lack of support from their partners or communities. This threatens their ability to build a better future for themselves, their families and their communities.

UNFPA works to support family planning by: ensuring a steady, reliable supply of quality contraceptives; strengthening national health systems; advocating for policies supportive of family planning; and gathering data to support this work. UNFPA also provides global leadership in increasing access to family planning, by convening partners – including governments – to develop evidence and policies, and by offering programmatic, technical and financial assistance to developing countries. Family planning methods include all hormonal methods (i.e. the pill, injectables and implants), intrauterine devices (IUDs), male and female sterilization, condoms, and modern vaginal methods. Modern family planning services include information and counselling by health personnel about modern contraceptive methods, provision of these methods or prescriptions, and related surgical procedures (e.g., IUD insertion or sterilization). They also include screening and testing for reproductive tract infections, sexually transmitted infections (including HIV), cervical and breast cancer, and other gynaecologic and urologic conditions.

Gender

Gender[17] refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and workplaces. When individuals or groups do not 'fit' established

[12] https://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health.
[13] UNFPA. Issue 3: Adolescent Reproductive Health. ICPD Plan of Action. https://www.unfpa.org/resources/issue-3-adolescent-reproductive-health.
[14] Doortje Braeken and Ilka Rondinelli (2012). "Sexual and reproductive health needs of young people: Matching needs with systems". *International Journal of Gynaecology and Obstetrics.*
[15] https://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf.
[16] UNFPA. https://www.unfpa.org/familyplanning#:~:text=Family%20planning%20is%20the%20information,and%20when%20to%20have%20children.
[17] https://www.who.int/news-room/q-a-detail/gender-and-health.

gender norms, they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories (WHO).

Gender-based violence

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

Human immunodeficiency virus

Human immunodeficiency virus (HIV) is an infection that attacks the body's immune system, specifically the white blood cells called CD4 cells. HIV destroys these CD4 cells, weakening a person's immunity against opportunistic infections such as tuberculosis and fungal infections, severe bacterial infections, and some cancers (WHO).[18]

LGBTIQ+ definitions[19]

L – Lesbian: A woman who is attracted to women.

G – Gay: A man who is attracted to men.

B – Bisexual: A person who is attracted to both men and women.

T – Trans: The term encompasses gender identities that do not coincide with those assigned at birth. This refers to two concepts: transgender and transsexual.

A transgender person is born with physical characteristics that do not coincide with the gender with which they identify. Transsexuals are transgender people who have begun hormonal or surgical treatment to begin or complete a sex change.

I – Intersex: A person born with physical characteristics of both genders.

Q – Queer: People who do not want to identify under traditional or socially accepted labels.

+ – Other: People who do not identify with any of the other definitions.

Life skills education

Life skills education[20] is a structured programme of needs- and outcomes-based participatory learning that aims to increase positive and adaptive behaviour by assisting individuals to develop and practise psycho-social skills that minimize risk factors and maximize protective factors. Life skills education programmes are theory and evidenced based, learner focused, delivered by competent facilitators, and appropriately evaluated to ensure continuous improvement of documented results.

Peer education

Peer education[21] is an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. Peer education is the teaching or sharing of health information, values and behaviour, educating others who may share similar social backgrounds or life experience (UNICEF).

Reproductive health

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and will provide couples with the best chance of having a healthy infant (WHO).

Sexual and gender-based violence

Sexual and gender-based violence (SGBV)[22] is violence that is directed against a person on the basis of gender. It constitutes a breach of the fundamental right to life, liberty, security, dignity, equality

[18] WHO. https://www.who.int/health-topics/hiv-aids#tab=tab_1.
[19] https://www.bbva.com/en/sustainability/lgbtiq-whats-behind-the-acronym/.
[20] https://www.unicef.org/education/skills-development.
[21] UNFPA (2006). Peer Education Toolkit. https://www.unfpa.org/resources/peer-education-toolkit.
[22] WHO. https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

between women and men, non-discrimination, and physical and mental integrity. SGBV often reflects and reinforces inequalities between men and women. SGBV and violence against women are often used interchangeably, as most SGBV is inflicted by men on women and girls. Violence against women is all acts of SGBV that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in the promotion of self-esteem and overall well-being.

All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and whom to marry;
- decide whether, when and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability and Quality" framework on the right to health.

The services should include accurate information and counselling on sexual and reproductive health, including:

- evidence-based, comprehensive sexuality education;
- information, counselling and care related to sexual function and satisfaction;
- prevention, detection and management of sexual and GBV and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth and postnatal care;
- safe and effective abortion services and care;
- prevention, management and treatment of infertility;
- prevention, detection and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection and treatment of reproductive cancers.

Sexually transmitted disease (STD) or sexually transmitted infection (STI)

A sexually transmitted infection is any infection that is acquired through sexual contact in a substantial number of cases.[23]

[23] WHO factsheet. https://www.who.int/news-room/fact-sheets.

Unmet need for contraception/family planning

A woman has an unmet need[24] for contraception if she is married, in a consensual union, or unmarried and sexually active; is able to become pregnant; does not want to have a child in the next 2 years or wants to stop childbearing; and is not using any method of contraception, either modern or traditional. Women who use modern or traditional methods of contraception are considered to have their contraceptive needs met. The 2020 Guttmacher factsheet provides important factual information on the unmet need of adolescents in low- and middle-income countries.[25]

Youth-friendly services (WHO)

Youth-friendly services[26] are services that all adolescents are able to obtain, and these services should meet adolescents' expectations and needs and improve their health.

ANNEX 3 (CONT'D) : GLOSSAIRE SRH/VIH/GBV - FRENCH

Abus sexuel

Un abus sexuel sur mineur est une action à caractère sexuel, blessant ou risquant de blesser un garçon ou une fille, physiquement ou émotionnellement, impliquant un partenaire adulte ou un autre enfant. Il comporte souvent un contact corporel, mais pas toujours (exhibition, contrainte morale ou pornographie). Ces actions constituent des délits ou des crimes fermement réprimés dans la plupart des pays. La plupart des acteurs d'abus sexuels sur mineurs sont des hommes et des proches de la victime, voire des parents.[27]

Adolescent et jeune

L'adolescence est définie par l'Organisation Mondiale de la Santé (OMS) comme la période de la vie pendant laquelle une personne n'est plus enfant mais n'est pas encore un adulte. Il s'agit d'une période au cours de laquelle une personne subite de profonds changements physiques et psychologiques. Les attentes et les perceptions sociales des adolescents évoluent également. La croissance et le développement physiques s'accompagnent d'une maturation sexuelle, qui aboutit souvent à des relations intimes. La pensée conceptuelle et l'esprit critique se développent également, tout comme la conscience de soi lorsque les perspectives sociales requièrent une certaine maturité émotionnelle.

Ainsi, les « adolescent (e)s » sont définis comme des personnes appartenant au groupe d'âge des 10-19 ans, tandis que les « jeunes gens » sont définis comme ceux appartenant au groupe d'âge de 15-24 ans. Ces deux groupes d'âges qui se recoupent forment la tranche des « jeunes » qui rassemble les personnes appartenant à la catégorie des 10-24 ans. La présente étude prendra en compte le groupe des « jeunes gens » c'est-à-dire les 15-24ans. (WHO)

Accès universel à la SSR

L'accès universel à la santé sexuelle et reproductive pourrait être défini comme suit : «la même capacité pour toutes les personnes en âge de procréer de bénéficier en temps opportun, selon leurs besoins, de services appropriés d'information, de dépistage, de traitement et de soins qui leur permettront, indépendamment de leur âge, sexe, classe sociale, lieu de résidence ou appartenance ethnique : de décider librement du nombre de leurs enfants et de l'espacement de leurs naissances, et de différer ou de prévenir une grossesse ; de concevoir, d'accoucher dans de bonnes conditions, d'élever des enfants en bonne santé, et de combattre les problèmes d'infécondité ; de prévenir, de traiter et de combattre les infections de l'appareil reproducteur et les infections sexuellement transmissibles, y compris le VIH/sida, et les autres pathologies liées à l'appareil reproducteur, comme le cancer ; et d'avoir des relations sexuelles saines, sûres et satisfaisantes, qui contribuent à l'amélioration de la vie et des relations personnelles. » (UNFPA 2030)

[24] Population Reference Bureau. https://www.prb.org/resources/unmet-need-for-contraception-fact-sheet/.
[25] Guttmacher Institute (2020). https://www.guttmacher.org/sites/default/files/factsheet/adding-it-up-investing-in-sexual-reproductive-health-adolescents.pdf.
[26] WHO Youth-Friendly Services.
[27] https://www.who.int/fr/about/ethics/sexual-exploitation-abuse.

Autonomisation

Ensemble des changements nécessaires pour qu'une femme jouisse de ses droits fondamentaux : les effets conjugués des changements concernant à la fois ses propres aspirations et capacités, l'environnement qui influence ou dicte ses choix, ainsi que ses inter actions quotidiennes. (UNWOMEN)

Avortement

Les soins complets liés à l'avortement sont inscrits sur la liste des prestations de santé essentielles publiée par l'OMS en 2020. L'avortement est une intervention sanitaire simple qui peut être prise en charge de manière efficace par un large éventail d'agents de santé utilisant des médicaments ou par une intervention chirurgicale. Au cours des 12 premières semaines de grossesse, un avortement médicamenteux peut également être entièrement ou partiellement autogéré en toute sécurité par la femme enceinte hors d'un établissement de soins de santé (par exemple à domicile). Dans ce cas, la femme doit avoir accès à des informations précises, à des médicaments de qualité et au soutien d'un agent de santé qualifié (si elle en a besoin ou le souhaite pendant le processus). Les soins complets liés à l'avortement comprennent la fourniture d'informations, la prise en charge de l'avortement et les soins après l'avortement. Ils englobent les soins liés à une fausse couche (avortement spontané et avortement manqué), à l'avortement provoqué (interruption délibérée d'une grossesse en cours par des moyens médicaux ou chirurgicaux), à l'évacuation complète ainsi qu'à la mort fœtale (mort fœtale intra-utérine). Les informations contenues dans le présent aide-mémoire portent essentiellement sur les soins liés à l'interruption volontaire de grossesse.(WHO)

Besoins en planification familiale non satisfaits

On considère qu'il existe un besoin en services de planification familiale non satisfait lorsque les femmes mariées, fécondes, en âge d'avoir des enfants (généralement entre 15 et 49 ans) déclarent qu'elles ne veulent plus avoir d'enfants (limitation des naissances) ou qu'elles veulent attendre au moins deux ans avant leur prochaine grossesse (espacement des naissances), mais ne se servent d'aucune méthode de contraception (UNFPA).

Comportements sexuels

Les comportements sexuels se rapportent à l'ensemble des conduites et pratiques en rapport avec le sexe et les pratiques contraceptives.

Un comportement sexuel est dit à risque lorsqu'il expose l'individu qui l'adopte à la contraction des IST/VIH/Sida et de grossesses précoces. La perception d'un risque de santé donné dépend de plusieurs facteurs dont les avantages et les dangers associés au risque encouru, les contextes socioculturels et économiques, etc. (OMS, 2002). Nous retenons ici comme comportement sexuel à risque : la précocité des rapports sexuels, le multi partenariat et la non-utilisation du condom.

Contraception

La contraception selon l'OMS (2013), se définit comme l'« utilisations d'agents, de dispositifs, de méthodes ou de procédures pour diminuer la probabilité de conception ou l'éviter ». La contraception est l'utilisation des moyens et techniques pour empêcher la survenue d'une grossesse. C'est une infécondité volontaire obtenue par l'usage des méthodes, techniques ou pratiques appropriées connues sous l'appellation de méthodes anticonceptionnelles ou méthodes contraceptives. L'efficacité de ces méthodes est conditionnée par leur utilisation correcte.

Droits sexuels

OMS : La santé sexuelle requiert une approche positive et respectueuse de la sexualité et des relations sexuelles, ainsi que la possibilité d'avoir des expériences sexuelles agréables et sûres, sans contrainte, discrimination et violence. Pour atteindre et maintenir un bon état de santé sexuelle, les droits sexuels de tous les individus doivent être respectés et protégés. (WHO)

Education Sexuelle Complète

Tous les jeunes doivent un jour ou l'autre prendre des décisions susceptibles de bouleverser leur vie en matière de santé sexuelle et reproductive. Pourtant, des études révèlent que la majorité des adolescent·e·s n'ont pas suffisamment de connaissances pour prendre ces décisions en toute responsabilité, ce qui les rend vulnérables aux rapports sexuels forcés, aux infections sexuellement transmissibles et aux

grossesses non désirées. L'éducation complète à la sexualité permet aux jeunes de prendre des décisions éclairées sur leur sexualité, leur bien-être et leur santé, et de défendre leurs droits dans ces domaines. Elle leur donne les ressources pour le faire sous forme de connaissances, de comportements et de compétences. Tout cela constitue un prérequis pour l'exercice d'une pleine autonomie corporelle, c'est-à-dire avoir le droit de faire ses propres choix en ce qui concerne son corps, mais aussi disposer de l'information permettant de faire ces choix de façon judicieuse.(UNFPA)

Genre

Par «genre», on entend les rôles qui, selon la représentation que s'en fait la société, déterminent les comportements, les activités, les attentes et les chances considérés comme adéquats pour tout un chacun dans un contexte socio culturel donné. Ce terme désigne aussi les relations entre personnes et la répartition du pouvoir dans ces relations.

Le genre a un lien avec le sexe biologique (masculin ou féminin), mais il est distinct de lui.

Le genre est un déterminant des inégalités en santé, aussi bien à lui tout seul qu'en association (phénomène d'intersectionnalité) avec la condition socio-économique, l'âge, l'appartenance ethnique, le handicap, l'orientation sexuelle, etc.

Le genre a une incidence sur toutes les cibles relevant de l'objectif 3 de développement durable parce qu'il interagit avec d'autres déterminants, influe sur les risques, les taux d'exposition et les comportements et suscite une réponse différenciée du système de santé.

Le genre a une influence sur l'emploi, les conditions de travail et le parcours professionnel des agents de santé et des travailleurs sociaux.

L'OMS apporte un soutien aux États Membres en s'attachant à promouvoir des systèmes de santé qui prennent en compte, comprennent et transforment la manière dont le genre détermine les comportements en matière de santé, l'accès aux services et le parcours thérapeutique, et la manière dont il interagit avec d'autres déterminants de la santé et facteurs d'inégalité (OMS)

L'égalité des sexes et autonomiser toutes les femmes et les filles (ODD5)

L'égalité des sexes n'est pas seulement un droit fondamental à la personne, elle est aussi un fondement nécessaire pour l'instauration d'un monde pacifique, prospère et durable. Des progrès ont été réalisés au cours des dernières décennies. Davantage de filles sont scolarisées, moins de filles sont contraintes de se marier précocement, davantage de femmes siègent dans les parlements et occupent des postes de direction, et les lois sont réformées afin de faire progresser l'égalité des sexes. En dépit de ces avancées, de nombreux défis subsistent : les lois et les normes sociales discriminatoires restent omniprésentes ; les femmes restent sous-représentées à tous les niveaux du pouvoir politique ; et, 20 % des femmes et des filles âgées de 15 à 49 ans ont subi des violences physiques ou sexuelles de la part d'un partenaire intime sur une période de 12 mois. (UNDG)

LGBTIA+

La plupart du temps, LGBTIA veut dire "Lesbiennes, Gays, Bisexuels, et Transsexuels ou et Transgenres". Cela dit, différentes personnes, communautés et organismes utilisent différents termes qui leur conviennent le mieux. Par exemple, des variantes qu'on peut voir sont LGBTQ ou LGBTI ou LGBTQI ou LGBTQIP. Dans ce cas, le "I" veut dire "intersexuel", le "Q" veut dire "queer" et le "A" veut dire "Autres". Personnes qui ne s'identifient à aucune des autres définitions Ces termes ont été créés pour respecter la diversité de la sexualité des gens et pour être aussi inclusif que possible dans le langage et l'approche à la sexualité.

Méthodes modernes

Il s'agit des méthodes cliniques et d'approvisionnement de planification familiale par opposition aux méthodes traditionnelles. Parmi les méthodes modernes nous pouvons citer, la pilule, les dispositifs intra-utérins (DIU ou stérilet), les injections, les préservatifs et la stérilisation sans oublié le diaphragme, les mousses et gels, les implants, le préservatif féminin. La méthode de l'aménorrhée de la lactation (MAMA), la méthode des jours fixes (MJF), la méthode d'ovulation de Billings, l'abstinence et le retrait, sont considérées comme des méthodes de planification familiale naturelle.

Planification Familiale

La planification familiale regroupe l'information, les moyens et les méthodes qui permettent aux individus de décider librement de la dimension de leur famille et de l'espacement des naissances. Cela comprend un large éventail de contraceptifs – dont la pilule, les implants, les dispositifs intra-utérins, les procédures chirurgicales qui limitent la fertilité et les méthodes barrières telles que les préservatifs – ainsi que des méthodes non invasives comme la méthode du calendrier ou l'abstinence. La planification familiale comprend également des informations sur la grossesse volontaire, ainsi que sur le traitement de l'infertilité. L'accès à la planification familiale volontaire et sans danger constitue un droit fondamental. La planification familiale est cruciale pour l'égalité des sexes et l'autonomisation des femmes ; c'est également un facteur essentiel de réduction de la pauvreté. Pourtant, environ 217 millions de femmes souhaitant éviter une grossesse n'ont pas la possibilité d'avoir recours à des méthodes de planification familiale efficaces et sans danger, soit parce qu'elles n'ont pas accès aux informations et aux services nécessaires, soit parce qu'elles ne sont pas soutenues par leur partenaire ou leur communauté. Cela met en danger leur capacité à assurer leur propre avenir, ainsi que celui de leur famille et de leur communauté. Pour élargir la portée de ces services, l'UNFPA milite en faveur de politiques de planification familiale, garantit un approvisionnement constant et fiable de contraceptifs de qualité, contribue à renforcer les systèmes nationaux de santé et recueille des données en vue d'étayer ses interventions. Le Fonds assure également un leadership mondial sur l'amélioration de l'accès à la planification familiale : il réunit ses partenaires, notamment les gouvernements, afin d'élaborer des politiques, et propose une assistance programmatique, technique et financière aux pays en développement. (UNFPA)

Santé de la Reproduction

Selon l'Organisation Mondiale de la Santé (OMS), la Santé de la Reproduction (SR) est « un état de bien-être physique, mental et social total, et non la simple absence de maladie ou de handicap, pour tout ce qui a trait au système de la reproduction, à ses fonctions et ses mécanismes. La santé de la reproduction suppose par conséquent que les individus aient une vie sexuelle satisfaisante et sûre, ainsi que la capacité de se reproduire et la liberté de décider quand et à quelle fréquence le faire. Cette dernière question repose implicitement sur les droits des hommes et des femmes à être informés et à accéder à des méthodes de planification familiale (PF) sûres, efficaces, abordables et acceptables qu'ils auront choisies eux-mêmes, ainsi qu'à d'autres méthodes de leur choix de régulation de la fécondité qui soient conformes à la législation ; elle se fonde également sur le droit à l'accès des services de soins de santé appropriés qui garantiront aux femmes une grossesse et un accouchement sûrs, et qui offriront aux couples une meilleure chance d'avoir un enfant en bonne santé. »

Les 8 composantes du paquet Santé de la Reproduction (CIPD1994 para 7.6)	
1.	La Santé Maternelle et Infantile (MMR, soins du nouveau-né, soins liés à l'avortement, PCIME);
2.	La lutte contre les IST VIH/SIDA
3.	La Lutte contre l'Infécondité /Infertilité et des Dysfonctionnement Sexuels
4.	La lutte contre les Pratiques Néfastes (excision, violence sexuelle domestique, mariage précoce)
5.	La lutte contre les Pratiques Néfastes (excision, violence sexuelle domestique, mariage précoce)
6.	La Santé de l'Adolescent
7.	La lutte contre le Cancer génitaux, mammaires
8.	La prise en charge de la Santé de la Reproduction des Personnes Âgées (IEC, Andropause, Ménopause, Sexualité)

Santé Sexuelle et Reproductive

Une bonne santé sexuelle et reproductive est un état de bien-être total sur le plan physique, mental et social, relativement à tous les aspects du système reproductif. Dans cet état, les personnes sont en mesure de profiter d'une vie sexuelle satisfaisante et sûre et ont la capacité de procréer et de décider si elles désirent le faire ou non, ainsi que quand et comment. Pour préserver sa propre santé sexuelle et reproductive, il faut pouvoir accéder à des informations exactes et à la méthode de contraception sûre, efficace, abordable et acceptable de son choix. Toutes les personnes doivent être informées et habilitées à se protéger des infections sexuellement transmissibles. Lorsqu'elles décident d'avoir des enfants, les femmes doivent également pouvoir accéder aux services qui pourront les aider à vivre au mieux leur grossesse, à accoucher en toute sécurité et à mettre au monde un bébé en bonne santé (UNFPA).

Santé sexuelle et reproductive des adolescents et jeunes

La Convention relative aux droits de l'enfant de 1990 a été la première reconnaissance internationale des droits des adolescents à la santé, notamment en matière de la reproduction. Dans cette même optique, la loi n° 2003 - 04 du 03 mars 2003 relative à la Santé Sexuelle et Reproductive (SSR) au Bénin déclare en son article 2, que : tous les individus sont égaux en droit et en dignité en matière de santé de la reproduction. Le droit à la santé de la reproduction est un droit universel fondamental garanti à tout être humain, tout le long de sa vie, en toute situation et en tout lieu. Aucun individu ne peut être privé de ce droit dont il bénéfice sans aucune discrimination fondée sur l'âge, le sexe, la fortune, la religion, l'ethnie, la situation matrimoniale. Cet article plante le décor par rapport à la nécessité de fournir aux adolescents et jeunes, l'information et les services pour les aider à comprendre leur sexualité et à se protéger des Grossesses Non Désirées (GND) et/ou précoces et des Infections Sexuellement Transmissibles (IST). (OMS)

VIH/Sida

Le virus de l'immunodéficience humaine (VIH) cible le système immunitaire et affaiblit les défenses de l'organisme contre de nombreuses infections et certains types de cancer que les personnes ayant un système immunitaire en bonne santé peuvent combattre plus facilement. Avec l'altération et la suppression du fonctionnement des cellules immunitaires par le virus, une immunodéficience s'installe progressivement chez les sujets infectés. La fonction immunitaire est classiquement mesurée par la numération des cellules CD4.

Le stade le plus avancé de l'infection à VIH est le syndrome d'immunodéficience acquise (sida), qui en l'absence d'un traitement peut mettre des années à apparaître selon la personne. Ce stade se définit par l'apparition de certains cancers, d'infections ou d'autres manifestations cliniques sévères à long terme. (OMS)

Violence basée sur le genre VBG

La violence basée sur le genre (VBG), parfois aussi appelée violence sexiste, se réfère à l'ensemble des actes nuisibles, dirigés contre un individu ou un groupe d'individus en raison de leur identité de genre. Elle prend racine dans l'inégalité entre les sexes, l'abus de pouvoir et les normes néfastes. (UN WOMEN).

ANNEX 4: INSTRUCTIONS FOR INTERVIEWERS

The tools have been piloted to test the content and format, focusing on the following:

- The clarity of the questions
- Respondents' willingness to provide the information sought in their specific cultural context
- The time required for administration
- Obstacles to use (e.g., cultural obstacles for sensitive subject areas, difficulty in identifying respondents such as key populations, institutional and contextual difficulties, etc.)

The interviews will take about 30 minutes with each respondent.

The ethical principles that should be observed during fieldwork are shown in Annex 2.

Interviewers should familiarize themselves with national laws and regulations relevant to SRHR, GBV and HIV, especially the following sensitive themes:

- Access to services for adolescents
- Access to safe abortion
- Laws related to LGBTIQ and other key populations for HIV/AIDS

Interviewers should be aware of local taboos and sensitivities, and be familiar with local terminology related to SRHR, GBV and HIV. Interview questions should be asked in the language normally used by respondents.

Data recording

Your organization will provide you with data collection sheets for recording responses. These may be 'paper-based' Excel sheets or may be digitized to save you time. Only key points should be noted in the responses to each question.

Data collection

Each tool will be used with a minimum of three respondents in each group in each location. This is a standard practice in market research: If results from the first two interviews differ, the third can give a first indication if one of the results is a maverick.

Identification of respondents

TOOL NUMBER	RESPONDENT PROFILES	COMMENTS
1 – Policymaker	• District disaster management staff • Mayor • Chief medical officer	Try to get one of each, if feasible
2 – Health provider	• Health facility manager • Medical staff – doctor, nurse	
3 – Community health worker	• Community health worker • Outreach worker • Peer educator	Can substitute with other community resource persons if necessary
4 – Community member	• Women • Adolescent girls • At-risk groups	If possible, one from each category
5 – Community-based organization	• Representative of civil society organization or network • Teacher • Community leader	
6 – Community priorities	• Women • Adolescent girls • At-risk groups	If possible, one from each category

If your organization is interested in specific at-risk groups, Tools 4 and 6 should be used with respondents from those groups.

Your organization will provide introductions to key people in the local context. You can request additional contacts from these key people, using a 'snowball' approach. Health sector staff and non-governmental organizations should be able to assist in identifying suitable people.

Procedure for the interviews

Before you start the interview, make sure you are thoroughly familiar with all the questions and with the SRHR, GBV and HIV context in your country and the locality.

Ensure a safe and comfortable place for the interviews. Request help from your initial contacts in UNFPA or other agencies if necessary.

- Some respondents can be interviewed in their work centre.
- Some may be willing to be interviewed in their homes.
- Check with local authorities if you may need to take extra precautions to safeguard respondents (e.g., to avoid backlash when discussing sensitive questions in given cultural contexts – this is especially important for vulnerable groups).
- Be very careful to ensure privacy so people can talk freely.

Note the start and finish time for each interview.

Explain the purpose of the interview clearly to the respondents and ask if they have any questions prior to the interview.

- Emphasize that the interviews are confidential and that the respondents will not be identified as individuals.
- Ensure the respondents feel comfortable and are willing to participate.
- Some guidance for introduction is included at the start of each tool.

Note answers to each question and transfer them to the Excel sheet or digitized data collection tool after the interview is finished.

When you close the interview, ask the respondents if they have any other comments or observations they would like to contribute.

ANNEX 5: DATA COLLECTION SHEET

Example of data collection sheet for Tool 1.

	QUESTIONS	INTERVIEWEE 1	INTERVIEWEE 2	INTERVIEWEE 3	INTERVIEWEE 4	INTERVIEWEE 5
1.	What is your role around emergency preparedness and disaster risk reduction?					
2.	What were some of the health and sexual and reproductive health challenges in the most recent emergency (outbreak of violence, natural disaster)?					
	Explain what we mean by challenges: e.g., reduced access to services, lack of supplies, impacts on service quality, etc.					
3	To what degree are you aware of the Minimum Initial Service Package for Sexual and Reproductive Health? *If the respondent is not familiar with the MISP standard, please review the objectives of the MISP. A short description is available at:* https://fp2030.org/sites/default/files/ready_to_save_lives/MISP_readiness_assessment.pdf.					
4.	Who within your community may be most at risk or vulnerable when a crisis occurs?					
	Probe for persons with disabilities, the elderly, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents, orphans and vulnerable children, pregnant women. Probe: How and why are such persons more vulnerable?					

	QUESTIONS	INTERVIEWEE 1	INTERVIEWEE 2	INTERVIEWEE 3	INTERVIEWEE 4	INTERVIEWEE 5
	Are such persons currently consulted to ensure health services, especially sexual and reproductive health services, best meet their needs? How so, and to what extent?					
5	What are the main challenges the district has experienced when responding to the community's sexual and reproductive health needs in past emergencies? What services were disrupted and how?					
6	Did that affect the community? What attempts were made to continue providing disrupted services?					
7	Which of these challenges could have been addressed before the emergency and in what way?					
8.1	Does the district routinely review the supply chain commodity risk management and pre-positioning?					
8.2	Does the review include SRH and HIV supplies? *These would include supplies for women to manage their menstruation, delivery kits for pregnant women, newborn kits for newly born babies, and hygiene kits.*					
9.1	Are there national or subnational policies, laws, protocols and strategies that hinder the provision of comprehensive SRH services to at-risk groups, including vulnerable women and girls, at the district level at any given time?					
10.1	Has the district identified an SRH, GBV and HIV focal point for emergencies?					

	QUESTIONS	INTERVIEWEE 1	INTERVIEWEE 2	INTERVIEWEE 3	INTERVIEWEE 4	INTERVIEWEE 5
10.2	Does the district allocate a budget for SRH preparedness and contingency planning specifically?					
10.3	Does the district routinely implement disaster-response simulations/drills and include SRH, HIV and GBV issues?					
10.4	Does the district have staff trained specifically in the MISP?					
11	Does the district work with groups serving at-risk populations to ensure their voices are heard in processes to build community resilience in SRHR, GBV and HIV?					
	Probe for persons with disabilities, the elderly, LGBTIQ persons, persons who engage in sex work, persons from minority groups, adolescents, etc.					
12	Has the district pre-positioned supplies and equipment to provide MISP for SRH services should an emergency occur? What do you think needs to be strengthened or improved for this district to better address preparedness for sexual and reproductive health in emergencies?					
13	Do you foresee any barriers that could impede efforts to strengthen or improve the district's capacity to address preparedness for sexual and reproductive health in emergencies? If so, what are they?					

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