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2gether 4SRHR

Harmonization of vulnerability assessment tools for SRHR, HIV and GBV in humanitarian settings

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Contents

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Abbreviations

AoR	
EAC	East African Community
DRC	Demographic Republic of Congo
ESA	eastern and southern Africa
GBV	gender-based violence
HESPER	Humanitarian Emergency Settings Perceived Needs Scale
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
JIAF	Joint and Intersectoral Analysis Framework
KII	key informant interviews
LGBTIQ	lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning
MICS	Multiple Indicator Cluster Survey
MIRA	Multi-sector Initial Rapid Assessment
MISP	Minimum Initial Service Package
NGO	non-governmental organization
NHMIS	National Health Management Information System
NVAC	National Vulnerability Assessment Committee
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RVAA	Regional Vulnerability Assessment and Analysis
RVAAC	Regional Vulnerability Assessment and Analysis Committee
SADC	Southern African Development Community
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAC	United Nations Disaster Assessment and Coordination
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees (UN Refugee Agency)
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WRC	Women's Refugee Commission

1 Executive summary

This report presents the findings from a study on the need for harmonized and integrated vulnerability assessment tools for sexual and reproductive health and rights (SRHR), gender-based violence (GBV) and HIV in eastern and southern Africa. The objective of the study was to develop and test a suite of harmonized tools to strengthen the evidence-based advocacy case for strengthening SRHR, HIV and GBV in vulnerability assessment practices and coordination mechanisms. The study was conducted in five countries: Democratic Republic of Congo (DRC), Madagascar, Malawi, Mozambique and Zimbabwe. The method was highly participative, with input from a wide range of stakeholders through interviews and workshops. Activities included document review, key informant interviews, rapid review of current vulnerability assessment processes in the study countries, and design and testing of the tools.

The study reviewed a range of existing SRHR, GBV and HIV tools and processes for identifying SRHR, GBV and HIV vulnerabilities, but most are designed as stand-alone tools rather than seeking integration with other vulnerability assessment processes. The study also identified challenges to harmonization and integration with assessments in other sectors. It highlighted important gaps in the data collected and used, particularly information on the perspectives and priorities of the people most affected by slow-onset and sudden-onset emergencies at the local level. There are limited tools and processes designed to collect information at the local level and/or for promoting the participation of the most vulnerable and hard-to-reach groups, whose voices are seldom heard.

On the basis of these findings, a suite of harmonized tools was developed to identify vulnerabilities in SRHR, GBV and HIV in local contexts to inform standard vulnerability assessments that do not routinely integrate SRHR issues. The tools are people centred and can be used to identify the priorities of different groups who are affected by humanitarian emergencies on both the supply and demand side of SRHR, GBV and HIV services, with a focus on community perspectives and the most vulnerable groups. The tools were adapted from existing WRC and WHO vulnerability assessment questionnaires, with input from the participating United Nations agencies and other regional and national stakeholders. They were designed to be flexible and adaptable to specific organizational needs and specific contexts, and can be used to complement other assessments or as a stand-alone exercise focusing on SRHR, GBV and HIV.

The tools were pilot tested in the five study countries. Information from the pilot was used to finalize the tools. They were compiled into a handbook explaining why they are needed, what they can do, and how they can be used to identify vulnerabilities and to inform work on strengthening community resilience. This final study report and the handbook were validated by national stakeholders in each country.

The study is seen as a first step towards harmonization and the integration of SRHR, GBV and HIV into vulnerability assessment, and towards increasing the focus on community perspectives and the needs of vulnerable groups. Next steps will include exploiting the potential value addition of regional structures for advocacy with decision makers; promoting the use of the handbook and tools to complement ongoing vulnerability assessment work; and exploring possible roll-out to other countries.

2 Introduction

Africa, in particular the eastern and southern Africa (ESA) region, is home to some of the world's worst humanitarian crises, leaving more than 76 million people in dire need of humanitarian assistance (OCHA, 2023). The increased frequency of climate conflicts and other humanitarian and public health emergencies in the region is posing multiple and emerging threats to the vision of sustainable development outlined in the International Conference on Population and Development Programme of Action. Climate-related hazards in the form of droughts, floods and cyclones push people into food insecurity, reduce their access to basic health care and education, and increase the risk of violence and abuse (see, for example, IAWG, 2018).[1] The recurrent humanitarian crises increase the risk of death, disease and loss of livelihoods among affected populations, and highlight the need to strengthen the resilience of individuals, communities and health systems to prepare for and respond to protracted and recurrent threats. The ongoing humanitarian crises left the population even more exposed to the impacts of the COVID-19 pandemic, which overwhelmed the health system and severely disrupted access to life-saving health interventions, in particular sexual and reproductive health (SRH) services.

Women and girls, especially adolescent girls and young women, people living with HIV, key populations at risk of HIV, and persons with disabilities are affected disproportionately in both sudden and slow-onset emergencies, and in conflict and post-conflict situations. They face multiple SRHR challenges such as early or unwanted pregnancy, and increased risks of GBV and HIV infection. They face obstacles to exercising their SRH rights due to stigma and discrimination within the community and from health service providers. They may be hard to identify and to reach with health and outreach services, and stigma or discrimination by health service providers makes them reluctant to use services. Changes resulting from emergencies can sever their support systems and increase their vulnerability. These groups require additional support and awareness of their needs, as well as opportunities to make their voices heard in planning for slow-onset and sudden-onset emergencies and in programmes to strengthen community resilience to reduce vulnerabilities (UNICEF, 2021).

Vulnerability assessments in emergencies and in 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 assessment 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, nor to integrate these areas into the principal vulnerability assessments carried out in other sectors such as food security, water, sanitation and hygiene (WASH), etc. Although many United Nations agencies have been working in humanitarian response for decades with well-established coordination mechanisms, there are important gaps in responding to the needs and priorities of vulnerable groups, including those related to SRHR. Harmonization of SRHR, HIV and GBV in vulnerability assessments is an important step towards addressing these gaps.

[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, the GBV Information Management 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).

The United Nations agencies are committed to taking action to reduce the disproportionate impacts of emergencies on vulnerable groups and ensure that SRHR, GBV and HIV are an integral part of humanitarian preparedness and a humanitarian response. To strengthen the frameworks for evidence-based humanitarian response on SRHR, HIV and GBV, four regional United Nations agencies (UNAIDS, UNFPA, UNICEF and WHO) covering the east and southern Africa region commissioned a study on strengthening vulnerability assessment tools for SRHR services in humanitarian settings. The study was commissioned under a regional SRHR programme (2gether 4 SRHR) where the four agencies since 2018 have joined forces in improving SRHR for all people in east and southern Africa, particularly adolescent girls, young people and key at-risk populations for HIV[2] across the humanitarian, development and peace nexus.

The study aimed to develop and test a suite of harmonized tools to strengthen the advocacy case for including SRHR, HIV and GBV in vulnerability assessments practices and coordination mechanisms. The study reviews a wide range of vulnerability assessment tools in slow-onset and sudden-onset humanitarian settings. It provides a contextual framework for the integration of SRHR, GBV and HIV within vulnerability assessments in the national health sector as well as in humanitarian response agencies covering food security, WASH and livelihoods, thus reflecting the integral needs of people in humanitarian situations.

Objectives

The overall study objective is to support the strengthening of regional humanitarian preparedness through the development of harmonized assessment tools that measure forms of vulnerability and their impact on the delivery of and access to SRHR, GBV and HIV services that can be integrated with and inform standard vulnerability assessments.

The study included the design and field testing of tools in five ESA countries (DRC, Madagascar, Malawi, Mozambique and Zimbabwe). By adopting participatory processes with key national and regional stakeholders, it is hoped that the assessment of the processes and the related findings and tools will encourage the inclusion of SRHR in vulnerability assessments in other ESA countries, with a corresponding positive impact on issues related to SRHR, GBV and HIV among vulnerable groups and those whose voices are often not heard in humanitarian situations. It is also hoped that the tools and processes will contribute to increasing the resilience of communities to sudden-onset and slow-onset humanitarian situations.

The key steps in the study methodology (discussed in more detail in Section 2.3 below) were the following:

1. Document review on existing approaches and tools for vulnerability assessment and inclusion of SRHR, GBV and HIV
2. Review of SRHR, GBV and HIV data sources and availability in humanitarian settings, including national surveys, online and real-time data, as well as publicly available information from the national health information systems, United Nations agencies and non-governmental organizations (NGOs)
3. Rapid assessments of current vulnerability assessment practices, needs, priorities and entry points for inclusion of SRHR, GBV and HIV in the five study countries
4. Development of draft prototype tools for piloting, with input from stakeholders through participative workshops
5. Piloting of the tools and finalization of a flexible module, including tools, interviewer instructions and guidance for advocacy

[2]Key populations include sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, and people in prisons and other enclosed settings.

What are the gaps the study tries to address?

The following are the key gaps:

- While vulnerability assessments are carried out in other sectors (food security, WASH, health), only a few include sufficient information on or coverage of SRHR, GBV and HIV.[3]
- The implementation of vulnerability assessments at country and regional levels is not sufficiently harmonized between humanitarian and social development agencies at local, national and international levels, including United Nations agencies, national government departments, international NGOs, NGOs and community organizations. Most organizations have their own specific focus and priorities. Harmonization is important to ensure coverage of the most important SRHR, GBV and HIV areas, without unnecessary duplication of effort and information.
- There are gaps in the collection and use of qualitative and quantitative information on vulnerability, as well as information related to the perspectives of communities and the priorities of vulnerable groups. This information is essential for effective responses. Information is often context specific and may also be specific to a certain humanitarian emergency. Furthermore, there are many existing sources of information within communities and target groups, along with other local data, but these are often underutilized in vulnerability assessments.

This report presents the principal findings of the study and the suite of vulnerability assessment tools that have been developed as a collective and participatory effort through consultation with stakeholders at regional and country levels.

The ensuing chapters cover the following:

- **Study methodology**
- **Existing vulnerability assessment practices, tools and data**
- **Development of integrated tools to harmonize SRHR, GBV and HIV vulnerability assessment**
- **Ways forward**
- **Recommendations**
- **Conclusions**

[3] SADC vulnerability assessments, for example, include some elements of gender and HIV, but not SRHR.

Methodology

The study was carried out between late 2021 and early 2023. It focused on the eastern and southern Africa region, with fieldwork in five study countries (DRC, Madagascar, Malawi, Mozambique and Zimbabwe). This section gives an outline of the overall approach and methodology. Give a voice to the people affected by humanitarian situations, including the most vulnerable groups.

3.1 Participative approach

This study involved active participation by a wide range of stakeholders at regional and country levels. Stakeholders' input was sought at all phases in the study through a series of workshops to present progress, validate analysis and agree on key points to be addressed at each stage. This ensured a high level of engagement and buy-in among government offices, United Nations agencies and development partners at country and regional levels, which is essential for promoting the use of the vulnerability assessment tools and the integration of SRHR, HIV and GBV into humanitarian responses.

3.2 Ethical considerations

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

- **Do no harm** – ensuring confidentiality and anonymity, gaining permission to collect data, and aligning with international human rights conventions.
- **Protection and empowerment** – respecting the attitudes and behaviours of informants during data collection, while ensuring privacy, objectivity, transparency and cultural sensitivity.

These principles are particularly important when gathering data from women, children, and marginalized or vulnerable groups, who were the focus of the study's proposals and fieldwork. Risks of stigmatizing key informants (individuals, families, communities or stakeholders from other levels) were identified and mitigated through careful planning and implementation of interviews and discussion groups. As vulnerable groups were included in data collection activities, the team ensured they could express themselves in a setting in which they felt comfortable and safe, and in which their dignity was respected. The data collection tools did not include any biased or affirmative questions, and all the contracted experts maintained a neutral position during data collection activities to ensure impartiality. National experts were fluent in the languages in which the beneficiaries were at ease. As the tools cover sensitive topics, the questions were designed to be culturally acceptable – and this was checked during fieldwork.

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

Prior to the start of the fieldwork for comprehensive piloting, all members of the field consultancy team were thoroughly briefed on the ethical principles of this study, the national ethical compliance requirements in the sample countries, and approaches to be used with specific respondent groups. Stakeholders participating in the assessment activities were informed about their right to withdraw from activities or refuse to answer questions at any time. The team explained that collecting data does not mean that participants' feedback would necessarily appear in the report or that it will lead to changes, thereby managing informants' expectations.

These ethical considerations are covered in more detail in the *Handbook for Conducting Multi-Stakeholder Vulnerability Assessments for Sexual and Reproductive Health and Rights, HIV and Gender-Based Violence in Humanitarian Settings*, abbreviated to 'handbook' in the rest of this text.

3.3 Activities

The study followed a stepwise process, each step building on the findings of the previous phase. The principal steps in the study were as follows.

STEP 1

A document review to:

a. identify existing vulnerability assessment processes and tools at global, regional and national levels, and the extent to which they include SRHR, GBV and HIV;

b. identify sources of primary and secondary SRHR, GBV and HIV data for humanitarian response.

STEP 2

Identification of gaps in existing tools, processes and data.

Key gaps in these three areas were identified during the desk study and validated in key informant interviews and a stakeholder workshop.

STEP 3

Rapid assessment of current vulnerability assessment processes and procedures in the five study countries.

The rapid assessments reviewed the level of inclusion of SRHR, GBV and HIV in existing activities, interest in the topics among stakeholders, and opportunities and challenges at country and regional levels. The methods used by the national consultants in each country were document review and key informant interviews (KIIs). Key informants included staff from government, United Nations agencies and other humanitarian agencies.

STEP 4

Analysis of findings.

Findings that were common to all the countries, as well as those that were context specific, were discussed in a stakeholder workshop, together with the challenges and opportunities for the next steps of the work. Stakeholders agreed on an approach to develop flexible tools and processes that incorporate the perspectives of communities and vulnerable groups, and that can be adapted by countries and agencies to their specific needs.

STEP 5

A prototype flexible module of tools that can be used in conjunction with other vulnerability assessment tools was designed. The module was based on existing tools, which were adapted to (a) cover the key SRHR, GBV and HIV topics of interest to participants, and (b) focus on communities' and vulnerable groups' perspectives. The module was discussed in a stakeholder workshop, with feedback for the finalization of prototypes.

STEP 6

Pilot testing of the module in the five study countries. Each tool was tested with three respondents in each country, achieving a total of 90 respondents.

The development of the tools module and pilot testing is discussed in more detail in the following chapters.

3.4 Limitations of the study

only five countries were included in the rapid assessments and field testing. The selected countries cover a range of contexts and humanitarian vulnerabilities. The selection of countries is not representative of the region, but findings that were common to several or all of the countries are likely to be relevant in other country contexts. Country-specific findings can indicate challenges, opportunities and entry points, which can also provide useful inputs for work in countries outside the ESA region.

Multiple participants in the study and different stakeholder priorities greatly enriched the process and its products, but also presented an important challenge in designing prototypes to cover a wide range of needs. This led to an agreement to develop a flexible module so that users can select the tools that are applicable to their own contexts and adapt them to meet their specific needs in national and local contexts.

Overview of existing vulnerability assessment practices, tools and data availability

This section presents key findings from the document reviews and rapid assessments in the five study countries and at regional level. It covers coordination mechanisms, available tools, data availability, and challenges, opportunities and gaps.

4.1 Humanitarian coordination mechanisms

The United Nations has established humanitarian response coordination mechanisms at global, regional and national levels. The overall humanitarian response is overseen by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA).[4]

Within the United Nations, Global Clusters and Areas of Responsibility have been set up to coordinate the work in different sectors.[5] The Global Health Cluster, led by WHO, and the Global Protection Cluster, coordinated by the United Nations High Commissioner for Refugees (UNHCR), are the most important coordination mechanisms for SRHR, GBV and HIV. Although GBV is part of the Protection Cluster, in recent years it has also been integrated as a cross-cutting issue in many other clusters. WHO, UNFPA and UNICEF participate in the Health Cluster; UNFPA and UNICEF are also members of the Protection Cluster, where UNFPA coordinates the GBV Area of Responsibility and UNICEF the Child Protection Area of Responsibility.[6]

HIV is also a cross-cutting issue. UNHCR, in partnership with UNAIDS, the World Food Programme (WFP) and the Inter-Agency Task Team to Address HIV in Humanitarian Emergencies,[7] has recently developed guidelines for the integration of HIV into the work of the Health, Protection, Nutrition and Food Security Clusters (2020). The clusters also work at the national level, where the Health and Protection Clusters work under the lead of the UN Humanitarian Coordinator (or Resident Coordinator) and the Humanitarian Country Team, and are also active in the coordination of regional humanitarian response.[8] Other coordination mechanisms at the global level are United Nations Disaster Assessment and Coordination (UNDAC),[9] which coordinates emergency response, and UNHCR,[10] which works with refugees affected by sudden-onset emergencies and ongoing emergencies such as climate change. The International Organization for Migration (IOM) coordinates with other agencies working with migrant populations.

The Inter-Agency Standing Committee (IASC) is an inter-agency coordination forum of UN and non-UN humanitarian agencies.[11] It has developed field manuals for integrated humanitarian response and for groups to focus on specific aspects of humanitarian response related to SRHR, GBV and HIV – for example, the IASC Reference Group on Gender and Humanitarian Action and the Inter-Agency Task Team to Address HIV in Humanitarian Emergencies.[12] Within the health sector, the WHO Health Emergency

[4] A full explanation of the United Nations global architecture for humanitarian response can be found on the OCHA website.
[5] The cluster approach was set up to ensure that there is readily identifiable leadership. Clusters have not been formed in sectors where leadership is already clear (e.g. FAO, WFP, UNHCR): https://interagencystandingcommittee.org/system/files/2021-03/Guidance%20Note%20on%20Using%20the%20Cluster%20Approach%20to%20Strengthen%20Humanitarian%20Response.pdf.
[6] For more information on the United Nations clusters, see https://www.unocha.org/our-work/coordination/humanitarian-coordination-leadership. For the Health Cluster, see https://healthcluster.who.int/our-work. For the Protection Cluster, see https://www.globalprotectioncluster.org/.
[7] Humanitarian emergency is an event or series of events that represents a critical threat to the health, safety, security or well-being of a community or other large group of people, usually over a wide area.
[8] Key informant interviews during the rapid assessments.
[9] See OCHA webpage for more information on UNDAC and its activities: https://www.unocha.org/our-work/coordination/un-disaster-assessment-and-coordination-undac.
[10] The UNHCR webpage has extensive information on functions and activities: https://www.unhcr.org/emergencies.html.
[11] https://interagencystandingcommittee.org/the-inter-agency-standing-committee.

and Disaster Risk Management (HEDRM) framework[13] (WHO, 2019) sets out a structure for an integrated approach to manage health risks and build resilience, one that includes SRHR, GBV and HIV.

There has been some tough criticism of how the coordination mechanisms work in practice from IASC itself, through the work of the Grand Bargain to implement the 2015 Sendai Framework for Disaster Risk Reduction. The Grand Bargain Workstream 5, convened by OCHA and the European Commission for Humanitarian Aid (ECHO), was specifically set up in 2016 to improve coordination in needs assessment.[14] The Joint and Intersectoral Analysis Framework (JIAF) was developed, sponsored by all the large UN and non-UN agencies working in humanitarian response. JIAF's aim is to develop a new methodology for the analysis of multiple needs in crisis situations, with a "holistic, people-centred analysis".[15]

A coordination mechanism for SRHR, GBV and HIV in humanitarian response with a wider membership, including non-UN agencies, is the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises.[16] UNFPA, UNICEF and WHO sit on the IAWG Steering Committee. The IAWG developed the Minimum Initial Service Package (MISP) for SRH in Crisis Situations and the recent MISP readiness assessment guidelines and tools.[17] The MISP priority lifesaving activities are included in the *Sphere Handbook Humanitarian Charter and Minimum Standards in Humanitarian Response* (2018),[18] which is a basic reference for humanitarian response in all sectors. The Sphere Handbook sets out universally recognized minimum standards for humanitarian response in all sectors including health. The Sphere project was started in 1997 by a group of NGOs working with the International Red Cross and Red Crescent Movement.

[12] https://interagencystandingcommittee.org/iasc-reference-group-on-gender-and-humanitarian-action.
[13] https://apps.who.int/iris/handle/10665/326106.
[14] The Grand Bargain (set up in 2016) is an agreement among some of the largest donors and humanitarian organizations, who have committed to get more means into the hands of people in need and to improve the effectiveness and efficiency of humanitarian action, https://interagencystandingcommittee.org/grand-bargain-official-website/workstream-5-improve-joint-and-impartial-needs-assessments-january-2020-update.
[15] https://www.jiaf.info/; https://gho.unocha.org/delivering-better/joint-intersectoral-analysis-framework.
[16] IAWG: "an international coalition of organizations and individuals working collectively to advance sexual and reproductive health and rights in humanitarian settings", https://iawg.net/.
[17] In partnership with the International Planned Parenthood Federation and UNFPA.
[18] https://spherestandards.org/handbook/.

The Women's Refugee Commission (WRC), a leading research and advocacy organization created to ensure that women's and children's rights and needs are taken into account in humanitarian response, has developed tools and processes for assessment.[19] SRH and GBV are two of WRC's principal focus areas. The International Planned Parenthood Federation, FP2030 (Family Planning 2030) and John Snow Inc. have also participated in humanitarian response work and are co-authors of the recent MISP readiness assessment tools (2020) and the *Ready to Save Lives* toolkit (2020).

Many of these mechanisms are designed for first response to emergencies rather than analysis and monitoring of long-term vulnerability to slow-onset and ongoing humanitarian situations such as those related to climate change. The MISP Readiness Assessment is designed for preparedness in response to emergencies. However, there is a growing body of work on the impacts of climate change and activities to reduce them.[20] The Grand Bargain's Joint and Intersectoral Analysis Framework and the Southern African Development Community (SADC) are existing mechanisms at the global level and regional level, respectively, that coordinate long-term vulnerability assessments. At the global level, Grand Bargain partners have recently developed and piloted humanitarian needs overviews and response programmes in 27 vulnerable countries. See JIAF (2021) for the latest Zimbabwe report, for example.[21] The humanitarian needs overviews have been designed within JIAF to analyse the multiple needs of crisis-affected populations in an integrated, multisectoral approach.

This study's rapid assessments showed that coordination mechanisms with United Nations agencies, United Nations clusters, WHO and NGOs exist and are used for emergency response in all five study countries. National stakeholders and United Nations agencies such as UNAIDS, UNFPA, UNICEF and WHO, which have a specific focus on SRHR, GBV and HIV, participate, but most of the clusters and their processes have limited coverage of these areas. The principal emergency assessment that does provide good coverage of SRHR, GBV and HIV topics is the MISP Readiness Assessment.[22] Some specific SRHR, GBV and HIV themes are also included in NGO assessments. The work of the coordination mechanisms is focused on emergency response to sudden-onset crises rather than vulnerability assessment for slow-onset, protracted humanitarian situations or actions to strengthen preparedness and resilience, addressing populations' ongoing vulnerabilities.

4.2 Coordination of vulnerability assessments in the ESA region

The coordination of humanitarian response mostly takes place at the country level, with leadership from national disaster management agencies. In the ESA region, the principal regional mechanism for the coordination of vulnerability assessment of ongoing and slow-onset humanitarian situations is the SADC's Regional Vulnerability Assessment and Analysis Committee (RVAAC) and the associated country-led National Vulnerability Assessment Committees (NVACs). The corresponding body for East Africa is the East African Community (EAC), which includes DRC, Tanzania, Kenya, Burundi, Kenya, South Sudan and Uganda. The EAC faces a different set of SRHR, GBV and HIV challenges to those of the SADC, although there are many areas of overlap. The EAC has developed minimum standards for reproductive, maternal, newborn, child and adolescent health and HIV integration (East African Community, 2020), but unlike the SADC it has not taken steps specifically in the integration of SRHR, GBV and HIV into vulnerability assessments.

For slow-onset humanitarian situations, all five study countries carry out annual assessments, coordinated by their respective NVACs, whose members include

[19] https://www.womensrefugeecommission.org/about/.
[20] https://esaro.unfpa.org/en/news/unfpa-elevates-climate-action-safeguard-wellbeing-women-and-girls-during-decade-action.
[21] https://www.jiaf.info/hnos2021/.
[22] The Minimum Initial Service Package (MISP) for SRH in Crisis Situations is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. The MISP Readiness Assessment is for governments, the United Nations, civil society organizations, community-based organizations and private sector actors – particularly those working in the area of SRH and disaster management – to come together and assess the readiness to implement the MISP during an emergency.

government ministries, United Nations agencies, donors, NGOs and civil society. The assessments are usually chaired by the government department responsible for disaster management and emergency response or by the Ministry of Agriculture, and they focus on food security, using common indicators to facilitate the consolidation of results at the regional level.[23]

The SADC aims for a more integrated approach to vulnerability assessments, addressing different vulnerabilities in rural and urban settings, but focusing on rural areas. The vulnerability assessments include other add-on themes, as well as food security.[24] Each country develops its own approach and processes while taking into account relevant guidance from the regional level. The SADC began to encourage member states to integrate nutrition, gender and HIV into the assessments from 2013. This has been partially successful, with only limited inclusion of these topics in the five study countries. In most countries in ESA, there is still no systematic coverage of gender issues, and countries are not always able to capture good quality data on this theme or on HIV (Southern African Development Community, 2022). Despite the integration of HIV, the SADC's focus on rural areas means it has incomplete coverage of the highly vulnerable populations in urban areas.[25] The SADC (2015; 2020/2021) has produced guidelines for tools and processes that incorporate nutrition, gender and HIV, but these were not well known at the country level.

The degree of integration that has been achieved depends on each country's capacity, their level of interest, the priority they give to these areas, and the resources available to extend assessment coverage. The Zimbabwe NVAC (Zimbabwe National Vulnerability Assessment Committee, 2019), for example, links agriculture with its impact on other sectors and includes GBV. The SADC's efforts to integrate these new themes have generated important lessons about the challenges and opportunities regarding the incorporation of SRHR, GBV and HIV into the vulnerability assessments of other development sectors, discussed in the SADC RVAAC final evaluation report (Southern African Development Committee, 2022).

In addition to SADC vulnerability assessments, whose implementation uses different processes according to country needs, other methods for **ongoing and slow-onset** humanitarian situations are used at the regional level and in-country. The following are Important examples:

- **National Adaptation Plans (NAPs)**, which identify ways to mitigate the expected impacts of climate change and are used at the regional level to identify transborder issues and priorities.

- WHO and Centre for Disease Control assessments, which use an integrated surveillance and response tool, along with vulnerability and risk analysis and mapping. These tools focus on infectious and vector-borne diseases, but potentially could be adapted for SRHR, GBV and HIV vulnerabilities. They are also used at the regional level to identify transborder issues and priorities.

In summary, there are mechanisms and processes for the coordination of some vulnerability assessments among stakeholders, but only limited integration of SRHR, GBV and HIV. Existing vulnerability assessments, including those of WHO, are based on supply-side analysis, with limited incorporation of user or community perspectives. The reasons for the non-inclusion of SRHR, GBV and HIV in SADC and other vulnerability assessments at the country level will be presented in subsequent sections detailing the challenges for future integration.

[23] See the terms of reference for a Joint Final Evaluation of the SADC Regional Vulnerability Assessment and Analysis programme (March 2017 to March 2022) for more background information on the SADC RVAA. The final evaluation report was published in April 2022 and provided important input for Deliverable 3: https://docs.wfp.org/api/documents/WFP-0000125259/download/?_ga=2.249605445.23895118.1635445001-614237401.1635445001. The SADC has also developed guidance for integrating gender and HIV into vulnerability assessment and analysis.

[24] The data collection and analysis costs of add-on themes are usually covered by the interested parties who participate in the NVAC.

[25] KII.

4.3 Existing tools for vulnerability assessment of SRHR, GBV and HIV

The document review found that **tools and processes** have been developed globally and in some specific countries for vulnerability assessment of different aspects of SRHR, GBV and HIV, although few have been designed specifically for ESA. The following aspects were covered:

- Service delivery
- Supplies, commodities and human resources
- Community knowledge of SRHR, GBV and HIV rights in humanitarian response
- Perspectives of vulnerable groups
- Integration of SRHR, GBV and HIV into health system strengthening

Vulnerability assessment processes are well covered in the literature, as well as actual tools for carrying out the studies. There is more focus on assessments for emergency response than on assessments for on-going vulnerability. Coverage of SRHR, GBV and HIV includes the MISP Readiness Assessments, which have sections on these specific topics. There is some reference to SRHR, GBV and HIV vulnerabilities in joint emergency evaluations and assessments, such as the Multi-sector Initial Rapid Assessment (MIRA). However, there is limited discussion of how different types of risks and hazards may affect these vulnerabilities. There are important gaps in the tools and processes for the collection and use of key qualitative information, such as communities' and vulnerable groups' perspectives and priorities in SRHR, GBV and HIV.

The rapid assessments in the five study countries found that vulnerability assessments in these countries use selected tools that cover their specific needs. For joint assessments and emergency response, they use the MISP, the MIRA or the WHO tools. National governments and NGOs often use their own tools, more specifically the humanitarian framework tools for joint missions. The joint assessment tools do not include a user or community perspective, although these are covered by some NGOs who seek community input. Key informants reported that the tools they use have limited specific SRHR, GBV and HIV content, with the exception of the MISP and the MISP Readiness Assessment.

Tools used in-country include household surveys, with some KIIs and focus group discussions. Few existing tools are appropriate for SRHR, GBV and HIV, as these topics need a sensitive, user-oriented approach to data collection and fine-tuning for specific country needs and contexts – for example, adolescent access to services, safe abortion and the needs of key populations are sensitive issues in some countries. Key informants mentioned the need for more digital tools to facilitate fieldwork and collation of data, as well as the need to harmonize tools. The only study country that used the RVAAC questionnaire tool, which incorporates gender and HIV, was Mozambique (SADC RVAA, 2020/2021).

4.4 Availability of data on SRHR, GBV and HIV for humanitarian response

the document review found that many sources of hazard data are used in humanitarian response. A number of these sources are freely available, and some are kept up to date in real time. There is more availability of data on natural hazards than on human-made hazards related to technology or conflict.

There are also reliable sources of quantitative data on SRHR, GBV and HIV for vulnerability assessment and humanitarian response. These include National Health Management Information Systems (NHMIS), which cover both supply of and demand for services, Demographic and Health Surveys, and UNICEF's Multiple Indicator Cluster Surveys (MICS). Some are compiled frequently (e.g. NHMIS), while others may need updating for specific vulnerability assessments.

The level of disaggregation of the data sources varies. Only a few sources provide specific information

for small geographical areas or populations. New techniques are being developed to enable better estimation of small area parameters based on existing data sources. However, there still is a critical gap in data availability for location-specific vulnerability assessments on SRHR, GBV and HIV.

There is less availability of qualitative data and information on community perceptions and priorities, which are essential for vulnerability assessment and humanitarian response in SRHR, GBV and HIV. Although some general data (e.g. on preferences and obstacles to the use of services) is applicable to different situations, most information on community and user perspectives and priorities is location specific, crisis specific and group specific. This information often has to be generated from primary data collection for vulnerability assessments and humanitarian situations. Although primary data collection can be time consuming and costly, there are important opportunities for harmonization among different organizations that have the same or overlapping priority population groups.

The rapid assessments showed that the study countries use both primary data and secondary data, including NHMIS, Demographic and Health Surveys and MICS. Primary data is collected from fieldwork, using specific sampling frames and processes for each country. Some use national sampling frames, while others only do assessments in areas affected by emergencies or natural disasters. Countries with few resources for data collection or limited management capacity (e.g. DRC) rely more heavily on secondary data.

Key informants identified the need to make better use of existing data and qualitative information, which is abundant in the communities and could be accessed by working more closely with local sources such as decentralized and municipal governments, community organizations, and NGOs.

4.5 Challenges and opportunities for harmonized and integrated vulnerability assessment in SRHR, GBV and HIV

The principal **challenges** identified in the desk review, KIIs and rapid assessments are listed below.

CHALLENGES

Integration of SRHR, GBV and HIV involves complex issues and processes, may be slow, and may present challenges.

There are multiple stakeholders with different national or institutional perspectives, capacities, mandates and priorities. Buy-in from national governments and country leadership is needed for successful implementation and sustainability.

Low level of awareness and interest of in-country decision makers in SRHR, GBV and HIV, and low level of information; reciprocally, low level of awareness of SRHR, GBV and HIV specialist agencies in the vulnerability assessment work of other sectors

Key in-country decision makers may not be aware of the relevance of SRHR, GBV and HIV for overall vulnerability, and the added value of integrating these areas into vulnerability assessments; and 2gether 4 SRHR partners who are focused on SRHR, GBV and HIV have a reciprocal lack of awareness of and information on the processes and relevance of vulnerability assessments done in other sectors. Experience in the SADC has shown that integration of SRHR, GBV and HIV themes is a long and complex process for organizations that are not specialists in these areas. Furthermore, there is great variability among countries and a high level of need for awareness raising and staff training.

Lack of coordination among stakeholders

Coordination problems among agencies were mentioned frequently in the KIIs, together with the lack of common indicators and harmonized tools. Each agency is primarily concerned with its own sector and its own priorities.

Low priority of SRHR, GBV and HIV in humanitarian settings in some countries

Although overall priority areas at the regional level include some coverage of SRHR, GBV and HIV, every country government and national organization has its specific priority policy areas and target groups. SRHR, GBV and HIV may not be high on their list, and many government institutions pay lip service to gender issues, but do not go much farther in practice.

Countries also have different priority target groups within SRHR, GBV and HIV – for example, some countries give adolescents a high priority and some focus on key populations, while others do not prioritize the needs of stigmatized and marginalized groups.

As emergencies are frequent in the study countries, they focus more on needs during crises rather than identification of ongoing vulnerabilities.

CHALLENGES

In-country stakeholders may not have sufficient institutional capacity to integrate SRHR, GBV and HIV into their policies, practices, institutional cultures, institutional mandates and priorities.

In-country stakeholders whose work is not focused on SRHR, GBV and HIV may lack the required capacity, procedures and policies, as well as staff with expertise in SRHR, GBV and HIV data collection and analysis – at both institutional and fieldwork levels. The themes may be outside their institutional culture and mandate. And they may lack experience and expertise in collection and analysis of qualitative and community-based data that focuses on users' perspectives. The difficulties experienced in the incorporation of gender into vulnerability assessment illustrate these challenges.

Existing data collection, sampling frames and processes for vulnerability assessment have been designed for other purposes.

Countries use their own systems and methodologies for data collection, which were designed for purposes such as food security vulnerability assessment (for SADC), or supply-side assessments (for WHO). Few vulnerability assessments include demand-side data or community perspectives, which are particularly important in SRHR, GBV and HIV, as service users and priority target groups may define their own vulnerability quite differently from the institutions.

Data collection costs may increase, even in countries that are open to more integrated and holistic vulnerability assessments, as more topics make questionnaires longer.

There is underutilization of existing data sources (especially data available at the local level) and underutilization of data for decision-making. There are challenges: the quality of existing data can be poor; there is reluctance to share data among institutions; and there is no clear definition of the data needed, how it will be analysed and presented, and who will use it.

Insufficient availability of resources (staff, infrastructure, transport, funds, expertise)

Throughout the region, there is a lack of material and financial resources and SRHR, GBV and HIV expertise. Field staff need training in SRHR, GBV and HIV and in suitable methodologies for data collection in these topics; decision makers need awareness raising on the importance of SRHR, GBV and HIV in overall vulnerability.

Non-supportive policy context

The SRHR policy and legal context is not supportive for all SRHR, GBV and HIV topics in all countries. Examples include the following: illegality of same-sex relations in some countries; abortion restrictions; poor access for adolescents to SRH services; and the right to non-disclosure of HIV status.

CHALLENGES

Low level of institutionalization for vulnerability assessments in general

Institutionalization of any sort of vulnerability assessment has not been uniform, although there is progress in some countries. The lack of institutionalization affects the future sustainability of vulnerability assessments, whether or not SRHR, GBV and HIV are integrated.

Insufficient focus on the nexus of emergency response and development

Vulnerable communities develop coping mechanisms, and problems arise mainly when their vulnerabilities change due to a humanitarian crisis – for example, displaced people lose the support of their social networks, they may be unable to access services, or there may be interruptions in the supply chain. Assessment of changes in vulnerability is a key element in emergency response, but data collection may be designed to identify ongoing weaknesses rather than vulnerability to change. Assessment of needs for support to ongoing and underlying vulnerabilities is a long-term task that is closely linked to ongoing development activities.

Opportunities for harmonization and integration of vulnerability assessment in ESA are listed below.

OPPORTUNITIES

Interest at the regional level and in some countries in the integration of SRHR, GBV and HIV and the harmonization of tools

Cross-cutting themes (such as GBV, HIV and access for adolescents) and cross-border issues in SRHR, GBV and HIV (such as maternal and child health, birth registration, and HIV) are priorities for the region and for many countries, particularly those with progressive leadership willing to tackle sensitive issues. Many partners and stakeholders are interested in the harmonization of vulnerability assessment tools.

Existing cooperation structures and processes that can be accessed for the harmonization and integration of SRHR, GBV and HIV

There are existing structures and processes for collaboration between humanitarian agencies and government stakeholders, and existing structures and past experience in vulnerability assessment that can be built upon at regional and country levels. Regional programmes such as the 2gether 4 SRHR programme cooperate with key partners and stakeholders and have credibility and a positive profile. Such programmes are starting a new phase with a thematic focus at the regional level and an emphasis on support for the implementation of initiatives at the country level.

OPPORTUNITIES

Vulnerability assessment for SRHR, GBV and HIV can build on and link to previous work and existing tools and processes.

There are opportunities to build on and dovetail with existing processes. Vulnerability assessment of specific elements of SRHR, GBV and HIV in emergency response is already included in United Nations and MISP procedures, especially the MISP Readiness Assessments. National stakeholders and 2gether 4 SRHR partners are already using these mechanisms. For slow-onset and ongoing humanitarian response, there are opportunities to strengthen links with the MISP and with the SADC vulnerability assessments of food security, where a lot of groundwork, including advocacy and awareness raising on SRHR, GBV and HIV areas, has already been done.

There are also important opportunities to build on lessons learned during the COVID-19 pandemic – for example, the value of community-based approaches, awareness raising and coping mechanisms in a changing environment. Lessons from the pandemic on coordinated response and incorporation of community perspectives and community-based initiatives are very relevant to the development of harmonized and integrated vulnerability assessment tools for SRHR, GBV and HIV. Users' perspectives on their vulnerability and changes provoked by humanitarian crises should be a core element of SRHR, GBV and HIV assessments.

Value addition of a regional approach

There is important added value in supporting in-country work with a regional approach. This has been shown by existing initiatives for the integration of SRHR, GBV and HIV, such as MISP Readiness Assessments and SRHR scorecards. Regional structures can identify and set regional priorities, such as identification of vulnerable populations and cross-border issues. The regional level has systems and experience for knowledge-sharing and structures for South–South learning and cooperation. It can identify learning from a comparison of progress in different countries and has the capacity for showcasing good initiatives. Regional teams are well placed for advocacy to strengthen awareness among decision makers. Regional structures can provide technical and material support to countries, realize potential for sharing resources (a current example is the sharing of regional laboratory capabilities), and develop guidelines, capacity building, and monitoring and evaluation.

Specific priority areas where important gaps and opportunities exist could be entry points for the integration and harmonization of SRHR, GBV and HIV into vulnerability assessments.

These include the following:

- Lack of user and community perspectives, use of community-based data collection, or use of secondary sources or qualitative data on users' priorities
- Insufficient inclusion of marginalized and key population groups and their perspectives in data collection and vulnerability assessment
- Few alternatives for vulnerability assessment for slow-onset humanitarian situations, e.g. the impacts of climate change, which are likely to be major elements in future humanitarian response work, and assessment of ongoing vulnerability, not just emergency assessments
- Important opportunities for the design of processes and tools to identify changes in vulnerability due to humanitarian crises, and methods to link these at the humanitarian–development nexus with assessments of underlying and long-term vulnerabilities addressed by development programmes
- Need for a focus on better use of data for decision-making – especially SRHR, GBV and HIV data

5 Integrated tools for harmonized SRHR, GBV and HIV vulnerability assessment

5.1 Developing a flexible module of tools

Given the range of different humanitarian situations, contexts and potential users, discussions with stakeholders focused on how to design flexible tools that cover the gaps and can be useful for a range of organizations working in different country contexts with different vulnerable groups. There was consensus that tools should focus on collecting qualitative in-depth data on the perspectives and priorities of affected groups and service providers in specific communities and humanitarian contexts. They should focus on local-level and community perspectives of priorities and needs, and should be able to complement other vulnerability assessments or be used alone in vulnerability assessments that focus on slow-onset and ongoing humanitarian situations (for example, in areas at risk of natural disasters or conflicts and areas vulnerable to the impacts of climate change). They should be easily adjustable to cover vulnerability assessment in emergencies, and should cover the principal SRHR, GBV and HIV focus areas. The tools were designed to take into account these factors and to develop a module that can be adapted by users to specific localities and to the key interests of the organizations implementing the vulnerability assessment by focusing on appropriate questions in each tool.

This study led to the development of a draft module of tools for use at the local level that covers the principal SRHR, GBV and HIV topics. Users can adapt the tools module to their own specific needs, and can select the areas that are of most interest to them. Regional and national stakeholders were consulted on the draft tools, and they provided inputs regarding the prototypes for pilot testing. The SRHR, GBV and HIV vulnerability assessment module includes six questionnaires to be used with different groups of respondents. Used together, they can generate a view of community vulnerabilities and priorities from both demand and supply sides. The module also includes interviewer instructions and materials for advocacy.

The tools address the gaps in existing vulnerability assessment and the need for context-specific instruments that can be used in conjunction with existing vulnerability assessments in the specialized fields of SRHR, GBV and HIV (e.g. MISP Readiness Assessments, WHO vulnerability assessments). They can also be used to add SRHR, GBV and HIV to other vulnerability assessments. The presentation is a stand-alone module from which users can select and adapt items that meet their specific needs.

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 the key participants are 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

Information gathered through the tools can be used to complement quantitative data from national surveys and databases (e.g. Demographic and Health Surveys; MICS; SRHR, GBV and HIV surveys

and statistics; national health information systems and infrastructure/resource databases; real-time databases for disaster risk). This approach will complement other existing data to ensure that community perspectives and priorities are included in policy and practice. And it provides an entry point for the voices of vulnerable groups to be heard when priorities are set for identifying needs and for strengthening community resilience to slow-onset and sudden-onset humanitarian situations. As community perspectives are context specific, this approach underlines the importance of focusing on the needs of the localities where the humanitarian situation has arisen in each country.

The SRHR, GBV and HIV vulnerability assessment module was compiled by selecting and adapting questions from the Women's Refugee Commission Capacity and Needs Assessment Tools to Build Community Resilience (2021), the WRC Facilitator's Kit that accompanies the tools (2021), and the WHO/King's College Humanitarian Emergency Settings Perceived Needs Scale (HESPER) tool for determining community and individual vulnerabilities in humanitarian situations (2011). The five questionnaires based on WRC's tools are aimed specifically at the assessment of ongoing SRHR, GBV and HIV vulnerability and the implications of slow-onset humanitarian crises such as climate change. New questions to cover additional priority topics identified by UNAIDS, UNFPA, UNICEF and WHO complement the tools. The HESPER tool explores communities' and individuals' own priorities and perceptions of vulnerability in a range of sectors. It was originally designed for people who have been displaced by humanitarian crises, but the methodology can also be used with non-displaced communities. For this tool, we developed new questions to specifically focus on SRHR, GBV and HIV.[26]

The draft tools were reviewed by a large group of stakeholders from United Nations agencies, humanitarian response specialists at the regional level, and health sector and other professionals working in humanitarian response and SRHR, GBV and HIV in each of the five study countries. Their suggestions and modifications were included in the prototype tools prior to field testing. The final version of the tools, together with guidance for their use, were compiled in the aforementioned handbook, which was validated by national stakeholders in country workshops.

5.2 Content of the SRHR, GBV and HIV vulnerability assessment module

There are six questionnaire tools in the SRHR, GBV and HIV vulnerability assessment module. The first five questionnaires are designed for use at the local level:

- **Policymakers** – district disaster management staff or mayor or chief medical officer
- **Health service providers** – health facility manager or clinical staff
- **Community health providers** – community health workers, outreach workers, peer educators, other community resource persons
- **Community-based organizations** – representatives of civil society organizations or networks, community leaders, teachers
- **Community respondents** – persons from groups such as women, adolescent girls, at-risk groups including lesbian, gay, bisexual, trans and gender diverse, queer, and questioning (LGBTIQ) persons, persons living with HIV, people with disabilities, sex workers, and other minority groups and key populations

The sixth questionnaire aims to identify community perceptions of SRHR, GBV and HIV vulnerabilities in comparison with other humanitarian needs, and community priorities. It includes some overall health-related questions[27] and new questions focusing on SRHR, GBV and HIV topics. The questionnaire can be used to interview people from key vulnerable and at-risk groups, including women, adolescent girls, persons living with HIV, LGBTIQ persons, people with disabilities, sex workers and other minority groups.

[26] WHO requests inclusion of the following statement: "This is an adaptation of an original work: Humanitarian Emergency Settings Perceived Needs Scale. Geneva: World Health Organization, (2011). Licence: CC BY-NC-SA 3.0 IGO. 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."

[27] Adapted from the original HESPER questionnaire.

The SRHR, GBV and HIV vulnerability assessment module also contains a set of instructions and further information for interviewers, including ethical considerations and reflections on how the data can be used for advocacy at the national level and for decision-making.

The six questionnaire tools are presented in a separate document *(Handbook for Conducting Multi-Stakeholder Vulnerability Assessments for Sexual and Reproductive Health and Rights, HIV and Gender-Based Violence in Humanitarian Settings*), which includes the tools and guidance for their implementation and use.

5.3 Pilot testing

The draft module – questionnaires and interviewer instructions – was piloted in the five study countries. Each tool was tested in the five countries, with three respondents per questionnaire in each country, to provide input on the clarity of the questions, whether the interviewees felt comfortable answering them, and how long the questionnaires took to administer.

Respondents included people from the most vulnerable groups, such as disabled people, persons living with HIV, adolescent girls and young women, LGBTIQ persons, sex workers, and other persons with special needs. Results from the five countries and different sociocultural contexts enabled comparisons of use in a variety of situations with different respondent groups, and also revealed how effective the tools are in identifying vulnerabilities and their potential for adding value to existing vulnerability assessment processes.

Zones for pilot testing were selected in discussion with 2gether 4 SRHR partners, taking into account the following criteria:

- Has had an emergency during the last year.
- Is accessible for the national consultants.
- National consultants have existing contacts to identify respondents, or UNFPA, UNAIDS, UNICEF and WHO country office staff can provide names.

Characteristics of the zones and their vulnerability to different types of humanitarian impact are shown in Table 1

Table 1. Zones and their vulnerability

Country	DRC	Madagascar	Malawi	Mozambique	Zimbabwe
Name of zone	Kalehe Territory	Analamanga region	Chikwawa District	Zambézia Province, Maganja da Costa District (two sites)	Chimanimani District, Manicaland Province
Urban/rural	Rural	Urban and rural districts	Rural	Urban and peri-urban	Rural
Type of vulnerability (climate change, natural disaster, conflict, other)	Conflict, **natural disasters**	Climate change	Natural disasters, climate change	Natural disasters, climate change	Natural disasters, climate change
Existing health and SRHR, GBV and HIV service provision (good, acceptable, poor)	Poor	Poor	Good	Good at one site, but services are 7 km distance from the other site	Health facilities exist, and there is a network of village health workers. There are important inputs from development partners for resources and capacity building.

5.4 Pilot tests: results

The pilot tests provided important information for finalizing the tools themselves and, perhaps more importantly, insights into their capacity to identify vulnerabilities and context-specific differences in responses.

5.4.1 Tool design

For the usability of the tools, the pilot tests explored the wording and clarity of the questions, respondents' comfort in answering questions on SRHR, GBV and HIV themes, and the time taken for the interviews.

They also provided important input on the following:

- Processes for carrying out interviews and permissions/clearance that may be needed and can delay implementation; good local contacts who facilitated snowballing and introductions to respondents
- Need for more explanation of terms such as SRHR, GBV and HIV, disaster response simulations, and SRH challenges; service quality
- Sensitivity of key themes of abortion, LGBTIQ, sex workers; the need to explore taboos and learn local vocabulary prior to starting interviews to help respondents feel comfortable discussing the topics
- Level of respondents' knowledge on SRH rights – e.g. respondents may not be aware that abortion is legal; necessity of providing more information on sensitive SRHR, GBV and HIV themes
- Importance of using local language and terminology

The pilot tests also generated suggestions for addressing some of these challenges (see next chapter).

Clarity of the questions

The pilot tests showed that most of the questions were clear for respondents. The few exceptions included those respondents who were not familiar with the full range of SRH services and needed further explanation (for example, some thought SRH referred only to family planning). This also caused difficulties for respondents in spontaneously listing the challenges encountered in SRH and ways to solve them (e.g. in Mozambique), and in responding to questions on service quality.

In some cases, there were inappropriate elements in the questions – for example, on the activities of community health workers, whose responsibilities may not cover all the services listed in the question (Madagascar, Mozambique), and on current SRH, GBV and HIV services, which are practically non-existent in the DRC pilot zone.

In Mozambique, community respondents requested an additional 'intermediate' category in the Tool 6 questionnaire ranking the seriousness of different problems.

These points were incorporated into the revised versions of the tools presented in the handbook and in the instructions to interviewers.

Were respondents comfortable with the questions?

The majority of the respondents were comfortable answering the questions. The principal exception was questions on abortion, which some interviewees were reluctant to discuss in countries where abortion is illegal or where there are social and cultural pressures and taboos. Some respondents were uncomfortable talking about the needs of sex workers or LGBTIQ people due to taboos in the country or in the local area (Madagascar, Mozambique).

These problems are addressed in the final version of the module and the handbook through more detailed interviewer instructions and guidance on how to deal with sensitive issues in SRHR, GBV and HIV. The instructions also indicate the need to translate the questionnaires into local languages.

Duration of interviews

Most of the interviews took between 30 and 60 minutes, with little variation among the respondent groups, the different tools and the different countries. Additional time was needed in some cases if the interviewers had to translate into local languages. More time was also taken with respondents who were not completely familiar with SRHR, GBV and HIV and needed more explanation of their content and services.

Table 2 summarizes key results from the questionnaires from the five countries.

Table 2. Results of the pilot tests

Country	DRC	Madagascar	Malawi	Mozambique	Zimbabwe
Clarity of questions	Questions were well understood; difficulties in listing challenges in access to services	Most questions easy to understand	All questions clear	Most questions clear, with more explanation of SRH services and service quality needed	Most questions clearly understood, with more explanation needed of MISP; use of local terminology and language would improve clarity
Were respondents comfortable answering all the questions?	Community respondents reluctant to answer questions on abortion and LGBTIQ due to religious and cultural beliefs	Community members uncomfortable with abortion questions, and sex workers are a taboo subject	Community members uncomfortable with questions on abortion for cultural and religious reasons	Community respondents reluctant to answer questions on abortion, LGBTIQ or sex workers due to religious and cultural beliefs	Community members reluctant to answer questions on LGBTIQ
Time taken for each questionnaire	30 to 45 minutes	About 1 hour	45 to 60 minutes	15 to 30 minutes; Tool 6 was quicker – 10 to 15 minutes	30 to 40 minutes, with slightly less for the community member interviews
Other points or information volunteered by respondents	Some respondents needed full explanation of SRHR Emergency response has been less effective where respondent groups were not involved in interventions Intersectoral problems exacerbate vulnerability	Need for advocacy with decision makers on SRHR, HIV/AIDS and discrimination against vulnerable groups Translation to Malagasy needed	Problems in access to safe abortion due to cultural factors; questions should be adapted to reflect this Tools 4, 5 and 6 need translation to local languages Lack of involvement of target groups in other vulnerability assessments	Respondents requested an intermediate category in Tool 6 for problems which are "fairly serious" Need for better service quality – humane treatment by health workers, supplies, youth-friendly services Need to strengthen partnerships in emergency response between government institutions and local organizations, NGOs Train emergency response activists in SRHR, GBV and HIV	Respondents not familiar with MISP Policymakers felt these are the questions they should be asking themselves Cultural issues affect answers on sensitive themes; if unwilling to answer, respondents say specific groups or problem areas are unknown in their zone, or do not answer the question

5.4.2 Does the module identify communities' own perceptions of vulnerabilities?

The pilot showed that many respondents are of the view that community perspectives are not sufficiently represented in vulnerability assessment and in setting priorities for support. This observation from the people directly affected by humanitarian situations confirms the gaps identified in the document reviews and rapid assessments. Results also highlighted the importance of community support and how this is weakened in humanitarian crises, especially when people are displaced from their homes.

The pilot sample was small and not designed to be representative. However, there are sufficient results to confirm that the tools can indeed identify community perceptions, as well as specific problem areas in different communities and vulnerable groups. We can observe similarities but also important differences in the pilot responses between countries, between the problems experienced by different groups affected by humanitarian situations, and between the priorities of supply-side workers (policymakers, health service providers) and those of the community.

The word cloud in Figure 1 (based on data from Tool 6) shows respondents' perceptions of the relative importance of different problems. Examples of context-specific responses to questions on the relative seriousness of problems varied widely between countries, although there were some cross-cutting issues.

Figure 1. Word cloud: respondents' perceptions of the relative importance of different problems

Differences include the following:

- Priorities identified by vulnerable groups (see Figure 1). While a reduced level of community support for both health (including SRHR) and other sectors was identified as a serious problem in all countries, the priority given to reduced mobility, lack of facilities for WASH, and displacement from home and family varied between countries and respondents.
- Increased vulnerability of supplies for health services that rely on outreach, but at the same time the reliability of personal support from community health workers and outreach workers.

Complementary data from Tools 1–5 shows that responses that were frequent in all groups were related to the following:

- Exacerbated problems of physical access to services in emergencies, for all population groups – in many communities there are ongoing problems, which become even more acute in emergencies
- Lack of supplies for SRHR, GBV and HIV at the community level
- Insufficient forward planning and preparedness for SRHR, GBV and HIV in humanitarian situations
- Lack on information on the services that are available in emergencies
- Little knowledge of MISP among decision makers and health workers
- Disconnect between policy and community attitudes (for example, access to abortion, stigmatization of LGBTIQ and other vulnerable groups)
- High level of adolescent needs for safety and support in SRHR, GBV and HIV
- Importance of cash support in emergencies – for health supplies and for community members' transport and other needs

As an example, Table 3 shows responses to some of the pilot questions from different groups in Malawi. Note that the table is based on a very small sample of three people in each group. It is not presenting definitive data, but it is included here to illustrate one type of analysis that may be appropriate. It shows that there are both similarities and differences in the challenges identified by the respondent groups. (The number of crosses in each box shows number of respondents mentioning the challenge.)

Table 3. Specific challenges identified by different respondent groups – examples from Malawi pilot

Challenge	Respondent groups				
	Policymakers	Health service providers	Community health workers	Community members	Community organizations
Human and financial resources, supplies	XXX	XXX	X	XXX	XXX
Lack of response plans for SRHR, GBV and HIV	XXX	XXX			XX
Reliance on community-based organizations for service provision	XX	XX		XX	
Service quality – lack of privacy		XX	XXX	XXX	
Cultural factors and taboos on SRHR, GBV and HIV themes		XXX	XX	XX	XX
Discrimination – ageism, stigmatizing old and young			XX	XXX	
Loss of documentation and health cards	X		XX	XX	XXX
Need to strengthen community-based services			XXX	XXX	XX

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.

5.4.3 Does this information provide input for decision-making?

The pilot showed that the module does generate new information on the specific SRHR, GBV and HIV problems of different groups in local areas affected by humanitarian situations. Information on the differences between groups, and especially the impacts on vulnerable groups at the local level, will support decision makers in the allocation of resources and priorities, in the design of services and outreach programmes, and in community education for humanitarian response.

This information is relevant for both humanitarian agencies addressing emergency needs and development organizations focusing on underlying vulnerabilities and slow-onset humanitarian situations. It provides inputs for decisions on priority areas for work and resource allocations to meet the perceived needs of the people affected, and with an appropriate sample selection can ensure that the needs of vulnerable groups are recognized and that these groups are able to make their voices heard in such decisions.

The tools can also give a first indication of where there are likely to be opportunities to ameliorate some of these problems through working with the community to find solutions. An example is the obstacles that exist for people who lose their documentation and health cards in an emergency, and hence lose access to regular medications. Another example is the lack of access to services due to self-stigmatization and fear of community reactions by some groups such as LGBTIQ persons, sex workers and older sexually active people.

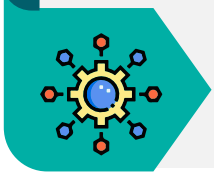
5.4.4 Will information from the tools be useful in work to reduce vulnerabilities, ensure inclusion and increase resilience?

The tools identify priorities from the perspective of the people most affected by humanitarian situations. This is a key element for community involvement in response and in building resilience. The tools (even with the small samples used in the pilot) are a means of generating ideas from the community themselves and can provide pointers towards potential community-based solutions. Examples include back-up systems to cover the loss of health cards and documentation; methods for ensuring toilets are lighted and/or under community surveillance, etc. The information provides important entry points for discussion with communities on where resilience needs strengthening, what can be done by community members themselves, where additional resources will be needed, and where the community may need support to develop their own responses (e.g. training, minor pieces of equipment, strengthening management systems and processes).

The module has been designed to complement other vulnerability assessments and existing SRHR, GBV and HIV data sources. By focusing on the community perspective, it provides a complementary view of priorities for service provision and potential challenges in access and use of services for different vulnerable groups. The information can be triangulated with quantitative data on services and users, above all from the national health information system, which is collected at health facilities and should be readily disaggregated to the local level. Key indicators for SRHR, GBV and HIV will include but not be limited to maternal and child health, safe delivery, family planning, antiretroviral users, and attention to GBV survivors. The SRHR, GBV and HIV content of the tools also complements information collected by other vulnerability assessments on food security, WASH, etc., some of which already include limited information on vulnerabilities related to gender. Information based on specific community perceptions will also enrich existing information on needs and priorities consolidated to district, provincial and national levels, identifying the extent to which these do (or do not) reflect local and community priorities.

The pilot responses show that the module could also be used as a stand-alone set of tools to identify entry points for working with communities and local stakeholders in strengthening resilience. Sensitive and context-specific selection of respondents can ensure opportunities for the inclusion of the voices of vulnerable groups that are often not heard.

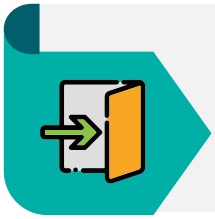
Validation of the handbook in national stakeholder workshops highlighted its appropriateness and its potential for the following:



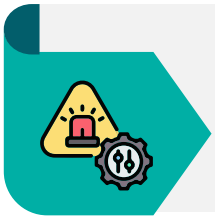
Integration of SRHR, GBV and HIV and harmonization of vulnerability assessment

Ensuring a **focus on the importance of inputs** from the community point of view and from vulnerable groups

Use of the information collected for advocacy at different levels – decision makers for resource allocation, the district level for inclusion of community perspectives, the community level itself to increase awareness of the importance of SRHR, GBV and HIV vulnerability assessment (the community level would perhaps involve behaviour change communication and information, education and communication rather than advocacy), and the government level, motivating the leadership in promoting the use of the tools



Serving as an entry point to include SRHR, GBV, HIV and the community perspective in all vulnerability assessments and preparedness planning



Integrating SRHR, GBV and HIV into emergency situations and the recovery phase, as well as assessing vulnerability in slow-onset humanitarian situations

The way forward – priority areas for the integration of SRHR, GBV and HIV into vulnerability assessments

The study results have identified a clear need for harmonization and integration of SRHR, GBV and HIV vulnerability assessment tools, both within existing vulnerability assessment mechanisms and between specialist agencies and organizations, as well as with other organizations that implement vulnerability assessments in other sectors, such as the SADC and the NVACs. All the study steps – document review, stakeholder workshops, rapid assessment in-country, pilot tests of the tools module – have pointed clearly towards the need to focus on vulnerable SRHR, GBV and HIV groups and to ensure that information is collected about their perspectives and that their voices are heard in identifying priorities.

This chapter looks at the priorities for the way forward.

6.1 The context for integration and harmonization

The study has highlighted issues which increase the importance of integration and the need to ensure that the most vulnerable groups participate in priority setting. These include the following:

- Vulnerability assessment will become ever more important as humanitarian crises are more frequent and larger shares of national and donor budgets are allocated to humanitarian preparedness and response. Vulnerability and ways of reducing it will be top priorities.
- Institutional stakeholders have shown a high level of interest in the integration of SRHR, GBV and HIV into vulnerability assessments, and some potential entry points have been identified in this study.
- There is a gap in information on the perspectives and priorities of communities and vulnerable groups. These are the key stakeholders, and they are the best placed to identify priorities and develop local solutions for adaptation. The pilot study highlighted communities' interest in more involvement and their wish to be proactive in determining priorities.
- Strengthening resilience is an important element in ongoing planning for SRHR, GBV and HIV. Clear lessons have been learned from the COVID-19 pandemic on the need for resilient service provision and supply chains, and the value of community-based processes and solutions for this and for emergency response. Vulnerability assessments are a first step in identifying where systems can be more resilient. They should be an integral part of national planning processes, placed at the nexus between humanitarian response and development.
- Integration with other sectors dovetails with an increasing trend for humanitarian response to seek more sustainable and holistic solutions to better meet people's needs. The flexible tools module has been designed for easy integration into vulnerability assessment in other sectors and will contribute to supporting this. The handbook explains how the module can be used in conjunction with other vulnerability assessments or as a stand-alone exercise, and the relative level of resources that will be needed for both alternatives. Use of the tools and the module constitute a low-cost method for obtaining key qualitative information to ensure that the priorities and needs of people affected by humanitarian situations are taken into account.

It has also identified challenges in addressing these issues, such as the following:

- Lack of awareness about the importance of SRHR, GBV and HIV exists among decision makers in other sectors; there is reciprocal lack of knowledge about other sectors' vulnerability assessments among SRHR, GBV and HIV specialists.
- Each stakeholder has their own agenda, strategy and approach for vulnerability assessment, which may not put a high priority on SRHR, GBV and HIV vulnerabilities, and reduces efficiency and effectiveness.
- Management and field staff may need training in SRHR, GBV and HIV for the design and implementation of vulnerability assessment data collection.
- There is a need for use of both existing local data sources in communities, municipalities and local organizations on vulnerability and how it changes over time, and new qualitative information from the vulnerable groups themselves.
- Analysis and presentation of data on SRHR, GBV and HIV vulnerabilities must be designed to facilitate decision-making on resource allocation and to motivate the development of participative methods to increase resilience.

6.2 Priorities for the way forward

priority areas to contribute towards evidence-based advocacy for integrating SRHR, HIV and GBV into existing vulnerability assessments include the following.

Awareness raising and advocacy

More work is needed to raise awareness about SRHR, GBV and HIV among policymakers, decision makers and humanitarian response agencies. Participation by decision makers in the rapid assessment, pilot and stakeholder workshops showed that more awareness raising is needed, especially in key entities such as ministries of finance and disaster and risk management departments, which affect the allocation of resources. Awareness raising is also needed among the United Nations agencies and organizations that support vulnerability assessment in other sectors (the SADC, international NGOs) to make sure that SRHR, GBV and HIV priorities are clearly on their agendas. More effort may also be needed within the specialist SRHR, GBV and HIV agencies to strengthen their awareness of existing vulnerability assessment processes in other sectors.

Advocacy at the national level in each country to ensure that national organizations are fully involved in planning and decision-making will increase sustainability and reduce reliance on humanitarian actors such as United Nations agencies to respond to emergency needs.

At the **local level,** the need for advocacy with community organizations and leaders, municipalities, and health service providers was identified during the pilot studies. The studies indicated certain areas where local advocacy will be needed:

- Motivation and participation of local stakeholders to strengthen community and institutional strategies for the continuity and ownership of actions with the active participation of communities
- Allocation of financial and human resources at municipal council level for SRH and HIV/AIDS supplies, including emergency kits, disaster activity budgets and dedicated staff/focal points; financial and material resources to ensure the effective delivery of SRH/family planning services, including screening and prevention of HIV transmission, as well as the continuity of these services; resources to ensure the effectiveness of the physical, psychological and legal management of GBV during emergency periods to improve the reliability of reporting on needs
- Ensuring the prioritization of SRHR and HIV/AIDS in emergencies
- Capacity building of service providers in reproductive health rights and MISP Readiness Assessment; increased training and motivation in SRHR, GBV and HIV for community health workers; and adequate physical infrastructure and conditions for SRH service provision
- Consultation with and special attention to vulnerable groups – children, single women, widows, adolescent girls; health worker training in the humane treatment of vulnerable groups

such as sex workers; and provision of youth-friendly services

- Working with local NGOs and community organizations to reach out to women and girls in the internally displaced people community to improve identification of vulnerable cases, referral of cases to available SRH services, and referral of emergency cases to higher-level health institutions; encouraging these organizations to multiply awareness raising in the community to make sure that reliable information on the availability of SRH services is communicated and to encourage women and girls to break the silence in relation to their SRH problems in order to facilitate their access to these services (particular attention should be paid to neglected single mothers); training and motivation for these groups in emergency response
- Negotiations to legalize assisted (safe) abortion in places where it still is illegal; awareness raising among all actors where abortion is legal but still taboo in the communities

At the **regional level,** important areas that contribute to advocacy include the consolidation of comparative information on policies and practice, and country experiences of the harmonization of SRHR, GBV and HIV and their integration into vulnerability assessment. The regional level has a comparative advantage in access to high-level decision makers; this can be harnessed to contribute towards developing a consensus on the importance of SRHR, GBV and HIV in humanitarian response. Knowledge sharing among member states can provide back-up evidence for promoting a common approach such as the tools module.

Evidence is needed to support the advocacy agenda. Some is already available from previous experiences in SRHR, GBV and HIV integration, and results from the questionnaires in the tools module will generate more. This can be shared as an input for advocacy with others working in this field, such as IAWG and WRC, and with the principal humanitarian coordinating mechanisms.

Coordination

Policies and mechanisms are needed for coordination between government stakeholders (such as the ministries of disaster management, health, gender/ women, and finance) and others (United Nations agencies, 2gether 4 SRHR partners, donors, the SADC, NGOs) to ensure that resources are budgeted and allocated to SRHR, GBV and HIV vulnerability assessment.

Coordination at all levels can be strengthened through joint planning, decision-making and activities, as well as through partnership between relevant government departments and organizations working in the field, such as NGOs and community organizations/networks.

Strengthened coordination and joint activities between government institutions and other organizations already working in the field[28] will help to incorporate SRHR, GBV and HIV into their ongoing work with communities. And for those who are already working in SRHR, GBV and HIV, better coordination will help to strengthen their capacity to include emergency response support (DRC, Mozambique).

Resource availability for integration of SRHR, GBV and HIV

Vulnerability assessment requires money, people, transport, materials and other resources. Countries will need to identify resources for vulnerability assessment and where they could come from. In some cases, it may be most cost-effective to use existing resources (such as experienced fieldworkers who could be trained in SRHR, GBV and HIV; local NGOs, community organizations and consultants who could be contracted for fieldwork; or staff skilled in the design, implementation and analysis of vulnerability assessments for decision-making who include SRHR, GBV and HIV in their agendas).

Institutionalization of vulnerability assessment in SRHR, GBV and HIV

Institutionalization of vulnerability assessment in general is difficult, but very important for sustainability due to changes in government policy, staff and decision makers. SRHR, GBV and HIV will face the same challenges as other sectors. This point was discussed in the SADC's final evaluation of the RVAA in 2022 (SADC RVAA, 2022). It will be necessary to identify which agencies could take leadership of this process. More focus on the nexus between vulnerability assessment and ongoing planning for more resilience may be an entry point.

[28]For example, in Mozambique some districts already have activists and committees trained to sensitize the community about the risk of natural disasters and the need for communities who live in vulnerable locations to be ready to relocate.

7 Recommendations and possible next steps

Recommendations to take advantage of the opportunities and begin to address the challenges identified in this study are as follows:

- Define how the tools 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.
- Develop advocacy plans at regional and country levels to promote the 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.
- Disseminate the tools and the module to start awareness raising with a wider audience, in these and other countries in the region. Participatory processes where stakeholders can have specific inputs on 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, and possible organizational structures to take the work forward – e.g. inter-agency forums, coordination mechanisms.
- Define a realistic action plan to share knowledge and experiences in the harmonization of SRHR, GBV and HIV and in the use of the tools and handbook 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, 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 analysis and 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 data users may be necessary.

8 Conclusion

Vulnerability assessments will grow in relevance and importance in the future with climate change leading to more frequent natural disasters, conflicts and population displacement. Integrated approaches that reflect people's vulnerabilities and needs will be more important than ever. Linking and integrating humanitarian response with ongoing development programmes will need strengthening to develop a systematic approach and to increase resilience. Vulnerability assessment of SRHR, GBV and HIV must be an integral part of this work.

It is important to reach a consensus on how to identify and address SRHR, GBV and HIV vulnerability in order to coordinate stakeholders' strategies and optimize effectiveness and efficiency.

This study of existing processes and tools and the development and testing of a module of flexible prototypes is the first step in the process of harmonization and integration of SRHR, GBV and HIV in vulnerability assessments. The next steps towards harmonization and integration will be focused on the country level, with an important role at the regional level for advocacy, awareness-raising and knowledge-sharing activities.

Ownership and buy-in at the national level and by country stakeholders is essential for the sustainable inclusion of SRHR, GBV and HIV in vulnerability assessments. Advocacy will be needed to raise awareness about the importance of the topics and secure the allocation of the necessary resources. It will be important to foster partnerships with national, local and community organizations and networks for effective advocacy.

Most importantly, we must ensure that all stakeholders have opportunities to provide inputs and play an active role in planning and implementing vulnerability assessment. The tools tested during the study have been compiled into a handbook aimed specifically at increasing the participation of people affected by humanitarian situations, and to give a voice to vulnerable groups to ensure their needs are of high priority. The handbook has been designed as a flexible method to harmonize and integrate SRHR, GBV and HIV with existing vulnerability assessment. It is an entry point for strengthening coordination mechanisms and tools, for increasing participation, and for beginning to identify methods to strengthen the resilience of communities.

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