Pilot of a sexual and reproductive health (SRH) data collection tool for the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises

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ABSTRACT

Pilot of a sexual and reproductive health (SRH) data collection tool for the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises

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Background: IAWG is a broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for people affected by conflict and natural disaster. IAWG global reviews highlighted various gaps and challenges facing SRH in humanitarian settings. One identified gap was the need for effective data collection and a forum to share information in order to advance evidence-based strategies for SRH.

Purpose: The purpose of this special studies project was to develop, implement, and analyze a pilot data collection tool on SRH research conducted by IAWG's Data, Information, and Research Sub-Working Group (DIR-SWG).

Methods: An initial data collection tool drafted by IAWG's DIR-SWG and was further developed in collaboration with IAWG members. The refined tool was then translated into an online survey using *Survey Monkey*. The survey was sent to a total of 68 active IAWG members, representing 27 organizations and two independent consultants. Information was gathered on SRH research projects initiated, ongoing, or completed since January 2010. In-depth interviews (IDI) were conducted among five IAWG members using an in-depth interview guide. The interviews focused on: factors that drive SRH research; why certain agencies are not involved in SRH research; identifying the need for a tool to collect and distribute research being done on SRH in humanitarian settings.

Results: Of the 27 organizations we obtained information from 16 (59% response rate). Of the 28 SRH research projects since January 2010 most dealt with family planning (50.0 %), gender based violence (39.3%) and maternal health (35.7 %). Less research was done on post-abortion care (10.7%) and safe abortion care (3.6%). The IDI narratives identified funding as an important driving factor that determines SRH research and respondents agreed a database can potentially provide a repository of SRH research.

Recommendations: IAWG DIR-SWG should take the lead in building and maintaining of the database using Microsoft Access. Unique strategies are needed to promote the database's utilization within IAWG so that it is utilized. Public health implications of having such a database is that it will provide an important source of the current state of SRH research in humanitarian settings.

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ACRONYM LIST

ARC	American Refugee Committee
ARCS	Algerian Red Crescent Society
BPRM	Bureau for Population, Refugees and Migration (US Department of State)
CARE	Care International
CDC	Center for Disease Control and Prevention
CHE	Complex Humanitarian Emergencies
CRR	Center for Reproductive Rights
EmOC	Emergency Obstetric Care
GBV	Gender based violence
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
IASC	Inter-Agency Standing Committee
ICEC	International Consortium for Emergency Contraception
ICRW	International Center for Research on Women
IMC	International Medical Corps
IAWG	Inter-Agency Working Group
JHCRDR	John Hopkins Center for Refugee and Disaster Response
JHPIEGO	John Hopkins Program in International Education in Gynecology and Obstetrics
JSI	John Snow, Inc.
JHU	John Hopkins University
MSI	Marie Stops International
PAI	Population Action International
RH	Reproductive Health
SAVE	Save the Children
SPRINT	Sprint Initiative by International Planned Parenthood Federation
SRH	Sexual Reproductive Health
UNFPA	United Nations Fund for Population Activities/United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRC	Women's Refugee Committee

CHAPTER 1: LITERATURE REVIEW

Documentation of the global trends on the movement of civilians fleeing and seeking refuge within their country as internally displaced persons (IDPs) or across international borders as refugees, began approximately 40 years ago by United Nations High Commission for Refugees (UNHCR) [1]. There was a need to document such movements in the midst of increased civil tensions and armed conflict occurring between 1964 and 1999 [1]. During this time period the amount of refugees and IDPs were steadily increasing starting in 1991 [1]. Therefore, documenting such movements allowed for better camp management, provision of humanitarian assistance, and repatriation [1]. However, the year of 2013 marked the beginning of one of the most challenging years for UNHCR since the Rwandan Genocide of 1994 with ongoing refugee crisis in Afghanistan, Syria Arab Republic, and Somalia [2]. By the end of 2013 there was an estimated 33.3 million IDPs, 16.7 million refugees, and close to 1.2 million asylum seekers displaced by armed conflict, generalized violence, and human rights violations [2]. Despite the humanitarian response that occurred following the documentation of these numbers, close to the end of 2014 the international community was being overwhelmed with ongoing humanitarian crisis and new emerging conflicts [3]. By the end of 2014, UNHCR had documented 59.5 million people forcibly evacuated globally due conflict, persecution, human rights violations, and generalized violence [3]. It was a startling annual increase of 8.3 million compared from 2013, the highest seen in UNHCRs history [4]. The increase in the number of IDPs, refugees, and asylum seekers over the past five years have been mostly attributed to armed conflicts leading to complex humanitarian emergencies (CHEs) [4].

There are different definitions that describe CHEs with different focuses. In 1994 the Inter-Agency Standing Committee (IASC) through the United Nations (UN) provided a broad definition of CHEs as "…a humanitarian crisis in a country, region, or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country program" [5]. Other definitions of CHE provide a more specific description in the context of excess mortality. According to Toole et. al. CHEs are "relatively acute situations affecting large civilian populations, usually involving a combination of war or civil strife, food shortages, and population displacement, resulting in significant excess mortality," [6]. Salama et. al. define CHEs as "…situations in which mortality among the civilian population substantially increases above the population baseline, either as a result of the direct effects of war or indirectly through increased prevalence of malnutrition and/or transmission of communicable diseases, particularly if the latter result from deliberate political and military policies and strategies (national, subnational, or international)." [7].

Undoubtedly, CHEs have caused massive and accelerated population displacement in recent years [8]. Furthermore, this incredible rise of refugees, IDPs, and asylum seekers has not met the humanitarian response with respect to aid and thus, has created more complexity to the humanitarian response [3]. Some CHEs due to armed conflicts have prevented the proper delivery of social and medical services which can lead to: the limited pursuit of livelihoods for the people affected by the conflict; limited access to basic services; high security risks for people and relief workers; and gross violations of human rights, including sexual and reproductive rights, religious rights, and right to life [8].

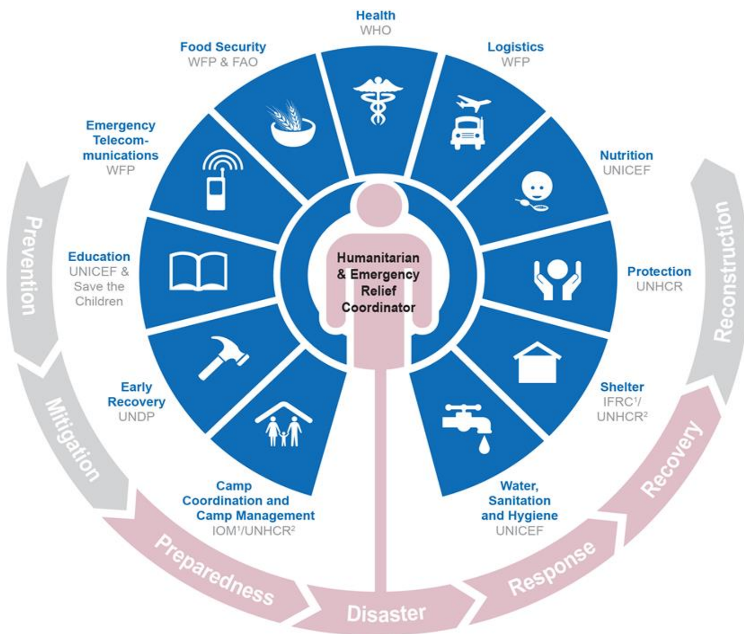
The humanitarian community has identified phases of CHEs to reflect the changing nature of conflicts. These are associated with key characteristics and priorities that evolve with each phase. [9]. In most cases, CHEs require an international presence because the governments involved have limited abilities to deal with the humanitarian emergency and provide refugees and internally displaced persons (IDPs) with adequate social and health related services. As such, CHEs need strategic responses that are focused, practical, and able to be implemented in a short amount of time to help the affected population [10]. Research has allowed for better response and implementation of programs in the field [10].

Crude mortality rate (CMR) is one of the key indicators used by humanitarian organizations to identify different phases in an emergency: acute, late or recovery, and post-emergency [11]; however, CHEs can be very dynamic and move between the above phases [8]. CMR is only one aspect of a CHE that has a tendency to be inaccurate when the affected population is dynamic [1]. However, compared to other health indicators the CMR is a simple and measurable indicator that provides a snapshot of the impact of the crisis and its scale [1]. In most developing countries the CMR in the adult population should not go above 2 per 1000 per month [11]. Humanitarian organizations have identified key priorities to address during a CHE that will control the CMR: rapid assessment of the health status of the population; mass vaccination against measles; water supply and implementation of sanitary measures; food supply and implementation of specialized nutritional rehabilitation programs shelter, site planning, and non-food items; curative care based on the use of standardized therapeutic protocols, using essentials drugs; control and prevention of communicable diseases and potential epidemics; surveillance and alert; assessment of human

resources and training and supervision of community health workers; and coordination of different operational partners[10].

To efficiently and effectively address the above priorities, humanitarian organizations need to coordinate their responses [12]. Accordingly, in 2005 'The Cluster Approach' was introduced by the IASC via the UN after the Humanitarian Reform Agenda meeting. The purpose of the cluster system is to encourage proper coordination of humanitarian response that allows humanitarian actors (both UN and non-UN organizations) to be organized into focused groups that work in a comprehensive manner [13]. These actors are usually organized based on their mandates and the services they can provide in a humanitarian setting. This system is activated when: an existing humanitarian situation deteriorates or a new emergency crisis develops; the national response is not adequate to deal with the acute humanitarian emergency; and/or the services required in the CHE go beyond what the country can handle and a multi-sectoral approach is needed [14].

For that reason, some of the UN agencies are heavily involved in humanitarian work and assume leadership responsibilities and accountability over the main clusters seen in Figure 1.



Source: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/cluster_approach.png

Figure 1: IASC Cluster Approach

The cluster approach outlined in Figure 1 has been incorporated in the Sphere Project Handbook, *Humanitarian Charter and Minimum Standards*, which is another reference to which response can be streamlined for better accountability of humanitarian agencies during a response. Established in 1997, the Sphere project is a comprehensive inter-agency collaboration with various humanitarian response practitioners committed to being responsible to the stakeholders while providing a uniform framework to work in during a CHE [15]. Organizing humanitarian response has led to heightened predictability, inclusion of the affected communities, participation of local and national leaders, collaboration between clusters, effective advocacy and transparency during disasters [13]. Organizations have to be equipped to offer wide-ranging services that cover all the features of public health including epidemiological initial field assessment, epidemiological surveillance, communication, mass vaccination, WASH, food supply and nutrition, shelter, mental health and medical care [16].

While food, shelter, water, sanitation and hygiene are essential in the first response of CHE, the effects of war and conflict on women and children are hard to ignore [17, 18]. Women and girls who have been displaced due to war are vulnerable to a range of health problems including nutritional deficiencies and sexual violence such as rape, sexual abuse from intimate partner violence and sex trafficking in humanitarian settings [19]. Consequently, some of the SRH issues facing women and girls during CHEs include: unintended and unplanned pregnancies that may lead to unsafe abortions; the increased occurrence of common complications of pregnancy leading to excess mortality and morbidity in the absence of emergency obstetric care (EmOC) [20]; growing concern of the HIV transmission due to lack of condoms and little observation of universal precautions when handling blood products [20]; absence of a protocol to deal with rape victims [20]; and forced prostitution [8].

Furthermore, available demographic data from UNHCR indicates that since 2003, the percentage of women and girls in the refugee population has increased from 48% [2] to 50% at the end of 2014 [4]. So one of every 2 refugees is female [4]. Due to the rising number of women and girls in refugee settings and the need to provide specialized health services for this vulnerable group, the evolution of SRH in CHEs stimulated the necessity for research to understand the effects of crises on women [21]. Consequently, studies have demonstrated the need to have adequate and appropriate sexual reproductive health care services while providing psychosocial support and security for women in humanitarian settings [22-26]. The acknowledgement to address the needs of women and girls in CHE started during the 1994 International Conference on Population and Development (ICPD) [27]. This recognition of SRH in crisis situation led to an increase activity by policy makers, donors, humanitarian agencies by providing focused SRH services to conflict

affected populations and creation of SRH policies in humanitarian settings [27]. Consequently, SRH was put under the global health cluster with World Health Organization (WHO) as the lead [28]. Furthermore, the proceedings of the ICPD'94 led to the development of collaborative body in 1995 that comprised of a network of 450 agencies and 1,700 individual members called the Inter-agency Working Group (IAWG) on Reproductive Health in Crises [27]. Subsequently, the above research and the formation of IAWG promoted two key SRH guidelines: the *Minimum Initial Service Package* (MISP) and the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* [29].

Key SRH Resources

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

This field manual was first created in 1996 by IAWG to provide program guidance and technical advice to humanitarian staff on the ground [30]. The manual was later updated in 1999 and then 2010 to deliver more information regarding the best practices in SRH programming and to reinforce the fundamental principles while undertaking SRH care in the field [30]. The broad SRH categories indicated in the manual include: Minimal Initial Service Package (MISP), Assessment, Monitoring, and Evaluation; Adolescent Care; Family Planning; Maternal and Newborn Health; Comprehensive Abortion Care (newly added in the 2010 version);Gender Based Violence (GBV); STI (newly added in the 2010 version); and HIV(newly added in the 2010 version) [30]. It must be noted that MISP provides the set of activities that must be implemented at the onset of a crises; the other technical areas of the manual are implemented when the situation has stabilized and enters the recovery phase of the crisis [30]. In addition, the

manual encourages the linkages to related services in other clusters and services so that there is continuity of care for the affected population [30]. Ideally, all the technical areas within the manual should be implemented in all phases of the humanitarian crisis. Fundamentally, this manual is a key reference in providing programmatic direction to humanitarian agencies regarding SRH in humanitarian settings.

Minimum Initial Service Package (MISP)

MISP outlines SRH priority activities, with accompanying supplies, that must be provided in the acute stages of a crisis (natural disaster or conflict) [31]. Furthermore, the main objective of MISP is to reduce morbidity and mortality, by providing women and girls SRH services in the emergency phase of humanitarian situations., Unlike in stable situations, the MISP can be performed without a needs assessment [31]. The MISP has been incorporated in the Sphere Handbook on *Humanitarian Charter and Minimum Standards* becoming an international standard endorsed by the Global Health Cluster to provide SRH services in emergencies as outlined in the IASC Health Cluster Guide [32]. Generally, the MISP describes critical SRH activities that need to be implemented at the beginning of a humanitarian crisis and health programming information required to sustain the activities [32]. As the crisis enters the recovery and reconstruction phase, MISP outlines comprehensive SRH services that need to be implemented after the acute situation has subsided [32]. The programming activities included in the MISP are:

- Establishing an SRH lead agency and SRH officer [30].
- Prevention of sexual violence and respond to the needs of survivors [30].

- Reduce the transmission of HIV [30].
- Prevention of excess maternal and newborn morbidity and mortality [30].
- Provision of supplies to implement the MISP [30].
- Integration of comprehensive SRH services into primary health care (PHC) [30].

All these activities must be strategically implemented in a coherent and coordinated manner to offer the minimum SRH services needed [31]. In addition, the services should be provided by properly trained staff at the onset of a humanitarian emergency [31]. Accordingly, IAWG on Reproductive Health in Crises has been encouraging humanitarian agencies to ensure the adequate implementation of MISP interventions at multiple levels of a response (i.e. site-planning, WASH, health sectors, community services, etc.) [20].

Inter-agency Working Group (IAWG) on Reproductive Health in Crises

IAWG is a coalition of dedicated individuals and organizations providing information to the humanitarian community on how to improve SRH services in communities suffering from conflict and natural disasters [27]. In addition, it advocates for quality SRH services to be provided to people affected by conflict and natural disasters [33]. Since its inception in 1995, IAWG has worked to document research done on SRH in crisis, evaluate SRH services in humanitarian settings, address gaps in the field, provide policy makers evidence on how to improve SRH services in humanitarian settings and advocate for women's sexual and reproductive health rights in global development agendas [34]. In addition, IAWG has sub-working groups (SWG) on strategic SRH issues that allow members to share experiences, identify challenges, and advocate for the implementation of reproductive health care services in

affected communities [35]. The IAWG SWG groups include: Adolescent Reproductive Health; Data, Information & Research; Family Planning; Gender-Based Violence; HIV/AIDS/STI/RTI; Logistics; Maternal and Newborn Health; MISP; and Safe Abortion Care [35]. Every year during the IAWG Annual Meeting each of the SWGs meet to review their terms of reference, address gaps and challenges, and create strategies to address identified needs for IAWG members and the field [35].

One of the many achievements by IAWG was the release of the first global evaluation of SRH in humanitarian settings in 2004 [36]. This evaluation highlighted improvements in the SRH field compared to 1995, however, concerning gaps in the provision of SRH services existed in humanitarian settings at all levels [36]. Even though this evaluation was done in stable refugee settings and not in acute complex emergency settings, it did give insight on the various technical areas (e.g. gender based violence) that needed more research and funding [36]. In addition, the report emphasized the need to create tools that allow for better data collection, surveillance, and monitoring and evaluation of SRH services [36]. The report did not explicitly state the types of tools that were needed but it suggested that best practices and example program models in the implementation of SRH services should be more widely shared [36]. However, the report did not mention how IAWG members could share data, information, and research so everyone could stay abreast of SRH activities in humanitarian settings.

Ten years after the first global evaluation, IAWG conducted another evaluation from 2012-2014 that explored whether SRH research and services in humanitarian settings had improved since the last evaluation [37]. This global review was published in a series of papers that included: a

systematic literature review evaluating SRH services in humanitarian settings [38]; tracking funding of SRH services in humanitarian settings from 2002-2013 [39]; MISP in Irbid City and Zaatri Refugee Camp in Jordan [40]; mixed methods case studies on the progress and gaps of SRH services in humanitarian settings [41]; assessment of agency commitment and capacity [37]; and review of the UNHCR Health Information System (HIS) data [37]. The latest global evaluation was greatly anticipated in the humanitarian community and some of these components of the global review will be highlighted briefly.

Casey described 36 papers that discussed 30 programs related to SRH services in humanitarian settings and noted that rigorous evaluation and implementation methods were needed to demonstrate the best ways to address SRH gaps in humanitarian settings [38]. She also recommended thorough and effective data collection and suggested that a forum was needed to share information so "…that proven evidence-based strategies for SRH are implemented in humanitarian settings." [38]. However, tangible solutions on how SRH programs could improve their M & E plans and how such plans, data, and research findings could be shared with the SRH community were not further discussed in the paper.

In another component of the global review, an analysis done by WRC described various proposals for the implementation of SRH services in humanitarian settings and the extent to which these proposals (and other SRH services) received funding for the various RH activities from 2002-2013 [39]. Generally, Tanabe et. al. stated that in a 12 year period sectoral Health and Protection proposals requesting funding for SRH services increased by 136.4% and 200.8%, respectively [39]. However, certain areas of SRH like family planning services and abortion care

received little attention and limited funding [39]. This analysis also reviewed duplication of proposals submitted by a lead agency when in fact it was being implemented by partner agencies at lower levels [39]. As a result, there was obvious overestimation of the funds received and proposals implemented [39]. Unfortunately, there was no mention of how the duplication of efforts could have been avoided so that tracking funding for SRH services could be more accurate. In addition, the authors noted it was difficult to ascertain the amount of money received by the various SRH components if an agency had a multi-phase study to implement [39]. In the end, this particular component of the global evaluation also failed to offer palpable solutions on how funding the various SRH components could be tracked, the tools that can be used to track these efforts to avoid duplication, and how such funding proposals and/or strategies can be shared to the SRH community without duplication of efforts.

Another aspect of the recent global review was Krause et. al. evaluation of the MISP in two Syrian refugee camps in Jordan: Zaatri Camp and Irbid City [40]. It evaluated the effectiveness of the implementation of MISP for Syrian refugees in Jordan to determine if it prevented excess mortality and morbidity in women and girls [40]. This evaluation found that due to a stable Jordanian health infrastructure, funding and adequate trainings for the implementation of MISP for Syrian refugees was acceptable [40]. However, MISP service uptake had gaps due to lack of knowledge of the services and no management protocol for rape survivors in Jordan [40]. The evaluation had limitations because it did not consider the implementation of MISP in non-camp settings or camps with limited health infrastructure. In addition, the report did not mention how humanitarian agencies could share their experiences of MISP implementation to improve programming of MISP priority areas.

Although the two IAWG evaluations pointed out various gaps and challenges facing SRH in humanitarian settings, there has been little to no mention of how efforts can be made to unify SRH research into a database. IAWG has many members and agencies doing various programs and interventions in SRH but some of these efforts have been difficult to track so that interested stakeholders may keep abreast of such research. There have been efforts by other sectors to create and maintain databases so that the humanitarian community is informed about research efficiently. By way illustration, the Complex Emergency Database (CEDAT) provides valuable information on nutrition indicators and mortality patterns in conflict-affected communities [42]. CEDAT offers a central repository of 3309 surveys from 51 counties that supplement official statistics from various countries dealing with humanitarian situations [42]. In addition, the CEDAT repository offers a wealth of information regarding conflict research programming [42]. However, this database focuses on mortality and nutrition indicators from conflict-affected communities with little mention of SRH information [42]. Even a web-based search on the CEDAT website conducted by the author did not reveal any survey discussing maternal mortality or other related SRH areas of interest [43]. Despite this limitation, CEDAT continues to be a vital source of nutrition and health surveys from humanitarian settings and complements official nationwide statistics. [42].

The idea of having a resource similar to CEDAT where IAWG members can keep abreast of SRH activities in humanitarian settings had been discussed at several annual IAWG meetings by the Data, Information and Research Sub-working group (DIR-SWG). The initial draft tool of such a database was in the form of an Excel spreadsheet created by DIR-SWG with the idea thatIAWG members would update past, ongoing, and completed research on the IAWG website.

Members would then utilize this information and be aware of what sort of SRH research was going on. However, the idea had not been fully developed or implemented at the time of this study.

Special studies project

The purpose of this special studies project was to develop, implement, and analyze a pilot data collection tool on sexual and reproductive health research conducted by IAWG members. In brief, the process included taking the initial draft tool designed by the DIR-SWG that was further developed by receiving feedback from DIR-SWG. We then conducted a pilot of the above tool by translating it into an online web-based survey and emailed it out IAWG members. Also, in-depth interviews were conducted with a subset of IAWG members on aspects of SRH research and potential use of the tool. Recommendations are made at the end of the paper on how best IAWG members can implement, maintain and utilize a SRH research database.

This special studies project meets the needs of IAWG by suggesting a unique form of data collection and a repository of SRH research. Having such a database will allow for quick identification of gaps, impact, cost-effectiveness, and possible implementation of SRH services in other regions. Furthermore, this database would provide some information on SRH areas that need more funding and advocacy. In addition, this resource will allow for better collaborations between IAWG members and other agencies/organizations who have done comparable research.

CHAPTER 2: METHODS

The author worked with members of the DIR-SWG through email to develop the types of information to be incorporated in the original Excel spreadsheet (i.e. initial draft tool). This information was gathered and incorporated into an updated version of the initial tool. The questions in the tool were then translated into an online survey using *Survey Monkey* [44], a web-based survey tool (Appendix 1). The questionnaire asked a subset of IAWG members about SRH research projects in CHEs at their agency initiated, ongoing, or completed since January 2010 (Appendix 1). Research was broadly defined as surveys, operational research and surveillance and could be either qualitative or quantitative in order to capture a wide array of activities. The survey research topics included: reproductive health (RH) coordination; GBV, sexually transmitted infections (STI) prevention/management/treatment; maternal health; neonatal health; comprehensive RH planning; family planning; adolescent RH; reproductive cancers; safe abortion care; post abortion care; and other.

Currently, IAWG consists of a network of 450 agencies with more than 1,700 individual members. However, active membership within IAWG includes representatives of 27 organizations on the IAWG Steering Committee and Associate level. These members pay a fee and are more engaged in the annual activities of IAWG than the general public member. As a result, a pilot survey was sent to 18 members of the IAWG DIR-SWG on March 9th 2015 with a deadline of March 24th, 2015 to complete the online survey (Appendix 1). In addition, on March 24th 2015 emails were sent to 55 members of the IAWG Steering Committee and associate level members to participate in the online survey with a deadline of April 07th 2015 (Appendix 1). There was overlap of five members between the three groups. Therefore, the survey was sent to a

total of 68 individuals representing 27 organizations and with two members as independents. Two follow-up emails were sent to the above survey groups in their respective time periods to complete the survey. For the non-respondents and respondents who had attempted but not completed the survey, an additional two emails were sent so that they could initiate and complete the online surveys by May 05th, 2015.

These members were affiliated with 27 organizations: ARC, ARCS, BPRM, CARE, CDC, CRR, ICEC (specifically, Family Care International), ICRW, IMC, IPAS, IRC, JHCRDR, JHPIEGO, JSI, JHU, MSI, PAI, SAVE, SPRINT, UNFPA, UNHCR, UNICEF, WHO, WRC, Columbia University, University of New South Wales, University of Ottawa, and the University of Technology at Sydney. Twenty-eight (28) IAWG members (41.2 % of 68) attempted the online survey; but 16 (23.5 % of 68) were fully completed from March 09th 2015 to May 18th, 2015. The 16 members who completed the survey represented 14 organizations.

To complement the information collected in the survey, an in-depth interview was conducted among five IAWG members using an in-depth interview guide (Appendix 2). Interview participants were from NGOs, UN agencies, and independent consultants. Participants were selected to represent agencies that were and were not involved with SRH research. Email requests to participate were sent on Wednesday May 27th, 2015. One of the originally selected IAWG members for the in-depth interview could not participate "due to the challenges relating to the current circumstances in the country" he was working in, as communicated through email. Fortunately, a replacement from his organization was found within 48 hours. The other selected IAWG members responded within two weeks of the email request to participate in the study.

Interview topics included SRH research being done at their agency, resources available to conduct such research, how agencies keep abreast of SRH research, and why particular agencies were not involved in SRH research. Interviews were conducted from Friday June 05th, 2015 to Monday June 08th, 2015 by phone and Skype taking no longer than 20 minutes. The responses to the questions were written down in the member's own words; no recording took place. In summary, 14/27 organizations responded to the online survey; 2 additional organizations by interview—or a total response rate for organizations of 16/27 or 59%.

CHAPTER 3: RESULTS

Quantitative Data

Of the 68 IAWG members who received an email to participate in the online survey only 28 members (41.2%) attempted the online survey and 16 (23.5%) fully completed it from March 09th 2015 to May 18th, 2015. The 68 members represented 27 organizations with 2 members being independent consultants. The 16 members who completed the survey represented 14 (51.9%) organizations with 1 member being an independent consultant and another member not stating any affiliation. The members who did not complete the survey represented 3 organizations, 2 universities, and 1 member being an independent consultant. Of the complete online surveys, 4 of the organizations attempted the online survey twice, completing one and the other being incomplete (Table 1). Of the incomplete surveys 2 organizations made 2 attempts, both being incomplete (Table 1). Of the eligible respondents that *did not* attempt the online survey, 5 were organizations and 2 universities (Table 1).

Table 1: Eligible respondents by response category.

Completed online survey	Incomplete online survey	Non-respondents[±]
Algerian Red Crescent Society	Columbia University[+]	BPRM
American Refugee Committee	CARE	CRR
CDC	Independent	JHCRDR
Independent	Marie Stopes International[+]	JHPIEGO
ICEC	University of Ottawa/Cambridge Reproductive Health Consultants	ICRW
IPAS	World Health Organization	IMC
IPPF – SPRINT Initiative		PAI
International Rescue Committee*		The University of New South Wales
John Snow Inc.*		
Save the Children*		
UNHCR*		
UNICEF		
UNFPA		

University of Technology, Sydney		
Women's Refugee Commission		
Undeclared affiliation to an organization		
Note: * Indicates the organization made 2 attempts to the survey – one incomplete and the other incomplete; + Indicates the organization made 2 attempts to the survey, both incomplete; ±Indicates organizations that *did not* attempt the online survey.		

The job titles of the respondents were diverse and included: Policy advisor, Regional Manager, Project Director, Research Fellow, Technical Advisor, Senior Program Officer, Independent Consultant, Nurse Anthropologist/Epidemiologist, Senior RH/HIV Coordinator, Reproductive Health Specialist, Senior Advisor Health Emergencies, Program Coordinators, Family Planning and EmOC Advisor, Reproductive health Specialist, and Deputy Directors of programs.

Survey respondents entered information on 28 SRH research projects that were initiated, ongoing, or completed between January 2010 and the time of the survey. Of the 28 SRH research projects, 14 (50%) involved family planning; 11 (39.3%) involved GBV; 10 (35.7%) involved maternal health; 10 (35.7%) involved *other* SRH related work; 8 (31.3%) projects were done on STI (prevention/management/treatment); 8 (28.6%) involved comprehensive RH planning; 6 (21.4%) neonatal health; 6 (21.4%) involved adolescent RH; 5 (17.9%) of the projects involved RH coordination; 3 (10.7%) involved post-abortion care; 1 (3.6%) safe abortion care; and none involved reproductive cancers research (Figure 2)**.** Also, Table 2 depicts the reported research projects since January 2010 in specific SRH research topics per organization that completed the online survey.

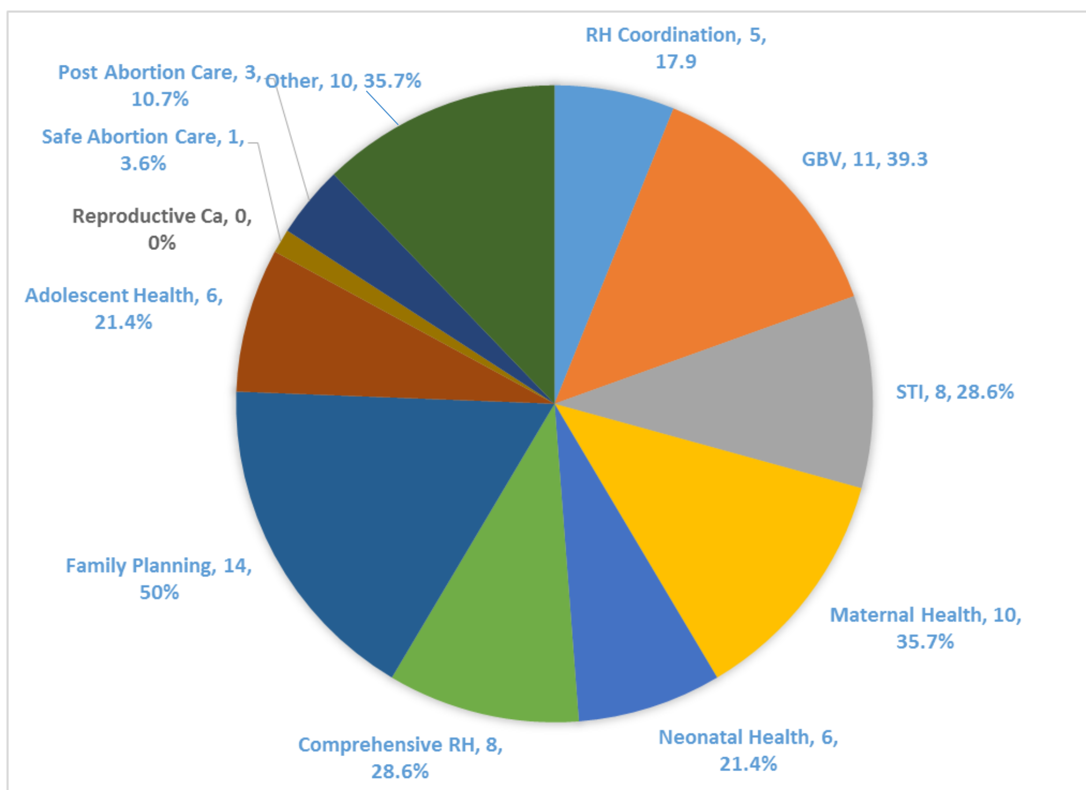


Figure 2: SRH topics of research projects done in crisis situations (i.e. citing projects initiated, ongoing, or completed) since January 2010*.

*: More than one topic could be selected for each research project so percent will equal greater than 100.
Note: *Other* included: Lessons learnt of the application of RH voucher program; quality of EmOC; Measures the level of MISP integration in the National Disaster Management policy as well as to examine the capacity of the Country Coordination Teams or the Reproductive Health Working Group in coordinating the MISP in emergency responses of different levels; MISP; Emergency obstetric newborn care (EMONC); Quality of RH Services; implementing MISP commodities; contraception.

Table 2: Reported projects since January 2010 in specific SRH research topics per organization that completed the online survey.

ORGANIZATION/AGENCY	Project(s)	SRH Research Topic(s)	Status	Countries/Regions
Algerian Red Crescent Society	1	RH coordination STI Maternal health Neonatal health Comprehensive RH Family planning Post abortion care	Completed	Chad, Sudan
American Refugee Committee	1	Maternal health	Completed	Thailand, S. Sudan
CDC	2	GBV Other	Both completed	Haiti, Jordan

Independent	1	RH coordination STI Family planning Post abortion care Other	Completed	Various countries where RH Kits were ordered
ICEC	1	GBV Family planning Post abortion care	Completed	Global/Organizations providing health services in crisis
IPAS	1	Other	Completed	Not indicated in the survey.
IPPF – SPRINT Initiative	2	GBV STI Maternal health Neonatal health Comprehensive RH Family planning Adolescent RH Safe abortion care Other	Both completed	Myanmar, Indonesia, the Philippines, the Solomon Islands, Papua New Guinea, Timor Leste, Uganda, The Democratic Republic of the Congo, Afghanistan, Pakistan Bangladesh
International Rescue Committee	3	GBV Family planning Adolescent health	1 completed; 2 ongoing	Kenya, Liberia, Ethiopia, Jordan, and DRC
John Snow Inc.	1	Comprehensive RH Family planning Adolescent health Other	Ongoing	Kenya
Save the Children	1	GBV STI Maternal health Comprehensive RH Family planning Post abortion care	Completed	Not indicated in the survey.
UNHCR	5	RH coordination Neonatal health Family planning Comprehensive RH Other	All completed	Bangladesh, Chad, Ethiopia. Kenya, Nepal, Rwanda, Sudan, Tanzania, Uganda and Zambia, Malaysia, Djibouti
UNICEF	1	Neonatal Health	Planning	South Sudan
UNFPA	1	RH coordination Maternal health Comprehensive RH Other	Completed	Syria
University of Technology, Sydney	1	Other	Completed	Sri Lanka
Women's Refugee Commission	5	RH coordination GBV STI	1 ongoing; 4 completed	Karen State, Eastern Burma (through Thailand); Malakal,

		Maternal health Comprehensive RH Family planning Adolescent RH Other		South Sudan; Port-au-Prince, Leogane and Jacmel in Haiti; Uganda; Colombia; Bangladesh, Djibouti, Jordan Kenya, Malaysia
Undeclared	1	GBV STI Maternal health Neonatal health	Ongoing	Global

Of the 28 SRH research projects, the types of research conducted in SRH in crisis situations (citing projects initiated, ongoing, or completed) since January 2010: 15 (53.6%) of the projects involved operational research; 11 (39.3%) involved in needs assessment; 5 (17.9%) in surveillance; 4 (14.3%) involved in program evaluation; and 5 (17.9%) in *other* types of research (Figure 3).

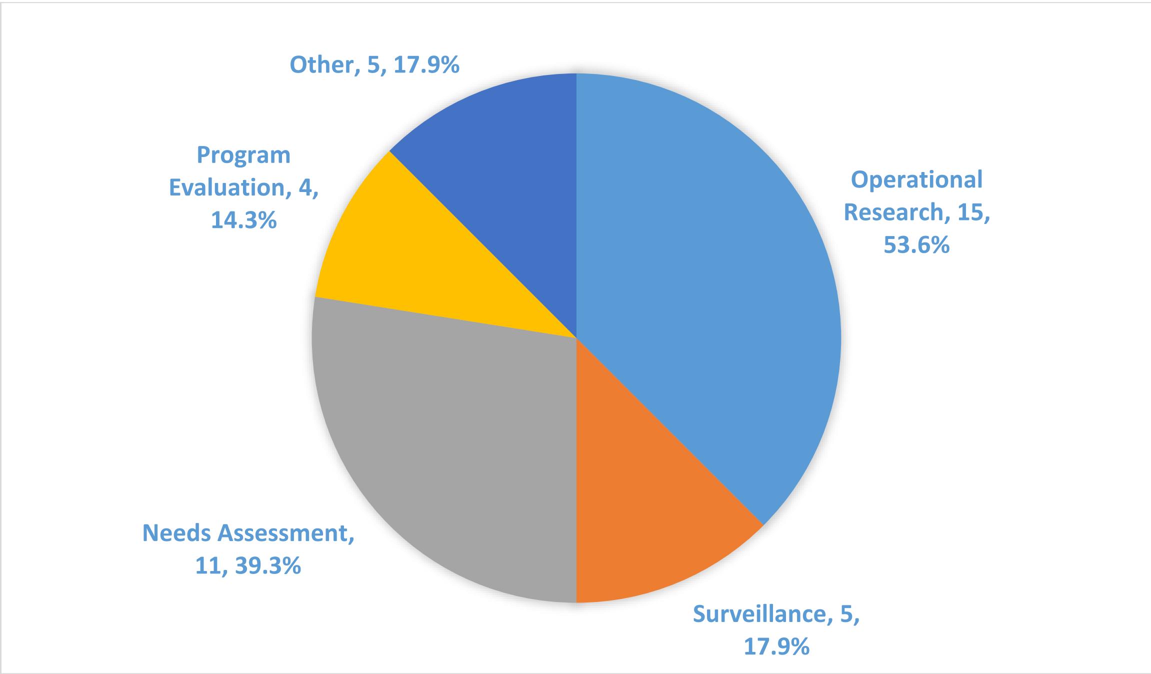


Figure 3: Types of research conducted in SRH in crisis situations (i.e. citing projects initiated, ongoing, or completed) since January 2010*.

*: More than one topic could be selected for each research project so percent will equal greater than 100.
Note: *Other* includes: desk review of funding trends and past/existing programs from 2009-2012; retrospective analysis of maternal death reviews; publications review; and situational analysis

Of the 28 SRH research projects, the research methods used to conduct SRH studies in crisis situations (i.e. citing projects initiated, ongoing, or completed) since January 2010: 15(53.6%) of the projects used mixed methods approach; 10 (35.7%) conducted qualitative survey; 8 (28.6%) conducted facility survey; 5(17.9%) did household/population survey; 3 (10.7%) used participatory action research and 7(25%) conducted *other* methods (Figure 4).

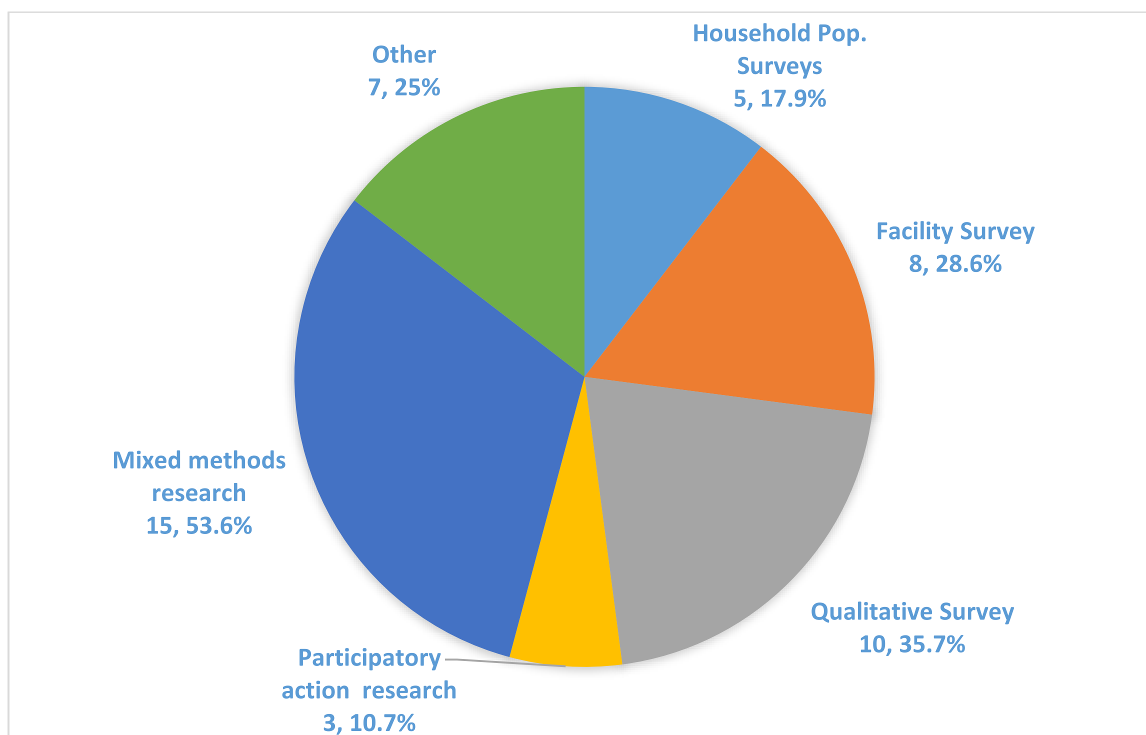


Figure 4: Research methods used in SRH in crisis situations (i.e. citing projects initiated, ongoing, or completed) since January 2010*.

*: More than one topic could be selected for each research project so percent will equal greater than 100.

Note: *Other* includes: retrospective analysis of surveillance data; key informant interviews; survey of organizations and donors working in crisis settings; retrospective analysis of maternal death reviews; systematic analysis of Financial Tracking System data; and qualitative mixed methods: FGDs & participant observation.

Qualitative Data

Characterization of the interview participants:

The collection of data was done through four phone interviews and one Skype interview conducted from Friday June 05th, 2015 to Tuesday June 23rd, 2015 taking no longer than 20 minutes. Interview participants were from NGOs, UN agencies, and independent consultants. Participants were also selected to represent agencies that were and were not involved with SRH research. Table 1 gives the description of the in-depth interview participants.

Table 3: Description on the in-depth interview participants.

Agency	Position	Organization involved in SRH research
CARE	Senior Technical Advisor	No
Columbia University	Deputy Director of RAISE Initiative	No
Independent	PhD candidate	Yes
UNFPA	Program Technical Advisor	Yes
WRC	Senior Program Officer for RH	Yes

The interviews focused on: factors that drive SRH research; why certain agencies are not involved in SRH research; resources available to conduct SRH research; identifying how agencies kept abreast on SRH research; identifying the need for a tool to collect and distribute research being done on SRH in humanitarian settings. It also focused on the feasibility of such a tool and how it can translate information so that there will be no duplication of efforts. The responses to the questions were written down in the member's own words; no recording took place. The following is the summarization of information from the interviews according to themes.

Driving factors that determine SRH research

The narratives from the respondents identified funding as an important driving factor that determines which SRH topics will be selected for research in humanitarian settings. Most funding was donor driven and most project proposals catered towards the research objectives of donor organization which sometimes didn't match the agencies objectives. In addition, SRH service areas that lacked attention or demonstrated obvious gaps were considered factors that drove SRH research in some agencies. These gaps have traditionally been brought to light through research in the field and one participant noted the following SRH service areas still have gaps according to her PhD research: newborn health, comprehensive GBV services, protection of women, gynecological cancers and adolescent health. Also, one agency mentioned that their mandate was determined by member states involved in the agency and funding for SRH programs was voluntary. If funding was not available, no research or SRH-based interventions could be done. Another respondent mentioned that challenges encountered in the field while providing humanitarian assistance may stimulate the need to do research in certain SRH areas.

The two respondents who represented agencies that did not participate in SRH research explained that their agencies' mandates were directed towards SRH programming and interventions in humanitarian settings. Some of the reasons for not being focused on research included: agency having new strategic objectives; "pure" SRH research not being part of the agency's mandate; and funding that is focused more on program implementation of SRH services in humanitarian settings.

Resources for SRH research

Funding was found to be a key resource to support various SRH research in humanitarian settings, especially from research specific grants. Other support came from partnerships with academic institutions that offered staff and IRB approval of research projects; namely: John Hopkins Center for Refugee and Disaster Response; Columbia University; and IAWG. As one respondent stated, "These partnerships were a collective of everyone strengths." However, even though funding was available for general SRH in humanitarian settings, certain SRH areas (e.g. safe abortion care, GBV, accountability of services) had little or no attention. Funding tended to be very specific based on donors' interests in SRH services limiting an agency's flexibility in pursuing research based on their organization's mandate.

Strategies to keep up-to-date on SRH research in humanitarian settings

Interestingly, non-research agencies use the same methods as the research agencies to keep abreast of SRH research in humanitarian settings SRH research in humanitarian settings. The following ways in which they kept up-to-date:

- Being involved with IAWG and the various meetings it conducts.
- Participating in various SRH related meetings and conferences at different levels: field, regional, domestic, and international.
- Being part of various domestic and international listserv committed to SRH in humanitarian settings.
- Operations research; participatory research
- Using social media to connect with professionals e.g. Facebook
- Getting involved in cluster group meetings

- Interacting and consulting with professionals and agencies in formal and informal settings.
- Research assistants at a certain agency updates members of SRH activity in humanitarian settings.
- Accessing journals

Despite the above ways on keeping up-to-date on SRH research, one of the respondents noted that the current methods of receiving research updates through listservs was overwhelming. Furthermore, the ability to attend IAWG related meetings/conferences was sometimes difficult due to logistical issues like scheduling conflicts.

Benefits and Challenges of having a database

One of the respondents noted that an effort was made in 2003 to create a database of SRH research but it was not followed through due to logistical issues that included: availability of a dedicated individual with the technical knowledge to build and maintain the database; funding to start the database; and support from IAWG members . Generally, all respondents agreed that such a database could potentially allow the SRH community to learn what research is going on and the status of the various areas within SRH. Most of the respondents noted some challenges that could inhibit the usefulness of the database included: the database not being comprehensive enough and not having a consistent interface for agencies to use the database; not having a technical person within the agency (or within IAWG) to maintain the database; one of the non-research agency respondents stated that "…not sure how we [agency] would us it"; little or no participation in using the database; agencies lack of willingness to share research and data. As one respondent stated, "Some agencies are not open to sharing until publication".

Additional ways for IAWG members to keep abreast of SRH research.

In an effort to explore other possibilities in which IAWG members can be kept up-to-date on SRH research, all the respondents agreed that agencies need to be willing to share information to the SRH research community that is easily accessible. To some, the current methods of staying up-to-date on research are not adequate. One respondent stated that there needs to be a "proactive approach to sharing of information" so that members can learn from one another. Also IAWG members need to "actively and proactively push the information" to the greater humanitarian community so that the SRH presence is felt, known, and understood. One respondent summarized it well and stated that beyond the database creating intrapersonal networks to drive research and productivity may allow IAWG members to stay abreast of research information.

CHAPTER 4: DISCUSSION

The Study

This study is important for several reasons: it provides information on the research IAWG members are currently involved in; it highlights research gaps that still exist in SRH in crisis situations following the 2012-2014 global review; and demonstrates the need for a specific research database for IAWG and the challenges of using such a tool.

SRH research in humanitarian settings

Based on the responses from the survey, IAWG members are involved mostly in research relating to family planning, GBV, and maternal health. There is minimal attention to adolescent care, neonatal health, and SRH coordination. Furthermore, there is an obvious lack of attention to research relating to post abortion care, safe abortion care, and reproductive cancers according to the survey. This is consistent with the findings of the 2012-2014 global review that demonstrated gaps in adolescent health research and abortion care research [34]. This continued emphasis in certain SRH areas and the lack of attention in other SRH areas can be due to the several reasons that were mentioned in the in-depth interviews. Such reasons include: agencies have limited freedom to make research decisions if a donor is involved; lack of technical expertise to research certain SRH area(s); and certain stakeholders determine the research focus within an agency. Nonetheless, most of the participants agreed that funding is the main determining factor that drives SRH research in crises. This sentiment is consistent with the findings from Tanabe et. al. which also demonstrated that certain SRH areas receive more financial support due to donor driven mandates [39]. In addition, one of the in-depth interview participants mentioned that “challenges in the field” can determine what SRH areas an agency

can realistically do research on. For example, the political and cultural climate in the field may not allow for the investigation of abortion-related services. As a result, legal restrictions within the country of interest may prevent such research taking place, which may lead to donor sensitivity about certain SRH topics [39].

Types of Research

This study added additional information to the IAWG global reviews by collecting information on the types of research being conducted by IAWG members. Most of the respondents noted operational research and needs assessment as the main type of research being conducted, with minimal attention to surveillance and program evaluation. Evidently, IAWG member agencies need to focus on surveillance and program evaluation; and consider unique types of research so that SRH areas that haven't had much attention can be researched using such methods in crisis situations.

Research Methods

In contrast to the IAWG global reviews, this study received unique information on the research methods being used by IAWG members in order to understand SRH in crisis situations. It's possible that the mixed methods approach is the most used research method because it offers flexibility in humanitarian settings and the some organizations have the technical expertise to conduct that research method. Furthermore, mixed methods approach may provide greater information since it's a combination of qualitative and quantitative approaches to research. Few respondents documented the use of household/population survey, and participatory action research. These types of research methods require considerable funding, logistics, and personnel

which may not be available to an agency. Also, the field experience an agency has in working in humanitarian settings may determine what sort of research method can be done. For instance, it's possible that some agencies may find it easier using certain types of research methods in certain regions where such research methods can be used (due to ease, networks with people and agency, and understanding the dynamics of the region).

Possibility of a SRH research in crisis situation database

According to the literature review done for this study, the author did not find any research investigating the need for a specific database on SRH research in humanitarian settings. This study is distinctive in that in-depth interviews were used to collect information about the possibility of a database. Interestingly, all the participants agreed that a tool is needed to keep IAWG members abreast of SRH research being done in humanitarian settings. The participants agreed that having such a tool will be helpful in letting members know who is working where and on what. Furthermore, the prospects of having a unique database for SRH research in humanitarian settings would allow for the sharing of research methods and tools that can be adopted and adapted, depending on the context for SRH related needs. This is consistent with the recommendations made by Chynoweth in the 2012-2014 global review that agencies need to find better ways for data collection and management [34]. The potential of a database to act like a repository of information can enhance collaborations, promote the exchange of funding opportunities, and encourage the sharing of information from the field. The sharing of information from the field is very critical because it will promote the reporting of lessons learned and stimulate the evolution of new research approaches to use in the field.

Challenges to having a database

Despite the positive response to the idea of having a database for SRH research in humanitarian settings, most respondents agreed there would be certain challenges to establishing it. To begin with, deciding who would be responsible for creating and keeping the database up-to-date. With so many research projects being conducted by IAWG members, finding the staff availability and time to build and maintain the database may prove to be difficult. Furthermore, ensuring the database contains quality information and double checking the validity of the information reported requires technical expertise. Also, deciding on how to deal with research done in other languages and if such information requires translation to English or not. Besides the above, even if IAWG members have the ability to access such information it doesn't necessarily mean they will have time to review it and be informed of the various projects to make meaningful interpretations of the studies.

Characteristics of the respondents

The respondents to the study came from diverse organizations and backgrounds. It was interesting to find that 5 universities were eligible to participate in the study but only one university (University of Technology, Sydney) documented a project and one participated (Columbia University) in the in-depth interview. Future studies need to consider what may guide SRH research in universities. Also, if academic institutions have any unique challenges and/or privileges when conducting SRH specific research in humanitarian settings.

Limitations to this study

Although this study provided valuable information not explored in the two global reviews of reproductive health programs in humanitarian settings, the response rate to the survey was less than expected. The 73 members who received the email to complete the surveys represented 27 organizations with 3 members being independent consultants. Only 38.4% of the members tried the online survey; but 21.9% were fully completed. The 21.9% who completed the survey represented 14 organizations with 1 member being an independent consultant and another member not stating any affiliation. When looking at these numbers from an individual perspective one may argue that a larger sample size would have been better. However, considering that some of the individuals who were contacted worked for the same or similar agencies, looking at these numbers from how many organizations were represented presents a better response rate. Essentially, 14/27 organizations responded to the online survey; 2 additional organizations by interview—or a total response rate for organizations of 16/27 or 59%.

Another limitation to the study was that more probing could have been done during the in-depth interviews to investigate other challenges faced while keeping abreast of SRH research while using the current methods. Finally, it is possible that the individuals who responded to the survey were not aware of some of the SRH research that had been done in their organizations. Even with the low response rate and the limited information from the interviews, the data retrieved from the IAWG members through the online survey and in-depth interview should still should be used to consider the implementation of a SRH research database.

Recommendations

As mentioned earlier, the idea of having an SRH research database came from the DIR-SWG of IAWG. It was envisioned that members could access the Excel spreadsheet from the IAWG website where agencies could update other IAWG members on their research efforts. This study came in to further develop the draft Excel tool and use this to creat a web-based survey to gather information on the current state of SRH research. Furthermore, additional information was retrieved through interviews about the need and potential utilization of the database. In order to address the aforementioned limitations and to promote the creation of database for SRH research in humanitarian settings, the following are recommendations intended to create a starting point for this initiative. These recommendations describe: how the database should be developed; proposes a better software for the building of the database; how the database should be maintained; and how to encourage the utilization of the database by IAWG members. In the long-term, all of these recommendations are aimed at encouraging more program evaluation and systematic research as suggested by the recent global review so that SRH needs are being fulfilled in crisis-affected communities [41].

Development of the database

Considering that DIR-SWG is responsible for moving research goals forward within IAWG they must create a strategic plan for the "*IAWG SRH Research in Humanitarian Settings Database* " detailing how this initiative will unfold. DIR-SWG should take the lead in building the database for IWAG and encourage members to document past, ongoing, and completed research. Furthermore, the database can be created initially using a relational database software like Microsoft Access. The benefit of using Microsoft Access is that it will allow IAWG to manage

large amounts of information more proficiently compared to Microsoft Excel [45]. Considering that Microsoft Excel uses spreadsheets, spreadsheets are not efficient in managing hundreds of records like the details of various research projects [45]. Fortunately, Microsoft Access allows for better data management, efficient organization of that data, cross-referencing that will allow for the display of multiple data sets compared to Microsoft Excel [45]. In addition to describing the implementation of the database using Microsoft Access in the strategic plan, DIR-SWG needs to decide if this database will be open access to others outside of IAWG.

Maintaining the database

As an alternative to DIR-SWG being responsible for this initiative, IAWG member agencies can designate an individual within their organization who has the technical expertise to report past, ongoing, and completed research to the DIR-SWG. On the other hand, IAWG can create an internship and/or fellowship position and hire someone with the technical proficiency to build and maintain the database on behalf of the DIR-SWG. However, during the study the author encountered problems in sending email reminders to members to participate in the completion of the survey so that the information could be catalogued. Essentially, reaching out for information to multiple people within an agency was difficult for the author. In order to counteract the low response rate, the author recommends IAWG agencies assign a point person to respond to DIR-SWG requests for information. That point person would be responsible for communicating within their agency to gather information and then put it into database or deliver it to the DIR-SWG point person. In addition, IAWG members need to be more proactive and participate in the sharing of information so that an SRH research database may be realized. Also, considering that IAWG members who participated in the survey and in-depth interviews had other roles and

responsibilities within their respective agencies, its possible many were busy and/or overwhelmed with other work related duties and thus had no time to participate in the study. In this context, until the designated "point persons" with the technical proficiency of maintaining a database are known, DIR-SWG must build the database and be responsible for an "engagement plan" to encourage IAWG members to submit research work.

Encouraging Utilization of the database

We are grateful to the IAWG members who participated in this special studies project and offered valuable information that can be used to develop and implement a database. The survey findings revealed that SRH research gaps still exists and the in-depth interview participants welcomed the implementation of a SRH research database. The lessons learned from this study and the feedback received from some of the IAWG members can be presented in the next DIR-SWG meeting. Hopefully, DIR-SWG can create unique strategies that can promote the database's utilization within IAWG so that it can be appreciated and valued. At the next IAWG annual meeting DIR-SWG should share these findings and the strategic plan to the members. At the meeting the DIR-SWG can have a workshop to convince members how the database will be an asset to them and offer a tutorial on how to use it. This will be a great opportunity to allow IAWG members to engage in the launch of the database and offer relevant feedback about better utilization of it. For IAWG members who are unable to attend the annual meetings and/or conferences, the DIR-SWG should post an online tutorial of the database so that members can actively engage using this forum. Also, periodic webinars should be conducted to allow for discussion about any challenges experienced when using the database and how it can be

improved. Hopefully, through these particular outreach methods IAWG members will find the SRH research database more meaningful and relevant.

CONCLUSION

With the sharp escalation of refugees, IDPs, and asylum seekers globally in the past five years as a result of new and on-going CHEs [4], better research methods are needed to assess the SRH needs of those in humanitarian settings. Particularly, considering that females currently make up half of the refugee and IDP population according to UNHCR, IAWG must take an aggressive research role in the humanitarian community. Building and maintaining a database will provide a repository of such research efforts where IAWG members can share information, collaborate more efficiently and thus avoid duplication of efforts. Fundamentally, this study demonstrated a unique perspective in which IAWG can take a research role in the humanitarian community. Specially, this study tried to pilot a data collection tool, explore perceived uses and barriers of using a database, and examine recent and current SRH research projects among IAWG members.

In the face of the low response rate, the findings from the survey demonstrated the various gaps in SRH research that still exist, which are consistent with the latest global review on SRH in humanitarian settings. Furthermore, the in-depth interviews provided relevant feedback on the driving forces that push SRH research and the challenges that still exist when doing such research. In addition, there was a willingness from the interview participants to consider an SRH research database that provides a repository of such information so that SRH needs are addressed. They agreed that such information will be helpful in providing evidence based interventions that can be adopted and/or adapted.

All things considered, the public health implication of having such a database is that it will provide an important source of the current state of SRH research in humanitarian settings. The

potential of such information to be used by other humanitarian actors is great and should be exploited for the purpose of strengthen evidence based program interventions that can possibly benefit hard to reach populations.

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APPENDICES

APPENDIX 1: IAWG Organizations and Members

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APPENDIX 2: Survey Monkey – Note: Below includes the questions for the 1st research project. Participants were also given the opportunity to fill in multiple projects with the exact same questions.

INSTRUCTIONS

The purpose of this survey is to collect information regarding research done in sexual and reproductive health (SRH) in crisis situations. Please complete the questions below, citing research projects initiated, ongoing or completed since January 2010. Research can be surveys, operational research and surveillance. Research can be either qualitative or quantitative.The date can be either the projected end date or the actual end date. Major findings should be a summary of about two sentences. Thank you for your participation!

1. Which organization/lead agency are you affiliated with?

2. Please provide your contact information below.

Name

Job Title

Email address

Research Project #1

Please complete the following questions for SRH research done for one project.

3. What is the project title?

4. What is the topic area(s) for the SRH research done in humanitarian emergencies? Research can be either qualitative or quantitative. (Select all that apply)

- RH Coordination
- GBV
- STI (prevention/management/treatment)
- Maternal Health
- Neonatal Health
- Comprehensive RH Planning
- Family Planning
- Adolescent RH
- Reproductive Cancers
- Safe abortion care
- Post abortion care
- Other

Other (please specify)

5. What type(s) of research are involved in this project? (select all that apply)

- [ ] operational research
- [ ] surveillance
- [ ] needs assessment
- [ ] program evaluation
- [ ] Other

Other (please specify)

6. What research methods did you use for this project? (Select all that apply)

- [ ] Household/Population survey
- [ ] Facility survey
- [ ] Qualitative survey
- [ ] Participatory action research
- [ ] Mixed methods research
- [ ] Other

Other (please specify)

7. Please provide the country/countries of focus for this project.

8. Please provide the population(s) of focus for this project.

9. Please complete the following details regarding this project (can provide estimates if project has not been completed).

	Research/Project status	Start date - Year	End date - Year
Project #1			

10. In 2 sentences please describe the major findings of this project.

11. In 2 sentences please describe the products (or planned products) for this project.

12. Will these products (or planned products) be publicly available?

- ( ) Yes
- ( ) No

13. Do you have another project to add?

- Yes
- No

Research Project #2

APPENDIX 3: In-depth Interview Guide

SRH in Crisis – In depth Interview guide

Date of the Interview: ___________

INTERVIEW INFORMATION

Name: ________________________
Job Title: ________________________
Agency: ________________________
Location: ________________________
Email: ________________________

PURPOSE OF THE STUDY

Voluntary Participation
Participation in this in-depth interview is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Risks
None foreseen.

Reimbursements
There will be no direct incentive or benefit to you by participating in the in-depth interview.

Confidentiality
With your consent below, the information that we collect from this in-depth interview (including your name and agency) will be used in my thesis.

Sharing the results
The knowledge that we get from this research will be shared with the IAWG before it is made widely available to the public. Each participant will receive a summary of the results.

Who to Contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me at: ramla.namisango.kasozi@emory.edu or ramlakasozi@gmail.com.

Consent
Because we are doing a phone interview we are going to use verbal consent. You have been given the opportunity to ask questions about the above and any questions you have been asked has been answered to your satisfaction. Is that correct? Yes □ No □

Please repeat the following: "I consent voluntarily to be a participant in this study and authorize the researcher/person taking the consent to print my name below and to use the information that is collected from this in-depth interview (including my name and agency) to be used in the MPH thesis."

Print Name of Participant: ________________
Date (mm/dd/yyyy): ________________

Statement by the researcher/person taking consent: I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the above. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntary.

Print Name of researcher/person taking consent: __________________
Signature of researcher/person taking consent: __________________
Date (mm/dd/yyyy): __________________

QUESTIONNAIRE

1. Tell me about your role with the agency you work with.
2. Has your agency been involved in research in SRH in humanitarian settings in the past?
    a. What are the driving factors that determine *specific topics* of SRH research in humanitarian settings at your agency?
    b. What resources and support does your agency have when doing SRH research in humanitarian settings?
    c. What resources and support are lacking in your agency when conducting research in humanitarian settings?
3. Why isn't your agency involved in research in SRH in humanitarian settings?
4. What strategies does your agency use to keep up-to-date on SRH research in humanitarian settings?
5. In what ways would a database of SRH research be used at your agency?
6. How wouldn't a database be useful to your agency?
7. What ideas to do you have of additional ways for IAWG members to keep abreast of SRH research?

Summary

8. Do you have any other thoughts or comments that you want to share?