RESEARCH PAPER

Community Solutions for Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health in Humanitarian Settings in the Horn of Africa

With funding from
Austrian Development Cooperation

UN WOMEN

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UN WOMEN, EAST AND SOUTHERN AFRICA REGIONAL OFFICE

December 2021

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Austrian Development Agency

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ACKNOWLEDGEMENTS

UN Women East and Southern Africa Regional Office (ESARO) would like to acknowledge all those who made this study possible, including funding from the Austrian Development Agency and the respondents from the region. We appreciate the time and insights from various stakeholders in sister agencies within the United Nations System, including United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA) and United Nations High Commissioner for Refugees (UNHCR), other partners such as the United States Agency for International Development (USAID) (which funded the project Transform: Primary Health Care, led by Pathfinder International), and other non-governmental agencies both at the regional level and in the various countries in the Horn of Africa, USAID/Regional Health Integration to Enhance Services — North, Acholi (RHITES-N), Rehabilitation and Development Organization, International Medical Corps, and Humanity & Inclusion as part of the UK Foreign, Commonwealth and Development Office (FCDO)-funded Women's Integrated Sexual Health (WISH) consortium (International Planned Parenthood Federation, Marie Stopes International, Options Consultancy Services and Development Media International -DMI).

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
COVID-19	Coronavirus Disease 2019
DMPA-SC	Subcutaneous Depot-Medroxyprogesterone Acetate
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
ICMS	Integrated Community Mobilizers
MISP	Minimum Initial Service Package For Sexual And Reproductive Health In Crisis Situations
MNCH	Maternal, Newborn And Child Health
MUAC	Mid-Upper Arm Circumference
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PMTCT	Prevention Of Mother-To-Child Transmission Of Hiv
PPE	Personal Protective Equipment
RADO	Rehabilitation And Development Organization
RHITES-N	Regional Health Integration To Enhance Services — North, Acholi
SRH	Sexual And Reproductive Health
SRHR	Sexual And Reproductive Health Rights
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child And Adolescent Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner For Refugees
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity For Gender Equality And The Empowerment Of Women
USAID	United States Agency For International Development
VHT	Village Health Team
WASH	Water, Sanitation And Hygiene

EXECUTIVE SUMMARY

UN Women East and Southern Africa Regional Office (ESARO) is implementing the Programme On Women's Empowerment (POWER) in Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) rights in humanitarian settings in the Horn of Africa with the current focus being on Ethiopia and Uganda. This is part of the broader work of UN Women ESARO in support of gender equality and women's empowerment in other Horn of Africa countries, including Djibouti, Eritrea, Kenya, Somalia, South Sudan, and Sudan.

Horn of Africa

As part of the POWER programme activities, this study was conducted to document the effective SRMNCAH community solutions in humanitarian settings in the Horn of Africa region. The aim of this document is to facilitate cross-country learning and contribute to informing community interventions, advocacy initiatives and programme development on SRMNCAH in humanitarian settings, not only for the POWER but also for other programmes. This report is based on a study that involved a review of the existing literature, as well as qualitative data collected remotely through emails or online interviews owing to the current coronavirus disease of 2019 (COVID-19) related travel restrictions.

Humanitarian crises arise when normal life and activities are disrupted by events that may be natural or induced by humans. Complex humanitarian crises arise from a combination of both natural and human-created events or more than one natural event. The effects of such crises may be short or long term and may or may not result in displacement of people from their homes, communities, or countries.

Humanitarian crises often result in disruption of multiple services, including health (sexual, reproductive, maternal, newborn, child, and adolescent health — SRMNCAH), education, legal, and water, sanitation and hygiene and other related services that have implications on health outcomes. The disruption of SRMNCAH and routine services not only results in women and children being more severely affected by humanitarian crises, but also increases their vulnerability, especially of those who are living with disability. The need for SRMNCAH services is greater during crises due to increased risk of gender-based violence (GBV), transactional sex, trafficking, forced marriage, child marriage and increased risk-taking behaviour. This leads to increased need for contraception, maternal and newborn health services, and prevention and treatment of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), as well as health care responses to GBV.

The COVID-19 pandemic worsened the situation in humanitarian settings because the restrictions placed on movement and gatherings limited both the provision and uptake of SRMNCAH services. The economic effects of the pandemic further reduced uptake of services and water shortages in humanitarian settings make it difficult to implement preventive hygiene practices, which prolonged the effects of the pandemic on such populations. To overcome the challenges posed

by the pandemic, several innovations have been implemented, including the use of mobile phone technology, loudspeakers for mass sensitization, outdoor house-to-house mobilization to comply with COVID-19 prevention measures, and combining distribution of SRMNCAH information and supplies with COVID-19 activities, such as during the distribution of food and other supplies.

The Horn of Africa countries all are affected by humanitarian crises, with over 5.5 million (4.1 million internally displaced and 1.4 million refugees) being displaced by the end of 2017. These crises include natural disasters like droughts, floods, locust swarms, landslides, and cyclones, as well as human-made challenges due to conflict, insecurity and irregular migration. In some countries, the situation is worsened by attacks on humanitarian workers (e.g. Somalia) and the burden of refugees from neighbouring countries (e.g. Sudan, Uganda). Women and girls often bear the burden during such crises given their diverse SRMNCAH needs, from menstrual hygiene, contraception (including emergency contraception), antenatal care, delivery and postnatal services, child health and GBV services. In humanitarian settings, the lack of access to basic sanitation facilities (including water), further challenges efforts to meet critical SRMNCAH needs.

To address SRMNCAH in the region, various community solutions have been implemented by stakeholders, which include both demand creation and service delivery interventions.

Demand creation interventions identified as promising and potentially effective include:

(i) Community awareness creation and dialogue toward transforming gender inequitable and discriminatory attitudes, norms and practices

(ii) Innovative approaches to engage communities for increasing knowledge and skills for promoting SRMNCAH

(iii) Peer education, particularly for young people and mothers

(iv) Engagement of men and boys in SRMNCAH activities

(v) Dedicated teams of community-based health educators

Service delivery interventions that have been found to be promising include:

(i) Community-based distribution of SRMNCAH supplies including dignity kits, menstrual hygiene kits, delivery kits, contraceptives

(ii) Community outreach services and rapid response teams that provide SRMNCAH services in hard-to-reach areas on a regular basis

(iii) Provision of continuous basic SRMNCAH services through community health workers or village health teams

(iv) Mainstreaming of services for women and girls living with disability.

(v) Safe spaces for women and girls to access SRMNCAH information and services (including on GBV)

(vi) Facilitation of referral and linkages to SRMNCAH services.

The challenges implementing these interventions include lack of data for planning, low capacity for service provision among health workers (on SRMNCAH and addressing GBV), limited number of female health workers, recognizing people's preferences to see health providers of the same sex, and inadequate capacity for programming for specific age groups and for women and girls with disabilities. These challenges are exacerbated by the relatively poor coordination and engagement of sector ministries and organizations that are needed for effective emergency response. Other challenges include lack of access to sexual and reproductive health (SRH) products like contraceptives, especially in the initial stages of crises, not planning for the needs of young people, insufficient allocation of funding, despite the existence of the UNFPA's Minimal Initial Service Package (MISP) for Sexual and Reproductive Health in Crises. There are also insufficient connections between the plans and investments covering the immediate humanitarian needs and the longer-term investments across the humanitarian–development-peace nexus, which need to be considered.

Recommendations on how to improve SRMNCAH in humanitarian settings include the following:

Legal frameworks, policies, and guidelines

(i) Detailed costed implementation plans should be developed to operationalize existing commitments, policies and guidelines for SRMNCAH in humanitarian settings to ensure the needs of women, adolescents and girls, especially internally displaced persons and refugees, are addressed.

(ii) Budget allocations for SRMNCAH support should be included in guidelines for allocations of immediate humanitarian responses, especially in the initial stages of crises.

(iii) There should be continuous advocacy to ensure funds are made available for SRMNCAH interventions in humanitarian settings, which could build on existing gender-responsive budgeting efforts.

Programme Design, Implementation

(i) The humanitarian response should reflect investments that can be a bridge to long-term development, especially in countries with both humanitarian and development settings, such as Somalia and South Sudan.

(ii) Deliberate efforts should be made to assess and meaningfully address gender inequality and social inclusion aspects (and disability, age, gender) among vulnerable populations to address demand barriers in the planning and response to any humanitarian crisis.

(iii) Alternative models for delivering SRMNCAH services in humanitarian settings need to be explored to address service disruptions due to restrictions of movement or gatherings.

Partnerships and Coordination

(i) Partnerships with women's rights, youth organizations and organizations of persons with disabilities should be strengthened to ensure SRMNCAH demand generation is gender-responsive and reflects the experiences and needs of diverse women, adolescents and children.

(ii) Coordination between partners should be strengthened so that resources can be pooled to achieve better results in both humanitarian and development contexts by leveraging the comparative strengths of partners.

(iii) Multisectoral coordination and connections between SRMNCAH interventions and national disaster risk management and response mechanisms should be strengthened to ensure the needs of women and girls in areas such as livelihoods, education or water, sanitation, and hygiene are addressed, which affect their SRMNCAH.

Service delivery

(i) Emergency response plans should be integrated in SRMNCAH services so that health systems can adapt and deliver responses appropriately and without delay when a crisis occurs.

(ii) Deliberate measures should be taken to address the needs of women and girls with disabilities within existing SRMNCAH services.

(iii) The SRMNCAH needs of internally displaced people (IDP) should be considered as a distinct group, regardless of whether they reside in IDP camps or are integrated with host communities.

Monitoring Policies and Programming

(i) There should be investments in sex, age and disability disaggregated data related to SRMNCAH that can be used for effective planning in all the countries in the region.

(ii) Refugees should be included in national data systems which capture SRMNCAH indicators, with data used to inform SRMNCAH programmes, monitor and address disparities in access to services in a more effective and sustainable manner.

(iii) Easily accessible and confidential complaints mechanisms for GBV- and protection-related reports should be established and should be guided by clear procedures to improve safe information sharing between different parts of the referral system to meet the needs of survivors in their diversity.

BACKGROUND

UN Women East and Southern Africa Regional Office (ESARO), with the generous support of the Austrian Development Agency, is implementing the Programme on Women's Empowerment (POWER) in Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) rights in humanitarian settings in the Horn of Africa, with a focus on Ethiopia and Uganda. This is part of the broader work of UN Women ESARO in support of gender equality and women's empowerment in other Horn of Africa countries, including Djibouti, Eritrea, Kenya, Somalia, South Sudan, and Sudan.

As part of the POWER programme activities, this study was commissioned to document promising SRMNCAH community solutions in humanitarian settings in the region. The document aims to facilitate cross-country learning and to inform community interventions, advocacy initiatives and programme development on SRMNCAH in humanitarian settings, as part of POWER and other programmes.

Photo: UN Women/Carlos Ngeleka

METHODOLOGY

The study involved a desk review of the existing literature on the SRMNCAH situation in humanitarian settings and some of the interventions implemented to address SRMNCAH issues in a humanitarian context. The documents reviewed included programme manuals, guides, reports and bulletins, policy briefs, journal publications and statistics dashboards. This was followed by the development of interview questions and the collection of qualitative data from stakeholders by email or through online interviews. The data were then analysed and informed the report.

The main limitation of the study was the inability to conduct data collection in person due to the coronavirus disease of 2019 (COVID-19)-related travel restrictions. In this regard, respondents were limited to development partners and the perspectives of government officials and community members are not captured in this document. As such, the initiatives identified as promising should be further validated with these groups as part of the report's use.

Photo: UN Women/Deepika Nath

CONTEXT

Various events can disrupt the normal life and activities of a population and result in a humanitarian crisis affecting the safety, health, and well-being of people in a specific area, including:

- Climate-related natural disasters like flooding, earthquakes, hurricanes, locust infestations, drought, famine, volcanic eruptions, and wildfires
- Human-made issues such as conflict, insurgency, banditry, or war
- A combination of natural and human-made issues, such as a conflict, which prevents people from farming and then results in famine, or conflict may arise from competition for scarce resources in areas of natural disasters such as flooding.

Humanitarian crises often break down key services such as health, social protection, or education due to restricted movement, destruction of infrastructure, loss of service providers (displaced or killed) and lack of required supplies. Health services, including SRMNCAH services, may be targets of violent attacks in such situations, limiting access to these services for those who need them. Many women, girls and boys in such settings need routine services such as contraception, antenatal care, delivery, postnatal care, immunization, nutrition, and child welfare services. The increased vulnerability of women, girls, boys, and people living with disabilities to sexual exploitation and gender-based violence (GBV) often resulting from loss of shelter, family, income, and protection services may also result in an increased need for SRMNCAH services. In addition, trafficking for sexual exploitation, forced and child marriage and transactional sex may become more common in such situations as people try to find a way to survive. Humanitarian settings may also result in increased risk-taking behaviour such as unprotected sexual intercourse, multiple sex partners and substance abuse that further increase the vulnerability of these individuals. This leads to an increased need for contraception, abortion care, antenatal, delivery and postnatal care, as well as services for the prevention and treatment of sexually transmitted infections (STIs), and gender-based violence.

Among children under the age of 5 years and pregnant women, the destruction of farms and food supply lines, loss of family income earners and reduction in income, can result in increased malnutrition and increase the need for SRMNCAH services. Losing family income earners and reductions in income also increase the risk of malnutrition due to the loss of purchasing power and increases the need for SRMNCAH services in humanitarian settings. The loss of livelihoods and incomes makes it more difficult for people in crisis to access SRMNCAH services because of a lack of funds for transportation to service providers or to pay for the services. It is important to note that women and children living in poverty, who have limited capital, assets, and social networks, are particularly vulnerable to shocks induced by a humanitarian crisis. As such, it is important that governments and development partners conduct vulnerability analyses so that efforts can be tailored to reach those in greatest need first.

The COVID-19 pandemic and its Impact on SRMNCAH in humanitarian settings

The COVID-19 pandemic has worsened the SRMNCAH situation in humanitarian settings because of:

(i) The fear of becoming infected, both among people in need of the services and service providers, which limits the demand for services and the delivery of services

(ii) COVID-19 infections among health workers, resulting in loss of life or absence from work

(iii) Movement restrictions, which limit the demand for and the provision of services. Additionally, the movement restrictions have increased the risk of GBV as people are required to remain in close contact for long periods and may be unable to escape when threatened

(iv) Loss of income, which limits the demand for services and increases the risk of sexual exploitation among women, girls, children, and people living with disabilities

(v) Movement restrictions and diversion of resources to the COVID-19 response, which decreased humanitarian and SRMNCAH programme implementation and monitoring

(vi) Increased risk of child marriage and adolescent pregnancy following school closures and loss of livelihoods.[1]

The water shortages, lack of soap and other hygiene supplies, and the limited opportunity for social distancing in such settings also make it difficult to practice preventive measures for COVID-19 and other infectious diseases.

The situation in the Horn of Africa

The Horn of Africa comprises eight countries: Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, and Uganda. All countries in the region have large numbers of people who are affected by various humanitarian crises as detailed in the table, which is followed by a summary of country-specific information. Given the dynamic context of humanitarian crises, these figures are provided as an illustration of the scope of the needs in the region, and updated figures should be used for planning purposes.

Photo: UN Women/Catianne Tijerina

Humanitarian needs in the Horn of Africa

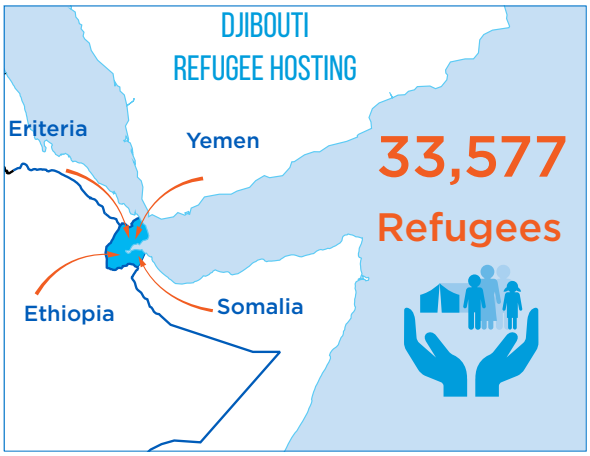
Country	Total people in need	Women of reproductive age	Pregnant women	Young people (15–24 years)
Djibouti	1.2 million	298,278	16,819	314,590
Eritrea	0.002549 million	n/a	n/a	n/a
Ethiopia	10.0 million	2.5 million	227,250	3.4 million
Kenya	14 million	3.7 million	288,478	4.7 million
Somalia	5.9 million	1.3 million	180,983	2.0 million
South Sudan	7.3 million	1.7 million	181,613	2.40 million
Sudan	12.7 million	3.1 million	292,418	4.1 million
Uganda	3.6 million	862,605	180,331	1.2 million

Source: UNFPA, April 2021. **"Humanitarian Emergencies." Accessed 1 September 2021.** https://www.unfpa.org/data/dashboard/emergencies.

Note: n/a, not available.

Djibouti

Djibouti is prone to natural disasters, including droughts, floods, and major storms like cyclones. Djibouti has unique migration challenges owing to its location at the crossroads linking Europe, Asia, and Africa. It is also a gateway from the Horn of Africa to the Middle East and, although not documented, is increasingly becoming a source and transit country for movements across the Gulf of Aden and beyond. The country hosts 33,577 refugees from neighbouring countries (including Eritrea, Ethiopia, Somalia, and Yemen) and 100,000 migrants mainly from Ethiopia.[2,3] Up to 25 October 2021, there were 13,451 COVID-19 cases in the country with 181 deaths.[4] Malnutrition and diarrhoeal diseases are common in humanitarian settings, and female genital mutilation (FGM) is widely practised in the country. Irregular migration often places people in vulnerable situations and exposes migrants to the risks of economic exploitation, abuse, physical and/or GBV, detention with poor humanitarian conditions and the potential for disease transmission, including TB and diarrhoea, destitution and, in extreme cases, even loss of life. The influx of migrants into the country places challenges on services, which require additional capacity to cope with the current situation.



Source: UNHCR figures as of 14 August 2021.
OCHA Accessed 30 November 2020.

Eritrea

Conflicts and natural disasters such as recurrent droughts, locust infestations and floods create humanitarian crises in the country, although access to data are limited. From 2020 to 2021, the humanitarian situation of Eritrea worsened because of the combined effects of the economic

impact of COVID-19, price increases for basic commodities, desert locust infestations and weather shocks. There are many refugees from Eritrea in neighbouring countries such as Ethiopia, as well as other countries in the Middle East and Europe. Eritrea also hosts refugees from neighbouring countries like Somalia.[5,6,7] Up to 25 October 2021, there were 6,792 COVID-19 cases and 45 deaths.[8] Although literature and data on the humanitarian situation in the country are limited, GBV is a significant concern, with common forms including torture, rape, FGM and child marriage and abduction of women and girls, especially migrants.[9]

Ethiopia

Among those in humanitarian settings in the country, an estimated 5.9 million people need health services and of these, 22 per cent are women, 54 per cent are children and 11 per cent are people living with disabilities. The risk of GBV, including sexual violence and harmful practices, is higher in humanitarian settings, especially among displaced populations and among people with disabilities; Floods affected over 1.1 million people in various parts of the country and, of these, over 340,000 people were displaced while desert locust swarms destroyed over 200,000 hectares of cropland affecting the food supply for 1 million people. On 25 October 2021, 362,335 COVID-19 cases had been reported, with 3,200 deaths.[10] Ethiopia is also prone to droughts, with resulting food shortages. Between December 2020 and January 2021, there were more than 1.8 million internally displaced people in Ethiopia, mainly due to conflict, drought and seasonal floods.[11] As a result of the recent conflict in Tigray region over 45,000 people have fled to Sudan.[12] In addition, Ethiopia hosts over 700,000 refugees from Eritrea, Somalia, South Sudan and Sudan.[13]

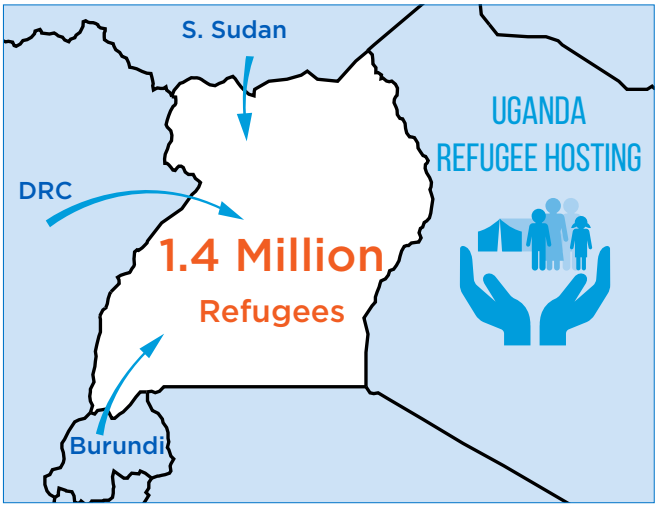
Ethiopia Health Services

Immunization coverage is low in Ethiopia, which makes adults and children vulnerable to vaccine-preventable illnesses, and there are outbreaks of communicable diseases like measles, cholera, and dengue fever. It is estimated that 2 million children need emergency vaccinations, and 1.2 million women and girls need access to family planning and maternal health services.[14] In addition, about 4.4 million children under the age of 5 years, pregnant women and breastfeeding mothers need access to treatment for acute malnutrition.[15]

Uganda

There are over 1.4 million refugees in Uganda from neighbouring countries, particularly Burundi, the Democratic Republic of Congo, and South Sudan. Over 80 per cent of these refugees are women and children.[16,17] Recent floods resulted in the displacement of over 581,000 people,[18] while COVID-19 cases in the country as of 25 October 2021 stood at 125,758, with 150 deaths.[19]

There is a need for sexual and reproductive health (SRH) and GBV services, particularly among internally displaced persons and in refugee-hosting areas. Treatment of acute malnutrition is also required for children and pregnant women, while immunization and treatment of childhood illnesses are needed for children under the age of 5 years.[20]



Source: OCHA. Accessed 4 November 2021.
UNHCR. 2020. Accessed 4 November 2021

Kenya

In 2020, floods and landslides affected 233,000 people and of these, 116,000 were displaced. In addition, over 1,700 people were displaced due to communal conflicts. The country hosts over 494,000 refugees (especially from Ethiopia, Somalia, and Sudan), more than half of whom are children.[21] Up to 25 October 2021, 252,672 COVID-19 cases had been reported in the country, and 5,257 deaths. Kenya also experienced infestation by desert locusts and displacement due to flooding in 2020; however, the situation has improved.[22]

Kenya acute malnutrition

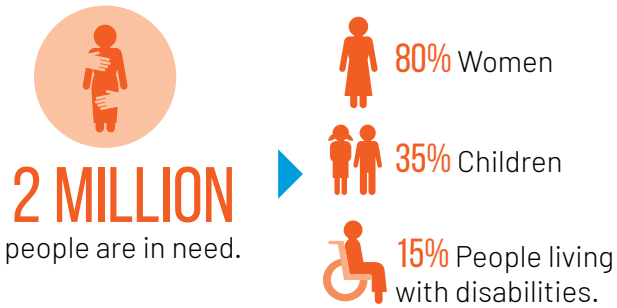
There are outbreaks of communicable diseases like measles and cholera. More than 600,000 children, pregnant and breastfeeding mothers need treatment for acute malnutrition. Levels of GBV and teenage pregnancy are increasing due to the COVID-19 pandemic's negative effects on social life.[23]

Sudan

About 8.6 million people in Sudan need health services in humanitarian settings and, of these, 59 per cent are women or girls, 63 per cent are children and 15 per cent are people living with disabilities. About 2 million people need of GBV services, of whom about 80 per cent are women, 35 per cent are children and 15 per cent are people living with disabilities.[24,25] Up to 25 October 2021, 40,443 COVID-19 cases had been reported, and 2,995 deaths.[26] Sudan has 2,550,000 internally displaced persons due to protracted conflicts and natural disasters. Floods affected about 885,000 people in 2020 and almost 45,000 refugees from the Tigray region of Ethiopia were in Sudan as of late 2020 and have since increased.[27] The country also hosts more than 1 million refugees, mostly from South Sudan.[28]

Among people in humanitarian settings in Sudan, about 3.5 million children need health services to address childhood illnesses and about 2 million women need SRH services, including GBV services. Immunization coverage is low, malnutrition is widespread among children and pregnant women, and access to SRMNCAH services is limited.[29]

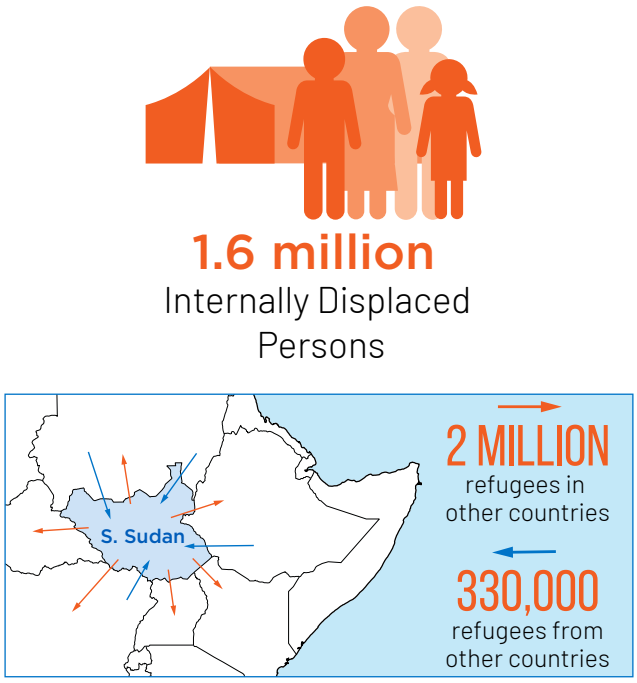
Sudan GBV Services



South Sudan

The country has experienced many years of conflict resulting in humanitarian crisis and this was compounded by flooding in 2020. There are 1.6 million internally displaced persons in the country, over 2 million South Sudanese refugees in other countries, and more than 300,000 refugees from other countries in South Sudan.

South Soudan IDPs and Refugees



Source: OCHA. South Sudan Humanitarian Snapshot, October 2020. Accessed 4 November 2021.

Up to 25 October 2021, 12,293 COVID-19 cases had been reported in the country, and 133 deaths.[30] About 3.6 million people need health services in humanitarian settings in the country and, of these, 50 per cent are women or girls, 54 per cent are children and 13 per cent are people living with disabilities. Women and girls are at risk of GBV, especially those that are displaced and those with disabilities.[31]

The health system in the country is inadequate because of the prolonged conflict and this has resulted in low immunization coverage and limited access to SRMNCAH services, particularly maternal health and GBV services. Malnutrition is widespread, and there are outbreaks of communicable diseases like measles, respiratory illnesses, and diarrhoeal diseases.

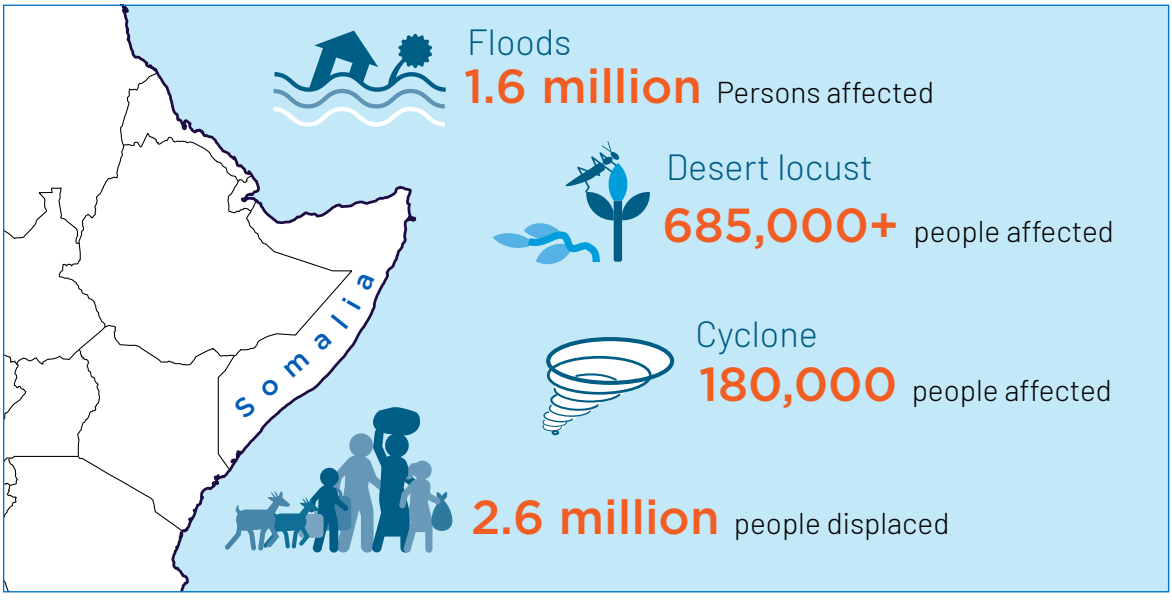
Somalia

Somalia has experienced many years of conflict. The situation has been complicated by natural disasters, including flooding, locust infestations and cyclones. This has resulted in the displacement of more than 2.6 million people within the country, as well as over 740,000 Somalian refugees in other countries.[32] Floods affected more than 1.6 million people in 2020, desert locust infestations affected more than 685,000 people, a cyclone affected about 180,000 people and, up to 25 October 2021, 21,998 COVID-19 cases had been reported, and 1,208 deaths. Unfortunately, the humanitarian response in the country is hampered by attacks on humanitarian workers.[33]

Somalia has firmly entrenched gender roles that often subjugate women and girls. GBV is pervasive, particularly female genital mutilation/cutting (FGM/C), affecting to 98 per cent of women aged 15-49, and early marriage and psychological abuse is also common. Protracted conflict coupled with an elevated risk of famine due to cyclical below-average rainfall has created overlapping protection concerns that disproportionately affect the safety of women and girls.

Care for pregnant mothers is lacking and only 33 per cent of births in these settings are attended by skilled birth attendants. Access to contraceptives is limited. GBV affects an estimated 77 per cent of internally displaced persons and 20 per cent of the host population.[34] The form of GBV most reported is physical violence (59 per cent), followed by rape (14 per cent), sexual assault (12 per cent), denial of resources (5 per cent) and forced/early marriage (3 per cent).[35] In June 2020, the Somalia Protection Monitoring System in South-Central Somalia indicated that child/early marriage remains one of the highest protection concerns reported. Malnutrition is widespread and immunization coverage is less than 50 per cent, which makes the population even more vulnerable to vaccine-preventable illnesses.[36]

Somalia Natural Disasters



Source: IRC (International Rescue Committee). 2020. 2020 Emergency Watchlist. London: IRC.
OCHA. 2020. *Somalia Humanitarian Bulletin*. 12 November 2020. Accessed 4 November 2021.

Addressing SRMNCAH in humanitarian settings

Responses to humanitarian crises must be multi-sectoral to cater for the various and often complex needs of the affected population. The health sector is primarily responsible for addressing SRMNCAH issues, however there is a need for collaboration with other sectors. For example, providing water sources within shelters may reduce the risk of women and girls being exposed to GBV that occurs when they travel long distances to fetch water. SRMNCAH needs may be addressed through interventions at the facility level or at the community level. This document focuses on community-level interventions to promote SRMNCAH and some common interventions are described below.

Community awareness and mobilization activities can be organized to increase uptake and encourage the use of SRMNCAH services among women and girls. Information and services should be made available, affordable, and accessible not only to women and girls but also to men and boys, as they also need health services and can support their family and community members to access services. For example, in Djibouti, Care International carried out family planning awareness campaigns in emergency situations reaching all community members.[37] In the context COVID-19, community awareness-raising efforts on SRMNCAH can accompany or be combined with efforts to communicate the risks of the virus, recognizing the need to reach all crisis-affected persons.

The distribution of basic supplies for SRMNCAH in communities affected by emergencies is critical. This can include provision of antenatal medicines, hygiene supplies like soap and menstrual and personal hygiene supplies, delivery kits and non-prescriptive contraceptives like condoms. In Sudan, Alight (previously the American Refugee Committee) provided vitamins, soap, and medication to pregnant women.[38] Similar initiatives have also been conducted by other agencies, such as UNFPA, who worked with local non-governmental organizations in Malawi, the Republic of Benin and other parts of Africa.[39]

Mobile outreach services can allow skilled health workers to provide services to those in need, regardless of their location, including people facing barriers to access services, such as persons with limited mobility, time or resources. For example, Care International provided bicycles and motorcycles to midwives in South Sudan to support their outreach with pregnant women in remote areas.[40]

Incorporating SRMNCAH with programmes that address other issues, like nutrition, can also be introduced during responses to humanitarian crises. For example, SRMNCAH information and services were integrated into the activities of government and non-governmental organizations by UNFPA in Ethiopia and Madagascar to provide SRMNCAH information, delivery kits and referral to health facilities for SRMNCAH services. Other aspects of services could be considered, such as mental health and psychosocial support for crisis-affected populations.

Community-based health workers provide an essential bridge to health services: they provide ongoing counselling, referrals, and linkages to SRMNCAH services in health facilities, including community-based distribution of condoms, emergency contraceptive pills or resupplies of oral contraceptive pills. Traditional birth attendants may also be trained to recognize danger signs and refer expectant mothers to health services appropriately. In Sudan, International Medical Corps trains community health providers in SRMNCAH.[41]

The establishment of inclusive youth centres as safe spaces for young people, including those from minority groups and those with disabilities, to seek information and services about SRMNCAH is crucial. Such centres may also offer other benefits, such as skills acquisition training, entertainment, and life skills education (edutainment), mental health and psychosocial support and referrals to other services. For example, the Straight Talk Foundation established the Gulu Youth Centre in northern Uganda, which provided SRH information and services to young people in a conflict and, later, post-conflict setting.[42] UNFPA established a similar service in Malawi to address the needs of young people following an earthquake.[43]

Peer education is useful for reaching adolescents, as they become even more vulnerable during crises. Peer educators are a valuable resource for promoting SRMNCAH during crises, when they can provide information and counselling.[44] Peer

education may be provided in various settings such as youth centres or schools, as well as organizations engaging youth with disabilities, or youth living with HIV and AIDS through community outreach.

Engaging men and boys in SRMNCAH is key for them to promote good health practices, avoid risk-taking behaviours and support women and girls to access services. Providing accurate information on SRMNCAH issues, their impact, prevention measures and available services is important, as men often have unequal decision-making power in families and relationships, and they are the main perpetrators of GBV. In the Horn of Africa, USAID supported the GREAT (Gender Roles, Equality and Transformations) Project in a post-conflict setting in northern Uganda to institute gender transformative approaches for the improvement of SRH among adolescents and their communities especially in relation to gender norms, family planning and GBV.[45]

The UNFPA-led Minimum Initial Service Package (MISP) for SRH in humanitarian settings includes some of the community interventions mentioned above, for instance community awareness and provision of clean delivery kits where access to health facilities is limited.[46] Implementing community interventions along with facility-based interventions will contribute significantly to the efforts to improve the well-being of people in humanitarian settings.

Photo: UN Women/Yulia Panevina

PROMISING COMMUNITY SOLUTIONS THAT PROMOTE SRMNCAH IN HUMANITARIAN SETTINGS

There are many stakeholders that address the SRMNCAH needs of women and girls in humanitarian settings in the Horn of Africa. Some of these stakeholders were interviewed to obtain information on promising interventions that have been implemented to address these needs. Based on their responses, the following community solutions might be considered as part of future efforts to address SRMNCAH in humanitarian settings in the region. The solutions, grounded in a community-based approach, include interventions to create demand, as well as interventions to improve access to SRMNCAH services in communities.

Demand creation

1. **Community awareness-creation and dialogue** activities have been employed in all countries in the region to improve information and create discussion on SRMNCAH to increase utilization of services. Both male and female community stakeholders, including traditional and religious leaders, healers, women's groups, youth groups, organizations of persons with disabilities and other community-based organizations are engaged to create discussion on SRMNCAH issues, to identify related needs in the community and to offer solutions to address these needs. This approach has been used successfully in the region by UN Women, UNICEF, UNFPA, UNHCR, United States Agency for International Development/Regional Health Integration to Enhance Services — North, Acholi (USAID/RHITES-N), Pathfinder, International Medical Corps, Rehabilitation and Development Organization (RaDO) and Humanity & Inclusion. It has been observed that this approach has improved the acceptance of SRMNCAH services, such as family planning, in communities. Some of the groups that have been effectively engaged in communities for the improvement of SRMNCAH include:

   - Community-based adherence support groups that improve adherence to treatment for people living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS)
   - Adolescent sexual and reproductive health promoters, female teachers, and social workers, that engage young people to promote SRMNCAH by providing information on SRMNCAH issues such as prevention of STIs and prevention of unwanted pregnancy
   - School-based anti-AIDS clubs and comprehensive sexual education programmes that provide information to young people on prevention of HIV and other STIs, as well as other SRH issues
   - Group of young people with disabilities convened for the purpose of discussions.

Specific examples of community awareness and dialogue in the Horn of Africa are as follows:

RaDO uses information, education and communication in the Gambella refugee camps in Ethiopia to raise awareness of SRMNCAH issues and services and dispel myths and misconceptions. This is done through one-to-one discussions with service providers, formal awareness-creation campaigns, and distribution of contextually and culturally appropriate materials like leaflets, posters, and banners. These efforts have increased awareness among men and the community generally, of misconceptions about SRMNCAH issues, the harmful effects of certain patriarchal gender norms and the advantages of a violence-free home for the well-being of families and communities. The increased awareness may have contributed to men's support for women's rights, as there are now reports of men supporting women to attend awareness/information sessions, and to utilize SRMNCAH services and safe spaces for women and girls. In addition, there are reports of men avoiding intimate partner violence and accepting that girls have the right to go to school and to be protected from FGM and early or forced marriage.

USAID Transform Primary Health Care programme in Ethiopia is implemented by Pathfinder International, along with its consortium partners JSI Research and Training Institute Inc., Abt Associates, EnCompass LLC and Ethiopian Midwives Association. The programme has also successfully used community awareness approaches on gender-based violence (GBV) and to create safety in the community. This has resulted in increased reporting of GBV among displaced populations. Similarly, UNHCR in Ethiopia supports International Medical Corps and Danish Refugee Council to implement activities to prevent GBV in refugee camps in Ethiopia using the Start, Awareness, Support, Action! (SASA!) community mobilization intervention and the Zero Tolerance School Alliance (ZSTA) approach, resulting in increased reporting of GBV incidents. SASA! is an evidence-based model for preventing HIV and violence against women that can contribute to promotion of sexual and reproductive health and rights (SRHR).

Humanity & Inclusion works with mass media in Uganda, South Sudan and seven other countries in the region to raise awareness of SRHR among people with disabilities. The organization airs programmes on radio involving people with disabilities to share their experiences. UNICEF also supports mass media engagement in the region through radio dramas, where characters portray the modelling of new behaviours. This has been found to be effective, especially among younger audiences.

In Somalia and other countries in the region, UN Women supports intergenerational community dialogue on various issues, including SRMNCAH. Such dialogue brings youth together with traditional and religious leaders to identify solutions to challenges within their communities.

Similar community interventions by UNHCR in refugee camps in Djibouti have resulted in improvements in gender relations. For example, the community health committee in the Markazi camp, which houses mostly Yemeni refugees, is headed by women and has the full support and cooperation of the men.

UN Women Sudan supports capacity development of women and human rights organizations in Darfur, to document and report GBV and FGM to protect their SRMNCAH rights. UN Women also engages the police and legal system in Sudan and across Southern Africa to identify their roles in preventing and responding to violations of the rights of women and girls such as GBV.

2. **Innovative community engagement approaches** have also been successful in humanitarian settings. For example, UNICEF supports non-governmental organizations to implement the Communities Care programmes in Somalia and South Sudan. This involves discussion and dialogue

sessions with small groups of caregivers, influencers and adolescents, usually as separate groups, but occasionally as mixed-group sessions. These groups discuss issues and gender norms at the root of various community challenges, for example child marriage. The implementing partners research the issue of interest, including gender norms that influence the practice, develop a curriculum, train facilitators, and carry out continuous engagement with the community groups. The programme reaches small numbers initially, with these initial groups then supported and encouraged to become advocates and engage other small groups. This iterative process leads to the diffusion of information and new ideas.

In Ethiopia, there is a one-to-five network government programme, where one trained woman is linked with five other women to create awareness on SRMNCAH services and women's rights. These women serve as advocates and facilitators for SRMNCAH-related services in the refugee camps and host communities. This networking method is currently being used at the grassroots level in various communities and has been shown to be effective among women. The one-to-five women networks are trained, supported, and supervised by a health extension worker on key health issues and the government-approved health extension package.

3. **Peer education** has been used successfully by various partners to promote SRMNCAH service uptake, particularly among young people. For example, RaDO used this approach in refugee camps in Gambella (Ethiopia), to address the SRMNCAH needs of girls with disabilities in schools, safe spaces for women and girls, and in the general community. Also in Ethiopia, International Medical Corps established and trainsed mother support groups to contact young mothers and meet with them to identify their SRMNCAH needs and challenges, to disseminate information, link women with SRMNCAH services, and to discuss SRMNCAH (e.g. prevention of HIV mother-to-child transmission of HIV, STIs, and GBV) during coffee ceremonies, tea and talk sessions or other traditional activities that involve gatherings of women.

   Similarly, in Uganda, UN Women set up 14 POWER clubs engaging young and adult women, both from refugee and host communities in the West Nile sub-region, which resulted in skills acquisition on how to raise issues of SRMNCAH with members of their community, and improved knowledge of SRMANCH rights and services. This Group-Care model allows women to become members of a 'POWER club', that are women-only safe spaces for women to freely share experiences and discuss issues that are of concern with peers and experts on SRMNCAH. The Group Care model is designed so that the 'club members' are empowered to reach out to other women and girls on issues on SRMNCAH and gender equality and women's empowerment.

   UN Women also set-up another model of peer support in West Nile (Uganda), involving a network of young people living with HIV, which subsequently received funding from another partner as part of a consortium to engage in peer education for SRMNCAH promotion in refugee settlements. This network provided information to their peers and encouraged them to use SRMNCAH services while the other members of the consortium worked with the districts to provide SRH information and services targeting young people without judgement or discrimination. This approach resulted in increased uptake of SRMNCAH services by young people.

   Humanity & Inclusion has also successfully used peer education to promote SRH and rights among women and girls with disabilities.

   UNICEF complements community interventions in humanitarian settings through peer support using mobile phone technology. This technology is used to ask adolescents for their views on seeking and receiving information, referrals, and reporting via the U-Report digital platform to provide updated information on various topics, including SRMNCAH, protection and social inclusion, to young people, community activists and mentors. The U-Report platform can also be used by young people to report issues and ask questions, and by community activists or mentors of young people if they have doubts or concerns. UNICEF also supports the use of U-Report to register and track migrants in humanitarian settings in Uganda and provide them with information about services and organizes

volunteering activities and workshops. The addition of peer counselling to the UNICEF-supported "U-Report on the move", provides a platform through which anonymous responses on various topics, including SRMNCAH, protection and social inclusion, can be given through the platform to those using U-Report in humanitarian settings with privacy and confidentiality.

4. **Engagement of men and boys in SRMNCAH activities** including discussions about power and gender norms that prevent women and girls from accessing services and that increase the risk of GBV. Some examples of successful engagement of men and boys in SRMNCAH in humanitarian settings in the region are as follows:

   The network of young people living with HIV in West Nile region of Uganda has engaged men and boys as champions/advocates, sparking the interest of men and boys in the communities through peer-networks. These individuals subsequently became more involved in SRMNCAH issues and volunteer to become interpreters, offer to convene meetings when the team is not around and participate in efforts to improve the lives and well-being of women and girls in their communities. There are reports of men helping with household chores, reminding women of antenatal and immunization appointments, and engaging in discussions about family planning with their wives/partners, and reducing intimate partner violence (IPV). This suggests that working with men and boys to transform their own attitudes and practices can contribute to an enabling environment for women and girls to discuss and negotiate as partners in households.

   UNHCR Uganda has engaged male community health workers to provide information on safe male circumcision, resulting in increased knowledge and access to services, and a situation where satisfied clients also serve as advocates. Research has also indicated that male circumcision significantly reduces a man's risk of acquiring HIV. The USAID RHITES-N project in Uganda also engaged male role models to reach out to men and boys in the Palabek refugee settlement camp.

   International Medical Corps, with support from UNHCR, established male network groups in the Gambella region (Ethiopia). The men who are part of these network groups serve as role models by supporting their wives to access SRMNCAH services using the Engaging Men in Accountable Practices (EMAP) approach. These male role models disseminate key messages and encourage other men to support their wives to access SRMNCAH services. UNHCR in Ethiopia also noted reports of men and boys showing interest in community-based male networking groups for preventing GBV and protecting the rights of women and girls in refugee camps.

   In Southern Africa, UN Women used the HeForShe model to engage men as advocates on HIV prevention from communities, while encouraging service providers and decision makers to prevent GBV and improve access to HIV treatment, protect the rights of women and girls, and respond to the needs of survivors. The intervention was targeted at men and resulted in them working together with women and girls to fight for their rights and demand accountability from decision makers.

5. **Dedicated teams of health educators and community mobilizers** are another approach to ensure continuous promotion of healthy practices within communities. For example, UNICEF South Sudan has a team of integrated community mobilizers (ICMs) who promote health and create demand for key health interventions (including newborn and child health). The ICMs also work with rapid response teams during various disease outbreaks (e.g., diarrhoea, measles, malaria, viral haemorrhagic fevers, COVID-19) to promote essential practices like handwashing, use of face masks, and other measures to prevent and control disease outbreaks, which can also be trained to create demand for SRMNCAH services.

   UNICEF also supports frontline health workers in communities affected by emergencies in Somalia to conduct household visits and encourage pregnant mothers to attend antenatal clinics and deliver in health facilities. These frontline health workers also encourage immunization and track its coverage in their communities. The frontline workers mostly reach out to women who live in the communities and are not likely to move away.

Across the different interventions, activities vary in their frequency of engagement and the materials used. The examples provided above illustrate the diverse approaches that can be utilized for promoting SRMNCAH, noting that assessments of existing programmes and consultations with local organizations should inform the design and direction of any new intervention, or the production of new content to create demand for SRMNCAH rights. These assessments should specifically focus on groups led by and representing women, youth, and organizations of persons with disabilities in humanitarian settings. It is also valuable to promote coordinated efforts in the development of interventions. For example, the United Nations H6 partnership, which includes UNFPA, UNICEF, UN Women, WHO, UNAIDS and the World Bank Group, provides an important platform for effective coordination of SRMNCAH interventions in humanitarian settings.

Community-based services

1. **Community distribution of basic SRMNCAH supplies.** In the Gambella (Ethiopia), UNHCR supports the distribution of newborn kits, blankets, mosquito nets, soap and sanitary pads after delivery, as well as distribution of condoms to female sex workers. International Medical Corps undertakes similar interventions in Gambella with support from UN Women via the POWER Programme. UNHCR Djibouti supports the distribution of condoms in refugee camps. UNFPA in Kenya and Uganda procure and preposition various SRH emergency kits (e.g., for pregnancy prevention, menstrual hygiene, clean and safe delivery) as part of emergency preparedness and distribute these kits during emergencies. The SafeBoda app (in Uganda) facilitated delivery of SRH commodities, particularly contraceptives, to women and girls, including those with disabilities, and those in humanitarian settings during the COVID-19 lockdown. The SafeBoda also delivered foodstuffs and other essential consumables to households during the COVID-19 lockdown, and UNFPA Uganda leveraged the app to supply SRH commodities to those in need.

2. **Provision of SRMNCAH services through community outreach** to ensure that services reach underserved populations, including those located far from infrastructure and marginalised areas. For example, UNICEF supports service delivery during emergencies in areas with few facilities in South Sudan through outreach activities that provide maternal, newborn and child health (MNCH) services. UNICEF South Sudan also implements an innovative approach that uses rapid response teams comprising doctors, nurses, nutritionists, and other relevant health workers to provide MNCH services during emergencies in areas that are often only accessible by helicopter because of limited road infrastructure. These rapid response teams deliver services to women, newborns and children in each of these communities for one week and return after three months.

   UNFPA has also successfully equipped and supported partners to undertake integrated community outreach in humanitarian settings in countries including Kenya and Uganda. This involves training health-care workers on MISP for SRMNCAH and undertaking community outreach during which a wide range of health services are provided, including SRMNCAH, family planning, GBV, nutrition and other primary health interventions. In addition, UNFPA supports the distribution of various SRH emergency kits during outreach activities.

   Similarly, in Uganda, USAID RHITES-N project has conducted community outreach using existing health facilities within settlement camps to provide integrated SRMNCAH services including immunization, nutrition assessment, counselling and support, growth monitoring for children, malaria testing and treatment, family planning services, antenatal care and prevention of mother to child transmission of HIV.

3. **Provision of basic SRMNCAH services via community health workers.** For example, Boma health workers, who have basic literacy (primary school education), have been successfully engaged in South Sudan (with support from UNICEF) to provide basic MNCH care. These health workers are trained to provide basic life-saving interventions, such as identifying malaria using rapid diagnostic tests, identifying pneumonia in children using beads to count respiratory rate, managing diarrhoea using oral rehydration solution and zinc, and visiting the homes of newborns within the first three days of birth to ensure adequate thermal care, eye care and other basic newborn care. They provide community case management of pneumonia, malaria, and diarrhoea, and they track the immunization status of children and refer them for vaccination or invite health workers to come and vaccinate the children in the communities. These community health workers also conduct nutrition screening using mid-upper arm circumference (MUAC) tape and monitor nutritional status of children. These services are complemented with demand creation activities for MNCH and linking community members to other services based on their needs.

   USAID RHITES-N project has a similar intervention in the Palabek settlement camp in Uganda, which involves engaging village health teams (VHTs) to register all pregnant women and children under the age of 5 years and tracking them by their zones within the camp for SRMNCAH services. The VHTs were also engaged to provide family planning counselling, short-term contraception methods (oral pills, injectables (subcutaneous depot-medroxyprogesterone acetate — DMPA-SC/Sayana Press), condoms) and referral to nearby health facilities for long-term and permanent family planning methods.

   Similarly, UNFPA Uganda supports VHTs and condom promoters to provide SRMNCAH services in addition to providing support for the camp command teams that oversee the general well-being of refugees in camps and help to address any impending SRMNCAH issues. These teams are supported by health assistants at sub-county or zonal levels who address health issues (including SRMNCAH) of people in settlements and host communities. In Uganda, UNHCR supports community health workers to map and refer pregnant women for antenatal care and delivery services, and to provide family planning information and services, including self-administered contraceptive injections (such as the DMPA-SC/Sayana Press).

   In Sudan, UNICEF supports the deployment of community midwives in areas affected by humanitarian crises to provide antenatal care, delivery care, postnatal services, essential newborn care, community-based management of acute malnutrition and community integrated management of childhood illnesses. These community midwives contribute to the improvement of the maternal and newborn health services for internally displaced persons and refugees. The community midwives are regarded as community leaders and are also involved in raising awareness of harmful practices (such as child marriage and FGM) through house-to-house visits, which aim to empower women and eliminate these practices.

4. **Mainstreaming needs of people with disabilities in all SRMNCAH services** to ensure that their needs are addressed. This ensures that women and girls with disabilities receive equal attention when seeking services to women and girls who do not have disabilities. In Ethiopia, Humanity & Inclusion conducted sign language training for health workers to facilitate sign language communication during SRMNCAH outreach activities. In Nigeria, a national organization of persons with disabilities developed a glossary for service providers to provide information on SRMNCAH in sign language when sign language experts are not available. In addition, Humanity & Inclusion implements measures to ensure women and girls who have disabilities can physically access services. This relates to transport to the service, accessing the building/facility, accessing examination couches, or providing alternatives to climbing onto examination couches. The organization works with networks of people with disabilities in various countries (including from humanitarian settings in South Sudan and northern Uganda) to ensure that their needs are met, and that information reaches their members in a timely manner.

Similarly, some programmes in Ethiopia have provided information, education and communication/behaviour change communication materials in braille for people who are blind, and some have incorporated sign language in their SRMNCAH education activities. UNHCR Ethiopia supports community health workers to identify women and girls with disabilities, provide them with health education, and link them to appropriate interventions including referral and transportation.

The UN Women HeForShe model in South Africa empowered communities to demand HIV and other services and resulted in some communities demanding services that are inclusive of people with disabilities.

UNFPA has also supported the provision of SRMNCAH services to women and girls with disabilities affected by floods in Kenya. The services provided included skilled birth attendance, family planning and the distribution of dignity kits.

In Uganda, USAID RHITES-N involves representatives of women and girls with disabilities during the planning of outreach events and community dialogues, to ensure that their needs are taken into consideration during these activities. In addition, the project engages women and girls with disabilities as part of the teams that provide services during these activities. The project also advocates for ending stigma and discrimination against women and girls with disabilities through awareness raising, training and other activities to remove barriers for them to access SRMNCAH services. Humanity & Inclusion and partners also do similar work in Ethiopia, South Sudan, and Uganda.

5. **Provision of safe spaces for women and girls** to access SRMNCAH (including GBV) information and services. In Ethiopia the Office of the Attorney General and the Ministry of Women, Children and Youth runs one-stop centres in hospitals which provide services such as counselling, referral, skills building and livelihood activities for women-headed households. Women and girls can also report and discuss issues, socialize, and relax in these centres.

   International Medical Corps in Gambella (Ethiopia) supports youth-friendly centres that provide safe spaces where young women and girls, including those with disabilities, can access SRMNCAH information and services.

6. **Facilitation of referral to health facilities** by supporting the provision of transportation and the establishment and maintenance of referral systems for SRMNCAH including GBV. For example, UNFPA Uganda supports the provision of ambulances to facilitate referral for SRMNCAH services and the establishment of a GBV referral system. The GBV referral system has improved the response process and clarifies to survivors and their families how to proceed to access the required services. Humanity & Inclusion, in cooperation with a sexual and reproductive health and rights partner, is also developing digital and hard copy referral directories for health workers. These will provide a list of relevant referral points adding aspects of disability friendliness and accessibility, and disability-specific services (e.g. rehabilitation assistance). This supports health workers to make high-quality referrals, consider the specific needs of clients and focus on comprehensive care.

   In Ethiopia, UNHCR has supported traditional birth attendants' groups in Gambella to identify high-risk pregnancies and women with disabilities and link them to health facilities for SRMNCAH services. UNICEF also supports the establishment of child protection groups that help to identify vulnerable girls and facilitate referral for services.

EVALUATION FINDINGS ON SRMNCAH COMMUNITY SOLUTIONS

Among the SRMNCAH community solutions described in earlier sections, there are evaluations for select interventions, with examples of the evaluation results detailed below.

Ethiopia[47]

The UNHCR's distribution of dignity kits was observed to have increased utilization of SRMNCAH services by helping to attract women to deliver in health facilities.

Kenya[48]

The UNFPA support to non-governmental organization partners (Kenya Red Cross and International Rescue Committee) to provide SRH outreach services in humanitarian settings (Kakuma and Dadaab refugee camps) facilitated access to services to vulnerable populations. The intervention evaluation found a need to strengthen coordination of SRH and GBV services and improve data management in these settings.

Somalia[49,50]

The UNICEF-supported Communities Care programme was found to be effective in tackling negative social norms and perceptions that perpetuate GBV and the marginalization of women and girls, particularly during humanitarian crises. The programme was also found to be effective in increasing confidence in the usefulness of GBV services (including justice, health and social) and recommended for GBV responses to be integrated with the provision of SRMNCAH services.

South Sudan[51]

There is a network of over 2,500 ICMs and they reach over 450,000 households in the country to promote health and create demand for services. These ICMs helped to reach 95 per cent coverage of the polio immunization target. Although no details on SRHR results are available, a limitation of the rapid response teams is that the reach is relatively small, and provision focuses on immediate short-term services. The rapid response strategy was recommended to transition into an integrated partnership model to attract non-governmental partners to operate in underserved areas.

Uganda[52,53]

Although the VHTs are recognized as a source of health information in the communities, health-seeking behaviour is not only influenced by information. For example, there are economic considerations, distance to the health facility, health worker attitudes, and availability of drugs and equipment. The VHTs have been shown to significantly facilitate and expand access to family planning in refugee settlements and other settings. Engagement of communities through dialogue, and involvement of men and boys in SRH and rights activities have contributed to the transformation of harmful social norms in humanitarian settings. In South Sudan and Uganda, community or volunteer health workers have been trained on disability inclusion in SRHR by Humanity & Inclusion, in cooperation with local organizations of persons with disabilities, which increased the level of understanding and enabled exchange and cooperation across disability and health sectors.

EFFECT OF COVID-19 ON SRMNCAH COMMUNITY INTERVENTIONS

The COVID-19 pandemic response resulted in challenges for SRMNCAH community solutions, including both demand creation and community service delivery activities. Programme activities, such as training and research, were also delayed due to the restrictions implemented as part of the pandemic response.

Demand creation

The restrictions on movement (lockdowns and curfews) and public gatherings, as part of the COVID-19 mitigation, severely limited community activities such as community dialogues, mass awareness campaigns and community mobilization. However, there have been some innovations to address these challenges and some examples are detailed below.

In refugee camps in Ethiopia, RaDO carried out mass sensitization within zones and blocks using loudspeakers mounted on vehicles to provide information about available SRMNCAH services during the lockdown. RaDO also carried out mobile community distribution of media and adapted information, education and communication/ behaviour change communication materials integrated with COVID-19 messages. In addition, the organization conducted outdoor house-to-house information sharing sessions while adhering to COVID-19 prevention measures (using face masks, maintaining physical distance, and avoiding activities requiring physical contact).

Humanity & Inclusion trained organizations of people with disabilities in the region on how to use WhatsApp and distributed mobile phones, to allow access to information about where to get SRMNCAH services during the pandemic lockdown. Humanity & Inclusion country programmes also used the distribution of COVID-19 materials to provide information on SRMNCAH, such as where to get services and details on helplines.

UN Women supported the use of WhatsApp and Zoom calls to continue dialogue and meetings of support groups in the Southern Africa region, and in specific contexts, financed the establishment of services (e.g. shelters and helplines) in response to growing demand for GBV response services.

UNHCR Ethiopia is piloting a digital complaints system for appointments, feedback and other issues related to GBV. This service is currently only in English but will be available in 10 different languages.

UNICEF conducted knowledge and skills building activities remotely via radio, television, U-Report, and other online platforms. However, access to these platforms, especially those online, is limited. UNICEF also supported virtual trainings for front-line health workers in Somalia on the continuity of essential health services including SRMNCAH services.

In Djibouti, UNCHR supported the use of WhatsApp to monitor activities remotely and established a hotline to provide support to GBV survivors.

Community-based services

The fear of being infected by COVID-19 resulted in the disruption of health services, including SRMNCAH. In Ethiopia, some health facilities and health workers were dedicated to COVID-19 services, which decreased both the availability and uptake of SRMNCAH services. The restrictions on movement and gatherings put in place in many countries also resulted in a low uptake of SRMNCAH services. Health workers feared getting infected, especially as personal protective equipment (PPE) was not provided in a timely manner, limiting the availability and quality of SRMNCAH services. In some areas (e.g., Uganda), the total lockdowns were replaced by curfews, which limited the amount of time people had to travel

to health facilities, especially in rural areas and refugee settlements where the distances to health facilities are greater than in urban areas. Women using short-term family planning methods were more affected by reduced SRHR services, especially IDPs and refugees.

The lockdowns also prevented the physical interactions needed to facilitate sustained transformation of individual mindsets and for peer support and mental health, especially for young women with complicated household issues. As the restrictions on gatherings relaxed, small groups in a household were supported to have discussions using Zoom.

The fear of contracting COVID-19 from health workers resulted in the stigmatization of health workers in some settings, leading to community health workers withdrawing their services. Other health workers withdrew their services due to fear of contracting COVID-19, leading to staff shortages in some areas. Community health workers and VHTs were not recognized as essential health workers in many instances, resulting in their inability to move around to provide services and to collect new supplies and submit reports. Similarly, the movement restrictions and delays in global supply chains made it difficult for SRMNCAH supplies which community-based health workers routinely distribute to reach health facilities. In some areas, non-medical persons oversaw coordination for the COIVD-19 response and lockdowns and curfews led to situations where women started developing serious health complications while waiting to obtain permission to be admitted to the hospital.

The loss of income for women during the COVID-19 pandemic further limited access to SRMNCAH services. In many countries, women's jobs were disproportionately affected by COVID-19, as a larger share of women are often in informal jobs with no forms of social protection, including in the health sector, as home and family caregivers, and in client-facing roles, which makes them more exposed to contagions. Pregnant women are still particularly vulnerable in this context. This especially affected people requiring long-term support, such as people receiving treatment for HIV and those using short-term family planning methods. This is due to the cost of the service and associated costs, such as transportation, the cost of face masks for COVID-19 prevention and out-of-pocket expenses for medication needed if a disease is contracted. The economic challenge has persisted even after the restrictions on movement and gatherings have eased, which continues to present a barrier to accessing SRMNCAH services. One example of a response that addresses the health and economic needs is in South Sudan, where UNICEF supported women's groups to produce cloth masks which were supplied to community health workers to enable them to continue with their work. The production of the cloth masks also served as an income generation activity for these women's groups, helping to address the economic effects of COVID-19 among these women.

The effects of COVID-19 are even more severe for women and girls with disabilities who often rely on others for their mobility, access to information and for their economic needs.

There has been a visible uptake of SRMNCAH services following measures taken by various programmes across the region to mitigate the effects of the COVID-19 response. These measures include risk communication and community engagement, training service providers in infection prevention and control, case management, surveillance and contact tracing, and ensuring continuity of essential health services through provision of PPE and maintenance of supply chains. These efforts increased trust in the safety of health services during COVID-19 and encouraged use of SRMNCAH services where they remained operational.

CHALLENGES FOR THE IMPLEMENTATION OF SRMNCAH COMMUNITY INTERVENTIONS IN HUMANITARIAN SETTINGS

Challenges to the implementation of SRMNCAH community solutions in humanitarian settings include:

- Varied interests of influential groups: Different community groups have varying levels of influence and diverse groups represent different sub-groups within the affected population. UNICEF analysis found women's groups and youth groups are quite influential in these settings and are resilient. These groups can be supported to implement community interventions in these settings.
- Gender preferences in service provision: In certain countries, there is a preference among women to see female community health workers, but they are not available in all areas. In these contexts, the presence of male-only health workers affects the uptake of services by women and girls.
- Lack of disability-inclusion in programmes: There is inadequate capacity for programming with and for women and girls with disabilities, which is compounded by a lack of representation of women with disabilities, data on the magnitude of the problem, the common types of disabilities and the challenges faced by these women and girls.
- There is also inadequate capacity for providing services to women and girls with disabilities, and there are difficulties in physical access and challenges with communication, such as the limited availability of information in braille and the low number of health workers who know sign language.

Country-specific challenges

- Inadequate capacity of health workers: In South Sudan and Djibouti, the low capacity for SRMNCAH and GBV service provision among health workers limits the availability and quality of services. This situation is a challenge for the delivery of high-quality services and for related interventions, such as capacity development, supervision, monitoring and data management.
- Lack of humanitarian-development nexus linkage: In South Sudan, there is a mix of both humanitarian and development challenges with the risk of longer-term development issues being neglected because attention is focused solely on the immediate humanitarian response. This is particularly important in areas where there is a complex humanitarian crisis such as flooding, famine, or other natural disasters in areas of protracted conflict.
- Gaps in addressing the needs of young people/adolescents: In Uganda, the SRHR refugee response plans do not include a component that fully addresses the specific SRHR needs of young people, although efforts are underway to address this gap.
- Limited access to family planning: in Sudan and Ethiopia humanitarian settings, access to SRMNCAH supplies such as contraceptives is a challenge, especially in the initial stages of a crisis.
- Inadequate funding: in Somalia, there is inadequate funding for SRMNCAH services in humanitarian settings and this affects the availability and quality of both community- and facility-based services. Often, funds for humanitarian response interventions are completely donor driven.

RECOMMENDATIONS

The Horn of Africa countries all have some form of humanitarian crisis: some are recurrent, and others are protracted. This has limited women and girls' enjoyment of their rights to SRMNCAH. Refugees, internally displaced persons, those with disabilities and fewer social supports and assets are particularly at risk of poor health services and are also at increased risk of GBV. The COVID-19 pandemic worsened the already poor situation due to the restrictions placed on movement and gatherings, which limited both the provision and uptake of SRMNCAH services. In this context, consultation with development partners across the Horn of Africa has identified interventions with promise to create demand and deliver community-based services. In support of these efforts, the report identifies the following recommendations for consideration by government policymakers, development partners, including the United Nations and donors, civil society organizations and community stakeholders.

Legal frameworks, policies, and guidelines

(i) Detailed costed implementation plans should be developed to operationalize existing commitments, policies and guidelines for SRMNCAH in humanitarian settings to ensure that the needs of women, adolescents and girls, especially internally displaced persons and refugees, are addressed.

(ii) Budget allocations for SRMNCAH support should be included in guidelines for allocations of immediate humanitarian responses, especially in the initial stages of crises.

(iii) There should be continuous advocacy to ensure funds are made available or establish pools of funds for SRMNCAH interventions in humanitarian settings. This is especially important in countries with recurrent and protracted humanitarian crises (e.g., cyclical flooding and famine), and could build on existing gender-responsive budgeting efforts. Governments and donors should ensure funding is flexible, as the needs of women and girls in such settings are dynamic.

Programme design and implementation

(i) The humanitarian response should be a bridge to longer-term development, especially in countries with both humanitarian and development issues, such as South Sudan and Somalia. It is important to use available resources for humanitarian responses to build resilience of institutions and communities to better manage stresses and acute shocks, while also responding to the crisis.

(ii) There should be a deliberate effort to assess and meaningfully address gender inequality and social inclusion (including disability, age, gender) barriers to demand for SRMNCAH in the planning and response to any humanitarian crisis. It is crucial to have representation of marginalized groups (e.g. adolescent girls, and women and girls with disabilities), involved in the design and implementation of responses to any crisis. This requires adequate data to plan effectively and should involve groups affected by crises in the implementation and monitoring of interventions to ensure that activities are achieving the desired effects.

(iii) Alternative models for delivering SRMNCAH services in humanitarian settings need to be explored to address service disruptions due to restrictions of movement or gatherings. Humanitarian crises are often unexpected, and countries must endeavour to plan ahead through continued innovation.

Partnerships and Coordination

(i) Partnerships with women's rights, youth organizations and organizations of persons with disabilities should be strengthened to ensure SRMNCAH demand generation is gender-responsive and reflects the experiences and needs of diverse women, adolescents and children.

(ii) Coordination between partners should be strengthened so that resources can be pooled to achieve better results in both humanitarian and development contexts. Such collaboration should involve governments and all partners within and outside the United Nations system to leverage the comparative strengths of each partner.

(iii) Multisectoral coordination and connections between SRMNCAH interventions and national disaster risk management and response mechanisms should be strengthened to ensure the needs of women and girls in areas such as livelihoods, education or water, sanitation, and hygiene are addressed, which affect their SRMNCAH.

Service delivery

(i) Emergency response plans should be integrated in SRMNCAH services so that health systems can adapt and deliver responses appropriately and without delay when a crisis occurs. In addition, services should be flexible enough to cater for the needs of returnees when a crisis ends, and displaced people return to their communities. This should also include the strengthening of SRMNCAH-related logistics management systems and support for services within returnee and reintegration programmes.

(ii) Deliberate measures should be taken to address the needs of women and girls with disabilities within existing SRMNCAH services. These measures should take into consideration issues of physical access for those with limited mobility, and access to communication for those with visual, hearing or speech impairments. Similarly, there should be provisions to address the SRMNCAH needs of women and girls with cognitive or intellectual disabilities in humanitarian settings.

(iii) The SRMNCAH needs of internally displaced persons (IDP) should be considered as a distinct group, regardless of whether they reside in IDP camps or are integrated with host communities.

Monitoring Policies and Programming

(i) There should be investments in sex, age and disability disaggregated data that can be used for effective planning in all countries in the region. This should be institutionalized to ensure sustainability. Studies should be carried out on the SRMNCAH needs of women, girls, and person with disabilities in humanitarian settings in the region, with specific information on the impact of various interventions, especially those working to transform gender relations and GBV, including harmful practices (e.g. child marriage and FGM).

(ii) Data on refugees, internally displaced people and other crisis-affected groups should be included in national health information systems which capture SRMNCAH indicators, with data used to inform SRMNCAH programmes, monitor and address disparities in access to services in a more effective and sustainable manner.

(iii) Easily accessible and confidential complaints mechanisms for GBV- and protection-related reports should be established and should be guided by clear procedures to improve safe information sharing between different parts of the referral system (e.g. health, shelter, etc.) to meet the needs of survivors in their diversity, in line with the UN Essential Services Package for Survivors of Violence against Women and Girls.

APPENDIX
LIST OF RESPONDENTS

Name	Organization	Designation
ESARO		
Jacqueline Utamuriza-Nzisabira	UN Women	African Regional Advisor on HIV and Gender South African Multi Country Office
Massimiliano Sani	UNICEF	Communication for Development (C4D) Specialist
Ethiopia		
Gloria Mukama	UNHCR	Senior Community Based Protection Officer
Soliyana Negussie	UNHCR	Community Based Protection Associate
David Dak	UNHCR	Assistant Public Health Officer, UNHCR Gambella sub-office
Dr Mengistu Asnake Kibret	USAID Transform: Primary Health Care Project/ Pathfinder International	Chief of Party/Senior Country Director
Tsehay Muhie	Rehabilitation and Development Organization	SRH and GBV Programme Coordinator
Hailu Bekele	International Medical Corps	Health Manager
Uganda		
Elizabeth Mushabe	UN Women	Programme Specialist Gender and HIV
Ronald Nyakoojo	UNHCR	Assistant Public Health Officer
Patrick Komakech	USAID/RHITES-N, Acholi	
Gisela Berger	Humanity & Inclusion	Regional Technical Manager
Sudan		
Mary Mbeo	UN Women	Programme Specialist Women, Peace and Security (WPS) and Humanitarian
Dr Saja Abdullah	UNICEF	Chief of Health and Nutrition
South Sudan		
Dr George Ameh	UNICEF South Sudan	Chief of Health
Somalia		
Julius Otim	UN Women	Programme Specialist Women Peace & Security
Dr Shyam Pathak	UNICEF	Health Manager MNCH
Kenya		
John Wafula	UNFPA	Humanitarian Specialist
Djibouti		
Tongna Alain Rodriguez Zoure	UNHCR	Associate Public Health Officer

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