Sexual and Reproductive Health and Rights in Humanitarian Settings: An Implementation Research Agenda

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About us

We are a global organisation that finds solutions to complex humanitarian problems through research and innovation. We are an established actor in the humanitarian community, working in partnership with humanitarian organisations, researchers, innovators and the private sector to tackle some of the most difficult challenges facing people all over the world. Through our globally recognised programmes, we have supported more than 200 world-class research studies and innovation projects, championing new ideas and different approaches to evidence what works in humanitarian response. R2HC aims to improve health outcomes for people affected by humanitarian crises by strengthening the evidence base for public health interventions. Our globally-recognised research programme focuses on maximising the potential for public health research to bring about positive change and transform the effectiveness of humanitarian response.

The R2HC programme is funded by the UK Foreign, Commonwealth & Development Office (FCDO), Wellcome and the Department of Health and Social Care (DHSC) through the National Institute for Health Research (NIHR).

> We equip humanitarian responders with knowledge of what works, so that people affected by crises get the right help when they need it most.

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Authors and affiliations

Sara Nam, Avicena Health and Social Projects
Arantza Abril, Avicena Health and Social Projects
Gillian McKay, Senior Humanitarian Health Research Advisor, Elrha
Enric Grau, Avicena Health and Social Projects
Karl Blanchet, Geneva Centre of Humanitarian Studies, Faculty of Medicine, University of Geneva

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The **Core Expert Group** comprised: Sara Casey, Assistant Professor and Director, Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, Columbia University Mailman School of Public Health; Chi-Chi Undie, Senior Associate and Technical Director, International Programs Division, Population Council, Kenya; Neha Singh, Associate Professor and Co-Director, Health in Humanitarian Crises Centre, London School of Hygiene & Tropical Medicine; Aliki Christou, Research Fellow, Institute of Tropical Medicine; Tewodros Seyoum Nigussie, Assistant Professor and Postdoctoral Researcher, University of Gondar, and member of the Africa Regional Professional Committee at the International Confederation of Midwives (ICM); Tamara Fetters, Senior Research Scientist, Ipas; Ann Moore, Principal Research Scientist, Guttmacher Institute; Yohannes Dibaba Wado, Research Scientist, African Population and Health Research Center (APHRC); Dr Patricia Lledó Weber, Director of Clinical Services, MSI Reproductive Choices; Stefania Paracchini, International SRHR Advisor, Médecins du Monde (MDM); Benjamin Black, GynObs Advisor, MSF; Maura Daly, SRH and Midwifery Advisor, MSF; Emily Dwyer, Co-Founder, Board Director and Head of Strategy, Edge Effect; Claire Bossard, Epidemiologist, Epicentre; Robyn Drysdale, Independent Consultant, Australia; Lauren Bellhouse, Senior SRH Advisor, International Medical Corps; Catrin Schulte-Hillen, SRH in Emergencies Specialist, UNFPA; Dr Atziri Ramirez, Chair of the Committee on Women Facing Crises, International Federation of Gynecology and Obstetrics (FIGO); Wycliffe Barasa, Managing Director, and Gloria Mairura, Development & Communications Manager, Resilience Action, Kenya; Emele Sima Duituturaga, Independent Consultant and former Executive Director, Pacific Islands Association of Non-Governmental Organisations (PIANGO); and Tatayana Seliman, Executive Director, Skoun.

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FOREWORD

In 2025, it is estimated that over 300 million people are in need of humanitarian assistance, driven by conflict, forced displacement, climate-related disasters and economic instability.

In these crises, sexual and reproductive health and rights (SRHR) are among the most urgent but also the most neglected needs. Women, girls and other vulnerable groups often face increased risks of maternal and newborn mortality, lack of access to contraception and comprehensive abortion care, and poor care following sexual violence. Yet the evidence base for **how** to deliver effective services in these crisis contexts remains thin.

Earlier global prioritisation exercises helped establish an initial research agenda for SRHR in crises, but new challenges (and opportunities) have since emerged: the growing role of self-care, the need for climate resilience and the urgency of integrating SRHR services at scale. Without an updated agenda, critical operational questions risk being overlooked, leaving humanitarian actors without the evidence needed to respond effectively.

To address this, our Research for Health in humanitarian crises (R2HC) programme convened a global, inclusive consultation process across six world regions and nine thematic areas within SRHR. More than 350 ideas were collected, refined into 73 operational research questions and prioritised by over 270 experienced practitioners, researchers and policymakers. The result is a clear, evidence-informed agenda that highlights where implementation research is most needed in the next three to five years.

This report presents the outcomes of that process. It reflects the perspectives of humanitarian responders, researchers and representatives of affected communities, and points the way towards investment in research that is feasible, impactful and relevant to real-world crisis contexts.

Our commitment now is to work with funders, researchers, humanitarian organisations, as well as crisis-affected communities themselves, to turn this agenda into action. By building the evidence base together, we can strengthen SRHR services, protect the rights of women and girls, and ensure that even in the most unstable settings, access to essential care is not compromised.

Kai Hopkins
Head of Research Initiatives, Elrha

Abbreviations

AI	Artificial intelligence
ANC	Antenatal care
ART	Antiretroviral therapy
BWRP	Budget-weighted research prioritisation
CHNRI	Child Health and Nutrition Research Initiative
CHW	Community health worker
CSE	Comprehensive sexuality education
CSO	Civil society organisation
EAP	East Asia and the Pacific
ECA	Europe and Central Asia
EmONC	Emergency obstetric and neonatal care
FP	Family planning
GBV/SGBV	Gender-based violence/sexual and gender-based violence
HHER1/HHER2	First or second Humanitarian Health Evidence Review
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IDP	Internally displaced people
IEC	Information, education and communication
INGO	International non-governmental organisation
IQR	Interquartile range
IRC	International Rescue Committee
LAC	Latin America and the Caribbean
LARC	Long-acting reversible contraceptives
LMIC	Low- and middle-income countries
MENA	Middle East and North Africa
MNH	Maternal and newborn health
MSF	Médecins Sans Frontières
NCD	Non-communicable diseases
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PNC	Postnatal care
PrEP	Pre-exposure prophylaxis
RAISE	Reproductive Health Access, Information and Services in Emergencies
R2HC	Research for Health in Humanitarian Crises
SD	Standard deviation
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund

Executive summary

EXECUTIVE SUMMARY

This report presents findings from a global consultation that resulted in a new research agenda for SRHR in humanitarian settings.

Why a new research agenda for SRHR in humanitarian settings?

SRHR needs rise sharply during conflict, displacement and climate-related disasters, yet only a fraction of operational questions have been rigorously answered. Earlier global exercises provided an invaluable start, but did not cover newer challenges such as digital self-care, climate resilience or service integration at scale. Through our R2HC, we commissioned a fully updated prioritisation exercise spanning nine SRHR Domains and six World Bank regions to steer investments for the next three to five years.

What is the scope of the prioritisation exercise?

The agenda spans the full range of sexual and reproductive health (SRH) across nine SRHR Domains: Comprehensive Sexuality Education (CSE); Sexual Health and Wellbeing; Family Planning (FP) and Contraception; Cancers of the Reproductive System; Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV); Maternal and Newborn Health (MNH): Antenatal/Perinatal Care; Maternal and Newborn Health (MNH): Postnatal/Newborn Care; Comprehensive Abortion Care; Clinical Management of Rape; and three crosscutting domains: Stakeholder Engagement, Service Delivery and Health Systems, and Climate Resilience. The scope includes humanitarian settings affected by conflict, forced displacement, climate-related emergencies and other crisis conditions. While global in outlook, the focus is on low- and middle-income countries (LMIC).

Only research questions amenable to implementation research were included, ie, those concerned with how to adapt, deliver, integrate or scale known SRHR interventions in real-world crisis contexts. Questions solely focused on describing needs or estimating prevalence were excluded, except where such data collection was explicitly positioned as a baseline or implementation input.

How the priorities were identified

Evidence-informed foundation: From over 350 ideas gathered through literature and consultations, 73 operational questions were curated, incorporating 31 questions from earlier global exercises.

Broad and inclusive consultation: 91 experts – 44% from non-governmental organisations (NGOs) and 24% from academia – took part in 11 virtual regional workshops and nine language-specific sessions. Many remained engaged through follow-up discussions and email feedback.

Participatory prioritisation: A global survey engaged 271 practitioners, researchers and policymakers with more than five years' SRHR-in-crises experience. Respondents were asked to allocate a hypothetical $100 per domain across the research questions they felt would have the greatest impact, feasibility and relevance. Participation was strong overall (more than 170 responses in most domains) but thinner in Europe and Central Asia (ECA), Latin America and the Caribbean (LAC), and East Asia and the Pacific (EAP) despite a two-week extension and targeted outreach.

Quantitative analysis: Mean scores and standard deviations (SDs) were calculated by domain and region. Wide SDs or overlapping interquartile ranges (IQRs) indicate divergence of views, while narrower distributions signal stronger consensus.

Who participated?

Experience and roles: All respondents had five years or more experience in SRHR in humanitarian settings; 48% had between five and nine years and 33% had ten years or more. A balanced mix of professional profiles were represented, including clinical services (14%), research (14%), public health programming (8%) and humanitarian response management (7%), with many also combining service delivery and research roles.

Geography: 63% of respondents contributed to the Sub-Saharan Africa (SSA) region, 22% to the Middle East and North Africa (MENA) region; other regions accounted for between 10 and 17% per region.

Summary scorecard showing the top three or four ranked research topics by SRHR Domain for all respondents globally

1. Comprehensive Sexuality Education (CSE) (n=172)	Score (mean)	SD
Effective delivery models for CSE	21.80	11.4
Engaging parents and caregivers in CSE	16.86	8.0
Training and supporting CSE facilitators	16.35	8.1
Integrating CSE into adolescent-friendly health services	16.34	10.8
2. Sexual Health and Wellbeing (n=181)		
Integration of sexual and reproductive health and rights (SRHR) and mental health	15.78	8.3
Strengthening SRHR and mental health training for providers	15.56	7.9
Overcoming stigma and barriers to mental health and SRHR access	14.06	8.1
3. Family Planning (FP) and Contraception (n=216)		
Ensuring reproductive choice in humanitarian settings	16.71	10.6
Increasing adolescent access to contraception	14.90	7.8
Overcoming barriers to long-acting reversible contraceptives (LARC) access and acceptance (demand-side)	14.37	7.9
4. Cancers of the Reproductive System (n=116)		
Equitable human papillomavirus (HPV) vaccination	34.78	14.2
Integrating HPV-based cervical cancer screening into existing SRHR services	34.74	11.9
Raising awareness where treatment is accessible	30.47	16.1
5. Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) (n=174)		
Scaling up STIs and HIV testing for displaced and high-risk populations	17.35	7.7
Preventing STIs in forced migration settings	14.78	6.8
Scaling up STI prevention and post-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP)	14.64	9.1
6. Maternal and Newborn Health (MNH): Antenatal/Perinatal Care / continuity of care (n=190)		
Strengthening basic emergency obstetric and neonatal care (EmONC)	21.76	8.9
Context-specific approaches for increasing access to MNH	20.95	10.0
Emergency referral mechanisms	19.65	10.0

7. Maternal and Newborn Health (MNH): Postnatal/Newborn Care (n=184)	Score (mean)	SD
Essential newborn care in conflict settings	28.27	12.20
Community-based postnatal care (PNC)	26.44	11.67
Mitigating and managing postnatal depression	24.95	12.84
8. Comprehensive Abortion Care (n=149)		
Improving women's experience of and access to abortion care	16.49	8.1
Policies	16.33	9.2
User acceptability, quality and person-centred abortion care	14.73	7.0
Service delivery innovations for comprehensive abortion care	14.46	7.5
9. Clinical Management of Rape (n=114)		
Increasing timely access to post-rape care in legally restrictive settings	20.25	12.2
Increasing health-seeking behaviours and referrals	16.49	8.1
Task sharing the clinical management of rape	14.39	6.0
Expanding the clinical management of rape access for marginalised and key populations	14.27	7.3
Crosscutting – Stakeholder Engagement (n=219)		
Community-led interventions to increase access	18.35	9.5
Preventing mistreatment and ensuring respectful care	16.95	9.1
Community engagement and equity	15.00	6.9
Crosscutting – Service Delivery and Health Systems (n=215)		
Training models for sustained community health worker (CHW) learning	16.01	10.8
Digital information, education and communication (IEC) to increase SRHR knowledge and access	15.58	9.4
Service delivery during pandemics and large-scale emergencies	14.71	7.4
Increasing SRHR services for people-on-the-move	14.37	8.0
Crosscutting – Climate Resilience (n=153)		
Resilient SRHR service provision	35.59	16.0
Mitigating climate effects in MNH	34.63	18.0
Distribution of SRHR commodities	29.77	13.5

Key insights from the domain scores

Rather than producing a definitive 'top three' for each domain, the data reveal clusters of closely ranked priorities. Across most domains, the gap between the first- and third-ranked questions was fewer than three to five points on a 0 to 100 scale. This affirms the relevance of the full long list and suggests that several research questions within each domain need attention.

- **CSE** – Community-supported delivery and caregiver engagement ranked highest overall. LAC elevated gender-transformative approaches; ECA prioritised adolescent-focused services.
- **Sexual Health and Wellbeing** – Mental health (MH) integration dominated globally; however, stigma reduction was ranked first in ECA, and menopause entered the top three in several regions.
- **FP and Contraception** – Reproductive choice and adolescent access ranked highest overall. ECA prioritised support for vulnerable groups.
- **Cancers of the Reproductive System** – Human papillomavirus (HPV) vaccination and cervical screening consistently ranked first and second in all regions.
- **STIs and HIV** – Testing and prevention access were key themes. STI vaccines drew particularly high interest in ECA.
- **MNH: Antenatal/Perinatal Care** – Basic emergency obstetric and neonatal care (EmONC) and context-specific access strategies led globally. EAP prioritised community-based care.
- **MNH: Postnatal/Newborn Care** – Newborn care in conflict settings and community postnatal care (PNC) led. Polarised views on postnatal depression were most evident in ECA.
- **Comprehensive Abortion Care** – Improving access and autonomy were consistent priorities; user acceptability and cost were more emphasised in Latin America and Europe.
- **Clinical Management of Rape** – Timely post-rape care was universally prioritised. ECA valued services for marginalised groups; EAP prioritised task-sharing.
- **Crosscutting – Stakeholder Engagement** – Community-led access and respectful care were top-ranked.
- **Crosscutting – Service Delivery and Health Systems** – Training for community health workers (CHWs) and digital information, education and communication (IEC) were most valued, but services for people-on-the-move and supply-chain preparedness showed high regional volatility.
- **Crosscutting – Climate Resilience** – All three questions (resilient provision, commodities, MNH adaptation) received nearly equal support, reflecting their interdependence.

How to use the agenda

This agenda is designed as a navigation tool for donors, governments, implementers and researchers to identify high-priority, practice-relevant research questions in SRHR in humanitarian settings. The focus on delivery, equity and system resilience makes the questions well suited to implementation studies, operational pilots and embedded research.

At the same time, the agenda should be read with context in mind. Each World Bank region aggregates a wide variety of settings: urban displacement, hard-to-reach rural areas, protracted and sudden-onset emergencies. Priorities that look similar on paper may translate into very different research or programme needs on the ground. Users are therefore encouraged to treat the domain rankings as a starting framework: adapt them to local epidemiology, legal constraints, community preferences and service-delivery realities, and document how those contextual factors change both questions and methods in consultation with local stakeholders. In short, the agenda guides 'where to look first', but context determines the final shape of the work.

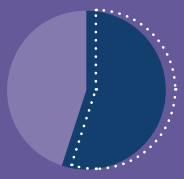
1

Background

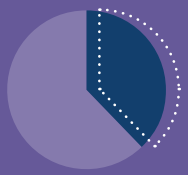
1. BACKGROUND

SRHR are fundamental to health, dignity and equality.

Yet, they are often severely compromised during humanitarian crises, where access to services is disrupted by conflict, displacement or environmental disaster. Women, adolescents and marginalised groups face heightened risks of maternal mortality, unsafe abortion, sexual violence and STIs.[1–3]



Currently, countries affected by humanitarian emergencies account for **55%** of maternal mortality and **38%** of neonatal deaths and stillbirths worldwide.[4]



Despite two decades of increased investment and programming in SRHR in humanitarian settings, significant gaps in operational research persist. Fragmented health systems, constrained resources and complex humanitarian contexts have limited the ability to generate rigorous, actionable evidence. This, in turn, restricts efforts to design, scale and sustain effective interventions in some of the world's most vulnerable settings.

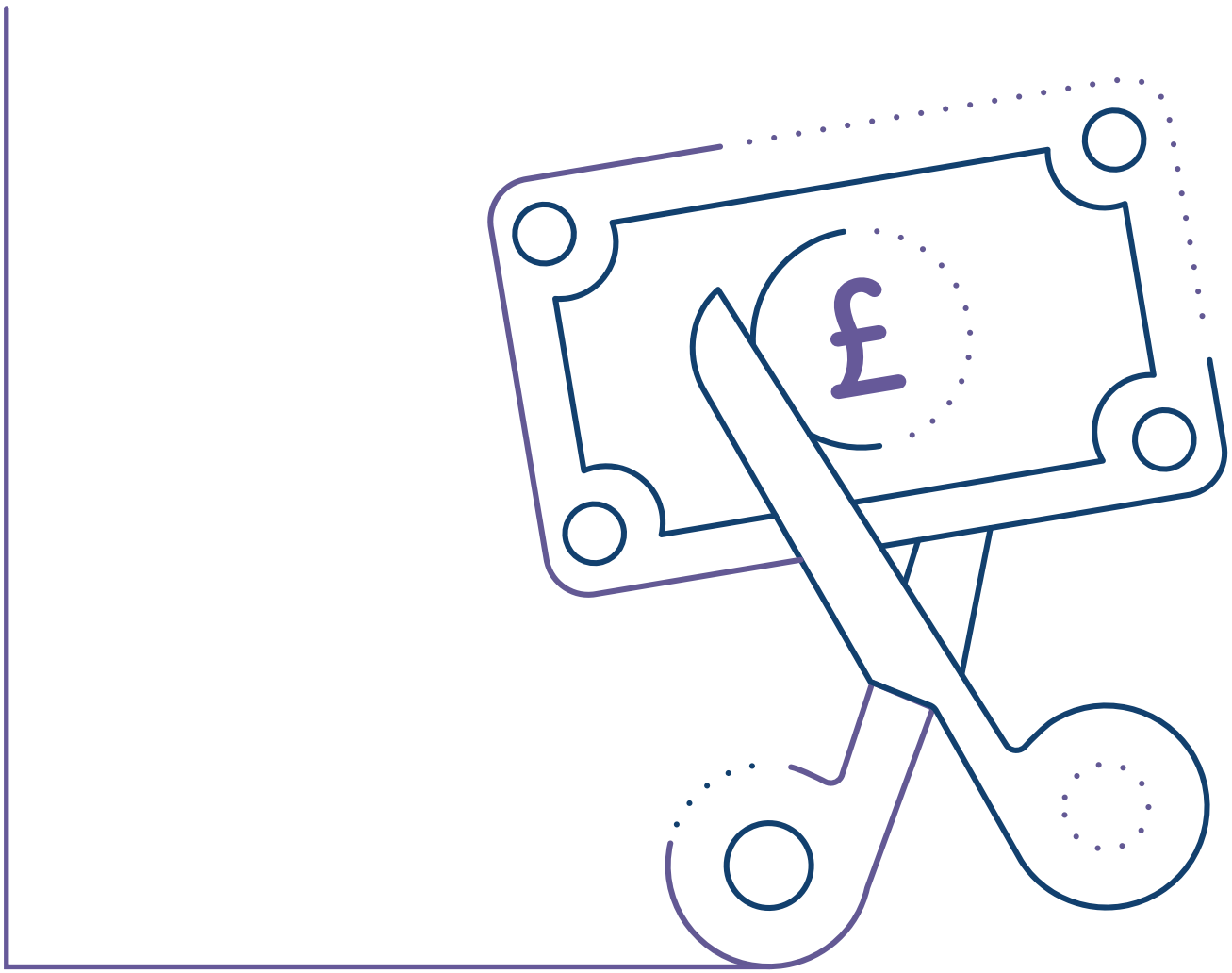
The second Humanitarian Health Evidence Review (HHER2)[5,6] and subsequent reviews have highlighted critical areas with limited research, including FP, safe abortion, adolescent health, integration of services and quality of care. Innovations such as digital health platforms and task-sharing have shown promise but remain under-evaluated.

Previous prioritisation exercises, including those led by WHO and the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) in 2018[7–9], provided valuable starting points but require updating to reflect emerging evidence, shifting humanitarian contexts and evolving community needs. Our Innovation for Sexual and Reproductive Health in Humanitarian Crises situational analysis[10] also emphasised the need for research and innovation tailored to fragile settings.

At the time of writing, the global health landscape is shifting dramatically, and financial support is being significantly reduced, particularly affecting SRHR programmes, including in humanitarian health. Major bilateral donors, including the U.S. Agency for International Development (USAID), have drastically scaled back or halted funding for SRH, HIV and maternal health interventions across LMIC.[11]

These financial constraints threaten the continuity of health services and curtail the capacity of health systems to implement evidence-based interventions. Analysis by the Center for Global Development has shown that at least 16 LMIC, many of them affected by conflict and crisis, stand to lose more than 20% of their total external assistance due to these cuts, with limited ability for other donors to fill the gap.[12] USAID's abrupt funding freeze is disrupting contraceptive access for over 46.7 million women, couples and girls annually, leading to 17.1 million unintended pregnancies and 34,000 preventable maternal deaths.[13] This will hit SSA particularly hard. In this context, it is essential that research investments are highly targeted, addressing the most pressing evidence gaps and supporting the scale-up of proven, cost-effective, context-appropriate and locally driven SRHR interventions in crisis settings.

Implementation research plays a critical role in bridging the persistent gap between innovation and real-world impact, particularly in the complex, resource-constrained and rapidly evolving contexts of humanitarian settings. Unlike efficacy trials conducted in controlled environments, implementation research seeks to understand how, why and under what conditions interventions can be successfully adopted, adapted, scaled and sustained. This approach is increasingly recognised as essential for advancing SRHR in humanitarian contexts, where service delivery is shaped by shifting population needs, fragmented systems, and acute logistical and security challenges.[14]



2

Goal and objectives

2. GOAL AND OBJECTIVES

In response to the enduring evidence gap and need to ensure judicious use of resources, our R2HC programme commissioned a new prioritisation study.

The overarching goal of the study was to develop an updated and actionable set of operational research priorities to strengthen SRHR outcomes in humanitarian settings through a transparent, participatory, inclusive and evidence-informed prioritisation process.

Building on the scoping review, the specific objectives of the prioritisation study were:

To synthesise existing operational research evidence on SRHR in humanitarian settings through a scoping review, highlighting recent advances, ongoing gaps and emerging needs.

To map and align research questions derived from prior SRHR prioritisation exercises, ensuring continuity with earlier global and regional efforts while identifying areas requiring refinement or updating.

To consult extensively with the global SRHR in humanitarian settings community of practice, including regional and national actors, to systematically generate a long list of operational research questions and validate them.

To design and implement a participatory prioritisation exercise using a budget-weighted allocation method, allowing stakeholders to allocate limited resources across research options in a way that reflects both value and feasibility.

To analyse and synthesise prioritisation results, disaggregated by thematic domain and geographic region, to identify both global and regional operational research priorities.

To generate a final, publicly available research agenda for SRHR in humanitarian settings, intended to guide investments by our R2HC programme and inform broader research investment strategies.

3

Scope of the study: Thematic topics, contexts, geographies, populations and settings

3. SCOPE OF THE STUDY: THEMATIC TOPICS, CONTEXTS, GEOGRAPHIES, POPULATIONS AND SETTINGS

Thematic domains included

The SRHR Domains were determined at the outset and organised conceptually, drawing from the WHO life course perspective[15] that aligns with UNFPA's package of SRHR interventions.[16]

1. CSE
2. Sexual Health and Wellbeing
3. FP and Contraception
4. Cancers of the Reproductive System
5. STIs and HIV, including prevention of infertility
6. MNH: Antenatal/Perinatal Care
7. MNH: Postnatal/Newborn Care
8. Comprehensive Abortion Care (safe and post-abortion care)
9. Clinical Management of Rape

In addition, crosscutting themes were anticipated that capture research topics that spanned multiple technical areas or addressed system-level questions (eg, governance, accountability, health systems strengthening or climate resilience). These research questions identified were categorised and grouped into three additional crosscutting domains during the analysis phase to reflect emergent thematic patterns and ensure clarity in prioritisation.

Thematic domains excluded

Some topics were deliberately excluded to preserve methodological coherence and focus. Specifically, sexual and gender-based violence (SGBV) prevention and psychosocial support were not included. This decision followed our recommendation that the topic merits a standalone evidence review. SGBV prevention research typically relies on distinct conceptual frameworks, outcome measures (eg, incidence of violence, shifts in social norms) and literature repositories, and is evaluated through different methodologies from those used for health service interventions. Including it would have required an entirely separate search strategy, appraisal tool and synthesis approach, which were beyond the scope and resources of this study.

Menstrual health and hygiene was also excluded, as it is primarily situated within the water, sanitation and hygiene (WASH) sector rather than the health sector. Intervention studies in this area are guided by different technical standards, implementation channels and outcome indicators (eg, water quantity, safe latrine access, availability of menstrual materials), and are funded and evaluated through distinct mechanisms. Including such studies would have introduced heterogeneity in evidence types and analytic approaches incompatible with the health-sector focus of this review.

Finally, infertility treatments (such as in-vitro fertilisation) were excluded, in alignment with WHO guidance on reproductive health in humanitarian settings,[17] which prioritises access to basic infertility prevention and management (eg, treatment of STIs and pelvic inflammatory disease) over advanced reproductive technologies that are rarely feasible or appropriate in crisis contexts.

This framing ensured that the literature review remained focused on implementation research relevant to the delivery of SRHR interventions through health-sector channels in humanitarian settings. Detailed methods, data extraction tools and included articles are available in the full literature review report.[18]

Humanitarian settings

The study team drew on the HHER1/HHER2 definition used for 'humanitarian settings', which refers broadly to any contexts where populations are affected by conflict, displacement, extreme weather events or other crises resulting in significant humanitarian needs. This includes both acute emergencies and protracted humanitarian settings where needs remain severe but where conflict or disaster may no longer be active, such as in long-term refugee camps.[6,19] The study team also included fragile and conflict affected settings, as defined by the World Bank,[20] if the settings fit the geographical focus areas (see below). The term 'humanitarian setting' is used deliberately throughout the study to distinguish from 'crises', which often implies only acute conflict or disaster events.

Geographical focus

The prioritisation exercise targeted research questions relevant to LMIC as classified by the World Bank;[21] the study team also used the World Bank regional groupings to group countries. Participants involved in consultations were encouraged to apply their expertise to the regions they were most familiar with, including:

- Latin America and the Caribbean (LAC)
- Middle East and North Africa (MENA)
- East Asia and the Pacific (EAP)
- South Asia
- Europe and Central Asia (ECA)
- Sub-Saharan Africa (SSA)
- Global (for expertise spanning two or more regions, plus experts who self-categorised as 'global experts')

Population focus

Research priorities were considered across diverse populations affected by humanitarian settings, including:

- refugees
- internally displaced people (IDP)
- people-on-the-move
- host communities.

Evacuees, resettled refugees or refugees living in high income settings were not included, as their health needs are shaped by fundamentally different service delivery systems, policy contexts and research priorities. Including them would have reduced the contextual coherence of the study, which focused on populations in low- and middle-income humanitarian settings.

Types of research

This study sought to identify implementation research priorities across the agreed SRHR Domains. The study team adopted the WHO/Alliance for Health Policy and Systems Research working definition for this of:

> **"Implementation research is the scientific inquiry into questions concerning implementation—the act of carrying an intention into effect, which in health research can be policies, programmes, or individual practices (collectively called interventions)."**[22]

A research option was therefore retained or adapted if it:

1. Focused on an intervention or implementation strategy that is intended for use in humanitarian contexts.
2. Proposed to measure at least one implementation or service outcome such as acceptability, feasibility, fidelity, coverage, equity of reach, cost or sustainability and/or downstream health outcomes (eg, service uptake, quality of care, morbidity, mortality) under routine field conditions.

Research questions designed solely to estimate prevalence, describe needs or assess knowledge, attitudes and practices were excluded unless the data were explicitly framed as a formative or baseline component of a larger implementation research study. This distinction ensures that the priorities identified will generate actionable evidence to improve the design, delivery, scale-up and long-term sustainability of SRHR interventions in humanitarian settings.

4

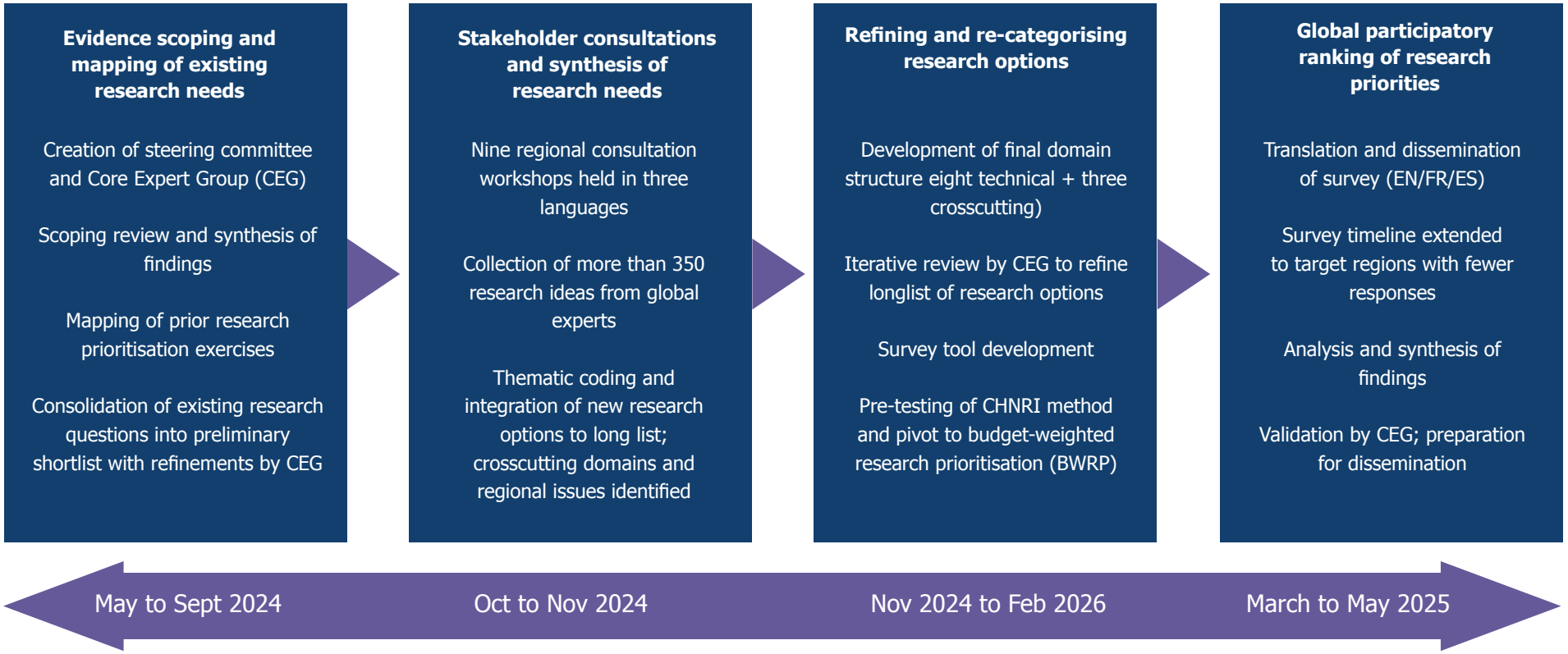
Methodology

4. METHODOLOGY

Overview

The study was conducted in four interconnected phases (illustrated in Figure 1), combining systematic evidence review and mapping of existing research priorities, stakeholder consultation, refining and re-categorising research options and designing and implementing a global participatory survey to rank research options. The methodology was designed to ensure transparency, inclusiveness and a strong grounding in operational realities within humanitarian settings.

Figure 1: Phases and timelines of prioritisation study



First, a scoping review was undertaken[18] to synthesise recent operational research on SRHR in humanitarian settings, building an evidence base for priority identification. Concurrently, research questions from previous global and regional SRHR prioritisation exercises were mapped and aligned, ensuring continuity while allowing for refinement in light of new evidence and evolving humanitarian contexts.

Extensive stakeholder engagement followed, including regional consultations with practitioners, researchers and policymakers to identify, refine and validate a long list of research questions. Special emphasis was placed on ensuring regional diversity and elevating the perspectives of experts working closest to humanitarian-affected populations.

To prioritise among the long list of research questions, a budget-weighted allocation approach was used.[23,24] Rather than traditional ranking methods, participants were asked to allocate a hypothetical budget across research questions within each thematic domain, reflecting both the perceived importance and feasibility of each question. This method was a pivot from the use of the Child Health and Nutrition Research Initiative (CHNRI) method (discussed further in the prioritisation approach section).

The final analysis produced a prioritised list of operational research questions for SRHR in humanitarian settings, disaggregated by domain and geographic region, ready to guide our – and the broader SRHR community's – future research investments.

Ethical considerations and project governance

Ethics review and approval: This study was reviewed and approved by the Ethics Review Board of the University of Geneva, ensuring that all components adhered to international ethical standards for research involving human participants. The review focused on safeguarding participants' autonomy, privacy and data security throughout the prioritisation exercise (ethics approval certificate identification number: CUREG-20250213-265-2).

Voluntary, anonymous participation: Participation in the online survey was voluntary. All respondents were required to confirm that they had at least five years of relevant experience in SRHR in humanitarian settings before proceeding. No personal identifiers such as names or contact details were collected. Participants had the option to save their survey responses and return to complete the questionnaire at their convenience before the survey closing date.

Consent and data protection measures: Informed consent was obtained electronically prior to participation. Participants were presented with clear information about the purpose of the study, the use of their responses and assurances regarding confidentiality and data security. Survey responses were stored securely and only aggregated results were shared in the final analysis. All findings are reported in ways that prevent the identification of individual participants.

Core Expert Group and Study Steering Committee: A Core Expert Group and a Study Steering Committee were established at the outset to guide the project's design, implementation and validation processes.

The Core Expert Group included 21 SRHR practitioners, researchers and humanitarian specialists from diverse geographic and institutional backgrounds. They provided technical input into the development of research questions, survey tool refinement and interpretation of results.

The Study Steering Committee, comprising 11 representatives from donors, United Nations (UN) agencies, ministries of health, academia and international non-governmental organisations (INGOs). It oversaw project governance, ensuring methodological rigour and alignment with the study's strategic objectives.

Both groups were instrumental in maintaining transparency, ensuring scientific credibility and supporting stakeholder engagement throughout the exercise.

Mapping of SRHR research priorities from previous prioritisation exercises and scoping review

At the outset of the prioritisation exercise, a systematic mapping was conducted to build a comprehensive list of operational research questions about SRH, extracting research questions from three key previous exercises that provided a critical foundation for our study.

These were:

- **The IAWG's Workshop on Sexual and Reproductive Health Research Priorities in Humanitarian Settings (2018)**, which focused on practical implementation challenges in SRHR during humanitarian response. It developed a list of high-priority operational research topics, focusing on practical implementation challenges. Using a modified CHNRI approach, it ranked questions across domains such as adolescent SRH, contraception, safe abortion care and emergency preparedness. A major strength was the emphasis on developing draft concept notes to catalyse research funding and action.
- **The WHO's Setting research priorities for sexual, reproductive, maternal, newborn, child and adolescent health in humanitarian settings (2021)**, which applied a rigorous CHNRI-Delphi methodology across sexual, reproductive, maternal, newborn, child and adolescent health domains. It generated 25 global research priorities with a particular emphasis on intervention strategies, data needs and service quality improvements.
- **The WHO African Region: Research Priorities on Sexual and Reproductive Health and Rights (2021)**, which focused on operational research needs specific to LMIC in Africa. It identified 21 priority questions, many of which addressed critical service gaps such as access to contraception, care for gender-based violence (GBV) survivors and SRHR service coordination.

  From these sources, the study team extracted an initial list of 31 draft research questions, aligned to the nine SRHR Domains, adding three crosscutting domains to include research questions addressing several thematic domains or broader health systems topics.

Each question was reviewed the study team and Core Expert Group. Where necessary, they also revised the questions to:

- reflect updated terminology and humanitarian contexts.
- emphasise operational and actionable research angles.
- integrate advances in the field such as digital health, task-sharing and self-care models.
- improve clarity, specificity and potential feasibility within a short- to medium-term research timeframe.

Research options were grouped into thematic domains consistent with the SRHR Domains encompassed by the study, ensuring a logical, participant-friendly structure while maintaining fidelity to the original research gaps identified. This mapped and refined list was then used as a basis to inform the global consultations.

This structured mapping phase ensured that the prioritisation exercise built on existing knowledge, avoided duplication of earlier efforts, and maintained continuity with previously identified global and regional research needs, while also refining the list to better reflect evolving humanitarian realities.

Stakeholder consultation

Stakeholder mapping and identification

A key pillar of the prioritisation process was broad and inclusive engagement with the global SRHR in humanitarian settings community of practice. Stakeholders were identified through the study team's networks and through nominations from the Core Expert Group and Steering Committee, professional networks, relevant webinars and conferences, and snowballing approaches.

An open call for nominations was also shared widely through networks, inviting individuals to submit expressions of interest, and outline their thematic, geographic and cross-sectional expertise.

The following stakeholders were targeted:

- Academic and research institutions
- National non-governmental organisations (NGOs) and INGOs
- Civil society organisations (CSOs) and community-based organisations
- Governments and policymakers
- Professional associations
- Humanitarian practitioners and service providers
- Donor and funding organisations.

Regional consultation meetings

Building on the initial stakeholder mapping, 11 online regional consultation meetings were held between November and December 2024. Meetings were organised by geographic region and linguistic groups (including English, French and Spanish) to maximise participation. The regions covered and number of participants per region are shown in Figure 2 on the next page.

The meetings were structured to:

- Provide a background to the study's overarching goal, share feedback on the findings, form the scoping review and review an initial draft list of research questions.
- Gather additional regional and thematic research ideas that met the criteria for research questions defined for this study (see Box 1).
- Identify nuances or new areas not covered in the initial list.
- Discuss and agree on any priority adjustments relevant to each region.

Box 1: Guidance for generating and including SRHR research questions

SRHR research questions must be:

- Thematically aligned with the nine SRHR Domains within the scope of this study
- Relevant to SRHR in humanitarian settings in LMIC

Implementation research must:

- Assess the effectiveness of an intervention/approach/programme
- Assess outcomes that are measurable and cover health outcomes or factors that contribute to health outcomes.

Needs assessment/prevalence studies or studies measuring knowledge, attitudes and practices (KAP) alone are not included (unless this is done as a baseline to assess the effectiveness of an intervention or approach).

Meetings were supported by online collaboration tools (eg, Miro boards) and supplemented by post-meeting email feedback opportunities.

A total of 91 experts participated in these meetings (see Figure 2) and were encouraged to submit additional ideas even after the live discussions, which the study team received by email.

Among the **91 experts** with whom the study team consulted, most were located in Africa (37%), with an additional 8% in a group from the Horn of Africa;; the second largest groups were located in South and East Asia (17%) and the Eastern Mediterranean (15%), with other groups located in the Americas (12%), Europe (8%) and the Western Pacific (3%).
More than half of the expert contributors (58%) were female. The majority were employed in either NGOs (44%) or academia (24%). See Figure 3.

Figure 2: Location of consultation meeting participants (n=91) who were SRHR experts in humanitarian settings

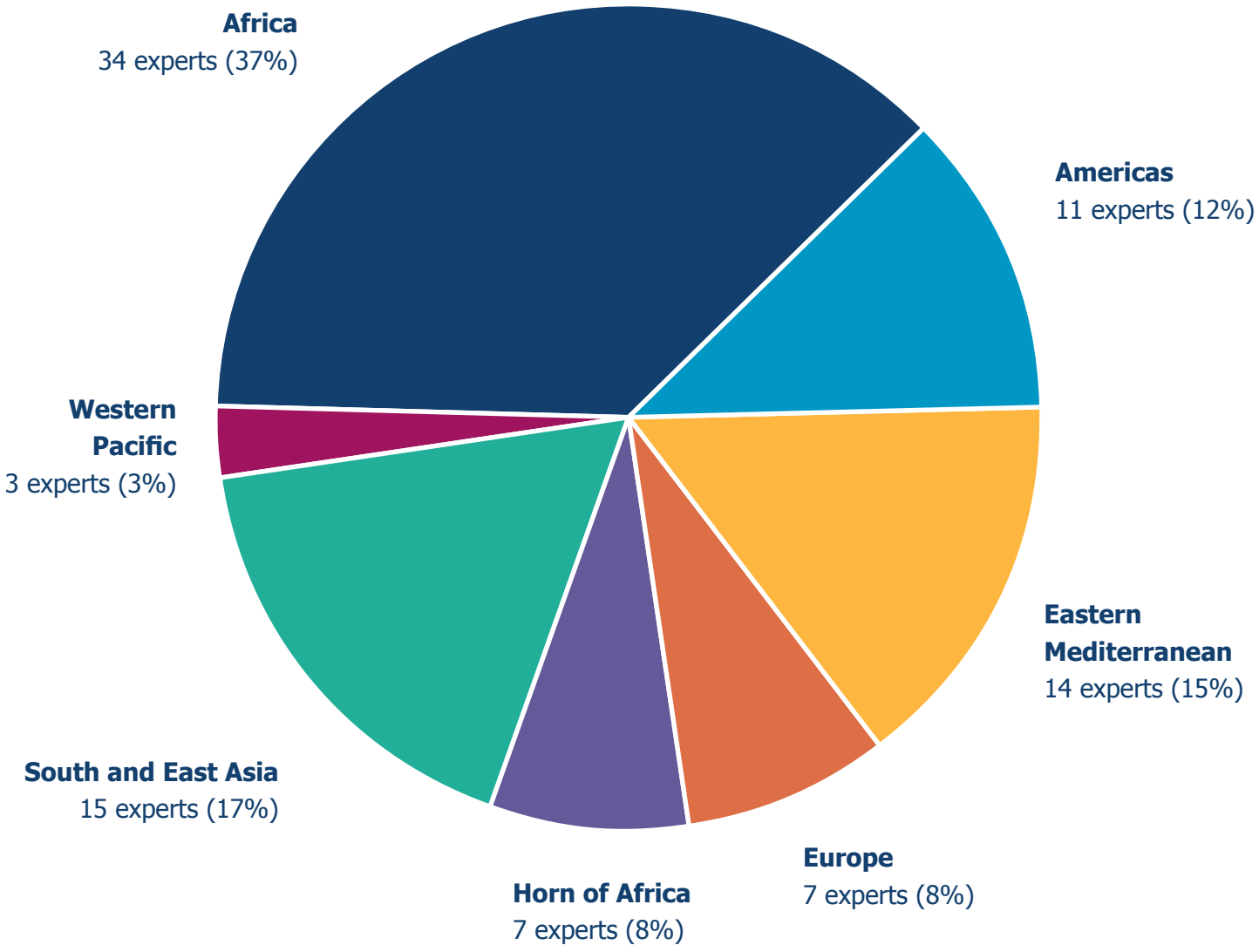
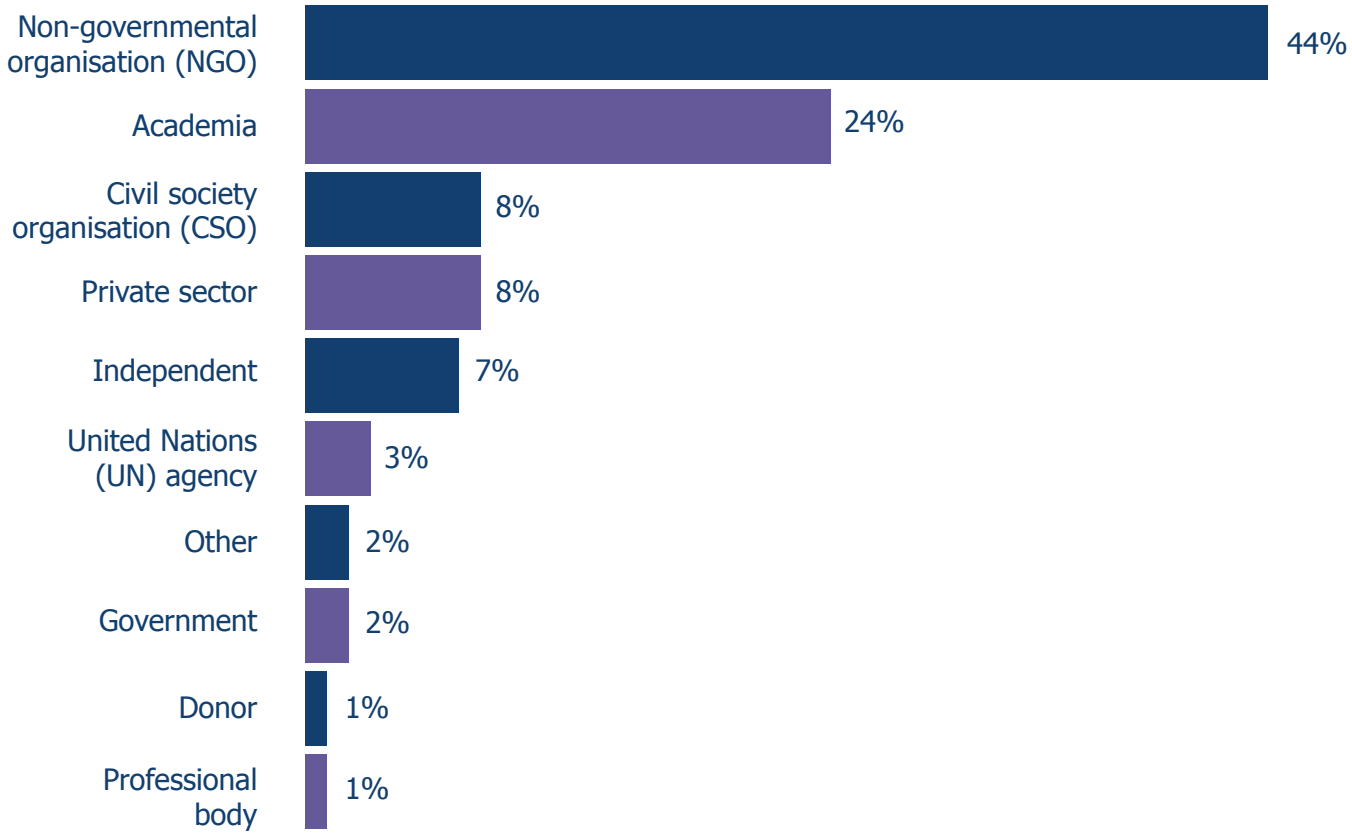
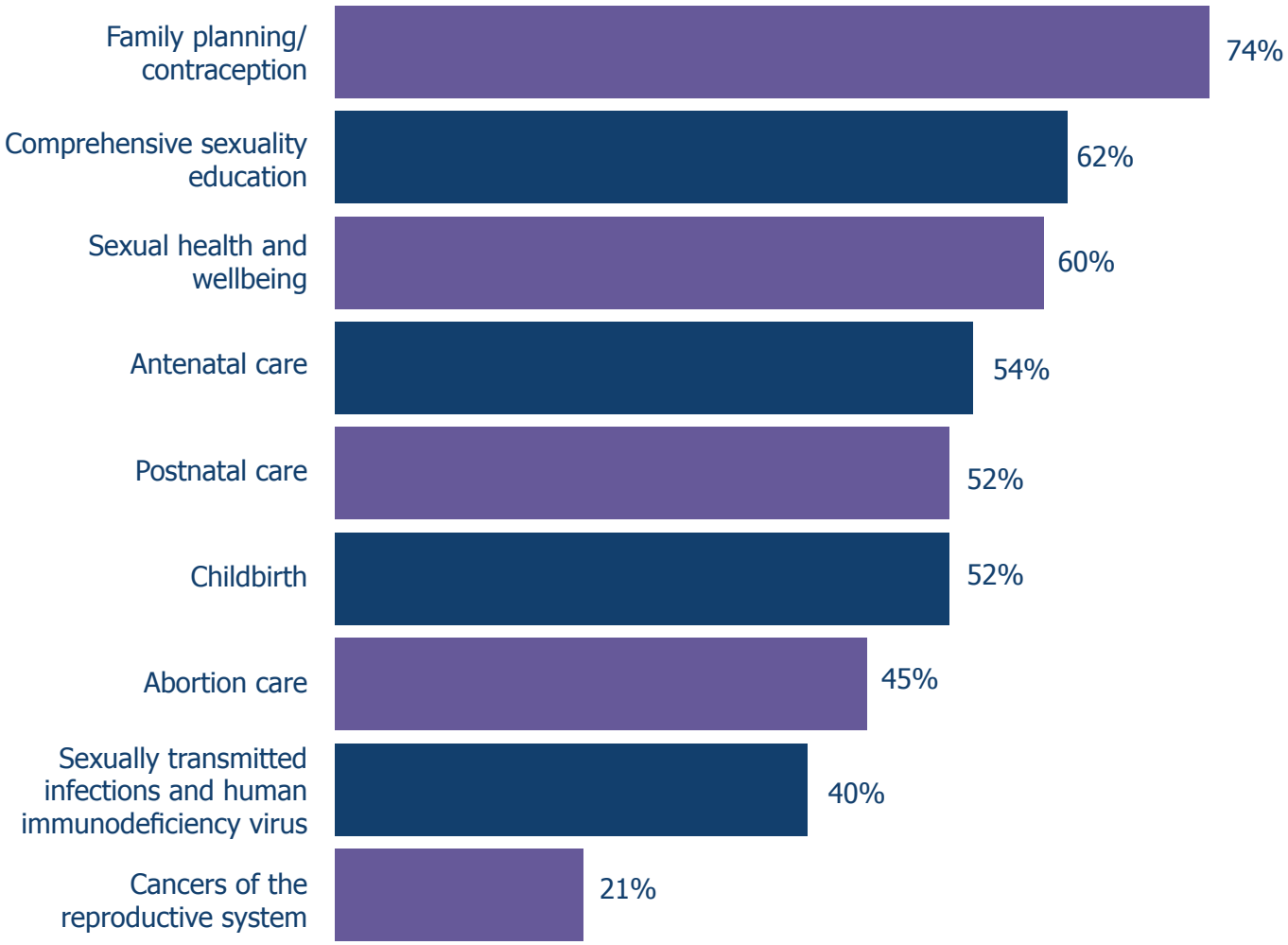


Figure 3: Primary type of institutional affiliation among 91 regional experts in consultation meetings



In terms of core SRHR Domain expertise among the experts, the most frequent area of expertise was FP/contraception (74%), followed by CSE (62%), and sexual health and wellbeing (60%). Around half reported expertise in ANC (54%), PNC (52%) and childbirth (52%), while fewer experts were in the SRHR Domain of abortion care (45%) and STI and HIV (40%). Reproductive cancers had the lowest representation at 21%. See Figure 4.

Figure 4: Core SRHR Domain expertise among 91 regional experts expressed as a proportion



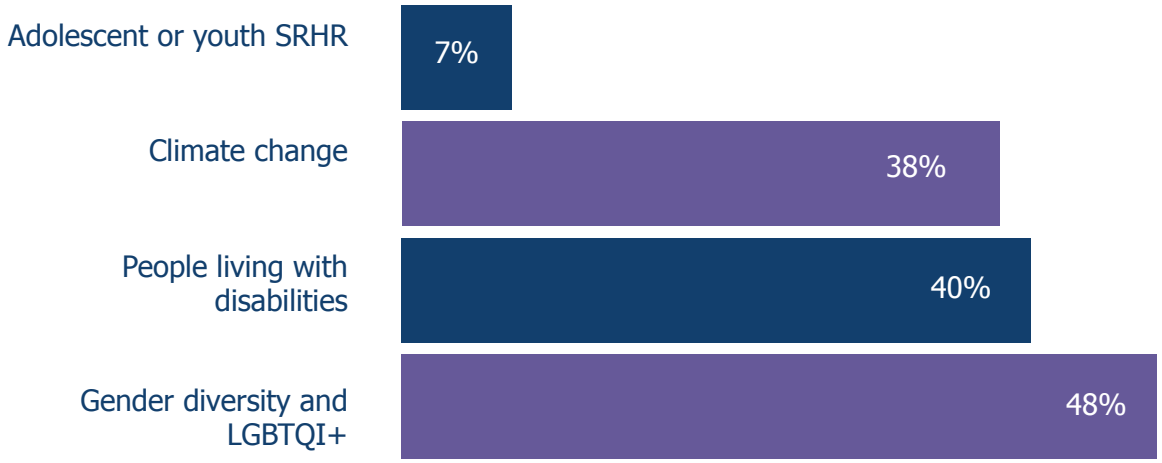
Respondents contributed a wide array of crosscutting skills and areas of expertise that extend beyond the nine primary SRHR Domains (see Figure 5 for the most common). These insights reveal the diversity and intersectionality of knowledge within the global SRHR in crises community, with many participants bringing complementary strengths from broader health, rights and humanitarian disciplines.

The most commonly reported areas of expertise included:

- **Gender diversity and LGBTQI+:** Referenced by over 60 respondents, making it the most frequently cited additional area. Many noted specific work with gender minorities in humanitarian settings and inclusive SRHR services.
- **People living with disabilities:** Cited by 36 respondents, highlighting experience with disability-inclusive programming and SRHR accessibility.
- **Climate change:** Cited by 35 respondents, indicating a strong overlap between SRHR and environmental resilience, particularly in relation to displacement and service continuity.
- **Adolescent or youth SRHR** was explicitly mentioned as an area of expertise among six people.

In addition, some individual experts mentioned important expertise, including menopause, mental health and sexual violence prevention. This range of crosscutting expertise reflects the intersectional nature of SRHR in humanitarian settings and affirms the importance of integrating inclusive, climate-resilient and equity-focused approaches in future research and programming.

Figure 5: Percentage of regional experts consulted with expertise in SRHR-specific topic areas



Collection and thematic synthesis of research ideas

Through the regional consultations and subsequent written feedback, over 350 individual research ideas or SRHR needs were collected. Each input was carefully documented and analysed manually, categorising each idea by region, domain and thematic relevance.

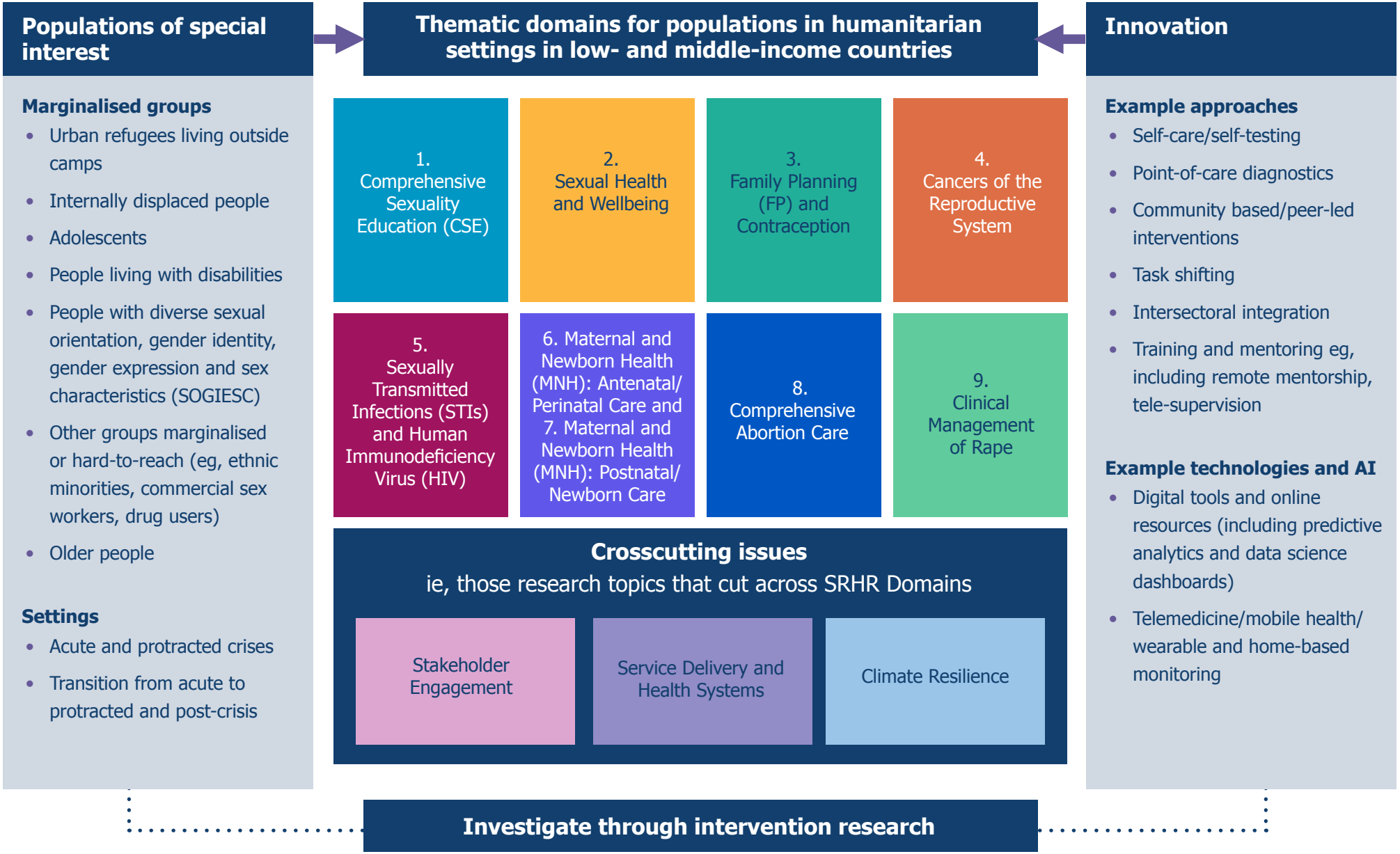
A fourth prioritisation exercise was identified by a Core Expert Group member during this consultative phase – the WHO global research priorities for sexually transmitted infections (2024). In 2022, WHO initiated a research prioritisation process to identify the most important STI research areas to address the global public health need. The process identified 40 priority STI research needs with "top priorities centred on developing and implementing affordable, feasible, rapid point-of-care STI diagnostic tests and new treatments, especially for gonorrhoea, chlamydia, and syphilis; designing new multipurpose prevention technologies and vaccines for STIs; and collecting improved STI epidemiologic data on both infection and disease outcomes".[24] The study team ensured the STI-related priorities identified from this exercise were reflected in its long list.

The study team conducted a thematic analysis to group overlapping ideas, and remove duplicates and ideas that did not meet the study criteria (see Box 1). It also ensured that diverse perspectives including regional nuances and crosscutting issues, such as equity, climate resilience and digital health, were captured. During the analysis, the study team considered each individual idea carefully to ensure there were no ideas unnecessarily excluded, and for each question, drew from the consultation data to list the areas of focus and interventions suggested by experts.

This systematic consolidation produced a preliminary long list of 101 research questions. The long list was shared with all 91 consultees for transparency, and seven participants submitted further feedback to refine phrasing, ensure clarity and share further ideas.

The study team developed a conceptual framework illustrating the key themes that arose as important features to reflect in the research agenda. This was drawn from evidence gathered from the scoping review, the mapping of earlier prioritisation exercises and the reflections of experts with whom the study team consulted, both the project's Core Expert Group and the experts who took part in the consultations – see Figure 6.

Figure 6: Conceptual framework illustrating the key components that require special attention for future SRHR intervention research in LMIC humanitarian settings



Systematic listing and refinement of research questions

Following the broader consultation phase, a final refinement process was conducted in collaboration with the Core Expert Group:

- Core Expert Group members were invited to select two or three domains aligned with their expertise, allowing focused review while managing workloads.
- They reviewed the draft research questions for operational clarity, feasibility in humanitarian settings, relevance to pressing field challenges and potential for measurable impact.
- Feedback included suggestions for refining wording, merging similar questions or introducing important nuances.

The study team systematically incorporated the feedback received:

- Duplicated or overlapping questions were merged.
- Language was sharpened to ensure each question was operational and actionable within a humanitarian context.
- Emerging thematic gaps, such as climate-related health impacts and digital health innovations, were further addressed. The crosscutting questions were categorised by research topic and grouped to sub-domains that enabled no fewer than three and no more than seven per group (in order to make the ranking feasible).

Through this iterative review, the final long list was refined to 73 prioritisation-ready research questions, shown by domain in Table 1. These questions formed the basis for the subsequent budget-weighted research prioritisation (BWRP) survey.

Table 1: Number of questions in the final list of SRHR in humanitarian settings research questions

Domain		Number of questions	Sub-totals
1. Comprehensive Sexuality Education (CSE)		6	56
2. Sexual Health and Wellbeing		8	
3. Family Planning (FP) and Contraception		8	
4. Cancers of the Reproductive System		3	
5. Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)		8	
6. Maternal and Newborn Health (MNH): Antenatal/Perinatal Care		5	
7. Maternal and Newborn Health (MNH): Postnatal/Newborn Care		4	
8. Comprehensive Abortion Care		7	
9. Clinical Management of Rape		7	
Crosscutting	Stakeholder Engagement	7	17
	Service Delivery and Health Systems	7	
	Climate Resilience	3	
	TOTAL	**73**	

Prioritisation ranking survey for the global community of practice

Rationale for revising the prioritisation approach

The original plan for the prioritisation exercise was to apply a modified CHNRI methodology[18,26,27] involving expert scoring of each research question against three predefined criteria: feasibility, effectiveness and relevance.

However, pre-testing of the survey instrument revealed significant challenges: experts provided highly consistent scores across most questions, resulting in minimal differentiation between research options. This limited the ability to identify true priority areas.

In response, the study team, in consultation with some members of the Core Expert Group, revised the prioritisation method to better stimulate meaningful prioritisation while reducing the burden on participants.

Overview of the BWRP approach

The final prioritisation survey applied a BWRP approach. Instead of scoring each research question separately against multiple criteria, respondents were allocated a hypothetical budget of $100 per thematic domain and asked to distribute it across the research questions in that domain.

This method draws on principles from:

- **Priority-based budgeting:** Ensuring that limited resources are distributed according to perceived value.
- **Participatory budgeting:** Involving a diverse expert community in resource allocation.
- **Optimal computing budget allocation**: Using a fixed budget to optimise selections under constraints.

Structured budgeting approaches have been recommended as practical alternatives to multi-criteria scoring, particularly where detailed cost-effectiveness data are unavailable or where it's important to stimulate clearer differentiation among competing options.

Daniels[23] emphasised the need for prioritisation tools to force real-world trade-offs between options, rather than relying purely on risk or technical scores, while Mills[28] highlighted that resource-constrained allocation exercises can maintain rigour while reducing burden on participants. Similarly, Mabayo demonstrated that participatory budget allocation can offer a transparent and inclusive method for strategic prioritisation.[24]

Key features of the BWRP approach included:

- **Equal weighting across domains:** Each SRHR Domain was treated independently; no cross-domain comparisons or normalisation were applied.
- **Implicit prioritisation:** Experts embedded their judgments on feasibility, relevance and effectiveness (and potentially other factors) directly into their budget allocations without needing to score separately.
- **Reduced respondent burden:** Participants found the task more intuitive and faster compared to traditional multi-criteria scoring exercises.
- **Reflects real-world decision-making:** Budgeting mirrors how resources are allocated in practice.

Survey structure and participation

The final survey instrument contained 73 research questions grouped into nine SRHR and three crosscutting domains. Clear instructions were provided, including definitions of humanitarian settings and guidance on criteria to consider (relevance, effectiveness and feasibility).

The LimeSurvey platform was used to build the survey tool, which included a built-in validation step that ensured participants were allocated exactly $100 per domain before proceeding.

Participation criteria included a minimum of five years of experience working in SRHR in humanitarian settings. The study team also extended the invitation to ensure representation from SRHR humanitarian practitioners, researchers, implementers, policymakers and service providers worldwide. The survey tool was made available in English, French and Spanish.

The final survey question invited respondents to select up to three additional prioritisation criteria they considered, if any, when allocating their hypothetical budget. Participants were provided with a pre-defined list drawn from the CHNRI methods, ie, maximum impact, community involvement, deliverability, answerability, affordability, cost, ethical aspects and public opinion.

Analysis approach

Survey responses were analysed as follows:

- Mean allocation per research question within each domain and by region.
- SD of allocations to assess consensus or divergence among respondents.

Each domain (and sub-domain) was given equal weighting and no aggregation across domains or weighting of respondents was performed, preserving the independent integrity of each domain. The analysis was conducted for each World Bank region, and one overall global analysis was conducted.

Results were visualised using bar charts showing mean allocations by research question and region, and scorecards to illustrate relative rankings and consensus thresholds were developed.

Ranking process

To avoid overinterpreting marginal score differences, the study team applied a consistent rule to identify ties between research questions. Specifically, if two or more questions had mean allocation scores that differed by **fewer than 0.5 points**, the study team considered them tied and presented them together. This threshold reflects the limited discriminatory value of small differences, particularly given the variability in expert preferences and the subjective nature of budget allocation.

For example, if the third- and fourth-ranked questions in a domain scored 10.6 and 10.2 respectively, they would both be assigned third place, eliminating the fourth position. The next highest scoring question would then be ranked fifth.

This approach was applied consistently across all domains and regions, in both the main and supplementary materials. By adopting this threshold, the study team aimed to avoid overinterpreting negligible score differences and more accurately reflect the range and clustering of expert opinion.

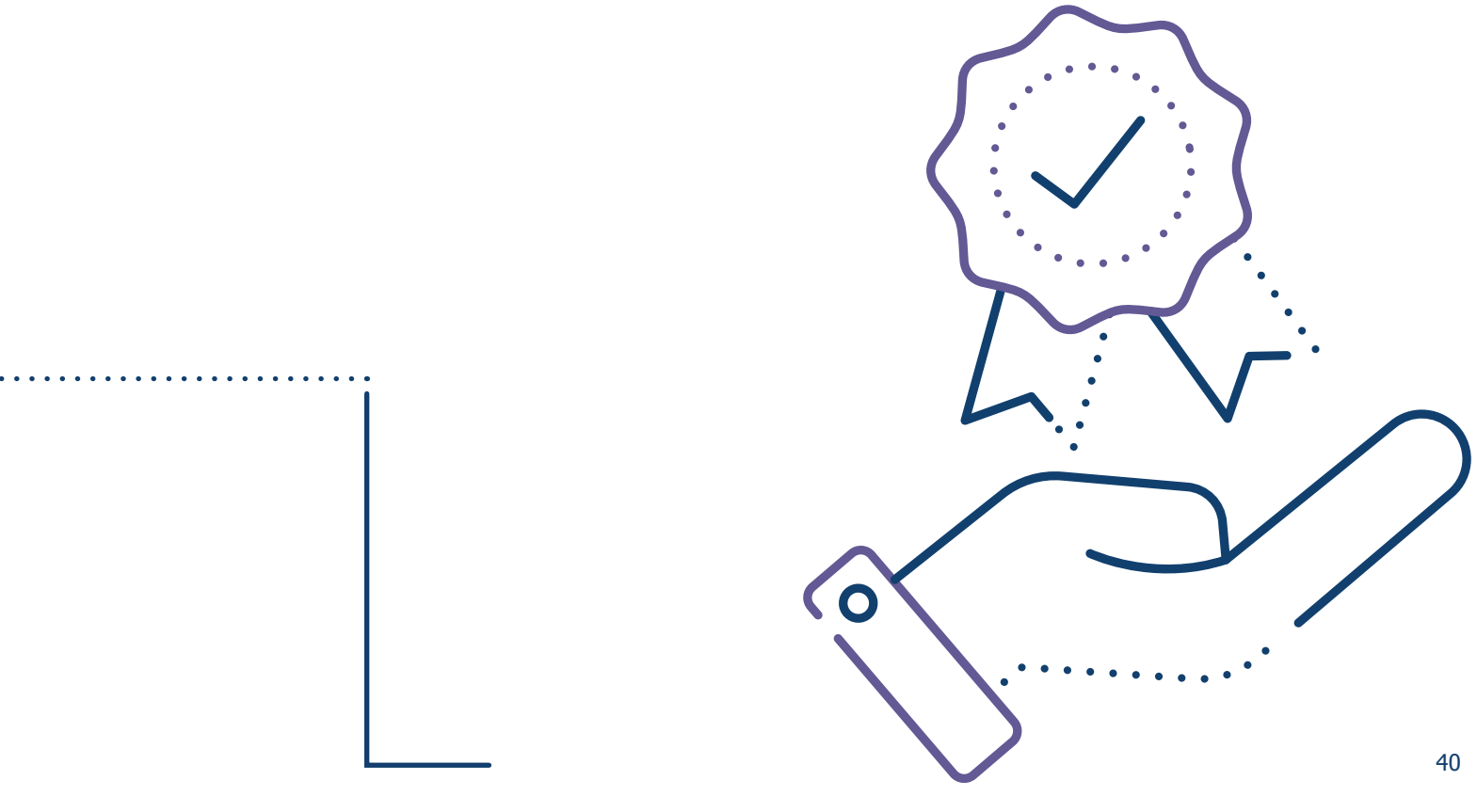
To quantify the overall importance assigned to each additional criterion selected by respondents, a weighted scoring system was applied, assigning three points for each first place ranking, two points for second place, and one point for third place.

Limitations of the BWRP approach

As participants were not asked to score priority-setting criteria (feasibility, relevance or effectiveness) separately, the rationale behind their choices remains partially inferred rather than directly measured. Domains with very different numbers or complexity of questions may still have subtly influenced participant behaviour. Finally, while necessary to preserve fairness, this approach limits the ability to compare questions across different SRHR areas.

Quality assurance

Quality assurance included systematic cleaning, bilingual harmonisation, dual review of recoding decisions and analysis of research ideas. Ranking scores and raw frequency tables were cross-checked for identical totals, and outlier allocations were retained after confirming they reflected genuine views rather than data errors.



5

Results of the prioritisation survey

5. RESULTS OF THE PRIORITISATION SURVEY

Characteristics of survey participants

A total of 271 professionals with direct SRHR experience in humanitarian contexts completed the prioritisation survey.

Their depth of expertise was high: 91% had at least five years' field experience and one-quarter had worked for 15 years or more in the field.

Respondents brought region-specific knowledge that mirrored the geographical burden of humanitarian settings; almost two-thirds had worked in SSA, and substantial numbers contributed insight from the MENA, South Asia, LAC and other regions. Just over half (58%) were female; 36% were male and 2% identified as non-binary or third gender.

Clinical services (14%) and research (14%) were the most frequently reported primary roles, together accounting for 28% of the 271 respondents. Public-health programming (8%), other SRHR service provision such as counselling and training (8%), and humanitarian response planning or management (7%) were also well represented, while smaller proportions worked mainly in policy (2%), combined service-delivery-and-research roles (2%) or advocacy/communications (1%). For the 42% of entries with corrupted free-text fields, cross-checking other variables suggested most held managerial posts that also encompassed service delivery and/or research.

Nearly two-thirds of participants (62%) reported a single institutional affiliation, a quarter (24%) held two or more existing affiliations and 14% provided unusable affiliation data. National NGOs, INGOs and UN agencies predominated among those with clean data, followed by academic institutions and governmental health services.

Figure 7: Number of experts who wanted their replies reflected by region (among 271 respondents)

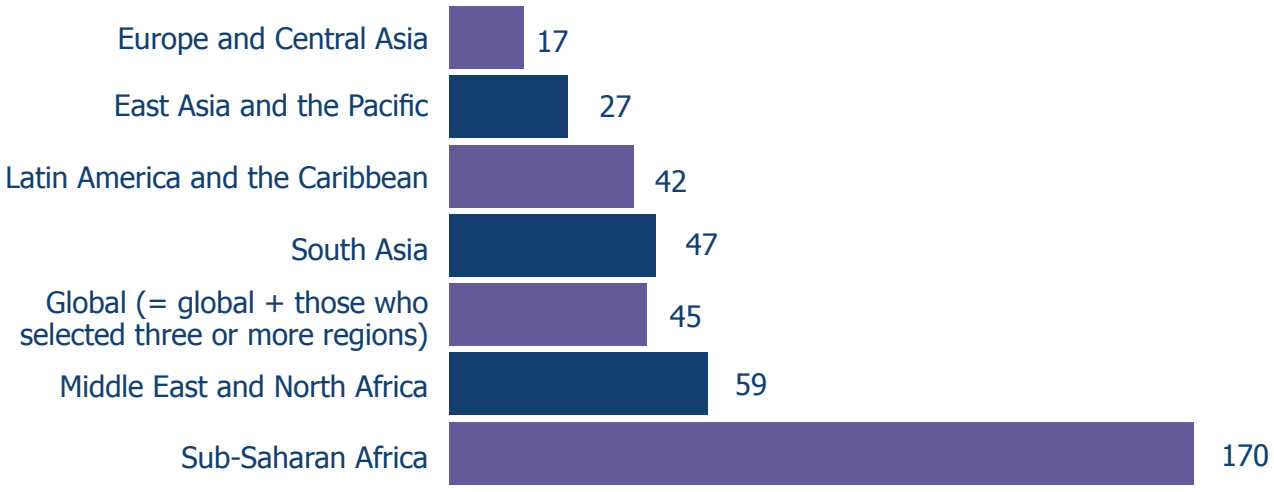
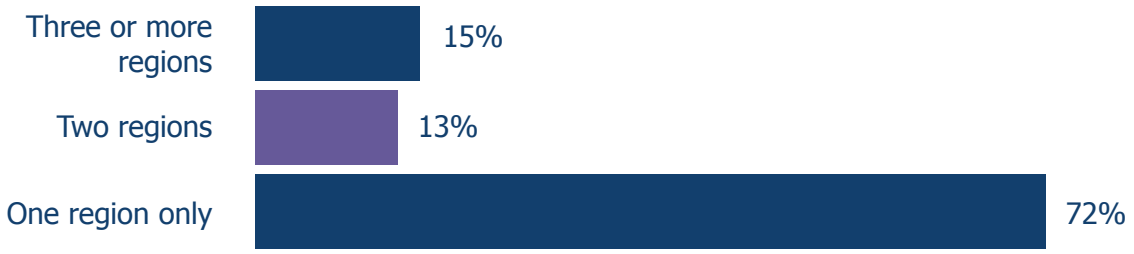


Figure 8: Number of regions of expertise selected by respondents (n=271)



Ranked priority list within each thematic domain, disaggregated by geographical region

For each region and one overall or global category, a ranked list of research questions was generated for each domain based on the mean allocation per research question. The study team also calculated the SD to assess the range of dollar allocation to each question in that region and allow detection of polarised versus largely consensus allocations.

We first present the scores for research questions within each domain and region. We then present all the boxplots showing mean scores, the IQR and outliers for each research question in each domain by region. To make presentation and interpretation easier, we show the topic of each research question only. The full questions can be found in Annex 1, and the scorecards and boxplots should be considered alongside the full questions. For each scorecard, we use the same legend to illustrate the ranking of questions in order based on the mean score. Finally, the results are narrated.

Scores are tightly clustered and should therefore be compared only within the domain, not against those from domains with different numbers of questions. The boxplots display the IQR to show how closely the middle 50% of respondents' allocations cluster for each research question, while the accompanying table presents the SD to summarise the overall spread – including any extreme values – within each domain. Thus, a narrow IQR and low SD point to broad consensus, a wide IQR coupled with a high SD signals genuine divergence of opinion, and a narrow IQR alongside a high SD indicates general agreement tempered by a handful of outlying views.

The full scorecards for each region are shown in Annex 2, with the research questions listed in order of ranking. This scorecard also needs to be interpreted alongside the full questions, suggested areas of focus and suggested interventions to investigate (see Annex 1).

SRHR Domain 1: Comprehensive Sexuality Education (CSE)

Highlight: Delivery models ranked highest globally, but ECA prioritised integrating CSE into adolescent-friendly services. Intervention ideas include mobile and digital platforms, and tailored strategies for out-of-school young people.

Within this SRHR Domain, the top-ranked research question focused on identifying the most effective and culturally relevant delivery models for adolescents in humanitarian settings (Q1). This question addressed the need to tailor delivery approaches for both in-school and out-of-school adolescents, with explicit differentiation by age (ten to 14 vs. 15 to 19 years) and attention to cultural appropriateness.

This question received the highest average allocation within the CSE domain in nearly all regions, except in ECA, where it was ranked third. In ECA, greater emphasis was placed on engaging parents and caregivers in CSE, suggesting some regional divergence in perceived entry points or enablers.

Experts the study team consulted recommended practical lines of inquiry aligned with the top-ranked topics, for example, mobile or radio-based CSE delivery, intergenerational dialogue programmes to engage caregivers and digital mentorship for facilitators. They also advised testing one-stop, youth-friendly health centres (mirroring the strong European interest in integration). These proposals offer concrete starting points while the score pattern cautions against treating the leading question as a runaway priority.

Other questions receiving high average scores in this SRHR Domain addressed the engagement of parents, caregivers and community leaders (Q2), the training and support of CSE facilitators (Q4), and the integration of CSE into adolescent-friendly health services (Q5). While their ranking order varied slightly across regions, these questions consistently appeared in the top half of CSE priorities. Expert contributors had highlighted strategies such as intergenerational dialogue, digital and participatory training, and linkages between CSE and health services as promising areas to investigate further.

Scorecard for SRHR Domain 1: Comprehensive Sexuality Education (CSE)

Region:	**All**	**Latin America and the Caribbean**	**East Asia and the Pacific**	**Europe and Central Asia**	**Middle East and North Africa**	**South Asia**	**Sub-Saharan Africa**
Total number of respondents:	172	28	20	11	35	25	106
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Effective delivery models for CSE	21.80	20.24	23.34	15.46	23.56	25.09	21.66
2. Engaging parents and caregivers in CSE	16.86	17.07	16.57	20.10	17.31	17.83	17.44
3. Gender-transformative approaches in CSE	15.30	17.54	11.68	13.39	11.40	15.25	15.05
4. Training and supporting CSE facilitators	16.35	14.49	16.11	13.82	17.49	15.01	15.94
5. Integrating CSE into adolescent-friendly health services	16.34	17.02	20.44	22.37	17.96	17.29	16.73
6. Safe and inclusive CSE for marginalised groups	13.36	13.63	11.86	14.86	12.28	9.53	13.19

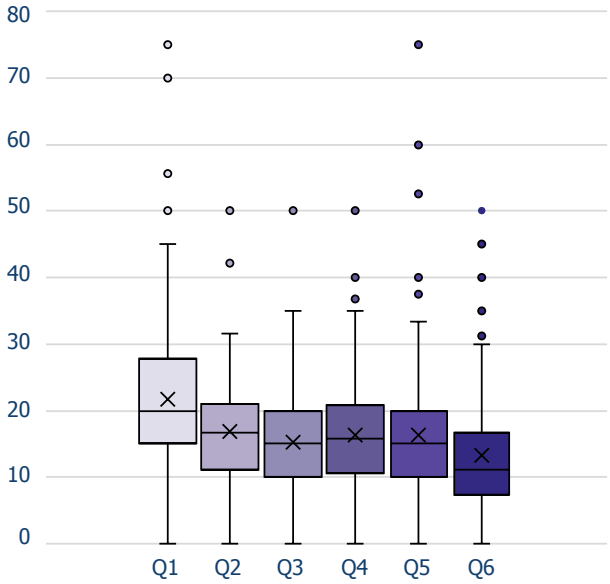
Boxplot figure 1: Mean dollar allocation (scores) for each question for SRHR Domain 1 – Comprehensive Sexuality Education (CSE)

Research topic

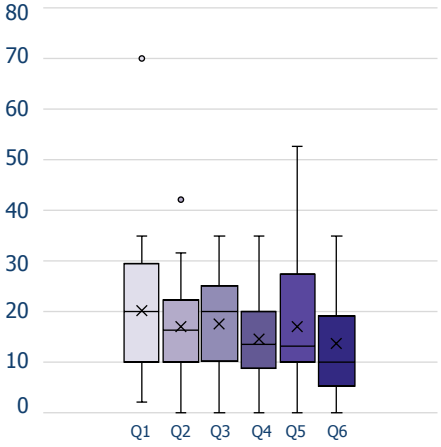
1. Effective delivery models for CSE
2. Engaging parents and caregivers in CSE
3. Gender-transformative approaches in CSE
4. Training and supporting CSE facilitators
5. Integrating CSE into adolescent-friendly health services
6. Safe and inclusive CSE for marginalised groups

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

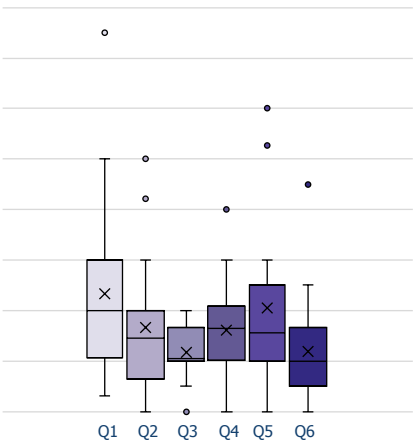
All respondents (n=172), Comprehensive Sexuality Education



Latin America and the Caribbean (n=28)



East Asia and the Pacific (n=20)



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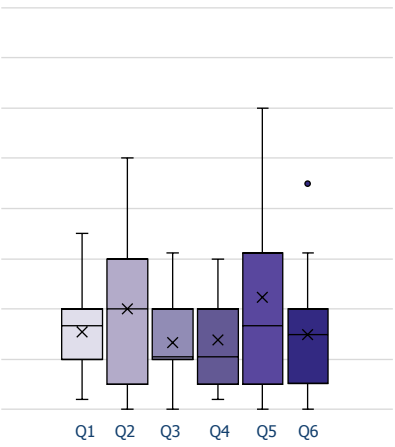

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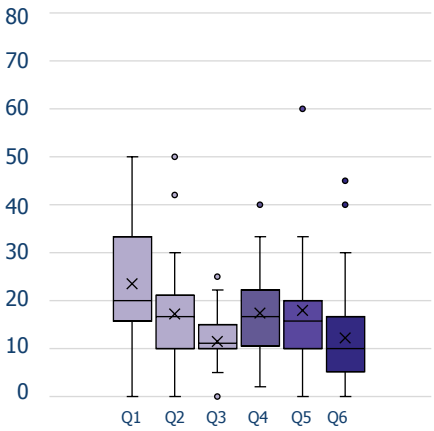
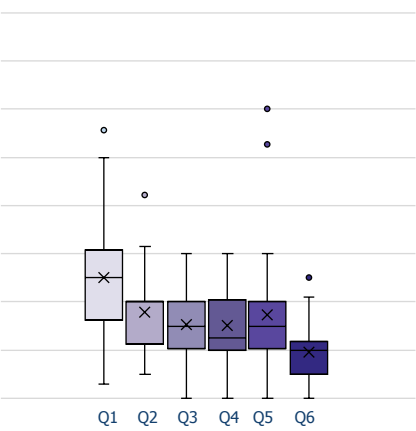
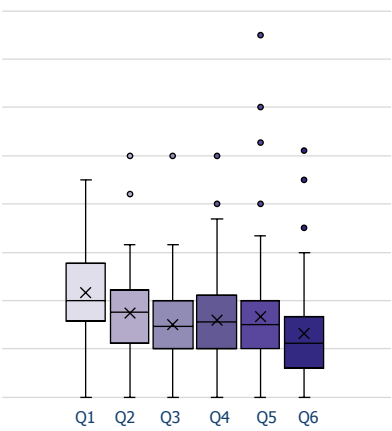


South Asia (n=25)



Sub-Saharan Africa (n=106)



SRHR Domain 2: Sexual Health and Wellbeing

Highlight: Reducing stigma and access barriers was the top-ranked question in ECA, showing regional urgency for peer-led campaigns, faith-based engagement and adolescent-safe spaces.

The three highest-ranked research questions in this SRHR Domain received closely clustered average scores. The top-ranked question (Q1) focused on the integration of SRHR and mental health services in humanitarian settings, followed closely by Q2, which addressed provider training (to deliver CSE and support this integration). These were allocated mean scores of 15.78 and 15.56, respectively. A third question, on overcoming stigma and access barriers to integrated SRHR and mental health services (Q3), received a slightly lower but still prominent overall score of 14.06, indicating continued attention to demand-side challenges.

Although these three questions held consistent overall positions, regional differences were apparent. In South Asia and SSA, Q1 and Q2 were assigned even higher relative values (greater than or equal to 15 points). In contrast, in ECA, Q3 was ranked first, suggesting that, in this region, social stigma and community-level barriers are prioritised over structural integration or provider preparedness.

Mid-ranked topics such as Q4 (integration of SRHR with non-communicable diseases, or NCDs) and Q5 (addressing menopause and sexual health needs) received lower overall scores (means: between 9 and 10) but appeared in the top three in specific regions. For example, Q4 ranked second in ECA, and Q5 was prioritised in LAC; demographic profiles may be shaping priority-setting.

During regional consultations, experts proposed practical examples of intervention strategies, including, for Q1, models such as community-based counselling, task-shared psychosocial support and digital mental health tools adapted to humanitarian constraints. For Q2, proposed approaches included competency-based, participatory and digital learning curricula, supported by supervision and mentorship models appropriate for humanitarian contexts. For Q3, experts had recommended a range of approaches to reduce stigma and enhance uptake, such as peer-led awareness campaigns, faith-based engagement and participatory media strategies.

Scorecard for SRHR Domain 2: Sexual Health and Wellbeing

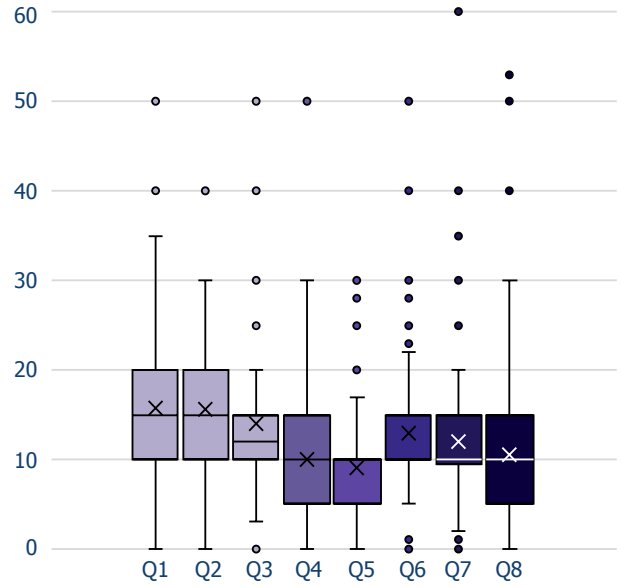
Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	181	23	21	11	42	32	113
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Integration of sexual and reproductive health and rights (SRHR) and mental health	15.78	13.07	15.10	10.91	16.38	17.72	15.81
2. Strengthening SRHR and mental health training for providers	15.56	14.30	14.38	12.27	17.05	18.06	15.49
3. Overcoming stigma and barriers to mental health and SRHR access	14.06	14.59	13.19	17.45	12.81	14.22	13.74
4. Integration of SRHR and mental health with non-communicable diseases (NCDs)	9.94	9.63	10.76	14.91	9.60	9.97	9.66
5. Addressing menopause and sexual health needs	9.13	10.93	9.57	13.82	8.21	8.78	9.23
6. Adapting and monitoring quality of SRHR interventions	13.06	14.26	15.05	13.36	14.19	11.31	13.55
7. Safe spaces as an entry point for integrated SRHR and mental health care	12.05	12.37	9.81	7.45	11.05	9.59	12.10
8. Addressing language and cultural barriers to SRHR access	10.50	10.85	12.14	9.82	10.71	10.34	10.42

Boxplot figure 2: Mean dollar allocation (scores) for each question for SRHR Domain 2 – Sexual Health and Wellbeing

Research topic

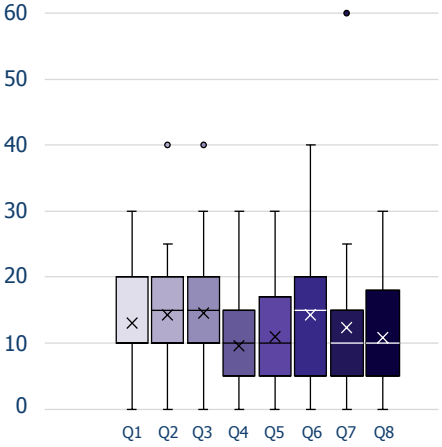
1. Integration of sexual and reproductive health and rights (SRHR) and mental health
2. Strengthening SRHR and mental health training for providers
3. Overcoming stigma and barriers to mental health and SRHR access
4. Integration of SRHR and mental health with non-communicable diseases (NCDs)
5. Addressing menopause and sexual health needs
6. Adapting and monitoring quality of SRHR interventions
7. Safe spaces as an entry point for integrated SRHR and mental health care
8. Addressing language and cultural barriers to SRHR access

All respondents (n=181), Sexual Health and Wellbeing

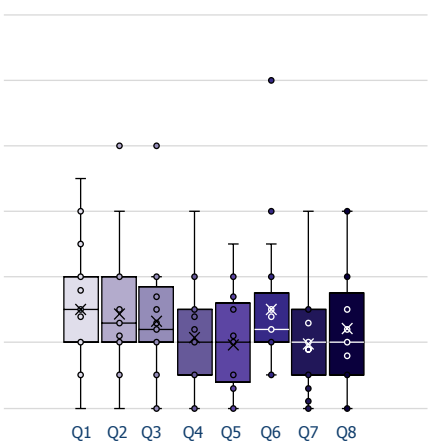


Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

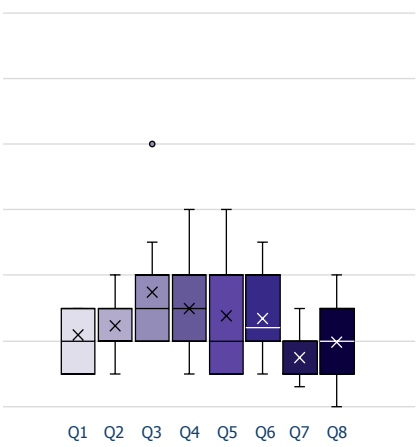
Latin America and the Caribbean (n=23)



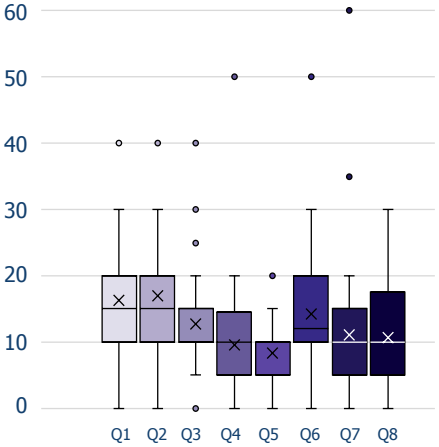
East Asia and the Pacific (n=21)



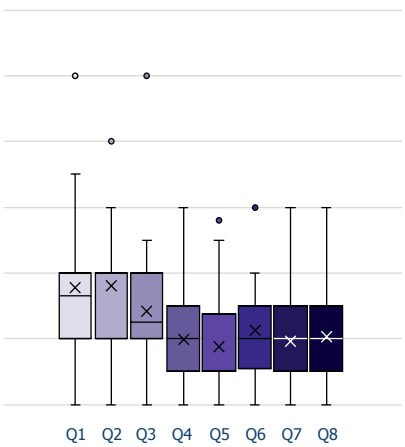
Europe and Central Asia (n=11)



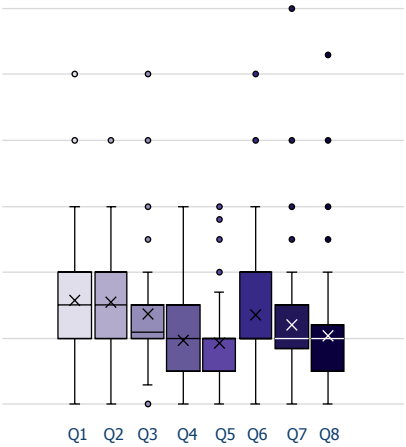
Middle East and North Africa (n=42)



South Asia (n=32)



Sub-Saharan Africa (n=113)



SRHR Domain 3: Family Planning (FP) and Contraception

Highlight: Adolescent access, self-administered contraception and digital delivery models were widely prioritised; ECA elevated equity for vulnerable groups, underscoring the need for inclusive, rights-based approaches in crisis-affected settings.

In this SRHR Domain, the top-ranked research question (Q1) focused on ensuring reproductive choice in humanitarian settings. It received the highest mean score overall (16.71) and was ranked first in five out of the of six regions, reflecting strong support for rights-based approaches to expand access to long-acting reversible contraceptives (LARC). Earlier expert consultations suggested possible delivery models such as CHW counselling, telemedicine and task-sharing to support person-centred contraceptive care.

Close behind were Q3 (increasing adolescent access to contraception; mean: 14.90) and Q2 (overcoming barriers to LARC access; mean: 14.37). These were ranked second and third overall, with consistent positioning across most regions. Expert advisers had proposed interventions such as youth-led outreach, self-administered contraceptives and digital support tools for Q3, and mobile outreach, community-based counselling and myth-busting multimedia campaigns for Q2.

Q4 (contraceptive use among vulnerable populations including ethnic minorities, LGBTQI+ communities, sex workers and people living with disabilities) ranked fourth overall but was the highest priority in ECA, suggesting a greater focus in that region on equity and service inclusion. Experts linked this question to models involving self-care tools, conditional cash transfers and mobile outreach tailored to marginalised groups.

Lower-ranked questions such as Q5 to Q8 addressed financial assistance, socio-economic barriers, contraceptive method availability at emergency onset, and supply chain resilience. These scored more modestly overall but remain relevant, particularly where systemic or logistical barriers to access persist.

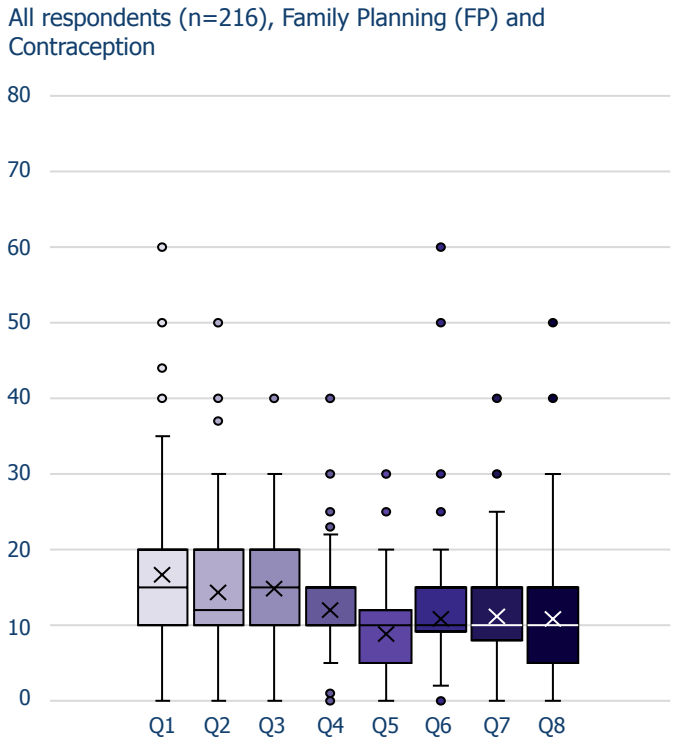
Scorecard for SRHR Domain 3: Family Planning (FP) and Contraception

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	216	34	25	14	48	43	136
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Ensuring reproductive choice in humanitarian settings	16.71	17.35	15.80	12.86	17.63	15.98	17.45
2. Overcoming barriers to long-acting reversible contraceptives (LARC) access and acceptance (demand-side)	14.37	14.94	13.16	10.43	14.69	15.88	14.46
3. Increasing adolescent access to contraception	14.90	16.18	13.88	14.36	13.48	14.70	15.01
4. Contraceptive use among vulnerable populations	12.08	11.21	13.72	17.14	12.06	11.47	11.76
5. Financial assistance to increase contraceptive uptake	8.94	7.79	8.67	11.00	9.02	7.74	8.80
6. Overcoming socio-economic barriers to contraceptive use	10.95	11.24	11.80	10.29	10.35	11.05	10.49
7. Implementing full range of contraceptive choices at the onset of an emergency	11.19	12.26	11.56	13.21	11.69	11.05	11.18
8. Supply chains during active and ongoing displacement contexts (supply-side)	10.86	9.03	11.76	10.71	11.08	12.14	10.83

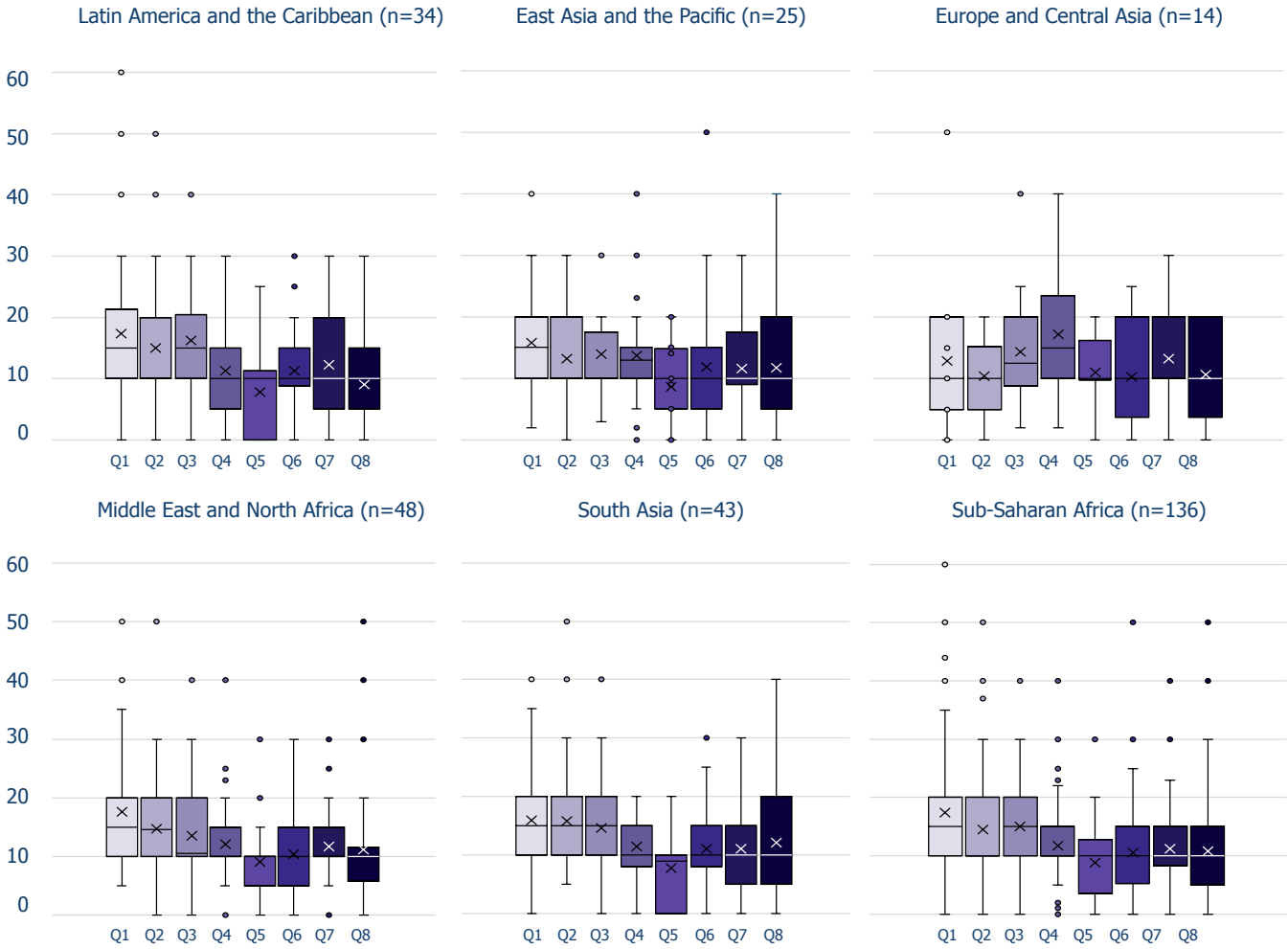
Boxplot figure 3: Mean dollar allocation (scores) for each question for SRHR Domain 3 – Family Planning (FP) and Contraception

Research topic

1. Ensuring reproductive choice in humanitarian settings
2. Overcoming barriers to long-acting reversible contraceptives (LARC) access and acceptance (demand-side)
3. Increasing adolescent access to contraception
4. Contraceptive use among vulnerable populations
5. Financial assistance to increase contraceptive uptake
6. Overcoming socio-economic barriers to contraceptive use
7. Implementing full range of contraceptive choices at the onset of an emergency
8. Supply chains during active and ongoing displacement contexts (supply-side)



Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.



SRHR Domain 4: Cancers of the Reproductive System

Highlight: HPV vaccination and cervical screening consistently ranked first and second across all regions, showing universal support. Community outreach, single-dose regimens and midwife-led delivery were among the recommended models.

Mean allocations for Q1 and Q2 in this SRHR Domain are very tightly grouped (34.7 to 42.0 points), signalling that respondents view them as near-equal priorities, ie HPV vaccination access and integrating HPV-based cervical cancer screenings into existing SRHR services. These two topics share first place in all regions. For Q1, interventions experts advised exploring single-dose vaccine regimens, outreach linked to routine immunisation, and task-shifting to community midwives and health workers. For Q2, integrating HPV-based cervical-cancer screening into existing SRHR services, experts pointed to self-collection strategies, point-of-care testing, mobile screening teams and digital decision-support tools to shorten the pathway from screening to treatment as interventions to investigate.

The third topic, raising awareness where treatment is accessible, ranked third across all regions. Proposed interventions include task-sharing breast-examination skills to CHWs, deploying mobile mammography in protracted crises and offering psychosocial support to women with positive diagnoses.

Scorecard for SRHR Domain 4: Cancers of the Reproductive System

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	116	10	13	8	36	26	76
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Equitable human papillomavirus (HPV) vaccination	34.78	38.50	35.85	35.00	34.19	37.88	35.04
2. Integrating HPV-based cervical cancer screening into existing sexual and reproductive health rights (SRHR) services	34.74	42.00	38.92	39.38	35.67	37.12	34.61
3. Raising awareness where treatment is accessible	30.47	19.50	25.23	25.63	30.14	25.00	30.14

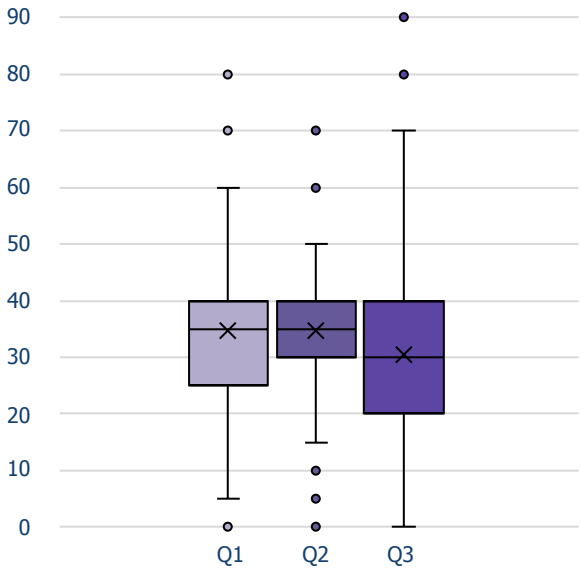
Boxplot figure 4: Illustrating mean dollar allocation (scores) for each question for SRHR Domain 4 – Cancers of the Reproductive System

Research topic

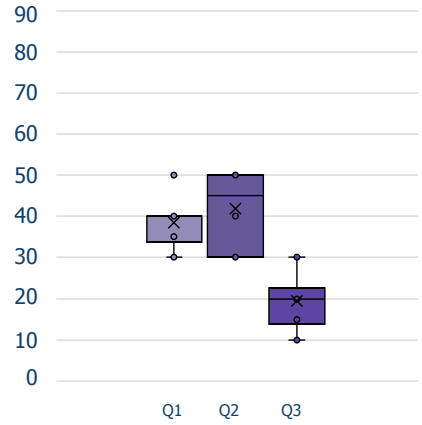
1. Equitable human papillomavirus (HPV) vaccination
2. Integrating HPV-based cervical cancer screening into existing sexual and reproductive health rights (SRHR) services
3. Raising awareness where treatment is accessible

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

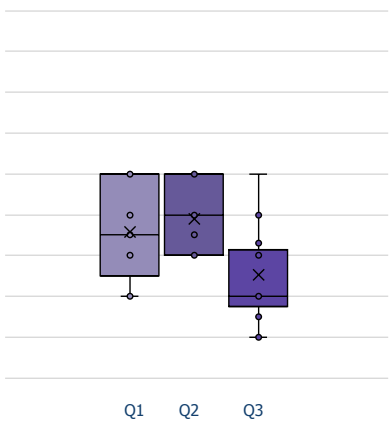
All respondents (n=116), Cancers of the Reproductive System



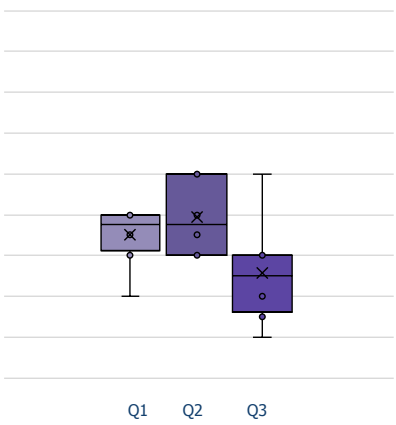
Latin America and the Caribbean (n=10)



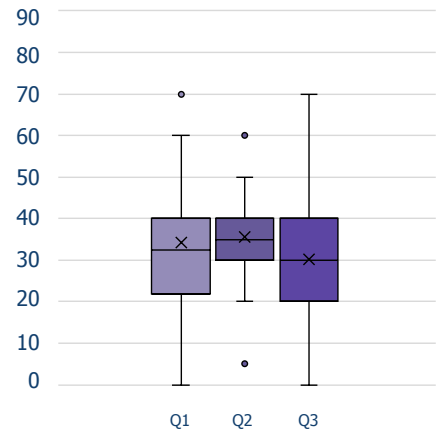
East Asia and the Pacific (n=13)



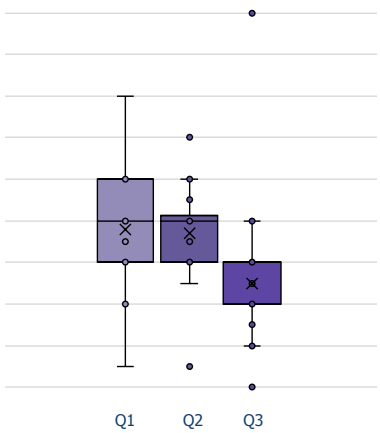
Europe and Central Asia (n=8)



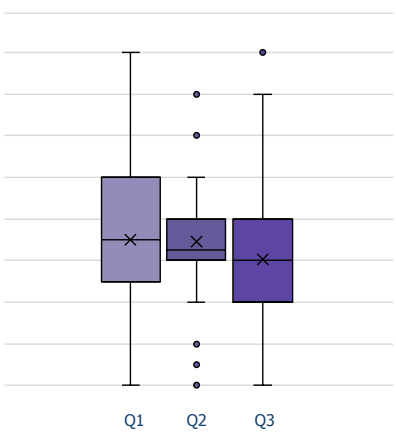
Middle East and North Africa (n=36)



South Asia (n=26)



Sub-Saharan Africa (n=76)



SRHR Domain 5: Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

Highlight: Vaccines to prevent STIs drew polarised responses, ranking third overall but first in ECA. Suggested research areas include vaccine delivery strategies and regional campaigns linked to immunisation.

In this SRHR Domain, three research questions formed a compact cluster at the top of the rankings. Q1 (scaling up STI/HIV testing for displaced and high-risk populations) led overall with a mean of 17.35, followed by Q2 (STI prevention in forced migration settings; mean: 14.78) and Q7 (scaling up STI prevention, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); mean: 14.64). While Q1 was the highest ranked in most regions, the margin was modest: all three questions had overlapping IQRs and similar SDs (means: between 7 and 9), indicating only moderate separation in priority.

Regional variations were evident. South Asia assigned the highest mean to Q1 (19.5), while LAC prioritised Q2, and ECA elevated Q3 (scaling up STI vaccines) to a mean of 22.31, well above its global average. This result, coupled with wide dispersion (long boxplot whiskers), suggests polarised but intense interest in vaccine-based prevention in that region.

Lower-ranked questions remained below 11 points in all regions, signalling lower relative urgency; these were anti-microbial resistance in gonorrhoea (Q4), partner notification (Q5) and preventing STI-related infertility (Q8).

Expert consultations helped shape the framing of these questions and proposed avenues for implementation research. For scaling up STI/HIV testing (Q1), they suggested point-of-care diagnostics, self-sampling and mobile testing outreach. For preventing STIs in forced migration settings (Q2), recommended approaches included integration of STI prevention into food or cash-assistance programmes and survivor-centred care models. For scaling up STI prevention in other settings (Q7), experts advised testing streamlined PrEP/PEP packages and digital adherence tools. Where Q3 (vaccines) was prioritised, they proposed catch-up HPV and hepatitis B campaigns, and cold-chain innovations to support routine immunisation in humanitarian settings.

Scorecard for SRHR Domain 5: Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

Region:	**All**	**Latin America and the Caribbean**	**East Asia and the Pacific**	**Europe and Central Asia**	**Middle East and North Africa**	**South Asia**	**Sub-Saharan Africa**
Total number of respondents:	174	23	20	13	34	32	116
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Scaling up STIs and HIV testing for displaced and high-risk populations	17.35	17.22	15.45	14.23	18.50	19.50	17.67
2. Preventing STIs in forced migration settings	14.78	17.91	15.55	19.85	14.56	12.38	14.53
3. Scaling up vaccines to prevent STIs	13.80	14.57	14.80	22.31	15.85	12.19	13.79
4. Responding to antimicrobial resistance for gonorrhoea treatment in conflict settings	9.96	8.13	10.30	9.15	11.24	10.66	10.03
5. Strengthening partner notification	9.80	5.84	9.50	7.54	8.12	8.91	9.66
6. Multipurpose prevention technologies (MPTs)	10.33	10.48	12.75	7.46	10.32	10.72	9.96
7. Scaling up STI prevention and post-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP)	14.64	15.91	14.85	13.85	15.38	11.47	14.51
8. Preventing STI-related infertility	9.33	5.74	6.80	5.62	6.03	6.53	9.86

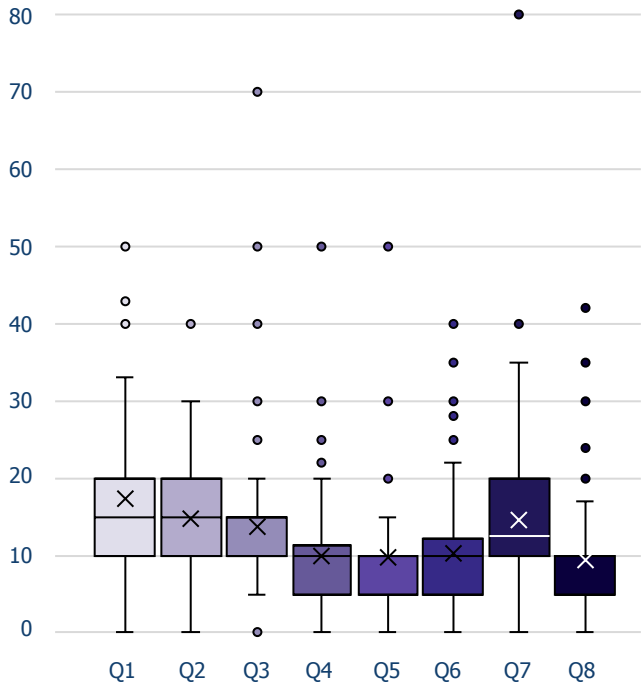
Boxplot figure 5: Mean dollar allocation (scores) for each question for SRHR Domain 5 – Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

Research topic

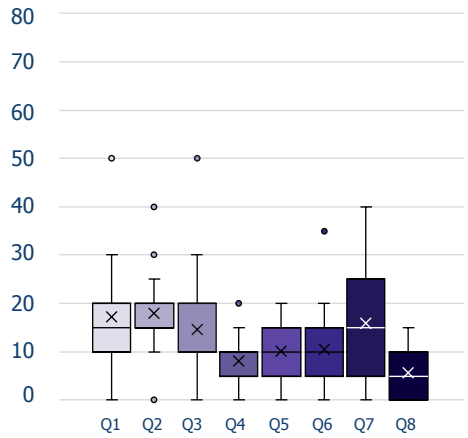
1. Scaling up STIs and HIV testing for displaced and high-risk populations
2. Preventing STIs in forced migration settings
3. Scaling up vaccines to prevent STIs
4. Responding to antimicrobial resistance for gonorrhoea treatment in conflict settings
5. Strengthening partner notification
6. Multipurpose prevention technologies (MPTs)
7. Scaling up STI prevention and post-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP)
8. Preventing STI-related infertility

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

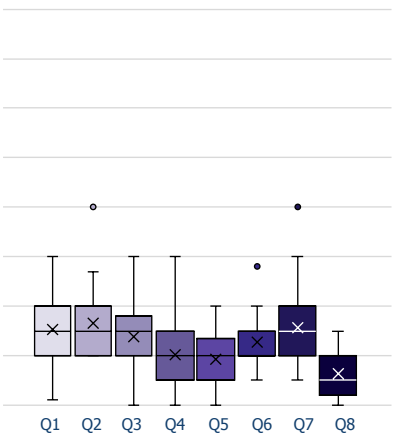
All respondents (n=174), Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)



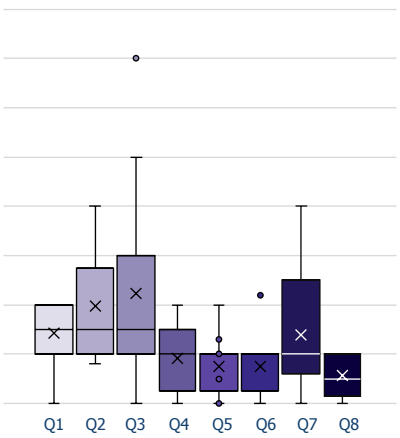
Latin America and the Caribbean (n=23)



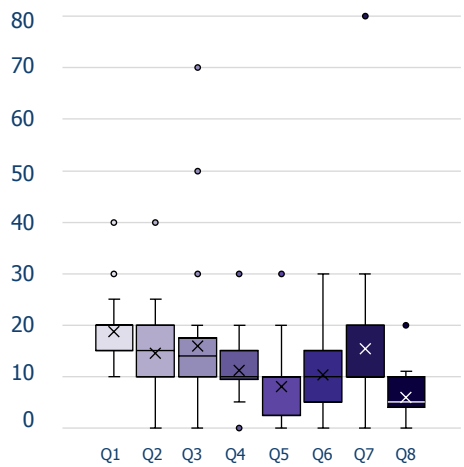
East Asia and the Pacific (n=20)



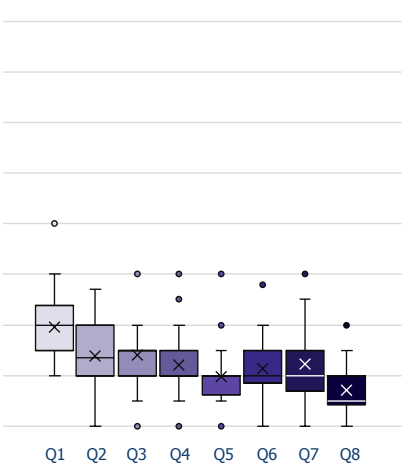
Europe and Central Asia (n=13)



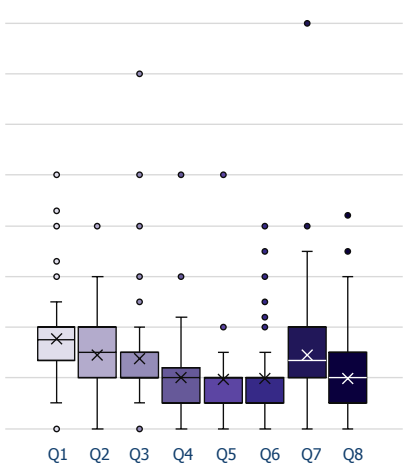
Middle East and North Africa (n=34)



South Asia (n=32)



Sub-Saharan Africa (n=116)



SRHR Domain 6: Maternal and Newborn Health (MNH): Antenatal/ Perinatal Care

Highlight: Strengthening basic EmONC ranked highest overall and in most regions. Respondents stressed CHW-run services, community misoprostol use and task-shared emergency care.

Scores in this SRHR Domain were relatively tightly grouped, ranging from 17 to 22 points, indicating general agreement on the importance of all five topics. The top-ranked questions were Q4 (EmONC) and Q1 (context-specific approaches to increase MNH access), both of which featured prominently across regions.

Q4 received the highest overall mean (21.76) and was especially prioritised in EAP (23.5) and South Asia (22.97), but also showed the widest spread of scores, suggesting differing views on feasibility or urgency across contexts. By contrast, Q2 (continuity of care for women and babies on the move) received a mid-range score (19.01) but exhibited the tightest IQR, indicating strong consensus despite its lower ranking.

Community-based antenatal and intrapartum care (Q3) ranked third overall but topped the list in ECA, LAC and EAP, reflecting regional preferences for decentralised care models. Emergency referral mechanisms (Q5) ranked lowest overall but remained within a narrow margin of other topics, underlining its persistent relevance.

Experts consulted during question development proposed context-adapted strategies such as mobile or midwife-led ANC/PNC, group ANC with digital tracking for displaced mothers, community distribution of misoprostol for postpartum haemorrhage prevention, and low-cost transport models to strengthen referral systems in low-resource and mobile settings.

Scorecard for SRHR Domain 6: Maternal and Newborn Health (MNH): Antenatal/ Perinatal Care

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	190	28	22	10	42	34	123
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Context-specific approaches for increasing access to MNH	20.95	19.11	16.91	18.90	20.50	19.22	21.12
2. Continuity of MNH care for women and babies on the move	19.01	17.96	20.32	19.10	17.88	19.81	18.82
3. Community-based antenatal and intrapartum care	18.63	23.21	21.05	24.80	17.38	17.51	18.01
4. Strengthening basic emergency obstetric and neonatal care (EmONC)	21.76	21.25	23.50	19.80	22.52	22.97	21.88
5. Emergency referral mechanisms	19.65	18.46	18.23	17.40	21.71	20.49	20.17

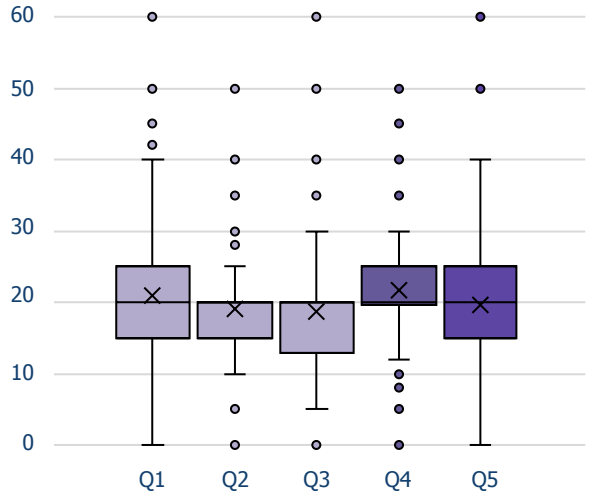
Boxplot figure 6: Mean dollar allocation (scores) for each question for SRHR Domain 6 – Maternal and Newborn Health (MNH): Antenatal/Perinatal Care

Research topic

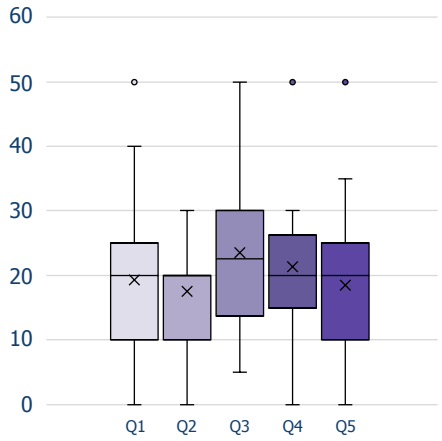
1. Context-specific approaches for increasing access to MNH
2. Continuity of MNH care for women and babies on the move
3. Community-based antenatal and intrapartum care
4. Strengthening basic emergency obstetric and neonatal care (EmONC)
5. Emergency referral mechanisms

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

All respondents (n=190), Maternal and Newborn Health (MNH): Antenatal/Perinatal Care



Latin America and the Caribbean (n=28)



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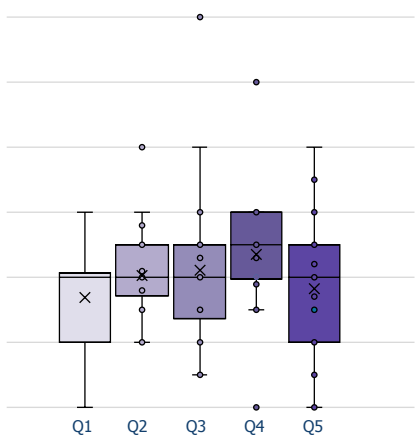
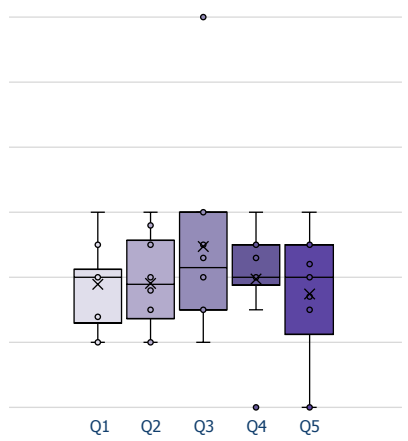
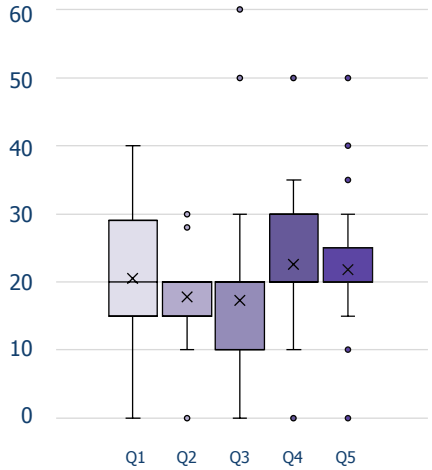


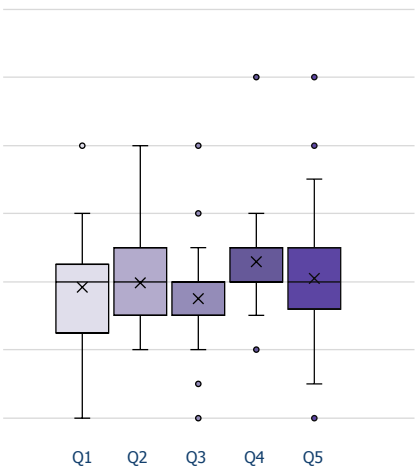
Europe and Central Asia (n=10)



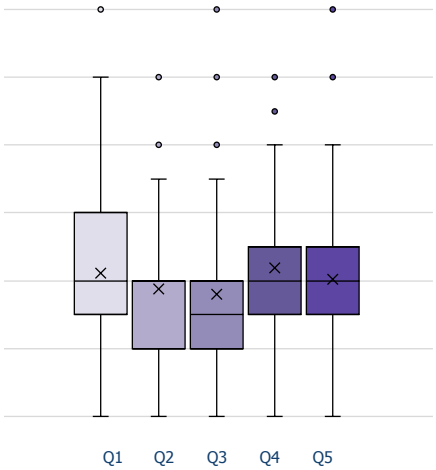
Middle East and North Africa (n=42)



South Asia (n=34)



Sub-Saharan Africa (n=123)



SRHR Domain 7: Maternal and Newborn Health (MNH): Postnatal/ Newborn Care

Highlight: Essential newborn care ranked the highest in four out of six regions. Postnatal depression showed highly variable scores and was prioritised in ECA. Suggested interventions include routine screening and peer-led mental health support.

This SRHR Domain showed strong support across all four research questions. The top-ranked question, essential newborn care in conflict settings (Q2), received the highest mean score (28.27) overall, followed closely by Q1 (community-based PNC; mean: 26.44). Their overlapping IQRs and similar SDs (approximately 12) suggest that most respondents valued both highly, with substantial spread at the extremes, indicating that neither dominated decisively.

Mitigating and managing postnatal depression (Q4) followed at 24.95, with the widest spread of scores, especially in ECA, pointing to polarised views. The early initiation of breastfeeding (Q3) scored fourth across all respondents.

Experts who helped develop these questions suggested context-adapted interventions for future research. For Q2, essential newborn care, they proposed Kangaroo Mother Care, mobile neonatal units and task-shared neonatal resuscitation in conflict zones. For Q1, community-based PNC, recommended strategies included CHW-led home visits, mobile outreach and bereavement support tailored to cultural contexts. For Q4, mitigating and managing postnatal depression, advisers highlighted the importance of routine mental health screening and peer support groups to address maternal depression during the postnatal period.

Scorecard for SRHR Domain 7: Maternal and Newborn Health (MNH): Postnatal/ Newborn Care

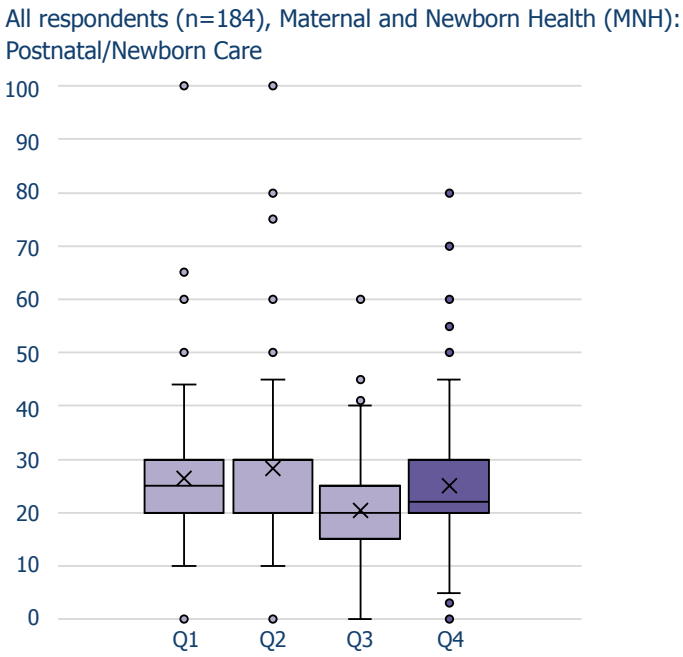
Region:	**All**	**Latin America and the Caribbean**	**East Asia and the Pacific**	**Europe and Central Asia**	**Middle East and North Africa**	**South Asia**	**Sub-Saharan Africa**
Total number of respondents:	184	28	21	10	42	35	120
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Community-based postnatal care (PNC)	26.44	30.71	22.81	28.80	25.48	24.14	25.80
2. Essential newborn care in conflict settings	28.27	26.07	31.05	23.50	31.26	32.71	27.78
3. Early initiation of breastfeeding	20.34	19.29	18.10	17.20	20.17	19.71	20.11
4. Mitigating and managing postnatal depression	24.95	23.93	28.05	30.50	23.10	23.43	26.32

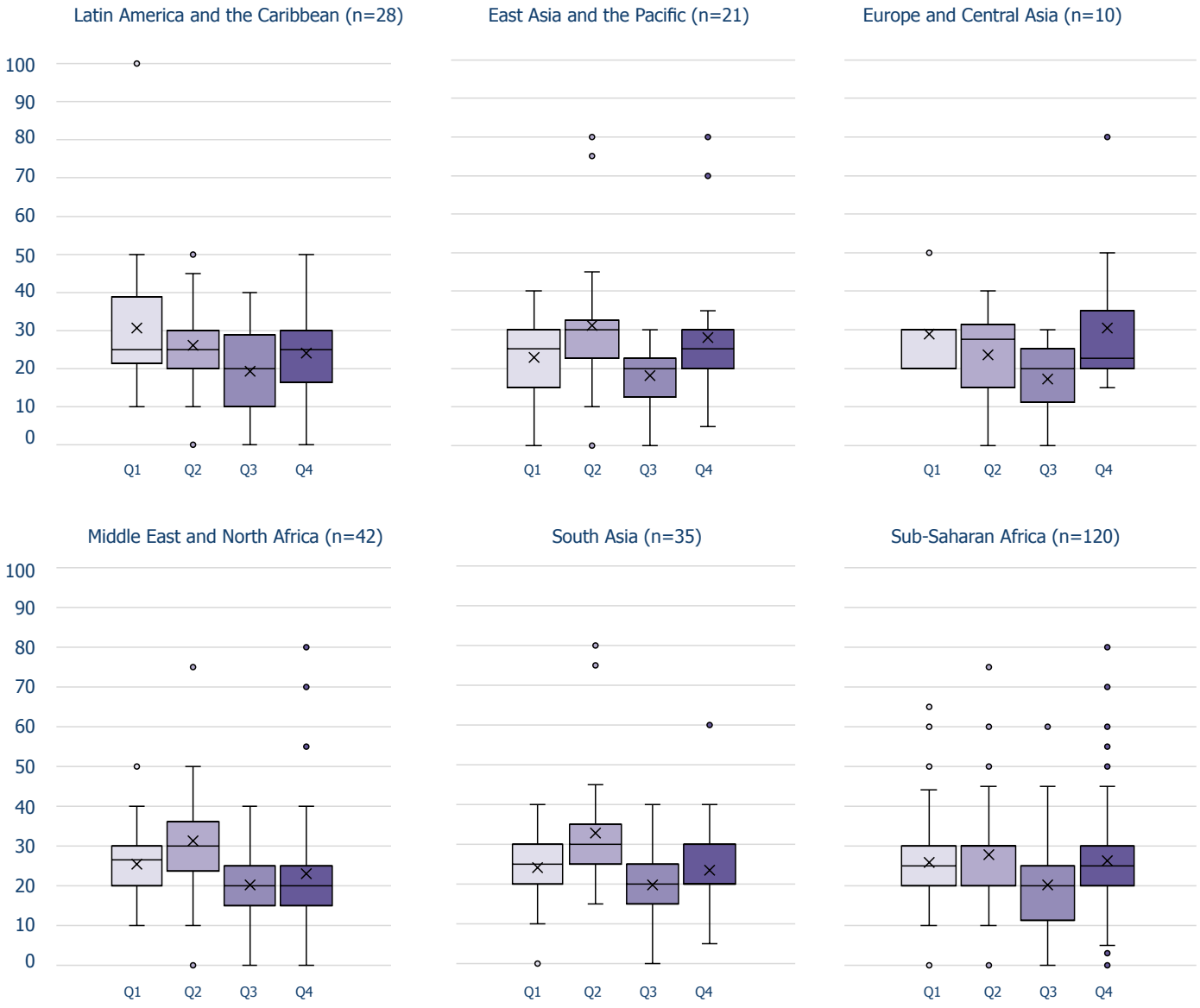
Boxplot figure 7: Mean dollar allocation (scores) for each question for SRHR Domain 7 – Maternal and Newborn Health (MNH): Postnatal/Newborn Care

Research topic

1. Community-based postnatal care (PNC)
2. Essential newborn care in conflict settings
3. Early initiation of breastfeeding
4. Mitigating and managing postnatal depression

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.





SRHR Domain 8: Comprehensive Abortion Care

Highlight: Improving women's experience and access to care ranked highest overall. Experts proposed user-centred models such as digital accompaniment and hybrid telemedicine, including in legally restricted settings.

In this SRHR Domain, the highest-ranked questions focused on improving women's experience and access to abortion care, specifically the effectiveness of different models of self-managed medical abortion (Q4; mean: 16.49) and supportive policy (including legally restrictive) environments (Q1; mean: 16.33), both appearing among the top-ranked in most regions. Q4 led in LAC, while Q1 took first place in MENA, reflecting emphasis on both structural and experiential dimensions of care.

Q3 (user acceptability, quality, and person-centred/less medicalised care) also ranked highly overall (14.73) but stood out sharply in ECA, where it received the highest mean (23.18), indicating particularly strong regional focus on care experience and quality standards.

While the top four questions were relatively close in score, there was greater clarity in the questions receiving the least prioritisation. Q6 (reproductive autonomy and interventions that contribute to changing social and gender norms around abortion stigma) and Q7 (provider support and wellbeing) were ranked lowest overall, with means of 12.46 and 12.99, respectively. They consistently fell in the bottom tier across all regions except South Asia and SSA, where Q7 rose slightly in rank. This suggests a shared de-emphasis on provider-centred and autonomy-focused research in the current landscape, though not uniformly.

Expert advisers proposed implementation strategies to support top-ranked areas. For Q1 and Q4, suggestions included policy reform analysis, legal support services and community-led accompaniment models. For Q3, they highlighted person-centred quality standards, feedback mechanisms and models of respectful abortion care. On Q2 (financing and cost barriers, 12.54), recommendations included voucher schemes, insurance integration and cost reduction mechanisms, especially for vulnerable populations.

Scorecard for SRHR Domain 8: Comprehensive Abortion Care

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	149	29	15	11	33	28	96
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Policies	16.33	15.24	17.07	15.55	20.48	14.39	16.23
2. Financing and cost barriers	12.54	10.83	12.87	12.18	10.45	12.25	12.27
3. User acceptability, quality and person-centred abortion care	14.73	14.31	15.07	23.18	11.09	16.32	15.26
4. Improving women's experience and access to abortion care	16.49	20.31	15.47	18.00	14.12	18.29	15.93
5. Service delivery innovations for comprehensive abortion care	14.46	14.48	15.13	14.00	12.12	13.29	14.72
6. Addressing barriers to reproductive autonomy and ability to choose	12.46	14.93	11.60	7.18	8.45	11.64	12.40
7. Provider support, wellbeing and training	12.99	7.79	12.80	9.91	9.06	13.82	13.20

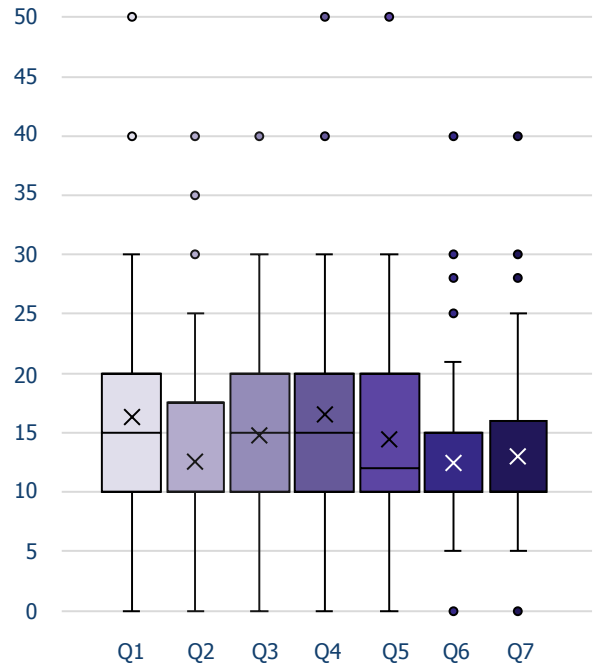
Boxplot figure 8: Mean dollar allocation (scores) for each question for SRHR Domain 8 – Comprehensive Abortion Care

Research topic

1. Policies
2. Financing and cost barriers
3. User acceptability, quality and person-centred abortion care
4. Improving women's experience and access to abortion care
5. Service delivery innovations for comprehensive abortion care
6. Addressing barriers to reproductive autonomy and ability to choose
7. Provider support, wellbeing and training

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

All respondents (n=149), Comprehensive Abortion Care



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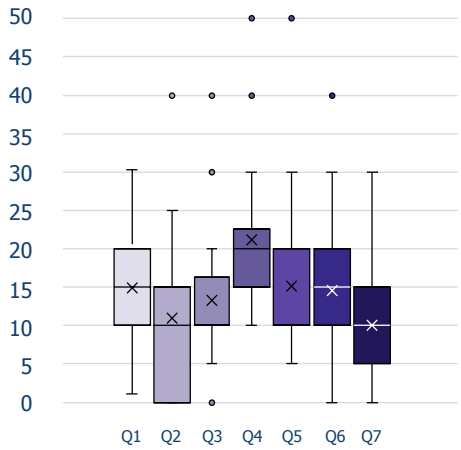

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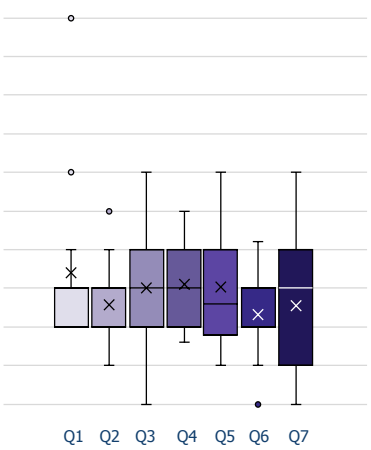
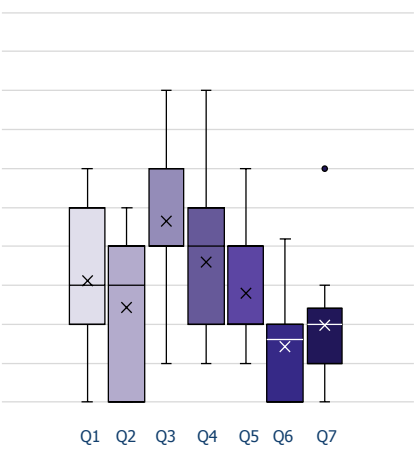
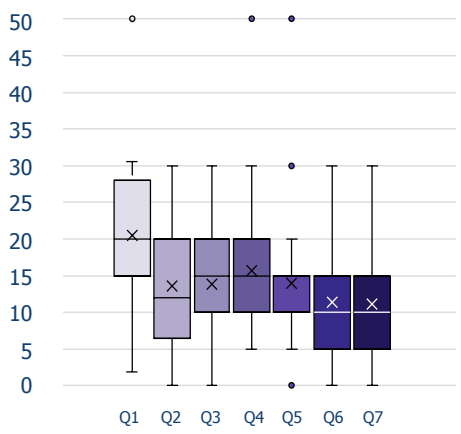


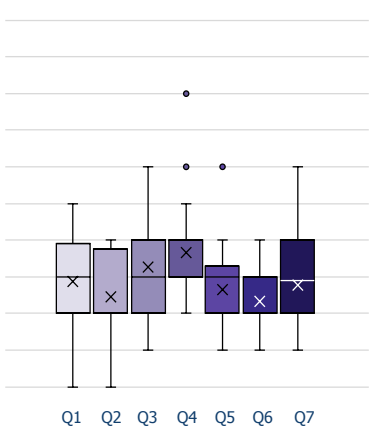
Europe and Central Asia (n=11)



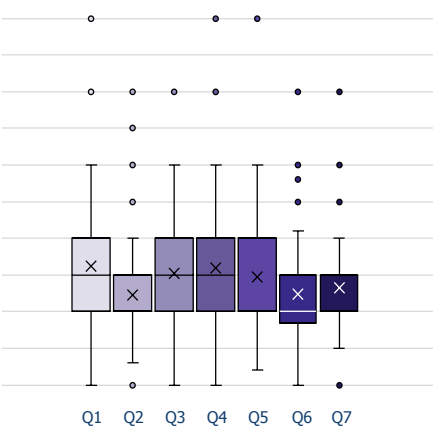
Middle East and North Africa (n=33)



South Asia (n=28)



Sub-Saharan Africa (n=96)



SRHR Domain 9: Clinical Management of Rape

Highlight: Task-sharing in clinical management of rape appeared in the top three priorities in EAP despite lower global ranking; experts suggested innovation potential for nurse-led or mobile post-rape care models.

In this SRHR Domain, Q1 (increasing timely access to post-rape care) received the highest mean score (20.25) and ranked first in all regions except ECA. The question focuses on how to improve access in contexts where abortion and emergency contraception may be legally restricted or stigmatised, with attention to survivor privacy, confidentiality and discreet access mechanisms. Experts suggested exploring community-based kit distribution, participatory advocacy and supportive supervision models as implementation strategies.

Q2 (increasing health-seeking behaviours and referrals) followed with a mean of 16.49, ranking second or third across all regions. It addresses how to build awareness and strengthen referral pathways through survivor-centred communication strategies, community mobilisation and integration with protection services. Experts recommended evaluating the impact of stigma-reduction campaigns, school- and faith-based outreach, and referral mapping for improved care-seeking.

While Q1 and Q2 led the SRHR Domain, the remaining questions were more evenly scored, reflecting moderate interest across several themes. Q3 (testing clinical guidelines to improve clinical management quality, including guidelines for task shifting) scored 12.04, focusing on the utility of national or facility-level guidelines to promote consistent care. Q4 (expanding access for marginalised and key populations) scored 14.27, but rose to the top three in ECA, where the need for inclusive service models appears especially important.

Scorecard for SRHR Domain 9: Clinical Management of Rape

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	114	18	19	9	33	24	74
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Increasing timely access to post-rape care in legally restrictive settings	20.25	19.17	21.37	13.78	23.21	22.50	20.30
2. Increasing health-seeking behaviours and referrals	16.49	14.72	15.00	18.11	16.45	14.79	16.76
3. Testing guidelines as a tool to increase quality of clinical management of rape	12.04	15.28	11.58	11.22	11.09	13.13	11.70
4. Expanding the clinical management of rape access for marginalised and key populations	14.27	15.56	13.47	17.44	15.00	14.38	13.47
5. Task sharing the clinical management of rape	14.39	8.57	15.63	14.44	11.85	13.96	14.57
6. Role of remote consultations to support health workers	10.08	8.89	9.95	8.67	10.03	10.63	10.00
7. Increasing access for males	12.47	9.72	13.00	16.33	12.36	10.63	13.20

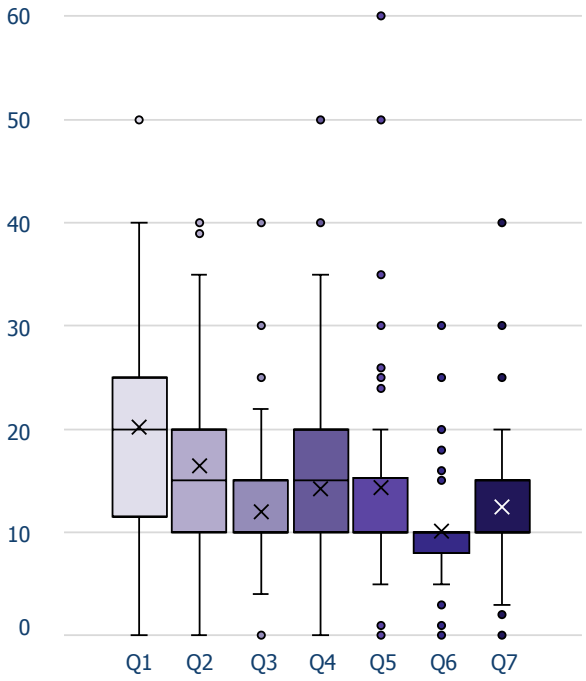
Boxplot figure 9: Mean dollar allocation (scores) for each question for SRHR Domain 9 – Clinical Management of Rape

Research topic

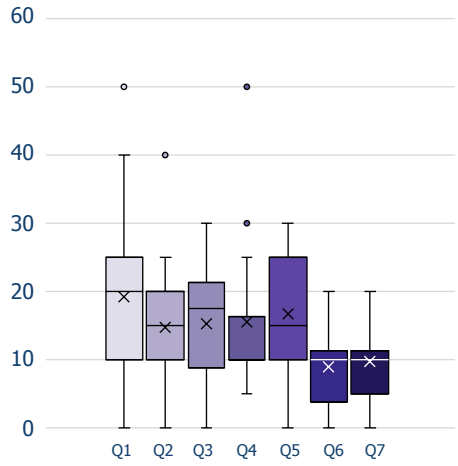
1. Increasing timely access to post-rape care in legally restrictive settings
2. Increasing health-seeking behaviours and referrals
3. Testing guidelines as a tool to increase the quality of clinical management of rape
4. Expanding access to the clinical management of rape for marginalised and key populations
5. Task sharing the clinical management of rape
6. Role of remote consultations to support health workers
7. Increasing access for males

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

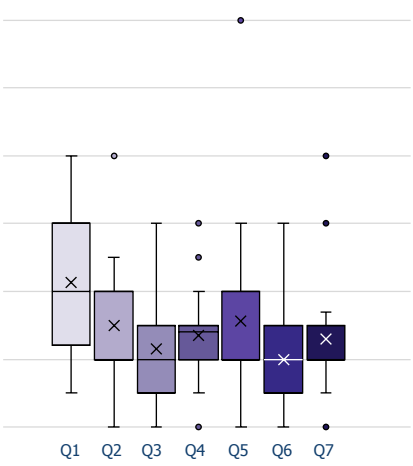
All respondents (n=114), Clinical Management of Rape



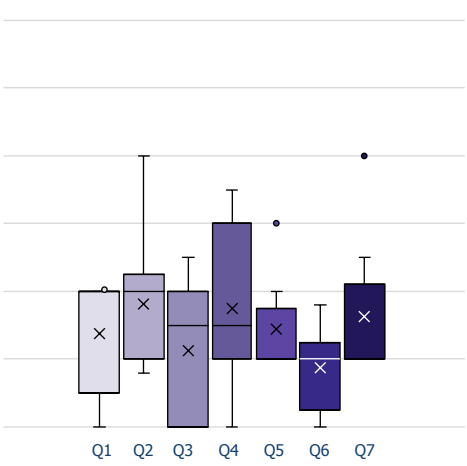
Latin America and the Caribbean (n=18)



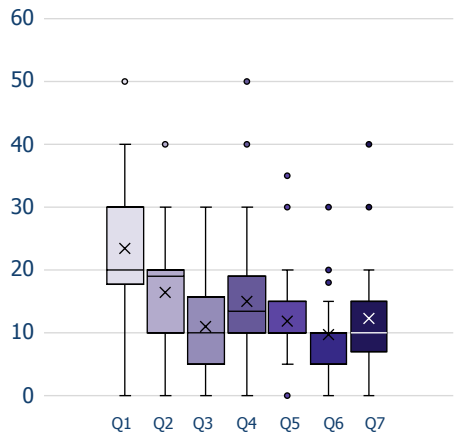
East Asia and the Pacific (n=19)



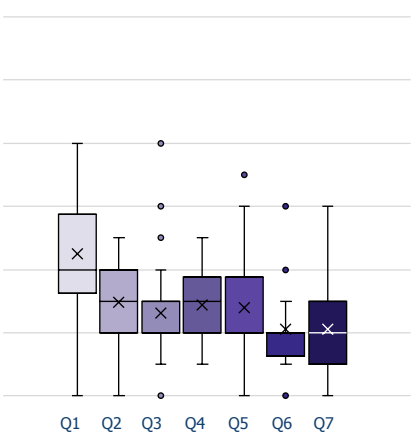
Europe and Central Asia (n=9)



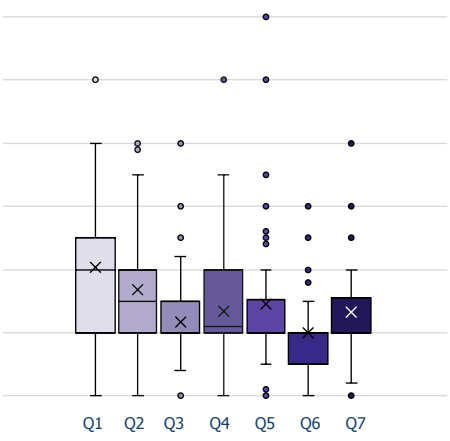
Middle East and North Africa (n=33)



South Asia (n=24)



Sub-Saharan Africa (n=74)



Crosscutting – Stakeholder Engagement

Highlight: Community-led interventions to improve SRHR access was the most consistently top-ranked question across the six regions. Experts recommended peer-led education and accountability mechanisms linked to community structures.

This domain revealed strong consensus around two leading priorities. Q2 (community-led interventions to increase access) emerged as the front-runner, with the highest overall mean score (18.35) and ranked first in five of out six regions, placing second in the remaining two. This question explores how to design and evaluate locally owned, context-adapted strategies to increase uptake of SRHR services, including through mechanisms such as CHW models, peer-led initiatives and citizen feedback loops.

Q1 (preventing mistreatment and ensuring respectful care) consistently ranked second, except in ECA where it dropped to fourth. Its global mean (16.95) was only modestly lower than Q2, and their overlapping IQRs indicate that most respondents viewed them as similarly high priorities. This question focuses on reducing abuse, neglect or discrimination in facility-based SRHR care and testing grievance mechanisms, staff support and accountability systems to uphold respectful care.

Q3 (community engagement and equity) formed the next tier, with a global mean of 15.00, but rose into the top three in ECA, where equity concerns featured more prominently. This question emphasises strategies to address social and structural stigma, especially in settings with limited health system legitimacy. Expert suggestions included mobile SRHR units, community dialogues and stigma-reduction campaigns.

Q4 (engaging boys and men) also performed relatively strongly in several regions, particularly ECA, where it ranked fourth. This question explores how to strengthen shared decision-making, supportive partner behaviours and norm change, with experts highlighting couple-based education, workplace outreach and community-led male engagement as promising models.

The lower-ranked questions – Q5 (social accountability), Q6 (communication strategies for SRHR) and Q7 (governance and partnerships between governments, NGOs and INGOs) – received the least attention overall (means: between 11 and 13), though Q7 performed slightly better in LAC and MENA. These findings suggest that while structural enablers and partnerships are recognised as important, they may be seen as less immediately actionable or harder to translate into researchable interventions.

Scorecard for Crosscutting – Stakeholder Engagement

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	219	34	22	14	49	38	136
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Preventing mistreatment and ensuring respectful care	16.95	18.03	18.82	14.93	17.88	19.47	17.46
2. Community-led interventions to increase access	18.35	19.44	19.09	21.07	17.27	18.45	18.19
3. Community engagement and equity	15.00	14.82	15.77	17.43	11.02	14.68	15.01
4. Engaging boys and men	13.90	14.26	15.00	17.29	11.78	14.47	13.82
5. Social accountability	11.44	9.35	10.86	7.50	10.29	11.71	11.45
6. Communication strategies	11.33	9.44	8.77	8.29	9.53	10.47	11.40
7. Governance and partnerships	13.02	14.65	11.68	13.50	11.92	10.74	12.68

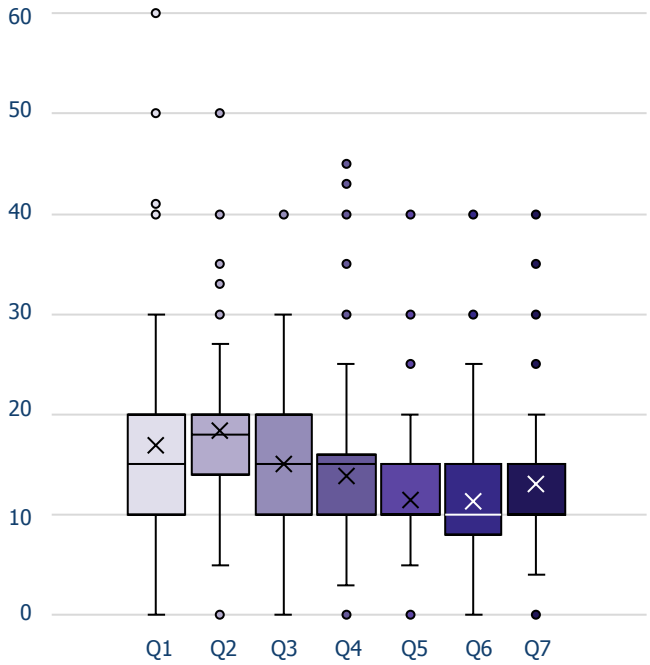
Boxplot figure 10: Mean dollar allocation (scores) for each question for Crosscutting – Stakeholder Engagement

Research topic

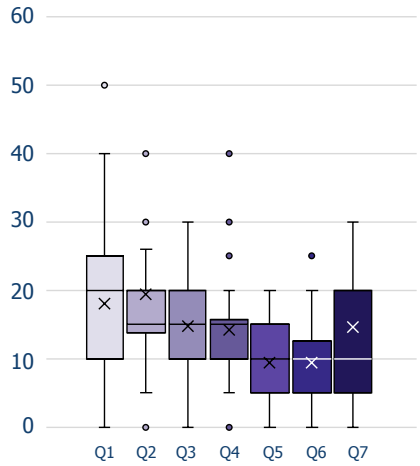
1. Preventing mistreatment and ensuring respectful care
2. Community-led interventions to increase access
3. Community engagement and equity
4. Engaging boys and men
5. Social accountability
6. Communication strategies
7. Governance & partnerships

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.
* One outlier allocated $100 for Q2 (from Middle East and North Africa) and for Q7 (from Latin America and the Caribbean); not shown here in order to improve the readability of the charts

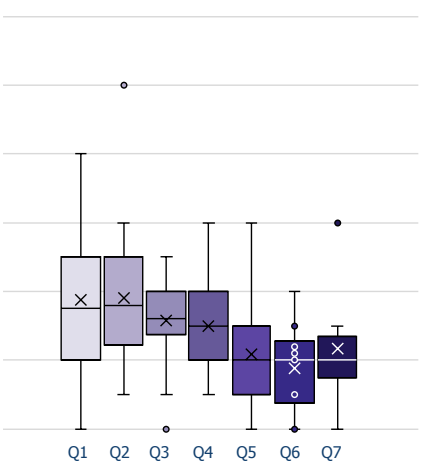
All respondents (n=219), Stakeholder Engagement*



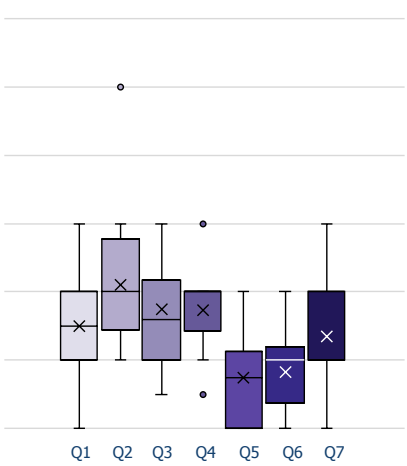
Latin America and the Caribbean (n=34)*



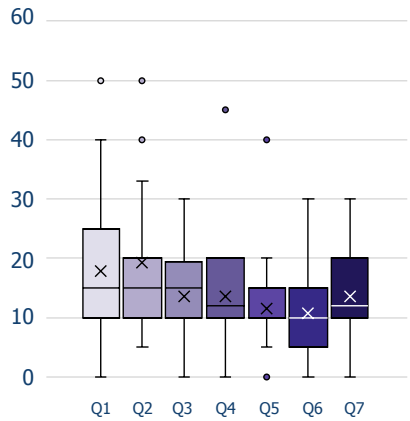
East Asia and the Pacific (n=22)



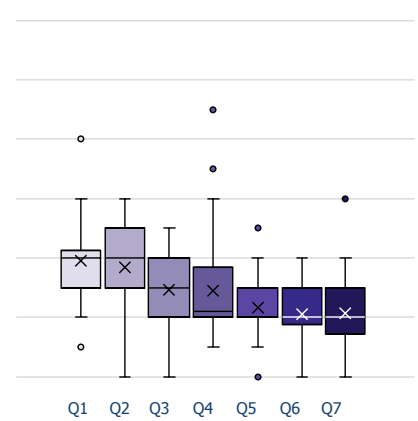
Europe and Central Asia (n=14)



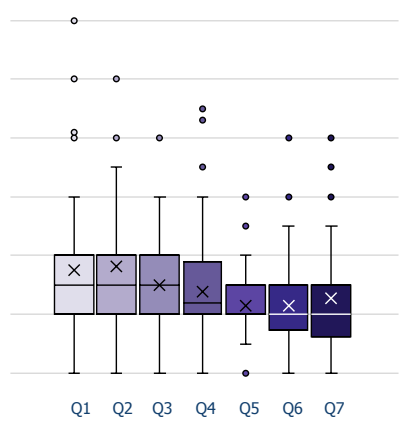
Middle East and North Africa (n=49)*



South Asia (n=38)



Sub-Saharan Africa (n=136)



Crosscutting – Service Delivery and Health Systems

Highlight: SRHR for people-on-the-move had a low global mean but ranked in the top three in South Asia, SSA and LAC, indicating strong context-specific interest in mobile, cross-border and linguistically adapted care.

Scores in this domain were tightly clustered, with all seven questions falling within a four-point range (12.00 to 16.01) for all respondents, indicating broad, distributed interest across topics, rather than a single clear priority. Q2 (training models for sustained learning) led marginally (16.01), focusing on building long-term competencies among CHWs through approaches like digital mentorship, blended learning and supportive supervision. It was followed closely by Q1 (digital information, education and communication; mean: 15.58), which targets the reduction of knowledge and access barriers to SRHR services using rights-based, locally tailored digital tools.

Other questions were nearly as highly ranked in some regions. Q4 (service delivery during pandemics and large-scale emergencies) and Q5 (transitioning from acute to comprehensive care) received greater emphasis in MENA and ECA, respectively, reflecting interest in sustaining services beyond the initial humanitarian response.

Although Q6 (increasing access for people-on-the-move) and Q7 (supply chain preparedness) ranked lowest overall, they rose to the top three in several regions, particularly those facing protracted displacement or infrastructure challenges. These two questions had the highest score variability, suggesting region-specific prioritisation rather than low global relevance.

Expert advisers proposed a range of strategies across questions, including task-shared training platforms for CHWs (Q2), mobile-optimised tools (Q1), mobile outreach and cross-border service models (Q6), and preparedness audits and decentralised stockpiling (Q7).

Scorecard for Crosscutting – Service Delivery and Health Systems

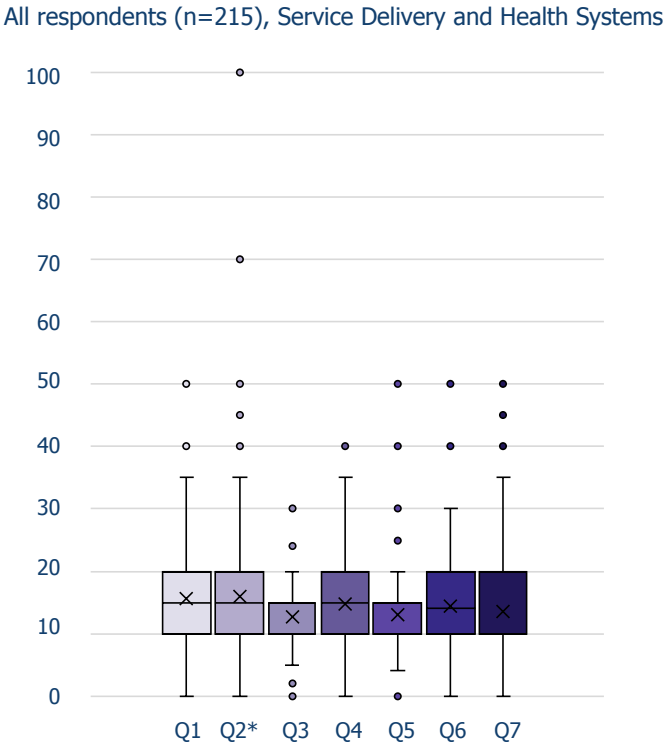
Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	215	36	37	17	48	40	132
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Digital information, education and communication (IEC) to increase sexual and reproductive health and rights (SRHR) knowledge and access	15.58	16.11	13.97	15.59	14.73	14.43	14.84
2. Training models for sustained community health worker (CHW) learning	16.01	17.44	16.51	12.94	14.69	18.58	14.90
3. Values-based education	12.61	13.42	12.95	13.76	12.69	13.13	12.57
4. Service delivery during pandemics and large-scale emergencies	14.71	13.22	15.08	12.82	16.21	15.25	14.77
5. Transitioning from acute to comprehensive care	13.10	13.17	14.35	16.76	12.77	12.83	13.39
6. Increasing SRHR services for people-on-the-move	14.37	16.25	14.11	14.00	14.50	14.38	14.95
7. Supply chain preparedness	12.00	10.39	13.03	14.12	14.42	11.43	14.59

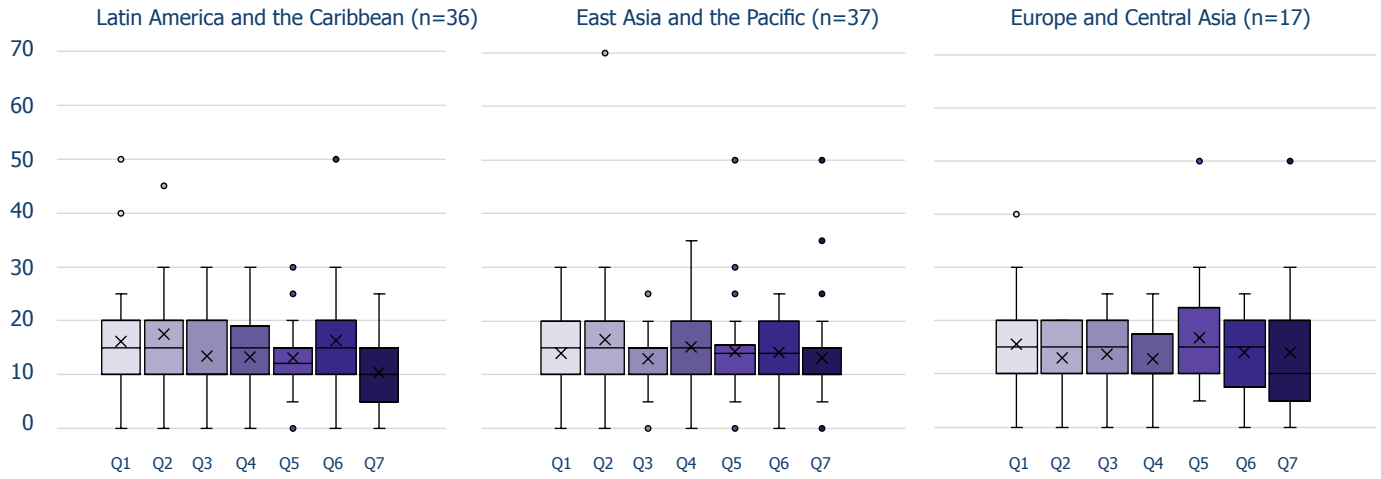
Boxplot figure 11: Mean dollar allocation (scores) for each question for Crosscutting – Service Delivery and Health Systems

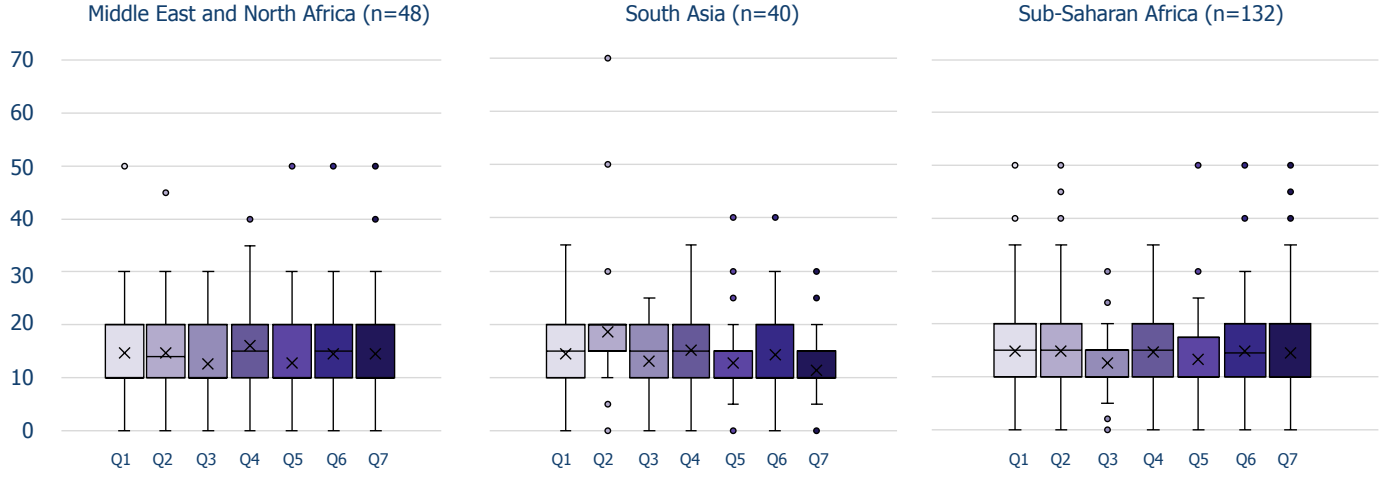
Research topic

1. Digital information, education and communication (IEC) to increase sexual and reproductive health and rights (SRHR) knowledge and access
2. Training models for sustained community health worker (CHW) learning
3. Values-based education
4. Service delivery during pandemics and large-scale emergencies
5. Transitioning from acute to comprehensive care
6. Increasing SRHR services for people-on-the-move
7. Supply chain preparedness

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.
* One response for 100 from Latin American and the Caribbean region (for Q2); otherwise maximum is 70.







Crosscutting – Climate Resilience

Highlight: All three climate questions (resilient services, commodities, MNH) scored closely and showed wide score dispersions, reflecting strong, shared urgency. Proposed interventions include heat-adapted ANC and renewable-powered clinics.

All three questions in this domain received similarly high average scores, possibly suggesting that respondents viewed them as interconnected priorities rather than standalone issues. Q1 (resilient SRHR service provision) ranked highest overall (35.59), followed closely by Q3 (mitigating climate impacts on MNH; mean: 34.63) and Q2 (supply and distribution of SRHR commodities in climate-affected settings; mean: 29.77). The overlapping IQRs and broad SDs across regions confirm that, while preferences varied, all three were broadly valued as components of a comprehensive climate-resilience strategy.

Q1 focuses on how to design SRHR service delivery models that remain functional during climate-related disruptions, including extreme weather, flooding and displacement. Annex 1 highlights approaches such as resilient health facility design, solar-powered infrastructure and community co-designed service models that are both climate-adapted and inclusive.

Q3 addresses mitigating direct and indirect climate effects on MNH, including heat exposure, food insecurity and disease patterns. Experts pointed to research gaps in heat-adapted ANC and PNC protocols, cooling strategies for pregnant women and early warning systems to support decision-making in high-risk weather conditions.

Q2 focuses on ensuring continuity of SRHR commodity distribution under climate-related stress. It considers the role of community-managed, last-mile delivery systems, drone logistics and cold-chain innovations that can withstand transportation or infrastructure breakdowns during climate events.

Regional variations reinforced these distinctions. LAC and EAP pushed Q1 above 38 points, while South Asia and SSA placed Q3 on nearly equal footing. In ECA, Q2 earned first place (36.0), reflecting supply-chain vulnerabilities during protracted crises.

Together, these results suggest that stakeholders envision climate resilience not as a single intervention but as an integrated package of research priorities that span infrastructure, care pathways and logistics.

Scorecard for Crosscutting – Climate Resilience

Region:	All	Latin America and the Caribbean	East Asia and the Pacific	Europe and Central Asia	Middle East and North Africa	South Asia	Sub-Saharan Africa
Total number of respondents:	153	18	21	10	41	31	94
Research topic	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)	Score (mean)
1. Resilient sexual and reproductive health and rights (SRHR) service provision	35.59	41.39	38.19	35.00	35.12	34.52	32.22
2. Distribution of SRHR commodities	29.77	27.50	27.05	36.00	29.98	27.90	30.62
3. Mitigating climate effects in maternal and newborn health (MNH)	34.63	31.11	34.76	29.00	34.90	37.58	37.16

Boxplot figure 12: Mean dollar allocation (scores) for each question for Crosscutting – Climate Resilience

Research topic

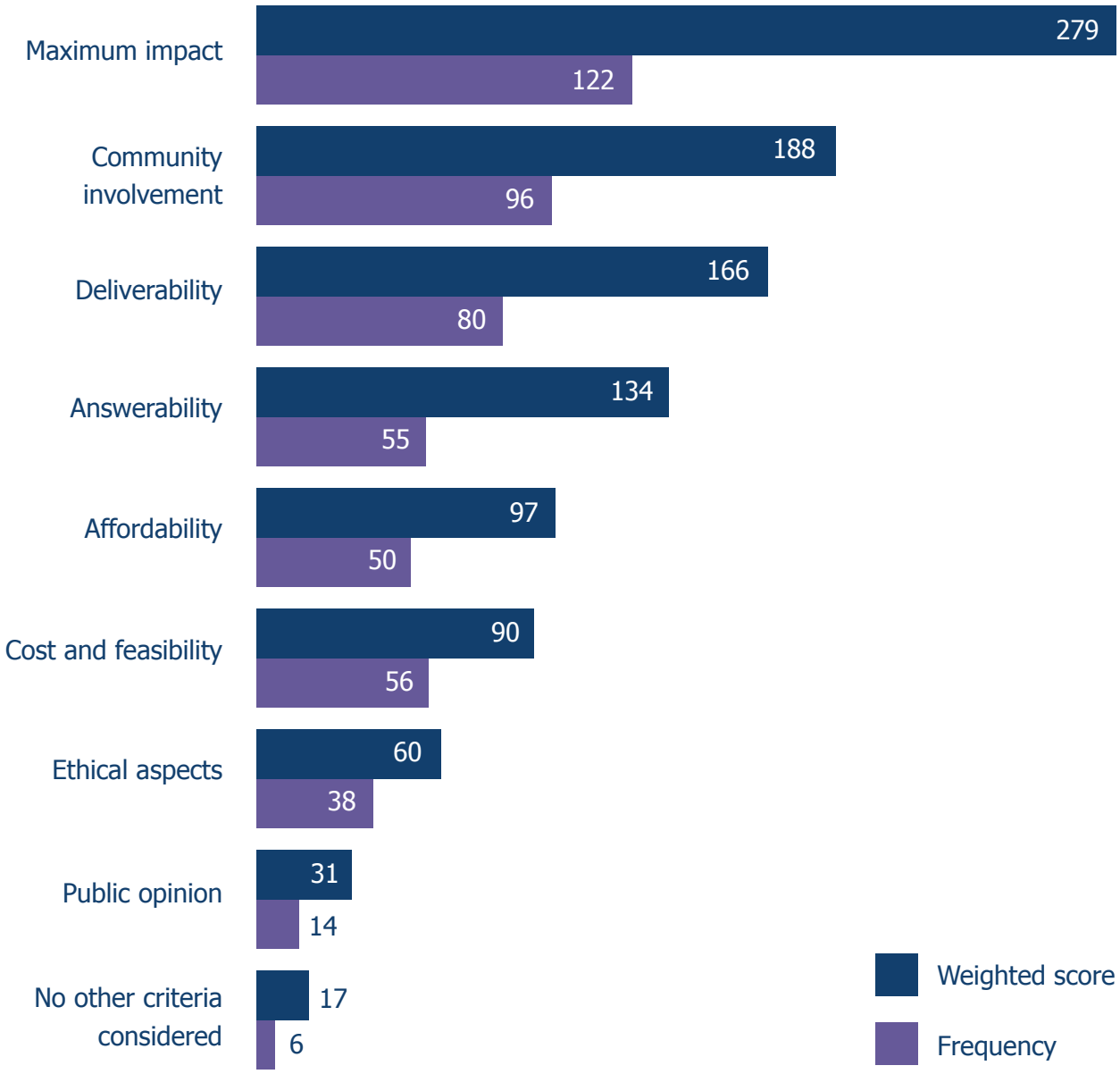
1. Resilient sexual and reproductive health and rights (SRHR) service provision
2. Distribution of SRHR commodities
3. Mitigating climate effects in maternal and newborn health (MNH)

Box and whisker plots showing mean score (X); interquartile range marked by box; range marked by whisker and outlier scores.

Prioritisation criteria analysis

A total of 187 (69%) responded to the final survey question about whether they used additional criteria to guide their allocation of funds across research domains. Respondents selected up to three predefined criteria and ranked them in order of importance (first, second, third). To quantify the overall importance assigned to each criterion, a weighted scoring system was applied, assigning three points for each first place ranking, two points for second place and one point for third place. The most frequently prioritised criterion was **maximum impact** (weighted score: 279), followed by **community involvement** (188), **deliverability** (166), **answerability** (134) and **affordability** (97). Respondents with five to nine years of experience contributed the largest proportion of responses across all criteria. The final scores highlight how a mix of pragmatic and values-based considerations informed prioritisation decisions.

Weighted scores of prioritisation criteria (and frequency) among 187 respondents



6

Discussion and conclusion

6. DISCUSSION AND CONCLUSION

This prioritisation exercise reveals four consistent themes:

1. **Service delivery and implementation dominate:** Across nearly all domains, the research priorities point toward service delivery challenges rather than the efficacy of specific interventions. Whether in CSE, SRHR and mental health, abortion care or climate resilience, the emphasis lies on how to make existing interventions reach people in humanitarian contexts. Questions addressed delivery channels, provider roles, supervision and mechanisms for ensuring uptake under conditions of legal restriction, crisis or systemic disruption.
2. **Focus on underserved and hard-to-reach groups**: A strong equity theme runs through the dataset. Respondents consistently prioritised strategies that improve access for displaced populations, people-on-the-move, adolescents, people living with disabilities and those facing legal or cultural barriers to care. Questions often explored how to tailor delivery models to out-of-school adolescents, refugee populations or those with intersecting vulnerabilities.
3. **Building resilient systems and provider capacity:** Across domains, respondents highlighted a need to strengthen SRHR systems and build frontline capacity. This includes sustained CHW training, task-sharing for abortion and digital supervision platforms for the clinical management of rape, and strategies for service continuity during pandemics and climate events. Questions also reflected demand for resilient infrastructure and adaptable workforces able to respond flexibly to future crises.
4. **Close clustering of scores indicates broad interest rather than dominant winners:** Although each domain has a top-ranked question, the gap between first and third is usually just a few points on the 0-to-100 scale. IQRs and SDs are often wide, indicating that respondents saw value in multiple research options. It is often difficult to distinguish between ranks beyond the first few, suggesting that many questions warrant parallel investment. This aligns with the breadth of the long list, which drew from extensive expert consultation and regional engagement.

A distinctive agenda – implementation-focused and crisis-aware

Compared with earlier global priority-setting exercises, this agenda was shaped by a more diverse constituency and reflects newer thematic concerns. It is implementation-centred, emphasising how to deliver, rather than what to deliver. Topics such as mental health integration, digital service channels, health systems resilience and climate adaptation feature prominently, reflecting lessons learned from COVID-19, protracted displacement and extreme-weather events.

Importantly, this prioritisation focused specifically on SRHR (and complements existing GBV-focused research agendas). The questions most commonly prioritised are actionable, time-sensitive and system-oriented, suggesting an urgent need for implementation research grounded in humanitarian realities.

Lower-ranked topics still hold value

Topics that ranked lower globally, such as partner notification for STIs, supply chain preparedness or social accountability, should not be interpreted as irrelevant. Several show strong regional support or high variability, indicating divergent views rather than disinterest. In contexts where those concerns are more immediate, targeted research remains warranted.

Criteria influencing priority setting of research questions

The criteria selected by respondents to guide their decision-making offer important context for interpreting the ranked research questions. The strong emphasis on maximum impact, deliverability and community involvement suggests that respondents prioritised questions they perceived as actionable, measurable and grounded in the needs of affected populations. This likely favoured research questions related to intervention effectiveness and service accessibility, while deprioritising those focused on upstream policy reform or systemic structural barriers, which may be seen as less immediately feasible in crisis settings. Ethical considerations and public opinion, though ranked low, may reflect underlying assumptions that these are foundational principles, rather than topics requiring new research.

Limitations and interpretation cautions

Although the overall response rate was strong (greater than or equal to 170 respondents in most domains), LAC, ECA and EAP contributed fewer than 25 responses in several domains. This reduces confidence in regional stability of rankings. To address this, the study team extended the survey period and ran targeted outreach, but gaps still remain.

Respondents were also mostly professionals already networked with the organising partners; direct community voices are under-represented. The single-round format contributed to wide SDs in several domains, and although all survey questions were reviewed for clarity, some variety in wording may have affected interpretation.

A crucial point to note is that each domain was weighted equally. Domains included different numbers of questions, so scores are not comparable across domains, only within them. Normalising or ranking domains would therefore misrepresent the data. The survey was deliberately structured to maintain independent research agendas per domain, with respondents allocating budgets within, but not between, topic areas. Each domain stands alone as a priority area.

Opportunities for future use and refinement

The prioritisation scorecards provide a strong foundation for SRHR research investment over the next three to five years. However, their use can be tailored further. In domains or regions where questions are closely ranked, donors or programme leads could consider, for example, conducting sensitivity testing and/or small-group rating exercises to sharpen decision-making. This would be particularly valuable where funding constraints require a smaller, more targeted shortlist.

Biannual light-touch updates are recommended to monitor emerging themes such as digital delivery, climate shocks or shifting migration routes. This could be guided through light-touch scoping reviews and informed by members of the community of practice as new evidence emerges. A full reprioritisation exercise is advised in around five years, or earlier if major global events intervene.

Conclusion

This prioritisation exercise has adopted a highly inclusive consultation. Building on the expert-focused methods used in earlier exercises, the study team broadened the net to the wider community of practice: invitations were extended to practitioners, policy-makers and researchers across all humanitarian regions, with a self-screening step that asked anyone with fewer than five years' experience in SRHR-in-humanitarian settings to defer to colleagues. Engagement was sustained through nine virtual regional workshops that drew more than 90 participants, supplemented by email contributions and a global online survey. Throughout, the international Core Expert Group (comprising senior figures, many of whom had led or advised previous priority-setting efforts) provided technical stewardship, reviewed interim findings and steered the analysis. The result is a dataset both deeper and wider than those that informed earlier agendas, combining the voices of established specialists with insights from the frontline of current humanitarian practice.

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Annexes

ANNEX 1

Implementation Research Priorities for Sexual and Reproductive Health and Rights (SRHR) in Humanitarian Crises

Supplementary document 1: Final long list of research questions on SRHR in humanitarian settings by domain with original number referencing and with examples of interventions provided by experts.

SRHR Domain 1: Comprensive Sexuality Education (CSE)

1. Effective delivery models for CSE: What are the most effective and culturally relevant delivery models for comprehensive CSE in humanitarian settings for both in-school and out-of-school adolescents, and how does their effectiveness vary for younger adolescents (ten to 14 years) versus older adolescents (15 to 19 years)?

- *Focus areas:* Cultural relevance, specificity of out-of-school adolescents and explicit age-disaggregation (younger vs. older adolescents), community-based / peer-led, non-formal, digital, self-learning.
- *Examples of interventions to explore:* Mobile-based learning, radio programming, interactive theatre, and peer-led education tailored to different age groups.

2. Engaging parents and caregivers in CSE: How can CSE in humanitarian settings effectively engage parents, caregivers and community leaders in supporting adolescent SRHR, while addressing cultural and religious sensitivities, and what are the most effective approaches for different age groups of adolescents?

- *Focus areas:* Cultural and religious sensitivities, role of community leaders. Age-specific parental engagement approaches.
- *Examples of interventions to explore:* Parent-child communication programmes, peer education for younger parents, intergenerational dialogues, community-driven CSE discussions.

3. Gender-transformative approaches in CSE: What are the most effective strategies for integrating gender-transformative approaches into CSE to challenge harmful social norms, reduce child marriage or prevent gender-based violence (GBV) in humanitarian settings?

- *Focus areas:* Challenging social norms, preventing GBV; age-specific transformative approaches.
- *Examples of interventions to explore:* Engaging men and boys in CSE, school-based gender clubs, integration of CSE into life-skills training for different age groups, interactive games / videos / social media with messaging for adolescents.

4. Training and supporting CSE facilitators: How can teachers, health workers and community facilitators be effectively trained and supported to deliver CSE in humanitarian settings, ensuring cultural acceptability and adherence to human rights principles?

- *Focus areas:* Cultural acceptability (inc. with community / camp leaders / peer-led interventions), human rights principles.
- *Examples of interventions to explore:* Mentorship models; digital training (including self-paced) for frontline workers; participatory community-based training, Explicit age-appropriateness in training strategies.

5. Integrating CSE into adolescent-friendly health services: What is the impact of adolescent-friendly health services, inclusive of CSE, on reducing adolescent pregnancies and increasing service uptake in humanitarian settings?

- *Focus areas:* Focus on social and structural barriers; reducing teenage pregnancies, harm-reduction to reduce 'risky' behaviours, increased use of SRHR services by adolescents.
- *Examples of interventions to explore:* One-stop adolescent health centres, youth-friendly counselling integrated with CSE, digital linkage tools with age-disaggregated approaches for adolescent health services.

6. Safe and inclusive CSE for marginalised groups: What CSE programme designs are safe, inclusive, accessible and free from stigma and discrimination for marginalised and at-risk groups (eg, LGBTQI+ young people, adolescents with disabilities, displaced populations, people who use drugs or affected by criminalisation, and what are the most effective approaches for different age groups?

- *Focus areas:* Age-specific inclusion strategies, emphasis on stigma and discrimination protection, language in CSE content, targeted materials for older adolescents, inclusive, harm reduction approaches for youths affected by criminalisation.
- *Examples of interventions to explore*: Safe spaces for younger adolescents.

SRHR Domain 2: Sexual Health and Wellbeing

1. Integration of SRHR and mental health: What are the most effective strategies (adapted for different crisis-affected populations, such as adolescents or refugees) for integrating mental health (including perinatal mental health) and psychosocial support into existing public healthcare/SRHR programming in humanitarian settings?

- *Focus areas*: Expanded to include different vulnerable groups (adolescents, people on-the-move).
- *Examples of interventions to explore:* Community-based counselling, digital mental health tools, task-sharing with community health workers / peer educators, group counselling and resilience building.

2. Strengthening SRHR and mental health training for providers: What are the most effective training methodologies and curricula for SRHR providers and community health workers to enhance the integration of mental health into SRHR services in humanitarian settings and improve service delivery outcomes (eg, quality of care, provider performance, patient satisfaction)?

- *Focus areas:* Developing and implementing training curricula that facilitate the integration of MH into SRHR services; evaluating different training methodologies for effectiveness in crisis settings.
- *Examples of interventions to explore:* Competency-based training, participatory learning, digital training modules, on-the-job mentorship, cross-training between MH and SRHR providers, supervision models, integration-focused quality improvement initiatives.

3. Overcoming stigma and barriers to mental health and SRHR access: What are the most effective community awareness and stigma-reduction strategies for improving access to, and uptake of, MH services integrated to SRHR care in humanitarian settings, and how do these approaches impact service utilisation and quality?

- *Focus areas*: identifying and evaluating stigma reduction and behaviour change approaches that enhance MH service access, effectiveness of integrated SRHR-MH models.
- *Examples of interventions to explore:* Peer-led awareness programmes, faith-based engagement, participatory media campaigns.

4. Integration of SRHR and mental health with non-communicable diseases (NCDs): What approaches can enhance the integration of SRHR services with mental health and non-communicable disease (NCD) care in humanitarian settings?

- *Focus areas*: Expanded to include SRHR-NCD integration.
- *Examples of interventions to explore*: screening within NCD clinics, dual-service provision models, integration into primary healthcare.

5. Addressing menopause and sexual health needs: How can menopause care be improved in humanitarian settings by enhancing better diagnosis, providing culturally appropriate support and access to effective treatment?

- *Focus areas:* Specific focus on menopause, a previously neglected area in humanitarian SRHR.
- *Examples of interventions to explore:* Community-based screening, CHW-led menopause education, integration into SRHR services.

6. Adapting and monitoring quality of SRHR interventions: How can the fidelity and quality of comprehensive SRHR interventions be adapted and monitored in humanitarian settings to ensure sustained improvements in wellbeing for vulnerable groups such as adolescents and refugees?

- *Focus areas:* Focus on adaptation and quality assurance for improved client user satisfaction.
- *Examples of interventions to explore*: Real-time monitoring dashboards, community feedback loops, mobile data collection tools.

7. Safe spaces as an entry point for integrated SRHR and mental health care: How can SRHR interventions be integrated into safe spaces used for mental health programming in humanitarian settings, and what are the most effective models for ensuring accessibility, safety and service quality?

- *Focus areas*: Explicit integration of SRHR into existing mental health spaces.
- *Examples of interventions to explore:* SRHR service provision in women's safe spaces, SRHR counselling within GBV survivor services.

8. Addressing language and cultural barriers to SRHR access: What strategies can overcome language and cultural barriers that delay access to SRHR services in humanitarian settings, ensuring equitable care for diverse populations?

- *Focus areas*: Expanded beyond language to include cultural adaptation.
- *Examples of interventions to explore:* Multilingual CHWs, use of cultural mediators, culturally adapted counselling tools, translation services in health facilities.

SRHR Domain 3: Family Planning (FP) and Contraception

1. Ensuring reproductive choice in humanitarian settings: What are the most effective interventions to expand access to, and continuation of, long-acting reversible contraceptives (LARC) in humanitarian settings, while ensuring culturally appropriate, person-centred care?

- *Focus areas:* Improving LARC access and continuation through rights-based approaches; testing models of counselling (effectiveness-based vs person-centred share decision model) to assess which leads to better uptake and continuation.
- *Examples of interventions to explore:* CHW-led counselling, task-sharing, and community-informed FP services, telemedicine approaches Role of AI-mediated information sharing (i.e. Apps that provide correct information to guide choices and fight misinformation and myths regarding LARC) Integration with child nutrition programmes, post-partum FP within the EmoNC setting, Self-managed contraceptive options, rapid response mechanisms.

2. Overcoming barriers to LARC access and acceptance (demand-side): Which strategies are most effective at overcoming barriers to LARC access, continuation and removal specifically among displaced and people on the move and in protracted crises?

- *Focus areas:* Ensuring choice and access to prevent unwanted pregnancies among populations on the move / displaced populations. Addressing challenges of LARC access, including removal of barriers / misconceptions/myths related to LARCs and lead to increased informed choice,
- *Examples of interventions to explore:* Mobile outreach, task-sharing for LARC removals, community-based counselling, multi-media inc. social medial platforms, edutainment films. digital FP/contraception tracking and reminders, integrating post-partum FP with MNH services for people on the move.

3. Increasing adolescent access to contraception: How can humanitarian FP programmes effectively increase contraceptive uptake and continuation among adolescents, including LARCs and self-administered contraceptives, ensuring age-appropriate, accessible and stigma-free services?

- *Focus areas:* Reducing adolescent pregnancies, adapting contraceptive services for adolescents, addressing barriers to access and use (including age-appropriate CSE).
- *Examples of interventions to explore*: Youth-led outreach, self-administered contraceptives, integrated adolescent SRHR services, telemedicine, postal pharmaceutical services /e-commerce.

4. Contraceptive use among vulnerable populations: Which financial and service delivery models are effective in expanding contraceptive access to highly vulnerable groups, including ethnic minorities, LGBTQI+ communities, sex workers and people living with disabilities?

- *Focus areas:* innovations to increase access by vulnerable groups self-care, digital health, task-sharing, conditional cash transfers, digital-AI tools for peer-educators.
- *Examples of interventions to explore:* self-care – including over-the-counter, chatbots and support tools for community health workers; task-shifting and sharing for offline digital support tools, Mobile FP services, community-based FP models, Conditional Cash Transfers for contraceptive access.

5. Financial assistance to increase contraceptive uptake: What are the most effective cash and voucher assistance (CVA) models for increasing modern contraceptive use in humanitarian settings?

- *Focus areas:* Evaluating conditional cash transfer (CCT) and financial assistance models for FP service uptake including implementation of FP models in wider economic support models e.g. micro-credits for women in stable refugee settings or protracted crisis for agriculture and business. (Special care given to avoid pitfalls of early FP programs where cash incentives became coercive).
- *Examples of interventions to explore:* CCTs for contraceptive services, FP-linked vouchers, integration with social protection schemes.

6. Overcoming socio-economic barriers to contraceptive use: What are the most effective interventions to address sociocultural barriers (including gender norms and male or other decision-makers' involvement and current socio-political situation given the global gag rule) that limit contraceptive uptake specifically in humanitarian settings?

- *Focus areas:* Reducing opposition to contraception and improving women's autonomy.
- *Examples of interventions to explore*: Male engagement, community dialogues, policy reform for consent requirements, collaborations with faith-based organisations.

7. Implementing full range of contraceptive choices at the onset of an emergency: What are the most effective strategies to implement good quality comprehensive contraceptive services, including long-acting, short-acting and emergency contraception (EC) – according to United Nations Population Fund (UNFPA)'s Minimum Initial Service Package (MISP) Objective 5 – are accessible from specifically the onset of humanitarian crises?

- *Focus areas:* Prevention of unintended pregnancies, Ensuring FP service availability during acute emergencies and addressing supply chain disruptions, increasing acceptability and access to users (good quality including counselling and community awareness services).
- *Examples of interventions to explore:* Mobile SRHR teams, EC pre-positioning, integration into emergency response, strengthening the quality of counselling services, pre-positioning of a variety of contraceptives by category of self-administration, staff provision level (e.g. pharmacist vs nurse).

8. Supply chains during active and ongoing displacement contexts (supply-side): What is the impact of innovations for supply chain model for uninterrupted contraceptive access in active and ongoing displacement contexts, despite humanitarian and logistical constraints?

- *Focus areas:* Strengthening FP commodity security and mitigating supply chain disruptions, ensuring product quality including storing conditions.
- *Examples of interventions to explore:* Cross-border collaborations, community-managed stock monitoring, digital prescription models, interventions to overcome the current funding of FP supplies and access.

SRHR Domain 4: Cancers of the Reproductive System

1. Equitable human papillomavirus (HPV) vaccination: What are the most cost-effective and sustainable strategies for delivering the HPV vaccine, ensuring equitable access in humanitarian settings, including for displaced and vulnerable populations?

- *Focus areas:* Integration of HPV vaccination into emergency-response immunisation efforts and routine humanitarian health services; Overcoming policy and regulatory barriers to vaccine access, eg. if HPV vaccination is not part of the host country's national health system; Supply chain management strategies to ensure availability and sustainability of HPV vaccines; addressing vaccine hesitancy in communities in humanitarian settings, including displaced and vulnerable populations; cost-effectiveness models including the long-term impact on quality-adjusted life years (QALY) and health costs averted over 20 years.
- *Examples of interventions to explore:* Using single-dose HPV vaccine regimens for cost-effectiveness in humanitarian settings; outreach-based HPV vaccination linked with routine immunisation programmes; task-shifting models, using CHWs and midwives to deliver vaccines.

2. Integrating HPV-based cervical cancer screening into existing SRHR services: What are the most effective and sustainable models for integrating HPV-based cervical cancer screening and treatment into SRHR services in humanitarian settings?

- *Focus areas:* Optimising HPV testing implementation including rapid point-of-care HPV testing and integration with existing diagnostic platforms. Feasibility and acceptability of HPV self-sampling. Reducing delays between screening and treatment, with a focus on improving linkages between HPV-positive women and appropriate follow-up services. Integration of cervical cancer screening into routine SRHR services, including, ANC &PNC. Training and task-shifting models, involving midwives and CHWs in the distribution and follow-up of self-sampling HPV tests. Economic modelling and sustainability, assessing the cost-effectiveness of integrated cervical cancer screening strategies.
- *Examples of interventions to explore:* HPV self-collection strategies in crisis-affected settings, with same-day results and linkages to care Use of TB GeneXpert machines for HPV screening, leveraging existing diagnostic infrastructure. Mobile and community-based HPV screening initiatives, ensuring access for displaced and vulnerable populations. Thermal ablation as a treatment approach, replacing cryotherapy in resource-limited and humanitarian settings. Digital decision-support tools for frontline health workers to improve screening, triage, and follow-up care.

3. Raising awareness where treatment is accessible: What are the effective approaches for communication and messaging on information about signs and symptoms of breast cancer and endometrial cancer to increase (early) detection in humanitarian settings (where referral pathways and treatment options exist)?

- *Focus areas*: psychosocial support; strengthening referral pathways to national health systems.
- *Examples of interventions to explore:* Task-sharing models (e.g., training CHWs in clinical breast exams); mobile mammography units in stable protracted displacement settings; psychosocial support mechanisms for women with positive diagnoses.

SRHR Domain 5: Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

1. Scaling up STIs and HIV testing for displaced and high-risk populations: What are the most cost-effective strategies for integrating and scaling up STI and HIV testing in humanitarian settings, specifically among displaced and high-risk populations taking into account stigma, privacy concerns and cultural barriers to increase access?

- *Focus areas:* Point-of-care STI diagnostics in low-resource settings. Expansion of self-testing/ self-sampling for STIs (beyond HIV). Syndromic vs. multiplex STI testing approaches.
- *Examples of interventions to explore*: male involvement; STI self-sampling kits adapted for refugees and IDPs. AI-driven diagnostic support tools for syndromic STI management. Mobile STI/HIV testing outreach in informal settlements and conflict zones.

2. Preventing STIs in forced migration settings: What are the most effective strategies to prevent STIs (including HIV, HPV, Hepatitis B and syphilis) in forced migration settings, where condom access is low, and sexual violence and transactional sex increase risk?

- *Focus areas:* Understanding incidence and transmission risks during displacement in order to target interventions. Feasibility of multi-disease prevention approaches (e.g., combining HIV, Hepatitis B, and syphilis prevention). Access to vaccination for HPV and Hepatitis B.
- *Examples of interventions to explore*: Integration of STI prevention into humanitarian food and cash assistance programmes. Survivor-centred STI care for displaced populations facing sexual violence. Task-sharing models for CHWs to distribute STI prevention tools.

3. Scaling up vaccines to prevent STIs: What are the most effective strategies to introducing and scaling up STI vaccines (HPV, Hepatitis B and future gonorrhoea/syphilis vaccines) in humanitarian settings, considering health system integration, vaccine hesitancy and supply chain challenges?

- *Focus areas:* Feasibility of integrating STI vaccines into routine humanitarian health responses. Overcoming vaccine hesitancy in displaced populations. Ensuring cold chain and supply chain reliability. Free-of-cost vaccines.
- *Examples of interventions to explore:* HPV vaccination catch-up campaigns in refugee and crisis settings. Integration of Hepatitis B vaccines into maternal health services. New STI vaccine delivery models adapted for fragile health systems.

4. Responding to antimicrobial resistance for gonorrhoea treatment in conflict settings: What are the most effective strategies for monitoring and responding to antimicrobial resistance (AMR) in gonorrhoea treatment in conflict settings?

- *Focus areas*: Feasibility of AMR surveillance in humanitarian health programmes. Ensuring availability of alternative treatments for gonorrhoea. Task-sharing strategies to increase provider knowledge on AMR risks.
- *Examples of interventions to explore:* Integrating AMR tracking for gonorrhoea into humanitarian lab networks. Training non-specialist providers on AMR risks and alternative treatments. Developing AMR-sensitive STI treatment guidelines for conflict settings.

5. Strengthening partner notification: What are effective strategies for partner notification and management of STIs in acute crisis settings, specifically among mobile and displaced populations?

- *Focus areas*: Feasibility of digital or anonymous partner notification in humanitarian settings. Addressing barriers to STI disclosure in conflict-affected populations. Community-led partner management approaches for key populations.
- *Examples of interventions to explore*: SMS-based STI partner notification systems. Peer-led contact tracing models in displaced communities. Integration of partner STI screening into existing SRHR services. digital contact tracing and community-led partner engagement.

6. Multipurpose prevention technologies (MPTs): How acceptable is the introduction of multipurpose prevention technologies (MPTs) for combined STI and pregnancy prevention in humanitarian settings and what is their potential for improving health outcomes based on estimated uptake?

- *Focus areas:* Evaluating acceptability of MPTs among crisis-affected populations. Feasibility of distributing MPTs through humanitarian aid channels. Cost-effectiveness of MPTs compared to separate prevention strategies and modelling studies to estimate impact on health outcomes.
- *Examples of interventions to explore:* Introducing vaginal rings that prevent both HIV and pregnancy. Testing MPT acceptability among refugees, Internally Displaced People -IDPs, and sex workers. Training humanitarian providers on MPT counselling and distribution, estimating impact on health outcomes.

7. Scaling up STI prevention and pre-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP): What are the most effective strategies for scaling up STI prevention and PrEP, as well as STI management and PEP, in humanitarian settings for high-risk populations (including sex workers, displaced populations and survivors of sexual violence), considering legal, social and mobility barriers?

- *Focus areas:* Preventing STIs and HIV among especially high risk, vulnerable populations.
- *Examples of interventions to explore:* pre-exposure prophylaxis combined with STI management and post-exposure prophylaxis (PEP).

8. Preventing STI-related infertility: How can STI-related infertility prevention be strengthened in humanitarian settings, ensuring early detection, treatment and access to fertility-preserving interventions?

- *Focus areas:* STI-related infertility risks among displaced women and adolescent girls. Access to infertility care in protracted crisis settings.
- *Examples of interventions to explore:* Survivor-led peer education on STI-related infertility prevention. Incorporating STI screening into maternal and newborn health services. Community awareness campaigns on STI-related infertility.

SRHR Domain 6: Maternal and Newborn Health (MNH): Antenatal/Perinatal Care

1. Context-specific approaches for increasing access to MNH: Which context-specific models improve the quality, accessibility, and utilisation of antenatal and postnatal care in active conflict settings or those with severely limited infrastructure?

- *Focus areas:* Addressing access barriers and improving ANC/PNC service quality, acceptability, Person-centred Maternity Care, midwife-led care
- *Examples of interventions to explore*: Midwife-led continuity of care, Midwife-led birth centres, midwife-led outreach, digital tracking tools, Mobile ANC/PNC models, AI clinical decision support tools that work offline; support to interpret rapid diagnostic tests, telehealth for ultrasound scans.

2. Continuity of MNH care for women and babies on the move: What are the most effective strategies for delivering antenatal care (ANC), intrapartum and postnatal care to pregnant women who are on the move during humanitarian crises?

- *Focus areas:* Ensuring access to continuity of MNH care for populations on the move / displaced populations.
- *Examples of interventions to explore*: Group ANC, ANC self-care initiatives such as BP and urine sample tracking, Mobile MNH services, digital MNH tracking, community midwifery support.

3. Community-based antenatal and intrapartum care: What are effective strategies for delivering community-based antenatal care in acute conflict settings or among people on the move where facility-based access is highly challenging

- *Focus areas*: Strengthening antenatal home visits, involving male partners in ANC.
- *Examples of interventions to explore:* self -care interventions; AI clinical support offline; CHW-led postnatal care, digital monitoring tools, mobile outreach.

4. Strengthening basic emergency obstetric and neonatal (EmONC) care: What are the most effective models for improving safe delivery, basic emergency obstetric and neonatal care (EmONC) at primary level health facilities?

- *Focus areas:* primary health care; exploring effectiveness of the 7 signal functions of a basic EmONC and possible adaptations needed to increase feasibility and effectiveness in humanitarian settings; reducing mortality among women referred to higher level comprehensive EmONC facilities.
- *Examples of interventions to explore:* community-based models of prevention; community distribution of misoprostol to prevent postpartum haemorrhage.

5. Emergency referral mechanisms: What are the most effective referral mechanisms for emergency obstetric cases in resource-constrained humanitarian settings?

- *Focus areas:* Improving community-based and facility-based emergency referrals.
- *Examples of interventions to explore:* Transport models for crisis settings, community referral networks, health financing options for transport.

SRHR Domain 7: Maternal and Newborn Health (MNH): Postnatal/Newborn Care

1. Community-based postnatal care (PNC): What are effective strategies for delivering community-based postnatal care, including bereavement care in humanitarian settings?

- *Focus areas:* Strengthening postnatal home visits and integrating bereavement care following stillbirth and newborn death; mitigation mental health crises; preventing postpartum depression.
- *Examples of interventions to explore:* CHW-led postnatal care, mobile outreach, culturally adapted bereavement support; partner involvement / involving men and religious leaders.

2. Essential newborn care in conflict settings: What are the most effective models for delivering essential newborn care, including for vulnerable newborns (small and sick), in acute and protracted conflict settings?

- *Focus areas:* Improving survival of preterm and low-birth-weight newborns.
- *Examples of interventions to explore:* Kangaroo Mother Care (KMC), neonatal resuscitation, mobile neonatal units, community health extension workers and self-care implementation of identification of danger signs

3. Early initiation of breastfeeding: What are the most effective strategies to promote early initiation of breastfeeding in humanitarian settings and sustained breastfeeding where breastfeeding rates are low?

- *Focus areas:* Understanding and overcoming barriers to early-initiation of breastfeeding; continuation of breastfeeding.
- *Examples of interventions to explore:* Lactation support networks, community-based peer support, safe breastfeeding spaces.

4. Mitigating and managing postnatal depression: How can postpartum depression be effectively identified, mitigated and managed in humanitarian settings, and how can mental health support be integrated into maternal health services?

- *Focus areas:* Screening, rising awareness & knowledge among community & health providers, exploring models of psycho-social support, Integrating mental health into maternal and newborn care.
- *Examples of interventions to explore:* Peer support models, maternal mental health screening, CHW-led psychosocial support.

SRHR Domain 8: Comprehensive Abortion Care

1. Policies: What are effective strategies for ensuring implementation of comprehensive abortion care policies in humanitarian settings, including restrictive legal environments, to increase access to, and use of, abortion care services?

- *Focus areas:* Understanding how laws and policies facilitate or hinder Safe Abortion Care / Self-Managed Abortion / Post-Abortion Care access, and using this to inform the strengthening of policy frameworks, legal protections for service providers, advocacy strategies, access to misoprostol/medication abortion, provider or client criminalization, capturing morbidity and near miss-related morbidity due to abortion complications in humanitarian health response.
- *Examples of interventions:* Opposition/political change/regression monitoring and overcoming resistance from policymakers and service providers and community members through participatory Stakeholder dialogue. Advocacy strategies increasing awareness among high-level political leaders and social media influencers about the circumstances under which abortion is legal; operationalising legal and regulatory frameworks that secure safe abortion access. Cross-border referral mechanisms.

2. Financing and cost barriers: What are the direct, indirect and opportunity costs of providing comprehensive abortion care in humanitarian settings, and what financial arrangements improve access?

- *Focus areas*: Cost-effectiveness, financing models, impact of cash transfers, community-based health insurance, universal health coverage, health disparities between citizens and refugees
- *Examples of interventions:* Conditional/unconditional cash transfers (CCTs), community-based health insurance for SAC/PAC, integration into broader cash-based assistance, community-based health insurance models; alternative modes of financing.

3. User acceptability, quality and person-centred abortion care: What is the impact of less medicalised abortion care on women's abortion experience, clinical outcomes and post-abortion contraceptive uptake (ie, care led by midwives, nurses or trained community providers)?

- *Focus areas:* Implementation research-effectiveness, Feasibility, safety, acceptability, impact of the model of the care, financial impacts of cost-shifting, quality of care
- *Examples of interventions:* Midwife-led SAC/PAC, training and supervision models for non-physician providers, task-shifting.

4. Improving women's experience and access to abortion care: How effective are different models of self-managed medication abortion (SMA) (ie, digital support SMA, pharmacist-led, telemedicine, midwife-led or community-based approaches) for improving women's ability to choose and access SAC/PAC in conflict-affected and remote settings?

- *Focus areas*: Women's needs/preferences on SAC/PAC in humanitarian settings. Different model's ability to deliver SAC/PAC in humanitarian settings - surgical Vs medication abortion.
- *Examples of interventions:* Testing different models to see how well interventions effectively meet women's needs and influence acceptability and decision-making: Telemedicine for SAC/PAC, CHW task-sharing for MA guidance, digital tools for abortion access, CHW and midwife-led MA, self-use MA with digital support, and pharmacist-led care. Gender and agency-based frameworks for improving abortion services.

5. Service delivery innovations for comprehensive abortion care: How effective are telemedicine platforms and digital support tools in delivering comprehensive abortion care among displaced populations and conflict-affected areas?

- *Focus areas:* Safety, privacy, acceptability, hybrid telemedicine/in-person models, MA (including screening for eligibility). Combining digital consultations with human accompaniment models, helping people to women (and their families when relevant, i.e. they are needed to support the woman to get to care for her to reach care) to identify complications using different telemedicine and digital support tools, increasing access to post-abortion care.
- *Examples of interventions:* Telemedicine models for SAC/PAC, digital decision support tools, hybrid models combining telemedicine with in-person referrals. Virtual abortion accompaniment models, remote counselling. Connecting with just the woman vs. including family members to see what is more effective at increasing women's access to SAC/PAC.

6. Addressing barriers to reproductive autonomy and ability to choose: What are the effective interventions that contribute to changing social and gender norms around abortion stigma, which harm women's ability to exercise their ability to access SAC?

- *Focus areas:* Understanding how gender norms, stigma, and social agency affect SAC/PAC access and use of those services in different delivery models.
- *Examples of interventions to explore:* Approaches which are effective at increasing access to/use of services, community-based interventions addressing abortion stigma, person-centred care models for SAC/PAC, building individual agency and autonomy to exercise reproductive choices across the spectrum (from fully self-managed to clinical management by a health provider).

7. Provider support, wellbeing and training: What approaches most effectively improve healthcare workers' willingness and wellbeing to provide abortion care services in humanitarian settings?

- *Focus areas:* Addressing stigma / attitudinal barriers among healthcare providers; addressing mental health of providers and other types of support; values clarification training; incentives; Provider confidence in different methods; Protecting abortion care providers from prosecution in restrictive settings. Prevalence of conscientious objection with the health facility. Structural barriers faced by healthcare providers. Providers' preferences for different methods of abortion and post-abortion contraceptive provision for different clients.
- *Examples of interventions to explore:* Training and sensitisation for midwives and CHWs, incentive models, values clarification workshops.

SRHR Domain 9: Clinical Management of Rape

1. Increasing timely access to post-rape care in legally restrictive settings: What are the effective strategies to increase timely uptake of clinical management of rape (CMOR) in humanitarian settings where abortion is restricted, ensuring access to emergency contraception and PEP?

- *Focus areas*: Overcoming legal and social barriers to accessing comprehensive CMOR services. Addressing stigma and misinformation around post-rape care. Ensuring effective distribution of kits to health workers and facilities.
- *Examples of interventions to explore:* Community-based education and sensitisation campaigns to increase survivor knowledge of services. Discreet distribution models (e.g., pharmacies, community health workers). Training midwives and frontline providers to deliver CMOR interventions including education on legal frameworks.

2. Increasing health-seeking behaviours and referrals: What are effective strategies to improve timely health-seeking behaviours among sexual violence survivors and increase linkages to CMOR services in settings where abortion is legally permitted?

- *Focus areas:* Understanding & addressing factors affecting survivors' willingness to seek care. Ensuring CMOR service integration within maternal, FP, and STI care. Strengthening referral networks for comprehensive care.
- *Examples of interventions to explore:* Community-based education programmes to increase awareness of CMOR services. Integrating CMOR services into routine SRHR care. Provider training on survivor-centred approaches within FP and STI services.

3. Testing guidelines as a tool to increase quality of clinical management of rape: What are the effective approaches and strategies for implementing simplified guidelines for the clinical management of rape in health facilities that improve the quality of care and experiences of survivors of rape and sexual violence?

- *Area of focus:* testing and adapting newly developed CMOR guidelines; sensitising and training health providers; measuring changes in provider attitude / experiences by service users.
- *Examples of interventions to explore:* adaptations needed for existing or new guidelines for different contexts and health cadres; exploring different skills-building approaches and platforms (in-person, online, telehealth, etc).

4. Expanding the clinical management of rape access for marginalised and key populations: What are the effective and adapted models of CMOR that increase access for marginalised and key populations (eg, LGBTQI+ individuals, sex workers and people who use drugs)?

- *Focus areas:* Addressing stigma and discrimination in post-rape care services. Ensuring tailored, survivor-centred care in humanitarian settings. Improving health provider capacity for inclusive CMOR services.
- *Examples of interventions to explore:* Community-based service delivery models for hard-to-reach populations. Training programmes for healthcare workers on non-discriminatory care. Referral pathways tailored to marginalised survivors' needs.

5. Task sharing the clinical management of rape: What are the effective strategies and approaches for training community health workers (CHWs), midwives or nurses to support rape survivors and improve CMOR service delivery in acute humanitarian settings?

- *Focus areas:* Expanding CMOR service provision beyond hospitals and clinics. Addressing barriers to training CHWs, nurses and midwives in emergency settings. Ensuring legal protections and ethical safeguards for CHWs providing CMOR.
- *Examples of interventions to explor*e: CHW-led screening and referral models for CMOR in conflict zones. Capacity-building programmes for frontline workers providing CMOR. Telemedicine support models for CHWs handling complex CMOR cases.

6. Role of remote consultations to support health workers: What are the effective strategies for remote consultation services (eg, telemedicine, digital platforms) to support healthcare workers in providing CMOR in humanitarian settings?

- *Focus areas:* Expanding provider access to expert guidance via remote consultation. Strengthening real-time medical back-up for frontline workers. Overcoming connectivity and privacy challenges in humanitarian settings.
- *Examples of interventions to explore:* Telemedicine support for CHWs and midwives providing CMOR. Digital training and mentoring platforms for CMOR providers. Virtual case management and referral tools for CMOR survivors.

7. Increasing access for males: What are the effective strategies to increase access to CMOR services for male survivors, including service mapping and improving community perceptions?

- *Focus areas:* Understanding barriers to disclosure and reporting among male survivors. Addressing social norms and perceptions that limit male survivors' access to care. Ensuring adaptation of existing CMOR protocols for men and boys.
- *Examples of interventions to explore:* Health facility readiness assessments for male CMOR services. Outreach and education campaigns to improve male survivors' health-seeking behaviours. Provider training programmes on treating male sexual violence survivors.

Crosscutting domains

Crosscutting – Stakeholder Engagement

1. Preventing mistreatment and ensuring respectful care: What monitoring, feedback and response mechanisms are safe and effective to identify and address non-respectful practices, and prevent mistreatment and promote person-centred SRHR care, including maternity care during pregnancy, childbirth, post-natal and abortion care in humanitarian settings?

- *Focus areas:* Evidence-based structural contributing factors, Safe patient feedback mechanisms; Behaviour change support and attention to structural contributing factors to reducing mistreatment and increase in acceptability of services.
- *Examples of Interventions:* Respectful maternity care (RMC) frameworks, accountability mechanisms, provider training; Empowering women to demand RMC, e.g. SMS chatbots used to increase level of information on what to expect in a health facility.

2. Community-led interventions to increase access: What are the most effective community-led interventions to improve access to, and quality of, SRHR services in humanitarian settings?

- *Focus areas:* Community-driven / human-centred service design, locally-led governance; Community monitoring, patient-led service evaluation, local governance.
- *Examples of Interventions:* Peer-led education, community health worker (CHW) models; Citizen report cards, patient feedback mechanisms, social audit tools.

3. Community engagement and equity: What community engagement strategies effectively increase access to SRHR services for marginalised populations, including adolescents, people living with disabilities, LGBTQI+, sex workers and people-on-the-move in humanitarian settings, and ensure parity with/for host communities?

- *Focus areas:* Barriers to access, service adaptation, inclusive healthcare approaches.
- *Examples of Interventions:* mobile SRHR units, Targeted outreach campaigns, Stigma-reduction campaigns, differentiated service models, economic support mechanisms (e.g., Conditional Cash Transfers).

4. Engaging boys and men: What are the most effective strategies to engage men and boys in SRHR to improve service uptake for women and girls?

- *Focus areas*: Male inclusion in family planning, addressing gender norms.
- *Examples of Interventions:* Couple-based SRHR education, male peer groups, workplace-based engagement models.

5. Social accountability: What are the most effective social accountability models for ensuring good quality, equitable SRHR services in humanitarian settings?

- *Focus areas*: Community-led oversight, feedback mechanisms, transparency initiatives, acceptability / client satisfaction, increased uptake by all sectors of population
- *Examples of Interventions:* Citizen report cards, patient-led quality audits, grievance redressal systems.

6. Communication strategies: How can the media be leveraged to improve public awareness and access to SRHR services during humanitarian crises?

- *Focus areas*: Media-driven policy influence, crisis communication strategies.
- *Examples of Interventions:* Media training for SRHR providers, advocacy-based storytelling, digital health literacy campaigns, social media platforms.

7. Governance and partnerships: How can partnerships between governments, non-governmental organisations (NGOs) and international organisations increase coverage and use of SRHR services in humanitarian settings?

- *Focus areas*: Governance coordination, public-private partnerships, sustainability.
- *Examples of Interventions:* Multi-stakeholder coordination platforms, inter-agency accountability frameworks.

Crosscutting – Service Delivery and Health Systems

1. Digital information, education and communication (IEC) to increase SRHR knowledge and access: What are the effective strategies and potential risks of using digital or mobile platforms for SRHR communication, education and service access in displaced and conflict-affected communities, and how does this improve preventive health behaviours and service uptake?

- *Focus areas*: Access to digital health resources, risks of misinformation, user safety concerns, equity, increasing SRHR service use, barriers to digital access, misinformation management.
- *Examples of Interventions:* Mobile apps for SRHR education, telemedicine for crisis-affected populations (including those affected by climate crises), community-based digital literacy programmes, communally available digital devices Off-line apps; tablet support; AI-driven SRHR chatbots, SMS-based SRHR health education campaigns, language-adapted mobile apps for refugees Remote training models, simulation-based SRHR training,

2. Training models for sustained community health working (CHW) learning: What are the effective training programmes for CHW to improve sustained CHW performance and improve maternal and neonatal outcomes in humanitarian settings? What features of the training are most effective (duration, structure, delivery modalities, content)?

- *Focus areas:* Training models, skill-building for non-specialist provider; task-shifting Measuring sustained improvements in performance.
- *Examples of interventions to explore:* online/offline tools, use of chatbots and simulations, mentorship models, CHW-led birth preparedness. Short training programmes Include individuals who may have been former traditional birth attendants.

3. Values-based education: What capacity-building strategies are effective in reducing provider biases and ensuring rights-based approaches in SRHR service delivery (leading to increased access to, and uptake of, SRHR services)?

- *Focus areas:* Healthcare provider training, bias reduction strategies, culturally competent care, supportive supervision.
- *Examples of Interventions*: Anti-bias training programmes, provider accountability mechanisms, survivor-centred care protocols.

4. Service delivery during pandemics and large-scale emergencies: What are the most effective strategies to ensure the continuity of essential SRHR services (MISP and comprehensive) during pandemics and other large-scale emergencies?

- *Focus areas:* Remote/ digital consultation models, workforce adaptation, public health messaging.
- *Examples of Interventions:* Digital SRHR services, telemedicine for crisis settings, community-based continuity models.

5. Transitioning from acute to comprehensive care: How can SRHR service delivery models transition effectively from MISP to comprehensive SRHR in protracted humanitarian settings?

- *Focus areas*: Service integration, sustainability, workforce training / task-sharing
- *Examples of Interventions:* PHC integration models, midwife-led service expansion, community task-shifting.

6. Increasing SRHR services for people-on-the-move: What strategies are most effective in increasing demand for and uptake of SRHR services among people-on-the-move?

- *Focus areas:* Overcoming cultural, logistical, and policy barriers to service access.
- *Examples of Interventions*: Mobile outreach, peer-led demand generation, targeted social media health campaigns.

7. Supply chain preparedness: What are the most effective approaches for ensuring SRHR supply chain preparedness for acute humanitarian crises or conflict?

- *Focus areas*: Stock pre-positioning, supply chain resilience in conflict settings.
- *Examples of Interventions*: AI-driven forecasting, climate-adaptive storage solutions, mobile stock replenishment models.

Crosscutting – Climate Resilience

1. Resilient SRHR service provision: What resilience-building strategies and interventions can be implemented to ensure continuity of SRHR services (provision and access/use) and protection of SRHR health in climate-affected humanitarian settings?

- *Focus areas:* Service continuity in climate crises, climate-resilient infrastructure; Local ownership of climate-resilient SRHR responses, community-driven adaptation strategies.
- *Examples of Interventions*: Mobile SRHR clinics; creating emergency pools of health providers & resources to mobilize for extreme climate events); solar-powered health facilities, climate-adaptive workforce planning; digital health tools (including telemedicine; AI-drive service delivery; cross-sectoral adaptation strategies; inter-ministerial climate-health initiatives

2. Distribution of SRHR commodities: What are the most effective distribution models for SRHR commodities in populations affected by climate crises and displacement?

- *Focus areas*: Last-mile delivery innovations, community-based distribution, stock replenishment in disaster settings-; availability of essential medicines & supplies; access to essential medicines.
- *Examples of Interventions:* Drone-assisted SRHR supply delivery, CHW-led contraceptive distribution, mobile stock replenishment for displaced populations.

3. Mitigating climate effects in maternal and newborn health (MNH): What are the effective strategies and interventions to mitigate the effects of climate-related crises (eg, heatwaves, drought) on maternal and newborn health outcomes?

- *Focus areas:* Measure climate-related impacts on maternal and newborn health and impact of mitigation / response strategies and interventions. protecting pregnant women and newborns from extreme temperatures (Kangaroo mother care / heat exposure).
- *Examples of interventions to explore:* Heatwave-adapted ANC/PNC model / facilities / technologies, climate-responsive maternity care; community-led mitigation strategies.

ANNEX 2

Scorecards for 2025 SRHR research priorities by domain and by region, listed in order that research questions were presented in the ranking survey tool, showing score (mean) and standard deviation (SD)

Scorecard for SRHR Domain 1: Comprehensive Sexuality Education (CSE)

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	172		28		20		11		35		25		106	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Effective delivery models for CSE	21.80	11.4	20.24	13.6	23.34	17.1	15.46	9.2	23.56	12.0	25.09	13.5	21.66	9.2
2. Engaging parents and caregivers in CSE	16.86	8.0	17.07	10.0	16.57	12.6	20.10	16.6	17.31	10.4	17.83	8.4	17.44	8.6
3. Gender-transformative approaches in CSE	15.30	8.7	17.54	9.9	11.68	5.9	13.39	8.9	11.40	6.8	15.25	7.7	15.05	8.8
4. Training and supporting CSE facilitators	16.35	8.1	14.49	8.9	16.11	9.7	13.82	8.8	17.49	8.9	15.01	7.8	15.94	8.5
5. Integrating CSE into adolescent-friendly health services	16.34	10.8	17.02	12.0	20.44	18.0	22.37	19.5	17.96	13.4	17.29	13.6	16.73	12.0
6. Safe and inclusive CSE for marginalised groups	13.36	9.5	13.63	9.5	11.86	10.8	14.86	13.6	12.28	10.4	9.53	7.2	13.19	9.8

Scorecard for SRHR Domain 2: Sexual Health and Wellbeing

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	181		23		21		11		42		32		113	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Integration of sexual and reproductive health and rights (SRHR) and mental health	15.78	8.3	13.07	7.2	15.10	8.2	10.91	4.4	16.38	7.5	17.72	11.4	15.81	7.9
2. Strengthening SRHR and mental health training for providers	15.56	7.9	14.30	8.3	14.38	9.1	12.27	5.2	17.05	9.3	18.06	9.3	15.49	7.9
3. Overcoming stigma and barriers to mental health and SRHR access	14.06	8.1	14.59	8.8	13.19	8.6	17.45	8.7	12.81	7.8	14.22	9.2	13.74	8.0
4. Integration of SRHR and mental health with non-communicable diseases (NCDs)	9.94	6.7	9.63	7.7	10.76	7.6	14.91	7.4	9.60	8.7	9.97	6.9	9.66	6.3
5. Addressing menopause and sexual health needs	9.13	6.2	10.93	8.3	9.57	7.6	13.82	8.4	8.21	5.8	8.78	7.6	9.23	6.4
6. Adapting and monitoring quality of SRHR interventions	13.06	7.8	14.26	9.3	15.05	10.2	13.36	6.4	14.19	9.2	11.31	6.8	13.55	8.4
7. Safe spaces as an entry point for integrated SRHR and mental health care	12.05	8.0	12.37	11.7	9.81	7.0	7.45	3.6	11.05	10.2	9.59	6.8	12.10	8.4
8. Addressing language and cultural barriers to SRHR access	10.50	8.2	10.85	7.9	12.14	8.5	9.82	5.5	10.71	7.2	10.34	7.8	10.42	8.2

Scorecard for SRHR Domain 3: Family Planning (FP) and Contraception

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	216		34		25		14		48		43		136	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Ensuring reproductive choice in humanitarian settings	16.71	10.6	17.35	14.5	15.80	9.2	12.86	12.8	17.63	9.3	15.98	8.8	17.45	11.6
2. Overcoming barriers to long-acting reversible contraceptives (LARC) access and acceptance (demand-side)	14.37	7.9	14.94	10.9	13.16	6.6	10.43	6.4	14.69	7.6	15.88	8.7	14.46	8.4
3. Increasing adolescent access to contraception	14.90	7.8	16.18	9.9	13.88	6.6	14.36	9.9	13.48	8.0	14.70	9.0	15.01	8.0
4. Contraceptive use among vulnerable populations	12.08	7.0	11.21	7.5	13.72	8.5	17.14	10.0	12.06	7.1	11.47	6.1	11.76	7.5
5. Financial assistance to increase contraceptive uptake	8.94	6.8	7.79	6.7	8.67	6.3	11.00	6.3	9.02	7.0	7.74	6.2	8.80	6.8
6. Overcoming socio-economic barriers to contraceptive use	10.95	7.7	11.24	6.7	11.80	11.0	10.29	8.2	10.35	7.0	11.05	7.2	10.49	6.8
7. Implementing full range of contraceptive choices at the onset of an emergency	11.19	6.8	12.26	8.4	11.56	7.5	13.21	7.2	11.69	7.6	11.05	7.1	11.18	7.2
8. Supply chains during active and ongoing displacement contexts (supply-side)	10.86	8.1	9.03	7.2	11.76	9.8	10.71	7.6	11.08	9.4	12.14	8.7	10.83	7.7

Scorecard for SRHR Domain 4: Cancers of the Reproductive System

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	116		10		13		8		36		26		76	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Equitable human papillomavirus (HPV) vaccination	34.78	14.2	38.50	5.8	35.85	11.7	35.00	7.1	34.19	14.5	37.88	12.7	35.04	15.6
2. Integrating HPV-based cervical cancer screening into existing sexual and reproductive health rights (SRHR) services	34.74	11.9	42.00	9.2	38.92	8.6	39.38	9.4	35.67	10.5	37.12	10.8	34.61	12.9
3. Raising awareness where treatment is accessible	30.47	16.1	19.50	6.9	25.23	11.7	25.63	12.4	30.14	15.4	25.00	16.1	30.14	16.0

Scorecard for SRHR Domain 5: Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	174		23		20		13		34		32		116	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Scaling up STIs and HIV testing for displaced and high-risk populations	17.35	7.7	17.22	10.0	15.45	6.5	14.23	5.7	18.50	6.4	19.50	6.7	17.67	7.5
2. Preventing STIs in forced migration settings	14.78	6.8	17.91	8.2	15.55	7.6	19.85	11.0	14.56	7.8	12.38	6.1	14.53	6.9
3. Scaling up vaccines to prevent STIs	13.80	8.9	14.57	11.6	14.80	7.3	22.31	19.2	15.85	13.2	12.19	7.1	13.79	9.2
4. Responding to antimicrobial resistance for gonorrhoea treatment in conflict settings	9.96	6.7	8.13	5.5	10.30	6.9	9.15	6.4	11.24	6.9	10.66	6.8	10.03	7.4
5. Strengthening partner notification	9.80	6.1	5.84	5.8	9.50	5.3	7.54	5.8	8.12	6.6	8.91	6.0	9.66	6.5
6. Multipurpose prevention technologies (MPTs)	10.33	6.6	10.48	8.0	12.75	6.0	7.46	6.0	10.32	6.7	10.72	6.2	9.96	6.9
7. Scaling up STI prevention and post-exposure prophylaxis (PrEP), STI management and post-exposure prophylaxis (PEP)	14.64	9.1	15.91	10.3	14.85	9.0	13.85	12.4	15.38	13.8	11.47	6.9	14.51	9.8
8. Preventing STI-related infertility	9.33	7.1	5.74	4.5	6.80	5.5	5.62	4.1	6.03	4.3	6.53	5.4	9.86	7.9

Scorecard for SRHR Domain 6: Maternal and Newborn Health (MNH): Antenatal/Perinatal Care

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	190		28		22		10		42		34		123	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Context-specific approaches for increasing access to MNH	20.95	10.0	19.11	12.1	16.91	8.0	18.90	6.2	20.50	8.7	19.22	8.8	21.12	10.7
2. Continuity of MNH care for women and babies on the move	19.01	8.1	17.96	7.3	20.32	7.1	19.10	7.0	17.88	6.5	19.81	7.0	18.82	9.0
3. Community-based antenatal and intrapartum care	18.63	9.8	23.21	12.0	21.05	12.0	24.80	14.0	17.38	11.0	17.51	7.7	18.01	10.7
4. Strengthening basic emergency obstetric and neonatal care (EmONC)	21.76	8.9	21.25	9.0	23.50	9.2	19.80	8.1	22.52	10.5	22.97	8.9	21.88	10.0
5. Emergency referral mechanisms	19.65	10.0	18.46	10.4	18.23	10.3	17.40	10.1	21.71	8.9	20.49	9.4	20.17	10.7

Scorecard for SRHR Domain 7: Maternal and Newborn Health (MNH): Postnatal/Newborn Care

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	184		28		21		10		42		35		120	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Community-based postnatal care (PNC)	26.44	11.67	30.71	17.09	22.81	9.77	28.80	8.75	25.48	9.25	24.14	9.19	25.80	10.81
2. Essential newborn care in conflict settings	28.27	12.20	26.07	11.50	31.05	18.11	23.50	13.55	31.26	13.71	32.71	15.36	27.78	10.12
3. Early initiation of breastfeeding	20.34	9.85	19.29	11.28	18.10	8.40	17.20	10.14	20.17	8.80	19.71	9.23	20.11	9.91
4. Mitigating and managing postnatal depression	24.95	12.84	23.93	11.33	28.05	17.07	30.50	19.92	23.10	15.14	23.43	10.34	26.32	13.24

Scorecard for SRHR Domain 8: Comprehensive Abortion Care

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	149		29		15		11		33		28		96	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Policies	16.33	9.2	15.24	8.9	17.07	10.4	15.55	9.3	20.48	11.7	14.39	5.6	16.23	9.5
2. Financing and cost barriers	12.54	7.4	10.83	9.1	12.87	5.3	12.18	9.3	10.45	8.6	12.25	6.0	12.27	7.5
3. User acceptability, quality and person-centred abortion care	14.73	7.0	14.31	8.9	15.07	8.7	23.18	9.3	11.09	7.2	16.32	6.2	15.26	6.8
4. Improving women's experience and access to abortion care	16.49	8.1	20.31	10.3	15.47	5.5	18.00	10.0	14.12	9.0	18.29	6.6	15.93	8.0
5. Service delivery innovations for comprehensive abortion care	14.46	7.5	14.48	9.6	15.13	9.0	14.00	7.1	12.12	10.6	13.29	6.0	14.72	8.3
6. Addressing barriers to reproductive autonomy and ability to choose	12.46	7.0	14.93	9.0	11.60	6.5	7.18	6.2	8.45	7.6	11.64	4.4	12.40	7.6
7. Provider support, wellbeing and training	12.99	7.7	7.79	7.8	12.80	8.2	9.91	8.3	9.06	9.0	13.82	5.9	13.20	8.3

Scorecard for SRHR Domain 9: Clinical Management of Rape

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	114		18		19		9		33		24		74	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Increasing timely access to post-rape care in legally restrictive settings	20.25	12.2	19.17	11.7	21.37	10.7	13.78	8.2	23.21	11.4	22.50	10.2	20.30	13.6
2. Increasing health-seeking behaviours and referrals	16.49	8.1	14.72	9.2	15.00	9.6	18.11	10.2	16.45	8.0	14.79	7.7	16.76	8.8
3. Testing guidelines as a tool to increase quality of clinical management of rape	12.04	7.4	15.28	10.2	11.58	7.8	11.22	10.0	11.09	7.4	13.13	9.1	11.70	7.8
4. Expanding the clinical management of rape access for marginalised and key populations	14.27	7.3	15.56	10.6	13.47	7.0	17.44	11.6	15.00	9.8	14.38	5.0	13.47	7.9
5. Task sharing the clinical management of rape	14.39	6.0	8.57	8.6	15.63	12.9	14.44	6.8	11.85	7.2	13.96	8.3	14.57	10.8
6. Role of remote consultations to support health workers	10.08	10.0	8.89	6.3	9.95	7.2	8.67	6.1	10.03	7.7	10.63	7.6	10.00	6.5
7. Increasing access for males	12.47	7.6	9.72	5.5	13.00	10.2	16.33	10.2	12.36	8.7	10.63	7.1	13.20	8.5

Scorecard for Crosscutting – Stakeholder Engagement

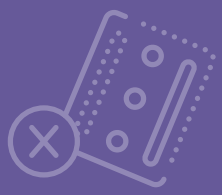
Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	219		34		22		14		49		38		136	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Preventing mistreatment and ensuring respectful care	16.95	9.1	18.03	12.4	18.82	9.9	14.93	8.3	17.88	10.9	19.47	8.0	17.46	9.5
2. Community-led interventions to increase access	18.35	9.5	19.44	16.3	19.09	9.7	21.07	10.6	17.27	15.6	18.45	7.6	18.19	10.6
3. Community engagement and equity	15.00	6.9	14.82	8.1	15.77	6.0	17.43	7.7	11.02	5.9	14.68	5.3	15.01	7.5
4. Engaging boys and men	13.90	7.4	14.26	7.8	15.00	5.6	17.29	6.0	11.78	7.5	14.47	8.1	13.82	7.8
5. Social accountability	11.44	6.3	9.35	6.0	10.86	7.6	7.50	7.3	10.29	7.9	11.71	5.4	11.45	5.9
6. Communication strategies	11.33	6.8	9.44	6.5	8.77	5.9	8.29	6.1	9.53	7.2	10.47	5.5	11.40	7.2
7. Governance and partnerships	13.02	9.6	14.65	17.2	11.68	8.4	13.50	8.6	11.92	7.3	10.74	6.1	12.68	8.3

Scorecard for Crosscutting – Service Delivery and Health Systems

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	215		36		37		17		48		40		132	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Digital information, education and communication (IEC) to increase sexual and reproductive health and rights (SRHR) knowledge and access	15.58	9.4	16.11	11.5	13.97	7.1	15.59	9.7	14.73	11.0	14.43	8.3	14.84	9.1
2. Training models for sustained community health worker (CHW) learning	16.01	10.8	17.44	16.9	16.51	11.3	12.94	6.9	14.69	8.8	18.58	11.7	14.90	9.2
3. Values-based education	12.61	6.6	13.42	8.0	12.95	5.5	13.76	7.1	12.69	6.7	13.13	6.2	12.57	6.8
4. Service delivery during pandemics and large-scale emergencies	14.71	7.4	13.22	7.1	15.08	7.6	12.82	6.2	16.21	9.0	15.25	7.7	14.77	7.3
5. Transitioning from acute to comprehensive care	13.10	7.4	13.17	7.1	14.35	8.8	16.76	11.3	12.77	8.9	12.83	8.0	13.39	7.6
6. Increasing SRHR services for people-on-the-move	14.37	8.0	16.25	9.0	14.11	6.7	14.00	7.6	14.50	8.9	14.38	8.2	14.95	8.5
7. Supply chain preparedness	12.00	8.8	10.39	6.5	13.03	9.1	14.12	12.4	14.42	11.4	11.43	6.4	14.59	9.2

Scorecard for Crosscutting – Climate Resilience

Region:	All respondents		Latin America and the Caribbean		East Asia and the Pacific		Europe and Central Asia		Middle East and North Africa		South Asia		Sub-Saharan Africa	
Total number of respondents:	153		18		21		10		41		31		94	
Research topic	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD	Score (mean)	SD
1. Resilient sexual and reproductive health and rights (SRHR) service provision	35.59	16.0	41.39	26.0	38.19	16.5	35.00	14.5	35.12	15.2	34.52	13.0	32.22	12.7
2. Distribution of SRHR commodities	29.77	13.5	27.50	23.1	27.05	10.4	36.00	12.9	29.98	15.3	27.90	11.5	30.62	13.9
3. Mitigating climate effects in maternal and newborn health (MNH)	34.63	18.0	31.11	23.3	34.76	19.1	29.00	9.7	34.90	16.6	37.58	20.4	37.16	17.7



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info@elrha.org

Elrha, 1 St John's Lane, London, EC1M 4AR, UK.

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