Strengthening Social and Behavior Change for Family Planning in Fragile and Humanitarian Crisis Settings

A Landscape Analysis and Recommendations

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Acronyms

ASRH	Adolescent sexual and reproductive health
CAC	Community Action Cycle
CBO	Community-based organization
CEA	Community engagement and accountability
CHAT	Community Engagement in Humanitarian Action Toolkit
CHW	Community health worker
CHW AIM	Community Health Worker Assessment and Improvement Matrix
CHV	Community health volunteer
CSC	Community Score Card
DRC	The Democratic Republic of the Congo
FP	Family planning
GBV	Gender-based violence
GREAT Toolkit	Gender Roles, Equality, and Transformation Toolkit
HSS	Health Systems Strengthening
IAWG	Inter-Agency Working Group in Reproductive Health in Crisis
IRC	International Rescue Committee
LARC	Long-acting reversible contraceptive
MISP	Minimum Initial Service Package
M&E	Monitoring and evaluation
MOH	Ministry of Health
MOPHP	Ministry of Public Health and Population
NGO	Nongovernmental organization
OCHA	UN Office for the Coordination of Humanitarian Affairs
PAC	Postabortion care
PAR	Participatory action research
PBC	Provider behavior change
PDQ	Partnership Defined Quality

RCCE	Risk communication and community engagement
SBC	Social and behavior change
SBCC	Social and behavior change communication
SEM	Socio-Ecological Model
SRH	Sexual and reproductive health
UN	United Nations
WHO	World Health Organization

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Background

An estimated 24% of the world's population (1.9 billion people) reside in the 60 countries that the Organization for Economic Cooperation and Development (OECD) identified as fragile settings in 2022.[1] An estimated 339 million people needed humanitarian assistance and protection in 2023, according to the global humanitarian overview.[2] However, these contexts are not always mutually exclusive. A country or context may be considered a fragile setting when a crisis hits, and become a humanitarian crisis setting as the crisis persists. Also, a country or context that wasn't previously fragile may become a fragile setting after a humanitarian emergency or crisis (**Box 1**).

Box 1. Defining fragile and humanitarian crisis settings

Fragility, according to the OECD, is "the combination of exposure to risk and insufficient coping capacities of the state, system and/or communities to manage, absorb or mitigate those risks. It occurs in a spectrum of intensity across six dimensions: economic, environmental, political, security, societal and human."[1]

A humanitarian crisis is considered an event or events that threaten the health, safety, or well-being of a large group of people. Humanitarian crises can be caused by conflict, natural disasters, famine and/or disease outbreak. Humanitarian crises have devastating physical, psychological, and social consequences for people in the community.[3]

A humanitarian crisis can emerge in a country that was not classified as fragile based on the OECD indicators. However, the humanitarian crisis may lead to fragility in context (e.g., the COVID-19 pandemic can be considered a humanitarian crisis,[4] and pushed some countries not categorized as fragile toward fragility during this life-changing event).[5]

Acknowledging the relationship between fragile settings and humanitarian settings, and how each impact sustainable development of and within a country, the Humanitarian-Development-Peace Nexus captures the interlinkages between humanitarian, development, and peace actions. The Nexus approach seeks to strengthen collaboration and complementarity between humanitarian and development actors. By capitalizing on the comparative advantages of each pillar—to the extent of their relevance in the specific context—the Nexus approach aims to reduce overall vulnerability and unmet needs, strengthen risk management capacities, and address root causes of conflict.[2] This document will reference both fragile and humanitarian contexts, and refer to development contexts mainly when speaking about crisis preparedness.

Family Planning in Fragile and Humanitarian Crisis Settings

In all fragile and humanitarian crisis settings, people continue to have reproductive health needs, including avoiding unintended pregnancy and childbearing through informed and voluntary use of family planning (FP) services.[6,7] However, FP continues to be under-prioritized in these contexts, and any pre-existing gaps in FP and sexual and reproductive health (SRH) quality and service access are further exacerbated in crisis settings, particularly when crisis preparedness is lacking.[8,9]

In humanitarian or fragile settings, respectively, short-term system or service disruptions or long-term fragility may occur due to chronic problems. Immediately after a crisis strikes, health services often become inaccessible when health workers cannot be paid or are themselves displaced.[5,10–13] As their personal safety and mobility becomes restricted, particularly during armed conflict, clients access health services—including FP/SRH services—less frequently.[14–16] When clients are able to access functioning services, the services may not be client-centered and may not offer a full range of contraceptive methods, including long-acting reversible contraceptives (LARCs),[9] which can offer the most reliable and lasting pregnancy prevention in otherwise unpredictable contexts. Pregnant women may be cut off from assisted deliveries and postpartum FP services in clinics, hospitals, and health posts.[14] Amid a crisis, unplanned pregnancies and incidents of intimate partner and gender-based violence (GBV) against women often increase.[17]

Adolescents, women of reproductive age, persons living with disabilities, and other groups affected by inequality and discrimination face additional barriers to FP services during a crisis as these groups' SRH needs are rarely a focus in fragile and humanitarian crisis settings.[9] This constellation of factors heightens the need for strong social and behavior change (SBC) for FP and preparedness in development, fragile, or humanitarian crisis settings to respond to identified gaps when a crisis happens or is ongoing. SBC for FP generally includes activities that aim to (1) positively impact FP knowledge, attitudes, skills, and risk perception; (2) adjust community, social, and traditional norms to increase FP acceptance and informed, voluntary desire for services; (3) improve quality of FP care through provider behavior change (PBC) interventions that improve interpersonal, provider-client interactions; and (4) link with health systems strengthening (HSS) partners to address provider knowledge and skills gaps through systems. Examples of SBC for FP in fragile and humanitarian crisis settings include working with CHWs and community, religious, and traditional leaders to organize discussions with community members about the benefits and availability of FP despite and during unrest; facilitating community and facility-led action planning or community-led solutions to improve FP service quality and access, leveraging available resources during a crisis; working with providers to provide quality, tailored, and non-judgmental FP counseling and services to clients with limited resources due to a crisis; and disseminating FP information in dynamic formats used by priority audiences during a crisis, such as through via operating radio stations, media, or other outlets.

In 2023, Breakthrough ACTION conducted a series of assessment activities to understand the current state of SBC for FP in fragile and humanitarian crisis settings, and opportunities to improve it in the future. The purpose of this brief is to summarize the process, findings, and insights gained from this landscape assessment and to highlight recommendations emerging from assessment activities to strengthen SBC for FP in fragile and humanitarian crisis settings. The information included here is intended for action among professionals and decision-makers at community, country, regional, and global levels who are working in development (pre-crisis), fragile, or humanitarian crisis settings in SBC or FP/SRH.

Activity Overview

Breakthrough ACTION conducted a landscape analysis of SBC for FP in fragile and humanitarian crisis settings exploring four research questions (Box 2). This analysis included global, regional, and country-level (DRC and Yemen) activities, specifically:

- A desk review of peer-reviewed and gray literature exploring the four research questions;
- KIIs with global, regional, and country-level stakeholders; and
- A technical consultation with experts working in SBC, FP/SRH, or fragile and humanitarian crisis settings at the global or regional level.

Box 2. Research Questions

1. What SBC for FP crisis-related guidance, strategies, and tools exist at the global and regional levels?
2. How are SBC for FP activities and approaches currently considered and integrated into programming across all phases of a crisis?
3. Based on what has been done to date, what is known about the objectives, key stakeholders, audiences, and impact of SBC for FP in humanitarian crisis settings?
4. What are key gaps and opportunities for SBC for FP in crisis settings?

Methodology

Breakthrough ACTION conducted the desk review and analysis from April through December 2023. While most key words used in the search were specific to FP, broader SRH topics emerged in our review. The search identified more than 20 peer-reviewed and gray literature documents. A full list of articles is available in the final desk review report. Most of the literature that emerged during the desk review pertained to humanitarian crisis settings. The literature included limited information on crisis preparedness but did not explicitly include development settings.

Breakthrough ACTION then developed KII guides for four different types of stakeholders working in fragile and/or humanitarian crisis settings, including implementing partners, MOH representatives, service providers, and CHWs, with attention to exploring gaps that emerged in the desk review. For example, through the KIIs, Breakthrough ACTION explored SBC for FP in fragile settings in addition to how SBC tools for development settings were adapted for use in fragile or humanitarian crisis contexts. The focus of the KIIs remained on FP with questions related to SRH included as an entry point to more detailed questions related to FP. Because "fragile" can be perceived as a loaded or political categorization that governments do not always receive well, Breakthrough ACTION did not include the word in interview questions. Instead, the project inquired about FP coordination, access, and SBC at various stages of "a crisis." A protocol outlining the process was submitted to Johns Hopkins University Institutional Review Board and received approval as a public health practice activity in November 2023. A total of 29 participants were purposively sampled including global/regional stakeholders (N = 12) and country-level stakeholders in DRC (N = 9) and Yemen (N = 8). The project conducted all interviews in December 2023 over Microsoft Teams or WhatsApp and recorded with participants' consent. Interviews included the interviewee, interviewer, and a notetaker. The interviews were manually coded and analyzed thematically by Breakthrough ACTION. The project did not offer any incentives for participating in KIIs.

Breakthrough ACTION then held a technical consultation with 19 experts working in SBC and FP in fragile and humanitarian crisis settings in January 2024. Participants represented implementing partners, representatives from technical working groups of coordinating bodies, academia, and donors. During the technical consultation, the project presented the desk review and KII findings, including key takeaways, challenges, gaps, and opportunities. Through group work, participants provided validation, additional feedback, and recommendations on how to strengthen SBC for FP in fragile and humanitarian crisis settings. Participants also shared their experiences adapting SBC tools designed for use in development settings, to fragile and humanitarian contexts.

Findings

Results from the desk review, KIIs, and technical consultation were triangulated and integrated into a single set of findings which reflect these data sources.

- **Understanding of SBC differs across the literature and by stakeholders in different sectors.** Descriptions of SBC in the literature and across stakeholder interviews varied widely. The literature describes SBC programs and interventions as interventions being conducted via different channels (e.g., mass media, community group engagement, digital);[18] another SBC strategy describes SBC as using participatory approaches (e.g., community-led processes, including the Community Score Card (CSC)* or the Community Action Cycle (CAC),†) to strengthen health resilience.[19] In KIIs, stakeholders' descriptions of SBC interventions ranged from participatory community engagement and community decision making to one-way communication to provide information to community members about available services. Stakeholders emphasized the need to holistically understand how to define SBC, the short- and long-term benefits of SBC, how to implement evidence-based SBC in humanitarian settings, and how programs can adapt in an acute crisis to include contextualized and well-thought-out SBC components.
- **The humanitarian, development, and peace communities have limited integration.** This means fewer opportunities are available for those working in each space to collaborate and integrate relevant SBC approaches within the Humanitarian-Development-Peace Nexus. Stakeholders, through KIIs and during the technical consultation, reinforced that more collaboration would lead to joint planning and facilitate integration of SBC program design.
- **Little documented research or literature is available that describes SBC activities across the different stages of crisis.** In the literature about SBC for FP in humanitarian crisis settings, guidelines and program descriptions rarely specified during what phase a given activity or approach should be or was used. While some literature alludes to a particular crisis phase, often the terms used were not uniform across authors and organizations. As part of its own analysis, Breakthrough ACTION attempted to map guidance and programs' respective strategic priorities and implementation approaches across crisis phases and referred to the following stages of crisis: preparedness, acute, post-acute, protracted, and recovery (Annex 1 contains definitions). In its analysis of the literature and KII findings, the project compiled a variety of SBC approaches (Annex 2 contains definitions) and how implements have leveraged them across the phases of crisis in humanitarian settings (details are in Annex 3). Key points include:

* CARE's CSC is a citizen-driven accountability approach for the assessment, planning, monitoring, and evaluation of public services.[20]

† CAC is a proven community mobilization approach which fosters individual and collective action to address key health program goals and related outcomes.[21]

- Key stakeholders do not see SBC approaches as "lifesaving." However, during KIIs and in the expert consultation, many stakeholders emphasized that when programs invest in SBC approaches during the **preparedness** phase in humanitarian crisis and fragile settings, such as advanced community engagement (e.g., CAC, Partnership Defined Quality (PDQ)[‡], and CSC) they can build more resilient communities. This resilience helps communities respond to and recover from different crises more quickly and allows programming to rebuild because communities have already developed crucial connections and structures. FP/SRH programs in this phase focused most at the policy, service delivery, and community levels.
- SBC activity objectives and implementation vary according to crisis phase and context. When an *acute* crisis occurred, programs tended to focus on risk communication, designed to inform people where they can access basic health and FP/SRH services. Programs designed or implemented in **post-acute** and **protracted** phases tended to focus on re-establishing quality health and FP/SRH services permanently. SBC for FP/SRH programs in these phases focused most on the service delivery, community, and individual levels. Once in the **recovery** and **protracted** phases, focus often returned to policy changes and (re)building community resilience amidst the revival of more accessible FP/SRH and other health services, along with re-established community structures.
- In times of crisis, access to the community is more restricted. Due to reduced access, KIIs found that implementers modified preparations for programming (including assessments) included distance-based approaches (e.g., photovoice) or rapid interviews to gather needed program planning information and ensure that programs respond to communities' real-time FP/SRH needs and priorities.

- The desk review highlighted that **funding in fragile and humanitarian crises is disjointed**, with limited, short-term funding focused on perceived life-saving interventions that did not always include FP/SRH. This finding was reinforced by KIIs and the technical consultation. In 2018, the average length of a humanitarian response plan was 9.3 years, up from 5.2 years in 2014.[23] However, typical humanitarian responses receive short-term funding of six months to one year.[24] The protracted nature of a crisis highlights the importance of multi-year funding and approaches to planning.[23] While humanitarian donor guidelines feature the Minimum Initial Service Package (MISP), which includes preventing unintended pregnancy, implementing partners may not perceive FP/SRH services a as a lifesaving intervention and therefore do not include them; instead, initial services usually include water, shelter, food, and immediate emergency health.[3] While donors and implementing partners often have specific mandates for work in crises, MOH staff usually have dual mandates covering both development and humanitarian programing. A lack of synergy in funding priorities between these stakeholders

[‡] Partnership Defined Quality (PDQ) is an approach for improving the quality and accessibility of services whereby the community is involved in defining, implementing, and monitoring the quality improvement process. It involves health care providers, community members and key stakeholders in overcoming inadequacies of health services.[22]

and mandates creates a gap for many services including FP/SRH. Overall, there is limited funding for SBC in FP/SRH within fragile and crisis settings at each stage of crisis.[15–17,25,26]

- **SBC for FP in humanitarian crisis settings is underprioritized.** Lack of funding for emergency preparedness work stymies inclusion of strong SBC for FP planning and implementation in humanitarian crisis settings. KIIs indicated that potential implementers often view using evidence-based approaches in SBC—which they may not understand well—as overly complex and challenging.
- **Coordination challenges persist within the humanitarian community.** While coordination mechanisms exist in different humanitarian settings (e.g., World Health Organization (WHO) and MOH-led national and subnational health clusters and SRH health working groups), the strength of that coordination mechanism varies by setting and crisis. This specifically arose during KIIs with global and regional stakeholders and at the country level with MOH and implementing partner stakeholders.
- **Available, detailed guidance for "how to" implement SBC for FP/SRH in humanitarian crisis settings is limited.** The desk review identified just five FP/SRH-specific guidelines for humanitarian settings that include references to SBC approaches, as well as six resources on SBC in humanitarian settings that were not specific to FP/SRH. Few of the identified resources provided sufficient information or detail on how to plan, implement, monitor, or evaluate SBC in crisis settings generally, or by crisis phase specifically. However, some humanitarian crisis resources that are not FP-specific can apply to SBC for FP/SRH programs; for example, the Community Engagement in Humanitarian Action Toolkit (CHAT) and Communicating with Communities in Epidemics and Pandemics: Risk Communication and Community Engagement Readiness Kit. Similarly, many SBC approaches and resources for development settings can and have been adapted and applied, and are proven effective, in many humanitarian settings. The desk review and KIIs identified a total of 41 guidelines or tools, including resources adapted from development settings to humanitarian crisis settings but not yet published or publicly available (see Annex 4 for a full list of guidelines and tools from the desk review and KIIs). For example, the KIIs identified a partner who adapted the Community Health Worker Assessment and Improvement Matrix (CHW AIM) tool. Here, the partner worked with country stakeholders and added three modules (preparedness, CHW safety, and risk communication and community engagement (RCCE)) to the existing 10 modules to make it applicable to humanitarian settings. Additionally, in KIIs, the MOPHP in Yemen noted general guidelines for all settings on SBC for RH would soon be available.
- **Opportunities are available to learn from other sectors' SBC work in humanitarian crisis settings beyond health.** SBC work involving health in the education sector (i.e., promotion of hygiene, menstrual health and hygiene, and comprehensive sexuality education in schools) can be adapted and used in SBC for FP/SRH approaches, as the technical consultation recommended.

- **SBC is gaining traction among Inter-Agency Working Group on Reproductive Health in Crises (IAWG)[§] partners and other coordinating bodies.** In 2023, the SRH task team of the WHO-led Health Cluster began to solicit existing SBC for FP resources. The Women's Refugee Commission and SRH task team will review and compile these materials in 2024, providing an excellent opportunity to continue learning about SBC for FP in humanitarian crisis settings.
- Despite limited guidance documents, **SBC for FP activities have been implemented in humanitarian settings for different audiences, and at various levels of the Socio-Ecological Model (SEM)** (**Figure 1**). An overview of these SBC approaches and activities include:[**]
    - Approaches for influencing individuals' behaviors, including young, married women; pregnant and postpartum women; adolescents; older women including with daughters of marriageable age; couples; and men: The desk review and KIIs identified interventions for impacting individual FP/SRH behaviors by working with community and key gatekeepers. Specifically, many interventions focused on partnering with community health volunteers (CHVs), community and religious leaders, and social mobilizers for health talks, door-to-door visits, peer education, and client-centered counseling by health providers.[19,23,26–29] Media was less frequently utilized. However, one example described leveraging interactive local radio talk shows with religious leaders and health workers, and a series of radio drama episodes covering five key FP and maternal, child, and newborn health topics, to support healthy birth spacing in Northeast Kenya. CHVs, equipped with solar-powered radios and memory sticks with the broadcast content, hosted community-based listening groups. Radio memory sticks allowed the CHVs to replay the shows if aired at a time some were not able to attend and in media dark areas.[28]
    - SBC approaches for working at the community level: The desk review also identified community-led approaches including participatory action research, working with Community Health Committees and community and religious leaders to elevate the

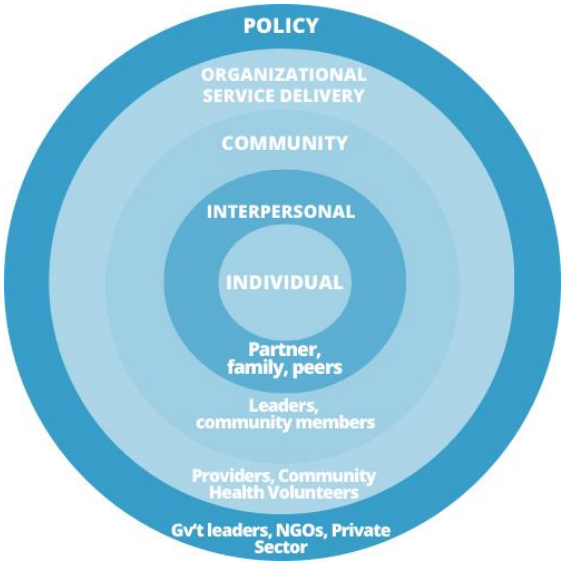

Figure 1. The Socio-Ecological Model, which considers how interrelated social and environmental factors impact health, knowledge, attitudes, and behaviors.

[§] IAWG is an international coalition of organizations and individuals working collectively to advance SRH and rights in humanitarian settings.

[**]Details of examples by level of SEM can be found in the desk review presentation annexes.

importance of FP/SRH access and facilitate community-based solutions, and social accountability mechanisms to ensure increased access to and use of FP/SRH services.[27,29,30,31] KII respondents elaborated on more participatory methods including community-led design/planning, social analysis and action, participatory action research (PAR), husbands' schools and community feedback mechanisms informing community action planning; KIIs mentioned specifically the Gender Roles, Equality, and Transformation (GREAT) Toolkit, CAC, and the CSC.

- SBC approaches for working at the organizational and service delivery level: Both the desk review and KII respondents described the importance of reinforcing health worker FP/SRH capacities, specifically in (1) service delivery interventions—including leveraging workforce trainings—to build health workers' FP/SRH knowledge and skills, supportive supervision and developing the skills of master trainers, as well as having training centers[30,32,33]; and (2) PBC approaches (such as the CHW AIM Checklist, PDQ, PDQ for Youth, and Beyond Bias) designed to identify and address behavioral determinants (e.g., structural, attitudes, knowledge, beliefs) impacting FP/SRH service quality and increasing social accountability.
- SBC approaches for working at the policy level and with project/institution staff: The desk review identified global advocacy efforts whereby IAWG partners (e.g., CARE, International Rescue Committee (IRC), Save the Children) advocated for acceptance and inclusion of FP and postabortion care (PAC) in the 2018 version of the MISP based on evidence from their FP and PAC projects. At the national level, IRC supported civil society organizations in Uganda and Chad to advocate for increased funding for SRH in emergencies and in DRC, IRC advocated to develop clinical protocols and SRH and rights guidelines during the Ebola virus disease outbreak which enabled task shifting LARCs to midwives and nurses;[27] in DRC and Somalia, Save the Children advocated with MOH and provincial authorities, and trained a variety of staff on FP, PAC, and SRH in DRC and Somalia, which likely influenced additional policies and training and guidelines;[33] and in Somalia, religious scholars, elders, and community leaders advocated for FP during community campaigns and in meetings with MOH.[33] KIIs described institutional and organizational interventions focused on strengthening SBC and FP/SRH capacity (skills, knowledge, attitudes) at varying levels of staff members at the global, regional, and national levels (e.g., United Nations (UN) agencies, international nongovernmental organizations (NGOs), civil society organizations, community-based organizations (CBOs), MOHs).

- **SBC in combination with HSS activities can improve FP adoption.** SBC for FP/SRH and HSS interventions often share common or complementary behavioral determinants and can mutually reinforce one another. For example, improving provider FP/SRH knowledge and counseling capacity can both increase informed, voluntary FP uptake and make FP/SRH services stronger and more effective. Or, strengthening provider FP/SRH counseling competency to offer a full range of contraceptive methods while also working to eliminate FP method stockouts will result in more robust, trusted FP/SRH services. The desk review identified multiple studies that combined SBC and HSS activities in humanitarian crisis settings. One approach, implemented in

Chad, DRC, Djibouti, Mali, and Pakistan, combined community mobilization with provider competency-based training and coaching, facility supervision, and continuous supply of contraceptives and medical supplies to achieve increased FP uptake and FP service use in 52,616 new users of modern contraceptives (rate of FP adoption ranged from 45% to more than 90% in areas implementing interventions to 3.2% in areas with no supportive interventions).[34] Another example coupled training facility-based providers and CHVs in FP counseling with the establishment of community health units, mobile outreach, and Community Health Committees trained to refer potential FP users to the units. CHVs also conducted household visits and dialogue activities, alongside radio programs and training religious leaders in FP. Ultimately, the program achieved a 19% average monthly increase of new FP adopters, which translated to 7,500 women new users of FP, total, and (1) increased "permission" and support for child spacing from religious and traditional leaders; (2) increased discussion between men and women with regards to child spacing and social support at a community level; and (3) reduced repercussions of norms around child spacing using modern FP methods.[27]

Case Study: The need for joint FP/SRH SBC and HSS programs in Yemen

In 2015, civil war erupted in Yemen over a proposal to divide the country into six federal regions. Since the conflict began, the situation has escalated in scale and severity, resulting in many crises including severe food and economic insecurity. Access to FP/SRH services in the South of Yemen has sharply declined, and since January 2022 and 5.5 million women have had difficulties in accessing SRH services. To understand SBC for FP in the south of Yemen, Breakthrough ACTION conducted KIIs with service providers, CHVs, MOPHP key personnel, and implementing partners. Examples of key challenges that programs aimed to address included cultural and traditional norms related to FP/SRH work—including sensitivities speaking about FP/SRH with adolescents seeking services—and insufficient supplies and commodities. Participants shared that there had been efforts to improve FP/SRH programs in the south through the joint efforts of the MOPHP and international organizations. This included strengthening FP/SRH service quality at health facilities and linking health services to CHVs in communities to increase demand for and acceptance of FP. Stakeholders aimed to make couples FP counseling more client-centered, in part by providing FP/SRH information to clients at the clinic before their appointments. Facilities displayed FP method pamphlets and showed FP-information videos in waiting areas. At the community level, CHVs reported using various methods to engage with the communities they serve, including (1) awareness raising sessions and dialogues, (2) follow up of FP clients, (3) mobilization of women in the communities using satisfied FP users, (4) educational sessions with adolescents at schools, and (5) group discussions about FP with homogenous groups. Key stakeholders shared maintaining funding and a consistent supply of FP commodities was a major challenge. Stakeholders also highlighted opportunities for improvement, including capacity strengthening for services providers, CHVs, and health managers. They also mentioned the importance of implementing the MISP and planning for

programs that balance demand creation and supply. They identified research and evidence building in need of resources and focus. The Yemen MOPHP has revised their FP strategy and is in the process of developing SBC for FP guidance.

- **CHWs are an integral part of many SBC for FP-related activities,** including door-to-door visits, counseling, and access to commodities.[27,32] CHWs are community-based; they can expand FP access to populations that might otherwise not be reached.[35] KIIs identified that if CHWs are included in the health system, as they are in Pakistan and DRC, for example, and if they are enabled to offer community-based distribution of different contraceptive methods, they can effectively expand access to FP services and SBC activities, particularly when health facilities may cease to function or be overcrowded, or when communities are displaced.[35]
- **People living with disabilities seem largely overlooked in FP/SRH programs in fragile and humanitarian crisis settings.** While the desk review identified few descriptions of SBC for FP for people with disabilities, KIIs reinforced the value of programming for people with disabilities, and this remains an important population of interest when considering equity.
- **Gender considerations are often overlooked in FP/SRH crisis programs and require more focus.** This point particularly came through in KIIs and during the expert consultation. Respondents and participants lamented the challenges of balancing short-term funding with the fact that gender issues (e.g., power imbalances, increased GBV during a crisis) often take more time to meaningfully address than the funding allows. KII respondents identified inclusion of men and boys, couples' communication, and women's leadership as common programmatic gaps in FP/SRH programs in humanitarian crisis settings and urged that more attention be paid generally to gender norms as key barriers to FP/SRH services, which are only exacerbated during a crisis. They described the value of working with gender advisors to make revisions and adaptations to existing programs to be more gender-sensitive and gender-transformative, and the need for a male engagement strategy to guide working with men and boys within the context of uncertainty and upheaval. KIIs also identified the importance of including gender and social inclusion analyses in assessments, training different cadres on the nuances of sensitive social norms as they related to gender (including technical and support staff), and having strong facilitation skills (not only communications skills) to navigate dialogue sessions where community members come together to discuss social norms.

Case Study: The need for FP/SRH SBC resources specific to humanitarian crisis settings in DRC

DRC is suffering from one of the world's most complex humanitarian crises, particularly in the eastern part of the country, including North Kivu. Years of violence and insecurity have led to DRC containing the largest number of internally displaced people in Africa and the largest number of food insecure people in the world.[36] Development and humanitarian

actors have implemented FP programs in DRC for decades. To contribute to the landscape analysis on SBC for FP in humanitarian settings, nine KIIs were conducted with representatives from the MOH (national and sub-national), implementing partners from national and international NGOs, service providers, and CHWs. Participants stressed the importance of engaging communities and CHWs during the response and shared that planning and preparedness are needed to ensure SBC for FP, and FP services are part of the acute response. Informants highlighted the need for an SBC for FP strategy in humanitarian crisis settings. Furthermore, they shared that while there are SBC for FP materials for development programs, these materials do not exist for humanitarian contexts. Key informants mentioned guidelines and tools are needed for emergency response, like those developed for infectious disease outbreaks. They also noted the importance of coupling demand creation activities with HSS to ensure that FP services are available (e.g., contraceptive supplies and trained providers). Participants in KIIs shared their belief that gender and social norms activities should be included in humanitarian response programs. When asked about specific SBC activities that had occurred, they mentioned SBC through household visits, radio spots, integration with other sectors including GBV, CHWs, couples champions, satisfied clients, health committees, health centers, and women's associations. Some interviewees spoke of the effectiveness of specific approaches (e.g., use of radios, working with satisfied clients), and use of participatory assessments combined with facility readiness and values clarification and attitude transformation for providers in a project focused on adolescents, "She Knows Best."

Recommendations and Opportunities

The following recommendations and opportunities frequently expand beyond FP to include SRH based upon findings in the landscape analysis.

Recommendation 1: Define, clarify, and expand a common language between humanitarian and SBC professionals.

Given the range of SBC work implemented and needed in crisis response settings, there is an opportunity for development, humanitarian, and SBC program implementers to learn from each other. One challenge is that development and humanitarian response SBC implementers frequently use different terminology. Development and humanitarian actors should come together to discuss and agree on terms and definitions for SBC concepts and approaches, crisis contexts (e.g., conflict, infectious disease outbreaks, and natural disasters that may or may not be influenced by climate change, such as earthquakes, cyclones, and drought), and phases of humanitarian crisis and response. Communication and technical discussions based upon a shared interpretation of terms and definitions will allow for adaptation and testing of adapted and new approaches for SBC for FP in humanitarian settings, and for more strategic crisis preparedness and response.

Recommendation 2: Define how to integrate SBC for FP in Nexus settings.

Since the Triple Nexus Model was introduced at the 2016 World Humanitarian Summit, the UN, several national governments, donors, and stakeholders have begun to recognize that needs, services, and systems exist in a continuum and the need to design funding and programming models that reflect collective outcomes to reduce need, risk, and vulnerability as part of nexus programming. Given SBC for FP/SRH activities along the Nexus will contribute to effectively meeting peoples' needs, mitigating risks and vulnerabilities, and moving toward sustainable peace, involved actors will need to define entry points and design programs and interventions that incorporate SBC for FP/ SRH into Nexus programming. Further, SBC for FP/SRH within this framework contributes to addressing gender-related disparities and ensuring women's rights are integrated within immediate crisis response and longer-term outcomes.

Recommendation 3: Develop operational SBC for FP/SRH tools and guidance for fragile and humanitarian response program implementers.

A wealth of experience and evidence-based tools and guidance documents have been used in development settings; these need to be adapted and piloted in fragile or humanitarian settings. Learning from piloting existing SBC for FP guidelines and/or new tools may be used to develop simple, easy-to-use operational guidance and tools for fragile and humanitarian contexts. These resources should be user-friendly, easily accessible to implementers, include definitions of key SBC terms and concepts, and be organized according to different types and phases of humanitarian crisis responses. Following are a few examples of content to include by phase of crisis response:

- **Preparedness** might include guidance to support and develop robust community engagement approaches in development settings for resilience and crisis response (e.g., CAC, PDQ, and CSC), including guidance on the following:
    - Conducting participatory gender, disability, youth-centered, and other assessments to ensure inclusion of key communities in FP/SRH service programs during a crisis.
    - Integrating SBC into competency-based FP/SRH service provider trainings (e.g., Values Clarification and Attitude Transformation, Beyond Bias Practical "How-to Guide," and applying the Provider Behavior Change Toolkit for Family Planning).
    - Advocating for SBC integration into emergency preparedness planning in development programs.
    - Advocacy tools for SBC capacity strengthening among fragile state or humanitarian response stakeholders, so they are able to comfortably articulate the SBC work that might be needed during a crisis with collaborating projects or with donors.
- Guidance and tools for the **acute response** phase might include how to integrate SBC approaches by mobilizing existing or establishing new community platforms for basic SBC, specifically risk communication (e.g., information on where and how to access FP/SRH services through available channels, the benefits of so doing), guidance on effective FP/SRH message creation and dissemination and gathering and integrating community feedback into FP/SRH programs and outreach where possible.
- During the **post-acute crisis** phase, guidance could include the following:
    - Steps to improve SBC for FP/SRH service quality by working with healthcare providers and community members.
    - How to create an enabling environment for new and continued FP/SRH service use during the transition from the acute to post-acute phase.
    - How to deepen community feedback and community engagement for robust and equal FP/SRH access through co-design, community and social accountability, and implementation.
- In the **protracted crisis** phase, guidance should include information on conducting assessments—including participatory, gender, social, and disability inclusion assessments—that can be used to expand SBC approaches to include FP/SRH demand generation and shifting norms based on the context including experiences from the recent crisis. In addition, intervention guidance for this phase would benefit from inclusion of effective approaches for moving towards development and implementation of community-led approaches.
- During the **recovery** phase, guidance on scaling up relevant new approaches from crisis response to improve FP/SRH information and services is needed. During this phase preparedness activities may also be introduced such as the CAC, CSC, and PDQ.

Recommendation 4: Prioritize SBC for FP programming for preparedness and protracted crisis environments.

SBC activities during the preparedness phase have many functions, including building community resilience. Participatory, community-led processes such as co-creation of solutions, CAC, CSC, and PDQ build trust between community members and stakeholders (e.g., health workers, programs, MOH, community leaders, etc.) and increase social accountability. These approaches are also inclusive of developing community governance structures, for example, Community Action Groups (via CAC) or Quality Improvement Teams (via PDQ), which provide a community-level structure for strengthening community systems and referral networks. In addition, they can develop community solutions which are applicable and adaptable in times of acute crisis. Developing these mechanisms within communities can allow donors, governments, and programs to support individuals, households, communities, and health systems to have the platforms and systems to prepare for, mitigate, and respond to crisis. These community structures can put together plans for how they will mitigate and respond to a social, political, or even environmental disturbance, resulting in a more rapid response during an acute crisis.

Recommendation 5: Advocate for longer funding cycles in humanitarian settings, including funding for SBC for FP in fragile and humanitarian contexts.

Longer-term and earlier humanitarian funding is required to achieve more holistic and effective SBC for FP activities in all phases of a crisis, starting with the preparedness phase. Funding for, and implementation of, more holistic SBC during preparedness, including in fragile states, will help identify key barriers and facilitators to FP/SRH service access at multiple SEM levels, build community resilience, and enable the health system to continue service provision and better decision-making around FP during a crisis. Lifesaving and essential interventions for FP/SRH should also be redefined to include SBC to ensure funding, community empowerment, and ownership of FP/SRH programs.

Likewise, funding directed toward the documentation of SBC for FP/SRH in a crisis will contribute to the evidence base and support Ministries of Health and donors to identify the most effective programs and approaches to ensure FP/SRH access. Funding for SBC for FP/SRH preparedness, program implementation, and evidence generation can be integrated within SRH-related development and humanitarian programs (e.g., multi-sectoral, primary health care, nutrition, protection, water, and sanitation) and interventions. Increasing funding for preparedness in SBC for FP/SRH is essential for evidence generation and research, particularly when many humanitarian settings are protracted with constant events of acute emergency.

Recommendation 6: Include gender, social inclusion, and disability analyses in assessments.

Given the influence of gender, social, and traditional norms on disability, social inclusion, and access to FP/SRH, and that these factors can be exacerbated in a fragile setting or during a crisis, initial assessments used to design SBC for FP/SRH approaches require gender, social inclusion, and disability analyses across different phases of humanitarian crisis response. This involves working with gender advisors to develop, revise, and adapt programs to make them more gender sensitive and gender

transformative. This requires adequate funding for longer periods of time, strategies for male engagement and GBV prevention and response, and training different cadres (e.g., technical and support staff, and local partners) on sensitive social and gender norms and how to facilitate these discussions with community members.

Recommendation 7: Enhance and expand documentation, evidence building, and dissemination about FP/SRH SBC programs in humanitarian crisis settings.

Key informants and technical consultation experts provided numerous examples of SBC for FP approaches used in humanitarian settings, yet the desk review yielded limited examples. Evidence generation and documentation in coordination with other initiatives (e.g., SRH Task Team and the MOMENTUM Integrated Health Resilience Project's work to adapt, pilot, and document evidence-based approaches in humanitarian settings) will help practitioners identify what does work in SBC for FP, what does not work, and best practices. Specifically, evidence on the most effective approaches for male engagement, gender transformative work, and disability inclusion are needed. This can be used to inform the development of evidence briefs, planning templates, and operational guidance and tools.

Financial and human resources are needed to pilot and document SBC for FP approaches during each phase of a humanitarian crisis response. This requires advocacy to donors and key decision makers so that sufficient resources are allocated to evidence generation and documentation.

Conclusion

Findings from the desk review, key informant interviews with global, regional, and country-level stakeholders, and technical consultation were mutually reinforcing, and yielded key findings and recommendations for strengthening SBC for FP/SRH in fragile and humanitarian crisis settings. This exercise was an opportunity to not only learn from key stakeholders and literature, but to gather information on several initiatives to address SBC for FP/SRH currently underway, especially those in the two focus contexts of DRC and Yemen.

Alongside these contributions, there were some limitations to these assessment activities:

1. The desk review search was limited to identification of peer reviewed journal articles and gray literature using Google, Google Scholar, and ReliefWeb searches and specific organization websites. Therefore, it was not an exhaustive literature search of all possible databases.
2. The desk review included only English-language articles and reports (see Annex 5), and therefore does not include or provide any insight into resources that may be available in French, Arabic, or other languages.
3. The desk review included literature on humanitarian crisis settings. There was limited breakdown by the phase of crisis though some information highlighting the importance of preparedness emerged. Limited literature on development or fragile settings emerged.
4. There may have been some potential bias in article searches and identification due to Save the Children's history of active involvement in FP/SRH in humanitarian crisis settings, and the fact that the organization led the assessment activities and subsequent analyses and documentation process.
5. The KIIs and the technical consultation did not include all humanitarian and development stakeholders around the world. As such, the sample may not reflect the full host of perspectives and may not be generalizable to all contexts.
6. The assessment activities focused primarily on FP; while SRH topics did emerge during each assessment, the assessment is not a comprehensive summary of FP and SRH SBC in fragile and humanitarian settings.

Some of these limitations were addressed by broadening our outreach in identifying stakeholders for key informant interviews.

In summary, this landscape analysis represents the first time such an assessment has been conducted regarding SBC for FP/SRH in humanitarian crisis settings. This process, including the desk review, KIIs, and technical consultation, revealed what has been done, what has worked, where challenges exist, and some critical gaps in SBC for FP/SRH in humanitarian crisis settings. Further exploration of these successes, challenges, and gaps led to the identification of actionable recommendations for policy makers, implementers, and donors. This landscape analysis is timely, as initiatives exploring SBC for FP/SRH in these settings have begun and the analysis provides some background in addition to current

thinking on the critical role that SBC for FP/SRH plays in strengthening access to quality FP/SRH services for people wishing to realize their fertility goals and prevent unplanned pregnancy in humanitarian crisis settings. This process resulted in linkages to these initiatives and the landscape analysis process contributed to bringing together actors in SBC, FP, development, and humanitarian sectors.

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Annexes

Annex 1: Stages of Crisis used by Breakthrough ACTION in analysis

Preparedness: The UN and WHO define preparedness as the ability of governments, professional response organizations, communities, and individuals to anticipate, detect, and respond effectively to, and recover from, the impact of likely, imminent, or current health emergencies, hazards, events, or conditions. It means putting in place mechanisms that allow national authorities, multilateral organizations, and relief organizations to be aware of risks and deploy staff and resources quickly once a crisis strikes.[37]

Acute: Acute emergencies involve rapid onset disasters and humanitarian contexts that require a quick response to cover the immediate needs of affected people.[38]

Post-acute: The post-acute, or post-emergency, phase occurs as the population movement slows and the crude mortality rate returns to its baseline rate. During this phase, aid organizations turn their focus to providing more routine services and developing local capacity to support the needs of the affected population.[39]

Protracted crisis: Countries experiencing protracted crisis have at least five consecutive years of UN-coordinated humanitarian or refugee response plans as of the year of analysis. This gives an indication of the countries that have consistently, over a period of years, experienced humanitarian needs at a scale that requires an international humanitarian response. Those needs can be limited to specific geographical regions or populations (such as forcibly displaced people).[39,40]

Recovery: Recovery, or early recovery, addresses recovery needs that arise during the humanitarian phase of an emergency; using humanitarian mechanisms that align with development principles. It enables people to use the benefits of humanitarian action to seize development opportunities, build resilience, and establish a sustainable process of recovery from crisis.[41]

Annex 2: SBC approach definitions used to analyze the desk review and KII results

Advocacy: Includes efforts of individuals or groups to influence a variety of levels including public policy, institutional, and organizational systems (e.g., social systems, health care systems). Technically advocacy can be bi-directional, programs usually reference bottom-up advocacy by community, institutional activists, or practitioners (e.g., health care workers/administrators) to influence or build partnerships to influence others (for example, to support health programs or the public health agenda). At a personal level, satisfied adopters of a new health behavior can be encouraged to advocate for similar behavior change to friends and family. Programs can accomplish this through public engagement and campaigning (engaging the public to shift political conditions for changed in policy and or practice) and advocacy (a set of activities to influence decision-makers on institutional policies and practice to achieve positive change).

Capacity building: The process through which stakeholders obtain, strengthen, and maintain the capabilities to set and achieve desired behaviors. Examples include approaches to build skills and competencies (training), confidence/self-efficacy (training and mentorship), accountability (supportive supervision for health workers).

Community engagement: Developing community self-governance structures and engaging community members to solve issues in their communities. Community engagement is a spectrum and ranges from community-owned (highest level of engagement)—where community members mobilize to develop systems of self-governance, establish and set priorities, implement interventions, and develop sustainable mechanisms for SBC—to community-based and to community-oriented (the lowest level of engagement), where external implementers inform and mobilize the community to participate in addressing issues.

Social mobilization: Leveraging a social network within the community to reach and influence others, e.g., community and religious leaders to reach community members through community dialogues and sermons or CHWs through household or community visits. Mother-to-mother support groups are another form of social mobilization. Social mobilization is often conducted (but not limited to) through interpersonal communication and storytelling.

Media (multi/mid-media) : Communication approaches which often are one-way dialogue or technologically driven, including radio, videos, interactive voice recording, local music, posters, SMS, social media. Some of these are bi-directional (e.g., radio, interactive voice recording); however, they are less interactive compared to other SBC approaches.

Annex 3: SBC for FP Interventions, by Crisis Phase and SEM Level

SUMMARY OF DESK REVIEW AND KII EXAMPLES OF SBC FOR FP ACTIVITIES BY STAGE OF CRISIS *The table also indicates at which level of the SEM interventions generally focused, per crisis phase*				
PREPAREDNESS (SEM level: Policy, Service Delivery, Community, Individual)	ACUTE CRISIS (SEM level: Service Delivery, Community, Individual)	POST-ACUTE CRISIS (SEM level: Service Delivery, Community, Individual)	PROTRACTED CRISIS (SEM level: Service Delivery, Community, Individual)	RECOVERY (SEM level: Policy, Service Delivery, Community, Individual)

• Advocacy/policy changes
• Capacity building and knowledge/ attitude shifts of stakeholders (staff and community):
  ○ UN agency
  ○ NGOs, CBOs, government
  ○ Community members
  ○ Providers/ healthcare workers
• PBC toolkit, CHW AIM
• Develop community resilience
• CAC, PDQ, CSC, husbands' schools, REAL fathers, GREAT toolkit, intergenerational dialogue, social mobilization
• PAR, social inclusion, and gender analysis
	• Risk communication, social mobilization, media
	• SBC combined with commodities (e.g., clean delivery kits, emergency contraceptive pills)
	• Provision of FP services to community (including men)
	• Support first responders who are leading community response
	  ○ MOH
	  ○ Community members/ neighbors
		• Assessments (KIIs, focus group discussions)
		• Transition to re-establish programs
		• Social mobilization
		• Community-led planning and response/ community feedback loops
		• Active referrals from community to facilities/ service delivery points
			• CAC, PDQ, REAL Fathers, GREAT toolkit, media, theatre
			• Community-based follow up with FP users for appointments
			• Service provision and counseling (including men) at community level
			• Active referrals from community to facilities/ service delivery points
			• Capacity/ mentorship of health workers
			• Awareness raising at schools for adolescents
			• PAR, social inclusion and gender analysis
				• Advocacy/ policy changes
				• Capacity building and knowledge/ attitude shifts of stakeholders (staff and community)
				• PBC toolkit, CHW AIM
				• Develop community resilience
				• CAC, PDQ, CSC, husbands' schools, REAL fathers, GREAT toolkit, intergenerational dialogue
				• PAR, social inclusion and gender analysis

Annex 4: Guidelines and Tools Identified through the Desk Review and KIIs

LEVEL OF SEM	DOCUMENT NAME AND DESCRIPTION	LINK	HUMANITARIAN/ DEVELOPMENT
Community, Policy	*Operational Guidance: Community Health in Refugee Settings 2022* The guidance provides practical orientation for the UN Refugee Agency (UNHCR) and partner staff in the field on providing community health services for refugees and include a range of approaches to community engagement for FP	Operational Guidance: Community Health in Refugee Settings 2022 (UNHCR)	Humanitarian
Service Delivery	*Reproductive Health in Emergencies Toolkit* The toolkit includes four sections: (1) Clinical Supervision and Training, (2) Communications and Fundraising, (3) Logistics and Pharmacy, and (4) Monitoring and Evaluation, which includes FP and contraceptive counseling for providers.	Reproductive Health in Emergencies Toolkit (Save the Children Resource Centre)	Humanitarian
Individual, Interpersonal	*Together We Decide* This game is designed for men to learn about ways to keep his family healthy and ways a man can discuss health topics with his partner.	• Together We Decide Instructions (ideas42) • Supporting Couples to Make Active Joint Decisions About Child Bearing (ideas42)	Development
Individual, Community, Interpersonal	*Strengthening Health Resilience through Multisectoral Population, Health, and Environment Programming in Tanzania Report* The report describes model households, a "First-Time Parents" framework, and community conservation microfinance groups approaches. Consists of three tools: the model households described in the report, First-Time Parents, and Village Savings and Loans.	• Strengthening Health Resilience through multisectoral Population, Health, and Environment Programming in Tanzania (USAID MOMENTUM) • Introducing E2A's First-Time Parent Framework (Pathfinder International) • Village Savings and Loans Associations (CARE International)	Development/ Adapted for humanitarian
Service Delivery	*Empathways* This card activity takes youth clientele and their FP service providers on a dynamic, engaging journey from awareness, to empathy, to action. The objective is to forge greater empathy between these groups, and then for providers to apply this empathy to improve youth FP service delivery	Empathways (Breakthrough ACTION)	Development/ Adapted for humanitarian

LEVEL OF SEM	DOCUMENT NAME AND DESCRIPTION	LINK	HUMANITARIAN/ DEVELOPMENT
Individual, Interpersonal, Community	*Husbands' Schools* Husbands' Schools are a voluntary and non-hierarchical intervention. Men must meet specific criteria before being admitted as members and become *maris modèles* (model husbands), serving as role models in their communities. The criteria stipulate that men must be at least 25 years old, have a wife who uses reproductive health services (any service, including antenatal, delivery, postpartum, and FP). Schools meet twice a month to discuss health and other topics and organize community awareness sessions, home visits, and carry out activities aimed at improving the health center.	Study of the Effects of the Husbands' School Intervention on Gender Dynamics to Improve Reproductive Health in Niger (USAID)	Development/ Humanitarian
Individual, Interpersonal, Service Delivery	*Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Project* The project worked to recruit, train, and deploy village health workers to improve families' health-seeking behaviors and relevant practices in humanitarian setting in Nigeria, while advancing the quality of health care provided at health facilities through complementary interventions. It developed two tools: a targeted training curriculum for the volunteer health workers and job aids to be more visual with fewer words.	• Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus, Including during the COVID-19 Pandemic – A Global Landscaping Assessment (Women's Refugee Commission) • Localizing Humanitarian Aid: Learning from a Consortium-Based Approach to Designing and Implementing a Village Health Worker program in Borno State, Nigeria (Women's Refugee Commission)	Humanitarian
Individual, Community	*Facilitator's Kit: Community Preparedness for Reproductive Health and Gender* This is a three-day training that aims to build capacity at the community level to prepare for and respond to risks and inequities faced by women, girls, and marginalized and underserved sub-populations in emergencies. It covers FP/RH including MISP. There is an optional additional half-day module on pandemic/epidemic preparedness.	Facilitator's Kit: Community Preparedness for Reproductive Health and Gender (Women's Refugee Commission)	Humanitarian
Individual	*WHO Flip Chart for CHWs* Mostly contextualized, shortened as needed, translated for humanitarian settings	A Guide to Family Planning for Community Health Workers and Their Clients (WHO)	Development/ Adapted to context

LEVEL OF SEM	DOCUMENT NAME AND DESCRIPTION	LINK	HUMANITARIAN/ DEVELOPMENT
Individual, Service Delivery	*Contraceptive Coach (CoCo)* A contraceptive decision-making app for humanitarian settings	Still in press. (Save the Children)	Humanitarian
Individual, Community, Service Delivery	*Values Clarification and Attitude Transformation tools* IAWG provided these tools to be used by providers and other groups, and for FP and other sensitive SRH topics. The workshops and activities support participants to explore, question, clarify, and affirm their values and beliefs about FP and other SRH issues. They are designed to challenge participants to reflect on their own attitudes and beliefs, while encouraging participants to question deeply held assumptions and myths.	Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: 2020 Edition (IAWG)	Development/ Humanitarian
Individual, Service Delivery	*Cue Cards for Counseling Adults and Adolescents on Family Planning* This set of contraceptive counseling cue cards was developed to support providers (such as facility-based providers, CHWs, pharmacists, outreach workers, counselors, and peer providers) in counseling adults and adolescents on their contraceptive options. The cards can be adapted to meet local circumstances and contexts.	• Adult Contraception Cue Cards (Pathfinder) • Adolescent Contraception Cue Cards (Pathfinder)	Development/ Humanitarian
Community	*Social Analysis and Action* This resource contains reflective dialogue to challenge individual and provider attitudes and behaviors.	Social Analysis and Action (CARE)	Development/ Adapted for humanitarian
Community	*Mobilizing Maternal Health (M-Mama)* This activity has three focuses: (1) engaging the community, (2) creating dispatch centers and providing transport, and (3) strengthening local health systems. M-Mama developed Community Care Groups to facilitate engagement in the mobile transport program, and to build awareness on maternal and newborn health.	Mobilizing Maternal Health (Pathfinder)	Development
Individual, Interpersonal, Service Delivery	*Beyond Bias "Practical How-To Guide"* The Beyond Bias intervention was designed to support health care providers at every phase of their journey from developing awareness of their own bias to becoming advocates for improved contraceptive services for youth in their community.	Beyond Bias Practical How-to Guide (Pathfinder)	Development

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Individual	*Act with Her* Engaging very young adolescent girls (10 up to 14) in weekly curriculum-based groups facilitated by "near peer" mentors ages 18–24 over the course of 10 months. Project designed to lay the health, education, and social foundations that adolescent girls need to thrive and navigate healthy transitions to adulthood.	Act with Her Learning Series (Pathfinder)	Development
Individual, Interpersonal	*Equal Partners for Healthy Choices* This curriculum for couples is a transformative couple's intervention promoting modern FP methods, positive communication skills, shared decision making, and gender equality that was adapted from a tool used by the protection sector.	No document available online (IRC)	Humanitarian
Service delivery	*CHW AIM Toolkit* Ten modules and three additional modules, provide guidance on preparedness of environment, safety of CHW, improving skills and ability of CHWs to prepare and respond in RCCE.	Updated Program Functionality Matrix for Optimizing Community Health Program (CHW Central)	Development/ Adapted for humanitarian
Individual, Community, Service delivery, Policy	*Provider Behavior Change Toolkit for Family Planning* The toolkit guides users through an empathy-focused, four-step process that supports providers, clients, and district health teams in identifying and prioritizing the root causes of provider behavior and generating local solutions. To deliver a holistic view of provider behavior, the toolkit employs a systems lens.	Provider Behavior Change Toolkit for Family Planning (Breakthrough ACTION)	Development
Service delivery, Community	*Partnership Defined Quality* A tool book for community and health provider collaboration for quality improvement guides quality improvement activities through partnership involving health providers and the community; can be used by project and health service managers, or facilitating agencies, and can be used by health workers or community advocates.	Partnership Defined Quality (PDQ): A Toolbook for Community and Health Provider Collaboration for Quality Improvement (Save the Children Resource Centre)	Development/ Adapted for humanitarian
Community	*Community Action Cycle* This guide has been designed to be used by health program directors and managers of community-based programs who want to design a program for community-led solutions and to create change at the community, family and individual level including to (1) develop local governance structures; (2) build local capacity to identify, explore and	How to Mobilize Communities for Health and Social Change: A Field Guide (Save the Children Resource Centre)	Development/ Adapted for humanitarian

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	develop solutions leveraging local resources, and (3) develop more resilient communities who can organize and mobilize themselves in the event of a crisis and rebuild more quickly post-crisis.		
Community	*Community Score Card* The CSC is a citizen-driven accountability approach for the assessment, planning, monitoring, and evaluation of public services.	Community Score Card: Citizen-Driven Accountability (CARE)	Development/ Adapted for humanitarian
Community	*Gender Roles, Equality and Transformation Toolkit* The GREAT approach uses radio drama, community mobilization, games, and stories to prompt small group discussions to promote dialogue and reflection among adolescents, with the goal of facilitating the formation of gender equitable norms and the adoption of attitudes and behaviors that positively influence health outcomes among boys and girls aged 10 to 29.	Gender Roles, Equality and Transformation (GREAT) Toolkit (Save the Children's Resource Centre)	Development/ Adapted for humanitarian
Community	*Bringing the Community to Plan for Disease Outbreaks and Other Emergencies: A Step-by-Step Guide for Community Leaders* This field guide is designed for community leaders to lead community members through exploration of issues and solutions; while the guide has reference to influenza, the guide could be adapted for other scenarios.	Bringing the Community to Plan for Disease Outbreaks and Other Emergencies: A Step-by-Step Guide for Community Leaders (Pan-American Health Organization)	Development: Planning for emergencies
Community	*Community-Led Action for COVID-19* This field guide is a resource book for community mobilizers, field staff, and trainers to support planning, implementing, and follow-up of Community-Led Action social mobilization activities. It provides tools and ideas to empower communities to do their own analysis and take their own action to become COVID-19-free.	Community-Led Action for COVID-19: A Field Manual for Community Mobilizers (GOAL Global)	Development/ Humanitarian
Community	*Social and Behavior Change at UNICEF* These three resources provide recommendations during a humanitarian crisis including monitoring and evaluation (M&E) in emergencies, the CHAT, and a guide to using the CHAT Toolkit.	• M&E in Emergencies (UNICEF SBC) • Community Engagement in Humanitarian Action Toolkit (UNICEF) • SBC in the Humanitarian Cycle: Using the CHAT Toolkit (UNICEF)	Humanitarian

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Community	*Community Resilience Assessment and Action Handbook* Provides practical community assessment and engagement (participatory rapid appraisal) activities to assess and respond to climate crisis with context for conflict and gender inclusion.	Community Resilience Assessment and Action Handbook (BRACED Myanmar Alliance)	Humanitarian
Institutional	*Scoping Review Report of Social and Behavior Change in Protracted Nutrition Emergencies* The scoping review of SBC in Protracted Nutrition Emergencies includes recommendations for actions the Bureau for Humanitarian Assistance could take to increase the use of SBC in protracted nutrition emergencies.	Scoping Review Report of Social and Behavior Change in Protracted Nutrition Emergencies (Advancing Nutrition)	Humanitarian
Individual, Household, Community, Institutional	*The SBCC Emergency Helix* This tool highlights how to plan to include social and behavior change communication (SBCC) during a public health emergency at different phases of crisis.	The SBCC Emergency Helix (Health Communication Capacity Collaborative)	Humanitarian
Individual, Household, Service Delivery, Institutional	*Provider Behavior Ecosystem Map* For program planning and design as it relates to FP and reproductive health with a focus on identifying the determinants related to provider behavior, this toolkit provides resources for practical diagnostic, synthesis, and programmatic tools to help program designers create a holistic PBC program.	Provider Behavior Ecosystem Map (Breakthrough ACTION)	Development
Community	*RCCE Readiness Kit* The kit supports RCCE efforts for NGOs preparing for an outbreak or pandemic in humanitarian settings with insights to NGO preparedness (staffing, operations); the kit supports coordination of RCCE activities, operationalizing community engagement, strengthening program quality through access to RCCE-related assessments, guidelines, and tools, and monitoring and evaluation of RCCE interventions.	RCCE Readiness Kit (READY Initiative)	Humanitarian
Individual, Community, Service Delivery	*Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* This manual's MISP chapter highlights the importance of information, education, and communication materials and as soon as possible, ensuring contraceptive counseling choice, effectiveness, privacy, and	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAWG)	Humanitarian

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	confidentiality. Also, to ensure the community is aware of the availability of contraceptives services.		
Community	*Community Engagement and Accountability in Emergencies* This page is a one-stop shop for community engagement and accountability (CEA) in emergencies. It outlines the minimum actions for community engagement at each stage of the response, and the tools to help you put these into practice. It has links to CEA training packs for emergencies, a guide to CEA in emergencies, and case studies specific to conflict, earthquakes, and extreme weather.	CEA in Emergencies Guide and Toolkit (Community Engagement Hub)	Humanitarian
Community	*Evidence-Focused Community Based Health and First Aid* This page contains training materials for facilitators and volunteers on volunteer modules (community mobilization, assessment, behavior change, psychological and basic first aid) and primary prevention modules (healthy ageing, maternal and newborn child health, noncommunicable diseases, youth, road safety, violence prevention, voluntary non-renumerated blood donation, communicable disease prevention, immunization, health in emergencies, and epidemic control for volunteers).	Evidence-Focused Community-Based Health and First Aid Training Materials for Volunteers and Facilitators (International Federation of Red Cross and Red Crescent Societies)	Development/ Humanitarian
Community	*Care Groups in Emergencies: Evidence in the Use of Care Groups and Peer Support Groups in Emergency Settings* These documents highlight the evidence regarding care groups in emergency settings and issues recommendations for adapting the care group model for emergencies including recommendations by phase of crisis. While the care group model is not recommended during the acute phase of crisis, it is recommended during other phases of a humanitarian crisis.	• Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings (People in Need) • Care Groups: A Reference Guide for Practitioners (Food Security and Nutrition Network)	Humanitarian

Annex 5. Overview of Articles Included in the Desk Review

This list represents an initial list of documents during the desk review; for a complete list of desk review references see slides 27–29 in the desk review presentation.

LEAD AUTHOR	TITLE OF ARTICLE	YEAR
Kelly Ackerson	Factors Influencing Use of Family Planning in Women Living in Crisis Affected Areas if Sub-Saharan Africa: A Review of The Literature	2017
Shivit Bakrania	Impact Evaluation in Settings of Fragility and Humanitarian Emergency	2021
Sara E. Casey	Meeting the Demand of Women Affected by Ongoing crisis: Increasing Contraceptive Prevalence in North and South Kivu, Democratic Republic Of The Congo	2019
Kingsley Chukwumalu	Uptake of Postabortion Care Services and Acceptance of Postabortion Contraception in Puntland, Somalia	2017
Dora W. Curry	Delivering High-Quality Family Planning Services in Crisis—Affected Settings I: Program Implementation	2015
Dora W. Curry	Delivering High-Quality Family Planning Services In Crisis-Affected Settings II: Results	2015
Development Media International	Women's Integrated Sexual Health (wish2action)	n.d.
IRC	Women's Integrated Sexual Health: Wish2action Consortium—Value For Money: Efficiency (Ethiopia, Somalia, South Sudan, Uganda, July 2021)	2021
IRC	Family Planning in Humanitarian Settings: The Right to Choose Matters Most in the Hardest of Times	2022
IRC	Sexual and Reproductive Health and Rights at the International Rescue Committee	2022
Catherine N. Morris	When Political Solutions for Acute Conflict in Yemen Seem Distant, Demand for Reproductive Health Services is Immediate: A Programme Model for Resilient Family Planning and Post-Abortion Care Services	2019
Gloria Nguya	The Triple Nexus (H-D-P) and Implications for Durable. UN Secretary-General's High-Level Panel on Internal Displacement	2020
Save the Children	Listening to Community Voices: Effective Program Design with Nomadic Pastoralists	2022
Save the Children	The Focus Tool—An SBC/C Planner	2018
Save the Children	Reaching Nomadic Populations with Social and Behavior Change: Overcoming Barriers to Child Spacing in Northeast Kenya	2022
Martha Silva	Learning From the Past: The Role of Social and Behavior Change Programming in Public Health Emergencies	2022
Victoria J. Steven	"Provide Care for Everyone Please": Engaging Community Leaders as Sexual and Reproductive Health Advocates in North and South Kivu, Democratic Republic of the Congo	2019
Nuguyen Toan Tran	Strengthening Health Systems in Humanitarian Settings: Multi-Stakeholder Insights on Contraception and Postabortion Care Programs in the Democratic Republic of Congo and Somalia	2021
Silvio Waisbord	Where Do We Go Next? Behavioral and Social Change for Child Survival	2014
Lucy West	Factors in Use of Family Planning Services by Syrian Women in a Refugee Camp in Jordan	2017