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Setting research priorities for sexual and reproductive health in humanitarian settings: a global, stakeholder-informed agenda

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Title Page

Setting research priorities for sexual and reproductive health in humanitarian settings: a global, stakeholder-informed agenda

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ABSTRACT

Background

Sexual and reproductive health and rights (SRHR) remain critically underfunded and underresearched in humanitarian settings. Existing global research agendas are outdated, lack an implementation focus and often exclude perspectives from frontline practitioners. This exercise aims to identify and rank actionable research priorities globally and by region.

Methods

We conducted a cross-sectional global, multiphase prioritisation exercise with information from frontline practitioners. The process included a scoping review and 11 regional consultations (informed by 91 SRHR experts), resulting in a long list of 101 SRHR research needs. Using these, we systematically listed and refinemended the SRHR research questions. A budget-weighted research prioritisation (BWRP) method was used for a global, multilingual survey to score 73 SRHR implementation questions across nine SRHR topical domains and three crosscutting domains. Domains were weighted equally, and regional priorities were identified.

Results

A total of 271 experts contributed to the prioritisation ranking. Themes prioritised within the domains included the delivery of community-based care, self-care strategies, the integration of mental health into SRHR services and the improvement of adolescent access to contraception. A strong consensus emerged on the need to research topics such as human papilloma virus (HPV) vaccination, emergency obstetric and newborn care, and resilient SRHR service delivery amid climate shock. Substantial regional variation underscores the need for locally contextualised agendas, e.g., Europe and Central Asia prioritised quality of care and noncommunicable disease integration, whereas Latin America and the Caribbean emphasised gender-transformative approaches and community leadership.

Conclusion

This stakeholder-informed research agenda responds to calls for context-specific SRHR research in humanitarian settings. The importance of tailoring research to local realities, including health system

capacity, legal constraints and cultural norms, was a recurrent theme across all regions. The BWRP method enables clear prioritisation while reducing respondent burden, offering a practical model for future exercises. As global funding for SRHR contracts, aligning research with frontline needs is critical to ensuring effective, equitable service delivery.

KEYWORDS

Reproductive health, Sexual health, Humanitarian settings, Research priorities.

BACKGROUND

Sexual and reproductive healthcare and rights (SRHR) are critical components of the minimum standards of care for any humanitarian health response yet remain underfunded. The global humanitarian crisis is growing in magnitude; approximately 305 million people currently require humanitarian assistance to meet their sexual and reproductive health (SRH) needs(1). Women, adolescents and other marginalised groups are disproportionately affected by disruptions to health care access, experience heightened exposure to sexual violence and are at greater risk of poor health outcomes. Conflict, displacement, insecurity, economic strain and extreme weather events amplify existing health inequities, exacerbating the unmet need for contraception and contributing to rising rates of unintended pregnancy and unsafe abortion(2,3). Despite global commitments to uphold SRHR, access to quality, comprehensive SRH services in humanitarian, especially acute, crisis settings remains fragmented and inadequate(4,5).

The second Humanitarian Health Evidence Review (HHER2) and earlier systematic reviews mapped significant gaps in the SRHR evidence base, particularly in terms of service effectiveness, health outcomes, and cost-effectiveness(6,7). Although implementation guidance exists for SRHR interventions in emergency settings, evidence to support delivery strategies that improve health outcomes, especially for family planning (FP), abortion and sexually transmitted infection (STI) services, remains limited and unevenly distributed (2). The evidence has mainly described service

availability or utilisation, with fewer studies examining real-world implementation, scalability or contextual barriers. A scoping review of implementation studies in conflict settings revealed that few peer-reviewed papers addressed how new SRHR research is translated into revised practices, especially in the actions of frontline actors (8).

In response to this enduring evidence gap, there is increasing emphasis on implementation science approaches to understand not only ‘what works’ but also ‘how, where and why’ interventions work or fail across diverse fragile contexts (8,9). This aligns with calls for global health research to prioritise relevance, local ownership and impact, especially in settings where resources are constrained and disruptions are frequent. Despite the growing recognition of the need for stakeholder-informed research prioritisation(10,11), few exercises have engaged implementers, care providers and researchers across crisis-affected low- and middle-income countries (LMICs) to identify actionable, implementation-oriented and outcome-focused research questions for SRHR (12,13).

At this time, the global health landscape is shifting dramatically, and financial support is undergoing a profound contraction, particularly affecting SRHR programmes. Major bilateral donors have drastically scaled back or halted funding for SRHR, including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV & AIDS), and maternal health interventions (14). These constraints threaten the continuity of health services and curtail health system capacity to implement evidence-based interventions. In 2023, the United States contributed approximately 42% of total global health assistance, including 47% of global humanitarian aid (15,16). The abrupt closure of the United States Agency for International Development (USAID) is disrupting contraceptive access for more than 46.7 million women, couples and girls annually, leading to 17.1 million unintended pregnancies and 34,000 preventable maternal deaths (17). If USAID funding for HIV permanently disappears, there could be an additional 6 million HIV infections and 4 million AIDS-related deaths by 2029, reversing hard-won gains since 1995 (18). This will hit sub-Saharan Africa particularly hard.

In this context, research investments must be 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 humanitarian settings.

Box 1: Definition of SRHR

This exercise aimed to systematically identify and prioritise research questions on SRHR in humanitarian settings that are actionable, grounded in implementation science, and investigate interventions or approaches with measurable effects on health outcomes and/or quality of care, aligned with stakeholder needs. Through a multistage global consultation and analysis process, we sought to develop a validated research agenda to guide future investment and evidence-informed decision-making in humanitarian contexts.

We use the term SRHR to reflect the global normative framework that positions access to SRH services as a legal and ethical entitlement grounded in international human rights law. SRHR encompasses access to a full range of SRH services and the ability to exercise reproductive autonomy, gender equality, and freedom from discrimination and coercion(19).

While this exercise focuses on implementation research related to service delivery in humanitarian settings, we retain the term SRHR to signal the importance of rights-based approaches, particularly for marginalised populations. A fuller discussion of rights-based dimensions is provided in the discussion.

METHODS

***Governance and technical oversight**:* A core expert group (CEG) of 21 SRHR humanitarian and civil society organisation (CSO) experts and a steering committee composed of donors, United Nations (UN) agencies, government ministries, academics and nongovernmental and civil society organisations together provided methodological and strategic oversight (see 'Acknowledgements'). Members were selected to include a range of different thematic, geography experts with demonstrable SRHR expertise in humanitarian settings. Individuals invited to take part were identified from the study team networks and further snowballing from members. Together, the CEG supported the review and refinement of the research questions, survey refinement and interpretation of the results, ensuring contextual relevance and stakeholder alignment. Limitations included that busy members were not always able to join meetings or contribute as fully as they would like. Opportunities to ensure engagement were made available through multiple meetings for different time zones, sharing videos/notes of meetings and seeking guidance in writing.

***Patient and public involvement*:** Patients and members of the public were not involved in the design, conduct or analysis of this study. However, over 90 experts from diverse regions and professional backgrounds, including civil society representatives, clinicians, program implementers, and researchers, have participated in regional consultations, contributing their contextual insights and shaping the research priorities. Additionally, 271 stakeholders completed the global prioritisation survey, reflecting the perspectives of those working closely with crisis-affected populations. Their collective input was instrumental in identifying implementation research questions aligned with frontline realities. Participation is detailed below.

Thematic, geographical and contextual scope: The scope aligned with HHER2 and limited research questions to SRHR in LMICs affected by humanitarian crises, including conflict, displacement, disasters, and fragile settings (6). Populations of interest included refugees, internally displaced persons (IDPs), people on the move, and crisis-affected host communities. A geographical lens was applied, with consultations and survey data mapped against World Bank regional groupings (20).

The prioritisation covered nine SRHR domains adapted from the WHO's Life Course Perspective and UNFPA's definition of the SRHR (21,22): comprehensive sexuality education (CSE), FP and contraception, sexual health and wellbeing, reproductive cancers, STIs and HIV, maternal and newborn health (MNH), comprehensive abortion care, and the clinical management of rape. The management of complications from female genital mutilation and infertility prevention due to STIs or unsafe abortion covered these topics.

Menstrual hygiene and infertility treatment were excluded because they fall outside the scope of essential SRHR services included in the Minimum Initial Service Package (MISP) (23). The exercise included the clinical management of rape, although the prevention of sexual violence was classified as 'protection' rather than 'health'.

The inclusion parameters for the research questions include the following: exercise aligned with implementation science principles(24); and research on interventions, delivery strategies, or approaches that could improve (and measure) outcomes, service quality, or equity in humanitarian settings. The questions had to be specific, actionable and relevant to the programme or system-level delivery. Questions with purely descriptive aims (e.g., prevalence, burden, or knowledge, attitudes

practices) or normative/governance/legal themes not linked to measurable outcomes were excluded. The final list emphasised measurable outcomes related to delivery, availability, accessibility, and utilisation.

Multiphase approach to conducting the project

The prioritisation followed five interlinked phases, drawing on the Child Health Nutrition Research Initiative (CHNRI) principles (11,25) while adapting methods for the SRHR in humanitarian contexts to enable a transparent, inclusive and operationally grounded approach.

Ethical approval for the survey was granted by the University of Geneva Ethics Committee (ref: CUREG-20250213-265-2).

a) A scoping literature review of SRHR evidence in humanitarian settings was conducted to inform domain refinement and validate research gaps. Methods and results are reported separately(26). This review highlighted recurrent implementation gaps such as digital health, self-care, community-based delivery, and climate-adapted service models.

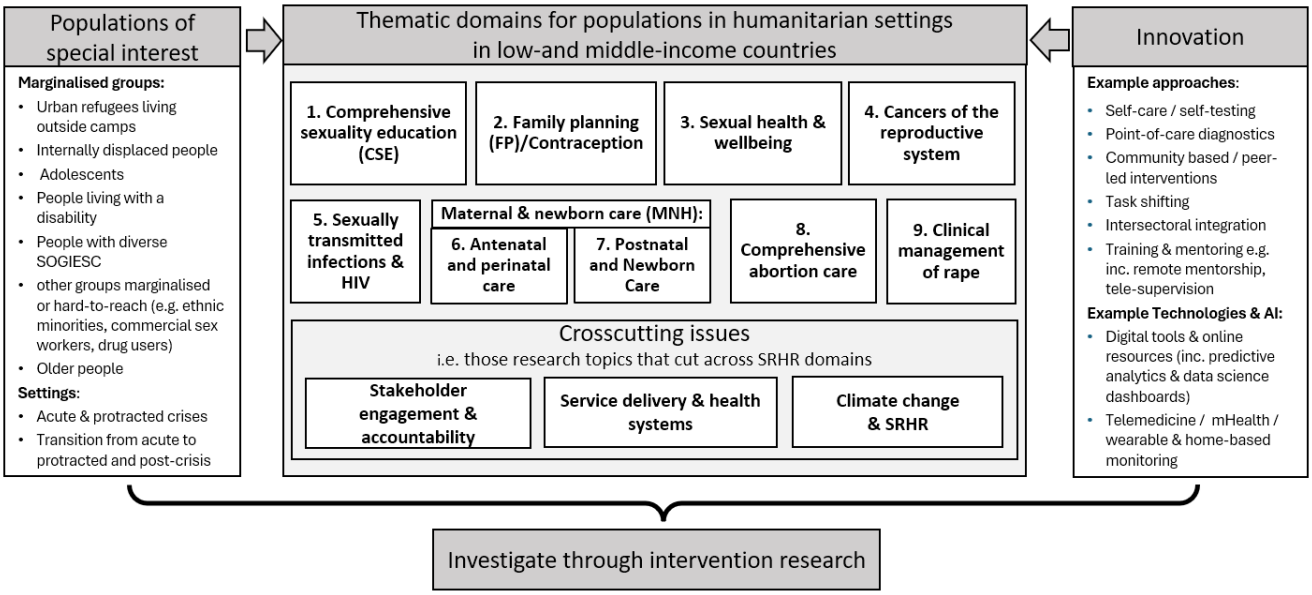
b) Mapping of existing research questions*:* A total of 45 candidate priority questions related to our definition of SRHR were extracted from three previous global SRHR research prioritisation exercises in humanitarian or LMIC settings (23,27,28). The questions were deduplicated, reviewed for framing and implementation focus, and updated in line with current guidance. This resulted in an initial list of 31 questions being used to initiate consultations (see phase c). A fourth STI-specific exercise (13) was considered retrospectively.

c) ***Regional stakeholder consultations and systematic listing of research questions****:*
Participants self-selected via professional networks and social media callouts. No limit was placed on participants per meeting to maximise inclusion. Among the 291 individuals who expressed interest, 91 (32%) participated in 11 regional online consultations (French, English, Spanish) between November and December 2024 across six regions: Africa (n=34), South Asia and East Asia (n=15), the Eastern Mediterranean (n=14), Latin America and the Caribbean (n=11), Europe and Central Asia (n=7), and the Western Pacific (n=3). Most were affiliated with nongovernmental agencies (NGOs) (n=40) or academia (n=23); 53 were women. The mean number of years of experience in SRHR in humanitarian settings was 7.6 years, with 5 years or more among 70% of respondents to the call.

The experts reviewed the initial 31 questions and discussed and reflected field experiences and emerging innovations to investigate them on context, implementation challenges, and localised evidence gaps. The inputs were captured via structured templates and summary matrices. Over 350 research ideas were categorised, consolidated and refined by the study team.

d) Refinement of research questions: Topics from the consultations not meeting eligibility criteria were excluded or reframed into evaluative implementation research. This process yielded a draft list of 101 SRHR questions. The CEG reviewed and further refined the questions, adding a layer of quality assurance to ensure that the research questions were relevant. A final list of 73 questions was produced, organised into 9 technical and 3 crosscutting domains [See Additional File 1 for the list of research questions organised by domain]. Each question was designed to be implementation oriented, adaptable across settings, and responsive to regional contexts. MNHs were split into two domains to ensure coverage of antenatal (ANC) and perinatal care, childbirth and postnatal care (PNC) interventions. During this process, potential approaches and technologies (for example, digital information tools, self-care diagnostics, or task-sharing models) were drawn from our data and listed as illustrative examples of interventions that could be investigated (depending on context). Details of these examples are provided in Additional file 1.

A conceptual framework was structured by SRHR domains, and data from consultations and the review informed the survey tool's organisation (see Figure 1).



* Themes were identified through a literature review; mapping of pre-existing research prioritisation exercises and through consultations with experts in SRHR in humanitarian settings

Figure 1. Key themes reflected in the SRHR research prioritisation exercise*

* Themes were identified through a literature review; mapping of preexisting research prioritisation exercises and through consultations with experts in SRHR in humanitarian settings, 2024--2025

(e) Global prioritisation survey: To rank the final list of questions, a multilingual online survey, hosted in LimeSurvey (29), was launched via the budget-weighted research prioritisation (BWRP) method. Sampling required self-reported expertise with at least 5 years of experience in SRHR in humanitarian, low-income settings. The participants were recruited via social media and professional and personal networks and were invited to snowball the survey. No participant cap was imposed, but we aimed for a total of 250 participants, with at least 30 per region. The survey was extended by 3 weeks to increase the number of responses in two underrepresented regions.

The respondents allocated a hypothetical US$100 across questions within each domain, using three criteria: relevance, feasibility, and effectiveness. This method was chosen over traditional CHNRI scoring following pilot testing, which revealed that cognitive burden and scoring inconsistency were barriers—issues also noted by others(30–32). The respondents were also asked to choose up to three additional prioritisation criteria and rank them from a predefined list derived from CHNRI methods: maximum impact, community involvement, deliverability, answerability, affordability, cost, ethical aspects, and public opinion. The survey was disseminated globally in multiple languages via social media and institutional networks.

Analysis methods

Each domain had a distinct set of questions and internal allocation of a hypothetical US$100 per respondent. This precluded statistical comparisons across domains due to differences in question numbers and domain structure. No score normalisation was conducted. The analysis was conducted by an SN with oversight by the KB and quality assured by the AA. Preliminary findings were shared with the 12-member CEG, who advised on refinements. The results were reviewed by all the CEG coauthors.

Within each domain, the mean allocation (score), standard deviation (SD), and interquartile range (IQR) were calculated, and the questions were ranked by the mean score. When the score differences were ≤0.05, the rankings were treated as tied to reflect the margin of variation.

Continuous variables (mean scores) were analysed without transformation; no grouping or categorisation was applied apart from tied ranks. The respondents selected the regions where their scores should apply (World Bank regional groupings (20)), with the option of selecting more than one. A global ranking of SRHR priorities was generated, with additional disaggregated scores by region.

To assess the importance of additional criteria selected by respondents, a weighted scoring system was used: 3 points for 1st place, 2 points for 2nd place, and 1 score for 3rd place.

RESULTS

Overview of the respondents

A total of 271 individuals with professional SRHR expertise in humanitarian settings completed the global prioritisation survey. Nearly half (48%) had 5–9 years of experience, 51% reported at least 10 years, and 13% had 20 years or more. Just over half (59%) identified as female, 36% as male, 2% as nonbinary or third gender, and 3% did not disclose their gender or had missing data.

Most respondents (72%) selected a single region in which they had the most experience; 13% selected two regions, and 15% selected three or more. Sub-Saharan Africa (SSA) was the most commonly cited region (63%), followed by the Middle East and North Africa (MENA, 22%), South Asia (17%), Latin America and the Caribbean (LAC, 15%), East Asia and the Pacific (10%), and Europe and Central Asia (6%). Fifteen percent of the participants reported global expertise, either by selecting ‘global’ or by identifying experience across 3 or more regions (see Figure 2).

Fig. 2a) Proportion of respondents selecting 1, 2, or ≥3 regions

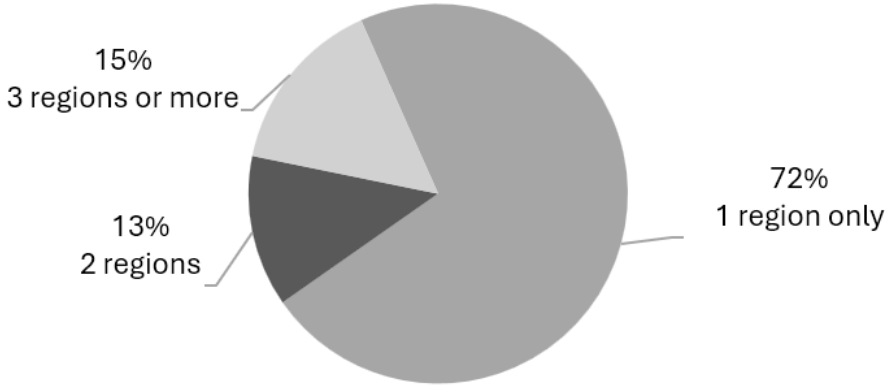


Fig. 2b) Number of survey respondents by selected region of expertise

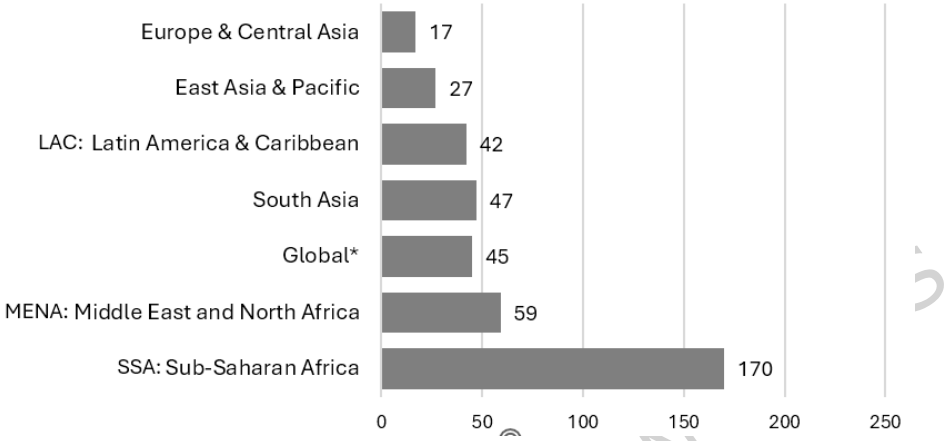


Figure 2. Respondents' regions of expertise (n=271)

Fig. 2a) Note: Reflects how many regional perspectives each respondent chose to represent in the survey.

*Fig. 2b) Notes: Respondents could select more than one region. 'Global' was treated as a distinct region. *Represents those who selected the option 'Global' + those who selected 3 or more regions.*

Due to a temporary server error, the data were partially corrupted for two fields related to ‘roles held in the humanitarian SRHR’: the ‘primary area of work’ (42% missing) and the ‘institutional affiliation’ (14% missing). All prioritisation scores remained intact. Where possible, missing role data were reconstructed via cross-referenced survey fields. Most of these respondents held management roles (n=114, 42%), often combined with research or service delivery responsibilities. Among the 58% of participants with complete data (n=156), the most common areas of work were clinical services (14%), research (14%), public health (8%), SRHR education or counselling (8%), and humanitarian project management (7%). Overall, the sample reflected a professionally diverse and experienced cohort.

Results of ranking

The findings are presented by the SRHR domain. The top-ranked research questions are shown in Table 1, with score dispersion illustrated in Figure 3. Regional patterns of convergence and divergence are described narratively. [See Additional files 2 for a full list of global & regional ranked priorities as scorecards and Additional file 3 regional boxplots by domain].

Table 1: Top-ranked SRHR research questions (Q) by domain on the basis of global prioritisation scores for all responses.

1. CSE, 6Qs **(n=172)**	Score	SD
Effective delivery models for CSE	21.80	11.4
Engaging Parents and caregivers in CSE	16.86	8.0
Training & supporting CSE facilitators	16.35	8.1
Integrating CSE into adolescent-friendly health services	16.34	10.8
2. Sexual health & wellbeing, 8Qs **(n=181)**		
Integration of SRHR and mental health (MH)	15.78	8.3
Strengthening SRHR & MH training for providers	15.56	7.9
Overcoming stigma & barriers to MH &SRHR access	14.06	8.1
3. FP & Contraception 8Qs **(n=216)**		
Ensuring reproductive choice in humanitarian settings	16.71	10.6
Increasing adolescent access to contraception	14.90	7.8
Overcoming barriers to LARC access and acceptance (demand-side)	14.37	7.9
4. Cancers of the reproductive system, 3Qs **(n=116)**		
Equitable HPV vaccination	34.78	14.2
Integrating HPV-based cervical screening cancer into existing SRHR services	34.74	11.9
Raising awareness where treatment is accessible	30.47	16.1
5. STIs & HIV, 8Qs **(n=174)**		
Scaling up STIs & HIV testing, specifically for displaced & high-risk populations	17.35	7.7
Preventing STIs in forced migration settings	14.78	6.8
Scaling up STI prevention, PrEP, STI management & PEP*	14.64	9.1
6. MNH – ANC/perinatal care, 5Qs **(n=190)**		
Strengthening basic EmONC	21.76	8.9
Context-specific approaches for increasing access to MNH	20.95	10.0
Emergency referral mechanisms	19.65	10.0
Community-based postnatal care	26.44	11.7
Mitigating and managing postnatal depression	24.95	12.8
8. Comprehensive abortion care, 7Qs **(n=149)**		
Improving women's experience of and access to abortion care	16.49	8.1
Effective strategies for implementing 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, 7Qs **(n=114)**		
Increasing timely access to postrape 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 access to the clinical management of rape for marginalised & key populations	14.27	7.3
Crosscutting-Stakeholder engagement & accountability, 7Qs **(n=219)**		
Community-led interventions to increase access	18.35	9.5
Preventing mistreatment & ensuring respectful care	16.95	9.1
Community engagement & Equity	15.00	6.9
Crosscutting - Service delivery & health systems, 7Qs **(n=215)**		
Community Health Worker training models for sustained learning	16.01	10.8
Digital information, education and communication	15.58	9.4
Service delivery during pandemics & large-scale emergencies	14.71	7.4
Increasing SRHR services for people-on-the-move	14.37	8.0
Crosscutting - Climate resilience, 3Qs **(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

Notes: n= total # responses for the domain. SD – standard deviation; see Additional file 1 for full question 1. When the mean allocation score of two or more questions differed by <0.05 points, the questions were ranked equally, so some domains had 4 questions ranked as the top priorities. *PrEP = preexposure prevention; PEP = postexposure prevention.

7. MNH - PNC & care of the newborn, 4Qs **(n=184)**	Score	SD
Essential newborn care in conflict settings	28.27	12.2

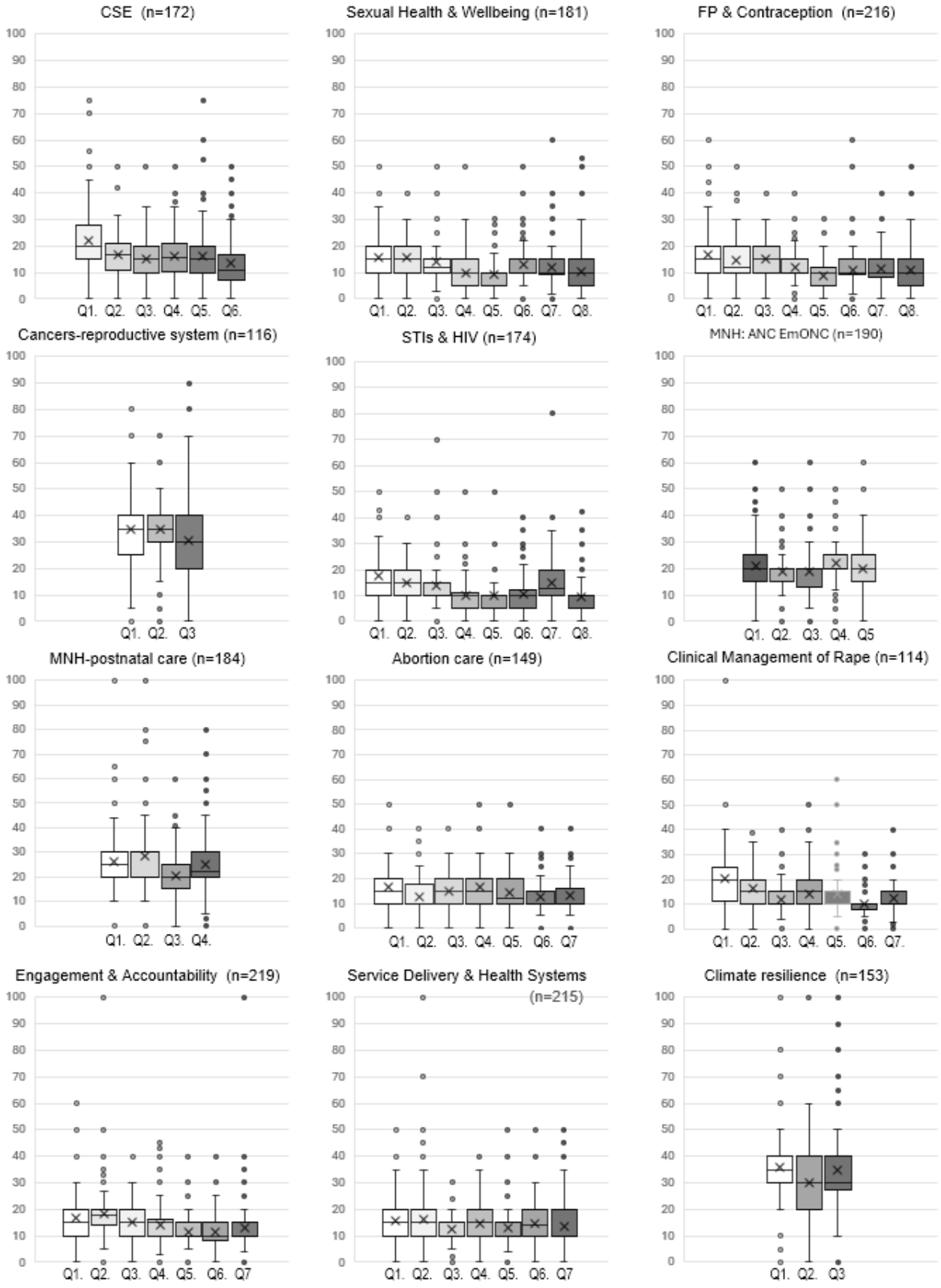


Figure 3: Boxplots and whisker charts showing the means, standard deviations (SDs) and dispersion of prioritisation scores for each research question by domain.

Figure 3 Notes: (n=total # participants who scored each domain globally. The research question (Q) numbers refer to the reference number from the original long list of questions (and survey tool) (see supplementary document) and not to their

ranking. Mean score (X); standard deviation marked by a box; interquartile range (25th to 75th percentile) shown by the box; SD shown by the line in the box; maximum and minimum exclusive scores shown by the top and bottom whiskers; outliers by small circles to illustrate the spread and density of scores allocated by individuals to any one Q. The vertical axis showing scores is set to 100 for each domain; however, this reduces the visibility of variation in scores between some Qs in domains where the maximum score given to any Q is less than 100. [See Additional file 3 for regional whisker and boxplot charts].

CSE

The top-ranked global priority focused on identifying *culturally appropriate and effective delivery models for adolescents* in humanitarian settings. Interventions suggested by experts during our consultations (hereafter referred to as *experts*) to inform research ideas included mobile and radio-based CSE delivery, digital platforms for out-of-school youth, and youth-friendly service integration. They emphasised the importance of disaggregating evidence by age group (10–14 vs 15–19 years). Regional variations included LACs' focus on *caregiver engagement* and *intergenerational dialogue* and Europe's and Central Asia's prioritisation of *integration into adolescent-centred services*. These priorities reflect persistent implementation challenges in ensuring inclusive, accessible CSE within disrupted systems.

Sexual Health and Wellbeing

The integration of mental health and SRHR services and the *strengthening of provider training* emerged as the top global priorities, closely followed by *stigma reduction*. During consultations*, the experts* proposed task sharing for psychosocial support, peer-led awareness campaigns, and digital tools for mental health delivery. Europe and Central Asia prioritised *addressing mental health* and *sexual health needs and* were the only regions to rank the need to address *menopause* among its top three priorities.

FP and Contraception

Ensuring reproductive choice and *expanding adolescent access to contraception* are top global priorities, echoing most regions. Europe and Central Asia diverged slightly, prioritising *services for vulnerable groups* and proposing CHW-led counselling, self-administered methods, and digital support tools. These priorities reflect strong support for rights-based, adolescent-friendly strategies and the need to address demand- and supply-side barriers in crisis contexts.

Cancers of the reproductive system

This domain includes three questions, with *equitable HPV vaccination* and the *integration of HPV-based cervical cancer screening into SRHR services* receiving closely ranked top scores across all regions.

The tight clustering reflects strong global consensus on the value and feasibility of scaling preventive interventions, particularly where access to secondary or tertiary care is limited. In contrast, *awareness-raising where treatment is available* scored slightly lower globally, suggesting that respondents prioritised strengthening delivery systems over demand generation alone. Experts have proposed strategies such as task-sharing with CHWs, single-dose HPV regimens, and self-sampling to improve accessibility and integration. These findings underscore a shared urgency to institutionalise basic cancer prevention within humanitarian SRHR services.

STIs and HIV

The top global priority was *scaling up STI/HIV testing for displaced and high-risk populations*, followed by *STI prevention in migration settings* and *increased PrEP/PEP availability*. Europe & Central Asia and MENA prioritised *scaling up STI vaccines*, reflecting strong regional interest in biomedical prevention. The experts highlighted mobile outreach, point-of-care diagnostics, and digital adherence tools as research strategies. These findings point to ongoing challenges in early detection and prevention, exacerbated by mobility and stigma. They align closely with the WHO global STI research agenda (13), particularly around advancing beyond syndromic management, expanding self-testing, and strengthening partner management. This convergence, despite differing scopes and methods, reinforces confidence in shared research priorities.

MNH – antenatal and perinatal care

The highest global priority was *strengthening basic emergency obstetric and newborn care (EmONC)*, followed by *context-specific strategies to expand access* and *community-based MNH models for displaced women and newborns*. The experts recommended mobile or midwife-led ANC/PNC, CHW distribution of misoprostol, and low-cost transport for emergency referrals. Community-based care has received greater emphasis in East Asia & Pacific, LAC, and Europe & Central Asia. While global scores are closely ranked, regional variations reflect differing service levels and research needs for context-responsive care, especially where facility access is limited.

MNH – postnatal and newborn care

Among the four questions, the top global priority was *delivering essential newborn care in conflicting settings*, underscoring the need to protect neonatal survival where systems are disrupted. *Community-based models to improve postnatal care coverage and quality* followed closely, with particularly strong support in Latin America and the Caribbean. Psychosocial care, *which mitigates and manages postnatal*

depression, is also among the top three methods globally and is ranked highest in East Asia & Pacific, MENA, and Europe & Central Asia. The SSA ranks these two factors jointly as top priorities. The findings reflect growing recognition of emotional wellbeing alongside survival outcomes and broad support for integrated, community-based care models that include psychosocial support.

Comprehensive abortion care

Among seven questions, two were jointly ranked as top global priorities and by SSA: *improving access and women's experience of abortion care*, particularly self-managed approaches via mHealth or telehealth, and *identifying supportive policy environments*, including those that are legally restrictive. Latin America & the Caribbean and South Asia ranked first; East Asia & Pacific and MENA ranked second. Europe and Central Asia prioritised *user-centered, nonmedicalized care models*. The results reflect the urgency of expanding safe, acceptable, context-adapted abortion care, especially under legal and structural constraints.

Clinical management of rape

Increasing timely access to postrape care in legally restrictive settings ranked highest across all regions except Europe and Central Asia, where it was fifth. This region instead prioritised *increasing health-seeking behavior and referrals*, which was second globally and top-ranked in MENA, South Asia and SSA. East Asia and the Pacific emphasised *task shifting to lower cadres*. The experts suggested decentralised, CHW-led models, improved referral systems, and community-based services. The domain highlights persistent implementation gaps and regional variation in system resilience and survivor-centered response strategies.

Crosscutting - Stakeholder engagement and accountability

Among seven research questions, *community-led strategies to increase access to SRHR care* and *ensure respectful care* were ranked first and second globally and held the top two positions in six of the seven regions. The experts proposed peer-led education, CHW-delivered services, and social accountability mechanisms such as citizen report cards and community scorecards to strengthen responsiveness and local trust. To enhance respectful care, suggested strategies include client feedback tools, social media platforms, and the use of artificial intelligence (AI) to increase access to information, generate demand, and monitor respectful care delivery.

The strong performance of these questions reflects widespread interest in approaches that foster trust, dignity, and accountability in settings where institutional legitimacy may be weak. While *engaging men*

and boys was also highly ranked, especially in Europe & Central Asia, other questions, such as those concerning partnerships, communication, and intersectoral coordination, were generally deprioritised. These findings suggest that community-facing and digitally enabled models for engagement and accountability are seen as more actionable and urgent research areas in humanitarian contexts.

Crosscutting - Service delivery and health systems

This domain comprises seven questions and shows the widest spread of scores globally, indicating divergent perceptions of feasibility and urgency. *Training models for sustained CHW learning* received the highest overall score (and were top-ranked in four regions), closely followed by *digital information, education & communication (IEC) tools to support SRHR uptake and adherence*. These priorities reflect a clear preference for scalable, frontline delivery models to strengthen care in constrained settings.

Service delivery during pandemics and *SRHR access for people on the move* were jointly ranked fourth globally, suggesting shared concerns around continuity and inclusion. Lower-ranked topics such as *value-based education*, *transition strategies from acute to sustained care*, and *supply chain preparedness* may have been viewed as less feasible or impactful in the current operational landscape.

Across all the questions, digital and AI-enabled approaches featured prominently among the strategies proposed by experts. While score dispersion was high at the global level, tight clustering within regions, particularly in MENA, where five questions tied for first and four tied for second, suggests that regional respondents viewed multiple service delivery strategies as interlinked and equally critical. Notably, MENA ranked *pandemic preparedness* clearly above the others, possibly reflecting recent experiences. These patterns suggest that although global preferences vary, within-region consensus highlights the perceived interdependence of delivery innovations in humanitarian SRHR systems.

Crosscutting - Climate resilience

Among the three questions in this domain, ensuring SRHR service continuity during climate-related displacement or disasters was the top global priority and ranked first in LAC, East Asia & Pacific, and MENA. This highlights the broad recognition of the urgent need to strengthen health system resilience amid escalating environmental crises. The adaptation of MNH services to climate shocks ranked second globally but was the top priority in South Asia, SSA and MENA, which are regions that are already experiencing major climate-related stressors. Uninterrupted SRHR commodity distribution ranked third globally, with regional variation reflecting differences in perceived relevance, feasibility or impact. These

findings underscore the increasing convergence between climate resilience and SRHR programming and the need for both structural and clinical adaptation.

Prioritisation criteria analysis

Among the 271 respondents, 187 (69%) ranked additional criteria that influenced their prioritisation. *The maximum impact* received the highest weighted score (279), followed by *community involvement* (188), *deliverability* (166), *answerability* (134), and *affordability* (97). The respondents with 5–9 years of experience provided the largest share of responses across all the criteria. As shown in Figure 4, these scores reflect a balance between pragmatic and value-based considerations guiding prioritisation.

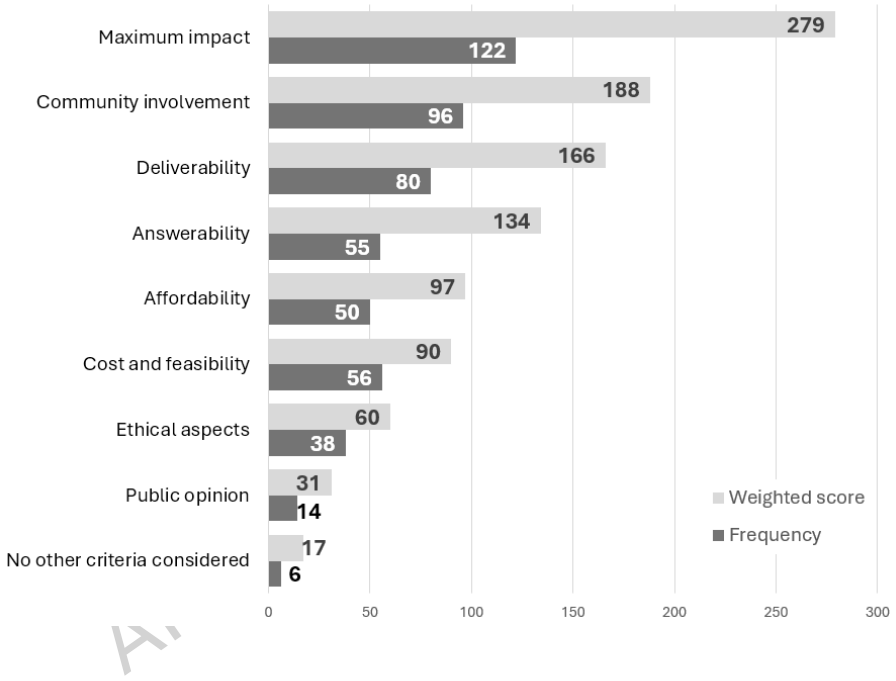


***Figure 4**: Weighted scores (and frequency) of prioritisation criteria (n=187) (69% of all survey respondents).*

DISCUSSION

This research prioritisation exercise is the first of its kind in this field to develop a stakeholder-informed, context specific, implementation-focused agenda for SRHR research in humanitarian settings. Building on but extending previous global and regional prioritisation efforts, this exercise adds breadth, inclusiveness, and contextual specificity to the SRHR research agenda for humanitarian settings. Across nine SRHR and three crosscutting domains, experts consistently ranked questions related to community-based delivery, self-care, task-sharing, and integration with mental health and resilience-building as top

priorities. These findings reflect the growing recognition that interventions must be context-responsive, locally led and tailored, scalable, and effective within fragile systems.

The prioritised research questions also highlight emerging approaches and technologies that hold promise for improving SRHR outcomes, such as community-based service models, digital and mHealth tools, and task-sharing innovations. However, their feasibility and effectiveness depend heavily on contextual realities, including infrastructure, sociocultural norms, and resource constraints. For example, mHealth messaging for antenatal care may be ineffective where internet connectivity or women's access to mobile phones is limited. Likewise, community-led or self-care interventions require varying levels of literacy, trust, and health system linkages that cannot be assumed across humanitarian contexts. These findings underscore that global prioritisation can identify broad areas of innovation, but successful implementation will require rigorous, context-sensitive testing and adaptation to ensure equitable and sustainable impact.

High rates of consensus were observed globally on topics such as equitable HPV vaccination, newborn care, and the integration of provider training with mental health. However, patterns of divergence between regions reveal important contextual nuances. The *Service Delivery and Health Systems* domain showed the widest score dispersion globally, suggesting differing views on which interventions should be prioritised. However, within individual regions, particularly in SSA, scores were far more tightly clustered, indicating strong agreement on the concurrent importance of multiple delivery strategies. Given that SSA hosts the largest share of people living in humanitarian settings and the largest proportion of survey respondents, this regional convergence significantly shaped the global results and underscores the need to invest in integrated, system-wide SRHR approaches.

Similar patterns were observed across other domains. For example, *STIs and HIV* and *comprehensive abortion care* displayed moderate global dispersion but concealed marked regional differences: questions rated as top priorities in one region received much lower rankings in others. In contrast, *postnatal and newborn care* and *climate resilience* showed both low dispersion and consistent regional clustering, indicating widely shared urgency across settings. Europe and Central Asia frequently diverged from other regions, emphasising quality of care, noncommunicable disease integration, and services for marginalised groups. Latin America and the Caribbean prioritised gender-transformative approaches to CSE and community-led access models, whereas East Asia and the Pacific gave greater weight to task-sharing in the clinical management of rape and the resilience of SRHR services in climate-

affected contexts. These variations highlight the influence of differing operational realities and underline the importance of context-sensitive priority setting.

While this study adopts the term *SRHR* to reflect international commitments to both health and rights, the prioritised questions focus on implementation research with measurable outcomes related to health or quality of care in humanitarian settings. Within this framing, many questions implicitly reflect rights-based principles, for example, those promoting informed choice (e.g., Q3.1, Q7.3, and Q7.4 in Supplementary document 1), respectful and person-centred care (e.g., Q9a.1 and Q9b.3), and inclusive access for adolescents, LGBTQI+ people, and displaced or disabled populations (e.g., Q1.6, Q3.4, Q8.4, and Q9a.3). Collectively, these priorities operationalise the core rights principles of nondiscrimination, participation, and accountability.(33,34) However, future prioritisation efforts could consider research that evaluates interventions to improve legal literacy, social accountability, or responsiveness to discrimination, issues that remain underrepresented despite their relevance to realising SRHR in practice.(19,35) Integrating such questions, while maintaining a focus on measurable outcomes, could help ensure that the SRHR is not only delivered but also equitably claimed and upheld in humanitarian contexts.

This exercise builds upon previous SRHR research agendas (13,23,27,28) but advances the field in breadth, inclusiveness, and practical orientation. he participation of more than 270 experts across diverse regions and disciplines enabled the identification of both global and region-specific priorities. The often-used CHNRI-style multicriteria scoring frameworks provided structured outputs but required abstract scoring across numerous questions. In contrast, our simplified budget-weighted survey made participation more accessible to implementers and nonacademic actors while still encouraging explicit trade-offs between relevance, feasibility, and impact. This adaptation broadened engagement without substantially compromising rigour and allowed clearer differentiation among competing priorities. As a result, the findings reflect not only expert opinions but also the operational realities of those delivering SRHR services in crisis-affected settings, ensuring that the priorities identified are both actionable and grounded in field experience.

Moreover, our focus on implementation research, rather than broader descriptive or burden-of-disease studies, was both deliberate and timely. As highlighted by Norton & Tappis (2024) (36), the current SRHR evidence base in humanitarian contexts remains fragmented and inconsistently grounded in implementation science. Their scoping review revealed that only six of 69 studies used formal

implementation research frameworks, underscoring a persistent gap in the application of theory-driven approaches to assess the real-world delivery of SRHR interventions. The prominence of questions in the agenda around provider competencies, mental health integration, and community accountability indicates a shift toward person-centered and systems-aware implementation science, underscoring the need to apply structured frameworks to guide contextual analysis from the outset (36,37). This study has several limitations. First, participation in the regional consultations was self-selected and included SRHR practitioners, academics, and implementers with varied experience levels; approximately 30% had fewer than five years of experience in humanitarian contexts. This may have influenced the framing of some research needs. To mitigate this, only individuals with at least five years of experience were eligible for the global survey, and all final questions were screened and refined by senior Core Expert Group members.

Second, although the study aimed for wide representation, participation from civil society and crisis-affected populations remained limited: only 8% of consultees were from community-based organisations. Future updates to this agenda should intentionally include displaced, conflict-affected, and youth representatives to ensure that their perspectives inform the contextualisation and uptake of research priorities.

Third, some regions were underrepresented in the survey despite extended recruitment, and minor data loss occurred in a few demographic fields; however, this did not affect prioritisation scores. Finally, because we did not normalise scores across domains, comparisons between domains are not possible. Each domain was treated as equally weighted to ensure balanced representation of SRHR areas, but some questions might have ranked differently if grouped under alternative domain structures.

The criteria selected by respondents to guide their decisions provide context for interpreting the prioritisation results. The emphasis on maximum impact, deliverability and community involvement suggests that participants valued research questions perceived as actionable, measurable, and grounded in frontline realities. This likely favours research related to intervention effectiveness and service accessibility while deprioritising upstream policy or governance questions, which may appear less feasible, especially crisis conditions.

These preferences align with a broader shift in the literature towards bringing research closer to implementation in complex, resource-constrained settings.(8,9) Kohrt et al. (9) emphasise that many questions of highest public health relevance can be answered only in humanitarian settings and caution

that crisis-affected populations must not be side-lined in pursuit of generalizable evidence. Our methodology and diverse stakeholder base were designed to reflect this imperative: the priorities identified address not only technical gaps but also operational challenges such as workforce capacity, mobility, and system fragility.

CONCLUSION

This study was conducted at a time of increasing concern about the sustainability of global health financing, particularly for SRHR in crisis-affected settings. Against this backdrop, the urgency of ensuring that limited research and implementation funding is guided by clear, practitioner-informed priorities should be highlighted. As Bhutta and Rulisa (2025) (14) argue, the “U-turn” in donor priorities risks stalling or reversing progress in women’s health in fragile contexts, especially where service coverage remains low, and cost-effective interventions have yet to be scaled. Currently, research agendas must align with real-world implementation needs, prioritising questions with measurable impacts on health outcomes, system resilience, and equity.

This study was conducted at a time of increasing concern about the sustainability of global health financing, particularly for SRHR in crisis-affected settings. Against this backdrop, our findings highlight the urgency of ensuring that limited research and implementation funding is guided by clear, practitioner-informed priorities. As Bhutta and Rulisa (2025) (14) argue, the recent “U-turn” in donor priorities risks stalling or reversing progress in women’s health in fragile contexts, especially where service coverage remains low and cost-effective interventions have yet to be scaled. Currently, research agendas must align with real-world implementation needs, prioritising questions with measurable impacts on health outcomes, system resilience, and equity.

This global prioritisation exercise sets out a practical, consensus-driven research agenda for advancing SRHR in humanitarian settings—one that centres on implementation, equity, and the realities of frontline service delivery. The experts identified well-established needs, such as post-natal and contraceptive care, and emerging concerns, including digital and self-care service models, climate resilience, adolescent-responsive services, and the inclusion of mobile populations. The highest-ranked priorities reflect a demand for delivery innovations and community-led solutions that ensure continuity of care in disrupted systems. Moving from identification to investment will require sustained commitment from funders, researchers, and practitioners to align research with both needs and opportunities. In a rapidly

shifting global health landscape, prioritisation must not remain a planning tool; rather, it must become a principle of action.

DECLARATIONS

Ethics approval and consent to participate

Ethical approval for the global prioritisation survey was granted by the University of Geneva Ethics Committee (Ref: CUREG-20250213-265-2). All participants in the survey provided informed consent electronically before beginning the questionnaire. For the regional consultations, participants provided verbal consent at the start of each session after being informed of the objectives, procedures, and use of anonymised outputs. Participation was voluntary, and no identifiable personal information was collected.

Consent for publication

Not applicable. This study did not involve individual patient data, identifiable personal information, or images. All survey and consultation data were anonymised and aggregated. The participants provided informed consent to participate in the survey and consultations.

Availability of data and materials

Additional files accompanying this article include the full set of research questions; global and regional prioritisation scorecards presenting the mean scores, standard deviations and rankings for each research question; and box and whisker plots for all the scores. The underlying anonymised survey tool and dataset are available from the corresponding author upon reasonable request.

Competing interests

Professor Karl Blanchet, a member of the study team who provided overarching strategic input and guidance, serves as a Co-Editor in Chief of *BMJ Global Health*. The authors declare that they have no other competing interests.

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This study was funded by Elrha (Purchase Order No. 200014730); the funder outlined the general approach to the study but had no role in data collection or data analysis and contributed to socialising

the survey, interpretation and presentation of the findings. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Authors' contributions

GMcK designed the overarching approach and coordinated governance mechanisms. SLN, AA and KB jointly contributed to the study design, led stakeholder engagement, and gathered and analysed qualitative data (research ideas), including their systematic listing and refinement. SLN, AA, KB, GMcK, TF, AMM and SP contributed to the piloting and refinement of the prioritisation tool and approach. SLN, AA and KB jointly developed the survey, and all the study team members and contributors supported the recruitment of consultation stakeholders and survey respondents. SLN led the quantitative analysis with quality assurance conducted by AA and KB, and EG supported survey administration and data management. All contributors (SC, CB, AMM, TeS, AC, PL-W, TF, NS and TaS) reviewed and helped refine the initial list of research ideas, alongside consulted experts (see Acknowledgements). SLN, AA, KB, GMcK, TF, AMM & SP contributed to piloting and refinement of the tool and approach. SLN prepared the first draft of the manuscript, and all the authors and contributors provided guidance with analysis and reviewed the findings. GMcK provided overall supervision, and EG oversaw project administration and liaison with the funder. All the authors read and approved the final manuscript.

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https://www.unige.ch/medecine/humanitarianstudies/application/files/4217/6217/9850/Members_of_Expert_Groups_oct2025.pdf to project website for participants). Finally, we are especially thankful to every expert who took the time to consider the research options and complete the prioritisation survey. This work would not have been possible without your contributions.

References

1. OCHA. Global Humanitarian Overview 2025. Trends in crises: a world on fire [Internet]. Geneva; 2024 Dec. Available from: https://humanitarianaction.info/document/global-humanitarian-overview-2025/article/trends-crises-world-fire#footnote-paragraph-8180-2

2. Munyuzangabo M, Gaffey MF, Khalifa DS, Als D, Ataullahjan A, Kamali M, et al. Delivering maternal and neonatal health interventions in conflict settings: a systematic review. BMJ Glob Health. 2021 Feb 1;5(Suppl 1):e003750.

3. Singh NS, Aryasinghe S, Smith J, Khosla R, Say L, Blanchet K. A long way to go: a systematic review to assess the utilisation of sexual and reproductive health services during humanitarian crises. BMJ Glob Health. 2018 May;3(2):e000682.

4. Bendavid E, Boerma T, Akseer N, Langer A, Malembaka EB, Okiro EA, et al. The effects of armed conflict on the health of women and children. The Lancet. 2021 Feb;397(10273):522–32.

5. Singh NS, Ataullahjan A, Ndiaye K, Das JK, Wise PH, Altare C, et al. Delivering health interventions to women, children, and adolescents in conflict settings: what have we learned from ten country case studies? The Lancet. 2021 Feb;397(10273):533–42.

6. Doocy S, Lyles E, Tappis H, Norton A. Effectiveness of humanitarian health interventions: a systematic review of literature published between 2013 and 2021. BMJ Open. 2023 Jul;13(7):e068267.

7. Singh NS, Smith J, Aryasinghe S, Khosla R, Say L, Blanchet K. Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review. Keygnaert I, editor. PLOS ONE. 2018 Jul 6;13(7):e0199300.

8. Leresche E, Hossain M, De Rubeis ML, Hermans V, Burtscher D, Rossi R, et al. How is the implementation of empirical research results documented in conflict-affected settings? Findings from a scoping review of peer-reviewed literature. Confl Health. 2023 Aug 22;17(1):39.

9. Kohrt BA, Mistry AS, Anand N, Beecroft B, Nuwayhid I. Health research in humanitarian crises: an urgent global imperative. BMJ Glob Health. 2019 Nov;4(6):e001870.

10. Rudan I. Setting health research priorities using the CHNRI method: IV. Key conceptual advances. J Glob Health. 2016 Jun;6(1):010501.

11. Kapiriri L, Tomlinson M, Chopra M, El Arifeen S, Black RE, Rudan I, et al. Setting priorities in global child health research investments: addressing values of stakeholders. Croat Med J. 2007 Oct;48(5):618–27.

12. Kobeissi L, Nair M, Evers ES, Han MD, Aboubaker S, Say L, et al. Setting research priorities for sexual, reproductive, maternal, newborn, child and adolescent health in humanitarian settings. Confl Health. 2021 Dec;15(1):16.

13. Gottlieb S. WHO global research priorities for sexually transmitted infections. Lancet Glob Health. 2024 Jul 20;12:e1544-51.

14. Bhutta ZA, Rulisa S. Implications of the USAID U-turn on women's health globally. Obstet Med. 2025 Jun;18(2):67–8.

15. Bishop S, Wexler A, Kates J. Policy Brief: 10 Things to Know About U.S. Funding for Global Health [Internet]. KFF The independent source for health policy research, polling, and news. 2025 [cited 2025 Jun 25]. Available from: https://www.kff.org/global-health-policy/issue-brief/10-things-to-know-about-u-s-funding-for-global-health/

16. UN News. US funding pause leaves millions 'in jeopardy', insist UN humanitarians [Internet]. UN News Global perspective Human stories. 2025 [cited 2025 Jun 25]. Available from: https://news.un.org/en/story/2025/02/1159746

17. Sully E, Friedrich-Karni A. Foreign Aid Cuts Will Lead to 34,000 More Pregnancy-Related Deaths in Just One Year. Ms [Internet]. 2025 Mar 19; Available from: https://www.guttmacher.org/article/2025/03/foreign-aid-cuts-will-lead-34000-more-pregnancy-related-deaths-just-one-year

18. Joint United Nations Programme on HIV/AIDS. AIDS, crisis and the power to transform: UNAIDS Global AIDS Update 2025. [Internet]. Geneva; 2025 Jul. Available from: https://www.unaids.org/en/resources/documents/2025/2025-global-aids-update

19. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher– Lancet Commission. The Lancet. 2018 Jun;391(10140):2642–92.

20. World Bank. World Bank Country and Lending Groups (FY 2025) [Internet]. 2025. Available from: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

21. WHO. Sexual and reproductive health and rights: infographic snapshot. 2022 Apr 29; Available from: https://www.who.int/publications/i/item/WHO-SRH-21.21

22. Sundewall J, Kaisr AH. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: AN ESSENTIAL ELEMENT OF UNIVERSAL HEALTH COVERAGE Background document for the Nairobi summit on ICPD25 – Accelerating the promise [Internet]. UNFPA; 2019 Nov. Available from: https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf

23. Inter-Agency Working Group on Reproductive Health in Crises (IAWG). Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings [Internet]. 2018. Available from: https://iawgfieldmanual.com/

24. Peters DH, Adam T, Alonge O, Agyepong IA, Tran N. Implementation research: what it is and how to do it. Br J Sports Med. 2014 Apr;48(8):731–6.

25. Rudan I, Gibson JL, Ameratunga S, El Arifeen S, Bhutta ZA, Black M, et al. Setting Priorities in Global Child Health Research Investments: Guidelines for Implementation of the CHNRI Method. Croat Med J. 2008 Dec;49(6):720–33.

26. Nam SL, Abril A, McKay G, Blanchet K. A Research Prioritisation exercise for R2HC: Sexual and Reproductive Health and Rights (SRHR) in Humanitarian Crises Results of a literature review (Report 1 of 2 to inform a prioritisation study) [Internet]. London, UK: Elrha; 2025 Apr. Available from: ToBeConfirmed

27. Kobeissi L, Nair M, Evers ES, Han MD, Aboubaker S, Say L, et al. Setting research priorities for sexual, reproductive, maternal, newborn, child and adolescent health in humanitarian settings. Confl Health. 2021 Dec;15(1):16.

28. Ouedraogo L, Nkurunziza T, Muriithi A, Asmani C, Elamin H, Françoise B, et al. Setting Regional Research Priorities for Sexual and Reproductive Health and Rights Services in Humanitarian Settings. Adv Reprod Sci. 2021;09(01):60–8.

29. Limesurvey GmbH. LimeSurvey: An Open Source survey tool [Internet]. Hamburg, Germany; Available from: http://www.limesurvey.org

30. Daniels J, Jones E, Lament A, Ladran T, Watz J. Evaluation of Risk Prioritization and Budget Allocation Methodsfor Pollution Prevention Activities [Internet]. National Technical Information Service, US Department of Commerce; 1997 Jan. Available from: https://www.osti.gov/biblio/643174

31. Mills B (Ed.). Agricultural Research Priority Setting: Information Investments for Improved Use of Resources. The Hague: International Service for National Agricultural Research; 1998.

32. Mabayo VIF. Framework for budget proposal prioritization for strategic resource allocation in universities. In 2024. Available from: https://www.researchgate.net/profile/Val-Irvin-Mabayo/publication/387692268_Framework_for_budget_proposal_prioritization_for_strategic_resource_allocation_in_universities/links/6777dd95894c5520853ffdc2/Framework-for-budget-proposal-prioritization-for-strategic-resource-allocation-in-universities.pdf

33. IPPF. IPPF position paper - The climate crisis and sexual and reproductive health and rights [Internet]. IPPF; 2021 Jan [cited 2024 Jun 27]. Available from: https://www.ippf.org/sites/default/files/2021-03/IPPF%20position%20paper%20The%20climate%20crisis%20and%20sexual%20and%20reproductive%20health%20and%20rights_Jan2021.pdf

34. Boydell V, Schaaf M, George A, Brinkerhoff DW, Van Belle S, Khosla R. Building a transformative agenda for accountability in SRHR: lessons learned from SRHR and accountability literatures. Sex Reprod Health Matters. 2019 May 31;27(2):64–75.

35. Tazinya RMA, El-Mowafi IM, Hajjar JM, Yaya S. Sexual and reproductive health and rights in humanitarian settings: a matter of life and death. Reprod Health. 2023 Mar 10;20(1):42.

36. Norton A, Tappis H. Sexual and reproductive health implementation research in humanitarian contexts: a scoping review. Reprod Health. 2024 May 13;21(1):64.

37. Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. Implement Sci. 2022 Oct 29;17(1):75.

LIST OF ADDITIONAL FILES

File name	File format	Title of data	Description of data
Additional File 1	.pdf	Final long list of 73 research questions on SRHR in Humanitarian Settings by domain with original number referencing and with examples of interventions provide by experts	List of final SRHR in humanitarian settings research questions that have been informed by experts around the world and systematically listed, categorised and refined.
Additional File 2	.xls	Global and regional scorecards.	Ranked list of all 73 research questions with mean scores, standard deviations, and

			interquartile ranges across nine SRHR domains and three cross-cutting domains.
Additional File 3	.pdf	Box & Whisker plot charts illustrating dispersion of rankings for each question globally and by region	Charts show dispersion of scores (rankings), mean, standard deviation and interquartile ranges as well as outlier values (scores). The charts are arranged by domain.

LIST OF ABBREVIATIONS

AI	Artificial intelligence
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
BWRP	Budget-Weighted Research Prioritisation
CEG	Core Expert Group
CHNRI	Child Health and Nutrition Research Initiative
CHW	Community health worker
CSO	Civil Society Organisation
CSE	Comprehensive sexuality education
FP	Family Planning
HHER2	2nd Humanitarian Health Evidence Review
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
IDP	Internally Displaced People
IEC	Information, Education and Communication
IQR	Interquartile range
LAC	Latin America & Caribbean region
LMICs	Low- and middle-income countries
MENA	Middle East & North Africa Region
MH	Mental health
MISP	Minimum Initial Service Package
MNH	Maternal and newborn health
PEP	Postexposure prophylaxis
PNC	Postnatal care
PrEP	Preexposure prophylaxis

SD	Standard deviation
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STI	Sexually transmitted infections
UN	United Nations
USAID	United States Agency for International Development