Guttmacher Policy Review

GPR

2017 | Vol. 20

In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations

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Over the last couple of years, the images and stories of those fleeing civil war in Syria—where conflict has displaced nearly half of the country's population[1]—have placed a spotlight on the intense human suffering faced by those in humanitarian crises. Globally, more than 65 million people in 2015 endured forced displacement by conflict and persecution—a record high.[2] Those forced from their homes are caught in humanitarian and crisis situations encompassing a range of human-made and natural emergencies, including armed conflict, political instability, natural disasters, epidemics and famine—which are often multiplied and compounded. Those from poor and fragile states with limited ability to carry out basic governance functions are even more prone to the effects of disasters and crises.

Of the 129 million people around the world in need of humanitarian assistance, approximately one-fourth are women and adolescent girls of reproductive age.[3,4] During emergencies, women and girls are at particular risk of harm when social and structural support systems around them collapse. They often lose their livelihoods, educational opportunities, homes and other assets. Many face disintegration of their families and other social networks, and are susceptible to mental and physical trauma, malnutrition, disease, long-term disability, poverty and especially violence from both intimate partners and others such as armed combatants. The dissolution of public infrastructure often includes the health system. Consequently, the increased threats to sexual and reproductive health, in particular, expose women and adolescent girls to unwanted pregnancy, unsafe abortion, STIs including HIV, and maternal illness and death.

HIGHLIGHTS

- *The world's humanitarian crises are enormous and ever-growing, as is the need for assistance—including assistance in meeting the sexual and reproductive health needs of women and adolescent girls.*
- *Despite progress in recent decades—especially related to the development of standards to address sexual and reproductive health in crisis settings—services on the ground have lagged far behind the need, because of challenges relating to culture and ideology, insufficient data, financial and resource constraints, and inadequate health care systems.*
- *Prevention, preparedness and resiliency are increasingly recognized as crucial to equipping communities to avoid crises, endure their effects and get on the path to recovery more quickly.*
- *U.S. leadership has been vital to addressing sexual and reproductive health needs in humanitarian situations, and that leadership is needed more than ever as global crises and needs proliferate and nationalism is on the rise.*

Given the unprecedented scale, frequency and duration of emergency situations in today's world and the sheer number of people in need of humanitarian assistance, the global community is mobilizing attention and resources at an extraordinary level to address these situations. Although the community recognizes the unique vulnerabilities of women and girls, and has developed guidelines to address their needs, the sexual and reproductive health needs of women and girls continue to go unmet during emergencies. Strategies to effectively respond to crisis situations must prioritize the delivery of sexual and reproductive health services throughout a

humanitarian situation—not only during the crisis phase, but also before its onset, during the recovery and beyond, toward long-term development.

Addressing the Need

Throughout the different stages of her sexual and reproductive life, a woman has many and varying sexual and reproductive health needs. Fundamentally, women need access to a full range of family planning methods to prevent an unintended pregnancy; safe abortion care and postabortion care for those who experience an unwanted pregnancy; and prenatal, delivery and postnatal care for those who carry a pregnancy to term. In addition, women need information and services for the prevention and management of HIV and other STIs, including antiretroviral therapy. Also critical is the prevention and management of sexual and gender-based violence, including clinical care for survivors.

Women's needs do not suddenly stop or diminish during an emergency—in fact, they may become greater. Advocates, humanitarian agencies and other actors have developed policies and guidelines that articulate standards on meeting the sexual and reproductive health needs and rights of those caught in humanitarian situations.

Establishing Standards

Until about 20 years ago, global awareness of and responsiveness to women's sexual and reproductive health and rights during a conflict or crisis were largely lacking. Instead, humanitarian responses made access to food, water, shelter, sanitation and immediate medical assistance the priorities. In 1994, a seminal report by the organization now known as the Women's Refugee Commission outlined the case for prioritizing the reproductive health of women in crisis.[5] Landmark United Nations (UN) conferences on women's health and rights in Cairo in 1994 and Beijing in 1995 recognized that women displaced by a conflict or crisis have the same right to reproductive health that all women do.[6,7] In 1995, a consortium of nongovernmental organizations (NGOs), donors, governments and UN agencies created the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG), which has since grown to over 2,100 individual members and 450 agencies.[8]

Through the years, IAWG has played a pivotal role in advancing advocacy, research and technical guidance in this field. Perhaps its most important contribution has been the development of a technical and programmatic guide, *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual*. The manual—first issued in 1999 and later updated in 2010—provides guidance to field staff on reproductive health interventions during emergencies.[9]

Importantly, the manual includes a chapter that delineates a set of five priority activities, known as the Minimum Initial Service Package (MISP), to be implemented at the very onset of every humanitarian emergency:

- identify an agency to lead the implementation of MISP activities;
- prevent sexual violence, and treat and support survivors through provision of medical and psychosocial services;
- reduce HIV transmission through infection control guidelines, freely accessible condoms and clean blood supply;
- prevent needless newborn and maternal death and disability; and
- plan for the provision of comprehensive reproductive health services, to be integrated into primary health care as soon as possible.

Advancing the Standards

Over the last dozen years, humanitarian agencies have increasingly integrated reproductive health standards into broader humanitarian policy documents. Notably, in 2004, the MISP was included in the Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response,*[10] which sets forth international benchmarks to guide humanitarian responders. Understanding that the MISP focuses on priorities during the beginning of a new emergency, UN agencies and IAWG issued the *Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery* in 2009 to identify priorities for enabling the sustainable provision of sexual and reproductive health services during situations of protracted crises and recovery, an ever-growing reality in the global landscape.[11]

In 2010, IAWG released a field-tested revision of the *Inter-Agency Field Manual* that includes a new chapter on safe abortion care, beyond postabortion care, as well as other updates to address gaps in the original manual. Another revision slated for 2017 will continue to address the shortcomings of the *Inter-Agency Field Manual,* including the MISP chapter. Ongoing discussions include the possibility of incorporating family planning and safe abortion services at the onset of an emergency and thus prioritizing them in the MISP.

Key Players

Typically, at the beginning of an emergency, a range of UN agencies, donors, governments and NGOs work together to deliver humanitarian relief. The World Health Organization (WHO) leads the health response in humanitarian crisis settings, supported by such other UN partners as the United Nations Children's Fund (UNICEF), the United Nations High Commission for Refugees (UNHCR) and the United Nations Population Fund (UNFPA).[12] Coordination with humanitarian NGOs—such as Save the Children, International Federation of Red Cross and Red Crescent Societies, International Medical Corps, CARE and International Rescue Committee—is a critical step in delivering health and humanitarian assistance.

When it comes to protecting women and adolescents, UNFPA takes a leading role in delivering sexual and reproductive health services. One of its most important functions is the procurement and dissemination of reproductive health kits that contain essential supplies, contraceptives and equipment. The agency delivered kits to 12 million people in 47 countries in 2016.[13] These reproductive health kits are an essential component of MISP implementation.

Among donor governments, the United States has played a pivotal part in supporting humanitarian assistance through its leadership on policy and funding. Indeed, the U.S. government was a major influence in ensuring the inclusion of provisions on refugees in the Cairo conference document and in supporting the formation and development of IAWG. The U.S. government's humanitarian assistance efforts overseas are primarily led by the U.S. Agency for International Development's (USAID) Office of U.S. Foreign Disaster Assistance (OFDA) and the State Department's Bureau of Population, Refugees, and Migration (PRM).

Both OFDA and PRM support the MISP as the roadmap for reproductive health activities in emergencies. Both agencies also provide humanitarian funding for UNFPA as a critical partner in reaching women and girls in crisis settings. OFDA's focus, however, is almost exclusively on internally displaced people (those who stay within their national borders when fleeing crisis). Among the interventions that OFDA funds are programs to prevent and respond to gender-based violence, including psychosocial and other services for survivors. While OFDA supports reproductive health—including family planning—as part of primary health care through education and integration of services, it does not support the purchase of contraceptive commodities, which instead must be secured through USAID's Office of Population and Reproductive Health.[14]

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On the other hand, PRM primarily directs assistance to refugees (those who leave the country when fleeing persecution, conflict or disaster). Although PRM does not fund specific issues or activities by sector (for example, by food, health or protection), it does identify protecting women and girls and ensuring their sexual and reproductive health and rights as priorities for its partnerships.

Gaps in Service Delivery

Even though substantial advances have occurred in the issuance of sexual and reproductive health guidance in humanitarian settings, implementation of these policies and standards has severely

lagged behind the enormous need. Advocates and agencies alike have identified a range of problems in delivering sexual and reproductive health services in humanitarian situations.

In 2004, IAWG released the findings of a global evaluation it undertook to assess reproductive health in crises from 2002–2004.[15] This evaluation documented progress in the availability of reproductive health services for refugees in established camps, but found services largely unavailable for internally displaced populations and for adolescents. The 2004 study found that significant gaps in programming existed in all technical areas, but for gender-based violence, it was especially scant.

In 2012–2014, IAWG conducted another evaluation, highlighting progress and gaps since 2004.[16] This assessment affirmed that humanitarian actors recognize that sexual and reproductive health is a key component of humanitarian assistance, and that steadily increasing awareness and implementation of the MISP have ensued. Programmatic expansion has occurred in areas such as postabortion care, maternal and newborn care, HIV and gender-based violence.

Nonetheless, the 2014 evaluation found that huge gaps remain.[16] Failure to fully implement the MISP at the onset of emergencies persists as a substantial problem. Among the weakest areas are services for adolescents and other vulnerable groups, such as those with disabilities, sex workers and LGBT populations. Adolescent girls, in particular, are at high risk of sexual and gender-based violence and exploitation, including trafficking; transactional sex for survival; early and forced marriage by relatives; and sexual assault by armed forces, humanitarian workers or others. Moreover, deficiencies exist in other sexual and reproductive health care areas, including safe abortion care; provision of long-term and permanent contraceptive methods; provision of emergency contraception, except in cases of rape; and clinical care and preventive services for victims of sexual and gender-based violence.

Barriers to Implementation

The reasons for gaps in sexual and reproductive health care are numerous and complicated. Obstacles include cultural and ideological barriers, data challenges, financial and resource constraints, and systemic and sectoral challenges, among others. Fundamentally, the same barriers that restrict access to sexual and reproductive health care during the most normal of circumstances still exist and are often magnified.

Cultural. Cultural norms and ideological opposition to family planning, abortion and other sexual and reproductive health matters often impede access to services, both before and during a crisis. Relatedly, stigma associated with sex, unintended pregnancy (especially outside marriage) and abortion, and concerns about privacy, may inhibit many from using services, especially survivors of sexual violence. Moreover, for sensitive issues like abortion, providers are often unwilling to offer services, even where abortion is legal.

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Research. Security and logistical obstacles in disaster zones and conflict-affected areas make it difficult to conduct research and collect information in those settings. In turn, there is little data to quantify the extent of unintended pregnancy, abortion and other reproductive health indicators. Such research is critical to promoting evidence-based interventions and advocacy for the special needs of those affected. Additionally, research is needed to test nonclinical or innovative approaches to service delivery in crisis settings.

Financial. The challenges of financing humanitarian aid for the world's crises are enormous. In 2017, global humanitarian funding needs will total $22.2

billion for the most vulnerable.[3] Humanitarian assistance is now the UN's most expensive activity. Yet, the needs far outpaced the funding. UN-coordinated appeals overall amounted to $22.1 billion in requests in 2016, but came up $10.7 billion short.[3] In 2016, UNFPA's humanitarian funding requests reached nearly $312 million, but only about half of those funding requests were met.[13]

The United States contributes nearly one-third of the total amount provided for humanitarian assistance, making it the largest international donor.[13] In fiscal year 2016, OFDA provided $1.4 billion in humanitarian assistance for disasters in 52 countries. Of PRM's fiscal year 2016 budget, approximately $2.85 billion was spent for overseas assistance.[17]

The shortfalls in overall humanitarian funding compound the shortfalls for sexual and reproductive health funding during emergencies. Indeed, the 2014 IAWG assessment found that although funding for reproductive health in humanitarian settings has increased since 2002, it remains systematically underfunded, which undermines full implementation of the MISP.[18] Of note, the 2014 assessment found that funding proposals for reproductive health in humanitarian health and protection appeals from 2009–2013 have consistently omitted requests for comprehensive family planning; funding appeals for abortion were practically nonexistent. The most-requested and most-funded reproductive health services in humanitarian health appeals were for maternal and newborn health care.

Systemic. Another major category of barriers to sexual and reproductive health access during emergencies is related to health systems. Notably, the strength of a health system before a crisis is an important indicator of what is to come with the onslaught of that crisis. Training of providers and adequately equipped facilities before an emergency are necessary so that they are ready during a crisis. Similarly, inadequate commodity management systems may be unable to deliver reproductive health supplies during a crisis, and critical supplies (such as emergency contraception) may not be accessible because they were never registered in the country.

Many of the barriers to effective assistance are not specific to sexual and reproductive health but obstacles endemic to the entire humanitarian sector. As such, in times of crisis, humanitarian responders may render the provision of family planning and other reproductive health services to secondary status behind other essential services, despite evidence and guidance to the contrary demonstrating their life-saving capacity. Another overarching problem is the failure to include affected communities—especially women and girls—in planning, managing and leading policies and programs to prepare and respond to crises.

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Perhaps the most entrenched and difficult challenge of all is that the focus of humanitarian funding and assistance heavily tilts toward reacting and responding to crisis. In fact, prevention, preparedness and resiliency are increasingly recognized as crucial to equipping communities to avoid crises, endure their effects and get on the path to recovery more quickly. For sexual and reproductive health, this means that it should be included in the primary health care system in addition to national plans to address both risk reduction and emergency response and recovery. Indeed, the bridge between short-term humanitarian responses and long-term development strategies can be connected by channeling more resources toward prevention and risk-reduction measures.

Marshalling Support

Given the urgent need to respond to the unprecedented humanitarian crises engulfing the planet, policymakers have convened throughout the past year to mobilize resources and attention. In May 2016, UN Secretary General Ban Ki-moon

organized the World Humanitarian Summit in Istanbul, which resulted in a set of commitments from governmental and nongovernmental leaders to reaffirm humanitarian principles and do more to prepare for and respond to crises and build resiliency against shocks. In the run-up to the summit, the Secretary General put forward a report, *One Humanity: Shared Responsibility,* to iterate five core responsibilities for action.[19] Notably, two of these broad responsibilities contain calls to global leaders to prioritize comprehensive sexual and reproductive health services as a strategy to empower and protect women and girls, and to provide comprehensive support to survivors of sexual and gender-based violence.

In September 2016, the UN General Assembly hosted the first High-Level Summit on Refugees and Migrants to marshal a more coordinated response to large movements of refugees and migrants. On issues related to women and girls, the summit's outcome document contains a commitment to mainstream a gender perspective in responses, promote gender equality, combat sexual and gender-based violence, and provide access to sexual and reproductive health care services.[20]

In recent years, the United States has shown important leadership in this area. The Obama administration released a number of policies and strategies that identify access to sexual and reproductive health services and programs on gender-based violence as important measures in humanitarian responses, including in the U.S. National Action Plan on Women, Peace, and Security, and the U.S. Strategy to Prevent and Respond to Gender-Based Violence—both of which were updated in 2016. Also in 2016, the Obama administration launched the U.S. Strategy to Empower Adolescent Girls, which recognizes the threats to girls' health and well-being during emergency situations and seeks to empower girls with information, skills and services, including sexual and reproductive health services. The one glaring exception to this progress is the continuing impact of the Helms amendment, which has long been incorrectly interpreted to bar U.S. foreign aid even in cases of rape (see "Abortion Restrictions in U.S. Foreign Aid: The History and Harms of the Helms Amendment," Fall 2013).

It is not clear whether the Trump administration will maintain or reverse these gains. And given the rising tide of nationalism in the United States and many European donor countries, there are fewer financial resources and less political will to delve into the complicated solutions necessary to address humanitarian challenges. This is worrisome, as the number and needs of those in humanitarian crisis situations will only grow. The United States has historically been at the forefront of addressing global crises, whether humanitarian or otherwise. It is incumbent upon the Trump administration to maintain this leadership role—the world is counting on it. ■

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Guttmacher Policy Review

From the Guttmacher Institute's policy analysts

Editorial Office: Washington, DC
policy@guttmacher.org
ISSN: 2163-0860 (online)
http:/www.guttmacher.org/about/gpr