**Submission to the UN Secretary General’s Independent Accountability Panel (IAP)**

**REPORT ON ACCOUNTABILITY FOR WOMEN’S, CHILDREN’S AND ADOLESCENTS’ HEALTH IN HUMANITARIAN SETTINGS**

1. **Introduction**

Respectful maternity care (RMC) is a universal human right and a component of quality maternal and newborn health (MNH) care that is due to every childbearing woman around the world. It expands the notion of safe motherhood beyond the prevention of morbidity or mortality to encompass respect for women’s and newborn's basic human rights, including recognition of and support for women’s autonomy, dignity, feelings, choices, and preferences, such as choice of companionship wherever possible, as well as, preventing separation of mother and baby. Ensuring accountability mechanisms that are effective, especially participatory accountability where women’s experiences are central, is a critical component of ensuring respectful care for mothers and babies in any setting. Accountability is even more important in humanitarian settings, where the vulnerability of women and newborns is most pronounced.

1. **Background on the Global RMC Council**

In 2011, the White Ribbon Alliance (WRA) convened a multi-sectoral group to launch a global campaign to promote clear standards for RMC rooted in international human rights. Together, the members of this community of concern produced a groundbreaking consensus document, the *Respectful Maternity Care Charter: The Universal Rights of Childbearing Women* (hereafter referred to as the RMC Charter), which demonstrates how fundamental human rights apply in the context of maternity care. (WRA 2011). The initial community of concern formed the Global Respectful Maternity Care Council (GRMCC). Today, GRMCC is a growing multi-sectoral group of 100 organizations, representing over 350 members from 45 countries around the world, including researchers, clinicians, technical advisors, program managers, advocates, professional associations, UN agencies, and donors. This submission represents the consolidated input of the GRMCC Advocacy Subcommittee.

1. **Gaps and challenges of RMC in humanitarian settings**
2. **Pregnant women and babies are especially vulnerable during an emergency**

According to a United Nations Population Fund (UNFPA) report on SRH in emergencies, one in five women of childbearing age in crisis settings is likely to be pregnant, and pregnancy and childbirth complications that would be treatable in other contexts can become fatal due to the destruction or disruption of health care services. UNFPA estimates that more than half of maternal deaths occur in emergency or fragile settings. Similarly, 5 out of 10 countries with the highest neonatal mortality rate (NMR) are in an acute or protracted humanitarian emergency. With concerns that humanitarian emergencies will only increase (UNSG n.d.), it becomes even more critical that health professionals identify effective strategies for ensuring safe and secure delivery in crises.

During a humanitarian crisis MNH services are severely interrupted as the crisis weakens the general health system (Southall 2011). The lack of health infrastructure (through destruction or abandonment), a poor referral system, lack of skilled medical staff and lack of key supplies, lack of quality management, inequity in who receives services, and attacks on health care providers (Elamein et al. 2017), are all symptoms of the general health system breakdown during a humanitarian crisis (Newbrander et al. 2011). For women, this breakdown of the health system is compounded by their lack of economic empowerment, that is evident for local women and acute for refugee women (Spiegel 2015). Food shortages, threats to hygiene and sanitation, and the breakdown of local support structures (Gasseer et al. 2004; O'Hare & Southall 2007), all hinder women in their ability to seek maternal healthcare during a humanitarian crisis.

In addition, there is a lack of intersectional approach in humanitarian settings (Matlin et al. 2018). For women in particular, the place they are leaving - voluntarily or by force, need or often a combination of both - is due to poverty or other structural issues that are inherently gendered, and on top of that, they contend with the daily issues of gender inequality and discrimination at the personal/interpersonal and community level, which is thrown in flux when migrating or fleeing - particularly if alone, but also when with family members, as the role of the caregiver is still upon their shoulders.

Women’s experiences with maternity providers can empower and comfort them or inflict lasting damage and emotional trauma. Disrespect and abuse (D&A) can be defined generally as “interactions or facility conditions that local consensus deem to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified” (Freedman et al. 2014).

While D&A is perpetuated and experienced by individuals, the practice is a manifestation of structural violence and gender inequality that has become normalized in societies around the world (Sadler et. al.,2016; Jewkes & Penn-Kekana 2015). As an example of D&A, Krause et al.’s study of reproductive health services in Za’atri Refugee Camp in Jordan revealed that Syrian refugee women living in the camp had low utilization of facility-assisted birth because of lack of respect women received from camp health providers. Despite the fact that the UN provided free maternal and reproductive health services, many women in Za’atri were reluctant to use them due to poor quality and lack of privacy. In addition, women described the facilities as being attended by unqualified providers and lacking basic resources (Krause et al. 2015). There is a normalization of D&A for women seeking maternal healthcare, and many women are not aware that they have the right to be respected (Bowser & Hill 2010).

Mistreatment towards women giving birth within the context of an emergency, such as a natural disaster or warzone, has not been well researched, yet remains a significant concern given that the heightened resource and security challenges and vulnerability of women in emergency settings may exacerbate the systematic causes of disrespect and abuse. Programs such as *Minimum Initial Service Package (MISP)* and *Sexual and Reproductive Health Clinic Outreach Refresher Training (S-CORT)* include respectful care (Onyango & Heidari 2017), but standards for intervention, training and implementation differ widely. Although disrespect and abuse are likely heightened in humanitarian settings, donor investment to date has focused primarily on developing country settings.

***Types of violations that are more likely in humanitarian settings:***

* ***Lack of information*:** A primary concern in crisis is that women lack information on where they can access MNH services. Providers may lack the time or resources to fully explain procedures or interventions. However, women who are giving birth in a hospital setting for the first time, may have fears surrounding childbirth or interventions, or have limited education. Efforts to educate, counsel, and when possible, accommodate women’s desires may help to alleviate women’s concerns (Fink et al. 2014).
* ***Lack of privacy*:** Issues of privacy can be of particular concern in camp settings, where there is very little space and one-room tents are often used as clinics (Women’s Commission 2004; Krause et al. 2015). During the earthquakes in Haiti and Pakistan, women hesitated to access care because of the lack of privacy that facilities provided (Bloem & Miller 2010).
* ***Lack of consent*:** Emergencies can cause migration, leading to groups of people living in places where they do not speak the language, are not familiar with the norms, or are unwelcome. Language and cultural barriers, compounded by discrimination, lack of education, and health personnel short on time, can lead to non-consensual health intervention. In Greece, many Syrian refugee women describe undergoing cesareans and even hysterectomies without their knowledge or consent (Ahmetasevic, 2016; Gill 2016a).
* ***Denial or delay of care*:** Interviews with women in the West Bank and Gaza found that restricted mobility and lack of funding led to limited functioning of facilities and an increase in deliveries at home and at military checkpoints. Military checkpoints have been found to block ambulances and women in labor, and there exist reports of women dying at military checkpoints because they were denied passage to reach the hospital (Aswad 2007; Bosmans et al. 2008). In Malaysia, for example, Rohingya who do not possess a valid UNHCR registration card cannot access government and private hospitals, even in emergencies when by law these hospitals are required to treat them; even with the cards, which allow for subsidized healthcare. Costs – especially those for pregnancy-related and childbirth services – are often out of reach and families must look to outside sources to cover fees (Sullivan 2016).
* ***Neglect and abandonment*:** The risk of neglect and abandonment is likely higher in emergencies due to severe human and material resource shortages and discrimination. In one study, Palestinian women described being left alone in the hospital for long periods during labor, without even family to provide support, because midwives and nurses were overwhelmed with patients; in addition, the women would often leave the hospital within hours of delivery and be lost to follow-up (Wick 2002).
* ***Issues relating to the presence of short-term, foreign aid health workers*:** In some cases, short-term mission staff working in emergency response may lack cultural competency or lack the time and resources to provide culturally appropriate care. Although not necessarily intended as D&A, laboring women may perceive care as disrespectful if providers do not share or adhere to their cultural norms (e.g. around gender, language, power), and consequently, be deterred from utilizing services. For example, in certain contexts, the presence of male providers or ancillary personnel, such as interpreters, may also be seen as disrespectful and prevent women from seeking care (Women’s Commission 2004; Bloem & Miller 2010; Krause et al. 2015).

1. **Intersectional discrimination and importance of social determinants of health**

The Global Strategy for Women, Children and Adolescents discusses the fact that an array of structural challenges persist, including gender inequality, poverty and intersectional discrimination (racism, ageism, ableism, etc.) and are all violations of human rights. A number of case studies illustrate that the cultural, language, and ethnic barriers that migrant pregnant women face are not only challenging in accessing pregnancy-related health care, but also basic social services to ensure a stable enabling environment for the mother and baby, such as housing, electricity, clothing and/or food. A notable gap is lack of information and data on how these inequalities, particularly those related to gender inequality and intersectional discrimination, are exacerbated and can be accounted for in humanitarian contexts for pregnant women and new mothers and babies. The importance of addressing the social determinants of health cannot be understated and are also inextricably linked to women’s health, related rights and well-being in humanitarian settings.

1. **Who is responsible for addressing these gaps?**
   1. **Global commitments**

On September 19, 2016, 193 member states unanimously signed on to the New York Declaration on Migrants and Refugees (“the New York Declaration”) at the UN General Assembly (New York Declaration 2016). In addition to strengthening global resolve to protect the rights and safety of refugees and migrants, the New York Declaration focuses on the commitments of States to meet the health needs of women and girls (Matlin et al. 2018). Specifically, there were four areas of action (UNHCR n.d.):

1. Strengthen humanitarian efforts to support the transition and resilience of refugees and host communities
2. Provide additional humanitarian financial support to host countries
3. Explore resettlement options for third countries
4. Support the development and implementation of a comprehensive refugee response network (CRRF) for new humanitarian efforts and protracted settings

The vision of the CRRF was to form a coalition of UN agencies, governments, non-government organizations, private sector partners, civil society and refugees themselves (UNHCR n.d.). Thus far, the CRRF has been rolled out in only 15 countries from sub-Saharan Africa, Central America and Afghanistan (UNHCR CRDF n.d.).

* 1. **National responsibilities**

The responsibility of attending to the health needs of refugees and migrants who are in communities, refugee camps and transit has rested on the shoulders of the States (Matlin et al.2018). In practice, there is often confusion among migrants and those in the health system on what entitlements are afforded to migrants as residents (Matlin et al. 2018). For example, in the United Kingdom, non-white residents and those considered “culturally distinct” face opposition from citizens, including national entitlements such as healthcare (Dempster & Hargrave 2017). Those who are able to access care in the UK have reported undignified treatment, such as lack of communication in women’s preferences for maternity services (Jentsch et al. 2007). Informal domestic workers in Spain were denied access to essential sexual and reproductive health care due to lack of residency permits, while those testing positive for pregnancy in the eastern Mediterranean may be immediately deported (Alcalá & Meghani 2018). In a review of refugees’ and asylum seekers’ experiences in accessing health care in eleven host countries, respondents reported feeling discriminated against by health care providers for being migrants, unvalued and frustrated due to feeling like a burden on the health systems (Cheng 2015). When state health systems fail migrants and refugees, civil society and the private sector are often left to provide basic health services, including maternity care (Matlin et al. 2018).

* 1. **Professional organizations and associations**

Professional organizations and associations need to be attuned to the barriers in care seeking, as clinicians in receiving countries may feel unable to attend to the emotional and physical needs of refugees and migrants (Jentsch et al. 2007). This may include standards and guidelines specific to caring for these vulnerable populations so that their members feel confident in providing culturally competent care. Professional associations need to work with Governments to increase support for providers - caring for the carers- who also have rights to work in fully equipped and safe enabling environments.

The International Federation of Obstetrics and Gynecology (FIGO) has taken a large step forward in partnership with the World Health Organization (WHO) in their Draft Action Plan for 2019-2023, Promoting the Health of Refugees and Migrants (FIGO 2019). The plan focuses on ensuring accessibility, affordability, acceptability and quality of care, and is explicit in promoting services for women and adolescents, including emergency obstetric services, the Minimum Initial Service Package (MISP), and antenatal care, as well as supporting member states for delivering these services (WHO 2017).

* 1. **Sphere standards**

Accountability for the provision of respectful and high-quality maternity services needs to be strengthened in humanitarian settings, with the continued commitment of all stakeholders to the Core Standard on Quality and Accountability. Notably, the tenets of respectful maternity care and universal rights of childbearing women are intrinsic to the four protection principles within these standards. The Sphere Minimum Standards for Health Care impress the importance of high quality, patient-centered care. Health care providers are often the first point of contact for women during a humanitarian event; building trust within that interaction is important for care at the point of services and the humanitarian effort as a whole. However, there are no Sphere key indicators specific to the experience of care or respect and dignity in service provision, other than for people who have experienced sexual violence. Expansion of key indicators for providing person-centered care in all service delivery, with specific focus on women who are in the most vulnerable situations during childbirth, is an important step in ensuring the rights of those in crisis and strengthening humanitarian response (IFC 2018).

1. **Examples of promising accountability practices at the local, national or global level**

Implementing social accountability mechanisms are particularly challenging in humanitarian situations. The underlying concept of rights holders (often focused on citizens) demanding accountability from duty bearers (often their own government), may be harder to replicate in situations where large populations are refugees, migrants or asylum seekers or where health systems are weak or failing. Strong humanitarian actors and agencies will then step in to provide the necessary assistance and services, but their relationship to the people they serve cannot be described in the same accountability framework and thus any mechanisms for accountability for their work will be voluntary, and not framed as legal responsibilities.[[1]](#footnote-1)

From the onset of a humanitarian crisis, accountability mechanisms should be strengthened, using innovative approaches and adapting social accountability models such as citizen monitoring. In conflict-affected Democratic Republic of Congo, a study found that community scorecards increased transparency and community participation in facility management and improved quality of care by “facilitating flows of information, increasing collaboration, and supporting user demands regarding their entitlements” (Ho et al. 2015). If implemented early on, such mechanisms could improve the functioning of health systems in fragile settings.

Feedback mechanisms need to be integrated into the system of health service provision and not as a one-off event. A promising example is the recent launch of a first-of-its-kind digital customer feedback system that was implemented with refugee populations in Somalia, Uganda and Rwanda. The system tracks customers’ levels of satisfaction at the point of service in real time and records customers’ ideas for how services might be improved. The feedback is aggregated into an interactive public platform.[[2]](#footnote-2) Service teams then analyze the data to implement quick service improvements as well as longer-term system changes to improve overall customer experience and satisfaction. Another example implemented in Yemen utilizes different complaint and response mechanisms, such as a toll-free hotline, complaint desks, complaint boxes, clients exit interview and regular community committees' meetings. This system gives women a better chance to share their experiences and leads to programmatic improvement of services on a regular basis, thus ensuring accountability in an acute humanitarian situation.[[3]](#footnote-3) Feedback mechanisms like these need to be institutionalized in humanitarian systems and implemented in both stable and humanitarian settings.

At the policy level, there is little evidence that women who are affected by humanitarian emergencies are involved in determining the policies that affect their health. Change is needed both at the country and international level to ensure that mechanisms that determine policies or coordinate humanitarian response are informed and led by the women who are most affected by the crisis. A transformation of the power dynamics within the humanitarian sector is needed to recognize women as leaders for their own health and to address reproductive health as a key priority in crisis. Only then can we talk about true accountability for women’s, children’s and adolescents’ health in humanitarian settings.

**Signed:**

The White Ribbon Alliance

American Refugee Committee

Averting Maternal Death and Disability Program, Columbia University Mailman School of Public Health

Center for Health and Gender Equity (CHANGE)

Childbirth Survival International (CSI)

El Parto Es Nuestro

Every Mother Counts

FIGO

Goodbirth Network

HealthRight International

Human Rights in Childbirth

Institute for Women’s Health, University College London

International Childbirth Initiative (ICI)

International Mother Baby Childbirth International (IMBCI)

International Stillbirth Alliance

Jhpeigo

Lamaze International

Management Sciences for Health (MSH)

Maternal Health Systems and Implementation Research Group, King’s College London– UK

Medical Women’s International Organization

Namati

Osservatorio sulla Violenza Ostetrica Italia

Population Council

Program of Social Sciences and Health at FLACSO, Argentina

Project Concern International

Regroupement Naissance-Renaissance–Canada

Safe Motherhood and Newborn Committee (Mesa de Maternidad y Nacimiento Seguras)– Bolivia

Save the Children

Save the Children Yemen

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1. See for example Humanitarian Accountability Partnership, 2013 Humanitarian Accountability Report, available at <https://reliefweb.int/sites/reliefweb.int/files/resources/2013-har.pdf> [↑](#footnote-ref-1)
2. See [www.kujakuja.com](http://www.kujakuja.com). [↑](#footnote-ref-2)
3. For more information contact Save the Children Yemen [↑](#footnote-ref-3)