Response from International Planned Parenthood Federation

Human rights council resolution on Maternal Mortality in humanitarian settings

The International Planned Parenthood Federation would like to thank for this opportunity to contribute to the High Commissioner's resolution on Maternal Mortality on humanitarian settings.

Human Rights

IPPF work is based on the premises that access to sexual and reproductive health not only saves lives, it is also a basic human right, as set out in the Programme of Action of the International Conference on Population and Development [1] and reiterated in Beijing Declaration and Programme of Action from Fourth World Conference on Women in Beijing 1995[2], their follow-up and review processes and United Nations resolutions and instruments. In humanitarian contexts, the rights of women, adolescents and girls affected by conflict are protected by multiple, complementary bodies of international law, including international humanitarian law (IHL), international human rights law (IHRL), international criminal law, and refugee law.[3]

Maternal Mortality (MM)

It is estimated that 830 women die due to pregnancy related causes every day.[4] Most of these deaths occur in developing regions with approximately 61% in countries affected by humanitarian crisis or fragile conditions.[5] The highest burden is on adolescent women and hard to reach populations[6].

Maternal mortality ratios (MMRs) in countries affected by conflict and natural disasters remain high and, despite the lack of reliable and systematic data, research has shown increase during periods of conflict and disaster events,. According to a Center for Reproductive Rights report, Syria's MMR has increased from 49 to 68 per 100,000 live births since the start of the conflict in 2011 and the Central African Republic has an MMR of 882 per 100,000 live births, which reflects improvement over the past 15 years but a slight increase since the start of the most recent period of unrest in 2013 .[7] While UNFPA reports that the maternal mortality ratio in countries in Asia Pacific is 127 compared with 187 in countries experiencing a humanitarian crisis. [8]

Patterns of maternal mortality and morbidity often reflect power differentials in society and the distribution of power between men and women.[9]

IPPF

IPPF is a locally-owned, globally connected civil society movement and delivers SRHR care and information through Member Associations (MAs) in 171 countries worldwide.

The organizational vision as reflected in the 2016-2022 strategic framework reiterates that "all people are free to make choices about their sexuality and well-being, in a world without discrimination". Recognizing that the right to SRH doesn't cease – regardless the situation the person is in- IPPF includes humanitarian lens to its strategic framework and created a dedicated hub of humanitarian specialist to work towards this commitment. IPPF responds to crises across the world to meet the need, wherever it is, whoever requires it, for as long as it

[1] Report of the International Conference on Population and Development, Cairo, 5–13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex https://www.ipci2014.org/sites/ipci2014.org/files/icpd_eng.pdf
[2] Beijing Declaration and Program of Action, http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf
[3] Ensuring Sexual and Reproductive health and Rights of Women and Girls affected by Conflict: Center for Reproductive Rights https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf
[4] www.who.int/mediacentre/factsheets/fs348/en/ Fact sheet November 2016.
[5] Maternal Mortality in Humanitarian Crisis and Fragile Settings, UNFPA, 2015 https://www.unfpa.org/resources/maternal-mortality-humanitarian-crises-and-fragile-settings?page=7%2C0%2C12
[6] www.who.int/mediacentre/factsheets/fs348/en/ Fact sheet November 2016
[7] Ensuring Sexual and Reproductive health and Rights of Women and Girls affected by Conflict: Center for Reproductive Rights https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ga_bp_conflictncrisis_2017_07_25.pdf
[8] Maternal Mortality in Humanitarian Crisis and in Fragile Settings, UNFPA https://www.unfpa.org/sites/default/files/resource-pdf/MMR_in_humanitarian_settings-final4_0.pdf
[9] "Human Rights-Based approach to reduce preventable maternal mobility and mortality: Technical Guidance", United Nations Human Rights Office of High Commissioner

is needed. The localized approach ensures work across the entire disaster management cycle, mitigation, preparedness, response, and recovery, to ensure life-saving SRH is provided to affected populations, especially those under-served and marginalized. In stable and crisis settings, IPPF protects all people's reproductive dignity and safety.

IPPF hereby presents key considerations towards the Human Rights Council resolution on Maternal Mortality in humanitarian settings.

Question 1: What steps has your organization taken to utilize a human right based approach (HRBA) in policies and programmes to eliminate preventable maternal mortality and morbidity; Did we use the technical guidelines? If so how did they assist in design, implementation and evaluation of policies and programmes?

A human rights based approach is essential to IPPF as to ensure that people, in all their diversity, have access to SRHR services, education and information. This includes adolescents, hard to reach populations including LGBTQ+[10], PLD[11] and PLHIV[12] , especially in humanitarian contexts, where vulnerabilities and marginalization is exacerbated.
Youth volunteers are part of IPPF's program approach which tailored to country and context. These programs enable reaching the (in many low-income countries) a growing number of young population that is at greatest risk for morbidity and mortality due to reproductive health and pregnancy related causes.
Through inclusion of PLD and PLHIV's organizations IPPF aims to provide access to services to the hard to reach population groups. Those who seek our services are offered awareness sessions and receive comprehensive information to enable them to decide on their SRH needs without coercion, stigma or discrimination. IPPF with its Member Associations (MAs) conduct advocacy activities to educate governments about the right to SRH services, information and education. Where possible joint trainings are conducted to develop capacity within IPPF as well as within the Ministry of Health (MoH) and other stakeholders to reduce barriers to SRH information and services and increase access for all who need. In 2016, IPPF reached to 112.4 million people with positive SRHR messages and 28.1 million young people completed a quality‐assured comprehensive sexuality education program. A staggering 145.1 million SRH services were provided, of which 74% were women and girls, resulting in 18.8 million couple years of protection. Of these, 6.3 million were first time users of modern contraceptives. Estimated 47.2 million people (~80%) served were poor and vulnerable including 3.2 million in humanitarian setting.

IPPF's health programs are in line with global evidence to reducing Maternal Mortality. IPPF aims to provide access to Maternal and Newborn Care services including basic obstetric emergency services and comprehensive obstetric emergency services to prevent excess maternal and newborn morbidity and mortality where possible. Meeting unmet needs for contraception reduces MM up to 30 % [13]and is in the core of IPPF's work. Within countries' legal framework, IPPF offers safe abortion services -medical method and manual vacuum aspiration (up to13 % of maternal mortality are due to unsafe abortion annually[14]). In a humanitarian context, IPPF recognizes that gender-based violence can increase and is often under-reported. As health services are often the first - and sometimes the only - point of contact for survivors seeking assistance for GBV, IPPF works to capacitate its service providers to ensure that they work to prevent and provide clinical care for GBV per the Minimum Initial Service Package (MISP), from the earliest stages of an emergency. This is based on a survivor-centered approach using rights-based principles, rooted in safety, confidentiality, respect and non-discrimination. Healthcare programming approaches to prevent, mitigate, and respond to GBV are adapted to the changing nature of emergencies. All humanitarian personnel are oriented to assume GBV is occurring and need to be prepared to take appropriate action. Service providers are trained to provide competent, confidential, and compassionate clinical care for survivors of GBV and that they have the supplies to do so. This is based on the understanding that health care providers frequently come into contact with survivors of sexual violence and are in a unique position to create a safe and confidential environment for survivors to disclose their experiences of violence. Sometimes the survivors will need clinical care to prevent or treat consequences of sexual violence and in some cases the appropriate support will be a referral to other resources and services depending on the survivor's needs and wishes.

[10] Lesbian, Gay, Bisexual, Transsexual, Queer, Intersexual and others
[11] People Living with disabilities
[12] People living with HIV
[13] S.Ahmed Lancet 2012; 380: 111–25
[14] Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health. 2014 Jun; 2(6):e323-33

Question 2: What are the challenges when implementing a HRBA?

Implementing a HRBA is challenging in contexts where country laws, harmful practices, religious and social norms do not support provision of selected SRHR services. One of these challenges between the right to best medical practice and local customs and restrictions is especially obvious in regard to Safe abortion services, child early and forced marriage and female genital mutilation. Where possible and within the national legal framework, IPPF offers safe abortion services to ensure that those who request these services have access to them.

Religious and social norms can also be a challenge to a HRBA in the provision of family planning, including access to modern forms of contraception.
IPPF conducts continuous advocacy work on national and sub-national level towards a wider acceptance of SRH services to enable women, men, adolescents and youth to access reproductive health services needed. An integral part of IPPF's work is on access to family planning, in particular access to contraceptives, as women have the right to know about and have access to contraception.

Question 3: Do we have evidence that majority maternal deaths occur in fragile states and humanitarian settings and that pregnant women have higher medical risks in crises settings?

26 million women and adolescent girls in their childbearing years are in need of humanitarian assistance around the world today.[15] Of the 830 women and adolescent girls who die every day from causes related to pregnancy and childbirth, 507 die in countries that are considered fragile because of conflict or disaster – which constitutes about three fifths of all maternal deaths worldwide[16].
Maternal mortality in humanitarian crises and in fragile settings is estimated to be 1.9 times the world average, and the number of maternal deaths in these countries represent 61 per cent of the total number of maternal deaths worldwide[17].
Addressing needs in a humanitarian situation is challenging as health systems are often disrupted, facilities destroyed, skilled health providers not available and the supply chain is not reliable. IPPF is well aware of these needs and strengthens its MAs to provide meaningful SRH services to save lives and prevent morbidity when it is needed the most.

The Initial Minimum Services Package for Reproductive Health (MISP) — the internationally accepted minimum standard of care to be implemented at the onset of an emergency in a resource-constrained environment is one measure to guarantee the principles of humanitarian action. IPPF humanitarian work centered on implementation of MISP. MISP offers the basic initial package of health care in humanitarian settings and is bolstered by longer-term healthcare solutions over time. MISP services should be in place within 48 hours, and should deliver on 5 key objectives: maternal care, SGBV, HIV/STI, abortion (within the national legal framework) and increased awareness. IPPF sees itself as one way to provide localized support to connect comprehensive service care and MISP support.

Although this package of services has been implemented in many humanitarian settings globally, including Pakistan, Chad, Kenya, Haiti and Indonesia, its successful implementation has been challenged by lack of awareness of the MISP among some key humanitarian actors, lack of human resources, poor logistics and poor co-ordination. [18].
The IAWG 2014 evaluation found that huge gaps remain in terms of 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 a higher 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,

[15] http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Adolescent_Girls_in_Disaster_Conflict-Web.pdf
[16] UNFPA (2015). State of World Population 2015: Shelter from the storm. UNFPA: New York, p.2.
[17] www.unfpa.org/sites/default/files/resource-pdf/MMR_in_humanitarian_settings-final4_0.pdf;

[18] Onyango MA, Hixson BL, McNally S. Minimum Initial Service Package (MISP) for reproductive health during emergencies: time for a new paradigm? Global Public Health: An International Journal for Research, Policy and Practice. 2013;8(3):342–56. [DOI: 10.1080/17441692.2013.765024][PubMed]

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.

Question 4: Do we collect data on sexual and reproductive health in crisis settings?

IPPF aims to collect age and sex disaggregated data including information about LGBTQI+, PLHIV and PLD. Reliable data collection is challenging in crisis settings due to various reasons:

- population movements make it harder to follow up with people who request our services;
- people who seek our services might not be aware of their age or don't want to disclose their status or sexual orientation or gender identity for fear of discrimination, stigma, violence or reprisals;
- lack of staff which leads to time constrains for data collection

Through strengthened collaboration across the stabile setting and humanitarian nexus IPPF aims to improve the level of data collection and use in humanitarian context. Through the flagship, SPRINT Project, IPPF have been providing SRHR services during crises across 3 regions, namely Africa, South Asia and East, South East Asia and Oceania. Over the years, the number of responses and outreach have increased to over 727, 448 beneficiaries in the previous Phase II (July 2012-June 2017). This includes 88,800 pregnant and lactating women, 243,046 women in reproductive age and 110,505 adolescents from 27 natural disasters and 12 conflicts responded. The SPRINT Project collects data on key SRH services including family planning, SGBV services, maternal & new-born care, HIV/ STI and SRH health information/ awareness sessions.