Submission for OHCHR call for inputs

Background and context

The World Health Organization (WHO) defines health emergencies as sudden-onset events from naturally occurring or man-made hazards, or gradually deteriorating situations through which the risk to public health steadily increases over time. Emergencies include natural disasters, such as earthquakes and severe meteorological events, but also armed conflict and its consequences, such as civil disruption and refugee crises (sometimes termed chronic emergencies).[4] In recent years, conflict, violence and disasters have brought a dramatic rise in the number of displaced people, both within and across national borders. According to the Office of the United Nations High Commissioner for Refugees, in 2015, there were 65.4 million internally-displaced people and international migrants, half of whom come from Afghanistan, Somalia and the Syrian Arab Republic. The average time spent in displacement has now reached 20 years.

The Sustainable Development Goals (SDGs) commit to an international development agenda based on the fundamental principle of leaving no one behind. No one should be denied their right to health simply because of where they live, the context in which they live or because the particular life-saving services or commodities that they need are inaccessible or unavailable. Yet, the global convergence between conflict, crises, migration, poverty and young populations is driving grave health and human rights consequences for those living in humanitarian settings, especially for sexual and reproductive health and rights.

Women and girls are affected significantly in both sudden and slow-onset emergencies, and face multiple sexual and reproductive health and rights (SRHR) challenges in emergency contexts.[3] There are an estimated 26 million women and girls of reproductive age living in emergency situations all of whom have the right to quality sexual and reproductive health information and services.[8] Three quarters of countries with the highest maternal mortality ratios are fragile states as defined by the Organisation for Economic Co-operation and Development. Humanitarian crises can increase the risk of poor SRH outcomes due to reduced access to services and supplies, damaged health facilities, and increased exposure to sexual violence, among other factors.[5,6]

Over the last several years WHO has supported the provision of SRH information and services in humanitarian settings through: (i) collaborating with partners to respond to sudden-onset crises which pose threats to the accessibility and availability of reproductive health services; (ii) developing and adjusting WHO guidance on health issues into understandable and usable resources for field situations; and (iii) disseminating these resources, including as part of the interagency working group (IAWG) on reproductive health in emergencies.

Over the last 30 years, significant progress has been made in recognizing the need for and implementing essential SRH services from the onset of an emergency on many fronts.[2,7,8]. Whilst demonstrated progress[9] has been made in scaling-up SRHR services in some crises settings, for example through increased funding and implementation of the Minimum Initial Service Package (MISP), expanded access to Post Abortion Care, HIV prevention and increased attention to gender-based violence (GBV), important gaps remain including:

- Lack of full and systematic implementation of MISP;
- Limited transition to integrated comprehensive SRH services within primary health care as situation stabilizes;
- Lack of availability of safe abortion care to the full extent of the national law;
- Limited contraceptive method options available, including emergency contraception;
- Little attention to the particular sexual and reproductive health needs of adolescents.

An absence of accurate data on the status of women's, children's and adolescents' health in emergencies, and of research-based evidence of what works in various humanitarian settings, hinder the design and implementation of cost-effective and sustainable programmes. A recent global review of SRH services in humanitarian settings indicated that the MISP was not being systematically implemented, and that several essential SRH services were being neglected (e.g. abortion, contraception, adolescents' care).[10] Data are needed to not only inform how to most effectively deliver services, but also to advocate for the SRH needs of individuals living in humanitarian settings. Furthermore, the number of displaced individuals has increased significantly over the last decades, and increased resources are needed to improve access for the continuously increasing number of people, especially girls and women.

To build upon the progress made, and to support efforts to achieve universal access to SRH for all individuals living in humanitarian settings, the following priority actions should be addressed: strengthening service delivery; strengthening implementation through research and data; and advocacy and leadership.

Strengthening evidence for delivering SRH services in humanitarian settings

Evidence highlights that routine health service data in most humanitarian settings is poor, and data collected by different clusters and not effectively coordinated.[9] Routine documentation of services provided and their follow-up is challenging in all humanitarian settings.

While guidance on SRH services in humanitarian settings exists, it is not always well known, updated, nd implemented systematically. Building capacity of the health workforce through specialised training and task shifting appropriate for humanitarian settings is a priority to enable both the delivery of services in rapid-onset settings, as well as to provide a foundation for transition to comprehensive and sustainable care when the situation stabilizes. This requires following key actions:

- Take effective steps to prioritise SRHR care and services in crises settings.
- Engage crisis-affected communities in programme planning. Community engagement will both improve community awareness of the availability of the services as well as enhance their acceptability. Efforts to increase demand for services, as well as increasing their accessibility, must be included in all response strategies.
- Improve data collection and analysis by strengthening HMIS systems and utilizing innovative technologies, including recent developments in digital health, to facilitate programme documentation, recordkeeping, reporting and use of data for decision-making.
- Refresh and update providers' competencies through training in SRH services and their delivery in humanitarian settings, and employ task shifting according to WHO recommendations as a means to build capacity in the health system serving humanitarian populations. Engaging national and regional professional societies in affected areas was identified as a potentially effective strategy for capacity-building.

Implementation of SRH services strengthened through research and data

Multiple literature reviews point towards substantial evidence gaps, which exist because of a historical lack of investment in systematic robust research and HMIS, and in strengthening capacity to design and undertake research and to implement appropriate routine data collection systems in humanitarian settings.

The existing evidence base is often limited; and as highlighted in a recent systematic review only 15 studies existed in this regard.[11] It was noted that for most aspects of SRHR, what is effective in general populations is largely known, but how to deliver SRH services in various humanitarian settings in not. Consequently, operations or implementation research are priorities for research in humanitarian settings.

Key priorities pertaining to research are:

- The limited existing evidence base jeopardizes the ability of implementing agencies to identify effective interventions and implement them efficiently and sustainably. Operations and implementation research that demonstrates the comparative advantage of different service delivery approaches in different contexts is a priority.
- Developing standards to guide research design and implementation in humanitarian settings that adheres to recognised ethical and technical principles is needed.

Advocacy and leadership for advancing SRHR issues in humanitarian settings

It is critical for advocacy efforts to increase awareness of the need for and health and economic benefits of, SRH services, as well as for the empowerment of women, adolescents and girls in humanitarian settings, rather perceiving them to be "victims" of their situations, is critically important.

However, it is important to note that more evidence is needed to support and effectively communicate the rationale for women and girls to be able to access and use essential SRH services right from the onset of an emergency if they are to exercise their right to the highest standards of sexual and reproductive health, regardless of the setting in which they live. Very high levels of sexual violence are often normalised in these settings, thereby increasing the risk of unwanted pregnancy from rape and its associated elevated levels of morbidity and mortality, as well as mental health problems. The need to generate data that can support effective advocacy for funding and for routine provision of these services from the initial onset of an emergency through the transition to a stabilised system is urgently needed.

Key priority actions in this regard are:

- Recognising the right to sexual and reproductive health and using the empowerment of women to achieve this is fundamental for humanitarian setting responses. Strategies to engage women as change agents in humanitarian contexts are needed.
- Many populations most in need of services during emergencies are often "invisible". Programming to be able to reach the most vulnerable groups, such as adolescents, newborns and rape survivors, must be a priority.
- Sufficient funding for SRHR in humanitarian settings is urgently needed. Integrated provision of all essential SRH services must be the focus of all responses, regardless of political pressures to limit access to certain services.

References:

1. WHO. Ensuring human rights in the provision of contraceptive information and services. Geneva, Switzerland: World Health Organization; 2014.
2. Program of Action: Report of the International Conference on Population and Development. Cairo1994.
3. WHO. Integrating sexual and reproductive health into health emergency and disaster risk management. Geneva, Switzerland: WHO; 2012.
4. Slama S, Kim HJ, Roglic G, et al. Care of non-communicable diseases in emergencies. Lancet 2016.
5. Warren E, Post N, Hossain M, Blanchet K, Roberts B. Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises. BMJ Open 2015;5:e008226.
6. Crises I-AWGoRHi. Inter-agency field manual on reproductive health in humanitarian settings2010.
7. Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery 2009.

8. Askew I, Khosla R, Daniels U, et al. Sexual and reproductive health and rights in emergencies. Bull World Health Organ 2016;94:311.
9. IAWG. Findings from the IWAG on Reproductive Health in Crises 2012-2014 Global Evaluation.
10. Chynoweth S. Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review. Conflict and Health 2015;9.
11. LSHTM. An evidence review of research on health interventions in humanitarian crises. 2015.