SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS – LIFE-SAVING SERVICES IN HUMANITARIAN SETTINGS

Oslo 4 June 2018

Conference report – action points from group work discussions

Foto: IPPF

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Sexual and Reproductive Health and Rights (SRHR) – Life-saving Services in Humanitarian Settings, Oslo 4 June 2018

The Norwegian Ministry of Foreign Affairs, Norwegian Church Aid, CARE Norway, Save the Children Norway and Sex og Politikk/IPPF Norway co-hosted this one-day conference in Oslo on 4 June 2018. The Conference aimed at achieving a broader understanding of the "why" and "how" of SRHR in humanitarian crisis and to identify best practices and action points on implementation and integration of SRHR.

A broad range of expertise and knowledge was shared by the almost 60 participants and presenters from a broad range of Norwegian non-governmental organisations, researchers, representatives from the Norwegian government and international experts from the UN and international organisations. The conference was also set as a part of the broader conversation and in-put to the then ongoing development of the Norwegian Ministry of Foreign Affair's humanitarian strategy[1].

Globally, 32.3 million women and girl refugees are affected disproportionately by emergencies and face multiple risks related to their sexual and reproductive health and rights (SRHR), requiring access to key services, including contraception and safe and legal abortion. During conflicts or natural disasters, family and social structures are often disrupted, and educational, health and social services are discontinued. Women, children and adolescents, especially girls, are, during flight and in host-countries at increased risk of sexual abuse and exploitation, unwanted pregnancies, unsafe abortions, and sexually transmitted infections (STI), including HIV. At the same time, adolescents in crisis settings have the same need for SRHR information and services as in non- crisis settings. However, adequate prevention and SRHR services are often lacking, particularly youth friendly services that have proven to be much needed.

Against this background the participants discussed and mapped out opportunities for strengthening access to SRHR for youth and adults in a crisis setting, taking into consideration the roles and responsibilities different actors, governments, organisations and donors have.

Under follows a summary of the outcome of the group discussion session. These are based on self-reporting from each group and will therefore vary in length and detail. The facilitator of each group gave a brief presentation of each of the five topics:
1) Integration of SRHR in other programme areas

2) Access to abortion

3) Youth and adolescents

4) SGBV and SRHR

5) Access to sexual and reproductive health commodities including contraceptives

We hope that the report will be useful in our further efforts to strengthen women's, girls', youth and adolescents' access to sexual and reproductive health in humanitarian settings. For further information regarding this conference or the report, you are welcome to contact the coordinator of the co-hosts, Sex og Politikk, kjersti@sexogpolitikk.no / post@sexogpolitikk.no

[1] Norway's Humanitarian Strategy: An effective and integrated approach, was launched 13 August 2018. The strategy can be accessed here.

GROUP WORK DISCUSSIONS –
CONTEXT, QUICK WINS AND LONG-TERM COMMITMENTS

Group 1. Integration of SRHR in other programme areas

A) CONTEXT

Challenges:

- The SRHR coordinator often arrives late to emergencies.
- SRHR coordinator not able to bring together partners and/or communicate effectively with the host government
- Outside safe-deliveries other SRHR aspects are not prioritised
- Delayed arrival of reproductive health kits (including accessing kits within a country) and effective use of kits.
- Kit composition (e.g. lac/limit of EC, Hep B, tetanus), though we understand it's under revision.

Opportunities:

- Increased recognition of SRHR issues.
- MISP exists
- Many aspects of MISP are transferrable from humanitarian to development settings (nexus, collective outcome).
- SRHR opportunities to mainstream soft components of SRHR into other sectors/clusters: Education, WASH, Protection/GBV/CP, NFO, "health".

B) QUICK WINS

- Donors includes SRHR as a priority, and earmark funding for SRHR.
- State-to-State advocacy to promote a safe and protective space for SRHR programming by local actors
- SRHR coordinator in place within 48 hours after sudden onset of crisis – Inter-Cluster Working Group.
- Reproductive health kit availability within 48 hours.
- Community health workers approach.

C) LONG TERM

- Enhance preparedness for SRHR in crisis programming, and policy for fragile states.
- Multiyear, predictable funding.
- Sustainable funding for protractive crisis as well as along the humanitarian-development nexus.
- Support research to ingorm best practices around coordination and integration of SRHR.
- Global advocacy to ensure progressive global policies.

Group 2. Access to safe abortion

A) CONTEXT

Challenges

- There are challenges in relation to implementation and delivery methods and the perceived legalities around the different methods, for example what can we do versus what has to be done.
- There's a need for more trained providers.
- More and more abortions are happening outside of health systems, people need information on abortion care.
- Quality of post abortion care is not given priority, it very much comes down to the providers individual decision, more needs to be done on values clarification within organisations and service providers.
- Stigma prevails within the communities, government, organisations and donors.
- UNFPA can be very risk averse, which is challenging when collaborating on sensitive issues.

Opportunities

- There are already actors that are ready and able to provide safe abortion care (SAC).
- Donors could influence UNFPA to ensure they identify country partners to provide SAC.
- Speak to the existing organisational commitments, for example the commitment to gender equality.
- Actors that have experience within the fields should share best practices and inform about the possibilities.

B) QUICK WINS

- Prioritise country offices that can absorb the investment and use and package the experience to make the case for other countries to do the same
- Build on existing organisational commitments to prioritise SAC, for example through the gender equality commitments.
- Bring abortion to the table when coordinating and identify the right partners to give these services.
- Donors (Norway MFA) be particular on the need to include MISP/abortion when reviewing and funding proposals.

C) LONG TERM

- Develop advocacy messages from more than 1 perspective, for example; public health, gender equality or rights based depending on the audience
- Identify key strategic focal points within organisations to champion SAC.
- Do value clarification training for organisations and service providers.

Group 3. Youth and adolescents

A) CONTEXT

- The 2012-2014 global review identified that there has been little attention to adolescent reproductive health (RH) —especially around family planning.
- Lack of age disaggregated data at RH services. Age is usually captured in register books however there are no cumulative reports for this group generated on a routine basis during humanitarian crisis. Therefore, we often cannot tell if this group is accessing services.
- There are opportunities to do retrospective research/survey or use other methodologies but lack of funding
- Funding comes fragmented for the MISP. Main reasons include lack of adequate funding, lack of competency of field actors, operational challenges during emergency settings. Adolescent specific interventions are not prioritized at service delivery.
- The Adolescent Sexual and Reproductive Health (ASRH) in Emergencies Toolkit which is referenced in the MISP is not integrated. Some examples of interventions include: Capacity building of health providers to respond to the needs and behaviors of adolescents, have adolescent-friendly family planning and RH services counselling, offer a comprehensive package of FP methods, confidentiality, have adolescent friendly operating hours, have Community Health Workers that are under 24 (youth) to engage adolescent groups in counselling sessions and link them to the service delivery
- Coordination is important during humanitarian crisis and working groups, particularly the SRH working group usually led by UNFPA shall include ASRH components and advocate is needed with local Ministry of Health for action.
- Linkages with other sectors like protection and education are also important
- Identify existing youth groups like Red Cross first responders and involve them in preparedness.
- Meaningful participation of adolescents and youth is key and should be included in every recommendation at all levels of action in a humanitarian setting. It is a participatory process in which young people's ideas, expertise, experience and perspectives are integrated throughout programmatic, policy and institutional decision-making structures to best inform outcomes.
- Barriers to meaningful participation: Cultural and religious, lack of information and education, lack of trust & respect for youth perspectives, few safe spaces to learn
- Governments and donors must educate their departments on ASRH. It is recommended that they will participate or be linked in global working groups like the IAWG sub-working group that shares evidence and outlines what humanitarian organizations do in emergencies.
- Lack of multi-year and long –term programing. Funding comes fragmented and so does the services
- MISP is implemented fragmented at field level and is not adolescent-friendly
- Lack of age disaggregated data, 10-14 young adolescents, 15-18 older adolescents, under 24
- Lack of meaningful participation from youth and adolescent groups

B) QUICK WINS

- Fund long-term humanitarian programs that include resilience. Specifically fund the MISP, ensure appropriate costing that includes all components and is adolescence-responsive and friendly.
- Appoint ASRH in Emergencies focal point within the appropriate Government sector. Ensure report by implementing partners includes ASRH indicators
- Advocate for and fund research opportunities. Create links with national academic institutions. Support implementing partners to include age disaggregated data in their health management information systems (HMIS).
- Ensure, fund youth participation in program design, policy and institutional decision making

C) LONG TERM

- An individual that will participate in IAWG ASRH sub-working group, will participate in global event, will inform.
- Link youth associations globally
- Use gender/youth marker

Group 4. Sexual and gender-based violence (SGBV) and SRHR

A) CONTEXT

We grounded our discussion in a reflection on a specific context: the Rohingya refugee crisis in Bangladesh and Myanmar. Issues highlighted in our discussion:
We all have heard the reports of the widespread and systematic use of rape against Rohingya women in Myanmar, and as they fled Rakhine state to Bangladesh. We also have heard that sexual and gender-based violence continues In Cox's Bazar in Bangladesh.

- We have heard how unsafe and insecure the camp is – we hear stories from women who stay in their tents for 3 hours a day, lack of light and electricity at night, face a real lack of security at night.
- Insecurity both increases risk for SGBV but also acts as a powerful barrier to seeking information and services, including psychosocial support, clinical care for survivors of rape as well as other health services.
- Survivors of GBV are likely to be facing incredible stigma- which also acts as a powerful barrier to seeking the care and support they need. And which may contribute to their and their families' social isolation and exclusion.
- Women and girls may have poor information or poor access to services because of distance to services, or because of restrictions on their mobility due both to security concerns as well as social norms. Even when they know about GBV services, they may be reluctant to report GBV or seek services because of stigma or risk for further violence.
- We know that for some survivors of GBV, their first point of contact with care will be through outreach and safe spaces. How can we help make sure those outreach services are accessible and culturally and linguistically appropriate? And that outreach and safe spaces effectively link survivors to health care?
- Women girls and other survivors needs confidential, safe and stigma-free clinical services – where they can and want to seek critical services- including clinical management of rape to prevent unwanted pregnancies, prevent transmission of HIV and other STIs, and treat injuries.

- Beyond the clinical management of rape, how can we make sure that survivors of GBV can access other critical health services- for example without access to safe abortion care, women may seek unsafe abortions- resulting in preventable injuries, disabilities and death. We heard from Ipas about their success in expanding access to menstrual regulation or first trimester abortion in Cox's Bazaar.
- We need to ensure that health care services are provided in a respectful and non-stigmatizing way, ensuring confidentiality and quality. We also need to ensure that all providers are trained and supported to provide survivor centered care, in other words to support survivors to decide what treatment and services they want and need. No survivor should be compelled to report SGBV or seek legal services if they do not want to because of concerns about stigma and privacy. (concern- we understand there may be a new policy in place which compels women and /or providers to report sexual assault to law enforcement in order for them to receive services- this goes against our commitment to survivor-centered care.)
- We know that for other survivors of SGBV, their contact with a health care provider may be their point of contact with GBV services including psychosocial support, and legal services. How can we ensure that clinical services for survivors of GBV are linked to quality and confidential psychosocial services and to legal services?
- Some survivors also need obstetric and newborn care. UNFPA estimated there are at least 40,000 pregnant women who are expected to give birth in Cox's Bazaar in the coming year, some of whom are pregnant as the result of a sexual assault. Without reliable access to safe obstetric care women face increased risk of maternal health complications, injuries, or even death. In March 2018, IAWG partners estimated that approximately 20% of births were taking place in health facility with a skilled attendant.
- How can we do this all with an eye on our commitment to localization? We need to invest in the capacity of local organizations and women's networks to identify, refer for and even deliver key GBV and SRHR services. Throughout the meeting, we have discussed the importance of ensuring that local organizations can push and lead this agenda. We want to ensure the leadership of women and affected communities in shaping humanitarian action and driving accountability. We also want to strengthen the capacity of local government before during and after a crisis.
- We also need to locate our humanitarian responses in long-term efforts to address gender inequality and the root causes of GBV.
- We need to start working even ahead of a crisis, during disaster preparedness, to put in place systems to prevent, address and mitigate GBV and ensure strong linkages between GBV and SRHR.

B) QUICK WINS

Ground SGBV and SRHR responses in sound gender and context analyses.

- Ahead of and throughout a crisis- Engage with community opinion leaders, religious leaders to challenge stigma, normalize care-seeking for survivors of SGBV, and also engage them in speaking out against SGBV, challenging restrictive gender roles/gender-based power inequities that are root causes of SGBV
- Donors need to require/incentivize rapid gender analysis, inclusion of SRHR and SGBV in initial needs assessment, design of services informed by gender/power analysis.

Women and other "vulnerable groups" need to have meaningful roles in all stages of a humanitarian response to be sure that their needs and rights are not overlooked, and to drive action/accountability for SGBV and SRHR.

- Ensure that needs assessments proactively engage with women, girls and groups at high risk for SGBV including LGBTQI.

- Activate and invest in women's groups and women's networks at the onset of a crisis and throughout the response – also train and support refugees/displaced women to provide outreach, information and referral
- Donors should require/incentivize meaningful engagement with women and vulnerable groups in the responses they fund

C) LONG TERM

Ground SGBV and SRHR responses in sound gender and context analyses.

- As part of preparedness, create gender and power profiles for settings at high risk for disaster and conflict- (several organizations routinely create and share these.) Critical for development and humanitarian actors to coordinate/ ensure humanitarian response leverages existing investments in gender analyses and gender equity work.
- Conduct rapid gender and power analysis at the onset of a crisis- use findings to design an effective response that proactively reduces risk, addresses barriers to care-seeking, helps inform the design of accessible and effective outreach & referral services + high-quality and accessible survivor-centered clinical care.
- Ensure that SGBV and SRHR specialists have leadership roles in the initial needs assessments at the onset of a crisis- these assessments set the agenda for what is funded and prioritized in a response- critical to get SGBV and SRHR on the agenda from the outset.

Women and other "vulnerable groups" need to have meaningful roles in all stages of a humanitarian response to be sure that their needs and rights are not overlooked, and to drive action/accountability for SGBV and SRHR.

- Ahead of a crisis map and engage with and strengthen the capacity of women's groups & women's networks to provide outreach, referral and create safe spaces for survivors – these groups/networks have critical roles as first responders and frontline workers.
- Invest in ongoing feedback mechanisms with women, affected communities as well as first responders/frontline responders to identify gaps, monitor coverage and quality of response
- Put women in positions of authority and decision-making- as noted above, they need to be at the table as part of humanitarian response teams to ensure women's needs and realities at the centre of decisions about what services are provided, how and by whom.
- Employ women not only on humanitarian response teams and as service providers, but as police officers/security officers.

Invest in strengthening the capacity of local frontline healthcare workers and health authorities, ahead of and throughout a crisis

- Training for providers should focus on survivor-centered care. Ensure systems are frontloaded with essential supplies and medicines, build key skills to ensure clinical services as well as skills and actions to ensure respectful, non-stigmatizing and confidential care. It is critical to address provider biases and stigmatizing attitudes/behaviours as a core part of provider training. Monitor and reinforce this as a core standard of quality care during preparedness, at the onset of a crisis and throughout the response
- Ensure that clinical services for survivors of GBV are linked to quality and confidential psychosocial services and to legal services

Group 5. Access to sexual and reproductive health commodities including contraceptives

A) CONTEXT

Over-reliance on kits:

- Kits aren't tailored to a specific context and they are not meant to replace more sustainable supply chains. Because they are general estimates, not context specific, they cause wastage of less popular methods and stock-outs of more popular methods.
- Kitting is extremely costly and is always wasteful.

Poor coordination / lack of capacity:

- In addition to reproductive health (RH) kits there are other medical kits, but there is no coordination or harmonization among these kits.
- Often the SRH lead in the health cluster is responsible for ordering SRH supplies and they likely don't have the supply chain management (SCM) expertise.
- Different agencies have different SCM protocols, but there are very few people that have training in medical logistics.
- Donors aren't really funding this transition period from kits to sustainable supply chains.
- Reproductive Health Supplies Coalition (RHSC) has extensive costing info on the commodities gap in low-income settings but it's not focused on humanitarian settings.
- It's not just funding for the commodities themselves that's lacking. We also need to direct resources toward capacity building for SCM from the global to national to local/health facility levels.

There is a huge gap in transitioning away from the kits to sustainable supply chains.

- If a donor provided funding for tools and capacity building for the transition period, they could be the leader in that space – no other funder is really doing it.

Discussion of proposed regional kits (i.e. MENA regional kit) and prepositioning supplies:

- Kitting is extremely costly, so it's mostly done at the global level. Kits are always wasteful, whether regional or not.
- Only countries with recurring natural disasters should pre-position kits.

B) QUICK WINS

Overarching: Commit to addressing the transition from RH Kits to country-owned, sustainable SRH supply lines.

- Develop tools and roll them out
- Build capacity at global, national, and clinic levels on logistics management, including for SRH commodities
- Humanitarian pharmacy training
- Explore logistics surge capacity
- Foster local ownership and local capacity building wherever possible in supply chain management
- Develop/disseminate stronger messaging/advocacy around what the kits are and what they are not (and also on how wasteful they are)
- Improve preparedness measures that will facilitate a return to sustainable supply lines
- Standardize data collection on SRH commodities

For donors (Norway MFA):

- Commit to addressing the transition from RH Kits to country-owned, sustainable SRH supply lines. Invest in developing resources, evidence, capacity, and financing mechanisms to facilitate this process.
- Funding should never be earmarked for the kits. If donors need to earmark, it should be more general (e.g. SRH supplies). Earmarking for RH kits is problematic and exacerbates over-reliance on kits and the huge gap in transition.
- Funding can't be for only one year, otherwise implementing agencies will just order kits. The transition period needs to be considered and funded. Planning for the transition to more sustainable supply chains must be considered from the beginning of the response and key stakeholders should be identified.

C) LONG TERM

- Create a center of excellence focused on this issue to build evidence base and knowledge, as well as to recommend global financing mechanisms that would facilitate the transition process

Appendix 1
Programme

Oslo Conference 4 June 2018
Sexual and reproductive health and rights – life-saving services in humanitarian settings.

Litteraturhuset, Wergelandsveien 29
Room: Amalie Skram

Objectives:
To enhance knowledge and a common understanding of sexual and reproductive health and rights in humanitarian settings. To share best practices on how to improve implementation.

Co-hosts:
The Norwegian Ministry of Foreign Affairs, Norwegian Church Aid, CARE Norway, Save the Children Norway and Sex og Politikk/IPPF Norway.

Time	*Session*	*Topic and speakers*
8:30 – 9:00	Registration and coffee	Moderator of the day: ▪ Maria Holtsberg, Senior Gender and Inclusion Advisor Humanitarian Programme, International Planned Parenthood Federation (IPPF).
9:00 – 9:45	Welcoming address	▪ Guro Katharina Vikør, Senior Adviser Section for Humanitarian Affairs, The Norwegian Ministry of Foreign Affairs. Panel: ▪ Lisa Sivertsen, Acting Secretary General, Norwegian Church Aid. ▪ Gry Larsen, Secretary General, CARE Norway. ▪ Nora Ingdal, Director of Program Quality, Save the Children Norway. ▪ Tor-Hugne Olsen, Managing Director, Sex og Politikk. ▪ Pernille Fenger, Director Nordic Office, UNFPA.
9:45 – 11:00	Setting the scene	*Why is SRHR in humanitarian settings needed, the evolution of SRHR in crisis and current gaps. Examples of implementation of SRHR.* Speakers: ▪ Dr Loulou Kobeissi, Scientist Departement of Reproductive Health Research, World Health Organisation (WHO), ▪ Sarah Knaster, Senior Adviser, Inter Agency Working Group on Reproductive Health in Crisis (IAWG). ▪ Silje Heitmann, Senior Adviser Gender Based Violence, Norwegian Church Aid. Q&A
11:00-11:15	Coffee break	

11:15 - 13:15	**Norwegian launch of the revised Minimum Initial Service Package (MISP)**	*MISP demystified:* *What is MISP and what is new in the revised version?* ▪ Wilma Doedens, Technical Adviser Sexual and Reproductive Health in Emergencies, UNFPA Q&A *MISP preparedness:* *How can we prepare and ensure capacity for the implementation of MISP?* ▪ Nesrine Talbi, Programme Adviser, International Planned Parenthood Federation European Network (IPPFEN) *MISP implementation:* ▪ Ashley Wolfington, Senior Technical Adviser, International Rescue Committee (IRC) Q&A
13:15 14:15	**Lunch**	
14:15-16:00	**Group work: Action-points for the road ahead**	*Discussion groups on selected areas of SRHR. Brief presentation of the selected areas by each facilitator.* *Each group will discuss and report back on:* *1. What are the current gaps/challenges?* *2. What are the opportunities?* *3. What are the quick wins and long-term commitments?* *Consider how coordination between actors (government, NGOs, others) is impacting/needed for improvement.*
	Group 1	*Integration of SRHR in other programme areas* ▪ Facilitator: Benedicte Hafskjold, Head of Mission North Irak, Norwegian Church Aid.
	Group 2	*Access to safe abortion* ▪ Facilitator: Eileen McWilliam, Senior Manager for Partnership Development, Ipas
	Group 3	*Youth and adolescents* ▪ Facilitator: Maria Tsolka, Adviser Reproductive Health in Emergencies, Save the Children
	Group 4	*SGBV and SRHR* ▪ Facilitator: Christina Wegs, Global Advocacy Lead SRHR, CARE
	Group 5	*Access to sexual and reproductive health commodities including contraceptives* ▪ Facilitator: Sarah Rich, Senior Adviser SRHR, Women's Refugee Commission (WRC)
16:00-16:30	**Reporting back from group work**	
16:30-16:45	**Closing statement**	*Reflection of the day and the road ahead!* ▪ Laila Bokhari, former State Secretary to the Norwegian Minister of Foreign Affairs
16:45-17:00	**Thank you**	