



INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

Taking Stock of Reproductive Health in Humanitarian Settings: Key Findings from the IAWG on Reproductive Health in Crises' 2012-2014 Global Evaluation

By the end of 2013, roughly 51.2 million persons were displaced by conflict, persecution, generalized violence and human rights violations, the highest number since World War II.¹ In addition, 22 million persons were displaced by natural disasters.² Seventy-five to eighty percent of these crisis-affected populations are women, children and youth (ages 10-24).³ Over half of maternal and under-five deaths take place in settings affected by armed conflict or natural disasters.⁴ Addressing the reproductive health (RH) and rights of women, men and youth affected by these crises is essential to achieving Millennium Development Goals 4, 5 and 6.⁵

IAWG on RH in Crises

Formed in 1995, and currently comprising a network of over 1,700 individual members from 450 agencies, the Inter-agency Working Group (IAWG) on Reproductive Health in Crises is a broad-based, highly collaborative coalition committed to expanding and strengthening access to quality RH services for persons affected by conflict and natural disaster. Among populations affected by humanitarian crises, the IAWG documents gaps, accomplishments and lessons learned; evaluates the state of RH in the field; establishes technical standards for the delivery of RH services; builds and disseminates evidence to policy makers, managers and practitioners; and advocates for the inclusion of crisis-affected persons in global development agendas.

IAWG Global Evaluation

The IAWG⁶ undertook a global evaluation of RH in crises from 2012 to 2014. The evaluation set out to identify existing RH services, quantify progress, document gaps and determine direction for future programs, advocacy and funding. A decade after the first global evaluation (2002-2004), the humanitarian context has dramatically changed, with the roll out of the humanitarian reform process in 2005 and 2006, including the cluster system by the Inter-agency Standing Committee.⁷ High population growth has been observed in the poorest countries;⁸ climate change has increased the frequency and intensity of natural disasters;⁹ and multiple, simultaneous large scale humanitarian crises are occurring¹⁰ with an expanding array of humanitarian actors.¹¹

¹ United Nations High Commissioner for Refugees, Global Trends 2013.

² IDMC. 2014. [Global Estimates 2014: People displaced by disasters](#).

³ UNFPA. *State of the World Population 2000*.

⁴ Save the Children. *State of the World's Mothers 2014*.

⁵ MDG 4 is to reduce child mortality; 5 to improve maternal health; and 6 to combat major diseases.

⁶ The IAWG global evaluation has been led by a steering committee of agencies comprising: The US Centers for Disease Control and Prevention; Columbia University; International Medical Corps (IMC); Kings College London; Marie Stopes International (MSI); Médecins Sans Frontières (MSF); United Nations High Commissioner for Refugees (UNHCR); United Nations Population Fund (UNFPA); University of New South Wales (UNSW); and the Women's Refugee Commission (WRC).

⁷ United Nations Office for the Coordination of Humanitarian Affairs, Annual Report 2006

⁸ Population Reference Bureau, *The World at 7 Billion*, Vol. 66, No. 2, July 2011.

⁹ United Nations Office for the Coordination of Humanitarian Affairs and Internal Displacement Monitoring Center, Monitoring disaster displacement in the context of climate change, September 2009.

¹⁰ United Nations Office for the Coordination of Humanitarian Affairs, www.unocha.org

¹¹ Minear, Larry, *The Humanitarian Enterprise: Dilemmas and Discoveries*, 2002.

Evaluation methods included:

1. Systematic literature review;
2. Assessment of agency commitment and capacity;
3. Assessment of availability, use and quality of RH services (in-depth study) in South Sudan, Democratic Republic of the Congo (DRC) and Burkina Faso;
4. Assessment of the use/efficacy of the Minimum Initial Service Package (MISP) conducted in Irbid City and Zaatri Refugee Camp in Jordan;
5. Analysis of funding trends for RH in crises; and
6. Review of UNHCR Health Information System (HIS) RH data.

Key Findings:

Progress since 2004 includes:

Funding of RH in humanitarian appeals

- Between 2009 and 2013, proposals that included all of the components of the MISP and those with partial MISP components increased an average of almost 40% and 2.4%, respectively, per year.
- Emergency health and protection proposals that include RH increased at an average of 22% per year between 2002 and 2013.
- Humanitarian funding received for RH activities increased, amounting to 2.031 billion USD for 2002-2013, which was 43% of the total request.
- Maternal and newborn care was the most funded of all RH components, receiving 56% of requested funds, and the most absolute funds – \$684.8 million USD.

Services

- Country studies (Jordan, DRC, Burkina Faso and South Sudan) demonstrated:
 - Increased awareness of the MISP standard of care and implementation of the MISP.
 - Expanded access to post-abortion care.
 - Expanded HIV prevention; particularly regarding prevention of mother-to-child transmission and anti-retroviral therapy.
 - Increased attention to, and documentation of gender-based violence (GBV).

Capacity

- Agencies self-reported growth in institutional capacity to address RH in crises, including through instituting organizational policy frameworks and accountability mechanisms, as well as increases in dedicated staff and funding to address RH in humanitarian settings.

Remaining gaps include:

- Lack of full, systematic MISP implementation was recognized in the in-depth studies well beyond the acute emergency and in the UNHCR HIS study.
- Limited availability of obstetric and newborn care was documented in the in-depth study.
- Lack of availability of comprehensive abortion care—in particular, safe abortion care—was identified across all stakeholders.
- Limited use of long-acting and permanent methods of family planning—including the intrauterine device (IUD)—was documented in the literature review, funding and in-depth studies.
- Limited availability of emergency contraception beyond post-rape care was recognized in the MISP and in-depth studies.
- Limited efforts to prevent sexual violence and avail comprehensive clinical care for rape survivors were noted in the literature review, MISP assessment and in-depth studies.
- Lack of access to antiretroviral therapy for persons living with HIV/AIDS at the primary care level was documented in the MISP and in-depth studies.

- Limited diagnosis and treatment of sexually transmitted infections was found in the MISIP and in-depth studies.
- Poor commodity management and security caused stock-outs and prevented a smoother transition from the MISIP to more comprehensive RH services, as identified in the MISIP and in-depth studies.
- Little attention to adolescent RH—especially around family planning—was found in the in-depth and funding studies.
- Limited community engagement to increase service uptake—especially by women and adolescents—was identified in the MISIP and in-depth studies.
- Inequitable funding to conflict-affected countries, with non-conflict-affected countries receiving 57% more RH funding, was identified in the funding trends study.

For more information and to access the full articles please see the [IAWG Global Evaluation Supplement in Conflict and Health](#)

Key Recommendations

Donors

- Close the funding gap between conflict-affected and non-conflict-affected countries; ensure equitable funding across RH areas; and support fluid, innovative and cohesive humanitarian programs rather than short-term, quantifiable interventions.
- Ensure sustained, dedicated, predictable funding to maintain the coordination of IAWG and other collaborative efforts that embrace holistic, adaptive approaches.
- Support initiatives to address **commodity management and security; community mobilization; and access to long-acting family planning methods, obstetric and newborn care, and comprehensive clinical and psychosocial care for rape survivors.**
- Support community resilience-building and disaster risk reduction and preparedness activities, task-sharing and capacity development initiatives to address human resource challenges, as well as the development of alternative service delivery models to service hard-to-reach areas.
- Continue to support research to build the evidence base for the delivery of effective RH services in rapidly evolving humanitarian contexts.
- Support RH surge capacity and strategies to build the capacity of regional actors, Ministries of Health and Disaster Management, national and community-based organizations, health workers and communities themselves to lead and manage an effective humanitarian RH response.

Governments and Ministries of Health

- Support the integration of the MISIP into national medical and nursing curricula and address policy barriers, such as protocols around care for survivors of sexual violence and policies on types of health personnel who can provide certain RH services.

Agencies providing RH services

- Focus particular attention to the needs of adolescents and other marginalized groups, such as persons with disabilities; sex workers; elderly; and lesbian, gay, bisexual and transgender persons.
- With governments, strengthen commodity management processes to prevent stock-outs and provide consistent access to care.
- Support—at all levels—community involvement in the design and delivery of RH services to improve uptake of services.