

SUMMARY REPORT

REPRODUCTIVE HEALTH IN EMERGENCIES

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Beth Vann, Author

Elizabeth Rowley and Lauren Burns, Data Collection

SUMMARY

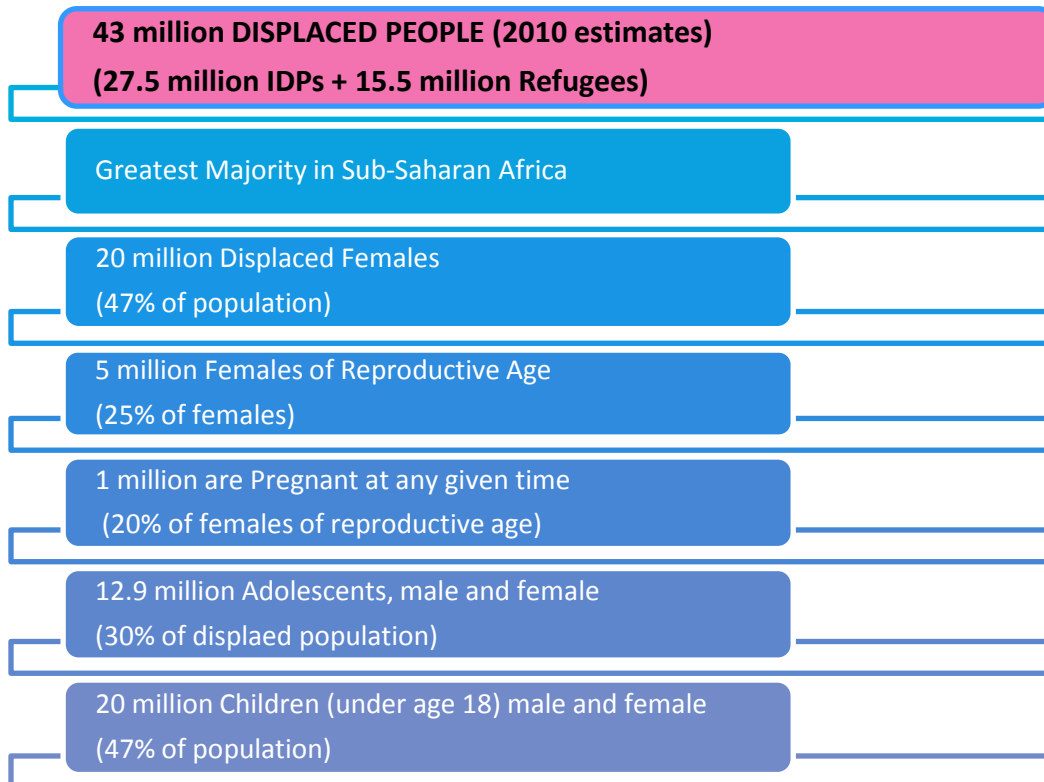
In 2011, the MacArthur Foundation commissioned external consultants to conduct a survey of humanitarian, development, and research organizations as well as donors engaged in reproductive health programming in the context of refugee/IDP settings. This report is a summary of findings and provides an overview of the current status, major actors, challenges, and funding situation. The report concludes with a set of recommendations for the Foundation to consider when determining its niche and funding strategy for reproductive health in emergencies.

The term “emergencies” in this report refers to situations of armed conflict or disaster, which usually involve population displacement. An “emergency” begins at the onset of the crisis and ends at some point after return (or resettlement) when individuals and families have returned to a “normal life” by rebuilding and restoring their communities. There are significant differences between internally displaced persons (IDPs, those who are displaced within their own country) and refugees (those who cross a country border and gain asylum in a host country) in terms of access, funding, and the nature of services and facilities provided by humanitarian actors.

SCOPE OF THE PROBLEM

At the end of 2010, there were an estimated 27.5 million IDPs and 15.5 million refugees across the globe, with the greatest majority in Sub-Saharan Africa. Figure 1, below, shows the approximate breakdown of this displaced population into groupings to reflect the population figures in terms of reproductive health needs.

Figure 1.



KEY ISSUES, CHALLENGES, AND GAPS

Cultural Differences and the Personal Nature of the Topic: Most areas of reproductive health are intensely personal and private concerns for individuals and families. Cultural and community norms will influence individual beliefs and decision-making about sexual activity, pregnancy, family planning, and other such issues. These beliefs directly affect how and whether a community accesses reproductive health services when they are available. In many communities, the taboo of sexual violence is so strong that communities – and health practitioners – will deny its existence. Family planning and abortion are extremely sensitive topics in many communities.

Given the sensitive nature of reproductive health, practitioners must be well qualified so that RH programs can be planned and implemented in ways that will work with individual communities. Although there are standards and good practice materials, there are many nuances in the way services should be designed, introduced, and delivered. Knowledge, skill, and capacity of health providers are therefore a central issue in this area of programming.

Knowledge, Skill, and Capacity: All organizations surveyed indicated that their programming includes training and capacity building. And all cited lack of capacity as one of the major challenges they experience in delivering reproductive health services.

The gap seems to be not only in capacity, but also in how to build and sustain capacity over time. There are a number of training guides; what seems to be missing in many organizations is a comprehensive plan for capacity development. This gap seems to be directly related to inadequate funding for reproductive health. Programs often under-budget for training and capacity building activities. In addition, this gap is a reflection of weak contingency planning and disaster preparedness at both national and international levels.

Implementation of the MISP: The Minimum Initial Service Package (MISP)¹ is a set of minimum priority reproductive health activities to be put into motion during the earliest days of an emergency. One key element of the MISP is an array of “kits” or prepackaged disposable supplies and medicines for specific types of reproductive health care.² Since its inception, the MISP has gained momentum and is internationally recognized as lifesaving care. The provision of sexual and reproductive health services, however, is not consistently integrated into international humanitarian response. There are long standing challenges in implementing the MISP that can be solved with dedicated attention and funding.

Evidence-based GBV Programming: Gender-based violence, especially conflict-related sexual violence, has gained much attention in recent years. GBV programming in most settings has evolved into stand-alone programs that are response-driven, with less emphasis on prevention. Although there are Guidelines for establishing minimum prevention and response to GBV in emergencies, clinical services remain quite limited in many settings. There is very little available information about program outcomes or evidence-based interventions. The GBV AoR global working group was formed in 2008 under the Protection Cluster. Given its late start, that group is only now showing signs of organizing its work and addressing issues and gaps in the field. A major

¹ MISP activities are aimed at reducing short- and long-term reproductive health related morbidity and mortality.

² Examples of MISP kits: Clean delivery kit, Post-rape kit, Condom kit.

challenge for the GBV AoR is engaging the Global Health Cluster to take more action for the health response to various forms of GBV, including sexual violence.

Adolescents: Adolescent programming is a significant gap in reproductive health in emergencies. There are a number of well-respected guides, tools, and resources on adolescent RH, but very few programs in the field. This seems to be largely due to lack of staff capacity – including among the RH staff who design programs – and funding.

Family Planning: Most implementing organizations surveyed indicated that there is a lack of family planning in their RH programs. For many humanitarian actors, family planning is not perceived to be a lifesaving priority. In addition, family planning often runs counter to cultural beliefs and practices in many of the communities affected by conflict or disaster.

Maternal Health: Historically, funding for maternal health has been relatively high as compared to some of the other RH program areas. This can be at least partly attributed to the higher costs associated with emergency obstetric care (EmOC) and other aspects of maternal health. There are very few technical guidelines and policy documents by governments, NGOs, IGOs addressing emergency obstetric care, yet GBV and HIV are quite well represented in policies related to reproductive health in emergencies.

Funding: RH programs in emergencies are funded by bi-lateral, multi-lateral, and private donors. It is difficult to find funding amounts specifically for reproductive health services for displaced populations (refugees/IDPs). One recent study can shed some light on the question. In 18 conflict-affected countries, an average of US\$20.8 billion in total ODA was disbursed annually to the 18 countries between 2003 and 2006, of which US\$509.3 million (2.4%) was allocated to reproductive health³. This translates roughly to US\$4 million per year per country – and this figure represents funding for both displaced and non-displaced populations in those countries.

According to the service providers, funds for RH in emergencies are inadequate. Most of the donors included in the survey were unable to give specific RH financial information. Rather, the RH services were rolled together with other health funds. Since the late 1990s, funding for RH in emergencies has been largely integrated into funding for emergency health programs. It has become quite challenging for implementing organizations to obtain funding for new or stand-alone reproductive health programs. At the same time, increases in funding for general health programs have not kept pace with the costs and needs for general health and reproductive health. As a result, organizations are faced with competing priorities and difficult choices. While it is good practice to integrate RH into a general health care package, there is still a need for designated RH funding within that package.

TYPES OF DISPLACED POPULATIONS AND EFFECTS ON LOCAL COMMUNITIES

Populations affected by emergencies include those that are displaced (refugees, returnees, or IDPs) and those who live in host or surrounding communities. Humanitarian aid is typically targeted to refugees, returnees, and IDPs. Surrounding communities have typically been excluded from the direct services provided to the displaced. Local communities are, however, often less well-off than the refugees, returnees, or IDPs living close by. This issue can easily result in protection problems

³ Zimmerman, L, Packer, C, Robinson, C. Reproductive Health in Post-Emergency Refugee Camps. UNHCR 2012. <http://paa2011.princeton.edu/papers/110927>

in that local communities may justifiably resent the displaced community for getting special care and favorable treatment while they, the locals, suffer the same or worse levels of poverty, hunger, disease, and death. Donors may - or may not - require that funds be used for the designated refugee, IDP, or returnee population. There is more flexibility now than in the past because the protection risks and issues are better understood, but this disconnect between the “designated” or “target” group and the local community remains an issue with some donors and in some settings. Most RH providers would like to serve the local community as well as the target community, and many have been able to build that flexibility into their programs.

CONCLUSION

While there have been great strides since the early 1990s toward inclusion of reproductive health services in the international humanitarian response to emergencies, there remains much work to be done.

Many donors are contributing funds to RH services, yet it is not clear what money is being allocated, how it is being spent, and with what results. What is needed for the long term is (a) a clearer picture of funding money is being allocated and how it’s being spent, and (b) an evidence base regarding the funds that are available versus the need for resources. Accomplishing these two points would allow a better picture of what support is being offered for reproductive health in refugee and IDP settings. This is information that the world does not have right now. Further, it will offer an important advocacy opportunity to point out the gaps that exist and make the case for filling those gaps with additional funding.

Knowledge and practice standards for RH in emergencies have grown exponentially in the past two decades, yet gaps remain not just in funding but also in implementation in terms of outcome measurement, staff capacity, and specific technical guidance in some areas of reproductive health. These gaps contribute to the continuing problem of reproductive health services not being consistently integrated into humanitarian responses in emergencies. In the long term, ad hoc training should be replaced by a results-oriented training and capacity building program for all RH providers working in the field. Advocacy aimed at strengthening institutional commitments to RH in emergencies is needed. Knowledgeable, skilled, and well supported staff in the field will be better able to implement life saving RH programs and services from the onset of emergencies.