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Sexual and reproductive health and rights in humanitarian crises at ICPD25+ and beyond: consolidating gains to ensure access to services for all

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The 1994 International Conference for Population and Development (ICPD) facilitated an unprecedented consensus among national governments, resulting in a Programme of Action (PoA) that positioned sexual and reproductive health (SRH) and gender equality at the heart of population policies and as a prerequisite for sustainable development. The PoA acknowledged the importance of provision of SRH services to persons affected by humanitarian crises, particularly women and girls, and their protection from sexual and gender-based violence. Crisis-affected women and girls, can experience higher levels of unwanted pregnancies, due to unmet contraception needs and lack of access to safe abortion.[1] Pregnancy in humanitarian settings can be life-threatening: an estimated 60% of preventable maternal deaths, 53% of under-five deaths, and 45% of neonatal deaths globally occur in humanitarian crises or fragile contexts.[1] Sexual violence against women and men is commonplace in many conflicts, with at least one in five women in complex emergencies having suffered sexual victimisation.[2]

Significant gains since ICPD

In 1995, catalysing the momentum generated by the ICPD, the Inter-agency Working Group on Reproductive Health in Crises (IAWG) was established to ensure that the ICPD commitments were upheld in humanitarian situations.[3] Along with other initiatives over the past two decades, IAWG has advocated the systematic integration of sexual and reproductive health and rights (SRHR) into humanitarian responses and has generated evidence for SRHR in crises and significantly contributed to improving the availability and accessibility of SRH services among conflict- and disaster-affected populations.[3] Organisational capacity and funding for SRH services have substantially increased.[3] The SRH services of the Minimum Initial Service Package (MISP), articulated in the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, are incorporated into existing standards and funding mechanisms for humanitarian response including the *Sphere Handbook* and Central Emergency Response Fund. The *Sendai Framework for Disaster Risk Reduction 2015–2030* also includes provision of SRH services as a critical component of strengthening individual and community resilience.* Global programs, such as the RAISE and SPRINT Initiatives, have contributed to capacity development and implementation of SRH services in emergencies at the regional, national, and local levels.[3] WHO and partners are developing a *Global Roadmap for Improving Data, Monitoring and Accountability for Family Planning and Sexual and Reproductive Health in Crises*.

Regional, national, and local actors have also achieved significant progress in some places. The Eastern Europe and Central Asia regional IAWG developed a MISP readiness tool and integrated SRHR into national emergency disaster risk management policies.[4] In Nepal, the Ministry of Health coordinated the implementation of the MISP after the 2015 earthquake.[5] In the Philippines,

*https://www.unisdr.org/files/43291_sendaiframeworkfordrren.pdf

community groups have been trained on SRHR and disaster risk reduction throughout the country.[6]

Persistent gaps and emerging threats

Despite notable progress, research shows that SRH services in humanitarian settings remain variable. A 2015 study from three crisis-affected settings in sub-Saharan Africa found that only five of 63 assessed health facilities provided adequate emergency obstetric and newborn care, and only three provided elements of clinical management of rape.[3] Safe abortion was unavailable across settings, despite unsafe abortion having been estimated to cause 25–50% of maternal deaths in refugee settings.[3] Moreover, most policy and programmatic efforts are tailored towards heterosexual, cis-gendered women of reproductive age. Certain groups, such as adolescents and older women, male survivors of sexual violence, sex workers, people living with disabilities, or those of diverse sexual orientations and gender identity and/or expression continue to face significant obstacles in accessing information and services in humanitarian settings.

Deficient health systems, shortages of skilled health providers, supply stock-outs, and restrictive policy environments hinder effective SRH provision. Often, these challenges were present before a crisis and are further exacerbated by the humanitarian situation. Socio-economic and cultural barriers, gender inequality and a lack of information about the availability and benefits of care also impede service uptake.

Addressing these challenges requires harmonisation of efforts and improved organisational policies, but most importantly sufficient funding and adequate capacity. Despite increases in financial support to SRHR in humanitarian settings since the ICPD, funding remains inadequate to meet the needs of the growing crisis-affected communities.[5] Between 2009 and 2013 there was a significant increase in the number of humanitarian proposals with an SRHR component, but with critical gaps.[5] For example, while the largest share of funds was allocated to maternal and newborn care, it fell short of meeting the programmatic needs. Family planning comprised the lowest proportion of funding received, while proposals including abortion were practically nonexistent.[7] Furthermore, only one-third of funding requests addressing gender-based violence in emergencies between 2016 and 2018 were met, leaving a deficit of more than USD 100 million.[8] De-prioritisation of SRHR among some health and protection actors, political resistance, leadership and coordination challenges and scarce research are additional barriers to progress. These challenges alongside inconsistent monitoring are compounded by inadequate mechanisms to hold humanitarian actors accountable for failing to fulfil the SRHR of crisis-affected populations.

New and emerging threats further jeopardise progress and risk considerable pushback. First, 2018 saw the highest recorded number of displaced people since World War II. More than 70 million people were forcibly uprooted as a result of increasing conflicts and disasters, compared to nearly 23 million in 1994, overwhelming aid agencies and health systems of countries affected. Second, the world is witnessing a rapid increase in natural disasters. The climate crisis already contributes to forced displacement, with women and girls accounting for more than half of the 200 million people affected annually.[9] The gendered impacts of climate change are aggravated in settings affected by armed conflict, political instability and economic strife. Third, the rise of authoritarianism and the reinvigoration of nationalism, xenophobia, homophobia, transphobia and anti-feminism are eroding funds and creating policy environments hostile to women's rights and SRHR. The Mexico City policy restricting abortion, for example, has caused the death and disability of thousands of women and girls.[7] Collective action is imperative to safeguard advances to date and curb emerging threats.

Looking forward: reinvigorating ICPD commitments

More recently, several aid agencies, donors, and political leaders have mobilised their resources and political will to improve humanitarian response. From the Grand Bargain and the Global Compact on Refugees to WHO's Global Action Plan on promoting the health of refugees and migrants, these political commitments emphasise the shared responsibility and urgency of coordinating effective responses and increasing investments.

The Nairobi Summit – which includes upholding the right to SRH care in humanitarian and fragile contexts as a key theme – offers an opportunity for Member States to reaffirm their commitments towards an inclusive and comprehensive approach to SRHR and to integrate them as part of their

humanitarian obligations. These commitments should be accompanied with increases in investment for comprehensive SRH services in humanitarian settings channelled through transparent and accountable funding mechanisms. Financial support should be allocated to local women's organisations, which are on the front lines of providing services yet often receive a mere trickle of funds. Humanitarian and development agencies should institute comprehensive SRHR policies consistent with international standards such as the MISP and adopt an inclusive approach to SRHR programming to meet the needs of *all* crisis-affected communities equitably. Adolescents, older women, female and male sexual violence survivors, persons with diverse sexual orientation and gender identity/expression, sex workers, and those living with disability need and have a right to respectful SRH care. Finally, aid agencies must meaningfully partner with crisis-affected communities, in particular marginalised groups and local and community-based organisations, to involve them in preparedness, implementation and evaluation of humanitarian programs, as well as to support them to lead these efforts directly, which could increase their resilience. These groups must also be better engaged in efforts to address the climate crisis. Neglecting their involvement will further contribute to their marginalisation as well as rob the international community of their insights and solutions.

The Nairobi Summit is a time for stocktaking and reinvigorating ICPD promises. We must push governments to renew their commitments to SRHR and reaffirm the equal rights of displaced and crisis-affected populations to health. With commensurate attention and a concerted effort, we can urgently and significantly scale up investments, advance policies and improve capacity to equitably meet the rights and needs of those in humanitarian settings, deliver on the Sustainable Development Goals and truly leave no one behind.

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