



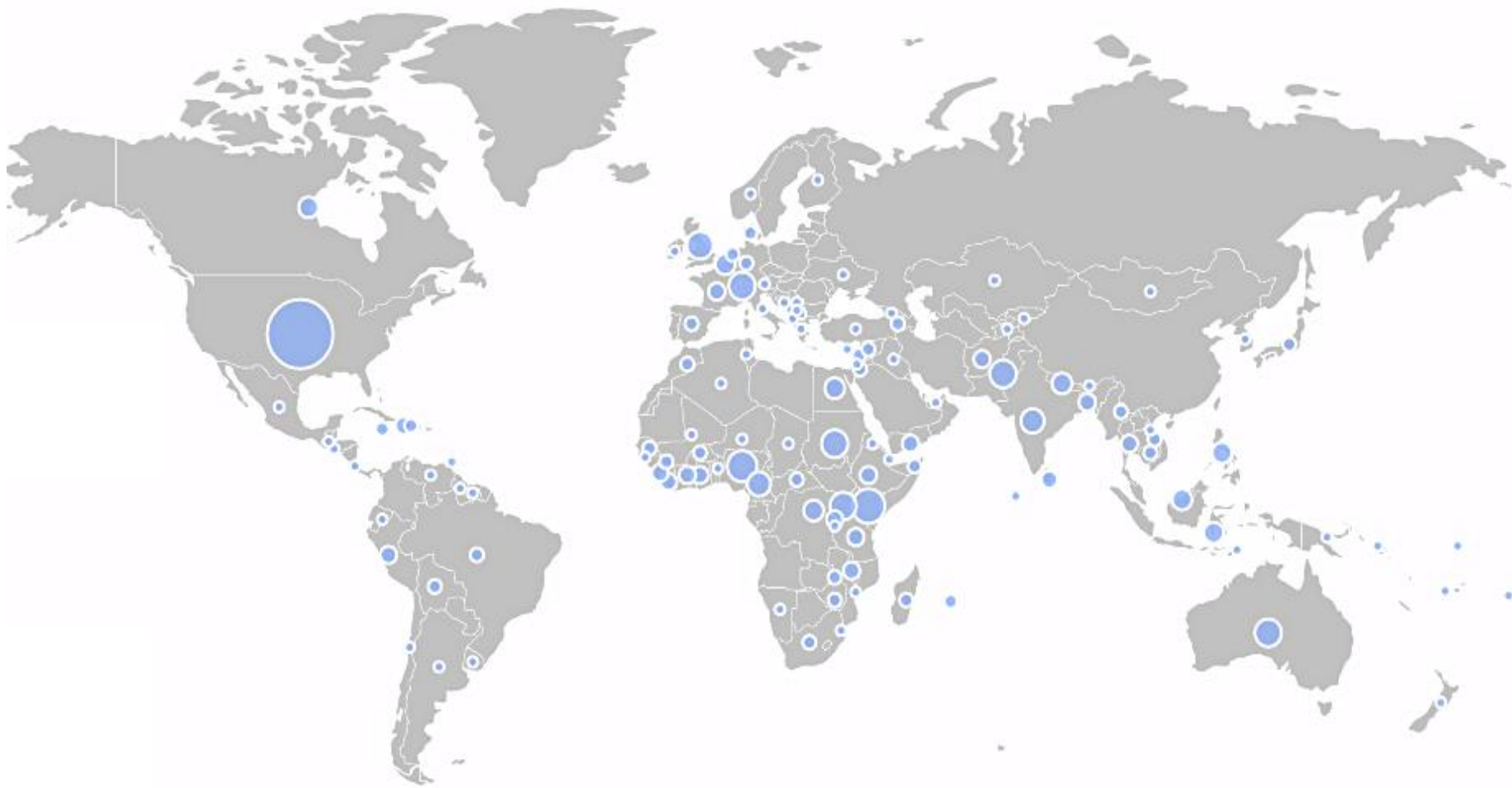
INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

Introduction to the IAWG

Dakar, Senegal

March 9-11, 2016

IAWG Members by country



IAWG Steering Committee

- American Refugee Committee (ARC)
- CARE
- The U.S. Centers for Disease Control and Prevention
- Columbia University – The Heilbrunn Department of Population and Family Health
- Emory University
- International Medical Corps
- International Planned Parenthood Federation – The SPRINT Initiative
- Ipas
- The International Rescue Committee
- Jhpiego
- JSI Research and Training Institute, Inc.
- Save the Children
- Population Action International
- United Nations Children’s Fund (UNICEF)
- United Nations High Commissioner for Refugees (UNHCR)
- United Nations Population Fund (UNFPA)
- Women’s Refugee Commission
- World Health Organization (WHO)



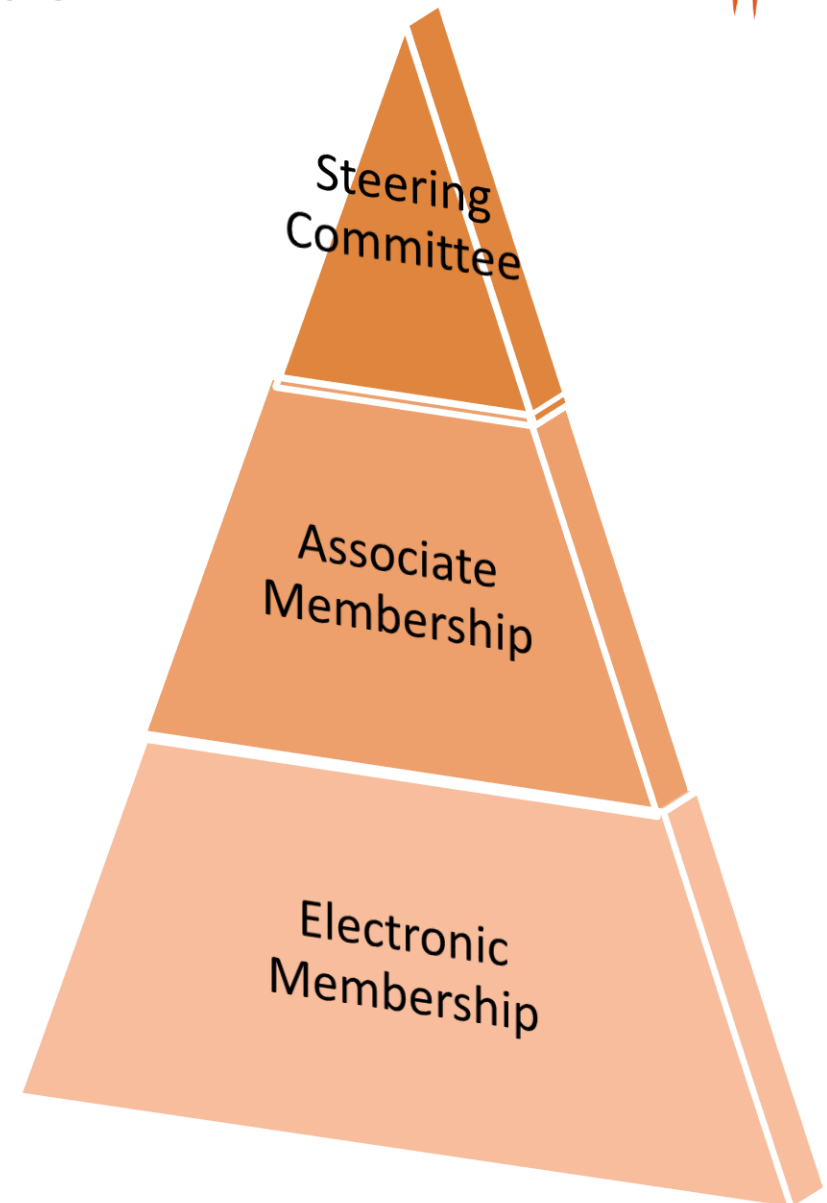
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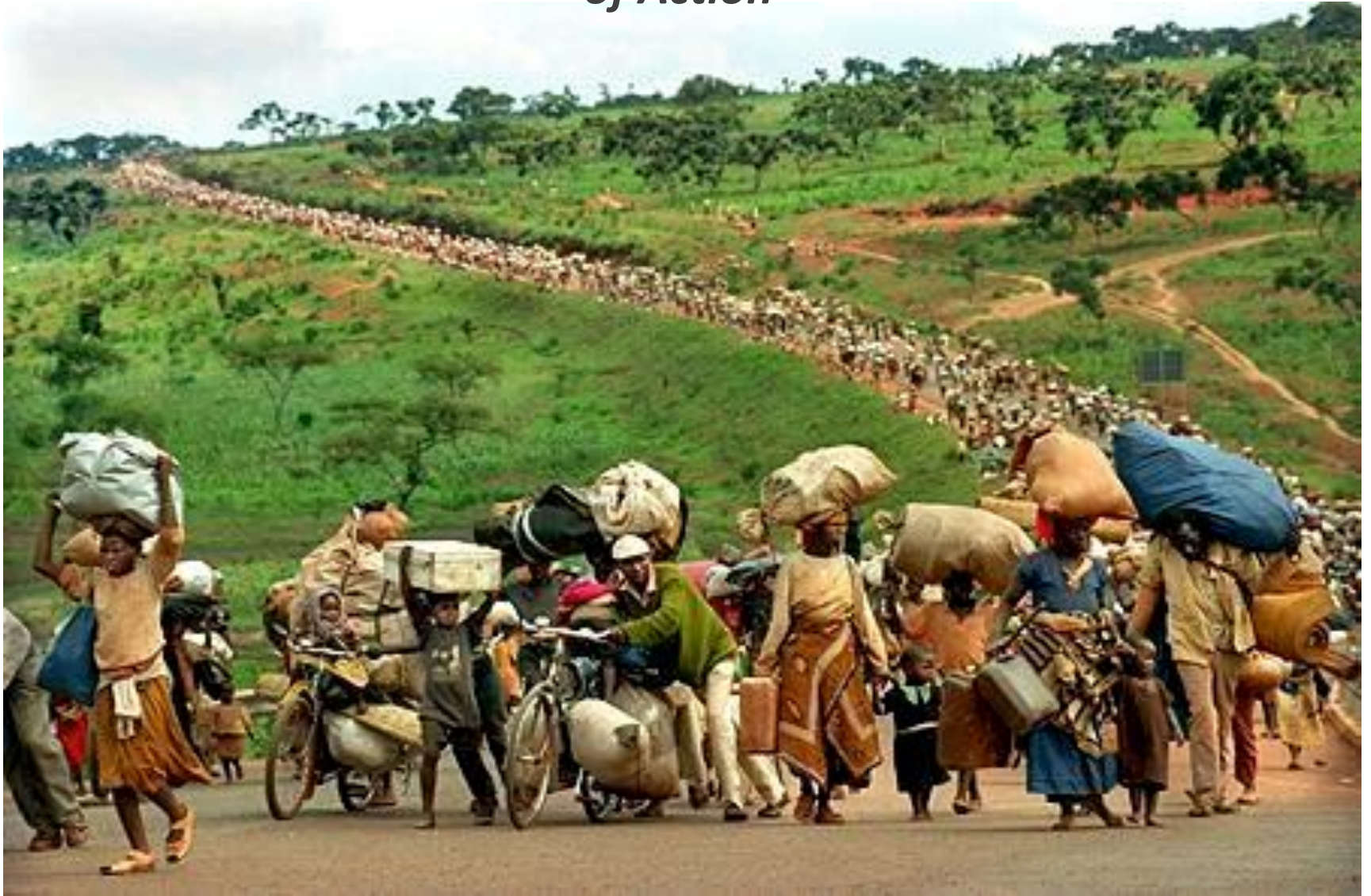
Sub-Working Groups



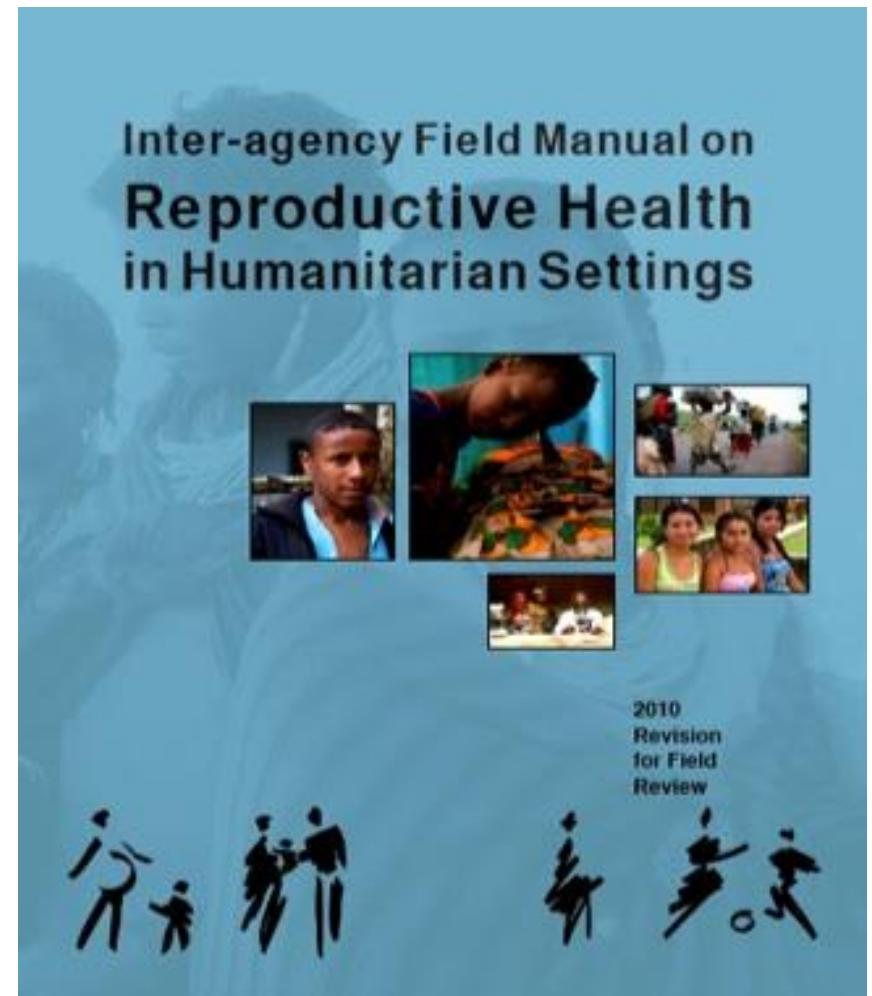
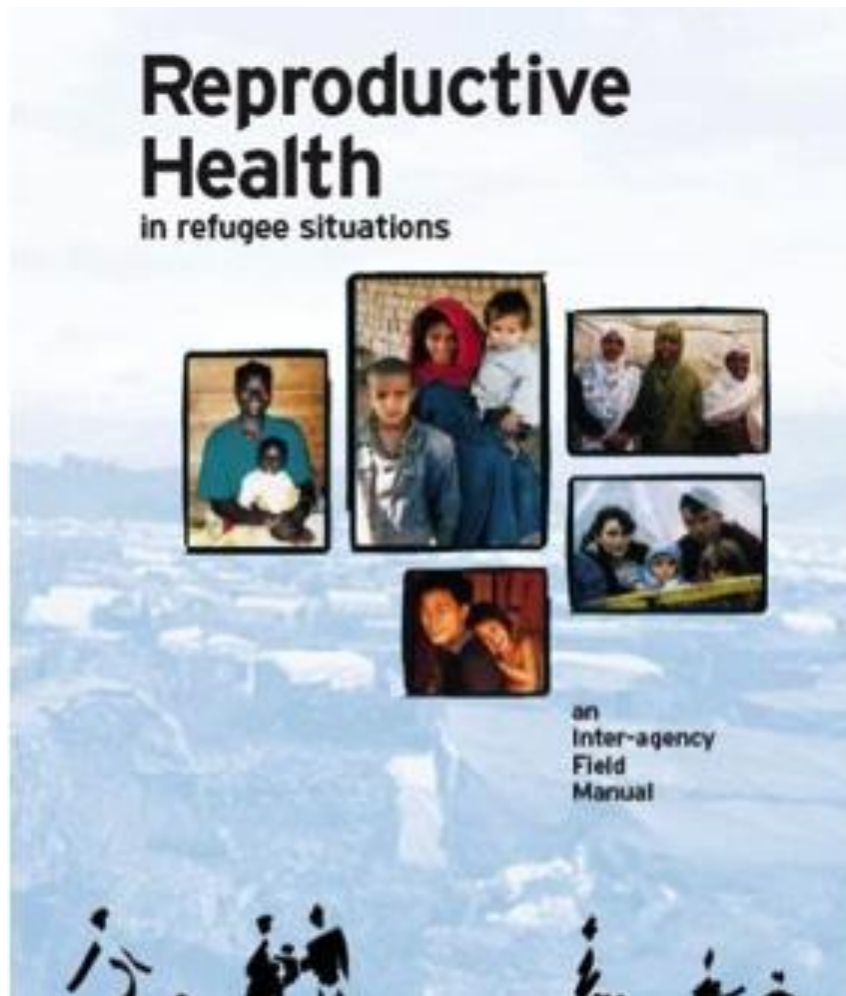
- **MISP**
- **Adolescent RH**
- **Safe Abortion Care**
- **Data, Information & Research**
- **Voluntary Contraception**
- **GBV**
- **Logistics**
- **Maternal and Newborn Health**



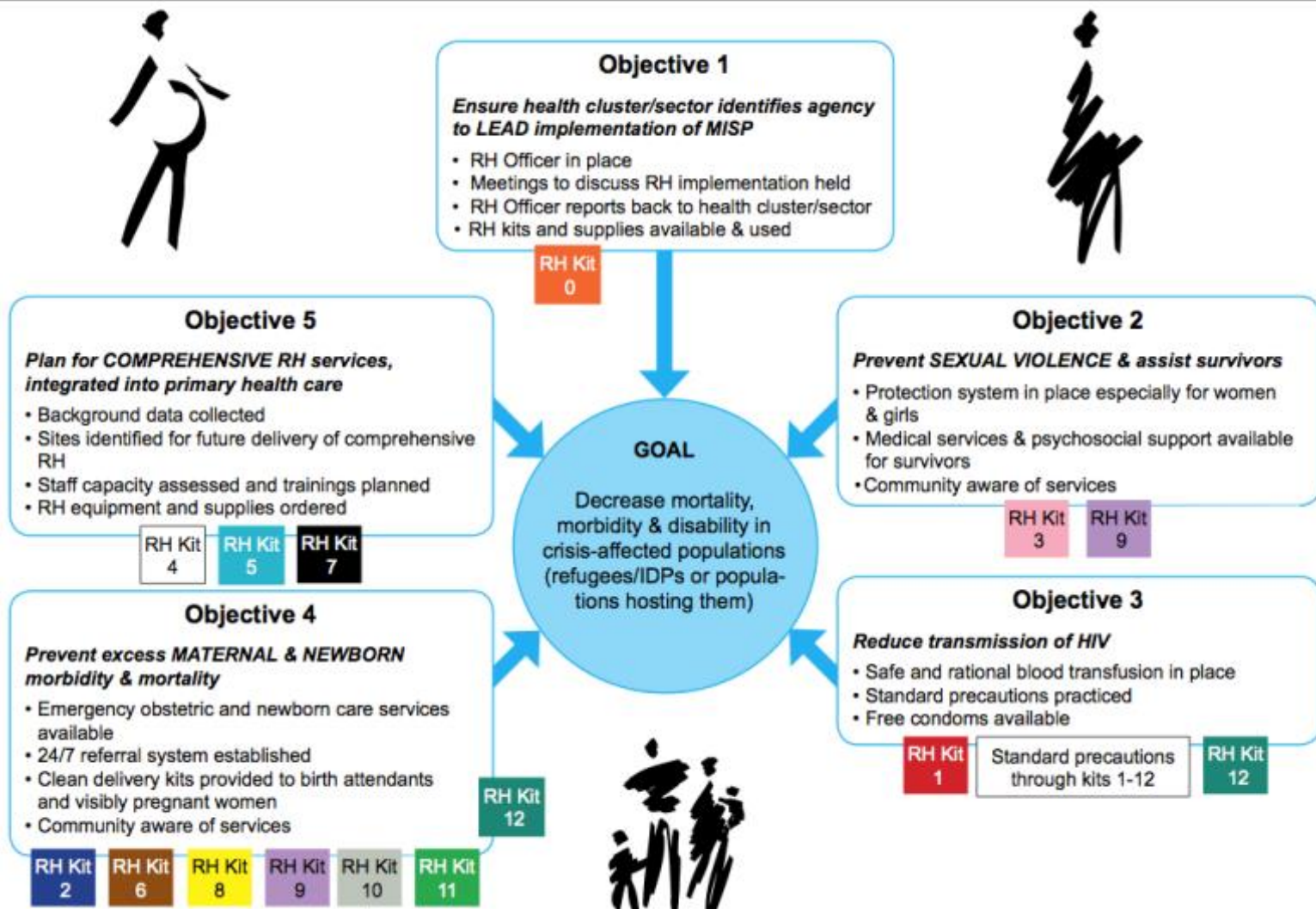
Refugees should be provided with access to adequate accommodation, education, health services, including family planning, and other necessary social service.” – ICPD Programme of Action



THE INTER-AGENCY FIELD MANUAL (IAFM)



THE MINIMUM INITIAL SERVICE PACKAGE FOR REPRODUCTIVE HEALTH (MISP)



INTER-AGENCY RH KITS



Photo Credit: UNFPA

2002-2004 Global Evaluation



Progress, Gaps and Challenges Ahead:

Inter-agency global evaluation of reproductive health
for refugees and internally displaced persons



Prior to the mid-1990s very little was done to address the critical reproductive health (RH) needs of refugees and internally displaced persons (IDPs). Findings from the Women's Commission for Refugee Women and Children's seminal report, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, published in 1994, spurred advocacy at the International Conference on Population and Development (ICPD) in Cairo, Egypt, where the rights of refugee and IDPs to RH were specifically recognized in the Programme of Action.

In 1995, UNHCR, UNFPA, WHO and more than 50 United Nations, governmental and non-governmental organizations (NGOs) met at a symposium, following which 50 of the groups formed the Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations. The IAWG developed the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* for people assisting refugees, outlined the minimum services that must be provided in all disaster settings, designed kits for rapid deployment to aid workers and recognized the need for continued advocacy, funding and technical assistance for RH programmes in refugee situations.

Now, ten years after Cairo, the IAWG has completed an unprecedented global evaluation of reproductive health in conflict settings worldwide covering the issues at the field, agency and global levels. Its purpose was to determine when and where RH services are provided and to identify gaps and constraints so that UN agencies, governments and NGOs can better target resources and interventions.

OUTCOMES

Global and Agency Levels

Since 1995 significant progress has been made in raising awareness and advancing reproductive health for conflict-affected populations in all areas of RH programming and technical support. Collaboration and exchange among organisations involved in reproductive health for refugees (RHR) have increased, due in large part to the vital roles played by the IAWG and the Reproductive Health Response in Conflict (RHRIC) Consortium, as well as other key groups.

However, the gains achieved in RHR are threatened by a difficult political and economic climate. The evaluation's findings show that funding has declined since 2000 due to

*Every year, millions of people
around the world flee their homes
to escape conflict and violence*



weakening support for RH programs in general and the continuing perception at some levels that RH is not an essential part of an emergency response.

Key recommendations: Encourage new partnerships between relief and development organizations to expand understanding and support for RHR and facilitate transition from emergency response to longer-term development assistance; actively engage academic centres and institutes; reinvigorate IAWG operations and advocacy strategies.

Field Level

Evaluation findings show that RH services in stable refugee settings have increased, are generally well established and are consistent with those outlined in the *Inter-agency Field Manual*. However, some areas, such as gender-based violence (GBV) and HIV/AIDS services, are weaker and critical gaps remain within safe motherhood, family planning and sexually transmitted infections (STI) programmes. Furthermore, specific programming to ensure youth-friendly services and male involvement is needed.

In contrast, RH services for IDPs are severely lacking and in need of urgent attention. Moreover, little is known about the RH of populations in acute complex emergencies where information is particularly difficult to collect.

I. Minimum Initial Service Package (MISP)

The Minimum Initial Service Package (MISP), a set of priority RH activities established for the acute phase of an emergency, aims to prevent and manage the consequences of sexual violence; reduce HIV transmission; and prevent access-restricted and maternal morbidity and mortality. While the MISP is gaining ground, evidence shows that more attention is needed to make this standard of care available in the earliest days of an emergency. Supplies to support the MISP activities, available in standardised kits, are increasingly used in emergency settings, although in-country storage and distribution of the kits are an ongoing challenge. However, findings from an assessment of the MISP conducted in April 2004 during the Sudanese refugee crisis in Chad indicated that most humanitarian actors were not familiar with nor implementing, the MISP activities.

Key recommendations: Increase awareness and understanding about the MISP among humanitarian actors; UN agencies and donors; improve health coordination and appoint an RH coordinator early in every emergency; allocate funds to support implementation of the MISP in the early days and weeks of emergencies.

II. Safe Motherhood

Complications of pregnancy and childbirth are the leading cause of death and disability among women of reproductive age in developing countries. Obstetric complications are exacerbated in emergency settings by the trauma of flight and the conditions of exile.

The evaluation findings show that while safe motherhood services are good overall in most stable refugee sites, not all elements of antenatal care are consistently available. The major gap in assuring safe motherhood is inadequate attention to emergency obstetric care, which must be strengthened and made accessible to all women suffering from complications in pregnancy and childbirth.

Key recommendations: Ensure all elements of antenatal care are available; improve standing health facilities and emergency referral systems by ensuring the availability of qualified staff, essential drugs and equipment for emergency obstetric care; develop creative strategies to ensure communication and transportation 24 hours per day, 7 days per week.

III. Gender-based Violence

GBV remains the least developed aspect of RH programming. Evaluation findings show that sexual exploitation, domestic violence and rape are widespread, particularly affecting women and girls. Rape survivors are not routinely receiving medical attention and there is limited programming to address the other forms of GBV.

Key recommendations: Increase general awareness of GBV in emergency situations; ensure established protocols for the medical management of rape survivors are implemented; strengthen multi-sectoral programming to prevent and respond to GBV.

IV. STIs/HIV/AIDS

During civil strife and flight, displaced persons, especially women and girls, are at increased risk of contracting sexually transmitted infections (STIs) due to a variety of factors, including the disruption of social norms governing social behavior, gender inequity, poverty, non-compliance with universal precautions and lack of condoms. The evaluation

findings also indicate problems with the quality of care provided by health workers to manage STIs in some settings. Sexual violence and proximity to peacekeeping forces, military and police may also facilitate the spread of STIs, including HIV. Finally, the mixing of populations with high and low HIV prevalence may result in an overall increase in HIV in the region.

Key recommendations: Ensure a continuous supply of essential drugs for treating STIs; increase staff capacity to diagnose and treat STIs using the syndromic approach; expand HIV/AIDS programming to include behaviour change communication strategies, voluntary counselling and testing and prevention of mother-to-child transmission.

V. Family Planning

Family planning programs have become much more widely available for refugees over the last decade. However, evaluation findings show significant gaps in the availability of contraceptive methods as well as in the skills and abilities of service providers. Cultural resistance may also contribute to a low demand for services.

Key recommendations: Improve the quality of family planning services; increase community awareness about the benefits of family planning.

VI. Adolescents

Unprotected adolescents are especially vulnerable to sexual violence and exploitation. They are typically underserved by health programs and often face multiple barriers to accessing services and information. Young people also face an increased risk of contracting STIs, including HIV/AIDS. In addition, girls suffer from unwanted pregnancies and complications from unsafe abortions.

Key recommendations: Involve youth in the design, implementation and evaluation of multi-sectoral programmes that support their protection needs; establish youth-friendly reproductive health services.

VII. Health Information Systems

The study found that while RH data were collected in most settings, in some cases the wrong information was collected or existing data were misinterpreted.

Key recommendation: Improve data collection and use by establishing simple systems that provide useful information based on guidelines outlined in the *Inter-agency Field Manual*.



CONCLUSION

Although more remains to be done, RH for conflict-affected populations has made great strides in the past decade. However, these significant gains are threatened by the current difficult political and economic climate. Policy makers, donors, managers and implementers are called upon to strengthen their response to RH in conflict-affected settings, particularly among IDPs, to respond to these challenges. Renewed leadership at all organisational levels must address the demand for sufficient human and financial resources to prevent and respond to HIV/AIDS and GBV, while improving emergency obstetric care, family planning and programs that specifically serve youth and encourage male involvement. Priority RH activities must be implemented in the early days and weeks of an emergency to save lives and to provide the foundation for comprehensive RH care once the situation stabilises. Additional challenges include improving the collection and appropriate use of data, nurturing the growth of inter-agency collaboration and developing an advocacy strategy aimed at ensuring that RH for refugees and IDPs remains securely on the agendas of donors, governments and relevant international organisations. Collectively, these challenges will provide direction for the future work of IAWG.

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Taking Stock of Reproductive Health in Humanitarian Settings: 2012-2014 Global Evaluation



2016 meeting objectives

- **Review progress** towards achieving the programmatic goals outlined in the Terms of Reference from the 2015 IAWG meeting.
- **Share information and identify areas of common work**; plan next steps for 2016-2017
- **Strengthen the regional IAWG forums**



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