HPG roundtable learning note

Better humanitarian responses to SRHR in crises

Mapping the architecture for change

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January 2024

HPG Humanitarian Policy Group

ODI

In partnership with Canada

Acknowledgements

The author would like to thank Marc Banzet, Amanda Oeggerli and Jennifer Castello of the Permanent Mission of Canada to the United Nations in Geneva for hosting the in-person roundtable on which this note is based. Manisha Thomas (Women's Refugee Commission) provided capable support and facilitation during the roundtable itself as well as a critical eye on this note.

Thanks are also due to Sandra Krause (Women's Refugee Commission), Ashley Wolfington (PROPEL Adapt), Patrick Mwesigye Sewa and Marta Royo (Profamilia), who were speakers at the virtual roundtable.

Essential support also came from Kate Oliver, Jessica Rennoldson, Sara Hussain, Nosheen Malik and Marika de Faramond.

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How to cite: Daigle, M. (2024) 'Better humanitarian responses to SRHR in crises: mapping the architecture for change'. HPG roundtable learning note. London: ODI (www.odi.org/en/publications/better-humanitarian-responses-to-srhr-in-crises-mapping-the-architecture-for-change).

Purpose of the note

Following our launch of new research on barriers to sexual and reproductive health and rights (SRHR) in crises, the Humanitarian Policy Group (HPG) convened two roundtables of thematic experts, practitioners, policy specialists and decision-makers for a solutions-focused discussion of shared obstacles, challenges and strategies in a trusted space. Together, participants mapped the current landscape for SRHR in crises and the architecture for change, identifying blockages, champions and enablers within the humanitarian system. In a moment of both optimism and struggle, the need for comprehensive services that prioritise the most vulnerable is clear. This note brings together key themes and findings from these roundtables.

Figure 1 HPG's new research on barriers to sexual and reproductive health and rights in crises

See https://odi.org/en/publications/reproductive-justice-sexual-rights-and-bodily-autonomy-in-humanitarian-action-what-a-justice-lens-brings-to-crisis-response/ and https://odi.org/en/publications/sex-health-and-rights-in-displacement-and-humanitarian-response-crises-upon-crises-in-lebanon-and-beyond/.

Box 1 Where next for SRHR in crises?

Participants identified areas where additional evidence can equip allies and champions to position SRHR in crises as a priority:

- **Growing the evidence base on SRHR in crises and diverse crisis-affected populations.** Major evidence gaps exist around the knock-on effects of SRHR gaps on: social and economic indicators; needs, risks and opportunities for youth, older people, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC); experiences and needs beyond maternal, newborn and child health, including fertility; and refugee settings and/or where clusters have been deactivated.
- **Tracking funding for SRHR in crises.** Funding is a proxy for prioritisation, and being able to demonstrate underfunding was a useful tool for gender-based violence (GBV) work. Emerging data from the Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service and Family Planning 2030 may prove useful.
- **Translating experiences into better policy and practice.** The growing quantification of evidence – especially on sensitive topics like SRHR – can fail to capture the true weight of barriers to access and lead to bad policy. Participants called for more translation of everyday experience and impacts of SRHR gaps for higher-level policy spaces in order to demonstrate the stakes, especially for marginalised people facing intersecting exclusions.
- **Engaging with values clarification for action and transformation (VCAT).** Consider the use and potential of VCAT programmes for combatting stigma and reducing attitudinal barriers amongst health professionals, humanitarian responders and decision-makers.
- **Using integrated approaches to SRHR.** 'One-stop shops' that offer SRHR alongside GBV, mental health and psychosocial support (MHPSS) or protection services have potential to increase acceptability, reach and cost-effectiveness. Capturing learning and scalability for successes and/or pilots for new models would be useful.
- **Documenting what works.** Better understanding settings, programmes and interventions that have achieved success is key. This might include stakeholder mappings in particular settings, tracking/evaluating programmes, and capturing learning from areas like GBV prevention and mitigation and/or HIV/AIDS. Programmes like Ukraine's Blue Dot Safe Spaces are a key example here.[i]

i Blue Dot Safe Spaces are an initiative to provide multidisciplinary services, including protection and access to information, to displaced people in countries surrounding Ukraine. See details at https://bluedothub.org/.

The current landscape

In complex and protracted humanitarian crisis settings, unmet needs for SRHR are stark. Emerging research by HPG demonstrates the complex, overlapping barriers that confront diverse crisis-affected people when seeking SRHR. Despite progress in the last 30 years, seemingly intractable problems persist in humanitarian coordination, growing cost barriers, and discriminatory attitudes on the part of healthcare providers and even humanitarians themselves. These gaps and barriers are detrimental to health, protection, wider wellbeing and future engagement with healthcare.

Amidst growing anti-gender backlash worldwide, including against key SRHR components like abortion and bodily autonomy, a comprehensive agenda is more critical than ever. Humanitarian actors are not immune to this politicisation of SRHR: increasingly working from a limited, 'needs-focused' approach to SRHR, they often set aside or even dismiss rights as the purview of other actors. This narrowing is driven by both shrinking funding pots as well as dwindling humanitarian space, which has motivated agencies to refocus on immediate needs and de-emphasise the humanitarian–development–peace nexus, but it comes with ramifications for SRHR in crises, and thus for the health, wellbeing and agency of crisis-affected people. The context for humanitarian response is also changing, amidst rising needs, changing donor priorities and a shifting political landscape.

Due to this environment, participants in both events pointed to initiatives and networks that are translating into momentum for comprehensive SRHR in crises, although visibility of and support for these networks remain constrained. Discussion centred on these groups' unique access and strategic importance in sitting across sectoral siloes, networks and disciplines.

Historically, the **Inter-Agency Working Group on Reproductive Health in Crises (IAWG)** has been a longstanding and collaborative network that has catalysed major achievements like the Minimum Initial Services Package (MISP), a set of priority actions for the acute stages of crisis. The MISP has since been included in the Sphere Standards and widely acknowledged as the gold standard for SRHR in the acute stages of a crisis, even if its implementation is often still lacking. In 2023, the IAWG also launched a **Global Call to Action for Sexual and Reproductive Health Self-Care in Humanitarian and Fragile Settings**.[1] In recent years, the IAWG has struggled to achieve sustainable funding, putting its global-level work at risk.

More recently, the **Sexual and Reproductive Health (SRH) Task Team** was formed in late 2022 under the Global Health Cluster. It has a two-year mandate to act as a platform for the

1 See the call to action here: https://iawg.net/resources/global-call-to-action-for-sexual-and-reproductive-health-self-care-in-humanitarian-and-fragile-settings.

coordination, prioritisation and standardisation of SRHR approaches across activated health clusters, starting with an ongoing baseline assessment. The remaining year of the Task Team's mandate presents a critical opportunity for it to be leveraged for meaningful progress.

Other initiatives include:

- **Joint Operational Framework for Health and Protection**, created by the Global Health Cluster, the Global Protection Cluster and its Areas of Responsibility, the IAWG, and the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support in Emergency Settings.
- **Donor group on SRHR in crises**, led by the United States and the Netherlands.
- **Sexual and reproductive health in crisis and post-crisis situations (SPRINT) Initiative**, funded by Australia, which works on regional pre-positioning of supplies, building country capacity and integrating SRHR into national-level response plans.
- **Implementing Best Practices (IBP) Network**, hosted by the World Health Organization (WHO), which circulates learning and tools for reproductive health programming, although with no particular focus on crisis settings.

Networks like the International Planned Parenthood Federation (IPPF) and the Red Cross and Red Crescent Movement, with expertise in SRHR and/or humanitarian response across a wide range of geographies and settings, also have potential to support locally led responses.

A roadmap for action

SRHR is lifesaving *for everyone*

There is frustration amongst long-time supporters at having to make and remake the case for comprehensive SRHR in crises, amidst low levels of understanding and creeping politicisation. **Nonetheless, participants were clear that progress – especially on issues like self-care, comprehensive sexuality education, and increasing the funding base – requires cultivating new allies rather than preaching to the converted.** Rallying around a set of simple core messages in lay terms may provide a path forward to counter the power of politicisation and backlash.

Key amongst these messages is positioning SRHR as 'lifesaving' and integrating it into primary care models, a framing that suggests the appropriate level of urgency and is likely to resonate better with audiences where 'reproductive justice' or 'bodily autonomy' achieve less traction. The Central Emergency Response Fund (CERF) Lifesaving Criteria, updated most recently in 2020, can be leveraged to that end as they already call for 'equitable and timely' access to primary care and centre the MISP.[2]

Getting SRHR recognised as lifesaving and integrated into primary care is no easy task – health itself is still frequently deprioritised – but participants highlighted that making just this kind of shift has been key to moving the clinical management of sexual and gender-based violence up humanitarian agendas, so there is much to be learned from that relative success. Along the way, supporters should resist the fragmentation of SRHR, highlighting not just maternal, newborn, and child health (MNCH), sexual violence and GBV, but also fertility, contraception and other areas that are critically important but rarely broached in crisis contexts.

Importantly, participants welcomed the inclusivity of HPG's new research, which highlights the SRHR needs of people of all genders, sexualities and gender identities. SRHR should therefore be positioned as lifesaving *for everyone* – that is, as universal rather than limited to women and girls – in recognition of the important SRHR needs of men, boys and gender-diverse people, as well as the fact that women and girls are better served when their SRHR needs are understood and supported by their partners, families and communities.

Here, considerations around both acceptability and contextualisation are critical, but go hand-in-hand with commitment to inclusive and accessible SRHR. Participants noted the importance of humanitarians' own attitudes and knowledge levels relating to SRHR, as well as a chilling effect when humanitarians presume the unacceptability of working on abortion, or of sexual activity amongst youth or people with lesbian, gay, bisexual, trans, queer/questioning, intersex and asexual (LGBTQIA+) identities.

2 See the CERF criteria, especially pp. 10–11, here: https://reliefweb.int/report/world/central-emergency-response-fund-life-saving-criteria.

To facilitate the necessary shifts, participants pointed to Ipas' work on shifting attitudes,[3] as well as opportunities to engage with middle-ground actors, countries and agencies that might simply lack the needed awareness, resources or frameworks. Highlighting how comprehensive SRHR in crises intersects with each actors' own priorities and objectives is also key.

SRHR gaps pose protection risks

The events also highlighted the importance of understanding how SRHR gaps can generate protection concerns. Participants found this framing compelling, urging policymakers to think about this lens as a new and powerful way to communicate urgency and address those gaps. These risks can be indirect, in the form of poor service coverage and barriers to access, which then create knock-on effects for marginalised groups including women and girls, people with diverse SOGIESC, people with disabilities, and displaced people and refugees. The harms may also be direct, in the form of discriminatory attitudes on the part of health workers and other intervenors, and even **obstetric violence** – problems that merit a concerted response through awareness and training, but which also should be critical areas of concern for protection actors.

Other participants expressed concern that linking health and protection is not a framing without problems, as it departs from field-level thinking and brings together two sectors that are already underfunded and overstretched. They highlighted struggles in some settings to conduct clinical management of GBV, for example, because of siloed ways of working between protection and health actors. Key protection agencies also lack needed expertise and capacity, seeing SRHR only through a lens of GBV that is problematic for the universal and comprehensive approach discussed above.

Therefore, positioning SRHR gaps as protection risks likely represents a longer-term aspiration rather than an easy win or a short-term practicality, alongside integration into primary care models. The Joint Operational Framework for Health and Protection noted above already lays some groundwork for starting this conversation, although without an explicit discussion of SRHR. This is not a question of SRHR 'moving' into protection's remit but rather one of building channels between health and protection, as well as encouraging, supporting and inciting protection actors to understand the risks that arise from these gaps. What matters, as participants highlighted, is responding to the risks people are confronting rather than agreeing definitions or structures.

SRHR should be community- and self-led

There is an existing movement within the SRHR field towards de-medicalised, community-led and patient-centred delivery models. This can entail relying on community health workers for various kinds of screening, information campaigns, education and follow-up; centring midwives

3 See the 2018 Ipas toolkit on attitude transformation here: www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences/.

in pregnancy-related care; and supporting self-care for contraception, elements of postpartum care, self-managed abortion care using the medication misoprostol, and self-testing for sexually transmitted infections (STIs) including HIV. Self-care shows real potential for expanding coverage, especially in harder-to-reach places; subverting institutional and attitudinal barriers in medical spaces; and reducing cost barriers – all of which dovetail with the humanitarian impetus to extend access and reduce cost. Self-care models require research and contextualisation, but current initiatives merit support – for example, the 2022 revision of WHO's guidelines on self-care interventions[4] and IAWG's call to action on self-care in SRH.

Support for de-medicalised and self-managed SRHR promises greater bodily autonomy and agency for patients, and while they can never displace the need for formal medical services or the responsibilities of both state institutions and humanitarian actors to provide them, they nonetheless show potential for inclusivity and accessibility in delivery models.

Participants also saw an important role for local and national organisations focused on SRHR service provision and inclusion, which are best placed to ensure that SRHR is acceptable, contextualised, accessible and effective. Participants were keen to see humanitarian response work with local and national partners like clinics, advocacy groups and country-based health networks through a health systems strengthening approach. Here, the work of Profamilia in Colombia, the Ugandan Youth and Adolescent Health Forum, and the International Rescue Committee's work with Edge Effect in Ukraine were all well noted. Participants acknowledged the need to start from where people in crisis settings go to seek care and their own self-defined needs, rather than from global-level priorities and agendas.

In addition to SRHR-focused actors, HPG's research points to 'by and for' organisations – that is, those representing marginalised groups like women, people with disabilities or those with diverse SOGIESC – as key to inclusive SRHR, and participants favoured partnerships with such organisations as an important pathway to recognising and reducing complex barriers.

SRHR requires preparedness and coordination

Participants argued strongly that responding to SRHR needs in crisis settings means anticipatory action and preparedness – but, importantly, they noted that preparedness is often difficult to fund and considered to be both everyone and no one's job. For SRHR specifically, preparedness means regional pre-positioning of supplies before crises descend and navigating supply-chain problems in conjunction with national health ministries; in-country health networks; water, sanitation and hygiene (WASH) actors; pharmacies and other actors. Preparedness is one of the six core functions of cluster coordination laid out in the Joint Operational Framework for Health and Protection, as well as a key component of the SPRINT Initiative – both discussed above – so participants agreed that anticipatory action and integrating SRHR into regional, national and local-level planning and preparedness are promising areas for progress.

4 See the full guidelines here: www.who.int/publications/i/item/9789240052192.

Bringing SRHR into response planning also means coordination between health and humanitarian actors, which are not always in good communication – and which participants argued meant renewed emphasis on the humanitarian–development–peace nexus as well as collaboration with ministries of health as part of a wider health systems strengthening approach. This means ensuring SRHR is raised in inter-cluster coordination. Place-based organisations can help to accomplish this kind of coordination: in Colombia, Profamilia's inclusion in the country's back-to-back coordination mechanisms has allowed it to ensure SRHR is taken into account.

Here, participants highlighted integrated programming as a way to ensure cross-sector and non-siloed coordination while also making interventions more accessible, effective and streamlined. Blue Dot Safe Spaces – a one-stop-shop model rolled out in countries surrounding Ukraine to provide protection services and information to at-risk displaced Ukrainians – were widely identified by participants as a model to replicate. Integrated programming on SRHR with GBV prevention and response, MHPSS, adolescent health, and HIV prevention and treatment were also highlighted as having potential.

SRHR needs financial and political commitment

Finally, throughout the discussion, participants noted the ongoing need for commitment from humanitarian actors in the form of both financial investment and political will.

Linking back to shared messaging, participants noted that humanitarians themselves have been a huge barrier to SRHR services to date. Going forward, and in the face of likely further decreases in funding, commitment needs to be seen at the highest levels – the Emergency Directors Group, IASC Principals and humanitarian country directors, for example – if we are to see the kind of integration and prioritisation described above.

Amidst backlash, donors can play an important role in keeping SRHR consistently on the table in their dealings with humanitarian agencies, as well as defending and working to depoliticise the issue in their diplomatic and intergovernmental work, especially with 'middle ground' or undecided states. Participants looked to the United Nations Population Fund's recent work resisting language backslide at the Human Rights Council, as well. This is not a straightforward task, given the current global environment for LGBTQIA+ rights and abortion in particular, but it is necessary work to see meaningful progress for more inclusive, accessible and effective SRHR in crises.

As one participant noted, a humanitarian crisis is never an SRHR crisis from the beginning, but the impact of wider crises is such that responding to SRHR needs cannot wait for weeks or months. The immediate impacts on health and wellbeing – as well as the knock-on effects on livelihoods, bodily autonomy and equality – call for emphatic support from donors, humanitarian agencies and practitioners alike.

The Humanitarian Policy Group (HPG) is one of the world's leading teams of independent researchers and communications professionals working on humanitarian issues. It is dedicated to improving humanitarian policy and practice through a combination of high-quality analysis, dialogue and debate.

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