Woodrow Wilson International Center for Scholars
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Family Planning in Fragile States: Overcoming Cultural and Financial Barriers

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Good afternoon, everyone. Thank you for being here. I'd like to also thank the panel organizers, the Woodrow Wilson Center, and CEDPA for the opportunity to be here with these esteemed panelists and to be able to speak to you about improving access to reproductive health in fragile states. I will present some select recommendations with regard to that subject.

Why is reproductive health important in fragile states? Well, conflict-affected countries have some of the worst reproductive health indicators. The recent Lancet report on maternal mortality shows that conflict-affected countries comprise four of the five countries with the highest maternal mortality in 2008: Afghanistan, Central African Republic, Chad, and Sierra Leone.

I'm just going to show you a few slides to give some context. This is the Rift Valley in Kenya, following the post-election crisis in 2007. Facilities are burned right to the ground—this is the type of thing that can happen during such crises. Here, this is in Aceh province, which is also conflict-affected, but was also affected by the tsunami. And this is a situation of forced displacement in the Democratic Republic of the Congo.

As Grace was saying, people's reproductive health needs don't go away when they're facing catastrophic events—in fact, they can become worse. Pregnant women can be in any crisis situation. In fact, about 6 to 14 percent of women will be pregnant, and among them, 15 percent will experience an unpredictable complication of the pregnancy and require emergency obstetric care. But there they are delivering along the roadside or in makeshift shelters, or in the case of Kenya, in the busses as they were fleeing conflict zones.

They have may have left or forgotten their birth control method. Families, communities, the whole of civil society as people know it, are broken down. Without access to information and services, adolescents are at risk.

There is also a problem of sexual violence. Sexual exploitation and abuse occur in conflict and natural disaster settings as people are trying to get their basic and survival needs. Without ready access to those needs, they might be in a position where they have to exchange sex, for example, for food rations. Rape occurs more in the disruption of civil society and as a tactic war. This sexual violence leaves women at risk of sexually-transmitted infections, unwanted pregnancies, and unsafe abortions.

So there is a need there, but the health infrastructure is highly affected. Whatever was there before is not necessarily still available—it has likely been weakened or destroyed. The shortage of health workers is compounded as health workers themselves grapple with the effect of the crisis on their personal lives, so they're not necessarily able to go to work, even if the facility and supplies remain.

I have talked to you about the onset, the immediate onset of the crisis picture, but then there is the long-term situation as well. Cases where the political context is such that the conflict is intractable can be long-term. And then there are numerous intermediate settings and circumstances between a long-term, stable, refugee camp setting and the initial transition from an acute emergency.

Now to give a picture of what the policy environment looks like. The International Conference on Population and Development explicitly recognized the needs of refugees and the internally displaced, including their right to reproductive health services, in the Programme of Action in 1994. Since that time, a number of guidelines have been established, including interagency guidelines for reproductive health in refugee settings. I'm just going to hold these up because all three of these guidelines are either currently under revision, recently revised, or recently developed. This is the Interagency Field Manual on Reproductive Health, and the revision is coming out next month.

The Global Health Cluster also just developed guidelines. WHO Leads the Global Health Cluster for Humanitarian Settings is the Health Cluster guide. And then there are the Sphere Minimum Standards in Disaster Response. What I want to say about these guidelines is that they are consistent in their recommendations for reproductive health, and specifically, they

recommend a minimum initial service package of reproductive health services at the onset of an emergency.

These are a set of very limited, priority activities to be implemented right from the beginning of any emergency. They include ensuring that there is some form of coordination for reproductive health within the broader health sector. They include measures to protect women against sexual violence as well as measures to ensure that women who have suffered sexual violence have access to care, such as emergency contraception, prep to prevent HIV, ensuring the blood is clean for transfusion, and condoms. Other limited actions for preventing maternal and newborn morbidity and mortality, such as ensuring that skilled health care workers are available to provide basic and comprehensive emergency obstetric care, are also called for. They recommend clean delivery kits for women and girls on the run who are pregnant, visibly pregnant, and due to deliver.

There are three important notations to the MISP, and one is that contraception should be available from the onset of an emergency to meet any demand. That means condoms, pills, injectibles, IUDs, and emergency contraception should all be available to meet any demand at the onset of any emergency; so should anti-retrovirals for anyone who is already taking them for HIV/AIDS, including those taking them to prevent maternal-child transmission, and also care for sexually-transmitted infections. Anyone present should get care.

Still, this is a very limited approach to reproductive health. In the MISP, there is a laminated sheet that outlines the difference between the MISP and more comprehensive reproductive health services, which should be established as soon as the situation starts to stabilize. In other words, MISP activities should be sustained, but they should also be built upon to ensure comprehensive maternal and newborn health, family planning, care for sexually-transmitted infections, broader gender-based violence care, safe abortion care, and care for adolescents.

Have these guidelines been followed? Does the global policy support these findings, these recommendations, and these guidelines? Not really. The Reproductive Health Access, Information, and Services in Emergencies initiative—RAISE—which is led by Columbia University's Mailman School of Public Health and Marie Stopes International and includes Women's Refugee Commission and JSI as members—conducted a global policy analysis looking at the policies of governments, EU institutions, UN agencies, and foundations. The pie chart on your left shows the policies; the one on the right is our guidelines. Basically, they show about 15 percent of the policies cover comprehensive reproductive health.

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Another 12 percent deal with reproductive health and rights or women's health. But then 19 percent deal with the important issue of HIV/AIDS and 19 percent deal with GBV. On the other hand, emergency obstetric care was only mentioned in one policy—and that is included in the comprehensive reproductive health analysis there. As for family planning, it was only included in one percent of policies.

This policy study complemented a RAISE-initiated donor's study, which was conducted in 18 conflict-affected countries from 2003 to 2006. That study found an annual average of 2.4 percent of total ODA—overseas development assistance—was allocated to reproductive health, and only 1.7 percent of the 2.4 percent, on average, was dispersed to support family planning. So that's quite a drop. What the policy and funding shows is that while there was important allocations to HIV and gender-based violence, the approaches are fragmented and don't complement the holistic comprehensive approach of ICPD.

What should be done? Policies and funding should support the existing guidelines and standards; they should support the MISP. They should support comprehensive reproductive health as soon as the situation starts to stabilize. It's also important to ensure that the reproductive needs of refugees and IDPs are fully integrated into any broader health proposals, such as the Global Health Initiative. That is, in every country, the needs of the refugees and the IDPs in that country should be considered, and there are many reasons for that.

One, the humanitarian funding tends to be very short-term, and even if it's there at the onset of crisis, it's not necessarily going to be there when the crisis is no longer garnering attention. That results in a situation where there is no funding. By building humanitarian funding in, however—and by giving the capacity to the Ministry of Health, the development agencies already on the ground in local actors, by supporting them in RFAs, and so forth—then the capacity is sustained in the country.

It's also important to support the leadership role of national and local authorities and build the capacity of local NGOs, including beneficiaries. It's fundamental right of theirs to be part of the solutions to the problems they're experiencing in the country, but they are also important in filling in during the transition from relief phase to long-term development. There is a tremendous gap in the transition that supporting these groups is more likely to prevent.

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One of the specific recommendations is supporting collaborative partnerships. The international community has long benefitted—I mean, the global international community working in reproductive health, the humanitarian community—has really benefitted from collaborative partnerships and working together on advocacy and developing standardized curriculum trainings. Groups like the Reproductive Health Response in Conflict Consortium have supported local NGO partnerships.

JSI has taken the lead for the Consortium on that with a collaborative partnership where local NGOs can work together with a shared curriculum and shared service delivery approaches. JSI has been working on this for a long time and has also published reports on the success of these projects. One of the reports is "Small Grants; Large Gains."

It's also important to include reproductive health and emergency preparedness in contingency planning. We have already heard a little about that from the panelists—that by having governments, ministries of health, development agencies, and local NGOs trained in advance of the MISP and prepositioning supplies and materials, those groups are much better able to respond in any new crisis, and certainly in any sudden onset type of emergency, because they're already in the country. Embarking on emergency preparedness, training, and stockpiling of resources capacitates the local actors.

And then there is the important issue of urbanization. Fifty percent of the world's population is now living in an urban context, and this is mimicked also in refugee settings, with 50 percent of refugees now in urban contexts as well. I think, again, that the ministry of health, the development organizations, and local NGOs are best positioned to respond to the needs of urban populations.

Finally, supporting community-based approaches to service delivery. Grace mentioned mobile outreach, including with it long-term family planning methods and community-based distribution of family planning. Now, that has long been popular in the developing context. A lot of research and implementation has been done there, but not as much has been done on the humanitarian side. Much more is needed.

Some groups, like the Global Health Access Program, have actually taken on community-based reproductive health care. There is a terrific project in Burma for IDPs called the Mobile Obstetrics Maternal Health Project, whereby a whole cadre of community health workers provides all the obstetric care, except for C-sections. And the Women's

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Commission is working now to integrate community-based care for women who have survived rape into that project, so that they may receive care that they otherwise wouldn't have because health facilities are not possible where they are, on the eastern border of the IDP area of Burma.

In summary, policies and funding should support the implementation of existing standards on the MISP in emergency preparedness and response. Comprehensive reproductive health, as a situation stabilizes and throughout projected crisis and recovery, should include refugees and IDPs in any health or reproductive health initiative in a country—they tend to be forgotten, but should be included. Further, programs should support capacity-building of local NGOs through network approaches and collaborative partnerships, and, in general, community-based approaches to service delivery where health facilities are not feasible or possible. Thank you.

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