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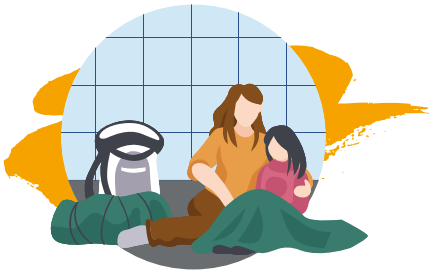
SEXUAL AND REPRODUCTIVE HEALTH CARE AND RESPONSE TO GENDER-BASED VIOLENCE IN HUMANITARIAN EMERGENCIES

Access to care in the context of humanitarian emergencies may be essentially affected or disrupted due to a series of reasons[1]:

Affected, disrupted or destroyed infrastructure (electricity and water supply, communication, transport connectivity, etc.)

Collapses caused by the emergency disrupt supply chains of drugs, equipment and other essential commodities



Extensive casualties may overpower capacities of the health system (personnel, equipment, infrastructure, etc.) to deliver effective care

Such situations make women and girls most vulnerable and expose them to a maximum life and sexual and reproductive health risk.

[1]Ensuring universal access to sexual and reproductive health supplies. *Recommendations to build resilient supply chains through collaboration in the humanitarian-development nexus. Advocacy brief by Reproductive Health Supplies Coalition, Inter-Agency Working Group (IAWG) on Reproductive Health in Crises. 2020*

Women and girls may be exposed to a higher risk of sexual violence

in humanitarian emergencies

Why is delivery of sexual and reproductive health (SRH) care to women and girls essential in humanitarian emergencies?

Global evidence shows that in any humanitarian crisis large groups of people have to abandon their places of living within a short time seeking safety and shelter.

Such displaced groups, at all times, will include:

Women of fertile age
(15-49)
26%

Adolescent girls aged
(10-14)
5%

Adolescent girls aged
(15-19)
4%

Neglected SRH needs in humanitarian crises may have far-reaching implications such as:

- substantially growing maternity and newborn morbidity and mortality;
- substantial growth of unsafe abortions;
- substantially growing sexual violence

In addition, displaced persons would always include 4% pregnant women, and it appears from global evidence that due to declining or blocked access to health care[2]:

In addition, 6% of displaced persons would have sexually transmitted infections (STIs).

- 15% of these pregnancies would end with miscarriage or unsafe abortion;
- 2% would end with still birth;
- only 15% pregnant women would have access to maternity care provided by skilled health staff;
- 15% of pregnant women would experience obstetric complications, such as dystocia or prolonged labor, preeclampsia/eclampsia, infection or heavy bleeding;
- 15% of women in labor would need stitching of maternal passage;
- 5% to 15% women in labor would need operative delivery;
- body weight of 5% of all newborns would be below 2 500 g;
- 20% of all newborns would experience birth complications.

Furthermore, in humanitarian emergencies women and girls may be exposed to a higher risk of sexual violence. Global experience shows that sexual violence against women and girls spiral when[3]:

- they have no personal documents to get food, care or services and depend on men in their day-to-day survival;
- only men are responsible for distribution of food and other essential goods;
- they have to go to remote places for health care, food, fuel and water without security or other protection;
- their sleeping accommodation is not locked or protected or not well-lit;
- men's and women's toilets and showers are not separated; they are not bolted from inside or located in unsafe parts of settlements.

[2]Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (2018)

[3]*Minimum Initial Service Package MISP For Sexual and Reproductive Health (SRH) in Crisis Situations: a Distance Learning Module (P. 38)*

An example of progression of a humanitarian emergency in hypothetical settlements with population 100,000 and 1,000,000 inhabitants (during 12 months)[4]

		Estimates, 100,000 persons	Estimates, 1 mln. persons
Women of reproductive age (15-49 years)	26%	26 000	260 000
Adolescent girls (10-14 years)	5%	5 000	50 000
Adolescent girls (10-19 years)	9%	9 000	90 000
Pregnant women	4%	4 000	40 000
Crude birth rate in Kazakhstan (2021; per 1000 persons)	23,5		
Live birth in next 12 months		2 350	23 500
Pregnancies ended with miscarriage or unsafe abortion	15%	352	3 525
Still births	2%	47	470
Pregnant women who would have access to childbirth attended by skilled health workers	15%	600	6 000
Pregnant women who would experience complications	15%	600	6 000
Women in labor who would need stitching of maternal passage	15%	600	6 000
Women in labor who would need operative delivery	5-15%	200 to 600	2 000 to 6 000
Newborns with body weight below 2 500.0 g	5%	117	1 175
Newborns who would experience birth complications	20%	470	4 700
Adults living with STIs	6%	6 000	60 000

This table estimates the number of people who could lose their lives or be violated in the next 12 months due to a humanitarian emergency if medical care is not deployed within 48 hours.

[4]the Minimum Initial Services Package (MISP) for Sexual and Reproductive Health (SRH) in Humanitarian Settings Calculator

[5](100 000*23,5)/1000

MISP

The Minimum Initial Service Package

The Minimum Initial Service Package is a coordinated set of prioritized essential SRH activities and services to be implemented within 48 hours of the onset of every humanitarian crisis.

What measures are recommended by the international community **to provide access to sexual and reproductive health care in humanitarian emergencies?**

The global community recommends and makes use of **the Minimum Initial Service Package** (MISP) for sexual and reproductive health.

MISP is a coordinated set of prioritized essential SRH activities and services to be provided at the onset (within 48 hours where practical) of every humanitarian crisis and used ideally for 3-6 months.

Ideally, at the end of this period MISP should be integrated into primary health care or taken over by the rebuilt health system.

MISP is designed to prevent SRH-related morbidity and mortality in humanitarian emergencies and at the same time protect the rights of the affected people to a decent life.

MISP was first developed in 1996 by Inter-Agency Working Group on Reproductive Health in Crises (IAWG). In 2018, the IAWG consisting of 21 UN agencies and organizations, international non-governmental organizations and academia updated the MISP[6].

UNFPA, in partnership with the stakeholders, supports implementation of MISP to ensure that all affected populations have access to essential SRH services .

UN Security Council Resolutions 1325[7], 1820[8], 1888[9] and 1889[10] concerning women, peace and security acknowledge unique needs, perspectives and contribution of women and girls in conflict situations.

UN Security Council Resolution 1889 expressly points to the need to ensure access of women and girls to SRH services and reproductive rights to improve socio-economic conditions in post-conflict situations.

[6]https://iawgfieldmanual.com/manual/introduction#iafm-development

[7]http://unscr.com/en/resolutions/doc/1325

[8]http://unscr.com/en/resolutions/doc/1820

[9]http://unscr.com/en/resolutions/doc/1888

[10]http://unscr.com/en/resolutions/doc/1880

The six objectives of the MISP in relation to SRH and one additional priority :

I. Lead implementation of the MISP:

- coordinate technical and operational support;
- raise awareness of stakeholders and general public;
- provide ongoing monitoring.

II. Prevent sexual violence and respond to the needs of survivors :

- work with other sectors and stakeholders to work with other sectors and stakeholders to put in place measures to prevent violence;
- make clinical care and support available for survivors of violence;
- ensure confidential and safe spaces within the health facilities for survivors of violence.

III. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs:

- establish safe and rational use of blood transfusion and standard precaution measures;
- ensure availability of antiretroviral therapy, post-exposure prophylaxis, condoms and lubricants, as well as co-trimoxazole;
- ensure the availability of syndromic diagnosis and treatment of STIs.

Additional priority: ensure availability of safe abortion care to the full extent of the national law.

IV. Prevent maternal and newborn morbidity and mortality:

- ensure availability of clean and safe delivery, essential newborn care and emergency obstetric and newborn care services;
- establish a referral system to specialists available 24/7;
- ensure availability of post-abortion essential services;
- ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable.

V. Prevent unintended pregnancies:

- ensure availability of contraceptives;
- provide information and counselling.

VI. Restore primary health care by replacing the MISP with integrated SRH services:

- search for and identify places for the delivery of care;
- ensure availability of trained staff;
- ensure collection of necessary information;
- arrange for supplies of medicines and medical products;
- arrange for financing of delivery of care;
- arrange for management of care process.

Inter-Agency Reproductive Health Kits (RH kits)[11].

To implement the MISP, standardized kits of medicines, medical products and other commodities were designed to deliver SRH care in humanitarian emergencies. These are Inter-Agency Reproductive Health Kits (RH kits)[11].

12 RH kits are designed for use at the onset of the humanitarian response. None of the equipment in the RH kits depends on electricity. The supplies contained in the RH kits are sufficient for a three-month period for the population size covered by the health facility targeted by each RH kits:

Set 1: RH kits 1-5 are intended for use on primary health care level for 3 months covering 10,000 persons.

Set 2: RH kits 6-10 are intended for use in facilities referred to by primary health care for 3 months covering 30,000 persons.

Set 3: RH kits 11-12 are intended for use on multidisciplinary hospital level for 3 months covering 150,000 persons.

Prospects and capacities in Kazakhstan

In 2021, relying on the revised guidance and tool for the assessment of country preparedness to provide MISP in crises, the Regional Office of UNFPA in Eastern Europe and Central Asia initiated a third round of assessment in the countries of EECA region.

Delivery of comprehensive SRH care in humanitarian emergencies is one of the objectives of the health sector. International experience has proven that country preparedness to humanitarian emergencies will save many lives.

The results of MISP preparedness assessment in Kazakhstan demonstrate some maturity of regulatory and civil defense frameworks which have a significant potential to improve specific preparedness mechanisms to deploy MISP.

[11]https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations

Results of the assessment in Kazakhstan

№	MISP Objective	What needs to be improved?
1.	Lead implementation of the MISP	1. National and regional humanitarian emergency response plans should present more details about: • prevention and response to gender-based violence; • prevention and reduced morbidity of HIV and other STIs; • prevention of unintended pregnancies. 2. Detailed protocols (standards) are needed for coordination and interaction in different humanitarian emergencies with various sectors and various healthcare facilities. 3. Indicators required for planning and estimating needs in MISP should be collected continuously and therefore they must be integrated into public information systems. 4. Rapid evaluation of crisis response should be implemented to improve preparedness of health sector. 5. Staff of government authorities should be trained in planning, interaction and deployment of SRH care in humanitarian emergencies. 6. Standards and rates for planning and estimation of needs in MISP, and mechanisms for procurement, storage and replenishment should be developed. 7. Mechanisms for emergency supply of RH kits related to family planning, STI prevention, mother and child health in humanitarian crisis should be in place.
2.	Prevent sexual violence and respond to the needs of survivors	1. Current standards of care make it possible to deliver necessary health care to survivors. However, psychological and social care covers only the initial needs of survivors while long-term follow-up and rehabilitation following violence remain uncovered. 2. Delivery of care to survivors of violence should be included into standards and algorithms of care delivery in humanitarian emergencies. 3. Mechanisms for planning, procurement, replenishment and supply of specialized kits to provide care following sexual violence should be in place. 4. Staff of healthcare facilities should be trained in deployment and delivery of care to survivors of violence in the context of humanitarian emergencies.

№	MISP Objective	What needs to be improved?
3.	Prevent the transmission of and reduce HIV and other STI morbidity and mortality	1. In Kazakhstan, the standard for rational and safe use of blood transfusion is in place. However, this standard does not cover safe blood transfusion in humanitarian emergencies. 2. Mechanisms for planning, procurement, replenishment and supply of specialized kits for STI treatment and kits containing condoms should be in place. 3. Staff of healthcare facilities should be trained in deployment and delivery of care to prevent transmission of STIs and HIV in the context of humanitarian emergencies.
4.	Prevent maternal and newborn morbidity and mortality	1. Mechanisms for the delivery of obstetric and neonatal care in humanitarian emergencies should be specified in detail, including delivery of care and patient pathways depending on the type of emergency. 2. Mechanisms for planning, procurement, replenishment and supply of specialized kits for (1) individual obstetrics, (2) birth attendants, (3) hospital-based obstetrics, (4) cervical and vaginal stitching, (5) management of premature delivery and complications following abortion should be in place. 3. Staff of healthcare facilities should be trained in deployment and delivery of mother and child care in the context of humanitarian emergencies.
5.	Prevent unintended pregnancies. Ensure availability of safe termination of pregnancy to the full extent of local legislation	1. Kazakhstan has a referral system to provide access to short- and long-term contraception which may be adapted in humanitarian emergencies. However, contraceptives are not included in the statutory scope of free health care or mandatory social health insurance. 2. Mechanisms for planning, procurement, replenishment and supply of condoms, oral and intrauterine contraceptives should be in place. 3. Mechanisms for planning, procurement, replenishment and supply of kits to manage terminated pregnancy, including complications following terminated pregnancy should be in place. 4. Staff of healthcare facilities should be trained in deployment and delivery of care to prevent unintended pregnancy.

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