



**KIT | Health**

## **Sexual and Reproductive Health and Rights in Fragile Environments**

*Turning challenges into opportunities*

Symposium 10 December 2015, KIT, Amsterdam



**KIT**



**HealthNet<sup>TM</sup>**



## *Sexual and Reproductive Health and Rights in Fragile Environments.*

### *Turning challenges into opportunities.*

#### **KIT – HEALTH Symposium, 10 December 2015**

##### **Introduction**

Over half of all maternal, newborn and child deaths occur in around 50 countries categorized as fragile states. Fragile states have some of the worst health statistics in the world, especially with regard to the health of women and children. Nearly two-thirds of fragile states will fail to halve extreme poverty by the end of this year- the deadline of meeting the Millennium Development Goals (MDGs). The Sustainable Development Goals (SDGs) are set to repeat this pattern without targeting people in conflict and fragile environments. A different approach is needed.

In fragile states, delivery and scaling up of reproductive health services is more difficult than other low-income settings. This is due to poorer governance, severe human resource and financial constraints, the lack of supplies and infrastructure, and particular problems faced by the communities. Under these circumstances family planning is often particularly neglected. Resource constraints are further worsened both by a contested policy environment and a reliance on international aid, which frequently comes with unpredictable and unstable funding.

Despite all these challenges and constraints, progress can be made when strategies are applied which are comprehensive and multidimensional. Strategies that have had most impact have moved beyond medical interventions only, adopting a combined approach to include girls' education, work on increasing the age of marriage and first pregnancy, family planning and abortion services and efforts to reach out to young people.

##### **The symposium**

On December 10<sup>th</sup>, 2015, the Royal Tropical Institute (KIT) hosted a symposium titled 'Sexual and Reproductive Health and Rights in Fragile Environments. *Turning challenges into opportunities*'. The symposium was organised in collaboration with Cordaid, the International Medical Corps, HealthNetTPO, Share-Net International, and the Ministry of Foreign Affairs of the Netherlands.

The aim of the symposium was to learn from and share evidence-based information of existing SRHR programmes and researches conducted about sexual and reproductive health in fragile environments. Four topics were explored more in-depth throughout the sessions:

1. Sharing ways how to optimize supply and delivery of SRH in fragile environments
2. Responding to the Sexual and Reproductive Health needs of adolescents in fragile environments
3. Diving deeper into community factors –e.g. gender inequality, social norms/preferences- that influence the uptake of SRHR services in fragile settings
4. Financing for SRHR response in fragile environments; global developments

The symposium was facilitated by **Sally Theobald**, Professor in Social Science and International Health at the Liverpool School of Tropical Medicine in the UK. Thanks to the 18 speakers from different countries –most of them fragile states- and the session facilitators, the symposium offered a space

for inspiring discussions and recommendations for future interventions. About 120 participants joined the meeting from all continents in the world, practitioners in the field of SRHR, fragile settings, humanitarian and development aid, policy makers, researchers, consultants, donors and students.

The recommendations and lessons learned during the symposium will be further addressed through five webinars that will be organized throughout 2016. In addition the organising committee has expressed its interest to organise a second symposium by the end of 2016 on SRHR in fragile environments. The continuation of these learning processes on SRHR in fragile environments is vital to reinforce the sexual and reproductive health and rights, and maternal and child health of many resilient women, men and adolescents living in fragile environments.

### Opening sessions

**Dr. Alexander Dimiti**, Director General Reproductive Health of the Ministry of Health (MoH) in South Sudan, described the SRHR situation in his country. South Sudan has one of worst maternal and child health indicators in the world. The number of teenage pregnancies is high. Access to healthcare is complicated due to scarce human resources and a displaced population. The MoH is looking for strategies and support to improve this situation, for example to attract and retain health workers, have minimum package of Emergency Obstetric Care in place, and to ensure the quality of services.

**Yvonne Stassen**, Adjunct Director Ministry of Foreign Affairs (MoFA), also emphasized the strong need to address SRHR in fragile states. Sexual violence is used as a weapon to humiliate men, women and children. This leads to more hostilities as people protect girls and women. Attempts to safeguard adolescent girls from violence lead to higher numbers of early marriage and therefore early pregnancy. However, often violence takes place in the domestic sphere. Other problems in fragile settings include unsafe abortions, deliveries without skilled birth attendants, increasing HIV infections, collapsing health care systems and the fleeing of qualified health workers. Women and girls should be better engaged in meeting their own needs, as actors of change. Males should be involved. A selection of Dutch government-supported programmes to address SRHR were highlighted, both through diplomatic as programmatic strategies.

**Egbert Sondorp**, Senior Advisor Health Systems KIT, presented the complexity of fragility. Over time, several definitions have been used for fragile states. Despite the diversity of fragile states, they have one thing in common: they have weak institutions. Other characteristics of fragile states are: poor governance, insecurity, poverty, and sometimes armed conflict. Fragile states made the least progress in reaching the MDGs, especially MDG 5 on reduction of maternal mortality. Three possibilities for further discussion were presented on what to do to address SRHR in fragile environments: Wait till fragility is over? Promote SRHR despite the fragility? Promote SRHR and reduce fragility? He ended with the demonstration of a video on the experiences from the South Sudan Health Action Research Programme SHARP.

<https://www.youtube.com/watch?v=fwP34oky9X4>

During the question and answer session, the following issues were discussed:

- The influx of refugees from fragile into non-fragile states is a problem for those neighbouring states, forming a difficult dilemma. It disrupts their health system and SRHR indicators worsen.
- Working with male perpetrators -from the army or rebels- of sexual and gender-based violence (SGBV) forms an opportunity to influence their behaviour towards women. The Dutch MoFA

supported programmes where military/rebels are asked to reflect about sexual violence. Despite some progress more efforts are necessary and women leaders need to be engaged.

- Donor models have not adjusted sufficiently to match the needs in emergency situations. They focus mainly on the acute emergency and refugee camps using traditional funding cycles. The post-emergency situation and the large numbers of internally displaced people (not living in camps) also need attention. The MoFA both supports SRHR programmes in fragile settings as well as other forms of humanitarian programming from within (e.g. through UNFPA) which are also powerful.

## Parallel sessions and debriefing to the plenary audience

All presentations are available at the KIT health website: <http://www.kit.nl/health/symposium/>

### 1. Sharing ways how to optimize supply and delivery of SRH in fragile environments

The supply and delivery of SRHR services and commodities is crucially important, especially in fragile states. Three presenters shared ways how their organizations tried to optimize supply and delivery in their contexts: Sarah Ashraf (Save the Children), Melissa Sharer (JSI/IAWG), and Ashraf Badr (Marie Stopes International Yemen). The topics discussed during the parallel session and the debriefing in the plenary session are summarized below.

SRH became a focus within humanitarian aid in the mid-nineties, when the Inter Agency Working Group of Reproductive Health in crises (IAWG on RH) was formed by UN agencies, NGO's and Governments. This group developed the field manual 'Minimal Initial Service Package' (MISP) for reproductive health, which was included in the existing Sphere minimal standards for humanitarian support. The MISP has 5 objectives: 1) ensure the health sector/cluster identifies an organization to lead implementation of the MISP, 2) prevent sexual violence and assist survivors, 3) reduce transmission of HIV, 4) prevent maternal and newborn mortality, and 5) plan for comprehensive RH services, to be integrated into primary health care (PHC). Pre-packaged 'Inter-agency Reproductive Health Kits' were developed with essential drugs, equipment and supplies needed to provide reproductive health care in crises, to enable the implementation of the MISP.

One of the findings from an evaluation of the IAWG in 2014 (including programmes in DRC, Burkina Faso, South Sudan, Jordan), was that systems of logistics and supplies were dysfunctional. There are many supply chain challenges to get the kits and other commodities to the local health services in a short period of time, including transport problems, kits being insufficiently responsive to the context, and wastage. In addition, WHO and UNFPA did not align their efforts to distribute kits, leading to parallel systems. A strong appeal was made on these agencies to improve the coordination of efforts. Participants also emphasized the importance of a better coordination of supply and delivery of SRHR services between all the different actors: local health authorities, the MoH –if still functional-, international and national NGOs, and UN agencies. The existing health system needs to be used and strengthened when necessary.

An extremely important element of SRH services in fragile states is family planning (FP). Due to lack of supply, FP use declines, leading to unwanted pregnancies and unsafe abortions. More attention should be given to FP, including long-acting reversible contraceptives (LARCs). FP methods are not in the MISP and should be included.

Furthermore, there is a need for alternative solutions to bring supplies into the country and to the end users. Methods mentioned to get it into the country are transport companies such as DHL or airfreight. Countries would need to have a preparedness plan with a list of available certified suppliers that can be resorted to in case of an emergency. Getting supplies to the local health services and end users is even more difficult, due to the poor security situation (roadblocks, airstrikes) and shortages of fuel. The use of local entrepreneurs can be explored. MSI Yemen has supported social franchises to provide SRH services in hard-to-reach areas, and used bicycles or public transport to overcome the fuel problem. Services like SGBV counselling were provided by phone. Operational health facilities could be given more autonomy to procure their own supplies.

Health workers in fragile states tend to leave the health facilities due to a very poor security situation. As a consequence these facilities close. Health care providers staying cannot move to affected communities. Solutions have been to work through NGOs or local district health offices, instead of through central government systems. Electricity cuts are another problem that was solved by a solar system for electricity by MSI Yemen.

Emergency obstetric care is a crucial service in fragile settings where women continue to get pregnant and deliver, and where the number of abortions is likely to increase. In emergency or conflict situations these services are often of poor quality or unavailable. Basic emergency obstetric care should be integrated in PHC, where people can also access services beyond SRH, such as drinking water, food, and life-saving care.

The term 'sexual and reproductive health and rights' may have to be adapted according to the local context, e.g. to 'reproductive health'. Topics such as comprehensive abortion care, access of youth to contraception and even family planning may be sensitive and often not accepted by governments or societies. Still, policies need to be adapted to enable the delivery of SRHR services, also in fragile situations. For example, the use of Manual Vacuum Aspiration (MVA) for Post-Abortion Care (PAC) by midlevel providers and the development of guidelines for care to victims of SGBV.

The question raised from the parallel to the plenary session was: ***How can we scale up innovative practices that improve services and commodity security?***

During the discussion of this question in the plenary session, participants came up with a series of ideas, including the use of mobile technology to mobilize (especially young) people, the use of publicprivate partnerships and social entrepreneurship, the improvement of communication between UN agencies for quick scale up, and the implementation of research on effective interventions to inform scale up.

***Recommendations:***

- Family Planning is a basic reproductive health service and right; it should be part of the MISP and the kits.
- Find alternative ways of distributing supplies to health facilities in fragile settings.
  - Create public private partnerships. ○ Using private entrepreneurs.
  - Allow health facilities to procure their own supplies if they can.
  - Preparedness; have list of available certified suppliers ready; be aware of the essential medicines package in a certain country.

- Work through the existing health system.
- More coordination between WHO and UNFPA and international and national NGOs.

## **2. Responding to the Sexual and Reproductive Health needs of adolescents in fragile environments**

Adolescents are especially vulnerable in crisis situations. The experts Janet Meyers (International Medical Corps), Mihoko Tanabe (Women's Refugee Commission - WRC), Michel Zabiti and Juvenal Ndayishimiye (Cordaid), and Lotte Dijkstra (CHOICE & Youth Ambassador MOFA) gave presentations on strategies to respond to the SRH needs of adolescents in fragile contexts. Discussions followed in the parallel session and in the plenary debriefing session.

The very young adolescents (between 10 and 14 years old) are a vulnerable but often neglected subgroup. They are in a crucial behavior forming phase that impacts their future health. Pregnancy and childbirth in this age group can lead to serious morbidity or mortality of the adolescent and the newborn. In fragile settings, their risk to early pregnancy increases while the access to SRHR information and services is decreased. A research study performed by an international consortium<sup>1</sup> in Ethiopia showed that very young adolescents face problems as poverty, being forced to work, limited access to school inhibiting development of aspirations and social progress, early marriage often resulting in early pregnancy, and sexual violence towards girls but also boys. Service needs also included menstrual hygiene and SRH information.

Adolescents with a disability face additional problems. Findings of a study in Kenya, Nepal and Uganda (amongst others) showed that attitudes of providers are a barrier to access SRH services, that they face risk of molestation or forced abortion, and that marital status will make a difference in treatment of women and girls with a disability. A tool was developed to identify at risk adolescents ('I'm here approach').

The programme 'Next Generation' by Cordaid addresses the SRH challenges for young people in Burundi, DRC and Rwanda. It aims to reduce unwanted pregnancies and maternal mortality among young people, by providing information, giving access to contraceptive methods and other commodities, and enable public and private clinics to provide SRH services. Youth-friendly approaches are used such as comprehensive sexuality education using tablets, youth involvement and peer educators.

Adolescents are often mostly seen as the target population, and not as actors. Throughout the presentations, the importance of meaningful engagement of adolescents in research and advocacy programmes was emphasized. They should be at the centre of programme design, implementation, and decision-making. To this end, the use of participatory approaches is the most appropriate, e.g. through body mapping, safety mapping, timeline, and sorting.

Short term funding was identified as a problem, as it hinders gender transformative change in relief and humanitarian aid.

The group recommended to build on lessons learned and existing evidence; new research or innovations are not always necessary. Furthermore, efforts to respond to the SRH needs of

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<sup>1</sup> Johns Hopkins, Women's Refugee Commission, IMC, Save the children, Adolescent reproductive health network, American University in Beirut



adolescents should be more coordinated at all levels: governments, donors, researchers, local communities. By joining forces and discussing actions, overlap can be avoided and efforts can be strengthened.

The question that came up during the parallel session was: ***How can adolescents effectively contribute to change in the situation of fragility? Will investing in ASRHR lead to fragility reduction?***

During the plenary discussion, the group agreed that adolescents can become strong agents of change and should be given a platform for action. They can be supported to do so, for example by engaging young people in the whole cycle of interventions to ensure ownership, or through their education. Furthermore, youth actors have many ideas but are not very experienced in the technical part to get donor funding. They need some capacity building to approach donors. For a real transformation of society, power relations will also need to be tackled, and youth and women given the right to talk.

***Recommendations:***

- Meaningful engagement and leadership of (diverse groups) of adolescents.
- Coordination (funding) of donors, programmers, researchers, communities.
- Invest in scaling up good practices.

**3. Diving deeper into community factors –e.g. gender inequality, social norms/preferences- that influence the uptake of SRHR services in fragile settings**

During the parallel session on community factors influencing the uptake of SRHR services in fragile settings, three presenters shared their work with the participants to the parallel session: Primus Che Chi (Doctoral Researcher PRIO), Maryse Kok (KIT), and Elisabeth Wayamba (HealthNet TPO South Sudan). Results of the discussions and recommendations were debriefed to the plenary group.

The studies presented demonstrated that (mostly pre-existing) social and cultural factors influence the access to SRH services. In the countries where the studies took place (Burundi, Uganda, South Sudan), SRHR is a sensitive topic and talking about issues around sexuality is taboo. The poor uptake of SRHR services is further exacerbated by conflict and war, causing that people are fleeing or displaced, that health services are destroyed, that no health personnel is available, and that community and family structures break down.

While the countries are different in context, several cultural, religious and social factors identified by the presenters were comparable. For example, women were expected to marry at an early age, and having many children was considered normal. Women may also fear to use contraceptive methods. In South Sudan, knowledge on child spacing was actually high but not implemented. Moreover, in fragile settings child spacing may not be a priority as families want to ‘replace’ family members lost in the war.

Traditional gender roles and community expectations were other important factors influencing access SRH services. The studies showed that men have the decision-power. Husbands need to approve the use of contraceptive methods. The men or mothers-in-law, and sometimes the community leaders, should give permission for women to access the health services.

In Burundi and Uganda, women were reluctant to access services due to bad experiences in the health facilities formed a barrier, including unfriendly provider attitudes, having to pay, feeling uncomfortable, and in Burundi - ethnic discrimination. They also feared for a lack of confidentiality and privacy. In South Sudan, the poor quality of the services offered, distance to the facilities and a low risk perception were also reasons for not seeking care.

Interventions ongoing or proposed include working with communities on the acceptability of contraception, strengthen male involvement, increase the quality and financial accessibility of the services, to provide comprehensive sexuality education, support education of girls and women, and improve policies to improve access to SRH services. Health net TPO has guided this process in South Sudan through generational dialogues with the older and younger generations, of men and women, and boys and girls. They reflect on how to improve the sexual and reproductive health and plea for action in the communities.

One of the conclusions from the discussion was that it is not important to put a label 'fragile' or 'notfragile' on a community. The division of a society in conflict or post-conflict is fluid, and conflict is not the only issue that plays a role in access and uptake of SRHR services. It seems better to look from the reality of the community and adapt interventions accordingly.

The question raised was ***whether norms, preferences and expectations regarding SRHR actually differ between communities in fragile and non-fragile settings?***

In the plenary group's discussion one of the differences brought up was that in a fragile setting, the SRHR package is not comprehensive. It includes mainly maternal health and sometimes SGBV. Family planning is difficult to introduce. Sometimes fragility can also cause a positive spin, for example in Burundi, where women became empowered and social norms started to change. Another example is the education women receive in refugee camps, they would otherwise not have received. Engagement of multiple players from multiple sectors to discuss problems and ways to address them has worked for Cordaid, through inter-sectoral community committees.

***Recommendations:***

- Programmes should have the community reality as the basis, therefore community engagement and decision making is vital for developing programmes and strategies.

**4. Financing for SRHR response in fragile environments; global developments**

Throughout the dedicated parallel session and the plenary discussion, financing of SRHR in fragile states was one of the key topics raised. Marco Gerritsen (Dutch Ministry of Foreign Affairs), Maria Bordallo (IPPF), and Remco van der Veen (Cordaid) presented their views on the global developments in financing for SRHR responses in fragile environments. The discussions and recommendations were debriefed in the plenary.

SRHR is part of several international development agendas, including the SDGs, the Global Strategy for Women's, Children's and Adolescents' Health and others. The system of financing system is complex, overlapping, and operating at different levels (multilateral, bilateral, national). Still, a large funding gap remains for SRHR globally, and the funds available are not spent efficiently.



In order to promote financial sustainability of funding, countries need to shift away from Official Development Assistance (ODA), and increase domestic resources. This can mean a decrease of funding in real terms.

In 2015, the Global Financing Facility (GFF) was launched as a new financing mechanism to close the funding gap by mobilizing domestic resources from both public and private sectors. Financing is mobilized from three key sources: domestic financing (public and private), GFF Trust Fund and International Development Assistance (IDA)/International Bank for Reconstruction and Development (IBRD) resources, and additional donor resources. It focuses on the 'best buy' interventions, prioritizing interventions with a strong evidence base demonstrating impact, and focusing on improved service delivery to ensure an efficient national response. The idea is to generate a leveraging effect, as investments can be multiplied by loans from IDA and IBRD and private investors are brought in through social investment bonds. So far, USD 875 million has been committed, with 62 countries being eligible.

The lack of funding for SRHR is further exacerbated in fragile states. From the shrinking pie of ODA, SRHR funding for fragile states is not prioritized over SRHR programmes in other countries. At the same time, the GFF is hard to access by fragile states given the importance of domestic resources. These resources are scarce and taxation is problematic.

This leads to high client out-of-pocket (OOP) spending which may increase the barriers to care or lead to catastrophic costs for people, while the quality of services is often poor. Models of remittance of OOP or micro-transfers may be an alternative for centralized funding and ODA in often corrupt governmental systems.

As a result of the parallel session, the following question was raised regarding the 'shrinking pie' – ***should we ask for more SRHR funding or a broader focus in health systems strengthening (HSS)? How do we get a bigger size of the pie for SRHR?***

Opinions in the plenary group varied. Some called for advocacy for specific SRHR funds as it does not appear otherwise in other government budget lines, because governments may be reluctant to spend on sensitive topics such as abortion, and because in a country with a collapsed health system specific areas need to be prioritised and supported. Others believed that investing in health systems strengthening is a better option as it increases service coverage, is more sustainable, and it has a broader influence on society touching upon social norms, culture and education.

The group also discussed complications related to ODA and other international donors: the tendency that in countries that receive ODA often reduce their domestic resources, volatile aid cycles, and the focus of funding agencies on acute emergencies.

#### ***Recommendations:***

- More research is needed, emphasizing the research-policy-practice cycle. Topics for research include:
  - The effects of out-of-the-pocket spending for families and communities.
  - The interaction between ODA and domestic funding.
  - The effect of volatile aid cycles.
  - Strategies to increase bottom-up funding, rather than relying on donor priorities and topdown government programmes.

- Strategies to increase allocation of resources for SRHR and avoid wastage of funding.
- Harness the power of the private health sector. Explore strategies to add services of the proliferated and unregulated private providers in fragile states.
- Accept the new realities (related to demographic changes, resources, climate change, trade or other) and opportunistically grab the chances (e.g. the GFF).

### Panel discussion

During the panel discussion, the panellists, Dr Alexander Dimiti, director general ministry of Health South Sudan, Lucy Barh Associate president Liberia Midwifery association, Primus Che Chi Doctoral Researcher PRIO, and Jesse Rattan Programme Director on SRHR in emergencies of Care, were to respond to the central question: *'SRHR in fragile environments: How to make a difference?'*. The members of the panel were given a four-minute opportunity to give their answer to this question.

*Dr. Alexander Dimiti* described South Sudan's Ministry of Health's ( MoHs) commitment to make a difference in SRHR by addressing three of its major challenges: the shortage of human resources, adolescent SRHR (youth in and out of school), and the SRHR of the population living in rural areas. Within the framework of the Sustainable Development Goals (SDGs), the MoH aims to increase investments and strengthen its health system to achieve this, with the support of the international community. He emphasized the need for an exit strategy of international donors to avoid collapse.

*Primus Che Chi* emphasized the need for incorporating contextual factors in the delivery of interventions in fragile settings, in order to make a difference. He made a case for conducting more implementation research, as an essential component for scaling up interventions, and for synthesizing the evidence to make it easily accessible for policy makers.

*Jesse Rattan* stressed the importance of making contraception and safe abortion care available. In addition, she highlighted the resilience of community leaders and the opportunities posed in fragile contexts: maximum learning, creativity and flexibility is demanded. She called for working in partnership, sharing and learning.

*Lucie Bahr* from Liberia called for more investment in SRHR to address the high numbers of maternal mortality and teenage pregnancy in her country, and to inform community leaders to break taboos and count with their commitment. Furthermore, she made a compelling call to invest in midwives and empower them; this will make the difference in SRHR.

The panel discussion continued with the discussion of questions posed through Twitter and by the audience. The first cluster of questions centred on **funding resources and priority settings**. Highlights of the discussion were:

#### *Investments*

- Dr. Dimiti - An emergency obstetric care needs assessment in South Sudan identified the need for referral health care centres, where comprehensive EmOC can be provided. The MoH came up with an investment plan. The budget in South Sudan for Health has gone down to 4% and the budget for Reproductive Health is almost negligible.

### *Accountability*

- Mr. Che Chi – The Abuja Declaration is a usable tool for programmes. Countries need to be held accountable, they need to implement the declarations they signed up to. Rwanda is a good example where tremendous improvements were made.

### *International collaboration and donor dependency*

- Mrs. Barh – In Liberia the whole health system has broken down because of years of conflict and the impact of Ebola. Health workers were infected and died. The condition of roads is very bad. The country is highly donor dependant. The governments need to see what they can do to stand on their own.
- Dr. Dimiti – Even if governments try to contribute, they value collaboration with international donors, such as the Dutch Ministry of Foreign Affairs (e.g. the SHARP consortium). These collaborations and scholarships for frontline workers are very beneficial.

### *Keep advocating*

- Mrs. Rattan – We can also be positive on the progress made, maternal mortality is reduced. We gave voice to these issues. Money does follow the attention. We have to hold up the need within the budgets, otherwise it becomes invisible.

Questions and comments around **gender, power, and livelihood in fragile setting** were:

### *Family planning and other SRHR services, engagement of men*

- Mrs. Barh – You have to inform men about the different types of FP methods and motivate them.
- Mrs Rattan - Involving men is like a slow cooker, it takes a while, you have to be gentle, and open the dialogue. Care created spaces to open the discussion in the communities. They worked with police and military on unsafe abortion, all could tell a story of a woman dying or fleeing. People's deepest values are universal. There was energy to tackle these norms. Men made commitments on zero tolerance on violence. Partnerships are possible across multiple layers.
- Mr. Che Chi – We have to include long-acting and permanent methods of FP. This can create a problem, as partners are often not cooperative. You have to think about what is in it for the men. Let them know the choices they have, and address their needs too.
- Dr. Dimiti – In South Sudan, health workers were trained to do manual vacuum aspiration (MVA) for women with incomplete abortions, and traditional birth attendants (TBAs) were trained to use misoprostol for women with postpartum haemorrhage in the communities.

### *SGBV*

- Dr. Dimiti- While SGBV is happening at a great scale, talking about rape is taboo. However, survivors need to be provided with PEP for and emergency contraception. Illiteracy is a huge problem. UNFPA started husband schools in Niger which is a good example to work with men. Also females need to be empowered and girls need to finish school, to prevent teenage pregnancies. Social mobilization is needed for decision-makers, parliamentarians, communities, and husbands to make informed choices.
- Mr. Che Chi – SGBV is seen as normal in some countries. We have to say it is not normal and not right.

### *Livelihood*

- Dr. Dimiti – many women in South Sudan have obstetric fistula. They become outcasts. In a campaign they are offered treatment, and afterwards business training and seed money to start their own enterprise.

A third round of discussion was held around the theme of **models and approaches** of intervention:

- Mr. Che Chi –recommended a review Sara Casey on an evaluation of humanitarian interventions – maternal, newborn and reproductive health interventions in conflict and disaster situations.<sup>2</sup>
- Dr. Dimiti – South Sudan established a General Medical Council for physicians.
- Mrs. Barh – there is a need to address emergency preparedness – health workers need to be trained, materials and drugs need to be available, and there needs to be a conducive environment. All need to be on board of trainings, especially community leaders.
- Mrs. Rattan - Preparedness can be achieved through ensuring core skills of frontline workers, availability of long-acting methods FP, prepositioning supplies and stock, rapid training using anatomical models, innovations, engagement, respect and conversation.

### **Conclusions, follow up and closure**

The concluding remarks of the panellists were:

1. Acknowledge fragile states as places of resilience and opportunity.
2. Strengthen health systems of fragile states.
3. Ensure a professional midwife association in fragile states, empowered to make a difference.
4. Accelerate the production of human resources that are quality minded.
5. Work on the equity challenges in SRHR in fragile states.
6. Ensure a sustainable exit strategy of international partners.

Concluding thoughts across the room included that research should be used as part of action; evidence is needed to know what works, adequately respond to priorities and scale up. One of the participants remarked that we should keep in mind the women that touched our heart, and think about what each of our organizations or government can do and be the voice of these women, to really make a difference. Let us all be part of the solutions, with our different backgrounds and different strengths.

Many ideas came up from the debates and groups on *what* to do. In a fragile setting with weak institutions, the challenge will be to figure out *how* to implement the ideas. There is much work ahead to strengthen institutions, civil society and communities.

### **Overall Conclusions**

- Resilience and opportunity - Fragile states offer surprising opportunities to bring about changes. Examples are the use of entrepreneurship, mobile technology, mobilization of community leaders and society for addressing sensitive issues, and accelerated women empowerment.

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<sup>2</sup> Sara E. Casey ( February 2015) Evaluations of Reproductive health programmes in humanitarian settings: a systematic review <http://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-9-S1-S1>

- Financing – Traditional funding cycles need to be changed to respond to needs of fragile states: more flexible, including SRHR, including post-emergency period, and including adequate exit strategies. GFF is hard to access given the emphasis on domestic contributions that are scarce in fragile states.
- Health providers - Strategies need to be found to retain health workers. Midwives are key for SRHR services provision in fragile settings.
- SGBV – Huge problem. More interventions needed with male perpetrators, with society (break taboos on rape), improve services to victims ( male & female) (PEP, EC, safe abortions, have guidelines in place)
- Inclusive partnerships are key - Between UN organizations, between donors and governments, between programmes and target population (e.g. adolescents).
- Health system strengthening – To provide SRHR services in addition to other services that are crucial in fragile settings.
- Emergency preparedness – more efforts are needed to improve preparedness, in order to avoid complete breakdown of the health system.
- Implementation research – More evidence is needed to know what works, to scale up successful interventions, and to convince donors of the need for more funding.

Report written by Marieke van Dijk