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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Expert meeting to discuss good practices, gaps and challenges in the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity in humanitarian settings

Summary report of the United Nations High Commissioner for Human Rights*

Summary

The present report is submitted pursuant to Human Rights Council resolution 39/10. As requested in that resolution, the United Nations High Commissioner for Human Rights organized a two-day meeting on 7 and 8 May 2019 in Geneva to discuss good practices, gaps and challenges in the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity in humanitarian settings. The present report is a summary of the discussions which took place at that meeting.

* Agreement was reached to publish the present report after the standard publication date owing to circumstances beyond the submitter's control.

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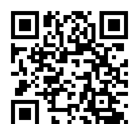

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I. Introduction

1. In resolution 39/10, the Human Rights Council requested the United Nations High Commissioner for Human Rights to organize a two-day meeting in 2019 to discuss good practices, gaps and challenges in the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity in humanitarian settings. The Council also requested the High Commissioner to prepare a summary report on the meeting and to present it to the Council at its forty-second session.

2. The present report is submitted by the High Commissioner in response to the Council's request. In it she summarizes the discussions held and interventions made by the experts, including their examples of good practices, gaps and challenges, as well as recommendations. The expert meeting was held in Geneva on 7 and 8 May 2019 and brought together 35 experts from a diversity of backgrounds and nationalities.

3. The discussion at the expert meeting was informed by Council resolution 39/10, initial reflections highlighted in the follow-up implementation report to the Council (A/HRC/39/34), inputs from key stakeholders and United Nations partners, and the work of humanitarian service providers, coordinating bodies and other stakeholders active in this area. Relevant documents for the meeting are available on the website of the Office of the United Nations High Commissioner for Human Rights (OHCHR).[1]

II. Building common understanding

4. The experts sought to establish a foundation and common understanding among a diversity of experts. This included a discussion on the concepts and language used and applicable legal and policy frameworks, as well as on shared goals, approaches and principles among different constituencies active in humanitarian settings to advance sexual and reproductive health.

A. Legal framework

5. On the applicable legal frameworks and their interlinkages in humanitarian settings, the significance of human rights law as the general body of law that cuts across all contexts and remains applicable in each type and stage of an emergency was emphasized. Experts also highlighted the importance of international humanitarian, refugee and criminal law, including how all bodies of international law reinforce one another.

6. Experts also specifically emphasized the relevance of emerging international disaster law, which is elaborated by the International Law Commission in its draft articles on the protection of persons in the event of disasters (A/71/10, chap. IV.E). Although human rights and humanitarian response feature centrally, the draft articles omit sexual and reproductive health, gender-based violence and other gender-specific concerns. They are also still open for comments by the General Assembly and this was identified as a possible area of attention.

7. The importance of a robust international legal framework to assist and protect affected women and girls and their sexual and reproductive health and rights is broadly accepted. Experts found that the challenge is comprehensive practical implementation. Articulating a human rights-based approach to policies and programmes in humanitarian settings can therefore add value, in particular when it concerns ensuring there is rights-based accountability for every woman and girl, tailoring humanitarian action to their views, lived experiences and needs.

[1] See www.ohchr.org/EN/Issues/Women/WRGS/Pages/FollowUpReport2018.aspx.

8. In certain contexts, the question of which law is applicable creates challenges and tension, particularly when national laws, policies and practices contradict international legal obligations of States. These may be misunderstood or directly or indirectly discriminate against women and girls. In addition, emergency contexts influence the ways in which criminal laws are deployed against certain population groups, such as in the context of counter-terrorism or irregular migration or in relation to certain services or conduct, such as the provision of reproductive health care, sexual conduct between consenting adults, HIV transmission and adultery. Application of a human rights-based approach can play a complementary role in clarifying, identifying, preventing or advocating against such laws and policies.

B. Human rights-based approach

9. The experts clarified that a human rights-based approach is based on and seeks to advance international human rights norms and standards. They explained that the main elements of the technical guidance (A/HRC/21/22 and Corr.1 and Corr.2) are valuable for application in humanitarian settings. They provide a unique lens through which to identify gaps and challenges and strengthen humanitarian preparedness, response and transition, as well as identify situations that are contrary to human rights. Experts also observed that a human rights-based approach is similar and mutually necessary to medical ethics and that it can be adaptable to different contexts and phases of an emergency.

10. The discussions revealed a need to raise awareness among a variety of actors working in humanitarian contexts about human rights standards and to demystify what applying a rights-based approach means in practice. For example, rights-based accountability is often perceived as being only concerned with courts, individual liability and blaming service providers, rather than holistically aiming to strengthen health systems and creating enabling environments for the realization of rights.

11. Furthermore, experts emphasized that human rights are for everyone, including health workers. The conditions in which health providers undertake their professional responsibilities, particularly in humanitarian settings, are often precarious, without dependable wages and characterized by high levels of stress. A human rights-based approach exposes these realities and works to identify solutions whereby health workers' rights are also respected.

12. Experts also noted that affected populations can often be seen in humanitarian settings as "beneficiaries" of services provided as "charity", rather than this being a matter of rights. It is important to dispel misconceptions about human rights and strategize on how a rights-based approach can best be applied in practice, if not in name. For instance, efforts have been made to bridge the languages of different disciplines and to unpack terminology and concepts in accessible and operational language, which has assisted in ensuring local buy-in and acceptability by providers and affected populations.

13. As more attention today is directed towards applying a human rights-based approach in humanitarian settings, experts also noted that different actors often use the term to describe specific aspects of programmes and their implementation rather than an overall approach. Some elements of the approach, such as understanding accountability to also include effective remedies and redress, may therefore receive less attention.

14. It was observed that human rights violations are a common denominator which underlie and are exacerbated in most humanitarian settings. Incorporating human rights systematically into humanitarian preparedness and response is therefore an important avenue for understanding, recognizing and addressing root causes of crisis and developing sustainable programming.

C. Commonalities

15. Experts emphasized that, although the terminology and languages may vary, human rights and humanitarian actors have common goals, frameworks and core principles.

16. Highlighted were the centrality of affected people and localization, correlation between the principles of non-discrimination and impartiality, and linkages between the rights to life and health and the humanitarian principle of humanity. Moreover, humanitarian actors working on sexual and reproductive health also often discuss ensuring the availability, accessibility, quantity and quality of services as good medical practice. This is central in the normative content of the human right to health.

17. Strengthened linkages between human rights and humanitarian action concerning maternal and newborn health is also evident through developments in the Inter-Agency Working Group on Reproductive Health in Crises and the organization Sphere, where concerted efforts have been undertaken to strengthen bridges between the different constituencies. In 2018, the revised *Sphere Handbook* re-emphasized and strengthened its rights-based foundations.[2] In the same year, the Inter-Agency Field Manual on Reproductive Health in Crisis was also revised with human rights as its core principle.[3] Experts also noted processes such as the Global Roadmap for Improving Data, Monitoring and Accountability for Family Planning and Sexual and Reproductive Health in Crises and subsequent technical consultations.

18. Human rights and humanitarian actors were encouraged to collectively build on these efforts and seek to harmonize them with several other technically oriented processes and developments at the global level to flesh out and integrate human rights norms and standards in different humanitarian spaces, including in the context of Women Deliver, the Inter-Agency Standing Committee, and the anniversaries of the International Conference on Population and Development, the Fourth World Conference on Women and the adoption of the women, peace and security agenda.

19. At the same time, experts also acknowledged challenges. Some of these relate to misconceptions about human rights, including particularly the normative content and applicability of economic, social and cultural rights in humanitarian settings. In practice, this may exclude ensuring an effective remedy in the context of service roll-out and delivery and inhibit closer collaboration between humanitarian and human rights actors. Other challenges relate to navigating the politics of maintaining access to affected populations in complex environments, the reality of operating in insecure settings and the difficulty of providing immediate, urgent medical care which displaces attention to systematic health-care needs and the inequalities that may restrict its provision.

D. Rights holders and duty bearers

20. A human rights-based approach identifies who has rights (rights holders) and what freedoms and entitlements they have under international human rights law, as well as the obligations of those responsible for making sure rights holders enjoy their rights (duty bearers).

21. Experts identified as rights holders affected populations, host populations, internally displaced persons and refugees, among others. With respect to duty bearers, experts stressed that there is a need to insist on the legal accountability of the State as the primary duty bearer to affected individuals. This includes obligations to ensure and maintain access of humanitarian and human rights actors when assistance is required and preventing premature shutdown of humanitarian operations.

22. Experts also explained that the primary responsibility of the State must be viewed across different potential and changing scenarios which also have a direct impact on the roles of the different actors involved. For example, there are circumstances where the State is willing and able to provide assistance, is willing but unable to provide assistance and is neither willing nor able to provide assistance; where there is no State or Government in place; or where there is a state of occupation.

[2] See www.spherestandards.org/handbook-2018/.
[3] See http://iawg.net/iafm/.

23. In reality, many other actors take on responsibilities as duty bearers in emergencies, including service providers, national and international organizations and the private sector. While their responsibilities are not the same as a State's human rights obligations, there are important issues to consider in terms of the obligations to do no harm, to observe a certain duty of care and to ensure collective responsibility for the affected populations. As part of a human rights-based approach, analysis should be devoted to further understanding the parameters of these responsibilities.

III. Humanitarian context

24. The experts also considered the different kinds of humanitarian contexts and how these are different from and unique to other settings in addressing preventable maternal mortality and morbidity. Experts highlighted that crisis tests health and justice systems alike and imposes additional burdens on duty bearers to provide sexual and reproductive health services than in stable settings. Moreover, emergencies do not exist in a vacuum and pre-existing challenges, including inadequate health systems, insufficient budgetary allocations, and multiple and intersecting forms of discrimination and inequality and barriers to access services, particularly for women and girls, are often exacerbated.

A. Intersection between humanitarian and development settings

25. Humanitarian crises today, including their frequency, intensity and dispersed and protracted nature, as well as the urbanization of crisis, is straining the existing humanitarian architecture and blurring the lines between humanitarian and development settings. This demands a new way of working which integrates multiple sectors, connects different actors and strengthens synergies in humanitarian preparedness, response and transition. This also means starting transition early in an emergency context and not only at the recovery stage of a crisis. Sexual and reproductive health and rights is at the heart of this point of intersection. Although there is a need to better recognize and adapt to this new context and on-the-ground reality, there is also value in drawing on the technical guidance, for example, and being inspired by good practices, lessons learned and strategies applied in stable settings.

26. One key challenge is arriving at a common understanding of what is deemed a "humanitarian setting", because there are differences in the way we perceive them and our roles within them. Some experts noted that, more generally, a humanitarian emergency begins when there is a disruption of the normal state of affairs, also referred to as the "baseline". Experts observed that there is a need to be aware of and distinguish between humanitarian settings and their often vastly different respective baselines, as each kind also requires a different contextualized response.

27. Another point raised concerned the question of what development means in the context of emergencies involving refugees and migrants. In host countries, the importance of leaving no one behind and the Sustainable Development Goals is often underlined, but it is not always clear where refugee and migrant populations fall between the countries concerned, and priorities and perceptions of durable solutions – integration or repatriation or return – are often very distinct. In such instances, the individual woman and girl refugee and migrant and their rights is not at the heart of the response.

28. Experts further emphasized that what is required to bridge the divide between humanitarian and development settings is accountability to affected populations, ensuring that the voices and agency of individual women and girls are meaningfully taken into account and that such localization is driving responses. As in development settings, experts highlighted that lives are saved when empowered clinical service providers come into contact with patients empowered to claim their rights. However, the ways in which the enabling environment for such interactions is built requires adapted approaches to reflect the realities of humanitarian settings.

29. Some experts observed that although the overlap between humanitarian, development, peace and security and human rights is important, this can be abstract with

respect to the realities on the ground. There are practical distinctions that may need to be maintained. With limited resources, there is often a tension between the need to address acute needs in a conflict – such as surgery on bullet wounds – and the need to devote attention to long-term health gains and systems, including realization of sexual and reproductive health and rights.

30. At the same time, stakeholders in emergencies may become mired in discussions around whether something is considered humanitarian (acute) or development (longer-term), when affected populations, particularly in protracted emergencies, simply want and need to use the broader health system. In practice, national health systems are often replaced by unsustainable international systems and therefore undermined, including in their provision of services to reduce preventable maternal mortality and morbidity.

31. The distinctions between humanitarian and development settings are not mutually exclusive, as often claimed, and they can reinforce one another. Experts noted that a middle ground can be found where provision addresses systemic issues without sacrificing immediate and urgent medical needs. A human rights-based approach can help identify such solutions. For instance, engaging meaningfully and listening to affected women and girls can, in fact, help guide assistance to where it is most needed, which can help identify and address acute needs while at the same time reinforce, rebuild and strengthen the existing health-care system.

32. Experts also observed that the division between humanitarian and development settings can be perpetuated by the “siloization” of funding, including what can be funded, who can fund what, to whom and for how long. Experiences were shared of protracted emergencies, which include an armed conflict, blockade, sanctions and disease outbreaks, where the lines drawn between humanitarian and development are difficult to navigate. This impacts what is funded, as “humanitarian” issues are often prioritized while sexual and reproductive health and rights are often perceived as a “development” issue. Dedicated attention to and interrogation of how and which kinds of interventions are actually costed is needed. As a good practice, some donors have mainstreamed sexual and reproductive health throughout their assistance without making any distinctions between humanitarian or development work.

B. Preparedness

33. Experts highlighted the importance of the need to discuss, clarify and fund what we should do before a crisis hits in terms of establishing a strong baseline of the health system. Realization of human rights ensures a robust baseline in any context. Examples were shared of contexts where well-established elements of the health system prior to the crisis, such as effective referral pathways for victims of gender-based violence, were in fact successfully built on rapidly at the onset of the emergency. Identifying and supporting organizations on the ground, including health and human rights organizations, already doing this work is a good practice example.

34. A focus on preparedness can also involve ensuring that the Minimum Initial Service Package for Reproductive Health is integrated in medical curricula and practice at all levels, as well as building the capacities of local organizations and communities that are often first responders in an emergency. Good practice examples shared included advocating with Governments for the inclusion of comprehensive sexual and reproductive health services into disaster response plans and establishment of multi-stakeholder “disaster response committees” which would help elaborate the roles and responsibilities of different actors when crisis hits. A human rights-based approach calls for multi-stakeholder engagement and helps uncover pre-existing discrimination, women and girls in vulnerable situations, preparedness needs, and different stakeholder roles and responsibilities. Despite the importance of preparedness, however, identifying funding for this work has proven to be difficult.

35. Experts also underlined that preparedness is not only relevant before a crisis hits but also during crises, when new emergencies can arise. Outbreaks of disease in existing crises are not uncommon and can lead to their own emergency, impacting efforts to address

preventable maternal and newborn mortality and morbidities with gaps in terms of coordination around responses. Moreover, once an outbreak has been established, the imperative is to contain and control it, often at the cost of everything else, including provision of sexual and reproductive health. This has also led to the curtailment by States of human rights and targeting of specifically marginalized populations.

C. Partnerships and coordination

36. Experts noted that everyone agrees on and wants to strengthen coordination between humanitarian providers in a given emergency, including to ensure a comprehensive, holistic and integrated approach that puts the individual woman and girl at the centre. However, there are unique challenges, particularly when each actor has separate obligations to report on and financial resources to use within a set time frame, reflecting diverse priorities of donors and actors at the global level.

37. In addition, experts also emphasized the importance of partnerships across stakeholders and sectors, including how task sharing and shifting can help address challenges in sexual and reproductive health service provision. As also highlighted in the technical guidance, there is an opportunity to better reflect on and harness the different perspectives, strengths and roles of the diversity of actors operating in emergencies. Moreover, through such partnerships and collaboration, silos in programming can be overcome and gaps in service delivery identified, revealed, learned from and adequately addressed.

38. Experts also noted that in many contexts, despite playing a significant role, private actors are often overlooked and excluded from cluster coordination meetings and processes. At the same time, other experts observed that partnering with the private sector will require careful consideration of their role and contribution as well as alignment with human rights and humanitarian principles such as accessibility and affordability.

39. It was also highlighted that collaboration with law enforcement and other uniformed personnel such as peacekeepers, as well as judicial actors, is beneficial. They are often the first point of contact when a human rights violation has occurred, including when certain services are denied to an individual, and they can also assist in terms of increasing accountability, strengthening service delivery and providing adequate referrals.

D. Linkages with gender-based violence and mental health

40. Humanitarian crises exacerbate pre-existing forms of gender-based discrimination and violence, such as trafficking, sexual slavery, rape, forced pregnancy and harmful practices, and survival strategies such as transactional sex. This creates additional barriers to gaining access to services, further increasing potential exposure to sexually transmitted infections, unintended pregnancies, unsafe abortions and maternal mortality and morbidity.

41. Experts pointed to a need to strengthen the linkages between sexual and reproductive health, gender-based violence and mental health programming. It was noted that responses to gender-based violence and mental health can be entry points to build response frameworks for sexual and reproductive health (and vice versa), including provision of services that would otherwise be considered sensitive.

42. It was also highlighted that in emergencies, there has been evidence of girls forced into marriage due to the perception that marriage will provide a degree of security, but also because their families could not provide them with food. These child marriages have serious implications on the sexual and reproductive health of the girls. Moreover, there is a lack of funding for and clarity and coordination on how to deal with mental health and providing psychosocial support for victims of trauma in emergencies, which also impacts maternal and newborn health.

43. Experts shared examples of a refusal by certain service providers to issue to women and girls who were victims of sexual violence the medical certificates required to access justice in many contexts. In these examples, providers used the pretext that medical

examination could not "prove" sexual violence to avoid getting involved in legal processes, stating that their job was to provide services, not to uphold the law. In other instances, victims of sexual violence were not provided with information about the possibilities for seeking justice, if that was the path they wished to pursue, due to fears for their safety. These are gaps which a human rights-based approach would help identify and seek to address from the perspective of the individual concerned.

IV. Operationalizing a human rights-based approach in humanitarian settings

A. Availability, accessibility, acceptability and quality

44. Human rights requires that sexual and reproductive health facilities, goods, information and services be available (e.g., sufficient quantity and range), accessible (e.g., physically and economically accessible to all affected individuals and communities), acceptable (e.g., scientifically and medically appropriate, gender responsive and centred on the individual woman and girls) and of good quality.[4]

45. In a discussion around this "AAAQ framework", experts highlighted that it is in line with medical practice. They emphasized that the complex nature of a humanitarian crisis, including extreme adversity and insecurity, a restriction of mobility, as well as the breakdown of infrastructure and health and justice systems, poses unique challenges for women and girls to avail themselves of needed services and for all actors to fully deliver on availability, accessibility, acceptability and quality of facilities, goods, information and services.

46. In addition, one of the challenges to addressing preventable maternal mortality and morbidity concerns real or perceived restrictive legal, policy and social environments. A human rights-based approach can help clarify the legal, policy and social context in an emergency and dispel overly broad assumptions about what is permitted and accepted – and when there is genuine operational risk. In restrictive environments, certain interventions that are critical to prevent maternal mortality and morbidity, such as safe abortion and post-abortion care and contraception, are often deprioritized or avoided, with significant availability and accessibility implications for affected women and girls. A good practice identified in this context is legal risk assessments, which analyse what the risk to providing certain services is, what the exceptions are in law and what mitigation strategies can be developed.

47. Another barrier in this context includes the potential stigma faced by individual woman and girls seeking certain reproductive health services, as well as the reticence of providers to provide such services at the individual, agency and institutional level. This reality has become further entrenched by the emergence of highly restrictive donor policies around health funding. Stigma is an area that could best be addressed before a crisis hits, and practice has shown that once an agency is clearly on board, providers feel more secure about providing the required comprehensive package of sexual and reproductive health services. Experts highlighted that consistent guidance, drawing on a human rights-based approach as articulated in the technical guidance, can help providers address real or perceived sensitive areas in service provision in emergencies.

48. Good practice examples were also shared of rights-based trainings with policymakers and then health providers, alongside clinical trainings, to address any possible misconceptions, stigma and biases. Other good practice examples included the need to insist on holistic and comprehensive service provision to address preventable maternal mortality and morbidity. It was underscored that collaboration with local organizations and service providers on how best to do so was critical.

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[4] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health.

49. Experts noted that there is frequently a striking absence of family planning and contraception in humanitarian preparedness and response plans and a lack of availability of a wide range of contraceptive methods, including the often-preferred copper intrauterine device (IUD), which inhibits the informed choice at the heart of a rights-based approach. Moreover, mobility is often restricted and educational opportunities curtailed in refugee or internally displaced person camp settings, two human rights violations which further restrict the ability of women and girls to access contraception.

50. An innovative good practice shared in this context involved women trained to use mobile technology to monitor and report on stock-outs of contraceptives. The results were then shared with humanitarian providers to inform programming. Other experts also highlighted the innovative opportunities technology is beginning to bring to ensuring sexual and reproductive health in emergencies. However, the use of information and communications technologies for health, or “eHealth”, may also lead to privacy concerns, including with respect to security of patient data and the role of the private sector in developing the technologies.

51. Another aspect highlighted, and one where human rights can play a particular role, concerns attacks against health workers as military targets or because of the kinds of services they provide. Experts highlighted the importance of documenting and analysing such attacks, understanding the impact they have on access to services and delivery as well as strategies developed to overcome them, and how to concretely strengthen protection of providers and women and girls seeking care. Attacks can also take many forms beyond armed force, including threats, legal attacks, criminalization, defamation campaigns and defunding. In addition, services are undermined in contexts where many service providers at the clinical level do not receive a salary and are facing human rights challenges which also need to be addressed.

52. In terms of quality, experts noted that, even when services and facilities are available, women and girls often do not seek them out not only because of security concerns or prohibitive costs, such as those related to travel, but because of the disrespect and abuse they may face and perceptions that the services provided are of low quality. This is compounded by the failure of donors to prioritize or fund respectful maternity care, as it is perceived to be a development and human rights, not a “humanitarian”, concern. Although the evidence is well established in stable settings, the importance of further research, including human rights analyses, on the experience of disrespect and abuse in health-care settings in emergencies was highlighted.

53. Health systems require reasonable capacity, with the availability of skilled human resources and quality medicines. It is difficult to attract skilled human resources to work in insecure and remote locations, in particular women skilled birth attendants, in contexts where the provision of sexual and reproductive health services is not considered life-saving and is deprioritized. Furthermore, a continuum of care needs to be emphasized at all stages of an emergency. Insecurity often restricts the critical provision of 24/7 services, such as emergency obstetric and neonatal care, especially when Governments and other actors cannot ensure the continuous protection of service providers. At the same time, experts noted that in other contexts the focus of providers was solely on providing emergency obstetric and neonatal care rather than comprehensive sexual and reproductive health services, which also led to gaps in service provision.

54. Good practices shared involved embedding core human rights principles into a non-negotiable approach to health care, including standards of care that adopted the rights of patients as a core element of quality that was frontloaded into system delivery. This also involved adequate resourcing and trainings for service providers, in particular during preparedness but also at the onset of and during crises, through inclusion in refresher trainings, as well as continued follow-up through supervision. In a number of emergencies, this has led to rights-based services of high quality that were well received and responsive to individual demands and needs.

B. Participation and empowerment

55. All experts agreed that participation and empowerment are critical to ensuring accountability to women and girls affected by crisis. In this context, humanitarian preparedness, response and transition should always emphasize informed consent, choice and autonomy of women and girls in their sexual and reproductive health.

56. Addressing paternalistic approaches in emergencies and ensuring informed women's and girls' consent to and choice of the services they receive is key and requires further unpacking. In many cases it is not always clear, especially in the absence of language translation and awareness by providers of the local sociocultural context, that women and girls in fact fully understand what it is that they are "agreeing" to. In practice, the power imbalance leans towards the provider who makes the assessment of what the individual patient needs. This is particularly acute when it comes to adolescents. Human rights treaty bodies have explained that the onus of proving consent lies with the provider and must never be placed on a patient. Third-party authorization requirements are another challenge that was identified in this context.

57. Working with communities and understanding their views and demands concerning service provision was highlighted as an essential component of participation. This also includes partnerships and supporting and empowering local women's organizations and rights defenders. Actors operating in humanitarian contexts often fail to notice and quantify the human element; the spirit, cohesion and resilience of communities' responses to emergencies, including family and neighbourhood networks, which could be drawn on and reinforced before, during and after crisis.

58. Examples were shared where awareness of and demand and need for contraception by affected populations drove provision, ensuring that contraception was provided at an early stage beyond what was required in the Minimum Initial Service Package. Access to contraception is a life-changing intervention, and it is needed throughout all stages of a crisis. Examples were also shared of innovative initiatives which provided the space for girls to be programme designers and implementers.

59. Inclusive and participatory, multi-stakeholder approaches should be implemented starting at the preparedness and planning stages, in particular along with communities and first responders, to ensure that different stakeholders can participate meaningfully, including in their own language, and are clear about everyone's roles and responsibilities when crisis hits. These initiatives should also be specifically targeted to population groups that are most at risk of being left behind and disproportionately impacted by a crisis. Human rights analysis can play a role in helping identify these populations groups, including the reasons for their possible marginalization, and help devise effective, inclusive responses.

60. In the same vein, experts underlined that reaching all affected communities remains a challenge, including due to insecurity, lack of infrastructure and remoteness. Reaching women and girls can be particularly challenging as in practice, consultation with communities frequently starts with a meeting of elders or traditional leaders, who are often all men. Experts underlined the important impact of reaching and meaningfully engaging also with women and girls in such communities, as emphasized by the technical guidance. This not only ensures that services reflect their experiences and needs; it also empowers them to understand and claim their sexual and reproductive health and rights. At the same time, experts also noted the need to understand the risks in the local context, including how humanitarian actors and activities could in fact do harm at the community and family level, including by potentially putting women and girls in situations of vulnerability.

61. In this context, working with men and boys, including male religious and community leaders, was also considered a good practice. They can be the support mechanism for women and girls seeking sexual and reproductive health services and play important roles in helping overcome sociocultural obstacles to the provision of services perceived as sensitive and addressing the stigma women, girls and providers may face.

C. Discrimination and inequality

62. Experts highlighted the need to view discrimination and inequality within the broader context of the backlash against women's rights and gender equality around the world, including in discourse, practices and funding. Addressing this broader context also requires attention to the intersections of national security, sexism, racism and populism and their impact on the individual person either displaced by or remaining in a humanitarian setting.

63. In this same context, experts also highlighted the importance of addressing discrimination throughout the different stages of an emergency and how this impacts enjoyment by women and girls of their sexual and reproductive health and rights. An understanding of pre-existing discrimination and inequality, driven by social norms and power structures and often exacerbated when crisis hits, is required to design effective interventions. A human rights lens and analysis reveals this dimension.

64. Further, experts observed that in humanitarian settings, affected populations are often framed as a homogeneous group when in fact there is a need to zoom in on the individuals. When it comes to preventable maternal mortality and morbidity, within these "population groups" one can identify women and girls who are particularly at risk of being discriminated against and left behind. In this context, gender-based discrimination intersects with discrimination on other grounds related to, among other things, age, disability, sexual orientation, gender identity, health status, ethnicity, nationality, caste, poverty, urban/rural residence, refugee/migrant/internally displaced status and sex work, and whether one was a victim of gender-based violence, a victim of trauma, living inside/outside camp settings, displaced/not displaced and an established/new arrival.

65. Experts also shared examples of maternal deaths attributed to denial of care because of status, caste, ethnicity and an inability to pay. This can also inadvertently be reinforced by siloed programmatic distinctions and framings. Experts therefore highlighted the importance of paying specific attention to individuals of diverse population groups and ensuring accountability to them, including through full transparency and meaningful participation in decisions concerning by whom, to whom, when and where assistance is provided, and of what kind. Awareness should be raised to help women, authorities and providers understand that access to services is a matter of rights, not a favour.

66. Experts also raised the need for political will on the part of States in certain cases of emergency to address preventable maternal mortality and morbidity of all affected populations. In cases highlighted by experts, the State receiving refugees was primarily concerned with its host communities and the risk of disease outbreaks. This led to the prioritization of vaccinations and water and sanitation services to refugees, rather than a focus on their sexual and reproductive health and rights. Moreover, differential treatment and access to sexual and reproductive health services for host communities and for refugees and migrants is common.

67. It was emphasized that the situation of adolescent girls and boys in humanitarian responses was often overlooked, with adverse impacts on effective protection of their rights, including access to and information or awareness of sexual and reproductive health services. This is also reflected in investment and funding often being the least for adolescents and their sexual and reproductive health and rights, including for their participation in decisions on service provision. Good practice initiatives shared included youth centres staffed with psychologists, nurses and other professionals in urban settings to reach refugee and migrant adolescents, raise awareness of their sexual and reproductive health and effectively refer them to services.

D. Sustainability and international cooperation and assistance

68. Experts agreed on the critical importance of transition as soon as possible from the Minimum Initial Service Package to comprehensive sexual and reproductive health services in order to reduce preventable maternal mortality and morbidity. As noted above, experts expressed a need to devote attention and resources to rebuilding and reinforcing an existing

health system when crisis hits rather than establishing new and parallel systems with parallel coordination and communication processes. Otherwise, responses may actually harm what is already in place, leading to dependency and an even more daunting path to recovery and transition.

69. One good practice shared was supporting strong existing, albeit underresourced, midwifery centres during an emergency. Sustained investment would allow not only for the training and employment of midwives in areas where there are urgent human resource gaps and critical needs, but also help rebuild the health system.

70. Experts also highlighted a need to have a conversation about adequate budgetary allocations by States at the national level for comprehensive sexual and reproductive health services during stable periods, in preparatory stages, at the onset and during crises and in the transition. This will establish stronger baselines and thus resilience to build on and also help ensure sustainability.

71. The focus of long-term impact tends to be on quantifiable data, thereby losing sight of local and community-based interventions, which has had far-reaching and sustainable impacts. In one example, a project with a community-based organization to address HIV-related stigma in one village was so successful that it was independently replicated in neighbouring villages. Community-based interventions and monitoring, as well as women-led organizations, should be adequately financed in a sustainable manner in humanitarian preparedness, response and transition. Documenting and validating such good practices of similar rights-based approaches is also key.

E. Accountability and transparency

72. Throughout the meeting, experts agreed that ultimately, accountability for preventable maternal mortality and morbidity must be ensured to all women and girls affected by crisis.

73. Many questions were put on the table, including who is accountable at what level; what does accountability encompass beyond health outcomes; what are the different forms of accountability; how can accountability be ensured throughout the humanitarian programme cycle; and how can accountability of the system as a whole be established. Similarly, it was also recognized that there is a need to unpack what is happening at all levels of accountability, cascading down from global/system level to cluster level, to provision and health facility level and to community and first responder level.

74. As has also been articulated in the technical guidance and by human rights mechanisms, although the State is primarily accountable for their human rights obligations, experts agreed that other actors in emergencies, including the private sector, donors, service providers, civil society organizations and the United Nations, also bear duties and responsibilities vis-à-vis affected populations.

75. Moreover, the technical guidance and research conducted in humanitarian settings highlight that beyond legal and institutional accountability to donors, there are also other kinds of accountability including financial, political, social and professional. It was repeatedly emphasized that human rights accountability is holistic, goes beyond individual liability and has a particular focus on identifying health system failings in order to take corrective action.

76. At the global level, different forms of accountability are integrated into humanitarian frameworks of the Inter-Agency Standing Committee and the *Sphere Handbook*, for example. However, these do not explicitly address sexual and reproductive health and rights, instead highlighting gender and human rights more broadly. Similar to legal frameworks, there remains a gap in these global commitments and in on-the-ground implementation. Experts noted that this is often due to a perception among implementers in emergencies that such frameworks are far removed from reality, with unrealistic expectations. Ensuring on-the-ground accountability to affected women and girls in emergencies for their sexual and reproductive health and rights should therefore be

adequately resourced, funded and prioritized, including to reveal accountability gaps and impact on service delivery.

77. Experts also emphasized the importance of accountability for how funding is allocated in humanitarian settings to ensure better alignment between upholding health and human rights. Funding prioritization can often reflect national priorities more than the lived experiences, demands and needs of affected women and girls. Moreover, there does not seem to be any clear obligation on donors wishing to divest or defund to sustain their funding, despite the significant potential harmful impacts on affected populations' sexual and reproductive health and rights and the means by which they can be realized.

78. The role of the United Nations human rights staff can add value and new perspectives to humanitarian action and help ensure rights-based accountability. Human rights investigative bodies of peace missions, for example, monitor and analyse the situation of human rights in a given context, document violations, analyse trends and provide recommendations on legal and administrative procedures and mechanisms to ensure remedial action and redress. They can also form part of or participate in the cluster system in humanitarian settings.

79. However, such bodies may also face a number of challenges, including mandate limitations; a lack of resources, including access to humanitarian funds, limited capacity to engage in humanitarian responses and few field actors with expertise in bringing in a human rights-based approach to help shape interventions; and the frequent deprioritization of women-specific issues in such settings.

80. It was also noted that, besides peace missions, human rights advisers in the offices of humanitarian coordinators or as part of United Nations country teams can play a key role in emergencies, including supporting humanitarian actors to integrate a rights-based approach, as well as identify human rights risks in response plans and programmes. In this context, experts also suggested similar frameworks to strengthen "human rights integration" in the humanitarian program cycle such as the Inter-Agency Standing Committee Gender Standby Capacity (GenCap) project, which deploys gender advisers on short notice to support coordination and response in the initial stages of humanitarian emergencies, providing guidance on how to integrate gender into humanitarian funding proposals and plans.

81. United Nations human rights mechanisms, such as treaty bodies and special procedure bodies and their wealth of country reviews, thematic reports, jurisprudence and interpretative guidance on sexual and reproductive health and rights, also play an important role. It was further highlighted that these mechanisms can help shift the narratives and articulate what accountability for sexual and reproductive health and rights in these settings looks like. For example, direct engagement in a cluster meeting by a special procedure mandate holder during a country visit brings a new perspective and helps shift perspectives, which in turn can advance implementation of a rights-based approach.

82. Other mechanisms also exist at the global level, including newly established commissions of inquiry and fact-finding and monitoring missions. Experts highlighted the unique opportunity to explore how sexual and reproductive health and rights can be integrated systematically into their work. Experts also drew attention to the work and upcoming report on humanitarian settings of the Independent Accountability Panel for Every Women, Every Child, Every Adolescent, established by the Secretary-General to monitor implementation of the Global Strategy on Women's, Children's and Adolescent's Health (2016–2030).

83. One good practice example was also shared by experts of a national inquiry on sexual and reproductive health and rights conducted by a national human rights institution, which highlighted that humanitarian responses in certain disaster affected-regions of the country in question did not include sexual and reproductive health, despite the displacement of women and girls and evident need.

84. At country level, when it comes to remedy and redress, the focus should go beyond gender-based violence. Dedicated analysis of what is actually happening on the ground in terms of the accountability of the State, humanitarian actors and the humanitarian system

for maternal mortality and morbidity is critical. Experts highlighted that safe spaces where humanitarian actors can undertake critical reflection, examine their practice and be open about what is not working is needed. In this context, dispelling the notion that human rights are limited to a "blame and shame" approach is particularly relevant. In addition, addressing accountability within the health system also requires attention to the risks that health providers can face, such as reprisals from the family, if there is a perception of medical malpractice. Despite these challenges, experts found that being self-reflective and adaptable when things do not work and responsive to changing circumstances and demands from affected populations are critical elements of accountability in their work.

85. Good practices to uphold human rights accountability through social accountability tools were also shared, for instance, community scorecards and other forms of community monitoring, complaint mechanisms and feedback loops at the local level. These are also critical to transparency and ensuring that humanitarian actors are accountable at the service level. At the same time, how changes are made following such initiatives and who is accountable for these changes is less clear. It is important to clarify this aspect and further support similar social accountability initiatives – also highlighted in the technical guidance – in emergencies. This would lead to more accountable services that reflect the views and experiences of affected women and girls.

86. When it comes to ensuring legal accountability, training for communities, in particular women and girls, about their rights and how to claim them is also required. A good practice identified in this context is mobile clinics for the provision of legal and judicial services. Mapping of local justice actors and mechanisms and identifying possible entry points for strengthened service provision and accountability were also highlighted. Moreover, experts emphasized that legal accountability is not necessarily adversarial and can also be a positive experience for all actors concerned. Public interest cases before courts in certain contexts actually helped identify where problems lie and come to effective rights-based solutions.

87. Experts also noted the challenge of a lack of disaggregated data or sharing and pooling of data on sexual and reproductive health and rights in emergencies, including on what does and does not work. Collection of such data could also include information on funding and could be used to build an evidence base for rights-based interventions in emergencies that captures what works and the impact of successful actions to inform future interventions.

88. With vital and birth registration systems absent, one particular challenge in emergencies concerns the lack of counting, registering and notification of maternal deaths and morbidities and calculating the cost, in order for actors operating in a humanitarian setting to learn and avoid the action or inaction in the future. The focus is not on who is guilty, but on identifying the problem and possible remedial actions. For instance, experts suggested further implementation of maternal death surveillance and response in emergencies, which involves a continuous cycle of identification, notification and review of maternal deaths followed by actions to improve quality of care and prevent future deaths.

89. Although data gaps need to be filled, experts also argued that the real result and impact are measured not only by quantitative work and through indicators but also through qualitative work, including human rights analysis.

V. Conclusion

90. **The meeting provided for a rich and constructive discussion between a diversity of actors operating in humanitarian settings. A human rights-based approach to policies and programmes to address preventable maternal mortality and morbidity in humanitarian settings gives an added value to humanitarian action that should be further emphasized and better articulated.**

91. **This means advocacy at the global level against silos, attacks, criminalization, funding incoherence and restrictions and other obstacles and undue restrictions in emergencies that impact the enjoyment of the sexual and reproductive health and**

rights of women and girls. It also requires genuine and proactive political will, including dedicated attention and resources, on the one hand, and cognizance of the real on-the-ground challenges to be factored in and contextualized, on the other.

92. **At the level of implementation, this means insisting that States and other actors operating in a humanitarian setting provide national funding and programmes for comprehensive sexual and reproductive health services. It also means advancing concrete guidance, trainings and follow-up on a human rights-based approach in emergencies so that the added value is clear and is accessible, practical and tangible for implementers.**

93. **Preparedness is as essential as responses, as during crises disease outbreaks and other new emergencies often arise. It is especially at the early stage that the root causes, including gender-based discrimination, that drive emergencies and exacerbate their impacts can be laid bare, addressed and transformed. This in turn reinforces the resilience of societies and their communities. It is also a time when existing health systems can be bolstered rather than replaced and local providers' and first responders' capacity strengthened, with roles and responsibilities clearly clarified.**

94. **Partnerships between diverse actors at all levels and sectors, and between international and national and community actors, is core to a rights-based approach. Its indispensable value in reducing preventable maternal mortality and morbidity was also highlighted by the experts. Actors in emergencies have distinct mandates and different roles and responsibilities. Inclusive, multi-stakeholder dialogues and initiatives, including through the humanitarian programme cycle and cluster system, to coordinate, share information and analysis, and leverage the niches, spaces and perspectives of the different actors are therefore essential.**

95. **A central focus throughout the meeting was the particular significance, in line with rights-based accountability, of holistic, integrated, comprehensive action that places the affected woman and girl at the heart of preparedness, investigations, response and transition. This means prioritizing their voice, agency and meaningful participation in interventions at the global, regional, national and community and implementation levels. Experts encouraged efforts to map and identify existing accountability frameworks for sexual and reproductive health and the gaps therein, as well as dedicating resources to build the evidence base and highlight the impact and added value of a rights-based approach in emergencies. A human rights-based approach, when applied by all actors comprehensively and collaboratively, can clarify and ensure accountability to every woman and girl and their sexual and reproductive health and rights, including in the complex and challenging operating environment of emergencies. OHCHR anticipates taking this discussion forward and working with States, participating experts and other actors seeking to reduce preventable maternal mortality and morbidity in humanitarian settings.**