

A Global Strategy for Every Woman Every Child in Every Setting¹

Abstract

The worst rates of preventable mortality and morbidity rates among women, adolescents and children occur in humanitarian settings. 60 per cent of preventable maternal deaths and 53% of under-five deaths take place in settings of conflict, displacement and natural disasters. Newborns younger than 28 days old are at highest risk of mortality in these circumstances. Worldwide, women and children are up to 14 times more likely than men to die in a disaster. A humanitarian crisis puts every woman and every child – every new born and every adolescent - at grave risk. However, national planning processes often do not take into account humanitarian crisis (preparedness, response and recovery) into their longer term development planning. As a result, schisms may arise between humanitarian response and development interventions. Further several Sustainable Development Goal (SDG) targets will not be reached without specific attention to humanitarian and crisis contexts. This is dramatically the case for women, adolescents and children.

With humanitarian crisis, conflict and disasters a stark feature of the global landscape, presenting major impediments to the advancement of health, development and human rights more broadly, it is essential to commit to a global fulfillment of “Every Woman Every Child Every Where” and in “Every Setting”. This is a truly universal agenda with significant life saving implications.

Despite bringing major breakthroughs for the health related MDGs, the 2010 Every Women Every Child global strategy did not sufficiently address the role that humanitarian and crisis contexts, whether emergency or protracted, play in driving health outcomes across the life course. It is crucial, and urgent, that the next EWEC Global Strategy includes clear measures to better support countries and the international community to uphold fundamental human rights across the life-course in every setting.

1. Background and Introduction

The eight Millennium Development Goals (MDGs), including their strong focus on women’s and children’s health, galvanized unprecedented efforts by and between governments, civil society and leading development institutions to meet the needs of the world’s most impoverished people and communities. However, as global, national and local partners work to build on the momentum of the MDGs and prepare to focus on an ambitious post-2015 development agenda, the devastating impacts of crisis and fragile settings on individuals’ and families’ well-being, physical security and future prospects drive tragedies of grave proportion, extracting deeply pernicious costs on communities’ and nations’ development in the immediate and longer terms. In this context, the new EWEC Global Strategy must prioritize a focus on women’s and children’s health, and, for greater relevance to adolescents and young people, on sexual and reproductive health more broadly, noting that these are life-saving priorities in all settings, particularly and specifically in humanitarian contexts.

¹ This paper draws on inputs received from participants at the expert consultation in Abu Dhabi 10-11 February: Sarah Zeid, Kate Gilmore, Heather Papowitz, Danielle Engel, Rajat Khosla, Henia Dakkak, Njoki Rahab, Janet Meyers, Laurie Noto Parker, Sandra Krause, Paul Gimson, Ribka Ansalu, Sarah Knaster, Marian Casey-Maslen, Joe thomas, Janna Patterson, Anita Sharma, Kathleen Hamill, Dounia Dekhili, Haifa Madi, Shyama Kuruvilla, Arvind Bharadwaj, Enrica Leresche, Ugochi Daniels, Shible Sahbani, Mollie Fair, Sherin Saadallah, Pamela Delargy, Alanna Armitage, Ziad Rifai, Amal Al Ahmadi, Jawaher Al Saffar, Nancy Merheb, Saeed Al Ismaily, Mohammed Saeed Al Rumeithi.

Integration of specific attention on humanitarian settings in the second generation of the "Every Woman Every Child" Global Strategy is key to achieving the targets set for 2030. This is further affirmed by the Abu Dhabi Declaration that underscores essential steps to advance the health, dignity, and well-being of every woman and every child **everywhere in every setting**:²

- **Context counts:** Women's, children's and adolescent's health and wellbeing are largely context dependent, notably worsening in humanitarian settings. The familiar separations – by planning, funding and operations – between *development* and *humanitarian* interventions are counterproductive to effectiveness, value-for-money and sustainable outcomes.
- **Strengthen risk assessment and mitigation:** Country development plans – inclusive of women's children's and adolescent's health – should integrate humanitarian planning by robust assessment of risks (i.e. multi-hazard health sector risk assessment) and mitigation; disaster risk reduction planning; response and recovery capacity analysis and contingency funding.
- **Protection, participation and accountability:** Actively engage and protect women's and young people's human rights including as key partners in preparedness, response and recovery and be accountable to them via continuous monitoring and feedback looping on all interventions that affect them.

2. Problem and Opportunity

2.1. Every woman's, newborn's, child's and adolescent's health is context dependent

It is not by chance that the worst mortality and morbidity rates among women and children occur in humanitarian settings. These chaotic environments, caused by and creating a breakdown in governance, are characterized by: destruction (even targeting) of public infrastructure including health facilities; massive population displacement; insecurity, and a collapse of the social contract. In such settings, governments may even become hostile to displaced populations.

In conflict settings, armed state and non-state actors, by terrain and air, may actively target stigmatized civilian populations. Meanwhile, it is the poor who suffer most from natural disasters – 95 per cent of disaster fatalities occur in developing countries.³ Of the high-mortality countries, which are unlikely to achieve the MDGs for women's and children's survival, more than 80 per cent have suffered a recent conflict or recurring natural disasters or both.⁴ In fact, worldwide, women and children are up to 14 times more likely than men to die in a disaster.⁵ With children and adolescents comprising half of those populations affected by conflicts and disasters, of the more than 84 million people in need of humanitarian assistance in 2014, over 75% were women and children, the majority of whom are deeply impoverished.^{6,7}

² The Abu Dhabi Declaration "Upholding health and wellbeing for women, newborns, children and adolescents in humanitarian and fragile settings" – also an outcome of the consultation from which this technical paper was drafted – set out the case as to why *context* is crucial in efforts to reduce preventable deaths to rates promised by the MDGs . http://www.everywomaneverychild.org/images/The_Abu_Dhabi_Declaration_Feb_2015_7.pdf

³ UNDP. Fast Facts: Disaster Risk Reduction and Recovery. (New York: 2012)

⁴ This analysis was limited to the set of 25 and 44 "Countdown" countries classified as making "no progress" or "insufficient progress" towards MDG 5 and MDG 4, respectively. 84 percent of each set of countries has a recent history of conflict and/or was characterized by a pattern of persistent natural disasters over the period 1999-2013. For details, see Methodology and Research Notes.

⁵ Peterson, Kristina. "From the Field: Gender Issues in Disaster Response and Recovery." Natural Hazards Observer, Special Issue on Women and Disasters. Volume 21, Number 5 (1997) cited in: Plan International. Because I am a Girl: The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters. (Surrey, UK: 2013)

⁶ OCHA, Overview of Global Humanitarian Response 2014 (Geneva: December 2013)

⁷ UNICEF, Humanitarian Action for Children 2014 (New York February 2014)

60 per cent of preventable maternal deaths⁸ and 53 per cent of under-five deaths⁹ take place in just such settings: in settings of conflict, displacement and natural disasters. In particular, newborns younger than 28 days old have the highest risk of mortality in these circumstances.¹⁰ A humanitarian crisis puts every woman and every child – every new born and every adolescent - at grave risk but particularly those who have the least:

- 99% of the 2.9 million **newborns** deaths that occurred in 2012 took place in low- and middle-income countries. Many of the countries with the highest **neonatal mortality rates** globally are currently or have recently been affected by complex humanitarian emergencies.¹¹
- More than 250 million **children under the age of 5** live in countries affected by armed conflicts.¹²
- At any given time, 4 per cent of any displaced or otherwise disaster-affected population are **women who are pregnant**¹³ and of these, approximately 15 per cent will experience an obstetric complication. Without access to emergency obstetric services, many women die during pregnancy or-childbirth and many more suffer long-term health consequences that otherwise are preventable. In these circumstances, many newborns do not survive even their first 24 hours of life. In humanitarian settings, child-bearing risks are compounded for adolescents due to increased exposure to forced or transactional sex and reduced availability of adolescent sexual and reproductive health services.¹⁴
- In fragile or hostile settings, **women and adolescent girls** in particular, also confront exclusion, marginalization, and exploitation, including sexual and gender-based violence (S-GBV). In countries emerging from conflict, the imposts of continued lack of access to medical care, psychological, social support and justice, coupled with ongoing S-GBV contribute additional insecurity further impeding recovery and development, and individual well-being.

National planning processes often do not take the prospect of humanitarian crisis (preparedness, response and recovery) into account in their longer term development planning; as a result, schisms may arise between humanitarian response and development interventions. Furthermore, several Sustainable Development Goal (SDG) targets cannot be reached without specific attention to humanitarian and crisis contexts. This is dramatically the case for women and children.¹⁵

⁸ This data are calculated for 50 fragile states based on the 2015 OECD report on States of Fragility. Data are not available for three countries namely Kosovo, Marshall Islands and Tuvalu. The maternal mortality data is based on: Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division, 2014.

⁹ The proportions of under-five and neonatal deaths that occurred in 2013 in the fragile states listed in the OECD Report were 53% and 45% respectively. The calculation was done using the UN IGMe Report 2014 data, which can be found at http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2014/en/ and www.childmortality.org

¹⁰ Oestergaard MZ, Inoue M, Yoshida S, Mahanani WR, Gore FM, Cousens S, Lawn JE, Mathers CD: Neonatal mortality levels for 193 countries in 2009 with trends since 1990: a systematic analysis of progress, projections, and priorities. *PLoS Med* 2011, 8:e1001080

¹¹ Diane F Morof, Kate Kerber, Barbara Tomczyk, Joy Lawn, Curtis Blanton, Samira Sami and Ribka Amsalu, Neonatal survival in complex humanitarian emergencies: setting an evidence-based research agenda, 2014.

¹² Calculation by Save the Children. Estimate includes all children under age 5 living in Syria and the 22 countries that experienced war or minor conflict in 2013, as identified by the Uppsala Conflict Data Program (UCDP). Sources: UCDP Conflict Encyclopedia: www.ucdp.uu.se/database, Uppsala University [Accessed April 20, 2013]; UNICEF. The State of the World's Children 2014 In Numbers. (New York: 2014) Table 6

¹³ UNFPA, Manuel- Inter-Agency Reproductive Health Kits for Use in Crisis Situations 5th Edition, 2011, page 24

¹⁴ WRC, Save the Children, UNFPA, Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services, 2012.

¹⁵ Save the Children, *State of World's Mothers*, 2014.

2.2. Urgent need to broaden the Scope of the EWEC Global Strategy

With humanitarian crisis, conflict and disasters a stark feature of the global landscape presenting major impediments to the advancement of health and development more broadly, it is essential, and now pressing, to commit to a global fulfillment of “Every Woman Every Child” “Every Where” in “Every Setting”. This is a truly universal agenda with significant life saving implications.

Although a major breakthrough for accelerated effort globally to achieve the health related MDGs, the 2010 Every Women Every Child global strategy did not sufficiently address the role that humanitarian and crisis contexts, whether emergency or protracted, play in driving health outcomes across the life course. It is crucial, and urgent, that the next EWEC Global Strategy includes clear measures to better support countries and the international community to uphold fundamental human rights across the life-course (younger and older women, newborns, children and adolescents) in every setting, including specifically in emergencies.

At the heart of this opportunity and responsibility, resides the need for strong commitment to ensure that genuinely every woman and every child have access - even in fragile settings - to essential health care services and lifesaving interventions. And, this requires investment in stronger, more resilient health care systems overall.

This more focused and strategic commitment must include provision – in the context of fragile settings – for reliable and secure access to life saving commodities, such as those necessary to protect women and adolescent girls from unwanted pregnancies, to reduce sexually transmitted infections and respond to HIV/AIDS. And, this enhanced commitment must extend to programmes that also engage boys and men in support of better sexual and reproductive health outcomes – their positive contributions to these being as yet largely underexplored.

Meeting reproductive, maternal, newborn, child and adolescent (RMNC&A) health needs in crisis and fragile settings, including by acting to prevent and respond to S-GBV, while addressing fundamental needs for nutrition and “WASH”, is the pathway to realizing the aims of the MDGs and to sustaining this over the course of the SDGs. Critical to emergency response, protection in these ways of every woman’s and every child’s human rights is also fundamental for the resilience and more rapid recovery of affected communities overall.

3. Response: Strengthen specific EWEC measures to better address women’s, newborns’, children’s and adolescents’ health in humanitarian contexts

3.1. Recalibrate EWEC for greater relevance to and effectiveness in every setting

The framework for the revised EWEC Global Strategy is people-centered and thus also to be guided by **human rights norms** and **humanitarian principles**. However, for human rights to health and well-being to be upheld for every woman and every child in every setting, the next Global Strategy must call on its implementers to **more fully integrate humanitarian and sustainable development action** for a **contiguuum** approach grounded locally and nationally in continuous preparedness, adjustment to changing circumstances and resilience efforts. These fundamental steps are prerequisite to the meeting of needs in all settings and across the life-course, inclusive of women, newborns, children and adolescents.

This also means that the next Global Strategy for EWEC must call for **greater and more focused attention on the power, potential, and participation of people themselves** as both the key means and the ultimate purpose of development including – rather than separate from – humanitarian response.

Whether diverted and undermined by humanitarian crisis or not, the advance of sustainable development – in all settings – is more certain where there are healthy, secure and confident women,

children and adolescents whose human rights are protected and respected. For sustainable development, both humanitarian and non-humanitarian support must be **demand-driven, led and owned by local communities** and aimed at reinforcing the quality of **life-enhancing social networks at the household and community levels**.

To this end, health sector interventions must be shaped by **population data**, respond to the findings of **health sector risk assessments and according to local hazards**, and be delivered to meet priority needs across the life course in each specific context. Monitoring of data is required of both **processes and outcomes**. To **address, rather than deepen, inequities** – which also undermine development and aggravate fragility – these health services (including commodities, supplies and human resources) and interventions must be **available, accessible, acceptable, accountable** and of **quality**. Of central importance are adequately trained and resourced **healthcare workers**, in particular functioning community health workers. This also requires mechanisms to ensure **security and safety** of healthcare workers.

For relevance and responsiveness, health sector interventions – including specifically those for every woman and every child – must be designed for agile and timely **adaptation as contexts change**, as and when those changes take effect. Resilience – which must be a core objective of development planning inclusive of humanitarian effort – requires planning **for and with communities, and for their and their countries', enhanced capability and capacity** to respond to humanitarian shocks so that corresponding diversions from the path to sustainable development are reduced in terms of both their severity and duration.

Health system strengthening is key but the test of its value as a development intervention therefore, must include the ability of health systems to respond during times of crisis: to absorb shocks, adapt to changed circumstances and return to optimal levels of functionality as soon as possible. For this purpose, multi-sectoral engagement of national and local actors such as ministries of health and education as well as local communities must be prioritized to better situate humanitarian plans, priorities and processes with sustainable development frameworks.

Innovations in technology, including social media and communications offer significant opportunities to better influence health-seeking behaviour, support health workers, and context-adaptability in health systems and ensure greater accountability of all stakeholders. This also helps in connecting communities and individuals to support each other, share knowledge and demand accountability of systems.

Accountability at all levels and ultimately to local communities and individuals should be reinforced through good governance, and supported by systems for participation of all stakeholders, especially at local levels, with civil society and critically through the **empowerment, participation and leadership of women and young people**. Police/military should understand health as part of **human security**.

3.2. Support critical interventions across the life course and relevant to every setting.

For greater relevance to humanitarian contexts and in the interests of every women, every newborn, every child and every adolescent, tailored intervention packages are recommended as follows (references for these interventions can be found at the end of this document):

Women

Key health conditions to be addressed: Pregnancy and child birth, S-GBV, family planning, HIV/AIDS, STIs, emerging diseases (Ebola, cholera and other communicable and non-communicable diseases), mental health (including post-traumatic stress, trauma) and malnutrition.

Health Interventions	Determinants	Health System enablers		
Service Delivery	Non-health interventions	Health Systems Resilience	Innovation and Research	Financing
<ul style="list-style-type: none"> ● Preventive care: Sexuality education, S-GBV (IASC list) prevention, HPV (cervical cancer screening) vaccine, contraceptives (short-acting and long-acting, emergency contraceptives), PEP, Menstrual hygiene management, HIV prevention, Micronutrients TT, IPTp, LLIN, Iron/Folate, FP, ● Treatment: Assisted vaginal delivery, EmONC (basic and comprehensive): Misoprostol, AMTSL, oxytocin, MgSo4, NAG blood transfusion,, antibiotics, anti-hypertensives, Abortion care, comprehensive abortion care, C/S,STI/UTI treatment Post natal care include. postpartum depression Treatment of traumas/ orthopedic surgery Maternal morbidity i.e. obstetric fistula and vaginal prolapse Clinical management of rape ● Delivery models: MISP, Ambulance temporary and mobile clinics, community-based service delivery (postnatal care, misoprostol for PPH prevention, prenatal care, family planning, care for survivors of sexual violence, clean delivery kit distribution) PEP kits, menstrual hygiene management ● Medical devices/ kits: MVA, Vacuum Extraction, Doppler for Fetal Monitoring, Uni-Ject for Depo-Provera 	<ul style="list-style-type: none"> ● Build women’s and girl’s assets (financial, social and other) ● Invest in livelihood for woman ● Invest in and build capacity of women’s support groups ● Establish safe spaces for women ● Establish IYCF – baby friendly spaces ● Provide psychosocial care & address postpartum depression ● Develop conflict sensitive programs and promote women’s and young people’s engagement in peacebuilding ● Establish climate mitigation & adaptation strategies ● Recognise the role of and engage men and boys ● Strengthen reparations and justice mechanisms (GBV); through documenting human rights abuses ● Invest in women’s and young people’s participation in decision making and all levels of humanitarian response 	<ul style="list-style-type: none"> ● Cross-cutting: Open source database with HMIS sex, age and disability disaggregated data ● Human resources: task sharing, protection of health workers & increase the numbers of female service providers ● Logistics/ Supply Chain ● Accountability/ quality: Maternal death notification standardization of protocols, cause of maternal death audits ● Removal of user fees 	<ul style="list-style-type: none"> ● NASG (PPH) ● Social media, mobile technologies for data management, cash transfers, programing, crowd sourcing 	<ul style="list-style-type: none"> ● External funding (short & long term) ● CERF ● Flash appeals/ ● Traditional humanitarian donors: ECHO, OFDA, BPRM, programming development funds (GF, GAVI) ● SRPs, pooled funds, trust funds.

Newborns and children

Key health conditions to be addressed:

- **Child health conditions to be addressed:** malaria, pneumonia, diarrhea, measles, malnutrition and mental health and well-being
- **Newborn conditions to be addressed:** pre-term, LBW, Sepsis, Intra-partum complications

Health Interventions	Determinants	Health Systems	Health System enablers
<p>Service Delivery</p> <p>NEW BORN</p> <ul style="list-style-type: none"> • Preventive care: Thermal care, immediate/ exclusive BF, cord care/CHX, vaccination, dexta, toxycotics, hygiene (hand hygiene), WASH, PMTCT • Treatment: KMC, antibiotics, Newborn Resuscitation, Intra-partum care, Emergency Obstetrics Care, oxygen, NICR, ARVs <p>CHILDREN</p> <ul style="list-style-type: none"> • Preventive care: LLIN/IRS, measles vaccination, WASH, IYCF, psychosocial health • Treatment: Antibiotics, ACT, ORS, zinc, vitamin A, RUTF, mental health • Delivery Models: Facility-based care: PHC (existing, mobile or temporary clinics, transit site clinics). Community based care: iCCM, CMAM. Home-based care. Campaigns: mass measles vaccinations, distribution of LLIN, child health days, mass malaria chemotherapy 	<p>Non-health interventions</p> <ul style="list-style-type: none"> • Water, sanitation and hygiene • Early childhood development (ECD) • CSF (child friendly spaces) • Basic education • Child protection • Psychosocial support • Birth certificates & registration • Early stimulation • Cause of death surveillance 	<p>Health Systems Resilience</p> <ul style="list-style-type: none"> • Age disaggregated data • Integrate risk assessment and analysis into health systems strengthening for resilient systems and services • Develop capacity of health systems to have flexible and adaptable financing and service delivery, trained and available staff, priority medicines available when needed, reliable information systems and leadership and governance that takes into account emergency risk • Accountability/ quality: Newborn cause of death notification/audit • Include children in the design, planning and implementation from preparedness to the onset of an emergency 	<p>Innovation and Research</p> <ul style="list-style-type: none"> • PCV13, Rotavirus, Hib, dispersible tablets, single-dose vaccines, single-dose antibiotics, vaccines that don't need cold-chain, remote monitoring/teaching, mHealth • Micro-nutrient powder • Newborn: uni-ject Gentamycin, CHX for cord care, Doppler (technology), gestational age estimate methods, AST for preterm labor (home level/self care), SATT for Sepsis, <p>Financing</p> <ul style="list-style-type: none"> • External funding (short term) • CERF • Flash appeals/ • Traditional humanitarian donors: ECHO, OFDA, BPRM, programming development funds (GF, GAVI) • SRPs, pooled funds, trust funds.

Adolescents – in particular girls

Key health conditions to be addressed: Early pregnancy, HIV/AIDS & STIs, unsafe abortion, S-GBV (SEA, child early forced marriage, FGM), menstrual hygiene, nutritional deficiencies, traumas

Health Interventions	Determinants	Health System enablers
<p style="text-align: center;">Service Delivery</p> <ul style="list-style-type: none"> • Preventive care: Contraception, condoms, emergency contraception, GBV prevention, mental health, sexuality education, life skills • Treatment: Treatment of STIs, comprehensive abortion care, adolescent friendly health facilities, clinical care for survivors of sexual violence, Emergency contraception, nutrition, trauma surgery • Delivery models: Flexible and integrated ASRH services, Community-based, mobile and temporary clinics, provision of comprehensive SRH services for adolescents at a single site, home-based care, education and outreach through non-health facilities. Safe Spaces, Adolescent lens to MISP/Assessment • Kits: Menstrual Hygiene Kits (dignity kits), post-rape kits, STI kits, contraception kits 	<p style="text-align: center;">Non-health interventions</p> <ul style="list-style-type: none"> • Ensure schooling options through i.e. targeted support (safe passage; financial support to families) • Access to life skills and comprehensive sexuality education in and out of schools • Protection of girls from child marriage • Systems for adolescents' and young peoples' participation in decision making (including specifically girls') at community, provincial and national levels • Strengthen program linkages and referral pathways, and coordination among sectors, including protection, education and livelihoods, for a holistic, multi-sectoral response. 	<p style="text-align: center;">Health Systems Resilience</p> <ul style="list-style-type: none"> • Age/sex/ disability disaggregated data • Health workforce: Qualified and dedicated ASRH staff, including clinical staff: CHW, RC/RC volunteers, nurses, midwives, doctors, paramedics, national and international • Information: surveillance of priority illnesses including malnutrition, motility data, • Include adolescents in the design, planning and implementation from the onset of an emergency, as well as in monitoring and projects evaluation <p style="text-align: center;">Innovation and Research</p> <ul style="list-style-type: none"> • Use of social media to promote access to quality health information, • Flexible outreach strategies, including transportation budgets in view of reaching adolescents in insecure environments and otherwise hard-to-reach areas. • Focusing on adolescent and youth's specific potential for and actual contributions to resilience, response and recovery as part of sustainable development, <p style="text-align: center;">Financing</p> <ul style="list-style-type: none"> • External funding (short term) • CERF • Flash appeals/ • Traditional humanitarian donors: ECHO, OFDA, BPRM, programming development funds (GF, GAVI) • SRPs, pooled funds, trust funds.

4. Conclusion

Around the world, humanitarian needs are on the increase. Strategic action to address and prioritize support to reproductive, maternal, newborn, child and adolescent health even in the toughest settings is just essential. Action must be more context sensitive, adapted to and adaptable for changing circumstances and across the life course. Specifically, the action needed in fragile settings must be better anticipated, planned and resourced if every woman and every child everywhere is to have every chance for health and well being in every setting.

While the EWEC community has been working globally to address RMNCA&H needs, the humanitarian community has been working to deliver in the most challenging settings. Today and tomorrow - more than ever before – we need these communities to come together, to support each other's efforts and work in more complementary ways. We need this cooperation between and across humanitarian and development actors not only to bridge gaps but also to maximize the opportunities for sustained impact on the health and wellbeing of women, newborns, children and young people whose rights not only oblige this, but whose potential for invaluable contribution to their communities' and the countries' resilience, response and more enduring recovery from emergencies and crises will surely reward such effort.

/ends

(The recommended interventions are drawn from such reference as:

- Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings- A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings; <http://www.unfpa.org/publications/adolescent-sexual-and-reproductive-health-toolkit-humanitarian-settings#sthash.3RLOg8yd.dpuf>; UNFPA, Save the Children 2009
- Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services; WRC, UNHCR, Save the Children, UNFPA, 2012
- Clinical management of rape survivors
<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>
- Emergency Reproductive Health Kits Manual <http://www.iawg.net/resources/rhkits.html>
- Granada Report on Sexual and Reproductive Health in Protracted Crises and Recovery http://whqlibdoc.who.int/hq/2011/WHO_HAC_BRO_2011.2_eng.pdf, UNFPA, WHO, Andalusian School of Public Health
- Health Cluster Guide: A practical guide for country-level implementation of the Health Cluster
http://www.who.int/hac/global_health_cluster/guide/en/
- Humanitarian Action for Children, <http://www.unicef.org/appeals/index.html>
- IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings -
<http://www.unfpa.org/publications/guidelines-gender-based-violence-interventions-humanitarian-settings>;
<http://www.raiseinitiative.org/library/factsheets.php>
- IASC Guidelines for addressing HIV in humanitarian settings
<http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=9>
- IASC Guidelines for addressing mental health and psychosocial support in humanitarian settings
http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
- Inter-agency field manual on reproductive health and handbook <http://iawg.net/resource/field-manual/>
- Neonatal survival in complex humanitarian emergencies: setting an evidence-based research agenda, D. Morof, K. Kerber, B. Tomczyk, et al., 2014
- Proceedings of Technical Consultation On Neonatal Health in Humanitarian Settings; CDC and Save the Children, 2012)