

Toolkit on Rights Based Accountability and Sexual and Reproductive Health and Rights

Rights-Based Accountability, Strategies for
Accountable Health Systems and Community
Monitoring of Sexual and Reproductive Health and
Rights During Disasters

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About the Toolkit

This is a professional toolkit designed to create a training of trainers (TOT) curriculum that provides stakeholders with a comprehensive understanding of rights-based accountability and effective strategies for promoting accountable health systems, specifically focused on sexual and reproductive health and rights (SRHR) during disasters and emergencies. This toolkit equips trainers with information and resources to conduct TOT programs on the crucial intersection of rights-based accountability, accountable health systems, and community monitoring of SRHR. In today's healthcare landscape, mere service provision or a charity-based approach is insufficient. Achieving equitable and effective SRHR necessitates accountable health systems that prioritize human rights, respond to community concerns, and deliver quality care without discrimination. This toolkit aims to empower the trainers, to become a catalyst for positive change.

The toolkit is an outcome of collaborative efforts among all partners, including the Center for Reproductive Rights, CARE Nepal, and Forum for Women, Law and Development and NEEDs Nepal.

The toolkit provides a comprehensive framework for:

- Delving into the principles of rights-based accountability,
- Crafting and implementing strategies for accountable health systems,
- Cultivating community led SRHR monitoring, and
- Empowering communities to become agents of change.

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We hope this toolkit catalyzes transformative action, empowering stakeholders at every level to uphold the human rights principles in SRHR service delivery, in disaster preparedness, response and recovery.

Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
AI	Artificial intelligence
CCCM	Camp Coordination and Camp Management
CESCR	Committee on Economic, Social and Cultural Rights
CHS	Core Humanitarian Standard on Quality and Accountability
CRPD	Convention on the Rights of Persons with Disabilities
CRR	Center for Reproductive Rights
DEOCs	District Emergency Operation Centres
DoHS	Department of Health Services
EDCD	Epidemiology and Disease Control Division
EMDTs	Emergency Medical Deployment Teams
FGD	Focus Group Discussion
FWLD	Forum For Women, Law and Development
GBV	Gender Based Violence
HEOC	Health Emergency Operation Center
HRBA	Human Rights Based Approach
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
ICESCR	International Covenant on Economic, Social and Cultural Rights 1966
ICPD	International Conference on Population and Development
IDPs	Internally displaced persons
IHMIS	Integrated Health Management Information System
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MISP	Minimum Initial Service Package
ML	Machine Learning

MoH	Ministry of Health
NEOC	National Emergency Operation Center
NGO	Non Governmental Organization
NHRC	National Human Rights Commission
NHRIs	National human rights institutions
NWC	National Women Commission
OHCHR	Office for High Commissioner for Human Rights
PHEOCs	Provincial Health Emergency Operation Centers
PTSD	Post-Traumatic Stress Disorder
RH	Reproductive Health
RRT	Rapid Response Team
RSMRH Act	Right to Safe Motherhood and Reproductive Health Act, 2018
SDG	Sustainable Development Goals
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TOT	Training of Trainers
UDHR	Universal Declaration of Human Rights
UNDRR	United Nations Disaster Risk Reduction
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
WASH	Health, Water Sanitation and Health
WHO	World Health Organization

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I. Introduction to Rights-Based Accountability, SRHR and Disasters

A. Human Rights, Health, and SRHR

The well-being of individuals and communities rests on a foundation of interconnected elements: human rights, health, and sexual and reproductive health and rights (SRHR). These areas are not isolated domains, but rather, intimately linked, where progress in one reinforces the others.

At the core lies the principle of human dignity, enshrined in various international human rights treaties. This ensures individuals have the right to control their bodies, make informed decisions, and access essential healthcare services. This includes SRHR, encompassing access to family planning, safe abortion, comprehensive sexuality education, and freedom from discrimination and violence. Denying or restricting SRHR directly violates fundamental human rights, particularly those related to privacy, equality, and health. For example, limited access to contraception can restrict the right to choose the number and timing of children, impacting education, economic opportunities, and overall well-being. Similarly, denying safe abortion services puts lives at risk and undermines bodily autonomy.

It should be noted that upholding SRHR contributes significantly to improved overall health outcomes. When individuals have control over their reproductive choices, they are more likely to engage in healthy behaviors, seek preventive care, and utilize other healthcare services. This leads to decreased maternal mortality, improved child health, and reduced risk of sexually transmitted infections (STIs), including HIV/AIDS. Therefore, recognizing the deep connection between human rights, health, and SRHR is crucial.

Human Rights

Human rights are the basic rights and freedoms inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status.¹ In Jack Donnelly's words, human rights are, literally, the rights that one has simply because one is a human being.²

Special Features of Human Rights³

- Human Rights are not just abstract values such as liberty, equality and security. They are rights, particular social practices to realize those values.
- Human rights traditionally have been thought of as moral rights. They have become international legal rights.
- Human rights authorize and empower citizens to act to vindicate their rights. They are not just merely aspirations, suggestions, requests or laudable ideas.
- Human rights would appear to have humanity or human nature as their source. Human needs establish human rights.
- Human rights are needed not for life but for a life of dignity.

¹ Human Rights, Online material, available - [https://www.un.org/en/global-issues/human-rights#:~:text=Human%20rights%20are%20rights%20inherent,and%20education%2C%20and%20many%20more.\(accessed on 5 Feb 2024\)](https://www.un.org/en/global-issues/human-rights#:~:text=Human%20rights%20are%20rights%20inherent,and%20education%2C%20and%20many%20more.(accessed%20on%205%20Feb%202024))

² Jack Donnelly. (12 April 2013). Universal Human Rights in Theory and Practice. Cornell University Press.

³ Jack Donnelly. (12 April 2013). Universal Human Rights in Theory and Practice. Cornell University Press.

Human rights are universal, inalienable, interrelated, interdependent and indivisible.⁴ Human rights range from the most fundamental - the right to life - to those that make life worth living, such as the rights to food, education, work, health, and liberty.⁵ Everyone is entitled to these rights without discrimination.

Human Rights Characteristics⁶	
Universal	Human rights are universal, regardless of political, economic or cultural systems.
Inalienable	Human rights are inherent in all persons and cannot be alienated from an individual or group except with due process and in specific situations.
Interrelated	Improvement in the realization of any one human right is a function of the realization of the other human rights.
Interdependent	Human rights are interdependent, as the level of enjoyment of any one right is dependent on the level of realization of the other rights.
Indivisible	All civil, cultural, economic, political and social rights are equally important. Improving the enjoyment of any right cannot be at the expense of the realization of any other right.

As everyone is entitled to human rights, rights holders are all human, by virtue of being human that have a claim to certain entitlements, and the primary obligation to ensure human rights lies with States i.e. States are the primary duty-bearers under international human rights law. They have a legal obligation to respect, protect, and fulfill human rights.⁷

State Obligations⁸		
Respect	Protect	Fulfill
Respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. This includes the obligation to not violate human	Protect means that States must protect individuals and groups against human rights abuses. This includes the obligation to investigate and prosecute	Fulfill means that States must take positive action to facilitate the enjoyment of basic human rights. This includes the obligation to provide access to

⁴ UN General Assembly, World Conference on Human Rights. (12 July 1993). Vienna Declaration and Programme of Action. A/CONF.157/23. Para 5.

⁵ What are human rights?, Online material, available - <https://www.ohchr.org/en/what-are-human-rights>. (accessed on 5 February 2024)

⁶ Office of High Commissioner for Human Rights. (2012). Human Rights Indicators: A Guide to Measurement and Implementation, p.11.

⁷ Maastricht Principles on the Human Rights of Future Generations. (2023). <https://www.ohchr.org/sites/default/files/documents/new-york/events/hr75-future-generations/Maastricht-Principles-on-The-Human-Rights-of-Future-Generations.pdf>. (accessed on 4 February 2024).

⁸ International Human Rights Law, Online material, <https://www.ohchr.org/en/instruments-and-mechanisms/international-human-rights-law> and Maastricht Principles on the Human Rights of Future Generations. (2023). <https://www.ohchr.org/sites/default/files/documents/new-york/events/hr75-future-generations/Maastricht-Principles-on-The-Human-Rights-of-Future-Generations.pdf>. (accessed on 4 February 2024).

rights through their laws, policies, and actions.	human rights violations, and to provide remedies to victims.	education, healthcare, and other essential services.
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In addition to States, other actors also have a role to play in ensuring human rights such as international organizations, non-governmental organizations and individuals. The protection of human rights is a shared responsibility.⁹

Further Readings

- Office of High Commissioners for Human Rights. (2012). Human Rights Indicators:A Guide to Measurement and Implementation.

Health

Generally, across the globe, good health is consistently recognized as wealth. It is because poor health can significantly impact individuals' ability to participate in education, work, family life, and community activities.

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹⁰ The WHO stresses that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition and the health of all peoples is fundamental to the attainment of peace and security.¹¹ Likewise, the achievement of any State in the promotion and protection of health is of value to all.¹² It should be noted that the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.¹³

It should be noted that the right to the highest attainable standard of health is a human right recognized in international human rights law including the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR). Article 12 of the ICESCR recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'¹⁴ and in order to achieve full realization of this right, it obligates the State parties take necessary steps for 'the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child'¹⁵; 'the improvement of all aspects of environmental and industrial hygiene'¹⁶; 'the prevention, treatment and control of epidemic, endemic, occupational and other

⁹ See UN General Assembly. (9 December 1998). Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, General Assembly resolution 53/144.

¹⁰ Constitution of the WHO. (1946). Preamble.

¹¹ Id

¹² Id

¹³ Id

¹⁴ UN General Assembly. (16 December 1966). International Covenant on Economic, Social and Cultural Rights (ICESCR). United Nations, Treaty Series, vol. 993, p. 3. Article 12(1).

¹⁵ Article 12(2)(a), ICESCR

¹⁶ Article 12(2)(b), ICESCR

diseases¹⁷; and 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness'¹⁸.

Key aspects of the right to health¹⁹	
The right to health is an inclusive right.	It is not limited to access to health care and hospitals. It includes a wide range of factors that can help us lead a healthy life such as safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality.
The right to health contains freedoms.	These freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.
The right to health contains entitlements.	These entitlements include the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; equal and timely access to basic health services; the provision of health-related education and information; participation of the population in health-related decision making at the national and community levels.
Health services, goods and facilities must be provided to all without any discrimination.	<ul style="list-style-type: none"> ● Availability: Sufficient quantity of facilities, goods, and services within a State. ● Accessibility: Physically reachable for all (including vulnerable groups), affordable, and free from discrimination. ● Acceptability: Respecting medical ethics, gender-sensitive, and culturally appropriate. ● Quality: Medically sound with trained professionals, safe equipment, and proper sanitation.

The Committee on Economic, Social and Cultural Rights (CESCR) has elaborated normative content and interpretation of Article 12 of the ICESCR in the General Comment No. 14.²⁰ As per the General Comment No. 14, States have following core obligations relating to right to health:

¹⁷ Article 12(2)(c), ICESCR

¹⁸ Article 12(2)(d), ICESCR

¹⁹ OHCHR & WHO. (2008). The Right to Health. Factsheet No. 31.

²⁰ A general comment is an explanation and interpretation of a specific international treaty or convention, typically issued by a committee of experts overseeing that treaty. General Comment No. 14 is related with the Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR) issued by the UN Committee on Economic, Social and Cultural Rights on 11 August 2000.

- guarantee access to healthcare for all, especially vulnerable or marginalized groups;²¹
- ensure everyone has access to basic, nutritious, and safe food; and everyone is free from hunger;²²
- provide essential housing, sanitation, and safe drinking water;²³
- make essential medications readily available;²⁴
- ensure fair access to health resources across all groups;²⁵ and
- develop and implement a public health strategy based on evidence and community participation, and monitor progress using right-to-health indicators paying particular attention to vulnerable or marginalized groups in planning and implementation.²⁶

Likewise, States have following comparable obligations for right to Health:

- guarantee access to services supporting reproductive health, maternal (prenatal and postnatal) and child health;²⁷
- protect children from major infectious diseases through vaccination programs;²⁸
- implement measures to prevent, treat, and manage epidemic and pandemic diseases;²⁹
- disseminate knowledge on common health issues and preventive measures;³⁰ and
- equip healthcare professionals with training such as health and human rights principles.³¹

It should be noted that achieving full enjoyment of the right to health may not be immediately possible due to resource constraints and other challenges. However, States have a binding obligation to take concrete steps, continuously and to the maximum of their available resources, to move towards the full realization of this right for all - i.e. the progressive realization of the right to health.³² It should be stressed that core obligations, the most essential elements of the right to health, are considered non-derogable, meaning States cannot ignore them even under challenging circumstances including disasters and emergencies whereas comparable obligations are important but may not be as fundamental as core obligations.³³ States cannot, under any circumstances whatsoever, justify its non-compliance with the core obligation.³⁴

Considering health emergency and disaster risk management, it is necessary to protect public health and take measures to reduce morbidity, mortality and disability associated with emergencies through effective prevention, preparedness, response and recovery measures.³⁵ It is important to note that community-led primary health care strengthens resilience before, during, and after emergencies. This approach safeguards public health, services, and

²¹ Committee on Economic, Social and Cultural Rights. (11 August 2000). General Comment No. 14: the Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR). Para 43(a).

²² Para 43(b), General Comment No. 14

²³ Para 43(c), General Comment No. 14

²⁴ Para 43(d), General Comment No. 14

²⁵ Para 43(e), General Comment No. 14

²⁶ Para 43(f), General Comment No. 14

²⁷ Para 44(a), General Comment No. 14

²⁸ Para 44(b), General Comment No. 14

²⁹ Para 44(c), General Comment No. 14

³⁰ Para 44(d), General Comment No. 14

³¹ Para 44(e), General Comment No. 14

³² OHCHR. (December 2008). Frequently Asked Questions on Economic, Social and Cultural Rights. Fact Sheet No. 33.

³³ Para 47, General Comment No. 14

³⁴ Para 47, General Comment No. 14

³⁵ WHO et.al. (11 October 2012). Integrating sexual and reproductive health into health emergency and disaster risk management. Policy Brief.

infrastructure by proactively addressing vulnerabilities of at-risk populations, empowering communities to prevent, respond to, and recover from crises, providing a foundation for scaling up healthcare during emergencies, and prioritizing the well-being of women, children, and adolescents to prevent avoidable deaths and illnesses.³⁶

Further Readings

- OHCHR & WHO. (2008). The Right to Health. Factsheet No. 31.
- WHO et. al. (11 October 2012). Integrating sexual and reproductive health into health emergency and disaster risk management. Policy Brief.

SRHR

The United Nations 1994 International Conference on Population and Development (ICPD) defines reproductive health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes that implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”³⁷ Sexual health is defined as “a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity that requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”³⁸

The Guttmacher-Lancet Commission, defines SRHR as the recognition and fulfillment of the universal right of all individuals to have control over and decide freely and responsibly on matters related to their sexual and reproductive health.³⁹ It encompasses a comprehensive range of rights, including the right to access information, education, and services related to sexual and reproductive health, the right to make autonomous decisions regarding sexuality, contraception, and reproduction, and the right to be free from discrimination, coercion, and violence in relation to matters of sexual and reproductive health.⁴⁰

Sexual and reproductive health and Rights⁴¹

³⁶ WHO et.al. (11 October 2012). Integrating sexual and reproductive health into health emergency and disaster risk management. Policy Brief.

³⁷ UNFPA. (5-13 September 1994). *Programme of Action of the International Conference on Population and Development*. Cairo, Egypt. U.N. Doc. A/CONF.171/13/Rev.1, (1995). Para 7.2.

³⁸ World Health Organization. (2006). Defining Sexual Health cited by UNFPA and CRR. (n.d). Reproductive Rights: A Tool for Monitoring State Obligations. p.3.

³⁹ Ann M Starrs, Alex C Ezeh and others. (May 9, 2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, [http://dx.doi.org/10.1016/S0140-6736\(18\)30293-9](http://dx.doi.org/10.1016/S0140-6736(18)30293-9) (accessed on 5 Feb 2024)

⁴⁰ Ann M Starrs, Alex C Ezeh and others. (May 9, 2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, [http://dx.doi.org/10.1016/S0140-6736\(18\)30293-9](http://dx.doi.org/10.1016/S0140-6736(18)30293-9) (accessed on 5 Feb 2024)

⁴¹ Ann M Starrs, Alex C Ezeh and others. (May 9, 2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, [http://dx.doi.org/10.1016/S0140-6736\(18\)30293-9](http://dx.doi.org/10.1016/S0140-6736(18)30293-9) (accessed on 5 Feb 2024)

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health. The services should include:

- accurate information and counseling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counseling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of STIs, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

As aforementioned, SRHR includes both rights and services as well as freedom and entitlements. SRHR are crucial for the realization and enjoyment of all human rights.⁴² SRHR embraces human rights that may or may not be recognized in national laws but they have been

⁴² Reproductive rights are human rights. See UNFPA, The Danish Institute of Human Rights and OHCHR. (2014). Reproductive rights are human rights (A Handbook For National Human Rights Institutions); available at <https://www.ohchr.org/sites/default/files/Documents/Publications/NHRIHandbook.pdf> and CRR, Reproductive rights are human rights, 2009, available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf.

already guaranteed by international human rights instruments and other relevant UN consensus documents.⁴³

Twelve Human Rights Key to SRHR⁴⁴

- The Right to Life
- The Right to Liberty and Security of the Person;
- The Right to Health
- The Right to Decide the Number and Spacing of Children;
- The Right to Consent to Marriage and Equality in Marriage;
- The Right to Privacy;
- The Right to Equality and Non-Discrimination;
- The Right to be Free from Practices that Harm Women and Girls;
- The Right to be Free from Torture or Other Cruel, Inhumane, or Degrading Treatment or Punishment;
- The Right to be Free from Sexual and Gender-Based Violence;
- The Rights to Education and Information; and
- The Right to Enjoy the Benefits of Scientific Progress.

It is utmost important to ensure SRHR are accessible, affordable, acceptable and of quality.⁴⁵ Further it is important to ensure non-discrimination and equal treatment as well as consideration of gender based approaches including taking care of special needs of women, children, adolescents, elderly, and people with disabilities.⁴⁶ It is important to note that non-discrimination, in the context of SRHR, also encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity and intersex status.⁴⁷ This means SRHR are critical for individuals' health and wellbeing, encompassing physical, mental, and social dimensions. For instance, access to contraception, safe abortion, and preventative care empowers individuals to make informed choices about their bodies and lives, leading to improved maternal and child health, reduced STIs and HIV/AIDS, and stronger mental well-being. Therefore, they should be respected and fulfilled to ensure healthy lives where individuals can realize their full potential.⁴⁸ Violation of SRHR is a violation of human rights that may perpetuate inequalities and harmful consequences to individuals and communities at large.

⁴³ CRR. (2009). Reproductive rights are human rights, p.7 available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf (accessed on 5 Feb 2024)

⁴⁴ CRR. (2009). Reproductive rights are human rights, p.7 available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RRareHR_final.pdf (accessed on 5 Feb 2024)

⁴⁵ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22), para 12-21.

⁴⁶ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22), para 22-24

⁴⁷ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22), para 22-24

⁴⁸ Ann M Starrs, Alex C Ezeh and others. (May 9, 2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, [http://dx.doi.org/10.1016/S0140-6736\(18\)30293-9](http://dx.doi.org/10.1016/S0140-6736(18)30293-9) (accessed on 5 Feb 2024)

Importance of Ensuring SRHR

Improved Health Outcomes	<ul style="list-style-type: none"> ● Reduces maternal mortality and morbidity. ● Prevents unintended pregnancies and unsafe abortions. ● Decreases the spread of STIs and HIV/AIDS. ● Promotes better overall health and well-being.
Empowerment and Equality	<ul style="list-style-type: none"> ● Enables individuals to make informed choices about their SRH. ● Contributes to gender equality by promoting women's bodily autonomy and participation in decision-making. ● Upholds the human rights of all people, regardless of background or identity.
Addressing Disparities	<ul style="list-style-type: none"> ● Non-discrimination ensures everyone has equal access to SRHR services, regardless of factors like gender, sexual orientation, or disability. ● A gender-based approach acknowledges the specific needs of women, children, adolescents, the elderly, and people with disabilities in accessing SRHR services. ● Addressing the needs of marginalized groups promotes equity and social justice.
Respecting Diversity	<ul style="list-style-type: none"> ● Non-discrimination extends to LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex) individuals, ensuring they can access SRHR services without fear of judgment or discrimination based on their sexual orientation, gender identity, or intersex status. This results in respect for diversity of sex and gender.
Sustainable Development	<ul style="list-style-type: none"> ● Critical role in achieving Sustainable Development Goals (SDGs) including Goal 1 (End poverty in all its forms everywhere), Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Goal 5 (Achieve gender equality and empower all women and girls), Goal 10 (Reduce inequality

	within and among countries) and SDG 13 (Take urgent action to combat climate change and its impacts).
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Availability, Accessibility, Acceptability and Quality (AAAQ) framework

- Availability: An adequate number of functioning health-care facilities, services, goods, programs, trained medical and professionals should be available to provide the population with the fullest possible range of sexual and reproductive health care.⁴⁹
- Accessibility: Sexual and reproductive health care should be accessible to all individuals without discrimination or barriers.⁵⁰ It should be available within a safe physical and geographical reach, ensuring timely services and information.⁵¹ Affordability of these services is essential, whether provided publicly or privately.⁵²
- Acceptability: All facilities, goods, information and services related to SRH must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements.⁵³
- Quality: Sexual and reproductive health facilities, goods, information, and services must meet high-quality standards.⁵⁴

The States have an obligation to respect, protect and fulfill SRHR. The obligation to respect requires States to refrain from directly or indirectly interfering with the exercise by individuals of SRHR.⁵⁵ States must not limit or deny anyone access to sexual and reproductive health, including through laws criminalizing sexual and reproductive health services and information.⁵⁶ The obligation to protect requires States to take measures to prevent third parties from directly or indirectly interfering with the enjoyment of SRHR.⁵⁷ This includes regulating private healthcare facilities, insurance and pharmaceutical companies, and manufacturers of

⁴⁹ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 12

⁵⁰ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 15

⁵¹ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 16

⁵² Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 17

⁵³ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 20

⁵⁴ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 21.

⁵⁵ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 40

⁵⁶ Id

⁵⁷ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, para 42

health-related goods and equipment.⁵⁸ Discriminatory practices and violence must be prohibited, ensuring that no individuals or groups are excluded from accessing SRH services.⁵⁹ States are obligated to adopt appropriate measures to fully realize the right to sexual and reproductive health. Universal access without discrimination should be aimed for, particularly for disadvantaged and marginalized groups.⁶⁰

The core obligations⁶¹ of the State regarding SRHR include:

- an obligation to repeal and eliminate laws, policies, and practices that criminalize, obstruct, or undermine access to health facilities, services, goods, and information;
- an obligation to ensure universal access to quality sexual and reproductive health care, which includes maternal health care, contraceptive information and services, and safe abortion care as well as prevention, diagnosis, and treatment for infertility, reproductive cancers, STIs, and HIV/AIDS; and
- an obligation to ensure that everyone has access to comprehensive education and information that is non-discriminatory, evidence-based, and considers the evolving capacities of children and adolescents.

Human rights and indicative State obligations underpinning sexual and reproductive health (as set out in human rights norms and by UN Treaty Bodies Mechanisms)⁶²

The Right to Life

- Prevent maternal mortality and morbidity through safe motherhood programmes;
- Ensure access to safe abortion services at least when the life and health of the pregnant woman is at risk and in cases of rape and severe fetal impairment.
- Decriminalize abortion

The Right to Equality and Non-Discrimination

- Prohibit discrimination in access to health care on grounds of sex, age, disability, race, religion, nationality economic status, gender identity, sexual orientation, marital status, health status including HIV, etc.;

⁵⁸ Id

⁵⁹ Id

⁶⁰ Id

⁶¹ Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22), para 49 and UNFPA, *A Guide in Support of National Human Rights Institutions: Country assessments and national inquiries on human rights in the context of sexual and reproductive health and well-being* (New York, 2019), p. 14, with a few updates based on recent developments.

⁶² UNFPA. (2019). *A Guide in Support of National Human Rights Institutions: Country assessments and national inquiries on human rights in the context of sexual and reproductive health and well-being* (New York), p. 48, with a few updates based on recent developments.

- Do not deny access to health services that only women need.

The Right to Consent to Marriage and Equality in Marriage

- Prevent, prohibit, and punish child, early, and forced marriages;
- Set the minimum age limit for marriage at 18, equally for boys and girls.

The Right to be Free from Sexual and Gender-Based Violence

- Ensure gender-based violence, including domestic and intimate partner violence, is effectively prohibited and punished in law and in practice;
- Prohibit and punish all forms of rape, in peacetime and in conflict, including marital rape;
- Prohibit and punish all forms of violence perpetrated on the basis of sexual orientation.

The Right to Health

- Ensure adolescents have access to the full range of sexual and reproductive health care services and information;
- Ensure reproductive health services are available, accessible, acceptable, and of good quality.

The Right to Decide Number and Spacing of Children

- Ensure the full range of modern contraceptive methods;
- Ensure women are given comprehensive and accurate information to ensure informed consent to contraceptive methods, including voluntary sterilization.

The Right to be Free from Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment

- Guarantee access to emergency contraception, especially in cases of rape;
- Guarantee access to termination of pregnancy when a woman's life or health is in danger, in cases of rape and fatal fetal impairment;
- Prevent and address obstetric violence, including at health care facilities.

The Right to an Effective Remedy

- Ensure effective mechanisms are in place for women to complain of sexual and reproductive health and reproductive rights violations;
- Ensure women who are unable to afford a lawyer [have] access to effective counsel.

The Right to Education and Information

- Ensure school curricula include comprehensive, evidence-based, and non-discriminatory sexuality education;
- Ensure accurate public education campaigns on the prevention of HIV

transmission.

The Right to Privacy

- Ensure the right to bodily autonomy and decision-making around sexual and reproductive health issues;
- Guarantee confidentiality and privacy with regards to patient health care information, including prohibiting third party consent, such as spousal and parental, to sexual and reproductive healthcare services.

The Right to be Free from Practices that Harm Women and Girls

- Prohibit and punish all forms of female genital mutilation.

States must ensure satisfaction of minimum essential levels of SRHR that cannot be set aside in the time of disasters.⁶³ It means, as a part of core obligations, States should proactively review and repeal laws or policies that might hinder access to SRHR services during disasters. For example, restrictions on abortion, sex education, or access to contraceptives for certain groups or populations should be reviewed and removed at pre-disaster settings. Otherwise, there might be an increase in pregnancy related complications during disaster and consequently loss of lives of pregnant women due to unavailability of services and restrictions. Likewise, States should ensure all disaster response efforts are non-discriminatory, including access to SRHR services. In order to ensure universal access to quality care, States should invest in strengthening healthcare infrastructure, including facilities and personnel trained in SRHR in pre disaster time as well as stockpile essential supplies like contraceptives, medications for reproductive health needs, and dignity kits (containing sanitary pads, soap, etc.). Likewise, States should develop contingency plans to ensure continuity of SRHR services in emergencies. These plans should be implemented during and post-disaster setting. It is utmost important to adapt service delivery models to reach displaced populations by setting up temporary clinics, mobile units, or utilizing community outreach programs. Likewise, States have core obligation to prioritize the needs of vulnerable groups, such as pregnant women, lactating mothers, survivors of sexual violence, and adolescents. Most importantly, at pre-disaster setting, States should integrate SRHR information into disaster preparedness campaigns, including topics like maintaining hygiene during emergencies, preventing sexual violence, and accessing available SRHR services. During and Post-disaster, States should have mechanisms to disseminate clear and accessible information through multiple channels about available SRHR services, considering language and cultural needs. They can utilize various communication means like radio broadcasts, text messages, and community outreach workers to reach affected populations. Additionally, considering the fact that disasters can exacerbate mental health issues, mental health and psychosocial support should be incorporated into SRHR services to address the emotional well-being of those affected. For this purpose, it is critical to actively involve communities in planning, implementing, and monitoring the

⁶³ See, Committee on Economic and Social Council. (14 December 1990). General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), E/1991/23 and Committee on Economic, Social and Cultural Rights. (11 August 2000). General Comment No. 14: the Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR). Para 43(a).

delivery of SRHR services during disasters. This ensures services are culturally appropriate and cater to specific needs.

Further Readings

- CRR. (2009). Reproductive rights are human rights.
- CRR & UNFPA. (n.d.). Reproductive Rights: A Tool for Monitoring State Obligations.

B. Overview of Rights-Based Approach in Health and SRHR

A Human Rights Based Approach (HRBA) is a framework for analyzing and addressing issues through the lens of fundamental human rights principles and standards.⁶⁴ It is not just about protecting rights, but also about actively empowering individuals and communities to claim and enjoy those rights. The WHO emphasizes that a HRBA requires mainstreaming fundamental human rights principles and standards across health services and health system policies, including public health emergency preparation and responses.⁶⁵ Equally, it aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development problems.⁶⁶

Distinction between Charity Based Approach and HRBA⁶⁷

	Goals	Individuals	Responsibilities
Charity Based Approach	Filling the gaps of (often material) needs	Beneficiaries, Objects of charity,	Discretion of givers, no obligations
HRBA	Fulfilling aimed human rights in a human rights sensitive manner	Subjects as rights-holders as well as duty bearers in different contexts	National and international law oriented obligations and accountability for fulfilling the rights of individuals

⁶⁴ OHCHR. (2006) Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation.

⁶⁵ <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>

⁶⁶ WHO and OHCHR. (n.d). A Human Rights-Based Approach To Health, https://www.ohchr.org/sites/default/files/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf

⁶⁷ Hisayo Katsui. (2008). Downside of the Human Rights-Based Approach to Disability in Development. Working Paper Series of IDS at Helsinki University 2008/02.

HRBA is based on human rights principles i.e. universality, indivisibility, equality and non-discrimination, participation, and accountability, and focuses on developing the capacities of both ‘duty-bearers’ to meet their obligations, and ‘rights-holders’ to claim their rights.⁶⁸

The heart of HRBA lies in equality, equity and non-discrimination. It is important to recognize and address overlapping forms of discrimination (e.g., race, gender, disability) that contribute to health inequities and focus on closing the gap for disadvantaged groups through equity.⁶⁹ Likewise, participation requires empowering health service users, communities and civil society to actively engage in all stages of health planning, decision-making, and implementation.⁷⁰ Strategies to address power imbalances and ensure meaningful participation are crucial. Equally, establishing transparent and accessible mechanisms for holding governments and other stakeholders including private sector and non-governmental sector accountable for upholding health-related human rights obligations.⁷¹

In this light, it is important to ensure a right based approach to SRHR during disasters. Disasters disrupt access to essential services including SRHR. Therefore, in order to ensure everyone's right to have access to essential services including SRHR during disasters, a right based approach becomes critical:

Rights-Based Approach to SRHR During Disasters⁷²

Disaster	Interventions	Steps
Pre-Disaster Preparedness	Policy and Law	<p>Review and revise existing SRHR policies and laws to ensure they comply with human rights principles.</p> <p>Review existing laws and policies to identify and eliminate any discriminatory provisions that might hinder access to SRHR services.</p> <p>Develop clear legal frameworks that define the State's obligations regarding SRHR and hold them accountable for fulfilling those obligations.</p>
	Capacity Building	Invest in healthcare infrastructure to ensure adequate

⁶⁸ The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies. Online material. Available at: <https://unsdg.un.org/resources/human-rights-based-approach-development-cooperation-towards-common-understanding-among-un>. (accessed at 15 February 2024).

⁶⁹ <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> (accessed at 15 February 2024).

⁷⁰ <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> (accessed at 15 February 2024).

⁷¹ <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> (accessed at 15 February 2024).

⁷² This table is an indication of steps to be taken by States and concerned authorities while applying HRBA in disaster settings. This is based on National Strategic Action Plan on Disaster Reduction 2018-2023 of the Government of Nepal.

		<p>facilities, equipment, and trained personnel to deliver quality SRHR services.</p> <p>Integrate SRHR training into medical and healthcare professional curricula and invest in training healthcare professionals, including first responders, on providing SRHR services in disaster settings..</p> <p>Raise awareness among policymakers, healthcare providers, and the public about the importance of SRHR and the rights enshrined in national and international law.</p>
	Community Engagement	<p>Promote community participation in decision-making processes related to SRHR service delivery and program development.</p> <p>Work with communities, including marginalized groups, to develop disaster preparedness plans that address specific SRHR needs. This fosters trust and ensures plans are culturally appropriate.</p> <p>Encourage community mobilization to hold governments accountable for upholding SRHR rights.</p>
	Mobilizing Resources	<p>Increase national budgetary allocations for SRHR services and programs.</p> <p>Explore innovative financing mechanisms including public-private partnerships, user fees with exemptions for the most vulnerable, and international development assistance.</p>

		Ensure efficient and transparent allocation and utilization of resources for SRHR programs.
	Resource Stockpiling/prepositioning of essential services	Stockpile essential supplies for SRHR services, including contraceptives, medications for reproductive health needs, hygiene kits, and dignity kits.
	Promoting Gender Equality	Address gender-based discrimination as a key barrier to accessing SRHR services. Empower women and girls so that they would be able to make decisions related to SRHR independently.
	Promoting Cooperation, Coordination and Collaboration among different stakeholders	Collaboration between health ministries, NGOs, and civil society organizations to ensure comprehensive SRHR services are available and accessible to all Joint efforts can lead to the development of efficient referral systems, ensuring individuals receive the care they need, when they need it.
Disaster Response	Needs Assessments	Conduct rapid needs assessments to identify populations most in need of SRHR services. Prioritize services for vulnerable groups like pregnant women, lactating mothers, survivors of sexual violence, and adolescents.
	AAAQ	Ensure services are accessible by establishing temporary clinics, mobile units, and utilizing community outreach programs. States should consider waiving fees for SRHR services to make them affordable for everyone.
	Non-discrimination and equality	Implement measures to ensure all individuals, regardless of background, sexual orientation, gender identity, or disability, have equal access to SRHR services.

	Information Dissemination	Disseminate clear and accessible information about available services in multiple languages and formats, considering cultural needs. Utilize various communication channels like radio broadcasts, text messages, and community outreach workers
	Mental Health and Psychosocial Support	Integrate mental health and psychosocial support into SRHR services to address the emotional well-being of those affected by disasters.
	Monitoring and Accountability	Establish mechanisms to monitor the delivery of SRHR services and ensure they adhere to human rights principles. This allows for addressing any gaps or discrimination during response efforts.
	Community Engagement and Participation	Actively involve communities in decision-making and monitoring of service delivery. This ensures culturally appropriate and responsive services.
Disaster Recovery	Addressing needs	Address needs of women, senior citizens, persons with disabilities, and children while reconstructing facilities like senior citizen homes, orphanage homes, and community homes. This should include priority for health facilities and hospitals.
	Awareness programs	Conduct awareness programs "build back better" integrating Green principles and SRHR needs and rights.

Further Reading

- WHO & OHCHR. (n.d). A Human Rights-Based Approach To Health.
- WHO. (2019). Health emergency and disaster risk management framework. <https://iris.who.int/handle/10665/326106>.

C. Importance of Accountability in SRHR⁷³

Accountability has three dimensions: it refers to the obligation of those in authority to take responsibility for their actions, to answer for them to those affected, and to be subject to some form of enforceable sanction if their conduct or explanation is found wanting.⁷⁴

Dimensions of Accountability

Accountability	<p>Responsibility</p> <p>Responsibility requires that those in positions of authority have clearly defined duties and performance standards, enabling their behavior to be assessed transparently and objectively.</p>
	<p>Answerability</p> <p>Answerability requires public officials and institutions to provide reasoned justifications to those affected by their decisions, to oversight bodies, and to the electorate and the public at large.</p>
	<p>Enforceability</p> <p>Enforceability requires putting mechanisms in place that monitor the degree to which public officials and institutions comply with established standards and ensure that appropriate corrective and remedial action is taken when this is not the case.</p>

Accountability takes many forms such as political accountability, social accountability, administrative accountability and legal accountability.⁷⁵

Forms of Accountability

<p>Legal Accountability</p> <p>This involves the enforcement of laws and regulations, with penalties for violations. It is upheld by the legal system, including Courts, Law enforcement and regulatory bodies.</p>	<p>Social Accountability</p> <p>Social accountability involves mechanisms led by citizens, communities, civil society organizations and independent media that are used to hold duty bearers accountable for their actions and performance.</p>
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⁷³ This section is limited to legal accountability related to SRHR. However, social accountability tools may play important role in ensuring accountability for SRHR.

⁷⁴ OHCHR & Center for Economic and Social Rights. (2013). Who Will Be Accountable? Human Rights and the Post-2015 Development Agenda.

⁷⁵ WHO. How to make sense of government accountability. (Online material). Available at <https://blogs.worldbank.org/governance/how-make-sense-government-accountability> (accessed on 15 March 2024).

Litigation is a critical component for establishing legal accountability.	
<p>Political Accountability</p> <p>To ensure political accountability in SRH, both national and subnational governments must be transparent in justifying the criteria used and decisions made to legislators.⁷⁶ Meaningful legislative oversight necessitates that the Executive branch furnishes parliamentarians and local legislatures with comprehensive budget and planning documents, along with program results. This transparency allows for informed deliberation by legislators.⁷⁷ Adequate time for review is also crucial for effective legislative oversight.⁷⁸</p>	<p>Administrative Accountability</p> <p>To ensure effective administrative accountability in SRH, healthcare facilities and the Ministry of Health should establish comprehensive internal policies and guidelines.⁷⁹ These directives should clearly define standards of conduct for staff and delineate lines of accountability within the hierarchy. An independent oversight body, free from conflicts of interest, should be designated to monitor adherence to these established protocols.⁸⁰</p>

The OHCHR's technical guidance emphasizes that right based accountability must be embedded in all stages of humanitarian/SRHR programming.⁸¹ Accountability is not an afterthought after human rights violations occur but seeks to transform health systems and sustain change through acknowledging contextual and political factors, power dynamics, processes of contestation, and need for meaningful participation to realize human rights including SRHR.⁸² The OHCHR's technical guidance states that planning should involve rights based need assessment, for instance, identifying healthcare needs from a woman's rights perspective, ensuring services address discrimination and accessibility issues.⁸³ Likewise, budgets should reflect the resources needed to fulfill healthcare needs, prioritizing equitable and quality healthcare services.⁸⁴ It articulates that ensuring implementation in practice requires human rights training to healthcare providers and community engagement in designing and implementing programs that address their specific needs and cultural contexts.⁸⁵ Similarly,

⁷⁶ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. p.12.

⁷⁷ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. p.12.

⁷⁸ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. p.12.

⁷⁹ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. p.12.

⁸⁰ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. p.12.

⁸¹ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance.

⁸² Arnott, G., Otema, C., Obalim, G., Odallo, B., Nakubulwa, T., & Okello, S. B. T. (2022, August 22). *Human rights-based accountability for sexual and reproductive health and rights in humanitarian settings: Findings from a pilot study in northern Uganda*. PLOS Global Public Health. <https://doi.org/10.1371/journal.pgph.0000836>

⁸³ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. pp. 4-7.

⁸⁴ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. pp. 7-8.

⁸⁵ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. pp. 8-11.

establishing accessible and effective mechanisms to report violations of rights and ensuring mechanisms to investigate and address complaints of rights violations and hold perpetrators accountable should be in place.⁸⁶ It is important to regularly collect data and monitor processes. Likewise, ensuring remedies for right violation including compensation is required to ensure greater accountability for human rights including SRHR.⁸⁷

Right Based Accountability for SRHR⁸⁸



Source: CRR

Additionally, the Core Humanitarian Standard on Quality and Accountability (CHS) sets out Nine Commitments that organizations and individuals involved in humanitarian response can use to improve the quality and effectiveness of the assistance they provide.⁸⁹ It also facilitates greater accountability to communities and people affected by crisis: knowing what

humanitarian organizations have committed to enable them to hold those organizations to account.⁹⁰

9 Principles of the CHS⁹¹

S.N.	Nine Commitments	Quality Criterion
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⁸⁶ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. pp. 11-12.

⁸⁷ OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance. pp. 13-14.

⁸⁸ The image below is based on CRR's slide presentation.

⁸⁹ CHS Alliance, Group URD and the Sphere Project. (2014). Core Humanitarian Standard on Quality and Accountability.

⁹⁰ CHS Alliance, Group URD and the Sphere Project. (2014). Core Humanitarian Standard on Quality and Accountability.

⁹¹ CHS Alliance, Group URD and the Sphere Project. (2014). Core Humanitarian Standard on Quality and Accountability.

1	Communities and people affected by crises receive assistance appropriate and relevant to their needs.	Humanitarian response is appropriate and relevant.
2	Communities and people affected by the crisis have access to the humanitarian assistance they need at the right time.	Humanitarian response is effective and timely.
3	Communities and people affected by crises are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.	Humanitarian response strengthens local capacities and avoids negative effects.
4	Communities and people affected by crises know their rights and entitlements, have access to information and participate in decisions that affect them.	Humanitarian response is based on communication, participation and feedback.
5	Communities and people affected by crises have access to safe and responsive mechanisms to handle complaints.	Complaints are welcomed and addressed.
6	Communities and people affected by the crisis receive coordinated, complementary assistance.	Humanitarian response is coordinated and complementary.
7	Communities and people affected by crisis can expect delivery of improved assistance as organizations learn from experience and reflection	Humanitarian actors continuously learn and improve.
8	Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.	Staff are supported to do their job effectively, and are treated fairly and equitably.
9	Communities and people affected by crises can expect that the organizations assisting them are managing resources effectively, efficiently and ethically.	Resources are managed and used responsibly for their intended purpose.

Core Humanitarian Standard on Quality and Accountability



Source: The Core Humanitarian Standard on Quality and Accountability

Circle of Accountability⁹²

A Community Circle of Accountability is a social accountability tool designed and utilized by civil society organization like CARE Nepal that includes structured group comprised of right holders – those who represent the interests of marginalized communities – and duty bearers⁹³. This circle fosters an environment of open communication and collaboration. Members work together to ensure a clear understanding of fundamental human rights, specifically those related to SRH. Through this collaboration, the circle aims to:

- Hold duty bearers accountable for upholding SRH principles and standards.
- Empower vulnerable women and girls to claim their SRH rights.
- Ensure the full range of SRH services are accessible and of high quality for excluded populations.

The model of Community Circle of Accountability is jointly supported and facilitated by community-based monitors and civil society partners working for human rights and humanitarian actions.

- **Community-based Monitors:** Community-based Monitors (CBMs) are trained individuals from local communities with a desirable capacity and motivation to facilitate the Community Circle of Accountability. They conduct regular meetings, sensitize members on SRH rights, and discuss emerging SRH issues, stigmatization, harmful social norms and violation of human rights. They will collect SRH related complaints and organize advocacy campaigns to uphold the SRH rights. Community-

⁹² This section is based on internal document shared by CARE Nepal - Circle of Accountability (CoA) SoP. The latest version is of 11 March 2024

⁹³ Duty bearers include governments, healthcare providers, NGOs, and other institutions responsible for upholding SRH rights.

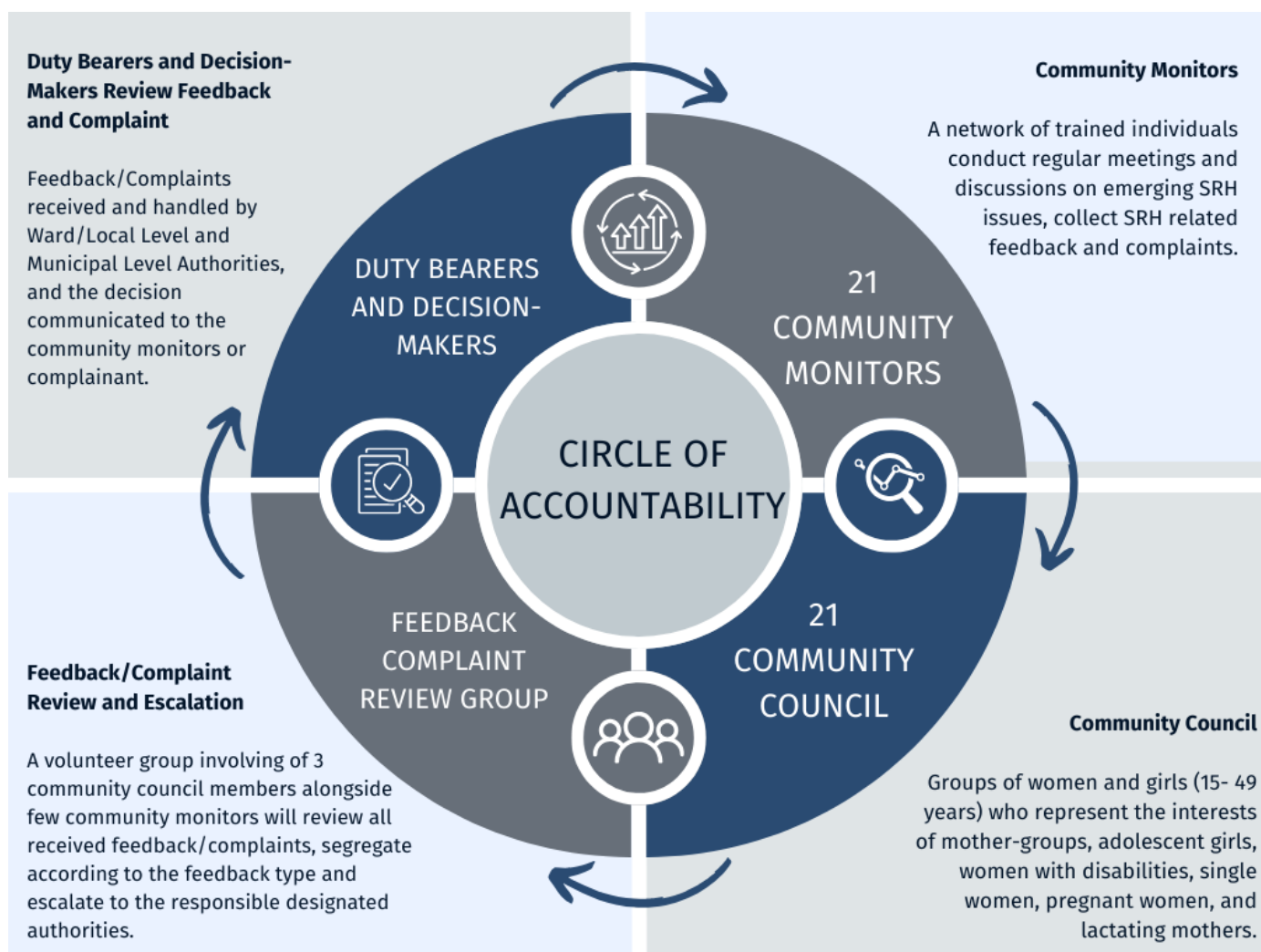
based Monitors are integral part of the Community Circle of Accountability as they actively engage with and take the role as a mediator between duty bearers and right holders, channeling the complaints and follow-up with accountable authorities and reporting back to the community on response outcomes over the complaints. Community-based Monitors are also sensitized about emergency situations and how they can best support during this time. They play a crucial role in enhancing transparency, accountability, and community engagement to build and strengthen SRHR-related services in disaster settings.

- **Community Council:** A community council is formed at each marginalized and disaster vulnerable settlement, consisting of 20-21 individuals. The council will consist of women of 15- 49 years of age, including but not limited to, members from mother-groups, adolescent girls, women with disabilities, single women, pregnant women, and lactating mothers. The community council meets regularly, understands SRH rights, discusses SRH service issues, harmful social norms, behavior of duty bearers, express their impression on SRH service quality and advocate for changes. The council members are chosen because they are active leaders of their communities who are aware and sensitized about SRHR issues. Further onsite coaching is also offered by Kailali based field staff, to the council members, if needed. Community council members collect SRHR related feedback and complaints from its surrounding community and bring it for discussion during regular meetings—the feedback and complaints are then reviewed, analyzed, and categorized. The community council decides on reporting channels based on interest, priority, and local context based on priorities of marginalized and excluded women, girls, and other minorities.

Operational Model of Community Circle of Accountability

The feedback and complaints will be reported anonymously and classified as confidential unless the complainant requests to be identified for specific reasons. The received feedback and complaints will be segregated based on their severity and escalated by a Volunteer Feedback/Complaint Review Group of 3 community council members in close support of community monitors. Based on their categorization, the feedback and complaints will be reported to various levels of concerned authorities and followed up to get a timely response. The response provided by the authorities regarding the feedback and complaints is reviewed at the community council, cohort of Community Monitors and reported back to concerned complainants. It collaborates, lobbies and builds effective alliances with relevant civil society and human rights actors, legal aid services, rehabilitation centers to appropriately address the complaints of sensitive nature and ensure justice to the survivors. Additionally, the community score card tool is integrated at each community circle of accountability where duty bearers and right holders are brought together to assess readiness, willingness, and timeliness of right holders to respond the received feedback and complaints, and resolution outcomes. The operational modality is shown in the figure below.

Circle of Accountability



Source: CARE Nepal

In this light, importance of accountability in SRHR can be described as follows:

- It helps to promote equity and access by holding duty bearers like governments and healthcare providers accountable for fulfilling their obligations to provide quality SRHR services.
- It ensures resources allocated for SRHR are used effectively and reach marginalized groups often facing discrimination and barriers.
- It helps to increase transparency and trust in the healthcare system, leading to better utilization of services.
- It fosters an environment where individuals can exercise their SRHR freely and make informed decisions about their bodies and lives.
- It empowers communities to advocate for SRHR-friendly policies and hold governments accountable for ensuring their rights.
- It fosters collaboration and dialogue between stakeholders, including communities, providers, and policymakers.
- It provides individuals and communities with mechanisms to voice concerns and seek redress if their SRHR are violated.

- It contributes to achieving SDGs related to health and gender equality.

Further Readings

- CRR . (2021, June 8). *Technical Paper: Accountability for Sexual and Reproductive Health and Rights in Humanitarian Settings*. <https://reproductiverights.org/accountability-for-sexual-and-reproductive-health-and-rights-in-humanitarian-settings/>
- Arnott, G., Otema, C., Obalim, G., Odallo, B., Nakubulwa, T., & Okello, S. B. T. (2022, August 22). *Human rights-based accountability for sexual and reproductive health and rights in humanitarian settings: Findings from a pilot study in northern Uganda*. PLOS Global Public Health. <https://doi.org/10.1371/journal.pgph.0000836>
- OHCHR. (n.d.) Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance.
- CHS Alliance, Group URD and the Sphere Project. (2014). Core Humanitarian Standard on Quality and Accountability.
- Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response

D. Disaster Management and SRH Risks

Disaster means "a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts."⁹⁴ Disasters, whether natural or human-made, can have wide-ranging and devastating consequences on individuals, communities, and entire societies such as loss of life and injuries, property and infrastructure damage, displacement, loss of livelihood, social and psychological impacts including widespread trauma and emotional distress, and environmental damage, such as landslides, deforestation, and pollution. Equally, several factors may exacerbate the consequences of disaster such as pre-existing vulnerabilities (poverty, social inequality, and lack of access to healthcare and resources) and inadequate preparedness and responses.

Hazard, Risk and Vulnerability

A hazard is a process, phenomenon or human activity that may cause loss of life, injury or other health impacts, property damage, social and economic disruption or environmental degradation.⁹⁵ Hazards may be natural, anthropogenic or socionatural in origin.⁹⁶

⁹⁴ <https://www.undrr.org/terminology/disaster> (accessed at 15 February 2024).

⁹⁵ Sendai Framework Terminology on Disaster Risk Reduction. Online Material. Available at <https://www.undrr.org/terminology/hazard> (accessed on 14 March 2024).

⁹⁶ Sendai Framework Terminology on Disaster Risk Reduction. Online Material. Available at <https://www.undrr.org/terminology/hazard> (accessed on 14 March 2024).

Vulnerability means the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.⁹⁷

Disaster Risk is expressed as the likelihood of loss of life, injury or destruction and damage from a disaster in a given period of time.⁹⁸ disaster risk results from the complex interaction between development processes that generate conditions of exposure, vulnerability and hazard.⁹⁹

Disaster risk has many characteristics such as:

- It is forward looking - the likelihood of loss of life, destruction and damage in a given period of time.¹⁰⁰
- It is dynamic meaning it can increase or decrease according to our ability to reduce vulnerability.¹⁰¹
- It is invisible. It consists of not only the threat of high-impact events, but also the frequent, low-impact events that are often hidden.¹⁰²
- It is unevenly distributed around the earth. Hazards affect different areas, but the pattern of disaster risk reflects the social construction of exposure and vulnerability in different countries.¹⁰³
- It is emergent and complex. Many processes, including climate change and globalized economic development, are creating new, interconnected risks.¹⁰⁴

Understanding Disaster Risk



⁹⁷ Sendai Framework Terminology on Disaster Risk Reduction. Online Material. Available at <https://www.undrr.org/terminology/vulnerability> (accessed on 14 March 2024).

⁹⁸ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

⁹⁹ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

¹⁰⁰ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

¹⁰¹ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

¹⁰² Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

¹⁰³ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

¹⁰⁴ Disaster Risk. Online Material. Available at <https://www.preventionweb.net/understanding-disaster-risk/component-risk/disaster-risk> (accessed on 14 March 2024).

The Sphere handbook emphasizes that "a well-functioning health system can respond to all healthcare needs in a crisis so that even during a large-scale health crisis [...], other healthcare activities can continue."¹⁰⁵ The Inter-agency Working Group on Reproductive Health in Crises (IAWG) points out that disaster/humanitarian crisis poses a critical threat to the health, safety, security or well-being of a community or other large group of people and the coping capacity of the affected community is overwhelmed, in-country infrastructure is disrupted, and external assistance is required.¹⁰⁶ In disaster settings/humanitarian settings, providing SRH services is crucial. These environments often magnify existing risks and create new barriers to crucial healthcare. As access to SRH care is a fundamental human right, those affected by conflict or disaster deserve protection and assistance. By delivering these services promptly, deaths, illnesses, and disabilities related to pregnancy, childbirth complications, gender-based violence, HIV, and other reproductive issues can be prevented.¹⁰⁷

Sphere Protection Principles¹⁰⁸

1. Enhance the safety, dignity and rights of people, and avoid exposing them to harm.
2. Ensure people's access to assistance according to need and without discrimination.
3. Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.
4. Help people claim their rights.

Fundamental Principles Of Sexual And Reproductive Health Programming In Humanitarian Settings¹⁰⁹

1. Work in respectful partnership
2. Advance human rights and reproductive rights through SRH programming
3. Ensure technical soundness, human rights, and financial accountability
4. Share information and results

Nevertheless, disasters and humanitarian crises pose significant challenges to ensuring access to SRH services. Various researches highlight the increased vulnerability to poor SRH outcomes in these settings. Disruptions caused by crises, such as damaged health facilities, depleted human resources, and population displacement, hinder service delivery and utilization

¹⁰⁵ Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response, p.297.

¹⁰⁶ **Inter-Agency Working Group on Reproductive Health in Crises. (2018). Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018, p. 2.**

¹⁰⁷ Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018, p. 2

¹⁰⁸ Four Protection Principles apply to all humanitarian action and all humanitarian actors. See Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.

¹⁰⁹ The foundation of SRH programming in humanitarian settings should be guided by 4 fundamental principles as per IAWG. See IAWG. (2018). Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018

while limited financial resources further exacerbate these gaps, leading to unmet needs for key populations within affected communities.¹¹⁰ The representative data from a 2015 study from three crisis-affected countries in sub-Saharan Africa suggests that safe abortion was an alarming gap across all facilities, despite unsafe abortion having been estimated to cause 25–50% of maternal deaths in refugee settings and despite policies, guidelines and funding, there remains an urgent need to address gaps in implementation, quality of care, utilization of SRH services, monitoring and evaluation.¹¹¹

The 2021 study - Innovation for Sexual and Reproductive Health in Humanitarian Crises: Where we are now and how to move the agenda found following priority humanitarian SRH gaps. It should be noted that the list does not include GBV related gaps.

Priority Humanitarian SRH gaps¹¹²

Gaps	
Services	<ul style="list-style-type: none"> ● Safe abortion/post-abortion care and advocacy ● Family planning, especially long-acting reversible contraceptives ● Long-acting reversible contraception(LARCs) and emergency contraception (EC) ● Interventions addressing neonatal mortality, including stillbirths ● Interventions addressing utero-genital fistulae and female genital mutilation/cutting (FGM/C) ● Quality maternity care, including respectful care ● Home-based maternity care by community health workers (CHWs) ● Home or community-based newborn care ● Pregnancy and newborn care education for caregivers ● Integrated mental health/psychosocial support (PSS) and SRH services
Populations	<ul style="list-style-type: none"> ● Vulnerable newborns (small and sick) ● Adolescents (10-19) and young people (up to 24) ● Older people (particularly women) ● People with disabilities ● LGBTQIA+

¹¹⁰ ELRHA. (2021). Innovation for Sexual and Reproductive Health in Humanitarian Crises: Where we are now and how to move the agenda forward. p.10.

¹¹¹ Cited by ELRHA. (2021). Innovation for Sexual and Reproductive Health in Humanitarian Crises: Where we are now and how to move the agenda forward. p.10.

¹¹² ELRHA. (2021). Innovation for Sexual and Reproductive Health in Humanitarian Crises: Where we are now and how to move the agenda forward. p.14.

	<ul style="list-style-type: none"> ● People living with HIV/AIDS ● Sex workers ● Urban refugees and refugees outside of camp settings
Capacities	<ul style="list-style-type: none"> ● MISP to comprehensive SRH implementation ● Skilled healthcare providers across SRH components ● Collection and monitoring of data on maternal and neonatal mortality ● Use of data for evidence-based decision-making ● SRH supply chain management

In this light, Disaster Risk Management for Health Factsheets by WHO presents key SRH risks at disaster setting as follows:

- **Violation of Rights:** Disasters can exacerbate existing vulnerabilities and inequalities, increasing the risk of human rights violations. Protecting the rights of women and girls, including their SRHR, is essential in ensuring their safety and well-being during disasters.
- **Risks Faced by Adolescents:** Disasters often lead to school closures, hindering access to essential life skills education, including sexual and reproductive health information.¹¹³ Likewise, breakdown in social norms and community structures during disasters can heighten the risk of gender-based violence, including sexual assault and exploitation, for adolescent girls.¹¹⁴ It is often seen during disasters that economic hardship and displacement can pressure families to marry off their daughters early, increasing their risk of complications during pregnancy and childbirth.¹¹⁵ Equally, disruptions to healthcare systems can make it difficult for adolescents to access confidential SRH services, including contraception and counseling.¹¹⁶
- **Family Planning:** Disasters can disrupt supply chains and damage health facilities, leading to stockouts of essential contraceptives. This can make it difficult for women to reach healthcare facilities for family planning services. In chaotic situations, misinformation about reproductive health can spread easily, leading to harmful choices. Consequently, this may lead to increased risk of unplanned pregnancy and increased risk of unsafe abortion, with further risk in situations where there is rape and sexual violence.¹¹⁷
- **Maternal and Newborn Health:** Disasters can overwhelm healthcare systems, reducing the availability of skilled birth attendants, which can increase the risk of complications

¹¹³ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹¹⁴ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹¹⁵ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹¹⁶ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹¹⁷ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

during childbirth for mothers and newborns.¹¹⁸ Disruptions to healthcare services can make it difficult for pregnant women to access essential antenatal care, increasing the risk of pregnancy-related complications.¹¹⁹ Poor water, sanitation, and hygiene conditions in disaster settings can increase the risk of infections for mothers and newborns.¹²⁰

- Trauma and GBV: Disasters can cause significant trauma, leading to mental health problems such as anxiety, depression, and post-traumatic stress disorder (PTSD), which can affect women's and girls' SRH.¹²¹ Due to increased vulnerabilities during disasters, this can lead to an increase in gender-based violence, including sexual assault, domestic violence, and exploitation. It can be very difficult for survivors of GBV to access essential support, including medical care, counseling, and legal aid during a disaster.
- STIs: Displacement and disruption of social norms can increase risky sexual behavior, putting individuals at greater risk of contracting STIs. Disruptions to healthcare services can make it difficult for people to get tested and treated for STIs, leading to further transmission. It should be noted that populations (particularly if affected by complex emergencies) are at greater risk of HIV due to reduced access to HIV prevention and treatment services and greater exposure to sexual violence and transactional sex.¹²²

Disaster preparedness is key to a well-coordinated response to preventing sexual violence and assisting survivors, reducing the transmission of HIV and other STIs, and preventing excess maternal and neonatal mortality and morbidity.¹²³ Governments and communities should improve public health emergency response capacity across various levels (systems, organizational, and individual) and various phases of the disaster management cycle (preparedness, response, recovery, mitigation).¹²⁴

In this light, key actions for SRH disaster preparedness and response include:

- Integrating SRH into disaster risk management laws, policies and strategies with necessary resources and community participation;
- Assessing population's needs and health system capabilities for SRH services;
- Building resilient health systems and ensure primary care can function during disasters;
- Conducting regular drills and simulations to test the readiness of health facilities and personnel to respond to SRH needs during disasters.

¹¹⁸ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹¹⁹ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹²⁰ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹²¹ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹²² WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹²³ Beek, K., Drysdale, R., Kusen, M., & Dawson, A. (2021, September 20). Preparing for and responding to sexual and reproductive health in disaster settings: evidence from Fiji and Tonga. *Reproductive Health*. <https://doi.org/10.1186/s12978-021-01236-2>

¹²⁴ Beek, K., Drysdale, R., Kusen, M., & Dawson, A. (2021, September 20). Preparing for and responding to sexual and reproductive health in disaster settings: evidence from Fiji and Tonga. *Reproductive Health*. <https://doi.org/10.1186/s12978-021-01236-2>

- Undertaking population-based health education around the needs of women and babies before, during and after birth with a particular emphasis on danger signs and when and where to seek care;
- Identifying health workers with midwifery skills and facilities for basic and comprehensive emergency obstetric care;
- Including SRH messages and needs in disaster awareness campaigns; and
- Strengthening existing services and improving coordination, planning, training, and capacity to rapidly implement the Minimum Initial Service Package (MISP) in emergencies.¹²⁵
- Providing psychosocial support and counseling services for survivors of gender-based violence and other traumatic experiences.

Further Readings

- UNFPA. Reproductive Health for Communities in Crisis (UNFPA Emergency Response) (old publication)
- IAWG. (2018). Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018.
- Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.
- WHO. (2022). WHO guidance on research methods for health emergency and disaster risk management (Revised).

F. Most Vulnerable Populations and Potential Risk Factors

Vulnerability is the human dimension of disasters and is the result of the range of economic, social, cultural, institutional, political and psychological factors that shape people’s lives and the environment that they live in.¹²⁶ It should be noted that disasters don't affect everyone equally as some individuals and communities are more vulnerable due to various factors, leading to a greater impact when disaster strikes.

Vulnerability¹²⁷	
<p>Physical Vulnerability</p> <p>Physical Vulnerability may be determined by aspects such as population density levels, remoteness of a settlement, the site, design and materials used for critical infrastructure and for housing.</p>	<p>Social Vulnerability</p> <p>Social Vulnerability refers to the inability of people, organizations and societies to withstand adverse impacts to hazards due to characteristics inherent in social interactions, institutions and systems of cultural values. It includes aspects related to levels of literacy and</p>

¹²⁵ WHO. (May 2011). Disaster Risk Management for Health Factsheets, Disaster Risk Management for Health: SEXUAL AND REPRODUCTIVE HEALTH, Global Platform.

¹²⁶ Vulnerability. (9 June 2021). Understanding Disaster Risk. Available at: <https://www.preventionweb.net/understanding-disaster-risk/component-risk/vulnerability#:~:text=Vulnerability%20is%20the%20human%20dimension,environment%20that%20they%20live%20in.> (accessed on 10 February 2024)

¹²⁷ What does Vulnerability mean? Online material, available at: <https://www.unisdr.org/2004/campaign/booklet-eng/Pagina8ing.pdf> (accessed on 10 February 2024)

<p>Example: Wooden homes are less likely to collapse in an earthquake, but are more vulnerable to fire.</p>	<p>education, the existence of peace and security, access to basic human rights, systems of good governance, social equity, positive traditional values, customs and ideological beliefs and overall collective organizational systems.</p> <p>Example: When flooding occurs some citizens, such as children, elderly and differently-able, may be unable to protect themselves or evacuate if necessary.</p>
<p>Economic Vulnerability</p> <p>The level of vulnerability is highly dependent upon the economic status of individuals, communities and nations. The poor are usually more vulnerable to disasters because they lack the resources to build sturdy structures and put other engineering measures in place to protect themselves from being negatively impacted by disasters.</p> <p>Example: Poorer families may live in squatter settlements because they cannot afford to live in safer (more expensive) areas.</p>	<p>Environmental Vulnerability</p> <p>Natural resource depletion and resource degradation are key aspects of environmental vulnerability.</p> <p>Example: when people cut down too many trees at a faster pace than nature can replace them. This is what we call deforestation. It increases the vulnerability of many communities to rain which, when they fall on unprotected soil, cause mudslides, landslides, floods and avalanches.</p>

Thus, poverty, inequality, geographical location, weak governance, and age and disability affect vulnerability. For instance, marginalized groups often have limited access to resources and decision-making. Likewise, weak governance can hinder disaster preparedness and response. Equally, children, senior citizens, and people with disabilities may have specific needs and require additional support which might be very difficult to find during a disaster if not well prepared in advance.

<p>Social Determinants of Health¹²⁸</p> <ul style="list-style-type: none"> ● Income and social protection ● Education ● Unemployment and job insecurity ● Working life conditions ● Food insecurity ● Housing, basic amenities and the environment ● Early childhood development ● Social inclusion and non-discrimination ● Structural conflict

¹²⁸ According to WHO, social determinants of health (SDH) are the non-medical factors that influence health outcomes and health inequities. This may affect health impact during disasters.

- Access to affordable health services of decent quality.

Understanding Vulnerability and Capacities¹²⁹

Access current situation and trends over time			
<ul style="list-style-type: none"> - Who is affected? ^[L]_[SEP] - Needs and vulnerabilities ^[L]_[SEP] - Coping strategies and capacities ^[L]_[SEP] - Displaced? Mobile? ^[L]_[SEP] - What are affected people's priorities? ^[L]_[SEP] 	<ul style="list-style-type: none"> - Protection threats and risks ^[L]_[SEP] - Security situation and rule of law ^[L]_[SEP] - Access to assistance ^[L]_[SEP] - Access to people in need? ^[L]_[SEP] - Seasonal variations in hazards ^[L]_[SEP] 	<ul style="list-style-type: none"> - Stakeholders and power relationships ^[L]_[SEP] - Capacity and intent of responders ^[L]_[SEP] - Response plans of authorities and other actors ^[L]_[SEP] - Role of host population ^[L]_[SEP] 	<ul style="list-style-type: none"> - Available goods and services ^[L]_[SEP] - Market systems and supply chains ^[L]_[SEP] - Capacity of infrastructure ^[L]_[SEP] - Service providers (financial and others) ^[L]_[SEP] - Logistics capacities, constraints ^[L]_[SEP]



Analyze and prioritize
<p>What problems must be addressed? For which groups of people? In what geographic area? Over what timeframe? Against which standards?</p>



Review options and decide how the response will be delivered	
<p>consider available options in your context:</p> <ul style="list-style-type: none"> - Direct service delivery - Commodity distribution - Technical assistance - Market-based programming - Cash-based assistance 	<p>From these, select response options based on your assessment of:</p> <ul style="list-style-type: none"> - Urgency and timeliness ^[L]_[SEP] - Feasibility ^[L]_[SEP] - Capacities ^[L]_[SEP] - Dignity ^[L]_[SEP] - Protection threats, risks ^[L]_[SEP] - Efficiency, cost- effectiveness

¹²⁹ Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response. p.11.

	<ul style="list-style-type: none"> - Resilience^[L]_[SEP] - National ownership - Government policy
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Design a program built on quality and accountability			
Essential lenses <ul style="list-style-type: none"> - Disaggregate data by sex, age and disability^[L]_[SEP] - Vulnerabilities and protection^[L]_[SEP] - Sustainability or transition^[L]_[SEP] 	Communication and accountability <ul style="list-style-type: none"> - Feedback and complaints mechanisms^[L]_[SEP] - Coordination^[L]_[SEP] - Systematic community engagement^[L]_[SEP] 	Monitoring context, process, progress and results <ul style="list-style-type: none"> - Selection of indicators - Appropriate data disaggregation 	Transition and exit strategies <ul style="list-style-type: none"> - Local engagement and ownership^[L]_[SEP] - National systems and ownership^[L]_[SEP] - Partnerships^[L]_[SEP]

Source: Sphere project (2018)

Most vulnerable populations during disasters are as follows:

- Women and girls, particularly pregnant and lactating women, adolescents, and those already facing marginalization, poverty, or disability.
- Children, especially those unaccompanied, separated from caregivers, or with special needs.
- Senior Citizens, particularly those facing limited mobility, chronic illnesses, or residing in institutions.
- People with disabilities who face physical barriers, communication challenges, and increased dependence on support systems.
- Indigenous communities who are often marginalized with unique cultural needs and limited access to resources.
- Internally displaced persons (IDPs) and refugees who face displacement trauma, disrupted access to services, and potential exploitation.
- LGBTQIA+ individuals who are facing potential discrimination and limited access to specific SRHR needs.

Likewise, potential risk for vulnerable populations and SRHR are as follows:

- Limited access to SRHR services
- Increased risk of gender-based violence including exploitation, sexual assault, and domestic violence due to breakdown of social norms and increased vulnerabilities.
- Unintended pregnancies and unsafe abortions due to limited access to contraception and safe abortion services.
- Risks to maternal and newborn health complications

- Increased risky sexual behavior leading to STIs and limited access to testing and treatment.
- Mental health issues such as trauma, stress, anxiety and lack of mental health support.
- Increased vulnerability to human trafficking for sexual exploitation.
- Lack of information and communication including Difficulty accessing critical SRHR information and communicating needs.

Further Readings

- UNFPA. Reproductive Health for Communities in Crisis (UNFPA EMERGENCY RESPONSE) (old publication)
- IAWG. (2018). Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018.
- Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.

II. Framework for Rights-Based Accountability in Health Systems

A. Principles of Rights-Based Accountability

Right-based accountability is a framework that holds duty-bearers responsible for fulfilling the human rights of rights-holders. It is a tool for promoting and protecting human rights by ensuring that everyone can enjoy their rights fully and equally and also empowering individuals and communities to hold duty bearers accountable. As aforementioned, accountability is not an afterthought after human rights violations occur and goes beyond legal accountability and includes principles of participation, transparency, agency, sustainability, international assistance and non-discrimination.¹³⁰

Key principles of Right based accountability are as follows:

- Participation: Human rights law ensures that everyone has the right to participate in decisions which affect their human rights. Participation must be active, free, informed, meaningful and give attention to issues of accessibility, including access to information in a form and a language which can be understood.¹³¹
- Accountability: Accountability requires effective monitoring of human rights standards as well as effective remedies for human rights breaches. For accountability to be effective there must be appropriate laws, policies, institutions, administrative procedures and mechanisms of redress in order to secure human rights.
- Non-discrimination and equality: All human beings in all their diversity are entitled to the protection and enjoyment of their human rights.¹³² In practice, this means interventions must assess patterns of inequality and discrimination in terms of protection, advantages and opportunities. All forms of discrimination in the realization of rights must be prohibited, prevented and eliminated. It also requires the prioritization of those in the most marginalized situations who face the biggest barriers to realizing their rights.
- Empowerment: A human rights based approach means that individuals and communities should know their rights. It also means that they should be fully supported to participate in the development of policy and practices which affect their lives and to claim rights where necessary.
- Legality: A human rights based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law.
- Capacity building of rights-holders and duty- bearers. Care providers and all other accountable bodies must be sure that their practices and procedures are grounded in human rights law. Under the law they must not breach the human rights of anyone.
- Transparency: This entails making information on policies and interventions understandable and accessible to all stakeholders. It promotes the right to freedom of information. State institutions become more accountable with transparent, reliable and

¹³⁰ WHO. Human Rights. Online material. Available at: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>; and ENNHRI. Human Rights Based Approach. Online material. Available at: <https://ennhri.org/about-nhris/human-rights-based-approach/> (accessed on 11 February 2024)

¹³¹ WHO. Human Rights. Online material. Available at: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>; and ENNHRI. Human Rights Based Approach. Online material. Available at: <https://ennhri.org/about-nhris/human-rights-based-approach/> (accessed on 11 February 2024)

¹³² WHO. Human Rights. Online material. Available at: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>; and ENNHRI. Human Rights Based Approach. Online material. Available at: <https://ennhri.org/about-nhris/human-rights-based-approach/> (accessed on 11 February 2024)

trustworthy information, available via accessible channels and access to information regimes. The principle promotes the availability of disaggregated data, especially sex and age disaggregation. It ensures that data is also related to groups in more vulnerable situations. For instance, Governments who have ratified the Convention on the Rights of Persons with Disabilities (CRPD) are obliged to collect data on persons with disabilities in a transparent way. On the other hand, access to information for persons with disabilities means that information should be provided in various formats (written, audio, easy-to read, sign language, etc.) and that consultation mechanisms should be inclusive and accessible (for example meetings are organized in accessible buildings).

B. Components of Accountable Health Systems

The primary purpose of health systems is to improve health and health systems deliver preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and personal health care - by both State and non-State actors.¹³³ Therefore, health systems need to be responsive and financially fair, while treating people respectfully.¹³⁴ It is not possible without, among others, adequate staff, funds, information, supplies, transport, communications and enabling laws and policies.

Some of the key components of accountable health systems are presented below:

- **Leadership and governance:** Accountability is an intrinsic aspect of leadership and governance. It focuses on setting strategic direction, managing resources, and ensuring accountability within the health system. It includes strong leadership at all levels, effective policies and legal frameworks, and mechanisms for community participation. Effective health systems governance is essential for ensuring that healthcare services are accessible, equitable, efficient, affordable and of high quality for all.¹³⁵
- **Service delivery:** This refers to the organization and provision of health services to individuals and communities. It encompasses essential services like immunizations, maternal and child health care, communicable disease control, and non-communicable disease management. Efficient delivery systems, equitable and quality services, skilled healthcare providers, and accessible facilities are crucial.
- **Health system financing:** It deals with mobilizing, allocating, and managing financial resources for health services. It includes various sources like government funding, user fees, and health insurance schemes. Sustainable financing ensures equitable access to quality care without financial hardship and catastrophic expenditures. It should be noted that health system financing must aim to make healthcare services financially accessible to all, removing financial barriers and minimizing burdens on individuals and families. For instance, provisions of health insurance can improve financial affordability of health services.
- **Health workforce:** This refers to the personnel providing health services, including doctors, nurses, community health workers, and other skilled professionals. It encompasses adequate numbers, appropriate training, fair distribution, and supportive work environments to deliver quality and effective services.

¹³³ WHO. (2010). Monitoring The Building Blocks Of Health Systems: A Handbook Of Indicators And Their Measurement Strategies.

¹³⁴ WHO. (2010). Monitoring The Building Blocks Of Health Systems: A Handbook Of Indicators And Their Measurement Strategies.

¹³⁵ WHO. Health System Governance. Online material. Available at: https://www.who.int/health-topics/health-systems-governance#tab=tab_1 (accessed on 11 February 2024)

- Medical products, vaccines and technologies: It covers the availability, affordability, and accessibility of essential medicines, vaccines, diagnostic tools, and other health technologies. It necessitates efficient procurement, supply chain management, and rational use to improve health outcomes.
- Health information systems: This refers to the collection, analysis, and use of health data to inform decision-making, monitor progress, and improve service delivery. Robust information systems with data quality and availability are essential for evidence-based policy and resource allocation.

Likewise, some of the other aspects of accountable health system are presented below:

- Quality of Service: It is crucial to ensure quality of service i.e. ensuring the standard of care provided by healthcare systems, encompassing clinical effectiveness, safety, patient satisfaction, and adherence to established standards.
- Access to Service: It is utmost important to ensure and create an enabling environment for individuals to receive necessary healthcare services without barriers like distance, cost, discrimination, or lack of information.
- Care Coordination: Effective collaboration between various healthcare providers involved in a patient's care, ensuring continuity and avoiding duplication of services is needed.
- Client Engagement: It is crucial to ensure active participation of individuals in decision-making regarding their healthcare, promoting informed choices and ownership of their health.
- Financial Accountability: It is important to responsible use of resources allocated to healthcare systems, ensuring transparency, efficiency, and value for money.
- Provider Accountability: It is crucial to hold healthcare professionals responsible for adhering to ethical and professional standards, delivering quality care, and being responsive to patient needs.
- Outcome Measurement and Reporting: It is important to ensure systematic collection, analysis, and reporting of health data to assess progress, identify areas for improvement, and promote accountability.
- Privacy and Confidentiality: Accountable health system protects the privacy of individuals' healthcare information, ensuring trust and ethical data handling.
- Comprehensiveness: Offering a broad range of healthcare services to meet the various needs of a population, including preventive, curative, and rehabilitative care is a part of an accountable health system.
- Culturally Sensitive: In order to enhance acceptability of health services, they should be culturally sensitive i.e. providing health care that respects and acknowledges the cultural beliefs and practices of diverse populations, promoting better engagement and health outcomes.
- Equity: In order to redress marginalization and disadvantages, equity in health services is required. It is necessary to ensure fair and just access to healthcare services for all individuals, regardless of their background, social status, or other factors.

In this light, components and functions of accountable health system during disasters are presented as follows:

Components and Functions of Accountable Health System during Disasters¹³⁶

S.N.	Component/Function	Time	Key Points
1	Policies, Strategies and Legislation	Pre-disaster Phase	<p>Clear guidelines and frameworks that integrate health considerations into disaster risk management plans must be developed.</p> <p>Law and Policy that that supports the implementation of Health emergencies and disaster risk management activities must be enacted</p>
2	Planning and Coordination	Pre-disaster Phase and during disaster	<p>Effective planning and coordination are crucial for a successful health emergency and disaster management. Multi-sectoral collaboration (among various sectors like health, emergency response, and public works in planning and response efforts) with clear defined role and responsibilities must be ensured.</p>
3	Human Resources	Pre-disaster Phase and during disaster phase	<p>It includes - training healthcare professionals in emergency preparedness and response skills; developing mechanisms to rapidly increase the health workforce during disasters through volunteers and deployments; and providing mental health and psychosocial support for healthcare workers responding to disasters.</p>
4	Financial Resources	Pre-disaster Phase and during disaster	<p>It includes allocating sufficient national and</p>

¹³⁶ This table is adapted from the Health Emergency and Disaster Risk Management publication of WHO. See WHO. (2019). Health Emergency and Disaster Risk Management. pp. 9-11.

			international resources for Health EDRM preparedness, response, and recovery efforts; developing strategies for mobilizing additional resources during disasters and ensuring efficient use of financial resources for maximum impact.
5	Information and Knowledge management	Pre-disaster Phase and during disaster	It includes collecting and analyzing health data to track outbreaks, identify needs, and monitor response effectiveness; establishing mechanisms for timely and accurate information sharing among all stakeholders and promoting the sharing of best practices and lessons learned from previous disasters.
6	Risk Communication	Pre-disaster Phase; during disaster and post disaster phase	It includes creating clear communication plans to disseminate accurate and timely information to the public; utilizing various communication channels like radio, television, and social media to reach diverse populations and addressing rumors and misinformation to maintain public trust.
7	Health Infrastructure and logistics	Pre-disaster	Building resilient health infrastructure and establishing efficient logistics systems are crucial for delivering health services during disasters.
8	Health and related services	During Disaster phase and post disaster	Health and related services must be continued disasters, including maternal and child health; communicable

			disease control and mental health and psychosocial support.
9	Community Capacity	Pre-disaster, During Disaster phase and post disaster	Empowering communities is crucial for a sustainable Health system. It must include community engagement, community based health workers and volunteers, and public awareness.
10	Monitoring and evaluation	During Disaster phase and post disaster	It includes developing monitoring indicators; data collection and analysis; and evaluation and feedback.

Accountable health system and Disaster¹³⁷

Disaster Cycle	Components	Key Points
Preparedness	Pre-disaster planning	Collaboration between healthcare providers, emergency response agencies, and public health officials to develop response plans for disasters. This includes stockpiling essential supplies, training staff in disaster response protocols, and establishing communication channels.
	Investing in infrastructure resilience	Strengthening healthcare facilities to withstand disasters and ensuring backup power and communication systems.
Response	Focus on essential services	Prioritizing life-saving care like trauma treatment, emergency surgery, and maternal health services.
	Resource allocation based on need	assessing patients effectively to allocate limited resources fairly and efficiently.

¹³⁷ This table is adapted from WHO publication including building blocks of health systems. See, WHO. (2010). Monitoring The Building Blocks Of Health Systems: A Handbook Of Indicators And Their Measurement Strategies and WHO. (2019). Health Emergency and Disaster Risk Management.

	Surge capacity	Having mechanisms to quickly increase healthcare workforce and bed capacity during disasters, utilizing volunteers and deploying mobile clinics.
	Data collection and reporting	Collect and analyze data to track health outcomes, resource utilization, and population needs in order to guide response efforts and identify gaps.
Transparency and Accountability	Transparency	Communicating clearly with the public about available services, resource limitations, and response efforts.
	Performance monitoring	Tracking key metrics like mortality rates, access to care, and efficiency of resource allocation to ensure effectiveness of the response.
	Equity	Ensuring all affected populations have access to essential services, regardless of background or location.
Challenges	Limited resources	Disasters often strain healthcare systems, requiring difficult decisions about resource allocation.
	Disrupted infrastructure	Damage to health facilities and communication networks can hinder response efforts.
	Population displacement	Locating and providing care to displaced populations can be challenging.

Further Readings:

- Inter-Agency Standing Committee. (December 2022). Handbook Mental Health And Psychosocial Support Coordination.
- WHO. (2019). Health Emergency and Disaster Risk Management.
- WHO. (2010). A Conceptual Framework for Action on the Social Determinants of Health.
- WHO. (2010). Monitoring The Building Blocks Of Health Systems: A Handbook Of Indicators And Their Measurement Strategies.

C. Linking SRHR with Accountability Frameworks

Accountability frameworks play a crucial role in holding duty bearers and stakeholders responsible for delivering essential services. It helps to bridge service gaps, and advance health equity as individuals, especially those marginalized or facing vulnerabilities, struggle to access these crucial services.

Actors involved in rights-based accountability (duty-bearers and rights-holders)

- **Empowering rights-holders:**

It should be noted that individuals regardless of age, gender, sexual orientation, disability, ethnicity, or other factors are SRHR rights holders. Likewise, considering the fact that specific groups often face greater barriers to SRHR, such as adolescents, LGBTQIA+ individuals, people with disabilities, indigenous communities, refugees, and sex workers, groups and communities are rights holders.

What does it mean to empower right holders?	
Knowledge and information	It requires equipping individuals and communities with accurate information about their SRHR, including available services, legal frameworks, and their rights.
Access to resources	It requires removing barriers to accessing quality SRH services, including financial limitations, geographical constraints, and discriminatory practices.
Voice and Agency	It requires promoting participation in decision-making processes, allowing individuals to express their needs and advocate for themselves.
Capacity building	It requires providing training and resources to individuals and communities to understand their rights, navigate systems, and hold duty-bearers accountable.

Empowering rights holders requires effective strategies as below:

Strategies for empowering right holders

Capacity building workshops	It requires educating individuals and communities about their SRHR, available services, and legal frameworks.
Community mobilization	It requires forming networks and support groups where individuals can share experiences, learn from each other, and collectively address challenges.
Media and communication campaigns	It requires raising awareness about SRHR issues and challenging harmful stereotypes and gender norms.
Legal aid and support	It requires providing legal assistance to individuals who face discrimination or violations of their SRHR.
Youth engagement	It requires ensuring young people have access to age-appropriate SRH information and services, fostering informed decision-making
Advocacy and lobbying	It requires engaging communities with policymakers to enact/update laws and policies that uphold SRHR and hold duty-bearers accountable.

One of the examples of empowering rights holders include peer educators in refugee camps in Rwanda.¹³⁸ The local organization called Alight in partnership with UNFPA conducts training sessions for young people in refugee camps and they utilize their knowledge and skills to advocate for Adolescent Sexual and Reproductive Health and Rights and become a peer educator to their fellow young people in the camp.¹³⁹ Taking the example of Rwanda, peer educators play a crucial role in providing SRH information and education to fellow refugees, particularly women and girls.

An example of a project 'DISHA: The Development Initiative Supporting Healthy Adolescents' from India shows the impact of empowering adolescent youths regarding sexual and reproductive health needs.¹⁴⁰ The DISHA documented behavior change

¹³⁸ <https://rwanda.unfpa.org/en/news/empowered-empower-others-peer-educators-promoting-sexual-and-reproductive-health-humanitarian>

¹³⁹ Id

¹⁴⁰ ICRW. (2008). Catalyzing Change (improving Youth sexual and Reproductive Health Through disha, an Integrated Program in india).

including increased contraceptive use among youth and enabled youths to claim their SRHR.¹⁴¹

- **Strengthening the role of duty-bearers**

States are the primary duty-bearer for upholding human rights, including SRHR, through legislation, policies, resource allocation, and ensuring service delivery. Therefore, States should ensure healthcare providers, hospitals, and clinics are responsible for providing quality, accessible, and non-discriminatory SRH services. In larger picture, education sector including schools and educators should be made responsible for providing comprehensive sexuality education and addressing harmful gender norms whereas justice Sector including police, lawyers, and courts should be made responsible for protecting individuals from SRHR violations and upholding the law. Media and community leaders and organizations play a crucial role in raising awareness, mobilizing communities, and advocating for SRHR.

It is important to note that private sectors including companies involved in pharmaceutical production, healthcare delivery, and advertising have responsibilities to respect and promote SRHR.

International organizations including UN agencies, human rights organizations, and development partners can support States and other actors in fulfilling their SRHR obligations. This is subject to their mandate, funding structure and commitments. For instance, UN Agencies like UNFPA and WHO have specific mandates to promote SRHR. They set global standards, conduct research, and provide technical assistance to countries. Likewise, Development Partners, agencies and NGOs often integrate SRHR into broader development goals like poverty reduction, universal health coverage, and SDGs.

Strategies to make duty bearers accountable for SRHR

Strengthening Legal and Policy Frameworks	<p>It is necessary to ensure that legislation upholds SRHR and makes duty bearers accountable for their obligations. Likewise, the legal and policy framework should ensure remedies for violation of SRHR.</p> <p>In this light, strategies should include continuous advocacy on implementation of SRHR laws and supporting individuals and groups experiencing SRHR violations to seek legal remedy and redress.</p>
Utilizing Monitoring and Reporting Mechanisms	<p>This requires developing and utilizing complaint mechanisms.</p>
Enhancing Transparency and Participation	<p>Financial transparency can be improved by advocating for public reporting on finances aimed at SRHR programs and demanding</p>

¹⁴¹ Id

	<p>for timely and regular social audit of budgets.</p> <p>It is important to promote public participation in decision-making processes. For instance, inclusion of right holders, especially marginalized groups, is important in planning and budgeting for SRHR services.</p> <p>Utilizing social media and technology can promote sharing information, help organizing campaigns, and holding duty bearers accountable.</p>
Strengthening national human rights institutions (NHRIs)	NHRIs may investigate and document SRHR violations. Likewise, NHRIs may publish reports and share findings widely to raise awareness and demand accountability from duty bearers.
Building partnerships with diverse stakeholders and improving coordination/collaboration	It is important to collaborate with healthcare professionals, civil society organizations, and media to amplify advocacy efforts.
Holding international actors accountable	It is important to advocate for accountability of international organizations and donors regarding their commitments to SRHR.

Further Readings

- Agarwal, Sanjay; Van Wicklin, Warren A. (2012). How, When and Why to Use Demand-Side Governance Approaches in Projects. World Bank, Washington, DC. <http://hdl.handle.net/10986/13064>.

Selected Accountability Mechanism

United Nations Human Rights Accountability Mechanism

Human rights accountability mechanism is mainly a recommendation body and relies on highlighting or drawing the attention of the concerned States regarding human rights violations. It is related to the obligations of States to protect and promote human rights. It should be noted that it is not the court system that enforces human rights. It recommends States to investigate and prosecute human rights violations and bring the perpetrators to justice as well as provide reparation to victims of human rights violations.

At UN level, human rights accountability mechanisms are broadly categorized into two category i.e. Charter based bodies and Treaty based bodies.

Distinction between Charter based bodies and Treaty based bodies

Charter Based Bodies	Treaty Based Bodies
These bodies are established under the UN Charter and are responsible for promoting and protecting human rights in general.	The human rights treaty bodies are committees of 18 independent experts that monitor implementation of the core international human rights treaties.
They are established to monitor the compliance of human rights standards and treaties by member States.	They are established to monitor implementation of international human rights treaties.
Charter based bodies include Human Rights Council, [SEP]Universal Periodic Review, Special Procedures of the Human Rights Council and Human Rights Council Complaint Procedure.	Treaty based bodies include 9 committees and 1 sub committee established under core human rights treaties. (List is provided below under Treaty monitoring bodies section)

Human Rights Council

The Human Rights Council is an inter-governmental body within the United Nations system made up of 47 States responsible for the promotion and protection of all human rights around the globe.¹⁴² It has the ability to discuss all thematic human rights issues and situations that require its attention throughout the year.¹⁴³ It has adopted numerous resolutions including 'Promoting, protecting and respecting women's and girls' full enjoyment of human rights in humanitarian situations (RES 45/29)'.¹⁴⁴

Universal Periodic Review

The Universal Periodic Review (UPR) is a unique process which involves a review of the human rights records of all UN Member States.¹⁴⁴ The UPR is a State-driven process, under the auspices of the Human Rights Council, which provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfill their human rights obligations.¹⁴⁵ As one of the main features of the Council, the UPR is designed to ensure equal treatment for every country when their human rights situations are assessed. The ultimate aim of this mechanism is to improve the human rights situation in all countries and address human rights violations wherever they occur.¹⁴⁶ Currently, no other universal mechanism of this kind exists.¹⁴⁷

Example: In 2021, the CRR, FWLD and JuRI Nepal made a joint submission to the UPR of

¹⁴² <https://www.ohchr.org/en/hrbodies/hrc/home> (accessed on 11 February 2024)

¹⁴³ <https://www.ohchr.org/en/hrbodies/hrc/home> (accessed on 11 February 2024)

¹⁴⁴ <https://www.ohchr.org/en/hr-bodies/upr/upr-home> (accessed on 11 February 2024)

¹⁴⁵ <https://www.ohchr.org/en/hr-bodies/upr/upr-home> (accessed on 11 February 2024)

¹⁴⁶ <https://www.ohchr.org/en/hr-bodies/upr/upr-home> (accessed on 11 February 2024)

¹⁴⁷ <https://www.ohchr.org/en/hr-bodies/upr/upr-home> (accessed on 11 February 2024)

Nepal.¹⁴⁸ The joint submission focused on two areas related to SRHR in Nepal: Legal and procedural barriers that continue to restrict access to safe abortion services and the negative impact of the COVID-19 pandemic on SRHR in the country.¹⁴⁹

Special Procedures

The special procedures of the Human Rights Council are independent human rights experts with mandates to report and advise on human rights from a thematic or country-specific perspective.¹⁵⁰ As of November 2023, there are 46 thematic and 14 country mandates.¹⁵¹ For instance, the Special Rapporteur on the right to health is very crucial to protect and promote SRHR.

Treaty Monitoring Bodies ^[15]_{SEP}

The human rights treaty bodies are committees of 18 independent experts that monitor implementation of the core international human rights treaties.¹⁵² They consider States parties' reports; consider individual complaints; conduct country inquiries; and adopt general comments and organize thematic discussions to interpret the provisions of their treaty or treaties.¹⁵³ The Committee on economics, social and cultural rights is crucial to ensure the right to health and SRHR.

List of Treaty Monitoring Bodies

Treaty	Treaty Body	State Parties (as of 15 February 2024)
International Convention on the Elimination of All Forms of Racial Discrimination	Committee on the Elimination of All Forms of Racial Discrimination	182
International Covenant on Civil and Political Rights	Human Rights Committee	173
International Covenant on Economic, Social and Cultural Rights	Committee on Economic, Social and Cultural Rights	171
Convention on the Elimination of All Forms of Discrimination against Women	Committee on the Elimination of All Forms of Discrimination against Women	189

¹⁴⁸ CRR, FWLD & JuRI Nepal. (2021). Joint Submission To The Universal Periodic Review Of Nepal. 37thSession of the UPR Working Group of the Human Rights Council. Available at: <https://fwld.org/wp-content/uploads/2020/07/RHR-UPR.pdf> (accessed on 17 March 2024).

¹⁴⁹ CRR, FWLD & JuRI Nepal. (2021). Joint Submission To The Universal Periodic Review Of Nepal. 37thSession of the UPR Working Group of the Human Rights Council. Available at: <https://fwld.org/wp-content/uploads/2020/07/RHR-UPR.pdf> (accessed on 17 March 2024).

¹⁵⁰ <https://www.ohchr.org/en/special-procedures-human-rights-council> (accessed on 11 February 2024)

¹⁵¹ <https://www.ohchr.org/en/special-procedures-human-rights-council> (accessed on 11 February 2024)

¹⁵² <https://www.ohchr.org/en/treaty-bodies> (accessed on 11 February 2024)

¹⁵³ <https://www.ohchr.org/en/treaty-bodies> (accessed on 11 February 2024)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Committee Against Torture; Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	173
Convention on the Rights of the Child	Committee on the Rights of the Child	196
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Committee on Migrant Workers	58
International Convention for the Protection of All Persons from Enforced Disappearance	Committee on Enforced Disappearance	70
Convention on the Rights of Persons with Disabilities	Committee on the Rights of Persons with Disabilities	186

Example: The CRR and FWLD have made numerous submissions to treaty bodies including Committee on the Elimination of All Forms of Discrimination against Women and Committee on the Rights of Persons with Disabilities on various issues including SRHR. In February 2023, the CRR made the submission on SRHR of persons living with disabilities.¹⁵⁴

Further Readings

- UNFPA and CRR, Reproductive Rights: A Tool for Monitoring State Obligations.
- OHCHR. (2012). The United Nations Human Rights Treaty System. Fact Sheet No. 30/Rev.1.

National Human Rights Institutions

NHRIs play a crucial role in ensuring accountability for SRHR globally. They act as independent bodies within a country tasked with promoting full enjoyment of human rights, monitoring human rights implementation and investigating human rights violations. In large contexts, NHRIs act as investigation and complaint mechanisms for individuals alleging human rights violations including SRHR. Individuals generally can submit complaints to NHRIs, who then investigate the claims and potentially recommend remedies or sanctions. Likewise, NHRIs can initiate investigations based on reports of widespread SRHR violations or systemic issues. Likewise, they can conduct public hearing and publish report that share their findings and recommendations, drawing attention to specific violations and holding duty-bearers accountable.

NHRIs are generally mandated with reviewing national laws and policies and assess whether they comply with national and international commitments. NHRIs examine the accessibility, quality, and non-discrimination of SRH services, identifying gaps and

¹⁵⁴ CRR. (28 February 2023). Submission from the Center for Reproductive Rights following the call for written submissions related to the Day of General Discussion organized by the Committee on the Rights of Persons with Disabilities regarding article 11 of the Convention. Available in the OHCHR's website: <https://www.ohchr.org>. (accessed on 17 March 2024)

inequalities and produce thematic reports highlighting key SRHR challenges and recommending improvements to the government and relevant stakeholders. NHRIs role is more important in disaster and humanitarian settings as NHRIs can work with as well as make recommendations to government agencies, healthcare providers, and civil society organizations to promote respect for SRHR during disasters.

Further Readings

- UNFPA. (2019). A Guide in Support of National Human Rights Institutions (Country Assessment and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health Rights).
- Asia Pacific Forum. (May 2018). A Manual on National Human Rights Institutions.

Health System Accountability Frameworks

A health system accountability framework is essentially a roadmap that outlines how different health services are being delivered and how different actors within a healthcare system are held responsible for their actions and performance. It ensures transparency, improves service delivery, and fosters trust between various stakeholders. Thus, the Health Information system and health data are crucial to improve accountability and ensure evidence based decision making. Likewise, during disaster, access to essential SRH services are disrupted, which can lead to an increase in maternal mortality, newborn deaths, unsafe abortions, and STIs. Thus, the MISP is crucial because disasters help to address these critical needs by providing a basic level of SRH care, even in the most challenging circumstances.

Health Information System

Health information system and health service data play a crucial role in patient management, facility administration, disease surveillance, and monitoring service delivery and resource utilization.¹⁵⁵ Likewise, better health information and data are needed to improve accountability and ensure evidence based decision making.

In Nepalese context, the Government of Nepal, Ministry of Health and Population, Department of Health Services (DoHS) manages an integrated health management information system (IHMIS) that collects health service information from provincial and local level health facilities to the DoHS and provides a base for planning, monitoring and evaluation of the health system at all levels.¹⁵⁶ The IHMIS collects data on thirteen government health programs including safe motherhood, family planning, female community health volunteers, primary health care outreach, immunization, integrated management of childhood illnesses, nutrition, HIV/AIDS, curative service and health facilities.¹⁵⁷ If utilized properly, the IHMIS can produce accurate, comprehensive and disaggregated data on the health sector to gauge its performance and improve health coverage, access to quality health services including SRHR services and effective remedy for discrimination and rights violation occurred while accessing health

¹⁵⁵ WHO. (24 April 2023). Framework and Standards for Country Health Information Systems.

¹⁵⁶ Government of Nepal, Ministry of Health and Population, Department of Health Services, Health Management Information System Indicators 2070, available at <https://dohs.gov.np/wp-content/uploads/2019/03/IHIMS-Indicators-booklet.pdf> (accessed on 12 February 2024)

¹⁵⁷ Id

services.¹⁵⁸ However, the study report shows that it is faced with challenges such as incomplete and irregular reporting from non-public health facilities and late reporting from public health facilities, and inconsistent measurement of indicators and discrepancies in estimated vs. actual target populations.¹⁵⁹ Likewise, there is insufficient capacity at the local level to generate and use IHMIs data and insufficient capacity to advocate decisions based on such data.¹⁶⁰ Thus, it is utmost to put efforts to improve IHMIS and ensure accountability of concerned stakeholders including local governments.

Selected IHMIS Indicators and SRHR

Indicators	Link
<ul style="list-style-type: none"> ● Antenatal care coverage, skilled birth attendance, and postnatal care utilization. ● Family planning acceptance rates for modern contraceptive methods. ● Maternal mortality ratio and newborn mortality rate. ● Adolescent antenatal care coverage and adolescent birth rate. ● STI/HIV testing and counseling services utilization. ● Abortion rate ● Institutional delivery ● CPR modern contraceptives 	Indicators directly address and linked with SRHR services and outcomes
<ul style="list-style-type: none"> ● Health facility availability and accessibility in different regions. ● Human resource availability for SRHR services, including skilled birth attendants and trained counselors ● Availability of essential SRHR products and medications including contraceptive prevalence, HIV self test kits, self abort kits. ● Availability of Skilled Birth Attendant trained staff at facility 	Indicators indirectly linked with SRHR access and quality

Further Readings

¹⁵⁸ Id

¹⁵⁹ UKaid and NHSSP (n.d). Improving the use of Health Management Information System for evidence-based decisions, Technical Brief, p.2, available at <https://www.nhssp.org.np/Resources/EA/Improving%20the%20use%20of%20HIMIS%20for%20Evidence%20Based%20Decision.pdf> (accessed on 7 February 2024)

¹⁶⁰ Id

- Government of Nepal, Ministry of Health and Population, Department of Health Services. (2013). Health Management Information System Indicators 2013. (Revised Indicators). Available at https://dhorupandehi.gov.np/downloads/Revised_HMIS_Indicators_Book.pdf
- Government of Nepal Kathmandu, Nepal Ministry of Health and Population Department of Health Services. (2079/80).Annual Health Report 2079/80

The Minimum Initial Service Package

The MISP for SRHR in Crisis Situations, designed by the IAWG in 1999 and endorsed by a wide range of international organizations including WHO, and UNFPA, is a set of life-saving activities and services designed to meet the urgent SRH needs of populations affected by humanitarian emergencies and is to be implemented at the onset (within 48 hours whenever possible) of every humanitarian emergency.

The goal of the MISP for SRH is to prevent SRH-related morbidity and mortality while protecting the right of the affected community to live with dignity. The MISP focuses on key areas such as:

- Preventing STIs and HIV: This includes providing contraceptives, promoting safe sex practices, and offering HIV testing and counseling.
- Reducing maternal mortality and morbidity: This includes providing skilled birth attendance, emergency obstetric care, and postpartum care.
- Preventing unwanted pregnancy: This includes providing emergency contraception and safe abortion services.
- Providing care for survivors of sexual violence: This includes providing counseling, medical care, and legal support.

The MISP has been shown to be an effective way to reduce maternal mortality and morbidity, prevent the spread of STIs and HIV, and provide essential care for survivors of sexual violence in disaster situations. Implementing the MISP requires a coordinated effort from a variety of stakeholders, including governments, humanitarian organizations, and local communities. It is important to ensure that the MISP is implemented in a way that is culturally sensitive and respectful of human rights and dignity.

Further Readings

- IAWG and Women's Refugee Commission. (2019). Minimum Initial Service Package For Sexual and Reproductive Health (SRH) in Crisis Situations: A Distance Learning Module.
- IAWG. (2022). Quick Reference for the Minimum Initial Service Package for Sexual and Reproductive Health.

Social Accountability Mechanism

Social accountability mechanisms include mechanisms led by citizens, communities, civil society organizations and independent media that are used to hold duty bearers accountable

for their actions and performance.¹⁶¹ Civic engagement is a key to exact accountability. Social accountability mechanisms can be used to ensure and enhance accountability for SRHR.

Selected Social Accountability Tools¹⁶²

Information Tools	Accountability & Integrity Tools	Participatory Development Tools
<ul style="list-style-type: none"> ● Citizen’s Charter ● Checklists of entitlements ● Budgets of local governments and local bodies ● Right to Information ● Checklists of relevant laws, policies, regulations that affect a citizen’s life 	<ul style="list-style-type: none"> ● Civic Education ● Public Expenditure Tracking ● Check lists of standards and indicators ● Community Score Cards ● Citizens Report Cards ● Public Hearings ● Public Audits ● Public Revenue Monitoring ● Citizen’s Complaint Structures 	<ul style="list-style-type: none"> ● Multi Stakeholder Groups ● Participatory Planning ● Participatory Budgeting ● Community Led Procurement ● Declaration of Assets ● Understanding Conflict of Interest ● Integrity Pacts

Further Readings

- WHO. (2012). Source Book of 21 Accountability Tools. Published by Program for Accountability in Nepal

¹⁶¹ WHO. (2004). Social Accountability: An Introduction to the Concept and Emerging Practice. p.3.

¹⁶² WHO. (2012). Source Book of 21 Accountability Tools. Published by Program for Accountability in Nepal.

III. Strategies for Building Accountable Health Systems

A. Policy and Legal Frameworks for Disaster and SRHR

Disasters can significantly disrupt access to essential SRHR services, putting vulnerable populations at greater risk. To reduce and mitigate this impact and ensure the well-being of individuals during crises, strong policy and legal frameworks are crucial. These frameworks should address the specific SRHR needs that arise in disaster situations and promote the continuation of essential services.

Checklist on Law and Disaster Risk Reduction¹⁶³

1. Does your country have a dedicated law for disaster risk management that prioritises disaster risk reduction and is tailored to your country context?
2. Do your country's laws establish clear roles and responsibilities related to risk reduction for all relevant institutions from national to local level?
3. Do your country's laws ensure that adequate resources are budgeted for disaster risk reduction?
4. Do your country's relevant sectoral laws include provisions to reduce existing risks and prevent the creation of new risks?
5. Do your country's laws establish clear procedures and responsibilities for conducting risk assessments and ensure risk information is considered in development processes?
6. Do your country's laws establish clear procedures and responsibilities for early warning?
7. Do your country's laws require education, training and awareness-raising to promote a whole-of-society approach to disaster risk reduction?
8. Do your country's laws ensure the engagement of all relevant stakeholders, including civil society, the private sector, scientific institutions and communities, in risk reduction decisions and activities?
9. Do your country's laws adequately address gender considerations and the special needs of particularly vulnerable categories of persons?
10. Do your country's laws include adequate mechanisms to ensure that responsibilities are fulfilled and rights are protected?

¹⁶³ International Federation of Red Cross and Red Crescent Societies and UNDP. (October 2015). The Checklist on Law and Disaster Risk Reduction. p.3.

Checklist on Law, Disaster Risk Reduction and SRHR¹⁶⁴

1. Do your country's laws explicitly recognize the importance of ensuring continued access to SRHR services during disasters?
2. Do your country's disaster risk reduction plans include specific measures to protect and maintain SRHR service provision during emergencies?
3. Do your country's laws allocate adequate resources for strengthening SRHR service delivery capacity in disaster preparedness, response, and recovery?
4. Do your country's relevant disaster laws include provisions to reduce existing risks and prevent the creation of new risks relating to SRHR?
5. Do your country's laws establish clear legal frameworks for conducting risk assessments and ensure SRHR risks information is considered in development processes?
6. Do your country's laws establish clear procedures and responsibility for ensuring the availability, affordability, accessibility and quality of essential SRHR supplies, including contraceptives, hygiene kits, and safe abortion services, during emergencies?
7. Do your country's laws promote the integration of SRHR information and services into broader disaster risk reduction training and awareness programs and promote a whole-of-society approach to disaster risk reduction?
8. Do your country's laws ensure the participation of all relevant stakeholders including women, adolescents, and other key stakeholders in planning and implementing SRHR interventions during disasters?
9. Do your country's laws adequately address the specific needs of vulnerable groups, such as pregnant women, people with disabilities, and those living with HIV/AIDS, regarding SRHR access during disasters?
10. Do your country's laws protect the privacy and confidentiality of individuals accessing SRHR services in disaster situations?
11. Do your country's laws include mechanisms for monitoring and enforcing legal provisions related to SRHR and disaster risk reduction?

National Context on Disaster and SRHR

Nepal is one of the most disaster prone countries in the world due to its topography and climatic condition.¹⁶⁵ The variation of altitude from 60 meters to 8,848 meters within less than 200 kilometers distance has led to the prevalence of natural disaster.¹⁶⁶ Moreover, Nepal's diverse geo-climatic system, combined with heavy monsoons, steep terrain, and remoteness, renders the country vulnerable to natural disasters as well as non natural disasters.¹⁶⁷ Most recently, Nepal has already been witnessing the impacts of climate change i.e. species' ranges are shifting to higher altitudes, glaciers are melting and the frequency of precipitation extremes is

¹⁶⁴ This checklist is adapted from International Federation of Red Cross and Red Crescent Societies and UNDP's publication "The Checklist on Law and Disaster Risk Reduction". See, International Federation of Red Cross and Red Crescent Societies and UNDP. (October 2015). The Checklist on Law and Disaster Risk Reduction. p.3.

¹⁶⁵ Government of Nepal, Ministry of Home Affairs, National Policy for Disaster Risk Reduction 2018, p.1, [https://bipad.gov.np/uploads/publication_pdf/DRR_National_Plan_of_Action_2018-2030_\(Nepal\).pdf](https://bipad.gov.np/uploads/publication_pdf/DRR_National_Plan_of_Action_2018-2030_(Nepal).pdf)

¹⁶⁶ Nepal: A brief country profile on Disaster Risk Reduction and Management, https://www.adrc.asia/countryreport/NPL/2019/Nepal_CR2019B.pdf

¹⁶⁷ <https://climateknowledgeportal.worldbank.org/country/nepal/vulnerability>

increasing.¹⁶⁸The vulnerability of Nepal's communities, particularly those living in poverty, in remote areas, and operating subsistence agriculture, increases the risk posed by climate change¹⁶⁹ and other disasters.

It should be noted that Nepal transitioned from a unitary state to a federal state in 2015, after the promulgation of the Constitution. The country is divided into three tiers for governance, namely the federation, the province and the local level.¹⁷⁰ According to the schedules in the Constitution, health related power is included in the 'exclusive power'¹⁷¹ of the federation, province and local level respectively and also in the 'concurrent list'¹⁷² of three tiers of governments i.e. federal government, provincial government and local governments.¹⁷³ On the other hand, disaster management is included in 'concurrent list' of three tiers of government whereas 'early preparedness for, rescue, relief and rehabilitation from, natural and man made calamities' is included in 'concurrent list' of federations and provinces.¹⁷⁴ Notwithstanding, the exclusive list of local governments include disaster management.¹⁷⁵ This means both disaster management and SRHR are the shared responsibilities of three tiers of governments. The three tiers of governments need to manage disaster risks effectively and to respect, protect and fulfill their health related obligations including SRHR during disaster.

Nepal is greatly affected by natural disasters such as floods, glacier lake outburst floods, landslides, lightning, earthquakes, droughts, snowfalls, hailstorms, avalanches, heavy rainfalls, cold waves, heat waves and forest fires.¹⁷⁶ Likewise, Nepal faces, among others, road accidents, epidemics, snakebite, toxic gas and chemical leaks, gas explosions, fires and environmental pollution.¹⁷⁷ Rapid population growth, poverty, haphazard urbanization and risk-insensitive development are some of the factors that contribute to increasing risks of disasters in Nepal.¹⁷⁸ For instance, in April 2015, Nepal was overwhelmed by a 7.8 magnitude earthquake which claimed 9000 people's lives and injured more than 22,000 people.¹⁷⁹ The earthquake affected more than 8 million people.¹⁸⁰ It should be noted structural and environmental conditions seriously challenged the SRH response after this earthquake and that four days after the

¹⁶⁸ Climate Risk Country Profile of Nepal, World Bank and ADB, <https://www.adb.org/sites/default/files/publication/677231/climate-risk-country-profile-nepal.pdf>

¹⁶⁹ Id

¹⁷⁰ Article 56, the Constitution of Nepal

¹⁷¹ The exclusive power of the federal government contains subjects that only the federal government can legislate on. Likewise, the exclusive power of the provincial government contains subjects that only the provincial government can legislate on. The exclusive power of the local government contains subject that only the local government can legislate on.

¹⁷² This list contains subjects that both the federal government, provincial governments and local governments can legislate on. However, if there is a conflict between the laws of the federal government and the provincial governments or the federal government and the local governments, the law of the federal government prevails.

¹⁷³ Schedule 5, Point 16; Schedule 6, Point 9; Schedule 8, Point 9; Schedule 9, Point 3, the Constitution of Nepal.

¹⁷⁴ Schedule 7, 9, the Constitution of Nepal.

¹⁷⁵ Schedule 8, the Constitution of Nepal.

¹⁷⁶ Government of Nepal, National Policy for Disaster Risk Reduction Policy, 2018, p.no.1, available at: <http://drrportal.gov.np/uploads/document/1476.pdf> (accessed on 5 Feb 2024)

¹⁷⁷ Id

¹⁷⁸ Id

¹⁷⁹ Nepal: Earthquake Emergency Appeal Final Report (MDRNP008) and Government of Nepal, National Planning Commission, Nepal Earthquake 2015 Post Disaster Needs Assessment, 2015, p.XI-XII, https://www.npc.gov.np/images/category/PDNA_volume_BFinalVersion.pdf, (accessed on 5 Feb 2024)

¹⁸⁰ Nepal: Earthquake Emergency Appeal Final Report (MDRNP008)

earthquake, an 'Reproductive Health (RH) sub-cluster'¹⁸¹, led by the Family Health Division of the MoH and co-led by UNFPA, was activated under the umbrella of the central health cluster. The RH sub-cluster started to advocate for the inclusion of SRH, maternal, newborn and child health services in all immediate life-saving responses implemented by health and other sectors and with its effort, C-section services were available in all district hospitals except one in the 14 most affected districts at the end of May 2015, around 1.5 month after the earthquake.¹⁸² Generally, the RH sub-cluster is considered to be in a position to lead an effective SRH response to the disaster.¹⁸³

National Legal and Policy Frameworks for Disaster

Among others, existing legal and policy framework for disaster risk management includes the Constitution of Nepal (2015), federal laws (including Disaster Risk Reduction and Management Act, 2017, and National Policy on Disaster Risk Reduction Management 2018 and the Disaster Risk Reduction National Strategic Action Plan (2018-2030)) and provincial laws on disaster management that are guided by the Sendai Framework for Disaster Risk Reduction 2015-2030. Due to its cross cutting nature, various laws like Forest Act 2019; Environment Protection Act, 2019; Public Health Act, 2018; Local Government Operation Act, 2017; Building Act 1998; Water Resources Act, 1992; Soil and Watershed Conservation Act, 1982; and Infectious Disease Act, 1964 have provisions related to plan and management of the disaster risk reduction and management activities.

Mapping of Disaster Management Related Federal Laws of Nepal

Law	Types of disaster					Level of Governance			Cycle of Disaster			
	Flood	Landslides	Earthquake	GLOF	Fire	Epidemic	Federal	Province	Local Level	Prparedness	Response	Rehabilitation and Mitigation
Constitution of Nepal (2015)												

¹⁸¹ Sub-cluster is not planned in the National Disaster Response Framework. It was decided by the Health Cluster to form sub-cluster on SRHR. The decision was based on the MISP for RH guidelines that was adapted and endorsed by the MoH in early 2015.

¹⁸² Pushpa Chaudhary, Giulia Vallese, Meera Thapa, Valerie Broch Alvarez, Latika Maskey Pradhan, Kiran Bajracharya, Kazutaka Sekine, Shilu Adhikari, Reuben Samuel, & Sophie Goyet. (December 2017). Humanitarian response to reproductive and sexual health needs in a disaster: the Nepal Earthquake 2015 case study. *Reproductive Health Matters*, 25:51, 25-39, DOI: 10.1080/09688080.2017.1405664.

¹⁸³ Pushpa Chaudhary, Giulia Vallese, Meera Thapa, Valerie Broch Alvarez, Latika Maskey Pradhan, Kiran Bajracharya, Kazutaka Sekine, Shilu Adhikari, Reuben Samuel, & Sophie Goyet. (December 2017). Humanitarian response to reproductive and sexual health needs in a disaster: the Nepal Earthquake 2015 case study. *Reproductive Health Matters*, 25:51, 25-39, DOI: 10.1080/09688080.2017.1405664.

Disaster Risk Reduction and Management Act, 2017											
Forest Act 2019											
Local Government Operation Act, 2017											
Water Resources Act, 1992											
Soil and Watershed Conservation Act, 1982											

Source: An updated table based on P. Nepal; N. R. Khanal; and B. P. Pangali Sharma's article¹⁸⁴

There are many policies, plans and programs related to disaster risk reduction and management activities. Legal arrangements like National Policy for Disaster Risk Reduction, 2018; 15th National Plan; the National Strategic Action Plan for Search and Rescue, 2014; Disaster Victims Resettlement Procedure 2014; Post Disaster Corpse Management Guidelines 2011; Fire Brigade Operation and Management Procedure, 2010; Disaster Rescue and Relief Standard, 2007; and Prime Minister Disaster Relief Fund Operation Regulations 2006 are equally important in this regard.¹⁸⁵ Likewise, National Disaster Response Framework, 2013; Guidance Note - District Disaster Preparedness and Response Planning, 2011, National Agriculture policy, 2004, and Industry Policy, 2010 guide the activities of preparedness,

¹⁸⁴ P. Nepal; N. R. Khanal; and B. P. Pangali Sharma. (2018). Policies and Institutions for Disaster Risk Management in Nepal: A Review. The Geographical Journal of Nepal. Vol. 11, pp 1-24. Available at <https://www.nepjol.info/index.php/gjn/article/view/19546> (accessed on 10 February 2024)

¹⁸⁵ Disaster Risk Reduction National Strategic Plan of Action 2018 – 2030

responses and recovery. Additionally, the National Health policy 2014, National Reconstruction and Rehabilitation policy, 2015, Water Induced Disaster Management Policy, 2015, National Adaptation Programme of Action to Climate Change 2010, and National Framework on Local Adaptation Plans for Action 2011, Climate Change Policy, 2019 are also related to disaster risk reduction and management.

As the provincial governments are responsible for developing and implementing disaster preparedness and response plans for their respective provinces. They have enacted and formulated laws/policies as follows:

Mapping of Provincial level disaster management laws

Province	Laws	Comment
Koshi Province	Disaster Management Act 2075 BS	It has enacted a provincial Act on disaster management which has similar provisions like the federal Act.
Madhesh Province	Disaster Management Act 2075 BS	It has enacted a provincial Act on disaster management which has similar provisions like the federal Act.
Bagmati Province	Provincial Disaster Management Act 2075 BS	It has enacted a provincial Act on disaster management which has similar provisions like the federal Act.
Gandaki Province	Provincial Disaster Management Regulation 2077 BS	It has formulated regulation on disaster management under the federal Act. It has not enacted its own Act.
Lumbini Province	Provincial Disaster Management Activity Operation Guideline (Second Amendment) 2077 BS	It has formulated only operational guidelines on disaster management.
Karnali Province	Karnali Province Disaster Risk Reduction and Management Regulation 2076	It has formulated regulation on disaster management under the federal Act.
Sudur Paschim Province	Provincial Disaster Risk Reduction and Management Act 2075 BS	It has enacted a provincial Act on disaster risk reduction and management which has similar provisions like the federal Act.

Further Readings

- Government of Nepal, Ministry of Forests and Environment. (2021). Vulnerability and Risk Assessment and Identifying Adaptation Options Summary for Policy Makers. Available at: <https://www.mofe.gov.np/uploads/documents/vulnerability-repnew1630571413pdf-2940-766-1658827788.pdf>.
- UNFPA, Norwegian Embassy, IPAS & FWLD. (2023). Disaster Law Compilation (विपदसम्बन्धी कानून, नीति, रणनीति तथा कार्ययोजनाहरूको संगालो). (Nepali Language)

National Legal and Policy Framework for SRHR

Legal and policy landscape of SRHR in Nepal includes primarily the constitution of Nepal, Right to Safe Motherhood and Reproductive Health Act 2018, Public Health Act 2018, and Muluki Penal Code 2017. There are numerous laws that have some provisions relating to SRHR. Likewise, Nepal has been implementing family planning programs, safe motherhood programs, Female Community Health Programs, Adolescent and Sexual Reproductive Health Programs, Primary Health Care Outreach Program, and Safe Abortion Services.

Mapping of Federal Laws and Policies

Federal Level		Link with SRHR
Constitution	Constitution of Nepal (2015)	It recognizes SRHR as a fundamental right.
Special Act	Right to Safe Motherhood and Reproductive Health Act, 2018	The Act is a special Act enacted to ensure fundamental rights of women relating to safe motherhood and reproductive health. The primary aim of this Act is to make motherhood and reproductive health service safe, qualitative, easily available and accessible and secondly, to respect, protect and fulfill the right to safe motherhood and reproductive health of the women conferred by the Constitution of Nepal. ¹⁸⁶
Other Acts	Individual Privacy Act, 2018	The Act protects "privacy of the matters relating to physical and mental condition of a person" ¹⁸⁷ as well as "privacy of matters such as biological or biometric identity, gender identity, sexuality, sexual relation, conception or abortion, virginity, potency, impotency or physical illness related to his or her personal life." Information relating to reproductive health is protected as private information. ¹⁸⁸
	Crime Victim Protection Act, 2018	The Act has defined "damage" as among others, 'pregnancy occurred due to rape' and 'Destruction of physical, intellectual, sexual or reproductive capacity or serious damage caused to such capacity'. ¹⁸⁹ The crime

¹⁸⁶ Preamble of the Constitution of Nepal (2015)

¹⁸⁷ Section 3, the Individual Privacy Act, 2018

¹⁸⁸ Section 6, the Individual Privacy Act, 2018

¹⁸⁹ Section 2(m) of Crime Victim Protection Act 2018

		<p>victims are provided with the right to compensation and social rehabilitation.¹⁹⁰</p> <p>While determining the amount of the compensation, among others, bases include 'damage caused to physical, intellectual, sexual or reproductive capacity of the victim' and 'where the victim becomes pregnant due to rape, expenses incurable in abortion or giving birth to and nurturing the baby', and 'medical treatment expenses in the case of abortion caused from the offence.'¹⁹¹</p>
	Health Insurance Act, 2017	The Act was enacted with the objective of providing healthcare to Nepalese citizens without financial hardship. ¹⁹² The health insurance services include services like immunization/vaccination, family planning and safe motherhood but it does not include artificial insemination/in vitro fertilization. ¹⁹³
	Labor Act, 2017 and Regulation, 2018	<p>The Labour Act provides maternity leave up to 14 weeks, fully paid for 60 days.¹⁹⁴ The Act has also made it compulsory maternity leave from 2 weeks before the delivery up to at least 6 weeks after the delivery. The Act provides up to 15 days, fully paid paternity leave/maternity care leave.</p> <p>The law provides for additional one month unpaid leave on the recommendation of the medical doctor. Likewise, maternity leave will be granted to the female labor who has a still born or suffers miscarriage if she is 7 months or more pregnant. The law provides that "where the mother dies before the completion of sixty days of the birth of her child, the labor whose wife has so died may take paid leave for the remaining period for the care of the child from the employer for whom he is working."</p>
	Local Government Operation Act, 2017	The local government's functions, duties and powers are related with among other basic health and sanitation. ¹⁹⁵
	Rights of Person with Disability Act, 2017	The Act was enacted to provide access to persons with disabilities to basic services, human rights, opportunities including health, education and employment. The Government of Nepal has to make necessary provisions for the protection of health and reproductive rights of

¹⁹⁰ Section 19 of Crime Victim Protection Act 2018

¹⁹¹ Section 31 of Crime Victim Protection Act 2018

¹⁹² Preamble, Health Insurance Act 2017

¹⁹³ Section 5-6 of the Health Insurance Act 2017

¹⁹⁴ Section 45, the Labor Act 2017

¹⁹⁵ Section 11, the Local Government Operation Act, 2017

		women with disabilities, taking into account their special situation. ¹⁹⁶
	Contribution Based Social Security Act 2017 and Regulation 2018	The Contribution Based Social Security scheme includes medical, health and maternity benefit; accidental and disability benefit; benefits for dependent family members and old-age benefit. ¹⁹⁷
	Prison Act, 2022 and Prison Regulation (15th Amendment), 2023	When taking custody of female inmates, prison officials are required under the Prison Act to record and keep records of their reproductive health status. ¹⁹⁸ The necessary arrangements are made to protect their reproductive rights. ¹⁹⁹ Regular medical care, nutritious food and clothing are provided to pregnant inmates, and new mothers. ²⁰⁰ After completion of 6 months of pregnancy, pregnant inmates are given permission to leave the prison; however, they must return to the prison after 98 days of maternity leave. ²⁰¹ This Act allows minors and dependent children below the age of five to stay with their inmate mothers. ²⁰² The Act also ensures that the inmate willing to marry the person outside the prison is allowed for registration of marriage. ²⁰³
Policies and Strategies	Safe Abortion Service Program Management Guidelines, 2022	It outlines the procedures and protocols for managing safe abortion services. These guidelines were developed with the aim of improving the quality and safety of abortion services provided to women in Nepal.
	National Health Policy, 2019	Policy number 6.20 is related to safe motherhood and reproductive health.
	National Strategy for Reaching the Unreached 2016-2030	The National Strategy for Reaching the Unreached 2016-2030 of Nepal is a comprehensive plan aimed at ensuring that all communities, including marginalized and vulnerable groups, people living in squat settlements, street children, migrant workers, HIV positive, LGBTIQ+ communities, sex workers, female prisoners and minorities have access to free basic health services, and universal health care. ²⁰⁴

¹⁹⁶ Section 19(2), Rights of Person with Disability Act, 2017

¹⁹⁷ ILO, Nepal launches contribution-based Social Security Scheme, online materials, https://www.ilo.org/kathmandu/info/public/pr/WCMS_651182/lang--en/index.htm.

¹⁹⁸ Section 13, the Prison Act, 2022

¹⁹⁹ Section 22-23, the Prison Act, 2022

²⁰⁰ Section 37, the Prison Act, 2022

²⁰¹ Section 37(2), the Prison Act, 2022

²⁰² Section 33, 34, 35, the Prison Act, 2022

²⁰³ Section 28, the Prison Act, 2022

²⁰⁴ Nepal Government, Ministry of Health and Population, National Strategy for Reaching the Unreached 2016-2030 (Nepali Language), pp. 1-4.

	National Strategy to end Gender Biased Sex Selection in Nepal 2021-2031	It aims to address the deeply ingrained cultural practices that have led to gender-biased sex selection (GBSS) and also to discourage sex selective abortion in Nepal.
	Nepal Safe Motherhood and Newborn Health Road Map 2030	It is a comprehensive plan to reduce maternal and neonatal morbidity and mortality rates in Nepal.
	5th National Human Rights Action Plan 2077/2078 BS- 2081/2082	The Office of Prime Minister and Council of Ministers have endorsed the fifth national human rights action plan which have four objectives relating to sexual and reproductive health rights, i.e. ensuring everyone's access to sexual and reproductive health services by conducting awareness programs and making family planning services accessible; improving safe motherhood and reproductive health services by improving access to safe abortion services and providing free surgery for uterine prolapse etc; conducting immunization/vaccination programs for all pregnant, newborn and children; and improving health of newborn and children.

Further Readings

- FWLD. (2019). Women's Reproductive Health Rights: Media Resource Toolkit (महिलाको प्रजनन स्वास्थ्य अधिकार: संचार स्रोत सामाग्री). (Nepali Language).

Selected Precedent of the Supreme Court of Nepal on Disaster and SRHR

The Supreme Court of Nepal has played an important role in upholding SRHR and developing the legal framework of SRHR. Likewise, the Supreme Court has decided two important cases that played an important role to ensure legal accountability for failure to protect human rights during disaster. However, the Supreme Court has not specifically delivered any judgment linking accountability for SRHR during disaster setting.

A few landmark decisions are presented below:

Court Decision related to Legal Accountability for Impact of Disaster

- *Rakshyaram Harijan (Chamar) v. Home Ministry, Singhadurbar and Others*²⁰⁵

Rakshyaram Harijan, a Madhesi Dalit community member sued the government for failing to provide relief after a fire destroyed homes on 8 April 2016, violating their right to life and dignity. During fire, 118 houses were destroyed, disproportionately

²⁰⁵ Rakshyaram Harijan (Chamar) v. Home Ministry, Singhadurbar, Kathmandu and others, Case number 072-WO-0791, Decision number 10203, Decided by the Supreme Court of Nepal, Decision Date 16 November 2017

affecting Dalit families and Government provided no relief beyond data collection. The Supreme Court recognized disaster management as a shared responsibility (federal, provincial, local) and disaster preparedness includes risk reduction and infrastructure planning. The Court ordered immediate relief, financial assistance for rebuilding, and fire prevention measures to the affected people.

- ***Amarnath Jha v. Office of Prime Ministers and others***²⁰⁶

Amarnath Jha filed the petition against the government for violating their right to life, dignity, housing, and clean environment due to inadequate flood management after incessant rains caused floods in Saptari district, damaging houses and infrastructure in July 2017. The applicant argued that despite spending on flood control, existing measures were ineffective and affected people faced food, shelter, and clothing shortages, violating their rights. The Supreme Court noted that floods are natural hazards, but proper management can minimize risks and vulnerability and lack of coping capacity worsen disaster impact.

The Supreme Court of Nepal held that for the enforcement of the rights guaranteed by the constitution, the victims should not only get effective relief but must also be rehabilitated.²⁰⁷ Thus, the Court issued an order of mandamus stating that the Ministry of Home Affairs should coordinate with other stakeholders to update details of the distribution of relief and other facilities, collect the statistics of each village and family affected in Saptari district, distribute the relief, and ensure the rehabilitation of the affected persons, families and communities; also, in order to reduce the damage caused by floods in Mehuli, Dudhaila and Khado rivers and to minimize the impact of disasters, assess the risk and build embankments in places where there is a risk of flooding and manage the rivers, build strong and stable embankments in places affected by floods and with high probability of flooding, and if the construction of such must be done on private land make alternative arrangements including providing shelter in other safe and construct the dam by providing proper compensation as per the law.²⁰⁸

Court Decision related to SRHR

- ***Annapurna Rana v. Gorakh Samsher JB Rana***²⁰⁹

In Annapurna Rana's case, the petitioner challenged a court order compelling her to undergo a "virginity test." The Supreme Court invalidated the order as a violation of petitioner's constitutional right to privacy, recognizing the right to privacy over one's own body and reproductive organs as an "inviolable" right under the constitution.

The federal government has already enacted a special law on individual privacy but it has not recognized live-in relationships or sexual rights through operation of relevant laws.

²⁰⁶ Amarnath Jha v. Office of Prime Ministers and others, Case No: 073-WO-1404, available at <https://supremecourt.gov.np/cp/assets/downloads/supreme_173032.pdf>

²⁰⁷ Id, para 41

²⁰⁸ Id, para 41

²⁰⁹ *Annapurna Rana v. Gorakh Samsher JB Rana*, NKP 2055, Decision No. 6588, Vol. 8, p. 476

- ***Advocate Prakash Mani Sharma and others v. Government of Nepal***²¹⁰

This case is related to uterus prolapse that affects reproductive health and rights of women. The Court established the following principles in this case:

- Uterine prolapse, although related to reproductive health, is a problem specific to women, requiring constitutional and legal recognition and State intervention.²¹¹
- The right to a dignified life includes access to healthcare, linking the right to life with the right to health.²¹²
- The State must fulfill its obligations by enacting laws and programs to ensure the enjoyment of rights, and the court may intervene if necessary.²¹³
- Reproductive health is inadequately recognized in the Constitution, necessitating the establishment of infrastructure and policies to enable its realization.²¹⁴

The Court ordered the government to take several actions related to reproductive health. These actions include developing special action plans, providing free consultation and treatment, ensuring access to health services, and raising awareness about women's rights and issues related to uterine prolapse. Additionally, the Court has issued a directive order to the Office of the Prime Minister and Council of Ministers, instructing them to draft a bill and present it to parliament for the enactment of appropriate legal provisions on this matter, after consulting with experts and representatives of society.

The government has enacted the RSHRM Act 2018 that recognizes the right against reproductive health morbidity.²¹⁵ The Act guarantees that reproductive health morbidity cannot be the ground for divorce or grounds to expel from home.²¹⁶

- ***Advocate Prakash Mani Sharma and others v. Government of Nepal***²¹⁷

This writ petition is related with discriminatory provision of the Prison Act 2019 BS regarding the enjoyment of reproductive rights of women in prison.

The court held that the Prison Act 2019 BS does not have adequate provisions such as pregnancy care for women in prisons and protection of the health of newborn babies. The government has responsibilities to adequately fulfill them and make policies and programs to arrange appropriate facilities including health, nutrition and protection of pregnant women prisoners and breastfeeding prisoners.

²¹⁰ *Advocate Prakash Mani Sharma and others v. Government of Nepal*, NKP 2065, Decision No. 7991, Vol. 8, p. 956

²¹¹ *Id.*, para 8

²¹² *Id.*, para 10

²¹³ *Id.*, para 16

²¹⁴ *Id.*, para 17

²¹⁵ Section 20 and 21, the RSMHR Act 2018

²¹⁶ *Id.*

²¹⁷ *Advocate Prakash Mani Sharma and others v. Government of Nepal*, NKP 2065, Decision No. 7952, Vol. 4, p. 412

- *Laxmi Dhikta and others v. Government of Nepal*²¹⁸

Despite the change in the legal status of abortion, multiple barriers have prevented women from accessing abortion services. Laxmi Dhikta case is an example of an extremely poor woman from the far-western region of Nepal, who had already had five children when she became pregnant for the sixth time and wanted to undergo abortion at a government hospital. She could not pay Rs. 1130 for the procedure and had no choice but to continue the unwanted pregnancy.

In this case, the Supreme Court established the following principles:

- Fetuses do not exist separately from a mother's body; they only exist within her womb. Even if we did recognize the interests of a fetus, we could not say that those interests would prevail over a mother's interests.²¹⁹
- Reproductive health and reproductive rights include a woman's decision to have or not have children. Within such matters, it must be recognized as the right of a pregnant woman who does not wish to conceive or continue a pregnancy.²²⁰
- Abortion services will only be meaningful if they are accessible and affordable to people in need.²²¹
- Abortion is a health concern and a fundamental right related to the right to health. The protection of women's rights is a responsibility of the State, and therefore, the right to abortion should not be seen as separate from the State's public duties.²²²
- Abortion goes beyond the decision to continue a pregnancy and availability of services. It has broader implications for women's overall health. Legal remedies are necessary to address violations of the right to abortion, including cases of denial or poor quality of services. These remedies should include appropriate provisions for punishment, compensation, and healthcare facilities for the victim.²²³

The Court held that the government must guarantee access to safe and affordable abortion services as the right to abortion is an essential component of reproductive rights and forced pregnancy violates women's fundamental human rights guaranteed under national and international laws. Interestingly, the court held that a fetus does not have legal status of a human life. The court ordered the government to enact comprehensive abortion law that fully protects women's rights and the government should provide compensation for women who are forced to carry unwanted pregnancies.

The government has not enacted comprehensive abortion law but later it enacted the RSMHR Act 2018. The RSMHR Act 2018 recognizes and establishes abortion as the right but continues to conditionals access to safe abortion services.

²¹⁸ *Laxmi Dhikta and others v. Government of Nepal*, NKP 2067, Decision No. 8464, Vol. 9, p. 1551

²¹⁹ *Id.*, para 15

²²⁰ *Id.*, para 40

²²¹ *Id.*, para 62

²²² *Id.*, para 75

²²³ *Id.*, Para 96

- ***Achyut Prasad Kharel v. Office of the Prime Minister and Council of Ministers***²²⁴

Various Nepalese legal framework such as the Remuneration, Service Conditions and Facilities Act of the Secretary General of the Parliament, the Secretary of the House of Representatives and the Secretary of the National Assembly; Act on Remuneration, Facilities and Other Conditions of Service of Judges of Appeal and District Court, Nepal Health Service Regulations 2055, Nepal Law Practitioner; the Auditor General's Department Staff Regulations, 2050, Education Regulations, 2049), the Civil Service Rules, 2050, Labor Rules, 2050, the Police Rules, 2049, the Armed Police Rules, 2060, Parliament Secretariat Staff Administration Regulations, 2059, Local Self-Government Regulations, 2056, Regulation on Working Journalists provided maternity benefits and leaves only to two surviving births. The Court held that these legal provisions are inconsistent with the fundamental rights of women i.e. Article 20(2) of the Interim Constitution of Nepal, 2063. The court declared these provisions invalid, null and void as it controls reproductive health rights of women based on the number of births and the number of children.

As mandated by the verdict, the regulations were amended. However, many of these regulations currently need amendment to have consistency with the provisions of the RSMRH Act 2018 on maternity leave.

- ***Bimala Khadka and others v. Government of Nepal***²²⁵

The petition was filed to ensure rights of people with disabilities including SRHR. In this petition, the court held that women, men and gender and sexual minorities with disabilities should not be deprived of enjoying the fundamental rights guaranteed by the constitution and human rights under international conventions, subject to progressive realization. Therefore, the Court ordered the government to enact laws and policies to implement the Constitution and the Convention gradually so that the people with disabilities would be able to have simple and easy access to all facilities including hospitals, public transport.

Nepal has already enacted the Rights of People with Disability Act, 2017 ensuring numerous rights both included in the Convention on Rights of People with Disabilities 2006 and the Constitution of Nepal.

- ***Pushpa Raj Pandey v Office of Prime Minister, Ministry of Health and Population including others***

Advocate Pushpa Raj Pandey filed writ petition before the Supreme Court in August 2015, claiming that surrogacy services were being operated illegally in the country. Following the legal petition, the service was banned by a cabinet meeting on September 19, 2015.

The Court held that there should be complete ban on commercial surrogacy since a mother's womb can never be commercialized but surrogacy should be allowed if a

²²⁴ *Achyut Prasad Kharel v. Office of the Prime Minister and Council of Ministers*, NKP 2067, Decision No. 8384, Vol. 6, p.895

²²⁵ *Bimala Khadka and others v. Government of Nepal*, Writ No. 0748, Decision Date - 2067 Shawna 12, CRR and FWLD compendium

Nepali married couple has been certified by a medical board that they are incapable of producing children because of infertility or other health conditions.²²⁶

The Court ordered to legislate the law on altruistic surrogacy. However, as of July 2023, the conversation with the government or the government's efforts regarding legislating laws on altruistic surrogacy are very nascent at the moment. Meantime, the government has planned to offer free infertility and childlessness treatment at all federal hospitals as announced in the budget of the financial year 2080/81.²²⁷ The announcement of a free national infertility treatment program is a welcome development, given the high cost of such treatment in Nepal.

- ***Manju Tamang and others v. Government of Nepal, Office of the Prime Minister and Council of Ministers and others***²²⁸

The writ petition was filed asking to issue a mandamus order to make a reasonable budgetary arrangement and to provide the facility of trained counselors and the flow of accurate information about contraceptives and reproductive health services through local health institutions.

The court held that the fundamental rights of women protects reproductive health of women including marginalized groups and the poor. The government of Nepal needs to make necessary amendments to the Family Planning National Strategy, 2068 and to formulate other necessary policies, laws, programs, human resources, and budget.

It should be noted that the new Prison Act of 2022 has included the provisions on reproductive health services for inmates but it does not describe what they entail in terms of rights and services.²²⁹

- ***Roshani Poudyal and others v. Office of Prime Minister and Council of Ministers***²³⁰

The petition was filed before the Supreme Court because during the COVID-19 pandemic, among others, women and girls, especially affected by gender-based violence were denied access to emergency and immediate rescue services and other judicial remedy. Further, women's reproductive health was severely affected and the needs and problems of women in relief distribution, quarantine management and essential services did not properly address them.

The court observed that the different and complex experiences that women have had and will have must be taken into account when formulating and implementing plans related to Covid-19. In order to effectively address the adverse and unequal effects on

²²⁶ *Pushpa Raj Pandey v Office of Prime Minister, Ministry of Health and Population including others* (writ no. 072-WO-0119) and *Prabin Pandak v Office of Prime Minister and others* (writ no. 072-WO-0120)

²²⁷ Point 139, Plans and Policies of Government of Nepal for fiscal year 2080/81, available at <https://www.opmcm.gov.np/en/download/plans-and-policies-of-government-of-nepal-for-fiscal-year-2080-81/>

²²⁸ *Manju Tamang and others v. Government of Nepal, Office of the Prime Minister and Council of Ministers and others,*

²²⁹ See section 3.2.12 of the report below.

²³⁰ *Roshani Poudyal and others v. Office of Prime Minister and Council of Ministers* (writ no. 076-WO-0962), NKP 2077, Decision No. 10526, Vol. 6, available at https://nkp.gov.np/full_detail/9592

women, plans designed to prevent and control COVID-19 need to be woman-friendly and include a 'feminist response' against the epidemic.²³¹

The court ordered the government of Nepal to prepare a study report regarding the adequacy and effectiveness of existing laws, such as the Infectious Disease Act, 1964, in mitigating the current challenges due to COVID-19, and to formulate laws that prioritize gender-friendliness and high-risk groups.²³²

Further Readings

- CRR & FWLD. (2021). Reproductive Health Rights Decisions Compendium (प्रजनन स्वास्थ्य अधिकार सम्बन्धी सर्वोच्च अदालतबाट भएका फैसलाहरूको संगालो). (Nepali Language)

SRHR in Disaster Preparedness, Response and Recovery

Nepal's disaster management laws primarily focus on reducing and mitigating the impacts of disasters and emergencies and provides for emergency response frameworks. Disaster management laws *per se* do not have provisions directly linked with SRHR in disaster settings. Utilizing existing laws and policies, SRHR can be integrated in disaster preparedness, response and recovery as below:

Indicators for Disaster Preparedness, Response and Recovery²³³

Cycle of Disaster	Indicators	
Disaster Preparedness	Identification of Open Space	Strategically mark open spaces for various purposes including temporary shelter, landing zones, distribution centers and community gathering/healing.
	Early warning systems	effectiveness of early warning systems for floods, earthquakes, landslides, and other hazards.
	Community awareness and drills	Frequency and participation in community disaster preparedness drills and education
	Stockpiles of emergency supplies and prepositioning SRH supplies	Availability, accessibility and quality of essential supplies like food, water, medicine, and shelter materials. Likewise, SRH supplies like contraceptives, emergency contraception, and medications to prevent and treat STIs

²³¹ Id, para 7

²³² Id, para 64

²³³ This table is an indicative table based on various publications including Nepalese laws and policies on disaster.

		should be strategically prepositioned in advance.
	Training health workers on SRHR in emergencies	Trained health workers that are able to provide essential services to affected communities.
	Local-level planning and resources	Existence and accessibility of local disaster response plans and dedicated resources.
	Infrastructure resilience	Strength and maintenance of infrastructure like roads, bridges, and buildings to withstand disasters. Assessment of hospital buildings and facilities should be properly done to ensure their infrastructure resilience.
Disaster Response	Timeliness and effectiveness of initial response	Speed and efficacy of search and rescue operations, medical treatment, and evacuation. Distribution of MISPs within 48 hours of disaster.
	Setting up safe spaces for women and girls	providing a safe place where women and girls can access SRHR services and counseling without fear of violence.
	Coordination between government, international actors, and NGOs	collaboration and information sharing between different response actors. Effective activities from Cluster system and sub-cluster
	Effectiveness of communication and public information	Accuracy and clarity of information provided to the public during the disaster. This is important to prevent spreading of misinformation and fake messages among the public creating panic and terror.
	Delivery of essential aid and relief materials	Timely and equitable distribution of food, water, shelter, and other essential supplies including SRH services.
Disaster Recovery	Needs assessments and prioritization	assessment of needs and clear prioritization of recovery efforts. It should include SRH services and facilities as priority.
	Reconstruction and rehabilitation	Speed and quality of reconstruction of housing, infrastructure, and livelihoods. It should prioritize reconstruction on hospitals, birthing centers and SRH facilities.
	Psychosocial support	Availability, accessibility, acceptability and quality of mental health and psychosocial support services for affected communities.

	Community participation and inclusion	Level of community involvement in decision-making and implementation of recovery efforts
	Building back better	Integration of disaster risk reduction strategies into reconstruction efforts to prevent future disasters.

Coordination between government, international actors, and NGOs

Disaster management demands a coordinated and multi-faceted response among various actors. Considering the facts that Nepal's law and policies have recognized various institutional mechanisms for disaster risk reduction, response and management, it is utmost to coordinate, and collaborate among federal government, provincial governments, local governments, governmental institutions, NGOs and international actors playing distinct yet interconnected roles.

Institutional Structure for Disaster Risk Reduction and Management

The Disaster Risk Reduction and Management Act 2017 has envisioned decentralized mechanisms to effectively deal with all issues relating to disaster risk reduction, disaster response and recovery. It encourages the involvement and partnership of all stakeholders of the society based upon the principle of participation, accountability and transparency in disaster risk reduction, prevention and management. The institutional structure for disaster risk reduction and management includes National Council for Disaster Risk Reduction and Management²³⁴, Executive Committee²³⁵, and National Disaster Risk Reduction and Management Authority²³⁶ at federal level whereas Provincial Disaster Management Council²³⁷ and Committee²³⁸ at the province and District Disaster Management Committee²³⁹ and Local Disaster Management Committee²⁴⁰ at the local level.

National Council for Disaster Risk Reduction and Management

The National Council for Disaster Risk Reduction and Management occupies a central position within Nepal's disaster risk management architecture. Functioning under the leadership of the Prime Minister, this high-level council serves as the strategic policy making body for national DRM efforts.

The council's primary responsibility is to formulate and oversee the implementation of comprehensive national policies and plans for disaster risk reduction and management.²⁴¹ This ensures a proactive approach to addressing the various natural hazards Nepal encounters. By establishing clear policy guidelines and strategic direction, the Council fosters collaboration

²³⁴ Section 3, 4 and 5, Disaster Risk Reduction and Management Act, 2017

²³⁵ Id, Section 6, 7, 8 and 9.

²³⁶ Id, Section 10 and 11.

²³⁷ Id, Section 13(a)

²³⁸ Id, Section 14

²³⁹ Id, Section 16

²⁴⁰ Id, Section 17

²⁴¹ Section 5, Disaster Risk Reduction and Management Act, 2017

and ensures alignment across different government agencies involved in disaster preparedness, mitigation, response, and recovery.²⁴²

The National Disaster Risk Reduction and Management Authority serves as the council's operational counterpart. The Authority translates the Council's policies and plans into concrete actions. They oversee the day-to-day implementation of national disaster risk management initiatives, manage critical resources, and lead emergency response efforts during disasters.

Composition of National Council for Disaster Risk Reduction and Management²⁴³

Composition	<ul style="list-style-type: none"> a. The Prime Minister - Chairperson b. Ministers to Government of Nepal - Member c. Leader of Opposition Party in the House of Representative - Member d. Chief Ministers of all Provinces - Member e. Vice-Chairperson of Nepal Planning Commission - Member f. Chief Secretary of Government of Nepal - Member g. Commander in-chief of the Nepal Army - Member h. Commander in-chief of the Nepal Army - Member i. Three persons including at least one female nominated by the Council amongst the persons having expertise in the field of disaster management - Member j. The Executive Officer - Member-Secretary
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(National Disaster Risk Reduction and Management) Executive Committee²⁴⁴

It serves as the operational arm of the National Council for Disaster Risk Reduction and Management. Chaired by the Home Minister, this high-level committee translates the Council's strategic policies into actionable plans.

Composition of Executive Committee

Composition	<ul style="list-style-type: none"> a. Minister for Home Affairs of Government of Nepal - Chairperson b. Ministers looking after the portfolio of Urban Development, Health, Federal Affairs and Local
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²⁴² Section 5, Disaster Risk Reduction and Management Act, 2017

²⁴³ Section 3, Disaster Risk Reduction and Management Act, 2074

²⁴⁴ Section 6, Disaster Risk Reduction and Management Act, 2074

	<p>Development of Government of Nepal - Member</p> <ul style="list-style-type: none"> c. *(c) Secretaries of all Ministries of Government of Nepal - Member d. Secretary of the Office of Prime Minister and Council of Ministers, Government of Nepal - Member e. Lieutenant General, the Nepal Army - Member f. Chiefs of Nepal Police, the Armed Police Force, Nepal and National Investigation Department - Member g. The Executive Director, Nepal Rastra Bank - Member h. The Chairperson, Nepal Telecommunications Authority - Member i. The Member Secretary, the Social Welfare Council - Member j. The Chairperson, Nepal Chamber of Commerce - Member k. The Chairperson, Nepal Red Cross Society - Member l. The Chairperson, Federation of Nepalese Chambers of Commerce and Industries- Member m. The Chief Executive - Member-Secret
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National Disaster Risk Reduction and Management Authority

Established in 2019 under the Disaster Risk Reduction and Management Act, 2017, the National Disaster Risk Reduction and Management Authority serves as the central executive body for Nepal's disaster risk reduction and management strategy.²⁴⁵ It plays a critical role in safeguarding the nation from the ever-present threat of natural hazards.

Core Functions of the National Authority includes policy and planning, resource management, emergency response leadership, inter-agency collaboration, and public awareness and capacity building.²⁴⁶

The National Authority is headed by an executive head who leads the internal operations and staff. The Act designates the NDRRMA's executive head to concurrently serve as the member-secretary of both the National Council for Disaster Risk Reduction and Management (chaired by the Prime Minister) and the Disaster Risk Reduction and Management Executive Committee (chaired by the Home Minister). This implies a close connection between the National Authority and National Council and these higher-level policymaking bodies.

²⁴⁵ <https://bipad.gov.np/en/about-us> (accessed on 17 March 2024)

²⁴⁶ <https://bipad.gov.np/en/about-us> (accessed on 17 March 2024)

Provincial Disaster Management Committee²⁴⁷

Each of Nepal's seven provinces has a Provincial Disaster Management Committee. It is led by the Chief Minister of the province, the PDMC plays a crucial role in developing and overseeing policies and plans specifically for disaster risk reduction and emergency response within their provincial jurisdiction. The Disaster Risk Reduction and Management Act of 2017 outlines the Provincial Disaster Management Committee's responsibilities, including formulating provincial disaster management plans aligned with the national framework. The committee typically includes representatives from various provincial ministries, security forces, and the Nepal Red Cross Society

Example of Madhesh Province and Bagmati Province are presented below:

Provincial Disaster Management Committee of Madhesh Province²⁴⁸

Composition	<ol style="list-style-type: none">a. Chief Minister - Chairpersonb. Minister of Internal Affairs and Law - Memberc. Finance Minister- Memberd. Physical Infrastructure Development Minister - Membere. Social Development Minister - Memberf. Province Secretary - Member secretary
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Provincial Disaster Management Committee of Bagmati Province²⁴⁹

Composition	<ol style="list-style-type: none">a. Chief Minister - Chairpersonb. Minister of Internal Affairs and Law - Vice-chairc. Finance Minister- Memberd. Minister of Land Management, Agriculture and Cooperatives - Membere. Minister of Industry, Tourism, Forest and Environment - Memberf. Social Development Minister - Member
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²⁴⁷ Section 14, Disaster Risk Reduction and Management Act, 2074

²⁴⁸ Disaster Management Act of Madhesh Province, Province Gazette dated 2075/06/26, available at: <https://ocmcm.madhesh.gov.np/sites/ocmcm/files/2020-02/%E0%A4%AA%E0%A5%8D%E0%A4%B0%E0%A4%A6%E0%A5%87%E0%A4%B6%20%E0%A4%B5%E0%A4%BF%E0%A4%AA%E0%A4%A6%E0%A5%8D%20%E0%A4%B5%E0%A5%8D%E0%A4%AF%E0%A4%B5%E0%A4%B8%E0%A5%8D%E0%A4%A5%E0%A4%BE%E0%A4%AA%E0%A4%A8%20%E0%A4%90%E0%A4%A8%2C%20%E0%A5%A8%E0%A5%A6%E0%A5%AD%E0%A5%AB.pdf> (accessed on 17 March 2024)

²⁴⁹ Disaster Management Act of Bagmati Province, Province Gazette dated 2075/06/04, available at: <http://mowsei.bagamati.gov.np/en/post/province-disaster-management-act-2075> (accessed on 17 March 2024)

	<ul style="list-style-type: none"> g. Opposition leader of Province Assembly - Member h. Three members of Province Assembly including one woman member - Member i. Vice-chair of Province Policy and Planning Commission - Member j. Province Secretary - Member k. Two nominated experts including one woman, nominated by the committee - member l. Secretary of Minister of Internal Affairs and Law - Member secretary
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District Disaster Management Committee

Functioning at the district level, each of Nepal's 77 districts has a District Disaster Management Committee. The District Disaster Management Committee is headed by the Chief District Officer that plays a critical role in coordinating disaster preparedness, response, and recovery efforts at the local level. The District Disaster Management Committee brings together representatives from various stakeholders, including local government bodies, Health and security officials, Nepal Red Cross leaders and Local NGOs.

This composition allows the District Disaster Management Committee to leverage the expertise and resources of various entities to effectively manage disasters within their district. Composition of District Disaster Management Committee²⁵⁰

District Disaster Management Committee

Composition	<ul style="list-style-type: none"> a. Chief District Officer - Chairperson b. Representative, District Coordination Committee - Member c. Chairpersons and Chiefs of Local levels Within the district - Member d. Chief of health-related office of the district - Member e. Chiefs of Security Agencies of the district - Member f. Chiefs of infrastructure and social development related offices of the district - Member g. Chairpersons or representatives of nationally recognized political parties of the district - Member h. Chief, Nepal Red Cross Society District Chapter - Member i. Chief, NGO Federation of Nepal District Chapter - Member j. Chief, Federation of Nepalese Journalist District Chapter - Member
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²⁵⁰ Section 16, Disaster Risk Reduction and Management Act, 2074

	k. Chief, District Chamber of Commerce and Industries - Member l. Officer as prescribed by the Chief District Officer - Member -Secretary
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Cluster Systems for Disaster Response and Recovery

The first amendment of National Disaster Response Framework in 2019 has institutionalized a clustered approach and created 11 humanitarian clusters, namely Health, Water Sanitation and Health (WASH), Emergency Shelter, Food Security, Nutrition, Camp Coordination and Camp Management (CCCM), Protection, Early Recovery, Education, Logistics, and Emergency Communication.²⁵¹ These clusters are managed with international and national assistance.²⁵²

Cluster System for Disaster Response and Recovery

Cluster	Government Agency	International Humanitarian Agency
Health	Ministry of Health and Population	WHO
WASH	Ministry of Water Supply	UNICEF
Emergency Shelter	Ministry of Urban Development	IFRC/UN HABITAT
Food Security	Ministry of Agriculture and Livestock Development	WFP/FAO
Nutrition	Ministry of Health and Population	UNICEF
CCCM	Ministry of Urban Development	IOM
Protection	Ministry of Women, Children and Senior Citizen	UNHCR/UNICEF/UNFPA
Early Recovery	Ministry of Federal Affairs and General Administration	UNDP
Education	Ministry of Education, Science and Technology	UNICEF/SC
Logistics	Ministry of Home Affairs	WFP
Emergency Communication	Ministry of Communication and Information Technology	WFP

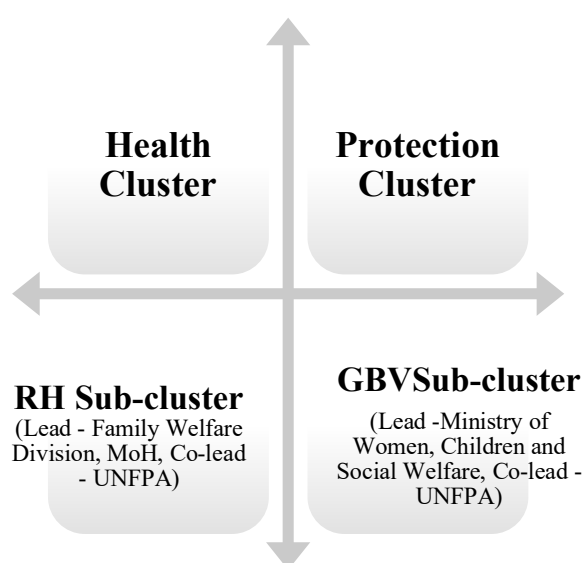
²⁵¹ Id

²⁵² Id

Source: First Amendment 2019 of National Disaster Response Framework in 2019

During the 2015 Earthquake, the Reproductive Health (RH) sub-cluster has been formed by the decision of the Health Cluster whereas Gender based violence sub-cluster has been formed under the protection cluster. Sub-cluster is not planned in the National Disaster Response Framework but the decision was based on the MISP for RH guidelines that was adapted and endorsed by the Ministry of Health in early 2015.²⁵³

Sub-clusters relating to SRHR



The RH sub-cluster and the GBV sub-cluster, addresses specific needs that arise during disasters and emergencies. The RH sub-cluster focuses on critical SRH Services during disasters such as prenatal care, safe delivery, and family planning. The RH sub-cluster ensures these services are prioritized and available, preventing complications and unwanted pregnancies. The RH sub-cluster coordinates efforts to provide essential services like STI prevention and treatment, and mental health support. Likewise, the GBV sub cluster focuses on preventing and responding to GBV, protecting vulnerable populations. Meantime, it coordinates the work of organizations providing specialized support to survivors. This includes safe spaces, counseling, legal aid, and medical services. The RH sub cluster is led by the Ministry of Health, Family Welfare Division whereas the GBV Cluster is led by the Ministry of Women, Children and Social Welfare. Both sub-clusters are co-led by UNFPA.

National Emergency Operation Center (NEOC) and District Emergency Operation Centres (DEOCs)

²⁵³ Pushpa Chaudhary, Giulia Vallese, Meera Thapa, Valerie Broch Alvarez, Latika Maskey Pradhan, Kiran Bajracharya, Kazutaka Sekine, Shilu Adhikari, Reuben Samuel, & Sophie Goyet. (December 2017). Humanitarian response to reproductive and sexual health needs in a disaster: the Nepal Earthquake 2015 case study. *Reproductive Health Matters*, 25:51, 25-39, DOI: 10.1080/09688080.2017.1405664.

The National Emergency Operations Centre (NEOC) was opened on 17 December 2010, by the Minister of Home Affairs (MOHA) and is operated under the Planning and Special Services Division.²⁵⁴ The NEOC is a coordination and communication point for disaster information across Nepal, including government agencies and other response and recovery stakeholders such as Nepal Red Cross Society, UN agencies, INGOS and NGOs.²⁵⁵ As part of MoHA's strategy to further develop Nepal's emergency preparedness and response capacity, district emergency operation centers (DEOCs) are established in district levels.

Among others, NEOC plays functions as follows:

- act as a central coordination point in response to disasters and humanitarian assistance;
- enhance coordination among all responding agencies;
- collect and analyze information on the disaster;
- disseminate information on disasters to stakeholders; and
- promote preparedness activities to central and local levels of government.²⁵⁶

Health Emergency Operation Center (HEOC) and Provincial Health Emergency Operation Centers (PHEOCs)

The Health Emergency Operation Center (HEOC) was established in 2014 with the support of the WHO.²⁵⁷ It operates as the secretariat of the Ministry of Health and Population (MoHP) during any public health emergencies or disasters.²⁵⁸ It plays a crucial role in coordinating and managing the response to various disasters and public health emergencies. Since the 2015 Earthquake, the HEOC has been the main coordinating center for the health sector's response during disasters such as floods, landslides, windstorms, and the COVID-19 pandemic.²⁵⁹

The HEOC is responsible for preparedness and readiness activities and facilitates the establishment and strengthening of hub and satellite hospitals networks, the formation and orientation of Emergency Medical Deployment Teams (EMDTs), stockpiling of emergency medical logistics, and the conduction of Emergency Care System Assessments.²⁶⁰

Provincial Health Emergency Operation Centers (PHEOCs) have been established in all seven provinces of Nepal that play a vital role in coordinating and supporting the response during various disasters.²⁶¹

Rapid Response Team (RRT)

As per Rapid Response Team and Emergency Medical Team Deployment Guideline, 2079 by the Epidemiology and Disease Control Division (EDCD) of Department of Health Service, Ministry of Health and Population, there shall be RRT in three tiers of governments. The team shall be composed of multidisciplinary teams with epidemiologists, public health

²⁵⁴ <http://neoc.gov.np/en/introduction-2.html>

²⁵⁵ Id

²⁵⁶ Id

²⁵⁷ <https://heoc.mohp.gov.np/about-us>

²⁵⁸ Id

²⁵⁹ Id

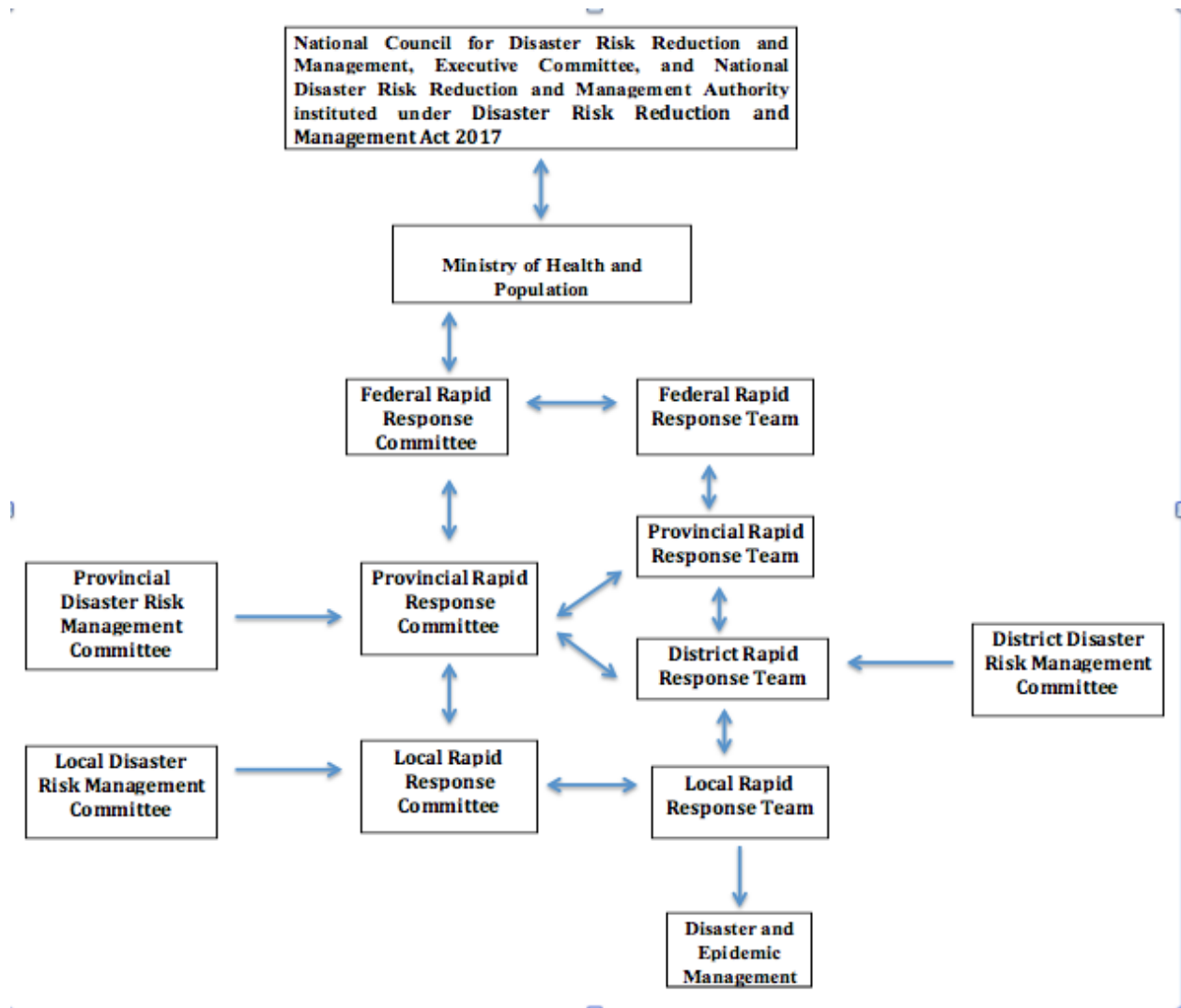
²⁶⁰ Id

²⁶¹ Id

specialists, clinicians, laboratory technicians, communication specialists, and logistics experts.²⁶² They are activated based on disease outbreak alerts or disasters.

RRT are assigned with the task of early warning and reporting of potential epidemics, preparedness for potential epidemics, management of disease outbreaks and institutionalization of disaster management.

The coordination and collaboration among various actors aforementioned is envisioned as follows:



Source: Rapid Response Team and Emergency Medical Team Deployment Guideline, 2079

²⁶² Section

B. Strengthening Governance and Transparency

Governance shapes the capacity of the health system to cope with everyday challenges as well as new policies and problems.²⁶³ Strengthening governance and transparency in the health system is crucial for ensuring equity, efficiency, and quality care for all.²⁶⁴

Key aspects of governance include strengthening leadership of health institutions, enhancing regulatory frameworks for public health and SRHR, promoting community engagement and combating corruption.²⁶⁵ Likewise, it is required to ensure financial sustainability of health institutions so that equitable access to quality care without excessive financial burden on individuals could be delivered.²⁶⁶

Health system transparency requires the openness and availability of information about the functioning and performance of a healthcare system. It starts with making health data and performance indicators publicly available in easily understandable formats. Likewise, for greater transparency, open communication between healthcare providers, policymakers, and the public is required regarding health system challenges and solutions. Transparency demands for establishment of accessible and responsive grievance mechanisms for individuals to report concerns and seek redressal for grievances. For instance, the Report of the United Nations Secretary-General's High-Level Panel On Access to Medicines showed concern about lack of transparency regarding pricing of medicines.²⁶⁷

Further Readings:

- Greer, S., Wismar, M., & Figueras, J (eds). (2015, November 16). Strengthening Health System Governance: Better Policies, Stronger Performance. McGraw-Hill Education (UK).
- WHO. (2012). Governance for Health in the 21st Century.

C. Community Engagement and Participation

Community engagement is widely recognised as a cornerstone of public health programming to achieve universal health coverage as they collaborate with other stakeholders in the identification, planning, design, governance, and delivery of health services to tackle health related matters and promote wellbeing.²⁶⁸ Community engagement results in a positive effect on health awareness, builds community capacity to respond to health issues, and improves the acceptability and ownership of communities and patients to health services.²⁶⁹

²⁶³ Greer, S., Wismar, M., & Figueras, J (eds). (2015, November 16). Strengthening Health System Governance: Better Policies, Stronger Performance. McGraw-Hill Education (UK), p.4.

²⁶⁴ WHO.

²⁶⁵ <https://ti-health.org/health-system-governance/>

²⁶⁶ See United Nations Secretary-General's High-Level Panel On Access To Medicines. (September 2016). Report of the United Nations Secretary-General's High-Level Panel On Access To Medicines: Promoting innovation and access to health technologies.

²⁶⁷ See United Nations Secretary-General's High-Level Panel On Access To Medicines. (September 2016). Report of the United Nations Secretary-General's High-Level Panel On Access To Medicines: Promoting innovation and access to health technologies.

²⁶⁸ Id

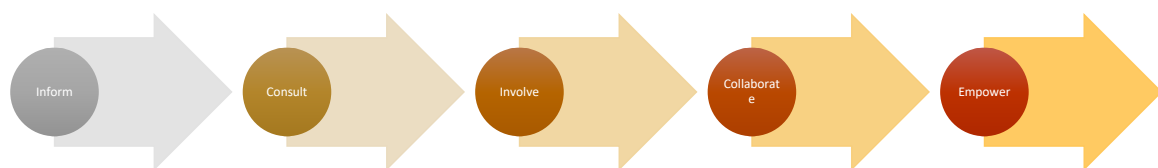
²⁶⁹ Id

Taking an example of Nepal, it has mobilized community health workers such as female community health volunteers, and mothers' groups in various health programs. They work closely and collaboratively with communities to improve health. This has positively impacted Nepal's overall health system. For instance, due to mobilization of community health providers and female community health volunteers, access to health services has been increased and expanded, especially for rural and marginalized groups and health outcomes have improved.²⁷⁰ For instance, skilled birth attendance contributed to positive change in maternal, newborn, and child health indicators.²⁷¹ It is cost-effective and has enhanced social accountability, ensuring better quality of care.

The WHO describes five level of community engagement and participation i.e. – inform, consult,

involve, collaborate and empower.²⁷² Empowerment is considered a level with the highest degree of participation.

Level of Community Engagement and Participation



Source: WHO

The WHO describes trust, accessibility, contextualization, equity, transparency and autonomy as community engagement principles.²⁷³

²⁷⁰ Panday, S., Bissell, P., Van Teijlingen, E., & Simkhada, P. (2017, September 4). The contribution of female community health volunteers (FCHVs) to maternity care in Nepal: a qualitative study. *BMC Health Services Research*. <https://doi.org/10.1186/s12913-017-2567-7>

²⁷¹ Id

²⁷² WHO. (2020). *Community Engagement: A health promotion guide for universal health coverage in the hands of the people*.

²⁷³ Id

Principles of Community Engagement

Trust	Trust is a key component to collective work throughout the collaboration process.
Accessibility	Accessibility should be promoted thereby removing geographic, linguistic, cultural and socioeconomic barriers to access.
Contextualization	Understanding what is of value to the community and working on the community's perception of value leads to stronger engagement.
Equity	To effectively address the social determinants of health, equity must be placed at the center of any public health initiative
Transparency	Transparency is key to successful engagement of the community and considered crucial for participatory processes and decision-making. Transparency is essential for trust and can promote other enabling factors required for effective community engagement.
Autonomy	Community engagement develops autonomous and empowered individuals and communities at all levels.

Empowering communities

Empowering communities (also see Empowering rights-holders section above) includes following aspects:

- Capacity building: Individuals and communities should be equipped with the knowledge, skills, and resources to understand and advocate for their health needs. This includes training on health issues, communication, and leadership development.
- Community leadership development: It is important to identify and nurture local champions who can represent their communities' voices and concerns within the health system and decision-making processes.
- Building trust and relationships: It is important to foster mutual trust and respect between communities and healthcare providers is crucial for open communication and collaboration. This involves transparency, responsiveness, and cultural sensitivity.

Creating participatory mechanisms

Community engagement and empowerment requires effective channels for participation. These mechanisms offer platforms for communities to engage actively with the health system.

Some of examples are as follows:

- Community councils and committees: Community councils and committees are formal structures where community representatives directly participate in decision-making, planning, and monitoring of health services.
- Public hearings and forums: Public hearings and forums offer spaces for open dialogue, feedback, and addressing community concerns regarding health services and SRHR access.

- Community monitoring initiatives: Community monitoring initiatives empower communities to track progress, identify gaps, and hold accountable actors responsible for achieving health goals.
- Social accountability tools: Social accountability tools such as complaint redressal systems and budget transparency help to ensure service quality and responsiveness to community needs. (Also see Social Accountability Tools above)

Leveraging Community Knowledge and Resources

- Communities hold valuable knowledge and resources that can contribute significantly to accountable health systems and SRHR.
- Traditional healers and community health workers: Utilizing Traditional healers and community health workers' expertise and integrating them into the formal healthcare system can expand access and culturally appropriate care. For instance, many people in rural parts still rely on *dhami jhakri* (traditional healers) for their primary health care needs.²⁷⁴
- Local knowledge and needs assessments: Understanding local contexts, needs, and perspectives is crucial for tailoring interventions and ensuring relevance.
- Local innovations and solutions: Supporting and learning from locally developed solutions that address specific challenges and barriers faced by communities.

Overcoming Challenges and Ensuring Sustainability

Building an accountable health system and ensuring SRHR requires acknowledging and addressing potential challenges as below:

- Power imbalances and inequalities: Identifying and addressing underlying power dynamics that hinder equitable access to services and participation.
- Cultural sensitivity and language barriers: Ensuring culturally appropriate communication and addressing language barriers to facilitate inclusive participation.
- Resource constraints and capacity limitations: Recognizing resource limitations and working collaboratively to secure funding, build capacity, and develop sustainable solutions.
- Sustainability and long-term commitment: Fostering long-term commitment from communities, government, and stakeholders to ensure continued engagement and progress.

Further Readings

- WHO. (2020). Community Engagement: A health promotion guide for universal health coverage in the hands of the people.
- WHO. (2023, August 1). *Addressing trust through digitally enabled community engagement approaches in HIV/AIDS*. <https://www.who.int/westernpacific/publications/i/item/WPR-2023-DSI-003>
- McCoy, D., & Khosla, R. (2023, July 7). *Public health leaders must confront the power imbalances that harm global health*. *Nature Medicine*. <https://doi.org/10.1038/s41591-023-02446-w>

²⁷⁴ Subedi, B. (2023, November 15). Integrating Traditional Healers into the National Health Care System: A Review and Reflection. *IntechOpen eBooks*. <https://doi.org/10.5772/intechopen.109885>

- Geri-Ann Galanti. (2012). Cultural Sensitivity (A Pocket Guide for Health Care Professionals) (Second Edition).

D. Monitoring and Evaluation Systems

Monitoring and evaluation can be conducted in three ways: Internal Monitoring and Evaluation, External Monitoring and Evaluation and Community monitoring and evaluation.

NHRIs as a Mechanisms for External Monitoring and Evaluation in Nepal

Nepal has eight constitutional commissions that are responsible for implementation of human rights in Nepal, namely National Human Rights Commission²⁷⁵, National Women Commission²⁷⁶, National Dalit Commission²⁷⁷, National Inclusion Commission²⁷⁸, Indigenous Nationalities Commission²⁷⁹, Madhesi Commission²⁸⁰, Tharu Commission²⁸¹, and Muslim Commission²⁸². Among these, only the National Human Rights Commission has power to investigate human rights violations whereas National Women Commission has relatively some power to investigate and refer gender based violence/domestic violence cases to concerned authorities. All commissions have monitoring implementation of human rights as per their mandates.

National Human Rights Commission of Nepal

The National Human Rights Commission, established as an independent statutory body in 2000, has now been elevated to a powerful constitutional body with a commensurate mandate, competence and independence.²⁸³The NHRC was elevated to a constitutional body by Article 131 of the Interim Constitution of Nepal, 2007 and by Article 248 of the present Constitution of Nepal (2015). The NHRC's motto, 'Human rights for all, at every household: basis of peace and development' has set a new goal to take human rights consciousness in every household.²⁸⁴

The mandate of NHRC includes:

- to respect, protect and promote human rights and ensure effective enforcement thereof.
- to inquire/investigate on its own initiative or on a petition or complaint lodged in or sent to the Commission, and make recommendation for action against the perpetrators.
- to recommend to the concerned authority to take departmental action against any official, who fails to fulfill or perform his or her responsibility or duty or shows reluctance in preventing violations of human rights.
- to recommend to file a case in the court in accordance with law against any person or organization who has violated human rights.

²⁷⁵ Article 248-249, Constitution of Nepal

²⁷⁶ Article 252-254, Constitution of Nepal

²⁷⁷ Article 255-257, Constitution of Nepal

²⁷⁸ Article 258-260, Constitution of Nepal

²⁷⁹ Article 261, Constitution of Nepal

²⁸⁰ Article 262, Constitution of Nepal

²⁸¹ Article 263, Constitution of Nepal

²⁸² Article 264, Constitution of Nepal

²⁸³ <https://www.nhrcnepal.org/aboutus> (accessed on 15 February 2024)

²⁸⁴ <https://www.nhrcnepal.org/aboutus> (accessed on 15 February 2024)

- to coordinate and collaborate with civil society in order to enhance awareness on human rights.
- to carry out periodic reviews of human rights laws and make recommendation for reform and amendments
- to recommend the implementation of any international treaty or agreement on human rights, to which Nepal is a party.
- to publish the names of the officials, persons or bodies who have failed to observe or implement any recommendations or directives made or given by the Commission in relation to the violations of human rights, and record them as violators of human rights.

The representative data suggests that The NHRC provided 1,994 recommendations to the government during 2019-20. Among the recommendations, 13.59 percent were implemented, 37.15 percent were partially implemented, and 49.29 percent (almost half) were not implemented.²⁸⁵ The data reflects the government’s inconsideration and nonchalance towards the authority of the NHRC.

Selected Laws and Policies Related with NHRC

Law	Link with SRHR and/or Disaster
National Human Rights Act 2012	No provision directly linked with SRHR and/or Disaster
Gender Equality and Social Inclusion Policy	Policy may help in creating enabling conditions for rights based approach to health, SRHR and disaster.
6th Strategic Plan 2021-2026	It includes "monitoring the human rights situation during natural disasters and pandemic related effects upon the enjoyment of human rights including the plan, preparedness and response to mitigate the disaster" as one of the strategic directions of the plan. The Plan can be used to advocate and ensure accountability for SRHR during disaster.

National Women's Commission

The National Women Commission (NWC) was established on March 7, 2002, according to the decision of the Council of Ministers.²⁸⁶ After the promulgation of the Constitution of Nepal in September 2015, NWC received constitutional recognition.²⁸⁷ The NWC Act (2017) and Regulations (2021) further strengthened the legality of the Commission and shaped a defined role, responsibilities and mechanism.

The mandate of NWC include:

- to formulate policies and programs concerning the rights and interests of the women and submit them to the Government of Nepal for implementation;

²⁸⁵ Saving National Human Rights Commission, News paper article, The Kathmandu Post, 29 April 2023

²⁸⁶ <https://nwc.gov.np/en/about/our-introduction/> (accessed on 15 February 2024)

²⁸⁷ Article 252-254, The Constitution of Nepal (2015).

- to monitor implementation status of laws relating to women and treaty obligations under international law and make recommendations for their effective compliance and implementation to the Government of Nepal;
- to assess, monitor and evaluate the existing policies and programs through gender inclusion lens, and make recommendation to the Government of Nepal for their effective implementation;
- to carry out study and research work on the legal provisions relating to gender equality, empowerment of women and relating to women, make recommendations to the concerned bodies on reforms to be made on such laws, and monitor the same;
- to make suggestions to the Government of Nepal regarding implementation of international treaties obligations concerning women's rights.
- to file cases against any persons or bodies on matters of violence against women or being subjected to social ill-practices or infringement of or deprivation of enjoyment of women's rights, and to make recommendations to the concerned bodies to file such cases in courts in accordance with the law.

Selected laws and Policies of NWC

Law	Link with SRHR and disaster
National Women Commission Act 2007 and Regulation 2009	No provision directly linked with SRHR and/or Disaster
Third Strategic Plan 2078/2079 - 2082/83	The plan is important to protect women's rights and promote gender equality. It includes no explicit provision relating to SRHR and disaster.

Community Monitoring and Evaluation Systems

Community monitoring and evaluation systems refer to the process by which community members themselves actively participate in gathering information and assessing the quality, accessibility, and effectiveness of health services and programs within their own communities. (See IV. Community Monitoring of SRHR linking to Circle Of Accountability for detail)

Examples of community monitoring and evaluation tools are as follows:

- **Community Score Card**

A community scorecard is a simple but powerful tool used to assess and improve public services like healthcare or education.²⁸⁸ Designed by the community themselves, it allows them to score the service based on predefined criteria, highlighting strengths and weaknesses.²⁸⁹ This collaborative process leads to identifying service delivery gaps and jointly developing solutions with the service providers.²⁹⁰ For instance, the Community Score Card used to score service delivery by Nepal police.²⁹¹ It was introduced in 2017 as part of the UK government-funded Integrated Programme for Strengthening Security

²⁸⁸ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁸⁹ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁹⁰ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁹¹ A Community Score Card: A Tool to Strengthen Mutual Accountability and Community Partnership, March 2021.

and Justice.²⁹² It allows community members to work with service providers to mutually assess, reflect, relate and collaborate.²⁹³

Community score card is significant because it includes regular feedback on quality of service to service providers and subsequently, enables reforms in service provision as a result of feedback. Likewise, it links service providers to the community by empowering citizens to provide immediate feedback to service providers.

Example: CARE Nepal has been using Community Health Score Board, a tool developed to quantify health issues and service delivery within a specific community setting.²⁹⁴ It measures the accessibility and quality of health services, including SRH.²⁹⁵

- **Citizen Report Card**²⁹⁶

Citizen Report Card is a powerful medium to express the opinions and voice of citizens about the services they receive. It is a method of providing feedback to government offices after evaluating citizens' direct experience, observation, and feelings through a participatory survey method.

- **Gender Responsive Budget Analysis**

Gender-responsive budget analysis is a method used to assess how a government's budget impacts different genders. It goes beyond simply looking at the amount of money allocated to programs with the words "women" or "girls" in their titles. Instead, it analyzes the entire budget through a gender lens, asking questions like: Does the budget allocate resources equitably to men, women, boys, and girls? Are there hidden biases in the budget that favor one gender over another? Does the budget promote gender equality and address existing inequalities?

It increases transparency and accountability in the budget process by focussing on where the budget goes and who benefits and helps in pushing the government to spend on critical sectors such as health, education, water and agriculture; where increased spending directly contributes to positive gender outcomes.²⁹⁷

- **Social Audits**

A social audit is a formal review process that assesses an organization's social and ethical performance, particularly its impact on various stakeholders like employees, right holders, and the community at large and demand its accountability and transparency on utilization of resources and service delivery.²⁹⁸ Social audits help prevent corrupt practices and measure consistency between the promises and the actual results of organization's policies and programs.

- **Public Hearings**²⁹⁹

Public hearings are formal meetings at the community level where local officials and citizens have the opportunity to exchange information and opinions on community affairs. It enables the citizens to raise their concerns in front of elected officials and bureaucrats on the one hand and an important feedback mechanism for the officials to gain a better understanding of the citizens' experiences and views. It offers citizens to

²⁹² Id

²⁹³ Id

²⁹⁴ CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB). Available at https://carenepal.org/wp-content/uploads/2023/08/CARE_CHSB-technical-brief.pdf (accessed on 17 March 2024).

²⁹⁵ CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB). Available at https://carenepal.org/wp-content/uploads/2023/08/CARE_CHSB-technical-brief.pdf (accessed on 17 March 2024).

²⁹⁶ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁹⁷ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁹⁸ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

²⁹⁹ <https://countytoolkit.devolution.go.ke/social-accountability> (accessed on 15 February 2024)

share on matters of public interest and to put forward personal and community related problems to the service providing officials. It helps make service providers accountable to citizens, and increases transparency in the service provider's activities.

- **Public Expenditure Tracking Surveys**

Public expenditure monitoring is the process of tracking and analyzing how the government spends its money. It plays a crucial role in ensuring transparency, accountability, and efficiency in public finance management. It tracks actual spending compared to budgets and identifies waste and inefficiencies.

- **Public Revenue Monitoring**

Public revenue monitoring is the systematic process of tracking, analyzing, and understanding the sources and levels of government income. It plays a crucial role in ensuring fiscal sustainability, efficient resource allocation, and accountability to citizens. It reduces chances of corruption and mismanagement of public resources.³⁰⁰

- **Circle of Accountability**

A Community Circle of Accountability is a social accountability that includes a structured group of right holders – those who represent the interests of marginalized communities – and duty bearers. This circle fosters an environment of open communication and collaboration and works together to ensure a clear understanding of fundamental human rights, specifically those related to SRH. (See section I. Introduction to Rights-Based Accountability, SRHR and Disasters, C. Importance of Accountability in SRHR)

E. Grievance redressal mechanisms

Grievance redressal mechanisms are formal or informal avenues through which individuals or groups can raise complaints, express dissatisfaction, and seek solutions regarding an organization's actions, policies, or services.³⁰¹

Guiding principles of grievance redressal mechanisms³⁰² are:

- **Legitimate.** A mechanism must have clear, transparent, and sufficiently independent governance structures to ensure that no party to a particular grievance process can interfere with the fair conduct of that process.
- **Accessible.** A mechanism must be publicized to those who may wish to access it and provide adequate assistance for aggrieved parties who may face barriers of access, including language, literacy, awareness, finance, distance, or fear of reprisal.
- **Predictable.** A mechanism must provide a clear and known procedure, with time frames for each stage; clarity on the types of process and outcome it can (and cannot) offer; and means of monitoring the implementation of any outcome.
- **Equitable.** A mechanism must ensure that aggrieved parties have reasonable access to sources of information, advice, and expertise necessary to engage in a grievance process on fair and equitable terms.
- **Rights-compatible.** A mechanism must ensure that its outcomes and remedies accord with internationally recognized human rights standards.

³⁰⁰ <https://countytoolkit.devolution.go.ke/social-accountability>

³⁰¹ WHO. (2023). Annual Report FY23 Grievance Redressal Service: Finding Solutions Together.

³⁰² WHO. (2008). A Guide to Designing and Implementing Grievance Mechanisms for Development Projects. Advisory Note. pp.17-18 and UNDP. UNDP SES Supplemental Guidance: Grievance Redress Mechanisms.

- **Transparent.** A mechanism must provide sufficient transparency of process and outcome to meet the public interest concerns at stake and should presume transparency wherever possible.
- **A source of continuous learning:** A mechanism should draw on relevant measures to identify lessons for improving the mechanism and preventing future grievances and harms.
- **Based on engagement and dialogue:** A mechanism should consult the stakeholder groups for whose use they are intended on their design and performance, and focusing on dialogue as the means to address and resolve grievances.

Examples of grievance redressal mechanisms are as follows:

- **Hotline and Help desk**

Hotlines and help desks offer a readily accessible channel for people to report grievances, ask questions, and seek clarification. This can be particularly helpful for those who may not have the resources or confidence to pursue more formal complaint channels. For instance, Helpline 1145 is a national level 24-hour toll free helpline operated by National Women Commission to provide instantaneous and effective support to the survivors of GBV.³⁰³ A GBV survivor or witness may call the helpline and report the incident. It provides support for shelter, psychosocial services, child support and legal aid.³⁰⁴

FWLD operates Reproductive Health Rights Legal Clinic (RH Legal Clinic) to ensure the realization of the rights guaranteed by the Safe Motherhood and Reproductive Health Rights Act, 2018, Regulation 2020 and Interim Guideline 2021.³⁰⁵ Currently, it is operational in all 7 provinces and 77 districts covering the local levels.³⁰⁶

- **Community-based grievance committees**

Community-based grievance committees are local mechanisms empowered by the community to receive, investigate, and resolve grievances raised by community members. They function outside of formal legal systems and offer an accessible, culturally sensitive, and often faster alternative to pursuing complaints through official channels. Local Peace Committees, Para-Legal Committees or Local Mediation Committees are some examples of community based grievance committees in Nepal.

- **Technology based mechanisms**

Technology offers exciting possibilities for improving grievance redressal mechanisms. Online platforms for complaint submission and tracking including user-friendly online portals streamline complaint submission, document management, and status updates for both complainants and grievance officers.

With the use of Artificial intelligence (AI) and machine learning (ML), complaints can be screened and categorized based on keywords and patterns, directing them to the most relevant department or grievance officer, and prioritizing urgent cases. Likewise, Chatbots and virtual assistants can provide initial guidance and support to complainants, answer frequently asked questions, and collect basic information before

³⁰³ <https://nwc.gov.np/wp-content/uploads/2022/12/NWC-factsheet-Mangsir-2079.pdf> (accessed on 15 February 2024)

³⁰⁴ <https://nwc.gov.np/wp-content/uploads/2022/12/NWC-factsheet-Mangsir-2079.pdf> (accessed on 15 February 2024)

³⁰⁵ <https://fwld.org/wp-content/uploads/2022/02/Legal-aid-1.jpg> (accessed on 15 February 2024)

³⁰⁶ <https://fwld.org/wp-content/uploads/2022/02/Legal-aid-1.jpg> (accessed on 15 February 2024)

connecting them with human representatives. For instance, Kathmandu Metropolis has used a Chatbot named Mhyay Mayaju in its website for assistance.³⁰⁷

Mobile applications that allow real-time reporting can enable immediate reporting with photo and video evidence, facilitating prompt action and investigations and mobile applications that allow anonymous reporting can encourage reporting of sensitive issues, particularly where fear of retaliation exists. Nepal Police has a mobile application allowing reporting crimes online. There are many applications that offer legal aid and access to resources such as the "Mero Adhikar " app developed by FWLD.

Further Readings

- WHO. (2023). Annual Report FY23 Grievance Redressal Service: Finding Solutions Together.
- UNDP. (October 2017). UNDP SES Supplemental Guidance: Grievance Redress Mechanisms
- WHO. (2008). A Guide to Designing and Implementing Grievance Mechanisms for Development Projects. Advisory Note.
- CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB).
- CARE Nepal. (2024). Circle of Accountability (CoA) SoP. (Internal Document)

³⁰⁷ <https://kathmandu.gov.np/> (accessed on 15 February 2024)

IV. Community Monitoring of SRHR linking to Circle Of Accountability.

A. Introduction to Community Based Monitoring

Community monitoring of SRHR refers to the process by which community members themselves actively participate in gathering information and assessing the quality, accessibility, and effectiveness of SRHR services and programs within their own communities. This approach empowers communities to take ownership of their SRHR and hold relevant authorities accountable for meeting their needs.

Some of key features of Community based monitoring includes:

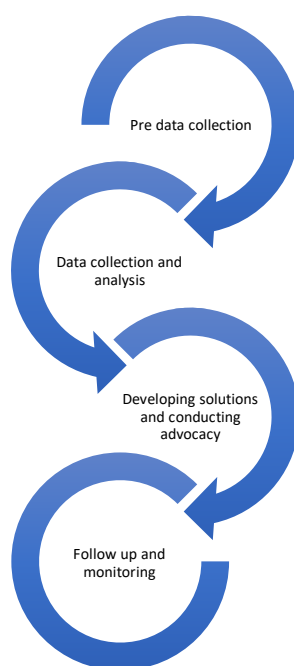
- It is focused on local context that helps to address specific issues and challenges faced by the community in accessing and utilizing SRHR services.
- Community based monitoring is based on participation of the community. Community members are actively involved in all stages of the process, from identifying concerns to collecting data, analyzing results, and advocating for change.
- Community based monitoring is flexible while using data collection methods. It employs various methods like discussion, surveys, focus group discussions, interviews, and observations, utilizing tools and techniques accessible to the community.
- It empowers the community and builds the capacity of community members to understand and advocate for their SRHR needs, fostering local leadership and accountability.
- Community based monitoring enhances and supports advocacy activities. The collected information is used to advocate for improvements in SRHR services, policies, and practices at local, and national levels.

Community based monitoring of SRHR helps to improve data collection of communities that may not be covered by regular monitoring systems. It may provide nuanced and context-specific data. With the participation and empowerment of community members, communities can hold service providers and authorities accountable for meeting community needs. For instance, marginalized communities can raise voices regarding barriers to accessing antenatal care and subsequently improve access to those services better. In many cases, documentation of gender based violence by the community leads to better advocacy for justice for the victims. Likewise, community based monitoring leads to more responsive, accessible, and equitable SRHR services in the community.

It should be noted that community based monitoring requires capacity building of community members, resources, data analysis and interpretation skills, and sustainability. In order to build capacity, well designed training and support should be provided to community members enabling them to conduct effective monitoring. Likewise, adequate funding and logistical support are needed to carry out monitoring activities. Skills and resources are needed to analyze and interpret collected data effectively. Likewise, it is important to ensure long-term engagement and impact of community monitoring initiatives.

Minimum Cycle of Community Monitoring³⁰⁸

³⁰⁸ Community Data for Change, Community Led Accountability Working Group, EANNASO-APCASO-ATAC Consortium. Community Led Monitoring: Best Practices for Strengthening the Model. White Paper.



Care Nepal has developed and implemented Community Circle of Accountability as a social accountability tool to build the agency of women, girls, and other disadvantaged populations, unite them for collective voices and claim their SRHR rights.³⁰⁹ It acts as a vibrant citizen forum that collects, reviews, and finds remedies on SRHR complaints and monitors effectiveness of SRHR service delivery. The model of Community Circle of Accountability is jointly supported and facilitated by community-based monitors and civil society partners working for human rights and humanitarian actions.³¹⁰

Further Readings

- CRR & CARE. Implementing rights based accountability for sexual and reproductive health and rights in humanitarian settings. Issue Brief.
- Grady Arnott, Charles Otema, Godfrey Obalim, Beatrice Odallo, Teddy Nakubulwa, and Samuel Okello. ‘Human rights-based accountability for sexual and reproductive health and rights in humanitarian settings: Findings from a pilot study in northern Uganda’ (22 August 2022) *PLoS Global Public Health*

B. Tools and Techniques for Community Monitoring

As aforementioned, community monitoring encompasses various tools and techniques that empower communities to actively track progress, identify issues, and hold stakeholders accountable in areas like public service delivery, health service and SRHR. (See Community Monitoring and Evaluation Systems under D. Monitoring and Evaluation Systems, III. Strategies for Building Accountable Health Systems)

³⁰⁹ SoP - Circle of Accountability - (Internal Document)

³¹⁰ SoP - Circle of Accountability - (Internal Document)

Example of Circle of Accountability

It utilizes a combination of monitoring tools and techniques to ensure effective oversight of SRH services as follows:

Feedback Channels and Accountability Tools³¹¹

Complaint Box	Physical or digital suggestion boxes placed in community spaces, public places, government offices, or online, allowing right-holders to submit feedback anonymously.
Focus Group Discussion (FGD)	FGDs involve a small, diverse group of participants who represent right-holders and duty-bearers. FGDs are typically conducted by a facilitator or moderator who guides a discussion among a small group of participants, usually ranging from 6 to 12 individuals. FGDs follow a semi-structured or structured format, with a predefined set of questions and topics. However, participants are encouraged to express their thoughts and interact with one another. They are typically 1-2 hours in length, and after the FGD, the data is analyzed to identify common themes, patterns, and insights that emerge from the discussion.
Community Meetings/ Town Hall gatherings	Regular community meetings or town hall gatherings provide a platform for right-holders to interact with local officials, share their concerns, and discuss community matters.
Feedback Survey	A structured questionnaire designed to collect information, opinions, and insights from right-holders (women and girls)
Community Score Card (CSC)	The CSC is a two-way and participatory tool that facilitates feedback, fosters accountable management, aids in planning and monitoring, and encourages the sharing of responsibilities with the goal of enhancing the quality of SRHR public services.

Feedback/Complaint Handling Mechanism³¹²

Stages	Process
Promote	<ol style="list-style-type: none"> 1. Spread information about the multiple channels and methods for individuals to submit complaints, such as physical complaint boxes, toll-free numbers, digital/online forms, in-person interviews. 2. Share information about accessible and clear point of contact information for complaint submission.
Collect Record, Categorize, and Escalate	<ol style="list-style-type: none"> 1. Maintain a centralized database or system (Physical Logbook OR Online Excel sheets) to record complaints, including essential details like date, time, complainant's information, nature of the complaint, and the person responsible for handling it.

³¹¹ This section is based on an internal document shared by CARE Nepal - Circle of Accountability (CoA) SoP. The latest version is of 11 March 2024

³¹² This section is based on internal document shared by CARE Nepal - Circle of Accountability (CoA) SoP. The latest version is of 11 March 2024

	2. Classify complaints into relevant categories to streamline their resolution.
Acknowledgment	1. Send an initial acknowledgment to the complainant to notify them that their complaint has been received and is under review. 2. Assign a unique reference number to each complaint to facilitate tracking and follow-up.
Investigation and Resolution	1. If at the local level. CBMs thoroughly investigate the issue by gathering information and talking to relevant parties. 2. If at a Palika, Provincial level, CBMs, share and allocate the complaint to an appropriate authority responsible for handling it. 3. CBMs take appropriate measures to address the complaint, or follow up with relevant authority designated to address the complaint
Response and Close	1. Keep the complainant informed of the progress and expected resolution date, especially if the resolution is taking longer than anticipated. 2. Share the outcome of the investigation and any actions taken to prevent similar complaints in the future. 3. Encourage two-way communication with the complainant to ensure they are satisfied with the resolution.
Continuous Improvement	1. Record and use complaint data to identify areas for improvement in services or processes. 2. Take proactive measures and advocate to implement changes to prevent similar complaints from arising in the future.

Example of Community Health Score Board

The Community Health Score Board utilizes various types of meeting as a tool and technique for community monitoring.³¹³

Steps in Community Health Score Board (CHSB)

Steps		Process
Step 1	CONSULTATION MEETING WITH LOCAL GOVERNMENT	The meeting is attended by <ul style="list-style-type: none"> • Deputy Mayor/Vice-chair • Executive officer, Municipality • Elected Representative
	Agenda <ul style="list-style-type: none"> • Selection of Priority wards/Health facility in local government area (criteria) <ul style="list-style-type: none"> – Population of disadvantaged Community – Low rate of health service utilization – High turnover and absenteeism of health workers 	

³¹³ CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB). p. 4. Available at https://carenepal.org/wp-content/uploads/2023/08/CARE_CHSB-technical-brief.pdf (accessed on 17 March 2024).

	<ul style="list-style-type: none"> - Irregular Management Committee meeting • Finalize the indicators for scoreboard 	<ul style="list-style-type: none"> • Health Coordinator, Municipality
Step 2	ONE-DAY ORIENTATION TO LOCAL GOVERNMENT REPRESENTATIVE, HFOMC AND FCHV ON CHSB	
	<p>Agenda</p> <ul style="list-style-type: none"> • Knowledge on modality and its intended outcome • Selection of HMG sites (criteria) <ul style="list-style-type: none"> - Population of disadvantaged Community - Low rate of health service utilization - Irregular Health Mother's Group (HMG) Meeting • Feedback on the indicator • Self-evaluation & preparation for upcoming activity ^[1]_{SEP} 	
Step 3	CONDUCTION OF HEALTH MOTHER'S GROUP MEETINGS USING SATH TOOL	Self-Applied Technique for Quality Health (SATH) is a social mapping tool designed to be used in health mother's group meeting to enable women in a community to analyze health status and service seeking behavior of a community.
	<p>Agenda</p> <ul style="list-style-type: none"> • Use of SATH tool to discuss on health issues and health behavior in the community ranging from service seeking practices of women to health services provided by the health facility which will help validate the claims/opinion of health service providers. • Feedback on the indicator. • Compilation of information from discussions in HMG meeting 	
Step 4	INTERFACE MEETING (First joint meeting)	Interface meeting is the final step on the implementation of CHSB where HFOMC, health workers, service users, FCHVs, representatives from CBOs, local political leaders and representatives from local bodies gather to discuss on the performance of health facility
Step 5	REVIEW MEETING (Every six months)	Review meeting is done after 6 months of interface meeting. The process of the interface and review meeting are the same.

Source: CARE Nepal

Further Readings

- WHO. (2010). Monitoring, Supervisory and Evaluation Tools for Community-based Initiatives.
- UCLC &OIDP. (2013). Basic Principles of Community Based Monitoring.
- CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB).
- CARE Nepal. (2024). Circle of Accountability (CoA) SoP. (Internal Document)

C. Community-Led Data Collection and Analysis

Depending on communities' needs, priorities, and gaps, data collection can involve any combination of surveys, individual interviews, and focus groups, collected in clinics, the surrounding communities, and/or in respondents' homes. Data is then analyzed by using necessary tools including software. The meetings of different stakeholders and broader communities are held to analyze the information and translate data into actionable insights and advocacy priorities.

It should be noted that community led data collection adheres to ethical data collection, consent, confidentiality and data security. Data collection must be verifiable, reliable, conducted in a routine or continuous cycle, and collected under “do no harm” principles.³¹⁴

Drawing a concrete reference on Community Circle of Accountability, Community council members collect SRHR related feedback and complaints from its surrounding community and bring it for discussion during regular meetings—the feedback and complaints are then reviewed, analyzed, and categorized. The community council decides on reporting channels based on interest, priority, and local context based on priorities of marginalized and excluded women, girls, and other minorities. The received feedback and complaints, based on their categorization, are reported to various levels of concerned authorities and followed up to get a timely response. The response provided by the authorities regarding the feedback and complaints is reviewed at the community council, cohort of Community Monitors and reported back to concerned complainants. It collaborates, lobbies and builds effective alliances with relevant civil society and human rights actors, legal aid services, rehabilitation centers to appropriately address the complaints of sensitive nature and ensure justice to the survivors. The whole process ensures privacy and confidentiality that encourages right holders to complain without any kind of fear or retaliation.

Based on analysis, complaints are categorized as follows:

Feedback/Complaint Types³¹⁵

³¹⁴ UNAIDS. (2023). Community-led monitoring in action: Emerging evidence and good practice. p.9. Available at: https://www.unaids.org/sites/default/files/media_asset/JC3085E_community-led-monitoring-in-action_en.pdf (accessed on 17 March 2024).

³¹⁵ This section is based on an internal document shared by CARE Nepal - Circle of Accountability (CoA) SoP. The latest version is of 11 March 2024

Levels	Types	Responsible Authority to resolve
Level 1: Routine Feedback and Minor Concerns	<ol style="list-style-type: none"> 1. Information Queries: General inquiries or requests for information related to SRHR services. These can usually be addressed at the point of contact (e.g., healthcare provider or community health worker). 2. Minor Service Delays: Complaints about minor service delays or scheduling issues. These can often be resolved by local healthcare facility staff or service providers. 3. Availability of Information Materials: Feedback regarding the availability or content of information materials. CBMs, local SRHR program coordinators or educators can address these concerns. 	<ol style="list-style-type: none"> 1. Community Monitors 2. Local Health-Facility
Level 2: Moderate Concerns and Service Issues	<ol style="list-style-type: none"> 1. Quality of Care: Complaints about the quality of SRHR services. The local health department may need to investigate and address these concerns. 2. Access Barriers: Concerns related to accessibility issues, such as long waiting times or transportation problems. Local health authorities or community organizations may need to coordinate solutions. 3. Stigma and Discrimination: Complaints about stigmatization or discrimination by healthcare providers. Local authorities and relevant organizations can intervene to address these concerns and provide sensitivity training. 	<ol style="list-style-type: none"> 1. Local Health-Facility 2. Ward Level Authority: Mediation Committee
Level 3: Serious Concerns and Rights Violations	<ol style="list-style-type: none"> 1. Privacy and Confidentiality Violations: Complaints about breaches of privacy and confidentiality that are serious in nature. Local health department, ethics committee, or relevant government agencies may need to investigate. 2. Reproductive Rights Violations: Complaints involving significant violations of reproductive rights or forced procedures. Legal and human rights organizations should be informed, and legal action may be necessary. 3. Severe Medical Negligence: Complaints related to severe medical negligence or harm during SRHR services. A higher level of healthcare oversight, including a medical review board, should be involved. 	<ol style="list-style-type: none"> 1. Municipal Level Authority: Judiciary Committee 2. In case of serious violations of Human Rights, the cases will directly be referred to legal authorities
Level 4: Critical Emergencies	<ol style="list-style-type: none"> 1. Emergency Medical Situations: Complaints involving critical emergency situations, such as 	<ol style="list-style-type: none"> 1. Palika Level Authority:

	<p>life-threatening complications during childbirth. Immediate medical intervention is essential, and healthcare authorities should be alerted.</p> <p>2. Violence, Abuse, or Human Trafficking: Complaints related to Sexual Harassment, Exploitation, Abuse (SHEA), child abuse, sexual misconduct, and human trafficking within SRHR services. Law enforcement and protection agencies must be involved to ensure the safety of individuals affected.</p>	<p>Judiciary Committee</p> <p>2. In case of serious violations of Human Rights, the cases will directly be referred to legal authorities (for SHEA, CA and other serious violations)</p>
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Further Readings

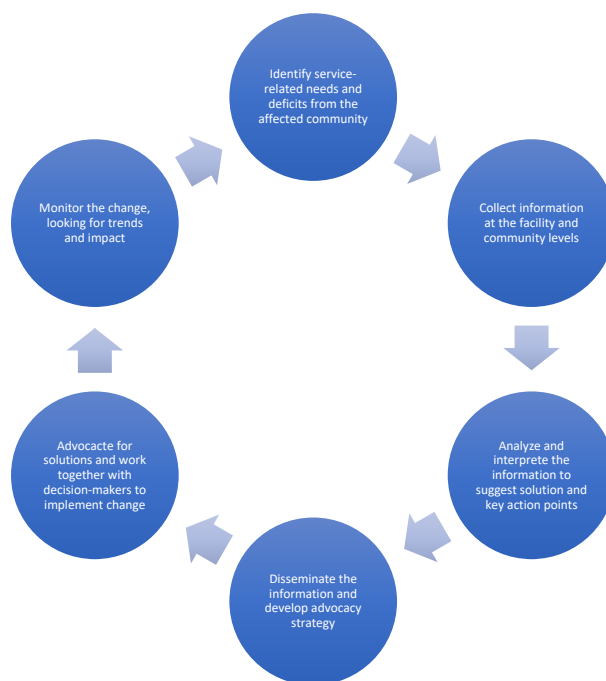
- WHO. (2010). Monitoring, Supervisory and Evaluation Tools for Community-based Initiatives.
- UCLC & ODP. (2013). Basic Principles of Community Based Monitoring.
- CARE Nepal. (n.d.) Technical brief #1 COMMUNITY HEALTH SCORE BOARD (CHSB).
- CARE Nepal. (2024). Circle of Accountability (CoA) SoP. (Internal Document)

D. Advocacy and Action based on Community Findings

Once the gaps and issues in service provision have been identified, the community monitoring program develops actionable, data-informed solutions to the gaps that have been identified. These advocacy messages are disseminated through targeted action to bring proposed solutions to the attention of decision-makers at the facility, regional, national, and international levels. This advocacy is typically conducted by a combination of re-visiting clinics, establishing community consultative groups, and/or by leveraging existing policy- and decision-making forums and governance structures. The community Monitoring program advocates for decision-makers to implement broader changes in policy and practice through public-facing community accountability meetings, and reports. The community Monitoring program continues its monitoring and follow-up to ensure that commitments from duty-bearers are enacted, as well as to identify trends and impact.

Advocacy and Action Based on Community Monitoring³¹⁶

³¹⁶ The following picture is based on UNAIDS's 2023 publication. See UNAIDS. (2023). Community-led monitoring in action: Emerging evidence and good practice. p.9. Available at: https://www.unaids.org/sites/default/files/media_asset/JC3085E_community-led-monitoring-in-action_en.pdf (accessed on 17 March 2024).. p.10



Source: UNAIDS (2023)

As aforementioned, referring to Circle of Accountability, Community Councils and Community Monitors collaborate, lobby and build effective alliances with relevant civil society and human rights actors, legal aid services, rehabilitation centers to appropriately address the complaints of sensitive nature and ensure justice to the survivors. It continues its monitoring and follow-up to ensure accountability of duty bearers to the fullest.

Further Readings

- WHO. (2010). Monitoring, Supervisory and Evaluation Tools for Community-based Initiatives.
- UCLC &OIDP. (2013). Basic Principles of Community Based Monitoring.
- CARE Nepal. (2024). Circle of Accountability (CoA) SoP. (Internal Document)

V. Training Curriculum based on the Toolkit.

A. Overview of Toolkit

This is a professional toolkit designed to create a training of trainers (TOT) curriculum that provides stakeholders with a comprehensive understanding of rights-based accountability and effective strategies for promoting accountable health systems, specifically focused on SRHR during disasters and emergencies. This toolkit equips trainers with the expertise and resources to conduct TOT programs on the crucial intersection of rights-based accountability, accountable health systems, and community monitoring of SRHR during disasters and emergencies.

Objectives of the toolkit:

- To develop the TOT curriculum that equips trainers with the knowledge and resources to train others on building accountable health systems that uphold SRHR during disasters and emergencies.³¹⁷

Who is this toolkit for?

This toolkit is primarily designed to build the capacity of project staff of all partners, including the Center for Reproductive Rights (CRR), CARE Nepal, and Forum for Women, Law and Development (FWLD) on rights-based accountability and SRHR in disaster settings. Nevertheless, this toolkit is relevant for everyone who has an interest in accountable health systems and SRHR during disasters.

What is this toolkit about?

The content of this toolkit includes modules and sub-modules as follows:

Module	Sub-Module
Module 1: Introduction to Rights-Based Accountability, SRHR and Disasters	Module 1.1: Introduction to Human Rights and Right to Health Module 1.2: Sexual and Reproductive Health and Rights (SRHR) Module 1.3: Right Based Approach in Health Module 1.4: Disaster Management and SRHR Risks
Module 2: Framework for Rights-Based Accountability in Health Systems	Module 2.1: Principles of Rights-Based Accountability and Accountable Health Systems Module 2.2: United Nations Human Rights Accountability Mechanism Module 2.3: Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism) Module 2.4: Role of Duty-Bearers and Right-Holders of SRHR and Disasters
Module 3: Strategies for Building Accountable Health Systems	Module 3.1: Policy and Legal Frameworks for Disaster and SRHR Module 3.2: Selected Precedent of the Supreme Court of Nepal On Disaster and SRHR Module 3.3: SRHR in Disaster Preparedness, Response and Recovery Module 3.4: Strengthening Governance and Transparency
Module 4: Community Monitoring of SRHR linking to Circle Of Accountability	Module 4.1: Community Monitoring and Evaluation Systems

³¹⁷ This toolkit would be used to train NHRIs and protection clusters on SRHR and disaster across Nepal.

	Module 4.2: Circle of Accountability Module 4.3: Community-Led Data Collection and Analysis Module 4.4: Advocacy and Action based on Community Findings
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What are learning objectives?

By the end of the TOT program, participants will be able to:

- **Define** rights-based accountability and SRHR in the context of disasters.
- **Explain** the importance of upholding SRHR during disasters.
- **Articulate** the framework for rights-based accountability in health systems during disasters.
- **Identify** strategies for building accountable health systems.
- **Analyze** relevant policy and legal frameworks for disaster management and SRHR.
- **Develop** strategies for incorporating SRHR into disaster preparedness, response, and recovery plans.
- **Develop** a plan for community monitoring of SRHR services in disaster settings.
- **Utilize** community based monitoring findings for advocacy and action to improve SRHR service delivery during disasters.

Toolkit Map



B. Training Module Outlines

Module 1: Introduction to Rights-Based Accountability, SRHR and Disasters

This module establishes the foundation by defining rights-based accountability and its connection to SRHR, particularly in disaster settings. It highlights the significance of accountability in upholding SRHR, particularly during disasters and details out disaster management and the specific risks to SRHR faced by vulnerable populations.

Module 1.1: Introduction to Human Rights and Right to Health

Goal: To establish a foundation for understanding how human rights principles apply to health, specifically focusing on the right to health.

Duration: 1.5 Hour

Core Content: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, A. Human Rights, Health, and SRHR, pp. .

Discussion Questions:

- What are human rights?
 - UDHR and core conventions
- What are international human rights instruments related to health?
 - Definition of the right to health according to ICESCR
 - Key components of the right to health (availability, accessibility, acceptability, and quality)
 - Core obligations of states regarding the right to health

Learning Objectives: By the end of this session, participants will be able to:

- Define human rights and their core principles.
- Analyze the core human rights treaties related to health.
- Articulate the definition of the right to health and its components according to ICESCR and the four key components of the right to health (availability, accessibility, acceptability, and quality).
- Describe the core obligations of states regarding the right to health including core obligations and comparable obligations.

Presentation: Please refer to presentation slide Introduction to Human Rights and Right to Health (Annex 1)

Module 1.2: SRHR

Goal: To create a comprehensive understanding of SRHR and its significance for overall well-being.

Duration: 1.5 hours

Core Content: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, A. Human Rights, Health, and SRHR, pp...

Discussion Questions:

- How is SRHR defined?
- What are some common misconceptions about SRHR?
- How do cultural and religious beliefs influence attitudes towards SRHR?
- How can addressing SRHR issues contribute to healthy family dynamics and community development?
- What are some of the potential health risks associated with limited access to SRHR services?
- How do international human rights frameworks translate into policies and programs at the national level?
- What are some of the challenges faced in implementing national SRHR commitments?
- What are possible ways for individuals and communities to hold governments accountable for upholding SRHR?
- Are there examples of how fulfilling SRHR needs can improve mental and social well-being?

Learning Objectives: By the end of this session, participants will be able to:

- Define SRHR and its key components
- Analyze the importance of SRHR for overall health and well-being
- Explain how fulfilling SRHR needs can contribute to positive health outcomes across different life stages
- Examine global and national commitments to SRHR

Presentation: Please refer to presentation slide **Sexual and Reproductive Health and Rights (Annex 2)**

Module 1.3: Right Based Approach in Health and SRHR

Goal: To equip participants with an understanding of how a rights-based approach can be applied to ensure access to SRHR.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, B. Overview of Rights-Based Approach in Health and SRHR, pp...

Discussion Questions: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, A. Human Rights, Health, and SRHR.

- What are core principles of rights based approach to health?
- How does the principle of rights based approach translate into ensuring equitable access to healthcare services?
- Why are SRHR considered fundamental human rights?

- What are some of the specific barriers that individuals might face in accessing SRHR services?
- How can a rights-based approach be used to address challenges in accessing SRHR services? Consider specific examples.
- Are there any case studies or real-world examples where a rights-based approach has been successful in promoting SRHR?

Learning Objectives: By the end of this session, participants will be able to:

- Define the core principles of a rights based approach to health, including equality, non-discrimination, participation, and accountability.
- Discuss the importance of these principles in ensuring equitable access to healthcare.
- Analyze the linkages between SRHR and a rights-based approach to health.
- Discuss the specific challenges faced in ensuring access to SRHR services.

Presentation: Please refer to presentation slide **Right Based Approach in Health (Annex 3)**

Module 1.4: Disaster Management and SRHR Risks

Goal: To equip participants with knowledge and skills to identify, address, and mitigate SRHR risks for vulnerable populations during disasters.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, D. Disaster Management and SRH Risks and F. Most Vulnerable Populations and Potential Risk Factors, pp...

Discussion Questions:

- How do pre-existing gender inequalities exacerbate SRHR risks for vulnerable populations including women and girls during disasters?
- What unique challenges might vulnerable populations including women, people with disabilities and LGBTIQ+ face in accessing SRHR services in a disaster context?
- How can disaster preparedness plans incorporate the specific needs of vulnerable populations regarding SRHR?
- What are some best practices for ensuring a gender-sensitive response in providing SRHR services during and after disasters?
- How can we prioritize access to essential reproductive health interventions like maternal healthcare in the aftermath of a disaster?
- What resources are available for communities to rebuild health infrastructure and ensure long-term access to SRHR services following a disaster?

Learning Objectives:

By the end of this session, participants will be able to:

- Identify vulnerable populations and potential risk factors related to SRHR in disasters.

- Analyze how disasters can disproportionately impact access to SRHR services for specific populations (e.g., women, girls, people with disabilities, LGBTQ+ individuals).
- Discuss potential risk factors for increased SRHR complications during disasters, such as lack of access to hygiene facilities, sexual violence, and unsafe abortion practices.
- Recognize the importance of considering pre-existing vulnerabilities before and during a disaster.
- Explain how different types of disasters (e.g., earthquakes, floods) can pose specific risks to SRHR
- Prioritize interventions for SRHR during disasters, such as emergency contraception and maternal health care.
- Discuss key strategies for ensuring access to essential SRHR services during and after disasters, such as mobile clinics and safe spaces for women and girls.
- Analyze the importance of gender-sensitive approaches in disaster response and SRHR service provision.

Presentation: Please refer to presentation slide **Disaster Management and SRHR Risks (Annex 4)**.

Module 2: Framework for Rights-Based Accountability in Health Systems

This module dives deeper into the framework for ensuring accountability within health systems during disasters. It explains the principles of rights-based accountability and the components of accountable health systems. It articulates how to link SRHR with accountability frameworks, including identifying duty-bearers and rights-holders, and exploring different accountability mechanisms.

Module 2.1: Principles of Rights-Based Accountability and Accountable Health Systems

Goal: To empower participants with knowledge and skills to advocate for and contribute to accountable health systems that uphold human rights principles.

Duration: 2 hours

Core Content: Please refer to Technical Content, I. Introduction to Rights-Based Accountability, C. Importance of Accountability in SRHR and II. Framework for Rights-Based Accountability in Health Systems, A. Principles of Rights-Based Accountability, and B. Components of Accountable Health Systems, pp...

Discussion Questions:

- What are key principles of right based accountability?
- What are the importance of these principles in holding health systems accountable for upholding the right to health and SRHR?
- What are key components of accountable health systems?
- What could be strategies for promoting right based accountability in health and SRHR.

Learning Objectives:

By the end of this session, participants will be able to:

- Explain the concept of rights-based accountability in the context of health systems.
- Analyze key principles of rights-based accountability, such as participation, transparency
- Discuss the importance of these principles in holding health systems accountable for upholding the right to health and SRHR.
- Describe the core features of an accountable health system
- Identify strategies for promoting rights-based accountability in health and SRHR.

Presentation: : Please refer to presentation slide **Principles of Rights-Based Accountability and Accountable Health Systems (Annex 5)**

Module 2.2: United Nations Human Rights Accountability Mechanism

Goal: To equip participants with a clear understanding of the UN Human Rights accountability mechanisms, namely, treaty bodies and charter bodies.

Duration: 2 hours

Core Content: Please refer to Technical Content, II. Framework for Rights-Based Accountability in Health Systems, C. Linking SRHR with Accountability Frameworks, Selected Accountability Mechanisms, pp...

Discussion Questions:

- What are some advantages and limitations of the treaty body system in holding states accountable for human rights violations?
- How can charter bodies like the Human Rights Council draw attention to human rights situations requiring urgent action?
- How can civil society organizations leverage their expertise to inform the work of treaty bodies through shadow reports?
- How can increased engagement with UN human rights mechanisms contribute to strengthening human rights protections overall?

Learning Objectives: By the end of this session, participants will be able to:

- Differentiate between treaty bodies and charter bodies
- Analyze the distinct mandates and functions of treaty bodies and charter bodies.
- Identify opportunities for engagement with UN human rights mechanisms.

Presentation: Please refer to presentation slide **United Nations Human Rights Accountability Mechanism (Annex 6)**

Module 2.3: Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism)

Goal: To broaden participants' understanding of human rights accountability beyond the UN system and explore the roles of NHRIs, health system accountability mechanisms, and social accountability initiatives.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, II. Framework for Rights-Based Accountability in Health Systems, C. Linking SRHR with Accountability Frameworks, Selected Accountability Mechanisms, pp...

Discussion Questions:

- NHRIs
 - How can individuals and communities utilize NHRIs to address human rights concerns related to healthcare access during disasters?
 - What are some strategies to strengthen the independence and effectiveness of NHRIs in promoting accountability?
- Health System Accountability Mechanisms
 - Are there examples of how complaint mechanisms within health systems contribute to addressing grievances and improving service quality?
 - What are some challenges in implementing effective community monitoring initiatives within health facilities?
 - How can ensuring transparency in health system data empower citizens to hold health institutions accountable?
- Social Accountability in Health
 - How can social accountability bridge the gap between policy and practice in the health sector?
 - Is there any real-world example where social accountability has successfully improved health outcomes in a community, particularly SRHR?

Learning Objectives:

By the end of this session, participants will be able to:

- Describe the role of NHRIs to establish accountability for human rights violations, including those related to health and SRHR.
- Explain different mechanisms within health systems for promoting accountability, such as complaint mechanisms, community monitoring initiatives, and performance audits.
- Explore the concept of social accountability and its application in health.
- Analyze how social accountability initiatives can complement other accountability mechanisms to improve health service delivery.

Presentation: Please refer to presentation slide **Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism) (Annex 7)**

Module 2.4: Role of Duty-Bearers and Right-Holders of SRHR and Disasters

Goal: To empower participants to identify and understand the roles and responsibilities of duty-bearers and right-holders in ensuring access to SRHR during disasters.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, II. Framework for Rights-Based Accountability in Health Systems, C. Linking SRHR with Accountability Frameworks, pp...

Discussion Questions:

- Who are duty-bearers operating at national, local, and international levels during disasters?
- How does the responsibility of specific duty-bearers, such as healthcare providers, differ in pre-disaster preparedness, immediate response, and long-term recovery phases?
- Why is it important to recognize individuals and communities as active right-holders with agencies regarding their SRHR needs in disasters?
- How do international human rights frameworks like the ICESCR guide the responsibilities of duty-bearers regarding SRHR in disasters?
- What specific actions can governments take to ensure access to essential SRHR services like contraception and maternal healthcare during a disaster?
- What are some best practices for humanitarian organizations to deliver SRHR services in a culturally sensitive and inclusive manner during disasters?
- How can right-holders effectively communicate their SRHR needs and concerns to duty-bearers during disasters?
- What mechanisms can be used by right-holders to hold duty-bearers accountable for failing to uphold SRHR obligations in disasters?
- How can we strengthen communication and collaboration between duty-bearers and right-holders to ensure effective SRHR responses in disasters?

Learning Objectives:

By the end of this session, participants will be able to:

- Define the concepts of duty-bearers and right-holders in the context of SRHR and disasters.
- Identify key duty-bearers responsible for upholding SRHR during disasters (e.g., governments, humanitarian organizations, healthcare providers).
- Analyze the specific obligations and responsibilities of duty-bearers in ensuring access to essential SRHR services in disaster situations.
- Identify right-holders whose SRHR needs must be addressed during disasters (e.g., women, girls, people with disabilities, LGBTQ+ individuals).
- Analyze the rights and entitlements of right-holders regarding SRHR during disasters.
- Explore how right-holders can hold duty-bearers accountable for fulfilling their obligations.

Presentation: Please refer to presentation slide **Role of Duty-Bearers and Right-Holders of SRHR and Disasters (Annex 8)**

Module 3: Strategies for Building Accountable Health Systems

This module examines policy and legal frameworks for disaster management and SRHR including selected Supreme Court precedent in Nepal. It discusses strategies for integrating SRHR into disaster preparedness, response, and recovery efforts, emphasizing coordination among various stakeholders. Likewise, it explores ways for strengthening governance, transparency, and grievance redressal mechanisms. It highlights the role of monitoring and evaluation systems, including NHRIs and community-based monitoring.

Module 3.1: Policy and Legal Frameworks for Disaster and SRHR

Goal: To equip participants with knowledge about key policy and legal frameworks that support access to SRHR during disasters.

Duration: 2 hour

Core Content: Please refer to Technical Content, III. Strategies for Building Accountable Health Systems, A. Policy and Legal Frameworks for Disaster and SRHR, pp...

Discussion Questions:

- What are key legislations related to disaster and SRHR respectively?
- How can national governments strengthen their legal frameworks to address the specific needs of vulnerable populations regarding SRHR in disasters?
- Why is it important to involve civil society organizations in developing and implementing national disaster response plans that address SRHR needs?
- What are some of the key challenges in implementing international guidelines like the IAWG MISP in disaster settings?
- How can humanitarian actors ensure their response efforts are culturally sensitive and address the diverse SRHR needs of different populations?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze key national laws and policies related to disaster management.
- Analyze key national laws and policies related to SRHR
- Discuss how these frameworks apply to SRHR service provision during disasters.

Presentation: Please refer to presentation slide **Policy and Legal Frameworks for Disaster and SRHR (Annex 9)**

Module 3.2: Selected Precedent of the Supreme Court of Nepal On Disaster and SRHR

Goal: To enhance participants' understanding of how the Supreme Court of Nepal has interpreted and applied legal principles to uphold SRHR during disasters in Nepal.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, III. Strategies for Building Accountable Health Systems, A. Policy and Legal Frameworks for Disaster and SRHR, pp...

Discussion Questions:

- How do these Supreme Court cases define and address the specific challenges faced by vulnerable populations regarding SRHR in disasters?
- What legal principles did the Court rely on when issuing rulings on access to SRHR services during disasters?
- How have these precedents influenced the way government agencies and humanitarian organizations approach SRHR in disaster response efforts in Nepal?
- How can these Supreme Court precedents be used to hold government agencies accountable for fulfilling their obligations regarding SRHR in disasters?
- What strategies can be employed to utilize these precedents in public awareness campaigns and community mobilization efforts?
- How can civil society organizations work together to strengthen legal frameworks and ensure effective implementation of SRHR protections during disasters?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze relevant Supreme Court precedents on disaster and SRHR in Nepal.
- Identify potential gaps or limitations in the current legal framework regarding SRHR in disasters.
- Explore the potential implications of these precedents for future advocacy efforts.

Presentation: Please refer to presentation slide **Selected Precedents of the Supreme Court of Nepal On Disaster and SRHR (Annex 10)**

Module 3.3: SRHR in Disaster Preparedness, Response and Recovery

Goal: To equip participants with a comprehensive understanding of the importance of SRHR in all phases of disaster management i.e. preparedness, response, and recovery.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, III. Strategies for Building Accountable Health Systems, A. Policy and Legal Frameworks for Disaster and SRHR, SRHR in Disaster Preparedness, Response and Recovery, pp...

Discussion Questions:

- What are indicators to measure inclusion of SRHR in all phases of disaster management?
- How can pre-existing inequalities exacerbate SRHR risks for women and girls during disasters?
- What are some potential consequences of neglecting SRHR needs following a disaster?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze the link between disasters and SRHR risks
- Describe key strategies for integrating SRHR into disaster preparedness plans
- Develop effective SRHR interventions in disaster response

Presentation: Please refer to presentation slide **SRHR in Disaster Preparedness, Response and Recovery (Annex 11)**

Module 3.4: Strengthening Governance and Transparency

Goal: To enhance participants' knowledge and skills to advocate for and contribute to a culture of accountability within the health system, ensuring effective access to SRHR services during disasters.

Duration: 1.5 hour

Core Content: Please refer to Technical Content, III. Strategies for Building Accountable Health Systems, B. Strengthening Governance and Transparency, pp...

Discussion Questions:

- How can clear communication and coordination mechanisms be established between government agencies, healthcare providers, and community organizations during disasters to ensure efficient SRHR service delivery?
- How can existing grievance redressal mechanisms, such as national human rights commissions, be adapted to address SRHR violations that occur during disasters?
- What characteristics are essential for grievance redressal mechanisms to be accessible and provide effective remedies for individuals whose SRHR rights have been violated?
- How can awareness campaigns be conducted to inform communities about existing grievance redressal mechanisms for addressing SRHR violations during disasters?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze the importance of clear roles and responsibilities in SRHR service delivery during disasters.
- Identify effective mechanisms for promoting transparency in SRHR service delivery
- Develop strategies for fostering community participation in SRHR decision-making.
- Explore existing grievance redressal mechanisms for SRHR violations.

Presentation: Please refer to presentation slide **Strengthening Governance and Transparency (Annex 12)**

Module 4: Community Monitoring of SRHR linking to COA

This module focuses on empowering communities to monitor the delivery of SRHR services and hold duty bearers accountable. It covers tools and techniques for community monitoring such as Circle of Accountability. It explores ways to utilize community based monitoring findings for advocacy and action.

Module 4.1: Community Monitoring and Evaluation Systems

Goal: To build participants' capacity, knowledge and skills to promote meaningful community participation and establish effective Community Monitoring and Evaluation Systems for improved disaster response and accountability for SRHR.

Duration: 2 hour

Core Content: Please refer to Technical Content, III. Strategies for Building Accountable Health Systems, D. Monitoring and Evaluation System, and Community Monitoring of SRHR linking to COA, A. Introduction to Community Based Monitoring, pp...

Discussion Questions:

- What communication tools and methods can be used to effectively engage with diverse communities before, during, and after disasters?
- How can data collected through Community Monitoring and Evaluation Systems be used to hold disaster response agencies accountable for meeting the needs of communities?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze the importance of community participation in disaster response
- Develop strategies for fostering effective community engagement in disasters
- Understand the role of Community Monitoring and Evaluation Systems

Presentation: Please refer to presentation slide **Community Monitoring and Evaluation Systems (Annex 13)**

Module 4.2: Circle of Accountability

Goal: To equip participants with an understanding of the Circle of Accountability (CoA) framework as a community monitoring and evaluation tool for disaster response and SRHR.

Duration: 1.5 hour

Core Content: Please refer to Internal Document Circle of Accountability SOP, and Technical Content, I. Introduction to Rights-Based Accountability, SRHR and Disasters, C. Importance of Accountability in SRHR, III. Strategies for Building Accountable Health Systems, D. Monitoring and Evaluation System, and IV. Community Monitoring of SRHR linking to Circle of Accountability, A. Introduction to Community Based Monitoring, pp...

Discussion Questions:

- In what ways can the CoA empower communities to hold themselves and external actors accountable for disaster response efforts?
- How can power imbalances within communities be addressed to ensure all voices are heard and represented within the CoA?
- What types of data collection methods would be most appropriate for a CoA initiative in a specific disaster context?
- How can findings from the CoA be used to influence decision-making processes and lead to concrete changes in disaster response policies or practices?
- What potential challenges might arise in implementing the CoA, such as lack of resources or resistance from local authorities?
- How can the CoA framework be adapted and sustained to ensure its long-term effectiveness in promoting accountability and improving disaster response?

Learning Objectives: By the end of this session, participants will be able to:

- Explain the core principles of the CoA framework.
- Evaluate the effectiveness of the CoA in promoting accountability and action

Presentation: Please refer to presentation slide Circle of Accountability (Annex 14)

Module 4.3: Community-Led Data Collection and Analysis

Goal: To provide participants with the knowledge and skills to design and implement effective community-led data collection and analysis processes for gathering valuable insights during disaster response efforts.

Duration: 1.5 hour

Core Content: Please refer to IV. Community Monitoring of SRHR linking to Circle of Accountability, C. Community-Led Data Collection and Analysis pp...

Discussion Questions:

- How can data collected directly from communities provide a more nuanced understanding of their SRHR needs and experiences during disasters?
- What potential biases might be present in top-down data collection approaches, and how can community-led data help address them?
- How can data collected from communities be used to challenge existing assumptions and promote more inclusive disaster response strategies for SRHR?
- What are some key considerations when selecting data collection methods that are appropriate for the specific context and cultural background of the community?
- How can community members be actively involved in designing data collection tools and ensuring their voices are reflected in the data collection process?
- How can ethical considerations such as informed consent and data security be addressed when collecting data from disaster-affected communities?
- How can qualitative data collected through methods like focus groups be effectively analyzed and interpreted to inform disaster response efforts and SRHR?

Learning Objectives: By the end of this session, participants will be able to:

- Analyze the importance of community-led data collection in disaster response and SRHR.
- Develop strategies for designing community-led data collection tools.
- Discuss strategies for ensuring ethical data collection practices that respect the privacy and dignity of community members.

Presentation: Please refer to presentation slide Community-Led Data Collection and Analysis (Annex 15)

Module 4.4: Advocacy and Action based on Community Findings

Goal: To equip participants with the skills and knowledge to develop effective advocacy strategies and take action based on community findings related to SRHR needs and challenges during disasters.

Duration: 1.5 hour

Core Content: Please refer to IV. Community Monitoring of SRHR linking to Circle of Accountability, D. Advocacy and Action based on Community Findings, pp...

Discussion Questions:

- How can community data be effectively presented and used to highlight specific SRHR challenges faced by different groups during disasters (e.g., women, girls, people with disabilities)?
- How can community voices be amplified and ensure they are central to advocacy efforts for improved SRHR in disaster response?
- What are some strategies for ensuring the long-term sustainability of advocacy efforts beyond the immediate post-disaster response phase?

Learning Objectives:

By the end of this session, participants will be able to:

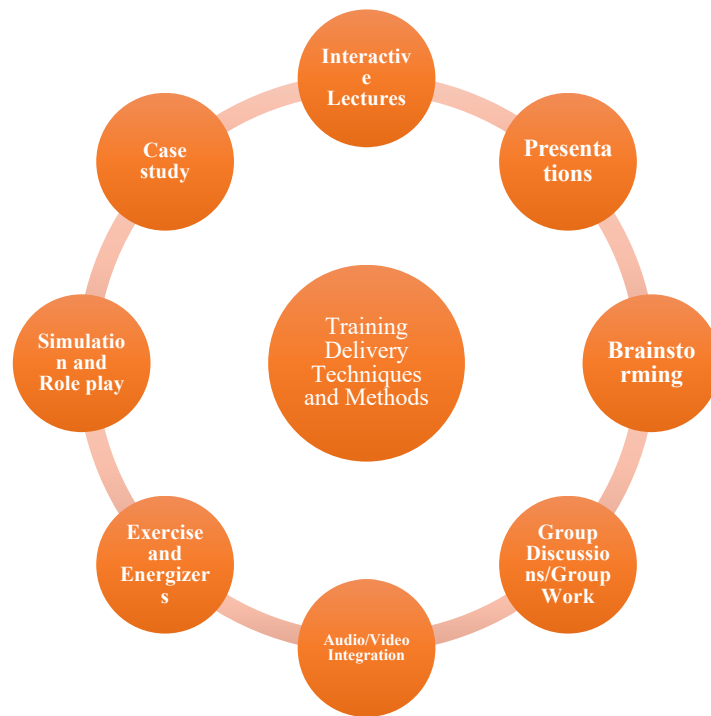
- Analyze the role of community findings in advocating for improved SRHR in disaster response
- Develop key components of an advocacy strategy based on community findings
- Discuss strategies for ensuring the sustainability of advocacy efforts and long-term improvements in SRHR during disasters

Presentation: Please refer to presentation slide **Advocacy and Action based on Community Findings (Annex 16)**

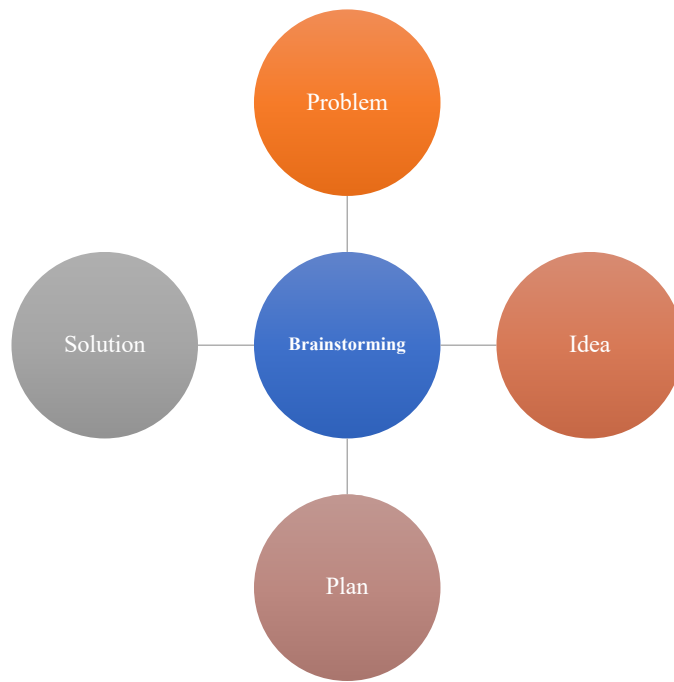
C. Training Delivery Techniques and Methods

This training program utilizes a variety of engaging training delivery techniques and methods to cater to different learning styles and maximize participant comprehension.

Training Delivery Techniques and Methods

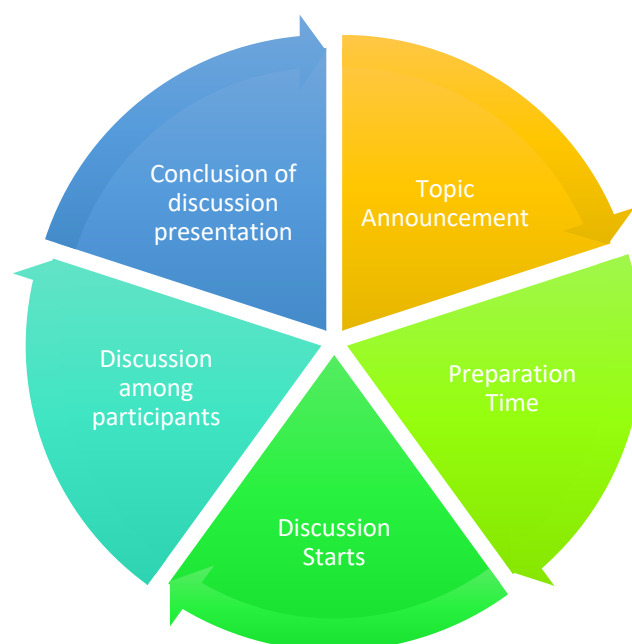


- **Interactive Lectures:** Interactive lectures are used to deliver core content/information of the training. These sessions will incorporate interactive elements like polls, Q&A breaks, discussion questions and case studies to keep participants actively engaged. Interactive lectures allow participants' active participation as they are not treated as passive listeners. They participate through activities, discussion and other methods that enhance and focus on learning objectives. Interactive lectures are suitable for TOT because they boost participation and engagement, and improve learning and analysis that are crucial for critical thinking.
- **Presentations:** Presentation can be a powerful tool for trainers/facilitators and they need to be used strategically alongside other teaching techniques such as interactive lectures. They allow for incorporating images, charts, graphs, and videos to enhance understanding and cater to visual learners. They help structure the lesson, highlight key points, and keep participants on track. While using presentations, it should be noted that presentations should be used as a visual aid, not replacement for trainers/facilitators' teaching.
- **Brainstorming Sessions:** Brainstorming sessions are a group activity designed to generate ideas for solving a problem or developing a new concept. They stimulate creative and free thinking to come up with as many ideas as possible, without judgment or criticism. During the TOT, brainstorming sessions are used to facilitate and encourage participants to generate ideas and solutions related to SRHR and accountable health systems during disasters.



- Group Discussions and Group Work:** Group discussions and group work are collaborative group work activities to promote learning, collaboration, and problem-solving. They provide opportunities for participants to exchange knowledge, share experiences, and build upon each other's insights. Group Discussions primarily focus on exchanging ideas, sharing perspectives, and developing a deeper understanding of a topic whereas group works focus on working collaboratively on a shared task to achieve a common goal. Group discussions and group works rely on active listening and clear communication to build upon ideas and exchange knowledge. They are important to bring participants experience to training and encourage peer learning.

Group Discussion/Group Work Process



- **Audio/Video Integration:** Audio/Video Integration refers to the process of combining and synchronizing audio and visual technologies to training methods. Documentary, interviews with experts, and short animations can be strategically incorporated to bring real-world context and diverse perspectives to the training content. Integrating multimedia elements in presentations and lectures fosters a more engaging and interactive learning experience.
- **Exercise and Energizers:** Energizing exercises and physical activities can be integrated in the training. These activities help participants maintain focus, and enhance cognitive function, leading to a more productive learning experience.
- **Simulation and Role Play:** Simulation and role-play allow participants to actively engage in scenarios that imitate real-world situations, fostering valuable skills and knowledge, leading to improved performance in real-world situations. They go beyond traditional lectures and presentations.
- **Case study:** Case studies present real-life or realistic scenarios that trainees/participants can analyze and discuss, fostering critical thinking, problem-solving, and decision-making skills.

This combination of methods ensures a dynamic and interactive learning environment that caters to auditory, visual, and kinesthetic learners. By fostering active participation and collaboration, the training program aims to create a more impactful and enriching learning experience for all attendees.

D. Training Agenda

Trainer/Facilitator's Agenda

Day 1 - Rights-Based Accountability, SRHR and Disasters

Time	Item	Components	Methodolog
8:30-9:30 (1 hour)	Preliminary Session (Training set-up, Welcome, Introduction and Housekeeping)	Welcome and participant registration Training pre-test Activity: Icebreaker Ground rules and expectations Presentation: Training Overview	Discussion Icebreaker game Presentation
9:30-11:00 (1.5 hour)	Module 1.1: Introduction to Human Rights and Right to Health	Presentation: Human Rights and Right to Health Activity: Group Work - Core obligations of states regarding the right to health	Interactive Lecture Presentation Group discussion

11:00-11:30	Tea Break		
11:30-13:00 (1.5 hour)	Module 1.2: Right Based Approach in Health	Presentation: Right Based Approach in Health	Interactive Lecture Presentation
13:00-14:00	Lunch		
14:00-15:30 (1.5 hours)	Module 1.3: Sexual and Reproductive Health and Rights	Presentation: SRHR Video: The changing world of adolescent sexual and reproductive health and rights (WHO)	Interactive Lecture Presentation Video
15:30-16:00	Tea Break		
16:00-17:30 (1.5 hours)	Module 1.4: Disaster Management and SRHR Risks	Presentation: Disaster Management and SRHR Risks Activity: Group Work - Priorities for SRHR and Gender in disasters	Interactive Lecture Presentation Group discussion
17:30-18:00 (30 minutes)	Closing and Next Steps	Gratitude Daily evaluation Agenda for tomorrow	Discussion

Day 2: Framework for Rights-Based Accountability in Health Systems

Time	Item	Components	Methodology
8:30-9:00 (30 Minutes)	Welcome, Review and Housekeeping	<ul style="list-style-type: none"> Review Housekeeping 	Discussion
9:00-11:00 (2 hour)	Module 2.1: Principles of Rights-Based Accountability and Accountable Health Systems	<ul style="list-style-type: none"> Presentation: Principles of Rights Based Accountability and Accountable Health Systems Discussion - Challenges and Opportunities in implementing Rights Based Accountability 	Interactive Lecture Presentation Discussion
11:00-11:30 (30 minute)	Tea Break		

11:30-13:00 (1.5 hour)	Module 2.2: United Nations Human Rights Accountability Mechanism	<ul style="list-style-type: none"> ● Presentation: United Nations Human Rights Accountability Mechanism ● Video: UN Human Rights System 	Interactive Lecture Presentation Group discussion
13:00-14:00 (1 hour)	Lunch		
14:00-15:30 (1.5 hour)	Module 2.3: Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism)	<ul style="list-style-type: none"> ● Presentation ● Activity: Group Work 	Interactive Lecture Presentation Group discussion
15:30-16:00 (30 minutes)	Tea Break		
16:00-17:30 (1.5 hour)	Module 2.4: Role of Duty-Bearers and Right-Holders of SRHR and Disasters	<ul style="list-style-type: none"> ● Activity: Group Work - Mapping Duty Bearers and Right Holders of SRHR and Disasters 	Group Discussion Presentation
17:30-18:00 (30 minutes)	Closing and Next Steps	<ul style="list-style-type: none"> ● Gratitude ● Daily evaluation ● Agenda for tomorrow 	Discussion

Day 3: Strategies for Building Accountable Health Systems

Time	Item	Components	Methodology
8:30-9:00 (30 minutes)	Welcome, Review and Housekeeping	<ul style="list-style-type: none"> ● Review ● Housekeeping 	Discussion
9:00-11:00 (2 hour)	Module 3.1: Policy and Legal Frameworks for Disaster and SRHR	<ul style="list-style-type: none"> ● Presentation: Policy and Legal Frameworks for Disaster and SRHR 	Interactive Lecture Presentation Discussion
11:00-11:30 (30 minutes)	Tea Break		
11:30-13:00 (1.5 hour)	Module 3.2: Selected Precedent of the Supreme Court of Nepal On Disaster and SRHR	<ul style="list-style-type: none"> ● Presentation: Selected Precedent of the Supreme Court of Nepal On Disaster and SRHR 	Interactive Lecture Presentation

		<ul style="list-style-type: none"> ● Activity: Brainstorming - Status of Implementation of court decision 	Brainstorming Group discussion
13:00-14:00 (1 hour)	Lunch		
14:00-15:30 (1.5 hour)	Module 3.3: SRHR in Disaster Preparedness, Response and Recovery	<ul style="list-style-type: none"> ● Presentation: SRHR in Disaster Preparedness, Response and Recovery ● Activity: Group Work - Brainstorming - Indicators of SRHR in Disaster Preparedness, Response and Recovery 	Interactive Lecture Presentation Brainstorming Group discussion
15:30-14:00 (30 minutes)	Tea Break		
14:00-17:30	Module 3.4: Strengthening Governance and Transparency	<ul style="list-style-type: none"> ● Presentation: Strengthening Governance and Transparency ● Discussion: Examples of strengthening Governance and Transparency 	Interactive Lecture Presentation Brainstorming Discussion
17:30-18:00	Closing and Next Steps	<ul style="list-style-type: none"> ● Gratitude ● Daily evaluation ● Agenda for tomorrow 	Discussion

Day 4: Community Monitoring of SRHR and Circle of Accountability

Time	Item	Components	Methodology
8:30-9:00 (30 minutes)	Welcome, Review and Housekeeping	<ul style="list-style-type: none"> ● Review ● Housekeeping 	Discussion
9:00-11:00 (2 hour)	Module 4.1: Community Monitoring and Evaluation Systems	<ul style="list-style-type: none"> ● Presentation: Community Monitoring and Evaluation systems ● Discussion: Effectiveness of community monitoring and evaluation systems 	Interactive Lecture Presentation Discussion
11:00-11:30 (30 minutes)	Tea Break		

11:30-13:00 (1.5 hour)	Module 4.2: Circle of Accountability	<ul style="list-style-type: none"> ● Presentation: Circle of Accountability 	Interactive Lecture Presentation Discussion
13:00-14:00 (1 hour)	Lunch		
14:00-15:30 (1.5 hour)	Module 4.3: Community-Led Data Collection and Analysis	<ul style="list-style-type: none"> ● Brainstorming and Group Discussion 	Brainstorming Group discussion
15:30-14:00 (30 minutes)	Tea Break		
14:00-17:30 (1.5 hour)	Module 4.4: Advocacy and Action based on Community Findings	<ul style="list-style-type: none"> ● Brainstorming and Group Discussion ● Advocacy Plan 	Interactive Lecture Presentation Brainstorming Discussion
17:30-18:00 (30 minutes)	Closing and Next Steps	<ul style="list-style-type: none"> ● Gratitude ● Final evaluation ● Post test 	Discussion

F. Training Set Up and Trainers/Facilitators' Responsibility

Trainers/Facilitators should arrive Early (at least 30-45 Minutes before Participants) and take care of following:

- Set up the training room: signage, registration table, refreshments, and seating arrangement (U-shape, circle, or clusters).
- Prepare handouts and test audio/visual equipment.
- Meet with a notetaker (if applicable) and interpreter (if applicable) to discuss the training and note-taking needs.
- Ensure accessibility accommodations are in place for participants who requested them.
- Briefly meet and greet participants to understand their learning preferences.

During the training, trainers/facilitators should

- Briefly introduce the module's objectives and learning outcomes.
- Deliver the module content using a variety of methods (interactive lecture, presentations, discussions, case studies etc.).

- Integrate interactive activities like group discussions, role-playing exercises, or simulations to enhance learning.
- Allocate time for participants to ask questions and clarify doubts.
- Maintain a respectful and inclusive learning environment.
- Encourage active participation from all trainees.
- Adapt the training pace and approach based on participant needs and interests.

Likewise, after completion of training, trainers/facilitators should

- Collect participant feedback through feedback forms, surveys or evaluations or post test
- Distribute training materials electronically (if applicable).
- Follow up with participants to answer any further questions.

Training Checklist for Trainers/Facilitators

Training	Checklist	
Before the Training	Materials	<ul style="list-style-type: none"> ● Trainer guides/toolkit for all modules and sub-modules ● Participant handouts for all modules and sub-modules ● Laptop ● Projector ● Presentation materials (PowerPoint, flipcharts, etc.) for each module ● Pre tests, post tests, case studies, discussion questions, simulations, or role-playing exercises (as applicable) ● Markers, pens, flip charts, meta cards and other training materials ● Balls for icebreakers
	Logistics	<ul style="list-style-type: none"> ● Training room booked and set up according to chosen format (U-shape, circle, clusters) ● Audio/visual equipment tested (projector, screen, laptop, audio connections, internet) ● Refreshments arranged (tea, breakfast, lunch, snacks) ● Registration table with sign-in sheet (name, position, organization, phone, email) ● Accessibility accommodations confirmed for participants who requested them
	Human Resources	<ul style="list-style-type: none"> ● Trainers and facilitators ● notetaker (if applicable)

		<ul style="list-style-type: none"> • interpreter(s) (if applicable)
After the Training	Feedback and Evaluation	<ul style="list-style-type: none"> • Feedback forms, surveys or evaluations or post test.

F. Training Materials

Presentation and Handouts

The presentation and handouts are included in the Annex section.

Module		Annex
Module 1: Rights-Based Accountability, SRHR and Disasters	Module 1.1: Introduction to Human Rights and Right to Health	Annex 1
	Module 1.2: SRHR	Annex 2
	Module 1.3: Right Based Approach in Health	Annex 3
	Module 1.4: Disaster Management and SRHR Risks	Annex 4
Module 2: Framework for Rights-Based Accountability in Health Systems	Module 2.1: Principles of Rights-Based Accountability and Accountable Health Systems	Annex 5
	Module 2.2: United Nations Human Rights Accountability Mechanism	Annex 6
	Module 2.3: Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism)	Annex 7
	Module 2.4: Role of Duty-Bearers and Right-Holders of SRHR and Disasters	Annex 8
Module 3: Strategies for Building Accountable Health Systems	Module 3.1: Policy and Legal Frameworks for Disaster and SRHR	Annex 9
	Module 3.2: Selected Precedents of the Supreme Court of Nepal On Disaster and SRHR	Annex 10
	Module 3.3: SRHR in Disaster Preparedness, Response and Recovery	Annex 11
	Module 3.4: Strengthening Governance and Transparency	Annex 12

Module 4: Community Monitoring of SRHR linking to COA	Module 4.1: Community Monitoring and Evaluation Systems	Annex 13
	Module 4.2: Circle of Accountability	Annex 14
	Module 4.3: Community-Led Data Collection and Analysis	Annex 15
	Module 4.4: Advocacy and Action based on Community Findings	Annex 16

Case Study

The following case studies can be used to analyze issues, concerns, and risk relating to SRHR and disaster.

*SRH during Floods in Assam, India*³¹⁸

Assam faced one of the worst floods in 2017, which affected more than 15 districts. There were three recurrences of floods with sporadic rainfall.

In one of the districts, it was noted that some women, even in relief camps and temporary shelters, religiously followed menstrual taboos. Menstruating women were expected to keep a distance from men of the family and follow separatist customs like eating from separate utensils, washing their hair only after three days of menstruation and sleeping and sitting in isolated places. The notion of menstrual blood to be impure was continually practiced by women in relief camps.

The separation of women from family members increased their risk of kidnapping, abuse or trafficking. Additionally, it added unwanted mental stress for many women. Likewise, menstrual hygiene practices were often compromised in tough conditions of a shelter. Sanitary Napkins were distributed as relief materials by local humanitarian agencies but many women were not used to using sanitary napkins. They continued to make their own local arrangements to use old cloth.

The negative impacts of floods on women's access to sexual and reproductive health services included:

- Disposal of the used cloth remained an issue. Some women threw without washing the cloth due to lack of access to water. However, over 50 per cent of women preferred to wash their cloth before disposal and managed to create a private space within the relief camps.
- Of those who used sanitary napkins, 32 percent burnt the soiled napkins, whereas 43 per cent buried them in secluded parts of the camp. More than 20 percent disposed of pads in plastic bags and weighed these down with pebbles so that it does not float in the flooded water.

³¹⁸ OHCHR.(n.d.). Sexual and Reproductive Health in Crisis Situations- India's Case Study.

- When asked about toilet use, one of the initial reactions was, “we could not even eat, let alone use toilets.” Some women mentioned limited food supplies at the shelter while others claimed eating less to avoid using toilets. More than 40 per cent women practiced open defecation during the floods. Women avoided using toilets as there were limited facilities and there were no separate facilities for women, which was a compromise of their privacy and dignity.

This was despite the guidelines by Assam State Disaster Management Authority to build separate toilet facilities for men and women. Uneven distribution of relief supplies was also reported. Lack of proper bathing facilities led to skin and urinary tract infections among women.

Earthquake in Nepal³¹⁹

On April 25, 2015, an earthquake of 7.8 magnitude hit Nepal, followed by more than 300 aftershocks, including one of 7.3 magnitude on May 12, 2015. Thirty-five of the 75 districts (now 77 districts) in the country were affected, close to 9,000 people died, and over 22,000 people were injured. The total number of displaced persons is 2.8 million, with around 600,000 houses destroyed and 290,000 damaged. UNFPA estimated that 5.6 million people are affected, including 1.4 million women of reproductive age.

Approximately 93,000 women are estimated to be pregnant, including 1,000-1,500 women likely to experience complications. Twenty-eight thousand women were estimated to be at risk of sexual violence. In Kathmandu, 20.1% of the district’s population (350,676 people) and in Sindhupalchowk, 99.9% of the district’s population (287,574 people) were in need of assistance.

Adolescents were not permitted to access sexual and reproductive health (SRH) services from health centers without parental consent. Communities, however, were eager to participate in the response through distributing materials, disseminating information about distributions, and identifying those most in need. Only one organization had reached out to address the SRH needs of persons with disabilities.

Flooding in Mozambique³²⁰

On March 14, 2019, Cyclone Idai made landfall in Mozambique, bringing devastation to the port city of Beira and surrounding areas. The following days, turbulent weather swept through Sofala, Zambezia, Manica, and Inhambane provinces, causing massive flooding and leaving entire communities submerged under 10 meters of water.

Sofala province was hardest hit, with some 660,000 people affected, and roads cut. Due to high winds and floods, the central hospital in Beira was damaged. Some 19 sub-provincial level health facilities were also damaged and dysfunctional in Sofala.

More than 462,000 people were women of reproductive age, with 55,500 estimated to be pregnant. In the next three months, 19,000 live births were expected, and 3,000 women were

³¹⁹ <https://www.womensrefugeecommission.org/wp-content/uploads/2014/11/Disaster-Preparedness-Reproductive-Health-Facilitators-Kit.pdf>, p.66

³²⁰ <https://www.womensrefugeecommission.org/wp-content/uploads/2014/11/Disaster-Preparedness-Reproductive-Health-Facilitators-Kit.pdf>, p.66

expected to experience complications during pregnancy or childbirth. There were also 77,000 women living with HIV.

In Beira town (Sofala), the transit centers were used during the day for displaced persons, and the men often went back home for fear of robberies. The rooms are shared with other men who are strangers; the latrines were dirty from the storm and have no doors.

The following questions can be used to discuss the case study above:

General Questions

1. Why are strong governance and transparency crucial for ensuring SRHR in disaster situations?
2. What are some of the challenges that can hinder good governance and transparency in disaster response, specifically regarding SRHR?

Questions on Transparency and Accountability:

- How can governments and organizations ensure transparency in how resources are allocated and utilized for SRHR services in disasters?
- What mechanisms can be established to hold duty bearers accountable for upholding SRHR during disasters?
- How can clear communication and coordination mechanisms be established between government agencies, healthcare providers, and community organizations during disasters to ensure efficient SRHR service delivery?
- How can existing grievance redressal mechanisms, such as national human rights commissions, be adapted to address SRHR violations that occur during disasters?
- What characteristics are essential for grievance redressal mechanisms to be accessible and provide effective remedies for individuals whose SRHR rights have been violated?
- How can awareness campaigns be conducted to inform communities about existing grievance redressal mechanisms for addressing SRHR violations during disasters?
- Can you think of any examples of successful initiatives that promote transparency and accountability for SRHR in disasters (real-world examples)?

Exercise and Energizers

Following exercise and energizers can be used during the TOT. It can be contextualized and adapted as per the needs of TOT and participants.

1. Ball Toss game

A ball toss game is a fun and engaging way to break the ice in training sessions, particularly when participants are unfamiliar with each other. It promotes interaction and engagement and can be easily adapted.

Preparation: A tennis ball

Instructions:

- Participants stand in a circle.
- Start by stating your name and sharing a fun fact about yourself.
- Toss the ball to someone in the circle.
- They repeat the process, introducing themselves and sharing a fact, then throwing the ball to someone else.
- Continue until everyone has had a turn.

Tips for trainers/facilitators:

- Choose the right ball and opt for a soft, lightweight ball like a tennis ball to avoid injuries during throws.
- Set clear instructions and briefly explain the game's objective, and rules.
- Consider modifications if any participant has physical limitations and adjust the game to ensure inclusivity.

2. Two truths and a lie

The "Two Truths and a Lie" is a classic icebreaker game. It's a simple yet effective way to spark conversation, encourage creative thinking, and help people get to know each other on a personal level.

Preparation: 5 minutes to write down two true statements and one lie.

Instructions:

- Each participant takes a few minutes to think of two true statements about themselves and one lie, ensuring all statements sound believable.
- Participants take turns sharing their three statements with the group.
- After each set of statements, the group tries to guess which statement is the lie. Encourage discussion and reasoning behind their guesses.
- Once everyone has guessed, the participant reveals which statement was the lie.

Tips for trainers/facilitators:

- Encourage participants to share genuine truths, even if they seem unusual.
- Give participants a reasonable amount of time to think of their statements and the group to guess (around 2-3 minutes each).
- Be mindful of the audience and ensure they are appropriate for the group setting.
- Remember this is a lighthearted activity to promote interaction and laughter.

Chinese Whisper

Chinese Whisper is a classic game that can be used to break the ice, encourage listening skills, and see how a message transforms through a group. This exercise can be used to highlight the importance of effective communication and coordination among various actors during disasters.

Preparation: 5 minutes to make all participants stand or sit in a circle in an open area

Instructions:

- Gather the participants in a circle.
- Choose one person to be the whisperer and ask to whisper a short, simple sentence (around 7-10 words) clearly to the person next to them in the circle.
- Each person in the circle then whispers what they heard to the next person.
- Once the message reaches the last person, they stand up and loudly announce what they heard.

Tips for trainers/facilitators:

- Explain that the message will likely change as it travels around the circle.
- Encourage clear whispering and request participants to focus on accurate transmission.
- Maintain a lighthearted atmosphere
- Do debriefing after the reveal and discuss how the message changed and why this might happen (communication and active listening).
- Multiple rounds can be played with different starting sentences to keep things engaging.

My First Job (My first job and What I learned from that job)

My First Job is a simple icebreaker where participants share their first job and what they learned from that job. It helps to continue conversation after the exercise.

Preparation: 3-5 minutes to write first job and what they learned from that job in the paper.

Tips for trainers/facilitators:

- Ask every participant to write down:
 - Their first job

- What they learn from that job
- Example:
 - My First Job: Children park assistant
 - What I learned from that job is I really like working with children, which led me to teaching and facilitation
- Ask every participant to put the note in the bowl/box
- Facilitator will read out the post and group has to guess which job belongs to which participant.

Pointless Questions

Pointless questions are a fantastic way to break the ice at an event or workshop. In this exercise, there would be silly and unexpected questions asked that guaranteed to get a laugh.

Preparation: 3-5 Minutes to set questions

Tips for trainers/facilitators:

- Ask questions that has no relationship with actual workshop but lighthearted questions to start the conversation
- Example of pointless questions
 - If you could invite any celebrity for dinner, who would it be? And why?
 - What is your most prized possession and why?
 - You can have an unlimited supply of one thing for the rest of your life. What do you choose?
 - If you could only eat one color of food for the rest of your life, what color would it be and why?

Pictionary

Pictionary is a perfect icebreaker for many reasons. It is inclusive and engaging, fun and active, and promotes teamwork.

Preparation: Prepare necessary prompts ahead of the workshop.

Tips for trainers/facilitators:

- Prepare some prompts ahead of the workshop
- Write everyone's name on a piece of paper and put them in a bowl/box
- Pick a name from a bowl/box, that person will be drawing.
- Give them a prompt and allow them 30 seconds to draw
- The group has to guess the prompt

Selected Activities

Disaster Evacuation Simulation: Priorities and Packing

This simulation places the participants in a disaster scenario where they are given only 5 minutes to evacuate their location. The goal is to see their priorities - what they would grab and why, revealing their thought process during a stressful situation. This activity is designed to spark discussion about preparedness and personal priorities.

Scenario: It's a sunny day. You hear a loud flood warning sound, followed by an emergency broadcast announcing an approaching flash flood. You have approximately 5 minutes to evacuate your current location before it becomes unsafe.

Instructions (Individual):

- Consider the situation: Think about the nature of the disaster and what immediate threats it poses.
- Prioritize your safety: Focus on items that ensure your survival and ability to reach safety.
- List your Grab-and-Go Items: Write down 5 essential items you would take with you, explaining why each item is crucial in this situation.

Debriefing (Group Discussion):

- Share your lists: Take turns sharing your chosen items and the reasoning behind them.
- Discuss commonalities and differences: Observe any recurring themes or contrasting priorities within the group.

Tips for trainers/facilitators:

- Encourage active participation and open discussion.
- Maintain a safe and respectful environment for sharing.
- Emphasize the importance of planning and prioritizing safety during disasters.
- Introduce SRHR Services and explain how SRHR services can be important in disaster situations, depending on the specific needs of the group. Examples might include feminine hygiene products, contraception, or medication.
- Reiterate the importance of preparedness
- Remember that there are no right or wrong answers in this simulation.

Cross the Line³²¹

The Crossing the Line exercise is a powerful activity used in team building, group discussions, and self-reflection. It's designed to explore shared experiences, diversity within a group, and empathy for different perspectives.

Preparation: 5 minutes to make a visible line on the floor

Instructions:

- Gather everyone on one side of the line and ask them to cross the line when the Statement being read reflects their experiences and perspectives.
- Emphasize participants that there is no “in between,” which means they must stand on one side of the line or the other, and that there are no right or wrong answers.

Tips for trainers/facilitators:

- Stand at one end of the line and start with a practice statement, such as: “Cross the line if you had coffee this morning.”
- Make sure everyone is ready and listening
- Read “Cross the line if” statements.

Debriefing:

- Discuss the activity, including with questions such as:
 - What did you learn from this activity?
 - Were there times when you felt tempted to move with the majority of the group?
 - Did you move or not? How did that feel?
 - What does this activity teach us, in general, about the stigma and cultural norms?
 - How might stigma and cultural norms influence an individual's decision about SRHR?
 - How might stigma and cultural norms influence the comfort of staff in your agency with providing or supporting the provision of SRHR in your projects?

Example of "Cross The Line If" Statements

- Cross the line if:
 - You believe that food is more important than stockpiling essential supplies like sanitary napkins, maternity kits, and contraception during disasters.
 - You believe that Pregnant women should not evacuate during a disaster.
 - You believe only women need to worry about SRHR.
 - You believe that birth control pills are dangerous and cause long-term health problems.
 - You believe that women are too preoccupied with basic needs after a disaster to think about SRHR.

³²¹ Women's Refugee Commission. (2021). Facilitator's Kit: Community Preparedness for SEXUAL and REPRODUCTIVE HEALTH and GENDER. This activity is adapted from Ipas's “Cross the Line,” Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences, 2018.

-
- You believe that discussing SRHR is against religious beliefs.
- You believe that talking about sex education encourages teenagers to become sexually active.
- You have had to tell a woman with an unwanted pregnancy as a result of rape that she cannot have an abortion.
- You believe that aid workers should be trained on rescue works but not on providing SRHR services in emergency settings

G. Tools for Rights-Based Accountability Assessment

FAIR flowchart ³²²

Facts

- Experience of individuals
 - How has the disaster impacted the individual's access to SRHR services?
 - Were they able to access essential services like prenatal care, safe delivery, or menstrual hygiene products?
 - Did they experience discrimination or violence in trying to access SRHR services?
- Being Heard and Supported
 - Did the individual have opportunities to voice their needs and concerns regarding SRHR during or after the disaster?
 - Did they receive adequate support in accessing SRHR services?
- Important Facts
 - What specific SRHR needs arose due to the disaster (e.g., increased risk of STIs, pregnancy complications)?
 - What actions were taken by authorities or aid organizations to address SRHR needs?

Analysis of (Rights at Stake):

- SRHR
 - Which specific SRHR rights were potentially violated (e.g., right to health, right to non-discrimination)?
 - Did the disaster response prioritize the protection and fulfillment of SRHR rights for all individuals?
- Restrictions on Rights
 - Were there any justifiable restrictions on SRHR due to the disaster (e.g., temporary limitations on movement due to safety concerns)?
 - Were these restrictions proportionate and necessary to achieve a legitimate aim?

³²² This chart is adapted from the Scottish Human Rights Commission's fair flow chart. The FAIR flowchart can be used to assess human rights based accountability for SRHR and Disasters. Available at: <https://careaboutrights.scottishhumanrights.com/section1-page03.html>. (Accessed on 13 March 2024).

Identification of shared responsibilities (Who's Accountable):

- Changes Needed:
 - What actions are needed to ensure access to SRHR services during and after disasters?
 - How can disaster response plans be strengthened to better address SRHR needs?
- Shared Responsibilities:
 - Who are the stakeholders responsible for upholding SRHR rights in disasters (e.g., governments, aid organizations, healthcare providers)?
 - What specific actions can each stakeholder take to ensure accountability?

Review actions (lessons learned):

- Actions Taken and Reviewed:
- Were efforts to address SRHR needs in the disaster response documented and reviewed?
- Did the review process involve individuals who were affected?
- How can future responses be improved based on the lessons learned?

Checklist for translating Rights Based Accountability into practice in crisis setting³²³

³²³ This checklist is developed by CRR and CARE.

TRANSLATING RIGHTS-BASED ACCOUNTABILITY INTO PRACTICE IN CRISIS SETTINGS

This checklist is a tool health care providers and other implementers can use to assess gaps in the provision of rights-based quality sexual and reproductive health (SRH) care services and to take steps to improve quality, access and equity of care.



ENSURING AVAILABILITY OF SERVICES

- Provide a range of SRH services or referrals for people-centered, non-discriminatory services in line with the Minimum Initial Service Package (MISP)
- Ensure individuals and communities know about what SRH services are available and where they can access them
- Foster continuity of care and follow-up



ENSURE INFORMED AND AUTONOMOUS DECISION-MAKING

- Use evidence-based, unbiased information on health condition, options and risks and benefits of each option to users to facilitate informed and voluntary choices
- Provide information in a manner understandable to service users (consider language, age, disability, etc.) and that is culturally sensitive
- Ensure decision-making free from coercion from spouses or others
- Evaluate capacity of user of any age to make their own informed decisions about their healthcare



RESPECT USERS' PRIVACY AND CONFIDENTIALITY

- Maintain patient confidentiality and avoid unnecessary disclosure of information
- Communicate to service users how confidentiality of written and digital information is maintained
- Conduct counselling, examination and treatment in private spaces for counselling and in a manner that ensures privacy and respect
- Maintain privacy and confidentiality in the presence of other individuals invited by the service user
- Acknowledge and accommodate varying cultural attitudes towards modesty



PROVIDE NON-JUDGMENTAL AND RESPECTFUL CARE FOR USERS

- Provide optimal health services to all users irrespective of their background and abilities, including age, gender, disability, nationality, race, migrant status, HIV status, religion, etc.
- Recognize how medical, social and cultural considerations affect patient decision-making
- Refrain from allowing personal and/or religious beliefs to shape the provision of health care information and services to patients
- Acknowledge and respect decisions that users make about their own health care



FACILITATING PARTICIPATION AND COMPLAINTS

- Establish a system for gathering patient feedback on services and treatment, and for developing, implementing and monitoring an action plan in response to client feedback
- Create a confidential and non-biased process for addressing complaints and making meaningful changes to services
- Where it does not create risk for service users, establish spaces for ongoing dialogue and negotiation between services users, communities and service providers
- Ensure that women and young people participate directly in the decision-making about the healthcare services in their community, and advocate for changes to ongoing planning and coordination mechanisms to facilitate their participation



CENTER FOR REPRODUCTIVE RIGHTS

H. Templates for Community Monitoring Tools: SRHR and Disasters

Template for Community Engagement Action Tool ³²⁴

Major action items	How will you convey the information back to your constituents?	How will you continue to engage your constituents as the larger action plan is being implemented?	How can your constituents be part of the monitoring process?	What is your timeline for activities?
Overarching/Objective 1: Coordination				
Objective 2: Preventing Sexual Violence and				

³²⁴ This template is adapted from COMMUNITY ENGAGEMENT ACTION TOOL from - Disaster-Preparedness-Reproductive-Health-Facilitators-Kit - <https://www.womensrefugeecommission.org/wp-content/uploads/2014/11/Disaster-Preparedness-Reproductive-Health-Facilitators-Kit.pdf>

Responding to the Needs of Survivors				
Objective 3: Preventing Transmission of HIV/STIs				
Objective 4: Preventing Excess Maternal and Newborn Morbidity and Mortality				
Objective 5: Preventing Unintended Pregnancies Objective				
Objective 6: Planning for Comprehensive SRH/ Building Resilience				

Focus Group Discussion Guide Template

Discussion: Access to SRHR Services and Disasters	
Before the Disaster	<ul style="list-style-type: none"> • Where did you typically access SRHR services (health post, hospital, clinics, pharmacies, etc.)? • Did you face any challenges in accessing these services?
After the Disaster	<ul style="list-style-type: none"> • Were you able to access SRHR services after the disaster? (e.g., prenatal care, safe delivery, family planning) • If yes, where did you access these services? • If no, what challenges did you face in accessing services? (e.g., distance, cost, transportation) • Did you experience any discrimination or violence while trying to access SRHR services?
Information and Communication	<ul style="list-style-type: none"> • Did you receive any information about available SRHR services after the disaster? • If yes, how did you receive this information? (e.g., radio announcements, community meetings) • If no, how could information about SRHR services be better communicated in future disasters?

Recommendation	<ul style="list-style-type: none"> • What suggestions do you have for improving access to SRHR services in future disasters?
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Community Survey Template

Sample Survey: SRHR Needs After the Disaster

Survey Questionnaire

Instructions:

Please answer the following questions to the best of your ability. All responses are confidential.

Circle the answer that best applies to you or write in your response if necessary.

Demographics:

Age:

Gender:

Location:

Access to SRHR Services:

1. Since the disaster, have you needed to access any of the following SRHR services? (Select all that apply)
 - Prenatal care
 - Safe delivery care
 - Family planning services
 - Sexually transmitted infection (STI) testing and treatment
 - Mental health services related to SRHR
 - Other (Please specify):
2. If you answered yes to question 1, were you able to access the services you needed?
 - Yes
 - No
3. If you answered no to question 2, why were you unable to access the services? (Select all that apply)
 - The services were not available in my area.
 - The cost of the services was too high.
 - Transportation was unavailable to reach the services.
 - I experienced discrimination when trying to access services.
 - Other (Please specify):
4. Did you receive any information about available SRHR services after the disaster?
 - Yes
 - No
5. If you answered yes to question 4, how did you receive this information? (Select all that apply)
 - Radio announcements
 - Community meetings
 - Flyers or posters

- Healthcare providers
 - Other (Please specify):
6. Any suggestion on SRHR need in post disaster situation

Community Observation Checklist Template

Community Observation Checklist

Location: (Name of health post, hospital, clinic, pharmacy etc.)

Date:

Instructions:

- Use this checklist to observe the availability, accessibility and quality of SRHR services at the location.
- Place a checkmark next to each item that is observed.

General Observations:

- Are there clear signs or directions indicating the availability of SRHR services?
- Are operating hours clearly displayed?
- Is the facility accessible for people with disabilities?

Availability of Services:

- Are prenatal care services available?
- Are safe delivery services available (including skilled birth attendants)?
- Are family planning services available (e.g., contraceptives)?
- Are STI testing and treatment services available?
- Are mental health services related to SRHR available?

Accessibility:

- Are services offered at affordable prices or are there options for subsidized care?

Acceptability:

- Are culturally appropriate services available (considering language, gender)?
- Do healthcare providers use respectful and inclusive language?
- Are there female healthcare providers available for women seeking SRHR services?
- Do information materials portray a range of genders, ethnicities, and abilities utilizing SRHR services?
- Are there visible efforts to ensure a welcoming and stigma-free environment for all seeking services?
- Are privacy and confidentiality measures in place?

Quality of Care:

- Are healthcare providers knowledgeable about SRHR best practices in disaster settings?
- Are there adequate supplies and medications available to deliver quality SRHR services?
- Is there a system in place for referrals to higher levels of care if needed?

MISP For SRH Monitoring Checklist ³²⁵

1. SRH Lead Agency and SRH Coordinator			
		Yes	No
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly	Yes	No
	National (MONTHLY)		
	Sub-national/district (BIWEEKLY)		
	Local (WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH working group meetings	Yes	No
	Ministry of Health		
	UNFPA and other relevant United Nations agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensure mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		
2.2	Number of women of reproductive age (ages 15–49, estimated at 25% of population)		

2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population, estimated at 4% of the population)		
3. Prevent Sexual Violence and Respond to Survivor's Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	Yes	No
	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100		%
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		
3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100		%
		Yes	No
3.5	Information on the benefits and location of care for survivors of sexual violence		
4. Prevent and Respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		

4.4	Lubricated condoms available free of charge		
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	Persons with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period Specify locations:		
4.7	Antiretrovirals available to continue treatment for people who were enrolled in antiretroviral therapy prior to the emergency, including PMTCT		
4.8	PEP available for survivors of sexual violence; PEP available for occupational exposure		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		
5. Prevent Excess Maternal and Newborn Morbidity and Mortality			
5.1	Availability of EmONC basic and comprehensive per 500,000 population	Yes	No
	Health center with basic EmONC, five per 500,000 population		
	Hospital with comprehensive EmONC, one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
	Hospital (to ensure comprehensive EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	One team of doctor, nurse, midwife, and anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care (PAC)		
	Coverage of PAC: (number of health facilities where PAC is available/number of health facilities) x 100		
Number of women and girls receiving PAC			
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 (means of communication [radios, mobile phones])	Yes	No
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		

5.4	Functioning cold chain (for oxytocin, blood-screening tests) in place		
5.5	Proportion of all births in health facilities: (number of women giving birth in health facilities in specified period/expected number of births in the same period) x 100		%
5.6	Need for EmONC met: (number of women with major direct obstetric complications treated in EmONC facilities in specified period/expected number of women with severe direct obstetric complications in the same area in the same period) x 100		%
5.7	Number of caesarean deliveries/number of live births at health facilities x 100		%
5.8	Supplies and commodities for clean delivery and newborn care		
5.9	Clean delivery kit coverage: (number of clean delivery kits distributed where access to health facilities is not possible/estimated number of pregnant women) x 100		%
5.10	Number of newborn kits distributed including clinics and hospitals		
5.11	Community informed about the danger of signs of pregnancy and childbirth complications and where to seek care		
6. Prevent Unintended Pregnancies			
6.1	Short-acting methods available in at least one facility	Yes	No
6.2	Condoms		
6.3	EC pills*		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine devices (IUDs)		
6.8	Number of health facilities that maintain a minimum of a three-month supply of each	Number	
	Condoms		
	EC pills		
	Combined oral contraceptive pills		
	Progestin-only contraceptive pills		
	Injectables		
	Implants		
	IUDs		
7. Planning for Transition to Comprehensive SRH Services			
7.1	Service delivery	Yes	No
	SRH needs in the community identified		
	Suitable sites for SRH service delivery identified		

7.2	Health workforce	Yes	No
	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		
8. Other Priority Activity: SAC to the Full Extent of the Law			
8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100		%
8.2	Number of women and girls receiving SAC		
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)		
9. Special Notes			
10. Further Comments			
Explain how this information was obtained (direct observation, report back from partner [name], etc.) and provide any other comments.			
11. Actions (For the "No" Checks, Explain Barriers and Proposed Activities to Resolve Them.)			
Number	Barrier	Proposed solution	

I. Evaluation and Feedback

To ensure a continuous learning experience and maximize the effectiveness of this training program, it is crucial to implement a comprehensive evaluation strategy. This includes daily formative evaluations to assess participant understanding, identify areas requiring clarification, and adapt the training content accordingly. Additionally, a summative evaluation should be conducted at the program's conclusion through a comprehensive evaluation form. This multifaceted approach helps to gather valuable insights into participant learning, overall program effectiveness, and areas for improvement in future iterations. By prioritizing both ongoing and concluding evaluations, it contributes in optimizing the training experience and equipping participants with the necessary knowledge and skills to achieve their goals. The evaluation and feedback process should allow participants to provide feedback confidentially and anonymously where applicable.

Evaluation should be done end of each day briefly as a crucial component of effective training programs and final evaluation and feedback after conclusion of training as a way forward for future training. Likewise, Pre-test/Post-test for Participants can be used to measure effectiveness of the training.

Sample Pre-test/Post-test for Participants

1. What are example of SRHR services?

- a. Comprehensive sexuality education for young people
- b. SRHR services include, among others, prenatal care, family planning, and STI testing.
- c. Cancer screenings (cervical, breast)
- d. All of the above (✓)

2. States have what obligations regarding the right to health/SRHR under the ICESCR?

- a. To respect
- b. To protect
- c. To fulfill
- d. All of the above (✓)

3. Which of the following is NOT a core principle of the right to health and SRHR?

- a. Availability
- b. Accessibility
- c. Acceptability
- d. Sustainability (✓)

4. Why is it important to ensure access to SRHR services during disasters?

- a. Ensuring access to SRHR services during disasters is crucial for protecting the health and well-being of individuals and communities.
- b. Disasters can increase the risk of pregnancy complications and STIs.

- c. Disasters increase difficulty for people to access existing SRHR services
- d. All of the above (✓)

5. What are some potential challenges communities might face in accessing SRHR services after a disaster?

- a. Communities face no challenges.
- b. Destroyed facilities, transportation issues, and lack of awareness about available services. (✓)
- c. Only issues related to rebuilding infrastructure.
- d. None of the above.

6. What do you understand by "community monitoring" in the context of disasters?

- a. Community members getting involved in search and rescue.
- b. Community members getting involved in assessing needs and identifying gaps. (✓)
- c. Monitoring government relief efforts only.
- d. Community members contributing in long term development activities.

7. How can community monitoring tools be used to improve access to SRHR services in disasters?

- a. Community members can use surveys, interviews, and focus group discussions to collect data on SRHR needs after a disaster.
- b. Community members can map service availability.
- c. Community monitors can track the quality of SRHR services being provided, including factors such as wait times, confidentiality, and the range of services available
- d. All of the above. (✓)

8. Name two medical services that should be provided, according to the MISPP, if someone experiences sexual violence.³²⁶

- (Accept: Emergency contraception/prevent pregnancies, treatment of injuries, post-exposure prophylaxis/prevent HIV, pre-emptive treatment of STIs/prevent illness or disease)³²⁷

9. How can communities be empowered in disaster response according to the Sphere Charter?

- a. By providing them with detailed technical information
- b. By including them in needs assessments and planning (✓)
- c. By offering them free food and shelter

³²⁶ based on - <https://www.unfpa.org/sites/default/files/event-pdf/Disaster-Preparedness-Reproductive-Health-Course-English%20%281%29.pdf>

³²⁷ based on - <https://www.unfpa.org/sites/default/files/event-pdf/Disaster-Preparedness-Reproductive-Health-Course-English%20%281%29.pdf>

- d. By taking over all decision-making responsibilities

10. The Sphere Charter focuses on which of the following during disasters?

- a. Search and rescue efforts
- b. Humanitarian response principles and standards (✓)
- c. Long-term development strategies
- d. Military intervention

11. True/False Statement³²⁸

S.N.	Statement	True	False
1.	In an emergency, access to reproductive health services saves lives	True	
2.	In a disaster and emergency there are NO minimum requirements for services that should be provided		False
3.	Women and girls have higher rates of mortality during a disaster.	True	
4.	During displacement, women and girls face higher risks to their health and safety than their male counterparts	True	
5.	It is recommended that men and women share wash and latrine facilities during disasters.		False
6.	Simple locks should always be available on the inside of latrine doors.	True	
7.	After sexual violence, there are no services or treatment that can be provided to help the survivor		False
8.	Nepal has a disaster management law.	True	
9.	Communities themselves are frequently the first responders during the first 72 hours (3 days) of an emergency	True	
10.	Communities are best positioned to identify solutions to address the risks they identify in their own community.	True	

End of Day Evaluation

End of Day Evaluation

³²⁸ based on - <https://www.unfpa.org/sites/default/files/event-pdf/Disaster-Preparedness-Reproductive-Health-Course-English%20%281%29.pdf>

Review

- What is something new that you learned today?
- Would anyone like to review some of the key pieces of information that we learned today?
- Would anyone like to share any thoughts or reflections from today's activities?

Evaluation

- What went well with the training today?
- What can be improved?
- Is there anything you would like to see change for tomorrow?
- Is there anything you would like to see stay the same for tomorrow?
- Confirm whether accessibility/accommodations are adequate for participants with disabilities. This should be done in private if more appropriate.

Final Evaluation and Feedback Form

Accountable Health System and Sexual and Reproductive Health Rights

(Rights-Based Accountability, Strategies for Accountable Health Systems and Community Monitoring of Sexual and Reproductive Health Rights During Disasters)

Evaluation Form

Name (Optional):

Please take a few minutes to answer the following questions. All responses will be kept confidential.

1. Time Management:

- The training schedule was well-managed and allowed for enough time to cover all topics. (Yes/No)
- The pace of the training was appropriate (too slow/just right/too fast). (Yes/No)
- There was enough time for discussion and questions. (Yes/No)
- Please provide any suggestions for improvement regarding time management:

2. Resource Person:

- The resource person was knowledgeable and presented the information clearly. (Yes/No)
- The resource person was engaging and facilitated discussion effectively. (Yes/No)
- Please provide any suggestions for improvement regarding the resource person:

3. Training Materials:

- The training materials (handouts, presentations) were clear, informative, and relevant to the topics. (Yes/No)

- The training materials were easy to understand and follow. (Yes/No)
- The training materials provided sufficient resources for further learning. (Yes/No)
- Please provide any suggestions for improvement regarding the training materials:

4. Usefulness:

- The training content was relevant to my work and will be helpful in my role. (Yes/No)
- The training provided me with new knowledge and skills related to SRHR and accountable health systems. (Yes/No)
- I feel more confident addressing SRHR issues and advocating for accountability in the health system. (Yes/No)
- Please explain how you plan to use the knowledge and skills gained from this training in your work:

5. Quality:

- Overall, I was satisfied with the quality of the training. (Yes/No)
- The training venue was comfortable and conducive to learning. (Yes/No)
- The training logistics (e.g., refreshments, breaks) were well-organized. (Yes/No)
- Please provide any additional comments or suggestions for future training sessions:

6. Others:

- What was the most valuable aspect of the training for you?
- What could have been improved about the training?
- Do you have any other feedback you would like to share?

VI. Useful Resources and References

A. List of Readings and Resources

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C. Links to Relevant Organizations and Networks

- CARE Nepal

CARE Nepal is a leading humanitarian organization fighting global poverty. In Nepal, CARE Nepal focuses on women's empowerment, disaster risk reduction, climate change adaptation, and inclusive economic development: <https://carenepal.org/>

- **Center for Reproductive Rights (CRR)**

CRR is a global legal advocacy organization working to advance reproductive rights worldwide, recognizing them as fundamental human rights. They use legal strategies, including litigation and advocacy, to promote access to safe abortion, contraception, maternal health, and other reproductive health services: <https://reproductiverights.org/>

- **Forum for Women, Law and Development (FWLD)**

FWLD is a national non-profit organization in Nepal advocating for women's human rights and social justice. They work on various issues, including disaster and SRHR. FWLD has collaborated with CRR on projects related to SRHR in Nepal, including advocating for legal reforms to ensure access to safe abortion: <https://fwld.org/>

- **Global Health Cluster (SRH task team)**

The Global Health Cluster is a coordinated effort by various organizations to improve health outcomes in emergencies. The SRH task team specifically focuses on sexual and reproductive health: <https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team>

- **United Nations Population Fund (UNFPA)**

UNFPA is a global agency that works to ensure sexual and reproductive health and rights for all. They have a specific focus on humanitarian emergencies, including resources on SRHR in disasters: <https://www.unfpa.org/>

- **United Nations Children's Fund (UNICEF)**

UNICEF works to improve the lives of children around the world, including ensuring their access to health care. They address SRHR issues in emergencies and have resources available: <https://www.unicef.org/>

- **World Health Organization (WHO)**

WHO provides global leadership on health issues, including sexual and reproductive health. They offer resources and guidelines on health including SRHR in emergencies: <https://www.who.int/>

- **UNDRR (United Nations Office for Disaster Risk Reduction)**

The UNDRR is a lead UN agency for coordinating disaster risk reduction (DRR) efforts globally and supports countries in implementing the Sendai Framework for Disaster Risk Reduction, a 15-year voluntary agreement adopted in 2015 that aims to prevent new and reduce existing disaster risk and strengthen resilience. It promotes integrating disaster risk reduction into development strategies and policies: <https://www.undrr.org/>

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Annex

Annex 1- Presentation Slides: Module 1.1: Introduction to Human Rights and Right to Health

Annex 2 - Presentation Slides: Module 1.2: Sexual and Reproductive Health and Rights (SRHR)

Annex 3- Presentation Slides: Module 1.3: Right Based Approach in Health

Annex 4- Presentation Slides: Module 1.4: Disaster Management and SRHR Risks

Annex 5- Presentation Slides: Module 2.1: Principles of Rights-Based Accountability and Accountable Health Systems

Annex 6- Presentation Slides: Module 2.2: United Nations Human Rights Accountability Mechanism

Annex 7- Presentation Slides: Module 2.3: Other Accountability Mechanism (NHRI, Health System and Social Accountability Mechanism)

Annex 8- Presentation Slides: Module 2.4: Role of Duty-Bearers and Right-Holders of SRHR and Disasters

Annex 9 - Presentation Slides: Module 3.1: Policy and Legal Frameworks for Disaster and SRHR

Annex 10- Presentation Slides: Module 3.2: Selected Precedents of the Supreme Court of Nepal On Disaster and SRHR

Annex 11 - Presentation Slides: Module 3.3: SRHR in Disaster Preparedness, Response and Recovery

Annex 12 - Presentation Slides: Module 3.4: Strengthening Governance and Transparency

Annex 13 - Presentation Slides: Module 4.1: Community Monitoring and Evaluation Systems (Annex 13)

Annex 14 Presentation Slides: Module 4.2: Circle of Accountability

Annex 15 -Presentation Slides: Module 4.3: Community-Led Data Collection and Analysis

Annex 16 - Presentation Slides: Module 4.4: Advocacy and Action based on Community Findings

Annex 17 - Detail Agenda

Annex 18 - NHRI and Indicators

