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Sexual and Reproductive Health in Emergencies: Promising Practices to Address the Crisis within a Crisis

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Armed conflicts, disasters, climate change, and global health emergencies are causing unprecedented levels of humanitarian need around the world. Women and girls are uniquely impacted – on top of enduring violence, displacement, and the loss of livelihoods and social safety nets, they often also face disruptions in their access to essential sexual and reproductive health (SRH) services and a heightened risk of gender-based violence (GBV). While emergency responses urgently focus on meeting food, shelter, and safety needs, humanitarian actors often do not view SRH and GBV as life-threatening issues and consequently do not prioritize them in aid programs, leaving millions of women and girls without vital services and undermining their human rights.

Ignoring SRH in emergencies has stark, life-threatening consequences. Data indicate that 65% of maternal deaths, 50% of newborn deaths, and 51% of stillbirths occur in humanitarian contexts.[1] Research also shows that "during humanitarian crises, rates of unintended pregnancies, unsafe abortions, sexually transmitted infections (STIs), pregnancy and obstetric complications, miscarriage, stillbirth, and maternal and newborn mortality all increase."[2]

To ensure that emergency responses effectively meet urgent needs on the ground, the humanitarian community – including donors, governments, multilateral agencies, NGO responders, and national and community-based actors – should integrate SRH and GBV into their work. This brief outlines critical challenges in doing so, as well as promising approaches and key policy recommendations for responding to some of the most pressing needs of women and girls in emergencies.

What Women and Girls Want: Core Aspects of Sexual and Reproductive Health and Gender-Based Violence Responses in Humanitarian Emergencies

While the needs of women and girls are often tied to their context and the nature of the emergency, past and ongoing crises illustrate several core health interventions required across all humanitarian settings:

- Obstetric care, including antenatal care, skilled attended delivery, appropriately equipped health facilities, and postpartum maternal and newborn care.
- Post-rape/sexual assault care and services for other forms of GBV, including clinical management of rape/sexual violence, psychosocial services, emergency contraceptives (EC) and prophylaxis to prevent unintended pregnancy and STIs, and availability of (and referral to) specialized care.

- Contraception/family planning services, including emergency contraceptives, a range of quality modern contraceptive methods such as long-acting reversible contraceptives (LARC), and family planning counseling.
- Prevention and treatment of STIs, including condoms, post-exposure prophylaxis (PEP), anti-retroviral drugs and other medications used to treat STIs, and appropriate diagnostic and protective supplies/equipment.
- Safe abortion and post-abortion care, including to address life-threatening pregnancy complications and to avert unsafe abortions, which increase the risk of death or other injury.
- Menstrual hygiene management, including culturally appropriate menstrual products and access to water, sanitation, and hygiene (WASH) facilities.

Underlying the above is the need for skilled health workers to deliver SRH and GBV services, functioning supply chains for SRH supplies to reach their destination, systematic data collection and management to assess needs and the efficacy of programs, effective coordination amongst aid providers, and consistent communication loops with impacted women and girls.

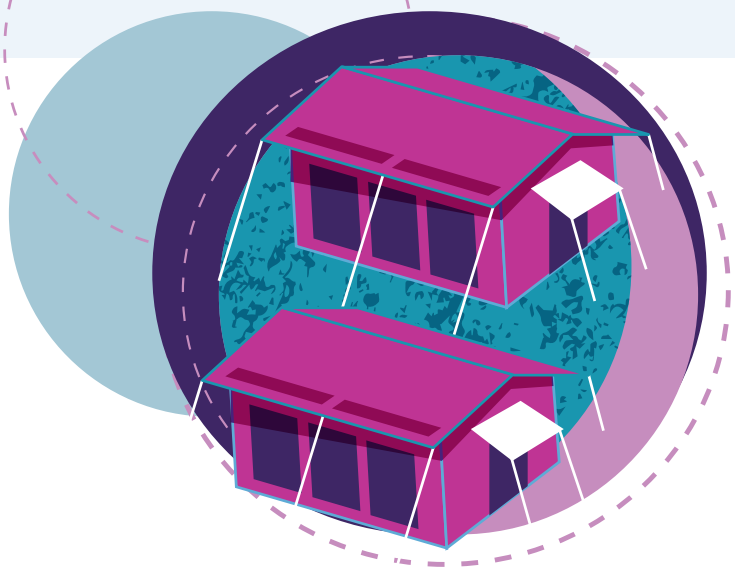
A human rights-based approach to SRH in humanitarian contexts requires available, accessible, adequate, and quality services that are delivered without discrimination. Those seeking services should have the information they need to make informed and autonomous decisions and their privacy and confidentiality should be respected. When individual rights are violated, survivors' access to justice and effective remedies must be upheld.[3]

Recognizing these needs, a common international standard of care – the Minimum Initial Services Package (MISP) – outlines a series of vital, lifesaving activities to respond to SRH needs at the onset of emergencies. Humanitarian actors are required to implement the MISP, which aims for zero maternal deaths, incidents of GBV, or unmet need for family planning.[4] The MISP also underscores coordination among humanitarian actors and the need to transition to comprehensive SRH services as soon as feasible.

Meeting Humanitarian Needs Means Prioritizing Sexual and Reproductive Health and Gender-Based Violence From the Start

The ultimate goal of humanitarian response is to save lives and reduce suffering. For women and girls, life-saving activities must include health services that reduce maternal and neonatal mortality, prevent unintended pregnancies, stem the spread of STIs, and ensure survivors of GBV receive appropriate support. In practice, however, the nature of crises, the impact of harmful gender norms, and resource limitations pose serious challenges to achieving those outcomes. Data and lessons learned from past or current crises provide some direction for humanitarian activities:

- **Urgency matters.** Due to immediate disruptions in health services and the increased risk of GBV starting from the earliest phases of an emergency, SRH and GBV services are urgent from the onset of a crisis. For example, UNICEF and UNFPA estimate that in Gaza, nearly 20,000 babies were born in the first 105 days of the conflict and childbirths will continue at a rate of 180 deliveries per day.[5,6] Every day that women lack antenatal and postpartum care, food, water, nutrition, and essential medications is life-threatening, particularly for the 15% of pregnant women who are already facing obstetric complications.[7]
- **Loss of health infrastructure drastically affects vital care for women and girls.** Prior to the outbreak of violence in November 2020, an estimated 94% of women in the Tigray region of Ethiopia had access to antenatal care.[8] Widespread looting, destruction, and occupation of health facilities by militants; blockades that crippled the flow of essential medical supplies; and the loss of half of the healthcare workforce left the health system in a "state of collapse."[9] Women and girls lost crucial SRH and GBV services, leading to unattended childbirths, abortions in unhygienic conditions,[10] the spread of STIs and other preventable diseases such as malaria or measles,[11] and severe outcomes from otherwise treatable conditions (e.g., the removal of reproductive organs).[12] While some health services recovered, the post-conflict health system has not fully bounced back – a World Health Organization (WHO) study determined that 88% of health facilities in



the region are still only partially functional and the lack of supplies and staff persists.[13]

- **Effective GBV prevention and response requires a comprehensive approach across the entire humanitarian system.** GBV occurs in nearly every emergency and certain forms of GBV, such as child marriage, intimate partner violence, and sexual violence, distinctly rise during crises. In the Democratic Republic of the Congo (DRC), authorities recorded a 91% rise in reported GBV cases between 2021 and 2022, and in South Sudan, "up to 65% of women report having experienced intimate partner and sexual violence, a rate double the global average."[14] In Lebanon, the percentage of Syrian refugee girls married before the age of 18 is three times higher than it had been in pre-conflict Syria.[15] The risk of sexual exploitation by aid workers also arises in various humanitarian sectors such as shelter, WASH, and food.

  Time-sensitive clinical interventions are critical to treating injuries and preventing STIs and unintended pregnancy. Psychosocial support to address trauma, depression, and suicidal behavior can save lives. Other services such as legal aid, cash assistance, and accessible transportation enable women to leave abusive situations. Delivering quality GBV support is hindered by stigma, which plays a significant role in discouraging survivors from reporting GBV and reaching out for support, and severe underfunding of GBV programs leading to shortages in supplies and skilled personnel and limited availability of specialized services.[16]

- **Contraceptives and family planning services are essential and lifesaving, but often overlooked and inadequate in emergencies.** Fulfilling the unmet need for contraception would prevent an additional 104,000 maternal deaths – a 29% reduction in global maternal mortality – and unsafe abortions would decline by 74%.[17] The widespread distribution of condoms would also reduce the spread of STIs and prevent unintended pregnancies. Despite these benefits and a demonstrated demand for contraception from women in humanitarian settings, funding appeals rarely include family planning services and humanitarian health programs also often omit them. Supply chain disruptions further impact the availability of contraceptive supplies while gaps in health provider training, misconceptions on how to administer contraceptives, and community and family stigma impede their use.[18]

  Women and girls in crisis contexts also regularly lack access to the full range of contraceptives. While LARCs are among the most efficient and effective reversible methods, potential users may not be aware of these options and providers often lack necessary clinical training to administer them.[19] Similarly, EC is a critical part of post-rape care and should also be available to anyone who has had unprotected sex, but this method is not universally accessible during crises.

- **Barriers for adolescents, persons with disabilities, and other marginalized groups are high.** Adolescent girls face unique risks of child marriage and sexual violence in emergencies, which elevates their exposure to STIs, early pregnancy, and intimate partner violence. As a result, their need for SRH and GBV services also rises. Due to strong stigma within the community, health providers may not make contraception, abortion, and other SRH services available to adolescent and/or unmarried girls.[20] Lack of resources to pay for services or regulations requiring parental or spousal approval also hinder adolescent girls from accessing care. Restrictive gender norms related to girls' role in their community and family also translate to limitations on their movement, financial independence, and bodily autonomy, raising additional hurdles to their access to SRH and GBV services.

  For women and girls with disabilities, additional challenges, such as distance from service delivery points, lack of transportation, and inaccessible facilities, can prevent them from accessing support. In Ukraine, for example, inaccessible shelters in Kiev meant that individuals with disabilities were isolated from services

offered at central delivery points.[21] Lack of specialized services or adaptive support, particularly for those with intellectual disabilities, also hinder the ability to communicate needs and receive appropriate care.

Other marginalized populations, such as LGBTQIA+ individuals, people engaging in transactional sex, and ethnic or racial minorities, further encounter discrimination or stigma that impedes their access to quality SRH and GBV services. For instance, Roma refugees from Ukraine reported being turned away from free medical treatment to which they were entitled, receiving sub-standard services, and facing verbal abuse in healthcare settings due to bias.[22]

Promising Approaches to Delivering the Services Women and Girls Need

Despite the significant obstacles to effective SRH support in emergencies, humanitarian actors have invested in a variety of approaches to broaden the reach of aid and address some endemic challenges. For instance, UNFPA supported 808 **mobile clinics** in humanitarian settings, extending health services to more people, including hard to reach populations.[23] These mobile clinics, staffed by trained health workers, provide services such as maternal health care, emergency contraceptives, family planning, STI prevention, and support for GBV survivors. In Somalia, UNFPA introduced a mobile maternity unit designed to provide comprehensive antenatal checkups, safe deliveries, and postpartum care directly within communities affected by crisis.[24] The clinics fill critical gaps in the national/local health infrastructure and put quality healthcare within reach of people who would otherwise experience difficult, sometimes fatal, challenges in accessing care. The impact is evident in places like the DRC where the maternal mortality rate is one of the highest in the world – from February-September 2023, zero maternal deaths were recorded in the regions in which mobile clinics operated.[25]

Investments in **midwives and community health workers (CHWs)** to provide skilled care also help meet women's and girls' essential needs in humanitarian contexts. According to UNFPA, if protected and supported, midwives can cover 90% of the global need for interventions across sexual, reproductive, maternal, newborn and adolescent health.[26] If the global midwife deficit were closed, they could potentially prevent two-thirds of all maternal and newborn deaths by 2035.[27] In Afghanistan, where distance from health facilities and skilled health workers make it one of the deadliest places in the world to give birth, midwives are often the only health care providers and they deliver life-saving, culturally sensitive services, particularly in remote areas.[28] In addition to assisting with safe deliveries and maternal care, midwives and CHWs are vital resources for contraceptives and family planning counseling, GBV support, and information to prevent the spread of STIs.

Integration of **cash assistance** into GBV prevention and response activities, when done appropriately, provides flexibility to meet survivors' immediate needs and promote longer-term recovery. Where healthcare or other necessities are prohibitively costly, cash assistance has helped survivors access critical care and empowered them to leave abusive relationships by offsetting the costs of rent, transportation, food, and other essentials. In Ecuador, participants in one GBV program reported using cash transfers for health services, shelter, legal aid, and psychosocial support, which reduced their exposure to further GBV, averted reliance on risky coping strategies such as sex work, and improved their access to medical and psychosocial care.[29] Additionally, GBV survivors in Jordan noted that cash assistance improved joint decision-making and shared control over financial resources within their households.[30] Given the demonstrated benefits of cash assistance for preventing and responding to GBV, additional research should focus on extending cash-based approaches for broader access to SRH services in humanitarian contexts.

Recommendations for Policy and Programming:

While the humanitarian community has made strides in targeting SRH and GBV challenges that commonly arise during emergencies, policymakers and program implementers are well-positioned to drive further progress and close systemic gaps. They should:

- **Prioritize SRH and GBV from the start:** Donors, implementing agencies, and on-the-ground responders should recognize SRH and GBV services as essential, lifesaving interventions from the onset of an emergency and proactively ensure that initial needs assessments, humanitarian appeals and funding proposals, program concepts, policy approaches, and funding decisions all reflect them as priorities for action.

- **Ensure preparedness planning integrates SRH and GBV**: As more communities in crisis-prone areas engage in preparedness planning, their strategies should anticipate disruptions in access to SRH care and an increased need for GBV services. Authorities should take proactive measures to strengthen supply chain resilience and ensure sufficient stocks of necessary SRH supplies, including contraceptives. They should establish partnerships with and amongst local actors such as national and provincial governments and community-based organizations during times of stability to enable timely, effective, and well-coordinated responses when crises occur. Preparedness planning processes should always include women, girls, and other marginalized groups to surface specific gaps and solutions and ensure community-wide buy-in.

- **Invest in health infrastructure before a crisis:** Linkages between development and humanitarian efforts on health system strengthening can mitigate some of the challenges women and girls encounter during a crisis. Development initiatives to train midwives and community health workers, build and equip healthcare facilities, establish referral and coordination protocols, and sensitize health professionals on women's and girls' unique health needs can better position the health system to withstand shocks and adapt during crises.

- **Facilitate and support community-based efforts:** Women-led and refugee-led organizations often serve as first-responders and conduits of information for their community – their unique understanding of the context and their reach within the community makes supporting their efforts critical to linking broader aid to local needs. Their ability to connect with community members is particularly relevant for SRH and GBV services, which often require trust, cultural sensitivity, and contextualized responses. Donors, international organizations, and others in the humanitarian system should establish meaningful partnerships with these groups, provide direct and flexible funding for them to deliver humanitarian services, include them in conducting needs assessments and designing humanitarian responses, and otherwise support their on the ground efforts.

- **Reverse or speak out against legal/policy restrictions that undermine women's and girls' health.** Donors, governments, and other humanitarian actors should repeal any regulations that place undue burdens on SRH and GBV services. Similarly, while aid organizations are obligated to work within the bounds of local laws and regulations, the humanitarian community must be prepared to support locally driven advocacy efforts and utilize diplomatic pressure to address legal and policy barriers that impede the effective and equitable delivery of assistance.

- **Address funding shortfalls**. Despite clear evidence that SRH and GBV services are essential during emergencies, these crucial interventions are still vastly underfunded relative to the need. In 2023, the global funding request for GBV programming accounted for only two percent of the overall humanitarian funding requirements, yet only 18.5% of that small portion was fulfilled.[31] Multilateral agencies and NGO program implementers should routinely include SRH and GBV in funding appeals and program proposals. Donors and governments should urgently meet these funding needs, prioritizing direct funding to community-led organizations to deliver assistance and other underfunded services such as contraceptives, adolescent-friendly services, and abortion care.

No One-Size-Fits-All Approach to Humanitarian Support: Women and Girls Deserve Emergency Crisis Responses that Meets Their Unique Needs

For emergency responses to effectively save lives and reduce suffering, humanitarian practice must proactively recognize and address the various ways in which crises impact women and girls. Utilizing a gender lens to identify their needs and barriers – including those related to SRH and GBV – empowers humanitarian actors to tailor their interventions to the reality on the ground, elevating the quality and efficacy of crisis response overall. Evidence-based, and inclusive approaches that incorporate SRH and GBV priorities into humanitarian action are imperative to saving women's and girls' lives, upholding their rights, and promoting their overall health and well-being.

CHILD MARRIAGE AND SEXUAL AND REPRODUCTIVE HEALTH

In crisis settings, the risk of child marriage increases as families face greater insecurity and the loss of livelihoods and social safety nets. The specific drivers of child marriage vary by context and community, but families often turn to the practice in humanitarian settings to cope with extreme economic hardship or to protect girls' honor. For instance, in Afghanistan, many families facing the threat of starvation traded their girls into marriage in exchange for a dowry (financial gift) in order to purchase urgently needed food and supplies.[32] Similarly, Bangladesh experienced a 39% surge in child marriage following climate disasters such as flooding given the loss of livelihoods and poverty.[33] Some families turn to child marriage to "protect" girls from the loss of honor tied to sexual violence, such as in Syrian refugee communities in Lebanon, Jordan, and Turkey where there have been dramatic increases in child marriage from pre-war levels.[34] In addition, girls in some conflict settings may experience forced marriage to combatants, like in Somalia where al-Shabaab fighters abducted and forcibly married adolescent girls.[35]

Crisis conditions further exacerbate the life-altering and sometimes life-threatening consequences of child marriage for girls. Child brides face increased risks of intimate partner violence, early pregnancy, and STIs.[36] However, support for married adolescents is scarce during crises given general limitations on SRH and GBV services in emergency settings combined with the additional barriers girls face in accessing these services due to their age and gender. The implications are stark – globally, complications from pregnancy and childbirth are among the leading causes of death for girls between 15-19 years old, and the risks increase further when support services are out of reach.[37]

Once married, girls' education also often ends as they manage household chores and care for children. This loss of education negatively affects their long-term economic autonomy and their short-term ability to learn skills that could provide income to meet their needs during a crisis. Removal from school also isolates them from information and resources related to their health and rights, such as comprehensive sexuality education and channels to report GBV.

Addressing child marriage in humanitarian contexts comprehensively, both as a matter of protection and as a violation of girls' human rights, includes ensuring that SRH and GBV services are adolescent girl-friendly and that nutrition, education, shelter, livelihoods, and other sectors of humanitarian assistance account for the needs of married or at-risk girls.

ABORTION CARE IN HUMANITARIAN EMERGENCIES

Abortion care is critical to women's and girls' health and rights, but health services delivered during humanitarian crises often neglect this form of health care. Poor or disrupted access to contraceptives or antenatal care during emergencies, as well as heightened exposure to sexual violence, increases the risks of unintended pregnancy or life-threatening pregnancy complications that lead to demand for abortion services. Safe abortion services, however, remain limited due to legal restrictions or assumptions about lack of demand.[38] Stigma from community members and health care workers also narrows the safe, dignified, and accessible options of those seeking abortion.

When demand for safe abortion services is unmet, people resort to unsafe abortions with potentially debilitating or life-threatening consequences. Globally, 7 million women and girls are disabled or injured and 29,000 die as a result of unsafe abortions every year.[39] By contrast, abortion supported by trained health workers is proven to be amongst the safest medical procedures, usually managed with medication or a minor procedure with local anesthetic.[40] The availability of quality post-abortion care also saves lives by treating severe injuries from unsafe abortions and provides pain management and contraceptive counseling.

Restricting access to abortion does not eliminate demand, but does make obtaining abortion more dangerous – unsafe abortions are significantly higher in places where the regulatory environment limits legal abortion access.[41] These burdens are compounded for refugee and displaced women – for example, in Poland, where sexual assault is one of the only exceptions to a near-total ban on abortion, regulations require rape survivors to formally report the assault to police and obtain a prosecutorial certificate before they can seek an abortion, which poses a significant barrier for refugee women experiencing language barriers, discrimination, or trouble navigating the legal system in their host country.[42] Donor restrictions such as the United States' Mexico City Policy and Helms Amendment, which limit NGO grantees' ability to provide abortions and abortion counseling, also effectively cripple health service providers in humanitarian contexts in delivering medically-appropriate care.[43]

To avert preventable maternal deaths and injuries and to uphold women's and girls' human rights, it is imperative that humanitarian operations include abortion and post-abortion care as part of essential SRH services. Humanitarian organizations, governments, and donors must:

- Supply flexible funding and support to programs that provide abortion procedures, post-abortion care, contraceptive counseling and access, and GBV services that include emergency contraception.
- Reverse legal and policy restrictions that criminalize or otherwise penalize abortion services and ease procedural and administrative burdens on obtaining or providing abortions.
- Address barriers within health systems related to abortion, including shortages in skilled medical personnel, medications, and supplies for abortion procedures and post-abortion care, and confront negative attitudes and lack of training amongst health care workers.
- Include community involvement in the design and implementation of health programs, including to address negative community perceptions of abortion and stigma against abortion-seekers and providers.

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