

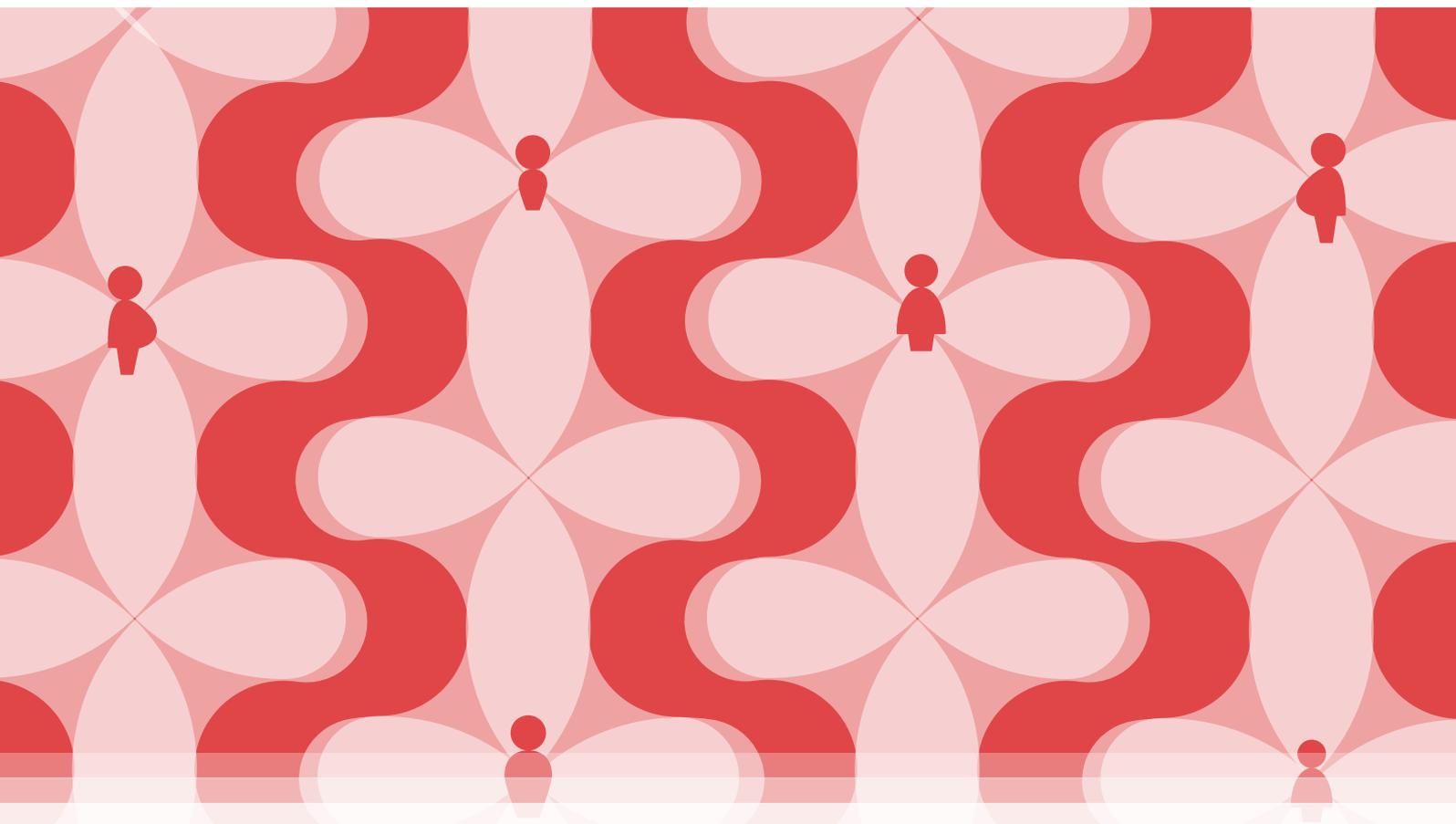
HPG working paper

# Reproductive justice, sexual rights and bodily autonomy in humanitarian action

## What a justice lens brings to crisis response

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November 2022





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# Acronyms

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<b>CSE</b>	comprehensive sexuality education
<b>GBV</b>	gender-based violence
<b>GRHA</b>	gender-responsive humanitarian action
<b>HIV</b>	human immunodeficiency virus
<b>IASC</b>	Inter-Agency Standing Committee
<b>IAWG</b>	Inter-Agency Working Group on Reproductive Health in Crises
<b>IHL</b>	international humanitarian law
<b>IHRL</b>	international human rights law
<b>IRC</b>	International Rescue Committee
<b>LGBTQIA+</b>	lesbian, gay, bisexual, trans, queer/questioning, intersex and asexual
<b>MISP</b>	Minimum Initial Service Package
<b>MSF</b>	Médecins Sans Frontières
<b>NGO</b>	non-governmental organisation
<b>PSEAH</b>	prevention of sexual exploitation, abuse and harassment
<b>RTI</b>	reproductive tract infection
<b>SDG</b>	Sustainable Development Goal
<b>SEA</b>	sexual exploitation and abuse
<b>SOGIESC</b>	sexual orientation, gender identity, gender expression and sex characteristics
<b>SRH</b>	sexual and reproductive health
<b>SRHR</b>	sexual and reproductive health and rights
<b>STI</b>	sexually transmitted infection
<b>UNFPA</b>	United Nations Population Fund

## Executive summary

Sexual and reproductive health and rights (SRHR) services are life-saving in humanitarian crises of all kinds, with needs for services rising even as underfunding and political deprioritisation of SRHR services remain stark. To date, however, humanitarians have not understood these lacks as a question of rights or justice for crisis-affected people.

As recently as 2014, the Inter-Agency Working Group on Reproductive Health (Casey et al., 2015) found no minimum standard of care across multiple crisis settings, along with dramatic gaps around emergency obstetric and newborn care, contraception provision and usage, treatment of sexually transmitted infections (STIs), and knowledge amongst affected people and medical professionals alike. Current crises in Afghanistan, Ethiopia and Ukraine are also underlining the heightened SRHR-related risks and needs that emerge in humanitarian settings, while the global political environment around SRHR – and especially abortion – demonstrates powerful resistance to bodily autonomy and rights.

Despite clear links to humanitarian response, humanitarians have not played a vocal or consistent part in these debates. SRHR is intertwined with all other areas of humanitarian response, and to a life with agency and wellbeing, even in the midst of crisis. Questions about what is ‘in scope’ or essential for meeting immediate needs can lead to inherently political (and often unspoken) assumptions about the nature and criticality of SRHR, to the detriment of quality referral pathways and care. To meaningfully address what SRHR means to crisis-affected people, what is needed is a **reproductive justice** lens that breaks down existing silos and sets SRHR against a wider backdrop of human rights, structural factors and wider notions of wellbeing.

### Humanitarian SRHR since the 1990s

Research and practice on SRHR in humanitarian settings improved significantly over the past 30 years. Gender-based violence (GBV) is an indispensable core component of a humanitarian SRHR agenda and has received significant attention – albeit still with paltry funding – including the foundation of the GBV Area of Responsibility (AOR) and the formulation of guidelines and standards. Maternal and newborn health, too, attracts specific attention in humanitarian settings, possibly due to the documented scale of concerns. Programmes also exist to cover access to contraception, promotion of sexual health including menstrual health and hygiene and management of reproductive tract infections (RTIs) and STIs, but immense gaps remain in understanding needs and barriers, as well as in service provision and utilisation.

### Gaps between meeting needs and realising rights

Few studies on crisis settings or humanitarian response reference the language or substance of sexual rights, bodily autonomy or reproductive justice. The salience of rights and rights-based approaches to humanitarian action is still not commonly accepted, and commitment to them may have even

waned, with a move ‘back to basics’ ensuring that needs-based approaches remain a strong current – and especially in health. In practice, many humanitarian actors shy away from rights-based discourse, sometimes for practical reasons like humanitarian access, even as they provide services that support people to claim their rights.

Framing SRHR – especially its more controversial components – as ‘needs’ can be a powerful and strategic choice, but it does not negate the fact that SRHR provision is also fundamentally a rights-based question. The delineation of needs is itself a question of rights, particularly with an eye to avoiding paternalism and colonialism. Thus, SRHR must be understood from a perspective that melds the two approaches: rights provide the force of duty and entitlement while needs imbue SRHR with a sense of urgency and apolitical moral imperative. This is important not only for making the most persuasive arguments possible for SRHR but also, potentially, for uniting rights-based and needs-based approaches in the context of wider humanitarian response.

This focus on ‘needs’ alone creates challenges to accessible, inclusive and effective SRHR services and pathways, particularly for marginalised groups of crisis-affected people. First, SRHR interventions have what might be described as a natural **focus on women and girls**, but there is little disaggregation of this monolithic category, with limited reference to displaced populations, youth, older people, sexual violence survivors, people with disabilities, men and boys, marginalised ethnic groups or those with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC). This is partly due to difficulties accessing these groups, especially in restrictive legal environments, but they are also simply not widely understood as having SRHR needs.

Current practice on SRHR in emergencies places a **narrow emphasis on ‘reproductive problems’**, and especially on excess fertility, with little focus on wider sexual health. The impetus to act quickly and efficiently leaves little room for confronting root causes, but the result can be health advice from providers that is based not on patients’ autonomy but rather on underlying assumptions that crisis-affected people should not have (more) children. Such an approach belies the complexity of decision-making about sex and reproduction, even amidst crises, and the importance of pleasure, healthy relationships, sex and family. The flipside of this is a **reduction of comprehensive SRHR to GBV response**, which is known to increase in scale and complexity in settings affected by crises. Responding to GBV effectively and sensitively – including the SRHR-specific needs that arise from it – is critically important, but this near-exclusive focus can mean that sexuality in general is perceived through a lens of harm.

Finally, significant challenges also remain in **under-utilisation of SRHR services** in crises – a fact that suggests the presence of additional economic, social, cultural or political barriers to access that are understudied or poorly addressed. Better knowledge of these barriers and how to work around them is pivotal, and to maintaining **political will and appropriate funding** to match. Both of these are proving difficult to mobilise amidst the current global backlash, resource scarcity and the perception that some settings are simply unfeasible for SRHR provision. It is important to note, though, that navigating

politically sensitive and legally restrictive environments is not uncharted territory, with many prominent voices laying out legal, ethical and political justifications for providing comprehensive SRHR to crisis-affected groups.

### Box 1 The reproductive justice framework

Reproductive justice is a conceptual framework developed by 12 US-based Black feminists in the 1990s, with the aim of shifting the pro-choice/pro-life divide and centring bodily autonomy.<sup>i</sup> Reproductive justice comprises three simple but fundamental core tenets:

- the right not to have a child
- the right to have a child
- the right to parent children in safe and healthy environments.

As the framework has evolved, emphasis on sexual rights, gender freedom and the importance of pleasure have been added. Realising SRHR through a lens of reproductive justice means redressing power relations that are not only gendered but also intersectional and colonial; acknowledging the structural determinants that shape ‘choice’; and restoring the dignity of diverse groups of people. This is a mission that is aligned with core humanitarian commitments to inclusion, rights-based approaches, locally led responses and gender-responsiveness.

<sup>i</sup> See in particular the work of Loretta Ross (Ross, 2017; Ross and Solinger, 2017).

## Deepening commitment to core humanitarian agendas

Reproductive justice is still not commonly applied in humanitarian settings. Yet such an expansive, justice- and rights-focused approach can support better outcomes in humanitarian SRHR and also further recent agendas in the sector, each of which aims to foment fairer, more effective, more inclusive, more accessible – **better** – humanitarian response.

## Principled humanitarian response

The relationship between SRHR and core humanitarian principles has not always been straightforward – and especially neutrality and impartiality, which have led humanitarians to avoid issues like abortion and services for people with diverse SOGIESC due to perceived sensitivities. However, this reading of the principles, is a question of interpretation. A justice framing shows that a willingness to class SRHR services as a less ‘immediate’ need than other health care represents a problematic and very political choice to solidify taboos around them. Strengthening humanitarian SRHR, and ensuring it is

comprehensive, accessible and inclusive, is about supporting people to make decisions about their own care and according to their own moral, ethical, cultural or political frameworks, in keeping with reproductive justice approaches.

### Gender-responsive humanitarian action

Humanitarian action remains largely gender-blind and many tools, guidelines and commitments treat gender concerns as monolithic. For gender-responsive humanitarian action (GRHA) to be meaningful, humanitarian decision-makers must be willing to engage deeply with the context-specific social dynamics that precede and underpin any humanitarian emergency. The principles of reproductive justice point to two key factors – the right structural conditions and the agency of affected people – as critical for better humanitarian decision-making, prioritisation and programme design. SRHR that lives up to and is grounded in reproductive justice has been shown to be a pre-requisite for gender transformation across the board, interconnected with all other areas of response including livelihoods and economic justice; political participation, voice and agency; shelter and housing; nutrition; and social cohesion. Key to this, as well as achieving wider GRHA, is orienting humanitarian work towards the stated needs of women, girls and people with diverse SOGIESC – and funding and empowering local organisations led by those groups.

### PSEAH and GBV

Both GBV and preventing sexual exploitation, abuse and harassment (PSEAH) speak to sexualised harms against crisis-affected people. Both engender acute SRHR needs, but they have tended to be pursued separately – GBV as a protection concern, PSEAH as a problem of accountability. Reproductive justice calls for a more holistic approach to sexuality, which positions healthy relationships and pleasure as key to supporting consent, and thus to recognising and confronting abuse. Endorsing a comprehensive, accessible and inclusive approach to SRHR – one that prioritises consent, pleasure, healthy relationships, and appropriate education and services for crisis-affected people and humanitarian staff alike – is a key way forward here. Conversely, embedding PSEAH, GBV and SRHR together across humanitarian response is critical for creating a scenario where everyone can recognise and appropriately respond to harm to their own bodily autonomy and that of others.

### Reproductive violence

Many recent conflicts and crises have seen the targeting of reproductive capacities and mothering itself, through reproductive coercion, obstetric violence, the exploitation of maternal roles and attachments, and enforced pregnancy and motherhood. Such harms – increasingly classified as reproductive violence – are often labelled sexual violence by humanitarian protection, transitional justice and peacebuilding actors alike, but this fails to capture abuses like forced abortion, contraception, sterilisation and pregnancy. Reproductive violence can be interpersonal as well as structural, encompassing institutional, political and structural dynamics that prevent, deny or refuse access to contraception and safe abortion care, including on the part of state institutions and medical professionals. The framework of reproductive violence is arguably already built on bodily autonomy, and it provides a new terminology

for confronting the paternalist and even eugenicist potential in SRHR. Humanitarians need to be active in identifying, detecting and responding to reproductive violence – which may be more acute during periods of crisis and especially conflict, particularly for marginalised groups – and avoiding facilitating them under the banner of ‘neutrality’.

### **Inclusive humanitarian response**

Inclusion has been a growing humanitarian agenda, but humanitarians are still struggling to translate commitments into outcomes. An intersectional lens informed by justice perspectives reveals how people with disabilities have had their autonomy violated and choices made for them; how people with diverse SOGIESC have often been ignored entirely in SRHR programming beyond responding to HIV; and how elders and youth may be underserved due to preconceptions about their sexual activity or behaviours. It also foregrounds structural conditions that shape whether and how people utilise SRHR services. While mandates may limit what humanitarians can do to remedy social exclusion, they do not absolve humanitarians from doing appropriate analysis and making connections with those actors who do have a mandate to meet affected people’s needs.

### **Beyond survival**

Humanitarians are increasingly asking what it might mean to think beyond the remit of immediate needs and ‘mere’ survival. In the field of SRHR, this means acknowledging sex as leisure, adolescent sexualities, sex work and transactional sex – and to do this beyond a lens of protection risks or GBV, with consideration for the complex calculations, choices and pressures that emerge. Humanitarians can begin to do this by promoting comprehensive sexuality education (CSE) that is non-judgemental and non-punitive, and informed by bodily autonomy, consent and justice, so that people of all sexualities and genders can engage in sex as safely as possible. Combating stigma is also key, including amongst humanitarians themselves, as it has been shown again and again to obstruct access to services, promote negative outcomes and normalise violence.

### **Conclusion**

Resisting the opposition of needs and rights, in SRHR and beyond, is crucial for ensuring that humanitarian responders – whether they are local, national or international – see, understand and constructively address those needs that are most pressing to affected individuals and communities themselves. Reproductive justice has the potential to shift the paradigm of humanitarian SRHR, facilitating better understanding of the meaning assigned to bodies, sexualities and reproduction. It also highlights the structural conditions, power relations, and interconnections that determine the potential for bodily autonomy in SRHR, in and out of crisis settings.

Reproductive justice can also demonstrate the potential for uniting rights-based and needs-based approaches to humanitarian response and improve humanitarians’ ability to tackle key agendas like inclusive and gender-responsive humanitarian action, PSEAH and GBV, and principled humanitarian

action. Global progress has proven slow on SRHR, and conflict, displacement, and humanitarian crises have the undeniable effect of deteriorating care models, raising new barriers and exacerbating existing power imbalances. These alone, however, cannot explain away the enormous gaps and silences around SRHR as an indispensable set of essential services. Humanitarian response must be one piece of a wider, interconnected puzzle that bridges sectors and places bodily autonomy at the centre of action.

# 1 Introduction

Sexual and reproductive health and rights (SRHR) services are life-saving in humanitarian crises of all kinds.<sup>1</sup> In 2020, of the nearly 2 billion people affected by conflict and 68.5 million displaced, 34 million were women and girls of reproductive age (Desrosiers et al., 2020: 2). Maternal mortalities in countries impacted by humanitarian crises account for 61% of the global total, while 10 countries with the highest maternal mortality rates are characterised by violent conflict. As of 2015, an estimated 53% of under-five deaths and 45% of neonatal deaths globally also occur in humanitarian crises or fragile contexts (UNFPA, 2015; Tran et al., 2021). Sexual violence and other forms of gender-based violence (GBV) against people of all genders tends to increase during and after crises, with at least one in five women in complex emergencies having suffered sexual victimisation (Vu et al., 2014, in Heidari et al., 2019).

At the same time, however, the underfunding and political deprioritisation of SRHR in crisis settings remains ‘pervasive’ (Tanyag, 2018: 655) and the dearth of services long documented (Starrs et al., 2018). Between 2002 and 2013, funding gaps for SRHR assistance in crisis settings were estimated to amount to \$2.7 billion. SRHR activities and services have been found to comprise as little as 2.4% of total assistance to conflict-affected countries (Tanyag, 2018).

Despite recent efforts, research shows that SRHR services in humanitarian settings remain variable: one 2015 study assessed 63 facilities across three crisis-affected settings in sub-Saharan Africa, finding that just five provided adequate emergency obstetric and newborn care, and just three provided elements of clinical management of rape (Heidari et al., 2019). As recently as 2014, researchers with the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) found no minimum standard of care across multiple crisis settings, along with dramatic gaps around emergency obstetric and newborn care; contraception provision and usage, including emergency and long-acting forms, treatment of sexually transmitted infections (STIs) other than human immunodeficiency virus (HIV), and knowledge of existing services amongst affected people or even medical professionals (Casey et al., 2015).

Current crises are also serving to underline the heightened SRHR-related risks and needs that emerge in humanitarian settings. In Ukraine, attacks on healthcare facilities have been reported as well as widespread sexual violence. This includes reports of at least 124 instances of sexual violence – likely, as always, an underestimate – including at checkpoints and in shelters, as of June 2022 (UN, 2022). An attack on a maternity ward in Mariupol in March killed at least one pregnant woman (Chernov, 2022). The Minimum Initial Services Package (MISP) is not being fully provided in many settings receiving Ukrainian refugees, and local women’s rights organisations are stepping in to provide frontline support (FIDH, 2022). Elsewhere, in Hungary, Poland, Romania and Slovakia, legal and policy restrictions are obstructing access to critical SRHR services for Ukrainian refugees, including emergency contraception,

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<sup>1</sup> See Box 2 and Table 1 for a discussion of terminology related to SRHR, including which terms we deploy over the course of this paper.

safe abortion care, antenatal care and post-exposure prophylaxis. All of these harms fall hardest on Romani women and women of African descent fleeing Ukraine, for whom racism poses an additional barrier to access.

Likewise, in Afghanistan, the United Nations Population Fund (UNFPA) reported in early 2022 that one woman was dying every two hours from pregnancy or childbirth complications that are mostly preventable, even as 1 million additional unintended pregnancies are anticipated annually between 2021 and 2025 due to conflict disrupting both health systems and women and girls' reproductive autonomy (UNFPA, 2022a; 2022b). In the Tigray region of Ethiopia, the fragile security situation have made service delivery nearly impossible and caused stockouts of key commodities for SRHR services, leaving internally displaced people without access to contraception, safe abortion care, STI treatment, antenatal care and counselling (Taft, 2022).

Thus, while there has been limited progress in some areas of humanitarian SRHR, in tandem with growing recognition of its importance, progress is utterly stalled in other areas – most notably, safe abortion care and access or tailored approaches for marginalised groups (IAWG, 2015; Singh et al., 2018b; Starrs et al., 2018: 2,649).

We also find ourselves at a key juncture for these debates globally: SRHR, and especially access to safe abortion care, is in the headlines and hotly debated around the world. Activist campaigns have brought about sea-changes in the law in Colombia, Argentina and Ireland.<sup>2</sup> At the same time, populist governments and global uncertainties have energised opposition to rights and bodily autonomy in Brazil, Malta, the Philippines and Poland. In 2021, the United Kingdom suddenly withdrew 85% of its funding for UNFPA's work on SRHR – a move that served as a 'clear illustration of the fragility of material support for SRHR' (Samuels and Daigle, 2021: 3). The Covid-19 pandemic also brought damaging restrictions and lines drawn between 'essential' and 'non-essential' services, to the detriment of comprehensive SRHR care (McCammon, 2020; Hurtes and Boffey, 2021; Samuels and Daigle, 2021). Most notable, however, is the repeal of *Roe v. Wade* (1973) in the United States – likely to bring global reverberations, alongside the Helms Amendment (1973) and the ongoing impact of the Global Gag Rule, which has come in and out of force repeatedly since the 1980s and caused profound upheaval in SRHR services (Ibis Reproductive Health and IPAS, 2015).<sup>3</sup>

As SRHR rises up global policy agendas, it is also meeting resistance in international forums. References to SRHR were ultimately removed from UN Security Council Resolution 2467 (2019), part of the Women, Peace and Security agenda, after it was threatened with a veto by core Security Council

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2 Importantly, opposition to abortion is continuing even in settings like Colombia, which is ostensibly the most permissive legal environment for safe abortion care in Latin America. This resistance is particularly apparent in post-conflict and peacebuilding discourses (Daigle et al., 2022).

3 The Helms Amendment (1973), which has remained in place continuously since its adoption, prohibits the provision of abortion using US aid spending. The Mexico City policy, also known as the Global Gag Rule, requires recipients of US aid funding to certify that they will not provide or promote abortion as a method of family planning, even with non-US funds. It was most recently repealed by the Biden administration in January 2021.

members. More recently, in 2020, six countries – the US, Brazil, Egypt, Hungary, Indonesia and Uganda – co-sponsored the anti-abortion Geneva Consensus Declaration on Promoting Women’s Health and Strengthening the Family, later signed by 34 countries.

All of these developments have clear humanitarian dimensions, but nonetheless humanitarians have not played a vocal or consistent part in them. The fraught global debate around SRHR also demonstrates that it is not enough to think in terms of service provision or non-provision alone, and that framing of the issue is always key. That is, SRHR that is inclusive, accessible and comprehensive is not just a question of health, but also of bodily autonomy, sexual rights and reproductive justice. It is intertwined with all other areas of humanitarian response, and with a life with agency and wellbeing, even in the midst of crisis. Humanitarians are constantly negotiating questions around what is deemed ‘in scope’ or essential for meeting immediate needs, which can lead to inherently political (and often unspoken) assumptions about the nature and criticality of SRHR, to the detriment of quality referral pathways and care. Therefore, to meaningfully address what SRHR means to crisis-affected people, what is needed is a reproductive justice lens that breaks down existing silos and sets SRHR within a wider context of human rights, structural factors and wider notions of wellbeing.

There are important lessons to be gained here, not just for humanitarian SRHR as an end in itself but for more inclusive and holistic humanitarian response broadly writ. Previous research has amply shown the links between rights-based humanitarian response and meaningful inclusion (Lough et al., 2022), how gendered norms and roles condition SRHR needs and access in displacement (Holloway et al., 2022) and how women-led humanitarian response produces more effective and appropriate interventions (Njeri and Daigle, 2022). SRHR is a valuable case that illustrates where technocratic service delivery and macro-level outcomes – that is, the kind of approaches that focus on bringing about change in high-level aggregate statistics like maternal mortality and morbidity – meet questions of rights, bodily autonomy, inclusion and agency.

It also bears noting from the outset that the humanitarian sector is certainly not immune from the problematic aspects of SRHR or its history. This includes embedded assumptions about who is in a position to have children or would make a good parent, as well as potentially steering service users towards choices that might be deemed ‘desirable’ by humanitarian actors or healthcare providers and the donors and governments that facilitate their presence. Here, critiques of humanitarian action as white saviourism or ‘rescue’ dovetail with the paternalism and even eugenics that have underpinned SRHR and are still being rooted out today. From the beginning, then, and as will be elaborated below, humanitarians must cultivate awareness of these pitfalls and address them head on, as part of an intersectional, anti-racist and decolonial approach. Sexuality is a field of constant political struggle between ‘repression and danger on the one hand and exploration, pleasure and agency on the other’ (Muhanguzi, 2015; see also Heidari, 2015). Reproductive justice is a key way that humanitarians can start to engage more meaningfully with that struggle.

## Box 2 A note on terminology

In this paper, we use ‘SRHR’ to refer to the provision of sexual and reproductive health services, as well as the related sexual and reproductive rights, as a holistic agenda in humanitarian response. We prefer ‘SRHR’ to ‘SRH’ precisely because it emphasises the centrality of rights rather than health alone. ‘Reproductive justice’, on the other hand, denotes the particular approach to SRHR that we elaborate in this paper. Where we cite the work of others, either directly or indirectly, we reproduce the authors’ own terminology. For a list of key terms and definitions in SRHR, see Table 1.

**Table 1** Key SRHR terms and definitions

Key term	Definition
Sexual and reproductive health (SRH)	‘A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity’ (WHO, n.d.a). Components include maternal and newborn health; contraception and fertility/infertility treatment; abortion and prevention of unsafe abortion; prevention, detection and management of reproductive tract infections (RTIs); STIs; sexual and gender-based violence; diversity in sexual orientations and gender identities; and promotion of sexual health/comprehensive sexuality education (WHO, 2006a; Starrs et al., 2018; UNFPA, 2019).
Sexual and reproductive health and rights (SRHR)	The addition of the second ‘R’ for ‘rights’ to SRHR can be traced to the International Conference on Population and Development (ICPD). Building on the health dimensions above, the ICPD Programme of Action posited that ‘reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health’ (ICPD, 1994: 46).
Sexual rights	‘Protects all people’s rights to fulfil and express their sexuality and enjoy sexual health, with due regard to the rights of others, within a framework of protection against discrimination’ (WHO, 2006 [updated in 2010], in WHO, n.d.a). Sexual rights were retrospectively added to the international human rights framework; in practice, existing human rights to sexuality and sexual health constitute sexual rights (ibid.; Ross and Solinger, 2017).
Bodily autonomy	‘The power and agency of individuals to make choices about their bodies without fear, violence or coercion’ (UNFPA, 2021).
Reproductive rights	‘Acknowledging, respecting and guaranteeing every individual’s ability to decide freely as to whether or not to procreate, including when and how frequently, as well as their freedom to decide responsibility as to the number of children they want to have’ (CRR, 2020: 7).

Key term	Definition
Reproductive autonomy	‘Having the power to decide and control contraceptive use, pregnancy, and childbearing’ (Bixby Center for Global Reproductive Health, 2014).
Reproductive justice	‘The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities’ (Sister Song, n.d.). Includes three key principles: ‘(1) the right not to have a child, (2) the right to have a child, and (3) the right to parent children in safe and healthy environments’ (Ross and Solinger, 2017: 9).
Reproductive coercion (and abuse)	Refers to ‘any deliberate attempt to influence or control a person’s reproductive choices or interfere with their reproductive autonomy’ (Miller et al., 2010, in Tarzia and Hegarty, 2021). It includes pressurising or forcing someone to become pregnant against their will; preventing use of birth control through destroying or hiding items; and controlling the outcome of a pregnancy through forcing abortion or forcing a pregnancy to continue.
Reproductive violence	‘Any form of abuse, coercion, exploitation or violence that compromises reproductive autonomy and self-determination, that is, the ability to decide if, how, and under what conditions to have and raise children’ (MSI Reproductive Choices and UNFPA, 2022).

### 1.1 Methodology

This paper builds on a wide-ranging scoping exercise that examined the state of play of SRHR in crisis settings in humanitarian response. It paid particular attention to the populations targeted through SRHR interventions; examples of programmes currently used in humanitarian policy and practice; and explored some of the enabling factors and challenges to providing and utilising SRHR services in humanitarian crises. This covered literature on SRH/SRHR from academia, UN bodies, non-governmental organisations (NGOs) and think tanks.

The desk review was complemented by consultations with a range of key voices on SRHR in crisis settings, including researchers, activists and humanitarian practitioners. Additional input was provided by the policy engagement committee that was convened to support this research.

### 1.2 About this research

This paper will examine how humanitarians have confronted SRHR to date and highlight the key gaps requiring urgent attention. It will then delve into the reproductive justice framework, what it can offer to more inclusive and accessible humanitarian response, and how it speaks to other key humanitarian debates, priorities and objectives.

This paper forms part of a two-year research project undertaken by the Humanitarian Policy Group (HPG) with support from the US Agency for International Development’s (USAID’s) Bureau of Humanitarian Affairs. The project examines the place of SRHR in humanitarian policy and practice

with the aim of fomenting more supportive, inclusive and accessible responses for all. In doing so, the project adopts an intersectional feminist, anti-racist and decolonial approach, to account for the diversity of needs and experiences amongst crisis-affected communities and to make the research inclusive of the most marginalised and vulnerable to the greatest extent possible. Building on the conceptual framework elaborated here, the project will undertake original, empirical research in Lebanon to better understand barriers and enablers to inclusive, accessible and comprehensive SRHR.

## 2 The state of play in humanitarian SRHR

A number of international and multistakeholder frameworks and initiatives have been developed over the past 30 years to support access to SRHR services for people in crisis settings (Figure 1). A well-recognised first step was the ICPD in Cairo, which took place in 1994. There,

diverse views on human rights, population, sexual and reproductive health, gender equality and sustainable development merged into a remarkable global consensus that placed individual dignity and human rights, including the right to plan one's family, at the very heart of development (UNFPA, n.d.a).

The resulting convention was the first to officially recognise reproductive rights in international forums, with a chapter on the importance of refugees' rights to SRHR (Singh et al., 2018a). This commitment to addressing emergency SRHR needs grew further with the formation of the Inter-Agency Working Group on Reproductive Health in Crises, made up of a range of UN agencies, NGOs and research institutes and tasked with addressing gaps in provision of SRHR for those affected by conflict and disaster (Onyango and Heidari, 2017; Singh et al., 2018a). In 1999, the IAWG developed a field manual for staff on reproductive health interventions in emergencies, which included a chapter setting out the first iteration of the Minimum Initial Service Package (see Box 3 for details) (Singh et al., 2018b). The manual has been updated twice, in 2010 and more recently in 2018, and is described as the 'authoritative source for SRH in crises' (IAWG, 2018a).

The importance of global SRHR needs since the ICPD has also been underlined by their inclusion in the Sustainable Development Goals (SDGs), although without specific reference to crisis settings or humanitarian response (Shiffman et al., 2018). Notably, SRHR features under target 3.7 on health; 4.7 on education, relating to CSE; and 5.6 on gender equality with the mention of bodily autonomy, informed decisions on sexual relations, contraceptive use and reproductive healthcare.

### 2.1 Key themes and advances since the ICPD

As detailed above, access to SRHR services in humanitarian settings has improved significantly over the past 30 years and, within that, some components of SRHR have notably seen more attention and progress. GBV and maternal and neonatal health feature prominently in SRHR literature and practice (see Singh et al., 2018a; Turner, 2019; Countdown 2030, 2020; Popple et al., 2021; McBride and Morgan, 2022; Rodo et al., 2022; and sub-sections 2.2.2 and 2.2.3, below).

**Figure 1** A timeline of guidelines and agreements



Sources: OHCHR, n.d.; CEDAW, 1999; UNDRR, 2015; UNECOSOC, 2016

### Box 3 The Minimum Initial Service Package

The MISIP is a compilation of life-saving measures to be introduced at the beginning of a crisis response and aims to do the following:

- facilitate the coordination of SRH services
- prevent sexual violence and respond to the needs of survivors
- reduce HIV and other STI transmissions
- minimise maternal and neonatal death and illness
- plan for comprehensive SRH services post-crisis phase.

(Singh et al., 2018a; 2018b; Desrosiers et al., 2020).

The MISIP is intended solely for use at the onset of acute crises and is supposed to facilitate a transition to more comprehensive SRH services. The Inter-Agency Standing Committee (IASC) Health Cluster tools and guidance set out the necessary role played by the Health Cluster in ensuring the roll-out of the MISIP (Roxo et al., 2019). The MISIP has been incorporated in the Sphere Humanitarian Charter and Minimum Standards in Disaster Response, as well as the first edition of the IASC 'Gender handbook for humanitarian action', setting the minimum standard of care in humanitarian response (IASC, 2006; Beek et al., 2021).

The MISIP has been criticised as 'too comprehensive to deliver at the start of a crisis' (Jennings et al., 2019: 11). Such perceptions are highly contestable, but they have nonetheless likely contributed to the lack of systematic implementation of the MISIP and the neglect of core SRHR services such as abortion, contraception and care for adolescents.

GBV is often cited as 'one of the most prevalent human rights violations in the world' (UNFPA, n.d.b) and, as a result, has received significant attention in the humanitarian sector and beyond. In 2006 the GBV Area of Responsibility (AOR) was established under the Global Protection Cluster (GPC), part of the humanitarian cluster system, giving the issue a prominent place in the international humanitarian system. The GBV AOR works to 'improve the effectiveness and accountability of humanitarian response for the prevention, risk mitigation and response to all forms of gender-based violence' (GBV AOR, n.d). The inclusion of GBV in the cluster system has arguably contributed to the recognition of GBV, including sexual violence, as a humanitarian concern. In addition, a range of policy documents has been developed to integrate and standardise GBV programming in emergency settings. For example, the IASC 'Guidelines on integrating gender-based violence interventions in humanitarian action' (updated in 2015) and the 'Inter-agency minimum standards for gender-based violence in emergency programming' aim to mainstream GBV prevention and mitigation activities across humanitarian response.

Responding to GBV is an indispensable core component of a humanitarian SRHR agenda as well as a protection concern (see Box 4). However, other SRHR components are deemed to have more medical or health-related connotations and as such tend to be categorised as development interventions (Countdown to 2030, 2020).

### **Box 4 GBV programming**

The International Rescue Committee (IRC) has developed a programme model and resource package entitled ‘Girl Shine’ that seeks to ‘support, protect, and empower adolescent girls in humanitarian settings’ (IRC, 2018: 18). It is primarily focused on providing young girls with the skills and knowledge to recognise types of GBV and equips them with the ability to seek support services if they are affected. The curriculum covers six main topic areas offering a more rounded education on emotional needs, SRH and social skills.

UNFPA Lebanon has piloted an innovative and sustainable GBV and SRH response model with its GBV-specialised partners in South Lebanon (UNFPA, 2020a). Through the Danish Refugee Council and its partner Al Moasat, a local SRHR service provider, GBV prevention and response services have been integrated into pre-existing sexual and reproductive health services at the same site. This has created a safe space for service users and two-way referrals between co-existing service providers and joint community-based interventions. To ensure sustainability of the project, the Danish Refugee Council will phase its exit from the joint venture.

Maternal and newborn health, too, attracts specific attention in humanitarian settings, possibly due to the documented scale of the issue (see Box 5). The World Health Organization (WHO) reports that ‘approximately 50% of maternal, new-born and U5 [under-5] mortality presently occur in humanitarian settings’ (WHO, n.d.b). Following critiques of newborn healthcare offered under the MISP (see Casey, 2015) and an increasing evidence base on newborn care interventions, the ‘Newborn health in humanitarian settings field guide’ was developed (UNICEF and Save the Children, 2018; McBride and Morgan, 2022).

### **Box 5 Maternal and newborn health programming**

Increased training for (community) healthcare workers is the most common strategy to increase the usage and quality of newborn care in humanitarian settings (Rodo et al., 2022). For example, the ‘Helping Babies Survive’ training programme has been rolled out in several humanitarian settings, including Somalia, Chad, Cameroon and Niger (Amsalu et al., 2020). It involves three key components: ‘Helping babies breathe’, ‘Essential care for every baby’ and ‘Essential care for small babies’. In Somalia, Save the Children in coordination with the Puntland Ministry of Health offered an eight-day training for service providers. It was supplemented with additional modules in response to reported gaps amongst providers, including maternal health, intrapartum care, supportive supervision and health information systems. An evaluation of the programme found the training in the city of Bosaso to be effective, and it was replicated in other cities across the region.

Beyond these two central thematic areas, programmes also exist to cover access to contraception, promotion of sexual health including menstrual health and hygiene and management of RTIs and STIs (Box 6).

### **Box 6 Innovations in SRHR programming**

Recent research conducted by Elrha (Poppo et al., 2021) aimed to highlight innovative interventions or practices in SRHR that are trying to address the increasingly complex challenges in the sector. It mapped innovations globally in different humanitarian crises, the populations they were trying to reach and the component of SRH the programme was trying to address.

In Sri Lanka, for example, prior to the October 2018 floods, a transgender activist raised the need for dignity kits for the transgender community in her area (Poppo et al., 2021). IPPF members Family Planning Association of Sri Lanka and the National Transgender Network of Sri Lanka used funding from a UNFPA Emergency Fund grant to collaboratively develop dignity kits tailored to the needs of transgendered persons. This included the provision of razors for transgender women and sanitary products for transgender men, supplies that are rarely offered to them in ‘standard’ dignity kits. Poppo et al. (2021: 51) describe this intervention as innovative as it represents ‘one of the first cases of dignity kits being adapted to fit the needs of the transgender community across the humanitarian sector’.

In response to a deterioration in adolescent sexual health indicators in Colombia, namely teenage pregnancy rates, Profamilia Educa developed an online CSE tool for adolescents in public schools (Chong et al., 2013). The course included five modules covering the topics of sexual rights, pregnancy and the use of contraceptives, STIs/HIV and the use of condoms, objectives in life and the role of sexuality, and the prevention of sexual violence. Web-based methods were chosen to maximise restricted budgets in public schools, and circumnavigated social stigma and an unwillingness by teachers to provide CSE. Profamilia reported a 50% increase in the redemption of vouchers for condoms, suggesting that the programme changed the behaviour of students.

Self-care interventions have also emerged as a potential for SRH innovation in the humanitarian sector, especially for expanding contraception access (Pople et al., 2021). Whilst the product itself is not new, the self-injectable contraceptive Sayana Press has been used in the Democratic Republic of Congo (DRC) for at least the last 20 years, and UNFPA has recently funded PATH to expand access in two refugee-hosting districts. The project utilised human-centred design principles to engage potential users and other stakeholders in the design and implementation of the project and ensure PATH Self-Injection Best Practices. Other organisations are implementing similar programmes with self-injectable contraceptives in other locations, including Marie Stopes International (Nigeria), Pathfinder (DRC), Jhpiego (Mali) and Médecins Sans Frontières (MSF) (ibid.). Innovation such as this represents significant potential for change, especially in ‘marginalised populations or in contexts of limited access to healthcare, such as conflicts or pandemics’ (ibid.: 59). Similar services can be offered to women seeking abortion, especially in places where it is not readily available:

in MSF pilot projects in the Middle East, women self-manage most of the process at home, taking the misoprostol [medication], undergoing the bleeding and cramping and managing side effects, while knowing when to seek emergency care if needed (ibid.: 60).

## 2.2 Subordinating rights to needs-based approaches

Whilst the humanitarian sector has increasingly acknowledged the importance of SRHR services for people in crisis, immense gaps remain in understanding needs and barriers, service provision and service utilisation. Most notably, rights have been subsumed under the banner of needs-based approaches, with many studies, policies and commitments going so far as to drop the second ‘R’ from SRHR.

As we will elaborate below, SRHR is not just a question of health, but of bodily autonomy, sexual rights and reproductive justice. However, few studies on crisis settings or humanitarian response reference or use language related to these elements (Tirado et al., 2020). To meaningfully address what SRHR means to crisis-affected people, a reproductive justice lens is needed to set SRHR against a wider backdrop

of human rights, structural factors and wider notions of wellbeing. This missing ‘R’, rhetorically and practically, then feeds into the other gaps, challenges and tensions in the framing and provision of SRHR services in crisis settings that we describe here.

The debate around whether humanitarian response should adopt needs-based or rights-based approaches was prevalent amongst mainstream humanitarians in the early 2000s, with exchanges between Fiona Fox and Hugo Slim the pivotal interventions (Borgrevink and Sandvik, 2022: 287). Proponents of needs-based approaches argue that humanitarian response should act on the basis of immediate needs – however these are determined – and should comprise approaches that are outcome-focused, purportedly apolitical and aimed at saving lives and alleviating suffering (Fox, 2001; Darcy and Hofmann, 2003). Conversely, those in favour of rights-based approaches envision humanitarianism that is both outcome- and process-focused, based not on philanthropy or altruism but on the rights to which crisis-affected people are entitled under international humanitarian law (IHL), international human rights law (IHRL) and other instruments like the Core Humanitarian Standard (Slim, 2002; Borgrevink and Sandvik, 2022: 287). The rise of rights-based approaches, to which many international humanitarian organisations now explicitly subscribe, is due largely to the institutionalisation of human rights throughout the 1990s, especially at the UN Security Council and in its peacekeeping missions (Barnett and Weiss, 2008: 26).

That said, the salience of rights and rights-based approaches in humanitarian response is still not commonly accepted, and commitment to them may have even waned slightly since the War on Terror and the rise of agendas around aid efficiency, effectiveness and value for money amidst resource strain. A move towards ‘back to basics’ approaches for humanitarian action, in the context of ever-widening gaps between humanitarian need and available resourcing, has ensured that needs-based approaches remain a strong current in the sector, especially in health. In practice, many humanitarian actors shy away from the right-based discourse, sometimes for practical reasons such as to avoid being ejected from the country where they are operating, even as they provide services to support people to claim their rights.

When it comes to SRHR, the focus has indeed been dominated by critical needs, particularly mortality and morbidity rates for pregnant people and infants. In a similar vein, in 2004, MSF took the important step of adopting a policy of supporting safe abortion care – a decision that was reflective of the organisation’s assessment that abortion is a critical need (Schulte-Hillen et al., 2016). Given that safe abortion care is arguably the most controversial area of SRHR, framing it as a ‘need’ can be a powerful and strategic choice; indeed, MSF’s stance and its reference to needs help depoliticise addressing an urgent and critical need for medical care. Or, put differently:

The need for abortion as defined by affected populations is reflected in their recourse to [it] regardless of legal, social, and economic barriers. Studies have routinely found that criminalization and other restrictions on abortion do not decrease the total number of abortion[s] (Radhakrishnan and Hites, 2022: 6).

Similar arguments have been used to facilitate access to contraception, HIV-related treatment and other critical SRHR concerns, particularly in the face of opposition from more conservative factions. This, however, does not negate the fact that SRHR provision is also fundamentally a rights-based question with basis in the rights to health, life, information, privacy, freedom from discrimination, and freedom from inhuman or degrading treatment. The delineation of needs is itself a question of rights, agency and bodily autonomy, particularly with an eye to not reproducing paternalism, colonialism or the kind of programming that presupposes, prescribes or denies the very intimate and personal choices of people living in crisis.

Beyond the humanitarian sector, putting ‘basic needs’ into opposition with human rights is a tactic also seen in wider debates on access to comprehensive SRHR, including during Covid-19 containment and mitigation measures, where certain services were deemed ‘non-essential’ or not meeting ‘real’ needs (Tanyag, 2021; Samuels and Daigle, 2021). This logic can be tempting amidst scarce resources, as it ‘mobilises the language of rational prioritisation’ (Tanyag, 2021), but ultimately it denies the interconnectedness of SRHR with other areas of human wellbeing and recovery from crisis:<sup>4</sup>

What this dichotomy ignores is that rights are merely the codification of needs, reformulated as ethical and legal norms and thus implying a duty on the part of those in power to provide all the means necessary to make sure those needs are met (Petchesky, 2000: 21).

Thus, putting rights and needs in opposition necessarily subordinates some needs to others – and this tends to apply most frequently to the needs (such as SRHR) of women, girls and gender-diverse people.

Importantly, the Global Justice Center has recently argued that rights-based and needs-based models are not opposing but rather mutually constitutive: ‘rights [...] protect access to needs. Conversely, needs inform the practical application of rights’ (Radhakrishnan and Hites, 2022: 1). Thus, SRHR must be understood from a perspective that melds the two approaches, wherein rights provide the force of duty and entitlement while needs imbue SRHR with a sense of urgency and apolitical moral imperative. This is important not only for making the most persuasive arguments possible for SRHR but also, potentially, as a case study for uniting rights-based and needs-based approaches in the context of wider humanitarian response.

### 2.3 Resulting gaps and challenges in needs-based approaches to SRHR

There is thus both a needs-based and a rights-based argument for providing comprehensive, inclusive and accessible SRHR as a key component of humanitarian response, whether through provision of services

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4 Since the start of the Covid-19 pandemic in 2020, alongside the restriction of SRHR services (see Samuels and Daigle, 2021), there has been a troubling misappropriation of the logic of bodily autonomy and slogans such as ‘my body, my rights’ by anti-vaccination factions as well as those who oppose other containment measures like the wearing of masks.

or pathways to existing providers. But it is also clear that neither rights nor needs are being appropriately addressed. More importantly, SRHR demonstrates that the distinction between rights and needs is meaningless in practice, given that needs are effectively a normative reflection of rights.

Humanitarian SRHR lacks a lens that centres crisis-affected people as rights-holders and the circumstances – that is, the structural elements, material constraints and intersectional oppressions – that condition their ability to access those rights. This elision of rights under the banner of needs is problematic per se, but it also produces a number of challenges that make the humanitarian SRHR services and pathways that exist less accessible, inclusive and effective, particularly for groups of crisis-affected people who are confronting multiple and overlapping marginalisations.

### 2.3.1 Binary gender and disaggregation

SRHR interventions tend to have what might be described as a natural focus on women and girls, but there is little disaggregation of this monolithic category to highlight intersectional vulnerabilities. There is some focus on adolescents or very young adolescents, but much more limited reference to older people, sexual violence survivors, people with disabilities, marginalised ethnic groups or those with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC). While some of this gap can be attributed to difficulties in accessing these population groups due to safety and protection concerns for participants, especially in contexts with restrictive legal environments, some of these groups are simply not widely understood as having SRHR needs, or as having particular needs that require a tailored response. It is particularly striking, for example, that people with diverse SOGIESC feature in such a limited way in SRHR literature, given that they face ‘disproportionately high risk of HIV and STIs due to stigma, legal context, financial vulnerability, poor mental health and [a] lack of services’ (Tirado et al., 2020: 19).<sup>5</sup>

Further overlooked and little understood groups include people with disabilities. They have historically been denied bodily autonomy with regards to SRHR, in part due to ignorance to their needs that has in some cases led to forced sterilisation, abortion or marriage due to stigmatisation (Tanabe et al., 2015). This is demonstrated by only recent reference to people with disabilities in the standard guidance for SRHR in emergencies (ibid.): the 2018 update of the ‘Inter-agency field manual on reproductive health in humanitarian settings’ is the first to include people with disabilities in its sections on ‘special considerations for specific populations’ (IAWG, 2018b: 35; see also Tanabe et al., 2015).

Lastly in terms of population characteristics, there is some reference to the importance of including men and young boys in SRHR programming, but there is a lack of literature on programmes focused on this group and their own SRHR needs (primarily in reference to access to contraception and CSE).

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<sup>5</sup> The work of Edge Effect has been particularly important in highlighting the particular needs and experiences of people with diverse SOGIESC in crises, including in SRHR (see George et al., 2021; Samuels et al., 2021).

In addition, existing research recognises a distinct challenge for displaced populations in accessing SRHR information and services (Tirado et al., 2020; Rivallas-García et al., 2021; George et al., 2021). Recent research has shown that 61% of women and girls who die from childbirth and pregnancy-related complications are from displaced communities (Ivanova et al., 2019, in Popple et al., 2021: 8). Displaced people are likely to face increased risks of sexual violence, HIV and other STIs, unintended pregnancies, unsafe abortions, and preventable maternal deaths (Tirado et al., 2020). This should be of particular concern to humanitarians, given that existing vulnerabilities tend to be exacerbated by humanitarian crises. But tailoring responses to confront specific risks facing particular groups of affected people – including the SRHR needs of women, girls and gender-diverse people – remains controversial in some circles (see, for example, Barbelet et al., 2021; Holloway et al., 2022; Daigle, 2022). Erin Baines argues that:

too often gender advocates for refugee women are simply concerned with ‘adding’ women to existing policies, laws and organizations dealing with refugees, without examining the nature of, limitations within, or constraints upon, the refugee regime itself (2004: 4).

### 2.3.2 A narrow and problem-centric approach

Current practice on SRHR in emergencies places an emphasis on ‘reproductive problems’, and especially on excess fertility as a problem to be solved and managed through intervention, with little focus on wider sexual health or CSE (Jennings et al., 2019; Chalmiers, 2021). Broadly, the literature highlights a focus on a single domain, such as maternal health and pregnancy or GBV, ‘which hinders a general understanding of the status of SRH services and outcomes in humanitarian settings as a whole’ (Broaddus-Shea et al., 2019: 23).

This approach may be attributable in part to the fact that humanitarians function on an impetus to act quickly and respond efficiently, which tends to leave little room for interrogating the ‘why’ around particular needs and behaviours or their root causes – something humanitarians have proven reluctant to do, especially in relation to fertility or sexuality (Inhorn, 1996: 230). The result can be that perceived high fertility rates become ‘an object of concern and investigation’ (Chalmiers, 2021: 50).

Especially in displacement and refugee settings, humanitarian responders, host governments and even donors have been known to approach fertility as a problem, or even as a Malthusian threat, to be managed via ‘family planning’ interventions with the explicit aim of reducing population growth at a macro level – and reflecting racist prejudices and assumptions about the habits of affected people.<sup>6</sup> This can lead to a tendency amongst service providers to recommend long-acting contraception and even termination of pregnancies, based not on the choices of people themselves but due to underlying assumptions that crisis-affected people should not, or could not possibly want, to have (more) children (Chalmiers, 2021; Holloway et al., 2022).

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<sup>6</sup> See, for example, recent concerns expressed by the Bangladeshi government about perceived high rates of fertility amongst Rohingya refugees in Cox’s Bazar (Rahman, 2022).

As Morgen Chalmiers writes, humanitarian responders and medical professionals interpreted

Syrian women's high fertility as a problem that stems from lack: a lack of healthcare access, a lack of agency within the marital relationship and a lack of education or knowledge about contraceptive methods (2021: 50).

Research shows, however, that people make choices about sex and reproduction against a much more complex backdrop of factors than humanitarian and development actors anticipate, and that the decision to pursue pregnancies and bear children is multifaceted and not always truncated by crisis or displacement (Johnson-Hanks, 2005; Maternowska, 2006; Greil and McQuillan, 2010; Fordyce, 2012; Singer, 2018; Sieverding et al., 2019, all quoted in Chalmiers, 2021).

Beyond the question of childbearing, there is also a lack of holistic understanding around pleasure, healthy relationships, and the cultural and personal significance of sex, family and relationships for people and their communities. Maria Tanyag notes that:

when positive experiences of sex in everyday life and during times of crisis are obscured, then a narrow picture of human sexuality is portrayed (2018: 662–663).

While humanitarians may hesitate to engage with something that seems superfluous or even unimportant in the context of responding to immediate needs, sex is always present – indeed, in crisis settings, sex can help individuals and couples to cope with stressors and seek escapism, but this too gives rise to needs around contraception and CSE. Amy Lind (2009) argues that development and humanitarian actors need to better understand not just reproductive but also sexual rights as central to human dignity, but that this is often obscured by the humanitarian imperative to protect women from sexual violence – a position that can converge with ultimately troublingly conservative concerns for women's chastity. Along similar lines, fairly normal adolescent sexualities risk becoming pathologised when routine behaviours are flagged as troubling under the banner of preventing 'early marriage'.

### 2.3.3 Beyond GBV, beyond 'bad sex'

The flipside of this silence around pleasure and healthy relationships is an overwhelming focus on GBV among humanitarian actors, sometimes to the neglect of other SRHR concerns or even other gendered harms experienced by crisis-affected communities (Turner, 2019: 50). GBV is known to increase in scale and complexity in settings affected by conflict, natural hazards or displacement, and responding to it effectively and sensitively – including responses to SRHR-specific needs that arise from GBV – is critically important, although still drastically underfunded (IRC and Voice, 2019). GBV is an inarguably critical concern in crisis response, and one of a number of major risks to life in the SRHR field, as noted above.

That said, when it comes to SRHR needs and services in crisis settings, this near-exclusive focus on GBV can mean that sexuality in general is perceived through 'narratives of violence and victimisation' (Tanyag, 2018: 671). The effect is that humanitarian SRHR is simplified, limited to mitigating the effects

of GBV rather than advocating for services and protections that support bodily autonomy or healthy sexualities and relationships, or integrating humanitarian approaches with other actors working in areas like legal reform related to abortion, contraception, same-sex relations and diverse gender expressions; ensuring access to CSE; and developing and providing health services. All of these need to be in place for crisis-affected people to be safe and exercise bodily autonomy (see Countdown 2030, 2020). In settings where GBV – and especially sexual violence – are prevalent, sensitive and comprehensive SRHR is even more important given that survivors tend to find that sex, pregnancy, parenthood or even accessing unrelated SRHR care is challenging, intrusive and re-traumatising (Noack-Lundberg, 2019). As Sangeeta Budhiraja, Susana T. Fried and Alexandra Teixeira write, aid actors' focus has remained on 'encouraging people to say no to risky sex, rather than empowering them to say yes to, or ask for, safer and more satisfying sex' (2010: 133).

This is emphatically not an argument to reduce priority or funding for GBV response – on the contrary, effective and comprehensive responses to GBV and SRHR should operate hand-in-hand. Rather, it is an argument to resist the reduction of humanitarian SRHR to GBV as the sole issue of relevance to humanitarian response – an oversimplification that suits humanitarian actors much more than it does affected populations.

### 2.3.4 Under-utilisation of existing services

Significant challenges also remain in the utilisation of SRHR services in crisis – a fact that suggests the presence of additional economic, social, cultural or political barriers to access that are understudied or poorly addressed. A recent systematic review reported progress on the availability of SRHR services in humanitarian crises, through an increase in funding and shifting perceptions of it being 'too difficult' or not an 'immediate priority', but that barriers remain to the full utilisation of those gains (Singh et al., 2018b).

There is some understanding of the role that peer pressure, stigma and familial norms or cultural beliefs, as well as the attitudes of service providers or fears of judgemental and undignified treatment, can play as obstacles for potential users. This is particularly the case for those experiencing intersecting oppressions, such as people with diverse SOGIESC and/or disabilities. Tanabe et al. quote refugees with a range of physical and sensory impairments and those who care for them in Somalia, Uganda and Kenya:

In hospitals, we face a lot of pressure. They [health providers] belittle us because we have disabled patients. [...] Health workers think persons with disabilities do not have a right to sex [...] [Persons with disabilities] are overlooked and neglected by doctors and nurses [...] [Health providers] don't consider them like normal human beings (2015: 418–419).

Ultimately, better understanding these barriers and how to work around them is pivotal to increasing service utilisation and better meeting the SRHR needs of affected populations. The directive is clear:

Humanitarian practitioners, academics and donors need to find ways of identifying policy and legal barriers that undermine the sexual and reproductive rights of populations and collectively strive to remove obstacles blocking the realisation of these fundamental human rights (Onyango and Heidari, 2017: 5).

### 2.3.5 Stalled funding and political will

In keeping with the contentious global politics that surrounds SRHR, and which was discussed at the outset of this paper, humanitarian SRHR is dependent on political will, commitment and prioritisation, as well as appropriate funding to match. Here, both may be conditioned by the perception – which we encountered in consultations and scoping for this research, carried out with advocacy actors, donor governments and other key figures – that there is no unmet need for SRHR services, that feasibility is low, or that attitudes of healthcare providers (or humanitarians themselves) pose barriers in particular settings.<sup>7</sup>

Political will can be particularly difficult to mobilise in settings that are, or are perceived by international actors to be, religiously or culturally conservative or legally restrictive. Around the world, abortion is mostly governed by criminal law, even in relatively permissive settings. Contraception, especially prior to or outside of marriage, as well as same-sex relationships, non-normative gender presentation, and even CSE are also restricted in some settings, including many settings that are widely recognised as facing acute or protracted humanitarian crises, such as Iraq, Lebanon and Uganda. In such settings, humanitarians and SRHR providers alike may share those views, or equally may have concerns about being perceived as activists or politicised in a way that threatens their access to communities in need. Tanyag notes that:

Sexual experiences in crisis settings that are neither entirely nor necessarily violent in nature are even more neglected when emergency and crisis assistance stems from conservative religious beliefs (2018: 662–663).

Regardless of the reasoning, the perception that SRHR – or, equally, particular needs or services that fall under the umbrella of SRHR – is politically too hot to touch can entrench a reluctance or even resistance amongst humanitarians themselves to tackle themes that they consider to be sensitive, or even potentially so. This is a version of what the Humanitarian Advisory Group and VPride (2018) have called – with regard to the intersecting exclusion of sexual and gender minorities from humanitarian response – consignment to the ‘too-hard basket’: neglect of an issue perceived as sensitive or political due to inability or unwillingness to engage with the related needs, risks and experiences.

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7 Starrs et al. (2018) and McGinn and Casey (2016) also note these misconceptions held by donors and decision-makers, as well as the impact of restrictive donor policies.

Previous research in Colombia and Uganda has also highlighted that humanitarian principles may also be interpreted as limiting factors on the ability to address SRHR needs within the remit of a neutral and impartial response (Holloway et al., 2022; Daigle, 2022). The result is a tendency within humanitarian response towards re-establishing the status quo ante in terms of political order, rather than establishing the kind of accessible and supportive SRHR services that affected communities are identifying as needs. Importantly, this – as we will elaborate further below – is just one way of reading humanitarian principles, which are themselves open to interpretation and whose applicability may vary for a diversity of place-based and international humanitarian actors.

This problem of political will and prioritisation is reflected in funding: SRHR services have been found to make up 2.4% of official development assistance (ODA) funding allocated to conflict-affected countries, and even that small amount tends to be largely targeted towards narrowly defined service provision rather than a more holistic or comprehensive notion of sexual health or care (see Patel et al., 2016). Conflict-affected settings tend to receive 57% less funding for reproductive health care than countries that are not affected by violent conflict (IPAS and Action Canada for Sexual Health and Rights, 2018). Perhaps unsurprisingly, safe abortion care has been almost non-existent in humanitarian settings, despite unsafe abortion causing an estimated 25–50% of maternal deaths in refugee settings (Heidari et al., 2019).

It is important to note here, as we will discuss further below, that navigating politically sensitive and legally restrictive environments is not uncharted territory in the field of humanitarian SRHR and need not become an insurmountable obstacle to inclusive, accessible or even principled responses. At the international level, organisations like the Center for Reproductive Rights, IPAS, MSF and the Global Justice Center have all grappled with these questions – all reaching similar conclusions that IHL and IHRL provide ample justification for providing comprehensive SRHR, including safe abortion care, to crisis-affected groups (Schulte-Hillen et al., 2016; IPAS and CRR, 2021; Radhakrishnan and Hites, 2022).<sup>8</sup> Furthermore, in each crisis setting, grassroots and place-based women’s organisations and feminist movements; lesbian, gay, bisexual, trans, queer/questioning and asexual (LGBTQIA+) groups; and organisations for people with disabilities are well-versed in emerging needs, stated priorities of affected people and the particular legal setting in which they are operating.

It is also worth noting that the question of whether to prioritise SRHR has clear gendered dimensions. Much like unpaid care work, which fills the gaps left by service cuts when governments pursue

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<sup>8</sup> Radhakrishnan and Hites (2022) enumerate the various entitlements of crisis-affected people under IHL and IHRL to comprehensive SRHR, including safe abortion care, that are based on the stated rights of pregnant people to receive the care they require, principles of non-discrimination and non-adverse distinctions, and guarantees of humane treatment, amongst others. IPAS and CRR (2021: 2) note that UN human rights treaty bodies have recognised that ‘refugees, stateless persons, asylum seekers and undocumented migrants are in a situation of vulnerability due to their legal status, which requires the State to take additional steps to ensure their access to affordable and quality sexual and reproductive information, goods, and healthcare’.

economic austerity policies, SRHR is seen largely as the purview of women and girls – and this shapes decision-makers’ willingness to see it as an added extra, a nice-to-have, or a luxury rather than an indispensable health service. Tanyag (2018: 657) draws out these connections:

Gaps in crisis responses and interventions, particularly when they neglect SRHR, suggest that survival and recovery are contingent on women’s willingness to make the necessary sacrifices – subordinating their personal needs to that of the family, community, and the state. Without replenishing or sustaining the bodily autonomy of women and girls, then lasting postcrisis recovery of households and communities are undermined too. The very bodies that meet intensified care demands end up depleted.

Given the ongoing and unnecessary impasse between rights- and needs-based approaches, and the challenges to inclusiveness and effectiveness that these tensions engender, better humanitarian SRHR necessitates a new way of understanding what is at stake and how it can be achieved. At issue here is not merely a notion of individual rights but rather an understanding of the environment in which rights and choice become possible. Therefore, moving forward means adopting an approach that can see and account for that environment, including structural and institutional barriers, a more holistic vision of healthy sexualities, and an intersectional power analysis. A framework rooted in **reproductive justice**, which we explain in the coming chapter, offers the potential for just this kind of approach to humanitarian SRHR.

## 3 The reproductive justice framework

**Reproductive justice** is a conceptual framework that seeks to embed SRHR within wider notions of social, cultural, political and economic justice – and to move beyond the narrow focus on personal choice and the experiences of relatively privileged white, cisgender, heterosexual and middle-class women that had dominated mainstream reproductive rights debates. The framework was developed by a collective of 12 US-based Black feminists in the 1990s, with the aim of transforming reproductive politics and centring bodily autonomy, but it is nonetheless still novel to the humanitarian space.<sup>9</sup>

Reproductive justice comprises three simple but fundamental core tenets (see Ross and Solinger, 2017: 9):

1. the right not to have a child
2. the right to have a child
3. the right to parent children in safe and healthy environments.

As the framework evolved, the LGBTQI+ movement advocated for an added emphasis on sexual rights, gender freedom and the importance of pleasure for healthy, consensual and non-coercive sexual relationships.

Thus, reproductive justice builds on existing SRHR activism and advocacy by seeking to show how SRHR depends on economic justice and stability, unpaid care work and childcare, shelter and housing, political voice and participation, education, food and nutrition, amongst other areas, as well as how success for those agendas also depends on comprehensive SRHR. With its focus on bodily autonomy, reproductive justice also confronts the early and problematic focus on population control and fertility management in SRHR, as well as its history of instrumentalisation against marginalised groups including Black and Indigenous people and those with disabilities (see Box 7).

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9 See in particular the work of Loretta Ross (Ross, 2017; Ross and Solinger, 2017).

### **Box 7 Moving from coercion towards justice**

The original formulators of the reproductive justice framework, as US-based Black feminists, were especially alert to long-standing reproductive coercion of Black, Indigenous and poor women and those with disabilities, with roots that can be traced to the institution of chattel slavery and Indigenous dispossession. This encompasses forced, coerced and involuntary sterilisation, including in US prisons, that has continued well into the 21st century (see Stern, 2005; Davis, 2019). Early advocates of contraception and other SRHR concerns, including Planned Parenthood founder Margaret Sanger, explicitly approved of these eugenicist and neo-Malthusian practices (Carey, 2012).

Of course, these harms were not limited to the US alone and can be found affecting racialised and colonised peoples around the world, as well as people with diverse SOGIESC and/or disabilities and other persecuted minority groups. Humanitarians should be especially aware of where such dynamics intersect with crisis – for example, forced sterilisation, abortion and contraception in Colombia’s civil war (CRR, 2020) – as well as any potential to enact coercion or pressure themselves, even under the guise of ‘meaning well’ or achieving health outcomes, in designing and delivering SRHR services.

Realising SRHR through a lens of reproductive justice means redressing unequal power relations and restoring the dignity of diverse groups of people, a mission that is aligned with core humanitarian commitments to inclusion, rights-based approaches, locally led responses and gender-responsiveness. Here, we set out what is new and important about the reproductive justice framework for humanitarian SRHR in terms of its structural analysis and its intersectional and decolonial potential, and the ways it has already been put to work.

### **3.1 Structural analysis beyond pro-choice and pro-life**

Reproductive justice seeks to go beyond the conventional rubric of ‘pro-choice’ and ‘pro-life’ (or anti-choice) that has overwhelmingly shaped debates about access to and choice in SRHR in recent decades, particularly relating to contraception, antenatal and obstetric care, and safe abortion care. It does this by recognising that ‘choice’ does not exist in a vacuum but rather depends on social and structural conditions that alternately support or obstruct the ability of diverse people to exercise it. Individual choice is unavoidably shaped by a range of social, political, economic, cultural, religious and institutional factors including economic justice and stability, unpaid care work and childcare, shelter and housing, political voice and participation, education, food and nutrition. An approach centred on choice alone therefore fails to see and analyse, for example, how some women might ‘choose’ to avoid pregnancy

through long-acting contraception, or even to terminate an existing and otherwise wanted pregnancy, not due to personal choice but rather concerns about sufficient income, affordable housing or access to childcare.<sup>10</sup>

True choice, then, is limited to those with sufficient resources to exercise it and ultimately commoditises SRHR service provision. As Tanya Saroj Bakhru writes:

When reproductive rights are embedded in notions of ‘free’ choice, all the social, political, and economic factors that surround how choices are made become hidden (2019: 7).

Those barriers can include the criminalisation of core elements of SRHR like abortion and contraception; coerced contraception, sterilisation and abortion; and stigmatisation of various kinds, all of which have a greater impact on those already marginalised for their racialisation and ethnic identity, disability, socioeconomic class, caste, citizenship or immigration status, religion, sexuality or gender identity. A structural analysis of these overlapping factors must therefore be foundational to understanding the barriers faced by marginalised women, girls and gender-nonconforming people in exercising their own reproductive rights and bodily autonomy.

By moving away from a narrow logic of individual choice and towards a structural analysis based in human rights and social, economic, political and cultural context, reproductive justice helps policy-makers and practitioners see how bodily autonomy differs widely across diverse, intersectional systems of oppressions and positions within those structures. It also adds nuance to humanitarians’ own analyses of how availability, accessibility, acceptability and quality of services translate into uptake and access for people in need.

### 3.2 Intersectional and decolonial potential

An important corollary of this focus on structures and context is the strong potential of reproductive justice as a framework to lay bare and confront intersecting oppressions in the field of SRHR. As Angela Davis (2019) has argued, the early birth control movement was shaped by neo-Malthusian ideas about population control, especially relating to impoverished, Indigenous and racialised communities. As a result, women and girls from these groups have suffered disproportionately from barriers to services and, conversely, coercion where services do exist. This is equally relevant for people with disabilities,

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<sup>10</sup> In the US, Davis points to how the lack of access to affordable contraception and safe abortion care is itself a coercive push factor towards permanent sterilisation, particularly in settings where that service is made available for free and encouraged for or even pushed on Black, Indigenous and low-income women (Davis, 2019).

especially women and girls, who have regularly experienced the curtailment of their choices and violations of their bodily autonomy around the world, and especially in humanitarian settings (HRW, 2010; Peta et al., 2015; Tanabe et al., 2015)."<sup>11</sup>

By ignoring these troubling dynamics and focusing on the needs of white, cisgender, heterosexual and middle-class women, SRHR movements have often elided the harms experienced by diverse and marginalised people in the SRHR space (Morison and Mavuso, 2022). Ross and Solinger write that, as a result, reproductive justice aims to bring about ‘the application of the concept of intersectionality to reproductive politics in order to achieve human rights’ (2017: 79). They stress that the framework must not rest on any assumption that particular experiences of reproductive or sexual life are shared, nor on an analysis of the validity of any one experience.

For the humanitarian sector, it is also critical to note that these power dynamics map onto ongoing colonial power relations between donors and decision-makers on the one hand, and the countries, cultures and communities where humanitarian responses unfold on the other. Every element of reproductive justice – the choice to have or not to have children, and the environment in which those children can be raised – is coloured by colonial systems of power. In purely practical terms, global inequalities and crises, including climate change-related hazards and armed conflict, tend to create supply chain problems, legal obstacles and disruption to services across the health sector – all profoundly shaped by colonialism and colonial relationships between the Global North and Global South.

Colonialism is also intrinsically bound up with the kind of eugenicist ideas that frame the fertility of refugees and other displaced populations as a Malthusian threat to host communities. Ample evidence exists of the use of population control measures and targeted promotion of sterilisations and abortions – for example, in South Africa against the Black population there (Kaufman, 2010) and in Canada and Peru against Indigenous women and girls (Rutherford, 2022) – from the colonial period to the present. Key technologies and advances in SRHR, from the invention of the speculum to oral contraceptives, have their roots in experimentation without consent on Black and Puerto Rican populations in the United States (Washington, 2008; Sowemimo, 2018).

This underpinning history, which continues in many ways today, has resulted in profound mistrust of the medical edifice amongst colonised and formerly enslaved peoples, especially relating to SRHR. Redressing these problems and supporting a more just SRHR approach therefore means a decolonial and anti-racist stance. ‘Against a global backdrop of legacies of colonialism, exploitation, and economic, social, and political disenfranchisement that carry on through generations,’ writes Bakhrū (2019: 7), ‘we need more than choices. We need justice.’

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<sup>11</sup> As Hawkey (2019) notes, sexual and reproductive rights are regulated to some degree in every country around the world. Particularly when it comes to the development and humanitarian sectors, then, it is important to avoid painting the West as a ‘utopia’ for bodily autonomy.

### 3.3 Applying reproductive justice around the world

The reproductive justice and bodily autonomy frameworks have yet to be taken onboard by humanitarian policy or practice, but they are increasingly being used by national and regional movements as well as in prominent international forums. At the Nairobi Summit in 2019, 12 commitments were agreed by governments and other actors, including a specific, non-negotiable commitment to ‘women’s and girls’ rights to healthcare, bodily autonomy and integrity’ (UNFPA, 2020: 18). In 2021, the W7 Summit<sup>12</sup> and the Generation Equality Forum<sup>13</sup> both called on governments to embed bodily autonomy into SRHR policy and programming. Shortly afterwards, the UNFPA-hosted High-Level Commission on the Nairobi Summit on ICPD25 Follow-up released its first annual report with a focus on rights; its second report, expected by the end of 2022, will adopt an explicit reproductive justice framework.

Reproductive justice has also propelled feminist movements in Latin America in recent years – in particular, in Argentina, Chile and Colombia – in ways considered to be impossible through a narrower focus on abortion alone. These movements connected

deadly and costly clandestine abortion [...] to domestic violence, sexual harassment and the gendered pay gap in the workplace, and to the murders of female environmental and Indigenous activists in rural areas (Gago, 2022).

Ultimately, this framing took the demand for abortion beyond the individual and their rights, and instead, recognised the interconnectedness of struggles; it ‘took on a collective and class dimension’ (ibid.). In Colombia, activists united under the banner *Causa Justa* (‘Just Cause’) in explicit reference to justice framings, drawing on frameworks of social justice and bodily autonomy (*Causa Justa*, n.d.).

Likewise, in South Korea, Joint Action for Reproductive Justice brought together a disability rights group, doctors’ organisations, feminist groups, youth activists and religious groups in 2017 to push for the decriminalisation of abortion. This stemmed from a recognition that

achieving abortion rights alone could not guarantee women’s reproductive rights in South Korea without first acknowledging and addressing the forced sterilisations and abortions experienced by women with disabilities (Kim et al., 2019: 100).

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12 The W7, a meeting of women’s rights organisations alongside the G7 process, called on G7 leaders to support the ‘strongest possible language’ on bodily autonomy, including explicit advocacy for safe abortion, emergency contraception, self-managed care and CSE (Women 7, 2022).

13 The Generation Equality Forum, a major global event marking the 25th anniversary of the Beijing Declaration and Platform for Action (see Figure 1), included bodily autonomy and SRHR amongst its six action coalitions (Generation Equality Forum, 2021).

Reproductive justice proved to be an effective way of convincing people that the abortion ban was not a simple matter of 'life versus choice' but instead a tool used by the government to regulate women's sexuality and behaviour, control reproductive rights and 'cherry-pick the lives it deemed most worthy' (ibid.: 105).

## 4 Linking reproductive justice to core humanitarian agendas

The critical needs of women and girls in SRHR are well established in terms of pregnancy and prenatal care, delivery and postpartum care, and access to contraceptive methods, amongst other areas. This very limited (or even absent) access to SRHR services creates severe risks to life and wellbeing with higher rates of morbidity and mortality, and is therefore of the ‘utmost importance in terms of service design, delivery and implementation’ (Ahmed et al., 2019: 2). While the needs of harder-to-reach populations – notably, people experiencing multiple marginalisations including impoverished women and girls; people with disabilities; those with diverse SOGIESC; and youth and older people – are less well evidenced, this is already indicative of the paltry capacity and resources dedicated to understanding and meeting these needs.

Amongst crisis-affected youth, unmet SRHR needs are ‘particularly dire’ (Desrosiers et al., 2020: 2; see also Singh et al., 2018a; 2018b). Crises of all kinds have proven to be ‘episodic disruptor[s] of human immunodeficiency virus (HIV) service delivery’, which tends to disproportionately affect youth and marginalised groups including people with diverse SOGIESC, people living with addiction and those involved in strategic sex<sup>14</sup> or sex work (Shiffman et al., 2018; Roxo et al., 2019: 1).<sup>15</sup> More than 1.6 million people living with HIV were affected by humanitarian emergencies as of 2013, but services remain all but non-existent, leaving those living with HIV doubly victimised by crisis and illness (MSF, 2014; UNAIDS/PCB, 2015).<sup>16</sup> In an era when humanitarians are committing to more participatory, inclusive and locally-led responses to crisis, this state of affairs speaks to a dearth of reproductive justice but also to major gulfs in achievement and understanding around such commitments.

The reproductive justice framework dovetails with but also expands understanding around many of the debates and agendas for change that have animated the humanitarian sector in recent years. That said, it is still not commonly applied in humanitarian settings, in large part due to perceived tensions

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14 Sexual interactions that can be described as ‘strategic’ (often referred to as transactional sex) exist on a spectrum from genuine to transactional, agentic to coercive, occasional to organised. They are shaped by gendered norms and power relations, and they have been shown to play a role in wellbeing in terms of meeting material needs, marriage and migration, escapism, romance and pleasure, even as they are also associated with stigmatisation and related harms (see Hoefinger, 2013; Daigle, 2015). While crisis settings see increases in strategic sex resulting from generalised increases in extreme poverty and food insecurity, changes in gendered labour conditions, and the presence of armed actors and/or peacekeeping forces, it is important to note that crisis is rarely the sole driver of this behaviour (Mwapu et al., 2016).

15 In 2015, research revealed that 20% of new HIV infections globally were among adolescent girls and 14% among adolescent boys due to ‘powerlessness, poverty and pressures – from partners, peers, families and communities’ (Shiffman et al., 2018: 1).

16 MSF (2014) writes that ‘the general perception is that HIV prevalence rates in unstable countries are low – but the reality is that pockets exist where HIV prevalence is as high as 10%’.

between such a framing and the structures, categories and practices of the international humanitarian system as it stands. Here, we engage with several of these agendas in turn to show how embedding a more expansive, justice- and rights-focused approach can support better outcomes in humanitarian SRHR and also serve to further these agendas, each of which aims to foment fairer, more effective, more inclusive, more accessible – better – humanitarian response.

### 4.1 Principled humanitarian response

The relationship between SRHR and core humanitarian principles<sup>17</sup> has not always been straightforward, especially with regard to the principles of neutrality and impartiality. To many humanitarians, providing comprehensive SRHR is simply not in keeping with their principled approach. In recent HPG research on gendered norms in displacement, and despite policy commitments to gender-responsive, rights-based and even feminist approaches, individual and especially field-based humanitarians

repeatedly cited humanitarian principles – namely, their commitment to remaining impartial and neutral – as inhibitors to engaging more meaningfully on gendered norms, roles and power relations. Impartiality was viewed as a reason to reject tailoring responses to the specific needs of women or gender-diverse people beyond protection concerns, whether in food distributions or other recognised immediate needs [while] participants pointed to their neutrality to explain shying away from topics perceived to be ‘sensitive’ (Daigle, 2022: 19; see also Holloway et al., 2022).

Depending on the setting, these purported sensitivities led humanitarians to avoid both safe abortion care and services aimed at people with diverse SOGIESC. This reading of the principles, however, is not a settled or merely technocratic question but rather one of interpretation.

With regard to impartiality, concern stems from the perception of differential treatment amongst affected populations, given that certain SRHR services may be more immediately relevant to some groups than others. For example, hormonal therapies and other services valued by trans women and trans men are not used by the wider population; similarly, cisgender men have less use for cervical screenings or mammograms. Humanitarian response, however, is about meeting the needs of a diverse population effectively. In recognition of the diversity and specificity of those needs, responses should be tailored appropriately to reach those with the most acute needs – many of whom will have specific and pressing SRHR needs, as well as facing especially severe consequences if those needs are not met – if humanitarians are to achieve inclusive and principled responses (Lough et al., 2022). Crucially, then, tailored responses do not equate to a failure of impartiality but rather a commitment to effective and appropriate responses to a diverse population with specific needs as part of a wider principled – and impartial – approach.

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17 The core humanitarian principles that are recognised by the mainstream international humanitarian sector as guiding their work – that is, the principles of humanity, impartiality, neutrality and independence – were first formalised in 1965 at 20th International Conference of the Red Cross in Vienna.

Neutrality, on the other hand, speaks to the need for humanitarian responses to eschew political stances, understood as a ‘moral pollutant’ (Barnett and Weiss, 2008: 4). Genuine neutrality may well be impossible, but conformity to a politically neutral position is nonetheless considered central to maintaining access to vulnerable populations.<sup>18</sup> Any risks of being perceived as activist or politicised is therefore a hard-hitting criticism for humanitarians, in light of the intense polarisation and politicisation of global SRHR politics. Neutrality, however, must not be allowed to stand in the way of responding to suffering without discrimination (O’Callaghan and Leach, 2013). And here, again, a reproductive justice framework proves useful to see how neutrality works against any questioning of the political status quo, which often drastically restricts bodily autonomy and choice.

Ultimately, the power and purported moral authority of humanitarian principles are eroded if those principles are deployed in ways that prop up the status quo amidst gendered harms and discrimination, amongst which the denial of timely and comprehensive SRHR is critical. By separating SRHR services from wider healthcare provision, or ruling on whether or not it counts as an ‘immediate’ need, humanitarians are in fact making a problematic and very political choice – and one that only solidifies the taboos around these rights in international instruments like the SDGs (Heidari, 2015: 2).

It also bears mentioning here that the principles have been largely formulated and espoused by Western and European humanitarian organisations, which also calls into question the legitimacy of using them in ways that restrict the bodily autonomy or choices of crisis-affected people, whatever those choices might be. Strengthening humanitarian SRHR, and ensuring it is comprehensive, accessible and inclusive, is therefore not about introducing a logic, a politics or an ethical stance – rather, it is about supporting people to make decisions about their own care and according to their own moral, ethical, cultural or political frameworks, in keeping with reproductive justice.

## 4.2 Gender-responsive humanitarian action

Gender, and subsequently the notion of gender-responsive and even gender-transformative humanitarian action, has become a watchword for humanitarian policy and practice over the last two decades. Gender-responsive humanitarian action (GRHA) encompasses any and all interventions that seek to be aware of and respond to gender dynamics in their design and delivery (Butt et al., 2019). It has been notably espoused in a range of humanitarian commitments, guidelines and agreements in recent years, although not always with specific

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<sup>18</sup> For more on the potential for neutrality in humanitarian response, see Redfield (2011) and Hammond (2015).

reference to SRHR as an issue area or reproductive justice as a guiding framework.<sup>19</sup> The IASC ‘Gender handbook for humanitarian action’, most recently updated in 2018, touches briefly on the importance of SRHR, positioning it as a key gender analysis question for humanitarian responses (2018: 238) and noting that SRHR and GBV programming are not interchangeable with gender programming (ibid.: 19). Similarly, the Women, Peace and Security (WPS) agenda acknowledges the importance of SRHR with UN Security Council Resolution 2106 (2013), and a significant proportion of WPS national action plans note the importance of both GRHA and SRHR, although – as noted above – a more recent resolution has seen references to SRHR removed (see Health in Humanitarian Crises Centre, 2019).

Nonetheless, despite these high-profile commitments,

gender responsiveness [...] in practice has remained patchy at best, even though it is known that displacement from home – and from stability and familiarity – tends to exaggerate gendered inequalities and can cause gender relations to shift rapidly (Daigle, 2022: 7).

Major actors and mechanisms like the Grand Bargain<sup>20</sup> remain gender-blind, while the many tools, guidelines and commitments that have proliferated tend to treat gender concerns as monolithic, such that gender experts find them less than helpful (Hart and Krueger, 2021: 2).

In many ways, the mainstream humanitarian system, as Baines (2004: 2) argues, is already ‘riddled’ with implicit power relations that it has proven loath to excavate. For GRHA to be meaningful, however, humanitarian decision-makers must be willing to engage deeply with the context-specific dynamics that precede and underpin any humanitarian emergency, on the understanding that gendered harms and social exclusion more broadly are shaped by pre-existing power relations and norms. The principles of reproductive justice are instructive here, as they point to the right structural conditions and the agency of affected people as critical for better humanitarian decision-making, prioritisation and programme design.

A key area where the GRHA agenda must unfold is SRHR, given that rights-based, comprehensive and inclusive SRHR – that is, SRHR that lives up to and is grounded in reproductive justice – has been shown to be a pre-requisite for gender transformation across the board. Approaching humanitarian SRHR with a commitment to reproductive justice means understanding that access to services exists in a mutually constitutive relationship with women, girls and gender-diverse people’s ability to exercise autonomy in all other areas of life, including livelihoods and economic justice; political participation, voice and agency;

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19 See, for example, the World Humanitarian Summit Core Commitments, IASC policy and accountability frameworks and the IASC Gender handbook, the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) Gender Equality Policy Marker, the G7’s Whistler Declaration on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action, and the Generation Equality Forum’s Women, Peace and Security–Humanitarian Action Compact.

20 The Grand Bargain was launched in 2016 at the World Humanitarian Summit as a five-year agenda to improve the efficiency and effectiveness of humanitarian aid. Gender was not included in the language, leaving gender advocates to attempt to use the Grand Bargain as a mechanism to propel other agreements on gender forward. The Grand Bargain 2.0 was agreed in 2021, but even this lacks a meaningful gender lens (ActionAid, 2021; Metcalfe-Hough et al., 2021).

shelter and housing; nutrition; and social cohesion – that is, progress in each of these areas facilitates bodily autonomy, and vice versa. Holistic SRHR services, including CSE and destigmatisation efforts, are also key for men, boys and gender-diverse people (Svanemyr et al., 2015; HIPs, 2017). One important way of doing this, as well as achieving wider GRHA, is orienting humanitarian work towards the stated needs of women, girls and people with diverse SOGIESC, and doing this by funding and empowering local organisations led by those who identify as such – amongst which is a clear and recurring call for SRHR services, even at the most acute stages of crisis (Njeri and Daigle, 2022).

### 4.3 PSEAH and GBV

Gender-based violence, including sexual violence, has long been an area of concern for humanitarian actors in general and protection specialists in particular, giving rise to a wealth of commitments and guidelines – notably, the Call to Action on Protection from Gender-Based Violence in Emergencies launched in 2013, the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, and the GBV Area of Responsibility, which falls under the remit of the Global Protection Cluster. In the last two decades, a parallel agenda has emerged known as preventing sexual exploitation, abuse and harassment (PSEAH), precipitated by revelations of widespread sexual abuse of children by aid workers in West Africa reported in 2002.<sup>21</sup> Where GBV is usually understood for humanitarian purposes as those gender-based harms that take place amongst and within crisis-affected communities, PSEAH – sometimes also described as safeguarding – addresses itself to those harms perpetrated against affected people by responders themselves, including military and civilian peacekeepers, aid workers and other intervenors. Both engender acute SRHR needs, given that they entail specifically sexual harms and necessitate timely and sensitive access to appropriate prophylactic, obstetric and other types of SRHR care.

While GBV has been the subject of intense and ongoing research, including in relation to SRHR – as discussed above – sexual exploitation by responders and the PSEAH agenda are remarkably understudied, despite major policy and media attention. This is especially true of abuses perpetrated by aid workers rather than peacekeepers (Westendorf, 2020); Angela Bruce-Raeburn (2018) describes how, ‘without missing a beat, safeguarding joined the aid sector lexicon’, propelled by major disclosures of sexual misconduct by aid workers not just in Liberia, Sierra Leone and Guinea, but subsequently in Haiti, the Central African Republic, the Democratic Republic of Congo and South Sudan.

Nonetheless, in response, the aid sector (humanitarians included) has made high-profile commitments, adopting codes of conduct, establishing an Inter-Agency Misconduct Disclosure Scheme<sup>22</sup> to share

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21 See the report by UNHCR and Save the Children on an assessment conducted in Sierra Leone, Guinea and Liberia (UNHCR and Save the Children, 2002).

22 See <https://misconduct-disclosure-scheme.org>.

information amongst agencies on abusers, and setting up the IASC Global Dashboard to compile data on SEAH (Morley, 2022; Reddick, 2022). Nonetheless, evidence and monitoring have been limited and difficult to use comparatively (Reddick, 2022). Other critics note that

an abundance of new, heavily branded tools have flooded the aid world in the rush to be seen to be doing something about the problem. But what is remarkable about many of these products is actually how unremarkable they are (Clare and Bys, 2022: 29; see also Naik, 2022).

Current reporting mechanisms also rely on survivors of SEAH to take on the burden of coming forward to report their experiences (Morley, 2022). Policy responses have been similarly reactive and individualised – that is, focused on employee misconduct – rather than oriented towards structural power dynamics of gender, racialisation, colonialism and power that enable it (Westendorf, 2020). Such an emphasis on better reporting mechanisms and ‘zero tolerance’ approaches may therefore be producing a rigid system that places too much burden on survivors and local staff without addressing the wider cultural changes that are needed.<sup>23</sup>

One key tension that emerges from the PSEAH agenda is the way it has been siloed away from GBV as an agenda for humanitarian response, even though both confront gendered and sexualised harms that are quite similar except for the professional positions held by their perpetrators. While GBV and PSEAH are sometimes conflated in the interest of avoiding investment in differentiated expertise or additional capacity (Clare and Bys, 2022), this does not extend to joined-up approaches or thinking around the two agendas, with GBV treated as a protection concern and PSEAH as a question of accountability. As humanitarians commit to more place-based or ‘localised’ responses, the dividing line between affected population and responders is increasingly meaningless because responders are themselves often members of affected communities, even if they do not always face identical sets of socioeconomic, cultural or other obstacles. Greater recognition of the continuities between harms committed by and against responders and affected people alike can only result in more effective responses, as well as better understanding of the SRHR needs that result. This is true for survivors from affected populations, regardless of their gender, as well as those who are national or international humanitarian staff.

Furthermore, both agendas – GBV and PSEAH – can arguably be expanded and strengthened through the application of a reproductive justice lens. This can be done first through a more holistic approach to sexuality as it intersects not only with SRHR but also with GBV and PSEAH, including healthy relationships and pleasure as key to recognising and confronting abuse. Pleasure is instrumental for addressing multiple dimensions of human wellbeing, including promoting safer, more consensual and mutually supportive relationships and combatting sexual violence, and thus it relates to existing humanitarian agendas on protection from GBV and from sexual exploitation and abuse (SEA). As Susie Jolly writes,

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<sup>23</sup> Bys (2022) also notes the disproportionate use of PSEAH measures against place-based aid workers, who tend to make up the vast majority of responders, rather than their international counterparts.

If you are not allowed to imagine or discover what it feels like to want sex, how do you know if you don't want it? Does consent mean anything if you are only allowed to say no? If you are only allowed to say no, you have to say no, even when you mean yes. This is going to be confusing for adolescents of any gender (2010: 34–35).

While it has been defined by the WHO (2006b), sexual pleasure – alongside other dimensions of human wellbeing – rarely features in the humanitarian, development, peacebuilding or human rights sectors, as we discuss further below. In the absence of concepts of consent, positive relationships and pleasure, however, humanitarian approaches to sexual harms of all kinds – and the PSEAH agenda in particular – risk conflating all forms of sexual interaction with exploitation, applying neocolonial and patriarchal prescriptions of appropriate sexuality and ultimately contributing to the complex power dynamics that already constrain their agency in and out of crisis (Sandvik, 2019; Bys, 2022). Endorsing a comprehensive, accessible and inclusive approach to SRHR – one that prioritises consent, pleasure, healthy relationships and appropriate services for crisis-affected people and humanitarian staff alike – is a key way forward here.

Second, both GBV response and PSEAH need to be better embedded across responses rather than atomised as siloed, standalone agendas, in recognition of the way that both – and the SRHR needs they engender – are connected to all other areas of life. This means that awareness of the potential for gendered and sexualised harms and appropriate responses should be integrated not just into protection but beyond it. Conversely, it also means that reproductive justice can be usefully built into GBV and PSEAH, including access to SRHR for survivors of GBV and SEAH with a focus on bodily autonomy, to strengthen their transformative potential:

A rights-based approach means building bodily autonomy into every stage of GBV and SRHR services, without resorting to assumptions about managing fertility or what choices a service user ought to make. Across GBV and SRHR, there is a clear need to respond to how affected people are coming to grips with these issues, rather than how humanitarian organisations think they should, with better communication and multisectoral approaches that incorporate health, justice, livelihoods and other areas (Holloway et al., 2022: 19).

In the absence of reports, humanitarians tend to believe that abuse is not happening, which tends to drive inaction especially amidst scarcity of resources and capacity. Embedding PSEAH, GBV and SRHR together across humanitarian response, however, is key to creating a scenario where everyone can recognise and appropriately respond to harms to their own bodily autonomy and that of others – a key plank of a reproductive justice approach.

Finally, reproductive justice can strengthen GBV and PSEAH by spotlighting the role of structural power dynamics and intersectional oppressions in conditioning consent and bodily autonomy. That is, it can help us to better understand and confront the root causes of gendered and sexualised harms in crisis settings. Both require political will, appropriate funding and approaches centred on inclusion, participation and – crucially, for a reproductive justice framework – bodily autonomy and consent. For

GBV, this means committing to gender-responsive humanitarian action that is spearheaded by place-based organisations led by women, girls and gender-diverse people (Njeri and Daigle, 2022). When it comes to PSEAH, humanitarian culture change is paramount: there is considerable research and commentary available on aid deployments as spaces characterised by raucous behaviour including casual sex, parties and substance use, and where standard norms of social behaviour are not seen to apply (see Appleby, 2010; HWN, 2017; Mazurana and Donnelly, 2017; Spencer, 2018; Jennings, 2019).<sup>24</sup> In 2021, the IASC global report on protection from sexual exploitation and abuse and sexual harassment made copious reference to the importance of culture change within humanitarian agencies and organisations. Moving away from an individualised approach and towards structural change and sector-wide accountability is an important first step here.

### 4.4 Reproductive violence

There is an emerging body of jurisprudence and debate around the concept of reproductive violence, especially in transitional justice, and this is also pertinent to humanitarian response. While there is no settled definition of reproductive violence, it can be usefully understood as

any form of abuse, coercion, exploitation or violence that compromises reproductive autonomy and self-determination, that is, the ability to decide if, how, and under what conditions to have and raise children (MSI Reproductive Choices and UNFPA, 2022).

This is especially salient as recent conflicts and crises have seen the targeting of reproductive capacities and mothering itself, through reproductive coercion, obstetric violence, the exploitation of maternal roles and attachments, and enforced pregnancy and motherhood (Mazurana and Proctor, 2015: 56).

For example, the deployment of pregnancy-related crimes in Bosnia – such as sexual violence against Bosnian Muslim women by Serbian militants, with the objective of forced impregnation or continuation of pregnancy – have been framed as reproductive violence and genocide (Altunjan, 2021). Likewise, over the course of Colombia's civil war, the perpetration by all sides of forced contraception and abortion against women combatants, sterilisation of civilian women, forced pregnancy and birth amongst captive women, and forced abortion to cover up crimes of sexual violence are all well-documented (Herrera and Porch, 2008; CNMH, 2018; CDR, 2020; Laguna Trujillo, 2021).

The harms that are increasingly classified as reproductive violence are often subsumed under the broad label of sexual violence by humanitarian protection, transitional justice and peacebuilding actors alike, but this categorisation fails to capture the full range of harms, such as forced abortion, contraception, sterilisation and forced pregnancy. In humanitarian settings in particular, this kind of violence can be interpersonal – part of the rising rates of domestic and intimate-partner violence that emerge alongside

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<sup>24</sup> These dynamics carry forward colonial and patriarchal histories that have allowed racialised people living in crisis-affected contexts to be seen as available for sexual propositions and encounters.

conflict, displacement and other crises – but it can also be structural. Especially when it comes to forced pregnancy, reproductive violence can encompass institutional, political and structural dynamics that prevent, deny or refuse access to contraception and safe abortion care, including on the part of state institutions and medical professionals, in ‘recognition of the structural conditions within which [reproductive rights] can be exercised’ (Laverty and de Vos, 2021: 617).

In some ways, the framework of reproductive violence is already built on a recognition of bodily autonomy and choice in SRHR. For example, the growing thinking around reproductive violence rejects intentionality – that is, the idea of ‘having good intentions’ or ‘meaning well’ – as a justification for overriding the autonomy of individuals or groups. The idea that medical practitioners or other authority figures know better than their patients, and especially those who are marginalised, has long underpinned violations of individuals’ will; instead, the reproductive violence framework stresses that autonomy and choice are paramount (Laverty and de Vos, 2021). In this regard, reproductive violence provides a new terminology for confronting the paternalist and even eugenicist potential – described in more detail above – in SRHR provision.

Humanitarians need to be active in understanding and responding to these protection risks and needs, which may be especially acute during periods of crisis and conflict. Given that marginalised groups who are deemed ‘undesirable reproducers’ – such as people with disabilities, particular ethnic groups or refugees and displaced people – may be particularly vulnerable to reproductive harms such as these, a rights- and justice-focused approach is critical to appropriate humanitarian response (Chadwick and Mavuso, 2021). Such an approach can help humanitarians and SRHR providers to better identify, detect and respond to reproductive violence, and avoid facilitating it under the banner of ‘neutrality’. Or, put differently, a reproductive justice lens facilitates an understanding of these harms for what they are – that is, denials and violations of bodily autonomy – and how they come to pass through structural inequalities and social exclusions.

### 4.5 Inclusive humanitarian response

Like GRHA, inclusion has been a growing agenda in humanitarian policy and practice, particularly since the mid-2010s. Its rise is evidenced by a number of charters and commitments related to people with disabilities, older people, people with diverse SOGIESC, minority-language speakers and other groups that have traditionally fallen through the cracks of humanitarian response. In line with this there has also been a proliferation of organisations specialising in the inclusion of particular groups or specific aspects of inclusion in the context of humanitarian response, all in keeping with the SDGs’ call to leave no one behind.

That said, humanitarians are still struggling to translate commitments into meaningful outcomes for people in crisis, especially those experiencing multiple marginalisations on the basis of their racialisation, ethnicity, religion, disability, citizenship status, age, gender or other axes of discrimination (see Lough et al., 2022). There is still a shift needed from addressing symptoms of discrimination to understanding and addressing root causes, in recognition of the reality that needs and vulnerabilities

are not static – rather, they can emerge, change over time and even potentially recede. Likewise, while mandates may limit what humanitarians can do in a particular context, they do not absolve humanitarians from doing appropriate analysis and making connections with those organisations – especially placed-based actors and those led by women, girls and gender-diverse people – that do have a mandate to meet affected people’s needs.

Intersectionality is key here, although humanitarians have struggled to come to grips with it, and reproductive justice is inherently intersectional with a complex understanding of context, social location and power. An intersectional lens informed by justice perspectives reveals how people with disabilities have had their autonomy violated and choices made for them; how people with diverse SOGIESC have often been ignored entirely in SRHR programming beyond responding to HIV; and how elders and youth may be underserved due to preconceptions about their sexual activity or behaviours. It also highlights the shortcomings of a framework based on an individualised notion of choice, as discussed above: where humanitarians tend to subscribe to a model focused on availability, quality and use to assess barriers to the services they offer, this risks overlooking the structural conditions that shape whether or not people utilise SRHR services.

As noted above in our discussion of GRHA, access to comprehensive SRHR informed by reproductive justice is also critical for inclusion outcomes around voice, participation and civil and political rights:

Bodily autonomy, especially for women and girls in crisis situations, is both an outcome of addressing pre-existing gendered inequalities and a precondition for meaningful political and economic participation postcrisis. [...] This endeavour is deeply intertwined with broader social justice projects that promote health and economic rights at the global level, and encompasses the rights of all women in and out of crisis settings (Tanyag, 2018: 670).

While the focus to date has been on women and girls, the same logic applies once again to people with disabilities, youth, older people and other groups that frequently confront denials of their bodily autonomy or ignorance of their needs regarding SRHR.

### 4.6 Beyond survival

Finally, humanitarians are increasingly asking what it might mean to think about crisis response beyond the remit of immediate needs and ‘mere’ survival – about what kind of lives humanitarian action seeks to save, and what makes those lives liveable. While humanitarian action has conventionally been governed by the ‘politics of necessity’, focused on immediate needs and positioning crisis-affected people as ‘in need’ (Trapp, 2016), such a material and instrumental focus can make humanitarian aid

profoundly dehumanising. New research is examining how humanitarians can engage more broadly with wellbeing and spheres of life like food, death and mourning, sexuality, family, sports, leisure and art.<sup>25</sup> To that end, Payal Arora remarks:

People who live in circumstances of scarce resources are, in the most fundamental ways, just like everyone else. They are proud. They are sexual beings. They look for love. They use humor as a powerful coping mechanism [...] They hunger for entertainment (2019: 49; see also Arora, 2012).

In essence, moving beyond survival in humanitarian response will mean acknowledging that life has content beyond simply living. By extension, humanitarian SRHR must account not only for disease prevention, emergency obstetric care or redressing GBV, but also for pleasure, sex as leisure, healthy relationships and the importance of family. Bodily autonomy, and the complex field of decision-making in which people pursue their sexual and reproductive lives, does not go away or become simplified in crisis settings; indeed, sex and sexuality may even take on new importance as ‘a form of coping mechanism, resistance or reclaiming, a jolly way to let off steam’ (Jolly, 2010: 33).

The first corollary of such a paradigm shift is understanding the importance of pleasure, in both its physical and psychological dimensions, as a driver of sexual behaviour and a key part of general wellbeing. As discussed above, sexual pleasure has now been defined by the WHO (2006b), but it is still little understood in advocacy, policy or practice in the humanitarian, development, peacebuilding or human rights sectors. However, there is evidence from the field of public health that

positive approaches to sexuality which include spaces for talking about pleasure can engender confidence and an ability to make positive decisions, while scare tactics and stigma leave people feeling disempowered and less able to assert themselves (Philpott et al., 2006, in Jolly, 2010: 34).

In this way, the impetus to look beyond immediate needs also speaks to the current, problem-centric approach to SRHR discussed earlier. To understand sex and reproduction, and the role they can and do play in the wider wellbeing of crisis-affected people, sexuality must be understood as ‘a personal and social asset rather than simply a health challenge to be prevented or resolved’ (Ford et al., 2019: 218). This should include not just heterosexual, monogamous sex for the purpose of procreation but masturbation, pre- and extra-marital sex, sex as recreation and diversion, sex for people with disabilities and those with diverse SOGIESC, and even consensual fetishistic sexual interests, so long as they are characterised by ‘self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations’ (GAB, 2016). It also means engaging with issues like adolescent sexuality, sex work and transactional sex beyond a lens of protection risks or GBV, considering the complex calculations and choices that people make.

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<sup>25</sup> See HPG’s forthcoming body of work, *Beyond survival: wellbeing in protracted crises*, which forms part of the 2022–2024 Integrated Programme ‘People, power and agency in humanitarian action’ (<https://odi.org/en/publications/people-power-and-agency-hpg-integrated-programme-20222024/>).

By recognising sexuality as a key component of wellbeing, comprehensive SRHR with a justice lens can also combat stigma and promote CSE, so that people of all sexualities and genders can engage in sex more safely. For those whose sexualities have been marginalised and sexual practices condemned, such as people with disabilities, people with diverse SOGIESC, or those engaged in sex work or strategic sex, this is critical: a non-punitive and non-judgemental approach informed by bodily autonomy, consent and justice for the people involved, even amidst competing pressures and coercive circumstances (Mwapu et al., 2016). Humanitarian crises and hazard-related emergencies are known to engender increases in strategic sex as material needs spike, and to unleash deep-seated prejudices against people with diverse SOGIESC and those with disabilities, all of which create acute SRHR needs.

The harms facing all of these marginalised groups, and that shape their ability to enact their sexualities in safety, are strongly linked to stigma. Stigma has been shown again and again to obstruct access to health services in SRHR and promote negative outcomes for people of all genders and sexualities, including GBV, STIs, unintended pregnancies, unaddressed reproductive cancers and RTIs, or clandestine pathways to services like contraception, abortion or hormonal treatments. Stigma also facilitates various forms of sexual and reproductive violence by posing barriers to accessing help or even information and by increasing GBV.

With all of this in mind, doing humanitarian SRHR right and supporting bodily autonomy are key components of wellbeing beyond a rubric of ‘mere’ survival. This requires coming to grips with the nuances of coercion and agency, getting comfortable with affirming sexualities and pleasure, and supporting the reproductive decision-making of affected individuals without exception.

In each case offered here, reproductive justice offers the potential to deepen humanitarian understanding and effectiveness, as well as mitigate the critical risks that come with a life lived without appropriate SRHR, which we have detailed throughout this paper. This is absolutely not a question of asking humanitarians to do it all: in some cases, where a dearth of provision exists, we are calling for badly needed services to be offered directly; in others, what is needed is more and better collaboration with place-based actors who are already committed to providing what their communities need.

Especially in protracted settings, it is simply not enough for humanitarians to limit themselves to ‘immediate needs’ by any definition. The risks to life are already clear, and even those elements of a comprehensive SRHR agenda that might be considered ‘non-life-threatening’ tend to compound an already complex and acute set of vulnerabilities, especially for those less able to withstand shocks, cope amidst crisis and adapt accordingly. Humanitarians are left with the responsibility to act, leaving aside attempts to draw lines between ‘immediate needs’ and a wider, more holistic and integrated understanding of SRHR. It is incumbent on humanitarian responders to understand and triage into a wider set of national and international actors, providing pathways and working collaboratively with parallel efforts, especially in those settings where humanitarians are the core conduit for vulnerable, crisis-affected people to access what they need.

## 5 Conclusion

The narrow framing of SRHR as solely a needs-based health issue, and a non-urgent one at that – barring certain services for pregnant women and survivors of GBV – helps give rise to its deprioritisation and drastic underfunding. A false dichotomy of needs and rights serves to produce and maintain:

- gaps in understanding, policy and programming, including a binary notion of gender that conceals diversity in gender identities, experiences and complex needs;
- a problem-centric approach that veers into pathologisation of sexuality itself, focusing on GBV to the neglect of other elements of a comprehensive SRHR agenda;
- under-utilisation of existing services; and
- the political complexities of providing SRHR services and advocating for sexual and reproductive rights, including safe abortion care, in crisis settings.

Ultimately, the assessment of needs is a normative reflection of the entitlements provided by rights, which are critical to ensuring that humanitarian response treats all crisis-affected people with dignity and bodily autonomy, regardless of who they are or their background. Framing select elements of a comprehensive portfolio of SRHR services as ‘immediate needs’ over others is also a dangerous endeavour that has been tactically deployed to divide and restrict access. Resisting the opposition of needs with rights, in SRHR and beyond, is therefore crucial for ensuring that humanitarian responders – whether they are local, national or international – see, understand and constructively address those needs that are most pressing to affected individuals and communities themselves. SRHR that is accessible, inclusive and comprehensive must therefore leave behind the distinction between rights- and needs-based approaches, melding the two approaches to bring together the entitlement of rights with the urgency of needs – a potential case study and lesson for the wider sector.

Reproductive justice has the potential to facilitate better understanding of and engagement with the political meaning assigned to bodies, sexualities and reproduction. It also highlights the structural conditions, power relations and interconnections that determine the potential for bodily autonomy in SRHR, in and out of crisis settings. As elsewhere, champions can play a key role in bringing political will and funding to the issue and ensuring that these translate into services and programming. At the same time, however, a major paradigm shift is needed to do this work ethically, inclusively, accessibly and comprehensively. Sexual and reproductive rights are pivotal, but they are meaningless without shifting structural conditions to enable the exercise of those rights.

An approach grounded in reproductive justice offers the potential for better health outcomes for all crisis-affected groups, including harder-to-reach and marginalised groups. It can also give rise to a greater sense of bodily autonomy that helps to reduce violence, grow confidence, and increase participation and leadership in inclusive humanitarian action. Beyond the SRHR agenda itself,

reproductive justice can also demonstrate the potential for uniting rights- and needs-based approaches to humanitarian response and improve humanitarians' ability to tackle key agendas including inclusive and gender-responsive humanitarian action, PSEAH and GBV, and principled humanitarian action.

Global progress has proven slow on SRHR, for a variety of reasons; the humanitarian sector is simply further behind than other architectures at the national and international levels (Starrs et al., 2018: 2,642). Conflict, displacement, climate hazards and other humanitarian crises have the undeniable effect of deteriorating current services and care models, raising new barriers to care and exacerbating existing norms and power relations. These alone, however, cannot explain away the enormous gaps and silences around SRHR as an indispensable set of essential services. Humanitarian response must be one piece of a wider, interconnected puzzle that bridges sectors and places bodily autonomy at the centre of action.

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