

OCTOBER 2019

How Can We Better Reach Women and Girls in Crises?

AUTHOR

Janet Fleischman

A REPORT OF THE CSIS GLOBAL HEALTH POLICY CENTER



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INTERNATIONAL STUDIES



THE CSIS COMMISSION ON
Strengthening America's
Health Security

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Acknowledgments

This report is a product of the CSIS Commission on Strengthening America's Health Security, generously supported by the Bill & Melinda Gates Foundation.

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Executive Summary

The United States is the world leader in supporting global health and humanitarian response, making it uniquely placed to elevate the critical health and safety needs faced by women and girls in emergencies and fragile settings around the world. While addressing these needs is an important goal on its own, it also forms a pillar of global health security, as the prevention of health crises and conflict, and recovery after they occur, are greatly enhanced when these needs are met.

The United States has unrivaled financial and programmatic capacities in maternal health, reproductive health, family planning, and gender-based violence (GBV) prevention and response. However, it seldom marshals these extensive capacities in emergency settings, where the needs and vulnerabilities of women and girls are most severe. In emergencies around the world—from the Ebola outbreak in the Democratic Republic of the Congo (DRC) to the simmering conflict in Venezuela to the protracted crises in Yemen and

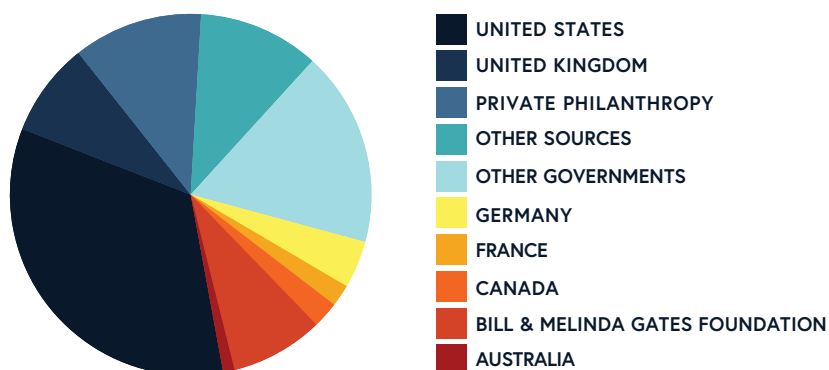
Syria—the United States has not channeled its extensive capacities to address glaring operational gaps in these critical areas. The alarmingly high risks of GBV and severely limited access to maternal health, family planning, and reproductive health services are too often overlooked in these and other crisis settings.

A categorical shift is required for the United States to prioritize women’s and girls’ health and protection in emergency settings to advance resiliency and health security. There is growing recognition among both practitioners and policymakers that failure to address these gaps significantly worsens the impact and trauma of crises and significantly undermines global health security. Conversely, the engagement of women, girls, and communities in decision-making and program design can help build public trust and confidence, which is sorely lacking in many health security crises around the world.

This report was produced under the auspices of the CSIS Commission on Strengthening America’s Health Security, which is calling for a doctrine of continuous

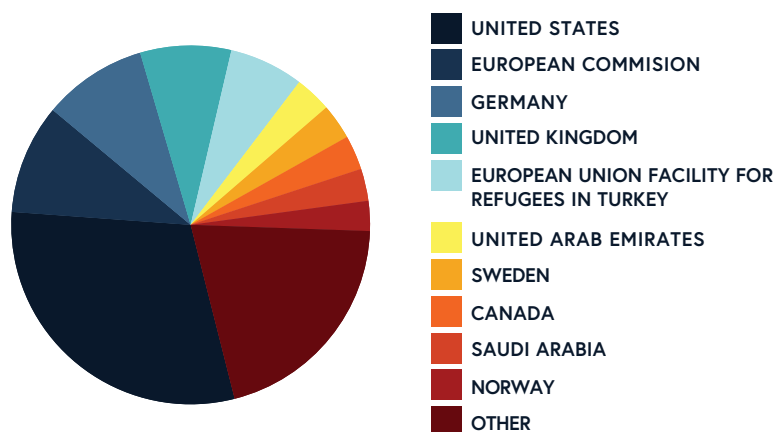
Global Health Financing Sources, 2018

Source: Institute for Health Metrics and Evaluation, “Flows of Global Health Financing,” 2018, <https://vizhub.healthdata.org/fgh/>.



2019 Humanitarian Aid Contributions from the Top 10 Donors Globally, as of October 8 2019

Source: UN OCHA Financial Tracking Service, “Humanitarian Aid Contributions,” 2019, <https://fts.unocha.org/>.



prevention, protection, and resilience to protect the American people and the world from a growing number of health security threats.¹ The Commission has recognized the importance of strengthening the U.S. government's capacities to operate in a "disordered world," spanning chronic and emerging conflicts, humanitarian crises, fragile states, and stateless and misgoverned places. In such contexts, women and girls are acutely vulnerable. Studies have shown that when women and girls are healthy, safe, and empowered, they form a cornerstone for building resilient communities.² Conversely, the trauma and impact of widespread GBV, combined with poor access to essential maternal health, family planning, and reproductive health services, can fracture families and communities while exacerbating fragility and instability.

This report proposes an approach to ensure that the extensive capacities of the U.S. government in the areas of maternal health, reproductive health, family planning, and GBV prevention and response are no longer left on the sidelines in crisis response and recovery. The overarching goal of this approach is to correct this persistent problem and bring existing resources and programs to bear to ensure the health and safety of women and girls in crises and disordered settings.

The United States has shown increased leadership and commitment to addressing these issues in recent years and is poised to do much more. This report reviews existing capacities and investments, analyzes progress made, identifies ongoing gaps, and proposes practical and affordable solutions for the U.S. government to adapt and focus current programs and investments in those disordered settings where the needs of women and girls are greatest.

This report calls on the U.S. government to:

1. Bring forward \$30 million in flexible funding annually over five years, which will be used to launch a model of service delivery for women's and girls' health and safety in two to three crisis settings. This additional flexible funding is essential to spearhead this effort and incentivize U.S. agencies and their partners to rapidly begin execution of the program. The funding will be catalytic: it is intended to attract higher-level financial commitments from existing programs at USAID and the Department

of State's Bureau of Population, Refugees, and Migration (PRM).

2. Pilot this model in two to three emergency or fragile settings of high unmet need and importance to U.S. health security and foreign policy interests. This model would provide an

integrated package of quality maternal health, reproductive health, family planning, and GBV prevention and response services as a core element of all emergency responses. An emphasis would be placed on building local capacity of health care providers, community outreach workers, and women's organizations to provide these essential health and protection services. This model should adapt, refocus, and integrate programs at USAID's global health bureau, the Office of Foreign Disaster Assistance (OFDA), PRM, and the Centers for Disease Control (CDC), where appropriate. The pilot should be used to demonstrate impact and generate data and learnings to inform future expansion of the model.

3. Establish a secretariat composed of USAID and PRM senior officials and technical experts to oversee delivery and ensure alignment and coordination of planning and investments. The secretariat would lead ongoing evaluation, adjustment, and analysis of results to inform future work and ensure accountability.

4. Ensure high-level, committed U.S. leadership to encourage other donor countries, multilateral organizations, UN agencies, and other implementing partners to contribute to and participate in this strengthened model.

This catalytic, incremental approach will ultimately ensure that existing U.S. government resources and capacities are channeled to those disordered settings where the needs of women and girls are greatest.

Introduction

"We know, when crisis strikes, it often strikes women hardest, as access to healthcare, including maternal care and family planning services, decreases. . . . And while access to care falls in crisis, incidents of sexual violence and exploitation rise."

*Senator Patty Murray (D-WA),
August 6, 2018³*

Crises and disordered settings around the world today put the health, safety, and security issues faced by women and girls in stark relief. Effectively addressing these issues in crisis settings is complicated and often compounded by underlying gender inequalities and harmful gender norms. Where there is determined commitment, such programs are viable

and impactful. Still, current crises demonstrate that the programs designed to provide critical services in crisis settings are not adequately addressing the needs of women and girls, to the detriment of their health and that of their communities.

Today, 34 million women and girls of reproductive age are estimated to be in emergency situations, often explicitly targeted with sexual violence as a weapon of war, including 5 million who are pregnant.⁴ Pregnancy and childbirth do not stop during emergencies, and inadequate or interrupted maternal health and family planning services can lead to increased maternal and neonatal mortality, unintended pregnancies, and unsafe abortions.⁵

Gender-based violence (GBV) is ubiquitous, often hidden, and gravely under-reported in crisis settings, with profound consequences for women's and girls' physical and mental health, safety, empowerment, and resiliency.⁶ While GBV is usually perpetrated against women and adolescent girls, men and boys also suffer from such abuses. GBV comes in many forms, including rape, sexual exploitation and abuse, intimate partner violence, forced and early marriage, sexual slavery, and emotional and psychological abuse. The health consequences of GBV include physical injuries, unintended pregnancy, sexually transmitted infections including HIV, and fistula, as well as mental health impacts. Adolescent



60% of preventable maternal deaths

take place in settings of conflict, displacement, and natural disasters.



1 in 5 refugees or displaced women

in complex humanitarian settings are estimated to have experienced sexual violence.



Girls are 2.5 times more likely

to be out of school in conflict-affected countries than in conflict-free countries.

Source: UN Women, "Closing the Gender Gap in Humanitarian Action," accessed October 2019, <https://interactive.unwomen.org/multimedia/infographic/humanitarianaction/en/index.html>.

girls are acutely vulnerable to increases in GBV, especially following conflict and displacement.

Humanitarian agencies and NGOs—often with U.S. support—have demonstrated that maternal health, reproductive health, family planning, and GBV prevention and response services can be delivered.⁷ While the United States and its partners have made considerable progress in recognizing the need to prioritize these interventions and conducting gender analyses, the response remains inadequate relative to the need. Time and again, the issues facing women and girls are de-prioritized and siloed. Crisis response needs assessment and planning processes often do not reflect gendered issues, and the results of past gender analyses are often not incorporated.

There is insufficient leadership and coordination at the global and country levels, and human and financial resources are inadequate to implement programs or too short-term to achieve impact. In acute crises, the focus on women and girls is often overtaken by competing priorities, such as food, water and sanitation, and shelter, and is fragmented by separate funding streams and siloed programs that do not incentivize integrated approaches. As a humanitarian expert noted: “Protection of women and girls isn’t on the radar of many people, it’s overshadowed by the tyranny of the urgent. . . . the humanitarian community focuses on easily quantifiable issues, which consistently don’t include women and girls.”⁸

Despite considerable U.S. capacities, no coherent U.S. strategy has been developed to effectively integrate the health and safety needs of women and girls into health security. Overcoming this will not be simple, but with determined, high-level U.S. leadership, coordinated action by key agencies, and additional flexible resources, it is possible to prevent and respond to GBV and ensure access to quality maternal health, family planning, and reproductive health services in disordered settings. Addressing these critical issues is fundamental to advancing both health security and USAID’s framework of helping countries on their journey to self-reliance.

Building on Existing Strategies and Programs

"Our experience shows that investing in women and girls accelerates gains across the full development spectrum, from preventing conflict to improving food security and economic opportunity."

Ambassador Mark Green, May 8, 2019⁹

The United States is the global leader in supporting health and humanitarian response, and U.S. government agencies have extensive capacities in women’s and girls’ health and protection. These extensive capacities provide a strong foundation upon which to build a more robust, comprehensive, and impactful approach to women’s and girls’ health security needs.

The primary U.S. government actors in these areas are USAID’s Office of Foreign Disaster Assistance (OFDA) and the Department of State’s Bureau of Population, Refugees, and Migration (PRM), which in recent years have expanded their investment in preventing and responding to GBV.¹⁰ USAID’s Bureau for Global Health is a world leader in supporting maternal health and family planning, providing technical support for high-burden countries, and investing in health systems strengthening.¹¹

Implementing partners are the backbone for the delivery of U.S. assistance and provision of technical expertise on women’s and girls’ health and protection, and a number of UN agencies and NGOs have strong capacity in these areas. The International Rescue Committee (IRC), for example, has demonstrated that it is possible to deliver these services, including a range of contraceptive methods, in crisis settings, but also that to do so requires strengthening competency-based training and supportive supervision, supply chain management, data man-



Women are seen washing their hands at an Ebola screening station as they enter the Democratic Republic of the Congo from Rwanda on July 16, 2019 in Goma.

JOHN WESSELS/AFP VIA GETTY IMAGES

agement, and community mobilization.¹² Several U.S. officials emphasized how much the United States relies on the capacity of its partners, referring to the international organizations and NGOs it funds: “It’s a shared responsibility—donors need to prioritize these issues [for women and girls] and partners need to be proactive about implementing and requesting funding.”¹³

Humanitarian organizations have developed international guidance on priority activities for women’s and girls’ health and protection to be implemented from the start of humanitarian crises. This guidance includes the Sphere standards for humanitarian response, the Minimum Initial Service Package (MISP) for Reproductive Health in Crises, and the Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings.^{14,15,16} The Inter-Agency Standing Committee (IASC) Guidelines for Integration of GBV Interventions in Humanitarian Action and the Re-

al-Time Accountability Partnership on Gender-based Violence in Emergencies provide GBV-specific guidance.^{17,18} The development of this guidance is a critical step in ensuring standard protocols, and the proper sequencing of steps, metrics, and support for on-the-ground actors. This guidance helps to equip actors with the information they need to provide these services in crisis situations.

CASE STUDY #1

Yemen

The ongoing conflict in Yemen is one of the largest humanitarian crises in the world, with an estimated 3.6 million internally displaced persons (IDPs), and women and children comprising over three-quarters of those displaced.^{19,20}

The gender inequalities in Yemen contribute to making women and girls “invisible” and under the radar of the humanitarian community. The conflict has intensified violence against women and adolescent girls, with an estimated 3 million women and girls at risk for GBV with limited access to health care or counseling.²¹ According to the UN secretary general’s report to the Security Council on Sexual Violence in Conflict in March 2019, there has been an increase in reports of sexual violence, including physical and sexual assault, rape, and sexual slavery, since the start of the conflict. Women and girls in Yemen are also at increased risk of trafficking and exploitation.²² These abuses are fueled by the conflict itself, as well as pre-existing gender inequalities that have been exacerbated by the crisis. Despite increased reporting of these abuses, the breakdown of law and order, impunity for perpetrators, and victims’ fear of reprisals all contribute to significant under-reporting of sexual violence.²³

The humanitarian response in Yemen has focused primarily on nutrition, water, sanitation, and health care. In certain instances, the humanitarian response has made concerted efforts to improve access to essential

services for women and girls, and these efforts should be expanded.

A number of humanitarian groups operating in Yemen have sought to improve maternal health, reproductive health, and family planning services for women and girls. In partnership with the Ministry of Health, Save the Children has piloted a task-shifting program that enables midwives—in addition to doctors—to insert and remove long-acting contraceptive implants.²⁴ Save the Children is also working to expand access to a range of family planning methods in Yemen by increasing demand for long-acting methods through community health worker outreach.²⁵ FHI360 is funded by OFDA to help internally displaced populations and host communities gain increased access to primary health care, which includes maternal and reproductive health and safe delivery. Clinical management of rape is also offered, but few women take advantage of these services. Working with UNFPA to address the lack of maternal and reproductive health services and supplies for conflict-affected women, FHI360 is also procuring and distributing reproductive health kits and training health providers on the MISP.²⁶

- **3 million Yemeni women and girls** are at risk of gender-based violence, and there are 60,000 women at risk of sexual violence.¹
- Incidents of gender-based violence have **increased by over 63%** since before the conflict.²
- One woman dies **every 2 hours from complications** during pregnancy or birth.³

1. International Rescue Committee, “Protection, Participation and Potential: Women and Girls in Yemen’s war,” January 2019, <https://www.rescue.org/sites/default/files/document/3550/yemenwomenandgirlspolicybriefinalreadyfordissemination.pdf>.

2. Ibid.

3. UNICEF, “One woman and six newborns die every two hours from complications during pregnancy or childbirth in Yemen,” June 14, 2019, <https://www.unicef.org/press-releases/one-woman-and-six-newborns-die-every-two-hours-complications-during-pregnancy-or>.

Primary U.S. Government Agencies

In recent years, the main U.S. government agencies charged with humanitarian and crisis response—US-AID’s OFDA and the Department of State’s PRM—have made advances in addressing the needs of women and girls, especially relating to GBV and the requirement to include gender analyses.²⁷ The U.S. government, through PRM and OFDA, is the leading donor for GBV in emergencies, amounting to \$140 million in 2018.²⁸

Beyond these two primary agencies, the Centers for Disease Control and Prevention (CDC) has expertise, including on reproductive and mental health, through its humanitarian health team in the Division of Global Health Protection’s Emergency Response and Recovery Branch. Other U.S. agencies and offices, such as the Department of Defense, also contribute in specific situations.

The flagship U.S. initiative on GBV prevention and response in emergencies is Safe from the Start, jointly launched by PRM and OFDA in 2013.²⁹ The program began as the U.S. commitment to the Call to Action on Protection from GBV in Emergencies.³⁰ The goal of Safe from the Start is to reduce the incidence of GBV, to ensure quality services from the onset of a crisis, and to increase accountability. Safe from the Start aims to change how the humanitarian community responds to GBV in emergencies and to bridge the gap between rhetoric and good intentions and policies to ensure that recommended practices are shared and implemented. An evaluation of a Safe from the Start-funded UNHCR program in the Mahama camp in Rwanda found a “clear correlation” between the deployment of a senior protection officer specializing in GBV with progress on prevention, mitigation, and response to GBV.³¹ Between FY 2013 and FY 2018, the U.S. government committed over \$76 million toward Safe from the Start programs.

The State Department's Bureau of Population, Refugees, and Migration (PRM)

PRM, which focuses on refugees and forcibly displaced people, recognizes that women and girls are often a “highly at-risk population,” due to violence,

SAFE FROM THE START

MISSION: *“To reduce the incidence of GBV and ensure quality services for survivors from the very onset of emergencies through timely and effective humanitarian action.”*

Three commitments:

1. Increase the number and reach of GBV prevention and response interventions;
2. Integrate the GBV risk mitigation activities across all humanitarian assistance sectors;
3. Strengthen accountability to prioritize GBV prevention and response in emergencies

Funding for Safe From the Start comes from USAID's OFDA and the Department of State's Bureau of PRM.¹

1. U.S. Department of State Bureau of Population, Refugees, and Migration, “Gender and Gender-Based Violence,” accessed October 2019, <https://www.state.gov/other-policy-issues/gender-and-gender-based-violence/>.

exploitation, and abuse, and that they are often “sidelined and forgotten” in humanitarian responses.³² To address these issues, PRM funds global and regional organizations to provide GBV prevention and response services at the early stage of all emergencies. PRM’s partners include UN agencies, such as the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM), and international NGOs, such as the International Committee of the Red Cross (ICRC). PRM funds partners for research, programing, capacity building, staffing, and development of deployment rosters for GBV experts.

GBV funding is separate from any reproductive health programing. To the extent that PRM funds maternal health, family planning, and reproductive health,

which is very limited, it is a component of broader health programs at the regional or country level.³³

PRM's funding through Safe from the Start supports a range of international organizations and UN agencies, including: ICRC and its 2018 special appeal on sexual violence, aimed at increasing reporting, facilitating monitoring and evaluation, and embedding the response to sexual violence across ICRC programs; IOM, to improve operational response to GBV through camp management and site planning; UNICEF, to promote learning on GBV in humanitarian settings, including through opening a GBV in Emergencies Helpdesk; UNHCR, to strengthen approaches to GBV prevention, mitigation, and response in accountability, quality control, and leadership; and the World Health Organization (WHO), to strengthen GBV capacity in the health cluster and in WHO's emergency work.³⁴

Beyond Safe from the Start, PRM's commitment to GBV is reflected in broader support for multilateral organizations and programmatic investments. PRM provides funding to support global GBV innovations. For FY 2018, PRM provided nearly \$51.5 million for GBV, including \$18.6 million for Safe from the Start and \$4.4 for global innovations, as well as regional GBV services including psychosocial support, safe spaces, and awareness-raising in refugee situations.³⁵ PRM is currently supporting an evaluation of its Safe from the Start partners, with results expected by the end of 2019.³⁶ PRM is also funding WHO's Global Health Cluster to strengthen the health-sector response to GBV in emergencies and to improve its capacity to support GBV survivors and enhance prevention, including by updating guidelines and tools.³⁷

Through an "innovation project" in FY 2018, PRM supported international and nongovernmental organizations. This included the Global Women's Institute at George Washington University, to reduce the risks of sexual exploitation and abuse in the distribution of life-saving goods (food and non-food); IRC, for prevention and response to early marriage of adolescent girls in crisis; Mercy Corps, to strengthen the capacity of humanitarians to target the energy needs of women and girls and

help mitigate GBV risks; and UN Women, to strengthen GBV and gender equality through the Grand Bargain.³⁸

PRM is not an implementer and does not have dedicated staff on women's health or GBV but rather relies on its implementing partners to have expertise in these areas.³⁹ This makes it difficult for PRM personnel to review and evaluate all programs on the ground. PRM refugee coordinators are usually foreign service officers deployed in the field, who are not generally experts in women and girls' health and protection. They would benefit from enhanced training to better report on these issues. In addition, every regional and, where appropriate, functional bureau at the State Department would benefit from including women's issues within the portfolio and performance requirements of a senior official, such as a deputy assistant secretary.

Within the State Department, PRM is the lead on humanitarian policy issues and engages in diplomatic efforts with other governments and multilateral agencies around refugee responses, including through donor support groups and other bilateral and multilateral mechanisms. When used effectively, PRM's convening authority and capacity in humanitarian diplomacy can help elevate the importance of issues confronting women and girls and convey high-level U.S. government commitments. PRM also can educate and inform other senior administration officials and encourage them to speak out on key issues.

At the May 2019 Oslo Conference on Ending Sexual and Gender-Based Violence in Humanitarian Crises, the director of PRM's Office of Multilateral Coordination and External Relations represented the United States. In a statement released at the conference, she made a critical point about how actors at all levels can better prioritize and improve these life-saving interventions: "We will continue to urge our partners to involve women and girls in decision-making and program design; consult and collaborate with communities in identifying and mitigating risks; and prioritize funding to service provision and safety mechanisms. These are among the biggest gaps in our work and areas where we can make an exponential difference."⁴⁰

SPOTLIGHT ON PANZI HOSPITAL

In Bukavu, South Kivu in eastern DRC, Dr. Denis Mukwege, a gynecological surgeon, founded the Panzi Hospital to provide health care and treat the gynecological injuries and obstetric care resulting from the brutal rape and sexual violence suffered by women and girls in the conflict. Out of the 450 beds in the hospital, 250 are dedicated to survivors of sexual violence. Panzi also runs a mobile clinic and has established two other sites in eastern DRC. The hospital's program goes beyond medical care to connect the survivors with other critical services necessary for healing, such as psychosocial care, community reintegration, livelihood assistance, and legal aid. Since its founding in 1999, the Panzi Hospital has treated more than 50,000 women and girls. Through the Dr. Denis Mukwege Foundation, the work has expanded into training other doctors and health care providers, advocating for their model to be adopted in other fragile settings and supporting survivor activists from around the world to become leaders and agents of change.⁴¹ In 2018, Dr. Mukwege won the Nobel Peace prize, along with Ms. Nadia Murad from Iraq, in recognition of his work on sexual violence in conflict.

USAID's Office of Foreign Disaster Assistance (OFDA)

OFDA leads and coordinates the U.S. response to humanitarian disasters overseas, focusing particularly on displaced populations based on humanitarian need. With technical experts in Washington, in regional offices, and in the field, OFDA is able to deploy quickly to help countries prepare and respond to crises and to provide technical guidance to field colleagues and NGO partners. This breadth of technical expertise makes OFDA unique among donors. OFDA's budget is needs-based, from non-earmarked international disaster assistance, and has notwithstanding authority that

provides more flexibility than regular development funding.⁴² In recent years, OFDA has particularly strengthened its focus on gender and GBV.

One of the ways that OFDA responds to an acute crisis is by deploying a Disaster Assistance Response Team (DART) to assess the situation, identify urgent needs, and coordinate the U.S. response. Not all responses include DARTs, with examples including Somalia, Nigeria, and Central African Republic. In these cases, OFDA has other mechanisms to evaluate needs, coordinate the interagency response, and guide field staff and partners. However, personnel with competency in gender analysis and women's and girls' health and protection are not required elements of OFDA's DARTs, and the rapid assessments used to inform program design do not always capture the risks and complexities that women and girls face. OFDA does not have technical experts focused specifically on women's and girls' health but integrates them under primary health care.

Beyond OFDA's internal capacities, it relies on its NGO partners to gain access to crises and implement programs on the ground. However, these partners are sometimes constrained by their own lack of capacity and staff to implement women's health and GBV programs, and that capacity is also stretched by the sheer number of current emergencies. In some cases, OFDA may have more funding available for programs than partners with capacity to absorb it. In addition, the majority of OFDA funding is short-term, a year or often less, and therefore does not provide continuous program support.

OFDA is organized into technical teams, including health and protection; agriculture and food security; nutrition; shelter; water, sanitation, and hygiene (WASH); economic recovery; and others. Health is OFDA's largest funded sector and includes life-saving medical assistance, immunization campaigns, disease surveillance, and training for health care workers. OFDA's proposal guidelines include sections on reproductive health and GBV in the areas of needs assessment, technical design, and indicators, which are supposed to be provided in an integrated manner through comprehensive primary health care packages.^{43,44} Again, the level of implementation frequently depends on the capacity of the implementing partners.



This photograph taken on April May 8, 2018 shows midwives attending a meeting on gender-based violence with United Nations Population Fund (UNFPA) workers (L) at Kutupalong refugee camp in Bangladesh's Ukhiya district.

MUNIR UZ ZAMAN/AFP/GETTY IMAGES

Work on women's health, including maternal health and family planning, is part of OFDA support for comprehensive primary health care. However, since health funding is not broken down by services, it is difficult to determine how much OFDA allocates to women's health programs. In addition, OFDA is unable to allow its partners to procure contraceptives with OFDA funding but relies on USAID's Office of Population and Reproductive Health or other donors.⁴⁵ OFDA's health team should have more staff to devote specific attention to women's health issues.

Safe from the Start has helped OFDA expand its work on preventing and responding to GBV. The OFDA protection team, which covers GBV, as well as child protection and psychosocial support, has grown from 2 staff in 2013 to 10 in 2019. The subsector for prevention and response to GBV emphasizes the pervasiveness of GBV, even in the absence of available data, and that humanitarian personnel should assume that it is

happening and treat it as serious and life-threatening.⁴⁶ In some settings, such as in South Sudan, where the protection risks have been recognized as requiring that the response go beyond the protection cluster, GBV issues have been integrated into programs focused on WASH and nutrition.

In FY 2018, OFDA dedicated nearly \$69 million to GBV programs, an increase of \$10 million from 2017. OFDA reports that in FY 2018, it funded 169 projects in 25 countries that contributed to GBV prevention and response, including field-level programs and global research, policy, and capacity building for GBV in emergencies. Programs included interventions for psychosocial support, case management and health care for GBV survivors, and community-based responses, such as safe spaces for women and girls.⁴⁷ OFDA also has a set of protection, gender, and inclusion requirements for partners.

USAID's Global Health Bureau – Office of Maternal and Child Health and Nutrition and Office of Population and Reproductive Health

USAID has extensive technical expertise in maternal and child health (MCH) and family planning, and the United States has made substantial investments in these areas, notably in sub-Saharan Africa and in South Asia. USAID has identified 25 priority countries for MCH programs, which together account for some 66 percent of maternal and child mortality, and 24 priority countries for family planning and reproductive health, based on total fertility rates and contraceptive prevalence rates.^{48,49} For family planning, the United States also supports the Ouagadougou Partnership, which focuses on family planning in nine francophone West African countries, including some of the most fragile countries in the Sahel.⁵⁰ It is important to note that all of USAID's global health programs are subject to the Trump administration's restrictions relating to abortion, under the Protecting Life in Global Health Assistance policy.⁵¹

Priority countries for both MCH and family planning include several fragile and emergency-affected states, such as Bangladesh, the DRC, South Sudan, and Yemen. Although USAID's Global Health Bureau operates with Congressionally-earmarked funding and does not have a specific strategy for transitioning from humanitarian to development settings, the fact that so many countries where they operate are dealing with natural or man-made disasters has propelled USAID to now look more seriously at these issues.

In an important acknowledgement of the need for integrated MCH and family planning in fragile settings and the need to decrease the divide between relief and development, USAID announced a new program statement in April 2019 for MOMENTUM (Moving Integrated, Quality, Maternal Newborn and Child Health and Family Planning and Reproductive Health Services to Scale). MOMENTUM will fund multiple awards to accelerate reductions in maternal, newborn, and child mortality and morbidity. This includes a \$200 million five-year program specifically focused on service delivery in fragile settings, including non-permissive environments. Covered services include skilled

attendance at birth, newborn resuscitation, voluntary family planning, and post-abortion care, as well as programs to address GBV, child marriage, and early sexual initiation. Additional resources are to be provided for capacity building and sustainability for local partner organizations. This program aims to increase coordination across USAID's bureaus and offices, align with USAID's framework for a journey to self-reliance, and recognize the need to span the relief to development continuum.⁵²

The MOMENTUM Round 1 announcement emphasized the importance of women's health in fragile settings:

*"In fragile settings, higher mortality rates are often a result of disruption of basic primary health services such as clean water, immunization, clean and safe delivery, family planning, and lack of essential supplies. This breakdown in service delivery only exacerbates the impact of major causes of mortality including infectious disease, under-nutrition and obstetric complications. . . . Oftentimes, these problems are perpetuated and compounded by donor requirements and siloed funding streams."*⁵³

MOMENTUM is an indication that USAID recognizes the gaps in integrated programs for women's health in fragile settings and in the transition to development and sees a mandate for the agency to work in such settings, although the strategy is not yet fully defined. At this writing, MOMENTUM is still in the planning and design phase. It is too early to tell how the program will be operationalized and specifically how it will better sequence, integrate, and complement the work of OFDA and other agencies. Given the different funding mechanisms and timeframes, reporting requirements, and policies under which USAID's Global Health Bureau and OFDA operate, this new initiative will introduce new complexities and demands for coordination into USAID's humanitarian and crisis response. The Global Health Bureau could introduce important resources and technical expertise on women and girls into humanitarian and fragile settings, but focused coordination with OFDA will be needed to ensure effectiveness and adherence to humanitarian principles and practice.

CASE STUDY #2

The Ebola Crises in West Africa and in DRC

Few epidemics epitomize the perilous and interconnected nature of health security risks more than Ebola outbreaks.

It is important to examine the disparate impacts and challenges experienced by women and girls in West Africa in 2014-2016 and today in eastern DRC.

At the time of writing, the Ebola outbreak in eastern DRC had recently been declared a public health emergency of international concern by the WHO, as the virus continues to spread and threatens other parts of DRC and neighboring countries. According to the WHO, as of August 6, 2019, 56 percent (1,572) of the reported Ebola cases were adult females, and 28 percent were children under 18.⁵⁴ Peter Piot, who co-discovered the Ebola virus in what was then Zaire (now the DRC) in 1978, articulated the necessity of examining the broader context of people's lives in an outbreak: "As we saw during the Ebola outbreak, addressing the complex health challenges of our time is not only dependent on epidemiology and biomedicine but also must engage with the political, social, and cultural factors that influence and determine health."⁵⁵

Women and girls are at increased risk of Ebola infection for a number of reasons, many related to harmful gender norms and inequalities. One of the main risks involves their caregiving roles and responsibilities for managing household prevention and hygiene and other household tasks in the affected communities. Because Ebola is transmitted through infected bodily fluids,

women and girls face a heightened risk of infection as caregivers.

Another area of risk that has attracted far less attention involves the sexual transmission of Ebola. The inability of many women and girls to refuse or negotiate safer sex increases their risk of infection. Studies from the West African outbreak have shown that traces of Ebola can be detected in semen for a year or longer, well after the men have recovered.⁵⁶ This highlights the importance of ensuring consistent patient exit counseling about the importance of condoms and instituting improved laboratory testing so that survivors can learn if their bodies are still shedding the virus.⁵⁷ These findings underscore the need for appropriate counseling about sexual transmission as part of Ebola treatment programs.

Research from the West African crisis also highlighted the particularly severe impact of Ebola on pregnant women, who faced a 90 percent mortality rate.⁵⁸ Pregnant women infected with Ebola usually do not present with the typical symptoms (e.g., fever, diarrhea, and vomiting) but rather present with more ordinary obstetric complications or spontaneous abortion. The implications of this are serious, as a pregnant woman presenting with symptoms of a spontaneous abortion might not be suspected of

- During the 2014-2016 Ebola outbreak in West Africa, the **mortality rate among pregnant women was 90%**, significantly higher than the average case fatality rate for Ebola virus of 50%.¹
- In the DRC, **26,800 cases of gender-based violence were registered in 2018 alone**, but many more were not reported.²

1. David A. Schwartz, Julianne Ngoundoung Anoko, and Sharon A. Abramowitz, eds., *Pregnant in the Time of Ebola* (Cham, Switzerland: February 2019).

2. UN OCHA, "DRC: 'Women and girls' bodies are not battlegrounds," May 13, 2019, <https://www.unocha.org/story/drc-'women-and-girls'-bodies-are-not-battlegrounds>".

having Ebola, which could both delay her treatment for Ebola and increase the risk of transmission to her health providers. Equally serious, health centers often do not have sufficient capacity to treat pregnancy-related complications and might isolate a pregnant woman suspected of Ebola and withhold providing the urgent life-saving services.⁵⁹ This highlights the need to develop guidelines and protocols for managing pregnant women during an Ebola outbreak and for greater data about cases of pregnant women.

Given the already fragile health systems in Ebola-affected areas, outbreaks further overwhelm the health facilities, making access to maternal and reproductive health services more difficult and potentially dangerous. Ebola outbreaks could therefore lead to greater maternal and neonatal mortality and morbidity, given the reduced access to health facilities for procedures such as cesarean sections and other obstetric care and the increased reports of women choosing to deliver at home instead of at health facilities.⁶⁰ Similarly, the rate of unintended pregnancy may increase when women and girls cannot access health facilities.

Risks of GBV are also heightened during Ebola outbreaks, both because women and girls may be more confined to their homes and because adolescent girls who are frequently charged with fetching

water may be exposed to GBV and exploitation. An assessment conducted by IRC found that women and girls' responsibility for caring for the sick and for managing household prevention puts them at risk and that adolescent girls face especially elevated risks of sexual violence and harassment in fetching water for the household. During the current Ebola crisis in the DRC, IRC reported that communities have perceived increased risks of sexual violence and domestic violence and increased sexual exploitation of women and girls, sometimes related to transactional sex. The lack of safe, confidential, and quality health services exacerbated the sense of risk and insecurity.⁶¹ These findings underscore the need to integrate GBV prevention and response services into Ebola response programs.

Going forward, special attention to the risks faced by women and girls and GBV programing should be implemented alongside infection prevention and control as part of the standard Ebola outbreak response. In the DRC, OFDA is now funding some work in these areas.⁶² Such concurrent programing is also important to helping address the severe lack of public trust and confidence that is undermining the Ebola response, since engaging women, girls, and communities is a critical way to serve both purposes.

Additional Areas of U.S. Capacity and Engagement

WOMEN, PEACE, AND SECURITY

In addition to these humanitarian and global health programs, the impact of armed conflict on women and girls has been increasingly reflected in the fields of security and post-conflict recovery. The Women, Peace, and Security agenda brings a gender perspective to conflict prevention, peacekeeping, and rehabilitation efforts and aims to ensure women's participation in peace processes and a focus on how women and girls are specifically targeted for sexual violence, exploitation, and abuse.

In June 2019, the Trump administration issued its Strategy on Women, Peace, and Security, as required by the bipartisan Women, Peace, and Security Act signed by President Trump in October 2017.⁶³ The act, the first legislation of its kind in the world, recognizes that women in conflict-affected regions have achieved significant successes in moderating violent extremism and stabilizing societies, and it takes steps to build on U.S. policies supporting women's safety and security and equitable access to relief and recovery. The act also calls for the United States to use diplomatic activity and programs to "promote the physical safety, economic security, and dignity of women and girls" and requires each relevant federal agency to develop implementation plans.⁶⁴

The Trump administration's Strategy on Women, Peace, and Security recognizes the roles women play in conflict prevention and post-conflict stability and includes the protection of women's and girls' human rights and safety from violence and abuse among its priority efforts.⁶⁵ The strategy offers an opportunity to strengthen the focus on GBV and to report on those efforts to Congress.

At least three of the U.S. military's combatant commands now have gender advisors (Africa Command, Southern Command, and Indo-Pacific Command). At a presentation on Women, Peace, and Security for the Uniformed Services University, Cori Fleser, the gender advisor at U.S. Africa Command, explained the importance of these positions: "Gender advisors not only generate awareness for the unique security needs of

men, women, boys, and girls. They also work with U.S. and sometimes partner nations forces to identify the military's role in addressing gender-based security challenges in concert with other U.S. interagency efforts."⁶⁶ This is an important opportunity to expand gender expertise and attention to women's and girls' security in the DOD's operations. It also indicates the military's growing recognition that gender capability is critical for its strategy, operations, and tactics. This applies to a range of areas, including how rape and GBV can exacerbate conflict, how Boko Haram in Nigeria uses female suicide bombers, and how women are the frontline caregivers in an Ebola outbreak and other epidemics.⁶⁷

In April 2019, the United States supported UN Security Council Resolution 2467, which clearly linked sexual violence with peace and security and built upon the landmark UN Security Council Resolution 1325 in 2000.^{68,69} The U.S. delegation threatened to veto the draft resolution unless references to sexual and reproductive health for victims of rape in war, which the Trump administration believed was code for abortion, were removed. Ultimately, the changes that the U.S. government required were included, and the United States supported the final resolution.⁷⁰

CASE STUDY #3

South Sudan

Despite the peace agreement signed in September 2018, the humanitarian crisis in South Sudan continues, taking a heavy toll on women and girls.

An estimated 85 percent of the 2 million internally displaced persons are women and children, and an additional 2.2 million have fled to neighboring countries, resulting in Africa's largest refugee crisis.⁷¹

South Sudan has one of the highest maternal mortality rates in the world (789 per 100,000 births), which has been exacerbated by attacks on health facilities and severely limited access to maternal health care.⁷²

Sexual violence against women and girls has been a devastating feature of the conflict, including gang rape, sexual slavery, and abductions.⁷³ Many attacks have occurred while women and girls are traveling to or from sites for food distribution or on other errands.⁷⁴

In the last three months of 2018, the office of the UN High Commissioner for Human Rights reported an

upsurge in sexual violence in South Sudan and documented 134 cases of rape, including 50 children, and an additional 41 women and girls suffered other physical and sexual abuse. Michelle Bachelet, the UN High Commissioner for Human Rights, called on the government of South Sudan to investigate these abuses, but the chances for any accountability appear slim; in December 2018, a government-led investigation led by the minister of gender found that the reports of rape were "unfounded and baseless."⁷⁵ In the context of such widespread GBV, the UN's Global Protection Cluster reported that the GBV response is funded at a mere 12 percent, highlighting the serious resource constraints of the humanitarian response.⁷⁶

- It is estimated that more than half of young women **aged 15-24 years have experienced some form of gender-based violence.**¹
- South Sudan has one of the highest rates of maternal mortality at **789 per 100,000 live births.**²
- Only **4.1% of married women** are using a modern contraceptive method.³

1. United Nations Development Programme, "Vulnerable to violence: empowering women in South Sudan," June 22, 2017, <https://www.undp.org/content/undp/en/home/presscenter/pressreleases/2017/06/22/vulnerable-to-violence-empowering-women-in-south-sudan.html>.

2. WHO, "South Sudan: Country Cooperation Strategy at a Glance," updated May 2018, https://apps.who.int/iris/bitstream/handle/10665/136881/ccsbrief_ssd_en.pdf;jsessionid=24460950949C16F7CE1F3F1F5D5B68DF?sequence=1.

3. Track 20, "South Sudan Projected Trends in mCPR," accessed October 2019, http://www.track20.org/pages/participating_countries/countries_country_page.php?code=SS.

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

Lessons in innovative approaches to addressing women's and girls' needs in the context of health security can be learned from the President's Emergency Plan for AIDS Relief (PEPFAR), which has garnered bipartisan support since its inception under President George W. Bush in 2003. Given the devastation caused by the AIDS epidemic in high-burden countries, especially in sub-Saharan Africa, there has been strong bipartisan support around the importance of "strategic health diplomacy" to achieve epidemic control.⁷⁷

In recognition of the disproportionate impact of the HIV/AIDS epidemic on women and girls in sub-Saharan Africa, PEPFAR developed strategies to focus on the specific risks faced by women and girls, including GBV, that increased their infection rates. This acknowledgement that reducing the HIV risks for women and girls was an element of protecting health security has grown in the intervening years. In late 2014, PEPFAR expanded its focus on adolescent girls and young women with the launch of DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe). A public-private partnership implemented in 15 countries, DREAMS has demonstrated the importance of developing multisectoral programs to meet the needs of adolescent girls and young women in the context of the HIV crisis.⁷⁸ PEPFAR has invested over \$800 million through DREAMS over the last four years.⁷⁹ DREAMS holds important lessons for health security and for reaching adolescent girls and young women in humanitarian and crisis settings.

CONGRESSIONAL ENGAGEMENT

The U.S. Congress has also taken recent legislative actions in the area of women and girls globally. The strong bipartisan support for many of these bills, even in the current polarized environment, is evidence of the importance many members of Congress place on creating opportunities to address the needs of women and girls worldwide.

In July 2019, Representative Grace Meng (D-NY) introduced the bipartisan Safe from the Start Act in the House of Representatives. The bill was introduced in the Senate by Senator Jeanne Shaheen (D-NH). The

bill focuses on reducing the incidence of GBV, ensuring quality services for survivors from the onset of emergencies, and promoting standards for prevention, mitigation, and response to such crises. The bill would codify Safe from the Start, complement existing guidance, legislation, and programs, and call for annual reporting to Congress on progress made by the United States and its humanitarian partners.⁸⁰

In April 2019, Representative Lois Frankel (D-FL) introduced the bipartisan Keeping Girls in School Act in the House of Representatives. Co-sponsors included Representatives Susan W. Brooks (R-IN), Brian Fitzpatrick (R-PA), Elise Stefanik (R-NY), Nita Lowey (D-NY), and Ami Bera (D-CA). The bill was introduced in the Senate by Senator Jeanne Shaheen (D-NH), co-sponsored by Senators Todd Young (R-IN), Lisa Murkowski (R-AK), and Benjamin Cardin (D-MD). The bill recognizes that education is a life-saving humanitarian intervention that protects girls' lives, futures, and well-being and calls on the U.S. government to address barriers to education, including child marriage and early pregnancy.⁸¹

In December 2018, Congress passed the bipartisan Women's Empowerment and Entrepreneurship Act, which was then signed into law by President Trump in January 2019.⁸² The bill seeks to address gender-related barriers to economic growth and to support women-led enterprises. It also calls on the USAID administrator to ensure that strategies, programs, and activities are informed by a gender analysis and to report to Congress within a year on implementation.

Multilateral Humanitarian System and other Donors

"Sexual violence is a hidden crime. . . . But once you operate under the hypothesis that it takes place and you're looking for evidence, you see that it is one of the most prevalent problems of violations of legal frameworks that we're encountering and that's the reason why we're convinced today that it has to be an institutional priority."⁸³

Peter Maurer, president of ICRC, speaking at a CSIS event in Washington D.C. on May 10, 2019

The United States is a main contributor to the multilateral humanitarian system. The United States supports UN agencies, including the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), UNHCR, UNICEF, and the WHO, though no longer the United Nations Population Fund (UNFPA). The United States also supports international NGOs, including ICRC and International Federation of Red Cross and Red Crescent Societies (IFRC). Through these partners, U.S. investments support work around the world on women's and girls' health and protection. For example, UNHCR now has regional GBV advisors, including approximately six in Africa, which the United States helps to fund.⁸⁶

Multilateral organizations and UN agencies—notably the WHO, UNFPA, and UNICEF—deliver and support health services in crises around the world. For example, the WHO provides global coordination and guidance on health issues, including through its leadership of the global health cluster, a platform for humanitarian partner organizations working on health in emergencies.⁸⁷ UNFPA is the lead on women's and girls' health, and in 2018, UNFPA worked in about 55 countries providing maternal health services, contraceptive commodities, dignity kits, and adolescent health services, as well as assisting in safe deliveries and training midwives.⁸⁸ UNICEF focuses on children's health, education, nutrition, WASH, HIV/AIDS, and protection, including health emergency preparedness.⁸⁹

SPOTLIGHT ON THE INTERNATIONAL COMMITTEE OF THE RED CROSS

Since 2015, ICRC has made annual appeals in response to instances of widespread sexual violence. In 2019, the ICRC launched a \$27 million appeal to respond to sexual violence in 14 countries. ICRC is placing dedicated specialists on conflict-related gender-based violence in 6 countries to increase on-the-ground coordination of their response to the needs of women, girls, men, and boys.⁸⁴ ICRC officials have described the need to reverse the burden of proof, meaning that GBV should be assumed to be occurring in every context unless proven otherwise.⁸⁵

SPOTLIGHT ON ZAATARI REFUGEE CAMP

Programs in the Zaatari refugee camp in Jordan, which houses over 80,000 Syrian refugees and a clinic run by the Jordan Health Association, supported by the United Nations Population Fund (UNFPA), show the positive impact of providing a range of maternal and reproductive health services. This is evidenced by the 10,000 safe deliveries and zero maternal deaths in the clinic and the establishment of safe spaces for women and girls with GBV services.⁹⁰ When the United States was able to fund UNFPA, it was a strong supporter of these efforts.

In March 2017, the U.S. government withdrew its \$32.5 million funding to UNFPA, the lead UN agency focused on reproductive health care around the world, including in conflict and humanitarian crises. The administration made this determination based on the 1985 Kemp-Kasten amendment, which prohibits U.S. funds for “any organization or program which, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.”⁹¹ The administration cited UNFPA’s work in China as a violation of Kemp-Kasten, although UNFPA refutes this charge and there is no evidence to date that UNFPA directly supports such activities in China or elsewhere.⁹² In July 2019, the

administration again invoked Kemp-Kasten to withhold 2019 funding for UNFPA.⁹³

In the past, women and girls have not been fully prioritized in the UN humanitarian appeals. However, one outcome of the May 2019 Oslo Conference on Ending Sexual and Gender-Based Violence in Humanitarian Crises was a new commitment from the UN to make women and girls more central in the humanitarian response planning process. It will be important to track the success of this commitment going forward. In particular, the UN humanitarian coordinators have a significant responsibility to address these issues in specific crises.

GAPS IN GLOBAL FUNDING FOR WOMEN'S HEALTH AND SAFETY SERVICES

International donors do not come close to meeting the humanitarian funding requests issued by OCHA, which often hover between 20 and 50 percent funded. This gap is even more acute in funding for women’s and girls’ health, safety, and security. Despite greater recognition globally of the need for effective programs and targeted investment, the need far outstrips the limited resources. An analysis of funding for reproductive health in emergencies between 2002 and 2013 found a gap of over \$2.6 billion in these areas.⁹⁴ Between 2016 and 2018, GBV funding received only an estimated 0.12 percent of humanitarian funding and one-third of the requested funds for GBV. However, it can be difficult to track precise investments in GBV, since

GBV programming is not always identified in multi-sectoral programs and is sometimes integrated into broader health or safety programs.⁹⁵

Nonetheless, it is significant that the first pledging conference for GBV in humanitarian crisis settings was held in Oslo in May 2019, leading to new commitments of \$360 million from 21 donors.⁹⁶ The conference brought together representatives from 100 countries, GBV survivors, international and regional organizations, civil society organizations, and specialists. Although the United States did not announce any new pledges, it did send a delegation to Oslo. In a statement released by the U.S. Embassy in Norway, the U.S. government reaffirmed its commitment to continuing to invest in GBV preparedness, training for first responders, and incorporating GBV risk reduction into humanitarian programs and systems.⁹⁷

<1% of global humanitarian funding is spent on sexual and gender-based violence (SGBV) prevention and response activities.

GAP IN GBV FUNDING, AS OF OCTOBER 2019:

TOTAL REQUIREMENTS **\$163,239,314**
 FUNDING MET **\$18,845,940**
 UNMET REQUIREMENTS **\$144,393,374**

Source: UN OCHA Financial Tracking Service, “Response plans and appeals snapshot for 2019,” accessed October 24, 2019, <https://fts.unocha.org/appeals/overview/2019>.

Part of the humanitarian response architecture is the cluster system, designed to improve leadership and accountability in specific areas in crises and to improve multisectoral action.⁹⁸ The global protection cluster includes a sub-cluster on GBV, with UNFPA acting as the focal point. However, funding for GBV is not always separated out from other protection budget allocations, although in 2016 it became a stand-alone sector in OCHA's Financial Tracking Service.⁹⁹ This work also includes a GBV roster that UNFPA has developed, with the aim of being able to deploy GBV advisors more quickly.¹⁰⁰ The global health cluster is coordinated by the WHO Emergency Risk Management and Humanitarian Response Department and includes maternal and reproductive health. A reproductive health working group is often established under the health cluster, usually coordinated by UNFPA, which also relies on a global emergency surge roster to rapidly provide qualified personnel to emergency settings.¹⁰¹

A number of multilateral initiatives have attempted to focus on gender equality programing in humanitarian settings, often with U.S. support. These include the Gender Standby Capacity Project (GenCap), an initiative created in 2007 by the IASC and the Norwegian Refugee Council to promote gender equality programing and strengthen humanitarian leadership in addressing the distinct needs of women, girls, men, and boys.¹⁰² GenCap deploys advisors to support UN humanitarian coordinators at the onset of emergencies or in later, more protracted phases.¹⁰³ The Protection Standby Capacity Project (ProCap), created in 2005, aims to build protection capacity in humanitarian responses by deploying senior protection advisors.¹⁰⁴ In addition, in 2018 the IASC updated the Gender Handbook for Humanitarian Action, a resource to help humanitarian actors build on commitments to gender equality and to women and girls in humanitarian programing.¹⁰⁵

Other key donors, notably the United Kingdom, Sweden, Denmark, the Netherlands, and Canada, are supporting women's and girls' health and protection in humanitarian settings. In December 2018, Canada took over rotating leadership from the European Union of the Call to Action on Protection from GBV in Emergencies. The United States led the Call to Action in 2015-2016 and remains active.

CASE STUDY #4

Rohingya Crisis

Between 2017 and 2018 nearly three-quarters of a million refugees fled ethnic cleansing and egregious abuses in Myanmar.

Sixty percent of those who fled were women and girls. GBV was widespread and systematic.¹⁰⁶ Following international media attention to the sexual violence and gang rapes by the Myanmar military, humanitarian organizations recognized that the need for maternal health and family planning services, post-rape care, psychosocial support, and GBV programs were urgent.

While the humanitarian organizations bolstered critical services, many gaps remained in providing maternal health, safe delivery, reproductive health, and GBV services, especially since home deliveries were common.¹⁰⁷ Refugees International attributed this weak initial response to a lack of expertise in and resources for implementing GBV programs. The Rohingya crisis demonstrated the value of safe spaces for women and girls, called women-friendly spaces, where health information, support services, and referrals could be provided, including psychosocial support and case management of GBV. However, Refugees International found that many of these

spaces lacked the internal capacity to appropriately train staff to offer the essential services and failed to comply with basic guidance provided by GBV experts in Cox's Bazaar.¹⁰⁸

One of the elements that proved helpful in the Rohingya crisis was the strong position of UNFPA, which had been present in Bangladesh before the crisis. UNFPA helped to focus efforts on strengthening the skills of local providers, working with international NGOs to condense training packages in the refugee camps and at the health facilities.¹⁰⁹ UNFPA also provided reproductive health kits for health facilities, including kits for clinical management of rape.¹¹⁰ Despite these efforts, many organizations realized that adolescent girls were not accessing health services or safe spaces, often due to security concerns related to GBV. To address this gap, CARE, for example, worked to strengthen the community outreach approach to better reach adolescent girls and to meet their needs, although programing tailored to adolescent girls remains limited.^{111,112}



Woman walks in front of a closed store with a graffiti reading "Is there bread?" in Caracas on July 23, 2018.

JUAN BARRETO/AFP/GETTY IMAGES

Additional Important Considerations

There are four important issues areas that should be accounted for in the design and implementation of sustainable, successful programs in this area.

ADOLESCENT GIRLS

Health and protection gaps are amplified for adolescent girls in crisis settings, especially when families are broken up and social services including health care and education collapse. Adolescent girls are at high risk of GBV, including forced marriage, trafficking, transactional sex for survival, and sexual assault by armed forces, humanitarian actors, or others. Adolescent girls face high rates of unintended pregnancy, with consistent barriers to accessing reproductive health and family planning services, as well as men-

strual hygiene supplies. Inadequate provision of safe and private toilets with inside locks and responsibilities for fetching firewood and water increase the risk of GBV for adolescent girls in crises. A recent study of donor development aid to 25 conflict-affected countries found that adolescent health has "continuously been neglected by donors."¹¹³

A holistic approach is needed to make health and social services more accessible to adolescent girls in crisis settings. Education Cannot Wait, a new global fund to address the educational needs of children in humanitarian crises, has recognized that connecting adolescent girls with appropriate health, hygiene, and protection services is indispensable in addressing sexual and other forms of physical violence that may result in unintended pregnancy and dropping out of school.¹¹⁴ The United States has contributed \$33 million to Education Cannot Wait since its inception.¹¹⁵



CASE STUDY #5

Venezuela

Venezuela faces an ongoing, entrenched humanitarian crisis.

The maternal mortality rate has escalated due to lack of medicines, and availability of contraceptives has been sharply reduced, leading to rising rates of unintended pregnancies.¹¹⁶ A rapid gender assessment conducted by CARE about Venezuelan refugees and migrants in Colombia estimated that almost half of Venezuelan women and girls (over 577,000) were at risk of GBV, including sexual violence, sex slavery, human trafficking, and transactional sex, with particular issues faced by adolescent girls and those from indigenous groups.¹¹⁷ The report found that women and adolescent girls were severely affected by unintended pregnancies and STIs and that most pregnant women and girls did not have access to antenatal care or safe delivery services. While humanitarian organizations are trying to provide services to address these issues, the scale of the crisis and weak local coordination means that women's and girls' health and safety remain a significant challenge.¹¹⁸

OCHA's most recent Humanitarian Response Plan (HRP) for Venezuela, covering July-December 2019, focused on particularly vulnerable groups, including pregnant and lactating women and adolescents.¹¹⁹ In addition to WASH and nutrition, the HRP identified key areas that need attention, which included GBV prevention and response and maternal and reproductive health services. The HRP highlighted the need for protection services to prevent GBV and sexual exploitation and the importance of providing services for survivors of violence, including establishing or strengthening safe spaces providing health, psychosocial, and legal services, as well as case management. The HRP emphasized the impact of the crisis on critical health services through disruption in supplies of medicines and medical equipment and loss of health providers, all of which has disproportionately affects vulnerable populations and contributes to risks of maternal and neonatal mortality and morbidity.

LOCAL CAPACITY TO BUILD SELF-RELIANCE

Strengthening local capacity of health care providers, information systems, community outreach workers, and women's organizations is critical to build resilience and sustain services in protracted crises. This focus on strengthening local systems too often falls through the cracks, outside of the purview of emergency responders. Yet the return on such investments could be significant for ensuring that health systems and supply chains can function and meet the needs of women and girls and the broader population.

This approach aligns with USAID's framework of helping countries on their journey to self-reliance. One government official emphasized the importance of embedding health and protection services for women and girls in crisis response and recovery. "You won't have self-reliant societies if systems break down every time there's a crisis. We need to put things in place to make sure services can continue, which is essential to long-term self-reliance."¹²⁰

The Grand Bargain, a 2016 agreement between the largest humanitarian donors and aid providers to improve humanitarian assistance, set a target of 25 percent of global humanitarian aid going to local and national organizations by 2020.¹²¹ Much more remains to be done in this area, including support for civil society organizations, women's groups, and other organizations focused on women's and girls' health and protection. At the moment, it is difficult for such local groups to apply directly for U.S. government funding, due to various protocols, regulations, requirements, operational standards, and other criteria that effectively exclude them.¹²²

DATA

There is consistently a shortage of quality data to assess and quantify the health and protection needs of women and girls. Nevertheless, it is now widely recognized that the absence of data on women and girls is not an excuse not to prioritize them. Gender-related data should be collected in all settings, including within the contexts of disease outbreaks or food and nutrition security crises. Targeted investments in surveillance systems will be required

to gain a greater understanding of the complexities that women and girls face in crises and ultimately improve their health and safety outcomes. An emphasis should be placed on building interoperable digital platforms to improve the quality, availability, and utility of the data.

MENTAL HEALTH

Crisis environments are known to profoundly impact the mental health of affected populations, including health workers themselves. Survivors of sexual violence often have critical mental health needs relating to depression, anxiety, and post-traumatic stress disorder (PTSD), all of which impact the physical and emotional well-being of the survivor and his or her family. The humanitarian community has increasingly recognized the prevalence of these issues for GBV survivors and the urgency of strengthening the capacity of health care workers to provide psychosocial support for survivors. The Mental Health Gap Action Program, an initiative of the WHO and UNHCR, produced a clinical guide on mental, neurological, and substance abuse disorders in humanitarian settings for general health care providers in non-specialized health care.¹²³

A study of GBV survivors in eastern DRC, an area plagued by conflict and where an estimated 40 percent of women have experienced sexual violence, found that effective mental health services could help survivors recover from PTSD, depression, and anxiety.¹²⁴ Other studies have demonstrated the value of integrating mental health services into maternal and child health programs and the importance of integrated screening tools in primary health care in low-income and crisis settings.

Recommendations

The U.S. government, backed by bipartisan Congressional support, has devoted extensive capacity and resources to strengthening maternal and reproductive health services, family planning services, and GBV prevention and response around the world. However, the U.S. government lacks a clear coordinated strategy and an integrated structure to focus these capacities in crisis settings, where the needs of women and girls are acute.

This report proposes an approach that will bring forward \$30 million in flexible funding annually for five years to ensure that the extensive capacities of the U.S. government in the areas of maternal health, reproductive health, family planning, and GBV prevention and response are no longer left on the sidelines in crisis response and recovery. This additional flexible funding is essential to spearhead this effort and incentivize U.S. agencies and their partners to rapidly begin execution of the program. The funding will be catalytic: it is intended to attract higher-level financial commitments from existing programs at USAID and PRM. This catalytic, incremental approach will ultimately ensure that existing U.S. government resources and capacities are channeled to those disordered settings where the needs of women and girls are greatest.

The \$30 million in flexible funding will be used to launch an integrated model of service delivery for women's and girls' health and safety. This model should be piloted in two to three priority emergency settings to demonstrate impact and generate data and lessons to inform future expansion and replication. This model should adapt, refocus, and integrate programs at USAID's global health bureau, OFDA, PRM, and CDC, where appropriate.

This model should be operationalized as follows:

SECRETARIAT

The responsibility for operationalizing this model should be shared between the USAID assistant administrator for Democracy, Conflict and Humanitarian Assistance (DCHA), the USAID assistant administrator for global health, and the PRM

assistant secretary, in close coordination with the CDC. A working group of core subject matter experts should support the secretariat in operationalizing the model, ensuring alignment of planning and investments, and promoting enhanced coordination between women's and girls' health and protection across the interagency process. The agencies should report to Congress on the impact, outcomes, and lessons learned.

GEOGRAPHIC FOCUS

In its initial pilot phase, the model should be implemented in two to three crisis settings such as the DRC, South Sudan, Syria, Venezuela, or Yemen, with the intention of generating learnings to inform potential replication in other disordered settings. To determine where the model should be operationalized, careful consideration should be given to the maternal mortality rate, the percentage of unmet need for contraception, the level of services available for adolescent girls, whether U.S. agencies or partners have access to the communities in need, and the impact of the crisis on U.S. health security interests. While GBV is severely under-reported, U.S. agencies and partners should, to the best of their ability, try to assess the scale and scope of GBV and share existing data in order to determine the initial priority countries. It is not necessary to obtain population-based data on GBV to prove the magnitude of the problem.

A mapping analysis of current U.S. capacities and investments in potential priority countries should also be conducted early on. USAID should identify the gaps in gender analysis and in technical capacity, services, and infrastructure for women's and girls' health and protection in the selected priority countries. This mapping analysis should evaluate where USAID (including the global health bureau and the new MOMENTUM project) and OFDA are investing in maternal health, family planning, and GBV. Where applicable, the mapping should include CDC programs as well.

FUNDING AND OPERATIONAL REQUIREMENTS

Congress should authorize quick disbursing and flexible programmatic funding through USAID—in-

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cluding the global health bureau and USAID missions—and PRM, in close consultation with other relevant U.S. government agencies. This funding should be used in two to three priority crisis settings to spearhead this integrated service delivery model and incentivize U.S. agencies and their partners to

rapidly begin execution of the program. The additional flexible funding is just the first step. This funding will be catalytic and is intended to attract higher-level financial commitments from existing programs at USAID and PRM.

The following operational requirements should be put in place:

- Ensure that OFDA's DARTs and their implementing partners, as well as the CDC and DOD when involved, prioritize women's and girls' health, safety, and security as part of the initial essential package of services offered in these crisis situations.¹²⁵
- Ensure that all U.S. government programs incorporate a meaningful gender and GBV analysis into all crisis responses and ensure that the results of these analyses are reflected in program design and implementation.
- Direct PRM to dedicate increased funding for women's and girls' health, safety, and security in refugee and forced displacement settings and to develop accountability criteria for its UN and NGO partners to demonstrate expertise and capacity in these areas.¹²⁶
- Strengthen local capacity of health care providers, community outreach workers, and women's

organizations to provide essential health and protection services for women and girls.¹²⁷

- Systematically evaluate the benefits, challenges, and operational costs of implementation in the two to three pilot countries to determine the impact of the model, improve effectiveness of integrated services and the enabling environment, and determine whether this model should be sustained and introduced in additional crisis settings. Dedicated capacity to conduct real-time evaluations would help ensure appropriate feedback loops and course correction.
- Ensure high-level, committed U.S. leadership to hold programs and partners accountable and to encourage other donor countries, multilateral organizations, and UN agencies to participate in this strengthened and integrated model. This includes strengthening partnerships with UN humanitarian agencies and expanding support for UN agencies in the priority countries.

Estimated Cost:

\$30 million per year for five years.

This is based on expert estimates of pilot program costs in two to three humanitarian crises, considering:

- (1) estimates of the number of affected women and girls in these crises from OCHA and UN-HCR;
- (2) costs of assumed 20 percent uptake of family planning services, based on cost per couple-year of protection;
- (3) cost of assumed 20 percent uptake in maternal health care, based on average cost per pregnancy;
- (4) cost of GBV care, based on assumed 20 percent uptake; and
- (5) estimated cost of health care worker and community outreach worker capacity building.

These figures cover approximately 4.6 million women and girls, aged 15-49, in three hypothetical priority countries: 1,600,000 in the DRC; 1,700,000 in Yemen; and 1,300,000 in Venezuela/Colombia. These figures have been informed by key humanitarian sources, including the OCHA DRC Humanitarian Response Plan for 2019, the OCHA Yemen Humanitarian Fund Biannual Dashboard, and the Humanitarian Needs Overview for Venezuela and Colombia, 2019. Assumptions of coverage were based on analysis of coverage of humanitarian response plans as reported by OCHA.¹²⁸

In addition, this effort will leverage the existing budgets from U.S. government agencies, notably USAID, PRM, and OFDA, to further amplify the impact of strategic, integrated investments in women's and girls' health and protection.

Conclusion

The U.S. government has an opportunity to catalyze action to improve the health, safety, and security of women and girls and advance global health security. Despite progress in recognizing the life-saving value of these programs, glaring operational gaps remain. The United States cannot tackle these issues alone, but its leadership and targeted investments in health security for women and girls in crisis settings are essential to mobilize action at the global and national levels.

The strengthened approach to women and girls in health security outlined in this report will rely on continued bipartisan Congressional engagement. In particular, Congress should ensure sustained implementation of U.S. government programs that address GBV, maternal health, and family planning. Working with the administration and U.S. government agencies, Congress should also ensure that these critical issues are reflected in and aligned with existing strategies on health security, global health, women's and girls' empowerment, GBV prevention and response, and the Strategy on Women, Peace, and Security. On the multilateral front, Congress should ensure that U.S. investments are leveraged through coordination with UN agencies. By establishing such an elevated approach that builds on current capacities, the United States will advance both the health and protection of millions of women and girls while promoting global health security.

About the Author

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118. Ibid., 11.

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124. Judith K. Bass et al., “Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence,” *New England Journal of Medicine* 368 (June 2013), <https://www.nejm.org/doi/full/10.1056/NEJMoa1211853>.

125. This means that experts in these areas participate in needs assessments and program design and implementation, focusing on provision of a quality, respectful continuum of care, through pregnancy, childbirth, and postpartum (including emergency obstetric and newborn care); provision of a range of family planning methods (including emergency contraception and long-acting methods); and provision of post-rape care (including case management, post-exposure prophylaxis to prevent HIV, psychosocial care, and GBV risk mitigation activities).

126. PRM should also improve its internal capacities

by filling current positions and expanding positions on women and girls’ health and protection, aimed at enhancing its expertise and strategy.

127. This includes establishing referral networks for other services for risk mitigation and capacity for case management of GBV.

128. These estimates cover services for MCH, family planning, GBV, and HCW training based on the following assumptions: costs for family planning came from NGO reporting, including IRC and PSI; GBV cost estimates, came from NGOs (IRC) and WHO experts, and calculated averages based on country data; MCH costs were calculated from prior work done by Avenir Health for the CSIS Task Force on Women’s and Family Health and adapted to address the cost differential between the 3 crises. HCW costs came from Field Epidemiology Training Program (FETP) estimates.

COVER PHOTO PER-ANDERS PETTERSSON/GETTY IMAGES

Gladys Aromo, age 12, carries a container with drinking water while walking to her house on May 26, 2005 in Laliya, Uganda.



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