What are the core challenges to providing sexual and reproductive healthcare to women and girls in humanitarian crises?

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Introduction

The right to sexual and reproductive healthcare (SRH) has been enshrined in international conventions, but its provision remains contested and challenging. Developing from the declarations made in the International Covenant on Economic, Social and Cultural Rights, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) define SRH thus: 'Sexual and reproductive health is a state of complete physical, mental and social well-being (not merely the absence of disease and infirmity) in all matters relating to the reproductive system and its functions and processes.'[1] Elaborated, best practice SRH enables everyone full access to safe and legal services, driven by each individual's personal agency and autonomy over their body. However, the 2018 Guttmacher-Lancet Commission found that annually in developing regions: 45 million women have inadequate or no antenatal care; 25 million unsafe abortions occur; 30 million women do not give birth in a health facility; and nearly one in three women will experience intimate partner violence or non-partner sexual violence.[2] Globally, unsafe abortions account for approximately 10% of maternal deaths, 99% of which occur in developing countries.[3] Overall, almost all 4.3 billion people of reproductive age worldwide will have inadequate SRH services during their lives.[4] Thus, despite such international standards the reality falls far short for many women, particularly in developing countries.

[1] "Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings," Inter-Agency Working Group on Reproductive Health in Crises, 2018, 1.
[2] Ann M. Starrs et al. "Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-Lancet commission," *The Lancet* 391, no. 10140 (2018): 2642-2692, 2642.
[3] "Inter-Agency Field Manual," Inter-Agency Working Group on Reproductive Health in Crises, 145.
[4] Starrs et al., "Accelerate progress," 2642.

However, SRH access in refugee crises is even more challenging, in particular for women and girls. Not only are refugee populations confronting the numerous barriers to accessing SRH faced in stable environments, but their refugee status compounds certain vulnerabilities. At the outset of a crisis, the priorities of humanitarian responders can often be on services such as access to food, water and other healthcare services; SRH and issues impacting women and girls more generally are not a key focus of institutional efforts or agenda-setting.[5] Although there are often limited resources at the outset of a humanitarian crisis, the IAWG outlines the severe consequences of neglecting SRH needs in such situations: preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy such as unsafe abortion; preventable consequences of sexual violence such as unintended pregnancies; the increased acquisition of Sexually Transmitted Diseases (STDs); increased transmission of HIV; and mental health challenges such as depression and trauma.[6] Although these consequences can occur in non-refugee contexts, they are exacerbated by several key factors: the general breakdown in societal infrastructure creating additional obstacles to accessing healthcare services; the heightened risk of sexual violence preponderating; the enhanced likelihood of displacement and the unpredictability that fosters, in terms of both knowledge regarding and equity of access to healthcare services; and the lack of resources specifically allocated to the needs of women and girls during crises.[7]

This paper will firstly analyse the specific vulnerabilities of women and girls in refugee contexts and how their access to adequate SRH can be impacted. It will then outline international frameworks for SRH provision in such contexts and the core challenges to implementation, as posited by such international actors. Once these international perspectives have been established, this paper will examine the Venezuelan crisis as a case study, firstly

[5] "Facts and figures: Humanitarian action," UN Women, last modified May 2017,
[6] "Inter-Agency Field Manual," Inter-Agency Working Group on Reproductive Health in Crises, 17-18.
[7] Ibid, 1; "Facts and figures.: Humanitarian action," UN Women.

by describing the broader crisis itself and then the SRH challenges faced by women and girls both in Venezuela and as refugees in Colombia. It will explore the concept of structural violence to argue that the problems women and girls face in crisis are deep-rooted and relate to pre-existing conditions, and thus that any policy recommendations for improving SRH for refugees requires addressing health systems in general, rather than response mechanisms alone.

Context: women and girls during a humanitarian crisis

No humanitarian crisis is gender neutral, women and girls have often become particularly vulnerable to certain abusive practices. During a crisis there is usually a breakdown in law and order, which heightens the risk of gender-based violence (GBV); meanwhile, survivors have limited support resources. Moreover, in conflict situations GBV can systematically be used as a weapon of that conflict.[8] When women and girls become refugees, UNHCR note their specific vulnerability to sexual and physical abuse and exploitation, as well as to sexual discrimination in the delivery of goods and services.[9] In addition, child marriage can increase as parents seek to gain protections for their children against an increased environment of sexual violence, hoping that marriage will ensure that they will be cared for.[10] Across a society enduring crisis, people often lose their livelihoods, educational opportunities, homes and other assets; many women can also face the disintegration of both their families and their social networks.[11] Alongside the aforementioned risks of GBV, the Guttmacher Institute note women's particular vulnerability to mental and physical illness, malnutrition, disease, long-term disability and poverty.[12]

[8] "Sexual and reproductive health and rights in conflict and emergencies," Irish Family Planning Association, 2016.
[9] "Guidelines on the Protection of Refugee Women," UNHCR, July 1991.
[10] "Sexual and reproductive health and rights in conflict and emergencies," Irish Family Planning Association.
[11] Sneha Barot, "In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations," Guttmacher Institute, 2017.
[12] Ibid.

Within this unstable context, women's SRH needs are particularly pronounced during a refugee crisis. In 1994 an organisation now called the Women's Refugee Commission published a landmark report positing that reproductive health in crisis should be prioritised. Later, in the UN conferences in Cairo in 1994 and Beijing in 1995 it was established that women displaced by conflict or crisis have the same right to reproductive health that all women do.[13] Despite such declarations, SRH risks remain exacerbated during crises. A general health system collapse, for instance, can cause interrupted access to contraception, thus increasing the risk of unwanted pregnancies, unsafe abortions, STDs including HIV, and ultimately maternal illness and death.[14] These risks are not only rooted in lack of access to effective health systems, but in wider societal conditions making women more susceptible to trauma, disease and malnutrition; these also contribute to the increase in risky pregnancies. Indeed, in 2015, UNFPA found that the estimated number of maternal deaths in 35 countries afflicted by humanitarian crises or fragile contexts comprised 61% of maternal deaths globally.[15] Furthermore, the increase of STDs in a refugee crisis is related not only to the limited availability of contraception, but also the increased incidence of GBV.[16] Collating data from numerous studies, a 2013 WHO report emphasises that GBV increases the incidence of STDs, given that women are unlikely to have control over contraceptive decisions in the context of non-consensual sex. Moreover, the report notes that perpetrators of GBV have a greater tendency to display HIV-risk behaviours, such as engaging with multiple sexual partners and frequent alcohol use.[17] In a humanitarian crisis, the risk of GBV contributing to STD incidence increases. A study on internally displaced women along the

[13] Ibid.
[14] Ibid.; "Sexual and reproductive health and rights in conflict and emergencies," Irish Family Planning Association.
[15] Luisa Kislinger et al. "Women on the Edge 2019: Women's Rights in the Face of the Worsening Complex Humanitarian Emergency in Venezuela," Equivalencias en Acción, May 2019, 7.
[16] "Sexual and reproductive health and rights in conflict and emergencies," Irish Family Planning Association.
[17] "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence," World Health Organization, 2013, 21.

Congo River basin in the Democratic Republic of Congo found that, while HIV prevalence amongst overall study participants was the same as national estimates, prevalence amongst female IDPs was over two times higher;[18] it further found that a history of sexual violence against female IDPs during the conflict was significantly correlated with HIV infection.[19] This is one case in which displacement, GBV and STD prevalence converge to create an extremely challenging SRH environment for women and girls. Given these numerous challenges, the IAWG emphasises that the 'timely provision of SRH services can prevent death, disease, and disability' related to the aforementioned risks faced by women and girls in crises.[20] The benefits of providing SRH during a crisis extend beyond pure fulfilment of rights obligations and carries a lasting impact for the wellbeing and lives of women, girls, and subsequently society at large.

Frameworks and challenges: SRH delivery during a crisis

The IAWG plays an important role in the establishment of international norms regarding the fulfilment of SRH needs during humanitarian crises. It was formed in 1995 following commitments made by over 50 governments, UN agencies, and NGOs, and in 1999 they released their first Field Manual.[21] Deriving technical guidelines from the World Health Organization (WHO) and other expert bodies, the Manual has been revised several times to adapt to rights and healthcare developments. An integral component to the Manual is the Minimum Initial Service Package (MISP), intended for use principally by SRH coordinators and health program managers when a crisis breaks. In their 2018 MISP, the priority objectives identified were: to ensure that the health sector identifies an organisation to lead

[18] IDPs: internally displaced persons
[19] Andrea A. Kim et al. "HIV Infection Among Internally Displaced Women and Women Residing in River Populations Along the Congo River, Democratic Republic of Congo," *AIDS and Behavior* 13, no. 5 (2009): 914-920.
[20] "Inter-Agency Field Manual," Inter-Agency Working Group on Reproductive Health in Crises, 2.
[21] Ibid, 2.

implementation of the MISP; to prevent sexual violence and respond to the needs of survivors; to prevent the transmission of and reduce morbidity and mortality due to HIV and other STDs; to prevent excess maternal and newborn morbidity and mortality; and to prevent unintended pregnancies.[22] Access to safe abortion is further identified as a standalone priority activity, although only 'to the full extent of the law' which is restrictive in the majority of countries.[23] These objectives are wide-ranging even within the realm of SRH, and thus they promulgate three priority activities to be instigated at the outbreak of a crisis (ideally within the first 48 hours):

1. Ensure the availability of multiple long-acting reversible and short-acting contraceptive methods at primary healthcare facilities, such that contraceptive demand can be met.
2. Provide information, education, and communications (IEC) materials, and contraceptive counselling that emphasises informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination.
3. Ensure that all members of a community (of all genders) are aware of the availability of contraceptives.[24]

The IAWG do not just provide guidelines for SRH priorities but also describe how implementation should be conducted. This includes a range of recommendations for programmers and service providers, such as the forging of respectful partnerships with communities while remaining aware of any violence or power dynamics that may act as structural barriers to a patient's decision-making ability.[25] The IAWG framework for SRH

[22] Ibid, 18-19.
[23] Ibid, 19.
[24] Ibid, 4.
[25] Ibid, 13.

provision during a humanitarian crisis thus provides a comprehensive outline of how SRH actors can respond to the needs of refugee women and girls and seeks to be applicable to any humanitarian situation.

However, major challenges remain to the delivery of the MISP and the international standard of SRH in a crisis. Although the Women's Refugee Commission emphasise that 'implementing the MISP is not optional: it is an international standard of care that should be implemented at the onset of every emergency,' these goals are ambitious even in peacetime or stable contexts.[26] The Guttmacher Institute notes that SRH services on-the-ground fall far short of both patient needs and established standards.[27] They attribute the barriers to implementation of effective SRH as fourfold: i) cultural, manifested in cultural norms and ideological opposition to SRH; ii) research, with logistical and security obstacles preventing capacity to conduct research and collect data; iii) financial, as needs far outpace funding generally in a refugee crisis, which is compounded for SRH services (in particular where the US is a major but inconsistent funder); iv) and systemic, whereby the strength of a health system prior to crisis is an important indicator to how it can respond to a humanitarian crisis.[28] Regarding financial barriers, a systematic analysis related to SRH in humanitarian crises found that 34.5% of health and protection proposals between 2002 and 2013 were relevant to reproductive health, with funding needs met totalling $2.031 billion USD in contrast to $4.720 billion requested. Moreover, of SRH components for the 2009-2013 proposals, maternal newborn health was allocated the largest proportion at 56.4%, whereas family planning only comprised 14.9% and proposals dedicated to HIV/STDs decreased during this period. In addition, just 5.6% of reproductive health proposals met MISP

[26] "Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations," Women's Refugee Commission, 2011, 101.
[27] Barot, "In a State of Crisis."
[28] Ibid.

standards, thus even where proposals are introduced, they do not meet the minimum standard of care propagated by international norms.[29] Overall, the four barriers to implementation of SRH are largely rooted in pre-existent norms, rather than arising from a crisis. Many of them are not specific to SRH alone but to the entire humanitarian response to a refugee crisis. Indeed, the IAWG notes that in order to plan and deliver SRH services, a community requires protection, health, nutrition, education, water, sanitation and hygiene, and community service personnel.[30] This provides another challenge, as it demonstrates that the ability to provide adequate SRH services is not the responsibility of stakeholders within this field alone, since it demands coordination across the humanitarian space.

The Venezuelan crisis: context and SRH provision

The Venezuelan crisis is useful for a contemporary analysis of SRH in a humanitarian context as it is an ongoing crisis, in which the SRH situation for women and girls is currently being reported. Additionally, it is unfolding in a region where SRH access has historically been severely lacking, but concurrently there are several stakeholders within and outside Venezuela seeking to assess and address the SRH challenges faced by Venezuelan women and girls. The humanitarian crisis in Venezuela began fully escalating in 2014, induced by economic policies, high levels of corruption, diminished income, and low investment in infrastructure and basic services.[31] In 2019, the International Monetary Fund projected the inflation rate rising to 10,000,000%.[32] Much government data has not been published since 2015 and thus it is difficult to gain an accurate assessment of the dimensions of the crisis, but it has brought about a collapse in healthcare and education, alongside increased unemployment rates and extrajudicial killings. As Venezuelan SRH network Equivalencias

[29] Mihoko Tanabe et al. "Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013," *Conflict and Health*, 9, no. 1 (2015).
[30] "Inter-Agency Field Manual," Inter-Agency Working Group on Reproductive Health in Crises, 2.
[31] Kislinger et al. "Women on the Edge 2019," 7.
[32] "República Bolivariana de Venezuela," International Monetary Fund, October 2019.

de Acción argue, the State's ability to deliver services including healthcare has collapsed, which has dire consequences for Venezuelans accessing their fundamental rights.[33] Reflecting on this humanitarian crisis, UNHCR has designated the majority of Venezuelans as entitled to refugee status.[34] As of October 2019, an estimated 4,486,860 Venezuelans have fled their country, although this is a likely underestimate.[35] Additionally, Colombia is by far the highest receiving country of Venezuelans, hosting over 1.4 million Venezuelans in August 2019; a number of Colombian returnees are also included in the mixed migration flow.[36] Catholicism is the dominant religion in Colombia and Venezuela, and with the Church's institutional opposition to certain SRH services including abortion, challenges for Venezuelans accessing SRH are multi-faceted not only at home, but in the primary receiving country to which they flee.

Venezuelan women and girls have historically had limited access to SRH, which has only been augmented by state collapse. The nation's 1915 Penal Code, reformed in 2005, prohibits abortion in its various forms except when intended to save the life of the woman, and it also diminishes the penalty when carried out to safeguard honour.[37] Thus, its abortion laws are very strict and fail to comply with various international agreements it has signed, such as the Montevideo Consensus on Population and Development. Prior to the crisis escalating, Venezuelans had access to contraception through private pharmacies without major restrictions, and in a minority of cases some had access through public bodies.[38] In 2016 however, the Pharmaceutical Federation of Venezuela reported family planning methods

[33] Kislinger et al. "Women on the Edge 2019," 7. The group was formed in 2016 and comprises the following organisations: Asociación Civil Mujeres en Línea, Asociación Venezolana para una Educación Sexual Alternative (AVESA), Centro de Justicia y Paz (CEPAZ) y el Centro Hispano-americano de la Mujer FREYA. This research scrutinises five city contexts, but is intended to be relevant for the wider Venezuelan context.
[34] "Majority fleeing Venezuela in need of refugee protection – UNHCR." UNHCR, May 21 2019,
[35] "Portal Operacional: Situaciones de Refugiados y Migrantes," Respuesta a Venezolanos, 2019,
[36] "Colombia: Situational Report – August 2019," Respuesta a Venezolanos, 2019.
[37] Ibid., 39.
[38] Kislinger et al. "Women on the Edge 2019," 21.

shortages of approximately 90%. In a 2019 study of five cities in the country, Equivalencias en Acción found contraceptive shortages ranging from 83.3% to 91.7%.[39] In an environment where abortion is restricted yet so is access to contraceptive methods, the SRH needs and options of women and girls are severely restricted. Indeed, surgical sterilisation – a permanent procedure – has been part of a National Surgery Plan since 2014 and is the primary form of state-provided birth control.[40] The use of this method was already prominent before the crisis, but has escalated as other contraceptive methods have suffered drastic shortages. In an investigation conducted by The Intercept, one doctor in Guárico state noted that in his hospital women initially had to be over 35 and with three or more children to receive the procedure, but these guidelines quickly collapsed with women aged 18 or 19 being sterilised for life.[41] For many women, it is seen as the only solution to avoiding risky or unwanted pregnancies. One 28-year-old woman stated, "I am a bit afraid of getting sterilized, but I would rather do that than having more children. Having a child nowadays means making [them] suffer."[42] In this unstable and inadequate SRH environment, maternal mortality has surged, with an estimated increase of 66% between 2015 and 2016, after which no official figures have been released.[43]

The SRH and wider context in which practitioners are operating in Venezuela is highly complicated and has numerous deep-rooted barriers to achieving adequate SRH. Not only are there shortages of medical supplies but of medical professionals themselves.[44] This is symptomatic of the fact that in Venezuela, as in many refugee crises, the first people to leave

[39] "Sexual and reproductive rights in contexts of humanitarian crisis: Venezuelan women at risk," Women's Link, September 24 2019.
[40] "Sexual and reproductive rights in contexts of humanitarian crisis: Venezuelan women at risk," Women's Link.
[41] Lou Marillier and Daisy Squires, "Lacking Birth Control Options Desperate Venezuelan Women Turn to Sterilization and Illegal Abortion," *The Intercept*, June 10 2018.
[42] Kislinger et al. "Women on the Edge 2019," 30.
[43] "Sexual and reproductive rights in contexts of humanitarian crisis: Venezuelan women at risk," Women's Link.
[44] Ibid.

were highly-skilled and upper class individuals. This exacerbates the problems of those left behind, as not only are there fewer societal resources, but they are of a lower socio-economic status and thus with fewer personal resources to support themselves. In March 2019, the Inter-American Commission on Human Rights (IACHR) granted protective measures for one of Venezuela's most renown public hospitals, Maternidad Concepción Palacios, finding that inadequate services and access to resources led to a severe emergency constituting discrimination and violence against women.[45] Indeed, Equivalencias en Acción concluded that the risk of dying from pregnancy-related complications is high in Venezuela, while following qualitative interviews with Venezuelan women, Amnesty International concluded that poor SRH services were a major factor forcing women to flee the country.[46] This maternal mortality includes unsafe abortion attempts, with hospitals observing practices that had not been witnessed in quite some time, such as the insertion of sharp, puncturing objects, the use of herbs and homemade beverages and the introduction of substances of various natures, including soapy substances.'[47] Given restrictive abortion laws, women are also reticent to seek medical support if a clandestine abortion goes wrong, fearing that doctors will report them to the authorities. Medical practitioners themselves attributed increasing maternal mortality as falling within the four-delay model of UNFPA Guatemala:

1. First delay: lack of knowledge by women, families and communities regarding dangers during pregnancy, labour, postpartum and of the newborn;
2. Second delay: the woman recognises signs of danger, but gender inequality prevents this turning into action and independent decision-making, with decisions made by their partner or close family members;

[45] Ibid.
[46] Kislinger et al. "Women on the Edge 2019"; "Exodus of Pregnant Women," Amnesty International, 2018.
[47] Kislinger et al. "Women on the Edge 2019," 42.

3. Third delay: relating to existing limitations such as lack of access to roads or means of transport to reach health services;
4. Fourth delay: inadequate and untimely institutional care due to numerous factors, principally lack of competency (knowledge, skills, abilities and attitudes) from health providers, and also a lack of supplies, medicine, and proper equipment.[48]

The ability for the remaining medical professionals – and incoming ones from international organisations – to provide adequate SRH is effectively non-existent in this crisis. Although UNFPA posit that they are improving conditions with "dignity kits" providing essential hygiene supplies, as the recent findings from Equivalencias en Acción reveal, the situation for women in the country remains stark.[49]

Although the regional response to the Venezuelan crisis has been unprecedented in its show of solidarity, the skyrocketing movement of Venezuelans across borders is stretching the capacity of host countries. This is particularly pronounced in the primary receiving country, Colombia. Venezuelans have myriad unmet needs on arrival relating to health, food, employment, education and housing. Colombian NGO Profamilia stress that these factors directly impact SRH needs, especially of women and children.[50] 65,000 healthcare services were provided to refugees and migrants during 2018, which has created challenges for the availability, quality, and accessibility to basic health services; this consequently detrimentally impacts the attainment of the intermediate universal health coverage goals in SRH, 'equity in resource distribution, efficiency and transparency, and accountability.' Of the Venezuelan women arriving in Colombia that were consulted for the Equivalencias en Acción report,

[48] Ibid., 44.
[49] Liliana Arias, "Amid economic exodus, left-behind women begin to feel safe in Venezuela," UNFPA, 2019.
[50] "Evaluation of the unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities on the Colombia-Venezuela border: Arauca, Cucuta, Riohacha and Valledupar," International Planned Parenthood Federation and Profamilia, 2019, 15.

56.04% of them noted their last gynaecological check-up was over a year ago, while 66.1% of Venezuelan women arriving in Colombia had children, with a quarter of those with two children.[51] By September 2018, Profamilia had provided 6,589 SRH services to Venezuelan immigrants, 165 of which were voluntary pregnancy termination. Overall in Colombia, the average number of births per month to Venezuelan mothers has drastically increased from 5.5 in 2015 to 136 in 2018.[52] As discussed, women and girls confront specific dangers as refugees, and that displacement enacts particular risks for SRH needs. Data from Colombia's National Health Institute shows that in the major border crossing of Cúcuta in 2018, 83% of perinatal and neonatal mortalities were reported in Venezuelan migrants, although in August 2018 there were just two documented cases of Venezuelan maternal mortality.[53]

Profamilia and the International Planned Parenthood Federation (IPPF) conducted assessments based on the application of the IAWG toolkit for evaluating the availability of the MISP during crises within four border cities with prominent Venezuelan populations. They sought to assess 'health institutions that provide services to the Venezuelan migrant population, key respondents on sexual and reproductive health, gender-based violence (GBV) and HIV; and focus groups with Venezuelan migrants and Colombian returnees.'[54] It was the first time such tools had been applied in a Latin American context, which the authors contend posed challenges in terms of their translation, adaptation and approach in Colombia, where SRH approaches are more liberal than Venezuela but remain nonetheless limited for the population at large.[55] They found that despite the capacity of Colombian institutions, this was not translated into effective or timely access to comprehensive SRH owing to numerous

[51] Kislinger et al. "Women on the Edge 2019," 66.
[52] "Evaluation of the unmet sexual and reproductive health needs of the Venezuelan migrant population," International Planned Parenthood Federation and Profamilia, 44.
[53] Ibid., 55.
[54] Ibid., 16.
[55] Ibid., 16.

factors. These include Venezuelans being rejected from healthcare services, funding deficits, xenophobia, and a lack of knowledge, training and implementation of the MISP, which in turn translated into a lack of coordination between different national and international organisations.[56]

For example, of the 23 service providers interviewed in the study, only two had heard of the MISP and just one received training for its implementation: 'when asked to identify the sexual and reproductive healthcare goals and priorities in an emergency situation, one respondent was able to identify all aspects covered by the MISP.'[57] Furthermore, only two of 23 respondents mentioned international agencies and NGOs responsible for HIV management during migration crises.[58] In addition, four of five of the hospitals in Cúcuta analysed offered some form of contraception, but uptake was low, with only one hospital documenting access of more than one contraceptive method, ranging from male or female condoms to injectable contraceptives.[59] Focus groups pointed to widespread xenophobia and discrimination but nonetheless praised the quality of healthcare services provided when accessed. Although health services have capacity to treat incidents of sexual violence against the migrant and refugee population, people often fail to seek care in the first 72 hours following an assault due to fears of deportation, misinformation, and rumours.[60] Moreover, although the authors emphasise that the MISP should be comprehensively implemented across Colombia, especially in most-affected regions, this is unachievable given inadequate preparedness and regulation from such receiving countries as to broader refugee and specific SRH needs.[61] The MISP was also conceived primarily for urban contexts, where refugees are normally

[56] Ibid., 16.
[57] Ibid., 42.
[58] Ibid., 43.
[59] Ibid., 56.
[60] Ibid., 58.
[61] Ibid., 1.

concentrated, but Venezuelans are spread throughout Colombia in such a way that healthcare facilities are not necessarily located nearby.[62]

Such challenges – of inadequate SRH provision and international frameworks – speak to the deeper nature of problems facing refugees from Venezuela and around the world. As discussed previously, unsafe abortions account for approximately 10% of maternal deaths, 99% of which occur in developing countries.[63] Meanwhile, over 80% of all refugees are hosted in developing countries, with one third in the Least Developed Countries.[64] In 2014 the WHO declared,

> "Human rights are guaranteed in international and regional treaties, as well as in national constitutions and laws. They include the right to non-discrimination, the right to life, survival and development, the right to the highest attainable standard of health, and the rights to education and to information. These rights have been applied… to a wide range of sexual and reproductive health issues…"[65]

However, despite these "guarantees" there are immense gaps between such declarations and their implementation. This is symptomatic of structural violence, defined by Paul Farmer as 'suffering [that] is "structured" by historically given (and often economically driven) processes and forces that conspire-whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life-to constrain agency.'[66] Poverty, and myriad factors that contribute to it including gender, ethnicity and political enfranchisement, informs the risk

[62] Ibid., 20.
[63] "Inter-Agency Field Manual," Inter-Agency Working Group on Reproductive Health in Crises, 145.
[64] "Global Trends: Forced Displacement in 2018," UNHCR, 2019.
[65] Quoted in Kislinger et al. "Women on the Edge 2019," 20.
[66] Paul Farmer, "On suffering and structural violence," in *Pathologies of Power*, (Berkeley: University of California Press, 2005) pp. 29-50, 40.

levels of individuals to suffering. This suffering is measured in metrics such as life expectancy and, in the case of Farmer's research, HIV. Such analysis can be extrapolated to the SRH refugee experience in Venezuela and across the world. As seen in Venezuela, those at greater risk of inadequate SRH are of a low socio-economic status. Refugees are also overwhelmingly represented in developing countries with fewer resources to provide an international standard of SRH services. Despite the attempts of international organisations to address unmet needs, huge resource gaps remain, with, for instance, UNHCR Colombia facing a 62.2% funding deficit to deal with their response to the Venezuelan crisis.[67]

Conclusions

Many of the inadequacies in SRH provision faced by refugees in Venezuela and elsewhere are rooted in a damaging combination of pre-existing conditions and fresh challenges brought about by the context of crises. Indeed, the Guttmacher-Lancet Commission notes that broader progress in SRH requires confrontation of barriers in i) laws, ii) policies, iii) economy, and iv) social norms and values, particularly regarding gender inequality.[68] Bettering SRH is possible with such mechanisms and developing stronger response resources and expertise at an institutional and community level. However, as alluded to by the Guttmacher Institute, SRH challenges faced by refugees are systemic and pre-date crises. They should be addressed in every country in order to strengthen the capacity of any context to respond to a crisis; this is nonetheless more difficult and a longer-term goal for countries that are already systematically underdeveloped due to structural violence. The key challenge with the implementation of crisis-specific recommendations is that they cannot prove fully successful until the structures in which they operate fully support SRH. Without meaningful addressing of gender inequality in healthcare and wider societal systems – and how those

[67] "Colombia: Situational Report – August 2019," Respuesta a Venezolanos.
[68] Starrs et al., "Accelerate progress," 2642.

power dynamics can manifest in an international context – effective, safe SRH is unachievable for everyone, especially refugees.

Nonetheless, there are forms of management that can mitigate already challenging conditions during a humanitarian crisis. In the case of refugee crises, the Guttmacher Institute posits that the majority of funding focuses on response rather than prevention, preparedness and resiliency. They also argue that SRH must be included in primary healthcare systems and national plans.[69] UN Women note that only 4% of UN inter-agency appeals were targeted at women and girls in 2014, while just 1% of all funding to fragile states – and most impacted by disasters – was dedicated to women's groups or women's ministries in 2015.[70] At a local level, Profamilia and the IPPF make various targeted recommendations for the successful implementation of MISP that encompass institutional response monitoring, information-spreading, and enhanced resource allocation and barrier-removal for migrant populations. Greater prioritisation of SRH in a humanitarian response would enable the diminishing of barriers that women and girls face during crisis, as they would confront fewer inconsistencies and less miscommunication in terms of understanding what SRH is available. Once SRH is institutionalised as a core component of crisis preparedness and response, women and girls will be better able to manage the wider problems perpetuated by crises and enhance their capacity to recover from the uncertainty and danger of crises.

[69] Barot, "In a State of Crisis."
[70] "Facts and figures: Humanitarian action," UN Women.

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