INTERNATIONAL
RESCUE
COMMITTEE

Sexual and Reproductive Health and Rights at the International Rescue Committee

Contents

SRHR Services include:

- Family planning and contraception methods
- Maternal and newborn health
- Prevention and treatment of STIs and HIV
- Clinical management of rape and intimate partner violence
- Safe abortion care and post-abortion care
- Self-care for health and well-being
- Education on safe and healthy relationships

Cover photo: Hagadera Refugee Camp, Kenya.
An IRC Caseworker (pictured right) chats with a mentor (pictured left) from the IRC Safe Spaces center.
Photo: Esther Sweeney for the IRC

The Global State of SRHR

Approximately 72 million women and adolescent girls are currently in need of humanitarian assistance.[1] Countries with humanitarian emergencies are home to only 13% of the global population, but they account for 58% of global maternal deaths, 39% of newborn deaths, 41% of stillbirths and 25% of women with an unmet need for family planning.[2, 3] In crisis and conflict settings, women and girls face heightened and compounded risks, including childbirth without skilled care, lack of contraception, increased exposure to violence and exploitation, and unsafe abortions. Displacement, health system collapse, gender inequality and resource scarcity deepen these vulnerabilities, cutting off access to the choices and services that protect health, dignity and rights.

In 2024, there was a staggering gap of nearly $25 billion between the funds required for UN humanitarian appeals and funds received.[4] Now, **this gap is set to more than double** as the United States, United Kingdom and European donors slash their Official Development Assistance (ODA) budgets. The U.S. Government (USG) has been the largest donor for reproductive health and family planning for decades, providing an average of $1 billion—42%—of global overseas development. Without alternative funding, millions of women and adolescent girls in crisis settings will lose access to essential reproductive health care, increasing rates of unintended pregnancies, unsafe abortions and preventable maternal and newborn deaths. Cuts and disruption to USG funding have severely impacted local partners (both civil society and government), for whom these funds are vital in supporting frontline humanitarian aid, local recovery, development and governance efforts. These local organizations are often the sole providers of critical services to women and girls in hard-to-reach and conflict-affected areas. The International Rescue Committee (IRC) is committed to ensuring that this new era of aid does not lead to a new era of suffering but rather transforms aid into an effective engine for sustainable outcomes.

The IRC approaches sexual and reproductive health and rights (SRHR) as a core component of primary health care. In **29 countries** affected by crisis in Africa, Asia, the Middle East, Latin America and Europe, **we support local governments and partners to expand access to SRHR through high-quality service delivery, evidence generation and strategic national and global advocacy.** We implement simple, cost-effective and proven solutions that result in fewer unintended pregnancies and unsafe abortions, safer pregnancy and childbirth, reduced harm from gender-based violence and reduced morbidity from STIs and HIV.

Evidence shows that when modern contraception and the full range of maternal and newborn health (MNH) services are available, maternal death can be reduced by roughly 73% and newborn deaths by 80%.[5] We aim to improve SRH service provision at the last mile, remove policy barriers and transform harmful gender norms that restrict bodily autonomy. The IRC leads strategic advocacy efforts for the inclusion of humanitarian considerations in global and national policies to support women and girls. We publish data, evidence and leadership insights to scale our learnings and ensure best practices are widely accessible. This approach enhances the broader ecosystem's efforts to improve women's mental and physical health, demonstrating our sustainable vision for growth and our role in the larger landscape of women's health initiatives.

1. OCHA Global Humanitarian Overview 2025
2. AlignMNH Data Sources
3. *Estimate derived from IRC internal analysis using data from 2024 Humanitarian Response Plans and global SRH-related burden estimates.*
4. OCHA FTS Coordinated Plans 2024
5. Guttmacher Institute, Greater Investments Needed to Meet Women's Sexual and Reproductive Health Needs in Developing Regions

An IRC client receives free health services in Peru.
Photo: Camila Montañez for the IRC

IRC's Impact by the Numbers

2020 – 2024

2,455,500
women attended first antenatal care visit.

1,613,577
clients started modern contraceptive method.

1,049,167
deliveries with a skilled provider in health facilities.

2,667,976
couple years protection[6] provided, averting

768,377
unintended pregnancies.

529,506
clients treated for STIs.

60,163
women received comprehensive abortion care.

6. Couple years of protection (CYPs) is a measure that estimates the protection from pregnancy provided by contraceptive methods during a one-year period

Priority Areas

CONTRACEPTION

Access to contraception empowers women to make informed decisions about their reproductive health, thereby reducing the risk of unintended pregnancies, which can contribute to coercive relationships and gender-based violence (GBV). Despite proven solutions, SRH remains underfunded in humanitarian settings, with fragile and conflict affected countries receiving less than 20% of global contraception assistance.[7]

By 2030, the IRC aims to increase access to the full range of modern contraceptive methods among the 42 million estimated women living in humanitarian settings with unmet need for contraception. To do so, we will:

- **Scale proven contraceptive delivery models** to the last mile, with government and local partners
- **Adapt, test and scale innovations** such as self-delivered contraception, transformational gender and social norms interventions and break through supply chain solutions
- Ensure contraception is consistently implemented as part of the **Minimum Initial Services Package** (MISP) for SRH in Emergencies.

To unlock broader impact, the IRC is partnering with other SRH researchers to build a compelling, evidence-based investment case for contraception in humanitarian settings. We will start by conducting rigorous research on the benefits and cost efficiency of contraception programming in South Sudan and Somalia.

MATERNAL AND NEWBORN HEALTH

Along the humanitarian cycle, from the earliest stages of crisis through recovery and development, the IRC is committed to ensuring safe pregnancy and childbirth by delivering essential MNH services in 29 countries across Africa, Asia, Latin America and the Middle East. We aim to improve the quality of care through pregnancy, childbirth and postpartum/postnatal periods at all levels of the health system, via community outreach, facility services and referral pathways.

Safer Births in Crises

The IRC and our partners aim to reduce preventable maternal and newborn death in humanitarian settings—starting with preventing and treating postpartum hemorrhage (PPH). Excessive bleeding after childbirth, or PPH, is the leading cause of maternal death worldwide, but it is almost entirely preventable. Global progress on reducing maternal mortality has stagnated, and with the greatest burden occurring in humanitarian-affected settings, there is a mandate to catalyze investment and progress in the places of highest need. A package of new and underutilized commodities has been found effective in greatly reducing mortality from PPH, allowing for more accurate diagnosis and more timely treatment. Proven solutions adapted to humanitarian realities could turn the tide on PPH. Funded by the Matariki Fund for Women, and led by the IRC in partnership with International Medical Corps, Jhpiego and UNFPA, the Safer Births in Crises (SBC) Consortium brings together diverse global expertise: clinical and training specialists, humanitarian response and access, and deep experience in research

7. Calculated by the IRC based on OECD data

and service delivery. By 2030, we aim to reach at least 2 million pregnant women living in conflict and fragile settings with evidence-based, lifesaving interventions to prevent and treat PPH. Beginning in Burkina Faso, South Sudan and Papua New Guinea, the consortium is working to expand learning sites across affected regions. The SBC initiative will:

- **Increase the capacity** of national health systems to expand access to new and underutilized medicines and supplies for the prevention and treatment of PPH.
- Focus on reaching under-resourced areas by **demonstrating innovative delivery approaches** tailored to the complexity of humanitarian settings and creating transferable models.
- **Generate evidence** on how to effectively introduce and support the latest evidence-based guidance.
- **Facilitate uptake** of evidence, ensuring that research informs policy, programming and scale-up.

COMPREHENSIVE ABORTION CARE

The IRC supports access to comprehensive abortion care—including safe abortion services and treatment for complications from unsafe procedures—as a fundamental component of sexual and reproductive health and rights. Denying access to abortion does not reduce its occurrence; it only makes it more dangerous, contributing to 10–13% of maternal deaths, most of which happen in countries with restrictive laws.[8] The IRC views comprehensive abortion care as essential to upholding bodily autonomy, protecting health and empowering women and girls to make informed decisions about their futures. In the past four years, IRC and our partners have enabled more than 60,000 clients to receive comprehensive abortion care services. As part of these efforts, IRC works to strengthen the health system's capacity to provide clinical abortion services across the arc of crisis, while also working to transform attitudes and support for abortion at the community, health system and policy levels.

Expanding Safe Abortion Care Practice and Policy in DRC

In the eastern area of Democratic Republic of the Congo (DRC), the IRC was one of the founding members of the Coalition to Combat Unwanted Pregnancies. This partnership of community advocates with local and international NGOs initiated a successful campaign to legalize abortion by codifying the Maputo Protocol into national law in 2018.[9] This legally binding treaty was adopted by the African Union (AU) in 2003 to advance and protect the rights of women and girls in Africa. Between 2011 and 2020, the IRC and government partners in the DRC enabled more than 240,000 women and girls to access contraception and nearly 11,000 women and girls to access comprehensive abortion care.

Between 2019 and 2020, the IRC implemented a two-pronged model in conflict-affected areas, which included providing safe abortion services in public health facilities to individuals who meet the criteria outlined in the Maputo Protocol, such as victims of sexual violence. For other clients, counseling was provided for self-managed abortion with referral to partner pharmacies for medication purchase. The program reached 4,395 women; 69% of them were referred for self-management, and 78% of these clients successfully followed up with family planning services in public health facilities. One of the key factors of this pilot project, implemented at the height of the COVID-19 and Ebola crises, was the strong partnership established with provincial and local health authorities and private pharmacies. The partners participated in all aspects of program design, implementation and evaluation, resulting in strong referral networks between private pharmacies and public health facilities.

8. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division
9. African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Key Strategies

STRENGTHENING FRAGILE HEALTH SYSTEMS

Crisis-affected settings have chronically weak and frequently disrupted health systems. To make sustainable progress amid instability, strengthening these fragile systems requires context-adapted and crisis-sensitive approaches. This involves working closely with sub-national government authorities, civil society organizations and affected communities to simultaneously ensure access to essential services, advance sustainable development, and prepare for future emergencies.

For example, in West Africa, the IRC is working to increase SRH access and strengthen regional commitments and accountability for SRHR in humanitarian settings. *Partnering for Resilience to Emergencies through Transformation of SRHR* (PRET-SRHR) *and Realizing SRHR in Crises by Shifting Power for Coordination and Response in the Sahel* (She Responds) both aim to improve access to and the quality of SRH services in protracted conflict settings in Burkina Faso, Mali, Niger and Nigeria. As part of these programs, the IRC collaborates with local government and civil society partners to improve emergency coordination for SRH among health actors working in conflict-affected settings.

Since 2018, the IRC has served as the lead humanitarian implementing partner in the two-phase project *Women's Integrated Sexual Health* (WISH), funded by the UK Foreign, Commonwealth and Development Office (FCDO) in partnership with the International Planned Parenthood Federation (IPPF). Under the initial WISH phase, *WISH2ACTION,* (2018 – 2024), the IRC worked with local partners to deliver family planning in the context of comprehensive SRH services in conflict-affected regions of Somalia, South Sudan, Ethiopia and Uganda. Through an integrated, client-centered approach that prioritized underserved populations, the IRC and local partners reached a total of 693,177 clients with family planning services. Of these clients, 56% were first-time users of contraception, while 17% were adolescents under the age of 20. In addition, the program generated 650,236 CYP, representing the estimated annual protection provided by contraceptive methods, and averting approximately 187,267 unintended pregnancies.

Building on these achievements, the IRC is continuing its implementation of the program in South Sudan and Somalia through *WISH Dividend* (Phase II, October 2024 – March 2029). This phase seeks to empower women and adolescents—particularly those who are poor and most marginalized—to exercise greater voice, choice, and control over their SRHR, while also strengthening the enabling environment for SRHR and contributing to sustainable gender equality outcomes. In both countries, the IRC continues to collaborate closely with the Ministry of Health (MoH) to strengthen the capacity of health care providers to deliver integrated family planning (FP) services both within primary health care facilities and through community-based platforms.

WISH Impact

In South Sudan's Unity State, disability often hinders access to FP services for a variety of reasons including distance to health facilities, fear of stigma and more. Mayier Maguol and Gatjang Nhial, a couple who both live with disabilities, faced significant challenges following the difficult birth of their first child, particularly during the postpartum period. After learning about FP through a local radio program, Mayier overcame her fear of discrimination and visited an IRC-supported clinic, where she received FP counseling. Encouraged by her positive experience, Gatjang joined her on a follow-up visit, and together they decided to switch to Implanon, a long-term FP method that aligned with their reproductive goals. The clinic staff provided tailored support and accessible information, ensuring the couple could make informed decisions. Their journey not only highlights the importance of accessible FP services but also challenges prevailing stereotypes about disability and parenting.

"Today I would like to thank IRC for the good services they have provided to my wife. We have now agreed to have our next child after four years so that we can support the children with our physical disability, and now my wife and I have agreed to switch to Implanon to allow this."

- Gatjang Nhial, IRC Client

DELIVERING LIFESAVING CARE DURING EMERGENCIES

The IRC deploys experts and critical resources at the onset of emergencies, in the immediate aftermath and throughout the stabilization phase—ensuring that lifesaving SRH services are available to those fleeing conflict and disaster. Within days, we deliver the MISP and collaborate with local partners to provide life-saving SRH services throughout the duration of the crisis.[10] We work to:

- Deploy an SRHR expert to jump-start the MISP in emergency health responses
- Ensure dedicated resources to deploy the MISP and provide quality services
- Disseminate practical learning on MISP implementation
- Improve the accountability of donors, implementers and governments for MISP resources and prioritization in all emergencies

These efforts are crucial to: preventing sexual violence; supporting survivors; reducing the transmission, illness and death associated with HIV/AIDS and other STIs; preventing maternal and newborn complications and deaths; avoiding unintended pregnancies; and minimizing the incidence and impact of unsafe abortion. As crises evolve from the emergency to recovery stage, the IRC invests in supporting rights-based policies, challenging harmful gender norms, and working with government and civil society partners to strengthen the health system. The IRC has implemented the MISP in at least 30 acute emergencies—most recently Gaza—across more than 15 crisis-affected contexts in Africa, Asia, Europe, Latin America, and the Middle East.

10. UNFPA MISP for SRH in Crisis Situations

In 2025, on behalf of the Global Health Cluster SRH Task Team—co-chaired by IRC and UNFPA—the IRC conducted a series of MISP Process Evaluations in selected crisis-affected settings. These cross-sectional, mixed-methods evaluations were carried out in crisis-affected communities in Chad, Ethiopia, Gaza and Mozambique. The purpose was to assess how the MISP is being implemented in recent emergencies, and to contribute to the evidence base guiding effective SRH responses in humanitarian contexts. The results are forthcoming and will inform recommendations and policies to strengthen consistent and accountable MISP implementation moving forward.

Building on these insights and broader achievements, we are now launching a Center of Excellence for SRHR in Emergencies. The Center will strengthen global commitment to and investment in MISP implementation, while advancing learning, advocacy and accountability to ensure SRHR is prioritized in every emergency response.

"As a health instructor for IRC in the Rohingya camp, I feel extremely privileged to participate in improving the quality of health service delivery, for better birthing experiences and health outcomes. It is for this reason that I consciously choose to model respectful care by treating every mother and child with dignity, a gentle touch, and a smile," said Irin, an IRC Health Educator.

Photo: Zanala Bangladesh Ltd. for the IRC

INTEGRATING SRHR WITH WOMEN'S PROTECTION AND EMPOWERMENT

1 in 3 women globally experience violence, but in humanitarian crises, the risk rises to 70%. As conflict and crisis become more frequent, severe and long-lasting, the number of people experiencing GBV is only set to increase.

The IRC has led the humanitarian field in integrating SRHR, GBV, and protection programs to the expressed needs of crisis-affected women and adolescent girls for more than 10 years. Alongside our primary health and SRH programs, the IRC delivers innovative, field-tested programming designed to support each survivor wherever they are, including mobile and static GBV services tailored to the realities of displacement. This approach is demonstrated through the integrated provision of services within Women and Girls Safe Spaces connected to health facilities. This model, unique in humanitarian settings, has been successful in South Sudan, Kenya, Nigeria, Bangladesh, and Myanmar and builds programming to address the holistic needs and safety of women and girls. In these Safe Spaces, select SRH services—including contraception, safe abortion, and care for gender-based violence and sexually transmitted infections—are integrated with psychosocial services, case management, and other life skills programs that empower women and girls take control and create change.

These efforts have culminated in a partnership between the IRC and UNFPA to enhance global capacity for integrated GBV and SRH response. This collaboration focuses on establishing the most effective integration models while strengthening the knowledge, tools, and skills needed to deliver high-quality, integrated, and accountable services in humanitarian settings. Ultimately, this work aims to transform humanitarian practice and center the desires of women and adolescent girls in the design and delivery of humanitarian programs.

COMMUNITY BASED CARE TO REACH WOMEN AND GIRLS AT THE LAST MILE

Compelling evidence demonstrates the benefits of investing in community health workers (CHWs) and the delivery of integrated packages of community-level health services. According to the World Health Organization (WHO), CHWs, when adequately trained and supported, could prevent up to three million deaths a year globally and provide an economic return of up to 10:1 by contributing to a healthier, more productive society, reducing the risk of costly epidemics, and yielding cost savings for families and health systems. CHWs can support referrals and deliver life-saving maternal and newborn health services and family planning. This includes community-based distribution of misoprostol to prevent PPH during homebirths when women are unable to reach a health facility, chlorhexidine for clean umbilical cord care, or kangaroo mother care to help small and sick newborns survive. For example, between 2022 – 2024, IRC Burkina Faso implemented a community-based misoprostol distribution program in areas with limited access to skilled birth attendants and closed health centers. IRC and MoH trained 45 Traditional Birth Attendants to administer misoprostol for the prevention of PPH to women, distributed 3,389 clean delivery kits, and 421 women who gave birth at home received misoprostol. No cases of PPH were recorded among the women who gave birth at home and received misoprostol in the third stage of labor. This program demonstrated how decentralized, community-led health care can effectively reach women in humanitarian and crisis-affected settings with limited access to health facilities.

TACKLING NEW CHALLENGES FOR WOMEN AND GIRLS AMIDST THE CLIMATE CRISIS

In the places where the IRC works, the climate crisis is already a pressing reality. Despite people in these vulnerable countries having done the least to contribute to the climate crisis—and being the least prepared for its impact—they are on the frontlines and reeling from its effects. Increasingly frequent, extreme natural disasters and weather are destroying livelihoods, increasing infectious diseases, worsening water and food insecurity, intensifying conflicts, uprooting people from their homes and exacerbating already dire humanitarian crises. Gender inequality leads to unequal access to resources, reduced food security and lack of decision-making power. These compounding crises make it more difficult for women and adolescent girls to effectively adapt to and cope with the consequences of climate change. Simultaneously, climate change is having direct and indirect impacts on the health of women and their families. Extreme heat and air pollution have been shown to increase risks of pre-term birth, low birth rates and still birth rates. Health systems disrupted by climate events further disrupt access to essential SRH services. Since 2011, an estimated 11.5 million women have lost access to contraception as a result of climate-related displacement.[11]

IRC Nigeria is currently implementing a formative research project focused on this issue— *The Intersection of Sexual and Reproductive Health and Flooding: Advancing SRH in Climate-Affected Contexts*. In this study, we aim to understand how seasonal flooding impacts access to SRH services for women and girls. We will also examine how service delivery strategies employed by different actors for SRH and non-SRH services during climate shocks can innovatively meet service delivery needs during times of flooding.

The IRC aims to support women, adolescent girls and their families at the intersection of climate change, conflict, and natural disaster to effectively adapt to their changing environment. This work starts with centering women and adolescent girls as leaders and ensuring they have the agency and services they need to plan for an uncertain future.

Research & Innovation

The IRC is dedicated to transforming humanitarian aid by designing and researching scalable solutions. By constructing teams with design thinkers, behavioral scientists, researchers, technical experts and frontline humanitarian workers, we approach innovation in a multidisciplinary way. We use iterative processes, generating a wide range of ideas from client perspectives while drawing on technical experience, on-the-ground expertise of our in-country teams, and the latest evidence.

11. People Planet Connect, Climate change solutions empowering women and girls through reproductive choice

SELF-CARE INNOVATIONS FOR SRH

Self-managed contraception and abortion care have significant potential to expand health coverage to hard to reach populations and reduce health inequities at scale. By shifting knowledge and care from facilities and formally trained providers to more accessible options for women and girls, we can bring products and information directly to our clients, increasing their autonomy and expanding their access to and choices for care.

In South Sudan, we are designing scalable ways to increase contraception access for low-literate women in rural contexts through quarterly self-injection (Sayana Press). Self-injection of contraception has been tested in other contexts but not adapted to the realities of low-resource, humanitarian areas. Our recent study showed that 57% of women who trained on self-injected contraception continued using it for a year, benefiting from reduced travel time, increased privacy, and prevention of unintended pregnancies. 64% of research participants were first time users of contraception—highlighting the potential for self-managed contraception to reach new underserved client segments.

We believe community-based and self-care program models can be a simple, but radical solution for more accessible and confidential care. For example, in Nigeria, henna artists and Kayan Mata (aphrodisiac) sellers routinely engage women on sexual wellness and beauty as a self-care practice. Our innovative self-care referral pilot trained these community members and reached 2,680 new family planning users. 61% of referred clients were supported by community agents who brought conversations about contraception—inclusive of self-managed care—into everyday spaces and empowered women with informed choices.

The WHO defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability, with or without the support of health workers.[12]

EQUAL: GENERATING EVIDENCE TO IMPROVE DELIVERY OF LIFE-SAVING MATERNAL AND NEWBORN CARE

The IRC continues to lead the EQUAL research consortium, a-multi country and multi-partner initiative that is generating evidence to improve the delivery of life-saving MNH care in conflict-affected settings, including Eastern DRC, Northeast Nigeria, Somalia and South Sudan. EQUAL's research agenda aims to inform and strengthen MNH efforts at the community, facility and health system levels to reduce preventable maternal and perinatal mortality.

12. WHO Self-care for health and well-being

EQUAL Research Consortium | Generating evidence to improve MNH care

Research is organized across five core streams

1. MNH Policies and Financing: In each location, EQUAL is conducting qualitative research to explore factors influencing the political prioritization and delivery of MNH service.
2. Maternal and perinatal death surveillance and response (MPDSR): In Eastern DRC, EQUAL partners completed a landscape analysis of MPDSR and health information systems in crisis-affected areas. Based on the findings, supportive guidance—including a pictorial guide—was developed to complement MoH reporting forms and is now being tested for clarity, usability and effectiveness among low-literacy CHWs.
3. Community-Based MNH Service Delivery: In Somalia and South Sudan, EQUAL is conducting implementation research on community-level MNH service packages delivered by Female Health Workers (Somalia) and Boma Health Workers (South Sudan) with support from the IRC. The research assesses the feasibility, acceptability, fidelity, cost-efficiency, and conditions needed to improve the uptake and coverage of life-saving community-based interventions.
4. Midwifery education and workforce development: In Somalia and Northeast Nigeria, EQUAL partners conducted a rapid assessment of midwifery education and launched a longitudinal cohort study of midwifery students and recent graduates. This study aimed to understand factors affecting midwifery workforce participation, performance, retention and resilience during periods of increased insecurity.
5. Facility-based quality of care: In Northeast Nigeria and eastern DRC, EQUAL partners assessed the quality of routine facility-based MNH care and the management of select obstetric and neonatal complications at health facilities in low-income, conflict-affected settings.

Overall Goal:

Inform Policy, Strengthen Practice, and Foster Learning for MNH Care

Through this research, EQUAL partners are not only generating actionable evidence, but also aim to inform policy, strengthen practice and foster learning for MNH care.

Strategic Advocacy and Transformative Policy Change

An enabling environment is critical for achieving sustainable and accessible SRHR in humanitarian and fragile settings. This environment requires supportive policies and consistent coordination among key decisionmakers, healthcare providers, and women and girls. The IRC works to build this environment by leading and supporting strategic advocacy—globally, regionally, and nationally—to ensure humanitarian considerations are fully integrated into all relevant policies, procedures, and practices.

Our team's combined experience in health service delivery, evidence generation and research

As a host of the IAWG Newborn Initiative from 2021-2024, we leveraged strategic advocacy and communications to advance the *Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings* (2020-2024).[13] This included advocating for humanitarian expertise to be represented within key MNH agenda-setting and technical bodies; championing MNH within humanitarian advocacy and knowledge exchange networks; and developing targeted advocacy and communications strategies to encourage positive attitudes towards newborn survival in emergencies.

13. Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings

uptake has established IRC as a leader in the SRHR community. We are long-standing leaders of the Inter-Agency Working Group on Reproductive Health in Humanitarian Settings (IAWG) and have consistently co-chaired sub-working groups and co-authored sector-leading guidance on best SRHR practices. We are currently serving as the chair of the Executive Committee. We also sit on the steering committee of the Self-Care Trailblazers Group and co-lead the Global Health Cluster Sexual and Reproductive Health Task Team with UNFPA. Additionally, we are members of the Country Implementation Group and the Advocacy and Accountability group of Every Woman, Every Newborn, Everywhere.

In addition to direct collaboration, we publish data, evidence and leadership insights. This scales our learnings and makes best practices widely accessible. This commitment enhances the broader ecosystem's efforts to improve women's mental and physical health, clearly demonstrating our sustainable vision for growth and our critical role in the larger women's health landscape. This global work is only possible through partners. We engage with FP2030 at the national, regional and global level. Regionally, we are also key humanitarian collaborators of the Ouagadougou Partnership to accelerate progress in the use of family planning services in West Africa.

We work closely with MoHs at the national and sub-national level, along with SRH Technical Working Groups and civil society partners. Together, we advocate for and progress evidence-based strategic policy and practice change. In 2024, our research on women's preferences for self-care in Northeast Nigeria directly shaped updates to the country's national guidelines for DMPA-SC, an injectable contraceptive. These expanded guidelines strengthen women's ability to access care on their own terms—when and where they need it. Building on the Federal MoH's Commitment to expanding self-care for SRH, the IRC is also spearheading efforts to adapt and implement the Nigeria National Self-Care Guidelines in crisis-affected Borno State—a critical step toward embedding guidelines within the state health system. In South Sudan, IRC worked alongside the MoH and UNFPA to update the National Family Planning Guideline and develop a National Communications and Advocacy Plan for dissemination and uptake nationwide. Furthermore, we are committed to supporting and promoting locally led advocacy efforts. Through the *She Cares* project, the IRC and partners led advocacy trainings SRH self-care in Uganda. Training for district health officials equipped them to make recommendations for how and when to include self-care in district workplans and budgets.

Prioritizing Partnerships

Working in partnership with local civil society, government and private sector actors is fundamental to IRC's mission. These collaborations are especially critical now, as SRHR funding faces severe cuts and remains at serious risk. Without urgent investment and strong partnerships, hard-won gains for women and girls could be rolled back. By working with local actors, we help safeguard progress and drive greater impact, scale and sustainability, even in the face of constrained resources. Amidst a rapidly shifting humanitarian landscape, grounding programs in local priorities and systems is not only strategic—it is essential to protect women and girls' access to care.

The IRC actively partners at the global level with like-minded organizations like International Confederation of Midwives, at the coalition level with groups like the Initiative Pananetugri pour le Bien-être de la Femme in West Africa or through our Safer Births in Crises Consortium. At the national level, we partner with organizations like the Reproductive Health Association South Sudan (RHASS) and the Women and Rural Development Network (WORUDET) in Uganda. Equally important, the IRC prioritizes the meaningful engagement of women and girls in SRHR, ensuring they have a voice in shaping our

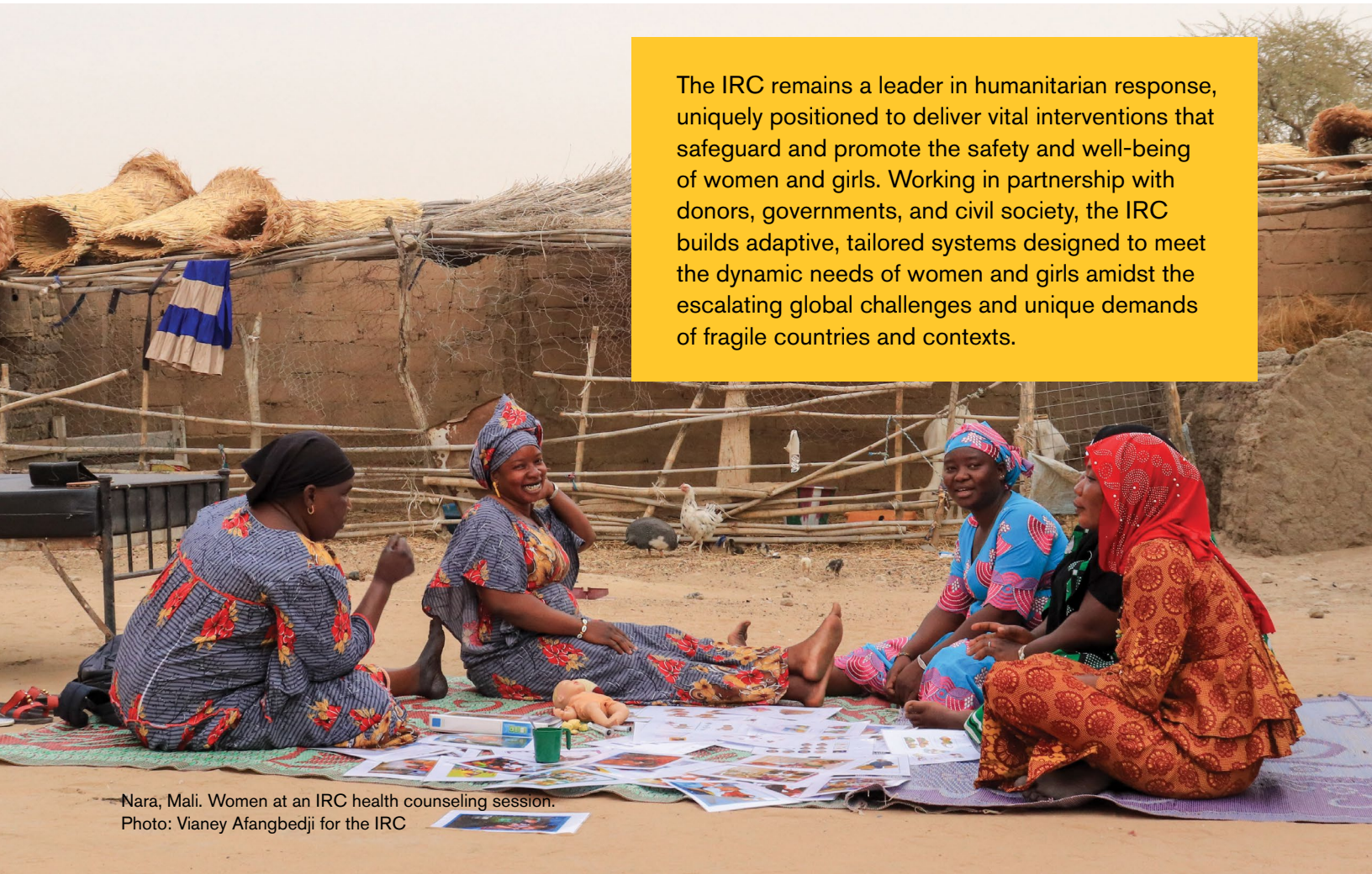
programs. For example, in DRC, Nigeria, and South Sudan, we used participatory action research to partner with adolescent girls as equals, which improved their access to SRH services. This approach has significantly enhanced the responsiveness and effectiveness of services to better meet the needs of adolescent girls.

Looking Ahead

Shrinking foreign assistance will exacerbate existing inequities across the sector that too often leave out women and girls in humanitarian settings. In this context, we will focus on three key areas to ensure women and girls most at risk are not left further behind:

1. **Consolidate resources in the most fragile, conflict-affected settings:** We will prioritize locations with the most severe situations and largest gaps in humanitarian assistance.
2. **Ensure a data-driven, evidence-based approach:** We will focus efforts on interventions with the strongest evidence and potential to save lives and protect dignity, while rooting programming within local systems and context realities.
3. **Implement an integrated, user-centered approach to programming:** We will avoid the vertical programming and siloes that make aid less efficient, and instead focus on cost-effective, integrated programming.

The IRC remains a leader in humanitarian response, uniquely positioned to deliver vital interventions that safeguard and promote the safety and well-being of women and girls. Working in partnership with donors, governments, and civil society, the IRC builds adaptive, tailored systems designed to meet the dynamic needs of women and girls amidst the escalating global challenges and unique demands of fragile countries and contexts.



Nara, Mali. Women at an IRC health counseling session.
Photo: Vianey Afangbedji for the IRC

Caption: Sere Kaniye Camp, Syria. IRC Client at an reproductive health check-up.

Photo: Luna Vieira for the IRC

INTERNATIONAL RESCUE COMMITTEE

To learn more about IRC's critical SRHR work, please visit www.rescue.org/srhr or contact Erin Wheeler, Global Practice Lead for SRHR, at erin.wheeler@rescue.org.