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Testimony Submitted to the House Foreign Affairs Committee
"Unique Challenges Women Face in Global Health"

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Chairman Engel, Ranking Member McCaul, distinguished members of the Committee, thank you for the opportunity to testify today as you examine the challenges facing women's health globally and the U.S. government's response. These are critical issues, and I am thankful for the Committee's attention to them.

My name is Sheba Crocker, and I am the Vice President of Humanitarian Policy and Practice at CARE USA. CARE began its story nearly 75 years ago when a small group of dedicated Americans sent the first CARE packages overseas to survivors of World War II. Today, CARE works in 100 countries around the world to address the root causes of suffering and to provide lifesaving humanitarian assistance to people in need. CARE's work focuses on women and girls because our experience has taught us that we must help communities address gender inequalities between women and men to respond effectively to crises and their underlying factors.

Before I begin, I would like to take this opportunity to thank this Committee and Congress for the continued bipartisan commitment it has shown to development and humanitarian assistance. Helping those in need around the world is not, and has never been, a partisan issue. CARE is grateful to have such strong champions on both sides of the aisle.

Around the world emergencies amplify inequalities. Community and household dynamics often shift during crises, creating new roles and opportunities, as well as new challenges and risks. Women and girls are often disproportionally affected and may have difficulty accessing food, health care services, shelter, and other resources.

Today, I will focus my remarks on four challenges to the health of women and girls in humanitarian settings and how the United States can provide critical support for their protection and empowerment. These challenges are: inadequate funding; lack of access of humanitarian workers to populations in need and of those populations to health care; social norms that expose women and girls to greater health risks; and issues that heavily affect or are unique to women and girls, specifically gender-based violence (GBV) and sexual and reproductive health, which includes access to contraceptives, quality obstetric care, pre- and post-natal services, and the prevention and treatment of sexually transmitted infections prevention.

First, funding for humanitarian operations is failing to keep pace with need. Today 132 million people -- or one in every 70 people -- around the world require relief assistance, an unprecedented figure. In 2019, the UN requested $2.4 billion to provide health care to vulnerable populations globally. Although the United States is the world's largest humanitarian donor, contributions from the international community met just 33 percent of that request, according to the UN Office for the Coordination of

Humanitarian Affairs. Moreover, a report by the International Rescue Committee and VOICE found that GBV prevention and response services received just 0.12 percent of the $41.5 billion allocated for humanitarian funding from 2016–2018, fulfilling only one-third of the amount requested for GBV programming. Without sufficient funding in place, we cannot address the challenges that women face to obtaining physical and psychosocial health care services in humanitarian emergencies.

Second, access—of humanitarian agencies to people in crisis, and of women to health care—is crucial. Without access, relief workers cannot reach populations in need. Access challenges for humanitarian workers take several forms. The Center for Strategic and International Studies Task Force on Humanitarian Access, of which I was a member, found that these include violence and insecurity; bureaucratic constraints, such as import restrictions on relief items; onerous visa processes that prevent humanitarian workers from entering a country; or donor-imposed requirements that may limit access. These issues might seem trivial, but they have consequences. For example, on January 29, 2020, the UN reported that 400,000 medical items that relief agencies had planned to deliver to Syria were being held at the Iraqi border, which will result in decreased medical services and supplies available in Northeast Syria. Humanitarian organizations have been unable to deliver the supplies after the UN Security Council failed to renew the authorization of cross-border deliveries from Iraq and Jordan into Syria early last month.

Vulnerable populations, such as women and children, face their own challenges in accessing health care during crises. Conflicts and natural disasters damage health care facilities and kill, displace or disincentivize staff . For example, Physicians for Human Rights reported that at least 914 Syrian health workers have been killed since the start of the conflict, while the UN found that at least 60 health facilities in Northwest Syria were damaged in airstrikes in just eight months in 2019, affecting tens of thousands of people. In some areas, where women are unable to attend clinics if no female staff are present or if male family members cannot accompany them, women's access to health care is further compromised.

Third, social norms—such as expectations that women and girls will nurse sick family members and receive assistance last, after men and boys—can expose women and girls to greater health risks. These norms mean that women and girls are more likely to contract infectious diseases but less likely to receive the timely care they need to keep their health concerns from worsening. For example, in the ongoing Ebola outbreak in the Democratic Republic of Congo (DRC), 56 percent of the confirmed and probable cases have been amongst women and 28 percent have been amongst children under 18 years old, the World Health Organization (WHO) reports. Only 11 percent of the cases recorded have been amongst males over the age of 18. The expectation of women to act as caregivers follows them outside of the home too; women comprise more than 75 percent of the health care workforce in many countries, according to the Human Resources for Health Global Resource Center. Women's higher participation in the health care workforce adds to the likelihood that they will be more exposed to infectious diseases and highlights the importance of ensuring that they can access appropriate health care services, particularly in emergencies when health systems and coping mechanisms are often severely degraded. The existence of harmful social norms, such as those noted above, also highlights the importance of CARE's work to address the gender inequalities that perpetuate imbalanced access to and availability of health care.

Finally, I would like to discuss the health risks that disproportionately affect or are unique to women: GBV and sexual and reproductive health. Although men, boys, and other groups can experience GBV, I will focus my remarks on the risks and effects of GBV as they pertain to women and girls. In times of

crisis, available evidence suggests that GBV incidents increase—with women and girls among those most affected. GBV can take many forms—including emotional, physical and sexual assault—and it can begin with something as simple as a security risk. Refugee camps and other displacement settings often lack adequate lighting and gender-appropriate showers and toilets. Women and girls frequently need to travel long distances to access basic commodities, such as food and water. These circumstances increase their risk of sexual assault by the people around them, as well as by armed groups. The UN estimates that 1 in 5 internally displaced or refugee women living in humanitarian crises or armed conflict have experienced sexual violence.

The strains of living in a humanitarian crisis, from financial to physical insecurity, weigh on families and can lead to other forms of GBV, such as intimate partner violence (IPV), sexual exploitation and abuse (SEA), and child, early and forced marriage (CEFM). IPV is one of the most common forms of violence against women and girls and includes physical, sexual, emotional and economic abuse and controlling behaviors by an intimate partner. Health organizations have estimated that one in three women worldwide have experienced IPV or non-partner sexual violence in their lifetimes, and evidence suggests that the rate of IPV is much higher in humanitarian crises. In fact, research by the IRC suggests that IPV may be the most common type of violence women and girls experience during emergencies. IPV can result in profound physical and psychosocial harm, treatment for which is often complicated by a lack of available health facilities and services.

Unfortunately, even those who are meant to help sometimes end up doing harm. Sexual exploitation and abuse of vulnerable populations by humanitarian personnel, a horrifying breach of trust, has begun to be better recognized and addressed but remains a serious concern. Statistics on the prevalence of SEA are often lacking, partially due to sensitivities around reporting, and vary by context, but SEA can have serious emotional and physical health complications for those affected.

In addition, child, early, and forced marriage often increases during emergencies. CEFM impedes women and girls from making decisions about their lives; disrupts their education; makes them more vulnerable to abuse, discrimination, and violence; and prevents their full participation in economic, political, and social spheres. The UN Office of the High Commissioner for Human Rights notes that CEFM is often accompanied by early and frequent pregnancy and childbirth, resulting in higher than average maternal morbidity and mortality rates.

GBV, particularly in crises, has serious implications for women and girls. Because obtaining health care, including contraceptive services, is so difficult, incidents of GBV can subject women and girls to additional psychosocial and physical harm. Health consequences may include anxiety, depression, exposure to sexually transmitted infections—including HIV—genital injuries, post-traumatic stress disorder, and unintended and unsafe pregnancies. Even where health care services are available, the stigma associated with GBV can hinder women and girls from reporting it and seeking help.

Pregnancy and childbirth can expose women to additional risk wherever they live. For the millions of women who require humanitarian assistance and may lack access to health care, the risks are even higher: globally, more than 60 percent of all preventable maternal deaths and 45 percent of all preventable newborn deaths occur in vulnerable states, many affected by conflict and humanitarian emergencies, according to WHO. GBV, coupled with lack of access to contraception and other forms of reproductive health care, can result in pregnancy complications, dangerous deliveries, and an increased risk of exposure to HIV/AIDS and other sexually transmitted infections.

As I mentioned above, gender inequalities are often exacerbated in emergencies. Relief agencies must take thoughtful action to meet the unique needs of women and girls in crises. Providing appropriate health care is every bit as important as providing clean drinking water, food and shelter. We must ensure that women and girls have access to the health care, including reproductive and contraceptive services, that they need from the beginning of an emergency response to its end.

Effectively responding to the needs of women and girls in emergencies is achievable, assuming adequate resources and political commitment. Around the world, organizations like CARE are helping address the health needs of women and girls with support from the United States and other donors.

For instance, CARE is working to meet the needs of Rohingya refugees in Cox's Bazar, Bangladesh, through women and girls' safe spaces that provide health checks, private psychosocial counseling and referrals to other services, such as specialized medical care. CARE is also training other camp-based staff in counseling and psychosocial support techniques, first aid and how to mitigate and respond to SEA.

In eastern DRC, we are training local partners to operationalize the Minimum Initial Service Package for Reproductive Health in Emergencies (MISP) and strengthen women and girls' access to quality health care and support. CARE is also partnering with women-led organizations to undertake GBV assessments and programming and to support capacity-strengthening and advocacy activities.

However, much more can—and must—be done. I would like to share with the committee six key recommendations based on CARE's experience in the field:

- First, the United States must prioritize funding for women's health services, including comprehensive GBV prevention and response efforts and family planning and reproductive health care, including access to contraceptives, quality obstetric care, pre- and post-natal services, and sexually transmitted infections prevention and treatment, from the outset of a humanitarian response.
- Second, and relatedly, CARE asks the Committee to urge humanitarian organizations to work directly with affected women and girls, to ensure that their concerns and priorities inform the direction of humanitarian programs. It is not enough to simply fund health care activities; we must do so in a way that allows women and girls to lead and participate in the design, implementation, and evaluation of emergency health interventions from inception to completion.
- Third, CARE strongly encourages the passage of legislation strengthening existing policies that promote the health of women and girls in emergencies. CARE supports the *Safe from the Start Act*, a bipartisan bill that has been referred to this Committee. The bill strengthens the U.S. government's current Safe from the Start program, which helps prevent and respond to GBV from the onset of a humanitarian crisis. Addressing GBV is integral to any legitimate and sustainable efforts to address the health burdens that women and girls are exposed to during humanitarian emergencies. CARE strongly encourages Congress to take up and pass this important bill.
- Fourth, CARE encourages the United States to address its own policies, where they are having detrimental effect on women's health in humanitarian settings. U.S. policy governing global health should reflect evidence-based methods that help prevent maternal and child death, including access to pre/post-natal care, safe delivery services, access to contraception and other primary health care services. Any action that jeopardizes the resources needed to achieve this

goal will have dire implications for the women, men and families that CARE works with and that the United States so generously supports with its assistance.
    - Policies that unnecessarily restrict NGOs' ability to provide life-saving services, such as the *Mexico City Policy*, have been shown to reduce access to health care and lead to poorer outcomes for women. CARE calls for this policy's repeal.
    - CARE regrets the Administration's decision to halt all funding to the United Nations Population Fund (UNFPA) despite consistent, bipartisan support for the agency. In more than 150 countries, UNFPA combats GBV and provides lifesaving reproductive health services, often in complex and dangerous settings. CARE has worked closely with UNFPA in many countries, including DRC, Nigeria, Syria, and Yemen, and has seen firsthand the important role it plays in supporting women's health, especially in emergency settings. CARE urges the speedy restoration of funds to UNFPA.
- Fifth, CARE recommends that the Committee encourage the implementation of the MISP at the onset of every crisis. The MISP is a series of actions aimed at preventing and managing the consequences of sexual violence; reducing HIV transmission; preventing maternal and newborn death and illness; and planning for sexual and reproductive health care. By bringing a standardized approach to GBV and sexual and reproductive health care in emergencies, the MISP can help save lives.
- Sixth, to support the protection of women and girls and their access to humanitarian assistance, the United States must continue its longstanding commitment to principled humanitarian action and be a global leader in promoting and ensuring compliance with international humanitarian law by all parties to conflicts.

I would like to thank the Committee for examining the issue of women's health in humanitarian settings around the world. This is a critical issue that has serious implications for millions of people. Supporting the particular health care needs of women and girls helps address existing gender inequalities and is an essential component of responding effectively to emergencies and their underlying factors. Moreover, it is critical to building a more secure and prosperous world, which is a central component of America's foreign policy.

I appreciate today's conversation. I hope that women's health in emergencies remains an ongoing priority for this Committee.

Thank you very much. I look forward to answering your questions.