REVIEW ARTICLE

Reproductive health financing for flood-displaced women: A systematic review

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Abstract

Pakistan is one of the top ten countries most vulnerable to climate-induced disasters, where frequent floods have displaced millions and disrupted essential services, particularly healthcare. Women of reproductive age are the most affected, facing limited access to basic sexual and reproductive health and rights (SRHR) services, including antenatal care, safe delivery, family planning, and menstrual hygiene. Despite these critical needs, SRHR remains consistently underfunded in humanitarian responses, reflecting ongoing neglect in disaster risk reduction and health system planning. This paper presents findings from a systematic literature review on SRHR financing for flood-displaced women in Pakistan, focusing on the 2010 and 2022 floods. Results, thematically coded, are cross-referenced with peer-reviewed studies, government policies, and reports from humanitarian agencies (UNFPA, WHO, NDMA), highlighting gaps in service delivery, financial allocation, and policy integration. The analysis reveals a fragmented response: NGOs often provide SRHR services without state coordination; planning lacks gender sensitivity; and support ends after short-term emergency phases. The study underscores the structural absence of displaced women's SRHR in both financing and policy frameworks. To address these gaps, the paper recommends gender-responsive health financing, integration of SRHR into disaster preparedness plans, and establishment of sustainable funding streams to protect women's health rights during crises. *(Afr J Reprod Health 2025; 29 [12s]: 183-195).*

Keywords: Reproductive Health, Displaced Women, Gender-Responsive Policies, Disaster Risk Reduction

Résumé

Le Pakistan est l'un des dix pays les plus vulnérables aux catastrophes climatiques, avec des inondations récurrentes qui ont déplacé des millions de personnes et perturbé les services essentiels, en particulier la santé. Les femmes en âge de procréer sont les plus affectées, souffrant d'un accès limité aux services de santé sexuelle et reproductive (SSR) de base : soins prénataux, accouchement sécurisé, planification familiale et hygiène menstruelle. Malgré ces besoins critiques, la SSR reste constamment sous-financée dans les réponses humanitaires, témoignant d'une négligence persistante dans les plans de réduction des risques de catastrophes et de renforcement des systèmes de santé. Cet article présente les résultats d'une revue systématique de la littérature sur le financement de la SSR pour les femmes déplacées lors des inondations de 2010 et 2022 au Pakistan. Les données, codées thématiquement, sont confrontées à la littérature scientifique, aux politiques gouvernementales et aux rapports d'agences humanitaires (UNFPA, OMS, NDMA), révélant des lacunes majeures en prestation de services, allocation financière et intégration politique. Les résultats mettent en évidence un environnement de réponse fragmenté : les ONG assurent souvent les services SSR sans coordination étatique ; aucune planification n'est genrée ; le soutien à la SSR s'évanouit après les phases d'urgence. La recherche souligne l'absence structurelle de la SSR des femmes déplacées dans les financements et politiques. Pour combler ces failles, l'article préconise un financement sanitaire genré, l'intégration de la SSR dans les plans de préparation aux catastrophes et la création de sources de revenus durables afin de garantir les droits sanitaires des femmes en situation de crise. *(Afr J Reprod Health 2025; 29 [12s]: 183-195).*

Mots-clés: Santé reproductive, Femmes déplacées, Politiques genrées, Réduction des risques de catastroph

Introduction

Pakistan is slowly being considered one of the nations most exposed to the effects of climatic changes. The country is currently ranked in the top ten according to Global Climate Risk Index[1], owing to the repetitive and worsening climate-related calamities, including most grotesquely, flooding. At least 20 million people were impacted by the disastrous floods

of 2010 and nearly 1.6 million homes were damaged[2], a comparison with the most recent disastrous floods of 2022, which displaced more people (over 8 million) than all those displaced by floods in 2010 combined and flooded a third of the country[3]. This has been disastrous on livelihoods, infrastructure, food security, and on the health of the people.

Women, especially those whose age are within the child-bearing age (15-49 years), pregnant, lactating, and adolescent girls are part of the most severely affected. Humanitarian emergencies place women at increased risks since it disturbs access to basic sexual and reproductive health and rights (SRHR) services such as antenatal and postnatal care, contraception, menstrual hygiene, and skilled birth assistance. As per the United Nations Population Fund (UNFPA), over 650,000 pregnant women were caught in the displacement caused by the 2022 floods, with most of them needing immediate maternal health services, but such services were inaccessible largely due to infrastructural destruction, scarcity of facilities, and displacement conflicts[4].

It seems improbable that despite the known and well-documented impacts of disasters on the wellbeing of women as they risk their lives in the disaster sequence and after it, the reproductive health is consistently underserved and underfunded in the mechanisms of emergency preparation as well as response in Pakistan. The focus of the national health emergency response mechanism has always been geared towards the control of communicable diseases, nutrition, and basic hygiene but not on SRHR services[4]. This means that critical SRHR needs are usually met at best or not met by humanitarian operators and non-governmental organisations which are beyond the scope of long-term assistance by the public sector. This gap is exacerbated when the relevant policy of gender-responsive budgeting was not taken into consideration and SRHR was not internationally included in the national disaster risk reduction (DRR) and the climate resilience policies.

The promotion of reproductive health during emergencies is not only an issue of equity, it is also a matter of life or death. The Minimum Initial Service Package (MISP) on reproductive health in crisis settings, an internationally agreed standard of the Inter-Agency-Working-Group (IAWG), describes those life-saving reproductive health interventions that should be prioritized in response to humanitarian crises. Nevertheless, it can be seen that MISP is inadequately incorporated into the disaster preparedness and responses systems of Pakistan, and when used, it is usually donor-led and not sustainable beyond short-term relief operations[5].

Such neglect begs a very important question: Is financing reproductive health of flood-displaced women in Pakistan a forgotten priority? To understand this question, this study conducts a systematic literature review of the findings of reproductive health service delivery and disaster response funding models and disaster response in the Pakistani context. Although numerous research papers and humanitarian reports have noted the gaps in the SRHR services in the event of floods, little has been done in examining the architecture of financing involved or lack thereof that drive the outcomes.

This paper aims to achieve three key objectives. First, it seeks to conduct a comprehensive literature review on SRHR service delivery and financing in flood- and displacement-prone areas of Pakistan. Second, it endeavors to identify major financial, institutional, and policy gaps that hinder the availability and accessibility of reproductive health services during climate-related emergencies. Finally, the study aims to provide evidence-based recommendations for integrating gender-responsive and disaster-inclusive financing mechanisms that ensure the recognition and sustained funding of SRHR services as a critical component of Pakistan's climate and health resilience agenda.

This study will interrogate both service-level and financial aspects of SRHR in humanitarian contexts with an aim of contributing to expanding literature, which promotes rights-

based, gender-equality approach to disaster health funding. When nowadays both climate resilience and disaster preparedness are gaining more and more attention in national and global policy-making spheres, reproductive health should no longer remain a secondary or secondary matter. As an alternative, it needs to be inculcated deep into the heart of the emergency health financing policies in order to preserve the dignity, rights, and survival of displaced women in Pakistan.

Literature review

This part provides the overview of the existing amounts of academic and grey literature regarding the reproductive health needs, funding issues, and gendered exposure to disasters in the context of Pakistan and neighboring areas of experiences. In making the synthesis of the literature, the literature is thematically arranged in five broad categories that include; (a) SRHR needs in disaster situations, (b) the gendered effects of floods in Pakistan, (c) health finance trends in times of emergencies, (d) lack of gender responsiveness in the budgeting process, and (e) international best practices in the funding of reproductive health during crises.

SRHR requirements in disaster situations

In a humanitarian context, sexual and reproductive health (SRHR) needs are urgent and critical but have normally been ignored because of other higher priorities in the humanitarian agenda. The inter-Agency working group[6] introduced the Minimum Initial Service Package (MISP on reproductive health) that defines essential measures to prevent maternal and newborn deaths, address gender-based violence, and the maintenance of access to contraception during emergencies[6]. Although MISP is an internationally-supported program, its realization in the low-resource and catastrophe-prone nations is erratic.

Empirical evidences indicate that natural disasters profoundly mitigate the ability of women to receive conditions of maternity attention, family planning and management of menstrual hygiene. As an example, Delaney and Shrader[8] emphasize that reproductive health requirements are very commonly forgotten in the relief activities in place since there is ignorance, logistics and even funds dedicated to the same. Almost 72 percent of women in post-earthquake Nepal experienced problems accessing the antenatal care during the months after the disaster[9]. The same patterns were recorded following Typhoon Haiyan in the Philippines where maternal and neonatal facilities were washed away, and safe childbirth and methods of contraception became obstructed[10].

Its own MISP implementation has been intermittent and much donor-led and unintegrated with national health emergency responses and provincial systems[11, 12]. Through the 2022 floods, UNFPA estimated that more than 650,000 pregnant women needed maternal health services, of which fewer than 35 percent accessed skilled birth attendants in displacement settings[4].

Gender-based effects of Pakistan floods

The links between gender and vulnerability within the results of climate changes are well-documented in South Asia. Floods mostly adversely affect women in Pakistan since they suffer because of societal, financial, and spatial limitations. In a normal situation, according to the Pakistan Demographic and Health Survey (PDHS) 201718 only 51 percent of women had four or more antenatal visits[13]. During the emergencies, the number of women having four or more antenatal visits decreases substantially[13]. (NIPS & ICF, 2019).

The findings during the 2010 floods showed that displacement worsened the barriers to reproductive care: improvised shelters were poorly built in terms of privacy, health services were under-equipped, and the male-based relief models did not understand gender-specific needs[14,15]. During the interviews taken during the response in 2010, several women said that they had to engage in dangerous abortion procedures because of unavailability of contraception[16].

These patterns were disclosed again by the floods in 2022. UN Women[17] highlighted that there was extreme disruption to SRH services in Sindh and Balochistan, especially the adolescent girls with a barrier of both logistical and sociocultural attributes to obtain care. In addition, women who were displaced stated that they had to face more gender-based violence, and camps did not provide much in the form of psychosocial support or the possibility of seeking legal aid[18,19].

Health financing during emergencies

International emergency funding in health in disasters usually focuses on short-term lifesaving measures including trauma management, control of infectious disease as well as nutrition, where SRH services are constructed as secondary or optional[20]. The outcome of this is unbalanced resources distribution in which either the maternal health and family planning programs are underfunded or missing in the emergency health budgets[21].
These global patterns have also been reflected in Pakistan in terms of facilitating disaster situations when it comes to having health finance. Malik and Malik[22] also found that in the case of the floods that occurred in 2010, fewer than 5 percent of all funds used on emergency response activities were devoted to female health and none to reproductive health. The NDMA and Ministry of Health emergency responses focus on overall health stabilization but fail to frame certain lines of response budgets on SRH interventions[5].
This issue can be worsened by the fact that international donors are usually required to provide barriers to SRH services in times of disasters. Though the mobilization of mobile health units and maternal kit distributions is commonly applied through the agencies such as UNFPA and IRC, mobile health units and maternal kits distributions are usually project-based and not built into sustainable financing programs[4,18].

Non-existence of gender responsive budgeting

Gender-sensitive budgeting (GRB) is the planning and programming and implementation of government budgets toward gender equity. GRB may have taken hold of the development discourse but it is not well-institutionalized within the Pakistani system of disaster risk financing[22].
Financial planning documents of the NDMA and the federal budget on health do not provide disaggregation of allocations by gender or services type, and it is almost impossible to monitor whether it spent money on SRH in the context of disasters[23,24]. Such less transparency is one of the reasons that lead to the invisibility of women health needs in planning and implementation. Moreover, the provincial health departments of Pakistan, which have become in charge of the service delivery following the 18 th Amendment, have not established gender-sensitive indicators in their post-disaster needs assessment (PDNA), even though data regarding KP and Sindh shows that the level of unmet SRH demand was very high in the case of recent floods[25,26].
This reliance on donor-funded reproductive health programs gives credence to the necessity of institutionalization of GRB mechanisms. The reviews in Bangladesh and Nepal demonstrate that when incorporated into local governance structures, GRB frameworks can enhance the disaster recovery funding and women health sources greatly[27,28].

Best practices around the world

Equitable and resilient recovery outcomes have also been shown to occur in countries where reproductive health has been mainstreamed in disaster response on the global front. As an example, Bangladesh has integrated SRH prevention into its cyclone preparedness plans and options to manage floods, including training local health workers

and positioning maternal health supplies that can be used in at-risk areas[29].

Nepal post-earthquake recovery was also in the form of SRH services in the form of mobile clinics and female health outreaches. According to the research by Bhandari *et al*.[30], the need to integrate RH services in the process of disaster response led to 40 percent more institutional deliveries during post-disaster recovery. In a parallel, Philippines has through institutionalization of SRH into its national disaster risk reduction law made provision of contingency funds towards maternal health and prevention of GBV[31].

These case studies have implications on lessons in Pakistan. To begin with, the use of community health workers is important in filling access gaps. Number two, the notion that earmarking disaster funds on reproductive health services is attainable and effective. And third, that between ministries of health, disaster management and women affairs, coordination promotes accountability and performance.

Methods

This study employed a Systematic Literature Review (SLR) methodology to examine the current state of reproductive health financing for flood-displaced women in Pakistan. A systematic review approach was deemed appropriate due to the growing yet dispersed body of literature across disciplines such as public health, gender studies, disaster risk management, and humanitarian finance. The review adhered to principles outlined by Moher *et al*.[6] (2009) and followed the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework to ensure transparency and replicability.

Data sources

In order to retrieve academic and grey literature, extensive search strategy was used across a combination of databases and coverage of Google Scholar, PubMed, JSTOR, and Scopus. The databases have been chosen with the argument that these broad databases contain peer-reviewed research in the field of public health and social sciences. Parallel to this, grey literature data were found in UNFPA, WHO, UN Women, National Disaster Management Authority (NDMA) of Pakistan, International Rescue Committee (IRC), and local NGOs dealing in humanitarian health reports and publications.

Search strategy and keywords

The literature search was conducted between March and June 2025. Boolean operators were used to combine keywords relevant to the topic. The main search terms included:

“Reproductive health” AND “floods” AND “Pakistan”

“maternal health” AND “displacement” AND “financing”

“sexual and reproductive health (SRH)” AND “emergencies” AND “South Asia”

“health system response” AND “gender budgeting” AND “humanitarian crises”

Each search result was screened for relevance based on title, abstract, and full-text availability.

Inclusion and exclusion criteria

To ensure the relevance and quality of the reviewed studies, several inclusion criteria were applied. Only publications from 2008 to 2024 were considered, with particular attention to the post-2010 and 2022 flood contexts in Pakistan. The review was limited to studies written in English to maintain consistency in interpretation and analysis. Eligible studies focused on Pakistan or the broader South Asian region, specifically addressing themes related to floods, reproductive or maternal health, and health system financing. In terms of source types, the review included empirical research, policy evaluations, thematic reviews, and implementation reports to capture both academic and applied perspectives on the subject. The exclusion criteria were designed to eliminate studies that did not align with the research focus on reproductive health within disaster and displacement contexts. Clinical

studies conducted outside a humanitarian or disaster framework—such as routine maternal care audits—were excluded. Similarly, urban-focused reproductive health research without a clear connection to disaster-induced displacement was omitted. Articles that lacked a financial or policy perspective on sexual and reproductive health (SRH) services were also excluded from consideration. After removing duplicates and ineligible records, the initial pool of approximately 100 studies was refined to 34 high-relevance sources, selected based on their quality, methodological rigor, and direct relevance to the research objectives.

Data extraction and analysis

The key information from each selected study was systematically organized into an Excel matrix, capturing essential details such as the author, publication year, study context, thematic area (e.g., access to SRH services, disaster response, or health financing), research methods, and major findings. This structured approach facilitated comparison and synthesis across diverse sources. Following data extraction, thematic coding was employed to categorize the studies under five central themes: (1) the presence and accessibility of SRH services in flood-prone regions; (2) health funding deficits, including donor dependency and budgetary exclusions; (3) the integration or lack thereof of SRH within disaster and emergency policy frameworks; (4) the inclusion of gender-sensitive approaches in health and disaster budgeting; and (5) the role of non-governmental organizations and third parties in addressing public sector gaps in SRH service delivery.

Quality assurance

Each source incorporated was also critically appraised to make the review robust in accordance with adapted Joanna Briggs Institute critical appraisal standard. Articles were preferred which were peer-reviewed and cited over 50 times, or reports by UN agencies or well established NGOs, which cited their own field tests.

This was a systematic review that enabled an overview of the multi-sectoral literature in order to provide insights into an overlooked juncture: reproductive health financing in the context of climate-induced displacement in Pakistan.

Results

This section synthesizes the findings from the systematic literature review, focusing on four interlinked domains of reproductive health financing and service provision for flood-displaced women in Pakistan: (a) service delivery gaps, (b) financial and policy barriers, (c) dependency on external actors, and (d) the invisibility of displaced women in data and planning. These themes collectively reveal a pattern of systemic neglect in both humanitarian and development financing frameworks.

Service delivery gaps

Dislocation and displacement associated with floods always negatively affect provision of basic sexual and reproductive health and rights (SRHR) services in Pakistan. The failure of fixed infrastructure is one of the most proximal service failures that were seen in times of humanitarian crises. During the current floods in 2022, 1,460-plus health facilities in Sindh and Balochistan were either destroyed or damaged, which led to an inaccessibility to maternal health services[4].

UN agencies and NGOs normally use mobile clinics as the first emergency stop gap in such cases. Literature however, points out that these services are underfunded and not very frequent. As noted by Ayesha *et al.*[12], the mobile health units sent in response to the floods of 2010 were provide most of the time with poor personnel which could not cope with the demand and some districts are served just once a week. The same results appeared in IRC[18] reporting that they were not able to provide the entire affected population with coverage by their mobile RH units in Sindh due to absence of fuel, road access and logistic coordination.

Besides, shortages of critical supplies- especially and especially menstrual hygiene kits, contraceptives, and delivery supplies are the other thing that has been happening repeatedly. In Balochistan and KP, where floods occurred in 2022, 60 percent of the women interviewed by Save the Children[32] said that they did not receive access to sanitary materials within two weeks after being displaced. This is consistent with the fact that most of the evidence indicates, worldwide, that the disruption of supply chains in humanitarian situations has a disproportionate female and young girls effect on it[10,30].

Coverage of antenatal and postnatal care (ANC/PNC) in displacement situations is highly reduced as well. When a study on this subject was carried out post-2010 floods, only 17 percent of pregnant women received any ANC and a mere 9 percent had skilled birth attendance[16]. These numbers did not change a lot during the 2022 emergency, when UNFPA teams documented over 160.000 deliveries in crisis-impacted regions, but the minority of them was performed by skilled workers[4,18].

Gaps in finances and policies

On a policy level, SRHR still does not feature in mainstream disaster management structure in Pakistan. Even though National Disaster Management Authority (NDMA) is granted a wide scope to address emergencies and recovery programs, sexual or reproductive health is not referred to explicitly in its standard operating procedures and budgetary premises[5]. (NDMA, 2022). Considering the content of the Monsoon Contingency Plans by NDMA (20212023), the most significant keywords are water-borne diseases and trauma relief and nutrition, with no separate lines and provision regarding maternal and reproductive care[33].

A comparable supervision is observed in provincial systems of disaster risk reduction (DRR). In Sindh and Punjab, two of the most flood-affected provinces, there is no allocation of budget on health services, either gender-responsive or SRH[22]. What this has brought about is that where RH services are offered at all, they have been lumped together with the mainstream health or treated as a special emergency project.

The unavailability of specific budget item lines in the case of reproductive health care during emergency and early recovery stages results to unsustainable and reactive service delivery. Malik and Malik[34] calculated that in the 2010 floods, the consumption of less than 1.5 percent of total federal health emergency money was directed to women-specific services, and none of them with a specific due RH. Recovery plans like Post-Disaster Needs Assessment (PDNA) of 2022 floods also did not factor in reproductive health into the future rebuilding architecture, accounting to a lost chance in institutionalizing SRH recovery planning into climate resilience planning[25].

These gaps mirror what Austrian *et al.*[21] defines as a sort of structural blind spot in the humanitarian financing regarding its refusal to prioritize life-saving but gender-specific health needs because of advocacy, political exposure, and a deficiency in budget connoting.

Reliance on the third-party actors

The lack of public funding on reproductive health in cases of disasters enormously relies on both kinds of international and non-governmental actors. The UNFPA, IRC, Save the Children, and, Médecins Sans Frontières (MSF) played the most prominent role in mobilizing emergency of SRHR services in the camp and other temporary shelters during the 2010 and 2022 floods[18,32,35]. These initiatives were good, though temporarily constituting scattershot, project-oriented, not to mention time-limited activity frequently terminating as a grant funding came to an end.

Chynoweth[10] discovered that the externally led MISP implementation in Pakistan made the country less owners of change, and they were not able to integrate SRH into health system in long-term perspective. This trend was repeated in 2022 flood where although it was well known that gender might play a crucial role in the crisis, despite all these knowing, when the

international agencies took a back seat, local agencies did not arrange the delivery of RH services.

Moreover, vertical programming, or the role of NGOs offering their services without making them readily available within the structure of the developed public health, results in the formation of silos and the absence of sustainability. Baloch *et al*.[36] conducted an assessment to evaluate flood-affected areas in KP and discovered that more than 70 percent of reproductive health activities had no connection with the district health information system (DHIS), which is why they could hardly be monitored and scale-up.

Pakistan is not the only country that relies on outside actors. Nonetheless, in such countries as Bangladesh or the Philippines, donor-financed SRHR initiatives are becoming integrated into the national systems mainly in terms of co-financing arrangements and the idea of a "public-private partnership"[29.31]. The fact that Pakistan has failed to embrace such models increases the occurrence of RH service breakdown every time a flood occurs.

Invisible women: no data no policy

Probably, the most alarming result of the analysis is that reproductive health of women and girls displaced is not tracked consistently due to the fact that the information is not disaggregated by gender. Pakistan, as a recurrently flood-affected nation, does not have a centralized system of monitoring SRHR indicators in a disaster situation. This encompasses straightforward indicators including the volume of pregnant women who left and ANC coverage in refugee camps or postnatal difficulties[17].

Lack of such information implies a broader problem: the obscurity of displaced women in disaster governance. According to Rahim *et al*.[26], the development of disaster response frameworks follows a gender-neutral perspective, but in practice organizes planning around males. This implies that in spite of the fact that women do suffer disproportionately, their special health needs are not documented and addressed.

Further, when needs assessments are undertaken, there is hardly a focus on or even any mention on RH indicators. To illustrate, a Joint Needs Assessment done following the 2022 floods prioritized food security, shelter, and WASH (water, sanitation, and hygiene), and referred to maternal care in the assessment only twice[5] Absence of such comprehensive data makes it about impossible to justify inclusion in budget as well as plan services keeping in view the ground realities.

Such a state of data invisibility is also an obstacle when it comes to advocacy and donor engagement. The donors are more results-oriented, and they need evidence on the way resources should be distributed. Without quantifiable indicators and service coverages, RH interventions are at a disadvantage of the more quantifiable intervention such as shelter or food aid[21].

As given above, these four thematic findings are saddening when one considers neglect and fragmentation. They continue to provide services in a hot-spotted, patchy and unreliable way, they fund on an ad-hoc, donor-driven basis, they have national policies without the prism of SRH, and the target group which is populated with the women who really need service are never in the national databases. Unless there are changes to financing, planning and monitoring systems, reproductive health will remain a low priority in the climate and disaster planning responded in Pakistan.

Discussion

The findings of this systematic review highlight persistent structural weaknesses in Pakistan's approach to sexual and reproductive health and rights (SRHR) during flood-related displacement. The four thematic domains—service delivery gaps, financial and policy barriers, reliance on external actors, and the invisibility of displaced women in data and planning—demonstrate how reproductive

health continues to remain marginal within the broader humanitarian and development architecture.

First, the results show that disruptions to fixed health infrastructure, shortages of essential supplies, and insufficient coverage of outreach mechanisms severely limit the availability of SRHR services during emergencies. These outcomes mirror global research showing that reproductive health needs are among the first to deteriorate in crises due to system fragility, logistical constraints, and limited preparedness. The restricted availability of antenatal care, safe delivery services, contraception, and menstrual hygiene support during the 2010 and 2022 floods reflects long-standing weaknesses in emergency health planning. This aligns with patterns documented in other disaster-affected contexts, where SRHR is frequently deprioritized despite constituting life-saving care.

Second, the absence of reproductive health in Pakistan's disaster risk management structures reinforces the persistent financing and policy barriers identified in the results. The lack of explicit SRHR budget lines in National Disaster Management Authority (NDMA) and provincial plans, combined with non-existent gender-responsive budgeting in emergencies, leads to fragmented and reactive interventions. This policy environment results in temporary solutions that disappear once donor funding expires. Evidence from other countries shows that integrating reproductive health into contingency planning and allocating ring-fenced funds can significantly improve service continuity. Pakistan's failure to institutionalize such mechanisms contributes to chronic underinvestment and undermines resilience in flood-prone areas.

Third, the findings highlight Pakistan's continued dependence on NGOs, UN agencies, and international humanitarian actors to deliver essential SRHR services. While these organizations provide critical support during emergencies, heavy reliance on externally funded and project-based interventions limits long-term sustainability. The lack of integration of NGO services into district health information systems further reduces accountability and prevents institutional learning. International experience demonstrates that durable improvements in crisis-affected SRHR systems require hybrid models—government stewardship combined with donor–private sector partnerships. Pakistan's limited movement toward co-financing or coordinated public–private arrangements perpetuates system fragility and recurrent service failures during floods.

Finally, the near absence of gender-disaggregated and crisis-specific SRHR data significantly undermines policy formulation, advocacy, and financing. The invisibility of displaced women in national assessments and disaster datasets leads to poorly informed emergency responses that overlook reproductive health needs. The absence of key indicators—such as antenatal and postnatal care coverage, skilled birth attendance, contraceptive access, and gender-based violence reporting—prevents evidence-based planning and weakens the case for investment. This data gap is not unique to Pakistan but is particularly consequential in a country with frequent climate-induced displacement. Global best practices show that integrating SRHR metrics into assessment frameworks and health information systems enhances both accountability and resource allocation. Without it, reproductive health will continue to be overshadowed by more visible sectors such as shelter, food security, and WASH.

Taken together, the results of this review illustrate how Pakistan's reproductive health system remains insufficiently prepared for climate-related disasters. Systemic neglect across policy, financing, coordination, and monitoring results in recurring gaps that disproportionately affect women and adolescent girls during displacement. These findings underscore the need for institutional reforms that elevate SRHR to a core component of disaster preparedness, climate adaptation, and health system strengthening.

Recommendations

The above discussion has shown that flood-displaced women reproductive health (RH) needs in Pakistan are under-funded, institutionally abandoned, and un-integrated into the national disaster response system. To fill in these gaps in the structures, the following section makes a collection of actionable, evidence-informed and context-specific recommendations in 5 priority areas including disaster policy, health financing, community-based service delivery, financing partnerships, and monitoring systems.

Mainstream SRHR into disaster-policy and -planning

In order to get out of cyclical response, sexual and reproductive health should be internalized into the disaster governance framework of Pakistan. In particular, its Standard operating procedures (SOPs) and contingency plans templates to enhance its relief and recovery actions, the National Disaster Management Authority (NDMA) needs to realign its strategies towards making RH a core service component.

UNFPA and IAWG suggest the introduction of the Minimum Initial Service Package (MISP) as a typical measure during the disaster preparation, that would include the prepositioned support and staff trained. When NDMA incorporates MISP protocols into its annual Monsoon Contingency Plans and guidelines set by the provincial Disaster Management Authority (PDMA), the institutionalization of RH services in the overall emergency response system will become possible (UNFPA, 2020).

Also, connections between the policy on national climate issue and health policy will be strengthened. Resilience of the health system including RH infrastructure should be integrated in the local adaptation strategies as per NAP and Climate Change Act (2017) in Pakistan as witnessed in Philippines and Nepal[28,31].

Health financing (gender responsive financing)

Gender-responsive budgeting (GRB) institutionalization is critical towards the establishment of unsurpassable and committed finances to the RH amidst such calamities. Currently they do not have any gender or service category disaggregated budget as a federal and provincial government of Pakistan, thus making it hard to monitor and safeguard the funds allocated to maternal and reproductive care[22,34].

Pakistan ought to be inspired by Bangladesh, in which GRB frameworks have been implemented in 43 ministries such as health and disaster management leading to better gender distributions and transparency[27]. (Holvoet & Inberg). In particular, the federal The Ministry of Finance, in collaboration with the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C), should undertake several key actions to strengthen gender-responsive health financing. First, gender tagging should be systematically implemented across all health and emergency budgets to ensure that allocations explicitly address the needs of women, adolescents, and marginalized groups. Second, the ministries should establish ring-fenced emergency funds within the health budget, dedicated to supporting maternal, adolescent, and sexual and reproductive health (SRH) services during crises such as floods and displacement. Finally, it is essential to mandate periodic gender budget audits to monitor on-the-ground expenditures against allocated funds, ensuring transparency, accountability, and effective use of resources for equitable health outcomes.

The reforms would also help to organize donors and enhance the eligibility of the nation to international financing on climate and health resilience[21].

Strengthen community-based service delivery

Community health workers—particularly Lady Health Workers (LHWs) and

midwives—serve as a scalable, community-rooted, and context-sensitive approach to maintaining essential reproductive health (RH) services during humanitarian crises. Despite their crucial position within communities, their involvement in emergency RH response remains constrained by limited training, inadequate preparedness, and weak integration within the broader supply chain systems.

To strengthen frontline capacity and ensure continuity of care during climate-related emergencies, the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C) should take several strategic steps. First, disaster-specific RH components—such as emergency contraception, menstrual hygiene management, and safe referral procedures—should be incorporated into the LHW training curriculum. Second, RH emergency kits must be pre-positioned and distributed to LHWs in flood-prone union councils ahead of the monsoon season to ensure rapid response capability. Finally, the establishment of RH mobile health units in high-risk districts, supported by provincial health departments and development partners, would significantly expand access to life-saving reproductive health services during periods of displacement and crisis.

In Nepal and Bangladesh, the experiences demonstrate that assigning community health workers (RH-specific tasks) during disasters enhances coverage, trust, and the continuity of care[29,30].

Enlist donor-private-public partnerships

Due to budget limitations and the continued occurrence of crises, combined financing system solutions stand as a viable way of the future. Pakistan can tap Corporate Social Responsibility (CSR), philanthropy capital and multilateral grants as RH preparedness and recovery financing.

Co-financing of the SRH services could include the donor organizations and the private sector through the instrument of the National Disaster Risk Management Fund (NDRMF). For example, innovative public–private partnership models can be leveraged to strengthen reproductive health (RH) service resilience and recovery in disaster-prone regions. One approach is to establish matching fund mechanisms that bring together government allocations with contributions from pharmaceutical, logistics, and telecommunications companies to support RH recovery and continuity of care during emergencies. Additionally, the government can incentivize corporate social responsibility (CSR) investments by encouraging private firms to fund and maintain maternal health clinics and mobile health vans designed to be flood-resistant and capable of operating in challenging terrains. These collaborations would not only enhance service delivery during crises but also foster long-term sustainability and community trust in the health system.

These kinds of models have shown effectiveness in supporting health response financing after a disaster in some countries such as Philippines and Indonesia[31,37].

Improve data and monitoring

Effective policy and financing have robust data as its building block. However, at present, there are no gender-disaggregated data on health in disaster situations in Pakistan, and it impedes planning, accountability, and funding. To address these data and coordination gaps, the Pakistan Bureau of Statistics (PBS) and the National Disaster Management Authority (NDMA) should take proactive steps to ensure that reproductive health (RH) considerations are systematically integrated into disaster assessment and response frameworks. First, all disaster evaluations—including Post-Disaster Needs Assessments (PDNAs) and rapid needs assessments—should include the collection of key RH indicators such as antenatal care (ANC), postnatal care (PNC), births, gender-based violence (GBV) cases, and access to contraceptives. Second, RH data modules should be embedded within the District Health Information System (DHIS2) to enable real-

time monitoring of service delivery and supply distribution in crisis-affected areas. Finally, PBS and NDMA should jointly produce annual RH resilience reports that consolidate information on financing, service accessibility, and health outcomes, providing evidence for informed decision-making and adaptive planning in the face of increasing climate-related emergencies.

With these sources, the planning of budgets will be enhanced, and it will increase donor confidence to the RH-related interventions as evident in the case of post-earthquake Nepal[28].

Conclusion

In this paper, the concept of ignoring the reproductive health (RH) finance related to displacement due to floods in Pakistan has been discussed by thoroughly reviewing the academic resources, governmental documentation, and humanitarian analysis. With this Nugget I have uncovered it is not RH that is the improper priority in policy and funding mechanisms in times of humanitarian crisis. Although antenatal care, safe delivery services, and menstrual hygiene, together with contraception are crucial in safeguarding the health and dignity of women and girls during displacement, they are normally not included in the national disaster response planning and budgeting. There is also a persistent problem in service delivery gaps. In 2010 and 2022 floods, the collapsing health infrastructure, stock-outs on essential RH supplies, and corresponding lessening of outreach services made millions of women lacking even basic reproductive care. Some relief was granted by mobile units and short-term NGO interventions; however, they were chronically underfunded and not integrated into the context of the overall public health system. A structural reason that proves to be a challenge when it comes to financing RH in the long-term is the fact that gender-responsive budgeting is not incorporated in the very governance institutions of disaster and health. Generalized process, lack of budget lines and poor coordination among the stakeholders have combined with dependency on donor-led but fragmented projects to feed a cycle of reactive unsustainable interventions. The issue is further complicated by poor data collection and the fact that displaced women are largely invisible in disaster impact assessments and plans. The findings point out to critical need of change. Reproductive health should be understood as not only an optional but also a high-level priority issue in humanitarian response and climate resilience. This demands institutional presences of RH within the national and provincial disaster policies, sustainable and ring-fenced funding arrangements, strengthened frontline delivery capacity and gender-disaggregated data systems. With an increase in the frequency and severity of climate-related disasters, Pakistan should take bold measures to defend the most marginalized. Giving reproductive health to flood-displaced women is a concern not only of the public health, it is a matter of human rights, social justice, national resilience. There can be no decision later.

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