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Accountability for Sexual and Reproductive Health and Rights in Humanitarian and Disaster Situations: Case Studies from Uganda, Bangladesh, and Nepal

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Abstract

Sexual and reproductive health and rights (SRHR) during conflicts and disasters are protected under multiple legal and policy frameworks; however, weak accountability mechanisms often prevent these rights from being realized. Drawing on case studies from Uganda, Bangladesh, and Nepal, this paper examines rights-based approaches for strengthening accountability for access to health services at the local level. The case studies adopt a "circle of accountability" as both a conceptual framework and implementation strategy to monitor, review, and prompt remedial action when reproductive rights are not respected. We argue that four interrelated strategies offer a promising approach to advance accountability for SRHR in displacement contexts marked by weakened governance, overlapping duty bearers, and power imbalances within humanitarian systems: (1) strategic legal and policy advocacy to promote alignment with human rights standards; (2) multi-sectoral partnerships and human rights champions to facilitate commitments among humanitarian actors; (3) equitable participation in humanitarian platforms to shape decision-making and remedial action; and (4) reimagined rights-based evaluation methods to promote people-centered accountability. Ultimately, we offer a road map for practitioners working in other humanitarian and disaster contexts to shift accountability for reproductive rights beyond performative checklists toward addressing both the immediate needs of displaced communities and systemic remedial action.

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Introduction

In an era of unprecedented humanitarian need, the complexity and scale of interconnected global crises demand more innovative and accountable approaches to humanitarian and disaster response.[1] This is particularly relevant in the domain of sexual and reproductive health and rights (SRHR), where there is continued need for maternal health care, contraception, comprehensive abortion care, holistic support for survivors of sexual and gender-based violence, and the protection of the rights to life, bodily autonomy, and nondiscrimination. Yet the availability of and access to health services are often fragmented and disrupted.[2] Access to sexual and reproductive health services and information is further limited in crisis by the influence of non-enabling legal and policy environments, harmful gender norms, misinformation during emergencies, and insecurity.[3] Global evidence consistently affirms SRHR as a lifesaving priority, with positive outcomes from the early implementation of key sexual and reproductive health activities at the onset of an emergency.[4] However, SRHR remains neglected across humanitarian response and preparedness cycles due to underfunding, limited health system capacity, and poor integration across humanitarian frameworks.[5]

To situate our discussion, we adopt the World Health Organization's definition of SRHR as encompassing both a broad range of health services (such as contraception, maternal health services, the prevention and treatment of sexually transmitted infections, and protection from gender-based violence) and the recognition that access to these services is a human right.[6] This framing distinguishes SRHR from narrower conceptions of sexual and reproductive health that focus mainly on service delivery and instead emphasizes rights-based entitlements, individual agency, and the structural conditions necessary for people to make decisions about their bodies and lives, linking health outcomes to autonomy, equality, and accountability.[7]

Established legal frameworks and practice standards protect access to sexual and reproductive health services in humanitarian situations, with both formal and informal accountability mechanisms ensuring that commitments made by states and professionalized civil society organizations are met.[8] These mechanisms—from global-level treaty monitoring bodies and Special Procedures, to core health indicators and monitoring frameworks for sexual and reproductive health, to local-level feedback and response systems—enable the identification of gaps, pathways for redress when violations occur, and ways to ensure that duty bearers uphold their obligations.[9]

Humanitarian standards and associated accountability mechanisms are well-established in theory, yet the reality of implementation is complex. Political will, systems' capacity to be timely and responsive to feedback from persons who are displaced, and power dynamics within the humanitarian system significantly influence and often constrain accountability for access to sexual and reproductive health services. These structural barriers create substantial gaps between legal and policy commitments and actual service delivery. This is further compounded by how SRHR programs in humanitarian and emergency situations are arranged to involve a complex network of actors with varying degrees of power and influence.[10] For example, while multilateral agencies provide normative guidance for international and national nongovernmental organizations (NGOs) that often serve as implementing partners, local actors with crucial contextual knowledge often occupy limiting roles in decision-making hierarchies. These power dynamics are also shaped by funding structures, with international donors exercising influence over program design and implementation through priority setting and reporting requirements, thus perpetuating vertical accountability structures.

The United Nations' *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality* envisions a restructuring of power relations and mechanisms for improved rights-based accountability.[11] The guidance situates accountability as one of four interdependent principles of a human rights-based approach—participation, nondiscrimination, empowerment, and account-

ability itself—and as a cross-cutting principle that underpins policy design, implementation, monitoring, review, and remedy. Within the guidance, the "circle of accountability" (CoA) builds on these foundations by embedding accountability throughout all stages of policy and program cycles, from national planning and budgeting through implementation and monitoring to mechanisms for assessment and redress, rather than treating it as an isolated response to rights violations or abuses.

Within the CoA framework, accountability reflects the legal obligation of duty bearers to be answerable for their actions and the entitlement of rights holders to demand redress, transforming displaced persons from passive beneficiaries into rights holders who can claim entitlements. It also contributes to transforming health systems and sustaining change by recognizing contextual and political factors, ensuring meaningful engagement in the realization of rights and access to justice, and envisioning the enforceability of decisions and actions from the outset of the policymaking cycle.[12]

Although the CoA does not prescribe specific rights-based benchmarks against which health interventions should be reviewed (thereby risking procedural rather than substantive accountability), adopting it alongside complementary accountability mechanisms that define measurable rights-based standards ensures review against health rights obligations. In humanitarian contexts, accountability must grapple with displacement-specific challenges, including the absence of traditional state-citizen relationships, the multiplicity of duty bearers with overlapping mandates, and power asymmetries embedded within humanitarian architectures. Implemented holistically, a rights-based CoA should identify and eliminate barriers that prevent or delay the inclusion and leadership of displaced persons in accountability processes and support transformative remedies that promote the realization of reproductive rights.[13]

While there is rhetorical traction for rights-based approaches and accountability in widely accepted humanitarian sector standards, such as the Core Humanitarian Standard on Quality and Accountability and the Sphere Standards, concrete policy and programmatic examples that apply and enforce health rights standards are limited.[14] This gap reflects persistent ambivalence and resistance to rights-based approaches and accountability frameworks within the humanitarian sector, rooted in concerns about their compatibility with traditional humanitarian principles of neutrality, operational efficiency, and depoliticized aid principles that, despite their ostensibly apolitical framing, are themselves argued to constitute political positions.[15]

Since 2019, the Center for Reproductive Rights has worked in partnership with humanitarian and human rights organizations to design and implement contextualized CoA models that respond to this gap: first, with CARE Uganda and South Sudanese refugees in settlements in Adjumani, Uganda; second, within the Rohingya refugee crisis in Bangladesh in partnership with Bangladesh Legal Aid and Services Trust, CARE Bangladesh, and Naripokkho; and third, in disaster-affected municipalities in Kailali District, Nepal, with CARE Nepal, the Forum for Women, Law and Development, and NEEDS Nepal. The relationship between humanitarian agencies and state health institutions providing sexual and reproductive health services varies across these contexts, reflecting differences in crisis status, state priorities, refugee policies, and health and legal systems. However, human rights principles remain universally applicable, providing a common thread to guide both the design and delivery of the case studies.[16] We designed all the initiatives with a rights-based accountability focus and used the CoA as a conceptual framework, yet varied their design processes, implementation strategies, and methodologies to ensure contextualization and fitness for purpose.

The methodologies and results from the case studies are presented elsewhere, including case study reports, advocacy materials, and toolkits to support other humanitarian practitioners in clarifying SRHR obligations and replicating methodologies in their respective contexts.[17] In this paper, we focus on promising cross-cutting strategies emerging from the case studies. In our view, these strategies will support future health rights efforts to hold the broad range of humanitarian actors, including

states, multilateral agencies, and professionalized civil society organizations, accountable for providing more people-centered sexual and reproductive health services, platforms, and processes. Drawing on comparative insights from these three country case studies, we present four common and transferable strategies for accountability. Specifically, we explore how health rights initiatives can navigate legal and policy alignment and advancement; benefit from multi-sectoral partnerships to build human rights champions; center community participation and decision-making in humanitarian platforms; and transform evidence requirements from standard evaluation into a process for improved accountability and remedial action.

Our analysis is underpinned by practitioner reflections that were shared during a February 2025 partners' dialogue. The cross-regional dialogue brought together organizations and allies engaged in the three initiatives for shared learning and knowledge exchange. Through structured discussions and deliberative processes, practitioners shared their perspectives and evidence, contested the different project models and strategies, and formed consensus-based recommendations to advance accountability for SRHR in humanitarian and disaster situations. Drawing on the meeting output documents and recommendations, we argue that for rights-based programming and accountability to be transformative rather than tokenistic, it must operate not only at the level of health service delivery but also as an institutionalized norm for redistributing power, guaranteeing meaningful participation and inclusion, and expanding legal, political, and social protections for SRHR.

Summary of the three case studies

This section summarizes the three case studies that we explore throughout this paper. The initiatives adopted a broadly coherent three-stage approach.

First, they were co-designed with refugee and host-community stakeholders through participatory workshops, focus group discussions, and key informant interviews to map SRHR accountability gaps and devise new strategies and systems, drawing on the CoA as a blueprint for the promotion and protection of SRHR.

Second, the initiatives trained and legitimized local community leaders and human rights defenders through structured capacity-strengthening, complemented by follow-up support and peer-learning sessions, to document SRHR claims, monitor service delivery against SRHR standards, and advocate for change through various platforms when reproductive rights were not respected. Among other topics, the capacity-strengthening addressed progressive legal and policy frameworks on SRHR at the regional, national, and global levels, survivor-centered documentation and referral procedures, and evidence-based advocacy strategies.

Finally, the initiatives monitored remedial action taken by duty bearers. Monitoring combined quantitative tracking of case outcomes (e.g., rates of resolution of cases and responsiveness time frames) with qualitative assessment of remedial outcomes, acceptability of remedies among refugee communities, and emerging institutional learning and adjustments, laying a foundation for sustained policy and practice change.

Adjumani District, Northern Uganda

In 2019, the Center for Reproductive Rights and CARE Uganda piloted a community-centered model for SRHR accountability in refugee settings. The co-designed model aimed to address the failure of existing humanitarian feedback mechanisms in the Pagirinya refugee settlement (e.g., feedback boxes, public dialogues, and hotlines) and enable more responsive remedial action when reproductive rights were not respected. As described by one South Sudanese woman living in the settlement, "When we use the current feedback boxes, we see no change and no response."

The Pagirinya model established three interconnected pillars: (1) a council for SRHR made up of refugee and host-community members who were trained to document SRHR issues; (2) an ombudsperson who served as an independent reviewer of SRHR-related complaints, with district government backing; and (3) community-based monitors who tracked SRHR programs and services to assess

whether commitments and state-mandated changes in response to complaints were implemented. Over a three-year period, the model led to concrete remedial actions to improve service delivery, including a newly authorized human rights and respectful maternal health care training for health service providers, adolescent-friendly appointment times at primary health centers, and permanent budget lines for maternal health departments to buy assistive devices for persons with disabilities.

Cox's Bazar District, Bangladesh

Building on the learning from Uganda, a partner consortium established a human rights-based accountability initiative in Rohingya refugee camps in Cox's Bazar between 2022 and 2025. The program integrated legal, social, and participatory accountability mechanisms, with leadership from Rohingya women and community leaders at its core. An adaptive program design framework characterized by flexibility and continuous evolution was used based on real-time data, national and local political constraints, and community recommendations.

Accountability for access to sexual and reproductive health services was operationalized through the establishment of four interconnected components: (1) a rights-based coordination platform for data-driven dialogue between humanitarian health stakeholders at the camp level; (2) community solidarity networks that provided peer support and feedback relating to SRHR, gender, and human rights realities; (3) an independent monitoring system within primary health facilities led by national and local women's rights defenders; and (4) holistic support centers where human rights lawyers and health advocates provided integrated health and legal assistance. Key remedial actions over the four-year project period include immediate measures to provide 24/7 outdoor lighting at health facilities to reduce the risk of sexual and gender-based violence at night; securing access for human rights defenders to accompany Rohingya women and girls to sexual and reproductive health services to reduce fears of discrimination and abuse; and guarantees from humanitarian organizations providing health services to train and support their staff in the delivery of respectful maternal health care, in response to reports of mistreatment.

Kailali District, Nepal

The 2023 collaboration in Nepal aimed to better understand the adaptability and transferability of the CoA strategies and arrangements tested in Uganda and Bangladesh, within the context of disaster. Similarly to the Uganda initiative, this model connected service users with municipal health authorities and providers using (1) a council for SRHR; (2) community monitors who were trained by national reproductive rights advocates and lawyers in human rights monitoring approaches and tools; and (3) improved feedback channels to document, monitor, and resolve SRHR complaints within existing municipal-level health monitoring and reporting systems.

The initiative also led legal and policy advocacy at the district and municipal levels, resulting in the government institutionalizing amendments to the Godawari municipal disaster preparedness and response plan guaranteeing the continuity of sexual and reproductive health services during emergencies. Strategic advocacy subsequently achieved the formal passage of the municipality's Safe Motherhood and Reproductive Health Rights Act of 2025, marking the first enactment of the national reproductive health law at the local level in Nepal.

Accountability for SRHR: Four pathways for change

These initiatives in Uganda, Bangladesh, and Nepal provide examples of innovative approaches to hold states, professionalized NGOs, and multilateral humanitarian agencies accountable for their SRHR commitments. In this section, we outline common pathways for change that the initiatives have found effective in holding powerful actors accountable and achieving real-time remedial action to improve SRHR. These approaches are promising to improve right to health realities and recenter the agency and rights of affected populations in humanitarian and disaster response governance.

Pathway 1: Strategic legal and policy advocacy to meet and advance human rights standards

The complex humanitarian landscape demands both the provision of essential sexual and reproductive health services and the strategic navigation of legal, political, and community contexts. While service delivery metrics remain important, true accountability requires dismantling structural barriers to sexual and reproductive health service access through integrated legal and policy advocacy. The three case studies actively engaged at various levels with legal and policy frameworks as leverage to advance rights protections.

In a notable example from Uganda, following increasing reports of sexual and gender-based violence during the COVID-19 pandemic, the ombudsperson identified a policy opportunity to strengthen local-level protections. With support from lawyers from the Center for Reproductive Rights, the ombudsperson worked with the local government to review national health rights standards and revise subnational bylaws to ensure better alignment with constitutional protections and the National Policy on Elimination of Gender Based Violence in Uganda.[18] The advocacy process highlighted how even with national legal frameworks in place, implementation often falls short due to local officials' discretionary power, revealing a significant gap during instability and crisis.

At the regional level, partners from the Uganda initiative drew on project evidence to advocate for the adoption of the African Commission on Human and Peoples' Rights Resolution 492, and the General Comment on Article 22 of the African Charter on the Rights and Welfare of the Child.[19] These landmark documents strengthen protections for women and children in armed conflicts by mandating prevention measures and comprehensive survivor support, including accessible sexual and reproductive health services. Partners are now using Resolution 492 and General Comment on Article 22 as key accountability resources to hold other conflict-affected African nations accountable and to inform recommendations to member states.

Similar efforts in Nepal focused on incorporating reproductive rights protections enshrined in the country's Safe Motherhood and Reproductive Health Rights Act of 2018 into Godawari municipal laws to ensure the continuity of sexual and reproductive health services during natural disasters.[20] Strategies that contributed to the policy adoption included rigorous mapping and review of existing laws and disaster frameworks to identify SRHR gaps; continuous multi-stakeholder consultations and policy dialogues involving municipal and provincial leaders, health officials, legal experts, and community representatives; and civil society support with drafting and validating language.

Policy advocacy also resulted in the revision of Godawari's disaster preparedness and response plan to secure SRHR priorities across all phases of disaster management, including provisions for the minimum initial service package, gender-based violence prevention, menstrual health, and a designated disaster response focal person trained in human rights and SRHR. Community-led advocacy through the CoA model, with trained community monitors collecting and escalating complaints, also directly informed legal and policy reform. These combined efforts not only codified SRHR protections at the local level but also institutionalized key components of the CoA conceptual framework. The Nepal case study showcases how local government engagement can accelerate, rather than impede, the implementation of reproductive health and accountability frameworks, which differs from our strategies used in other contexts.

Contrasting Uganda's and Nepal's experiences, where local and regional law and policy advancements were achievable, the initiative in Bangladesh was uniquely complex due to the limited protection framework for Rohingya refugees and the national political context.[21] Without strong entry points for advocacy, the project adopted a two-pronged approach: advocating for stronger rights-based standards in multilateral and international NGO (iNGO) humanitarian platforms and providing evidence to support existing legal sector efforts to expand refugees' access to family courts for restitution following SRHR violations.

Opportunities also arose to engage with the interim government's newly appointed Commis-

sion on Women's Affairs to discuss potential SRHR law and policy reforms that would improve the lived realities of all women and girls experiencing displacement in Bangladesh. This strategic combination of prioritizing remedial action within nonstate humanitarian platforms, while aligning with long-term and ongoing strategic entry points for national law reform, demonstrates how to achieve incremental progress toward accountability even in restrictive law and policy environments.

This pathway operationalized the CoA's commitment to structural and legal accountability by transforming evidence from community-level rights claims into enforceable policy and standards across local and regional systems. By codifying SRHR protections in municipal disaster plans (Nepal), subnational bylaws (Uganda), and regional human rights instruments (Africa), the initiatives embedded accountability within the policy design and budgeting stages of the cycle, establishing legal obligations that redefined the relationship between duty bearers and rights holders, whose entitlements became increasingly justiciable (i.e., amenable to third-party adjudication by suitable judicial or non-judicial bodies.)

Pathway 2: Building multi-sectoral partnerships and local human rights champions

SRHR-related humanitarian policy and programs straddle sectors and disciplines, including health, protection, water and sanitation, and shelter, yet implementation often occurs through siloed institutions and strategies.[22] For example, protection actors may focus narrowly on responding to gender-based violence, health actors on service delivery for survivors, and human rights actors on broader power relations and gender inequality factors that are often deemed peripheral but are, in fact, central to addressing gender-based violence and achieving equitable SRHR outcomes. Since humanitarian hierarchies and coordination structures are closely tied to funding and access, power dynamics and ways of working that privilege certain actors and sectors become further entrenched, while longer-term rights and gender priorities remain marginalized. The case studies addressed these dynamics directly through intentional cross-sectoral partnerships that unite health actors, lawyers, and community advocates in shared accountability problem-solving spaces.

In Bangladesh, humanitarian organizations, human rights advocates, and legal aid providers collaborated on a shared implementation strategy, overcoming initial disagreements about the meaning and focus of accountability. For example, during the design phase, legal practitioners questioned the enforceability and obligations underpinning social strategies and models, whereas social practitioners challenged the underlying power dynamics of legal frameworks and whether they meaningfully deliver access to justice and accountability in practice. While these orientations and organizational mandates related to accountability remained, deep collaboration during the design phase and routine partner meetings throughout implementation ultimately eliminated operational blind spots that might have otherwise limited addressing SRHR accountability as an issue of health service delivery or sexual and gender-based violence alone.

Direct partnership with refugee-led groups was modeled in the Uganda case study through co-led project design, implementation, assessments, and the resulting three community structures. At project closure, leaders of these structures led a self-directed process to register as the Women Empowerment Initiative Center (WEIC), a Ugandan community-based organization dedicated to sustaining community accountability for SRHR and health services.

Since 2021, WEIC has achieved notable remedial actions when health rights standards have gone unmet, including successfully advocating for a permanent maternity ward to replace a temporary structure that existed during the project period and which had registered poor maternal health services and outcomes. WEIC also conducts community monitoring of sexual and reproductive health outcomes through health facility and household visits, hosts weekly radio awareness programs, and conducts community dialogues on comprehensive and adolescent-focused SRHR. Additionally, the organization is entrusted by health authorities to

support counseling and referrals from the community level to settlement health facilities, which the refugee-led team funds directly through monthly member contributions of UGX$50,000 (approximately US$14).

At present, this member-supported model remains the primary funding source; however, WEIC is actively pursuing funding streams to diversify resources and strengthen long-term sustainability. While this self-financing mechanism reflects a high degree of community ownership, it also raises important considerations regarding reliance on member contributions, which may constrain participation and introduce inequities into otherwise inclusive governance structures. WEIC aims to mitigate risks of exclusion through hybrid financing arrangements, such as pooled donor funds and partnering with national NGOs, with a focus on promoting inclusivity and maintaining local autonomy. The evolution of this partnership demonstrates the value of institutionalizing community-led systems beyond conventional project time frames, whereby groups are formally recognized within the broader accountability ecosystem that outlasts the project and funding cycle. This strategy mitigates the limitations of projectized models, which often prioritize short-term outputs over integrating initiatives into broader systemic strategies and outcomes. Relatedly, Nepal uses a unique model requiring iNGOs to partner with national and local organizations for project delivery, creating a deliberate and long-term framework for collaboration rather than informal or emergent partnership strategies seen in other contexts.

A common theme across the case studies was the need for enhanced capacity-building for both the partnership and allied implementing organizations, especially concerning human rights standards and their practical application among humanitarian health workers. Early assessments in all three contexts confirmed that training and organizational onboarding for humanitarian and disaster response workers lacked this content. The absence of rights-based knowledge within humanitarian skill-building is not merely a training gap but a reflection of the broader ambivalence and resistance to rights-based approaches within the humanitarian sector, an orientation that obscures the intrinsically political dimensions of such work. Consequently, humanitarian workers have limited exposure to rights-based approaches and little awareness of how such strategies have transformative potential to support their mission and mandate. A significant gap also exists in basic advocacy training for humanitarian workers, which is necessary for those who serve as organizational representatives on key platforms and processes that make decisions on SRHR and human rights. These practitioners need dedicated skill-building to strategically advocate for important issues, especially stigmatized issues such as reproductive rights.

Interactive training programs on SRHR and human rights designed for humanitarian and health actors addressed these gaps. In Bangladesh, targeted health care and legal sector worker training programs served multiple capacity-strengthening purposes: improving SRHR awareness, clarifying service delivery standards, building trust with initially skeptical humanitarian and legal providers, and cultivating champions to advocate for rights-based sexual and reproductive health services and accountability on key humanitarian platforms. Training feedback surveys revealed broadly positive responses to this approach, with participants reporting high satisfaction with human rights education. One training participant acknowledged prior training gaps, commenting in their survey that "the second R (rights) of SRHR is rarely covered in humanitarian trainings and skill-building programs."

Ultimately, this pathway gave practical effect to the CoA's principles of participation and empowerment by redistributing power and knowledge through cross-sectoral partnerships that institutionalize community-led accountability beyond project cycles. It brought together health actors, legal advocates, and community monitors in shared problem-solving spaces to dismantle institutional silos that had fragmented SRHR into discrete technical domains. The collaboration also secured sustainable structures to maintain accountability beyond external funding and remain controlled by

rights holders rather than implementing partners.

Pathway 3: Equitable participation in humanitarian platforms and processes to shape remedial action

Participation is a cornerstone of the human rights framework and mutually reinforcing of accountability; yet in humanitarian contexts, participation is often reduced to consultation without power.[23] The case studies applied community-centered participatory design and monitoring to legitimize initial situational assessments and inform the design. While approaches varied significantly based on context and challenges, solidarity groups were fundamental across implementation strategies.[24] Uganda's and Nepal's models worked directly with refugee and local community members to lead health system monitoring and oversight and to hold duty bearers accountable. In Uganda, the evolution from informal refugee-led groups to a self-sustaining community-based organization demonstrates the organic growth of community ownership and accountability through these strategies.

Comparatively, the Bangladesh effort focused on securing openings for refugee voices in program design and broader humanitarian systems. Bangladesh's more restricted context for refugee inclusion necessitated creative approaches to overcome state limitations on Rohingya participation and leadership.[25] The program worked through existing "women and girls safe spaces" and established the Naripokkho women's center, which was complemented by door-to-door outreach led by human rights defenders, referred to in the camp context as community support monitors. Human rights defenders were experienced members of national feminist movements and previously supported programs that monitored quality of care in state hospitals. They understood their role as a balance between building trust to provide accurate SRHR information to the Rohingya community and challenging prevailing power dynamics that affect SRHR outcomes.

Following an accompaniment model, human rights defenders reported improved relations with midwives after recognition of their monitoring mandate in health facilities. Human rights defenders' logbooks confirmed that over a two-year period, Rohingya women's self-reported uptake of and referral to sexual and reproductive health services increased in the camp blocks where human rights defenders were working. According to local health actors and the camp administrative government, the broader camp dynamic during this time was conversely trending downward for health service uptake.

In Nepal, the strategy of mobilizing community monitors, who held a similar role and mandate to those in Uganda, resulted in positive potential for institutionalizing community monitoring as a recognized accountability mechanism. This was achieved through reforms to the municipal disaster preparedness and response plan, which was revised as a result of the project evidence and advocacy. While this role for local monitors has not yet been tested in a state of emergency, longer-term oversight will determine whether volunteers from Kailali continue to be systematically integrated into planning and response processes following the project closure.

The case studies surfaced consistent limitations on participation in traditional humanitarian accountability mechanisms (e.g., feedback boxes, complaints and feedback response mechanisms, and in-facility reporting systems).[26] These conventional arrangements often fail to address power imbalances, cultural and language barriers, and fear of reprisal among displaced populations who rely on humanitarian assistance.[27] Mapping accountability ecosystems as part of each initiative's design highlighted how these widely accepted and adopted arrangements frequently fall short in delivering meaningful accountability and ensuring responsiveness for SRHR abuses and violations.

Yet even systems designed to be innovative and responsive and to shift decision-making authority require participatory review and adaptation. Limited claims associated with certain stigmatized SRHR issues were common and indicate how contextually designed initiatives can still fall short of full rights alignment. For example, the Uganda initiative needed regular reassessment of its out-

reach and advocacy strategies to ensure inclusive participation and to address underreported issues of adolescent SRHR, including unsafe abortion. Project staff made additional efforts to gather testimony concerning SRHR and increased the number of adolescent peer-to-peer solidarity groups to provide safer, smaller spaces for adolescents to meet. In the Rohingya refugee camps, human rights defenders conducted extensive follow-up with health providers to verify that counseling and menstrual regulation referrals were being provided. Experiences from both settings show that while improvements to traditional accountability systems are necessary, significant time and advocacy capacity are often required to do so.

At the global level, ensuring meaningful opportunities for local actor participation in humanitarian and human rights decision-making forums cannot be overlooked. The three case studies prioritized resources, capacity-building, and support to ensure participation at the global level. Forum events included human rights defenders from Uganda and Bangladesh directly engaging in briefing Human Rights Council member states during critical discussions on accountability for women and girls in humanitarian settings. Leveraging project evidence in shadow reports submitted to Special Procedures and multilateral organizations also helped ground international guidance in lived realities rather than theoretical frameworks alone.[28] Finally, South Sudanese refugee leaders effectively utilized high-level forums, addressing member states at the United Nations Economic and Social Council Humanitarian Affairs Segment to call on states to fulfill their SRHR obligations and commitments as part of the global protection agenda.[29]

These platforms, coupled with strategic advocacy, amplify local voices and create direct channels for influencing global policy and practice, potentially transforming the traditional top-down humanitarian system into a more inclusive and responsive framework. However, global-level opportunities for direct engagement are rarely prioritized in humanitarian project planning and budgeting. This indicates a need for donors, organizations, and project designers to proactively incorporate and fund local actor participation across these crucial platforms from the outset.

In sum, this pathway applied the CoA's participatory and iterative principles by embedding displaced persons' leadership within community consultation, monitoring, legal accompaniment, and advocacy processes that directly informed remedial actions and institutional decisions. Through these mechanisms, rights holders identified violations, set priorities, and accessed safe accountability pathways created by human rights defenders and legal advocates, ensuring the inclusion of marginalized groups such as adolescents and persons with disabilities. Capacity-strengthening and engagement in global platforms further advanced empowerment by positioning refugee and disaster-affected communities as experts capable of challenging duty bearers at the highest levels. In this way, accountability evolved from passive feedback collection to a dynamic cycle of documentation, response, and review that redistributed power over how SRHR is defined and delivered.

Pathway 4: Reimagining evidence and evaluation as a process for improved accountability and remedial action

A common reflection across the case studies was that the most meaningful changes—power shifts, more accessible and enabling environments, and expanded participatory space—were the least evident through partners' standard monitoring, evaluation, research, and learning (MERL) tools. The Uganda initiative adopted mixed-methods research, including formal baseline and endline assessments, as well as routine monitoring of health service responsiveness and remedial follow-up rates.[30] Yet the most significant change according to participants and refugee leaders was a change in how community members perceived themselves and asserted their SRHR claims as rights holders. COVID-19 pandemic restrictions in Uganda also catalyzed a shift toward more rights-based data ownership during the project period. When humanitarian partners could not travel to the settlements, community monitors took increased

leadership and control of data collection and analysis, using real-time information for local advocacy. This change in situation accelerated the move away from an extractive MERL process, where iNGOs and implementing partners often control the data chain, and instead empowered refugee leaders to conduct evidence-based advocacy in their communities and with key duty bearers.

Similarly, Bangladesh project partners frequently reported the most significant change as subtle shifts in humanitarian actors' accountability norms. This is despite the minimal formal uptake of rights-based indicators beyond sexual and reproductive health-specific working groups and platforms operating in Cox's Bazar. Human rights defenders in Bangladesh also pioneered innovative documentation approaches through community monitoring, overcoming significant limitations on the Rohingya's access and freedom of movement. By building trusted networks and working through community intermediaries, they enabled Rohingya women and adolescents to safely share their experiences and define accountability and acceptable remedial action in their own terms. Both Rohingya and host communities in Bangladesh received training that enabled them to recognize SRHR issues, including reproductive decision-making, disrespect and abuse during maternity services, and discriminatory denial of essential medicines based on factors such as age or HIV status. This bottom-up approach to data collection proved successful in Nepal as well, helping center communities' understanding of SRHR and related services.

Nepal's approach stands out for also successfully developing and validating a set of human rights-based indicators and a checklist tool for the national human rights institutions to monitor SRHR services in disaster-affected areas, including the National Human Rights Commission and the National Women Commission. The checklist supports the tracking of SRHR outcomes both during and after disasters and includes indicators that measure not only service delivery (such as access to contraception, maternal health, and sexual and gender-based violence services) but also nondiscrimination, respect, and equity in care. This comprehensive framework will better ensure that SRHR monitoring captures the full spectrum of rights-based service provision in emergencies. The indicator development process involved consultations with the National Human Rights Commission, the National Women Commission, partners, and other Kailali District community stakeholders. An inclusive process helped ensure that the indicators were not only aligned with international human rights standards but also grounded in local definitions of rights, accountability, and community priorities. Both the National Human Rights Commission and the National Women Commission agreed to incorporate the indicators into their institutional monitoring systems—commitments that were recorded in formal meeting minutes, marking a major step toward institutionalizing SRHR accountability in Nepal's disaster governance.

Rights-based MERL methods are well-placed to redefine what counts and to develop metrics that are grounded in legitimacy, responsiveness, and structural change—not only health service uptake and coverage.[31] Reporting burdens, overstretched humanitarian workers, and the need for streamlined core indicators that expand beyond service-level metrics must be acknowledged.[32] Yet MERL experiences demonstrate how generating evidence and leveraging it with meaningful opportunities for participation and decision-making can lead to more promising long-term outcomes at local, regional, and global levels.

While reproductive decision-making and enabling legal environment indicators found in Sustainable Development Goal 5.6.1 and 5.6.2 provide a recognized foundation for the sector, it is equally important to incorporate measures that evaluate dignity and service quality from the perspective of rights holders themselves.[33] Expanding and adapting participatory methodologies are feasible and promising approaches to better capture power shifts and decision-making dynamics in complex settings.[34]

This pathway operationalized the CoA's monitoring and review dimensions by reframing evidence generation as a participatory and

rights-affirming process that transfers data ownership and evaluative power to affected communities. By centering rights holders' perspectives on what constitutes evidence, the case studies redefined monitoring and assessment from extractive exercises led by implementing partners into instruments for accountability. These processes enabled communities to evaluate duty bearers' performance, expose structural barriers such as discrimination and lack of dignity in care, and use evidence to drive both remedial action and systemic policy reform, thereby completing the accountability cycle from remedy back to policy design and resource allocation.

Conclusion

By institutionalizing multilevel and participatory accountability arrangements, health systems facing significant pressure from conflict and disaster can be supported to respond to immediate needs while also promoting long-term human rights objectives. This paper has sought to demonstrate how innovative accountability mechanisms to ensure access to sexual and reproductive health services and that address root causes of reproductive rights violations can be achieved through legal, policy, and social change strategies that build duty bearers' capacity and holds them to account. The case studies' experiences reveal concrete distinctions between the superficial integration of rights-based approaches and opportunities for transformative system change within the context of humanitarian and disaster response.

We propose that effective rights-based approaches require a comprehensive accountability framework—one that is embedded throughout the policy and program cycle and moves beyond reactive measures to generate a systemic and transformative realization of rights. The CoA offers a strong starting point for applying such a framework for humanitarian and disaster contexts. However, while it establishes pathways for monitoring, review, and remedy, the CoA provides limited guidance on compelling duty-bearer compliance beyond voluntary commitments. This limitation underscores the need to accompany it with complementary mechanisms that translate accountability principles into enforceable and practice-oriented obligations within complex humanitarian systems. Promising ways to implement this approach include adaptive legal and policy strategies; institutionally supported cross-sectoral partnerships and a commitment to building human rights champions at the local level; the genuine redistribution of power through more participatory platforms and processes; and MERL methods that prioritize rights realization alongside efficiency. The case studies also offer practical examples of how social and legal accountability practitioners, humanitarians, and advocates seeking to operationalize rights-based approaches can conceptualize program design, policy advocacy, and partnership development through a CoA framework that moves beyond aspiration and creates sustainable models for respecting, protecting, and fulfilling reproductive rights.

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Ethics approval

Research conducted in Uganda involving human subjects received ethics approval from the Mildmay Uganda Research Ethics Committee (#REC REF 0505-2021). Program monitoring and evaluation activities—including data collection and analysis protocols, instruments, and informed consent materials—for the initiatives in Bangladesh and Nepal received ethics approval from two independent research experts and qualified legal counsel. Ethics approval was issued in accordance with the Declaration of Helsinki, Bangladesh Medical Research Council regulations, and the International Ethical Guidelines for Health-Related Research Involving Humans issued by the Council for International Organizations of Medical Sciences.

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