Conflict, Control, and Care: Reproductive Rights and Humanitarian Aid in War

Streun, Melinda van

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Abstract

This thesis investigates the systematic neglect of sexual and reproductive health and rights (SRHR) in conflict-related humanitarian responses. Rather than approaching this neglect as a logistical failure, it argues that SRHR exclusion is a structural feature of humanitarian governance shaped by patriarchal, racialised, and (neo)colonial hierarchies. Through a comparative case study of Ukraine and Palestine, with Sudan as a shadow case, the research explores how aid systems govern reproductive life – through care, neglect, and active obstruction - according to biopolitical and necropolitical logics.

The theoretical framework integrates four concepts: biopolitics, necropolitics, intersectionality, and decolonial feminism. This layered approach enables a critical reading of how reproductive life and death are managed across geopolitical contexts. The thesis employs qualitative document analysis to trace how SRHR is framed, funded, and operationalised across the three cases. Ukraine illustrates how reproductive care is deprioritised even in well-funded, politically backed settings. Palestine reveals necropolitical abandonment, where SRHR is actively obstructed through settler-colonial control and infrastructural targeting. Sudan underscores that such patterns persist in contexts of extreme invisibility, especially where racial and geopolitical hierarchies converge.

Across cases, the thesis shows that SRHR neglect is not an exception of war, but a consequence of how humanitarian aid is structured. Addressing this injustice requires more than improved programming; it demands a fundamental rethinking of which lives are considered worthy of saving, and which are allowed to be forgotten in crisis.

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I would like to extend my gratitude to my supervisor for her thoughtful guidance, critical insights, and steady support throughout this process. I am also thankful to my friends and family, whose encouragement and presence sustained me during the writing of this thesis.

More importantly, this thesis is not just an academic exercise but a political act. It is rooted in a belief that critical scholarship has a responsibility to amplify marginalised voices, challenge dominant narratives, and confront structures of power that produce and legitimise suffering. The framing of conflict, the inclusion or exclusion of certain narratives, and the selective recognition of whose rights matter are not neutral decisions - they are deeply political.

Academia has a crucial role to play in exposing injustice. Scholars have both the tools and the responsibility to question dominant discourses, shed light on structural inequalities, and challenge the assumptions that shape public understanding and policy. We are living in a time of rising fascism, widespread disinformation, and increasing repression of critical voices – including within academic institutions. Universities that present themselves as protectors of freedom and debate too frequently act as agents of suppression. Student protestors are continuously confronted with police and with academic silencing. In that light, this thesis stands with those struggling for justice. It stands with organisers, with civil society actors risking everything to provide care in conflict, and with students, scholars, and activists resisting repression. It is written in solidarity with all those fighting for freedom – in Sudan, in the Democratic Republic of Congo, in Afghanistan, in Ukraine, in Myanmar, and, given the current political climate of repression, especially in Palestine. The call for the liberation of any people is not a threat; it is a demand for freedom, for safety, and for dignity.

This is written at a time when the war atrocities in Sudan continue to be severely underreported, when the ongoing genocide in Palestine is met with international complicity, and when the rights of women, including those in Ukraine, are quietly sidelined under the guise of neutrality, logistics, or pragmatism. These injustices demand more than recognition. They demand that we loudly take a side. In a world where it is easy to follow comforting ‘middle ground’ narratives, critical thinking and moral courage are crucial acts of solidarity.

To stand with those who are suffering is not optional. It is our responsibility – as scholars, as citizens, and as human beings.

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Introduction

The past decade has seen a sharp regression in sexual and reproductive health and rights (SRHR) across different political and geographic contexts. The reintroduction of the Global Gag Rule and the abolishment of USAID under the Trump administration restricted funding for international organisations that provided abortion-related services, cutting vital SRHR resources for vulnerable populations, particularly in crisis-affected regions (PAI 2025). In Afghanistan, the Taliban's return to power has resulted in the complete silencing of women in public life, including the near-total erasure of healthcare services (UN Women 2024). Meanwhile, in the West, a rise of the far-right has fuelled attacks on gender equality, demonstrated by developments such as the overturning of Roe v. Wade in the United States, which has emboldened similar legislative rollbacks in Poland and Hungary. More recently, the newly formed Dutch government has announced significant cuts to development aid and humanitarian assistance (Government of the Netherlands 2024), threatening essential funding for SRHR programs worldwide. These developments underscore a global trend of reproductive control being used as a means of governance and suppression, demonstrating that the erosion of SRHR is neither accidental nor isolated, but a strategic effort to reinforce patriarchal and authoritarian power structures.

Since October 2023, the world was shocked by reports of expectant mothers in Gaza undergoing C-sections without anaesthesia due to severe shortages caused by ongoing conflict and genocide (MSF 2025; OHCHR 2025). In Ukraine, maternity wards have been bombed, forcing women to give birth in underground shelters without adequate medical assistance (UN News 2024). Along the Mediterranean migration routes, it is estimated that 90% of women and girls are raped, with numbers likely being higher due to unreported incidences (UNHCR 2024). Meanwhile, Sudanese women fleeing violence face increased risks of sexual violence and forced pregnancies, with little to no access to contraceptives or maternal healthcare. These cases are not isolated tragedies; they are emblematic of a global pattern in which sexual and reproductive health and rights are systematically neglected in humanitarian responses despite international commitments, humanitarian policies often treat SRHR as secondary to food and shelter, reinforcing systemic exclusion (Tazinya et al. 2023, 1-2). This neglect is not incidental but reflects broader systems of control, where reproductive rights become tools of political and demographic regulation (Hedström and Herder 2023, 2).

Thus, the systematic neglect of SRHR in crisis settings is not merely a logistical failure but a deliberate outcome of political and ideological priorities. Historically,

reproductive control has been wielded as a tool of governance, used to regulate populations, suppress ethnic minorities, and maintain patriarchal dominance (Hedström and Herder 2023, 2). Today, these dynamics are reflected in humanitarian aid frameworks that consistently prioritise food, water, and shelter over reproductive healthcare, as though SRHR were an optional luxury rather than a fundamental human right (Tazinya et al. 2023, 1-2). The erasure of reproductive justice from crisis responses is part of a broader "war on women", in which reproductive autonomy is systematically undermined under the guise of cultural sensitivities, political neutrality, or resource constraints. This war is not limited to conflict zones but extends globally, as evidenced by recent policy shifts and ideological movements threatening gender rights worldwide.

The deliberate destruction of maternity hospitals in Gaza, the denial of emergency contraception to rape survivors in Sudan, and the exclusion of SRHR from aid responses in Ukraine all point to a troubling reality: in moments of crisis, women's and marginalised individuals' health is seen as expendable. This raises an urgent question: Why are SRHR services systematically neglected during conflict-related crises?

Despite extensive research on humanitarian aid and crisis response, SRHR remains largely absent from mainstream humanitarian discourse. Much of the existing literature on SRHR in crises has focused on climate-induced disasters, where issues such as displacement and disrupted healthcare systems mirror those found in conflict settings (Hedström and Herder 2023, 3; Okeke et al. 2024). However, while both climate and conflict crises lead to similar humanitarian breakdowns, the political dimensions of SRHR neglect in conflict remain critically understudied. Most research on SRHR in war zones focuses on service delivery constraints –such as damaged infrastructure or disrupted supply chains –without interrogating why reproductive healthcare is consistently deprioritised within humanitarian governance (Munyuzangabo et al. 2020, 12). This study aims to fill this gap by critically examining the systemic exclusion of SRHR from conflict-related humanitarian responses, exposing the deeper ideological and political forces at play.

SRHR neglect in war zones is not a neutral omission but a structural feature of the global humanitarian aid system, which reflects patriarchal and (neo)colonial dynamics. Aid frameworks are shaped by donor priorities, political sensitivities, and racialised hierarchies that determine whose lives are worth saving and which rights are considered essential. Western humanitarian institutions frequently present themselves as champions of human

rights, yet their selective approach to crisis intervention reveals entrenched biases. For example, Ukraine has received unprecedented humanitarian support, yet reproductive healthcare remains a blind spot in their aid response (UNFPA Ukraine 2024b). At the same time, in Gaza, reproductive healthcare facilities have been directly targeted, illustrating how SRHR can be not just neglected but actively obstructed as a tool of demographic control (Ferguson and Desai 2024, 76). The systematic sidelining of SRHR in both cases suggests that reproductive rights are not universally recognised as humanitarian priorities, but rather contingent upon political and racialised notions of which populations deserve full human rights.

This research critically engages with feminist, intersectional, and decolonial perspectives to challenge mainstream humanitarian frameworks that reinforce gendered and racialised inequalities. It seeks to expand the conversation beyond logistical explanations for SRHR exclusion by interrogating the power structures that dictate what counts as life-saving aid. The study argues that SRHR neglect in war zones is not an unintended failure but an active reproduction of patriarchal and colonial power dynamics that have long governed global aid policies.

The research is guided by the central question: Why are SRHR services systematically neglected during conflict-related crises? This question carries both academic and societal significance. Academically, the study critiques the fragmentation of humanitarian aid research by highlighting the intersectional nature of SRHR, conflict, and displacement. By addressing the gap in research on SRHR exclusion in war zones, this study contributes to feminist and decolonial debates on the role of aid in reinforcing structural inequalities. Societally, the findings have urgent policy implications for humanitarian governance. Recognising SRHR as an essential component of crisis response is critical for protecting the rights and health of marginalised populations, particularly in contexts where reproductive healthcare is deliberately weaponised.

This thesis argues that SRHR neglect in conflict settings is a product of systemic inequalities embedded in humanitarian governance. It examines how (neo)colonial, patriarchal, and racialised hierarchies shape donor priorities and humanitarian policies, leading to the systematic exclusion of reproductive healthcare from aid frameworks. In doing so, the study calls for a fundamental rethinking of humanitarian responses, one that centres reproductive justice as an essential, rather than optional, component of crisis interventions.

Addressing SRHR neglect requires not only logistical solutions, but a structural overhaul of how humanitarian priorities are defined, ensuring that gender justice is at the heart of crisis response.

By critically interrogating the mechanisms through which SRHR is sidelined, this study contributes to ongoing feminist and decolonial critiques of humanitarian governance. It challenges the dominant narratives that frame reproductive healthcare as secondary and exposes the global complicity in reinforcing gendered forms of violence in conflict zones. As the war on women's rights continues to escalate worldwide, recognising reproductive justice as a core component of humanitarian aid is not just a moral imperative, it is a necessary step towards dismantling the power structures that perpetuate gender-based oppression.

Literature Review

This literature review offers a descriptive account of the existing academic work on the marginalisation of sexual and reproductive health and rights (SRHR) in humanitarian settings. It outlines what scholars have already examined – from structural and logistical barriers to intersectional exclusions and funding dynamics – and identifies key patterns in how SRHR is consistently deprioritised. While this body of work sheds important light on different facets of SRHR neglect, the analyses often remain fragmented. Discussions of patriarchal aid structures, colonial legacies, and humanitarian governance rarely engage with one another in a sustained or integrated way. This thesis builds on these existing insights and brings them into conversation by showing how patriarchal and (neo)colonial logics intersect to systematically shape the exclusion of SRHR in conflict-related crises. In doing so, it identifies a critical gap in the literature and sets the foundation for the theoretical and empirical chapters that follow.

Structural and Systemic Barriers to SRHR in Humanitarian Aid

Sexual and reproductive health and rights are systematically deprioritised in humanitarian aid responses due to structural biases that frame reproductive healthcare as non-essential compared to immediate survival needs like food, water, and shelter. This perception is not only inaccurate but also dangerous, as SRHR services are critical to preventing maternal mortality, gender-based violence (GBV), and unsafe abortions (Tazinya et al. 2023, 1-2). Humanitarian frameworks often reflect a narrow, life-saving paradigm that marginalises SRHR needs, reinforcing the assumption that reproductive healthcare can be postponed in crisis settings (Pugh 2019, 4). The prioritisation of these essential needs over reproductive

healthcare underscores an ongoing failure within humanitarian responses to recognise SRHR as a fundamental human right, one that is not secondary to but rather interconnected with overall survival, well-being, and dignity.

Logistical and financial barriers further exacerbate SRHR neglect. Humanitarian crises disrupt supply chains, limit funding allocations, and create bureaucratic obstacles that prevent the effective delivery of reproductive health services. Limited funding, particularly in conflict settings, forces aid organisations to prioritise politically "neutral" interventions, sidelining SRHR due to its perceived sensitivity (Munyuzangabo et al. 2020, 10; Pugh 2019, 4). The instability caused by conflicts often leads to the destruction of health infrastructure, preventing access to contraceptives, safe abortion services, and maternal healthcare. Moreover, weak healthcare systems in crisis-affected areas lack the capacity to provide adequate reproductive healthcare, leading to increased morbidity and mortality among marginalised populations (Tazinya et al. 2023, 2). The lack of trained medical personnel in crisis zones further restricts the provision of comprehensive SRHR services, leaving displaced populations to rely on inadequate and often inaccessible healthcare options.

Political and cultural sensitivities also contribute to SRHR exclusion. In many crisis settings, patriarchal norms and conservative policies create environments where reproductive rights are framed as controversial, illegitimate, or unacceptable. In Yemen, for example, patriarchal norms and donor-driven priorities significantly restrict access to reproductive healthcare, disproportionately harming women and girls (Tanyag 2018, 655). Similarly, UNFPA highlights how gender-discriminatory norms in crisis settings amplify vulnerabilities by limiting women's autonomy over their bodies and reproductive choices (UNFPA 2021, 43). Cultural taboos surrounding reproductive health further prevent individuals from seeking necessary medical care, particularly in societies where discussions about contraception, sexual health, and abortion are heavily stigmatised. As a result, SRHR services remain politically and culturally marginalised within humanitarian responses, creating a cycle in which reproductive health is continuously sidelined in favour of less contentious aid interventions.

Layers of Marginalisation in SRHR Access

SRHR is neglected in a variety of contexts and for a variety of different marginalised groups. Displacement significantly heightens vulnerabilities to SRHR neglect. Forced migration, weak healthcare infrastructure, financial barriers, and legal restrictions all contribute to the

exclusion of displaced populations from reproductive healthcare services. Humanitarian settings often lack the necessary medical infrastructure to provide comprehensive SRHR services, disproportionately affecting refugees and internally displaced persons (IDPs) (Tazinya et al. 2023, 2). When individuals are forcibly displaced, they often lose access to consistent healthcare, making it difficult to obtain contraception, prenatal care, and safe delivery services. This neglect disproportionately affects adolescent girls, who face higher risks of GBV, child marriage, and unsafe pregnancies in crises (UNFPA 2021, 44). In refugee camps, limited resources and overcrowding exacerbate these issues, as well as the lack of access to safe spaces for reproductive health consultations.

Another intersection of marginalisation would be LGBTIQ+ individuals, who face systemic discrimination within both host communities and humanitarian aid structures, further limiting their access to essential SRHR services. LGBTIQ+ refugees often encounter hostility from aid providers, legal barriers to accessing healthcare, and an overall invisibilisation of their specific needs (Gambir et al. 2024, 15). Many humanitarian organisations lack clear policies on addressing the reproductive health needs of LGBTIQ+ individuals, leaving them without tailored medical care or psychosocial support. Transgender individuals, in particular, experience barriers to accessing hormone therapy, gender-affirming care, and STI prevention services, highlighting a critical gap in SRHR policies within humanitarian settings. The compounded stigma faced by LGBTQ+ individuals not only affects their physical health but also their mental well-being, as exclusion from healthcare services reinforces societal discrimination and marginalisation.

Women with disabilities also experience heightened SRHR barriers due to systemic neglect in humanitarian frameworks. Daigle et al. argue that women with disabilities are often invisible in humanitarian responses, as aid frameworks fail to consider their specific reproductive health needs (Daigle et al 2023, 64-65). Limited accessibility in health facilities, lack of disability-inclusive policies, and cultural stigmas contribute to their exclusion. The failure to integrate disability-inclusive reproductive health services into humanitarian responses results in increased risks for sexual violence, unplanned pregnancies, and preventable maternal health complications. Women with disabilities often face additional layers of dependency on caregivers, making it even more difficult for them to seek SRHR services autonomously. Furthermore, the absence of sign language interpreters, accessible transportation, and disability-friendly medical equipment in crisis settings reinforces barriers to SRHR access.

Moreover, conflict settings drastically increase the prevalence of GBV, further underscoring the need for comprehensive SRHR services. GBV – including rape, forced marriage, and female genital mutilation – surges during crises, particularly in overcrowded refugee camps with weak security structures (Tazinya et al. 2023, 1-2). For example, child marriage rates in Sudan soared following conflict outbreaks as families sought to protect daughters from sexual violence (UNFPA 2021, 43). The widespread use of sexual violence as a weapon of war further heightens the urgency of providing emergency reproductive health services in conflict settings. However, despite the increased risks, GBV survivors often lack access to post-rape care, emergency contraception, and psychosocial support due to systemic SRHR neglect (Gambir et al. 2024, 15). In many conflict zones, medical and forensic services for rape survivors are either unavailable or highly restricted, forcing survivors to navigate an already inadequate healthcare system while coping with trauma and stigma.

The Role of Conflict and Climate in SRHR Neglect

The intersection of conflict and climate-related crises presents profound challenges for SRHR access, as both forms of crisis contribute to displacement, healthcare system collapse, and deprivation of essential reproductive health services for vulnerable groups. Conflict-related displacement often occurs in politically unstable contexts, where healthcare infrastructures are already fragile, intensifying challenges for marginalised populations. In Lebanon, for instance, the healthcare system struggles to meet the SRHR needs of displaced Syrian women, as limited resources, legal restrictions, and social stigma hinder access to reproductive healthcare (Daigle et al. 2023, 53). Similarly, the ongoing genocide in Gaza has severely impacted healthcare infrastructure, restricting access to maternal care for internally displaced women and girls (Ferguson and Desai 2024, 2). The destruction of hospitals and targeted attacks on medical facilities further illustrate how conflict settings actively obstruct reproductive healthcare, leaving pregnant women without access to skilled birth attendants, emergency obstetric care (midwifery), or postnatal services.

In many conflict-affected regions, restrictive policies and donor-driven priorities determine the extent to which SRHR services are made available, further limiting reproductive autonomy. The highly politicised nature of conflict-related crises makes SRHR provision even more challenging, as governments and international organisations often hesitate to fund reproductive health programs due to their perceived controversial nature (Pugh 2019, 4). As a result, displaced women and girls in these settings are frequently left without access to family planning, safe abortion care, and essential maternal health services,

exacerbating their vulnerability to poor health outcomes. For example, Rohingya refugee women in Bangladesh face additional obstacles such as cultural stigma, underfunding, and resource shortages, which further restrict contraception access and GBV prevention services (Hossain and Dawson 2022, 51).

When looking at climate-induced crises, these are similarly disruptive. However, these often receive different levels of humanitarian response due to their less politicised nature. Natural disasters and environmental changes can force mass displacement, disrupting access to healthcare and increasing GBV risks, just like conflict-induced crises. For example, young women in the Pacific Islands face reduced access to contraception and menstrual health products during climate disasters, highlighting the ongoing SRHR disparities in climate-vulnerable regions (Murphy, Azzopardi, and Bohren 2023, 10). Unlike conflict settings, however, climate-related crises tend to facilitate greater international coordination and funding for humanitarian aid efforts. Nevertheless, the provision of SRHR services remains inconsistent, as resources are often allocated to immediate disaster relief rather than long-term reproductive healthcare solutions. The contrast between SRHR responses in conflict and climate settings underscores the geopolitical dimensions of humanitarian aid, where politically sensitive crises often result in the systematic deprioritisation of reproductive health services.

Humanitarian frameworks frequently prioritise basic needs like food and shelter over SRHR, sidelining essential reproductive health services. Although global initiatives such as the Minimum Initial Service Package (MISP) advocate for the inclusion of SRHR in emergency responses, implementation often falls short due to logistical and resource challenges (Tazinya et al. 2023, 4-5; Pugh 2019, 4). Additionally, international aid responses often fail to incorporate intersectional approaches that address the unique reproductive health needs of displaced populations, LGBTQ+ individuals, and women with disabilities. As a result, SRHR services in both conflict and climate crises remain fragmented and insufficient, leaving marginalised populations without adequate support.

Patriarchal and Colonial hierarchies in Humanitarian Aid

Academic literature increasingly emphasises that humanitarian aid systems are structured by intersecting patriarchal and colonial hierarchies, which together shape both the delivery and design of aid. Rather than separate forces, these systems work collectively to determine

which health needs are prioritised, whose lives are protected, and who remains excluded from care – particularly in the context of SRHR.

Moane provides a foundational analysis of these dynamics, arguing that modern Western institutions have normalised hierarchical structures across nearly every social system – politics, economics, religion, and education – where power is overwhelmingly concentrated in the hands of men (Moane 1999, 24–25). These patriarchal arrangements are not neutral but have been historically constructed and maintained through domination and subordination, shaping how societies – and by extension humanitarian actors – organise authority and distribute resources.

This gendered logic is deeply embedded in colonial systems as well. Spencer-Wood extends this critique by showing how patriarchal ideologies were central to the architecture of European colonialism, not merely an effect of it. She introduces the concept of patriarchal colonialism to describe how colonizing powers imposed gender hierarchies through institutions like missions, trade posts, and schools, where indigenous women were stripped of land, leadership, and labour rights (Spencer-Wood 2016, 477–480). These institutions not only enforced rigid gender roles – often equating indigenous women's domestic work with low status – but also legitimised racialised and sexualised control over their bodies through laws, missionary teachings, and exploitative labour systems. Moreover, Spencer-Wood distinguishes between external colonialism, characterised by the domination of foreign territories, and internal colonialism, which targets racialised or ethnic minorities within the 'home territories'. Refugee camps, boarding schools, and ethnic ghettos become sites where gendered and racial control are enacted in parallel ways (Spencer-Wood 2016, 479). The systematic subordination of women through these structures, including through unpaid domestic labour and institutionalised sexual violence, exemplifies how patriarchal power was both ideological and materially enforced across colonial systems (Spencer-Wood 2016, 483, 488).

These historical patterns of patriarchal colonial control resonate with how humanitarian priorities are structured today. The current global humanitarian aid system remains deeply entrenched in patriarchal and (neo)colonial structures, which perpetuate inequalities and marginalise specific groups, particularly women, girls, and LGBTQ+ individuals. These structural biases are evident in the prioritisation of certain forms of aid, such as food, shelter, and security, while neglecting critical services like SRHR, which are

deemed politically sensitive or culturally contentious despite being life-saving (Tazinya et al. 2023, 1-2). Humanitarian responses often reflect donor-driven priorities that align with Western political interests rather than the lived realities of affected communities. This can be seen in numerous conflict-affected regions, where local knowledge and community-driven initiatives are often overlooked in favour of top-down, externally imposed aid frameworks. Similarly, Hedström and Herder argue that more specified research is needed to understand how SRHR is experienced and contested on the ground, emphasizing the importance of centring community voices (Hedström and Herder 2023, 3).

Across this literature, there is growing recognition that patriarchy and colonialism function as interconnected systems shaping global power hierarchies. Spencer-Wood (2016) and Moane (1999) highlight how these dynamics have historically structured institutions and continue to influence governance today. Meanwhile, Tazinya et al. (2023), Tanyag (2018), and Hedström and Herder (2023) document similar patterns in humanitarian aid, particularly in the marginalisation of SRHR and the silencing of community-based knowledge. While these scholars address different facets of the issue, whether colonialism, patriarchy, or aid hierarchies, their findings point towards a shared underlying structure of exclusion.

What emerges is a fragmented yet overlapping body of research that has not always made these interconnections explicit. This thesis seeks to bring these perspectives into closer dialogue by exploring how patriarchal and (neo)colonial logics collectively shape SRHR neglect in humanitarian governance. These insights together are critical for understanding how SRHR neglect in humanitarian aid is not simply the result of funding gaps or logistical constraints, but a systemic feature of power structures that shape global aid architecture.

Western Identities Versus "The Rest"

The construction of Western identity has long relied on an oppositional framework that defines the "Self" in contrast to a subordinate "Other". This dynamic, rooted in colonial and orientalist discourses, continues to shape contemporary geopolitical narratives, humanitarian responses, and global power structures. Central to this construction is the idea of the good, white, Christian, liberated "Us" – positioned as the ideal subject of civilisation, rationality, and moral superiority – versus the racialised, veiled, Muslim, patriarchal, and backward "Other", framed as needing Western intervention, but never fully deserving of inclusion or equality.

Edward Said (1987) explores this dichotomy in Orientalism, demonstrating how the West has historically produced knowledge about the "Orient" in ways that justify its own supremacy. The West defines itself as rational, progressive, and morally advanced, while casting the East as primitive, despotic, and trapped in cultural stagnation (Said 1987, 40). This binary not only informs political rhetoric but also aims to legitimise military and humanitarian interventions, often under the guise of "saving" oppressed peoples. The depiction of Muslim women as victims of their own societies, in particular, has been instrumental in justifying Western involvement in the Middle East and beyond (Said 1987, 108). Yet, as Said highlights, this construction is not about genuine concern but about maintaining the West's ideological and material dominance (Said 1987, 204).

Similarly, Stuart Hall and David Morley (1992) in The West and the Rest: Discourse and Power argue that Western identity formation relies on a set of discursive strategies that distinguish "Us" from "Them". The West's self-representation as the bearer of progress and enlightenment depends on a racialised and gendered contrast with the “Rest”, who are positioned as obstacles to “modernity” (Hall and Morley 1992, 146). This distinction is not just theoretical but has real-world implications in policy and humanitarianism, where Western-led interventions are framed as neutral, benevolent, and necessary, while indigenous or non-Western approaches are dismissed as regressive or ineffective (Hall and Morley 1992, 152).

Hall and Morley also highlight how the West systematically erases its own complicity in patriarchal and neocolonial structures. Western societies present themselves as gender-equal and progressive, yet they sustain economic and political systems that disproportionately harm women and marginalised groups globally (Hall and Morley 1992, 169). By externalizing patriarchy and authoritarianism onto the "Other", Western nations avoid reckoning with their own histories of oppression and structural inequalities (Hall and Morley 1992, 174). This self-exonerating mechanism allows for the perpetuation of neocolonial power structures, wherein interventions in non-Western societies are framed as "helping", while the systemic inequalities perpetuated by the West remain unaddressed (Hall and Morley 1992, 181).

Mladjo Ivanovic (2019) extends this critique by analysing the colonial legacy embedded in Eurocentric humanitarianism. He argues that modern humanitarian efforts, rather than being neutral acts of goodwill, are deeply rooted in the West’s historical

entitlement to intervene in the lives of non-Western peoples (Ivanovic 2019, 45). This entitlement is a continuation of the "civilizing mission": the colonial justification for imposing Western norms and governance structures on indigenous populations (Ivanovic 2019, 49). Even today, Western-led humanitarianism positions non-Western societies as incapable of managing their own crises, reinforcing the idea that they require Western oversight (Ivanovic 2019, 61).

Additionally, Ivanovic critiques how Western humanitarianism selectively acknowledges suffering. The suffering of those within the "Us" category – predominantly white, Christian, and Western – is deemed worthy of immediate response, whereas the suffering of the racialised "Other" is often ignored or treated as an inevitable consequence of their own supposed cultural failures (Ivanovic 2019, 73). This selective empathy is evident in the disparities between humanitarian responses to conflicts involving predominantly white victims versus those affecting racialised populations (Ivanovic 2019, 79). The treatment of Ukrainian refugees versus Palestinian refugees or other people of colour (PoC) exemplifies this hierarchy, wherein the former are welcomed and integrated into Western societies while the latter face systemic exclusion and neglect.

A slowly growing body of literature documents the continued role of Europe as a geopolitical actor whose normative agenda is shaped by colonial imaginaries. Oleart and Roch (2024) demonstrate how the EU's foreign policy discourse towards Ukraine and Palestine reveals this asymmetry. While both Ukraine and Palestine face military aggression from more powerful neighbours, only Ukraine is framed by EU leadership as part of the "European family", deserving of full-scale political, financial, and military solidarity (Oleart and Roch 2024, 6–9). In contrast, Palestine is barely acknowledged as a political subject, and its suffering is framed as a humanitarian tragedy devoid of structural causes. These double standards, embedded in policy and discourse, illustrate the persistence of racialised and colonial hierarchies within the EU's conception of "Europe" (Oleart and Roch 2024, 13–18). This descriptive divergence in treatment contributes to the context in which SRHR neglect becomes more than just a humanitarian oversight – it becomes a symptom of who is recognised as worthy of protection.

This literature collectively demonstrates that Western identity is constructed in opposition to a racialised and gendered "Other" in ways that justify ongoing intervention, reinforce global inequalities, and mask Western complicity in patriarchal and (neo)colonial

violence. The refusal to acknowledge these structures allows the West to maintain its self-image as progressive and morally superior while continuing to exert control over marginalised populations. This ideological framework is not simply an abstract discourse but an active force shaping policies, humanitarian practices, and geopolitical decisions. It is through these discursive and material mechanisms that the West upholds its power while evading accountability for the very systems of oppression it claims to oppose.

Theoretical Framework

To examine the systemic neglect of sexual and reproductive health and rights in humanitarian settings, this study adopts an integrated theoretical framework that brings together four interrelated approaches: biopolitics, necropolitics, intersectionality, and decolonial feminist theory. Each of these concepts offers a distinct analytical entry point into how humanitarian aid structures reinforce hierarchies of power, determine which forms of care are prioritised, and reproduce patterns of exclusion. Rather than treating these theories as separate or competing, this framework conceptualises them as complementary and intertwined. Together, they enable a layered and critically engaged understanding of how SRHR is deprioritised or obstructed in conflict-related aid, whether through bureaucratic inaction, racialised hierarchies, or deliberate strategies of control.

Biopolitics and Necropolitics: Governing Life and Death in Humanitarian Aid

Michel Foucault's concept of biopolitics examines how power structures regulate life and survival, determining which populations receive care and under what conditions (Foucault 1984, 262). In humanitarian settings, SRHR is often deprioritised under the pretext of focusing on "life-saving" interventions such as food, shelter, and water. This biopolitical logic frames reproductive healthcare as non-essential, reinforcing systemic exclusions within aid structures. Despite substantial international support and humanitarian attention, SRHR remains politically deprioritised in Ukraine, illustrating how reproductive healthcare is treated as secondary even in well-organised humanitarian responses (UN Women 2025a, 14). The systematic neglect of SRHR in humanitarian decision-making reflects the way aid structures manage life in conflict settings, shaping which forms of healthcare are prioritised and which are sidelined. While the 'governance of life'-focus of biopolitics illuminates how humanitarian systems regulate life by prioritizing certain forms of care, it does not fully account for contexts where SRHR is not merely overlooked but actively denied. To address this, the framework turns to necropolitics.

Achille Mbembe's necropolitics expands this analysis by revealing how power determines not only who is allowed to live but also who is abandoned to death (Mbembe 2003, 40). SRHR neglect is not simply an omission but an active form of exclusion that disproportionately affects marginalised populations, rendering them disposable within global humanitarian hierarchies. Gaza exemplifies this necropolitical dynamic, where reproductive healthcare is not only neglected but deliberately targeted. Systematic hospital bombings, blockades restricting medical supplies, and the calculated denial of maternal and reproductive care illustrate how SRHR exclusion operates as a form of structural violence. In this context, SRHR neglect is not merely a lack of prioritisation but an intentional mechanism of demographic control, deepening Palestinian disposability within broader geopolitical hierarchies (Hanbali et al. 2024, 19).

Judith Butler's concept of grievability offers a crucial extension here, by revealing how public recognition of suffering and death is unevenly distributed. Grievability refers to the social and political framing of which lives are considered worthy of mourning, and which are not (Butler 2009, 38). In humanitarian discourse, this logic determines not only who is cared for, but whose loss is acknowledged as a violation. Populations deemed politically "ungrievable" can be harmed or neglected without eliciting institutional outrage or reparative action. The term grievable will therefore be used throughout this thesis to describe how reproductive suffering is differentially recognised and responded to across cases like Ukraine and Palestine, underscoring the political nature of visibility, care, and death.

The contrast between Ukraine and Gaza further demonstrates how biopolitical and necropolitical governance shape the humanitarian response to SRHR. In Ukraine, SRHR is deprioritised within an established aid system; it is treated as a secondary concern despite being recognised as essential for survivors of GBV. In Gaza, however, SRHR is not just excluded, it is actively obstructed, revealing how humanitarian structures facilitate rather than mitigate reproductive oppression. Together, these cases demonstrate that SRHR neglect is embedded within political hierarchies that determine whose health is protected and whose suffering is normalised. Necropolitics expands on the limitations of biopolitical governance by revealing how reproductive healthcare can be weaponised through abandonment and obstruction. Yet the combination of biopolitics and necropolitics still requires further nuance to understand how such exclusions are experienced differently across intersecting axes of identity, which will be done through a lens of intersectionality.

Intersectionality: Compounding Vulnerabilities in Conflict Settings

Intersectionality, developed by Kimberlé Crenshaw (Crenshaw 1991, 1245-1249), provides a critical framework for examining how overlapping systems of oppression – such as gender, race, class, and displacement – shape access to SRHR in conflict settings. Traditional aid frameworks often treat vulnerable groups as homogeneous populations, failing to consider the complexity of their identities and the compounded barriers they face in accessing reproductive healthcare.

Sudan exemplifies how gendered, ethnic, and political hierarchies shape access to SRHR. Women in Darfur, for instance, not only experience heightened risks of sexual violence and maternal health complications but also face systemic barriers to SRHR services due to their ethnic identity and displacement status (Hassan 2024, 117). The exclusion of displaced women from healthcare services is reinforced by both local patriarchal norms and the structural biases within international aid frameworks.

By applying intersectionality, this study highlights how SRHR exclusion is not uniform but shaped by multiple, intersecting structures of oppression. The vulnerabilities of women and LGBTQ+ individuals in conflict settings cannot be addressed through single-axis solutions; instead, responses must account for the unique and overlapping barriers these groups face in accessing reproductive healthcare. Humanitarian aid frameworks must move beyond one-dimensional approaches that treat all conflict-affected populations as if their challenges were identical and need to instead recognise the diverse and intersecting forms of oppression that shape SRHR exclusion. Intersectionality adds critical depth to the biopolitical and necropolitical perspectives by showing how SRHR neglect disproportionately affects those situated at the intersection of multiple oppressions. However, to fully understand how these patterns are embedded within global hierarchies of power and historical domination, the analysis must also engage with decolonial feminist theory.

Decolonial Feminist Theory: Challenging Colonial and Patriarchal Aid Structures

Decolonial feminist theory can aid with critiquing the (neo)colonial and patriarchal foundations of humanitarian aid, revealing how global power structures reinforce inequalities rather than dismantle them. Scholars such as Chandra Mohanty and Gayatri Spivak highlight how Western aid frameworks often treat women in conflict zones as passive victims, rather than as agents of change. Mohanty critiques the homogenisation of "Third World women" in Western feminist discourse, arguing that such frameworks erase local specificities and reinforce colonial hierarchies by imposing universalised, one-size-fits-all solutions (Mohanty

1988, 62–63). Spivak's concept of the "subaltern" further illustrates how marginalised voices are systematically excluded from global decision-making processes, leaving those most affected by crises without meaningful agency in shaping humanitarian responses (Spivak 1988, 280). This exclusion is mirrored in the operational logic of humanitarian governance, where SRHR is regularly deprioritised and framed as politically sensitive or culturally contentious despite its essential, life-saving nature. Tazinya et al. (2023, 1–2) identify this as a structural bias embedded in global aid institutions. Tanyag (2018, 655) demonstrates how patriarchal norms, combined with donor-controlled funding mechanisms, systematically restrict access to reproductive healthcare in conflict-affected regions. These patterns reveal that humanitarian aid often reflects donor-driven priorities aligned with Western political interests rather than the lived realities of affected communities.

SRHR exclusion is not only shaped by gendered hierarchies but also by racialised and geopolitical biases in aid distribution. In Ukraine, white European women receive structured and immediate humanitarian assistance, whereas refugees, migrants, and people of colour experience significant barriers to SRHR services (UNHCR 2024). This racialised hierarchy within humanitarian aid structures reflects broader colonial tendencies that prioritise the needs of white, Western-aligned populations while systematically overlooking racialised and displaced groups.

The case of Palestine provides a particularly stark example of how (neo)colonial and patriarchal biases operate within Western humanitarian frameworks. Despite the long-standing nature of the Israeli occupation and the chronic humanitarian crisis in Gaza, SRHR has remained systemically deprioritised (Ferguson and Desai 2024, 76). Western aid organisations often frame Palestinian aid as a politically sensitive issue, further limiting funding and international advocacy for aid services, including SRHR, in the region. The systematic exclusion of Palestinian women from comprehensive reproductive healthcare reinforces the colonial logic that certain populations are undeserving of full aid and protection.

Sudan further illustrates how patriarchal and ethnic power structures intersect with global aid frameworks, leaving the most marginalised populations without access to essential reproductive healthcare. Sudan's colonial legacy continues to shape its healthcare system, where British-imposed governance structures reinforced gendered and racialised inequalities that persist in humanitarian responses today.

To extend the decolonial feminist lens underpinning this research, Huber's (2025) concept of organised hypocrisy, rooted in the logic of coloniality, can be included. This logic explains how liberal norms such as human rights are applied unevenly across geopolitical contexts, not simply due to pragmatic choices, but as a reflection of enduring colonial hierarchies embedded in EU foreign policy. Huber draws on Quijano's work to articulate a "double absence" of the "Other": first, the absence of the Other as a rights-bearing subject in the international legal order, and second, the absence of their normative frameworks, histories, and lived experiences (Huber 2025, 3–4). In this sense, the EU's professed universality becomes a vehicle for exclusion. This aligns with Mbembe's notion of necropolitics, whereby certain populations are rendered disposable not just through material violence, but through narrative and juridical erasure. Huber is included here because the coloniality of humanitarian governance must be accounted for (Huber 2025, 18).

By integrating decolonial feminist perspectives, this study reveals that SRHR neglect in conflict settings is not simply a matter of logistical oversight but is fundamentally tied to global power structures that determine which populations receive reproductive healthcare and which remain invisible in humanitarian priorities. Decolonial feminism offers a framework for reimagining humanitarian aid, advocating for a shift away from Western-dominated, patriarchal paradigms towards community-driven and intersectional approaches that centre the voices and needs of affected populations.

Taken together, these four approaches form a coherent and multidimensional framework through which to analyse the governance of SRHR in conflict contexts. Biopolitics and necropolitics help explain how decisions about life and death are structured through aid, while intersectionality ensures that this analysis remains attentive to the compounding effects of race, gender, displacement, and other axes of marginalisation. Decolonial feminist theory extends this further by interrogating the foundational assumptions of humanitarianism itself, challenging the Western-centric and patriarchal logics that often shape international responses. This integrated framework not only informs the theoretical lens of this study but also underpins the selection and analysis of the cases. Ukraine, Palestine, and Sudan are examined not simply as individual instances of SRHR neglect, but as sites where these layered dynamics of exclusion play out in distinct and interconnected ways.

The following table presents the integrated analytical framework used in this thesis, outlining the function of each concept, the dimensions of SRHR neglect it helps to explain,

and how each interacts with the others. Rather than treating these theories as separate lenses, the table visualises their interdependence and collective analytical value, providing the conceptual structure through which the empirical cases are examined.

CONCEPT	FUNCTION IN FRAMEWORK	DIMENSIONS OF SRHR NEGLECT	INTERACTION WITH OTHER CONCEPTS	RELEVANT CASE(S)
BIOPOLITICS	***Foundation:*** Management of life and populations by states or humanitarian actors.	How life, health, and reproduction are governed through selective care.	Establishes the groundwork through which necropolitics, intersectional vulnerabilities, and colonial inequalities are produced and sustained.	Ukraine, Palestine, Sudan
NECROPOLITICS	***Extension:*** Expands biopolitics by highlighting how power exposes populations to death.	How certain populations are actively denied care or exposed to reproductive death and destruction.	Builds on biopolitics by showing who is actively harmed and left to die. Forms the basis for understanding intersectionality and decolonial critiques of active abandonment.	Palestine, Sudan
INTERSECTIONALITY	***Deepening:*** Reveals differentiated harm based on overlapping axes of oppression.	How race, gender, disability, sexuality, and class compound SRHR neglect and exposure to violence.	Builds on biopolitics and necropolitics by identifying which groups are most affected and why. Clarifies how structural neglect operates along intersecting identities.	Ukraine, Palestine, Sudan (esp. women, (I)DPs, PoC, disabled people, LGBTIQ+)
DECOLONIAL FEMINISM	***Structural Critique:*** Situates SRHR neglect within global and historical power hierarchies based on patriarchal and (neo)colonial ideals.	Why some lives are rendered worthy of care, while others are made invisible or expendable.	Contextualises all previous concepts within colonial, patriarchal, racial, and geopolitical structures. Critiques the imperial logic embedded in humanitarian governance.	Ukraine, Palestine, Sudan

Table 1: Integrated Theoretical Framework

Methodological Approach

This study employs a qualitative interpretivist approach, utilizing comparative case study analysis and document analysis to investigate the systematic neglect of SRHR services in conflict-related crises. Given the complexity of humanitarian decision-making and the structural exclusion of SRHR, a qualitative approach is best suited for uncovering the political, economic, and sociocultural mechanisms that shape aid priorities. Rather than quantifying SRHR neglect, this study aims to understand how and why it persists across different conflict settings. By comparing multiple cases, this research highlights both common patterns and context-specific dynamics that contribute to SRHR exclusion.

A comparative case study design provides the methodological foundation for this analysis. Case studies allow for an in-depth exploration of SRHR neglect in diverse humanitarian contexts while maintaining enough breadth to identify broader structural trends. This study employs a most-different systems design, selecting cases that vary in political sensitivity, levels of international attention and intervention, and governance structures. Despite these differences, each case demonstrates a consistent pattern of SRHR exclusion, reinforcing the argument that SRHR neglect is not an isolated failure but a systemic issue embedded in humanitarian governance.

This study focuses on two main cases, Ukraine and Palestine, while occasionally referring to Sudan as a supporting case. The selection of these cases ensures a diverse representation of conflicts, reflecting differences in visibility, humanitarian response, and structural inequalities. The primary analysis will compare Ukraine and Palestine, examining how SRHR is deprioritised in contrasting geopolitical and humanitarian contexts. Meanwhile, Sudan provides additional insights into the varying degrees of marginalisation in SRHR access. While the primary focus remains on Ukraine and Palestine, Sudan is used as a shadow case to illustrate the structural and systemic nature of SRHR neglect beyond high-profile crises. While not explored with the same depth as Ukraine and Palestine, Sudan allows for targeted comparisons that highlight intersectional vulnerabilities, racial hierarchies, and the geopolitics of humanitarian invisibility. Its inclusion confirms the broader patterns revealed in the primary cases while highlighting how reproductive harm operates in contexts of extreme neglect and global abandonment.

Ukraine, as a European conflict with high-profile international attention, provides insight into how SRHR is deprioritised even in well-funded humanitarian responses that are

aimed at aiding “Us”, rather than “Them”. Historically, Ukraine was part of the Soviet Union, and post-Soviet identities and ideologies continue to shape international humanitarian governance in the region, reinforcing Eurocentric priorities. Gaza, where healthcare is deliberately targeted, serves as an extreme case of necropolitical abandonment, in which reproductive healthcare is not just neglected but actively destroyed (Ferguson and Desai 2024, 76). The Israeli occupation, deeply tied to colonial legacies, has systematically shaped access to humanitarian resources, including SRHR. Sudan presents a supporting case in which internal displacement, patriarchal norms and fragile governance intersect with humanitarian hierarchies, contributing to SRHR exclusion (Hassan 2024, 112). British colonial rule entrenched structural inequalities that continue to impact Sudan’s governance and healthcare systems. Examining these cases together allows for an exploration of how SRHR neglect operates within different humanitarian frameworks and across varying (geo)political landscapes, while also highlighting the enduring impact of colonial histories on contemporary aid structures.

In Ukraine, despite substantial humanitarian aid, SRHR remains politically and structurally deprioritised (UNFPA Ukraine 2024b, 2-5). The case exemplifies biopolitical governance, wherein reproductive healthcare is framed as non-essential, despite mounting evidence of conflict-related sexual violence and reproductive health crises (Foucault 1984, 262; UN Women 2025a, 14). Moreover, racialised hierarchies within humanitarian aid reveal discriminatory differences in access: white Ukrainian women receive significantly more structured assistance compared to refugees, migrants, and people of colour (UNHCR 2024). By analysing Ukraine, this study examines how biopolitical decision-making determines which forms of (gendered) aid and healthcare are deemed “essential” and which populations are prioritised.

Gaza represents a different but complementary case, where necropolitical governance determines which populations are rendered disposable (Mbembe 2003, 40). Unlike Ukraine, where SRHR is deprioritised within an established humanitarian system, Gaza’s entire healthcare infrastructure is deliberately targeted. Reproductive healthcare is systematically obstructed through hospital bombings, medical supply blockades, and restrictions on maternal healthcare access (Ferguson and Desai 2024, 82; Hanbali et al. 2024, 19). The seemingly calculated denial of reproductive healthcare can also be understood as a tool of demographic control, furthering the displacement and disposability of the Palestinian population. By systematically obstructing SRHR, Palestinian women are left without essential maternal care,

access to contraception, or safe abortion services, accelerating mortality rates and worsening humanitarian conditions. The case of Gaza highlights how SRHR neglect can function as an active form of structural violence rather than a mere omission, making it a crucial site for examining how necropolitics operates within humanitarian governance and how reproductive oppression is weaponised as part of a broader strategy of erasure.

Sudan offers a supporting case that illustrates intersectional SRHR neglect, where gender, ethnicity, and resource scarcity combine to further marginalise vulnerable populations. The case of Darfur, in particular, shows how ethnic and gender-based hierarchies intersect to shape access to humanitarian aid (Crenshaw 1991, 1245; Hassan 2024, 117). Women in Darfur not only face heightened risks of sexual violence and maternal health complications, but they are also structurally excluded from SRHR services due to gendered and ethnic discrimination within both local governance and international aid frameworks (UNFPA 2024). This study examines how intersectionality influences SRHR neglect in resource-limited, conflict-affected settings, revealing how mainstream humanitarian responses often fail to address the compounding vulnerabilities of women from marginalised ethnic groups.

This study relies on document analysis as its primary method of data collection, taking policy papers, governmental documents, NGO and IO reports, and academic literature to deepen and triangulate findings in the two main case studies. Given that humanitarian priorities are largely shaped by policy frameworks, funding allocations, and advocacy narratives, document analysis is essential for examining how SRHR is framed and deprioritised within global governance structures. The study analyses a range of materials, including reports from international organisations such as UNFPA, WHO, UNHCR, and OCHA, NGO assessments from IRC, Oxfam Novib, and Human Rights Watch, and government and military policies affecting SRHR access in each conflict zone. Additionally, media narratives and advocacy reports are examined to assess how public discourse and donor priorities shape humanitarian responses to SRHR in crisis settings.

Moreover, the paper aims to identify patterns in how SRHR is discussed, funded, and implemented across different conflict settings with the aim of uncovering structural patterns in policy (language), humanitarian decision-making, and aid distribution frameworks. By studying these documents, this study aims to trace the systemic mechanisms that contribute to SRHR exclusion and assess the extent to which humanitarian organisations replicate

patriarchal, racialised, and (neo)colonial biases in their SRHR interventions. Internal validity is strengthened through triangulation, comparing findings across multiple sources – including policy reports, NGO assessments, and academic literature – to ensure that conclusions are not based on isolated or biased data points. External validity is reinforced through a most-different systems design, where cases with significant (geo)political, economic, and sociocultural differences all exhibit a common pattern of SRHR neglect in conflicts. This suggests that SRHR exclusion is not an anomaly of specific conflicts but rather a systemic issue embedded in humanitarian governance structures.

It is also important to acknowledge certain limitations. The study relies mainly on secondary sources rather than direct fieldwork, meaning that on-the-ground perspectives from affected populations are mediated through existing reports. Additionally, humanitarian organisations and governments may frame SRHR in ways that align with their political and institutional interests, potentially influencing the available data. To mitigate this, a critical discourse analysis approach is taken, ensuring that power dynamics and political goals in policy narratives are accounted for.

As with any qualitative study, the researcher's theoretical and ideological stance influences how data is interpreted and framed. This study takes an explicitly intersectional and decolonial feminist approach, which shapes the critique of humanitarian governance structures. While this lens is essential for highlighting power asymmetries, it is also acknowledged that alternative interpretations exist, such as logistical and financial constraints being primary factors in SRHR neglect rather than ideological exclusion. However, this study argues that such constraints are often symptoms of deeper structural biases rather than neutral barriers.

While this paper focuses on two distinct cases, with the support of a shadow case, the argument is not confined to them. Rather, the diversity of cases, spanning different regions, levels of international visibility and media attention, and political sensitivities, demonstrates the broader applicability of the findings. The fact that SRHR neglect persists despite these differences reinforces the argument that it is not a context-specific issue but rather a wider structural feature of colonial and patriarchal humanitarian aid frameworks.

Ukraine

Since the onset of the full-scale Russian invasion in 2022, Ukraine has received an unprecedented level of international support, particularly from Europe and North America. Aid flows have been comparatively swift, political solidarity nearly unanimous, and refugee protections relatively well-coordinated, especially when set against the often fragmented or exclusionary responses to other global crises. These responses reflect how Ukraine has been positioned within Western humanitarian and political imaginaries: not merely as one crisis among many, but as a conflict that demands action. The demographics of the affected population (white, Christian, and European) have aligned Ukraine with the moral and geopolitical sensibilities of Western powers, shaping whose suffering is seen as urgent and whose rights are readily defended. As one report observes, the solidarity extended to Ukrainian refugees – especially when compared to the reception of people fleeing conflicts in Syria, Sudan, or Afghanistan – constitutes "a striking display of racialised compassion" (Center for Reproductive Rights 2023, 7).

The EU's response to the Russian invasion of Ukraine reflects a dominant biopolitical narrative. Ukrainian lives are depicted as "worth saving", both for their proximity to European values and their alignment with liberal democratic norms. This solidarity is not merely rhetorical. European Commission President Ursula von der Leyen referred to Ukraine as the "flag of freedom", while the EU mobilised unprecedented levels of military and financial aid (Oleart and Roch 2024, 8–9). Ukraine is narratively included in the European project, further legitimating its integration into EU and NATO frameworks. This "inclusion" positions Ukrainian bodies as grievable and their reproductive and healthcare needs as legitimate, contributing to a logic of biopolitical care.

Yet despite this exceptional level of support, sexual and reproductive health and rights remain critically underfunded and inconsistently addressed. UNFPA's situation report from late 2024 identified a $44 million gap in funding for SRHR programming (UNFPA Ukraine 2024b, 2), and civil society organisations have repeatedly reported that even well-resourced humanitarian actors deprioritise reproductive care in favour of more "neutral" interventions such as food, shelter, or logistics (UNFPA Ukraine 2025, 5; UN Women 2025a). This gap in funding does raise the question: if SRHR is neglected in a high-visibility conflict like Ukraine – one that is geographically proximate, geopolitically strategic, and widely supported – what does that imply about how reproductive health is valued in global humanitarian governance?

Rather than an exception, Ukraine demonstrates the structural embeddedness of SRHR neglect. Despite the visibility of wartime sexual violence, the specific health needs of women, LGBTQ+ people, and marginalised communities remain at the periphery of humanitarian programming. This case study uses Ukraine to explore how biopolitical governance, rooted in patriarchal and (neo)colonial logics, prioritises some lives over others, even within the most "politically palatable" humanitarian response. By examining the mechanisms through which SRHR is sidelined, this chapter underscores that the neglect of reproductive rights is not an accidental omission, but a systemic feature of humanitarian aid as it is currently structured.

Biopolitical Control and SRHR Within Ukraine

The biopolitical management of reproductive life in Ukraine reveals sharp disparities in whose health is protected and whose needs are deferred. As the war continues, the reproductive rights of women and marginalised groups have become increasingly precarious. Access to basic reproductive services has been drastically reduced, with maternity wards and gynaecological units among the hardest hit (Amnesty 2022, 1-2). These attacks on healthcare infrastructure constitute not only violations of international humanitarian law but also a direct assault on the reproductive agency of women and girls, especially when reproductive care is already considered a peripheral concern in humanitarian priorities.

Within Ukraine, reproductive governance is shaped by both material shortages and longstanding institutional neglect. According to UNFPA Ukraine, access to quality perinatal care is critically limited, particularly for women with high-risk pregnancies. The integration of SRHR into Ukraine's primary healthcare system remains partial and uneven, requiring further investment in staff training and infrastructure (UNFPA Ukraine 2025, 13). In practice, many services are unavailable or only accessible through overstretched and under-resourced facilities, often requiring NGO intervention to fill the gaps. Internally displaced persons (IDPs), most of whom are women, face additional barriers due to their refugee status, inadequate transportation, and the collapse of local health services (UNFPA Ukraine 2025, 29).

The war has also intensified gender-based violence (GBV), including conflict-related sexual violence (CRSV), intimate partner violence (IPV), and sexual exploitation (Capasso et al 2022, 2). These forms of violence are not only increasing but becoming normalised within a militarised and crisis-stricken society. Reports reveal a marked rise in IPV due to economic

distress, militarisation, alcohol abuse, and collective living arrangements (UNFPA Ukraine 2025, 14–15). The humanitarian response, however, continues to deprioritise GBV programming in favour of more visible, “life-saving” interventions, even though GBV itself constitutes a life-threatening crisis for women and girls (UNFPA Ukraine 2025, 13).

This failure reflects a deeper biopolitical logic: reproductive and sexual violence are treated not as political emergencies requiring systemic redress but as private, unfortunate outcomes of war. The lack of clinical protocols for GBV survivors, including rape crisis care, highlights this neglect. Survivors face shame, fear, and systemic hurdles, such as mandatory reporting requirements and insufficient medical training for healthcare providers, that further disincentivises help-seeking (UNFPA Ukraine 2025, 13–14). These dynamics make reproductive healthcare not merely a service gap, but a tool of governance: a means of deciding which populations are worthy of care, protection, and survival.

Intersectional discrimination compounds these barriers. Roma women, LGBTIQ+ individuals, people of colour, people with a non-Ukrainian background, and people with disabilities are among the groups least able to access care (Kismödi and Pitchforth 2022, 2). Services are often unavailable in their languages, tailored for normative reproductive trajectories, and unequipped to handle diverse needs (Center for Reproductive Rights 2023, 11). Racial and ethnic minorities have been reported to receive discriminatory treatment when it comes to accessing aid during the war; foreigners, especially PoC, in Ukraine have reported being denied access to healthcare, due to their non-Ukrainian background or refugee status (Human Rights Watch 2022). These patterns reveal how racialised and marginalised bodies are rendered invisible within humanitarian infrastructures. The denial of care is not passive but operationalised through logistics, law, and silence.

In response to these structural failures, a network of civil society organisations, especially women-led and grassroots groups, have emerged as critical providers of reproductive care. Despite severe resource constraints, these actors have created mobile clinics, information campaigns, and safe spaces for GBV survivors (UNFPA Ukraine 2025, 19). Yet, international aid structures often fail to centre or fund these initiatives. UN agencies, while rhetorically committed to SRHR, have been criticised for still not engaging enough with national and local organisations (Center for Reproductive Rights 2023, 76). Their tendency to avoid politically “sensitive” issues like abortion or LGBTQ+ rights reveals a

risk-averse bureaucratic logic that reinforces exclusion rather than challenging it (UNFPA Ukraine 2025, 76).

Ultimately, the Ukraine case illustrates how SRHR is governed through a matrix of neglect, discipline, and containment. The state, international organisations, and donors collectively shape a reproductive regime that disciplines displaced and racialised bodies while selectively offering care. This biopolitical framework foregrounds not only who lives, but who is allowed to live under what conditions; it exposes the ways in which humanitarian aid, far from being apolitical, enacts a deeply gendered and racialised logic of life and death.

Discriminatory Frameworks and Unequal Access Across Borders

The SRHR landscape for Ukrainian refugees is shaped not only by the aftermath of conflict but also by the structural inequalities embedded in the healthcare and legal systems of receiving states, especially Poland, Hungary, Slovakia, and Romania. While the EU's Temporary Protection Directive was designed to offer refugees from Ukraine access to essential care, including reproductive healthcare, it has been inconsistently implemented across member states. This has left many women and girls without timely or safe access to SRHR services (Center for Reproductive Rights 2025, 1).

Access to SRHR is highly uneven across Hungary, Poland, Slovakia, and Romania. In Hungary and Slovakia, abortion access is heavily curtailed by procedural delays and the unavailability of medical abortion. In Poland, where abortion services are incredibly rigid, access is virtually impossible for refugees, many of whom have experienced (sexual) trauma, besides displacement (Center for Reproductive Rights 2023, 5). The legal and bureaucratic opacity is compounded for adolescent girls who fled without guardians; in these countries, parental consent is often required for SRHR access, placing young girls in a vulnerable and unsafe position (Center for Reproductive Rights 2023, 29).

Financial exclusion and poor public healthcare infrastructure also contribute to systemic inequality. In practice, many refugees must resort to costly private clinics, especially in Hungary and Slovakia, where public options are inaccessible or inadequate. These barriers are acutely felt by already-marginalised groups such as Roma women and girls, many of whom cannot afford private care and are frequently denied public services altogether due to discriminatory attitudes and institutional neglect (Center for Reproductive Rights 2023, 29, 30, 49). Furthermore, essential information regarding entitlements to care is rarely available in Ukrainian, Romani, or Russian. As a result, many women report delaying or avoiding care

due to the stress and humiliation they encounter when attempting to navigate foreign healthcare systems, often waiting until their needs become critical (Center for Reproductive Rights 2023, 41). Even when care is technically available, refugees report degrading experiences marked by xenophobia, harmful stereotypes, and provider bias (Center for Reproductive Rights 2023, 42).

Similar patterns of systemic exclusion can be observed in Sudan, where internally displaced women in Darfur, particularly those from marginalised ethnic communities, face acute barriers to accessing SRHR services. Over 12 million people have been displaced since the most recent escalation of violence, with women and girls representing the majority of the displaced population (UN Women 2025b). Their exclusion is not only the result of physical insecurity and logistical inaccessibility, but also a consequence of their invisibility within national and international humanitarian frameworks. This mirrors the challenges faced by Ukraine's internally displaced persons, Roma women, and other racialised populations, although in Sudan these dynamics unfold in the absence of international visibility or geopolitical solidarity.

These challenges reveal a deeper structural contradiction: while humanitarian discourses often emphasise universality, care remains stratified by gender, ethnicity, class, and migration status. The EU's promise of harmonised rights remains largely aspirational. Structural racism, patriarchal control over female bodies, and the politicisation of reproductive rights merge to undermine refugees' ability to access care on equitable terms. This is especially evident in cases where women return to Ukraine – despite the ongoing war – to access abortion care or safe delivery services, due to a complete absence of affordable and legal options abroad (Center for Reproductive Rights 2025, 1).

Ultimately, these patterns show how SRHR becomes conditional, selectively extended based on political acceptability, legal clarity, and ideological alignment, rather than a universal right. This aligns with broader biopolitical logics of who is permitted to live, reproduce, and access care in times of crisis.

Marginalised Populations and Intersectional Barriers to SRHR

While all refugees from Ukraine face challenges in accessing SRHR, the burden of exclusion is disproportionately borne by those at the intersection of multiple forms of marginalisation; Roma women, people of colour, LGBTQ+ individuals, adolescents, and people with disabilities. These groups are not merely underserved; they are structurally excluded from

systems that fail to recognise their specific needs. Roma women from Ukraine encounter both systemic racism and gender discrimination, often being turned away from public services or housed in segregated shelters. Many report verbal abuse from healthcare providers and being denied care to which they are legally entitled under EU law (Center for Reproductive Rights 2023, 50; Amnesty International 2022, 1). Even when services exist, informal justice mechanisms within Roma communities often discourage survivors of gender-based violence from seeking help, reinforcing silence and impunity (UNFPA Ukraine 2025, 226).

LGBTIQ+ refugees also face profound barriers. Discrimination, stigma, and lack of specialised services mean that many LGBTQ+ individuals, especially trans people and gay men, avoid healthcare entirely. Fear of outing, mistreatment, and legal vulnerabilities often prevent them from seeking SRHR support or reporting violence (UNFPA 2025b, 227; Center for Reproductive Rights 2023, 49). The situation is worsened by the erosion of civil society space and political backlash against SRHR advocacy. In Poland and Hungary, governments have diverted funding away from pro-SRHR initiatives, empowering anti-LGBTQ+ and anti-gender movements and constraining civil society action (Center for Reproductive Rights 2023, 64). Human rights defenders have reported harassment, intimidation, and legal persecution for their work – conditions that suppress the advocacy urgently needed to support the most vulnerable refugees (Center for Reproductive Rights 2023, 62). Yet, in the face of these hostilities, civil society has been central to bridging access gaps. Local NGOs and activists have mobilised quickly to establish helplines, distribute abortion medication, and offer psychosocial support. These efforts, while lifesaving, are undermined by chronic underfunding and lack of institutional support (Center for Reproductive Rights 2023, 11).

Biopolitically, the selective provision and denial of care along lines of ethnicity, sexuality, and class not only reproduce structural violence but also enforce a hierarchy of whose lives are deemed worth protecting. The stratified access to reproductive care reflects the broader logic of humanitarian governance, in which marginal populations are rendered invisible or disposable. By foregrounding the experiences of marginalised groups, this section underscores the need for intersectional SRHR frameworks that address not just the existence of services, but their accessibility, quality, and responsiveness to diverse needs.

Governance, Donor Priorities, and the Deprioritisation of SRHR

Despite Ukraine's elevated status within global humanitarian efforts, donor priorities have consistently skewed towards traditionally prioritised sectors such as food, security, and

infrastructure, leaving SRHR on the margins. This marginalisation reveals the biopolitical logic that frames reproductive health as a secondary or non-essential concern, rather than a life-saving service. In 2024, UNFPA requested $105 million to address GBV and SRH needs in Ukraine but received only 70% of the required funding. The situation worsened in 2025, with only 39% of the $94.4 million appeal met at the time of reporting (UNFPA Ukraine 2024b, 2). These shortfalls are not merely financial, they reflect structural decisions about which lives and needs matter.

This funding gap is mirrored in governance structures. The Ministry of Social Policy mentions gender equality and violence prevention in its new Demographic Development Strategy but fail to directly address SRHR – particularly services for marginalised groups or those affected by war (Ministry of Social Policy of Ukraine n.d.a). Moreover, while the Demographic Development Strategy emphasises increasing birth rates and returning migrants, it does not centre bodily autonomy, access to safe abortion, or comprehensive SRHR within its framework (Ministry of Social Policy of Ukraine n.d.a). Other policy frameworks, such as the Gender policy and the Policy for Victims of Armed Aggression, openly mention that victims of sexual violence in the war are offered social services, but only secondary to victims of violence associated with armed aggression (Ministry of Social Policy of Ukraine n.d.b ; Ministry of Social Policy of Ukraine n.d.c). These gaps suggest a reproductive logic tied more to demographic recovery than to reproductive justice.

This policy neglect is facilitated and reproduced by international governance structures. UN agencies have been criticised for lacking transparency in their engagement with national civil society actors, limiting information flows and failing to leverage their positions to advocate politically sensitive SRHR concerns (Center for Reproductive Rights 2023, 76). Interviewees noted a clear institutional reluctance to raise "difficult" issues, reinforcing a status quo in which reproductive rights are left off the agenda (Center for Reproductive Rights 2023, 64, 69). Even when international efforts are made, such as the Minimum Initial Service Package (MISP), implementation has been inconsistent (Amnesty 2022, 2). Legal, political, and cultural barriers in Ukraine and host countries alike undermine the delivery of essential care, particularly in areas like abortion, emergency contraception, and the clinical management of rape (Amnesty International 2022, 2). While mobile gynaecological teams and safe spaces exist in some areas, many regions remain underserved, and healthcare workers often lack adequate training or legal clarity to provide care (UNFPA Ukraine 2024b, 9).

In sum, governance failures and donor priorities intersect to deprioritise SRHR, reinforcing the notion that it is politically expendable. Humanitarian aid, rather than being an apolitical tool of relief, becomes a site of biopolitical control where reproductive injustice is structurally reproduced. The lack of prioritisation in what is possibly one of the most visible and politically supported conflicts in recent memory underlines how SRHR is consistently sidelined, even under "ideal" humanitarian conditions.

The Role of Civil Society: Feminist Resistance and Grassroots Infrastructure

Amid these institutional and financial barriers, national feminist organisations and civil society actors have emerged as vital agents of resistance and care. Following the full-scale invasion, Ukrainian women-led groups mobilised rapidly to offer shelters, legal aid, and psychosocial services, often reaching remote and devastated areas that international actors failed to prioritise (UNFPA Ukraine 2025, 5). These organisations play a crucial role not just in service provision, but in reframing reproductive health as a matter of justice and survival.

Yet despite their centrality, civil society actors operate in deeply constrained environments. Many face harassment, surveillance, and criminalisation, both within Ukraine and in host countries, particularly in conservative host countries like Hungary and Poland. Human rights defenders working on SRHR report threats of violence, intimidation, and legal reprisals, contributing to burnout and a shrinking civic space (Center for Reproductive Rights 2023, 62–64). As one activist from Hungary remarked, "We are in the final stages of starvation and dissection... we are just keeping our heads above water" (Center for Reproductive Rights 2023, 63). Feminist actors also struggle with a lack of political recognition and financial support. Many civil society organisations remain financially precarious, surviving on short-term project grants rather than long-term structural funding (Center for Reproductive Rights 2023, 74). Several interviewees emphasised the frustration of donor strategies that focus on "capacity-building" of NGOs without addressing broader structural needs voiced by grassroot organisations, such as training healthcare professionals, improving hospital systems, or advocating for legal reform (Center for Reproductive Rights 2023, 76).

Despite this, grassroots actors continue to resist. Their efforts highlight alternative models of care, ones rooted in solidarity, feminist ethics, and community knowledge. In the face of collapsing infrastructure and international disinterest, they build shadow systems: informal abortion networks, rape crisis lines, peer-to-peer aid, and multilingual information

hubs. These networks are often the only accessible routes to care for marginalised refugees, particularly Romani women and LGBTQ+ individuals, who face compounded discrimination in host countries (Center for Reproductive Rights 2023, 11).

This section avoids romanticizing civil society: their efforts are not framed as a silver bullet, but as a symptom of deeper governance failures. The fact that civil society often replaces, rather than complements, state and institutional actors reflects not their success but the abdication of responsibility by those with the power to implement systemic change. That grassroots actors are left to carry the burden of reproductive justice is a political failure, not a virtue. Ultimately, these grassroot feminist interventions expose the failures of formal humanitarian governance. They act as both critique and praxis, revealing what is possible when reproductive justice is centred rather than sidelined. Their work affirms that even in the context of war, care is political. The struggle for SRHR is not simply about access, but about power.

Conclusion: The Biopolitics of Reproductive Neglect in Ukraine

The case of Ukraine offers a stark illustration of how reproductive health is governed through a matrix of selectivity, exclusion, and biopolitical control – even in the context of a conflict that seemingly represents the best-case scenario for receiving support from the West. Ukraine is the "ideal" conflict: it is geographically proximate to Europe, geopolitically strategic, and populated by white, Christian victims whose suffering has elicited rare political and humanitarian consensus in the West. Yet despite these favourable conditions, sexual and reproductive health and rights SRHR remain consistently marginalised.

The Ukrainian case reveals something fundamental about the structure of humanitarian governance; that SRHR, and by extension the bodies and lives most closely associated with it, are systematically deprioritised. This is something that affects women as a general group, but reaches marginalised groups, such as LGBTQ+ people, racialised and displaced communities, or women with disabilities, even more. This deprioritisation is not an unfortunate side-effect of crisis management, but a function of deeper patriarchal and neocolonial logics that shape how care is allocated and whose suffering is deemed urgent.

This chapter has demonstrated how the biopolitical logic of humanitarianism in Ukraine operates at multiple levels. Domestically, attacks on healthcare infrastructure, a lack of clinical protocols for survivors of gender-based violence, and systemic underfunding of SRHR services have left many without access to basic care. These failures are particularly

acute for internally displaced women, women with a non-Western migration background, Roma communities, LGBTQ+ individuals, and people with disabilities, whose needs are further marginalised by layers of discrimination and logistical invisibility. Reports from UNFPA and Amnesty International highlight how maternity wards, rape crisis services, and mental health care are often unavailable or inaccessible, not only due to the chaos of war, but because of longstanding systemic neglect (UNFPA Ukraine 2025, 13–15; Amnesty International 2022, 1).

Across borders, the situation for Ukrainian refugees reveals a similarly grim picture. Despite the protections guaranteed under the EU's Temporary Protection Directive, access to SRHR services has been profoundly unequal. In Poland and Hungary, restrictive abortion laws and conservative social norms have created barriers to care, especially for survivors of sexual violence. The fact that some women have returned to Ukraine during an active conflict in order to access reproductive healthcare demonstrates just how broken these transnational care systems are (Center for Reproductive Rights 2023, 5; Center for Reproductive Rights 2025, 1). Here, the biopolitical dimensions of reproductive governance are unmistakable. SRHR access becomes conditional and not based on needs, but rather on legality, geography, ethnicity, and political acceptability. Refugees who do not conform to normative national, ethnic, or gender identities face intersecting layers of exclusion. These groups are not merely underserved; they are rendered structurally invisible within aid systems that prioritise uniformity and simplicity over complexity and intersectionality.

The same logic can be seen in funding flows and governance frameworks. Despite rhetorical commitments to gender equality and the inclusion of SRHR in humanitarian standards like the Minimum Initial Service Package (MISP), donor priorities consistently skew towards infrastructure, food, and "neutral" interventions. UNFPA's 2025 appeal for SRHR and GBV programming in Ukraine was met with less than 40% of the requested funding (UNFPA Ukraine 2024b, 2). This is a shortfall that cannot be explained by resource scarcity alone, but rather by political choices about what constitutes "essential" humanitarian care.

The Ukrainian government's own policy frameworks reflect a similar trend. The Demographic Development Strategy, for example, emphasises birth rates and repatriation but avoids explicit engagement with reproductive autonomy or comprehensive SRHR. Such framing instrumentalises reproductive bodies in service of national recovery, rather than

protecting them as rights-bearing individuals. This approach is deeply gendered and aligns with historical patterns in which women's bodies are sites of both nation-building and control.

Amid this institutional and political neglect, feminist civil society organisations have emerged as central actors, not only by providing services, but also by challenging the structural conditions that make their work necessary in the first place (UNFPA EECA 2025). These groups offer mobile clinics, distribute abortion pills, and support survivors of GBV, often in contexts where the state is absent or actively obstructive. Their work is transformative, but it is also a symptom of broader failure. That civil society is often the only provider of SRHR services is not only a testament to its strength, but a critique of humanitarian governance itself, as SRHR services are severely under-resourced by donors (Center for Reproductive Rights 2023, 63). Thus, while grassroots organisations are essential to SRHR provision, they are often expected to compensate for systemic gaps without the necessary support or decision-making power. Their contributions are frequently seen as add-ons rather than integral to humanitarian response. Treating feminist actors as secondary rather than central reinforces the very structural inequalities their work is trying to address.

What Ukraine ultimately demonstrates is that humanitarian aid is not neutral. It is a deeply political practice that reflects and reproduces global hierarchies of race, gender, sexuality, and power. The biopolitics of SRHR in Ukraine is not about the absence of care, but about its strategic and selective provision. It is about who is permitted to survive with dignity, who is allowed to parent safely, and who is denied reproductive autonomy altogether. These dynamics are not accidental; they are constitutive of the aid system as it currently operates.

In reimagining a more just and inclusive humanitarian aid system, the Ukraine case demands that we move beyond rhetorical inclusion of SRHR and towards structural change. This includes sustained funding for reproductive care, explicit recognition of marginalised identities, legal reform across borders, and the elevation of feminist and community-based knowledge as core to humanitarian expertise. Only by confronting the biopolitical and colonial foundations of humanitarian aid can we begin to dismantle the hierarchies that have rendered SRHR both invisible and expendable, even in a Western "ideal" crisis.

Palestine

In Palestine, sexual and reproductive health and rights are not merely neglected, they are actively and systematically obstructed and violated. This is not the result of resource scarcity or oversight, but part of a broader political logic that treats Palestinian life, and especially reproductive life, as expendable: Palestine illustrates the use of reproductive deprivation as a political weapon. This chapter situates the Palestinian case as an example of necropolitical governance, where Israel's settler-colonial project operates through the control, abandonment, and targeted destruction of reproductive life.

In sharp contrast to Ukraine, the EU's narrative towards Palestine is underpinned by necropolitics and coloniality. Palestinians are systematically excluded from the EU's political imaginary: while Israel is framed as a democratic ally defending itself against terror, Palestinians are reduced to abstract victims of "tragedy", with little acknowledgement of occupation, apartheid, or settler colonialism (Oleart and Roch 2024, 13–15). This reflects a "double absence": Palestinians are denied the status of a rights-bearing political community, and their historical and normative claims are erased (Huber 2025, 3, 4, 18). This narrative dispossession justifies a humanitarian framework that offers aid without addressing structural violence and therefore stabilises the status quo. SRHR neglect in this context becomes a tool of population control, reinforcing a necropolitical logic that renders certain lives less liveable and less worthy of reproductive autonomy.

Palestinians have been under attack since the British Mandate and the 1948 Nakba, during which over 750,000 Palestinians were forcibly displaced. In the decades since, Israel's occupation has evolved into a deeply entrenched system of control and elimination (Al Mezan 2025, 1; UN Women 2024, 4). From restrictive movement policies and military raids on hospitals to systemic denial of maternal aid and reproductive autonomy, Israel has embedded violence, but also specifically reproductive violence into the fabric of everyday Palestinian life. These are not isolated violations but a coherent strategy of settler colonialism that governs Palestinian demography by deciding who may live, reproduce, and die (Al Mezan 2025, 7).

The structural collapse of Gaza's healthcare system under siege – supplies are blocked at borders, hospitals are bombed, and Palestinians are denied ambulances – is not simply a humanitarian failure. It is a form of necropolitics: the calculated exposure of Palestinians to death, trauma, and inhumane conditions (UNFPA Palestine 2025, 2; HRW 2025, 3–4). This

extends itself to an even further extreme when it comes to women and other vulnerable populations. Maternal supplies are blocked, women are denied care and forced to give birth in dangerous and inhumane circumstances (UNFPA Palestine 2025, 2; HRW 2025, 3–4). Simultaneously, Western governments and major humanitarian donors either ignore these atrocities or treat them as unfortunate side effects, neutralizing Palestinian narratives in the name of "balance" or "complexity" (ActionAid Ireland 2024, 4; UNFPA 2024).

The collapse of Gaza's healthcare system has clear parallels in Sudan, where over 70 percent of health facilities in conflict-affected areas are no longer functioning, and more than 540 attacks on healthcare infrastructure have been recorded since 2023 (UNFPA 2025c; UN Women 2025b). In both cases, reproductive health is not simply neglected; it is deliberately obstructed. What distinguishes the Sudanese context is the near-total absence of international visibility and accountability, which allows reproductive collapse to occur largely unnoticed. The comparison underscores that necropolitical governance does not rely solely on acts of overt destruction, but also on the silencing of suffering in places considered geopolitically marginal.

This chapter positions Palestine not as a humanitarian anomaly, but as a revealing case of how reproductive health and rights are systematically undermined in contexts shaped by colonial power and protracted violence. Under Israeli occupation, the destruction of health infrastructure and the denial of essential reproductive care are not incidental, they are structured features of a political system that governs through abandonment and control (Hanbali et al. 2024, 2). These conditions reflect a broader logic in which health becomes a site of sovereign power, where care is withheld and reproductive life is rendered unliveable (Gabriel 2023, 29). Rather than being overlooked, SRHR in Palestine is actively obstructed. This case study argues that Palestine does not represent the mere failure of humanitarianism, but exposes its limits: when entangled with geopolitical interests, humanitarian aid can become complicit in the very systems of violence it claims to challenge.

Gendered Oppression as Settler Colonial Policy

In Palestine, the denial of reproductive healthcare is not a consequence of general crisis, but a deliberate outcome of settler colonial governance. The OHCHR documented multiple cases of forced public nudity, sexual threats, and harassment by Israeli forces, often filmed and disseminated online in an effort to degrade and humiliate Palestinian women based on their gender and ethnicity (OHCHR 2025, 25) Moreover, the destruction of healthcare

infrastructure, obstruction of medical supplies, and restriction of movement for pregnant women all function as technologies of reproductive control. The occupation targets the conditions of life necessary for reproductive health, thereby weaponizing fertility, childbirth, and maternal survival.

The Israeli military has repeatedly targeted hospitals, ambulances, and clinics, particularly maternity facilities. On 23 March 2025, the surgical unit of Nasser Hospital, one of Gaza's largest medical centres for maternal care, was struck and caught fire (UNFPA Palestine 2025, 2). Al-Shifa and Al-Quds hospitals in northern Gaza are no longer fully operational, while the Emirati field hospital in Rafah has also been rendered nonfunctional due to repeated bombardments (UNFPA 2025a). This pattern of attacks is not incidental; it constitutes a systemic campaign to dismantle Gaza's health infrastructure.

Concurrently, the Israeli blockade restricts the entry of essential SRHR supplies such as oxytocin, incubators, contraceptives, blood plasma, and prenatal vitamins. These items often languish at border crossings while women are forced to give birth without anaesthesia or adequate medical care (UNFPA Palestine 2025, 2-4; HRW 2025, 4). According to Medical Aid for Palestinians, even before the recent escalation, Gaza faced chronic shortages of contraception and emergency maternal care due to the ongoing siege (MAP 2025). Moreover, pregnant women are subjected to life-threatening travel barriers. Many are denied ambulances or forced to deliver at checkpoints due to the destruction of roads and prohibitive fuel costs (UNFPA 2025a; Al Mezan 2025, 5). In the West Bank, Israeli raids and movement restrictions have paralysed access to maternal care. Health workers report being unable to reach patients due to military checkpoints and settler violence (UNFPA Palestine 2025, 3).

This destruction is not limited to health infrastructure but includes the broader material and ecological systems necessary for safe childbirth: clean water, electricity, sanitation, and transport. These systems have been deliberately targeted. The result is what can be referred to as reproductive dispossession, a condition in which the occupation controls Palestinian life by denying the means to reproduce it (ActionAid Ireland 2025, 6; Gabriel 2023, 29).

This structural assault reflects the sovereign logic that governs not only through death but through degradation, through making populations perpetually unwell. The destruction of Palestinian health is not only material but legal and spatial, rooted in a colonial architecture that determines who may live and who is left to die (Gabriel 2023, 29). For reproductive

health, this logic manifests in a healthcare system stripped of power and capacity, where hospitals are bombed and fuel is blocked. Fewer than one-third of Gaza's hospitals and under 30% of its primary healthcare facilities remain even partially operational, severely limiting access to safe deliveries (Ferguson and Desai 2024, 2). Women are discharged almost immediately after birth into overcrowded and unsanitary shelters, where water scarcity and food insecurity further compromise maternal health and infant survival (Ferguson and Desai 2024, 2). The settler state does not simply neglect Palestinian birth, it actively polices and punishes it. These are not failures of governance; they are functions of governance.

Necropolitics and the Targeting of Pregnant Bodies

The Israeli occupation not only degrades reproductive infrastructure but directly targets pregnant Palestinian bodies as sites of violence, abandonment, and symbolic erasure. This regime of reproductive necropolitics governs life through the production of death, exposing Palestinian women to maternal mortality, trauma, and forced birth without adequate care. Israel's destruction of Palestine's reproductive infrastructure, including maternity wards and fertility clinics, amounts to acts of extermination and genocidal intent under international law, intended to cut Palestinian reproductive capacity (OHCHR 2025, 13). These deaths are not incidental but represent deliberate strategies of racialised population control.

Mbembe's theory of necropolitics is vividly materialised in Gaza, where sovereignty manifests not through welfare but through abandonment and exposure to death. The siege has transformed childbirth into a life-threatening event. According to UNFPA, 183 babies are born daily under conditions marked by malnutrition, displacement, and attacks on hospitals, while over 30% of pregnancies are now classified as high-risk (UNFPA Palestine 2025, 2, 6). With only a handful of hospitals able to perform emergency obstetric care, mothers undergo caesareans without anaesthesia and deliver in makeshift shelters, cars, or tents (UNFPA Palestine 2025, 2, 6; HRW 2025, 3).

The maternal death rate in Gaza has surged as a result of both direct and structural violence. Miscarriages have reportedly increased by over 300% since the start of Israel's bombardment in October 2023 (HRW 2025, 4), while malnourishment, untreated infections, and trauma are widespread. According to UNFPA, 10–20% of pregnant women are now severely malnourished, contributing to a sharp rise in low birth weights, preterm births, and preventable complications (UNFPA Palestine 2025, 2-3). These outcomes are not incidental lapses in aid logistics but represent a policy of reproductive abandonment embedded in settler

and military strategies. The siege has transformed childbirth into a life-threatening event: the destruction of health infrastructure, food systems, and water supplies, alongside fuel blockades, has created conditions in which obstetric complications are rising, newborns are dying of malnutrition, and women are unable to breastfeed due to extreme hunger, malnutrition, and starvation (Ferguson and Desai 2024, 2). Surgical procedures, including Caesarean sections, are increasingly performed without anaesthesia due to critical shortages (ActionAid Ireland 2024, 10; Ferguson and Desai 2024, 2-4; UN Women 2024, 9). These conditions reflect not only medical deprivation but a legal and political architecture that normalises reproductive suffering as a tool of domination (Gabriel 2023, 29). Under this reproductive regime, the Palestinian womb becomes a politically contested site, it is actively obstructed, surveilled, and destroyed. The systematic exposure of women to death during childbirth, through the targeted bombing of hospitals and the denial of safe deliveries, reflects a logic in which Palestinian reproductive capacity is perceived as a threat to be neutralised (al-Halabi 2024, 3–4). Military violence is directed not only at the physical infrastructure of healthcare but also at the symbolic function of women's bodies. The targeting of pregnant bodies thus is inherently political, a combination of both physical erasure and ideological warfare in a situation where reproduction is seen as an act of anticolonial resistance and survival (al-Halabi 2024, 8, 11).

Psychological suffering is deeply intertwined with the physical violence Palestinians face. Women report experiencing nightmares, insomnia, depression, and panic attacks linked to gender-based violence during the war, yet mental health services remain largely unavailable (ActionAid 2024, 3). Displacement shelters and camps offer little privacy or security, often lacking toilets and clean water, which further strips women of their dignity and safety. Pregnant women face additional risks, as they are denied safe spaces for childbirth and postpartum recovery, increasing their vulnerability to gender-based violence. In this context, reproductive trauma becomes an embodied and constant expression of colonial domination. The necropolitical logic of Israeli policy is also evident in direct attacks on reproductive health spaces. During the height of the bombardment in 2024, at least two mothers were reportedly killed every hour in Gaza, with actual figures likely even higher (UN Women 2024, 4). Facilities run by UNRWA and UNFPA, which once provided psychosocial support and maternal care, have been closed or targeted in strikes, while maternity wards have been raided or bombed (UNFPA Arab States 2025, 2; MAP 2025).

The denial of evacuation rights for critical medical cases is another example of reproductive necropolitics. Of the 12,000 Palestinians in need of medical evacuation, fewer than 5,400 were permitted to leave Gaza. Following Israel's closure of the Rafah crossing between Gaza and Egypt from May 2024 to January 2025, only 436 patients were allowed to evacuate, leaving thousands, many of them pregnant women, without access to life-saving care (HRW 2025, 4). These restrictions not only violate international law but also undermine the fundamental principles of humanitarianism. They convey that certain lives, and in this case certain births, are not simply expendable but deemed unworthy of medical care or even recognition.

The case of Palestine demonstrates that SRHR neglect under settler colonialism is not a humanitarian error, but a racialised reproductive regime. It is a policy architecture that renders Palestinian reproduction a threat to be neutralised. Under this regime, Palestinian women are not seen as subjects of reproductive rights but as reproductive risks to Israeli sovereignty (Ayyash 2022, 310-315). Their deaths are not unfortunate byproducts of war but its intended effects. The silence of humanitarian aid providers, donors, and Western governments is enabling the structural and systematic annihilation of Palestinian women (ActionAid Ireland 2024, 10-11; UNFPA Arab States 2025). Ultimately, the necropolitics of SRHR in Palestine is not simply about absence, it is about targeted presence. Reproductive care is not just withheld but rather actively dismantled. The Palestinian womb is not neglected; it is surveilled, obstructed, and, when deemed threatening, destroyed.

Gender-Based Violence, Displacement, and Fragmented Protection

Since October 2023, the intensification of Israeli occupation has created a gendered protection crisis in Palestine, where displacement, military violence, and the collapse of infrastructure have converged to increase women's and girls' exposure to gender-based violence (GBV). In this context, GBV is not only a consequence of war, but a tool of necropolitical control. With legal systems in disarray, support services destroyed, and shelters inaccessible, Palestinian women are left without protection.

Displacement is a core dimension of this crisis. Nearly 2 million Palestinians have been forcibly uprooted since the recent escalation of Israel's ongoing violence began, including over one million women (UNFPA Arab States 2025, 10). Overcrowded and unsafe camps expose displaced women to further risks. Women report going without food or water for extended periods of time due to shortages, and report avoiding restroom facilities due to

these being unsafe and unsanitary (UNFPA Arab States 2025, 11). These conditions heighten the risk of GBV, including sexual violence, exploitation, and forced marriage. In extreme cases, girls have been married off early as a form of protection amid the collapse of social structures (ActionAid 2024, 5; UNFPA Arab States 2025, 11; Veronese et al. 2025, 2-4).

Meanwhile, GBV services and protection mechanisms have deteriorated or vanished altogether. The destruction of Gaza's legal system has created a protection gap, making it nearly impossible for women to seek justice. Only 62% of women surveyed in shelters were even aware of available protection services, and many NGOs have lost the capacity to provide sustained support due to communications blackouts, displacement of staff, and funding shortages (UNFPA Arab States 2025, 12). Survivors are frequently trapped with perpetrators in displacement shelters and homes of distant relatives, facing shame, silencing, or retaliation if they seek help (ActionAid 2024, 4). Women are also excluded from basic humanitarian assistance. Aid distribution mechanisms often require male registration, disadvantaging female-headed households (ActionAid Ireland 2024, 4). Women face harassment and even blackmail by male aid distributors to access food or sanitation products (ActionAid Ireland 2024, 4). This economic and logistical dependence reinforces patriarchal control, making it harder for women to assert agency and to seek help in displacement and crisis.

Testimonies gathered by ActionAid and UNFPA also document cases of extreme sexual violence and torture in detention, particularly in the West Bank. One woman was stripped naked and attacked by dogs in front of her family during a home raid by Israeli soldiers, with many more cases like this going unreported (ActionAid 2024, 6; UNFPA 2025a). Such acts are not only dehumanizing but are meant to communicate total domination over Palestinian life – it is the using of women's bodies as a tool to show control over an entire population. Additionally, there are reported cases where women were forced to remain naked for extended periods during interrogations, subjected to sexual humiliation by Israeli male officers, and denied access to menstrual hygiene products while in confinement (OHCHR 2025, 22). These incidents are not isolated, but part of a wider pattern of gendered violence used as a tool of military repression and psychological warfare.

Sudan also exemplifies the strategic use of sexual violence as a weapon of war. In Darfur and Khartoum, women and girls have been detained, raped, and denied access to care, often within spaces of incarceration and displacement (Hassan 2024, 1807; UNFPA Sudan

2024). Over 12 million women and girls are currently estimated to be at risk of gender-based violence, and yet legal, medical, and psychosocial responses are collapsing under the weight of underfunding and deliberate obstruction (Ellsberg et al. 2021, 3031–3032; UN Women 2025b). These conditions are similar to those faced by Palestinian women under military occupation, reinforcing a pattern in which reproductive governance is structured around the control and degradation of marginalised bodies. In both contexts, SRHR is not only absent but actively undermined through policies and practices that expose women to continuous reproductive trauma.

The dismantling of feminist infrastructure, such as safe spaces, shelters, mental health centres, is both literal and symbolic. As UNFPA reports, three of its 17 women's safe spaces in Gaza have shut down due to insecurity, and the remaining 14 only offer partial or remote services (UNFPA Palestine 2025, 3). In a war zone where movement is fatal and communication is limited, "remote support" offers little more than a cruel gesture of care. This collapse leaves a gaping hole in the social safety net that women once relied upon, however fragile it may have been.

The destruction of what were once considered protected or "feminist" spaces – such as homes, hospitals, schools – underscores how colonial power remaps zones of safety into battlefields (al-Halabi 2024, 3). These spaces, deeply tied to care, reproduction, and everyday resistance, are now systematically erased, reflecting a gendered military strategy aimed at undermining the foundations of Palestinian social life. This targeted collapse of infrastructure is not only spatial but ideological; it works to delegitimise women's roles as caregivers, organisers, and political actors, reducing them to passive recipients of aid in a war that deliberately instrumentalises their disposability (al-Halabi 2024, 11).

Ultimately, GBV in Palestine is not an unfortunate byproduct of war. It is a systemic tool used to control, disempower, and break Palestinian women across geographic, psychological, and institutional lines. The overlapping violence of occupation, displacement, patriarchal constraint, and humanitarian neglect creates a multi-layered regime of gendered control. It renders Palestinian women not only unprotected but fundamentally unprotectable within existing legal and humanitarian frameworks.

Civil Society, Women's Resistance, and the Politics of Survival

Amid the collapse of healthcare, infrastructure, and protection services in Palestine, organisations and grassroots actors have emerged as critical agents of resistance and survival.

These groups operate in direct defiance of the state and donor systems that marginalise their work, offering care, information, and solidarity in contexts where international humanitarianism has failed. Their activities illuminate an alternative form of reproductive justice: one centred on collective survival and community resilience under siege.

Despite being underfunded and politically constrained, different anonymous organisations in Gaza have stepped in where international actors have withdrawn. They provide trauma counselling, distribute hygiene kits, organise community midwifery services, and document violations (ActionAid Ireland 2024, 5; MAP 2025). These efforts are not merely reactive; they constitute a form of structural resistance against the necropolitical order. Palestinian women have also taken on expanded caregiving and leadership roles. In displacement camps, they coordinate food distribution, sanitation, and caregiving, often while mourning their own losses. As Hala, a camp leader, explained: "Women eat last and the least to ensure others are fed" (ActionAid 2024, 4). These acts of endurance – carrying water for hours, cooking for hundreds, assisting births without supplies – are not simply maternal labour but feminist strategies of resistance in a system that seeks to erase them.

These forms of resistance reflect a broader strategy of incremental, community-rooted transformation. In rejecting depoliticised resilience discourses imposed by donors and NGOs, Palestinian women craft resistance tactics that are both politically legitimate and socially feasible within contexts of surveillance, patriarchy, and physical risk (Kayali 2024, 9–10). They mobilise everyday acts of survival as deliberate political gestures, offering care, preserving life, and maintaining dignity in the face of systematic dehumanisation (Kayali 2024, 15). This incrementalism challenges humanitarian framings that reduce resistance to apolitical service delivery, reasserting the political value of care as a form of resistance itself.

Donor frameworks often marginalise or defund these efforts. Western aid agencies prioritise large international NGOs, often bypassing Palestinian women-led groups due to "political sensitivities" or fears of association with resistance politics (UNFPA 2024). These funding dynamics render feminist work precarious and depoliticised, reducing reproductive justice to a set of apolitical service deliveries. This civil society landscape is further challenged by surveillance, raids, and direct attacks. Women's organisations are often monitored by the Israeli state and face barriers to movement, communication, and banking. Staff members are sometimes detained or harassed, while safe spaces are raided under

accusations of militancy (Al Mezan 2025, 4). Feminist work in this context is thus both lifeline and target.

Nevertheless, Palestinian feminist actors continue to document and speak out, even as conditions deteriorate. Reports by organisations such as Al Mezan, Medical Aid Palestine (MAP), and others gathered in the OHCHR's investigation highlight how women-led initiatives are not only collecting health statistics, but also preserving testimonies of survival, resistance, and dignity in the face of systemic erasure (OHCHR 2025, 28). These narratives counter the dominant framing of Palestinian women as passive victims or mute sufferers. Instead, they assert the right to live, to give birth, to heal, and to organise under siege. Ultimately, Palestinian women and women's organisations are reshaping what humanitarianism might mean: not distant, depoliticised service delivery, but grounded, defiant, and collective care. In doing so, these actors expose the failures of international law and the selective compassion of the international community. They expose that SRHR is guaranteed by law or policy declarations alone; it must be built from below, amidst violence and displacement, through sustained refusal and decolonial feminist solidarity (OHCHR 2025, 29).

Donor Complicity and the Politics of Silence

While the material devastation of SRHR infrastructure in Gaza is visible and horrifying, the silence of international donors and humanitarian institutions represents another form of reproductive violence. Western states and multilateral agencies have played an active role in shaping SRHR aid regimes that exclude Palestine or depoliticise its needs. This donor behaviour, far from neutral, is a reflection of geopolitical alliances, settler colonial bias, and racialised hierarchies of suffering.

As of March 2025, UNFPA requested $99.2 million for its operational response in Palestine, aimed at addressing both ongoing and emerging reproductive health needs. However, by April, only $12.5 million had been received, leaving a gap of $86.7 million (UNFPA Palestine 2025, 7). This level of underfunding, despite the severity and visibility of the humanitarian crisis, underscores the structural neglect of SRHR in Palestine. It reflects not only a funding failure but a political decision to deprioritise Palestinian reproductive life within global humanitarian agendas. A more extreme case is evident in the defunding of the UNRWA. Once a vital provider of healthcare – including SRHR-related services – in Palestinian refugee camps, UNRWA has faced years of aggressive defunding campaigns led

by Western states. In 2024, the U.S. halted all funding to the agency, creating a $300 million shortfall (AL Jazeera 2024).

Sudan also illustrates the extent to which SRHR neglect is shaped by geopolitical value and donor discretion. In 2024, only 17 percent of UNFPA's funding request for SRHR programming in South Sudan was fulfilled, while in 2025 only 20 percent of the $82.9 million requested for Sudan was received (UNFPA 2025c). These shortfalls resulted in clinic closures, reductions in mobile health teams, and the suspension of essential reproductive care. This pattern of abandonment reflects a deeper structural logic, in which reproductive health is treated as non-essential and is deprioritised not only in high-profile and high-alignment crises such as Ukraine, or a high-visibility and genocidal case such as Palestine, but even also in lower-visibility contexts like Sudan.

The SRHR crisis in Gaza is not new. Yet in the wake of the most recent escalation, major international donors have hesitated to even name reproductive rights in their appeals for aid. For example, UNFPA's repeated calls for the protection of maternal care and the urgent need for SRHR supplies in Gaza have been underfunded or ignored entirely by key contributors (UNFPA Palestine 2025, 4). In some instances, SRHR funding was contingent on recipient organisations avoiding any language deemed "too political", including references to Israeli violence, occupation, or apartheid (ActionAid Ireland 2024, 4). This conditionality reflects a broader donor framework that treats Palestinian reproduction as either too sensitive or too controversial to support. Unlike the case of Ukraine – where SRHR funding is described in apolitical terms of "continuity of care" and "displacement challenges" – Palestinian SRHR is either erased or couched in vague humanitarian language devoid of political specificity (UNFPA 2024). This creates what ActionAid calls the "politics of erasure", where Western donors instrumentalise gender without acknowledging the structural violence that shapes reproductive experiences in Palestine (ActionAid Ireland 2024, 5). The impact of this erasure is twofold. First, it undermines the ability of Palestinian feminist organisations to secure sustained funding. Organisations documenting violations or offering politicised care are deemed "too radical" for inclusion in donor networks. Second, it demonstrates the idea that Palestinians must be framed as neutral humanitarian subjects, not political agents resisting a colonial regime. This strips reproductive justice of its decolonial and intersectional meanings, reducing it to apolitical service delivery.

Moreover, international law and UN frameworks have done little to hold Israel accountable for violations of reproductive rights. While agencies like OHCHR and UN Women have documented attacks on hospitals and maternal clinics, such documentation has rarely translated into action. Donor countries often invoke "both-sides" rhetoric, blunting condemnation and denying the power asymmetry that undergirds the conflict (UN Women 2024, 3–4). This diplomatic balancing act results in a humanitarian architecture that is complicit in the necropolitical project it aims to tackle.

Donor silence also reflects global hierarchies of reproductive worth. In crises involving white and Western populations, such as Ukraine, SRHR is neglected but framed as a matter of bodily autonomy and human dignity. In Palestine, reproductive injustice is rendered a tragic inevitability. Ultimately, donor complicity reveals that reproductive governance in Palestine is not only a local or military issue. It is an international regime of selective investment, depoliticization, and structural abandonment. By refusing to name the political roots of reproductive death, the global aid system reinforces the very conditions it claims to want to improve.

Conclusion: Reproductive Necropolitics and the Global Politics of Abandonment

The case of Palestine demands that we fundamentally rethink the frameworks through which we understand SRHR neglect in conflict settings. This chapter has argued that Palestine is not merely a site of exceptional suffering, nor simply a failed humanitarian context. Rather, it is the logical endpoint of a necropolitical, settler-colonial order in which reproductive death is not incidental but central to the elimination of the Palestinian people.

Through the targeted destruction of hospitals, blockades on maternal supplies, and the denial of movement and medical evacuation, Israel has enacted a regime of reproductive violence that is both structural and intentional. Pregnant women giving birth in tents, miscarriages from trauma and starvation, and babies dying in incubators without power are not collateral damage; they are expressions of a political system that manages Palestinian life through dispossession, degradation, and death (ActionAid 2024, 4; HRW 2025, 3). This is reproductive necropolitics: the sovereign power to dictate not only who lives and dies, but whose reproduction is to be supported, obstructed, or extinguished. The Israeli occupation governs not only through military control but through the erosion of bodily autonomy, dignity, and the means to reproduce safely.

At the same time, the humanitarian system built to respond to such crises often becomes a collaborator in this necropolitical project. Donor silences, conditional funding, and the de-politicisation of SRHR discourse all serve to reinforce the structural erasure of Palestinian women's needs. As this chapter has shown, it seems that major international institutions require that Palestinian suffering be stripped of context and history before it can be acknowledged. This silencing reflects not humanitarian neutrality but political alignment – with Western states, with Israel, and with a broader racialised global order that classifies certain lives as expendable.

Crucially, Palestinian feminist actors have refused this erasure. In displacement camps and bombed-out clinics, women-led organisations continue to offer care, document violations, and create new forms of reproductive justice rooted in resistance. Their work affirms that reproductive rights are not technocratic tools but deeply political acts. Their strategies of trauma counselling under bombardment, underground distribution of aid, organizing births in rubble, are practices of survival that contest not just death, but the political frameworks that make death permissible. Here as well, it is crucial to not romanticise the resilience of Palestinian actors, but to frame this through a lens of international failure to protect the rights of women, and of life, in Palestine.

This chapter has also aimed to differentiate between different methods of SRHR neglect. In Ukraine, reproductive care has been marginalised within humanitarian response, often deprioritised in favour of more "urgent" forms of protection. But in Palestine, SRHR is not deprioritised, it is actively targeted, obstructed, and erased (UNFPA 2024). This contrast reveals the global stratification of humanitarian care: a world where some crises receive resources and political solidarity, while others are trapped in cycles of abandonment and selective empathy. The case of Palestine urges us to reconsider humanitarianism itself. What does it mean to offer reproductive care in a context where hospitals are actively bombed? What kind of reproductive justice is possible under colonial occupation, and who is allowed to speak it? These are not matters of logistics or law, they are ethical and political imperatives.

In answering the question – why SRHR is systematically neglected during conflict-related crises – this chapter suggests that neglect is not always passive. It can be structured, racialised, and politically useful. In Palestine, reproductive neglect is a modality of governance. It is part of a war not just on land, but on futures: on the ability to birth, to raise,

to survive. If reproductive justice is to mean anything in the 21st century, it must include the right to live and reproduce free from military occupation, racialised abandonment, and donor complicity.

In essence, this chapter has shown that SRHR neglect in Palestine must be understood not as an accidental shortfall, but as a necropolitical strategy grounded in colonial governance. The humanitarian system in this structure of abandonment. Palestine, therefore, is not an exception but a mirror: it reflects the broader colonial underpinnings of global humanitarianism, where patriarchal and racialised power determines who is granted the right to care, to parenthood, and ultimately, to life.

Discussion

This chapter explores how sexual and reproductive health and rights are governed under conditions of crisis through the comparative lens of Ukraine and Palestine. Building on the central research question, the chapter argues that this neglect is not an unfortunate logistical failure, but a deliberate expression of global governance structures that distribute care and abandonment along lines of gender, race, and coloniality. Specifically, it shows how SRHR is governed through intersecting regimes of biopolitics and necropolitics, which determine not only who may live or die, but who is permitted to reproduce, to grieve, and to be cared for.

By comparing Ukraine and Palestine, this chapter aims to show the contrast between biopolitical inclusion, where reproductive neglect occurs within an otherwise functional but racialised humanitarian crisis (as in Ukraine), and necropolitical abandonment, where reproductive capacities are actively targeted as sites of domination and control (as in Palestine). Importantly, these are not binary opposites, but differentiated expressions of the same global logic that assigns value to life unevenly.

Rather than asking which context is “worse” for SRHR, the comparative method here seeks to illuminate how different configurations of humanitarian crisis expose the deeper political implications and racialised infrastructures that sustain reproductive injustice. The chapter thus uses Ukraine and Palestine not only as case studies, but as conceptual sites through which to interrogate the governing logics of reproduction in crisis.

Biopolitical Inclusion vs. Necropolitical Abandonment

In Ukraine, the response to the 2022 full-scale Russian invasion was marked by swift international mobilisation, with rapid aid flows, expansive refugee protections, and political

solidarity from Europe and North America. Within this architecture of care, SRHR occupied a precarious space: not wholly ignored, but consistently deprioritised. Humanitarian agencies largely viewed SRHR as a secondary concern; important, but not urgent. Reproductive health supplies were included in planning only after civil society actors demanded their prioritisation, and even then, services remained uneven and fragmented girls (UNFPA Ukraine 2025, 13).

This neglect is best understood through the framework of biopolitics. In Foucault's terms, biopolitics refers to the governance of populations through the optimisation of life and health (Foucault 1984, 262). In Ukraine, certain lives, white, European, Christian, were rendered grievable (Butler 2009), thus deserving of care. Yet SRHR fell outside the bounds of what was considered politically neutral or logistically essential (UNFPA Ukraine 2025, 13). For instance, abortion services were frequently inaccessible to displaced persons, and access to contraception was unreliable, particularly for marginalised groups such as Roma women, people of colour, or LGBTQ+ individuals (Center for Reproductive Rights 2023, 42). This reveals the limits of biopolitical care: it includes populations into a humanitarian imaginary, but regulates which forms of life are protected, and which aspects can be sacrificed, such as SRHR.

Palestine, by contrast, is governed through a necropolitical logic, as theorized by Mbembe. Here, power is exerted not through the optimisation of life, but through its calculated exposure to death (Mbembe 2003, 40). The Israeli occupation and repeated military assaults on Palestine create conditions where SRHR is not simply deprioritised, but actively sabotaged. Hospitals and maternity wards are bombed, pregnant women are denied permits to access care, and reproductive infrastructure is weaponised as part of a broader strategy of control (UNFPA Palestine 2025, 2; HRW 2025, 3–4). This constitutes a form of reproductive violence that goes beyond neglect; it is reproductive governance through destruction.

What links these two cases is not the amount of care offered, but the underlying rationalities of governance that shape whose reproductive lives are valued, and in what ways. Ukraine exemplifies a context where humanitarianism operates through racialised inclusion: care is offered, but within strict limits that depoliticise reproductive rights. Palestine, conversely, is excluded from the humanitarian imaginary as a political subject; its people are rendered as crises to be managed rather than lives to be supported. Yet in both cases, SRHR is

subordinated to geopolitical interests – managed in Ukraine as a minor technical issue and erased in Palestine as a political threat.

These cases therefore do not represent opposite ends of a spectrum, but two structurally linked positions within a global order that governs reproduction through selective care and systemic abandonment. In one, reproductive health is rendered invisible within a functioning aid apparatus; in the other, it is rendered unthinkable through militarised denial. Taken together, they expose the fault lines of a humanitarianism that purports to protect life, but in practice polices which lives are permitted to flourish, and which can be allowed, or forced, to die.

Intersectionality and the Deprioritisation of Reproductive Rights

Understanding how SRHR is governed in crisis also requires attention to how different identities shape access to care. While biopolitical and necropolitical governance structures broadly shape the conditions in Ukraine and Palestine, intersectional analysis reveals how specific populations are differentially exposed to reproductive violence within each context. As Crenshaw argues, structural injustice is not experienced uniformly; rather, it is produced at the crossroads of race, gender, sexuality, ability, and class (Crenshaw 1991, 1245-1249).

In Ukraine, the dominant humanitarian framing constructs the refugee subject as white, Christian, able-bodied, and cisgender. Yet those who fall outside of this frame, Roma women, women of colour, LGBTQ+ individuals, and persons with disabilities, encounter additional barriers to SRHR access. Roma women, for example, were often excluded from formal shelters and medical services due to racial discrimination (UNFPA 2025b, 226-227). Similarly, LGBTQ+ people faced hostility within shelters and were denied access to gender-affirming care or safe reproductive services, reflecting how the aid system privileges normative embodiments of vulnerability (UNFPA 2025b, 227; Center for Reproductive Rights 2023, 49).

In Palestine, intersectionality takes a different form. Here, Palestinian women's reproductive lives are shaped by the coming together of settler colonialism, internal mass displacement, racialisation, and militarised occupation. The Israeli regime's control over borders, mobility, and healthcare infrastructure intersects with gendered forms of domination. Here, matters such as pregnancy become a high-risk condition, not only due to medical causes, but political ones. Women in Gaza often give birth at checkpoints, in tents, in the rubble; they are denied access to hospitals altogether, leading to maternal deaths as an

extended result of the war (MAP 2025). In these cases, the militarisation of care does not only deny services, but transforms reproductive life into a terrain of state violence.

The intersectional layers of marginalisation observed in Ukraine and Palestine are also evident in Sudan, where racialised displacement, gender-based violence, and reproductive neglect intersect in a context of extreme invisibility (UN Women 2025b). This context confirms the broader argument that marginalisation is not only about logistical failure or cultural distance, but about political legibility. Like in Ukraine and Palestine, reproductive bodies in Sudan are stratified through racial, gendered, and classed hierarchies, yet with the added layer of global abandonment. Sudan thus reinforces that intersectionality is essential to understanding how reproductive injustice operates, even in conflicts that barely register on the global stage.

Across all cases, the international humanitarian system tends to erase these layered experiences by appealing to a universal subject of care. This figure, frequently imagined as a passive, cisgender woman in need of rescue, obscures the real diversity of needs and vulnerabilities (Ivanovic 2019, 73; Said 1987, 108). As a result, SRHR interventions, if included at all, often fail to account for the ways that systemic racism, homophobia, and ableism operate within crisis settings. While the forms of marginalisation differ between Ukraine and Palestine, the shared logic is one of simplification: intersectional identities are flattened to fit into a politicised model of aid delivery. Here, intersectionality serves as an analytic lens that exposes the stratification of reproductive rights under crisis. Both contexts reveal that access to SRHR is not only a matter of logistics, but of legibility: who is seen, who is counted, and who is deemed worth saving.

Coloniality and the Politics of Humanitarian Legibility

If intersectionality exposes how identities shape access to SRHR, coloniality reveals the deeper geopolitical logics that govern which populations are rendered visible in the first place. In both Ukraine and Palestine, the international humanitarian system operates not in a vacuum of neutrality, but through histories of empire, racialisation, and geopolitical allegiance. The result is a deeply uneven politics of humanitarian legibility, one that structures who appears as a subject of care, and who remains invisible. These dynamics are underpinned by different levels of grievability (Butler 2009, 38), where some lives are rendered grievable and others disappear from the field of collective care altogether.

Ukraine's position in the Western political imaginary has facilitated its inclusion in global humanitarian concern. As a European nation facing Russian aggression, Ukraine has been framed as a symbol of liberal democratic struggle, deserving of solidarity and support (Oleart and Roch 2024, 8–9). This narrative has enabled a rapid humanitarian response, even as certain dimensions like SRHR have been marginalised within that narrative. Humanitarianism often functions through "hierarchies of suffering" that prioritise those who can be imagined as proximate, familiar, and saveable (Huber 2025, 3). In Ukraine, this proximity is racialised and geopolitical: the visibility of its people as "Us" enables biopolitical care, even if that care is selective and constrained. In Ukraine, this selective care defaults to a patriarchal standard, one that centres the presumed needs of the (white, male, able-bodied) citizen while rendering sexual and reproductive health care as secondary or optional. In practice, this means that more than half the population, all those with reproductive health needs, are structurally excluded from essential services. What is considered "neutral" humanitarian intervention thus reproduces a bias where women's bodies and SRHR are treated as an afterthought.

Palestine, on the other hand, occupies the opposite pole of this colonial ordering. It is not invisible in the sense of being unknown, on the contrary, the ongoing violence in Gaza and the West Bank is frequently reported. However, this hyper-visibility does not make Palestinian lives legible within humanitarian structures. Rather, Palestinians are constructed as a permanent crisis: ungovernable, complex, and in need of discipline rather than rights (Ivanovic 2019, 49). Their visibility does not translate into care but into surveillance and containment. Humanitarian actors often position themselves as "neutral", carefully avoiding any perceived political alignment. In practice, this means remaining aligned with the Israeli occupation, depoliticizing aid, and stripping Palestinian people of justice (Ivanovic 2019, 61). This logic of neutrality echoes Mbembe's necropolitics, wherein the colonial subject is not merely excluded from rights but is excluded from recognition altogether; managed as a population to let die, not one to protect (Mbembe 2003, 40).

Sudan further complicates this dynamic. Unlike Ukraine or Palestine, Sudan is both severely underfunded and largely absent from dominant humanitarian narratives. Despite alarming levels of sexual and reproductive violence, Sudanese women are rendered structurally invisible within the global humanitarian framework (UNFPA Sudan 2024). This absence is not neutral, it reflects a colonial ordering of whose crises are deemed worth intervening in. If Palestine represents the case of hyper-visible exclusion, Sudan represents

the inverse: near-total invisibility. Here it is illustrated again that humanitarian legibility is a matter of geopolitical values, racial hierarchies, and politics of abandonment.

This logic of depoliticization extends into SRHR as well. In Ukraine, reproductive services are seen as politically sensitive but ultimately compatible with humanitarian norms; SRHR is simply less important than other forms of aid. In Palestine, SRHR is entangled with discourses of resistance, population control, and securitisation; the provision of care becomes an act of survival and resistance rather than a guaranteed right (MAP 2025). As such, the very possibility of humanitarian reproductive justice is constrained by the colonial frameworks that determine who is allowed to appear as a subject with political and reproductive agency. Both cases illustrate how coloniality continues to shape humanitarian aid. Ukraine is seen and included, but through a racialised lens that sanitises reproductive neglect. Palestine is obscured and contained; its reproductive politics deemed too political for intervention. Neutrality, balance, and depoliticization are not value-free principles, but techniques of governance that obscure the structural violence shaping reproductive life.

Recognising this politics of legibility clarifies what is at stake in SRHR provision during crisis. It is not just about which services are delivered; it is about which lives are made to matter, which bodies are cared for, and which reproductive futures are allowed to exist. These decisions are not accidental. They reflect and uphold global systems of racialised, gendered, and colonial power.

Civil Society and Feminist Resistance

The neglect of SRHR in humanitarian response across both Ukraine and Palestine has created a vacuum that civil society and feminist actors are forced to fill. These actors respond not only to immediate needs but also challenge the deeper structures that marginalise reproductive justice in conflict. While their interventions are indispensable, they are also symptoms of broader institutional failures.

In Ukraine, feminist and grassroots organisations mobilised rapidly after the 2022 invasion. They established shelters, distributed contraceptives and abortion medication, and provided psychosocial care to survivors of gender-based violence (UNFPA Ukraine 2025, 5). Their work is grounded in local knowledge and feminist solidarity, yet it often remains structurally sidelined. Many of these groups operate without stable funding, surviving on short-term project grants, while being excluded from key decision-making platforms in humanitarian coordination (Center for Reproductive Rights 2023, 74–76). Donor frameworks

that prioritise "neutrality" often marginalise engaged SRHR work as it is politically loaded, framing feminist actors as optional or peripheral rather than central.

In Palestine, feminist civil society actors operate under conditions of siege, occupation, and constant surveillance. Their work is inherently political, not only because of the content of their interventions, but because simply providing reproductive care becomes a form of defiance. Organisations try to offer midwifery services, document violations, and provide trauma support, all while navigating the destruction of healthcare infrastructure and active targeting of SRHR spaces (MAP 2025; ActionAid Ireland 2024, 5). In displacement camps, Palestinian women take on leadership roles, coordinating aid and sustaining communal care despite extreme deprivation. Their labour, whether assisting childbirth without supplies or distributing food, becomes a feminist strategy of survival and refusal (ActionAid 2024, 4).

These actors are rarely supported by international systems. Donors often bypass both Palestinian and Ukrainian women-led organisations due to so-called “political sensitivities”, and many face surveillance, raids, or funding restrictions (Al Mezan 2025, 4; Center for Reproductive Rights 2023, 62–64). Feminist care work becomes both essential and criminalised.

Across both cases, civil society fills gaps left by humanitarian structures. But this reliance on feminist actors should not be romanticised. When grassroots groups become the primary providers of SRHR, it reflects not just resilience but also abandonment. A decolonial feminist lens makes clear that care must not be outsourced to the margins, but should be structurally embedded in humanitarian priorities. These actors are not temporary fixes to an issue, they are political agents who expose the limits of current humanitarian governance and insist that justice, autonomy, and collective care be treated not as add-ons, but as foundational.

Sexual and Reproductive Violence Against Men and Boys

While conflict-related SRHR discourse has justifiably centred the experiences of women and girls, men and boys are also subjected to sexual violence as a deliberate weapon of war. This dimension of reproductive violence remains critically underreported and insufficiently integrated into humanitarian SRHR frameworks. Its omission not only marginalises survivors but also limits the scope of intersectional and justice-oriented responses to sexual and reproductive harm.

In Ukraine, over 100 officially registered cases of conflict-related sexual violence against men have been documented since 2022 by the UNFPA, primarily in detention settings (UNFPA Ukraine 2024a). However, this figure likely represents only a fraction of the actual number of incidents, with estimates suggesting that for each reported case, as many as ten to twenty remain undocumented (UNFPA Ukraine 2024a). Stigma, shame, and the gendered framing of sexual victimhood contribute to chronic underreporting, while survivors describe experiences of torture, sexual humiliation, and abuse spread via social media, intensifying the violence through public exposure (Al Jazeera 2024; UNFPA Ukraine 2024a).

Palestinian men and boys face similarly violent forms of sexual abuse, particularly in detention and during forced evacuations. The OHCHR has documented cases of forced nudity, rape, genital mutilation, and digital recordings of abuse by Israeli forces (OHCHR 2025, 22–27). These acts, often carried out in front of family members or other detainees, aim not only to harm but to humiliate and destabilise communities through targeted sexualised domination. Far from being isolated incidents, this violence is systematic; it operates within necropolitical regimes that weaponise sexuality to fracture masculinities, break spirits, and reinforce colonial control.

A decolonial and intersectional SRHR framework must recognise that reproductive violence is not always bound by gender. It targets all those rendered disposable within systems of domination. Incorporating the experiences of male survivors is not just an expansion of scope, but a necessary mention to ensure the suffering is acknowledged, rather than allowing it to remain invisible.

Concluding the discussion

Across Ukraine and Palestine, the governance of sexual and reproductive health and rights in crisis reflects not disparate humanitarian failures, but structurally linked forms of global reproductive injustice. These cases operate on opposing ends of a humanitarian spectrum, Ukraine through a logic of biopolitical inclusion/exclusion, Palestine through one of necropolitical abandonment, yet both expose how humanitarian governance distributes care along lines of race, geopolitics, and coloniality.

In Ukraine, the humanitarian response following the 2022 invasion was rapid and expansive, underpinned by European solidarity and geopolitical proximity. Yet within this aid system, SRHR was consistently sidelined. This reflects a form of biopolitical governance in which life is regulated and supported only within specific parameters (Foucault 1984, 262).

In Ukraine's case, white, Christian, male victims are included within the humanitarian imaginary – but reproductive health, and therefore the needs of all women and girls, was not. SRHR was deemed politically sensitive and logistically secondary, disproportionately affecting Roma women, people of colour, LGBTQ+ people, and disabled persons who fell outside the normative template of the "ideal" victim (UNFPA 2022; Thesis, p. 18–19). In the case of Ukraine, reproductive needs were marginalised within a patriarchal and racialised understanding of what constitutes "essential" humanitarian aid.

Palestine, by contrast, exemplifies necropolitical governance. Here, reproductive life is not simply neglected but actively obstructed through militarised control of mobility, denial of medical access, and the destruction of maternal infrastructure (Mbembe 2003, 40; MAP 2022, 27; OHCHR 2025, 19–22). Palestinian women face conditions not of neglect, but of structural sabotage, where the ability to reproduce safely is seen as a threat to be managed or eliminated. Pregnant bodies are targeted rather than protected, and SRHR becomes a site of both biopolitical abandonment and settler-colonial violence. Unlike Ukraine, where care is unevenly distributed, Palestine is a case of reproductive warfare. The Israeli occupation's reproductive violence turns SRHR into a frontline of control and erasure.

Despite these distinct governance logics, both cases expose how SRHR is subordinated to broader humanitarian priorities shaped by racialised, patriarchal, and colonial assumptions. In both cases, feminist civil society actors have stepped in to provide essential reproductive care - from informal abortion networks in Ukraine to underground midwifery systems in Gaza. These grassroots interventions challenge the formal humanitarian system, offering relational, political, and situated responses that prioritise survival and dignity. But they also expose the structural failure of humanitarian institutions to treat SRHR as core to crisis response. When feminist actors are forced to substitute for institutional care, it is not a sign of resilience, it is a sign of abandonment (Center for Reproductive Rights 2023, 76).

Critically, both case studies illuminate how visibility does not equate to legibility. Ukrainian victims are narratively included in Western humanitarianism, but SRHR is still deprioritised, especially for marginalised groups (UN Women 2025a, 14). Palestinian suffering, though hyper-visible in media and UN documentation, remains illegible within humanitarian frameworks that avoid political confrontation (Ivanovic 2019, 49–61). This dynamic reflects Judith Butler's theory of grievability: some lives are marked as grievable and worth saving, while others are disqualified from recognition (Butler 2009, 38).

Humanitarian inclusion is not determined by need, but by geopolitical alignment and normative identity. Across both contexts, humanitarian structures reproduce hierarchies of reproductive worth. Whether through the biopolitical sidelining of care in Ukraine or its necropolitical obstruction in Palestine, SRHR is persistently treated as a dispensable category of aid. These exclusions are not incidental but instead are symptoms of a global aid structures rooted in colonial and patriarchal systems.

By comparing the cases of Ukraine and Palestine, we do not find two distinct failures of SRHR provision, but rather two expressions of a shared system of reproductive neglect. Both are happening within a global humanitarian order that privileges whiteness, patriarchal norms, and political neutrality, systematically sidelining women and vulnerable groups through SRHR neglect. Viewed together, these crises reveal that the marginalisation of SRHR is not merely a logistical oversight, but a structural feature of how humanitarian governance operates today.

Conclusion

This paper has explored how sexual and reproductive health and rights are governed, obstructed, and resisted in contexts of conflict and crisis. Contrary to dominant humanitarian narratives, this paper argues that the marginalisation of SRHR is not an accidental byproduct of war-induced chaos, but a structural expression of power. SRHR neglect reflects the gendered, racialised, and colonial logics that underpin humanitarian governance itself.

Through a comparative case study of Ukraine and Palestine, this research has shown how SRHR is systematically deprioritised across very different political and humanitarian crises. In Ukraine, reproductive care is sidelined within an otherwise functional humanitarian infrastructure. In Palestine, SRHR is actively obstructed by settler-colonial occupation and militarised governance. These are not isolated crises, they are expressions of a shared system of reproductive neglect. Thus, this paper aims to contribute by revealing how these patterns are not separate but rather interconnected through broader systems of global aid governance. SRHR neglect is not exceptional, in contrary, it is systemic, structured along lines of race, gender, and coloniality that define whose reproduction is protected, and whose is erased.

The integrated theoretical framework, combining biopolitics, necropolitics, decolonial feminism, and intersectionality, has provided essential tools for understanding how reproductive governance operates in crisis. Foucault’s concept of biopolitics reveals how

humanitarian aid distributes care not neutrally, but strategically, managing life according to racialised and gendered norms of worth (Foucault 1984, 262). In Ukraine, biopolitical governance constructs certain lives as "saveable" while treating SRHR as supplementary. Here, aid flows towards infrastructure and logistics, while reproductive needs are considered optional, even in contexts of sexual violence, displacement, and maternal mortality (UNFPA Ukraine 2024b, 5–6; UN Women 2025a, 14). Building on this, Achille Mbembe's necropolitics offers a framework for understanding Palestine, where SRHR is not simply neglected but actively targeted (Mbembe 2003, 40). Reproductive violence is enacted through bombings of hospitals, denial of medical evacuations, and the weaponisation of childbirth under occupation (MAP 2025; OHCHR 2025, 27–29). This is not passive exclusion; it is reproductive sabotage.

A decolonial feminist lens helps situate these frameworks historically. It exposes how humanitarianism continues to reproduce colonial hierarchies, positioning women, especially women of colour, as passive recipients of aid rather than holders of rights (Mohanty 2003, 503). Humanitarianism, often framed as benevolent and apolitical, frequently reproduces these hierarchies by privileging certain lives while abandoning others. This analysis is vital in both Ukraine, where the needs of women are deprioritised through SRHR neglect, and Palestine, where care for Palestinian women is actively obstructed by settler-colonial militarism.

Intersectionality further reveals that SRHR neglect is not evenly distributed. In Ukraine, Roma women, people of colour, LGBTQ+ people, and those with disabilities face heightened barriers to accessing care, accelerated by discrimination both within the country and in host states (Center for Reproductive Rights 2023, 11–13). In Palestine, reproductive injustice disproportionately affects displaced women, adolescent girls, and survivors of sexual violence in shelters and camps (UNFPA Arab States 2025, 10–12; ActionAid Ireland 2024, 4–6). It is thus important to acknowledge that the marginalisation of SRHR is not uniform, it is layered and dynamic, with no one-size-fits-all solution.

This thesis finds that SRHR neglect manifests differently across Ukraine and Palestine but stems from the same structural logic. In Ukraine, humanitarian governance operates through a regime of selective biopolitical care. Reproductive health is acknowledged but consistently deprioritised in funding appeals, national policies, and humanitarian coordination (UNFPA Ukraine 2025, 2). In Palestine, SRHR is governed through

necropolitical abandonment. Reproductive services are blocked at borders, destroyed by military assaults, or criminalised as forms of resistance (MAP 2025; OHCHR 2025, 22–27). Care becomes inseparable from colonial violence. In both cases, the control over SRHR equates control over reproductive bodies and thus control over a population. In Ukraine, this means that only those who fit the "perfect European victim" framework have access to (limited) SRHR care; those who do not fit within the white, Christian, Ukrainian archetype do not get the right to reproductive health and protection. In Palestine, this population control through SRHR extends into the annihilation of the Palestinian people; reproductive bodies are actively targeted as a means to control and eradicate the existence of Palestinians.

Despite these differences, both cases expose a shared pattern: SRHR is treated as non-essential. Whether through omission or obstruction, the result is the same; bodies that fall outside dominant norms of race, gender, and political legibility are rendered disposable. This is further evident in the politics of civil society. In both cases, feminist actors have built parallel infrastructures of care. In Ukraine, civil society organisations provide abortion pills, shelter, and GBV support where state systems falter (Center for Reproductive Rights 2023, 63). In Palestine, grassroots midwifery networks and underground clinics operate under siege, offering resistance through care (MAP 2025; OHCHR 2025, 28–29). These interventions are crucial, but their necessity reveals structural failure. When feminist labour is relied upon to fill systemic gaps, it is not a sign of humanitarian resilience, but of active abandonment.

This thesis challenges the idea that humanitarianism is failing SRHR because of logistical or contextual limitations. Instead, it shows that the exclusion of reproductive rights is a structural feature of the system itself – embedded in the patriarchal, colonial, and racialised logics that define humanitarian aid. Thus, humanitarian aid structures are not failing SRHR, they are functioning exactly as designed. If reproductive justice cannot be realised even in the most politically legible crisis and is simultaneously systematically denied in the most visible colonial war, then the issue lies not in oversight but in the structural design of aid systems that dictate which lives are protected, which are neglected, and which are abandoned altogether.

SRHR must be reclaimed as a political and humanitarian priority. Its marginalisation is not due to lack of resources but reflects whose bodies are seen as worthy of care. The notion of "life-saving" aid continues to be defined through donor priorities and geopolitical alignments, which often erase the needs of women, queer communities, and racialised

populations. This is why, despite overwhelming visibility, Palestinians remain structurally excluded, while Ukrainians receive aid that still neglects SRHR under the guise of political neutrality. Taken together, Ukraine and Palestine reveal not two isolated failures but a shared system of reproductive neglect.

A justice-centred approach requires reimagining humanitarianism from the ground up. This means dismantling donor frameworks that treat reproductive care as optional, and funding feminist and community-led responses as essential. It also means rejecting neutrality when it conceals complicity with violence.

This thesis has been written from a place of political and ethical responsibility, especially when engaging with contexts like Palestine, where research itself risks being complicit in systems of power. Examining SRHR in conflict zones is inherently not neutral; it confronts the politics of visibility, silence, and the ethical responsibility of producing knowledge about what is heard, seen, and remembered. Possible future research may examine how SRHR governance unfolds in underreported conflicts outside of dominant geopolitical narratives – such as Sudan or Myanmar – through localised, feminist, and decolonial frameworks. Activist and policy efforts must centre knowledge from the global South, build feminist and decolonial solidarities, and uphold intersectional commitments to reproductive autonomy.

Ultimately, to finalise this thesis, it is important to consider the way forward. The future cannot be built by refining the logic of a system designed to exclude. The call is not to care better, but to care differently – radically, intersectionally, and with intention.

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