UTS UNIVERSITY OF TECHNOLOGY SYDNEY

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

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Thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Certificate of Original Authorship

CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Hannah Ireland, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Publications included in this thesis

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Abstract

Humanitarian crises, including conflicts and natural disasters, significantly impact millions of people each year, with women being disproportionately affected in terms of sexual and reproductive health outcomes and access to services. While advancements, such as the introduction of the Minimum Initial Service Package for sexual and reproductive health in crises, have improved the coordination and delivery of sexual and reproductive health services, challenges remain in meeting the needs of women and girls in crisis settings. Social capital, which refers to the resources embedded in social networks, is critical in influencing health outcomes, including sexual and reproductive health. However, there is a notable gap in understanding the role of social capital in women's sexual and reproductive health in crisis settings, particularly in the Pacific region, which faces high vulnerability to climate-related disasters and significant sexual and reproductive health and rights challenges.

This thesis presents qualitative research exploring the impact of social capital on shaping women's access to sexual and reproductive health services and information during humanitarian crises in Fiji. A systematic literature review was first conducted to investigate existing studies in the research area and explore the relationships between social capital and women's sexual and reproductive health and rights in humanitarian settings. Following this, in the first research phase, a scoping review was conducted to map out how social capital was included in relevant policy and guidance documentation. In the second phase, field research captured the voices of Fijian women and community leaders affected by tropical cyclones, and professionals involved in emergency sexual and reproductive health responses in Fiji. Interviews and focus groups were conducted in remote island field sites in Fiji, which had experienced tropical cyclones in the preceding two years and with government, NGO, INGO and UN agency sexual and reproductive health service providers based in Fiji. The final research phase facilitated reflection and feedback on the emerging findings with Fijian NGO, INGO and UN agency professionals.

The findings reveal that social capital significantly influences Fijian women's access to sexual and reproductive health services and information in crisis settings through three primary pathways of socio-cultural norms and values, trust and social support. These pathways depend on formal and informal networks and nodes, which primarily draw on bonding and linking capital. Social capital has the potential to both facilitate and hinder women's access to sexual and reproductive health and information in humanitarian settings. The findings have important implications for practitioners and policy makers in the sector. These include harnessing the opportunities presented by natural disasters such as cyclones for systemic strengthening through linking capital, the need for ongoing

engagement with socio-cultural norms in preparedness efforts and the importance of localisation, especially at the ultra-local level, in humanitarian sexual and reproductive health service delivery.

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List of abbreviations

AACODS	Authority, Accuracy, Coverage, Objectivity, Date, Significance (a checklist for evaluating grey literature)
ANC	Antenatal Care
CASP	Critical Assessment Skills Programme
FP2020	Family Planning 2020
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IAFM	Inter-Agency Field Manual
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
IPPC	Intergovernmental Panel on Climate Change
IPV	Intimate Partner Violence
IRC	International Rescue Committee
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, and others
LLMIC	Lower and Lower-Middle Income Countries
MISP	Minimum Initial Service Package
NGO	Non-Governmental Organisation
NHMRC	National Health and Medical Research Council
OCHA	UN Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews
RFHAF	Reproductive Family Health Association of Fiji
SGBV	Sexual and Gender-Based Violence
SPRINT	Sexual and Reproductive Health in Crises and Post-Crisis Situations Initiative
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection

UNDRR	United Nations Office for Disaster Risk Reduction
UNFPA	United Nations Population Fund
WB-FCS	World Bank Fragile and Conflict Situations
WHO	World Health Organisation

Introduction

Humanitarian crises such as conflict and natural disasters impact millions of people worldwide each year. In 2023, a record 339 million people, or one in every 23, required humanitarian assistance. More than 1% of the world's population is displaced, acute food insecurity is increasing with 45 million people being at risk of starvation, and global public health continues to be hampered by COVID-19, monkeypox outbreaks, Ebola, cholera and vector-borne diseases (OCHA, 2022). Climate change is contributing to and exacerbating the impacts of humanitarian crises all over the world. Acting as a threat multiplier, climate change intensifies existing vulnerabilities, leading to cascading crises such as more frequent and severe natural disasters, displacement, and resource scarcity. This escalation disproportionately affects already marginalised populations, amplifying inequities and hindering access to essential services, including healthcare, food, and shelter (Baxter et al., 2022). Women and girls are particularly vulnerable in humanitarian contexts. The inequalities and discrimination faced by women and girls are compounded when disaster strikes. A loss of social networks, livelihoods and other protective factors leave them at a greater risk of gender-based violence, trafficking and the need to engage in transactional sex (Thurston et al., 2021). Access to healthcare, especially sexual and reproductive healthcare can be severely limited or even non-existent leading to poor sexual and reproductive health (SRH) outcomes including high maternal mortality rates (Tazinya et al., 2023). In 2023 64% of all maternal deaths came from countries with humanitarian responses in place (IRC, 2024). These challenges highlight the critical need to prioritise the SRH of women and girls in humanitarian responses, ensuring access to essential and lifesaving services.

The Pacific region has historically experienced frequent weather-related disasters and is highly vulnerable to the impacts of climate change (Barnes, 2020). Pacific Island countries are consistently included in the top ten most disaster-prone countries according to the World Risk Index (Aleksandrova et al., 2021). Pacific nations also face a number of sexual and reproductive health and rights (SRHR) challenges, which are exacerbated in the context of natural disasters. Notwithstanding significant contextual diversity across the Pacific, in general, the region has a high unmet need for contraception, stagnant contraceptive prevalence rates, very high levels of sexual and gender-based violence and some concerning national maternal mortality rates (IPPF, 2019; Pacific Community, 2024). The COVID-19 pandemic exacerbated these challenges through the disruption of essential services, travel restrictions, home isolation and redirected health resources. Women and girls in the Pacific experienced increased difficulty in accessing services, such as family planning, as a result of travel restrictions, closure of clinics and supply delays of essential commodities (Pacific Women, 2020a). In addition, intimate partner violence increased dramatically during the pandemic while

access to support services became more limited (Dawson et al., 2021; Pacific Women, 2020a). These compounding factors result in the need for strategic and robust SRH responses to, and planning for, the inevitable acute onset natural disasters that continue to occur throughout the region.

Over the past two decades, there has been growing global recognition of the need to address the SRHR of individuals affected by humanitarian crises. Prior to this, response efforts focussed primarily on food, shelter and water with the provision of SRH services as ancillary to these and subject to availability of funding and resources (Krause et al., 2017). In 2015, the Sendai Framework for Disaster Risk Reduction 2015-2030 (UNDRR, 2015) explicitly identified SRH as a critical health service, a priority further reinforced by the World Health Organisation's (WHO) Health Emergency and Disaster Risk Management Framework in 2019 (WHO, 2019). Continued inter-agency collaboration among key actors has advanced SRHR as a core focus in humanitarian responses, most notably through the inclusion of the Minimum Initial Service Package (MISP) for SRH in crises in the 2000 edition of The SPHERE Handbook, a widely accepted set of humanitarian standards (Sphere, 2018). The MISP outlines essential SRH activities to be implemented within the first 48 hours of any crisis. Despite these advances in coordination and service provision, significant opportunities for further improvement remain in order to fully meet the SRHR needs of women and girls in future crises and natural disasters, especially in the Pacific region.

Women's SRHR are influenced by a number of social determinants, including social capital, understood here as the resources (such as social support, information channels, social credentials, social control) that are embedded in an individual's social and interpersonal networks (Kawachi et al., 2008). There is an existing body of research linking social capital to health and more specifically to SRHR. Evidence shows that social capital acts through a number of pathways to impact health (Agampodi et al., 2017; McTavish & Moore, 2015; Story, 2014), and the outcomes can be both positive and negative (Paek et al., 2008). There is also extensive research exploring the role of social capital in general throughout all phases of the disaster cycle and a smaller group of studies investigating social capital and health in the context of disasters, however this is predominantly focussed on mental health (Aida et al., 2013; Noel et al., 2018). There is a significant gap in the literature in understanding the role of social capital in women's SRHR in crisis settings and how this could inform preparedness, response and recovery.

The research presented in this thesis aims to address the identified gap and explore how the incorporation of a social capital analysis could improve SRHR crisis preparedness, response and recovery efforts. A multi-phased study with a geographical focus on Fiji and the Pacific region sought to answer the following research questions:

1. Is social capital a consideration in Fiji national, Pacific regional and international disaster risk reduction, crisis preparedness and response planning and guidance documents and how is this addressed in relation to SRHR?
2. What are the pathways through which social capital influences access to and utilisation of SRH services during humanitarian response and recovery phases?
3. What opportunities does social capital provide, for strengthening access to and utilisation of SRH services in humanitarian settings?

Key concepts

Humanitarian settings

A humanitarian setting occurs when an "event or series of events has resulted in a critical threat to the health, safety, security, or well-being of a community or other large group of people" to the point that their coping capacity is overwhelmed and external assistance is required (IAWG, 2018a, p. 2). Armed conflicts, natural disasters, famines and epidemics can all cause humanitarian settings.

This thesis is primarily concerned with humanitarian settings which result from natural disasters. Natural disasters occur when natural hazards such as, earthquakes, cyclones, landslides and floods meet conditions of high exposure, vulnerability and low capacity resulting in human, material, economic or environmental loss and, or impact (UNDRR, 2017). Natural disasters can be rapid onset (e.g., earthquakes, cyclones) and slow onset (e.g., droughts, sea level rise). Rapid onset disasters, such as those caused by cyclones or earthquakes, often leave little time for preparedness and require immediate humanitarian response.

Climate change is increasing the frequency and intensity of natural hazards. The Intergovernmental Panel on Climate Change has reported on global increases in hot extremes, heavy precipitation events, fire weather and major tropical cyclones (IPCC, 2023). This, combined with other factors such as high population density, food energy price volatility, poverty and environmental degradation is augmenting the risk of disasters everywhere, but particularly for those regions of the world which face high levels of vulnerability and exposure such as the Pacific (IASC, 2015b). Vulnerable populations, such as women, children, people from lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) groups, and people with disabilities are also disproportionately impacted by natural disasters and other humanitarian crises. These groups often face increased risks and additional barriers to accessing services such as healthcare, shelter and food, making their needs in these settings more acute (Bain et al., 2023).

Humanitarian response

Humanitarian response has evolved significantly over the past century, driven by the increasing recognition of the need for coordinated, international efforts to address crises caused by conflict, natural disasters, and pandemics. Early humanitarian action was often fragmented and reactive, with organisations working independently to deliver aid. However, the founding of the International Committee of the Red Cross in 1863 and the establishment of the United Nations following World War II marked the beginning of more structured international humanitarian assistance. At this time there was also a rapid increase in non-government organisations (NGOs) as the focus of humanitarian aid moved away from Europe to Africa and Asia. Over time, the growing complexity of global crises prompted the development of international frameworks and standards aimed at improving the effectiveness and coordination of humanitarian response. In 1991 the four governing principles of humanitarian aid, humanity, neutrality, impartiality and independence, were formally established by the UN General Assembly. A significant milestone came in 2000 with the launch of the SPHERE Handbook, which set out universally recognised standards for humanitarian response, including key principles for the delivery of essential services such as water, food, shelter, and healthcare (Sphere, 2018).

In parallel with the development of broader humanitarian standards, there was increasing recognition of the need to address the root causes and risk reduction related to natural disasters, leading to the development of the Sendai Framework for Disaster Risk Reduction 2015-2030 (UNDRR, 2015)**.** Unlike the SPHERE standards, which focus on immediate humanitarian response, the Sendai Framework addresses disaster risk management and promotes a proactive approach to reducing vulnerability and enhancing resilience in communities prone to natural hazards. It places strong emphasis on preparedness, risk assessment, and long-term recovery strategies, encouraging governments and organisations to integrate disaster risk reduction into their policies and planning. Together, the SPHERE standards and the Sendai Framework reflect the growing recognition of the importance of not only responding to crises but also preparing for and mitigating the risks that lead to humanitarian emergencies.

Effective disaster management requires a comprehensive approach that encompasses all stages of a disaster, from mitigation to recovery. This is captured in the widely recognised concept of the disaster management cycle as illustrated in Figure 1, which outlines the cyclical processes of preparedness, response, recovery, and mitigation. By understanding and applying the disaster management cycle, humanitarian actors can ensure that they are not only responding effectively to disasters but also building resilience to reduce the impact of future crises.

Figure 1

Disaster Management Cycle

Note. Diagram adapted from *Ready to Save Lives: Sexual and Reproductive Healthcare in Emergencies* (FP2020 et al., 2020)

Sexual and reproductive health and rights in humanitarian settings

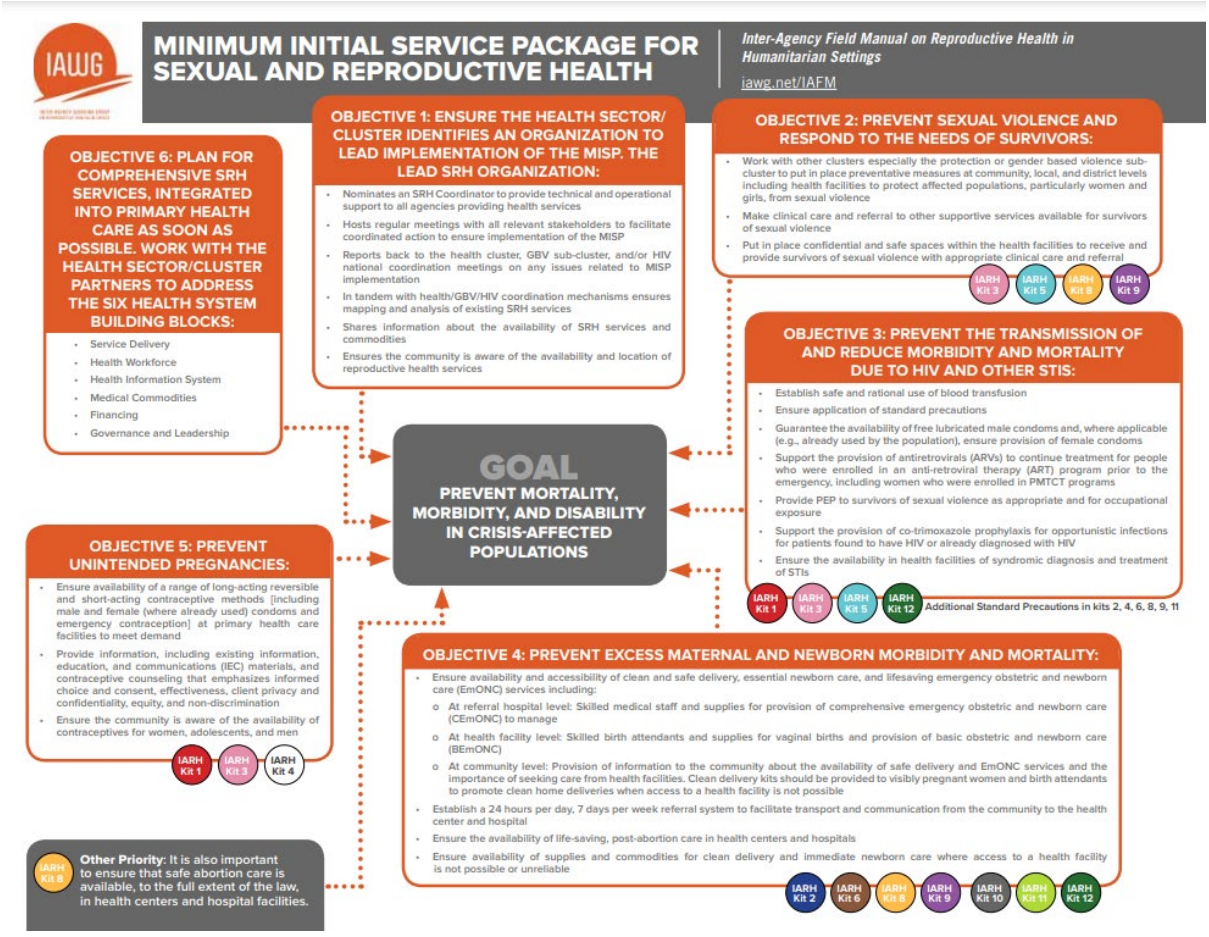
Sexual and reproductive health is an essential component of our general health and well-being. Starrs et al., (2018) proposed the current, integrated definition which describes SRH as a "a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity" (p. 2646). They emphasise that to achieve this requires meeting sexual and reproductive rights which are based on human rights including, among others, the right to make autonomous decisions about one's body, to engage in consensual sexual relations, to choose sexual partners, to choose whether to have children and if so how to space them, to have access to sexual and reproductive information, to terminate a pregnancy safely and to access sexual and reproductive healthcare free from coercion, discrimination and violence (Starrs et al., 2018).

People affected by humanitarian crises, especially women and girls, face increased risks and additional barriers to SRH services (IAWG, 2018a). Fulfilling the sexual and reproductive rights outlined in the definition above in crisis settings requires the timely delivery of high quality SRH services. As a result of advocacy by international agencies beginning in the 1990s SRH began to gain recognition as a critical component of humanitarian responses. In 1999 the Inter-agency Working Group on Reproductive Health in Crises (IAWG) produced the Reproductive Health for Refugees: An

Inter-agency Field Manual (IAFM) which was the first comprehensive technical guidance for providing reproductive health services in humanitarian settings (Krause et al., 2017). Importantly, this included specific guidelines which outlined a minimum set of priority reproductive health services to be implemented in the first 48 hours following the onset of a humanitarian crisis; the MISP. Designed to address the most critical SRH needs in humanitarian settings, the MISP focuses on preventing maternal and newborn deaths, managing complications from unsafe abortions, preventing sexual violence and providing care for survivors, reducing the transmission of Human Immunodeficiency Virus (HIV), and ensuring the availability of contraceptives.

Figure 2

Quick reference for the MISP for SRH



Note. Image taken from https://iawg.net/resources/misp-reference, 8/1/2025

Since the introduction of the MISP, SRH has continued to be embedded in international humanitarian coordinating frameworks, including its inclusion in the Sphere Handbook in 2000 and the World Health Organisation's Health Emergency and Disaster Risk Management Framework in 2019 (Sphere, 2018; WHO, 2019). The Sendai Framework for Disaster Risk Reduction 2015-2030 also acknowledges

the importance of SRH as a critical component of health services across the whole disaster management cycle (UNDRR, 2015). Translating this high-level progress to concrete outcomes for communities on the ground affected by humanitarian disasters has required a concerted effort by international actors. The Sexual and Reproductive Health in Crisis and Post-Crisis situations (SPRINT) program was launched in 2007 led by the International Planned Parenthood Federation (IPPF). Its aim was to address gaps in implementation with the following objectives: to increase regional capacity to implement the MISP for SRH in crises, to strengthen the coordination of SRH stakeholders and activities, to respond in a timely fashion to SRH needs in crises, and to enhance access to comprehensive SRH information and services for affected populations (Beek & Dawson, 2020). Since its inception, the SPRINT program has made significant achievements and been critical to the process of embedding SRH into humanitarian responses around the world (Beek et al., 2021; Krause et al., 2017). Despite this, challenges remain and there is potential for further improvement and strengthening.

Social capital

Women's SRHR are influenced by various social determinants, one of which is social capital**.** While social capital originally emerged from the field of sociology, it wasn't until the mid-1990s that it entered mainstream public health discourse. The concept itself is broad and has been the subject of debate and contestation, particularly in its application to public health (Kawachi et al., 2008). As a result, there are multiple, and sometimes conflicting, definitions and conceptualisations of social capital.

A review of the diverse interpretations suggests two broad approaches to understanding social capital. The first is the social cohesion approach**,** developed by Coleman (1988) and further popularised by Putnam in his influential work "Bowling Alone" (2000). This approach views social capital as the resources, such as trust and norms, available collectively to members of a social group. The second interpretation is the social network approach, first conceptualised by Bourdieu (1986) and later expanded by Lin (1999), which defines social capital as the resources or mechanisms (e.g., social support, information channels, social control) embedded within an individual's social and interpersonal networks. In this framework, these resources can belong to both the individual and the collective. Though this thesis primarily leans toward a social network definition, it adopts Szreter and Woolcock's (2004) understanding of social capital as "an important set of resources inhering in

relationships, networks, associations, and norms" (p. 661). This definition finds common ground between the social cohesion and social network approaches, integrating elements of both[1].

Social capital is often divided into bonding, bridging, and linking capital, which describe different types of ties between individuals and groups. Bonding capital refers to strong ties between individuals with shared identities, such as race or class. Bridging capital describes weaker, horizontal ties between heterogeneous groups of individuals, such as people from different ethnic groups but with similar levels of power or status. Linking capital, a more recent concept, refers to vertical ties that span institutionalised power differentials (Pitkin Derose & Varda, 2009).

It is well-established in the literature that social capital influences health through several mechanisms. At the individual level, these include social support, which can build self-esteem and provide direct resources; social influence, through shared norms or social control, which can impact health behaviours; and social engagement or participation, which brings individuals into networks and under the influence of others (Eriksson, 2011; Szreter & Woolcock, 2004). At the community level, social capital operates through mechanisms such as collective socialisation**,** where adults in a network influence children's health behaviours, informal social control which is the extent to which a group can regulate the behaviours of its members, and collective efficacy, which refers to a group's ability to organise and take action on issues affecting its members (Szreter & Woolcock, 2004). This thesis explores the social capital mechanisms manifested at both individual and community levels and also considers connections between the two.

Research also demonstrates the influence of social capital specifically on SRH. A systematic literature review on social capital and the utilisation of maternal and child health services in low- and middle-income countries found that social capital has a "dual role," with both positive and negative potential impacts (Villalonga-Olives & Kawachi, 2017). For example, a network member with some health knowledge might provide a woman with beneficial information, supporting her to access antenatal care and transport to a facility, while some traditional beliefs or socio-cultural norms within the same network might encourage home births over facility deliveries (Mengesha et al., 2021). This "dark side" of social capital is important to acknowledge, as the concept has sometimes been presented as having solely positive effects. As Villalonga-Olives and Kawachi (2017) argue, all of the mechanisms outlined earlier can have both positive and negative influences on health outcomes.

[1] Of note, the literature review, presented in the next chapter, takes only a social network approach. The literature review was conducted and written prior to the other chapters of this thesis, including this introduction chapter. The decision to use the Szreter & Woolcock (2004) definition, reflects the evolution of my thinking, broadening the understanding of social capital to include elements of a social cohesion approach.

Social capital was chosen as the conceptual framework for this study because it offered a realist approach suited to the applied, pragmatic aims of the research. While alternative frameworks, such as ethnographic or anthropological lenses, may have yielded valuable insights into cultural and power dynamics, the goal of this study is not solely interpretive. Rather, the aim is to generate practical, transferable insights that might inform humanitarian planning and strengthen health responses in real-world settings. Social capital, with its emphasis on social norms, relationships, and community resources, allows for a wide lens that views cultural and social dynamics not only as influences but also as potentially harnessable assets (Szreter & Woolcock, 2004). This makes it particularly appropriate for identifying actionable strategies for improving access to care.

Research rationale

Studies have been conducted across many humanitarian settings which demonstrate the role of social capital throughout the different phases of a disaster (Morsut et al., 2021). For example, in the immediate wake of a disaster, bonding capital can facilitate mutual support between neighbours helping to meet critical needs. In the recovery phase, studies have shown that communities with high levels of social capital have greater capacities to mobilise, voicing their demands and accessing necessary resources (Aida et al., 2013). In terms of the preparedness phase, it is believed that socially cohesive communities can enable preparedness through mechanisms such as strong communication channels and volunteer networks (Koh & Cadigan, 2008). There is also a body of research exploring the impact of social capital on health in humanitarian contexts. The focus of this research has been mostly on mental health, demonstrating the association between certain elements of social capital and improved mental health outcomes following disasters (Aida et al., 2013; Noel et al., 2018).

There are a number of studies which have included elements of social capital and its impact on women's SRHR in humanitarian settings. For example, Strang et al. (2020) explored the role of social connections and trust in seeking support for intimate partner violence in conflict settings, and Walstrom et al. (2013) who highlighted the importance of peer support groups for HIV positive women in the post-conflict setting of Rwanda. Although a systematic review of these papers, presented in the following chapter of this thesis, revealed important insights, almost none of the included studies specifically used social capital as an explanatory framework. There remains a gap in research, either quantitative or qualitative, specifically investigating the nexus of social capital and women's SRHR in humanitarian settings. The research underpinning this thesis is focussed on addressing this gap.

This research has the potential to provide significant benefits to the communities involved, addressing critical needs within humanitarian settings. Sexual and reproductive health is a fundamental aspect of well-being, particularly for women and girls, who often face considerable barriers to accessing healthcare in crisis situations. By exploring the role of social capital in women's SRHR and how this impacts their access to service delivery in humanitarian settings, this research will help identify and strengthen existing community resources and networks that can be leveraged to improve health outcomes. Empowering communities to utilise their social capital can foster more sustainable and locally driven solutions, strengthening their own capacity to respond to, recover from and prepare for crises. These insights can contribute to building stronger, more resilient communities, with robust social networks that support SRHR not only during crises but also in stable periods.

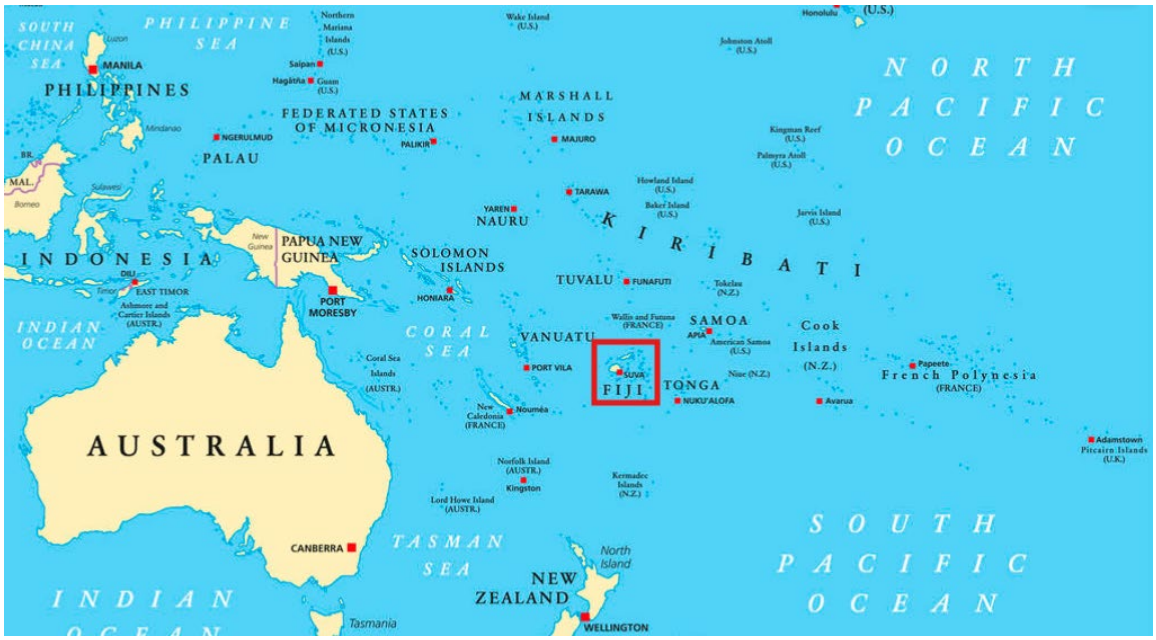
For practitioners and policymakers, this research will provide valuable insights that can help shape more effective and responsive SRHR interventions in humanitarian settings. By understanding the influence of social capital on SRHR outcomes, practitioners will be better equipped to tailor their programs to align with the social dynamics of the communities they serve. This evidence-based approach will support more targeted and culturally appropriate interventions, improving access to SRH services for those who need them most. Moreover, this research has the potential to bridge the gap between theoretical understandings of social capital and its practical application in real-world contexts, offering clear guidance on how to integrate social capital into humanitarian response strategies. Ultimately, these findings could inform policies and practices that lead to more resilient communities and effective SRHR interventions, contributing to long-term SRHR improvements in crisis-affected populations.

Research context

The research presented in this thesis focuses on the Pacific region and in particular, Fiji. Fiji can be seen on the map in Figure 3, located in the South Pacific Ocean and is made up of 332 islands and 500 islets. About 110 of the islands are inhabited with a total population of just over 950,000 people, though more than three quarters of these live on the two main islands, Viti Levu and Vanua Levu. iTaukei, or indigenous Fijians make up 56.8% of the population followed by Indo-Fijians (37.5%) and Rotumans (1.2%). The country is abundant in natural resources however the economy is highly dependent on tourism and as such was significantly impacted by the COVID-19 pandemic, experiencing its biggest economic contraction in modern history (OECD, 2022).

Figure 3

Map of central Pacific Ocean islands showing Fiji



The Pacific region faces a number of challenges relating to SRH. Fiji, despite making progress in some areas of SRH in recent years, is no exception. For example, 36% of Fijian women still have an unmet need for contraception (Guttmacher Institute, 2022). Of particular concern is sexual and gender-based violence with 72% of Fijian women aged 18-64 reporting to have experienced sexual, emotional or physical violence from an intimate partner in their lifetime (Velit et al., 2022). At a policy level, some progress has been made towards creating an enabling environment for the promotion of SRHR, including a soon to be completed new Reproductive, Maternal, Child and Adolescent Health national strategy. A number of gaps still remain however. For example, whilst access to contraception is not restricted it is also not explicitly guaranteed and in particular, there is a lack of policy and guidance relating to adolescents being able to independently access these services (UNFPA & The University of Melbourne, 2022). In relation to humanitarian contexts, SRHR is partially incorporated into policy and legal structures, including being mentioned in the *National Disaster Risk Reduction Policy 2018-2030* (The Government of Fiji, 2018) however the MISP is yet to be formally integrated at this level.

As mentioned earlier the Pacific region is particularly vulnerable to the impacts of climate change and is experiencing the combined effects of slow-onset hazards such as coastal inundation and the increasing frequency and severity of natural disasters, such as tropical cyclones (Enari & Jameson, 2021). Fiji experienced two cyclones in 2020, Tropical Cyclone Harold in April and Tropical Cyclone

Yasa in December, providing recent disaster case studies. Both occurred during the COVID-19 pandemic which added complexity to coordinating response and recovery. Tropical Cyclone Harold hit Fiji's main island, Viti Levu, and the smaller islands to the east on the 7th April as a Category 4 cyclone and temporarily displaced 10,000 people (IFRC, 2021). It caused landslides and widespread flooding leading to significant damage to infrastructure, especially in the Kadavu and Lau island groups (IFRC, 2021). Tropical Cyclone Yasa hit Fiji on the 17th December 2020 as a category 5 cyclone affecting in particular Vanua Levu and the Lomaiviti and Lau groups of islands. More than 2000 homes were destroyed with thousands more sustaining damage (Fiji NDMO, 2021). The fieldwork contributing to this thesis was conducted with communities impacted by these two cyclones on the islands of Kadavu, Koro and Vanua Levu.

National disaster responses in Fiji are implemented through a cluster system, as outlined in the *National Humanitarian Policy for Disaster Management* (The Government of Fiji, 2017). There are nine clusters, led by government representatives who work closely with INGOs, NGOs and UN agencies to deliver necessary services. The three clusters involved with SRH responses are Health, and Nutrition and WASH, both led by the Ministry of Health, and Safety and Protection, led by the Ministry of Women. IPPF and the United Nations Population Fund (UNFPA) were among some of the organisations who responded to Tropical Cyclones Harold and Yasa, within the cluster system. Both IPPF and UNFPA work globally in the area of SRH and have Pacific sub-regional offices in Fiji (IPPF, 2021b; UNFPA, 2021b). IPPF works with and through local Member Associations, who are nationally registered organisations (IPPF, 2021a). UNFPA works with local implementing partners for some of their work and also directly implements programs and responses in certain situations (UNFPA, 2021a). IPPF and UNFPA helped facilitate the research presented in this thesis, enabling me to connect with the communities in which they had delivered responses following Tropical Cyclones Harold and Yasa. IPPF's Member Association in Fiji, the Reproductive and Family Health Association (RFHAF) of Fiji was a key partner in conducting the research. Established in 1996 RFHAF works in collaboration with community, NGO, private sector and government organisations to deliver SRH services including sexual health and well-being, contraception, abortion care, sexually transmitted infections (STIs), HIV, obstetrics, fertility and sexual and gender-based violence. Supported by IPPF, RFHAF led the SRH responses in Kadavu and Koro following the cyclones in 2020.

Fieldwork sites

Kadavu

Kadavu Island, located south of Fiji's main island Viti Levu, is part of the Eastern Division of Fiji and covers 408 km² with a population of almost 11,000 (Fiji Bureau of Statistics, 2017). The island is

characterised by rugged volcanic terrain, with steep hills and limited flat areas along the coast, which presents challenges for infrastructure development. Transportation within Kadavu relies heavily on small boats, as there is only a limited road network, and access to the island from Suva is primarily via ferry or a short flight to Vunisea, the administrative hub of Kadavu (Connell & Waddell, 2006). Economically, Kadavu is largely dependent on subsistence agriculture and the production of kava (yaqona), which serves as the primary cash crop for local communities however the peripheral location of the island limits market access (Sofer, 2015). There are minimal opportunities for wage employment beyond government positions and some tourism-related roles. Culturally, Kadavu is predominantly iTaukei and maintains traditional social structures with villages organised along familial and communal lines. However, the out-migration of working-age individuals has shaped the demographic landscape, leading to higher dependency ratios compared to other parts of Fiji. The island remains reliant on informal support systems, remittances, and government assistance, reflecting the broader development challenges typical of Fiji's outer islands (Connell & Waddell, 2006; Sofer, 2018).

I conducted fieldwork in four villages, all located on Ono island, a small island off the eastern end of Kadavu with a little over 800 inhabitants. Each of the villages had been impacted by Tropical Cyclone Harold. Following an overnight ferry from Suva to Kavala we travelled to Ono island on a small motorised boat. Ono island has no road network so travel to other villages was all by motorised boat and was limited by weather and the tide.

Travelling between villages on Ono Island

Koro

Koro Island, part of Fiji's Lomaiviti Archipelago, spans approximately 104 square kilometres and is home to around 4,500 residents spread across 14 coastal villages. The island's interior consists of a central plateau that rises over 300 meters above sea level, with the highest point reaching 514 meters. Koro Island is known for its volcanic origins and fertile soil. The island's geography supports a mix of vegetation, including forests along the shorelines, and coconut plantations on coral sand flats near the coast. Additionally, parts of the island are cultivated with subsistence crops such as yams, taro, and breadfruit, giving Koro relative food security (World Atlas, 2023).

Economically, Koro Island is heavily reliant on agriculture and forestry. Key cash crops include kava root and copra (dried coconut) which are both integral to the island's economy. While the island has significant agricultural potential as a result of its fertile soil, well-watered land, and suitable climate, the development of agricultural resources is limited by challenges such as inadequate internal roads and inconsistent external shipping links (Brown, 2009).

Culturally, the island remains predominantly iTaukei, with most land under Fijian ownership. In recent years, the development of resorts and the sale of freehold residential subdivisions have attracted international buyers from Australia, New Zealand, the USA, and Europe (Brown, 2009). Despite these developments, the island's residents continue to maintain strong ties to traditional subsistence practices, reflecting the importance of local resources and networks in everyday life.

I travelled to Koro by plane, after a number of scheduled ferries were cancelled. The limited ferry service, precipitated by the increase in oil prices following the COVID-19 pandemic is a significant stress for inhabitants of Koro who depend on the service for food, fuel, and cash, amongst other things. I conducted interviews and focus groups in four villages along the east cost of Koro, travelling by car to each. Koro was severely impacted by Tropical Cyclone Winston in 2016, a category 5 cyclone that caused the loss of life, infrastructure and livelihoods. Many participants in my research referenced this time as one of great stress and suffering, with ongoing impacts to their lives. My research was focussed on people's experiences of the more recent Tropical Cyclone Yasa.

Koro airport

Vanua Levu

Vanua Levu is the second-largest island in Fiji, and spans 5,556 square kilometres. The central mountain range, with a high point of 1,032 meters divides the island into a wetter southeastern section and a drier northwestern region which supports the growth of sugarcane, one of the islands primary sources of income. Savusavu and Wainunu Bays along the southern coast are home to many upmarket resorts, making tourism another important part of the island's economy. In addition to tourism, Vanua Levu's economy is based on agriculture, with exports including sugar, rice, citrus fruits, and copra. Labasa, located on the north coast and home to a large Indo-Fijian community, serves as the primary administrative and commercial hub and is also a key port for trade. In contrast, Savusavu, on the southeast coast, functions as the island's official seaport of entry. There are airports in both towns and additional airstrips scattered across the island, which facilitate connectivity with Suva and the rest of Fiji (Stanley, 2001).

I travelled by plane to Vanua Levu and was based in Labasa. From Labasa I travelled by car to four villages where I conducted interviews and focus group discussions. Three of these villages were located several hours drive south-west of Labasa and one on the outskirts of Savusavu, a half day's drive away, in the south. Each of these villages was impacted by Tropical Cyclone Yasa including one whose inhabitants were still living in temporary tent accommodation nineteen months after the disaster.

Temporary tent accommodation since Tropical Cyclone Yasa in Vanua Levu

Methodology overview

The research informing this thesis was designed to explore how social capital influences women's access to SRH services and information across the disaster management cycle, with a particular focus on identifying opportunities for strengthening preparedness, response, and recovery efforts. The research employed a qualitative approach to enable a rich and nuanced investigation of social capital and its impact on women's SRH in humanitarian settings. Qualitative methods are particularly effective for exploring complex social processes and concepts like social capital, which are often debated and difficult to capture quantitatively (Baum et al., 2009). This inductive approach allowed for an open exploration of how social capital operates within crisis contexts without predefining a particular framework (Whitley, 2008). Additionally, qualitative methods provided insight into the less visible, sometimes negative aspects of social capital that tend to fall outside the scope of quantitative research (Whitley, 2008).

The research is framed within a critical theory paradigm, complemented by feminist theory perspectives. Critical theory, with its roots in critiquing power structures, emphasises social justice, human emancipation, and challenging the status quo (Spencer et al., 2020). It recognises that knowledge and reality are socially constructed and shaped by power dynamics. Similarly, feminist theory centres the lived experiences of women and marginalised groups, aiming to highlight inequalities and drive change (Marshall & Rossman, 2010). As a researcher working in cross-cultural contexts, I also drew on decolonising research principles to address the power imbalances inherent in research with non-Western communities. These principles guided efforts to practice critical reflexivity, embrace other ways of knowing, and foster reciprocity and transformative praxis (Keikelame & Swartz, 2019; Thambinathan & Kinsella, 2021).

The research design took a multi-phased approach beginning with a desk-based phase to identify how social capital is integrated into disaster planning documents in Fiji, the Pacific region and internationally. The second phase involved primary data collection in the field, gathering qualitative insights through interviews and focus group discussions on the role of social capital in SRH service delivery following tropical cyclones. The final phase sought to reflect on the findings with key informants, identifying practical ways to enhance disaster planning and SRH services.

Thesis structure

This thesis is organised into nine chapters. Following this introduction chapter, the second chapter provides a systematic literature review on SRH and social capital in humanitarian settings developing a theoretical foundation for the research. The third chapter describes the research methodology and methods used to gather and analyse the data, including the relevant ethical considerations. The fourth chapter is the first of four findings chapters and documents the scoping review undertaken to explore the incorporation of social capital into policy and guidance documents related to women's SRHR services in humanitarian crises with a specific focus on Fiji and the Pacific region. The fifth and sixth chapters present the findings collected from interviews and focus group discussions in the second research phase. The seventh chapter is the final findings chapter which outlines the reflections and feedback on the Phase Two findings, elicited from several NGO, INGO and UN agency key informants. The eighth chapter brings the findings together in a discussion, situating them in the broader literature and considering their implications for policy makers and practitioners. This chapter also reflects on the methodological choices and limitations faced during the study. The final chapter concludes the thesis.

Literature Review

This publication provides a systematic review of the literature concerning the nexus of social capital, and women's SRHR in humanitarian settings. Despite research showing the influence of social capital on health and separately, the impact of social capital throughout the disaster management cycle, there is a notable gap in the literature where these intersect and this review sought to address this gap and provide a basis for further research. The review of qualitative literature was undertaken following the steps outlined in the preferred reporting items for systematic review and meta-analysis guidelines. The findings of this literature review showed that social capital does play an important role in women's SRHR in humanitarian settings and highlight the need to further research in this area.

This review was published in *Conflict and Health* in 2021. The published version is attached in Appendix 15.

Ireland, H., Tran, N. T., & Dawson, A. (2021). The role of social capital in women's sexual and reproductive health and rights in humanitarian settings: a systematic review of qualitative studies. In *Conflict and Health* (Vol. 15, Issue 1, pp. 1–12). BioMed Central. https://doi.org/10.1186/s13031-021-00421-1

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings: a systematic review of qualitative studies

Abstract

Background: Social capital is an important social determinant of women's sexual and reproductive health and rights. Little research has been conducted to understand the role of social capital in women's sexual and reproductive health and how this can be harnessed to improve health in humanitarian settings. We synthesised the evidence to examine the nexus of women's sexual and reproductive health and rights and social capital in humanitarian contexts.

Methods: We undertook a systematic review of qualitative studies. The Preferred Reporting Items for Systematic Review and Meta-analysis (PRISMA) guidelines were used to identify peer-reviewed, qualitative studies conducted in humanitarian settings published since 1999. We searched CINAHL, MEDLINE, ProQuest Health & Medicine, PubMed, Embase and Web of science core collection and assessed quality using the Critical Appraisal Skills Programme tool. We used a meta-ethnographic approach to synthesise and analyse the data.

Findings: Of 6749 initially identified studies, we included 19 studies, of which 18 were in conflict-related humanitarian settings and one in a natural disaster setting. The analysis revealed that the main form of social capital available to women was bonding social capital or strong links between people within groups of similar characteristics. There was limited use of bridging social capital, consisting of weaker connections between people of approximately equal status and power but with different characteristics. The primary social capital mechanisms that played a role in women's sexual and reproductive health and rights were social support, informal social control and collective action. Depending on the nature of the values, norms and traditions shared by network members, these social capital mechanisms had the potential to both facilitate and hinder positive health outcomes for women.

Conclusions: These findings demonstrate the importance of understanding social capital in planning sexual and reproductive health responses in humanitarian settings. The analysis highlights the need to investigate social capital from an individual perspective to expose the intra-network dynamics that shape women's experiences. Insights could help inform community-based preparedness and response programs aimed at improving the demand for and access to quality sexual and reproductive health services in humanitarian settings.

Background

In 2018, 136 million people needed humanitarian aid as a result of being affected by conflict, hazards, pandemics and displacement. Of these, 34 million were women of reproductive age and five million were pregnant (UNFPA, 2019). Meeting the reproductive health needs of women and girls in these complex contexts requires the provision of and demand for quality services, and the recognition that sexual and reproductive rights—frequently violated in humanitarian settings—are human rights. These include, among others, the right to make autonomous decisions about one's body, to engage in consensual sexual relations, to choose sexual partners, to choose whether to have children and if so how to space them, to have access to sexual and reproductive information, to terminate a pregnancy safely and to access sexual and reproductive healthcare free from coercion, discrimination and violence (Starrs et al., 2018). The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises, developed for responding to reproductive health needs when a crisis occurs, reflects the integrated nature of sexual and reproductive health (SRH) and provides a concrete set of objectives in the areas of coordination, targeted clinical services and planning for the transition to comprehensive SRH services (IAWG, 2018a).

Social determinants impact women's sexual and reproductive health and rights (SRHR) in a myriad of ways. A key social determinant of health and wellbeing is social capital. In the field of public health research social capital has been approached from two different perspectives. A social cohesion approach, developed first by Coleman (1988) and built on by Putnam (2000), sees social capital as the resources (e.g., trust, norms, exercise of sanctions) which are available, collectively, to members of a social group (Kawachi et al., 2008). This is in contrast to a social network approach, first conceptualised by Bourdieu (1986) and later developed by Lin (1999) where social capital is understood as the resources, or mechanisms, (e.g. social support, information channels, social credentials, social control) that inhere within an individual's social and interpersonal networks. These resources can be the property of both the individual and the collective. Szreter and Woolcock (2004) summarise this succinctly, where a social cohesion view "...regards social capital as the 'wires' (or social infrastructure) while network theorists regard it as the 'electricity' (or social resource)" (p. 654). This review takes a social network approach. The contexts of the wires and their electricity flows are also critical to any social capital analysis, especially in terms of how norms, traditions and values mediate the distribution of power (Szreter & Woolcock, 2004). Social capital is often broken down into 'bonding' and 'bridging' types that cut across both cohesion and network approaches. Bonding social capital refers to strong links within groups with similar characteristics, such as class, race and age. This type of social capital facilitates support between group members and also a level

of social influence and control. Bridging social capital describes weaker links between people in groups of more or less equal status and power but with different identities and promotes some types of support, control and collective action (Ogden et al., 2014; Szreter & Woolcock, 2004).

We conducted a systematic review to explore how social capital impacts women's SRHR in humanitarian settings. We also examined the role of social capital concerning SRHR throughout the disaster management cycle that is currently unexplored in the literature. A clear understanding of the mechanisms and pathways through which social capital plays out in these settings could inform SRH responses in crisis settings. For example, in the context of implementing the MISP, this understanding could help to both ensure it is harnessing existing networks and resources and also anticipating normative resistance and potential deficits in social capital to enable more effective service demand, delivery and access. Incorporating a social capital analysis into SRHR in crisis settings may also strengthen approaches to health system preparedness, including community-based preparedness, and the rebuilding of health systems following crises.

Broader literature agrees that social capital influences health through several mechanisms, the first being the provision of social support (Berkman & Glass, 2000). Social support refers to the functional content of relationships (House & Kahn, 1985). It can be broken down into instrumental support (help to do things), informational support (help to know things), or emotional support (help to feel things) (Harpham, 2008). The second mechanism is social influence through shared norms or informal social control, which refers to the capacity of a community, or smaller group within a community, "to regulate the behaviour of its members according to collectively desired goals" (Kawachi et al., 2008, p. 16). The third mechanism is social engagement, or the enactment of social roles and connections in real-life activities with the aim of promoting the group or network. Social capital can also influence health outcomes by enabling the collective maintenance, or changing, of social norms, facilitating groups to organise and undertake collective action, and by the flow of resources such as information and instrumental support throughout a network (Villalonga-Olives & Kawachi, 2017).

Research into social capital in women's SRHR in the last decade has also concluded that social capital is an important determinant in health outcomes, and can act through a number of pathways (Agampodi et al., 2017; McTavish & Moore, 2015; Story, 2014). Studies have shown that networks with high levels of education can increase the health related information available to women (Gage, 2007), social support can facilitate access to health services (Green & Rodgers, 2001), and higher levels of social participation can lead to increased health promoting behaviours (Kawachi et al., 2008). McTavish and Moore (2015) found that women in rural Cameroon with stronger social

networks and access to resources, such as information or financial capital, within them were more likely to use maternal health care services. They described how, for example, a woman who is a member of a network which values maternal health care is more likely to have access to assistance to access health care services through that network. Story (2014) showed that women who lived in Indian communities that had higher numbers of intergroup connections, measured through civic participation in development, religious and cultural groups, were more likely to use antenatal care, professional delivery care and have their children fully immunised. Social capital can also have a negative impact on SRHR. For example, a study in Uganda found that social capital in the form of group norms and values discouraged the use of family planning methods (Paek et al., 2008). The research conducted in this area has predominantly used quantitative methods, providing data demonstrating the influence of social capital on SRHR and mapping the associated types, mechanisms and pathways. However, there is a gap in research exploring the intersection of SRH and social capital in humanitarian settings. In this specific area there are few, if any, quantitative studies. As a result, a review of qualitative studies is pertinent as a means of providing a rich description of the known evidence in order to inform future research endeavours.

A consistent critique of the concept of social capital has been the proclivity of researchers to focus on its beneficial impacts without paying sufficient attention to its potential downsides (Villalonga-Olives & Kawachi, 2017). Portes (1998) identified four dimensions of negative social capital including: exclusion of 'outsiders' as a result of strong in-group bonding, excess demands placed on some group members to support others, restriction of personal freedoms as a result of informal social control and a downward levelling of norms where close bonding ties hold group members in place making it difficult to mobilise upwards (Kawachi et al., 2008; Portes, 1998). To understand how social capital can be beneficial and detrimental to health, researchers explored the different impacts of bonding and bridging capital in disadvantaged communities. Studies showed that although bonding capital can be an important survival mechanism in adverse contexts, it can also be a health liability (Caughy et al., 2003; Ziersch & Baum, 2004). These studies suggest that it is the presence of bridging capital, the ability of people to access resources beyond their immediate community, which can improve health and wellbeing (Kawachi et al., 2008).

In humanitarian contexts, researchers have shown how social capital manifests throughout the different phases of a disaster, from social cohesion enabling community preparedness before a disaster, to immediate support between neighbours during and immediately after a disaster, to how better-connected communities could more effectively mobilise themselves to claim resources during the recovery phase (Aida et al., 2013; Koh & Cadigan, 2008). Aida et al. (2013) considered the role of

social capital in health following a disaster and reviewed epidemiological studies showing that higher levels of individual social capital were associated with improved mental health outcomes following disasters. These findings are echoed by Noel et al.'s (2018) review, which provides evidence for the importance of social capital in post-disaster mental health recovery, though the importance of differentiating between different types and mechanisms of social capital is noted as not all have a positive impact. Despite increasing attention on the role of social capital in post-disaster mental health and humanitarian contexts, few studies investigate physical health (Aida et al., 2013), including SRH. In particular, there is a dearth of qualitative research exploring social capital and health in general but even more so in relation to SRHR in humanitarian settings (Whitley, 2008). Although there are some qualitative studies that explore elements of social capital, such as social support or social networks (for example, Aida et al., 2013; Koh & Cadigan, 2008; Noel et al., 2018), very few explicitly employ a broader social capital framework.

Methods

This meta-ethnography of qualitative evidence sought to address the review question: what role does social capital play in women's SRHR in humanitarian settings? The review followed the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) Statement (Page et al., 2021), ENTREQ recommendations for reporting (Tong et al., 2012) and is registered with PROSPERO, under the registration number CRD42021232396.

Search strategy and study selection

We conducted an initial scoping exercise to identify appropriate databases and generate a comprehensive set of search terms. Previous systematic reviews involving social capital, SRHR or humanitarian settings were also consulted to expand further and develop the search terms. Six databases were searched, including Medline, Embase, CINAHL, Psycinfo, Proquest and Web of Science. Search strategies are provided as supplementary information to this paper. Only studies conducted in Low and Lower-Middle-Income Countries (LLMIC) as per the World Bank 2019-2020 classification were included in the review (World Bank, 2020).

This review focussed on the experiences of women, friends, family, community leaders and health workers, providing both emic and etic perspectives on the subject. Outcomes of interest included anything that was facilitated or hindered by belonging to formal or informal social networks and that influenced women in relation to their SRHR. Studies were included that provided examples of any form of social capital, positive or negative, understood through a network perspective as outlined above.

The review included English-language, peer-reviewed studies published from 1999, when the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* was first published (republished in 2010 as the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*) up until the time of searching (March 2021). The manual provided a shared point of reference for the international community and consistently highlights the importance of, and need for, identifying and utilising community networks, knowledge and other social capital related resources to strengthen response programming.

Following the literature search, we combined results and removed duplicates using EndNote. We identified an additional three studies through manually searching bibliographies. After removing duplicates, we used Covidence software to screen titles and abstracts and following this, came to a consensus on studies to be included in a full-text review.

Data extraction and synthesis

All relevant data in the finding sections of the included papers was extracted for analysis into an excel spreadsheet data extraction form. This included both direct participant quotations and author descriptions that related to the outcomes of interest. We used a meta-ethnography approach, as outlined by Noblit and Hare (Noblit & Hare, 1988), to analyse the data. This method was chosen as it is frequently used for qualitative analysis in health care research and provides a systematic approach whilst still maintaining the interpretive qualities of the data. This approach is appropriate for this review, concerned with the unique experiences of women in humanitarian settings, as it allows for the non-homogeneity of contextually-based data (Dixon-Woods et al., 2005; France et al., 2019) and enables us to identify examples of social capital in studies that did not necessarily use it as a conceptual framework. As guided by Noblit and Hare's (Noblit & Hare, 1988) process, we coded and organised the extracted data from each paper into concepts according to the nature of the social process being described (Cahill et al., 2018). These concepts were clustered into several groups and given descriptive headings that were used to develop a translations table. Using this table, the findings under each heading for each paper were studied, compared to each other and summarised, producing a synthesis of primary author interpretations. From this, we drew out the main points to form 'reciprocal translations' or, third order constructs, agreement on which was reached through discussion with all authors. At this point, a social capital framework and terminology was applied to the findings to interpret and describe the relationships between the third-order constructs and to develop a conceptual model to illustrate those relationships.

Quality Assessment

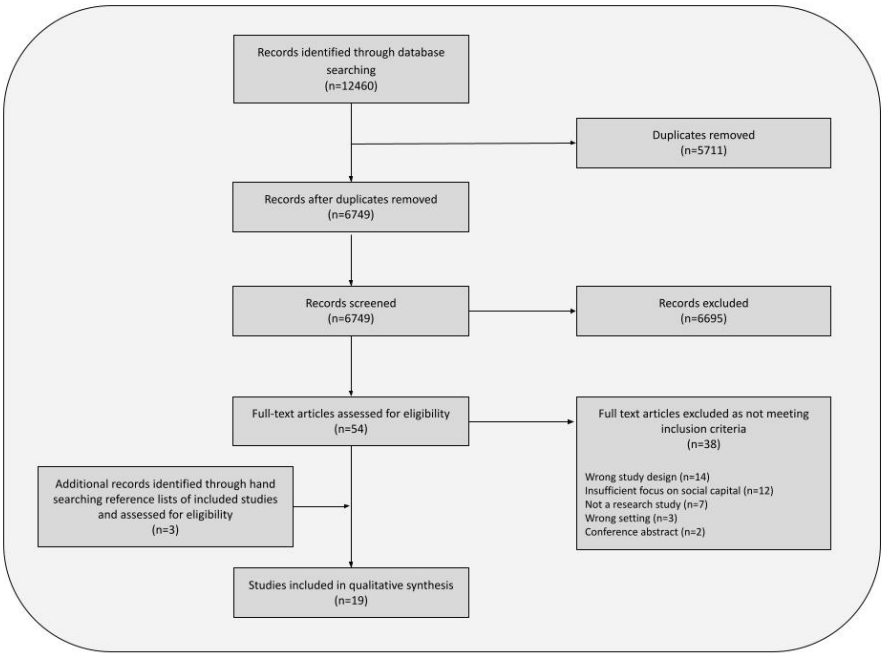
All included papers were critically appraised by two authors using the Critical Appraisal Skill's Programme (CASP) assessment tool for qualitative research (Critical Appraisal Skills Programme, 2018). All of the studies met most of the criteria outlined on the CASP checklist. However, only five clearly outlined their methodologies, identifying and describing guiding methodological frameworks and methods. The remaining 14 studies identified methods but did not explain their broader methodological approaches. No studies were excluded through this process, consensus on which was reached among all authors.

Findings

Our initial search returned 6749 studies of which 6695 were removed during title and abstract screening. Studies were removed at this stage because they were not research papers, not qualitative or did not consider any aspects of social capital. We conducted a full-text review on 54 papers, from which we identified 16 studies to be included in the analysis. An additional three studies were identified through hand searching the reference lists of included papers, assessed for eligibility and also included for analysis, bringing the total to 19. Figure 4 shows the results of the database search and study selection process.

Figure 4

PRISMA flow-chart showing database search and study selection results.



As outlined in Table 1, fourteen of the included studies were from Africa, four from Asia and one from the Middle East. The SRHR focus of the studies included intimate partner violence, sexual violence, maternal health, family planning, abortion-related care, and HIV. All the studies were conducted in conflict-related humanitarian contexts except for one study undertaken in a flooded region of Cambodia (Saulnier et al., 2020).

Table 1

Characteristics of studies included in review

Reference	Country	SRH focus	Humanitarian context	WB FCS*
Badal et al., 2018	Somaliland	Maternal health – ANC	Protracted, ongoing conflict, significant internal displacement. Research conducted in two IDP camps	X
Dossa et al., 2014	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement.	X
Elmusharaf et al., 2017	South Sudan	Family planning/abortion related care	Protracted, ongoing conflict, significant internal displacement.	X
Guruge et al., 2017	Sri Lanka	IPV	Post-conflict, recovery since end of civil war in 2009. At time of research 70,000 people were still displaced.	
Horn, 2010	Kakuma Refugee Camp, Kenya	IPV	Kakuma Refugee Camp. At time of research the camp was home to 96,000 refugees from nine countries, the majority from Sudan and Somalia.	
Horn et al., 2016	Sierra Leone and Liberia	IPV	Sierra Leone: Post-conflict recovery since end of civil war in 2002 Liberia: Post-conflict recovery since end of civil war in 2003	X
Koegler et al., 2019	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement.	X
Kohli et al., 2013	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement.	X
Kohli et al., 2015	Democratic Republic of Congo	IPV	Protracted, ongoing conflict, significant internal displacement.	X
Muzyamba, 2019	Democratic Republic of Congo	HIV	Protracted, ongoing conflict, significant internal displacement.	X
Rhine, 2009	Northern Nigeria	HIV	Ongoing communal and ethno-religious conflict	X
Saulnier et al., 2020	Cambodia	Maternal health	Acute onset flooding response	
Stark et al., 2016	Northern Uganda	Sexual violence	Post-conflict, recovery since the end of conflict in 2006 Research conducted in IDP camps	
Steven, et al., 2019	Democratic Republic of Congo	Family planning/abortion related care	Protracted, ongoing conflict, significant internal displacement.	X

Strang et al., 2020	Kurdistan, Northern Iraq	IPV	Protracted, ongoing conflict, significant internal displacement. Research conducted in an informal IDP camp and neighbouring settlement	X
Teela et al., 2009	Myanmar	Maternal health	Protracted, ongoing conflict.	X
Tol et al., 2018	Eastern Uganda	Maternal health - mental health	Post-conflict, recovery since the end of conflict in 2006	
Walstrom et al., 2013	Rwanda	HIV	Post-conflict, recovery since end of war in 1994	
Wild et al., 2010	Timor-Leste	Maternal health - birth choices	Post-conflict, recovery since gaining independence in 2002.	X

* WB FCS: The World Bank list of Fragile and Conflict Affected Situations (FCS) is produced annually and provides a classification of low- and middle-income countries that are affected by fragility and conflict. These studies appeared on the list in the year the research was conducted (The World Bank, 2021).
Abbreviations: ANC: Antenatal Care; IDP: Internally Displaced Person; IPV: Intimate Partner Violence

The analysis revealed social capital mechanisms that influenced women's sexual and reproductive health that were primarily social support, including instrumental, informational and emotional, informal social control and a few examples of collective action; each of these is described below. These mechanisms were largely driven through bonding, and some bridging social capital and led to a number of outcomes that had the potential to both facilitate and hinder women's SRHR. The nature of the outcomes was mediated by the values, norms and traditions held by network members. It should be noted that other social capital mechanisms may play a role in women's SRHR in humanitarian settings. However, these findings only represent those mechanisms that were identified in the included studies.

Instrumental social support

One of the forms of instrumental support provided by community members was in playing a counselling and mediating role for women experiencing intimate partner violence (Horn, 2010; Horn et al., 2016; Kohli et al., 2015; Strang et al., 2020). A hierarchy of response was consistently described across the studies in which women experiencing intimate partner violence would first go to family members for advice and counsel and then, if the issue was not resolved, to community leaders. A Yezidi woman outlined this process, "First I go to my daughter and try and resolve it with my husband. Then we go to the head of the household. If that doesn't work, we go to Baba Sheikh…" (Strang et al., 2020, p. 9). Beyond this, in some cases, the issue would be taken outside of the community.

"Elders will solve the problem… If he doesn't stop, the elders can take the case to the chairman, and if he can't solve it he will call security, who take the woman to Gender and Social Services" (Horn, 2010, p. 164 Somali Refugee)

Whilst these community processes for responding to intimate partner violence could be effective and protective mechanisms for women, they were often guided by male-dominated social norms and cultural traditions, which prioritised keeping the family together over the safety and wellbeing of the woman involved. This is demonstrated in the following quote where a typical response by parents or in-laws to a woman seeking help for intimate partner violence was described.

"They usually judge the case, and if you the woman are right, they usually beg you and ask you to please remain in that home. They get angry with the man and warn him strongly not to repeat. Then you go back home and continue." (Horn et al., 2016, p. 113)

Horn et al. (2016) also noted that where violence continued, women sometimes returned to their parent's household temporarily or permanently, although this was not always a possibility. The findings from these studies show how this social capital mechanism relating to community and family responses to intimate partner violence has the potential to impact women's health both positively and negatively, depending on the shared norms prevalent in the bonded networks it emerges from.

Another form of instrumental support identified in several studies was linking and referring women to formal institutions outside the immediate community. The studies reviewed included community members and leaders referring women to health services concerning induced abortion care, sexual violence, family planning and antenatal care (Saulnier et al., 2020; Stark et al., 2016; Steven et al., 2019; Tol et al., 2018).

The sharing of food and house or farm work was a common form of instrumental support described in studies investigating formal group networks such as HIV and sexual violence support groups. These groups often filled a gap for people who were isolated from their families and communities, providing essential day-to-day support.

"…When we are here we make a special kind of friendship. Suppose one of us fell sick, we go see her, we prepare food for her, try to console her and discuss what we can do to make her better. And when we go to see her in her area, no one will ask

why we come, we go there to visit as a friend, not as an HIV-positive person." (Walstrom et al., 2013, p. 10)

One of the HIV support groups filled a matchmaking gap, helping members navigate the social requirements for finding a spouse that would usually be conducted by family members.

"I enrolled [in this group] just to get a husband to marry...The chairman…found me a husband at [the hospital]…We met and although he was set to be introduced to some other girl, on seeing me he liked me" (Rhine, 2009, p. 13)

Informational social support

Informational social support crosses over somewhat with the linking and referring aspect of instrumental social support. The studies reviewed showed that women had access to sources of information regarding SRHR issues in their communities. This included information regarding illness during pregnancy (Tol et al., 2018), place of birth and strategies for labour (Saulnier et al., 2020; Wild et al., 2010), perinatal care (Badal et al., 2018; Saulnier et al., 2020), mental health, HIV (Muzyamba, 2019; Walstrom et al., 2013), abortion-related care and family planning (Steven et al., 2019). For example, Steven et al. (2019) documented how community leaders advised women who had terminated their pregnancy of the need to visit a health facility for post-abortion care, or village chiefs who promoted the value of prenatal care in a Cambodian study by Saulnier et al (2020).

However, the provision of information was not always consistent with promoting health outcomes for women. For example, some studies described how respected elders provided information regarding antenatal care suggesting it would cause complications in pregnancy and lead to needing a caesarean section (Badal et al., 2018). A study in Timor Leste showed how women drew on knowledge and tradition handed down through generations of mothers and grandmothers regarding place of birth: "Because it's like what happened a long time ago, the grandmothers had their baby at home so we will do it just like the grandmothers" (Wild et al., 2010, p. 2041).

One of the reasons women gave for choosing to give birth at home without skilled care, rather than at a health facility, was that traditional knowledge promoted birth occurring in an upright position, physically supported by family members. Health facilities did not allow more than one person to attend a woman's birth and this influenced women's and families' decisions to birth at home.

> *"I think giving birth at home is better than at the health centre because sometimes the midwife doesn't allow the husband or the parents to go in the room and there is nobody we can hold onto. In the house we have the husband and the parents to hold onto." (Wild et al., 2010, p. 2043)*

This example highlights the complexity of how social capital impacts women's SRHR. Here, the knowledge resource accessed by pregnant women encouraged the higher risk option of delivering their babies at home, without skilled care.

Emotional social support

Emotional support came primarily from close family or friend networks, and especially from mothers. This was particularly prominent in studies investigating intimate partner violence and other forms of gender-based violence (Koegler et al., 2019; Stark et al., 2016; Strang et al., 2020), in which affected women who were subject to stigma and shame from their broader communities found critical solace and safety in close relationships. A displaced Yezidi woman experiencing intimate partner violence described the nature of this social support, "When I cannot stand my miserable life then I go to speak to my mother to feel comfortable. I feel safe and free when I speak with her" (Strang et al., 2020, p. 9).

Another study in Uganda showed how women drew on emotional support from family and friends when experiencing poor maternal mental health (Tol et al., 2018) and a study conducted in Timor Leste emphasised the importance of emotional support from family and friends during labour and childbirth (Wild et al., 2010).

Studies that investigated formal group settings such as support groups for people living with HIV or affected by sexual violence found a high level of emotional support was provided through these groups (Dossa et al., 2014; Walstrom et al., 2013). Participants referred to their fellow group members as family and friends, emphasising the significant impact of this form of emotional support on their mental and physical health, such as in the following quotes: "When I'm with the other women who have also been raped, I also feel stronger." (Dossa et al., 2014, p. 251).

> *"…Before I came I was suffering from headaches – every day I was suffering from headaches – and then after meeting with counsellors and the other women, we've shared our experience and now I'm feeling better". (Walstrom et al., 2013, p. 7)*

Group participants often faced isolation from their families and friends due to stigma around issues such as HIV or being a rape survivor. This meant they could risk losing the social support they would

have had from those sources, increasing the importance of this source of social capital. The support groups researched in the studies relied on bonding ties which enabled members to connect around shared experiences. The groups also enabled bridging ties, which may have been previously lost, back into their communities (Walstrom et al., 2013). One woman recounted how the emotional support and safety accessed through participation in a support group enabled an improved sense of social functioning which led to reconnection and interaction with her broader community:

> *Nowadays after coming to the group I don't have any conflict with neighbours. I know how to handle them. I'm feeling comfortable when I talk to them and it's because of the support group" (Walstrom et al., 2013, p. 7)*

Informal social control

Informal social control was a common theme throughout many of the included studies in the areas of gender-based violence, abortion-related care, family planning and maternal health (Badal et al., 2018; Elmusharaf et al., 2017; Guruge et al., 2017; Horn, 2010; Kohli et al., 2015; Saulnier et al., 2020; Strang et al., 2020). Informal social control has typically been seen as a mechanism that bought about positive impacts to community members at large, however the majority of the examples identified in the studies had potentially adverse impacts on women's health or rights (Elmusharaf et al., 2017; Guruge et al., 2017; Horn, 2010; Kohli et al., 2015; Steven et al., 2019; Strang et al., 2020). By way of example, Elmusharaf et al. (2017) showed how deeply entrenched social norms created pressure and expectations to have large families. Women who did not, or were not, able to have large numbers of children were subject to stigma and shame, as seen in the following quote: "If a lady doesn't bring a child that means she's not good and people don't like her." (p. 5).

Stigma and shame were central in driving the process of informal social control in other contexts also, for example where women faced significant social pressure to keep unwanted pregnancies.

> *"A woman who terminates her pregnancy … she is considered a criminal, she is discriminated against, she is considered as the one who does not have friends because she is a murderer" (Steven et al., 2019, p. 5)*

Informal social control also played a role in the way communities responded to intimate partner violence, which as previously mentioned, did not always prioritise the safety and wellbeing of the women involved. The risk of possible humiliation and entailing consequences created social pressure

to remain in violent relationships (Guruge et al., 2017; Horn, 2010; Kohli et al., 2015; Strang et al., 2020).

> *"The violence is happening but I tell myself it is not worth it and I try to keep silent. He beats me but we are IDPs, it would be better to keep silent than making the problem bigger than its normal size." (Strang et al., 2020, p. 7)*

Women survivors of sexual violence in humanitarian settings also experienced discrimination and this sometimes influenced their decisions to disclose the violence and seek the support they needed (Dossa et al., 2014; Stark et al., 2016).

> *"It's a secret for us. If you approach us, we'll talk to you and you'll discover the problem we're living with. But if you don't come to us, it's not easy for us to stand up, like that, in front of a lot of people, or the assembly, and start saying, "I was raped." It's not easy." (Dossa et al., 2014, p. 250)*

Social norms around the ownership of women by their husbands and husbands' families were common throughout the studies. They helped facilitate informal social control around some SRH issues. The findings demonstrated that this could result in both positive and negative impacts on health behaviours. For example, Badal et al. (2018) described how husbands and family members could influence women to either attend or not attend antenatal care depending on their beliefs. Saulnier et al. (2020) similarly showed that women were expected to do as their husband and family chose in relation to where to deliver their babies, whether this be with or without skilled care. Regardless of the impact, however, in each of these examples women had minimal agency in their SRH-related decisions.

Collective Action

Though not as common in the reviewed studies as the two other social capital mechanisms, there were also two examples of collective action. Both examples were in the context of support groups, which used their collective voice to advocate, seeking to change norms and attitudes that had caused them harm (Horn et al., 2016; Muzyamba, 2019). An HIV-positive IDP from Congo describes this in the following quote.

> *"We now work in units to challenge the bad treatment, stigma and discrimination which we have been subjected to for a long time. We now speak as one voice." (Muzyamba, 2019, p. 3)*

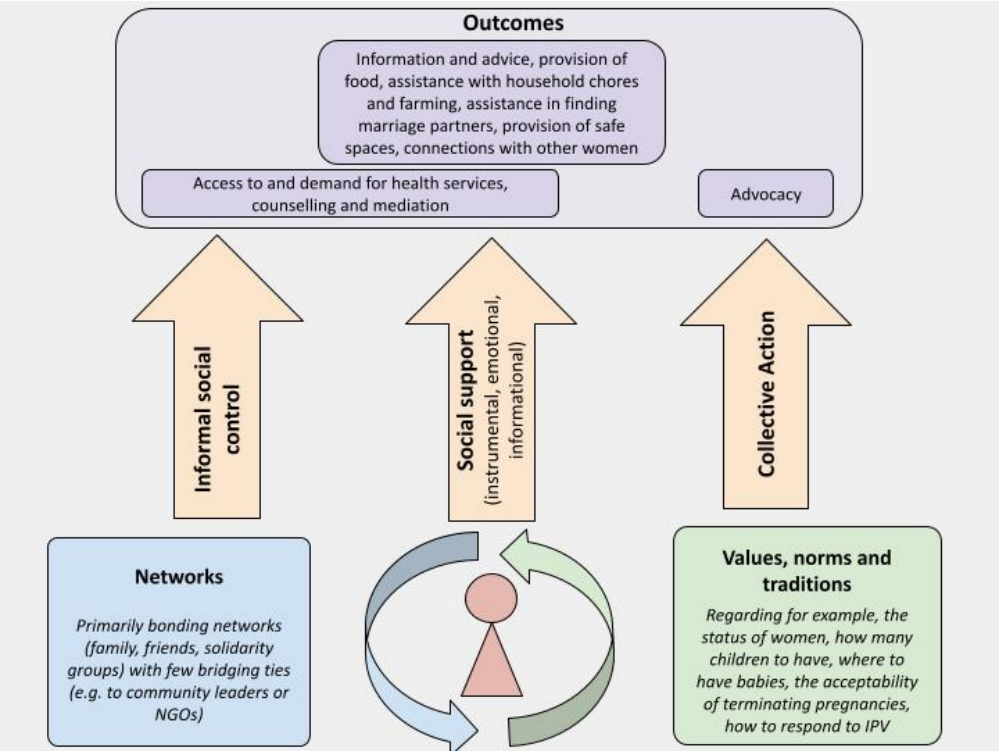
Muzyamba (2019) explained how the support groups could challenge issues such as patriarchy and sexual cleansing. Horn et al. (2016) described the power of collective action in the context of intimate partner violence. As a group, women could confront a man concerning his violent behaviour, which was often effective in bringing about change.

Discussion

This review found that women in the included studies belonged to interconnected family and community networks and in some cases, formal group networks. These networks were primarily connected with bonding ties, and some bridging ties to broader community networks. The ties were reinforced by a set of values, norms and traditions that guide how women and communities respond to women's SRHR. In the included studies, the three mechanisms through which social capital played a role in women's SRHR were social support, informal social control, and collective action, resulting in several outcomes. Figure 5 provides an overview of the types of networks, social capital pathways and outcomes identified in this review.

Figure 5

Relationships between social capital and outcomes identified in reviewed studies



These outcomes included access to and demand for health services, information and advice, provision of food, assistance with household chores and farming, safe spaces, connections with other women, counselling, mediation, assistance in finding marriage partners and advocacy. The outcomes were mediated by the prevailing values, norms and traditions, including the status of women and their decision-making power. As a result, the outcomes had the potential to have both beneficial, and in some cases, adverse impacts on women's SRHR. It should be noted that all the participants across the studies were of a similar socio-economic status so whilst this is a significant consideration in social capital analysis, its impact on outcomes was not variable.

The review findings are consistent with existing research that shows that social capital can play an important role in influencing health in humanitarian settings (Aida et al., 2013; Koh & Cadigan, 2008; Noel et al., 2018). They also echo previous research, which has explored the specific pathways through which social capital influences health throughout the different phases of the disaster management cycle (Aida et al., 2013; Koh & Cadigan, 2008; Masud-All-Kamal & Monirul Hassan, 2018). Most of the reviewed studies were conducted in the relief and recovery phases. They showed how social capital enables a bottom-up approach where community members provide instrumental, informational and emotional support for one another. The few examples of bridging capital in the findings were also consistent with broader research demonstrating its necessity in opening up "pathways to longer-term survival and wider…community recovery" (Aida et al., 2013, p. 174). Previous research has distinguished between existing social capital and new social capital, suggesting that literature to date has focussed mainly on the value of existing social capital in relation to disaster mitigation and recovery and the creation of new social capital concerning preparedness and response (Koh & Cadigan, 2008). In line with this, the review findings affirmed the importance of existing social capital in the context of the recovery phase. In contrast however, our review also highlighted the value of new social capital built through support groups during the recovery phase.

In the context of the existing literature, the review findings demonstrate the value of considering the role of social capital in women's SRHR across all phases of the disaster management cycle including an exploration of how the specific mechanisms and types may impact SRH outcomes. Applying a social capital framework to the planning and coordination of SRH programming, such as the MISP for SRH, could provide valuable guidance on how to harness the potential of existing networks and resources. This application could also help to identify where critical gaps exist and develop appropriate interventions to address them. Importantly, this should include an individual level of social capital analysis that considers the differential access to social capital *within* networks and how the social capital of some network members can limit the potential of others, as seen in the review findings. Not including this level of analysis risks implementing health interventions that are not as

effective as possible or, at worst, that reproduce forms of social capital that further constrain women's agency. This analysis should identify whose voices need to be 'in the room' when it comes to community consultation, and program implementation, developing the bridging social capital required for communities, and especially women, to build sustainable pathways to improved SRH.

In the context of the global COVID-19 pandemic the potential value of incorporating social capital into the analysis and response to crises is even more salient. Projections that warn of the serious impact that the pandemic could have on access to life-saving SRH services are now beginning to be borne out (Biddlecom et al., 2020; UNFPA, 2020). Emerging research points towards the importance of considering social capital in responding to and living with COVID-19, especially in ensuring that the most vulnerable and marginalised members of society are informed about existing services and have access to the services they need when they need them (Wong & Kohler, 2020). Social capital could play a critical role in helping to minimise the immediate impact of service demand and disruptions, social isolation, and a weakened health system on SRHR. In the longer term, it could help facilitate the recovery of local health systems that deliver equitable access to SRH services and that are built on robust connections with the communities and people they are designed to serve.

Limitations and future research

A significant limitation of this review was the lack of studies that explicitly applied a social capital approach. Only one of the 19 studies reviewed used social capital as an explanatory framework (Strang et al., 2020). When selecting studies to be included in the review we searched the studies for examples of social capital interventions, using a common definition of social capital, as outlined in the background of this paper. We addressed the potential for subjectivity through this process as far as possible by ensuring agreement from all authors regarding what constituted social capital in each paper. As most of the included studies did not set out to specifically identify or measure the role of social capital in women's SRHR in humanitarian settings, it is likely that there are some gaps in the picture this review presents. Another limitation lies in the heavy weighting of included studies towards conflict-related humanitarian settings, with only one conducted in a natural disaster context. Though both are humanitarian, there are differences in some of the issues, for example, conflict-driven sexual violence, which may be more prevalent in one than the other. The small sample of studies in natural disaster settings did not enable any themes or patterns to be identified specific to that context. There is a need for further research that explores the link between social capital and women's SRHR in humanitarian contexts, especially natural disaster settings. This review was also limited to peer-reviewed studies, and future research could benefit from exploring grey literature.

This review highlights a significant area for further research, exploring how a social capital analysis can be incorporated into SRHR crisis preparedness, response, mitigation and recovery efforts. As part of addressing this question, research is needed to identify the pathways through which social capital influences SRHR in humanitarian settings. While this review elicited some insights, further research is required to provide a more complete picture that would reveal the barriers and opportunities, relating to social capital in strengthening the demand for and quality of SRH services in humanitarian settings. Another important element of future research, which was not explicitly addressed in this review, would be investigating how crises break down social capital in relation to SRHR and how the health of women, who have lost most, or all of their social capital, is impacted.

Conclusions

Understanding how social capital influences health in humanitarian settings can offer important insights for professionals and communities in terms of service delivery, access and demand, from preparedness planning through to response and recovery. To date, little research has been conducted that focuses specifically on SRHR and future studies would be of great benefit in enhancing SRH responses in crisis settings. A more comprehensive picture of the relationships between social capital and SRHR in humanitarian contexts could enable more effective design and implementation of interventions resulting in improved SRHR for women in crisis settings worldwide.

Summary of chapter

This published systematic literature review has identified a number of findings relating to the impact of social capital on women's SRHR in crisis settings. These findings demonstrate the importance of understanding social capital in this context and highlight the need for a social lens in planning SRH responses in humanitarian settings. The review also identified the need for further research in this area and some of the specific gaps. In seeking to address these gaps, the following chapter outlines the study design and research methods used across the three phases of data collection and analysis.

Research methods

This chapter outlines my methodological approach and the methods I employed to answer the research questions. My research was qualitative in its approach and is underpinned by critical and feminist theories. The first section of this chapter explores these theoretical paradigms and describes the rationale for working within them. The second section of the chapter describes the research design, outlining data collection methods and the data analysis processes for each research phase. The final section of the chapter discusses the ethical considerations and how ethical concerns were mitigated through the research process.

Methodology and theoretical underpinnings

The research took a qualitative approach with the aim of enabling a rich and nuanced investigation. Qualitative research can be an effective tool for exploring concepts such as social capital, which are somewhat inchoate and subject to debate (Baum et al., 2009). The inductive nature of qualitative research can enable an investigation of social processes and how they impact health without pre-empting a particular conceptualisation of social capital (Whitley, 2008). Whitley (2008) has also highlighted the importance of qualitative research in investigating potential downsides of social capital, which are often found in the "fuzzy margins" rarely captured by quantitative research (p. 98).

This research is broadly situated within a critical theory paradigm and draws on feminist theory perspectives. Critical theory originated as a critique of positivism and is characterised by its commitment to seeking human emancipation and disrupting the status quo (Spencer et al., 2020). Underpinning critical theory is the belief that reality and knowledge are socially constructed and shaped by the power relations that exist in society. Subsequently, the research process aimed to privilege participants' voices and build a nuanced picture of reality. Importantly, critical theory also acknowledges the researcher's position and subjectivity in the generation of data. Sharing several foundational assumptions with critical theory, feminist theory has at its core the aim of precipitating change. Researchers operating within this paradigm situate gender at the centre of inquiry, focussing on the lived experiences of women and other marginalised groups (Marshall & Rossman, 2010).

As a white researcher conducting research with non-white communities, I also drew on decolonising research principles to inform this methodology. Decolonising research acknowledges the oppressive and exploitative impact that research has had and seeks to challenge Eurocentric research models that can undermine local knowledge and experiences (Keikelame & Swartz, 2019). Thambinathan and Kinsella (2021) propose four key decolonising practices that can be used by qualitative

researchers: (1) exercising critical reflexivity, (2) reciprocity and respect for self-determination, (3) embracing "Other(ed)" ways of knowing and (4) embodying a transformative praxis (p. 3). I took a number of steps to engage in these practices, which are further outlined throughout this methods section.

Within these ontological and epistemological contexts, and using a social capital lens, this research sought to understand the unique experiences of women and how social structures and processes impact their SRH and choices during and following humanitarian crises. The study is grounded in the disciplinary field of public health, with a particular focus on informing health policy and systems strengthening in humanitarian contexts. While it draws conceptually on social capital, critical theory feminist perspectives and decolonising research, these frameworks are used pragmatically to inform applied research questions and an effective methodology. As guided by one of the main tenets of critical and feminist theory, the aim of the research was to identify opportunities for change or strengthening in the demand for equitable access to SRH services across the disaster management cycle.

Situating myself in the research

It is a critical part of qualitative research to reflect on the role of the researcher. This includes how the researcher's experiences, values and beliefs influenced the research journey, from design to data collection, to analysis and finally meaning making (Berger, 2013; Dodgson, 2019; Dowling, 2006). In the following section, I offer a critical personal reflection that situates myself in relation to my research.

When I was in early primary school my family moved from Newcastle, an urban centre in New South Wales, Australia, to Timber Creek, a remote town in the Northern Territory. Following that we moved to Nepal, where I completed high school. These early experiences gave me a curiosity and a passion for working across cultures and an appreciation for other ways of seeing and knowing the world. Pursuing this passion, I completed a Bachelor of Development Studies which had a focus on understanding and addressing global inequality, poverty, and sustainable development, and an emphasis on the social, economic, environmental, and political factors that shape human wellbeing. This included an honours project that explored the intercultural spaces occupied by Australian Indigenous organisations and the challenges and opportunities they faced as a result. In the late 2000s, I began working in the international development sector managing health and education projects, together with local implementing partners, across South Asia and the Pacific. During this time, I undertook a Masters of Peace and Conflict Studies as I sought to understand more deeply some of the challenges facing communities I worked with in conflict-affected places like Ambon in

Indonesia and across Sri Lanka. Throughout my work and studies, I saw time and time again the disproportionate disadvantage and vulnerability faced by women and girls, especially in humanitarian settings. More importantly, however, I also saw the significant potential for transformation when women were empowered to use their agency and effect change.

These academic and professional experiences had already shaped my thinking, but it was the birth of my own children that sharpened my focus and personal connection to the realities of reproductive and maternal healthcare. My first two children, a son and daughter, were born in 2016 and 2018. These two babies were born in the Australian public health system and I felt lucky to have my antenatal care through a midwifery group practice, with a priority on continuity of care. Both babies were born in a birthing centre, with the same midwife who had provided most of my antenatal care. This firsthand experience of maternal healthcare in Australia sharpened my interest in women's reproductive health and health system strengthening in this area, precipitating the inception and development of this PhD research project. The research questions and design reflected my academic, professional and personal experiences in seeking to understand the complex social and cultural influences on women's access to sexual and reproductive health in humanitarian settings and how to harness this understanding to bring about positive change.

It is also important to consider and situate my role as a researcher during the fieldwork phase when I engaged face-to-face (albeit sometimes through a screen) with participants. The concept of being an 'insider' or an 'outsider' in relation to the research participants is a helpful way of reflecting on this part of the research journey. In very simple terms, an 'insider' is a researcher who is a member of the group to which participants belong and accordingly an 'outsider' is a researcher who does not belong to the same group as the participants (Bhopal, 2010; Milligan, 2016). My experience in this regard was not dichotomous but rather I experienced elements of both insider and outsider status with different research participant groups. I felt that my professional experience working in development NGOs sometimes gave me common ground with the group of participants comprising NGO, INGO and UN agency staff. We spoke a common language and shared some understanding of the context, and this often enabled a depth to our discussions. At the same time, however, I did not feel like a full 'insider' as my experience did not have a humanitarian focus, a whole world of its own within the broader sector. Being an outsider in this way positioned the participant as the expert, a dynamic I found helpful in interviews where I required the participant to describe and reflect on their work in detail.

My status in relation to the Fijian community members and leaders' participant group was very much as an outsider, bringing a different set of advantages and disadvantages. Although I had previously

spent time in Fiji and other Pacific countries for work related purposes it had been relatively limited and the cultural, and linguistic gap between myself and the community level participants was significant. In addressing this gap, especially in the field sites, I relied heavily on my local research assistant who was instrumental in guiding me in relation to cultural norms and expectations, more of which I describe later in this chapter. More generally, I drew on many years of living and working cross-culturally and, with the help of my research assistant and other 'local guides', sought to always engage respectfully, gently, and with an open mind.

Being a true outsider to their communities meant participants were sometimes willing to talk to me about sensitive issues that they couldn't speak with others about for fear of it becoming known in their community. The confidentiality enabled by being an outsider also emerged as an important finding in the context of building trust and delivering SRH services. My experience as a researcher gave me a small window into this. At the time of conducting field research, I was also five months, visibly, pregnant with my third baby. This gave me some common ground, the shared experience of pregnancy, with most of this group of research participants. I would not claim that this gave me 'insider' status by any stretch, but it provided an important point of connection, highly relevant to the area of research, which I often used to establish rapport, start conversations or to draw out reflections on their experiences in post-cyclone settings. More generally our shared roles as mothers was both a point of connection and a point of contrast. Questions back and forth around how many children each of us had, if they were boys or girls and how old they were provided easy ways into conversations. Beyond this however, the contrasts in our experiences of motherhood were stark, with gender norms and expectations for caring responsibilities shaping our lives in very different ways.

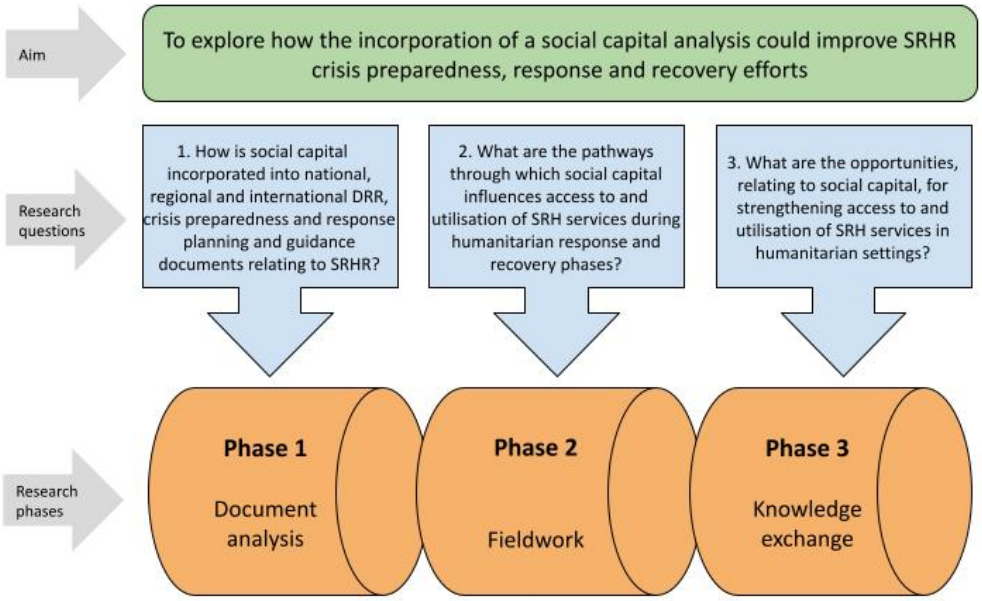
Listening to women speak about pregnancies and deliveries in challenging circumstances often made me reflect on and compare my own experiences. These personal reflections inevitably shaped my understanding of the data and the way I interpreted participants' accounts. The contrasts between my own circumstances and those of the women I interviewed made certain aspects of their narratives stand out more starkly, highlighting the structural and social determinants influencing their access to SRH services. My last baby was born a few months after returning from Fiji. He was born through the same group midwifery practice as my first two children, but I chose to have a home birth, with skilled midwives present and easy access to a hospital, if I had needed it, all provided through the public health system. The privilege I experienced to come this full circle in maternal healthcare was not lost on me. Reflections such as this inevitably shaped the lens through which I engaged with the research, influencing not only the questions I asked but also how I interpreted and made sense of the narratives shared with me.

The research design

As previously outlined, although social capital is an essential determinant of women's SRHR there is a gap in understanding how this plays out in humanitarian settings. This research set out to address this knowledge gap and identify opportunities for strengthening SRHR crisis preparedness, response and recovery efforts. Figure 6 illustrates the multi-phased approach to answer the three research questions. The first, desk-based, research phase aimed to build a foundational knowledge base and provide background and context for the following phases by identifying how social capital is integrated into relevant regional, Fijian national and international planning and guidance documents. The second phase collected primary, qualitative data from the field to explore how social capital influences access to and utilisation of SRH services during the response and recovery phases following tropical cyclones. The final phase sought to reflect on the Phase One and Phase Two findings with key informants and collaboratively identify opportunities for improving disaster planning and response concerning SRHR. This section will outline each of these phases in detail.

Figure 6

Research aim, questions and phases



Phase One - Document analysis

The first phase of research was designed to answer the following question and sub-question:

1. Is social capital a consideration in Fiji national, Pacific regional and international disaster risk reduction, crisis preparedness and response planning and guidance documents and how is this addressed in relation to SRHR?

    1.1 Where it is represented, what dimensions of social capital are the most common and which are absent?

This research phase aimed to develop a knowledge base and provide background and context for subsequent research phases by providing insights into how social capital is incorporated into planning and guidance documents. There is very little literature concerned with this specific issue. Therefore, a scoping review was chosen as it offered an appropriate method to "identify and map the breadth of evidence available" across a heterogenous set of primary policy and guidance documentation (Pollock et al., 2023). The review of these documents also facilitated the development of questions and points of inquiry for the second research phase.

Search strategy and document selection

The first step in this phase was to identify and obtain all national, regional and international disaster risk reduction, preparedness and response planning and guidance documents which included a focus on SRHR. These were found via internet searches. The search for documents was conducted on the websites of:

- Fijian and international organisations, networks and federations working in the area of SRH emergency response;
- Pacific regional organisations and networks; and,
- Fijian government ministries and offices involved in health and, or emergency response.

On each of these websites the following search terms were used to identify potential documents to be included:

(Sexual and Reproductive Health OR Sexual violence/Gender-based OR Violence/Intimate Partner Violence OR Maternal Health OR Newborn Health OR Contraception/Family Planning OR HIV) AND (Emergency OR Humanitarian OR Crisis)

The review included English-language national (pertaining to Fiji), regional (pertaining to the Pacific Region) and international disaster risk reduction, preparedness and emergency response planning

and guidance documents which also focussed on SRH. The documents that were included were all published in 2009, when the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* was first published (republished in 2010 as the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*). There was a considerable variance in the types of documents identified, and for the purposes of the review, 'planning and guidance documents' were defined as documents outlining current information, mandates, recommendations and best practice for practitioners and decision-makers involved in delivering emergency responses. This also included policies. Documents were not included if there was only a mention of SRH crisis response without any further description or information regarding implementation.

Data extraction and analysis

I undertook the data extraction using existing theory to inform the initial codes, following a directed approach to content analysis (Shannon & Hsieh, 2005). I used a set of pre-determined social capital indicators, outlined in Table 2, to code the data representing five dimensions of social capital (Kumari & Frazier, 2021). I undertook this coding process manually and extracted all relevant findings into an Excel document. I then undertook a content analysis to map the findings and provide more detailed descriptions of social capital elements, as recommended by Pollock et al. (2023). This process enabled the identification of key factors relating to the concept of social capital.

Table 2

Predetermined social capital indicators (Kumari & Frazier, 2021)

Community participation	Identification and engagement of community members, local groups, local leaders, community resources
Social organisation	Identification of capabilities of social organisations, coordination between NGO and governmental institutions
Social relations	Indication of importance of social relations (e.g. reciprocity, trust) for the exchange of information and resources, identification of how to overcome social barriers that may lead to inequality of access to resources (e.g. linguistic and cultural)
Social network	Indication of the importance of social networks for dissemination of information, identification of relationships between communities and organisations and how they can be utilised
Shared narratives and knowledge	Identification of how to incorporate existing knowledge and experiences into planning and responses, identification of ways to encourage collaborative learning

Quality Assessment

I appraised the included papers using the AACODS checklist (Authority, Accuracy, Coverage, Objectivity, Date, Significance) which was developed specifically for grey literature (Tyndall, 2010). The included documents all met the criteria outlined on the checklist. No studies were excluded through this process.

Phase Two - Qualitative Fieldwork

The second phase of research was designed to answer the following research question and sub-questions:

2. What are the pathways through which social capital influences access to and utilisation of SRH services during humanitarian response and recovery phases?
    - 2.1 What types of social capital influence women's access to and utilisation of services?
    - 2.2 How do crises change existing social capital and what impact does it have on access to and utilisation of services?
    - 2.3 How does response and recovery programming take into account and/or utilise existing social capital?
    - 2.4 Does response and recovery programming build new social capital?

The purpose of this research phase was to gain insight into how, in reality, social capital influences women's access to and utilisation of SRH services in the response and recovery phases of humanitarian settings.

Data collection was undertaken in Fiji between the 10th July and the 9th August 2022. In addition to this, a number of interviews were conducted remotely, using Zoom software, before and after this time period.

Research assistant

The need for a local research assistant was identified early in the research planning process to support translation, provide cultural guidance, facilitate entry into communities, and contribute to interpreting the data from a Fijian perspective. A local research assistant was essential, not only for logistical reasons but also to help ensure the research process was as culturally appropriate and ethically sound as possible.

My Fiji-based supervisor suggested that one of the volunteers who had previously assisted the local implementing partner during SRH emergency responses could be an appropriate candidate. Some of these volunteers had been members of emergency response teams that had travelled to the same

field sites I would be visiting and would have a strong understanding of the local contexts. My supervisor introduced me to a contact who knew the group of volunteers and who could help identify a suitable candidate. They suggested two potential research assistants, each offering distinct strengths. One was a younger university student with some experience in research and data collection, while the other was an older, retired nurse who, due to her age and professional background, was likely to be well respected in the communities.

Ideally, I would have liked to employ both candidates, as they each brought valuable but different skill sets to the research. However, resource constraints meant I could only select one. In consultation with my supervisors, I decided to engage the retired nurse, recognising that her credibility, cultural knowledge, and existing relationships within the communities would be invaluable. She accompanied me throughout all field sites, playing a crucial role in facilitating introductions and helping to build trust with participants.

As anticipated, her presence significantly eased our entry into communities, and she was instrumental in creating a comfortable and respectful environment for interviews and focus groups. She translated when necessary, provided explanations when discussions switched to iTaukei, and helped participants feel at ease during interviews. We spent a lot of time together during the fieldwork, staying together in accommodation, sitting in airports and on ferries, and waiting in villages for participants to arrive. This gave us extended time to reflect on the research process, discuss emerging themes, and exchange perspectives on the data. Her insights and lived experience greatly enriched my understanding of the findings, ultimately shaping the analysis in meaningful ways.

Study sites

I collected data in villages across three field sites including Kadavu (circled in orange on Figure 7), Vanua Levu (circled in green on Figure 7) and Koro in the Lomaiviti group (circled in blue on Figure 7). Kadavu was impacted by Tropical Cyclone Harold and Koro and Vanua Levu by Tropical Cyclone Yasa. IPPF, with its local member organisation coordinated the SRH response in Kadavu for Tropical Cyclone Harold and in Koro for Tropical Cyclone Yasa. UNFPA with its local partners coordinated the response in Vanua Levu following Tropical Cyclone Yasa. Additional interviews were also conducted in Suva with NGO and Government actors.

The three field sites were chosen in close consultation with IPPF and UNFPA. As well as needing to include villages which had experienced a cyclone and subsequent SRH emergency response, field sites needed to fulfill a number of logistical requirements. These included considerations such as the

availability of somewhere to stay, accessibility to a number of villages from one central location and regular transport to and from Suva.

Figure 7

Map of Fiji showing study locations

Note. Map taken from Bola (2017)

Participants

I aimed to recruit participants from the following groups:

- women from cyclone-affected communities

- community leaders from cyclone-affected communities

- volunteers from IPPF member association/UNFPA partner organisations involved in Tropical Cyclone Harold and/or Tropical Cyclone Yasa SRH response and recovery

- staff from IPPF member association/UNFPA partner organisations involved in Tropical Cyclone Harold and/or Tropical Cyclone Yasa SRH response and recovery

- other local NGO staff involved with SRH disaster response and recovery

- INGO and UN Agency staff involved with SRH disaster response and recovery in Fiji

- government representatives with responsibility for or involvement with SRH emergency planning and response

As far as possible, I aimed to achieve a high level of diversity amongst participants in order to maximise the scope of data elicited from interviews and focus groups. Regarding the women participants from cyclone-affected communities this needed to include consideration of age and ethnicity. Ideally, the group of participants would include a mix of ages within the eligible age bracket for the study of 16-49 years[2], and ethnicities represented in the communities. This is outlined in Table 3. The other groups consisted of participants who already held particular positions, such as a community leader, or an NGO staff member, and therefore I anticipated having less influence over diversity. However, where I played a role in selection, I aimed for diversity among all participants.

Table 3

Participant sampling matrix

		Women from communities	Community leaders	Partner organisation volunteers	Partner organisation staff	Local NGO staff	INGO and UN agency staff	Gov. reps.
Age*	*15 - 24*	33%						
	25 - 49	67%						
Ethnicity*	*(Fijian) Itaukei*	62%						
	Indo-Fijian	34%						
	Other	4%						
Relationship	*Married*	50%						
	Unmarried	50%						
Gender	*Men*		Equal representation of men and women as far as possible					
	Women							
Total number of interviews		15 - 30	3 - 6	3 - 9	3 - 9	2 - 5	2 - 5	1 - 2
Total number of FG participants		36-72						

* Percentages are calculated using national demographic distribution according to Pacific Community Statistics for Development Division data and the Fiji Bureau of Statistics (Fiji Bureau of Statistics, 2017; Pacific Community, 2025)

[2] This age bracket represents women of reproductive age, 15-49 years old (WRC & IAWG, 2019)

Recruitment

Recruitment of Group One participants

The recruitment of Group One participants, community members and leaders was undertaken through UNFPA and the IPPF member association, RFHAF, which were responsible for implementing the SRH emergency responses in each of the field sites and who I was initially introduced to by my supervisor. These organisations had existing and ongoing relationships with the study sites which provided an effective channel for communication. The first step in recruitment was obtaining the appropriate permissions from the Roko Tui (executive head of the provincial council) and the District Officer for each of the study sites. Once these permissions were obtained the Turaga ni Koros (village headmen) in each village were contacted by phone and given a brief overview of the research including the eligibility criteria and numbers of participants I was aiming to recruit. After arriving in each village my research assistant and I met with the Turaga ni Koro and participated in the traditional Sevusevu ceremony[3], where we gifted him kava roots and explained the research in more detail including the eligibility criteria of the community members and leaders we were seeking as participants. At this time we also discussed the logistics of the focus groups and interviews, specifically when and where we would conduct them. With this information the Turaga ni Koro informed community members and told them of the opportunity to participate either by visiting each household or at the weekly village meeting. The timeline for this process varied village to village. In some, more isolated, villages, we arrived in the morning and had to leave by the evening and in these situations we engaged in most of the planning over the phone before arriving.

When we met with the group of community members the research assistant explained the research in detail, in iTaukei, and distributed the participant information sheets and consent forms. They explained that there would first be a focus group discussion and that, following that, there would be several one-to-one interviews, with those who were willing to participate in this way. Women who wished to stay and participate in the focus group discussion signed the consent form and returned it to us. After the focus group discussion, the one-to-one interviews took place with the women who volunteered to participate in those. The female community leaders were recruited for interviews at the same time. Male community leaders were recruited through the Turaga ni Koro, who suggested potential leaders and contacted them to ask if they would be willing to be interviewed. When we met with them, usually just before or after the focus group discussion and interviews with female community members, the research was explained to them and they were provided with the

[3] Sevusevu, literally means 'kava that is presented' but more generally refers to the customary process for requesting entry into a home, village or community and usually involves the gifting of yaqona by the visitors to the village chief and sharing in a kava ceremony (Nabobo-Baba, 2008).

participant information sheet before giving verbal and written consent and continuing with the interview.

Recruitment of Group Two participants

Identification of participants for Group Two relied heavily on snowball sampling, where interviewees were asked to suggest other potential interviewees and so on, growing the sample size over time. The initial contacts were with UNFPA, IPPF and its Fijian member association. These primary contacts made several suggestions of potential interviewees from their own organisations, their partner organisations and other organisations, and provided me with contact details, usually an email address or phone number. I contacted each potential interviewee, provided them with information about the research and invited them to participate in an interview. During the interview, I asked for suggestions of other potential interviewees and followed those contacts up accordingly.

The government health staff were recruited while in the field sites in a similar way to the community leaders. Initial contact was made with them either through RFHAF, who often had existing contacts with them, or through the Turaga ni Koro when we first met him. We then usually visited them at the health post, providing further information about the research and inviting them to participate in an interview. If they agreed to participate, we then decided on a time and place that suited them.

Data collection

Data was collected from Group One participants using one-to-one semi-structured interviews and focus group discussions (interview and focus group discussion guides are attached as appendices). As described in the previous section, participants were informed of the research and invited to participate usually by the Turaga ni Koro. When everyone gathered, we explained the research in detail and invited the group to participate in a focus group discussion. Although I had anticipated having 6-12 participants in each focus group, they were mostly much larger than planned. While four of the ten groups had 6-12 participants the other six ranged from 13 to 24 participants presenting some challenges that will be discussed later. Focus group discussions loosely followed a set of pre-designed questions however, our approach allowed for flexibility to follow the flow of discussion as required. I ran the focus groups together with my research assistant who translated questions and discussion into iTaueki, or back to me in English as necessary throughout.

The one-to-one interviews with Group One participants were conducted following the focus group discussions and allowed for a richer investigation of individual participant's thoughts and experiences. The interviews used a pre-designed set of questions but followed a semi-structured approach enabling conversation to follow points of interest. I conducted the interviews in English

and from time to time the research assistant was required to translate a particular word or explanation from iTaukei.

Interviews with Group Two participants were conducted in person where possible and online when necessary. As with Group One, interviews were semi-structured, following a set of pre-designed questions which allowed room for following the flow of conversation and pursuing points of interest. I digitally recorded all the interviews and focus group discussions and occasionally made notes or observations on a notepad.

Analysis

I manually transcribed the interviews and focus group discussions. I tried to do this within a short timeframe after conducting the interview or focus group to ensure as much accuracy as possible. Undertaking the transcription myself, though time consuming, increased my familiarity with the data and helped me begin making observations and connections in the data, further facilitating the process of analysis as well as feeding back into the questions I was asking in ongoing interviews.

I undertook a thematic analysis of the data gathered during this phase, and in particular used the Framework Method (Pope et al., 2000). I chose the Framework Method as it was able to accommodate a mixed approach to inductively or deductively generating themes. In line with the research questions, existing social capital theory guided the development of the themes however, this approach enabled room for unexpected themes and connections to emerge. Employing the data analysis software, NVivo, to facilitate the process I used the steps outlined in the framework method (Pope et al., 2000, p. 116) as follows:

1. Familiarisation: I began this step during transcription and continued it by reading through transcripts and keeping a list of the key ideas and themes that I could see recurring across the data. These were descriptive in nature including, for example, 'physical assistance from community', 'Turaga ni Koro as information channel', 'role of Nurse ni Koro[4]', 'women needing consent from husbands for family planning', or 'trust in the village process'.
2. Identifying a thematic framework: For this step, I drew on a priori social capital issues in the broader literature to classify some of the key issues, concepts and themes, as well as drawing on the findings identified in the systematic literature review and the scoping review. For example, the concept of 'social support', and its three sub-types, as social capital mechanisms that can impact health are well documented in the literature, and were also observed in both reviews. Furthermore, I identified additional concepts emerging from the data, such as 'information as a

[4] Village nurse

resource', or 'credibility of health staff'. The outcome of this step was a detailed index of concepts, or ideas, moving towards themes.

3. Indexing: I used the index of themes that I developed in step 2 to systematically code the data. At several points during this process, I revised the index, sometimes amalgamating two concepts, or adding a new concept.
4. Charting: The NVivo software facilitated this step, in which the coded data was separated out into the emerging themes. The outcome was a list of themes, and within each theme was the supporting data, each of the references coded in the previous step. Importantly, this step also involved a level of synthesis - through this process of organising I also began to develop summaries of the perspectives and experiences of the participants for each emerging theme.
5. Mapping and interpretation: In this final step the previously identified themes were used to develop explanations for the findings by further defining the themes and concepts within them and mapping the connections between the themes. This process was guided by the research objectives as well as themes which emerged from the data. This final step was an ongoing process that I continued to circle back to as I began to write up the findings and begin interpreting them.

This process did not happen completely sequentially as outlined but was an iterative process which went back and forth between the steps as I made new connections and rethought initial observations.

I initially coded the two sets of data, Group One and Group Two participants, separately, starting with Group One. At step 4, it became clear that I could bring the two sets of data together under shared themes and from this point forward I treated the data as one set, still allowing identification of patterns within the themes which corresponded to different groups of participants.

Phase Three - Knowledge exchange

The final research phase was designed to answer the following research question:

3. What are the opportunities, relating to social capital, for strengthening demand for and quality of SRH services in humanitarian settings?

The purpose of this phase was to share the findings from Phase One and Phase Two with NGO, INGO UN agency and government stakeholders and to collaboratively identify possible opportunities for improving disaster planning and response in relation to SRHR.

I invited four to six of the Group Two participants, who were also Fijian, to a follow-up interview where I shared an overview of the findings and sought their feedback and input. I provided a brief

overview of the findings in written form before the interview and discussed them in more detail as we moved through the interview questions. The aim of these interviews was to reflect on the findings and discuss possible emerging opportunities and recommendations relating to SRH planning and response policy and practice. As in Phase Two, I used a semi structured interview approach for this phase, recording the interviews (all were conducted remotely, using Zoom software) and subsequently transcribing them. The analysis followed a similar process to Phase Two but without the inclusion of any a priori themes or frameworks.

This phase was critical in ensuring the inclusion of Fijian voices and perspectives in the analysis and development of recommendations, especially Fijian professionals who work in this area. Thambinathan and Kinsella (2021) suggest that working with 'cultural insiders' is an important way of promoting alternative, non-Eurocentric perspectives throughout the research process. Their involvement in the analysis provided a critical point of triangulation which recognises and draws on their cultural knowledge and experience.

Data management

Data was managed via an integrated data management system that ensures compliance with the Australian Code for the Responsible Conduct of Research (NHMRC, 2018). A Research Data Management Plan was developed and recorded in the UTS Stash platform.

Ethical considerations

Ethics approval was sought and granted from both the Fiji Human Health Research Ethics Review Committee (8/2022) and the UTS Health and Medical Research Committee (ETH21-6717). In addition to ethics approval from the Fiji Human Health Research Ethics Review Committee I was also required to obtain a research permit which entailed a complex process of approvals from the Ministry of Education, Heritage and Arts and The Ministry of iTaukei Affairs. This process took three months longer than anticipated and involved sharing detailed elements of research design such as interview questions and specific study locations with the various ministries.

The design and conduct of this research was, at all times, guided by the ethical principles of respect, research merit and integrity, justice and beneficence outlined in the *National Statement on Ethical Conduct in Human Research* (NHMRC, 2007). I have taken a number of steps to ensure a high level of ethical rigour throughout the research.

Respect

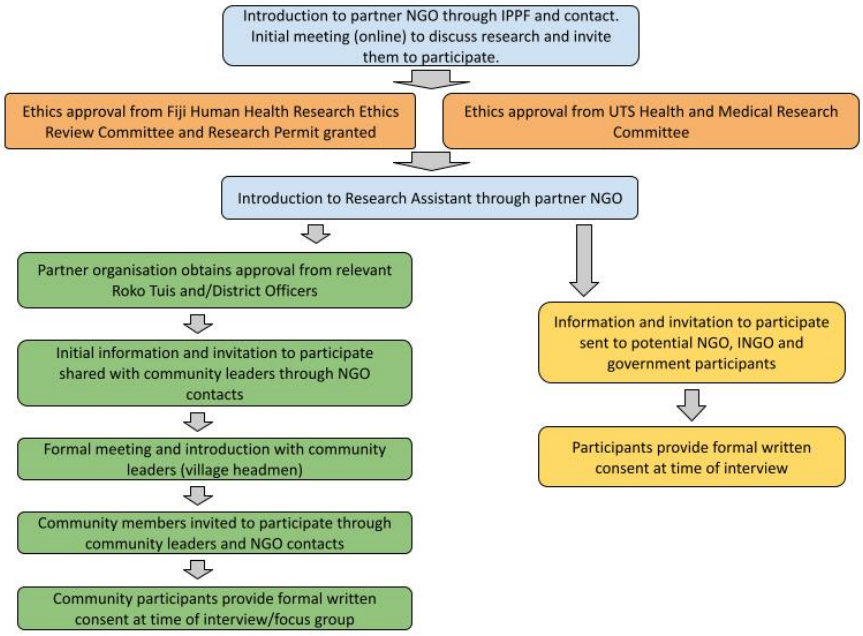
Throughout this research I sought to recognise and value participants and their contributions and to be aware and considerate of their welfare, beliefs, perceptions, customs and cultural heritage

(NHMRC, 2007). I ensured that the privacy and confidentiality of participants was maintained at all times. Focus group and interview recordings have been securely stored and are only accessible by the researcher and supervisory team. As part of the transcribing process, I de-identified all transcripts, by removing any potentially identifying information and replacing names with pseudonyms and participant codes. I respected the capacity of participants to make their own decisions throughout the process including making sure they knew they could withdraw at any time. Although the situation did not arise, participants were made aware of their agency in their decision to be involved both in the information form and also verbally, before the interviews and focus groups.

I worked closely with the local partner NGO and with my Fijian research assistant to coordinate and conduct the fieldwork. In the Pacific context valuing relationships, cultural protocols and processes is of utmost importance during research (Massey University Pacific Research and Policy Centre, 2016). The NGO staff and research assistant were critical in helping me understand and respectfully navigate the process. The NGOs identified and initiated contact with potential study sites based on their existing relationships and networks in the study locations and introduced me to community leaders. The research assistant I worked with also had an existing connection with some of the communities where research was undertaken. Figure 8 outlines the process that I followed to gain the necessary approvals, introductions, and consent.

Figure 8

Flowchart outlining the order of approvals, introductions and consent



Research merit and integrity

It is anticipated that the outcomes of this research will help strengthen SRHR crisis preparedness, response and recovery. Appropriate to this aim and the research questions, the qualitative research design draws on the experiences and perspectives of community members and staff and volunteers involved in SRH responses in the context of Tropical Cyclone Yasa and Tropical Cyclone Harold.

This research is informed by a thorough review of the literature and has been supported by a supervision team with appropriate experience, qualifications and competence. As the doctoral researcher, I led all aspects of the research in close collaboration with my supervisors who each have extensive experience in SRH research.

The research was also supported by the involvement of Fijian NGO staff and a research assistant. As well as facilitating the fieldwork and data collection, they were involved in data analysis providing an alternative perspective, informed by a Fijian worldview. In his Fijian Vanua Research Framework, Banobo-Baba (2008) identifies the responsibility of researchers to act responsibly in their selection of information which is to be reported publicly. In the context of SRH, which can be a sensitive topic, the contribution of research assistants and NGO staff who have existing relationships with the communities was important in ensuring this was achieved.

At all times throughout the research process, I aimed to maintain a high level of integrity, conducting research honestly and adhering to recognised principles of research conduct. The results of this research will be disseminated and communicated to all stakeholders. Phase Three of the research design included feedback of findings to key stakeholders. In addition to this, a summary of the findings will be communicated to community participants via partner organisations and through appropriate channels, such as social media. I also aim to disseminate the findings to a wider audience of practitioners and policymakers through the sharing of a report and academic publication.

Justice

The selection and recruitment of participants was fair and transparent, and has been clearly recorded and described in this methods chapter. Participation in the study was voluntary and prior and informed consent was obtained for each participant. Information was provided to potential participants and this clearly outlined the inclusion and exclusion criteria. In addition to sharing the physical copy, the content of consent and information forms was shared verbally, in iTaukei by the Research Assistant before all focus groups and interviews. Consent is an important element of self-determination in decolonising research and Thambinathan and Kinsella (2021) suggest that this

should be an iterative, continuous process, rather than something that is dealt with only once. Together with the research assistant we tried to convey this understanding of consent to potential participants as far as possible, providing opportunities to reflect on their ongoing participation throughout the process.

Beneficence

The potential benefits of this research were expected to outweigh the low chance of any risks to participants. One of the potential risks included feelings of discomfort or embarrassment when discussing sensitive issues. To minimise this risk participants were reassured that they did not have to answer any questions if they were not comfortable doing so, and if they needed to, they were welcome to leave the interview or focus group at any time. There was also a small risk of participants bringing up unpleasant or traumatic memories that could trigger distress. Although this did not happen, had it occurred, the participant information included contact details for appropriate services which could be accessed for support or counselling. A distress protocol was also developed to inform this process (attached as an appendix).

As previously mentioned, I employed a local research assistant to facilitate and strengthen the research process. I collaborated with them to plan the fieldwork and conduct focus groups and interviews. The research assistant was a volunteer from RFHAF who had been involved in previous emergency responses and I believe that their involvement in the project would have provided some capacity building, strengthening their research capabilities and skills which they might build on and use in the future to benefit themselves and their communities.

Conclusion

This chapter has outlined the methodological frameworks guiding the research, primarily a critical theory paradigm which also draws on feminist methodology and principles of decolonising research. Within these overarching frameworks the research design spans three phases, addressing three research questions and drawing on a number of qualitative research tools including a scoping review, interviews and focus groups. Finally, a number of ethical considerations were described including how potential ethical concerns would be mitigated and monitored throughout the research journey. The next chapter is the first of the findings chapters, a scoping review presenting the data and analysis conducted in the first phase of the research journey.

Scoping review

This scoping review forms the first of the findings chapters, presenting the data collected during the first research phase. The aim of this research phase was to explore the incorporation of social capital into policy and guidance documents related to women's SRH services in humanitarian crises with a specific focus on Fiji and the Pacific region. While research has linked social capital to broader health metrics and has explored its impact during disaster cycles, there remains a notable gap in understanding how social capital affects women's SRH in crisis settings including how policies, plans and guidelines promote and support social capital. A scoping review was chosen as the most appropriate method to fulfil the aim and it was conducted following the process outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Statement.

This review was published in *BMC Health Services Research* in 2025. The published version is attached in Appendix 16.

Ireland, H., Drysdale, R., Tran, N. T., & Dawson, A. (2025). Social capital and sexual and reproductive health and rights in Fiji: A scoping review of humanitarian preparedness and response planning and guidance documents. In *BMC Health Serv Res* (Vol. 25, 704) https://doi.org/10.1186/s12913-025-12836-0

Social capital and sexual and reproductive health and rights in Fiji: A scoping review of humanitarian preparedness and response planning and guidance documents

Abstract

Background: Social capital, the resources embedded in social networks, has been identified as a key determinant of sexual and reproductive health outcomes, yet its role in crisis contexts, particularly in shaping access to sexual and reproductive services and influencing policy and planning, remains underexplored.

Methods: We undertook a scoping review to examine the incorporation of social capital into policy and guidance documents related to women's sexual and reproductive health services in humanitarian crises, specifically focusing on Fiji and the Pacific region.

Results: The review identifies eight interconnected dimensions of social capital in two groups. The first group outlines approaches that service providers can take to harness and build social capital (community involvement, linking to existing services, and identifying community resources). The second group includes existing social capital mechanisms (trust, social norms and values, social power, social support, and the integration of traditional knowledge) that have the potential to both improve, and hinder access to information and services.

Conclusions: Findings indicate that while these dimensions are referenced in policy documents, there is often a lack of detailed implementation guidance. The findings underscore the importance of detailed guidance on leveraging existing social networks and understanding the nuanced nature of social capital and how it can impact sexual and reproductive health outcomes. Research is required to provide a deeper understanding of social capital and how such capital can be brought to bear to optimise sexual and reproductive health service preparedness and delivery in disaster recovery, particularly in Fiji and the broader Pacific region.

Background

Humanitarian crises, including conflicts and natural disasters, exert a profound impact on populations globally, with a significant portion of those affected being women of reproductive age (UNFPA, 2019). Such crises often exacerbate existing vulnerabilities, adversely affecting women and girls' access to SRH services and subsequently their health outcomes. Despite considerable improvements that have been made in the coordination and delivery of SRH services in crisis environments, highlighted by the development, implementation, and update of the MISP for SRH in crises, challenges persist in fulfilling the SRH needs of women in crises globally.

Social capital, defined here as the resources accessible through one's social and interpersonal networks (Kawachi et al., 2008), is acknowledged as a critical social determinant influencing women's SRHR (Agampodi et al., 2017; McTavish & Moore, 2015; Story, 2014). It encompasses social support systems, information channels, and the ability to exert social control, all of which play pivotal roles in health outcomes. While research has linked social capital to broader health metrics and has explored its impact during disaster cycles, particularly concerning mental health (Aida et al., 2013; Noel et al., 2018), there remains a notable gap in understanding how social capital affects women's access to SRH information and services in crisis settings including how policies, plans and guidelines take social capital into consideration. For example, do SRH emergency response policies, plans and guidelines consider the role of informal networks in disseminating health related information? Do they take into account social norms that might impact on women's decisions to access health services?

Service providers, including government agencies, NGOs and INGOs draw on a range of policies, plans and guidelines to conduct their work, including multi-laterally developed, well-recognised guidelines such as the *Sphere Handbook* (Sphere, 2018) and guidelines developed by and for specific organisations, such as the *CARE Emergency Toolkit – SRH* (CARE, 2022). These guidelines assist service providers by offering structured protocols and evidence-based practices for effectively delivering emergency SRH responses. They provide crucial frameworks that help practitioners navigate the complex challenges of delivering care in crisis situations, ensuring that the services are not only timely and efficient but also culturally sensitive and rights-based.

For the most part, these guidelines do not directly mention 'social capital' as a concept. This omission might overlook the significant role that existing social networks, community trust, and local resource mobilisation can play in the effectiveness of humanitarian interventions (Aldrich et al., 2021). Though not a new concept, current trends in the humanitarian sector are increasingly emphasising the importance of localisation in response strategies (Mulder, 2023). This shift towards localisation recognises the value of community-led responses and the need to leverage local resources and capacities (Rose & Elbaaly, 2024). Successful activation of localised responses heavily depends on the capacity of communities, which is intrinsically linked to their social capital (Mpanje et al., 2018). Hence, there is a growing need for these guidelines to incorporate social capital considerations to enhance the effectiveness of localised humanitarian efforts, ensuring that the responses are not only aligned with international best practices but are also rooted in the realities and strengths of the local communities they serve.

There is also a gap in research investigating social capital in the context of humanitarian crises in Pacific Island countries (PICs) (Nakamura & Kanemasu, 2020) which are usually precipitated by acute, rapid-onset natural disasters, and especially its influence on health outcomes (Murphy et al., 2023). PICs not only rank high on the World Risk Index for disaster proneness (Aleksandrova et al., 2021) but also grapple with significant SRHR issues, such as high unmet needs for contraception and elevated levels of sexual and gender-based violence (IPPF, 2019). This scoping review seeks to address part of the knowledge gap relating to social capital and health in Pacific humanitarian contexts and identify opportunities for strengthening SRH crisis preparedness, response and recovery efforts by investigating if and how social capital is considered in relevant planning and guidance documents. Through a review of grey literature it aims to develop a knowledge base and provide background and context for subsequent research phases by addressing the question: What dimensions of social capital are incorporated into Fijian national, Pacific regional and international Disaster Risk Reduction (DRR), preparedness and response planning and guidance documents relating to SRH? Giving an answer to this question will provide an overview of how social capital is incorporated into planning and guidance documents and will enrich the body of scientific research on this topic.

Methods

The research question guiding this scoping review emerged from an earlier systematic review which identified the need for research exploring how a social capital analysis is, and could be further, incorporated into SRHR planning, response and mitigation efforts (Ireland et al., 2021). Fiji was chosen as the national level focus for the research question as it experiences frequent natural disaster-related humanitarian crises. Additionally, Fiji serves as a regional hub in the Pacific region hosting several NGOs and INGOs who developed some of the guidelines under consideration in this review. A scoping review was chosen as it offered an appropriate method to “identify and map the breadth of evidence available” across a heterogenous set of primary policy and guidance documentation (Pollock et al., 2023). We followed the Joanna Briggs Institute approach to the conduct of scoping reviews informed by the Arksey and O’Malley framework (Arksey & O’Malley, 2005) which was further enhanced by Levac, Colquhoun and O’Brian (2010). This process is summarised in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Statement (Tricco et al., 2018). The protocol is registered with Open Science Framework https://doi.org/10.17605/OSF.IO/6PGSJ.

Search strategy and document selection

The search for documents was conducted on the websites of: (1) Fijian and international organisations, networks and federations working in the area of SRH emergency response; (2) Pacific regional organisations and networks; and (3) Fijian government ministries and offices involved in health and, or emergency response.

On each of these websites, the following search terms were used to identify potential documents to be included:

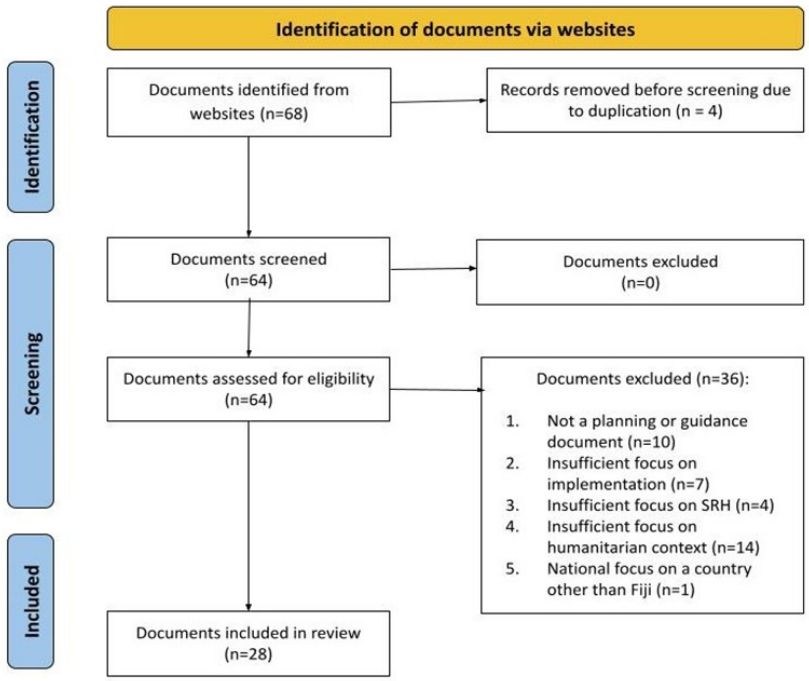
(Sexual and reproductive health OR Sexual violence/Gender-based OR Violence/Intimate Partner Violence OR Maternal Health OR Newborn Health OR Contraception/Family Planning OR HIV) AND (Emergency OR Humanitarian OR Crisis)

After an initial search, the identified websites and documents were shared amongst all authors and additional potential websites and documents were added. The review included English-language national (pertaining to Fiji), regional (Pacific Region) and international DRR, preparedness and emergency response planning and guidance documents, which also focussed on SRH. Included documents were all published since 2009, when the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* was first published (republished in 2010 as the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*). There was considerable variance in types of documents identified. For this review, 'planning and guidance documents' were defined as documents outlining current information, mandates, recommendations and best practices for practitioners and decision-makers involved in delivering emergency responses. This also included policies.

The initial search found 68 documents from 30 different organisations and institutions. Of these, four were duplicates. A preliminary review excluded a further 36 documents due to them not being a planning or guidance document; having an insufficient focus on implementation, SRH, or humanitarian settings (i.e. only including a mention of these without any further description or information); or having a particular focus on one country, other than Fiji. Figure 9 shows the results of the search and document selection process, resulting in 28 documents being included for review.

Figure 9

PRISMA flow-chart showing search and selection results



Quality assessment

Included papers were appraised using the AACODS checklist (Authority, Accuracy, Coverage, Objectivity, Date, Significance) developed specifically for grey literature (Tyndall, 2010). The included documents all met the criteria outlined on the checklist. No studies were excluded through this process.

Data extraction and analysis

We followed a directed approach to content analysis (Shannon & Hsieh, 2005), using existing theory (Kumari & Frazier, 2021) to inform the initial codes which guided data extraction. A set of pre-determined social capital indicators, outlined in Table 4, were used to code the data representing five dimensions of social capital. These dimensions were chosen as they had been effectively used in a similar study and represented aspects of social capital that have been shown to influence the impact of natural disasters on communities (Kumari & Frazier, 2021). We undertook this coding process manually and extracted all relevant findings into an Excel document. We then undertook a content analysis to map the findings and provide more detailed descriptions of the social capital elements identified, as recommended by Pollock et al. (2023) for scoping reviews that have the purpose of identifying key factors related to a concept.

Table 4

Predetermined social capital indicators (Kumari & Frazier, 2021)

Community participation	Identification and engagement of community members, local groups, local leaders, community resources
Social organisation	Identification of capabilities of social organisations, coordination between NGO and governmental institutions
Social relations	Indication of the importance of social relations (e.g. reciprocity, trust) for the exchange of information and resources, identification of how to overcome social barriers that may lead to inequality of access to resources (e.g. linguistic and cultural)
Social network	Indication of the importance of social networks for dissemination of information, identification of relationships between communities and organisations and how they can be utilised
Shared narratives and knowledge	Identification of how to incorporate existing knowledge and experiences into planning and responses, identification of ways to encourage collaborative learning

Results

Twenty-eight documents were included in the review (see Table 5). The included documents were mostly produced by INGOs and international multilateral organisations between 2000 and 2022. Although Fijian government documents were initially found, they were high-level and did not include sufficient attention on the review's focus areas. Five of the included documents considered conflict contexts, two focussed on epidemic contexts, one on refugee camp contexts, one on natural disaster contexts and the remaining majority took a generic approach, not specifying one particular type of humanitarian context. Thirteen of the documents considered SRH generically, and the remainder focussed on a particular SRH issue, including adolescent SRH, maternal health, contraception, sexual violence, LGBTIQ+ SRH and STIs. The target audiences for these documents span all levels of involvement in emergency SRH service delivery from decision makers to implementers including policymakers, advisers, program managers, donors, community stakeholders and those at the face of service provision.

Table 5

Documents included in the review

Document	Authority	Date of publication	SRH focus	Humanitarian context
Adolescent Sexual and Reproductive Health in Refugee Situations - A practical guide to launching interventions in public health programmes	UNHCR/Save the Children	2019	Adolescent SRH	Refugee
Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings	IAWG	2009, updated in 2019/2020	Adolescent SRH	General humanitarian context
Approaching Implementation of Respectful Maternity Care in Humanitarian Settings	IAWG	2022	Maternal Health	General humanitarian context
Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus - Summary of Gaps and Recommendations from a State-of-the-field Landscaping Assessment	IAWG/WRC/FP2030	2021	Contraception	General humanitarian context
Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings	UNFPA/UNICEF/UNHCR/Stop Rape Now/WHO	2012	Sexual violence	Conflict
Down By The River	Oxfam	2018	LGBTIQ+ SRH	Natural disaster
Emergency Contraception for Conflict-Affected Settings	The Reproductive Health Response in Conflict Consortium (American Refugee Committee/CARE/IRC/JSI/Marie Stopes Int/WRC/Colombia Uni)	2004	Contraception	Conflict
Facilitator's Kit - Community Preparedness for Sexual and Reproductive Health and Gender	WRC	2021	General SRH	General humanitarian context
Family Planning in Humanitarian Settings - A Strategic Planning Guide	Family Planning High Impact Practices	2020	Contraception	General humanitarian context
Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings	The Reproductive Health Response in Conflict Consortium (American Refugee Committee/CARE/IRC/JSI/Marie Stopes Int/WRC/Colombia Uni)	2004	STIs	Conflict
Integrating Sexual and Reproductive Health into Health Emergency and Disaster Risk Management	WHO	2012	General SRH	General humanitarian context

Inter-agency Field Manual on Reproductive Health in Humanitarian Settings	IAWG	2018	General SRH	General humanitarian context
LGBTIQ+ Inclusion in Humanitarian Action	IPPF	2019	LGBTIQ+ SRH	General humanitarian context
Mental health and psychosocial support for conflict-related sexual violence - principles and interventions	UNFPA/UNICEF/UNHCR/Stop Rape Now/WHO	2012	Sexual violence	Conflict
MISP for SRH in Crisis Situations - A Distance Learning Module	IAWG/WRC	2006 updated in 2019	General SRH	General humanitarian context
MISP Readiness Assessment - Assessing Readiness to Provide the MISP for SRH in Emergencies	IPPF (with UNFPA and IAWG)	2020	General SRH	General humanitarian context
Newborn Health in Humanitarian Settings - Field Guide	IAWG (Save the Children/WHO/UNICEF)	2015 updated in 2018	Maternal Health	General humanitarian context
Planning for Comprehensive Sexual and Reproductive Health (SRH) in Crisis-Affected Settings	IAWG (UNFPA/WHO/Health Cluster)	2020	General SRH	General humanitarian context
Providing Family Planning Services During an Epidemic	USAID/Johns Hopkins Center for Communication Programs/Johns Hopkins Bloomberg School of Public Health/WHO	2021	Contraception	Epidemic
Ready to Save Lives - Sexual and Reproductive Health Care in Emergencies	Family Planning 2020/IPPF/John Snow Inc/WRC/UNFPA	2020 (field test version)	General SRH	General humanitarian context
Reproductive Health during Conflict and Displacement	WHO	2000	General SRH	Conflict
Sexual and reproductive health during protracted crises and recovery	WHO/UNFPA/Andalusian School of Public Health	2011	General SRH	General humanitarian context
Sphere Handbook	Sphere	2000 revised 2018	General SRH	General humanitarian context
Thematic Brief - Gender and COVID-19 in the Pacific - Gendered impacts and recommendations for response	Pacific Women	2021	General SRH	Epidemic
Trauma-informed care for abortion providers treating sexual violence survivors in humanitarian settings	Ipas	2022	Sexual violence and abortion	General humanitarian context
Women and Girl's Safe Spaces - A toolkit for advancing women's and girls' empowerment in humanitarian settings	International Medical Corps/International Rescue Committee	2020	General SRH	General humanitarian context
Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action	Global Protection Cluster/IASC	2015	Sexual violence	General humanitarian context
CARE Emergency Toolkit - SRH	CARE	2017	General SRH	General humanitarian context

Our content analysis of the extracted data resulted in eight final categories: linkages to existing formal services and local organisations; community participation; identification of informal community resources; social support; trust; social power; social norms and values; and integration of traditional knowledge and experience. Table 6 shows these categories and their link to the original social capital indicators used to code them.

Table 6

Categories emerging from content analysis

Initial codes	Final categories	Description
Social Organisation	Linkages to existing formal services and local organisations	Identifying and connecting with local groups and services that already exist in communities (formal)
Community participation	Community participation	Identification of community stakeholders and their participation and involvement in preparedness and response efforts
	Identification of informal community resources	Identification of existing resources (e.g. people with particular roles/skills, networks, groups) in the community that can be used in preparedness and response efforts (informal)
Social Network		
Social relations	Social support	Acknowledgement of the role of social support among community members including how this may be affected in humanitarian settings and how establishing/using social support can be used to improve service delivery and access
	Trust	The role of trust in preparedness and response services and access; how existing trust can be used and new trust can be built to improve preparedness and response service delivery and access
	Social Power	Identification of social power within communities and how this can lead to inequality of access to resources
	Social norms and values	Acknowledgement of how social norms and values can impact service delivery and access
Shared narratives and knowledge	Integration of traditional knowledge and experience	Identification of how to incorporate existing knowledge and experiences into planning and responses

Community participation

The concept of 'community participation' was found throughout almost all of the documents that were analysed. This theme encompassed any references or descriptions relating to identifying community stakeholders and their participation and involvement in preparedness and response efforts.

The extent to which this was focussed on and how it was included ranged considerably throughout the documents. All the documents, apart from two more clinically focussed sets of guidelines (Ipas, 2022; WHO & CCP, 2022), included at the very least a statement affirming the importance of involving local people, and especially marginalised groups, throughout the process, such as,

> *"Meaningfully engage and include people of diverse LGBTIQ+ as leaders, participants, staff, and volunteers in all aspects of humanitarian action and disaster risk reduction actions…"* (IPPF, 2019, p. 4)

Several documents expanded on this and provided more detailed suggestions for implementing this type of participation (CARE, 2022; IASC, 2015a; IAWG, 2020b; IRC & IMC, 2020; Pacific Women, 2020b; WHO, 2000; WRC, 2021a; WRC & IAWG, 2019). Some common, practical guidelines provided were to ensure local community members, including those from marginalised groups, were appointed to working and consultation groups or trained as staff and volunteers in the operationalisation of programs (IASC, 2015a; IAWG, 2020a; Oxfam, 2018; UNHCR, 2019; WRC & IAWG, 2019). In the context of preparedness measures, another document referenced specific participatory development tools such as storytelling for collecting data and co-analysis (WRC, 2021a).

Identification of informal community resources

Across many of the documents, the identification of informal community resources was highlighted as an important part of effective planning and response activities. This category encompassed the identification of existing informal resources in communities, for example, people with particular roles or skills, networks or groups that could be used in preparedness and response efforts. Most commonly, documents made high-level statements in relation to this, such as, "identify existing community capacities to respond to crises" (WRC, 2021b, p. 19), or "interventions…should be based on assessment of capacities and needs, and build and strengthen existing resources…" (WHO, 2012c, p. 2). More specifically, several documents emphasised the importance of identifying and drawing on influential individuals, groups and community leaders (FP2020 et al., 2020; IASC, 2015a; IAWG, 2018a; UNHCR, 2019; WRC, 2021b). Some mentioned particular community members, such as Traditional Birth Attendants, who could be an important resource for linking with pregnant women in humanitarian settings (IAWG, 2018a, 2020a; WHO, 2000).

Many documents noted the importance of identifying and strengthening informal community networks (FP2020 et al., 2020; IASC, 2015a; IAWG, 2018a, 2020a; IPPF, 2019; IRC & IMC, 2020; Oxfam, 2018; Pacific Women, 2020b; Sphere, 2018; WHO, 2000; WRC & IAWG, 2019). In particular, informal networks were mentioned in relation to vulnerable groups such as youth, women and girls, people living with HIV, LGBTIQ+ and people with disabilities (FP2020 et al., 2020; IAWG, 2018a, 2020a; IPPF, 2019; Oxfam, 2018; Pacific Women, 2020b; Sphere, 2018). Several documents noted the importance of tapping into these networks, and others went further in providing guidelines on how networks could be used and, or developed to improve service access and delivery (IPPF, 2019;

Oxfam, 2018; Sphere, 2018; WRC & IAWG, 2019). Informal networks were noted as important channels for disseminating information (WRC & IAWG, 2019), for example, *the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* emphasised the importance of informal youth networks for sharing information about SRH services (IAWG, 2020a). Similarly, the *Down By the River (Oxfam)* report highlighted the importance and effectiveness of networks of friends and 'chosen family' in helping LGBTIQ+ people access information and services (Oxfam, 2018). Other documents noted the potential effectiveness of informal networks in the distribution of commodities (IPPF, 2019; Sphere, 2018). In the context of gender-based violence the *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (IASC)* noted the role of community protection mechanisms including family and kinship networks and how these can help monitor risks of gender-based violence against children and adolescents (IASC, 2015a). Where these informal networks do not already exist, some documents suggested the need for cultivating them, for example the *Women and Girls' Safe Spaces (IRC, IMC)* document outlined the need for safe spaces where women's networks can form and be channels for support, information and service delivery (IRC & IMC, 2020).

Linking to existing services and local organisations

The third category identified across the review of documents was connecting with existing formal groups and organisations and services in affected communities. Whilst this has been separated as a distinct category it has significant overlap with both categories previously outlined. By building partnerships with existing formal service providers, their resources, knowledge and expertise can be utilised to improve outcomes and maximise the impact of preparedness and response initiatives. If and to what extent this was included as an approach varied across the documents. Some did not mention it (CARE, 2022; HIPs, 2020; IASC, 2015a; IAWG, 2018b, 2020b, 2022; Ipas, 2022; RHRC, 2004a, 2004b; WHO, 2012b, 2011; WHO & CCP, 2022), and others simply acknowledged the need to coordinate with other organisations (IPPF, 2019; Sphere, 2018; WHO, 2012a, 2012c; WRC, 2021b). In addition to this, several documents listed potential formal community groups and organisations to connect with, such as youth groups, schools and churches (FP2020 et al., 2020; IAWG, 2020a; UNHCR, 2019; WRC, 2021b). Others had a more significant focus on this area and went into detail about the impact of linking with local groups, including increased ownership, sustainability, tapping into local expertise and contextual knowledge (FP2020 et al., 2020; IAWG, 2018a; IPPF, 2020; IRC & IMC, 2020; Oxfam, 2018; WRC, 2021a; WRC & IAWG, 2019). For example, the *Down By The River (Oxfam)* report emphasises that local organisations "…are most likely to understand these contextual factors. They should be at the centre of decision-making, and more funding should flow directly to them." (Oxfam, 2018, p. 30). Several documents highlighted the importance of working with

community health workers and the asset they can be during preparedness and response activities (FP2020 et al., 2020; IAWG, 2018a, 2020a). For example, the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* includes the following,

> *Given the barriers communities face in accessing health services, CHWs play a crucial role in bridging this gap, particularly for rural communities, as CHWs are often well-regarded members of their communities. CHWs can broaden access and coverage of health services in remote areas and take actions that lead to improved health outcomes, including for adolescents.* (IAWG, 2020a, p. 25)

Beyond outlining the importance of, and need for, connecting with local level services, groups and organisations, most documents did not include significant detail on the mechanics of such processes. The few that did included a reference to mapping exercises for understanding what services existed including those already providing SRH services and other potential linkages that might be used for distributing information, commodities or making referrals (IAWG, 2018a, 2020a; IPPF, 2020; WRC & IAWG, 2019). Linking via the formal cluster group was also suggested as a practical strategy (IAWG, 2018a, 2020a; IPPF, 2019).

Social Support

The findings relating to social support significantly overlap with the findings relating to informal networks because the former is provided through networks and, in turn, helps create them, resulting in a web of shared resources, knowledge, and support. For example, the importance of family, or 'chosen family' support during disasters is stressed in many of the documents (IAWG, 2018a, 2020a; IPPF, 2020; Oxfam, 2018; WHO, 2000, 2012c), as the presence of informal family and friend networks can provide emotional and practical assistance. Some documents acknowledge and emphasise the importance of maintaining and strengthening protective social support mechanisms, such as women's support groups or other community support mechanisms for survivors of domestic violence, while being cautious not to increase social stigma (IAWG, 2018a; IRC & IMC, 2020; WHO, 2012c).

Several documents noted how significant the loss of social support can be, when networks, families and communities are disrupted through humanitarian crises (CARE, 2022; IAWG, 2018a, 2020a; WHO, 2000; WRC, 2021b). For specific groups, such as adolescents or pregnant women, loss of social support can have a detrimental impact on their access to SRH services and lead to higher risks such as unsafe abortions and unsafe sexual practices (IAWG, 2018a). These documents promoted the creation of support groups to fill possible gaps that arise in humanitarian situations. For example,

the *Women and Girls Safe Spaces Toolkit (IRC, IMC)* provided detailed guidance on how to set up safe spaces so they could be a source of social support, including accessing information and resources (IRC & IMC, 2020). Similarly, the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* outlined how to facilitate forming adolescent peer groups as alternative sources of social support to help mitigate the impact of separation from their families (IAWG, 2020a).

Trust

Trust was acknowledged throughout some of the reviewed documents, primarily as a facilitator for the delivery of and access to SRH services in humanitarian settings (IAWG, 2018a, 2020a; IRC & IMC, 2020; Oxfam, 2018; UNHCR, 2019). Of note, mentions of trust were mainly limited to guidelines that included a focus on working with adolescent groups or minority groups such as LGBTIQ+ communities. These documents emphasised the need to develop trust to work effectively with these groups and the time needed to establish trust. Guidelines suggest that the trust-building process is often facilitated by leveraging existing trust relationships, such as the bonds between adolescents and their teachers, who may be regarded as trustworthy figures (UNHCR, 2019).

Several documents suggested the involvement of peers for specific groups as an effective strategy, primarily because of the pre-existing trust they have within their peer groups (IAWG, 2020a; UNHCR, 2019; WHO, 2000; WRC & IAWG, 2019). Their role can be pivotal in disseminating information and services, capitalising on the trust already established. Furthermore, documents noted the role of community gatekeepers and other trusted community members, who can hinder or facilitate other community members' access to SRH services, especially for adolescents and minority groups (IAWG, 2018a, 2020a; WHO, 2000; WRC, 2021b). Earning their trust is imperative, as they serve as influential decision-makers. Following this, guidelines highlighted the importance of a robust referral system, understood by those trusted community members, to ensure that those who confide in them are appropriately supported and guided to relevant services (IAWG, 2018a, 2020a; IPPF, 2020; WHO, 2000). Lastly references to trust were not limited to individuals but also extended to local organisations as these entities play a vital role in delivering essential services and building community resilience (IRC & IMC, 2020; Oxfam, 2018; WRC, 2021a).

Social norms and values

Most of the documents reviewed identified, to varying extents, the impact of social norms and values on SRH and SRH service delivery in humanitarian settings. Many of the reviewed documents

acknowledged that these social dimensions, rooted in the opinions, expectations, attitudes, and beliefs of both informal and formal leaders, be they community, religious, or youth figures, play a critical role in shaping the ability of community members to seek and obtain SRH services (IASC, 2015a; IAWG, 2018a, 2020a; Sphere, 2018; UNHCR, 2019; WHO, 2000; WRC, 2021a, 2021b).

The findings focussed almost solely on the negative impacts of social and cultural norms; the ways they can restrict access to SRH services. Stigma and negative attitudes were identified as major barriers to accessing health services, especially for minority groups (IASC, 2015a; IAWG, 2018a, 2020a; IRC & IMC, 2020; WHO, 2012a, 2012c; WRC, 2021a). Accordingly, many documents outline the need for a culturally sensitive approach that not only understands and respects but also critically engages with existing norms and values, aiming to challenge and transform harmful practices and attitudes (IAWG, 2018a; Sphere, 2018; WHO, 2000, 2012a; WRC & IAWG, 2019). A few of the guidance documents proposed proactive measures for mitigating potentially harmful norms. They suggested employing strategies like values clarification and attitudes transformation activities (IAWG, 2020a) and engaging community stakeholders to foster a more supportive environment for adolescents and other minority groups in need of SRH services (IAWG, 2020a; Oxfam, 2018). There were a few documents which also noted the existence of positive norms and the importance of promoting and strengthening these (IASC, 2015a; IAWG, 2018a; WHO, 2000).

Social power

Another grouping that emerged from the reviewed documents was 'social power'. Only one of the reviewed documents directly referenced the concept in explanation of gender inequality, and defined it as "the capacity of different individuals or groups to determine who gets what, who does what, who decides what, and who sets the agenda" (IRC & IMC, 2020, p. 12). This and other documents noted that men often occupied decision-making roles in families and communities giving them a form of social power that could impact women's access to SRH services (FP2020 et al., 2020; IAWG, 2018a; IRC & IMC, 2020; WHO, 2000). Although social power was not directly referred to in other documents there were several ways it was taken into consideration. Some documents noted the importance of identifying communities within communities in order to understand social relationships across different groups, for example, different ethnic or tribal groups within a refugee community (IAWG, 2020a; IPPF, 2020; UNHCR, 2019). The significant influence of the opinions, expectations, and beliefs of families and communities on adolescents' decision-making and ability to access SRH services was highlighted, as was the significant barrier presented by stigma and negative attitudes in the community (IAWG, 2020a; UNHCR, 2019; WRC, 2021a). For example, family

expectations, together with stigma from the community often stops unmarried girls from accessing contraceptive services (WRC, 2021a).

Integration of traditional knowledge and experience

A small number of the reviewed documents identified traditional knowledge and experience as a resource available in community networks which could be integrated into planning and responses (IAWG, 2018a; WHO, 2000; WRC, 2021b). One of the documents emphasised the expertise of community members in disaster risk reduction processes, due to their lived experience, and outlined some strategies for harnessing that knowledge into planning (WRC, 2021b). Two other documents referenced drawing on traditional knowledge in relation to working with sexual violence survivors where traditional healing processes might be beneficial (IAWG, 2018a; WHO, 2000), with the important caveat that these processes did not risk leading to victim-blaming or further harm to the survivor. *Reproductive Health During Conflict and Displacement (WHO)* also noted more broadly the role of traditional methods of healing and the importance of identifying and drawing on the respected community members who hold those roles and who "…have vital knowledge of traditional coping mechanisms and systems of support" (WHO, 2000, p. 123).

Discussion

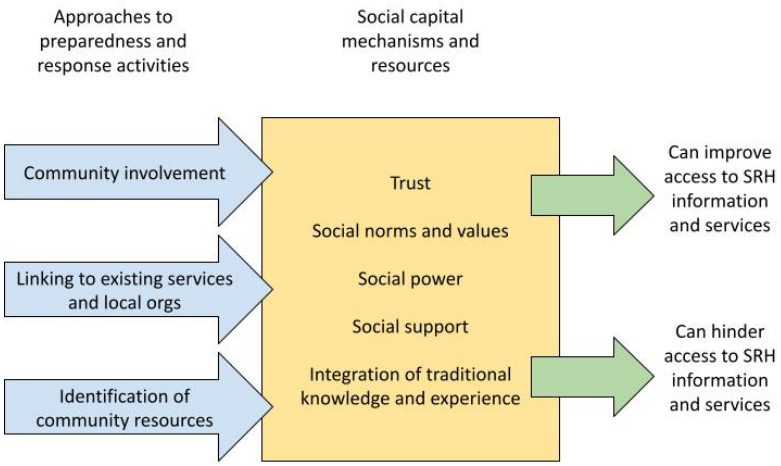
Policy and guidance documents are critical mechanisms to optimise resources and ensure the delivery of high-quality, appropriate SRH services in crisis settings. This review sought to understand if and how social capital is incorporated into such documents to support local, national and international responders in augmenting SRH care, services and information provision.

This scoping review found that social capital is indirectly incorporated into the reviewed documents to varying extents across eight, interconnected dimensions. These dimensions can be broken down into two groups as illustrated in Figure 10. Firstly, we identified three approaches (community involvement, linking to existing services and local organisations and the identification of community resources) outlined in the included documents that were suggested as ways providers can harness, and, or build social capital in preparedness and response activities to improve the delivery or SRH information and services. These approaches have been expolored in the literature in the context of the intersection between social capital and community development and, in some cases, health promotion (Chia, 2010; Laverack, 2003; Shan et al., 2014; Woolcock & Narayan, 2000). The three approaches to preparedness and response activities relate to structural forms of social capital, that is, "externally observable objective aspects of social organisation" (Agampodi et al., 2017, p. 2). These approaches were readily identified throughout most of the documents, with 'community involvement' being the most prevalent, followed by 'identification of community resources'

(especially in relation to the identification of community networks) and then 'linking to existing services'. Of note was the prevalence of high-level statements with few documents describing the steps required for effectively implementing said approaches.

Figure 10

Interconnected social capital dimensions represented in reviewed documents



The second group of social capital dimensions identified in the reviewed documents consisted of existing social capital mechanisms, or resources that can be drawn on to improve information and services or that may hinder the delivery of and access to information and services. These include trust, social norms and values, social power, social support and the integration of traditional knowledge and experience, and can be seen in the middle box of Figure 10. Primarily cognitive facets of social capital, these dimensions are mostly intangible and relate to people's perceptions rather than their actions (Kawachi et al., 2008). However, social support and traditional knowledge and experience also have some elements of structural social capital, indicating a level of overlap. A distinguishing characteristic of these social capital elements lies in their capacity to either improve or hinder access to services. Social capital is often referenced in the broader health literature in relation to its positive impacts. However, it can also negatively impact health outcomes (Villalonga-Olives & Kawachi, 2017, Portes, 1998), a nuance acknowledged by certain reviewed documents, which offer suggestions for mitigating these negative impacts.

The social capital mechanisms and resources, depicted in the middle box in Figure 10, were less commonly referenced across the reviewed documents compared to the approaches highlighted in the arrows. This suggests that the policy and guidance documentation may not consistently provide

sufficient insight into the need for understanding existing community resources and capacities. This finding echoes similar work in this area (Kumari & Frazier, 2021) and holds significance in light of the established importance of existing community resources and capacities in disaster recovery (Airriess et al., 2008; Nakagawa & Shaw, 2004) and specifically health during disaster recovery (Aida et al., 2013). In addition to providing limited guidance on the potentially beneficial impact of understanding existing social capital mechanisms and resources, there is also insufficient attention paid to the potential for some of these mechanisms to hinder access to information and services. Failing to understand and mitigate this possibility poses a risk that social capital could negatively impact post-disaster SRH outcomes (Villalonga-Olives & Kawachi, 2017).

The findings from this scoping review have identified some potential implications for policy and practice. The inclusion of social capital in the reviewed documents is largely limited to specific approaches to service delivery, such as 'community involvement'. Most commonly, though not exclusively, these approaches are simply referenced without much detailed guidance on implementation. There are many examples across the development and humanitarian sector of this type of detailed guidance. For example, though not specifically health related, the UNICEF *Minimum Quality Standards and Indicators for Community Engagement* (UNICEF, 2020) document or the Australian Council for International Development *Good Practice Toolkit* (ACFID, 2016) both provide a number of basic standards for community engagement in development and humanitarian settings and concise actions for achieving them. Many of the reviewed guidelines would benefit from including or referencing similar content, tailored to an SRH context, which could facilitate the harnessing and building of social capital, potentially leading to increased access to information and services.

Another area in which guidelines could provide more detail is in identifying and understanding formal and informal pre-existing networks which research has shown are important in aiding community recovery after disasters, including in relation to health (Noel et al., 2018, Nakagawa & Shaw, 2004, Koh & Cadigan, 2008). Guidance that included practical steps to identify and leverage existing networks could maximise the potential of this community resource for improving access to SRH information and services. A relevant example of this is the International Rescue Committee's *Social Network Analysis Handbook* which provides step-by-step guidelines to map relationships, analyse network structures and the influence of different actors (IRC, 2016). In addition, access to SRH information and services in a post-disaster setting could be optimised through a more thorough situational analysis of existing social capital in the community. Disaster recovery responses which employ an Asset Based Community Development approach, such the Adaptation for Recovery project following bushfires in East Gippsland, Victoria, Australia, go some of the way to doing this in

identifying and building on community assets such as individuals' knowledge, community groups and connections between people (Scott et al., 2018). Importantly however, a social capital analysis should include the potential for both positive and negative social capital. This kind of analysis could inform emergency responses regarding particular cultural sensitivities, ways to support minority groups and strategies to gain the trust of community gatekeepers, among other considerations.

Limitations

This scoping review's primary limitation was the documents' heterogenous nature. The reviewed policy and guidance documents represented a variety of institutional authors and had a range of different focuses and purposes. Although the scoping review aim and methodology allowed for this sort of heterogeneity, it did not facilitate direct comparison or evaluation across the documents, which might have elicited further insights. This represents a potential area for further research. An additional limitation lies in the subjective nature of social capital, a conceptual framework that has undergone multiple definitions by numerous scholars (Szreter & Woolcock, 2004). Despite employing a broad understanding of the term and addressing subjectivity by clearly articulating the initial social capital indicators, along with involving all authors in data verification, certain grey areas persist, limiting the replicability of the review.

Conclusion

In conclusion, this scoping review highlights the crucial yet nuanced role of social capital in shaping the delivery and effectiveness of SRH services in humanitarian crises, with a focus on the Pacific region. While policy and guidance documents acknowledge social capital, its incorporation often lacks depth, particularly regarding implementation strategies. The findings demonstrate the need for a more comprehensive understanding of both the positive and negative influences of social capital on women's access to SRH information and services following a crisis. Policies and practices that effectively harness community involvement, leverage local resources, and navigate complex social norms and power structures can significantly enhance SRH service accessibility and effectiveness in crisis settings. Future efforts should aim to provide more detailed guidance on utilising social capital mechanisms, recognising their potential to both facilitate and hinder SRH service delivery in disaster recovery scenarios. This approach is essential for developing resilient, culturally sensitive, and inclusive SRH interventions that address the unique challenges faced by communities in crisis.

Summary of chapter

This scoping review manuscript has identified a number of social capital dimensions that are incorporated into policy and guidance documentation relating to SRH in crisis settings but has also found a lack of detailed guidance in relation to implementation. These findings suggest the need for a deeper understanding of how social capital mechanisms support and hinder women's access to SRH information and services in crisis settings. This mapping of policies and guidance documentation has helped lay a foundation for the fieldwork phase of the research, the findings of which are presented in the next two chapters.

Community and service provider insights into social capital pathways to sexual and reproductive health service access and utilisation

Introduction

The previous chapter outlined the findings from the first research phase, a desk-based scoping review of guidance documentation used by practitioners to deliver SRH services in crisis settings. These findings, together with those in this chapter, the second phase of the research, will offer a more comprehensive understanding of the multifaceted dynamics shaping access to and utilisation of SRH services in crisis-affected communities. This chapter presents the findings of the qualitative data from Phase Two, which involved interviews and focus group discussions with community members impacted by cyclones in rural Fiji and SRH humanitarian response service providers from NGOs, INGOs, UN agencies and the government. These interviews aimed to capture the lived experiences, perspectives and challenges faced by those directly affected by cyclones in rural Fiji and by frontline responders.

The interview and focus group participants fell into two groups, Group one consisting of community members and leaders and Group two consisting of NGO, INGO, UN agency and government staff.

Group one: Community members and leaders

Most of the participants in this group were female community members who participated in interviews and focus groups. Figure 11 shows the age groups of the female community members who participated in one-to-one interviews. As the table shows, almost three-quarters of the women were aged between 25 and 44.

Focus group discussion in Vanua Levu

Figure 11

Age groups of female community members who participated in interviews

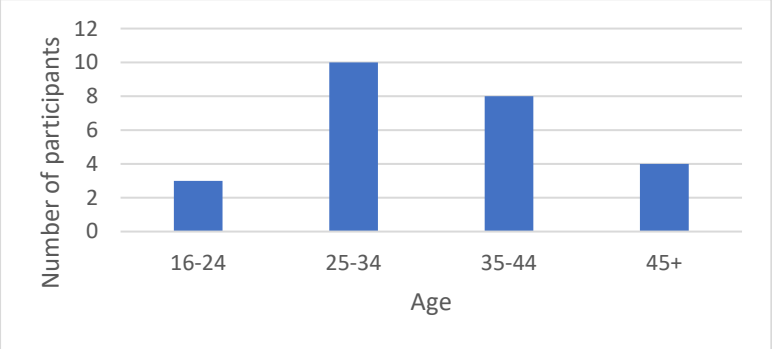
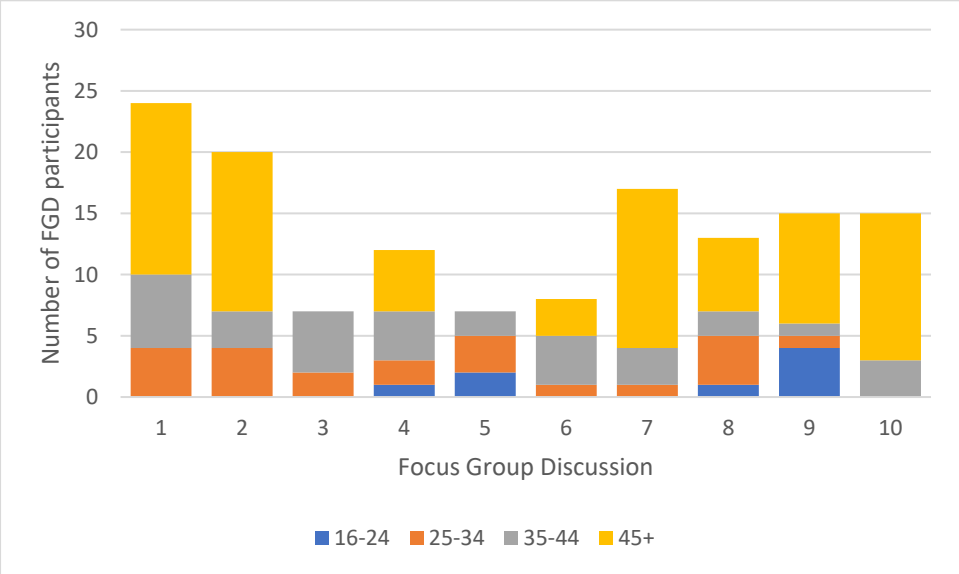


Figure 12 shows the age groups of female community members who participated in the focus group discussions. As the figure shows, there were a significant number of older women, outside of the eligible age range who participated in focus group discussions.

Figure 12

Age groups of focus group discussion participants



The second cohort of this group of participants was comprised of community leaders, who were both male and female and covered a range of leadership roles in the villages. Table 7 shows the sex and leadership roles of these participants.

Table 7

Sex and leadership role of community leader participants

Pseudonym	Sex	Role
Anaseini	F	Methodist Pastor's wife
Mere	F	Chief
Seru	F	Former TNK, current climate representative
Paulini	F	Assemblies of God Pastor's wife
Joana	F	Village health worker
Kelemedi	M	Turaga Ni Koro
Esekia	M	Chief at time of Tropical Cyclone Harold
Nikola	F	Village health worker
Epeli	M	Turaga Ni Koro
Kelani	F	Village health worker
Tomasi	M	NGO Focal Point
Aminiasi	M	Turaga Ni Koro
Katarina	F	Village health worker
Elisa	F	Women's Club Leader
Sisilia	F	Village health worker
Manasa	M	Turaga Ni Koro

All the community members and community leader participants were iTaukei.

Group two: NGO, INGO, UN agency and government staff and volunteers

This was a wide-ranging group of participants including the following:

- volunteers from IPPF member association/UNFPA partner organisations involved in Tropical Cyclone Harold and/or Tropical Cyclone Yasa SRH response and recovery;

- staff from IPPF member association/UNFPA partner organisations involved in Tropical Cyclone Harold and/or Tropical Cyclone Yasa SRH response and recovery;

- other local NGO staff involved with SRH disaster response and recovery;

- INGO staff involved with SRH disaster response and recovery in Fiji;

- government health staff who were working in study sites during the cyclones, and;

- government representatives with responsibility for or involvement with SRH emergency planning and response.

Figure 13 provides details of these participants including their sex and role.

Figure 13

Roles and sex of Group two participants

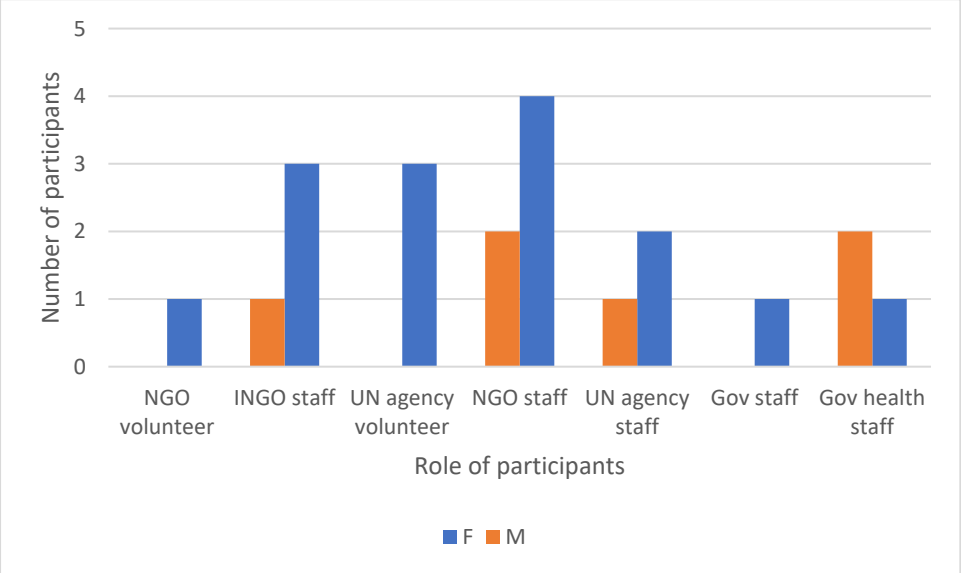


Table 8 shows the number of interviews and focus group discussions and where they were conducted. In total I conducted 62 one-to-one interviews, 41 with community members and leaders and 21 with INGO, NGO and government staff and volunteers. 16 of the interviews were in Kadavu, 14 in Vanua Levu, 17 in Koro, nine in Suva and six conducted online using Zoom software. The participants interviewed online were all based in Suva at the time of the interview except for one who was located in Denmark (previously worked in Fiji during the Tropical Cyclone Harold response). There were ten focus group discussions in total, three in Kadavu, three in Vanua Levu and four in Koro.

Table 8

Interviews and focus group discussions by field site

	Interviews		**Group 1 FGDs**
	Group 1	**Group 2**	
Kadavu	15	1	3
Vanua Levu	11	3	3
Koro	15	2	4
Suva		9	
Online		6	
Total	62		10

The findings of the interviews and focus groups are grouped into three themes that represent clear pathways through which social capital affects the access to and use of SRH services following a cyclone. These overarching themes were identified as socio-cultural norms and values, trust, and social support. Socio-cultural norms and values were shown to influence access to contraception, responses to intimate partner violence, and the broader prioritisation of women's health. Trust was highlighted as a vital element, particularly in smaller, remote communities, where the perception of privacy and confidentiality markedly impacts the accessibility of SRH services. In addition, the findings illustrated ways service providers establish trust, such as maintaining confidentiality, leveraging the recognised credibility of health personnel, sharing information strategically, and observing appropriate procedures for community engagement. Social support was found to be the third significant pathway, including firstly, instrumental support aiding in mitigating physical and logistical obstacles and facilitating the management of intimate partner violence, and secondly, informational support affecting the availability and reception of SRH service information and managing the influence of accurate and inaccurate information about contraception.

This chapter will describe the three pathways in detail, providing examples and participant quotes to illustrate and clarify their various facets. The following chapter will continue to build on these findings, presenting them through the lens of a social capital framework and providing additional layers of context.

Socio-cultural norms and values

The data showed that socio-cultural norms and values formed pathways through which social capital influenced access to and utilisation of SRH services during response and recovery phases in several different areas. These ‘pathways’ were mostly formed through the mechanism of ‘informal social control’ which is the capacity of a community, or smaller group within a community, “to regulate the behaviour of its members according to collectively desired goals” (Kawachi et al., 2008, p. 16). It can have both a positive and negative impact in terms of health. In particular, this was seen in relation to access to contraception for married women and young, unmarried women, intimate partner violence, and the underlying de-prioritisation of women’s health in crisis settings. Additionally the data showed how humanitarian response delivery teams harness social capital through traditional cultural processes to build trust and facilitate entry into communities.

"You have to get approval from your husband, and that's a barrier"

The first example illustrating the influence of socio-cultural norms and values was the way that husbands could be a barrier to women accessing contraception. Many of the women participants from communities talked about how, after cyclones, they had felt an increased desire to use contraception so as to not risk falling pregnant at a time that was challenging. In addition to this, NGOs providing SRH services reported that responses provided opportunities for women to easily access contraception. Despite these factors that did, in many cases, result in women accessing contraception, husbands were regularly noted as a barrier to access. Women community members and key informants alike referenced the need to gain approval from husbands to use contraception. However, in many cases, husbands did not want their wives to use contraception, even in post-cyclone times, as shown in the following quotes.

> *Because sometimes they have to talk with the husband, if they husband says yes, they should have this family planning, if the husband say no, no family planning. (Katarina, Community Leader)*

> *Our husbands. Mostly they don't want us to have family planning. (Focus Group Participant)*

> *You have to get approval from your husband, and that's a barrier. (Focus Group Participant)*

This view was not only expressed in relation to men living in rural villages. One participant who worked for the Ministry of Health expressed frustration relating to a recent event where a senior government official had shown public support for the idea that women should seek consent from their husbands to use contraception. The participant who shared this felt that these kinds of remarks validated and perpetuated such views at the village level.

A common reason given by participants for the need to seek consent from husbands was that men wished to have more children and were concerned about dwindling populations in their traditional iTaukei villages. Participants discussed a trend involving people moving away from their villages and to urban centres. They talked specifically about declining numbers of children in kindergartens and primary schools and very few young women staying in villages, leading to concerns relating to losing their traditional way of life, which they valued highly. Compounding this, land inheritance in iTaukei culture runs through male family members, perpetuating a need for male children to ensure the

continuation of familial land ownership. As Elisa, a community leader shared, “they think because, in Fiji, if they have boys, they will carry their name, they will own their land, that’s why”. A family with only girl children may continue having children until they have a boy who can inherit the land.

NGO service providers had also come across negative attitudes towards contraception among men during response efforts. One provider stated:

> *And we gathered at the village…before we even spoke about contraception and everything, there was this one group of men, and they were like, why are you bringing contraceptives? You can see our villages are empty. Even during normal times they say why bringing contraceptives when we want more children…the men are the ones, you know, like ‘stop giving this to our women’. And one of the villages we went to, even during normal times, it’s like, you know, you are doing this and it’s encouraging extramarital affairs, the contraception. (Sana, NGO Service Provider)*

Some participants expressed the belief that women who used contraceptives, were more likely to engage in extramarital affairs and therefore contraception should not be encouraged.

> *That is one barrier why women are not accessing contraceptives because it usually causes arguments between the couples, some women are being chased out of the house because they assume that this woman is having an affair because she accessed contraceptives. These women doesn’t want to have a family, that is why she is using contraception, to not have children. Those were the information that we got from the women. That is a barrier for them to accessing services. (Raymond, NGO Service Provider)*

Some participants described a link between the use of contraception and its perceived link to infidelity with intimate partner violence. They stated that disagreements over the use of contraception had the potential to escalate and result in physical violence. Another reason given for husbands not wanting their wives to use contraception was fear of side effects, as explained by the following NGO participant:

> *So some people think that family planning, when you do take family planning, contraceptives, you will never get pregnant again, so the myths that surround that…So I think once the men get that information some of them change their mind and they’re very*

supportive, but some of them are just stuck on no, you shouldn't be taking contraceptives. (Luca, INGO Manager)

These factors collectively fostered a normative expectation for women to have many children and subsequently discouraged the use of contraception. Despite this, a notable resistance to the norm was observed with some women using contraception without the knowledge of their husbands, as can be seen in the following quote.

Some of us, like my, was my husband, he told me he don't want me to take any family planning, but only me, I just take me to the health centre, then family planning….without him knowing… still doesn't know! (Elenoa, Community Member)

"I think it's only for married people": contraception and young people

Another socio-cultural norm that acted as a pathway through which social capital influenced women's access to SRH services during humanitarian response and recovery phases related to the deeply ingrained norm that contraception is only for people who are married. This is expressed in the following quotes:

It's a bit harder for them [young people] because they're not married. I don't know if they ask or not? They say that family planning is just for married women. (Selina, Community Member)

But young women no, they hardly do that [use contraception]. (Paulini, Community Leader)

I think it's only for married people. (Lanieta, Community Member)

This view was not just limited to community members. Some of the key informants believed that the promotion and provision of contraception to young people would encourage sexual activity, as suggested by a doctor in the following quote.

But for the school children, we don't encourage family planning, or high school students. Because, to me, it's more like you're encouraging them to be sexually active if you introduce family planning to them. For them, it's just abstinence. (Rahul, Doctor)

The views of key informants in this area seemed to vary depending on their seniority and their cultural background.

This norm becomes a barrier to young people accessing contraception when it is provided as a part of SRH humanitarian responses after cyclones because of the fear of stigma and judgement from the community. Some participants, like in the following quote, noted the potentially harmful impact of community-level health workers who may also perpetuate this norm, especially in a context where privacy and confidentiality may be compromised.

Because I think our health workers, they need a lot of advocacy and training to be able to be less judgmental or not judgmental because the communities are small and everyone knows each other. Everyone is related in some way. You come in a school uniform and you dare come and ask me for a condom I'll report you to your mother. 'You shouldn't be doing this kind of thing you should be focusing on school', so it's still quite, that's a big challenge and I think what we need to be doing more is to train our health workers to be adolescent friendly. Basically, to be able to provide services and be inclusive instead of discriminating against young people. Because the biggest barrier to, to access, is not information, but I think it is the attitude of others… (Sita, UN agency staff member)

Even when SRH responses were operationalised in villages with health staff that were not usually stationed there, the lack of privacy, together with the persistent norm that contraception is only for married people, prevented young people from accessing contraception.

…our clinics are public, everyone sees everyone that enters, and as a result of this, young people are afraid to enter because their elders are watching and there's huge issues with gossip and rumours and so they're worried about public image so they just stay away from these things. Otherwise they would be assumed to be having sex and be judged for it basically. (Hiro, NGO Service provider)

Many community people regarded the concept of a young, unmarried woman accessing contraception, even when readily available as part of a cyclone response, as unusual or inappropriate. However, it was acceptable for young men to obtain and use condoms. Quotes such as the following indicate the gendered disparity relating to this particular social norm.

> *Yes, it is definitely different for young men, you'll notice that young men will come, they'll ask questions, they'll even take condoms, it's seen as ok. When I was here, there seemed to be some social acceptance of promiscuity from men, but not from the women. (Hiro, NGO Service Provider)*

However, in contrast to these existing norms, many of the women who had young daughters suggested that they would want to make them aware of contraception as they grew older and would encourage them to use contraception when they were sexually active. This may signal a shifting norm.

> *If the time comes, they want a boyfriend, so I told her, if you have sex with your boyfriend, if you can't control yourself you have to go to the health centre, the nearby health centre and get the injection. We can't control them, they're growing up. So I told her, if you have a boyfriend and you have sex with your boyfriend, go to the doctor. (Paulini, Community Leader)*

The stated future intentions for their daughters however stood in stark contrast to the existing prevailing norms in the community relating to the acceptability of contraception for young, unmarried women.

"…it's the shame if other people know your problems"

The findings revealed a prevalent socio-cultural norm within village settings, which emphasised the importance of withholding personal problems and keeping issues to oneself. Participants described an expectation to maintain privacy in their close-knit communities where family and social ties are deeply interwoven. Participants believed that sharing problems would amplify them. A focus group member put it simply, stating that, "… it's like we Fijians, it's not part of our culture…we mind our

own business in the village" (Focus Group 5). Further to this, participants talked about the shame that could be associated with the public airing of problems.

> *Because now, it's the shame if other people know your problems. So it's better to keep it within your family…it's between you, you don't want other people to know. It's a shame for other people to know. (Focus Group Participant)*

This socio-cultural norm was particularly evident in discussions about intimate partner violence. Naomi, a community member shared that, "When my husband hurts me I just keep it to myself, I don't want to share it. It's a village". Speaking up about and reporting intimate partner violence was associated with shame as the following quotes show.

> *Normally for us Fijians we go to only share it at home. We solve it at home, we don't take it out. That's the Fijian tradition. It's so hard for us to share it with someone else, or to take it to the police station. It's hard. We just try and share it at home and solve it…. there's shame, it's making your family look, making your family shamed, so normally we just stay home, talk and solve it at home. (Teresia, Community Member)*

> *Yes [I would keep it to myself]. Because it's part of our culture. If you speak up that means we… if we speak up, if we go to the police or you go and report them that means we are not good. (Elisa, Community Leader)*

When participants were invited to talk about intimate partner violence women commonly denied the existence of any fighting or violence within homes, portraying a harmonious community, especially following cyclones, where, "everyone lives a peaceful life" (Katarina, Community Leader). However, in one-on-one interviews, for some women, this narrative shifted markedly, and they acknowledged the occurrence of intimate partner violence, exacerbated by the stresses following cyclones and sometimes relayed their own experiences.

This socio-cultural norm around keeping problems to yourself was further compounded by the 'no-drop' policy in Fiji, which mandates the prosecution of domestic violence cases once reported. This contributed to the hesitancy of women to report domestic violence, and even to tell health staff about violence-related injuries for fear of it being reported. The potential social and financial

consequences for their families, of reporting their husband and him being prosecuted were too great, as explained by an NGO key informant,

> *…if they go to the police, they will, if their husband gets arrested, they will lose their income, and then she'll be shamed in the community so that's another big barrier which is to be honest, I don't know what the answer is there… (Javier, INGO Manager)*

Another layer shaping norms around intimate partner violence was its general acceptance in some communities, put simply, "they still think violence is ok" (Sana, NGO Service Provider)[5]. Though a number of participants noted that this was a changing norm, several key informants observed its continuing influence and the way it was perpetuated by men and women alike.

> *And because of how tightly clung they are to their culture and traditions some people still accept it as normal. Like those patriarchal views where the man is the head of the house, what he says goes and any woman who doesn't listen is defying. (Hiro, NGO Service Provider)*

> *It's not brought to the police or the authorities and it's, in a way, it's actually perpetuated by women because I've heard stories where a woman will tell the daughter or another young person, 'well, my mum went through that, and I went through that, so what's the big deal, it just happens to you and you get over it. (Javier, INGO Staff member)*

This section has outlined several factors that emerged from the data. These included a culture of keeping problems to oneself, shame associated with sharing problems, a hesitancy to report due to potential family ramifications, and acceptance among some community members of intimate partner violence. Collectively, these factors form a pervasive norm that can act as a barrier to women accessing available SRH services following a cyclone.

[5] Importantly, this is not stating that Fijian culture is accepting of violence against women, rather it notes an observed perception of several participants.

"…health is usually put on the back-burner.": the de-prioritisation of women's sexual and reproductive health during crises

The general de-prioritisation of women's health appeared to underpin the findings of the focus groups and interviews. Service providers noted the challenges of getting women to attend SRH disaster preparedness and response awareness-raising sessions. These sessions were usually the first contact between the service provision team and the community members and involved sharing basic SRH information as well as an overview of the services they had come to provide.

> *I think one of the, some of the key challenges that I've experienced in the past is a prioritisation of their attending the outreach. For instance, the members associations[6], they go out there in the day, right? And after a disaster the women would be out doing other things during recovery. And so, most of the outreach has had to be done in the evenings. So it's competing priority for the affected community women. (Mei, INGO Staff member)*

Participants talked about the expectations of women to be the ones at home, cooking, caring for children and managing domestic duties. This was all prioritised ahead of their attendance at an SRH awareness-raising session.

> *Absolutely, it's really the priority within the communities where women are expected to be at home, involved in the day to day work and then once available then attend the session. (Sofia, INGO Staff member)*

> *The young people and the reproductive age group they were the last ones to come, old people would come first. The young people and the women had to prepare the food, and bathe the children. (Aisha, NGO Service Provider)*

This social norm can affect a comprehensive response when a cyclone hits. Women are focussed on the immediate needs and challenges facing their families but rarely their own needs.

[6] Refers to local and autonomous NGOs which are members of an INGO and who provide SRH service delivery with their support

… for the women when we talk about SRH, especially when disaster hits, it's something that is really, on the backhand of, in terms of them prioritising their needs, or their health needs. This is something that is really at the bottom of their list. For them the first thing is trying to get their family together, making sure they have a safe structure for their home. (Paula, NGO Service Provider)

As noted in the following quotes, not only is health a low priority in crisis times, but SRH is even lower.

…their mindset is food, shelter, safety, right now I don't have time to consider my health and that's from the people, health is usually put on the back burner because they're trying to look after their family. And reproductive health is even further back. (Hiro, NGO Service Provider)

So I like that they're making strides towards healthcare for all but certainly I'm worried about their health data outside the major centres. For the average Fijian, their SRH is…you literally need to come across someone in your village to access it. (Zara, INGO Staff member)

The previous quote also touches on an additional and important influencing factor, which is the lack of access to SRH services in remote parts of Fiji, even in stable times. This contributes to shaping the prioritisation of these services for women. Facilitating access to health services, in times of disaster and stability, is an important part of reprioritising women's health and SRH.

Overall, this was not a significant individual theme across the data, however it adds an important layer of context for understanding the socio-cultural norms and values that impact on women accessing SRH services following cyclones.

"…it will be a guaranteed way to make friends and get that opt-in": Cultural processes during service delivery

The data analysis revealed how teams delivering services harnessed social capital, specifically socio-cultural norms, to enter into communities in a way that facilitated mutual trust and respect. Throughout Fiji, in iTaueki villages there is a custom called 'sevusevu'. Sevusevu is a ceremonial presentation of kava to mark many formal occasions, including when visitors enter a village. The ceremony is a formal way of seeking permission from the Chief and Turaga ni Koro to enter a village. Participants who were part of the SRH response teams explained that,

> *…first we had to go and do our sevusevu to all the heads of the villages, all the big chiefs and the small chiefs were gathered and we had to explain what we were there for and the services we would provide. And then they would call the villagers. (Sana, NGO Service Provider)*

Some participants noted that the necessity of engaging in the sevusevu when providing an emergency response had been the subject of debate amongst NGO actors. Despite this, most participants related their positive experiences of engaging in this cultural protocol and the added value it provided. They explained the practical purpose it served, enabling the visiting team to explain to the Turaga ni Koro their reason for being there, and to provide him with the specifics of who, what and where, which he was then able to pass on to community members.

> *Interestingly, the sevusevu is a point of contention, some people feeling like a response team shouldn't have to do that, but most people I talked to found it a very practical way of facilitating that initial entry and buy in from the village heads and subsequently the rest of the village. (Zara, INGO Staff member)*

Due to the rapidly evolving context of delivering an emergency response, participants explained that sometimes they would arrive in the village and the Turaga ni Koro had heard minimal or no details of their visit. In situations like this the sevusevu was extremely important in conveying the purpose of the visit. In addition to its practical value, it built relationships by showing respect for traditional customs and planted goodwill with community leaders from the beginning.

But my hot tip is that it will be a guaranteed way to make friends and you know, get that opt-in. Sometimes we just weren't organised, and we were still welcome but it was nicer [when we engaged in sevusevu], because then we just jumped straight into men's health, because usually the women don't come, everyone else kind of hung back, hung with the women hung with the kids and we'd usually get the men started and talk about men's reproductive health and just MISP[7] related stuff and then once we had the blessing, we'd talk to the women. (Zara, INGO Staff member)

Trust

The second theme emerging from the data was trust, as one of the pathways through which social capital influences access to and utilisation of SRH services in humanitarian response and recovery phases. In particular, the data showed how the close-knit nature of small, isolated communities influences perceptions of privacy and confidentiality, affecting the willingness of individuals, especially young people and women, to access SRH services. In contrast, the findings also identified a number of ways that service providers can build trust with affected communities, including providing a high level of confidentiality, leveraging the existing credibility of health staff, sharing information, entering villages through the proper process and appropriate gatekeepers and strategically using existing social connections.

"when you go through the formal process… there's already established trust"

One of the ways trust was built by service providers was by entering villages through the appropriate gatekeepers and proper processes. The iTaukei villages have a well understood governance structure with a clear chain of command down through the tiers of government to the Turaga Ni Koro in each village. The traditional system of chiefs and clan leaders sits in parallel to this and the two interact as necessary. The community member participants trusted this structure and the key gatekeepers within it, for example the Turaga Ni Koro, to make decisions about who was entering their communities and the services being provided. Subsequently, community members already had a certain amount of respect for and trust in the services provided.

[7] Minimum Initial Service Package for SRH in Crisis Situations: a series of activities required to respond to the immediate SRH needs of affected populations at the onset of a humanitarian crisis.

That is a very good question. Usually when you go through the formal process, the Roko [provincial leader] etc. When you get to the village there's already established trust between them and the people that let you in. (Hiro, NGO Service provider)

As described in the previous section, by entering villages via the appropriate cultural processes, such as engaging in sevusevu with Turaga ni Koros and Chiefs, response teams were able to harness existing social credibility and trust to promote the services they were providing.

When they took some time to actually, culturally appropriate their presence in the sense, with a village leader, and then the village leaders kind of introduced them to the communities. 'Look we have here a resource for the next three months and women can really, freely access them'. So they work out these things with the village council and the village leaders. You know how it is, how news travels fast in the coconut wireless, so yeah, so it was not… a very difficult transition for them. (Teresa, UN agency staff member)

This included, in some villages, having the approval of faith-based organisations, such as churches.

Actually, the faith based organisations play a really critical role in the communities, so their involvement is quite important because they also sort of give the green light to communities that yes, it's important that you engage with this organisation and all of that, so for us, from the onset it pretty much has to be everybody not just the village organisation and the youth but also the faith based, or the church leaders, so that makes it quite easy for us to then move into the communities and engage everyone. (Sofia, NGO Service provider)

Although going through village gatekeepers, such as the Turaga Ni Koros, helped build trust between response teams and community members, it also presents a potential barrier as they have a certain level of control over what comes into villages, as illustrated in the following quote.

And sometimes when discussing it with village headman they say no, you can't discuss that. Like, we can't discuss abortion, which is understandable, but like relationships and family planning, access to family planning, some say no you can't, because this is a predominantly catholic village. And we say, ok, that's fine but can we tell you about all the pros and cons of family planning, ok fine. But what we do is we get into the village and then if anybody asks

we give that information, so it's really access. Once we get into the village we can work around it. But actually for the safety of our clinic nurses, we have to abide by the rules, otherwise they could be hurt. (Luca, INGO Staff member)

This level of control is magnified during and after cyclones, when lines of communication in and out of villages, and access to services are limited.

"People trust them because they present themselves as medical professionals": The credibility of health staff

One of the reasons community members trusted SRH humanitarian response teams was due to the high level of credibility and respect afforded to health professionals. Across all the study sites, when asked why they trusted the visiting response teams, community members responded with comments such as 'because they are educated' or,

Because they are midwives and they have experience and they shared it with us. So what they say, we have to follow because they have experience. (Selina, Community Member)

The staff from the NGO response teams were also aware of the respect and trust put in them as a result of their professional expertise and experience, as illustrated in the following examples.

From my experience, once they know I'm a nurse, I'm a Sister, when I come and they introduce me as that, automatically they trust you. They will come and talk at the end. We'll find a private place, and then they tell lots of things. (Aisha, NGO Service provider)

And people trust them because they present themselves as medical professionals, so she's a nurse. So they trust the reputation because she's a nurse, and because they're part of that organisation they start to trust the organisation as well. (Luca, INGO Staff member)

The latter quote highlights how trust in the individuals, as a result of their being experienced health professionals, built trust in the broader organisation delivering the response. A few participants also mentioned seniority and age as additional factors in the inherent credibility of some health staff.

> *So here you have a very seasoned senior midwife that is looked up to and respected because of her expertise and her depth of experience in a community and she is able to actually bring a community of women around her and they are also, this community of women was able to bring the Sisters around them. (Teresa, UN agency staff member)*

> *And I think some of these men, they melt under the magic of the midwives. These are old women, you know, my age or much older than me and they know how to, you know, to get around these issues in a very kind of motherly way…I think that is really important. And I think this is the, this is also because you have matured women that are dealing with these issues that have seen this all their lives. (Sita, UN agency staff member)*

This pre-existing trust was critical in enabling response teams to rapidly create safe environments where women felt comfortable discussing sensitive issues.

"…when we give them the information about SRH, that's when they open up"

Another way that response teams built trust with community members was through information sharing. When a team arrived, after setting up and being introduced they would usually engage in an awareness raising session, sharing basic SRH information. This served the dual purpose of providing people with important health promoting information and building trust and credibility.

> *Once we introduce ourselves and tell them our aim and objective why we are here, so when we give them the information about SRH that's when they open up. They like it. (Yasmine, NGO Service provider)*

In many of the field sites response teams were operating within very limited timeframes, sometimes, for example, only half a day in a village. This quick turnaround required teams to build sufficient trust with community members to enable them to be comfortable discussing sensitive issues within

a short period of time. The sharing of information, or awareness raising described by response team members, was a critical element in achieving that trust as described in the following quote.

> *We always ensure that firstly, whenever we get into a community we ensure that we do education and awareness first, we introduce ourselves, we introduce the services we're providing, before we actually carry out the services provision. So what this does, when we provide an introduction and an awareness session it kind of helps settle them a little bit by having to understand who are these people, what are they doing, but for those who do really listen and understand what we're offering, they're usually the ones who actually access the services. And so, that's one way that we build trust. (Paula, NGO Service provider)*

"…one way or another you'll be related to someone": Building trust through existing connections

Some participants also highlighted the importance of existing connections in villages. The following quote explains a cultural framework that can facilitate the provision of and access to services. In particular, this participant noted how beneficial it can be to include someone from the affected area on the response team.

> *Fiji has this really unique interpersonal relations system…I don't know what's the word in English I've never heard anyone say it in English. It's a like an interrelationship of 14 provinces. Say for instance, you are going with a Sister[8] to Kadavu. Now, she's from Kadavu, and that immediately, someone that's part of the team that is from that community or that province, that immediately changes the dynamics - there is more access and openness, willingness to facilitate from the affected community side. So it's that recognition that oh, you know this person is from here, we trust, she's not going to do bad things or whatnot, but that's one of the things that I've found has been really unique about operating not just in Fiji but in the Pacific. It's that link. And I think going in with the provincial authorities and the Turaga Ni Koros … I don't think that trust has been an issue in the past because, like I said, it's very, it's a very close-knit, very communal kind of … in Fiji. That's, that's how it is. It's very communal. if I am a part of the affected community and I find out that the response team*

[8] Nurses in Fiji are commonly referred to as 'Sister'.

members also from the same community there is immediate acceptance … like it's unheard of, I've never seen that anywhere else in the world. (Mei, INGO Staff member)

Similarly, the following participants explained how they were from the affected area where they were involved in running a response and that the relationships they inevitably had with community members helped lubricate the social processes involved in gaining and building trust.

Like I said, I was from that area, and they always joke about us in Fiji, saying that we're all related. So when we went to all the islands, one way or another you'll be related to someone. So that relationship that you have with islands and with the villagers…between islands, so that relationship, they see that as a way to communicate as well. So we build the trust. And like I said when we were related, they'll come to you easily and talk about what's happening in the village and that gives us an opportunity to ask questions, like what's the status of SRH and everything that's in the village. So I've said, going round the islands, one way or another you'll be related to someone in the village through marriage. (Sana, NGO Service provider)

"maybe the person providing the services is their aunty": considerations of confidentiality

The findings also showed a flipside to dense social interconnections. The small and often isolated villages the participants lived in resulted in close-knit communities where everyone knew everyone else. In these contexts, participants described that maintaining privacy and confidentiality was difficult to achieve. The perception of limited or no confidentiality for some participants extended to village and district health staff. When asked about accessing contraception from the local health clinic, Florina, a young woman, responded,

Too shy. You know village, when you go and ask about the thing, the doctors and nurses are going to tell. (Florina, Community Member)

She went on to say that if a young person wanted contraception they would wait until they travelled to the capital city of Suva where they believed the service would be confidential, outside of the village context. However, travel to Suva was often impossible for weeks or months during and after cyclones, leaving few options for women like Florina. The impact of limited confidentiality was also observed by NGO staff, who noted the potential effect of stigma associated with young people using contraception,

Also, stigma and shame. So young people not feeling confident to go and access services because they don't want to be seen, they're not supposed to be having sex. Or maybe the person providing the services is their aunty, because you know, everyone is related, they're small communities, so there's that barrier for young people… (Javier, INGO Staff member)

These concerns surrounding confidentiality when accessing local SRH services also arose in relation to intimate partner violence. NGO participants described how the relational connections of community members limited how much a woman might be willing to share in a group setting,

The women are sitting in a group, none of them said about GBV (gender-based violence) but we do not know how many women are related to the husband of the other woman, so you say something there the other women might share the information with the husband which would cause… (Raymond, NGO Service provider)

One to one, women are happy to talk about it especially with someone they believe to be confidential but in a group, and in front of the Turaga Ni Koro, 'this is a peaceful community, that happens elsewhere'. There was a real othering. (Aaliyah, Doctor)

In contrast to this perceived lack of confidentiality amongst community members and local health staff, community members described the trust and confidentiality they felt when speaking with visiting health staff.

She was here, she was telling us about what ladies go through, like if you don't have any other place to go you can call us, free, we can talk to you, counsel you in anything like those kinds of problems, having issues at home, broken families and all. And I just felt safe coming to her and her listening to what I was saying. I counted her as a mother at that moment. (Sera, Community Member) [talking about visiting local NGO member]

As the following quote explains, this feeling of safety came from the confidentiality enabled by an outsider coming in, without existing ties to the community.

Because we have lots of survivors that actually enquired from the midwives. From the midwives we deployed, not from the health centre midwives because they see them more neutral and more, more, I think independent and they're not close to the community so that there's this element of privacy and confidentiality. Because they're not residents there. They're just there for a time and they're not really locals. I mean they're locals because they're Fijians but they're not from the communities. (Teresa, UN agency staff member)

It should be noted that there were some exceptions to this norm. Although the village nurse, or Nurse Ni Koro was almost uniformly not seen as a confidential space, there were some examples of community members having trust in the confidentiality of their local health clinic nurses. This varied depending on the level of connection or relationship the nurse had with the villages they served. The following quote shows an example of a close and trusted relationship between a community member and their local nurse.

Yes I trust him, more than anyone here. I only trust him because I know he is still the one who can help me go through the challenges I'm facing. Sometimes at home, since I'm like this, I usually fight with my husband. He tells me off and I'm lazy, that I couldn't do anything right since I'm big. Sometimes I cry alone, sometimes I just keep things to myself. When I see the nurse, I share with him the things I'm going through. (Torika, Community Member)

Social Support

The third pathway through which the data identified social capital impacting women's access to and utilisation of SRH services during cyclone response and recovery phases was social support, namely instrumental support and informational support. In relation to instrumental support there were two clear mechanisms, the first being direct sharing, giving and lending of resources, usually money, to overcome barriers to travelling to health services in geographically isolated communities. The second type of instrumental support was community processes for managing intimate partner violence, which were shown to have the potential to be both protective for women experiencing intimate partner violence and also to pose a barrier to accessing necessary services. In terms of informational support, the data showed the importance of access to information regarding SRH services and that this sort of information is largely relayed through formal community mechanisms. In addition, the

data showed how information and misinformation relating to contraception circulating in the villages can both facilitate and hinder women's decisions to access these services.

"That's the system here…": sharing, lending and giving

A common form of instrumental support that facilitated access to SRH services was the sharing, lending and giving of resources. One of the most significant barriers to accessing services described by the participants was geographical isolation. For example, a number of the research sites were villages on small islands, only accessible by boat. In other sites, during and after cyclones, previously road-accessible villages could be cut off for several days or weeks. Villages were served by a local health post and a nurse who would visit on a regular schedule. Between visits, however, depending on the location of the village, visiting the health post would require paying for transport, including, for many, the cost of a boat and fuel. Participants described how community members would share the cost of a boat, pooling their resources to lower the cost.

> *But it's very hard to travel by themselves, like 3 or 4 houses they commit themselves to go together to have a check-up, they can't hire a boat by themselves, it's too expensive nowadays. (Mere, Community Leader)*

Alternately, participants explained that it was accepted practice to borrow money from family and community members to cover the costs of transport for travelling to a clinic.

> *That's the system here, you can ask your brother, or another family member to help you if you don't have the money at that time and you need to take your baby for a check-up. (Focus Group Participant)*

Another example of instrumental support was people directly sharing resources, such as a boat and fuel, in the following example and being paid back at a later date.

> *In our village, we have a village boat and a driver. He is ready to assist in an emergency. In emergency cases like that, he can take them. He can be paid later. Any emergency, he's always ready. (Kelemedi, Community Leader)*

Ferry and boats in Kadavu

"…as an elder, I have to step in and try to solve that problem": community processes for managing intimate partner violence

The second kind of instrumental support that was described by participants, in relation to women's SRH during and after cyclones was community processes for managing intimate partner violence. As described earlier in this chapter, there is a strong socio-cultural norm of silence relating to intimate partner violence, where women will, for the most part try and keep instances of it happening to themselves. However, where cases of intimate partner violence escalated to the point where they could not be ignored by community members, or to the point that women did, for whatever reasons, choose to disclose their experience there did appear to be a common approach taken. Across all the field sites participants described a similar process whereby, when fighting between husbands and wives is heard and judged by others to be of a certain risk, typically a male family member, such as a brother or an uncle would intervene to mediate the immediate conflict. Participants shared that women were then usually given advice from family and friends. The following quotes show how the advice given generally related to the woman doing or saying whatever was required to de-escalate the arguing and/or violence.

> *I helped the woman, with advice, told her not to fight back because the children are there, to stay calm and quiet. (Anaseini, Community Leader)*

Yes they come, 'please pray for my family' so we can just pray for their family and just give advice, 'don't go, just stay'. You know when your husband talks to you, keep your mouth shut, don't talk back. That's only the advice we give. (Paulini, Community Leader)

The close-knit nature of this layer of the social network provided a certain level of accountability that was often effective in stopping the problem, at least for some time.

It depends, if they fight, and their volume goes up, up, up and it's getting bigger, I'm going, I have to step in, as an elder, I have to step in and try to solve that problem. If they are using other equipment [as a weapon], I wouldn't be able to solve it then, I have to see the village headman to come in and then that's when they try to sit together and try to solve the problem with the family. (Lelea, Community Member)

As mentioned in the previous quote, if the situation escalates or if deemed necessary by the family, the Turanga Ni Koro is often called upon to mediate. This approach is widely accepted and practised, as confirmed by both community members and Turaga ni Koros. In some cases, the Turaga ni Koro will also draw on a village 'committee', comprising clan leaders who are predominantly male, to address cases of intimate partner violence. The church was mentioned in some villages as another potential avenue for couples seeking to resolve issues of intimate partner violence. Finally, if other avenues for mediation have failed, police will be called. However, participants suggested this would be a rare occurrence.

So in the village meeting there is a special committee that's taking care of all those kinds of things that are going on in the village. So those kinds of things are being taken care of by the Turaga Ni Koro and all the heads of the clans. So whenever the family keeps on fighting for a day or a week then they'll be taken up to, it's kind of a meeting that they'll have to respond to. And this clan they'll have to ask these families what's going on, what caused the starting of their fighting and they have to have something to solve those kinds of problems. The last thing is going out to the police. Firstly we'll just have to solve it by our own selves. (Seru, Community Leader)

Yeah, the closer relatives would go, if they can't they just call the Turaga Ni Koro to come. If he can't solve it, they would bring it to the police station. (Esekia, Community Leader)

These community-based avenues for managing intimate partner violence continue to be in place and accessible during and after cyclones, and can offer an important source of protection for women. Participants involved in humanitarian responses however described some of the potential negative aspects of the community-based mechanisms. For example, as the following quote describes, sometimes the support offered by the community is geared towards keeping the status quo rather than facilitating access to necessary services.

And usually the counsel is not about why it's bad to hurt the woman, it's about why it's bad to get caught doing it. So yeah, they're trying but they're not usually helping. (Hiro, NGO Service provider)

In a similar vein the following participant explained how the stigma relating to intimate partner violence can deter women from seeking help through the community mechanisms and that these mechanisms are not necessarily equipped to provide appropriate support to women.

But there are some communities where women who experience some kind of domestic violence, they would rather share what they're actually going through with someone other than a community member. I guess it comes down to individual preferences but mostly, I guess there's still a lot of stigma that's attached to actually understanding what it is and all that, the stigma of women having to share and it usually goes up to the village headman, or the religious leaders to then step in and lead reconciliation, to a point where they can say, they're back together, everything is fine, but they don't really see how, in terms of the psychological impact it has, the trauma, the impact on the survivors as well as the perpetrators, so that is really where the communities, no matter how much you can try to help them set up a community support system, you still need people who are actually trained in counselling services, who would then be able to step in and try to provide guidance to the couple in terms of the GBV (gender-based violence). (Paula, NGO Service provider)

Another issue observed by the following participants was that the inter-related nature of community members sometimes created barriers for community leaders reporting intimate partner violence to the police or for the police following appropriate steps when they became aware of it.

> *We have to report it, because of the setting because of the relationships, they're all related, so sometimes it's hard for the Turaga Ni Koro to report. (Yasmine, NGO Service provider)*

> *Often what they do, is if they do detect GBV (gender-based violence) they give it back to the village, so they let the village deal with it because they have their hierarchy with the chief and they let them deal with it. So they go through counselling with the Chief and often it's tailored towards the man. (Hiro, NGO Service provider, regarding local police)*

Disseminating SRH service information through communities after cyclones

Women's access, or lack of access to information, was critical in relation to accessing SRH services being delivered as part of post-cyclone responses. The primary channel through which community members reported hearing about SRH services after cyclones was through the Turaga Ni Koro. Participants described that one of the Turaga Ni Koro's responsibilities is to share news with community members and the main way they did this was by sharing at the weekly village meeting. Outside of this, they also delivered news by walking around the village, house to house.

> *The Turaga Ni Koro's assistant calls out to tell us, 'we have a meeting on this particular day, the women will be coming to tell us this and this'. So everybody will hear it, and the time. (Vilimaini, Community Member)*

> *The role of the Turaga ni Koro, he's basically the spokesperson of the village, not sure if they still practice it, but traditionally, what he'd do is at certain times in the morning and evening he has this session when he goes around the village and calls the announcements, like a mobile PA system. Each morning and evening and he announces anything he's been told regarding the village, so if they have meetings, if they have gatherings, functions, deaths, marriages, he announces it like that. (Hiro, NGO Service provider)*

Following cyclones, communication channels were often disrupted and sources of information were limited. There were several examples where community members had not heard about SRH services which had visited their village and had subsequently not had access to these services.

> *No, we live in the settlement, far from the village so maybe we didn't hear about it…. Only if the Turaga Ni Koro tells us what is happening in the village then… (Ranadi, Community Member, when asked if she heard about the visiting SRH services)*

"they hear about it from other women in the village…": information and misinformation

The other way that informational support could influence access to services was through information and misinformation, which inevitably spreads around communities. Participants mostly described this in relation to contraception. Women explained how they talked amongst themselves about contraception, the different types and their experiences of it. This sometimes led to scepticism or fear of using contraception because of possible side effects that they had heard others had experienced. This kind of flow of information resulted in some women deciding not to use contraception.

> *They hear about it from other women in the village, they would ask their mother. Like for me, when I came back to the village, it had been a long time since I'd been there, I asked the ladies in the village… Yes, they do sometimes, they share it amongst themselves, the good things about which one, you know like, the good things about injections and other ones and then the negative things. So they choose which one they want to take. Also when they go for check-up, the nurse also tells them the information. Then it's up to them which one they want to take. (Ema, Community Member)*

> *Because most of us, they didn't understand about family planning, some of their friends they go and talk about it about the advantages and disadvantages of the…we need a lot of awareness about family planning… (Oni, Community Member)*

Conversely, other informational support led to some women being encouraged to access contraception services when they were available, such as the advice offered in the following quote.

I always told the ladies, I have kids, two, three years, every year from married till now, so you go, if you go to Suva to deliver, you should get it [contraception]. That's my advice to them. Because sometimes with injections, we forgot, sometimes when it's time to get it, there's no boats, bad weather, no fare, so good you go and put the 5 years one [contraceptive implant]. That's my advice to them. (Paulini, Community Leader)

Conclusion

This chapter has presented data that illustrates three key pathways through which social capital influences access to and utilisation of SRH services during the humanitarian response and recovery phases. These high-level categories included socio-cultural norms and values, trust and social support, each of which brings together diverse examples illustrating their various facets. Socio-cultural norms impact access to contraception, intimate partner violence response, and the general prioritisation of women's health. Trust emerged as a critical factor, especially in small, isolated communities, where perceptions of privacy and confidentiality significantly influence SRH service access. The data also showed that service providers can build trust through various means, including upholding confidentiality, utilising the existing credibility of health staff, strategic information sharing, and adhering to proper community entry processes. Lastly, social support, encompassing both instrumental and informational aspects, plays a significant role. Instrumental support included the sharing of resources to overcome geographical barriers and community processes for managing intimate partner violence, while informational support pertained to access to information about SRH services and the impact of circulating information and misinformation on contraception use.

The next chapter will build on this solid foundation of primary data by situating and contextualising them in a social capital framework, building a bridge towards further exploration and interpretation.

Situating the findings: further insights into the broader context of social capital and access to SRH services in cyclone affected rural Fiji

Introduction

The previous chapter presented findings from the second phase of this research that identified three pathways through which social capital influences access to and utilisation of SRH services during humanitarian response and recovery phases. This chapter seeks to situate those pathways within a more comprehensive social capital framework, building a bridge to further analysis and discussion in the following chapters.

The three social capital 'pathways' identified in the last chapter do not exist in isolation. They exist in dynamic connection with each other and embedded in their contexts. To gain a complete picture of these interconnections and contexts, we also need to understand the networks that hold communities together and the bonds that form these networks. Using a social capital lens, this chapter builds on the last, presenting the findings as they relate to networks, the bonds holding them together and subsequently, how each of the social capital pathways were seen to impact upon each other. Together, this chapter and the two previous findings chapters will provide a rich snapshot of social capital in relation to women's SRH in crisis settings, which will enable an informed and nuanced discussion.

Networks and nodes – the web of connections across villages and beyond

The formal network most commonly referenced by participants was the village governance network. In Fiji, the governance of villages follows a hierarchical structure overseen by the Ministry of iTaukei Affairs. Provincial councils are the first line of communication between the government and the villages and are each headed by a 'Roko Tui'. Each village elects a village headman, the Turaga ni Koro, who communicates with the Roko Tui relating to any governmental administrative matters and who is paid a small government stipend. Each village also has a Village Council which oversees a number of village committees, such as a health committee, a youth committee and a women's committee, amongst others. These committees each have specific roles and responsibilities and provide a report on these at the regular Village Council meeting. This formal network structure and the key nodes, or gatekeepers, within it, is the backdrop, and facilitator, to many of the facets of social capital described in the previous chapter.

As described in the previous chapter, NGOs, INGOs, UN agency and government participants referenced the importance of working within the structure of this formal network to enter villages

and deliver services and that in doing so they were able to build trust with community leaders and members. The following quote from an NGO staff member describes this process,

> *So the first checkpoint for them would be, what would call the Provincial Authorities, these are the official government entry points into the villages. And then from there once they get the approval from these provincial authorities, they liaise with what we call the, probably you can call them village wardens if you want, the Turaga Ni Koros. So those are the appointed government liaison person for the community to government. So they are very critical. And then they go directly to, maybe the women's group, you know, the men's group, or they have like a committee in the village for women, men or young people, they would go directly to their contact if there is one. That's, that's the, the ideal the scenario. (Mei, INGO Staff member)*

This formal network was also the primary means for transferring information relating to SRH service delivery after cyclones. Either the Ministry of Health or the service-providing NGO would contact the relevant authorities at the top of the hierarchy, for example the Roko Tuis, who would then in turn communicate down the line to the Turaga Ni Koros who are then responsible for disseminating the information to the community members directly, or through other nodes.

The formal Ministry of Health network was also referenced frequently by participants as an entry point in relation to the dissemination of SRH service delivery information. This network relies on nurses and village health workers at the community level and overlaps with the primary village network, as can be seen in the following quotes.

> *Yeah, the main key players when it comes to community engagement, is our cultural system, in the Fijian cultural system there's this like… in the villages, there's someone who's called a Turaga ni Koro who's like a headman. So as a headman, he's one of the golden people, and within that space, usually his wife or someone from their church, space becomes like the lead of women's space. So they kind of become our contact persons and also the village health workers. So they kind of become key points and, and sometimes they do identify women or people in the during the disaster to, you know, like to be that contact person. (Aaliyah, Doctor)*

> *It's [dissemination of information] done through the, through the community health workers and I think that's, that's very important because we, we're trying to use the mechanism that exists and not create any new kind of fly by night, mechanisms that, you know, that will not last but the village health workers are on the ground. They've been appointed by government*

and they have their community mechanisms where they have the village, the Turaga ni Koro, the village health worker, the women's leader, or, you know, group. (Sita, UN agency staff member)

This formal village network was also referenced by participants from all the participant groups in relation to community processes for managing intimate partner violence. Specifically, where immediate family members or neighbours were not able to de-escalate conflict, or when it was an ongoing concern, the matter would be taken to the Turaga ni Koro and, where necessary, the village council. A community leader explained this mechanism which drew on the formal village network structure,

But whenever there's a problem in the house we're always asking about this committee, what are they doing? Because there's a problem in that house. By then the Turaga ni Koro will come and see what's going on here and he'll report it to those clans and they'll have a meeting and decide how to solve that problem. (Seru, Community Leader)

These formal networks are deeply connected to the informal webs of family and friends, through which social support flows, as described in the previous chapter. In terms of SRH, participants mostly referenced these personal networks at the very local, village level. However, they did extend beyond these local networks in some cases. For example, several participants mentioned family members living in Suva (the capital) or abroad as a source of financial support that could be drawn on in times of crisis to help meet health-related costs, such as paying for fuel to visit a health clinic.

The relatives in Suva will help. (Focus Group Participant)

Support from family in Suva was also often referenced when women from remote islands had to travel there to birth their babies, as per government policy. Women from two of the three research sites were required to travel to Suva at 24 weeks gestation and to stay there for three months following the birth. This involved significant expense and where possible women stayed with, and depended on their relatives, to the point that one INGO staff member observed,

You have to rely completely on informal networks to birth your baby. (Zara, INGO staff person)

Though not specific to a crisis context, this illustrates the importance of these informal networks.

Internal bonds and external links – forms of social capital and their relationship to SRH in crisis contexts

The findings also provide some insight into the forms of social capital present in the communities studied and how these impact on women's access to SRH services in post-cyclone settings. By 'forms' of social capital this refers to 'bonding', 'bridging' and 'linking' capital. These have been described in detail in the thesis introduction. In short, bonding social capital refers to strong network ties within groups with similar characteristics (e.g. class or ethnic group), bridging social capital describes weaker ties between people in groups of approximately equal status and power but with different identities and linking capital denotes ties across vertical, usually formal, power differentials.

Most of the communities across the field sites experienced geographical isolation. Two of the three field sites were small islands with limited transportation connections to the bigger islands. Access to Suva was usually by ferry. However, elevated fuel prices have decreased the frequency of ferry trips. For example, when I visited Koro, the ferry had not come for three weeks. Ferries were also impacted by weather events and often could not travel to communities until sometime after cyclones. Communities in the field sites on the bigger island of Vanua Levu, had better accessibility to urban centres but were still easily isolated in times of high rainfall, including when cyclones struck. This geographical isolation combined with the ethnic homogeneity of the studied communities gave rise to a high level of bonding capital and low levels of bridging capital. In terms of accessing SRH services and information in the wake of cyclones, almost all the social mechanisms outlined in the previous chapter (that related to community members themselves rather than NGO teams entering and working in communities) relied on and were a result of closely bonded networks.

Village in Koro

The findings showed that most of the linking social capital related to serving health needs and available to the studied communities, flowed through the Turaga ni Koro and/or community-based health staff. In terms of linking capital the Turaga ni Koro is often the interface between communities and the formal institutions that serve their needs. In times of cyclones, communication channels may be restricted and the role of the Turaga ni Koro became even more critical in ensuring SRH services can be delivered to the village and that community members are informed of them.

Aside from the Turaga ni Koro the other pathway for linking capital was through the formal health staff. The strength of the link with health staff was impacted by several factors. Firstly, the level of direct connection with health staff varied depending on the village. Some villages had a health clinic based in them, with a permanent nurse and sometimes a doctor. Having a health post based in a village gave members of that village a stronger connection with the staff and the services being provided. Other villages needed to travel to reach a health post, requiring time and money. This reduced the proximity, and accordingly the strength of the connection. Secondly, levels of trust in health staff also impacted the strength of the linking connection, and these were not consistent across the field sites. For example, one of the villages visited was the base for a health post with a permanent nurse who had built a high level of trust with the participants in that village. The following quote illustrates this trusted relationship which was echoed by several participants.

> *They always mention that in our village meeting, if you have anything to share, and whatever you share it will be with me, I won't tell anyone else, and for me facing difficulties at home I always shared to them and I always come to them often and I trust them because everything I shared to them, it's with them. They don't tell anyone else. (Sera, Community Member)*

Quotes like this one suggested the personality, style of engagement and professional conduct of this nurse helped build a strong connection with community members.

To illustrate another factor impacting linking ties between community members and health staff, a District Nurse described that because she was from the island where she was currently based some community members who had a particular relationship with her chose not to access the services when she was providing them but preferred to wait for a different nurse.

> *Whenever they come, they see me and they'll go, they won't come inside. And they'll just wait. Until another nurse comes and I'll say oh, someone is outside, can you just check them and then they'll go to the other nurse. (Leila, Nurse)*

These examples indicate some of what are likely many factors that impact community members' linking ties to health staff, and which suggest that linking capital between health staff and community members is very contextual and varied from village to village. Following a cyclone, strong and trusted linking relationships to locally based formal service providers, are critical as there may be a significant gap in time between the cyclone and response teams being able to access communities. For example, a District Nurse explained how,

> *..when [cyclone] Harold[9] hit, for almost three weeks there was no help coming…it was just me... Because this island, to be honest with you, we are like the forgotten place. I've been here for three years, most of the services come to the big island. If they have time then they'll come to us. (Yuki, Nurse)*

The locally based service providers are the first responders and strong linking capital between them and the communities they service can facilitate the provision of SRH services that may be required in the immediate aftermath of a cyclone.

The findings also showed how SRH response teams visiting villages to provide services in post-cyclone settings built linking capital for women living there by establishing those trusted face to face connections required to deliver health services. The previous chapter outlined how visiting staff were often able to quickly build a trusting relationship with community members. This was especially the case at the field site, where services were delivered through a central hub serving a number of villages for an extended period of time. This model of service delivery worked closely with the Nurse ni Koros, building their capacity and empowering them as a linking tie between community members and the health services that were being provided. The following quote illustrates this linking relationship in the context of accessing support relating to intimate partner violence, where the Nurse ni Koros played a critical role in getting women to the point of being able to disclose their experience in a safe, trusted space.

> *Yeah, because, well they use also the community health workers [Nurse ni Koros] to access the support, but it's actually the disclosure happens between the midwives but they do use them as bridge, to the midwives. I think when you're a survivor, you really find a person that can also boost your confidence in telling your story so that is the story of the community health workers. And then the follow up us a well. So that is also another thing because the community health workers are seen as essential support system to women for when they do follow up. (Teresa, UN agency)*

[9] Tropical Cyclone Harold hit Fiji on the 7th April 2020 as a Category 4 cyclone causing widespread damage.

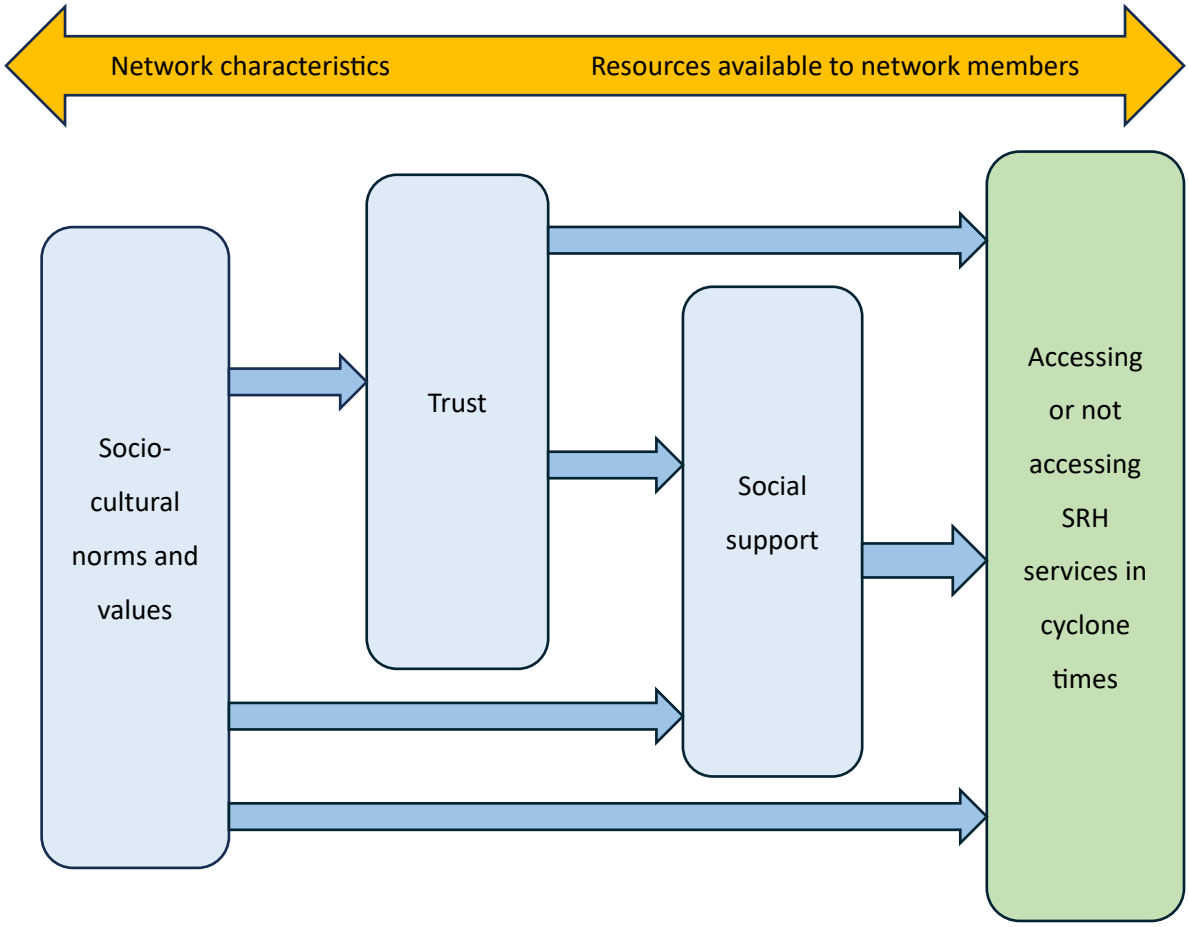
In terms of linking capital, as these examples have illustrated, the temporary nature of SRH services provided in an emergency response setting required drawing on existing linking capital, primarily through Turaga ni Koros and community-based health staff and the ability to quickly and effectively build trusted links across the power differential between community members and SRH service providers. Each of these were impacted by a variety of factors, some of which were evident in the findings.

The interconnections between social capital pathways

With the contextual backdrop of the webs of ties and networks that community members are a part of, Figure 14 brings together the social capital pathways described in the previous chapter and illustrates how they are dynamically interconnected in the way they impact women's access to SRH services in cyclone times.

Figure 14

Social capital pathways and interconnections



The arrow across the top of the figure further describes the nature of the three social capital pathways. On the left, socio-cultural norms and values shape the network characteristics by

influencing the nature and strength of the network ties whereas on the right, social support manifests as resources available to network members. Trust falls in the middle and can be conceptualised as both a network characteristic and a resource that community members are able, or not able, to draw on in accessing SRH services.

Socio-cultural norms and values ↔ trust

Data collected from participants showed how each of the social capital pathways overlap and connect with each other. Firstly, socio-cultural norms and values can both lay a foundation for trust and can also create barriers to its development. For example, when service providers engaged in the sevusevu custom to enter a village, they built trust with community members and leaders, 'bringing everyone along' with them, as described below.

> *This is credit to our Member Associations, they speak the local language, they're sitting down and drinking some grog[10] together [as part of sevusevu process], starting off with non-confrontational things, there's something for everyone this isn't just for women, so bringing everyone along with us. (Zara, INGO Staff person)*

A contrasting example described by participants is where norms dictating that contraception is exclusively for married individuals created barriers to the development of trust for young people discussing contraception with health providers. The prevailing norm necessitates a heightened level of confidentiality and trust, as young people must be absolutely confident that their privacy will not be compromised. Similarly, the socio-cultural norms that advocate for silence or keeping family matters private, especially concerning intimate partner violence, can hinder women from trusting and seeking help from community members or health professionals. These norms foster an environment of distrust where women may feel isolated and apprehensive about sharing their experiences due to the fear of judgment or reprisal, underscoring how socio-cultural norms and values can both facilitate and impede the establishment of trust in critical health matters.

Socio-cultural norms and values ↔ social support

Secondly, socio-cultural norms and values also directly influence the nature and extent of social support. The clearest example of this is how socio-cultural norms of mutual support, or reciprocity, play out in relation to SRH in a post-cyclone setting. Participants described two ways that reciprocity plays out in a Fijian iTaukei community setting, 'solesolevaki', the practice of working together, or shared labour and 'kerekere', the sharing, lending and gifting of resources. Examples of these included, family and neighbours coming together to rebuild damaged houses, people sharing their

[10] 'Grog' is a local term for kava.

houses with others while theirs were repaired and the sharing of food. The main example given specifically relating to SRH was the giving and lending of money or resources (such as fuel, or vehicles) to travel to health clinics in financially strained periods after cyclones. The following quotes from community leaders describe the embeddedness of this socio-cultural norm that generates material support for fellow community members.

> *After cyclones, we don't need to talk about helping each other. If she is your family or she is not your family…that's the only way you can help her or you can help me. If you don't help her or him, it's better for you to not be in the village. (Mere, Community Leader)*

> *[When asked what would happen if a woman unexpectedly went into labour in a post-cyclone setting] Well, the whole village would find a way for taking her to the nearest hospital. So it not only benefits the family it will benefit the whole village. We would take care of that mother to go to the hospital. (Seru, Community Leader)*

Trust ↔ social support

Thirdly, trust and social support are also closely interconnected. Trust and distrust can, respectively, facilitate and hinder the development and effectiveness of various types of social support. At a basic level, trust is integral to the previously discussed system of reciprocity, where, as can be seen in the following quote, resources are shared with an implicit trust that the favour will be returned.

> *They [pregnant women after cyclones] wanted to go and have their check-ups. They would go and ask their neighbours if they could help them with money for the fuel, and they can pay it back later. (Lanieta, Community Member)*

The findings also showed how the dissemination of information relating to incoming SRH services following a cyclone, a form of social support, flowed through trusted nodes of the village structure. This was described in the previous chapter, where Turaga Ni Koros were responsible for informing people that there would be a team coming to provide SRH services and that the trust in this process for information delivery and in the Turaga Ni Koro gave the information itself credibility.

Conversely, a lack of trust in community members and leaders to keep personal matters confidential deterred some women from disclosing experiences of intimate partner violence, which participants noted often increased in times of stress such as after cyclones. As a result, these women may have been unable to access community support or other helpful mechanisms. When asked why they didn't talk to anyone about what they were going through, women responded with, 'too much gossip', 'it's so hard to share it with someone else' or 'we don't trust each other'.

As represented in Figure 14, the three facets of social capital, socio-cultural norms and values, trust and social support are deeply interconnected and influence each other to collectively impact women's access to SRH services and information in the field sites post-cyclone settings. Socio-cultural norms and values shape the formation of trust and the nature of social support, while trust facilitates the development and effectiveness of social support networks and how resources do or do not flow through them.

Living with seasonal disaster risk

Finally, the particular way in which participants reflected on and described their experiences of living with cyclones provided an important contextual layer for understanding the findings of this research. Their narratives revealed communities accustomed to the unpredictability and regularity of weather extremes, including cyclones, which ranged in impact from causing minor disruptions to inflicting significant damage and loss.

It became evident that the social capital described by community members is a continuous resource, drawn on not only during crises but also in everyday life. The importance of established networks, communal trust, and bonds escalates in times of isolation post-cyclone when external assistance may be curtailed and when day-to-day stressors increase. A clear-cut example of this is the socio-cultural norms of reciprocity that facilitate the flow of social support between community members. Following a cyclone, when families have limited resources, the ability to easily borrow money for transport can be a critical factor in accessing health services. Similarly, the negative social capital impacts described in the findings are present in everyday life but may potentially be more acute when communities face periods of weather-related isolation or increased stress. For example, a number of participants noted the increased desire and subsequent demand for contraception in the wake of cyclones. In the face of increased financial insecurity and less access to food and services in general, contraception offered one way to make life more manageable as outlined in the following quote.

> *I think that the main reason why, for the increase in family planning, I'll tell you the situation we were in, you know, life was hard, most of the farms were damaged so when, some of the boats got damaged, all these things. For three weeks there was no boat coming in, services like fuel, shops were running out of food. So I believe that most of the families, most of the women, opted to take family planning. But then was because, for them to recover. Because of the situation they were in. (Yuki, Nurse)*

Whilst many women did access the family planning services following the cyclone, at the same time, the embedded socio-cultural norms and values relating to contraception described in the previous chapter continued to exert their influence at these times presenting barriers to some women accessing those services. Community members and service providers alike mentioned instances of men raising concerns about their wives using contraception in the SRH response awareness raising sessions. This unique intertwining of life in stable times and in crisis underscores the need for a nuanced understanding of social capital's role in both day-to-day living and in disaster response, especially concerning access to SRH services and information. This will be further explored in the following chapters of this thesis.

Conclusion

In conclusion, this chapter has presented another layer of findings, situating and contextualising the three pathways identified in the previous chapter within the broader social capital framework. This has highlighted the dynamic interplay between different pathways, the importance of the broader social networks, and the unique experience of living in disaster-prone settings, that shape individuals' access to and utilisation of SRH services. The findings and insights presented in this, and the previous findings chapters will inform further analysis and discussion, laying the groundwork for a nuanced exploration of social capital's role in women's access to and utilisation of SRH services and information in crisis contexts. The next chapter presents the insights and reflections on the findings of Fijian practitioners, drawing on their experience to interpret and analyse the findings with a view toward developing practical recommendations.

Reflections and insights from practitioners

Introduction

This chapter builds upon the findings outlined thus far, and presents data collected in the final research phase. In this phase the findings from the first two research phases were shared with several of the Fijian participants who work for NGOs, INGOs and UN agencies involved in delivering SRH emergency responses. Through one-to-one interviews they were invited to reflect on the findings and offer their feedback and insights regarding the implications on practice. The aim of this phase was to contribute to identifying the opportunities, relating to social capital, for strengthening access to and delivery of SRH services in humanitarian settings. These participants welcomed the opportunity to hear the research findings and provide their thoughts and perspectives. Of note, each of the participants interviewed emphasised the resonance of the findings with their own experience and understanding of the role of social capital in the context of providing SRH services to crisis affected communities.

As advocated by Thambinathan and Kinsella (2021), the integration of 'cultural insiders' in the research process is critical for fostering alternative, non-Eurocentric perspectives. This research phase sought to elicit reflections on the findings that drew on Fijian cultural knowledge and the lived and professional experiences of the interview participants. This collaborative endeavour aimed to enable a robust triangulation of perspectives, enriching the analysis and ensuring that the ensuing recommendations resonate authentically with the local context. The purpose of this research phase and the resulting findings also demonstrates an effort to bridge the gap between research and action, consistent with the overarching critical theory paradigm guiding the methodology.

The following chapter presents the reflections and insights drawn from 5 interviews conducted remotely in May, 2024. All of the participants were Fijian, who worked, or had previously worked, in NGOs, INGOs or UN agencies in the area of SRH service delivery, including in crisis settings. They had all, also, participated in interviews in the second phase of the research. As Table 9 shows, two men and three women were interviewed, two worked for INGOs, two for a partner NGO and one for a UN agency.

Table 9

Roles and sex of Phase Three participants

Pseudonym	Institution and role	Sex
Mei	INGO Staff	Female
Luca	INGO Staff	Male
Sana	Partner NGO Staff	Female
Raymond	Partner NGO Staff	Male
Sita	UN agency	Female

The findings fell into four overarching themes, which are presented below. These include the importance of specifically naming and identifying social capital, the need to work consistently across the entire disaster management cycle, strengthening existing support mechanisms and the importance of working in coordinated partnerships with government, NGO, INGO and UN agency actors.

Naming social capital

A consistent theme that emerged from the participant reflections on the findings was the importance of, and the need to specifically name and document social capital and the ways it impacts the delivery of and access to services. Participants were familiar with the social capital mechanisms that were identified in the findings and emphasised the importance of them in their work. Mei conceptualised the social capital mechanisms as what held response deliveries together and what enabled them to be successful.

> *I mean, these are, these are the key things. These are what fills up the spaces, right? The gaps. And this is what makes the interventions and the measures and the strategies work. (Mei, INGO)*

Despite their significance however, these concepts were talked about as intangible elements of their work, skills they might learn 'on the job', rather than non-negotiable considerations for service delivery. Luca notes this when he was asked if training for new service delivery staff includes information relating to issues such as building trust with community members.

> *I think they are trained with basic training, but on those skills, they're acquired over a period of time. So the basic training prepares you for it but the experience comes only when you do the responses as well. (Luca, INGO)*

The participants acknowledged that the first step to incorporating these considerations into their work more systematically was to identify and name them.

> *And the first thing is what you're doing, you're documenting it, you're putting a label to it and sharing it to others. (Mei, INGO)*

Similarly, in the comment below, Sita notes the value of understanding the social capital related processes and influences shaping the contexts they work in.

> *We develop SOPs [Standard Operating Procedures] stepping onto these existing mechanisms at the different levels when we were doing our response to Tropical Cyclone Yasa and Ana, for example.... and it's, it's a lot easier to, to work in the space when, when you know that these mechanisms exist and you are only there to, to further nurture it and take advantage of it and, you know, and use it to be able to, to gain the, you know, whatever mileage that's needed that works for both the partners and the communities more so, right? (Sita, UN agency)*

None of the informants who participated in this final research phase were surprised by the findings. Rather, they affirmed what they knew from their professional experience and gave voice to some of the unnamed influences that can facilitate or hinder the delivery of and access to SRH services provided as part of humanitarian responses. In identifying and naming these, each of the participants saw potential for strengthening future work in this area.

Working across the disaster cycle

The second consistent theme that arose from the interviews conducted in this phase, was the need for working with communities across the disaster cycle beyond the limited timeframe of an emergency SRH response. This most frequently arose in relation to activities like awareness raising, capacity building for community leaders and empowering women.

> *I mean there are some things that will be your takeaway message but that will be it, they can't capture everything that is given to them in a 2 hour period when they go for the outreach so you know like all those stable times, we should be taking advantage of in the sense that if you have access to the villages, if you have resources to go out during stable times, to go and run awareness session in all the services that you're providing and what you will do in the humanitarian response times. (Luca, INGO)*

When asked to reflect on the significant impact of socio-cultural norms on women's access to SRH services and information participants noted that overcoming these types of barriers could not be achieved in short timeframes. For example, Mei believed that the key to addressing barriers such as

husbands not wanting their wives to use contraception is found in empowering women.

> *At the end of the day, I think it's, it's the empowerment for the women. And that sounds like a cliche, but it is that, it's, it's that being enabled, being resourced with the right information. So I don't think there's like a fast and easy solution to it. (Mei, INGO)*

In one of the field sites, SRH services were delivered over several months, in contrast to the rapid, emergency response model implemented in the other field sites. In this instance, UNFPA established multi-month 'Women-Friendly Spaces' in areas impacted by Tropical Cyclone Yasa and Tropical Cyclone Ana. These hubs provided information, services, commodities and support to surrounding villages. They employed retired midwives and nurses who managed the hubs. Whilst this approach required women to travel to the hub to access services, the staff also engaged in ongoing outreach to the surrounding villages to raise awareness of SRH issues and the services being provided at the hub. One of the benefits of the Women-Friendly Spaces approach was the way it enabled multiple and sustained ways of connecting with communities, as Sita relates in the following quote.

> *I think the, the Women-Friendly Spaces, uh, were really useful avenues because you have people stationed there for like 3 months and they weren't only focusing on, you know, working within the health facility or within the tent that they were allocated but, uh, they worked in the communities… So even on Sundays, you know, we would go to local churches and talk through these issues, the importance of the supportive mechanisms and if they don't exist, you know, what can be done…so it did work, I think, for the longer term if, if they are on the ground, there are a lot of more opportunities that they can use to build on by going out into the communities, into the churches, even into the schools. (Sita, UN agency)*

In addition, this longer term approach prioritised working with local health staff, including the Nurse ni Koros and building their capacity in the area of SRH with the aim of leaving communities better prepared to respond in future crises.

Participants also highlighted the importance of existing relationships in facilitating access to and working with communities and noted that these relationships require ongoing effort to nurture and maintain, as explained below.

> *Not just during, during the emergency and the response, but making sure that outside of the, that time of the response, you're also keeping tabs, building the relationships…It's that networking, that relationship building before you need to engage these people when you need them. (Mei, INGO)*

Strengthening existing support mechanisms

Linked to the previous theme, participants also observed the need to maintain and strengthen existing support mechanisms. All the participants referenced the need to empower and sufficiently resource Turaga ni Koros to harness existing social capital as a result of their, often, trusted position in the community. There was consensus that the sensitive nature of some SRH issues presented a barrier to the engagement of Turaga ni Koros and that overcoming this would require dedicated effort.

> *But they're not resourced to be able, I mean, especially for something as, as sensitive like SGBV (sexual and gender-based violence), uh, yes or SRH service, that's, that's something that they would just quickly sweep under the carpet or say, you know, go to the nurse, the village nurse and they'll help you. (Mei, INGO)*

Nurse ni Koros were similarly seen as an existing support mechanism that could benefit from strengthening. One participant argued that Nurse ni Koros should be viewed as a critical part of the primary health care network and resourced accordingly.

Several participants noted the existing village governance structure which includes a women's group and a youth group, and that, with support, these groups could play an important role in facilitating access to SRH services and information in crisis settings and stable times.

> *So, the social capital, I think, would work again if we resource and build that capacity at the community level, but working with the different groups, because a young person is only going to go to the youth group. A woman will go, maybe to the youth group or the women's group…building that capacity, resourcing them generally, and information, I think information sharing about where to access support if needed like tangible things like where do I access condoms, if we can ask the Ministry [of Health] to provide a condom dispenser at a village hall that might not work, but it might work if one of the youth members or the village nurse would say, bring to my house, you know, leave it there… (Mei, INGO)*

One participant noted that these groups, though mandated, are not always active. One of the first steps towards empowering them would be to ensure that each leader is participating in the Village Development Committee and providing a channel for concerns to be brought to the village leadership.

In acknowledging the potential opportunity to strengthen the capacity of community leaders, such as Turaga ni Koros, Nurse ni Koros and women's and youth group leaders, participants highlighted the need to engage the heads of provincial councils, the Roko Tuis. As the conduit between the

government and the villages these roles hold significant influence, or as one participant noted, “whatever they say, goes”. Participants felt this influence could be harnessed to empower the community-level leadership and increase the effectiveness of existing community support mechanisms relating to SRH.

The SRH issue most commonly referenced in relation to existing community support mechanisms was sexual and gender-based violence and in particular the process of referrals.

> *So we are working with our Turaga ni Koro and the village health workers, you know, like how we can use them as referral pathways if It happens in the village. How can they come in to assist the women or even the men in terms of violence and how they can refer it to the organisations, appropriate organisations that can assist. (Sana, NGO)*

Another participant emphasised the need for dedicated capacity building of community leaders in this area. They noted in particular, the challenges that exist in small communities, where a perpetrator might be related to the Turaga ni Koro or the policeman. Clear, strong community reporting and referral mechanisms can help overcome some of these challenges.

> *They need to actually be, there needs to be a system that works, people really have to be bold in those situations, as well. And have to be really comfortable about the reporting system. (Luca, INGO)*

The importance of partnerships and coordination

Participants emphasised the critical role of partnerships between service delivery NGOs and government actors at both the local and national levels to effectively meet the SRH needs of communities, particularly in humanitarian contexts. Local actors hold valuable trust within their communities, which makes them indispensable partners. Their deep understanding of cultural norms and established relationships with community members can often enable them to help deliver services with greater acceptance and impact. As one participant noted,

> *I think there's something to be had in working with local, um, local colleagues and local networks, like, like we said, Turaga ni koro and the village health nurse, right? Because, um, they're based in the community, but also they have the trust of the community more than a health team coming out. (Mei, INGO)*

Partnerships were also highlighted as essential to maximise efficiency in the face of limited resources and logistical challenges. Given the geographical spread of Fiji's remote islands and the high costs associated with travel and outreach, no single organisation or government department can effectively meet the needs of the entire population alone. This is especially true in the context of

delivering SRH services where existing trust and connection are an important part of increasing effectiveness. One participant noted the impossibility of one NGO being able to have existing connections with every community it may be called upon to work with.

> *So I think like, for instance, with the Fiji reproductive health NGO, the staff have connections to where they come from, right? And then they might also have connections to communities that they've already done outreach in. But what we're essentially talking about, maybe not even 10 percent of the networks that we need. To put in place. And so…. how do you fix that?* (*Mei, INGO)*

As participants observed, "partnerships are the way to go". Working together is the only way to ensure that services are delivered equitably across the country. However, they acknowledged that effective coordination is crucial for partnerships to succeed. Participants related examples of strong coordinating mechanisms, including the cluster model used to manage the response following tropical cyclones, and also examples of poor coordination, such as an SRH response team being sent to an island where no local leadership was aware of their visit. There was consensus among the participants that coordination of SRH work done in stable times, including preparedness activities, could benefit from increased collaboration and more effective coordination.

Participants also discussed the role of established local actors, including NGOs with a local presence in credentialing external organisations, helping to build trust between communities and new service providers. This dynamic is particularly important when organisations without prior connections to a community are introduced. One participant described this organisational approach as follows.

> *So what we do, what strategy that we usually do, is that we build a strong relationship with other stakeholders, such as the Ministry of Youth and Sports. This is an organisation or ministry that usually visits the community more often compared to us. So when we build a good relationship with them, they somehow start to advocate on the work that we do on our behalf. So, and then when we come into the community, one thing that we usually hear from the community, 'Oh yeah, it's okay. We've already heard some sort of information from the Ministry of Youth and Sports about the work that you do'. (Raymond, NGO)*

Existing trusted partners can vouch for other organisations or individuals, making it easier to deliver services that might otherwise face resistance or scepticism.

Additionally, participants stressed that collaboration between organisations helps present a consistent message on key issues, such as sexual and gender-based violence, across different services entering communities. Consistent messaging from multiple organisations and actors strengthens the

effectiveness of programs and promotes long-term behavioural change, as described in the following quote:

> *You know, whether they be agriculture or forestry or, you know, or health education, [it's important] that everybody has the same message, and the consistency in getting that message, but also the regularity is very important … which means everyone needs to be on the same page, on the level of information that should be provided to these communities so that everybody else that goes, and when it's not your organisation, that they have your message very clearly articulated and they can share that message. (Sita, UN agency)*

Conclusion

This chapter has presented the reflections and insights on the findings of Fijian NGO, INGO and UN agency staff members involved in the delivery of SRH services in crisis settings. Firstly, these reflections highlighted the critical importance of naming, documenting, and understanding the role of social capital in humanitarian SRH work**.** While participants intuitively recognised the impact of social capital mechanisms, these were often treated as intangible, on-the-job skills rather than core components of service delivery. The act of identifying and naming these mechanisms provides a pathway for integrating them more deliberately into future practice.

Secondly, the need for continuous engagement across the disaster cycle emerged as a key theme. Participants described the value of stable periods for building capacity, raising awareness, and empowering communities**.** Long-term approaches offer sustained opportunities for fostering trust and engaging meaningfully with community members, something that cannot be achieved during brief emergency visits. Part of this work should include strengthening existing community support mechanisms, including empowering Turaga ni Koros, Nurse ni Koros and women's and youth group leaders. This was particularly pertinent in the context of community sexual and gender-based violence referral and reporting mechanisms. Finally, participants also outlined how partnerships are essential in meeting SRH needs efficiently and sustainably, especially given the logistical challenges of working across Fiji's remote islands. Strong, well-coordinated collaborations between local actors, NGOs, and government agencies can help maximise the value of trusted relationships and ensure consistent and effective messaging.

These insights and observations are an important thread between the findings and discussion sections of this thesis, drawing on the expertise and experience of key Fijian actors in interpreting the findings and moving to their implications in the real world.

Discussion

Introduction

Natural disasters affect millions of people each year. Earthquakes, tropical cyclones, landslides and floods destroy lives, homes and livelihoods often displacing whole communities and causing significant upheaval. Climate change is increasing the frequency and intensity of natural hazards. The Intergovernmental Panel on Climate Change have brought attention to global increases in hot extremes, heavy precipitation events, major (Category 3-5) tropical cyclones and fire weather and point towards this trend continuing (IPCC, 2023). These hazards become disasters when they occur in places characterised by high vulnerability and exposure and therefore, disproportionately impact poorer countries (UNDRR, 2017). The Pacific region is particularly vulnerable to natural disasters and the impacts of climate change (Barnes, 2020). The unique island geography of the region means remoteness, inaccessibility, economic marginalisation and dependency on natural resources all compound the impact of natural disasters. Fiji, a Pacific nation consisting of 332 islands has an extremely high exposure to tropical cyclones, which often cause loss of life and huge economic damage. Amongst the upheaval that cyclones and other disasters precipitate across Fiji and the wider Pacific, affected communities continue to be entitled to their human rights, including their right to health, and in particular SRH.

The last two decades have seen increasing global recognition of the importance of addressing the SRHR needs of individuals affected by humanitarian crises. In 2015, the landmark Sendai Framework for Disaster Risk Reduction 2015-2030 specifically recognised SRH as a critical health service and in early 2024 the Sendai Framework Gender Action Plan was released to support its implementation with access to SRHR in disaster contexts as one of its nine key objectives (UNDRR, 2015; UNDRR et al., 2024). In 2019, the Health Emergency and Disaster Management Framework developed by the World Health Organisation also directly included SRH as a health service component in emergency and disaster risk management (WHO, 2019).

Ongoing inter-agency collaboration amongst key actors in the sector has resulted in the advancement of SRHR as a priority area in humanitarian response as demonstrated by the inclusion of the MISP for SRH in the 2000 version of the SPHERE Handbook, a universally recognised set of humanitarian standards and principles (Sphere, 2018). The MISP outlines which essential SRH activities should be implemented within the first 48 hours of onset of any crisis. The Inter-Agency Working Group on Reproductive Health in Crises Field Manual was also developed to provide comprehensive guidance for SRH service providers implementing the MISP and working in humanitarian contexts (IAWG, 2018a). Despite this significant progress in coordinating and increasing

the effectiveness of global efforts there is still significant room to improve and thereby enhance the SRHR of women and girls in the years and natural disasters to come.

Social capital, or the resources accessible through one's social and interpersonal networks (Kawachi et al., 2008), is an important social determinant influencing women's SRHR (Agampodi et al., 2017; McTavish & Moore, 2015; Story, 2014). Studies also show that social capital plays an important role in humanitarian response, recovery and preparedness (Aldrich et al., 2021; Travers, 2024) including specifically in the area of health (Aida et al., 2013). The systematic literature review conducted at the outset of the research journey informing this thesis investigated the nexus of social capital and women's SRH in humanitarian settings, a relatively unexplored area of scholarship (Ireland et al., 2021).

Only one of the 19 studies reviewed explicitly used 'social capital' as an explanatory framework however by using a priori proxies for social capital and identifying these in each of the studies' findings, the review found that it does play an important role in women's SRHR in humanitarian settings. Specifically, it found that social capital influenced women's SRHR through three primary mechanisms of social support, informal social control and collective action. These were mediated by the prevailing socio-cultural norms and traditions of the communities resulting in the potential for either beneficial or adverse impacts on women's SRHR. These findings pointed towards the potential opportunities for strengthening SRH service delivery by leveraging the positive social capital and mitigating its negative impacts. The systematic review highlighted a gap in, and the need for research specifically focussed on the link between social capital and women's SRHR in humanitarian contexts, especially natural disaster contexts.

In light of the established gap in the literature, this research set out to explore how the incorporation of a social capital analysis could improve SRHR crisis preparedness, response and recovery efforts. This study was conducted over three phases. The first phase mapped the way in which social capital was incorporated across international, Pacific regional and Fiji national SRHR preparedness and response planning, policy and guidance documentation. The review found that social capital was indirectly incorporated into the documents, in two ways. Firstly, three approaches were identified that service providers can take to harness or build social capital. These were, community involvement, linking to existing services and local organisations, and the identification of community resources. Secondly, the review revealed several social capital mechanisms such as trust, social norms and values, social power, social support and the integration of traditional knowledge and experience that could be both employed to improve SRHR information and services in humanitarian settings or which could hinder the delivery of and access to information and services. For example,

the social support provided by trusted family or friends can provide critical practical and emotional assistance to women seeking SRH services in a crisis setting (IAWG, 2018a, 2020a; IPPF, 2020; Oxfam, 2018; WHO, 2000, 2012a). Conversely, a humanitarian situation might cause the loss of social support networks, which can have an adverse impact on women's access to SRH services or increase risks such as unsafe sexual practices. Of note, the review found that these social capital mechanisms were often not described in sufficient depth throughout many of the documents. A more explicit and comprehensive focus could add value to the documentation and help strengthen preparedness, response and recovery activities.

Phase Two of the study investigated the lived experience of delivering and accessing emergency response SRH services in Fiji. The qualitative fieldwork was conducted in 11 villages across three field sites that had experienced tropical cyclones and with 20 NGO, INGO, UN agency and government actors involved in delivering the SRH emergency responses. 62 one-to-one interviews and ten focus group discussions provided a rich dataset which demonstrated the critical role social capital plays in women's access to SRH information and services following tropical cyclones.

The findings showed that this occurs through three interconnected pathways: socio-cultural norms and values, trust, and social support. These pathways are dependent on formal and informal networks and nodes which, in terms of SRH, mostly draw on bonding and linking capital. For example, the village governance structure forms a critical network for information dissemination. Bonding ties, that characterise relatively homogenous groups of people, help hold this network together and it also provides a structure for linking ties, out to external institutions and service providers. The influence of social capital on women's access to SRH information and services after tropical cyclones can be both positive and negative. An illustration of this is the way family planning information and misinformation can spread through women's networks impacting their decisions relating to contraception, both positively and negatively.

The final research phase sought firsthand reflections on the findings from Fijian NGO, INGO and UN agency practitioners to collaboratively identify possible opportunities for improving disaster planning and response in relation to SRHR. In-depth interviews were held with five participants from Phase Two, two from local NGOs, two from INGOs and one from a UN agency. Each of the participants reinforced the salience of the findings and, in particular, the importance of naming and describing the 'softer' but critical social capital-related elements of their work. They highlighted strengthening existing support mechanisms, working across the breadth of the disaster cycle, and working in partnerships as areas with potential opportunities for improving the delivery of SRH emergency responses.

In sum, the two main findings of this research are: 1) Social capital both facilitates and impedes women's access to SRHR information and services in crisis settings in Fiji; and 2) There is scope to improve access to SRH services and service delivery in crisis settings in Fiji with a more explicit and comprehensive focus on social capital.

This chapter begins by critically contextualising the findings in the broader literature, noting where they resonate and where they diverge. The discussion will then explore the implications of the findings, considering first the opportunity offered by natural disasters like cyclones for systemic strengthening, especially through the development of linking capital. Secondly, the need for ongoing engagement with socio-cultural norms and values as part of preparedness activities will be discussed. And finally, the importance of localisation in providing humanitarian SRH services will be explored, considering the value of the 'ultra-local' level and the roles and potential of local community leaders. Importantly, I argue that localisation needs to be understood as a shift of resources and power to local actors and as a nuanced process that must account for the complexities of social capital and its mechanisms, which work within and across geographically bound spaces. Following this, a number of recommendations are made, shifting the focus to the real-life implications of the findings and discussion. I then provide a critical reflection on the methodological frameworks that guided the production of these findings and the final part of the chapter considers the limitations of the study.

Situating the findings in the social capital literature

This research has explored the potential for strengthening SRH service delivery and access by employing a social capital framework to understand how connections, networks and resources that inhere within them play a role in women's SRH in crisis settings. As discussed in the first chapter, the concept of social capital is broad, and often contested by scholars. The definition offered in the introduction chapter continues to be relevant to the ensuing discussion. However, at the outset of this section it is critical to note the following regarding the concept of social capital, best articulated by Szreter and Woolcock (2004),

> *Social capital is not a magic wand for improving society, nor is it a self-contained comprehensive theory. It is a useful concept, which focuses our attention on an important set of resources, inhering in relationships, networks, associations, and norms, which have previously been accorded insufficient priority in the social sciences and health literature. This is probably partly because they are not easy to categorize, study and measure in their effects. (p. 661)*

In this vein, I have employed a social capital framework as a useful tool to investigate and analyse what could be described as ethereal but which are nonetheless critical factors influencing women's SRHR in crisis settings. As noted by Szreter and Woolcock (2004) social capital is not a comprehensive theory however for the purposes of this research it provided a practical lens through which to explore the often intangible social dimensions that shape access to care. Its flexibility enabled an analysis that foregrounded relational assets, such as trust, without losing sight of broader social and institutional dynamics. Although alternative theoretical approaches, including more anthropological or feminist ethnographic perspectives, might have yielded different or deeper insights into power and culture, the social capital framework was well suited to the study's applied and solutions-oriented focus. It enabled a policy-relevant understanding of women's lived experiences, highlighting not only barriers but also opportunities to harness existing social resources in ways that support improved SRH outcomes.

As established in the introduction and literature review sections of this thesis, very little research has been conducted using a social capital framework to explore women's SRH in crisis settings. There is however, a robust and evolving body of literature that delves into social capital and health more generally. The following section will outline how the research presented in this thesis resonated with the established literature and where it diverged from it, exploring first social capital mechanisms, followed by types of social capital, and lastly considering the role of 'trust' and 'socio-cultural norms and values' throughout the findings.

Social capital mechanisms

In terms of the mechanisms through which social capital impacts on health, the findings largely aligned with previous research, though not every mechanism outlined in the literature was observed in these findings. Kawachi et al (2008) present these mechanisms as belonging to two groups, those relating to individual social capital and those relating to community level social capital. At an individual level they include, social influence, social engagement and the exchange of social support. At a community level social capital influences health through collective socialisation, informal social control and collective efficacy. The following outlines the ways the findings echo the literature and demonstrate these social capital mechanisms impacting women's access to SRH information and services following cyclones. It also notes which mechanisms were not identified.

The mechanisms of social support, social influence, collective socialisation and informal social control can be identified throughout the findings. Firstly, with regard to social support, the findings echoed previous work which agrees that social support can influence health through enabling or providing direct access to health resources (Berkman & Glass, 2000). A clear example of this is the lending of

money or fuel to travel to a health clinic. The critical nature of this kind of support and the way it could influence health is amplified in an emergency setting when weather and finance related stresses compound the challenges faced in accessing services.

Interestingly, the findings from this research did not include any examples of emotional support (a sub-type of social support) influencing women's access to SRH information and services in crisis settings. The literature review had previously found several studies that identified the positive impact of emotional support, usually from close family members, on the self-reported mental and physical health of women who had experienced sexual violence. There was not however a clear link between this support and women accessing SRH information and services. Similarly, in this research, although participants did sometimes reference the emotional support provided by friends and family members in times of stress after cyclones, it did not lead to accessing SRH services and consequently the interview questions did not pursue the investigation of this element of social support. Closely related to social support is social influence, the way that people in a network influence each other's health behaviours (Kawachi et al., 2008). An example of this in the findings is the way others in a woman's network influence both their decision to use contraception or not to, and if they do, which method they choose. This type of influence is leveraged through shared norms as well as individual experiences and opinions.

The community level counterparts of social influence are informal social control and collective socialisation, both of which can be seen in the findings. Informal social control and collective socialisation are similar mechanisms, ways in which communities influence or collectively regulate and maintain social norms and behaviours (Carpiano, 2006). Informal social control was the most common mechanism seen in the findings. An example of this is the perpetuation of norms and behaviours relating to intimate partner violence and how this can lead to women choosing to remain in violent situations, rather than access services that might be available to them, including in crisis settings. Interestingly, informal social control in the literature is mostly used to describe positive impacts on health outcomes, for example the way a community might regulate drug use amongst young people (Kawachi et al., 2008). I would argue however that it is the same mechanism at work in the findings and that the tendency toward viewing it as only having a positive impact is an example of the way social capital has not always been fully represented in the literature, which has sometimes missed, or downplayed its 'dark side' (Villalonga-Olives & Kawachi, 2017).

Collective socialisation is more specifically about the way adults shape the behaviours and health outcomes of children (Kawachi et al., 2008). An example of collective socialisation described in the findings is the influence of community members on young people's decisions to access contraception

when services were brought to communities as part of an emergency response. The social expectation that contraception should only be needed after a woman is married provided a significant barrier for young people accessing contraception, with the potential to impact their SRH outcomes in this regard.

Of note, the social capital mechanisms of social engagement and collective efficacy were not identified in the findings as impacting on women's SRH in post-cyclone settings. Social engagement is a social capital mechanism that is enacted at an individual level and refers to participation in social community activities. The impact this has on individual health is difficult to pinpoint but researchers agree that the attachment to community and sense of belonging that social engagement can engender, contribute to improved well-being (Eriksson, 2011). In a disaster setting, research has linked this to improved mental health (Aida et al., 2013) but no existing research has investigated the direct impact of social engagement on SRH in a disaster setting. Although it did not emerge from these findings it may still play a role, however further investigation would be needed to ascertain this.

At a community level, collective efficacy is the willingness of the community as a whole to advocate for the common good (Kawachi et al., 2008). In terms of how this can impact health, a community may come together to demand increased health services for example, or to campaign around a public health issue. This mechanism was identified in several studies included in the literature review in which groups had come together around an issue, for example, people living with HIV who advocated for reducing stigma and discrimination in their communities following conflict-related displacement (Muzyamba, 2019). The particular focus and context of the research presented in this thesis looked at access to SRH information and services following tropical cyclones in Fiji and did not consider collective advocacy efforts linked to this that might be made in stable times. However, even when talking about stable times no participants mentioned anything resembling collective efficacy relating to health, especially not SRH.

Bonds, bridges and links

Another dimension of social capital is the different types of social ties between individuals, communities and institutions. Unlike other elements of social capital, the bonding, bridging and linking distinctions are relatively consistent across the literature. These have been outlined in the introduction of this thesis, but in brief, bonding capital refers to strong network ties with homogenous groups whilst bridging capital denotes weaker network ties between people in groups of approximately equal status and power but different identities (e.g. race, class). The more recent concept of linking capital describes the vertical relationships and ties between community members

and formal institutions with decision making powers. Using this framework to interpret the findings, a number of observations are consistent with the literature however there are also some noteworthy divergences.

Bonding capital

As outlined in the literature review, in the broader field of social capital and health, bonding capital is understood as both providing an important health survival mechanism for community members but also potentially representing a health liability. These two sides of bonding capital were clearly reflected in the findings as touched upon in the findings chapters. Strong bonded ties between community members enabled the flow of instrumental support, for example, where women could draw on neighbours and family members for financial assistance to access health services following cyclones. The same bonded networks facilitated the dissemination of information relating to post-cyclone SRH services and provided the relational infrastructure for the community management of intimate partner violence.

Conversely, the findings also showed how the bonded networks had the potential to have a negative impact on women's access to SRH services after cyclones. Ferlander (2007) notes that closeknit, bonded social networks which include a high level of social influence and low level of external information coming in can encourage and enable unhealthy behavioural norms. The findings illustrated the way social influence played out through shared norms and values which underpin the bonding ties and help shape the way the resources flow through them. For example, some of the primary barriers faced by women in accessing contraception pertained to socio-cultural norms around who should be using contraception and how many children, especially sons, a woman should have. Similarly, norms relating to keeping problems to oneself influenced the willingness of women to seek support in the event of intimate partner violence.

Bridging and linking capital

Despite bridging and linking capital having definitions that are clearly distinguished from each other, the literature often conflates the two, or elements of them. For example, Szreter and Woolcock (2004) note the horizontal nature of the 'bridge' metaphor, emphasising that bridging capital links people or groups who hold approximately equal status or power. On the other hand, Koh and Cadigan (2008) suggest that an example of bridging capital could be connections between local communities and official agencies or trust between residents and authorities, implying a social tie which runs across power differentials. Without continuing down this theoretical rabbit hole, it is important to note that I will use the two differentiated definitions to interpret the findings as I believe the added layer of nuance provided by drawing on both is helpful to this discussion.

Bridging capital has generally been understood to be essential in improving health outcomes (Szreter & Woolcock, 2004). The findings of my research did not identify any forms of bridging capital that related to women's SRH in post-cyclone settings. In the context of the existing body of research, this is not surprising, several studies have shown that poorer, isolated communities tend to have less bridging capital (Poortinga, 2012; Story, 2014). Islam et al. (2006) described bridging capital as the opportunity for community members to connect with diverse, heterogeneous groups of people. The geographical isolation faced by community members in most of the field site villages is a significant limiting factor in being able to interact with groups other than those in the same village. In addition, the low priority put on their own SRH meant that the bridging connections that did exist, had no relation to SRH. For example, most women participated to varying levels in the formal women's group of their village and were part of a church congregation. Both forums provide avenues for connecting with their counterparts in other villages, which may have been a source of bridging capital. However, health, in stable or crisis settings, and especially SRH was not a part of the remit of these groups.

Linking capital is a newer concept compared to bonding and bridging capital and the literature broadly agrees that higher levels of linking capital correlate with better health outcomes (Poortinga, 2012; Sundquist & Yang, 2007). In line with this, the findings showed that the linking capital that existed between community members, or communities as a whole, and SRH service providers had a positive impact on women's access to SRH services and information. As described in the previous chapter, the primary connections between community members and SRH providers, were through the village headman, the Turaga Ni Koro, and the village-based health staff. For the most part, these links facilitated access to SRH information and services after cyclones. However, linking capital is also understood to be two way, in that it can give communities a voice into higher levels of decision-making (Ogden et al., 2014), an element which was not evident in the findings. Lastly, the findings also showed how visiting NGO teams providing emergency SRH responses built new linking capital with individual community members, including the Nurse ni Koros, which may have the potential for improved SRH outcomes in the future. The opportunity for building linking capital in crisis settings has not been explored in the literature to date.

Social network analysis

In light of this section which has considered the types of links and ties holding individuals and groups in broader networks, it is pertinent to note the inherent limitations of a qualitative research approach in this regard. My research broadly identified network ties and networks by using proxy indicators such as who participants drew on for social support in post-cyclone settings, their trust and willingness to engage with community leaders or their sources of SRH related information.

Whilst these provide important insights, it would be remiss not to acknowledge the wider social network literature and in particular the valuable tool of social network analysis. Social network analysis provides an important tool for systematically understanding and quantifying the links mentioned above and the networks they collectively create. The International Rescue Committee describes it as the process of mapping the relationships making up a network including an analysis of the network structure and the influence of the various actors in the network (IRC, 2016). Social network analysis has been applied across a variety of contexts including the health and humanitarian sectors (Berkman & Glass, 2000; Cachia & Ramos, 2020; Klärner et al., 2023).

In the context of disaster recovery, social network analysis has often been used to find patterns amongst the interorganisational networks participating in the emergency response (Varda et al., 2009). Using social network analysis in this manner can help service providing actors understand the flow of resources, dissemination of information and identify opportunities for collaboration to increase the effectiveness of finite resources. Social network analysis has also been suggested as a potential tool in the area of humanitarian protection, at both an individual and community level. For example, it can quantitively map the relationships of those requiring humanitarian protection and identify the resources, or social capital within those networks which could be mobilised (Cachia & Ramos, 2020). Using social network analysis in these settings, could add a quantitative, complementary element to building a comprehensive picture of the way social capital influences the delivery of humanitarian SRH services and women's access to them.

Disentangling 'socio-cultural norms and values 'and 'trust'

The final part of this section will situate the findings relating to 'socio-cultural norms and values 'and 'trust 'in the social capital literature. These concepts emerged as central themes in the analysis and it is important to understand where they fit in the social capital framework in a health context and to outline where they resonate with existing literature and where they diverge from it.

In seeking to understand the interplay between socio-cultural norms and values and social capital within the context of health, it quickly becomes evident that these concepts are deeply intertwined and often inseparable. The findings of this research illustrate that socio-cultural norms and values are not merely background factors but rather, pervasive elements that shape and are shaped by social capital mechanisms. This aligns with existing literature to a certain extent, which emphasises that social capital cannot be fully understood without considering the cultural context within which it operates (Kawachi & Berkman, 2000; Putnam, 2000). In addition, the concept of 'shared norms', most commonly 'norms of reciprocity' and how these can influence health are often referred to in the literature. It is not surprising that if group norms promote the use of health services, for example

routine immunisation of children, it is likely that uptake of those services will increase (Story, 2014). In the findings of my study the significance of socio-cultural norms and values lies in their centrality in understanding the way particular social capital mechanisms will have either facilitating or hindering roles on the delivery of and access to SRH services in crisis settings.

The findings showed that each of the social capital mechanisms found to be playing a role in women's SRH in crisis settings, (i.e. social support, social influence, collective socialisation and informal social control) were heavily mediated by socio-cultural norms and values. This was also identified in the systematic literature review however, most of the studies included in the review did not use an explicit social capital lens, so this observation was made as a result of interpreting the findings using a social capital framework, rather than it being part of the original research aims. Tying back to types of social capital, Derose and Varda (2009) note that the prevailing norms and beliefs within a network are critical to the effectiveness of bonding capital in improving healthcare access, and where those beliefs do not support healthcare access, then bridging and linking ties may play a more crucial role. The findings of my research support this hypothesis, highlighting the sometimes-negative impact of socio-cultural norms and values on women's access to SRH information and services in the highly bonded networks of the field site communities and the actual and potential role for linking capital in mitigating this.

In a similar vein to socio-cultural norms and values, the concept of 'trust' is difficult to separate out from other elements of social capital and analyse on its own. This can be seen in the complex interconnections between it and other elements of social capital which have been described in the sixth chapter (*Situating the findings: further insights into the broader context of social capital and access to SRH services in cyclone-affected rural Fiji*). This hard-to-grasp nature is reflected in the broader literature. Trust is always mentioned in theoretical descriptions of social capital and the understanding that it is essential to the broader framework is uncontested. However, pinpointing its exact role, especially in a health context is a greater challenge. Some see it as a feature of social organisation that facilitates cooperation in the interest of the network (Putnam, 1993), that is, a precursor to social capital whilst others see it as one of the resources that social capital makes available to members of a network, even using perceived trust in others, in some studies, as a measurement of social capital (Kawachi et al., 2008).

With regard to my findings, it can only be assumed, as I did not set out to quantitatively measure it, that trust between community members, facilitates the flow of social support described in the fifth chapter (*Community and service provider insights into social capital pathways to sexual and reproductive health service access and utilisation*). This is consistent with the general understanding

of how bonding capital operates. Most striking however, was that the majority of the findings relating to trust were concerned with identifying how service providers could build and leverage trust with community members in order to optimise their service delivery. Although this is not surprising in the context of linking capital with its reliance on 'respectful and trusting ties to representatives of formal institutions' (Szreter & Woolcock, 2004, p. 655), its particular significance in the specific area of SRH has not been flagged in the literature to date.

Implications and recommendations

This section transitions from an analysis of the findings and where they sit in relation to the literature, to the practical implications for the broader sector. The previous chapters and the preceding section of this chapter have highlighted and unpacked the significant role of social capital in shaping the delivery of and access to SRH information and services in crisis settings, particularly in the aftermath of natural disasters like cyclones. This section aims to outline the practical applications of these findings and focus on three key areas: leveraging cyclones as opportunities for system strengthening; the need for engaging with socio-cultural norms and values as part of preparedness activities; and promoting the localisation of SRH services. By exploring these dimensions, we can better understand how to strengthen health systems and ensure the effective delivery of critical SRH services in times of crisis, ultimately improving health outcomes for women and girls in vulnerable communities. This forward-looking approach seeks to bridge the gap between theoretical understanding and practical implementation, providing evidence-based recommendations for community and professional stakeholders to enhance SRH service delivery and access in emergency contexts. The following section will also draw on and include the insights provided by Fijian practitioners, presented in the previous chapter (*Reflections and insights from practitioners*), as an important layer of interpretation.

Crisis as opportunity

While cyclones and other natural disasters are, justifiably, viewed primarily as crises requiring an immediate humanitarian response, they also present unique opportunities to strengthen health systems, including SRH. As the findings showed, SRH is often given low priority by both women and their communities in general, but especially in the aftermath of disasters. This is the result of a number of factors, including social-cultural norms, lack of awareness, and the perceived immediacy of other basic needs. Despite the critical nature of SRH, there has been, and continues to be a gap in providing access to SRH information and services as part of broader humanitarian responses to disasters (Singh et al., 2018). Historically, the focus has often been on immediate survival needs such as food, water, and shelter, while SRH services were seen as secondary despite the need for them

usually increasing in crisis settings (Casey, 2015; Mcginn, 2000). This perspective has gradually shifted with increased recognition of the essential nature of SRH services, particularly in addressing the exacerbation of health issues related to crisis conditions, such as increased rates of sexual violence and maternal mortality. This is evidenced through the introduction of the MISP and the inclusion of SRH in the SPHERE Handbook as described in the introduction of this chapter.

In Fiji, IPPF, with the support of the Australian Government Department of Foreign Affairs and Trade, has been actively working to improve health outcomes in crisis-affected populations through the Sexual and Reproductive Health in Crisis and Post-Crisis Situations (SPRINT) initiative. This initiative aims to reduce SRH-related morbidity and mortality by enhancing the capacity of local service providers to implement the MISP effectively. Through targeted training and resource provision, IPPF has strengthened the capacity in Fiji to deliver essential SRH services during emergencies (Beek & Dawson, 2020). As a result of these efforts, there are now specialised SRH emergency responses being deployed to communities following cyclones to provide critical SRH services.

The findings showed that as well as being vital in addressing immediate health needs these responses also serve as an opportunity to build linking capital between community members and SRH service providers. This bridging of relationships enhances institutional trust and communication, which are essential for effective healthcare delivery both during crises and in stable periods. The concept of leveraging disasters as opportunities for health system strengthening is not new. Previous research has highlighted the potential for such events to bring about improvements in healthcare infrastructure and service delivery in several different ways. For instance, the Committee on Post-Disaster Recovery of a Community's Public Health notes that disasters, 'although unquestionably tragic, create new resources and opportunities to advance the design and realisation of health communities' (National Academy of Medicine, 2015, p. 48). The *Health and Disaster Management Handbook* published by the Australian Institute for Disaster Resilience (2019) highlights the opportunity to learn which is provided by disasters, and Nolen (2014) observes the benefits that arise from the collaboration of multiple sectors and disciplines in the aftermath of such events. However, the concept of using SRH emergency responses to build linking capital in rural, underserved communities has not been extensively studied. This approach involves creating and reinforcing connections between local populations and external health service providers, which could have lasting benefits beyond the immediate crisis response. The implications of this are significant in terms of how emergency response teams enter into communities and most effectively use their time there through the leveraging of relevant social capital mechanisms, as seen in the findings.

Health teams entering into communities after a cyclone, especially those where they have no prior connection, need to understand the importance of establishing trust and leveraging social capital, in order to both meet immediate needs but also to build lasting linking capital. Some of the ways this can be done were highlighted in the findings including the importance of engaging in cultural protocols such as sevusevu, connecting with the appropriate local figures, such as the Turaga ni Koro, local health staff, or the Nurse ni Koro and the value of incorporating information sharing into emergency responses.

The findings also revealed the way that emergency response teams have the potential to offer a confidential space which can increase accessibility for community members. This can be partially achieved through creating a physically private setting. In addition, external service providers are in a unique position, being sufficiently disconnected from the community, to give community members confidence in their confidentiality. Many participants noted their feelings of trust towards external health providers and the level of confidentiality they felt existed in these interactions. The 'disconnectedness' can also be described in social capital terms as the benefits, in this specific context, of linking capital vis-à-vis bonding capital. External health providers are not part of the closely bonded networks that make up the communities they are visiting and are therefore not subject to the specific sociocultural norms and power structures that impact trust and confidentiality relating to SRH issues at the village level.

External providers are connected to those accessing health services via linking capital and this, more 'distant', social tie enables objectivity which can help engender trust and confidentiality. As well as harnessing the benefits of their 'disconnectedness', external health providers can also draw on what connections they do have with the community members, such as inter-provincial or geographic ties to build trust in a brief window of time. Achieving the balance of connectedness and disconnectedness requires careful team selection and a high level of awareness from team members. Harnessing these elements of social capital can help emergency response teams leverage and build trust and linking capital in a brief window of time that they spend with a community. The use of quantitative tools, such as social network analysis could provide a systematic and valuable way for NGO service providers to map these network connections in order to optimise existing trust and social capital.

Building linking capital during SRH emergency responses has the potential to have enduring effects on women's SRH outcomes beyond the crisis period. Existing research on the concept of resilience supports the idea that actions which are taken to reduce vulnerability during crises can also have a positive impact on day-to-day life and community wellbeing in stable times (National Academy of

Medicine, 2015). Further research would be required however, to explore this in the specific context of linking capital and SRH. Another element for consideration by practitioners and researchers alike is the potential opportunity for linking capital to provide an avenue to community members for advocacy and having a voice in higher level health-related decisions which affect them. This component of linking capital, though described in the literature (Ogden et al., 2014) was not explored as part of the research informing this thesis but could have noteworthy implications for the sector.

Different models of disaster response offer different avenues for opportunities to build social capital. Two different methods for delivering post-disaster SRH services were used across the three field sites. In Koro and Kadavu services were delivered directly to each village. As has been previously described the delivery team would coordinate with village leaders, usually the Turaga ni Koro or local health staff, to find an appropriate time and would spend half a day to a day providing information and services. This method of service delivery prioritised ease of access to services for community members. By setting up within a village, community members did not have to travel long distances to access SRH services which, as the findings showed, were often not prioritised in the post-disaster setting. Some villages in Kadavu are only accessible by boat, and paying for fuel was a significant barrier in accessing health services. This format of service delivery removed that barrier for community members in isolated villages. Another benefit of this approach is that the whole village was invited to hear from the visiting NGO which meant that awareness raising messages were disseminated to a broad range of the population in each village rather than only women, or others seeking a particular service. By harnessing the social capital mechanisms described earlier in this section this type of service delivery creates opportunities for building linking capital with community members who would not otherwise connect with these types of services

In contrast, following Tropical Cyclones Ana and Yasa in Vanua Levu, SRH services were delivered through the establishment of multi-month 'Women-Friendly Spaces'. These were physical hubs set up to provide information, services and commodities to women from surrounding villages. Part of this approach also involved outreach to the villages, with staff travelling to speak with community members in villages about the services provided at the hub. The Women-Friendly Spaces were managed by retired midwives, in collaboration with local health teams and the Nurse ni Koros. These Women-Friendly Spaces provided a safe place for women to gather, and rebuild their social networks, as well as access any SRH related services in a more anonymous space than their own village. Health and coordination staff involved in the Women-Friendly Spaces found that women often felt safe and comfortable, and formed strong bonds with Nurse ni Koros, the retired midwives and other community members over the extended time period. They noted that this helped women

feel comfortable to talk about sensitive issues such as gender-based violence. Broader literature suggests that there could be opportunity for bonded support groups that form within these types of crisis response spaces, to leverage and build bonding capital which could be used as a platform for advocacy and the 'renegotiation of social norms' relating to SRH issues back in their communities (Gregson et al., 2008; Ogden et al., 2014, p. 1077). There is scope for further research in this area, to explore the potential for support group building as part of an SRH crisis response which could have an ongoing impact in the lives of community members.

Natural disasters can serve as critical junctures for reassessing and improving the infrastructure and delivery mechanisms of SRH services. By reframing cyclones as opportunities for systemic strengthening, particularly through the building of linking capital, or perhaps through the leveraging of bonding capital in support groups, there is potential to transform these challenges into catalysts for building more resilient and responsive health systems that better serve the needs of women and girls, both during crises and in stable times.

Engaging with norms – community preparedness and resilience

The findings of this research highlighted the pivotal role that socio-cultural norms and values play in mediating social capital mechanisms, especially in the context of family planning and intimate partner violence. The following section considers the implications of this for SRH service providers working across the disaster management cycle. These socio-cultural frameworks shape individual and community attitudes towards SRH services, influencing both the accessibility and utilisation of these services during times of crisis. For instance, societal expectations around family size and contraceptive use, as well as norms concerning gender roles and violence, can either facilitate or hinder access to necessary healthcare in humanitarian contexts. The study observed that these deeply embedded norms often play a mediating role, working through social capital mechanisms to either positively or negatively impact access and use of SRH services and information. Crises can also sometimes disrupt socio-cultural norms, creating openings for shifts in behaviour (Moreno & Shaw, 2018). The findings showed instances where women exercised autonomy by accessing contraception after a cyclone, despite a prevailing norm around big families and their husbands' objections. Whether these instances represent a temporary disruption of norms or signal a broader shift in women's agency and empowerment remains uncertain.

This observation alone is not novel. The initial literature review underscored the critical influence of socio-cultural norms and values on SRH outcomes and in their global evaluation of reproductive health care in crises, the IAWG also identified gaps in care that related to attitudes toward SRH. The first phase of research, a review of guiding documentation and policies found that these norms were,

at the very least, acknowledged across most of the documents. The majority of these recognised the significant impact of social norms on SRH service delivery and the ability of community members to access these services. In response to this, most documents also noted the need for a 'culturally sensitive approach' to service provision, respecting and understanding local cultural contexts. Some documents suggested specific tools, for example, the IAWG proposes a values clarification and attitude transformation framework in some of their guiding documents for addressing harmful norms and promoting positive SRH attitudes (IAWG, 2018a, 2020a). Participants in Phase Three were also very familiar with the way social and cultural norms impact on the uptake of SRH services and noted that to engage with these required an extended time period, beyond that of the crisis response phase. This need for longer timeframes is also acknowledged in the broader literature relating to activities with the aim of changing norms (Michau et al., 2015).

The study site communities were mostly recipients of time limited emergency SRH responses, designed and intended to meet the requirements of the MISP following tropical cyclones. They provided essential SRH services and also included brief information sessions for the communities which often touched upon some of the prevailing norms relating to family planning and intimate partner violence. While these visits are critical, they lack the capacity to engage deeply, in the ways mentioned above, with the socio-cultural norms and values that are influencing women's access to the services they are providing. This limitation is inherent to the response phase of the disaster management continuum, which focuses on immediate relief and does not extend to the prolonged engagement required to shift entrenched social norms.

This is not to say government service providers and NGOs are not already working, outside of crisis times, with communities to shift harmful norms. Indeed, NGO participants in both Phase Two and Phase Three talked about awareness raising and health promotion activities that they implement in stable times, some with the aim of shifting norms. A number of the guiding documents reviewed in Phase One also recognised this challenge and emphasised the importance of implementing activities, outside of the response phase, that integrate socio-cultural norm transformation into their framework. However, Phase Three participants indicated that the sector in Fiji is currently under-resourced, limiting the capacity for long-term community engagement needed to effect meaningful changes in socio-cultural norms. The reality of this is that the SRH emergency response visit was, for the most part, the first time community members in the study sites had encountered and engaged with an NGO focussed on SRH. Due to the resource limitations most of these communities have not been visited since. While local government health providers are a more continuous presence in communities they would also require additional resourcing and capacity building to engage with long-term socio-cultural norm transformation relating to SRH in communities across Fiji.

Engaging with norms and values, which work through social capital mechanisms to impact on women's access to SRH services in crisis times, should be included as an ongoing part of the disaster management cycle. This type of community engagement would fall into 'preparedness' activities. Ready to Save Lives, a key guidance document for the sector, defines preparedness as encompassing "actions that are intended to improve operational readiness to respond to a disaster or destabilising event, and that contribute to a more efficient and effective recovery" (FP2020 et al., 2020, p. 11). In SRH terms, as shown in the findings, working with communities to strengthen positive norms and mitigate potentially harmful norms is a critical contribution to enabling emergency responses and the ensuing recovery to be as 'efficient and effective 'as possible. Though often conceptualised as one distinct phase of the traditional disaster management model, it is important to emphasise that preparedness is ongoing and embedded throughout the cycle, rather than being bounded by beginning and end points. Understanding preparedness as ongoing also aligns with the lived experiences of community members and leaders who view the seasonal risk of cyclones as an integral part of life. For these communities, preparedness is not a sporadic activity but a constant necessity, deeply intertwined with public health interventions.

Building further on this, the notion of 'community health resilience,' as explored by Chandra (2014), provides a useful framework for understanding the intersection between public health interventions and emergency preparedness. The National Academy of Medicine (2015), describes this as a 'dual opportunity space where actions that can be taken to make communities less vulnerable in a disaster context can also provide benefits in stable times. This ties back in with the concept of seeing cyclones as opportunities for building social capital, where the linking capital built during the response phase has the multifaceted potential to positively impact on community members' SRH during stable times and increase their preparedness for the next crisis.

Phase Three participants highlighted the challenge of securing adequate funding for preparedness activities and activities focussed on community level norms. Highlighting the sorts of efficiencies offered by a 'dual opportunity space' should be particularly appealing in this context where funding for both public health emergency preparedness and community health promotion is increasingly scarce. This means that coalitions and partnerships formed for emergency preparedness can also be leveraged for ongoing health promotion, and vice versa creating a multi-purpose infrastructure that serves a number of public health goals. Phase Three participants echoed this in reflecting on how to reach all the communities that live with the annual risk of cyclones. They stressed the need for enhanced networking and collaboration within the sector to ensure comprehensive outreach to all vulnerable populations. Coming a full circle, achieving these goals requires leveraging social capital amongst sector actors and fostering partnerships that can maximise limited resources.

Taking this a step beyond preparedness activities and community health promotion, genuine and sustainable change in socio-cultural norms relating to SRH requires a holistic approach, beginning with education. SRH education in Fijian schools is delivered through the Family Life Education program. Despite this nationally delivered curriculum, concerning gaps exist in young people's SRH literacy (IPPF & UNFPA, 2021; Roberts & Seru-Puamau, 2008). Well designed and delivered comprehensive sexuality education has the potential to shape young people's knowledge, skills, attitudes and values and enable them to make informed and empowered decisions about their SRH (IPPF, 2012). Educating boys and girls to understand gender norms, power and rights is key to shifting deeply entrenched socio-cultural norms that can contribute to poor SRH outcomes for girls and women in both stable and emergency settings. This highlights the need for holistic, multi-faceted approaches to SRH that permeate all levels of society from national level policies down to community and household level SRH service delivery and awareness raising. The research showcased in this thesis provides a snapshot of a specific SRH context, the implications of which need to be understood within the full picture in order to bring about sustainable change.

Addressing the deeply entrenched socio-cultural norms that shape access to SRH services requires a multi-dimensional approach that extends beyond immediate emergency responses. While preparedness activities and community engagement are crucial components for addressing these norms, sustainable change also relies on long-term investments in education and public health. As this research demonstrates, socio-cultural norms are key mediators of social capital and influence SRH service uptake, especially in crisis settings. For meaningful, lasting change, it is essential to integrate these efforts into broader frameworks of resilience, community health promotion, and comprehensive sexuality education. By doing so, SRH service delivery can become more effective, equitable, and responsive, both in stable times and in the face of recurring crises.

Localisation

Building on the ideas of cyclones providing opportunities for building social capital and the need for ongoing preparedness activities which engage with community norms and values, the findings also point towards the value of localisation in humanitarian responses, particularly in the context of SRH services. In recent years localisation has increasingly become a buzzword among humanitarian actors, reflecting a growing consensus that more power, resources, and decision-making authority should be shifted to local actors. This shift is seen as a way to make humanitarian efforts more effective, sustainable, and culturally sensitive (Harris & Tuladhar, 2019).

The concept of localisation gained formal recognition with the Grand Bargain, an agreement forged at the World Humanitarian Summit in 2016. The Grand Bargain aimed to reform humanitarian

financing, with one of its key commitments being to provide at least 25% of humanitarian funding directly to local and national actors by 2020 (Roepstorff, 2020). This commitment was intended to empower local responders, enhance the efficiency of aid delivery, and ensure that interventions were more attuned to local needs and contexts. Despite these goals, the practical implementation of the Grand Bargain has been met with varying levels of success and significant debate within the humanitarian sector.

As with many buzzwords, the concept of localisation is not without contestation. While there is widespread agreement that local humanitarian action should be supported, what this support looks like in practice varies significantly across the sector. One of the primary points of contention is defining what constitutes 'local '(Wall & Hedlund, 2016). The term 'local' has been used to describe a broad spectrum of actors, ranging from local and national governments to civil society organisations, NGOs, and even locally-based branches of INGOs (Barbelet, 2018). This broad definition has led to differing interpretations and applications of localisation, making it a complex and sometimes ambiguous concept.

Across the literature, local NGOs are the most frequently discussed entities in relation to localisation. They are often viewed as critical players in the localisation agenda due to their close ties to the communities they serve and their ability to operate with cultural and contextual sensitivity (Barbelet, 2018). In two of the three study sites, SRH emergency responses following cyclones were implemented by a local Fijian SRH organisation, which was supported financially and otherwise by an INGO and worked in partnership with the Ministry of Health. This localised approach not only facilitated the delivery of essential services but also leveraged existing social capital within the communities.

There are several ways in which this localised response harnessed social capital to enhance both the provision of and access to SRH services, as detailed in the findings. For example, the local NGO was able to use existing connections between its staff and the communities, such as having previously visited the area or sharing a common background, such as being from the same island, or province. These connections eased logistical arrangements and facilitated smoother entry into the communities. The NGO also employed volunteers who were often retired nurses, well-respected due to their professional backgrounds. This preexisting credibility helped to build trust when entering communities, which was crucial for effective SRH service delivery. Additionally, because the response teams were primarily composed of Fijian team members, there were fewer cultural barriers to navigate. The teams had a lived understanding of local cultural processes and protocols, which

enabled them to enter communities respectfully, further building trust and facilitating access to the services they provided.

The value of local organisations, in terms of social capital, cannot be understated. Though not necessarily reflected yet in global humanitarian funding flows, the importance of local organisations is widely understood and appreciated in the academic literature and in guidance and policy documentation (Murphy et al., 2023). As outlined, the findings affirmed this and provided rich qualitative data relating specifically to SRH humanitarian responses run by local NGOs, which has been relatively underexplored in the localisation literature.

Furthermore, the findings also revealed that by applying the concept of localisation to the level of the affected community and community actors, there is significant potential for the strengthening of SRH service delivery and access, as a result of the social capital mechanisms at play. It remains unclear in the literature whether this 'ultra-local' level is included in broader understandings of 'local capacity'. However, there is a growing movement toward recognising affected communities as active agents in their recovery from crises, rather than merely as victims (Barbelet, 2018; Njeri & Daigle, 2022). Barbelet (2018) discusses this shift, emphasising the importance of empowering communities to take an active role in their recovery processes. The findings highlighted social capital mechanisms, active at the community level which impact on women's SRH. For example, the findings showed that communities have existing processes for managing incidents of intimate partner violence, although these processes are not without challenges and may not always provide adequate support. Challenges aside, these community structures represent a form of scaffolding that could be strengthened to become more effective community-based mechanisms for managing intimate partner violence in times of crisis, including proper reporting and referrals.

A key aspect of enhancing these community mechanisms is resourcing and empowering the Turaga ni Koros, the village headmen who are elected by the community and paid a small government stipend. The findings highlighted the central role these leaders play, not only in managing incidents of intimate partner violence but also in disseminating information related to SRH services and acting as conduits for linking capital between communities and service providers. The importance of further resourcing and empowering these leaders in relation to SRH preparedness was also emphasised by participants in Phase Three. They noted the sensitive nature of SRH issues and the need for focussed engagement with leaders to destigmatise these topics and enable them to provide strong leadership and facilitate access to services for women.

Another set of community actors with potential for strengthening SRH preparedness and response are the Nurse ni Koros. These roles, which receive a small stipend from the government, were found

to have varying levels of influence and trust within their communities. Unlike the Turaga ni Koros, who are almost always men, Nurse ni Koros are often women and are also chosen by community members. They have a direct line of communication with district or zone health clinics but remain based within their communities. Their intricate knowledge of their communities, social capital in the form of information, was identified as one of their key strengths. Local health staff and NGO service providers noted the value of liaising with effective Nurse ni Koros when visiting communities after cyclones, as they could provide up-to-date information on community members and their specific needs.

In addition to harnessing the social capital embedded in the roles and networks of community leaders like the Turaga ni Koros and Nurse ni Koros, empowering these community actors is crucial because they are the people on the ground when disaster strikes. In an island nation like Fiji, where even rapid SRH responses after a cyclone can be hindered by challenges such as weather and fuel availability, having adequately resourced first responders is of critical importance.

In terms of shifting this area of discussion towards practice, an asset-based model offers an approach to strengthening community capacity which aligns with principles of localisation and includes a focus at the 'ultra-local' level. Health assets are the resources which enhance "the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain and sustain health and well-being and to help to reduce health inequities" (Morgan & Ziglio, 2007, p. 18). An asset-based approach positions the community as a 'co-producer' of its members' health by strengthening the capacity of individuals and communities to realise the potential they already have. Asset mapping is the first step to identifying and connecting the existing community strengths such as respected leaders, support networks and links to service delivery institutions (Kretzmann & McKnight, 1993). In recent years, the value of asset mapping and strengthening in disaster management has begun to be recognised as a way to increase the resilience of communities prior to a disaster (O'Sullivan et al., 2014; WHO, 2021). Some humanitarian SRH guidelines, particularly those with a focus on adolescent SRH include references to identifying assets as part of preparedness activities (FP2020 et al., 2020; IAWG, 2018a, 2020a). Using a social capital framework, the research informing this thesis has highlighted some of the community level assets that can be leveraged to improve women's access to SRH services and information in a crisis setting. Incorporating asset mapping more systematically into SRH preparedness activities offers a practical and strategic approach to building community resilience and capacity, particularly at the 'ultra-local' level.

The potential of investing in and building the capacity of 'ultra-local' actors is significant, but this approach requires careful consideration of intra-network dynamics and the broader implications of

localisation. Although the term ‘community capacity’ has become ubiquitous in the health promotion literature it is also somewhat elusive in both its meaning and actuation (Labonte et al., 2002; Syme, 2004). Scholars have argued that the concept of ‘community’ in this context is often romanticised, ironing over lumpier parts of real-life communities such as cultural complexities and power relations (Chiu, 2008; Labonte et al., 2002; Traverso-yepez et al., 2012). As the findings showed, socio-cultural norms heavily influence social capital mechanisms, and community leaders are not immune to these influences. Njeri & Daigle (2022) caution that localisation, including ‘ultra-localisation’, “alone is not enough to ensure inclusion of the most marginalised or the organisations that represent them” (p.11). Therefore, investment in local leaders must be strategic, ensuring meaningful participation from all community members, including minority groups. For instance, in the Fijian iTaukei context, each village has a women’s group that meets regularly and holds varying degrees of influence in decision-making. These groups could be key avenues for empowering women community leaders, thus strengthening mechanisms that support women’s SRH in a more equitable way during crises.

A greater challenge exists for meaningfully engaging other vulnerable groups such as LGBTIQ+ people and people with disabilities. In the Pacific, and the Fiji context, people from these groups are heavily stigmatised and often discriminated against in communities, including by local leaders such as Turaga ni Koros and Nurse ni Koros (Oxfam, 2018; UNFPA & The University of Melbourne, 2022). Unlike women, there is not usually an existing, formalised group for them within the village structure. Intentional effort needs to be taken to consult with and include people from these groups when investing in capacity building at the ultra-local level which requires dynamic and multifaceted strategies. For people with disabilities this might include for example, the need to consider access issues when consulting with community members. Disability-focussed Civil Society Organisations are often well positioned to advise on these issues and to connect with individuals in communities (UNFPA & The University of Melbourne, 2022). For LGBTIQ+ groups it may be necessary to connect with informal networks, which are often important support spaces to identify strategies for participation, whilst ensuring the safety of everyone involved (Oxfam, 2018). Despite the emergence in recent years of guidelines for better serving and involving marginalised groups in humanitarian contexts their SRH outcomes continue to fall behind (Daigle et al., 2023; Oxfam, 2018). Policy makers and practitioners must continue working to address this gap through careful, inclusive and strategic investment in, and capacity building of, ultra-local actors.

Just as it is necessary to consider the context shaping dynamics at the ‘ultra-local’ level it is also critical to recognise the broader ecosystem of influences. In this vein, Roepstorff (2020) challenges the notion of the ‘local’ simply as the binary opposite of the ‘international’. She suggests that 'local'

should be understood as an activity occurring within complex webs of power and politics, where different actors operate and interact. This concept of 'critical localism' emphasises the need to analyse how social values, relations, resource use, authority, and power are shaped within local contexts, but also influenced by interactions beyond geographical boundaries. While alternative conceptual frameworks, such as classic socio-anthropological approaches or a localisation lens, could certainly have been applied to explore these issues, the use of social capital in this study provided a practical and asset-based approach to examining how relationships and networks shape both access to resources and participation in response efforts. It also enabled a focus on how these networks operate across scales, highlighting the interface between local systems and broader humanitarian structures.

A promising tool to consider in strengthening local capacity for SRH preparedness, response, and recovery is social media. Although social media was not explored as part of the research informing this thesis, emerging literature suggests its potential in this area (Lough, 2022; Madianou, 2015). Lough (2022) argues that social media enables community members to maintain and build social capital during crises, serving as a channel for both emotional and instrumental support. It also facilitates connections beyond immediate circles, removing geographical limitations that traditionally define 'the local' and allowing participation in a broader ecosystem. This could be particularly useful for building and maintaining bridging connections, which were notably absent in the findings, that support women's access to SRH services during crises. Additionally, social media could offer marginalised groups such as women, LGBTIQ+ and people with disabilities more anonymous and private channels to seek SRH-related advice or support, mitigating some of the confidentiality and privacy issues identified in the findings. However, the use of social media for supporting access to SRH services during crises must be approached cautiously. Madianou's (2015) research on the role of social media in the Philippines Typhoon Haiyan recovery highlights how digital inequalities often reflect and exacerbate existing social inequalities, allowing some to benefit more, in a recovery context, than others from access to these platforms. Further research could be of great value exploring how social media could be used to harness existing or build new social capital and improve access to SRH services in the context of humanitarian crises.

This section has outlined how the findings support the importance of localisation in humanitarian settings. They emphasised the need to consider the 'ultra-local' level and in particular the roles and potential of local community leaders. An asset-based model was noted as a potential approach for community-level capacity strengthening for SRH preparedness. Importantly, localisation needs to be understood not only as a shift of resources and power to local actors but as a nuanced process that must account for the complexities of social capital and its mechanisms which work within and across

geographically bound spaces. By recognising and empowering key community leaders like the Turaga ni Koros and Nurse ni Koros and understanding the broader webs of influence in which these actors operate, there is potential to strengthen the effectiveness and sustainability of humanitarian SRH service delivery and access.

Recommendations

Based on the findings, analysis and discussion presented in this thesis, I would like to put forward the following recommendations:

For NGO, INGO, UN agency and government actors involved in SRH humanitarian service provision:

- **Incorporate engagement with socio-cultural norms into ongoing preparedness efforts:** Ensure that ongoing preparedness activities actively engage with socio-cultural norms that impact marginalised groups' access to SRH services including women, LGBTIQ+ individuals, adolescents and people with disabilities.
- **Adopt an asset-based approach for community preparedness:** SRH service providers should implement asset-based mapping to identify and strengthen local community resources that could enhance SRH preparedness and resilience.
- **Maintain connections between health providers and local community members and leaders:** Identify strategies for sustaining linking capital relationships, after response periods, such as those between SRH service provision NGOs and village headmen, community health workers and other community members and leaders.
- **Enhance capacity building for local leaders:** Develop targeted capacity-building programs for local leaders such as village headmen and community health workers (including Nurse ni Koros) to better prepare them for SRH service delivery in crisis situations.
- **Explore opportunities for women's and youth groups:** Investigate the potential for village women's groups and youth groups to play a more active role in SRH preparedness and crisis response efforts.
- **Careful selection of response team members:** Ensure response teams are composed to include a balance of cultural competence and local connections as well as sufficient neutrality to foster safe, confidential spaces for service users.
- **Strengthen partnerships between NGOs, INGOs, UN agencies, government, and communities:** Maintain and reinforce strong partnerships and communication channels

between NGOs, government bodies, INGOs, UN agencies and local communities to ensure continuity in SRH service delivery across the disaster management cycle.

- **Mainstream diversity and inclusion across all SRH preparedness, response and recovery efforts:** Ensure that SRH preparedness, response, and recovery initiatives actively integrate diversity and inclusion principles, acknowledging and addressing the unique needs and vulnerabilities of marginalised groups, including women, adolescents, LGBTIQ+ individuals, people with disabilities, and ethnic minorities.

For Fiji government actors:

- **Prioritise comprehensive sexuality education in schools:** Ensure that Comprehensive Sexuality Education is consistently integrated into all school curricula and regularly evaluated to monitor its effectiveness in improving SRH knowledge and outcomes.
- **Increase the SRH capacity of Nurse ni Koros:** Support the upskilling of Nurse ni Koros in the area of SRH including relevant MISP related capacity building.

For researchers:

- **Explore the use of and potential for social network analysis in SRH humanitarian preparedness, response and recovery contexts:** Develop an evidence base demonstrating the value of social network analysis, specifically in a humanitarian SRH context, including at both community and organisational levels.
- **Investigate further the role of, and potential for linking capital in SRH humanitarian preparedness, response and recovery contexts:** Conduct research to examine if and how linking capital built during emergency responses continues to impact women's SRH outcomes beyond the crisis period, contributing to general resilience. In addition, explore the potential opportunity for linking capital to enable advocacy by community members to decision-making institutions.

Reflections on methodology

This section provides a reflection on the methodology that guided the production of the findings. The purpose of this reflection is to allow for a critical examination of how the research approach influenced the findings, to help contextualise the results, to provide transparency about the process and highlight the strengths and limitations of the methodology used. Through this reflection, I hope to articulate how the methods shaped the insights and conclusions drawn from the research.

This research was conducted broadly within a critical theory methodology and drew particularly on the critical theory strands of feminist and decolonising methodologies. This approach proved to be well-aligned with the research process and outcomes. In particular, the orientation of critical theory toward understanding and transforming the construction of knowledge and the organisation of power in society is well-suited to the exploration of social capital.

The literature review conducted at the outset of this research journey identified the need to consider the differential access to social capital within networks, and how the social capital of some network members can limit the potential of others. Critical theory provided a guiding framework which enabled a transformation-oriented approach to investigating and documenting the social realities facing Fijian women living in remote, cyclone-affected communities and identifying the key actors with the capacity to enact change. Though critical theory is often associated with observing what is 'wrong with social reality' (Spencer et al., 2020), this research equally highlighted positive social mechanisms with the aim of adapting practice to better utilise them.

Key tenets of feminist methodology complemented and sharpened the broad critical theory approach taken by this research. Feminist and critical theories share an "emphasis on vulnerable populations, social analysis and critique, and emancipatory action to promote social justice" (Kushner & Morrow, 2003, p. 31). Specifically, the research sought to focus on the accounts of women and to treat these as "legitimate and core sources of knowledge" (Spencer et al., 2020, p. 92). This approach affirmed the importance of exploring the messy realities of everyday life, especially when that takes place in a humanitarian context.

In order for me, as a white researcher, to conduct research with Fijian communities in Fiji within the critical and feminist paradigms it was essential to also engage with a decolonising methodology. As outlined in the Methods chapter, I undertook a number of decolonising practices throughout the research process to try and centre Fijian worldviews, cultural knowledges and epistemologies (Nabobo-Baba, 2008) in the data collection and analysis processes. This was not a straightforward, box-checking exercise which I can neatly 'finish' and I have continued to reflect on the successes and challenges I encountered throughout this thesis.

Paradis et al. (2020) outline a set of criteria for assessing quality and rigour of research methodologies conducted within a critical theory approach. Some of these are common across qualitative research more broadly and some are specific to critical theory. The criteria include: credibility, transferability, dependability and confirmability, substantive contribution, holism, evocativeness and emancipatory potential. The following self-reflection will consider the extent to

which my research met each of these criteria. Limitations are further described at the end of this chapter.

Credibility

Credibility refers to the believability and trustworthiness of the study's findings. To provide a high level of triangulation across the research design I drew from a number of different data sources, including policy and guidance documentation, community members, community leaders, NGO staff, INGO staff, UN agency staff, volunteers and government staff. I used three different research methods, a scoping review, one-to-one interviews and focus group discussions. I drew regularly on my experienced supervisory team, sharing my evolving analysis and writing with them and incorporating their reflections and feedback. The involvement of a Fijian research assistant during the fieldwork was another critical point of triangulation at the point of data collection and initial analysis of the findings. I also engaged in member checking to increase credibility. I did this firstly throughout the data collection process, offering participants the opportunity to view their transcript and make any changes or additions. Subsequently as part of Phase Three I shared the findings with several key informants and sought their feedback on the early interpretations I had made.

Transferability

This criterium is the extent to which the findings can be transferred and applied in different settings. One of the ways to demonstrate transferability is to provide a rich and detailed description of the methods, findings and their contexts. This thesis has aimed to achieve this by presenting the methods and findings in detail, including their contexts and providing participant quotes to bring the findings to life. Though this research is situated within a specific culture and specific sites, the 'thick' description is intended to enable the reader to make an assessment of the transferability to their own contexts. The resonance of the findings is demonstrated in the literature review and further elaborated on in the discussion, earlier in this chapter

Dependability and confirmability

To ensure dependability and confirmability, several rigorous steps were taken to conduct the research with high levels of consistency and transparency. Data saturation[11] was achieved independently at each research site, including Suva, and cumulatively across the three community field sites. An iterative approach was adopted throughout the data collection and analysis stages of each research phase. Insights from continuous examination and re-examination of the data informed

[11] Data saturation here refers to the point at which no new or additional data points were being identified from participant interviews and focus groups (Saunders et al., 2018)

the current and subsequent phases. I actively sought external feedback from peers and experts, including my supervisory team, fellow students, and through the process of academic publication. To maintain transparency, I kept a detailed audit trail of my research journey, documenting decisions and their rationales both at the practical fieldwork level and during the development and refinement of codes and themes. Reflexivity was central to ensuring confirmability and is a key component of the critical theory approach. I maintained a research journal to reflect on the process, particularly to identify my role and inherent biases. Regular discussions with my research assistant, who provided valuable insider knowledge and understanding of the Fijian iTaukei communities, were crucial in challenging my epistemological assumptions.

Substantive contribution

My research made a substantive contribution within the critical theory and qualitative research paradigm by challenging proceduralist approaches and emphasising the importance of substantive judgement (Eakin & Mykhalovskiy, 2003). This research advanced theoretical understanding by using a social capital framework to investigate women's SRH in crisis settings, specifically those relating to natural disasters. Methodologically, the research brought to the fore the voices of community members as 'experts' inunderstanding the realities and complexities of their lives. The practical implications of these findings are significant, informing policy and praxis that advocates for community-based interventions promoting local ownership and sustainability. By critically examining power relations and epistemological assumptions, my research contributed to a transformative agenda, supporting the integration of indigenous knowledge into broader academic and policy discourses.

Holism

My research was holistic in nature, incorporating multiple perspectives including community members, community leaders, both male and female, NGO volunteers and staff, INGO staff, UN agency staff and government staff to ensure a comprehensive exploration of the research topic. In using a social capital framework to explore a health-related research question, the research employed an interdisciplinary approach, combining insights from sociology and public health. This allowed for a richer and more rounded understanding of social networks and the community resources available to women which impact on their access to SRH services and information in the wake of tropical cyclones. These holistic elements of the methodology ensured that the research findings were grounded in the lived realities of the participants, providing a contextually relevant perspective.

Evocativeness

Drawing on principles outlined by Kumagai and Wear (2014) and Naidu and Kumagai (2016), my research was designed to be evocative, drawing on firsthand accounts of community members and professionals involved in delivering SRH emergency responses to capture the lived experiences of the research participants. Through these firsthand accounts, and the use of direct quotes to present the findings, the research aimed to encourage emotional engagement and foster a deeper connection between the reader and the subject matter. The language barrier presented a significant challenge, making it difficult to elicit rich narratives from some participants. However, with the assistance of my research assistant and culturally sensitive approaches, I was able to mitigate this obstacle as much as possible and ensure the voices of the community were effectively conveyed. As previously mentioned, reflexivity was a key component, with regular introspection and examination of my own biases enriching the research process and outcomes. The evocative nature of the research sought to present findings that were theoretically sound but also emotionally resonant, highlighting the deeply human aspects of social capital.

Emancipatory potential

Central to critical theory is research that is driven by a transformative agenda with emancipatory potential. This research has generated knowledge that meaningfully describes and explains the lived experience of both women accessing SRH related information and services in post-cyclone settings, and those delivering the services. This comprehensive documentation can be used to identify strategies and actors for change, particularly changes that prioritise local voices, networks, and systems. Such an approach challenges prevailing narratives and contributes to social justice by advocating for the integration of local knowledge and the empowerment of local communities in broader academic and policy discourses.

Limitations

As with any research endeavour, it is important to acknowledge the limitations that may have influenced the findings and interpretations. While this study was designed to address the research questions comprehensively, certain constraints, such as methodological choices, resource limitations, and contextual factors, may have impacted the scope and generalisability of the results. These limitations do not undermine the significance of the findings, but they offer important context for understanding the boundaries within which the research was conducted. Recognising these factors helps to provide a balanced perspective and highlights areas for further exploration and refinement in future research.

One of the primary limitations of this study was the language barrier I encountered during the research process. The community participants primarily spoke English as a second language, typically at a basic level, while I did not speak any iTaukei, the predominant language in Fiji, or for that matter any of the numerous dialects[12]. Although this language gap was somewhat mitigated by having an iTaukei research assistant, it inevitably limited the depth and richness of our conversations. This is somewhat reflected in the quotes that appear in this thesis, with more, and longer quotes coming from the professional group of participants. Although the interview and focus group discussion questions posed were designed for this particular context, and did elicit responses that contributed to answering the research questions, the discussions often remained at a superficial level. As a result, I did not obtain the anticipated richness and narrative detail in the data that I had anticipated with this group of participants which limited the extent to which I could explore the community perspective.

Another significant limitation was the size of the focus groups. Contrary to the initial plan, the focus groups were larger than ideal for fostering effective discussion. Although we always suggested the approximate number of participants we were seeking to the community contact we were working with (usually the Turaga ni Koro, or local health nurse), they inevitably invited any women in the village who might be interested in attending. The size of the groups posed a challenge in facilitating a smooth and inclusive conversation, as it became difficult to ensure that all voices were equally heard and that the discussion flowed naturally. Despite this challenge, in consultation with my research assistant, we decided to continue the focus group discussions with whatever number of women chose to attend because actively excluding some would have been perceived as rude in that particular context. Notably, many additional participants were older women who, although beyond the study's eligible age range, provided valuable insights. However, the presence of these extra participants, and their contribution to the larger group sizes, may have influenced the dynamics and outcomes of the focus group discussions.

The study lacked voices from marginalised groups such as LGBTIQ+ and people with disabilities, especially in the community member participant group. LGBTIQ+ community members and people with disabilities are especially vulnerable in humanitarian contexts, often facing increased challenges in accessing quality SRH services (IAWG, 2018a; Oxfam, 2018; UNFPA & The University of Melbourne, 2022). The under-representation of their voices, particularly from individuals who may face additional barriers such as stigma, discrimination, access-related issues or legal restrictions leaves a

[12] The islands of Fiji have significant dialectal diversity with around 300 different dialects which can be broadly classified into Eastern and Western groups (Mangubhai & Mugler, 2006).

gap in the findings. Including the voices of LGBTIQ+ individuals and people with disabilities in future research would not only enrich the data but also help ensure that SRH service delivery in humanitarian settings is more inclusive of and responsive to the needs of all individuals, regardless of their sexual orientation, gender identity or disability. Addressing this limitation is critical for strengthening emergency SRH activities and ensuring they do not perpetuate existing inequalities.

The study also faced constraints related to time and financial resources. Travel to remote locations on small islands was expensive, exacerbated by recent increases in fuel prices and the ongoing impacts of the COVID-19 pandemic. The timing of the field visits was largely dictated by the infrequency of transport options, such as flights and boats, to these islands. An example of this was the cancellation of the boat service to Koro during my stay in Fiji, necessitating more expensive and less frequent air travel. These logistical challenges not only inflated the cost of the research but also limited the time available for data collection. With more time and financial resources, I could have conducted follow-up interviews and focus group discussions in the same study sites, potentially yielding richer and more comprehensive data.

Conclusion

In conclusion, this chapter has critically examined the research findings within the context of the broader literature. By reflecting on the alignment and divergence of the findings with existing studies, it has provided a nuanced understanding of the way social capital influences women's access to SRH services and information in crisis settings. The exploration of cyclones as opportunities for building social capital and strengthening health systems highlighted the potential for disaster response to serve as a catalyst for systemic improvements. Additionally, the discussion considered the importance of engaging with socio-cultural norms as part of ongoing preparedness activities, a critical step toward increasing the sustainability and effectiveness of SRH humanitarian responses. Finally, the discussion explored the concept of localisation and further reinforced the need to empower communities and local actors in humanitarian responses, particularly at the ultra-local level. Emerging from the findings and discussion several recommendations were made for service providers including government, NGO, INGO, UN agency actors and researchers. After providing a reflection on the methodological frameworks that guided the research this chapter noted the factors that limited the study and pointed towards the need for further research in this area. Ultimately, this study offers valuable insights into SRH in crisis contexts while also paving the way for further research to address the gaps and build on these findings.

Conclusion

Sexuality and reproduction lie at the core of who we are as individuals, families and communities. SRH does not just describe the absence of disease or sickness but emphasises complete physical, mental and social well-being (Starrs et al., 2018). Achieving this in the Pacific requires responding to a unique set of challenges including high levels of gender-based violence, low contraceptive prevalence rates, hyperendemic levels of STIs, stigmatisation, discrimination and a lack of confidentiality in many health services. On top of this is the 'youth bulge' with many Pacific nations having large populations of 18-24 year olds, putting increased pressure on SRH services already weakened by the COVID-19 epidemic (Pacific Community, 2024). Cutting across these is the geographical isolation of many Pacific communities and their vulnerability to natural disasters, such as tropical cyclones, exacerbated by a rapidly changing climate.

Rising above these challenges and their unique contexts requires creative, multidisciplinary and flexible approaches. The SRHR of an individual, perhaps more than any other area of health, are inextricably tied to and influenced by their social and cultural context. The research presented in this thesis used a social capital framework to identify and describe some of these influences on women's access to SRH services and information in the wake of natural disasters. The research was designed to facilitate a holistic exploration of this complex terrain, its qualitative nature enabling participants to share their experiences in a panoramic fashion. The types of social capital pathways which emerged from the data as particularly significant with regard to SRHR in these settings, namely trust, social support and socio-cultural norms are somewhat amorphous concepts, difficult to definitively pin down. However, as the data showed, they are critical to understanding the resources that sit within women's relationships, networks and norms and how these can both support and hinder access to SRH information and services in crisis settings.

Central to my research and this thesis is the recognition that women's voices must remain at the forefront of every stage of planning, implementation, and evaluation of SRH interventions aimed at them. Women and girls should be key agents in shaping responses that meet their unique needs, especially in times of crisis. Their lived experiences offer invaluable insights into the barriers they face and the solutions they envision. Ensuring their voices are central requires not just inclusion but meaningful participation that informs both local and international decision-making processes.

One of the methodological principles guiding this research was to conduct it with an aim towards transformative praxis, that is, enabling a contribution that could support meaningful change on the ground. Through analysis and interpretation of the findings, enhanced by the inclusion of reflections and insights of Fijian practitioners in the space, several key implications emerged. These implications

highlight the potential opportunities offered in times of crisis, the importance of localisation and the need to consistently engage with socio-cultural norms throughout the disaster management cycle. Considered together, these implications call for creative, flexible, context sensitive strategies that work across traditional boundary lines and which are sustainable into the future. A rapidly changing climate means more frequent and more severe weather events in regions like the Pacific increasing the likelihood of natural disaster-induced humanitarian crises. It is critical for policy makers and practitioners to engage with frameworks like social capital to understand the nuances of women's experiences in accessing SRH information and services in crisis contexts.

Meeting local needs through international tools and frameworks remains a complex balancing act. While instruments like the MISP provide essential guidance, their effectiveness depends on their ability to adapt to local contexts. This research has shown that localisation is critical to bridging this gap. However, it also highlights the limitations of a one-size-fits-all approach, particularly in addressing deeply embedded socio-cultural norms that may vary significantly across communities. Achieving this balance requires a nuanced understanding of local realities and a willingness to evolve global frameworks to reflect them.

The findings also underscore the need for multifaceted approaches to these challenges. No single intervention can resolve the complex interplay of socio-cultural norms, logistical barriers, and systemic inequalities that impact access to SRH information and services in crisis settings. Instead, progress will require strategies that engage with multiple dimensions - education, infrastructure, cultural awareness, and social capital, while remaining flexible and adaptive to the unique dynamics of each community.

Finally, this research emphasises the importance of naming and addressing the deeply human elements of health systems - trust, respect, relationships, and connection. At its core, the provision of SRH services is about meeting the needs of human beings. Recognising the role of social capital means understanding that health systems are built on, and sustained through webs of relationships. Understanding these human connections and the social and cultural contexts in which they exist is essential for building equitable, resilient, and responsive SRH systems that can withstand future crises and foster better outcomes for women and their communities around the world.

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Appendices

Appendix 1: UTS Human Research Ethics Committee Approval

Outlook

HREC Approval Granted - ETH21-6717

From Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
Date Wed 3/23/2022 8:53 AM
To Research Ethics <research.ethics@uts.edu.au>; Angela Dawson <Angela.Dawson@uts.edu.au>; Hannah Ireland <Hannah.Ireland@student.uts.edu.au>

1 attachment (357 KB)
Ethics Application.pdf;

Dear Applicant

Re: ETH21-6717 - "The role of social capital in women's sexual and reproductive health and rights in humanitarian settings"

Thank you for your response to the Committee's comments for your project. The Committee agreed that this application now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH21-6717.

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat.
- The Principal Investigator will notify the Committee of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC or UTS MREC annually and notify the Committee when the project is completed at all sites. The Principal Investigator will notify the Committee of any plan to extend the duration of the project past the approval period listed above.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).

- The Principal Investigator will notify the Committee of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be
undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,
The Research Ethics Secretariat

On behalf of the UTS Human Research Ethics Committees
C/- Research Office
University of Technology Sydney
E: Research.Ethics@uts.edu.au

Ref: E38

Appendix 2: Approval from Ministry of ITaukei Affairs

MINISTRY OF ITAUKEI AFFAIRS

NORTH WING, ITAUKEI TRUST FUND BUILDING COMPLEX
87 QUEEN ELIZABETH DRIVE, SUVA
P.O.BOX 2100, GOVERNMENT BUILDING, SUVA, FIJI

TELEPHONE: (679) 3100 909 FAX: (679) 3300198

Reference: MTA – 42/2-3 10 May 2022

Ms Hannah Ireland,
University of Technology Sydney,
Australia.

Dear Ms Ireland,

Re: Ministry of iTaukei Affairs Research Support

1. Thanks for your letter dated 6 May 2022 on the above.

2. Approval is granted for you to visit, Narikoso village, Vabea village, Naqara village, Kavala village and Maunira Settlements in Kadavu province, Vatulele village, Nasau village and Sinuvaca village in Lomaiviti province, Wainunu Health Centre, Kubulau village, Lekutu Health Centre, Dawara village, Cogea village in Bua province, Kia Island, Nakorovatu Health Centre and Seaqaqa in Macuata province.

3. It is noted that the purpose of this visit is to explore how the incorporation of a social capital analysis could improve sexual and reproductive health and rights crisis preparedness, response and recovery efforts.

4. Please liaise with the following Provincial Council Officials who will facilitate your visit;

   (i) **Kadavu Provincial Council Office**
   Roko Tui Kadavu, Mr Waisake Manako on mobile no. [redacted] or Senior Assistant Roko Tui Kadavu Mr Filimoni Taka on mobile no. [redacted]
   Lomaiviti Provincial Council Office
   Acting Roko Tui Lomaiviti, Mr Levi Nayacalevu on mobile no. [redacted]
   Macuata Provincial Council Office
   Roko Tui Macuata, Mr Kalivati Rabuka on mobile no. [redacted] or Senior Roko Tui Macuata, Mr Maikeli Sauwaqa on mobile no. [redacted].
   Bua Provincial Council Office
   Roko Tui Bua, Mr Waisake Tuisese on mobile no. [redacted] or Senior Roko Tui Bua, Mr Kalivati Radororo on mobile no. [redacted].

5. I wish you all the best.

Yours sincerely,

Production Note:
Signature removed prior to publication.

Pita Tagicakirewa

Permanent Secretary for iTaukei Affairs

Appendix 3: Approval from Fiji Ministry of Education, Heritage and Arts

MINISTRY OF EDUCATION, HERITAGE & ARTS

Quality Education for Change, Peace and Progress

Marela House, 19 Thurston Street, Suva, Fiji Islands, Private Mail Bag, Government Buildings, Suva.
Ph: (679) 3314477 Fax: (679) 3303511

Our Reference: RA 18/22 *Date:* 14 June 2022

Ms Hannah Ireland,

University of Technology Sydney,
Australia.

RE: Official Approval to Conduct Research in Fiji

Dear Madam,

We are pleased to inform you that your request to conduct research in Fiji has been granted on the topic ***"The role of social capital in women's sexual and reproductive health and rights in humanitarian settings".***

The approval is granted until August 2022.

It is noted that in this research, you will work in collaboration with the Ministry of iTaukei Affairs who will be assisting with all the work that will be carried out during this study. Please liaise with the relevant personnel from the respective Ministry with regards to the logistics and the conduct of your research and be further advised that the Government of Fiji's legislations, procedures, policies and protocols must be unreservedly adhered to. This will include ensuring that your research complies with the COVID19 safety strategies.

As a condition for the research approval, a copy of the final research report must be submitted to the Ministry of Education, Heritage and Arts (MEHA) through this office upon completion, before the commencement of any publication. The report will be reserved in the MEHA Research Library and will be available for reference by Senior Ministry and Government officials.

Moreover, it is important to note that the Ministry of Education, Heritage and Arts reserves a right to publish the final report or an edited summary of it.

We wish you success in your research study.

Production Note:
Signature removed prior to publication.

Metuisela Gauna (Mr)

for **Permanent Secretary for Education, Heritage and Arts**

cc. MEHA Research File

Appendix 4: Approval from Fiji Human Health Research and Ethics Review Committee

Fiji Human Health Research and Ethics Review Committee

MINISTRY OF HEALTH AND MEDICAL SERVICES

Date: 03/05/2022

Professor Angela Dawson
University of Technology Sydney
Australia.

Project Title: "The role of social capital in women's sexual and reproductive health and rights in humanitarian settings".

FNHRERC Number:	8/2022
Principal Investigator(s):	Professor Angela Dawson, University of Technology Sydney, Australia.
Co- Investigator(s):	Hannah Ireland, University of Technology Sydney, Australia. Professor Nguyen T. Tran, University of Geneva. Dr Robyn Drysdale, International Planned Parenthood Federation.
Local Collaborator(s):	Adam Konrote, Reproductive & Family Health Association, Fiji. Benito Sigaveivola, Humanitarian Pacific, Fiji.

Dear Prof. Dawson

This is to inform you that the Fiji Human Health Research Ethics Review Committee (FHHRERC) has granted scientific, technical and ethical **approval** to your proposal titled "*The role of social capital in women's sexual and reproductive health and rights in humanitarian settings*".

As the Principal Investigator, it is **your responsibility to ensure that all the people associated with this particular project area aware of the conditions of this approval and copy of the final report is also submitted to the Ministry of Health and Medical Services at the conclusion of your project for our records.**

The following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

1. **Variation to the project:** Any subsequent variation s or modifications you may wish to make to your project must be notified formally to the Chair, FHHRERC for further considerations and approval. If the Chair considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

2. **Incidence or adverse events:** Researchers must report immediately to the Chair FHHRERC anything which may affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that may affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

3. **Monitoring:** Projects are subject to monitoring at any time by the Committee.

4. **Annual/Final Report:** You must submit a progress report at 6 months of your study and an annual/final report at the end of the year or at the conclusion of the project if it continues for less than or more than a year. Also you are to present the evidence back to the participating institutions.

Please quote the FHHRERC number and the name of the project in any future correspondence.

If you have any further queries or require any additional information, please do not hesitate to contact the Secretariat on telephone: (679) 3306177 ext. 340170 or email: fijihealthresearch@gmail.com .

We wish you all the best in your study.

Production Note:
Signature removed prior to publication.

Dr Eric Rafai
Head of Research Innovation
Ministry of Health and Medical Services

Appendix 5: Community Leaders Participant Information Sheet

PARTICIPANT INFORMATION SHEET
(Community leaders)

[ETH21-6717] – Social capital and women's sexual and reproductive health in humanitarian settings

WHO IS DOING THIS RESEARCH?

My name is Hannah Ireland and I am a PhD student at the University of Technology Sydney (UTS). My main supervisor is Angela Dawson who you can email at angela.dawson@uts.edu.au.

WHAT IS THE RESEARCH ABOUT?

I am doing this research to understand how to improve access to sexual and reproductive health care services and information during and after natural disasters, like tropical cyclones. To do this I will be looking at how social capital (which is the resources you have through your social networks) can be used to help make sexual and reproductive health services better during and after natural disasters.

WHY HAVE I BEEN INVITED?

You have been invited to participate because you are a community leader in a place where there was a Tropical Cyclone (TC) within the last two years, and you speak English.

FUNDING

The UTS Faculty of Health provides doctoral students with some funding to cover research costs. Most of the travel and research costs for this project are covered by this funding.

WHAT WILL I NEED TO DO?

If you decide to take part, I will invite you to a 45-60 minute interview with myself and a research assistant. We will talk to you to find a time and place which is good for you.

We will ask you questions about what it was like during TC Harold/Yasa and about women's sexual and reproductive health in your community at this time. By sexual and reproductive health, we mean anything to do with gender-based violence, Sexually Transmitted Infections (STIs), maternal health, family planning and contraception. We want to learn about how social networks and relationships, and the different resources women have through these, have an impact on their sexual and reproductive health and rights during and after cyclones. Although you may not know details about women's sexual and reproductive health, we believe that you will have know many things in your position as a community leader about social networks in your community and the resources within them.

If you agree, the interview will be audio recorded and transcribed (written out). This will then be de-identified, meaning your personal details (like your name, or the name of your village) will be removed from it so no one will know it was you.

You will not receive any direct benefits from participating in this research however by participating, I hope that you will gain a better understanding of how social networks might strengthen community responses

following cyclones, or other natural disasters in the future. Your participation will also hopefully contribute towards improving the way government and NGOs provide emergency sexual and reproductive health services in the future.

ARE THERE ANY RISKS/INCONVENIENCE?

Aside from giving up 45-60 mins of your time for the interview I do not expect that being a part of this research will involve any big risks or inconvenience to you.

During the interview we will discuss issues relating to women's sexual and reproductive health in your community during TC Harold/Yasa. You do not have to answer any question if you do not feel comfortable to do so. Because this research is focussed on what may have been a difficult time for you and your community during the cyclone, there is a chance that you might become upset during the interview. If this happens we will take steps to make sure you are ok at that time, and give you the option to leave if you want to. We will also organise for counselling or other support if that is needed. Here are the contact details for some helpful services:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

DO I HAVE TO TAKE PART IN THIS RESEARCH PROJECT?

Being a part of this study is voluntary. It is completely up to you whether you decide to take part.
If you decide not to participate, or to leave the study, it will not affect your relationship with the researchers, the Reproductive and Family Health Association of Fiji (RFHAF), or the University of Technology Sydney.

WHAT IF I DECIDE TO LEAVE THIS RESEARCH PROJECT?

If you wish to leave the study once it has started, you can do so at any time without having to give a reason, by contacting me (hannah.ireland@student.uts.edu.au). If you leave the study, I will not collect any more information from you but any information already collected will be kept and used to form part of the research findings. If you do not want this to be included please tell me when you leave.

WHAT WILL HAPPEN TO INFORMATION ABOUT ME?

By signing the consent form you agree to me collecting and using the information you give us for the research project. All this information will be treated confidentially, meaning it will not be shared with anyone outside of the research team. The information you provide will be de-identified, meaning it will not be connected to any of your personal details (eg. name, date of birth, address). Instead of your name, your data will be given a code number. All recordings and transcripts will be stored in online storage

protected by UTS online security systems. The only people with access to this will be me and my supervisors. Data will be stored for five years and then deleted.

The interview recordings from all participants will be analysed to understand if there are common themes or patterns among your experiences that are of interest. The findings of this research project might be shared with other people in the future through publications and presentations. In any publication and/or presentation, information will be provided in such a way that no one will be able to connect it to you.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information you disagree with be corrected.

The results of this research may also be shared through open access (public) scientific databases, including internet databases. This will enable other researchers to use the published data to investigate other important research questions. Results shared in this way will always be de-identified by removing all personal information (e.g. name, address, date of birth etc.).

WHAT IF I HAVE ANY QUESTIONS OR WORRIES?

If you have questions or worries about the research that you think we can help you with, please feel free to contact us:
Hannah Ireland: hannah.ireland@student.uts.edu.au
Angela Dawson: angela.dawson@uts.edu.au

You can also contact a local contact, the humanitarian focal person at Reproductive and Family Health Association of Fiji, .

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your participation in the study, below are some services you can contact:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

You will be given a copy of this form to keep.

NOTE:
This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines and the Fiji Human Health Research and Ethics Review Committee (Ministry of Health and Medical Services). If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact either:

UTS Ethics Secretariat
Ph.: +61 2 9514 2478
Email: Research.Ethics@uts.edu.au

In your communication, please quote the UTS HREC reference number, ETH21-6717. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Fiji Human Health Research and Ethics Review Committee
Ph.: (679) 3306177 ext. 340170
Email: fijihealthresearch@gmail.com

In your communication, please quote the FHHRERC reference number, 8/2022. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Appendix 6: Community members Participant Information Sheet

PARTICIPANT INFORMATION SHEET
(Community members)

[ETH21-6717] – Social capital and women's sexual and reproductive health in humanitarian settings

WHO IS DOING THIS RESEARCH?

My name is Hannah Ireland and I am a PhD student at the University of Technology Sydney (UTS). My main supervisor is Angela Dawson who you can email at angela.dawson@uts.edu.au.

WHAT IS THE RESEARCH ABOUT?

I am doing this research to understand how to improve access to sexual and reproductive health care services and information during and after natural disasters, like tropical cyclones. To do this I will be looking at how social capital (which is the resources you have through your social networks) can be used to help make sexual and reproductive health services better during and after natural disasters.

WHY HAVE I BEEN INVITED?

You have been invited to participate because you are between 16 and 49 years old, you live in a community which experienced a Tropical Cyclone (TC) within the last two years and you speak English.

FUNDING

The UTS Faculty of Health provides doctoral students with some funding to cover research costs. Most of the travel and research costs for this project are covered by this funding.

WHAT WILL I NEED TO DO?

If you decide to take part, I will invite you to a 60-90 minute group discussion with about 10 women from your village or nearby, myself and a research assistant. This will be somewhere not too far from your home.

You may also be invited to a 45-60 minute interview with myself and a research assistant. We will talk to you to find a time and place which is good for you.

We will ask you questions about what it was like during TC Harold/Yasa and about your sexual and reproductive health at this time. By sexual and reproductive health, we mean anything to do with gender-based violence, Sexually Transmitted Infections (STIs), maternal health, family planning and contraception. We want to learn about how your social networks and relationships, and the different resources you have through these, have an impact on your sexual and reproductive health and rights during and after the cyclones.

If you agree, the group discussion/interview will be audio recorded and transcribed (written out). This will then be de-identified, meaning your personal details (like your name, or the name of your village) will be removed from it so no one will know it was you.

You will not receive any direct benefits from participating in this research however by participating, I hope that you will gain a better understanding of how social networks might strengthen community responses following cyclones, or other natural disasters in the future. Your participation will also hopefully contribute towards improving the way government and NGOs provide emergency sexual and reproductive health services in the future.

ARE THERE ANY RISKS/INCONVENIENCE?

Aside from giving up 1-2.5 hours of your time for the discussion group and/or interview I do not expect that participating in this research will involve any significant risks or inconvenience to you.

During the group discussion and/or interview we might discuss some sensitive issues about sexual and reproductive health during TC Harold/Yasa. You do not have to answer any question if you do not feel comfortable to. You can also leave the group discussion or stop the interview at any time. Because this research is about sensitive issues and what may have been a difficult time during the cyclone, there is a chance that you might become upset during the group discussion or an interview. If this happens we will take steps to make sure you are ok at that time, and give you the option to leave if you want to. We will also organise for counselling or other support if that is needed. Here are the contact details for some helpful services:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

DO I HAVE TO TAKE PART IN THIS RESEARCH PROJECT?

Being a part of this study is voluntary. It is completely up to you whether you decide to take part.
If you decide not to participate, or to leave the study, it will not affect your relationship with the researchers, the Reproductive and Family Health Association of Fiji (RFHAF) or the University of Technology Sydney.

WHAT IF I DECIDE TO LEAVE THIS RESEARCH PROJECT?

If you wish to leave the study once it has started, you can do so at any time without having to give a reason, by contacting me (hannah.ireland@student.uts.edu.au). If you leave the study, I will not collect any more information from you but any information already collected will be kept and used to form part of the research findings. If you do not want this to be included please tell me when you leave and I will make sure it is removed.

WHAT WILL HAPPEN TO INFORMATION ABOUT ME?

By signing the consent form you consent to me collecting and using the information you give us for the research project. All this information will be treated confidentially, meaning it will not be shared with anyone outside of the research team. The information you provide will be de-identified, meaning it will not be connected to any of your personal details (eg. name, date of birth, address). Instead of your name, your data will be given a code number. All recordings and transcripts will be stored in online storage protected by UTS online security systems. The only people with access to this will be me and my supervisors. Data will be stored for five years and then deleted.

The interview/discussion group recordings and transcripts from all participants will be analysed to understand if there are common themes or patterns among your experiences that are of interest. The findings of this research project might be shared with other people in the future through publications and presentations. In any publication and/or presentation, information will be provided in such a way that no one will be able to connect it to you.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information you disagree with be corrected.

The results of this research may also be shared through open access (public) scientific databases, including internet databases. This will enable other researchers to use the published data to investigate other important research questions. Results shared in this way will always be de-identified by removing all personal information (e.g. name, address, date of birth etc.).

WHAT IF I HAVE ANY QUESTIONS OR WORRIES?

If you have questions or worries about the research that you think we can help you with, please feel free to contact us:
Hannah Ireland: hannah.ireland@student.uts.edu.au
Angela Dawson: angela.dawson@uts.edu.au

You can also contact a local contact, the humanitarian focal person at Reproductive and Family Health Association of Fiji, .

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your participation in the study, below are some services you can contact:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

You will be given a copy of this form to keep.

NOTE:
This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines and the Fiji Human Health Research and Ethics Review Committee (Ministry of Health and Medical Services). If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact either:

UTS Ethics Secretariat
Ph.: +61 2 9514 2478
Email: Research.Ethics@uts.edu.au

In your communication, please quote the UTS HREC reference number, ETH21-6717. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Fiji Human Health Research and Ethics Review Committee
Ph.: (679) 3306177 ext. 340170
Email: fijihealthresearch@gmail.com

In your communication, please quote the FHHRERC reference number, 8/2022. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Appendix 7: Local NGO staff and volunteers Participant Information Sheet

PARTICIPANT INFORMATION SHEET
(Local NGO staff and volunteers)

[ETH21-6717] – Social capital and women's sexual and reproductive health in humanitarian settings

WHO IS DOING THIS RESEARCH?

My name is Hannah Ireland and I am a PhD student at the University of Technology Sydney (UTS). My main supervisor is Angela Dawson who you can email at angela.dawson@uts.edu.au.

WHAT IS THE RESEARCH ABOUT?

I am doing this research to understand how to improve access to sexual and reproductive health care services and information during and after natural disasters, like tropical cyclones. To do this I will be looking at how social capital (which is the resources you have through your social networks) can be used to help make sexual and reproductive health services better during and after natural disasters.

WHY HAVE I BEEN INVITED?

You have been invited to participate because you worked or volunteered for a Fijian NGO as part of delivering their sexual and reproductive health crisis response to TC Harold and/or TC Yasa, and you speak English.

FUNDING

The UTS Faculty of Health provides doctoral students with some funding to cover research costs. Most of the travel and research costs for this project are covered by this funding.

WHAT WILL I NEED TO DO?

If you decide to take part, I will invite you to a 45-60 minute interview with myself and a research assistant. We will talk to you to find a time and place which is good for you. There will also be the option to do the interview over Zoom if that works better for you.

We will ask you questions about your work or volunteering in the TC Harold and/or TC Yasa sexual and reproductive health response. In particular, we will be talking about how social capital plays a role in this. It does not matter if you haven't heard of social capital, the questions and conversation will be about your knowledge and experience of helping provide sexual and reproductive health services to the communities that were hit by TC Harold and/or TC Yasa.

If you agree, the interview will be audio recorded. The recording will be transcribed (written out) as soon as possible, and shared with you to review. After this, it will be de-identified, meaning your personal details will be removed from it so no one will know it was you.

Several months after the interview we will be running a knowledge exchange workshop in Suva which you will also be invited to attend, along with other NGO, INGO and government representatives who took part in the research. During this workshop we will share the findings from our research and seek your input

into making practical recommendations for organisations providing sexual and reproductive health services in crisis settings. This workshop will be run over half a day.

You will not receive any direct benefits from participating in this research however by participating, I hope that you will gain a better understanding of how social networks might strengthen community responses following cyclones, or other natural disasters in the future. Your participation will also hopefully contribute towards improving the way government and NGOs provide emergency sexual and reproductive health services in the future.

ARE THERE ANY RISKS/INCONVENIENCE?

Aside from giving up an hour of your time for the interview and a half-day for the knowledge exchange workshop I do not expect that being a part of this research will involve any significant risks or inconvenience to you.

You may be worried about the small risk that something you say during an interview will impact your job security or relationship with the organisation you worked/volunteered with. I am taking several steps to minimise this risk. Firstly, this research is not about evaluating or comparing the way organisations work and you will not be asked questions about this topic. Secondly, you will be able to review your interview transcript and remove any part of it if you wish. And finally, the interview data will all be de-identified, meaning it will not be connected to any of your personal details (eg. name, employer, email address etc.). When the data is used in my doctoral thesis, or in any possible publications it will not be connected to you in any way.

Because this research is about sensitive issues and what may have been a difficult time working with cyclone-affected communities, there is a small chance that you might become upset during the interview. If this happens, we will take steps to make sure you are ok at that time, and give you the option to leave if you want to. We will also organise for counselling or other support if that is needed. Here are the contact details for some helpful services:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

DO I HAVE TO TAKE PART IN THIS RESEARCH PROJECT?

Participation in this study is voluntary. It is completely up to you whether you decide to take part.
If you decide not to participate, or to withdraw from the study, it will not affect your relationship with the researchers, the Reproductive and Family Health Association of Fiji (RFHAF) or the University of Technology Sydney.

WHAT IF I DECIDE TO LEAVE THIS RESEARCH PROJECT?

If you wish to leave the study once it has started, you can do so at any time without having to give a reason, by contacting me (hannah.ireland@student.uts.edu.au). If you leave the study, I will not collect any more information from you but any information already collected will be kept and used to form part of the research findings. If you do not want this to be included please tell me when you leave.

WHAT WILL HAPPEN TO INFORMATION ABOUT ME?

By signing the consent form you agree to me collecting and using the information you give us for the research project. All this information will be treated confidentially, meaning it will not be shared with anyone outside of the research team. The information you provide will be de-identified, meaning it will not be connected to any of your personal details (eg. name, date of birth, address). Instead of your name, your data will be given a code number. All recordings and transcripts will be stored in online storage protected by UTS online security systems. The only people with access to this will be me and my supervisors. Data will be stored for five years and then deleted.

The interview recordings and transcripts from all participants will be analysed to understand if there are common themes or patterns among your experiences that are of interest. The findings of this research project might be shared with other people in the future through publications and presentations. In any publication and/or presentation, information will be provided in such a way that no one will be able to connect it to you.

You have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information you disagree with be corrected.

The results of this research may also be shared through open access (public) scientific databases, including internet databases. This will enable other researchers to use the published data to investigate other important research questions. Results shared in this way will always be de-identified by removing all personal information (e.g. name, address, date of birth etc.).

WHAT IF I HAVE ANY QUESTIONS OR WORRIES?

If you have questions or worries about the research that you think we can help you with, please feel free to contact us:
Hannah Ireland: hannah.ireland@student.uts.edu.au
Angela Dawson: angela.dawson@uts.edu.au

You can also contact a local contact, the humanitarian focal person at Reproductive and Family Health Association of Fiji,).

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your participation in the study, below are some services you can contact:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

You will be given a copy of this form to keep.

NOTE:
This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines and the Fiji Human Health Research and Ethics Review Committee (Ministry of Health and Medical Services). If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact either:

UTS Ethics Secretariat
Ph.: +61 2 9514 2478
Email: Research.Ethics@uts.edu.au

In your communication, please quote the UTS HREC reference number, ETH21-6717. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Fiji Human Health Research and Ethics Review Committee
Ph.: (679) 3306177 ext. 340170
Email: fijihealthresearch@gmail.com

In your communication, please quote the FHHRERC reference number, 8/2022. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Appendix 8: NGO/INGO/Government Participant Information Sheet

PARTICIPANT INFORMATION SHEET
(General NGO/INGO/Gov)

[ETH21-6717] – Social capital and women's sexual and reproductive health in humanitarian settings

WHO IS CONDUCTING THIS RESEARCH?

My name is Hannah Ireland and I am a PhD student at the University of Technology Sydney (UTS). My principal supervisor is Angela Dawson who can be contacted at angela.dawson@uts.edu.au.

WHAT IS THE RESEARCH ABOUT?

The purpose of this research is to improve access to sexual and reproductive health care, services and information in disaster settings by identifying how social capital (the resources you can access through your social networks) can be used to strengthen sexual and reproductive health crisis preparedness, response and recovery efforts.

WHY HAVE I BEEN INVITED?

You have been invited to participate because you work for a Fijian NGO, an INGO with a presence in Fiji or a Fijian Government department that works in sexual and reproductive health crisis response, preparedness and/or recovery, you are involved in this area of their work and you speak English.

FUNDING

The UTS Faculty of Health provides doctoral students with some funding to cover research costs. Most of the travel and associated research costs for this project are covered by this funding.

WHAT DOES MY PARTICIPATION INVOLVE?

If you decide to participate, I will invite you to participate in a 45-60 minute interview with myself. I will communicate with you to organise a time and place convenient to you. There will also be the option to participate in the interview over Zoom if that is more suitable.

We will ask you questions about your work providing sexual and reproductive health and rights services in crisis settings and in particular about how social capital plays a role in this. It does not matter if you are not familiar with the concept of social capital, the questions and conversation will be focussed on your knowledge and experience of delivering sexual and reproductive health services to communities affected by natural disasters.

With your consent, the interview will be audio recorded. The recording will be transcribed as soon as possible, and the transcription shared with you to review. After this, the transcription will be de-identified, meaning your personal, identifying details will be removed from it so no one will know it was you.

Several months after the interview we will be running a knowledge exchange workshop in Suva which you will also be invited to attend, along with other NGO, INGO and government representative research participants. During this workshop we will share the findings from our research and seek your input into

formulating practical recommendations for organisations providing sexual and reproductive health services in crisis settings. This workshop will be run over half a day.

You will not receive any direct benefits from participating in this research however by participating, I hope that you will gain a better understanding of how social networks might strengthen community responses following cyclones, or other natural disasters in the future. Your participation will also hopefully contribute towards improving the way government and NGOs provide emergency sexual and reproductive health services in the future.

ARE THERE ANY RISKS/INCONVENIENCE?

Aside from giving up an hour of your time for the interview and a half-day for the knowledge exchange workshop I do not expect that participating in this research will involve any significant risks or inconvenience to you.

You may be concerned about the small risk that something you say during an interview will impact your job security or relationship with your employer. I am taking several steps to minimise this risk. Firstly, the focus of the research is not on evaluating or comparing the way organisations work and you will not be asked questions about this topic. Secondly, you will have the opportunity to review your interview transcript and remove any part of it if you wish. And finally, the interview transcripts will all be de-identified, meaning they will not be connected to any of your personal details (eg. name, employer, email address etc.). When the data is used in my doctoral thesis, or in any possible publications it will be anonymous.

Because this research is about sensitive issues and what may have been a difficult time working with cyclone-affected communities, there is a small chance that you might become upset during the interview. If this happens, we will take steps to make sure you are ok at that time, and give you the option to leave if you want to. We will also organise for counselling or other support if that is needed. Here are the contact details for some helpful services:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

DO I HAVE TO TAKE PART IN THIS RESEARCH PROJECT?

Participation in this study is voluntary. It is completely up to you whether you decide to take part.
If you decide not to participate, or to withdraw from the study, it will not affect your relationship with the researchers or the University of Technology Sydney or your employer.

WHAT IF I WITHDRAW FROM THIS RESEARCH PROJECT?

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason, by contacting me (hannah.ireland@student.uts.edu.au). If you withdraw from the study, I will not collect additional information from you but any information already collected will be kept and used to form part of the research findings. If you do not want this to be included please tell me when you leave.

WHAT WILL HAPPEN TO INFORMATION ABOUT ME?

By signing the consent form you consent to me collecting and using the information you provide for the research project. All this information will be treated confidentially. The information you provide will be de-identified, meaning it will not be connected to any of your identifying details (eg. name, date of birth, address). Instead of your name, once transcribed, your data will be given a code number. All recordings and transcripts will be stored in online storage protected by UTS online security systems. The only people with access to this will be me and my supervisors. Data will be stored in this location for five years and then deleted.

The interview recordings and transcripts from all participants will be analysed to understand if there are common themes or patterns among your experiences that are of interest. It is anticipated that the results of this research project might be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or NSW Privacy laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information you disagree with be corrected.

The results of this research may also be shared through open access (public) scientific databases, including internet databases. This will enable other researchers to use the published data to investigate other important research questions. Results shared in this way will always be de-identified by removing all personal information (e.g. name, address, date of birth etc.).

WHAT IF I HAVE ANY QUERIES OR CONCERNS?

If you have queries or concerns about the research that you think we can help you with, please feel free to contact us:
Hannah Ireland: hannah.ireland@student.uts.edu.au
Angela Dawson: angela.dawson@uts.edu.au

You can also contact a local contact, the humanitarian focal person at Reproductive and Family Health Association of Fiji,

If this research causes you any distress or emotional harm, or if you want to speak to a qualified professional about anything following your participation in the study, below are some services you can contact:

Medical Services Pacific
Phone number: (679) 3315295
Website: http://msp.org.fj/
Email: counsellor@msp.org.fj

Empower Pacific
Phone number: (679) 7780015
Toll-free helpline: 132454
Website: http://empowerpacific.com/counselling-helpline

You will be given a copy of this form to keep.

NOTE:
This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines and the Fiji Human Health Research and Ethics Review Committee (Ministry of Health and Medical Services). If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact either:

UTS Ethics Secretariat
Ph.: +61 2 9514 2478
Email: Research.Ethics@uts.edu.au

In your communication, please quote the UTS HREC reference number, ETH21-6717. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Fiji Human Health Research and Ethics Review Committee
Ph.: (679) 3306177 ext. 340170
Email: fijihealthresearch@gmail.com

In your communication, please quote the FHHRERC reference number, 8/2022. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Appendix 9: Participant Consent Form

CONSENT FORM

[ETH21-6717] - Social capital and women's sexual and reproductive health in humanitarian settings

I _____ *[participant's name]* agree to participate in the research project being conducted by Hannah Ireland (hannah.ireland@student.uts.edu.au, · [redacted]). I understand that funding for this research has been provided by the UTS Faculty of Health.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney or my organisation.

I understand that I will be given a signed copy of this document to keep.

I am aware that I can contact Hannah Ireland or if I have any concerns about the research.

_____ ____/____/____
Name and Signature [participant] Date

_____ ____/____/____
Name and Signature [researcher or delegate] Date

_____ ____/____/____
Name and Signature [witness, if needed*] Date

*** Witness to the consent process**
If the participant, or if their legally acceptable representative, is not able to read this document, this form must be witnessed by an independent person over the age of 18. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. By signing the consent form, the witness attests that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant (or representative) and that informed consent was freely given by the participant (or representative).

Appendix 10: Interview Guide (community members and leaders)

INTERVIEW GUIDE – community members and leaders

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

1. Tell me a bit about yourself?
    - *Name*
    - *Age*
    - *Family (married, unmarried, kids etc)*
    - *What is your role in the family/village?*
2. At the time of cyclone Harold/Yasa and in those days and weeks afterwards how did women in the community access sexual and reproductive health services? (explain that sexual and reproductive health services include services relating to: sexual violence, HIV, sexually transmitted infections, maternal and newborn health and family planning)
3. After the cyclone, did you know about the sexual and reproductive health services that were provided by [NGO]? What did you know about them?
4. How did women in the community find out about available services?
    - *From friends and family?*
    - *Direct from the organisation providing the service?*
5. How were people in the community involved in providing or helping provide those services?
    - *Who was involved and what were their roles?*
6. How were community groups and organisations involved in supporting women's SRH needs at the time of the cyclone?
    - *Women's groups, churches etc.?*
    - *Did they provide any services or support?*
    - *Did they help provide information about services?*
7. Can you tell me a bit about how pregnant women, and women with newborns, used the services provided by [NGO]?
    - What reasons did they use them for? (eg. breastfeeding, antenatal/postnatal checks, other?)
    - Do you know any reasons pregnant women/women with newborns might have chosen not to, or not been able to use these services?
    - Are there other places or people they might have gotten help from?
8. How did the community respond to fighting between husbands and wives, or beatings?
    - Did they seek help from anyone? Who from? What kind of help?
9. What about family planning?
    - Were women in the community needing to access family planning at this time?
    - Where did they access it and how did they know about it?
    - Do you know of any reasons women might not have been able to use this service from the [NGO]?
10. Can you tell me about any planning or preparation done in the community for managing sexual and reproductive health issues when cyclones come? For example, how does the community make sure that pregnant women can have a safe birth? Or make sure that family planning is available when cyclones happen?
    - *Who was involved in planning and preparation?*
    - *Did it work well when the cyclone came? Why?/Why not?*
11. *If the answer to the above questions is that there hasn't been any planning/preparation to date:* What kinds of things should be planned for? Who should be involved?

Appendix 11: Interview Guide (NGO volunteers)

INTERVIEW GUIDE – NGO volunteers

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

1. Could you tell me about how you were involved in [NGO]'s SRH response to Cyclone Harold/Yasa?
    - *What was your role?*
    - *Where did you go?*
2. How were community members involved during the SRH response?
    - *Did community members have any roles in helping deliver the SRH response?*
    - *What about through community groups? (eg churches, women's groups?)*
    - *Who did you talk to within the communities to help make decisions during the SRH response?*
    - *Did you talk to community leaders? Which ones?*
    - *Can you give me an example of how community members were involved through the SRH response in supporting pregnant women or women with newborns? Or women wanting to access family planning? Or women experiencing violence?*
3. How were community members informed about the services provided by the response? Did they access the services? Who accessed them?
    - *What about pregnant women or women with newborns?*
    - *What about people needing contraception/family planning?*
    - *What about people who were experiencing violence?*
4. How were various community resources used during the SRH response?
    - *Social networks? (eg. church networks? family networks?)*
    - *Customs/traditions?*
5. How did the [NGO] make sure that all community members (regardless of age, gender, ethnicity etc) could access services if they wanted to? What sort of strategies were put in place that drew on relationships and customs/traditions?
6. What kinds of barriers were there to accessing services?
7. How did the [NGO] try to overcome these challenges/barriers?
8. How would you describe the level of trust developed by the NGO and each community?
    - *Was it established before this cyclone? How?*
    - *If not, how was trust built during the response?*

Appendix 12: Interview Guide (NGO/INGO/Gov)

INTERVIEW GUIDE – NGO/INGO/Gov employees

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

1. Could you tell me a bit about your role in [*NGO/INGO/Gov*] and how you have been involved in SRH emergency responses in the past two years?
2. How do you involve community members in SRH responses and preparedness planning?
3. Who are the key people you work with in communities in relation to preparedness planning and responding to SRH needs during emergencies?
4. How are community leaders and/or community groups (eg. women's committees) involved in SRH responses or preparedness planning?
5. How do you inform community members about the services provided by a response?
    - *What about pregnant women or women with newborns?*
    - *What about people needing contraception?*
    - *What about people who are experiencing violence?*
6. Have you come across any barriers to women accessing the services provided during responses?
7. What community social networks are used for disseminating information during responses? How do you identify them?
8. Are there any other resources in communities that you have tapped into when delivering SRH responses?
9. How do you build trust with the community when planning and delivering responses? Can you give some examples?
10. How do you try to ensure that all community members (regardless of age, gender, ethnicity etc.) can access services if they want to?
11. How are networks/connections between communities and other agencies/organisations identified and incorporated into response planning/delivery?

Ask 12 and 13 only if NGO/Gov institution is involved in community preparedness activities

12. How do you identify and incorporate the shared experiences, knowledge and needs of community members/groups into SRH response plans for disasters?
13. Can you tell me about the ways you foster collaborative learning with community members to inform future disaster responses?

Appendix 13: Focus Group Discussion Guide

FOCUS GROUP GUIDE – community members

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

1. Let's go round and introduce ourselves.
    - *Name*
    - *Age*
    - *Family (married, unmarried, kids etc)*
    - *How long have you lived here?*
    - *What is your role in the family/village?*
2. At the time of cyclone Harold/Yasa and in those days and weeks afterwards how did women in the community access sexual and reproductive health services? (explain that sexual and reproductive health services include services relating to: sexual violence, HIV, sexually transmitted infections, maternal and newborn health and family planning)
3. After the cyclone, did you know about the sexual and reproductive health services that were provided by [NGO]? What did you know about them?
4. How did women in the community find out about available services?
    - *From friends and family?*
    - *Direct from the organisation providing the service?*
5. How were people in the community involved in providing or helping provide those services?
    - *Who was involved and what were their roles?*
6. How were community groups and organisations involved in supporting women's SRH needs at the time of the cyclone?
    - *Women's groups, churches etc.?*
    - *Did they provide any services or support?*
    - *Did they help provide information about services?*
7. Can you tell me a bit about how pregnant women, and women with newborns, used the services provided by [NGO]?
    - What reasons did they use them for? (eg. breastfeeding, antenatal/postnatal checks, other?)
    - Do you know any reasons pregnant women/women with newborns might have chosen not to, or not been able to use these services?
    - Are there other places or people they might have gotten help from?
8. How did the community respond to fighting between husbands and wives, or beatings?
    - Did they seek help from anyone? Who from? What kind of help?
9. What about family planning?
    - Were women in the community needing to access family planning at this time?
    - Where did they access it and how did they know about it?
    - Do you know of any reasons women might not have been able to use this service from the [NGO]?
10. Can you tell me about any planning or preparation done in the community for managing sexual and reproductive health issues when cyclones come? For example, how does the community make sure that pregnant women can have a safe birth? Or make sure that family planning is available when cyclones happen?
    - *Who was involved in planning and preparation?*
    - *Did it work well when the cyclone came? Why?/Why not?*
11. *If the answer to the above questions is that there hasn't been any planning/preparation to date:* What kinds of things should be planned for? Who should be involved?

Appendix 14: Distress Protocol

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DISTRESS PROTOCOL

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings

PURPOSE

The purpose of this protocol is to provide a clear guide on how to manage distress if it arises during the data collection phase of this doctoral research study. This protocol will be shared with the research team including local research assistants who are engaged in Fiji.

RISK OF DISTRESS

The purpose of this research is to improve access to sexual and reproductive health care, services and information in disaster settings by identifying how social capital (the resources you can access through your social networks) can be used to strengthen sexual and reproductive health crisis preparedness, response and recovery efforts. The primary methods of data collection are focus group discussions and semi-structured interviews.

Due to the nature of sexual and reproductive health there is a possible risk that community member or leader participants may experience feelings of discomfort or embarrassment if discussing sensitive issues during interviews and/or focus groups. This risk would be no greater than the level of a discomfort. There is also a slight risk of participants bringing up unpleasant or traumatic memories that could trigger distress, especially as the interviews/focus groups will be focused on their experiences during cyclones.

If this risk were to manifest (though the likelihood is low) the magnitude of it could be harmful to the participant. The interviews/focus group discussions could bring up traumatic memories from experiencing the cyclone, which could lead to emotional distress. Sexual and reproductive health also includes gender-based violence (GBV)/intimate partner violence (IPV) and participants may experience some distress if this was discussed.

STRATEGIES

In addition to strategies for managing and responding to possible distress in research participants, a member of our research team is a medical doctor with extensive experience working in humanitarian settings. They have training in monitoring and responding to distress and will be contactable if their advice or expertise is required.

If there is a need to evaluate the level of distress experienced by a participant we will use the Subjective Units of Discomfort scale (SUDs), where a participant rates themselves on a scale of 1-10, where 0 indicates no distress and 10 indicates extreme distress[1]. If the distress is transient, we would expect to see the SUDs score reduce by 2-3 points within 15 minutes. A rating of 3 or below will be considered as evidence that distress is mild and that the participant is not experiencing any ongoing harm[2].

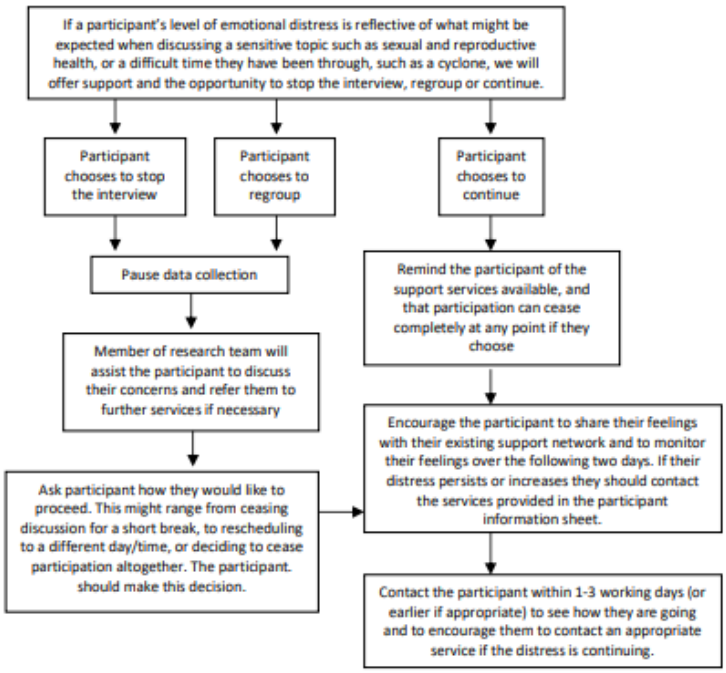
If a participant becomes distressed during an interview or focus group discussion, the following processes will be followed, as appropriate for different levels of emotional distress:

---

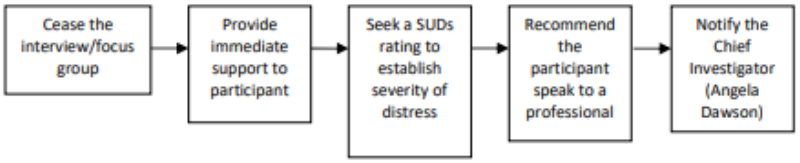
[1] Benjamin, C. L., O'Neil, K. A., Crawley, S. A., Beidas, R. S., Coles, M., & Kendall, P. C. (2010). Patterns and predictors of subjective units of distress in anxious youth. *Behavioural and Cognitive Psychotherapy*, *38*(4), 497–504. https://doi.org/10.1017/S1352465810000287

[2] UTS Research Ethics and Integrity, *Guidelines on the Management of Risk - Distress*

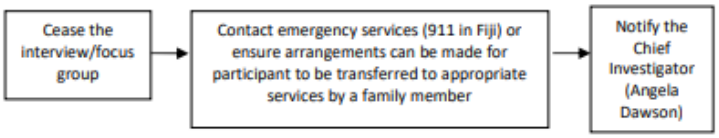
1. Emotional distress level is reflective of what is being discussed.



2. Acute distress or a safety concern



3. Distress that reflects imminent danger



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OTHER CONSIDERATIONS FOR FOCUS GROUPS

- At the beginning of each focus group discussion we will set guidelines for the group which outline the need for respect, confidentiality and safety.
- If a participant does experience distress during a focus group discussion, or discusses topics that may increase anxiety for other participants, we will facilitate de-briefing to enable other participants to process this in a safe space.

REMOVAL OF PARTICIPANT FROM PROJECT

- If a participant chooses to cease their participation they should be offered the choice to withdraw their data collected up to that point, as outlined in the Participant Information Sheet.
- If a participant experiences distress and chooses to cease their participation from the project, the researcher should still contact them to enquire about their wellbeing, but not revisit their decision to withdraw participation (unless raised by the participant).

RESEARCHER DISTRESS

There is a small chance that the researcher or research assistants will experience distress whilst conducting this research. The following steps will be taken if the researcher experiences more than mild, transient distress:

- Contact supervisors for debriefing
- If the researcher feels the need, contact UTS counselling service (02 9514 1177)
- In the unlikely event of extreme distress, contact emergency services (911 in Fiji)

If a research assistant experiences more than mild, transient distress:

- The researcher will facilitate a debriefing session with them
- If the distress is ongoing, researcher will encourage research assistants to contact appropriate services for counselling (Medical Services Pacific, (679) 7769224 or Empower Pacific (679) 7769224)
- In the unlikely event of extreme distress, contact emergency services (911 in Fiji)

Appendix 15: The role of social capital in women's sexual and reproductive health and rights in humanitarian settings: a systematic review of qualitative studies

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https://doi.org/10.1186/s13031-021-00421-1

Conflict and Health

REVIEW Open Access

The role of social capital in women's sexual and reproductive health and rights in humanitarian settings: a systematic review of qualitative studies

Hannah Ireland[1*], Nguyen Toan Tran[1,2] and Angela Dawson[1]

Abstract

Background: Social capital is an important social determinant of women's sexual and reproductive health and rights. Little research has been conducted to understand the role of social capital in women's sexual and reproductive health and how this can be harnessed to improve health in humanitarian settings. We synthesised the evidence to examine the nexus of women's sexual and reproductive health and rights and social capital in humanitarian contexts.

Methods: We undertook a systematic review of qualitative studies. The preferred reporting items for systematic review and meta-analysis guidelines were used to identify peer-reviewed, qualitative studies conducted in humanitarian settings published since 1999. We searched CINAHL, MEDLINE, ProQuest Health & Medicine, PubMed, Embase and Web of science core collection and assessed quality using the Critical Appraisal Skills Programme tool. We used a meta-ethnographic approach to synthesise and analyse the data.

Findings: Of 6749 initially identified studies, we included 19 studies, of which 18 were in conflict-related humanitarian settings and one in a natural disaster setting. The analysis revealed that the main form of social capital available to women was bonding social capital or strong links between people within groups of similar characteristics. There was limited use of bridging social capital, consisting of weaker connections between people of approximately equal status and power but with different characteristics. The primary social capital mechanisms that played a role in women's sexual and reproductive health and rights were social support, informal social control and collective action. Depending on the nature of the values, norms and traditions shared by network members, these social capital mechanisms had the potential to both facilitate and hinder positive health outcomes for women.

Conclusions: These findings demonstrate the importance of understanding social capital in planning sexual and reproductive health responses in humanitarian settings. The analysis highlights the need to investigate social capital from an individual perspective to expose the intra-network dynamics that shape women's experiences. Insights could help inform community-based preparedness and response programs aimed at improving the demand for and access to quality sexual and reproductive health services in humanitarian settings.

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Keywords: Sexual and reproductive health and rights, Social capital, Humanitarian, Social support, Conflict, Natural disaster, Systematic review, Qualitative

Background

In 2018, 136 million people needed humanitarian aid as a result of being affected by conflict, hazards, pandemics and displacement. Of these, 34 million were women of reproductive age and five million were pregnant [1]. Meeting the reproductive health needs of women and girls in these complex contexts requires the provision of and demand for quality services, and the recognition that sexual and reproductive rights—frequently violated in humanitarian settings—are human rights. These include, among others, the right to make autonomous decisions about one's body, to engage in consensual sexual relations, to choose sexual partners, to choose whether to have children and if so how to space them, to have access to sexual and reproductive information, to terminate a pregnancy safely and to access sexual and reproductive healthcare free from coercion, discrimination and violence [2]. The minimum initial service package (MISP) for Sexual and Reproductive Health in Crises, developed for responding to reproductive health needs when a crisis occurs, reflects the integrated nature of sexual and reproductive health (SRH) and provides a concrete set of objectives in the areas of coordination, targeted clinical services and planning for the transition to comprehensive SRH services [3].

Social determinants impact women's sexual and reproductive health and rights (SRHR) in a myriad of ways. A key social determinant of health and wellbeing is social capital. In the field of public health research social capital has been approached from two different perspectives. A social cohesion approach, developed first by Coleman [4] and built on by Putnam [5], sees social capital as the resources (e.g., trust, norms, exercise of sanctions) which are available, collectively, to members of a social group [6]. This is in contrast to a social network approach, first conceptualised by Bourdieu [7] and later developed by Lin [8] where social capital is understood as the resources, or mechanisms, (e.g. social support, information channels, social credentials, social control) that inhere within an individual's social and interpersonal networks. These resources can be the property of both the individual and the collective. Szreter and Woolcock [9] summarise this succinctly, where a social cohesion view "…regards social capital as the 'wires' (or social infrastructure) while network theorists regard it as the 'electricity' (or social resource)" (p. 654). This review takes a social network approach. The contexts of the wires and their electricity flows are also critical to any social capital analysis, especially in terms of how norms, traditions and values mediate the distribution of power [9]. Social capital is often broken down into 'bonding' and 'bridging' types that cut across both cohesion and network approaches. Bonding social capital refers to strong links within groups with similar characteristics, such as class, race and age. This type of social capital facilitates support between group members and also a level of social influence and control. Bridging social capital describes weaker links between people in groups of more or less equal status and power but with different identities and promotes some types of support, control and collective action [9, 10].

We conducted a systematic review to explore how social capital impacts women's SRHR in humanitarian settings. We also examined the role of social capital concerning SRHR throughout the disaster management cycle that is currently unexplored in the literature. A clear understanding of the mechanisms and pathways through which social capital plays out in these settings could inform SRH responses in crisis settings. For example, in the context of implementing the MISP, this understanding could help to both ensure it is harnessing existing networks and resources and also anticipating normative resistance and potential deficits in social capital to enable more effective service demand, delivery and access. Incorporating a social capital analysis into SRHR in crisis settings may also strengthen approaches to health system preparedness, including community-based preparedness, and the rebuilding of health systems following crises.

Broader literature agrees that social capital influences health through several mechanisms, the first being the provision of social support [11]. Social support refers to the functional content of relationships [12]. It can be broken down into instrumental support (help to do things), informational support (help to know things), or emotional support (help to feel things) [13]. The second mechanism is social influence through shared norms or informal social control, which refers to the capacity of a community, or smaller group within a community, "to regulate the behaviour of its members according to collectively desired goals" [6, p. 16]. The third mechanism is social engagement, or the enactment of social roles and connections in real-life activities with the aim of promoting the group or network. Social capital can also influence health outcomes by enabling the collective maintenance, or changing, of social norms, facilitating groups to organise and undertake collective action, and

by the flow of resources such as information and instrumental support throughout a network [14].

Research into social capital in women's SRHR in the last decade has also concluded that social capital is an important determinant in health outcomes, and can act through a number of pathways [15–17]. Studies have shown that networks with high levels of education can increase the health related information available to women [18], social support can facilitate access to health services [19], and higher levels of social participation can lead to increased health promoting behaviours [6]. McTavish and Moore [16] found that women in rural Cameroon with stronger social networks and access to resources, such as information or financial capital, within them were more likely to use maternal health care services. They described how, for example, a woman who is a member of a network which values maternal health care is more likely to have access to assistance to access health care services through that network. Story [17] showed that women who lived in Indian communities that had higher numbers of intergroup connections, measured through civic participation in development, religious and cultural groups, were more likely to use antenatal care, professional delivery care and have their children fully immunised. Social capital can also have a negative impact on SRHR. For example, a study in Uganda found that social capital in the form of group norms and values discouraged the use of family planning methods [20]. The research conducted in this area has predominantly used quantitative methods, providing data demonstrating the influence of social capital on SRHR and mapping the associated types, mechanisms and pathways. However, there is a gap in research exploring the intersection of SRH and social capital in humanitarian settings. In this specific area there are few, if any, quantitative studies. As a result, a review of qualitative studies is pertinent as a means of providing a rich description of the known evidence in order to inform future research endeavours.

A consistent critique of the concept of social capital has been the proclivity of researchers to focus on its beneficial impacts without paying sufficient attention to its potential downsides [14]. Portes [21] identified four dimensions of negative social capital including: exclusion of 'outsiders' as a result of strong in-group bonding, excess demands placed on some group members to support others, restriction of personal freedoms as a result of informal social control and a downward levelling of norms where close bonding ties hold group members in place making it difficult to mobilise upwards [6, 21]. To understand how social capital can be beneficial and detrimental to health, researchers explored the different impacts of bonding and bridging capital in disadvantaged communities. Studies showed that although bonding capital can be an important survival mechanism in adverse contexts, it can also be a health liability [22, 23]. These studies suggest that it is the presence of bridging capital, the ability of people to access resources beyond their immediate community, which can improve health and wellbeing [6].

In humanitarian contexts, researchers have shown how social capital manifests throughout the different phases of a disaster, from social cohesion enabling community preparedness before a disaster, to immediate support between neighbours during and immediately after a disaster, to how better-connected communities could more effectively mobilise themselves to claim resources during the recovery phase [24, 25]. Aida et al. [24] considered the role of social capital in health following a disaster and reviewed epidemiological studies showing that higher levels of individual social capital were associated with improved mental health outcomes following disasters. These findings are echoed by Noel et al.'s [26] review, which provides evidence for the importance of social capital in post-disaster mental health recovery, though the importance of differentiating between different types and mechanisms of social capital is noted as not all have a positive impact. Despite increasing attention on the role of social capital in post-disaster mental health and humanitarian contexts, few studies investigate physical health [24], including SRH. In particular, there is a dearth of qualitative research exploring social capital and health in general but even more so in relation to SRHR in humanitarian settings [27]. Although there are some qualitative studies that explore elements of social capital, such as social support or social networks (for example, [12–14]), very few explicitly employ a broader social capital framework.

Methods

This meta-ethnography of qualitative evidence sought to address the review question: what role does social capital play in women's SRHR in humanitarian settings? The review followed the preferred reporting items for systematic reviews and meta analyses (PRISMA) Statement [28], ENTREQ recommendations for reporting [29] and is registered with PROSPERO, under the registration number CRD42021232396.

Search strategy and study selection

We conducted an initial scoping exercise to identify appropriate databases and generate a comprehensive set of search terms. Previous systematic reviews involving social capital, SRHR or humanitarian settings were also consulted to expand further and develop the search terms. Six databases were searched, including Medline, Embase, CINAHL, Psycinfo, Proquest and Web of

Science. Search strategies are provided as supplementary information to this paper (Additional files 1, 2, 3, 4, 5, 6). Only studies conducted in Low and Lower-Middle-Income Countries (LLMIC) as per the World Bank 2019–2020 classification were included in the review [30].

This review focused on the experiences of women, friends, family, community leaders and health workers, providing both emic and etic perspectives on the subject. Outcomes of interest included anything that was facilitated or hindered by belonging to formal or informal social networks and that influenced women in relation to their SRHR. Studies were included that provided examples of any form of social capital, positive or negative, understood through a network perspective as outlined above.

The review included English-language, peer-reviewed studies published from 1999, when the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* was first published (republished in 2010 as the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*) up until the time of searching (March 2021). The manual provided a shared point of reference for the international community and consistently highlights the importance of, and need for, identifying and utilising community networks, knowledge and other social capital related resources to strengthen response programming.

Following the literature search, we combined results and removed duplicates using EndNote. We identified an additional three studies through manually searching bibliographies. After removing duplicates, we used Covidence software to screen titles and abstracts and following this, came to a consensus on studies to be included in a full-text review.

Data extraction and synthesis

All relevant data in the finding sections of the included papers was extracted for analysis into an excel spreadsheet data extraction form. This included both direct participant quotations and author descriptions that related to the outcomes of interest. We used a meta-ethnography approach, as outlined by Noblit and Hare [31], to analyse the data. This method was chosen as it is frequently used for qualitative analysis in health care research and provides a systematic approach whilst still maintaining the interpretive qualities of the data. This approach is appropriate for this review, concerned with the unique experiences of women in humanitarian settings, as it allows for the non-homogeneity of contextually-based data [32, 33] and enables us to identify examples of social capital in studies that did not necessarily use it as a conceptual framework. As guided by Noblit and Hare's [31] process, we coded and organised the extracted data from each paper into concepts according to the nature of the social process being described [34]. These concepts were clustered into several groups and given descriptive headings that were used to develop a translations table. Using this table, the findings under each heading for each paper were studied, compared to each other and summarised, producing a synthesis of primary author interpretations. From this, we drew out the main points to form 'reciprocal translations' or, third order constructs, agreement on which was reached through discussion with all authors. At this point, a social capital framework and terminology was applied to the findings to interpret and describe the relationships between the third-order constructs and to develop a conceptual model to illustrate those relationships.

Quality assessment

All included papers were critically appraised by two authors using the Critical Appraisal Skill's Programme (CASP) assessment tool for qualitative research [35]. All of the studies met most of the criteria outlined on the CASP checklist. However, only five clearly outlined their methodologies, identifying and describing guiding methodological frameworks and methods. The remaining 14 studies identified methods but did not explain their broader methodological approaches. No studies were excluded through this process, consensus on which was reached among all authors.

Findings

Our initial search returned 6749 studies of which 6695 were removed during title and abstract screening. Studies were removed at this stage because they were not research papers, not qualitative or did not consider any aspects of social capital. We conducted a full-text review on 54 papers, from which we identified 16 studies to be included in the analysis. An additional three studies were identified through hand searching the reference lists of included papers, assessed for eligibility and also included for analysis, bringing the total to 19. Figure 1 shows the results of the database search 1 and study selection process.

As outlined in Table 1, fourteen of the included studies were from Africa, four from Asia and one from the Middle East. The SRHR focus of the studies included intimate partner violence, sexual violence, maternal health, family planning, abortion-related care, and HIV. All the studies were conducted in conflict-related humanitarian contexts except for one study undertaken in a flooded region of Cambodia [36].

The analysis revealed social capital mechanisms that influenced women's sexual and reproductive health that were primarily social support, including instrumental,

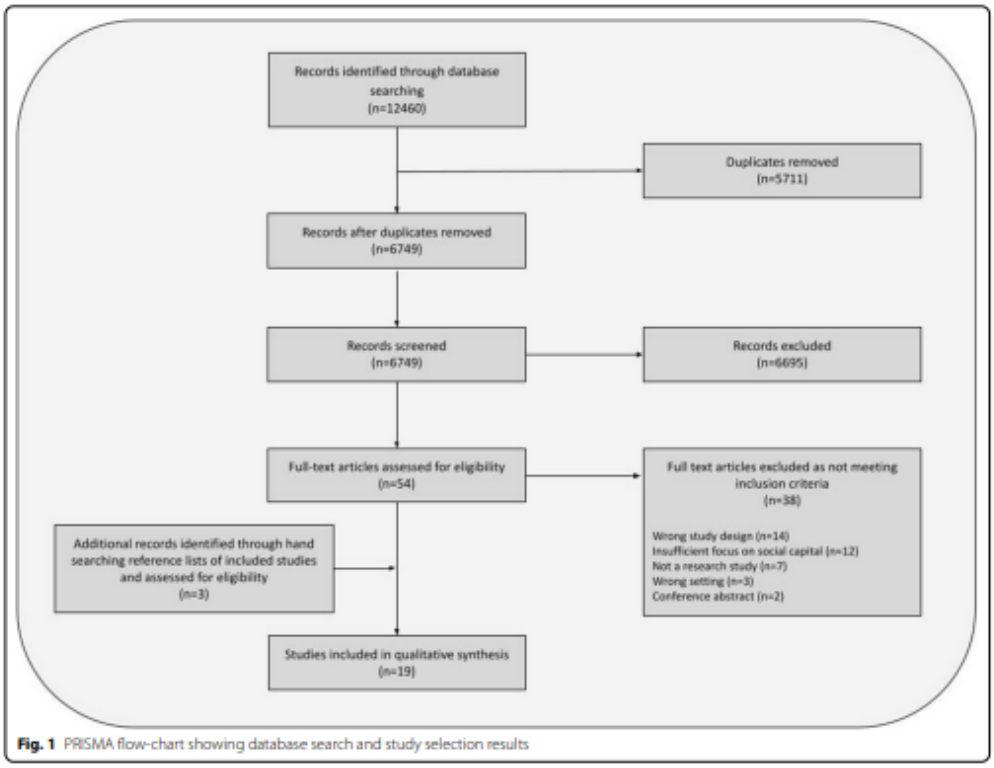

Fig. 1 PRISMA flow-chart showing database search and study selection results

informational and emotional, informal social control and a few examples of collective action; each of these is described below. These mechanisms were largely driven through bonding, and some bridging social capital and led to a number of outcomes that had the potential to both facilitate and hinder women's SRHR. The nature of the outcomes was mediated by the values, norms and traditions held by network members. It should be noted that other social capital mechanisms may play a role in women's SRHR in humanitarian settings. However, these findings only represent those mechanisms that were identified in the included studies.

Instrumental social support

One of the forms of instrumental support provided by community members was in playing a counselling and mediating role for women experiencing intimate partner violence (IPV) [41, 42, 45, 50]. A hierarchy of response was consistently described across the studies where women experiencing IPV would first go to family members for advice and counsel and then, if the issue was not resolved, to community leaders. A Yezidi woman outlined this process, "First I go to my daughter and try and resolve it with my husband. Then we go to the head of the household. If that doesn't work, we go to Baba Sheikh…" [50, p. 9]. Beyond this, in some cases, the issue would be taken outside of the community.

> *"Elders will solve the problem… If he doesn't stop, the elders can take the case to the chairman, and if he can't solve it he will call security, who take the woman to Gender and Social Services" ([41, p. 164] Somali Refugee)*

Whilst these community processes for responding to IPV could be effective and protective mechanisms for women, they were often guided by male-dominated social norms and cultural traditions which prioritised keeping the family together over the safety and well-being of the woman involved. This is demonstrated in the following quote where a typical response, by

Table 1 Characteristics of studies included in review

References	Country	SRH focus	Humanitarian context	WB FCS*
Badal et al. [37]	Somaliland	Maternal health—ANC	Protracted, ongoing conflict, significant internal displacement Research conducted in two IDP camps	X
Dossa et al. [38]	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement	X
Elmusharaf et al. [39]	South Sudan	Family planning/abortion related care	Protracted, ongoing conflict, significant internal displacement	X
Guruge et al. [40]	Sri Lanka	IPV	Post-conflict, recovery since end of civil war in 2009. At time of research 70,000 people were still displaced	
Horn [41]	Kakuma Refugee Camp, Kenya	IPV	Kakuma Refugee Camp. At time of research the camp was home to 96,000 refugees from nine countries, the majority from Sudan and Somalia	
Horn et al. [42]	Sierra Leone and Liberia	IPV	Sierra Leone: Post-conflict recovery since end of civil war in 2002 Liberia: Post-conflict recovery since end of civil war in 2003	X
Koegler et al. [43]	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement	X
Kohli et al. [44]	Democratic Republic of Congo	Sexual violence	Protracted, ongoing conflict, significant internal displacement	X
Kohli et al. [45]	Democratic Republic of Congo	IPV	Protracted, ongoing conflict, significant internal displacement	X
Muzyamba [46]	Democratic Republic of Congo	HIV	Protracted, ongoing conflict, significant internal displacement	X
Rhine [47]	Northern Nigeria	HIV	Ongoing communal and ethno-religious conflict	X
Saulnier et al. [36]	Cambodia	Maternal health	Acute onset flooding response	
Stark et al. [48]	Northern Uganda	Sexual violence	Post-conflict, recovery since the end of conflict in 2006 Research conducted in IDP camps	
Steven et al. [49]	Democratic Republic of Congo	Family planning/abortion related care	Protracted, ongoing conflict, significant internal displacement	X
Strang et al. [50]	Kurdistan, Northern Iraq	IPV	Protracted, ongoing conflict, significant internal displacement Research conducted in an informal IDP camp and neighbouring settlement	X
Teela et al. [51]	Myanmar	Maternal health	Protracted, ongoing conflict	X
Tol et al. [52]	Eastern Uganda	Maternal health—mental health	Post-conflict, recovery since the end of conflict in 2006	
Walstrom et al. [53]	Rwanda	HIV	Post-conflict, recovery since end of war in 1994	
Wild et al. [54]	Timor-Leste	Maternal health—birth choices	Post-conflict, recovery since gaining independence in 2002	X

*WB FCS: The World Bank list of Fragile and Conflict Affected Situations (FCS) is produced annually and provides a classification of low- and middle-income countries that are affected by fragility and conflict. These studies appeared on the list in the year the research was conducted (The World Bank, 2021)

ANC antenatal care, *IDP* internally displaced person, *IPV* intimate partner violence

parents or in-laws, to a woman seeking help for IPV was described.

> *"They usually judge the case, and if you the woman are right, they usually beg you and ask you to please remain in that home. They get angry with the man and warn him strongly not to repeat. Then you go back home and continue." [42, p. 113]*

Horn et al. [42] also noted that where violence continued, women sometimes returned to their parents' household temporarily or permanently, although this was not always a possibility. The findings from these studies show how this social capital mechanism relating to community and family responses to IPV has the potential to impact women's health both positively and negatively, depending

on the shared norms prevalent in the bonded networks it emerges from.

Another form of instrumental support identified in several studies was linking and referring women to formal institutions outside the immediate community. The studies reviewed included community members and leaders referring women to health services concerning induced abortion care, sexual violence, family planning and antenatal care [36, 48, 49, 52].

The sharing of food and house or farm work was a common form of instrumental support described in studies investigating formal group networks such as HIV and sexual violence support groups. These groups often filled a gap for people who were isolated from their families and communities, providing essential day-to-day support.

> *"...When we are here we make a special kind of friendship. Suppose one of us fell sick, we go see her, we prepare food for her, try to console her and discuss what we can do to make her better. And when we go to see her in her area, no one will ask why we come, we go there to visit as a friend, not as an HIV-positive person." [53, p. 10]*

One of the HIV support groups filled a matchmaking gap, helping members navigate the social requirements for finding a spouse that would usually be conducted by family members.

> *"I enrolled [in this group] just to get a husband to marry...The chairman...found me a husband at [the hospital]...We met and although he was set to be introduced to some other girl, on seeing me he liked me" [47, p. 13]*

Informational social support

Informational social support crosses over somewhat with the linking and referring aspect of instrumental social support. The studies reviewed showed that women had access to sources of information regarding SRHR issues in their communities. This included information regarding illness during pregnancy [52], place of birth and strategies for labour [36, 54], perinatal care [36, 37], mental health, HIV [46, 53], abortion-related care and family planning [49]. For example, Steven et al. [49] documented how community leaders advised women who had terminated their pregnancy of the need to visit a health facility for post-abortion care, or village chiefs who promoted the value of prenatal care in a Cambodian study by Saulnier et al. [36].

However, the provision of information was not always consistent with promoting health outcomes for women. For example, some studies described how respected elders provided information regarding antenatal care suggesting it would cause complications in pregnancy and lead to needing a caesarean section [37]. A study in Timor Leste showed how women drew on knowledge and tradition handed down through generations of mothers and grandmothers regarding place of birth: "Because it's like what happened a long time ago, the grandmothers had their baby at home so we will do it just like the grandmothers" [54, p. 2041].

One of the reasons women gave for choosing to birth at home without skilled care, rather than at a health facility, was that traditional knowledge promoted birth occurring in an upright position, physically supported by family members. Health facilities did not allow more than one person to attend a woman's birth and this influenced women's and families' decisions to birth at home.

> *"I think giving birth at home is better than at the health centre because sometimes the midwife doesn't allow the husband or the parents to go in the room and there is nobody we can hold onto. In the house we have the husband and the parents to hold onto." [54, p. 2043]*

This example highlights the complexity of how social capital impacts women's SRHR. Here, the knowledge resource accessed by pregnant women encouraged the higher risk option of delivering their babies at home, without skilled care.

Emotional social support

Emotional support came primarily from close family or friend networks, and especially from mothers. This was particularly prominent in studies investigating IPV and other forms of gender-based violence (GBV) [43, 48, 50], where affected women who were subject to stigma and shame from their broader communities found critical solace and safety in close relationships. A displaced Yezidi woman experiencing IPV described the nature of this social support, "When I cannot stand my miserable life then I go to speak to my mother to feel comfortable. I feel safe and free when I speak with her" [15, p. 9].

Another study in Uganda showed how women drew on emotional support from family and friends when experiencing poor maternal mental health [52] and a study conducted in Timor Leste emphasised the importance of emotional support from family and friends during labour and childbirth [54].

Studies that investigated formal group settings such as support groups for people living with HIV or affected by sexual violence found a high level of emotional support was provided through these [38, 53]. Participants referred to their fellow group members as family and friends, emphasising the significant impact of this form

of emotional support on their mental and physical health, such as in the following quotes: "When I'm with the other women who have also been raped, I also feel stronger." [38, p. 251].

> *"...Before I came I was suffering from headaches—every day I was suffering from headaches—and then after meeting with counsellors and the other women, we've shared our experience and now I'm feeling better". [53, p. 7]*

Group participants often faced isolation from their families and friends due to stigma around issues such as HIV or being a rape survivor. This meant they could risk losing the social support they would have had from those sources, increasing the importance of this source of social capital. The support groups researched in the studies relied on bonding ties which enabled members to connect around shared experiences. The groups also enabled bridging ties, which may have been previously lost, back into their communities [53]. One woman recounted how the emotional support and safety accessed through participation in a support group enabled an improved sense of social functioning which led to reconnection and interaction with her broader community:

> *Nowadays after coming to the group I don't have any conflict with neighbours. I know how to handle them. I'm feeling comfortable when I talk to them and it's because of the support group" [53, p. 7]*

Informal social control

Informal social control was a common theme throughout many of the included studies in the areas of gender-based violence, abortion-related care, family planning and maternal health [36, 37, 39–41, 45, 50]. Informal social control has typically been seen as a mechanism that bought about positive impacts to community members at large however the majority of the examples identified in the studies had potentially adverse impacts on women's health or rights [39–41, 45, 49, 50]. By way of example, Elmusharaf et al. [39] showed how deeply entrenched social norms created pressure and expectation to have large families. Women who did not, or were not able to, have large numbers of children were subject to stigma and shame, as seen in the following quote: "If a lady doesn't bring a child that means she's not good and people don't like her." [39, p. 5].

Stigma and shame were central in driving the process of informal social control in other contexts also, for example where women faced significant social pressure to keep unwanted pregnancies.

> *"A woman who terminates her pregnancy ... she is considered a criminal, she is discriminated against, she is considered as the one who does not have friends because she is a murderer" [49, p. 5]*

Informal social control also played a role in the way communities responded to IPV, which as previously mentioned, did not always prioritise the safety and well-being of the women involved. The risk of possible humiliation and entailing consequences created social pressure to remain in violent relationships [40, 41, 45, 50].

> *"The violence is happening but I tell myself it is not worth it and I try to keep silent. He beats me but we are IDPs, it would be better to keep silent than making the problem bigger than its normal size." [50, p. 7]*

Women survivors of sexual violence in humanitarian settings also experienced discrimination and this sometimes influenced their decisions to disclose the violence and seek the support they needed [38, 48].

> *"It's a secret for us. If you approach us, we'll talk to you and you'll discover the problem we're living with. But if you don't come to us, it's not easy for us to stand up, like that, in front of a lot of people, or the assembly, and start saying, "I was raped." It's not easy." [38, p. 250]*

Social norms around the ownership of women by their husbands and husbands' families were common throughout the studies. They helped facilitate informal social control around some SRH issues. The findings demonstrated that this could result in both positive and negative impacts on health behaviours. For example, Badal et al. [37] described how husband and family members could influence women to either attend or not attend antenatal care depending on their beliefs. Saulnier et al. [36] similarly showed that women were expected to do as their husband and family chose in relation to where to deliver their babies, whether this be with or without skilled care. Regardless of the impact, however, in each of these examples women had minimal agency in their SRH-related decisions.

Collective action

Though not as common in the reviewed studies as the two other social capital mechanisms, there were also two examples of collective action. Both examples were in the context of support groups, which used their collective voice to advocate, seeking to change norms and attitudes that had caused them harm [42, 46]. An HIV-positive IDP from Congo describes this in the following quote.

> *"We now work in unit to challenge the bad treatment, stigma and discrimination which we have*

been subjected to for a long time. We now speak as one voice." [46, p. 3]

Muzyamba [46] explained how the support groups could challenge issues such as patriarchy and sexual cleansing. Horn et al. [42] described the power of collective action in the context of IPV. As a group, women could confront a man concerning his violent behaviour that was often effective in bringing about change.

Discussion

This review found that women in the included studies belonged to interconnected family and community networks and in some cases, formal group networks. These networks were primarily connected with bonding ties, and some bridging ties to broader community networks. The ties were reinforced by a set of values, norms and traditions which guide how women and communities respond to women's SRHR. In the included studies, the three mechanisms through which social capital played a role in women's SRHR were social support, informal social control, and collective action, resulting in several outcomes. Figure 2 provides an overview of the types of networks, social capital pathways and outcomes identified in this review. These outcomes included access to and demand for health services, information and advice, provision of food, assistance with household chores and farming, safe spaces, connections with other women, counselling, mediation, assistance in finding marriage partners and advocacy. The outcomes were mediated by the prevailing values, norms and traditions, including the status of women and their decision-making power. As a result, the outcomes had the potential to have both beneficial, and in some cases, adverse impacts on women's SRHR. It should be noted that all the participants across the studies were of a similar socio-economic status so whilst this is a significant consideration in social capital analysis, its impact on outcomes was not variable.

The review findings are consistent with existing research that shows that social capital can play an important role in influencing health in humanitarian settings [24–26]. They also echo previous research, which has explored the specific pathways through which social capital influences health throughout the different phases of the disaster management cycle [24, 25, 55]. Most of the reviewed studies were conducted in the relief and

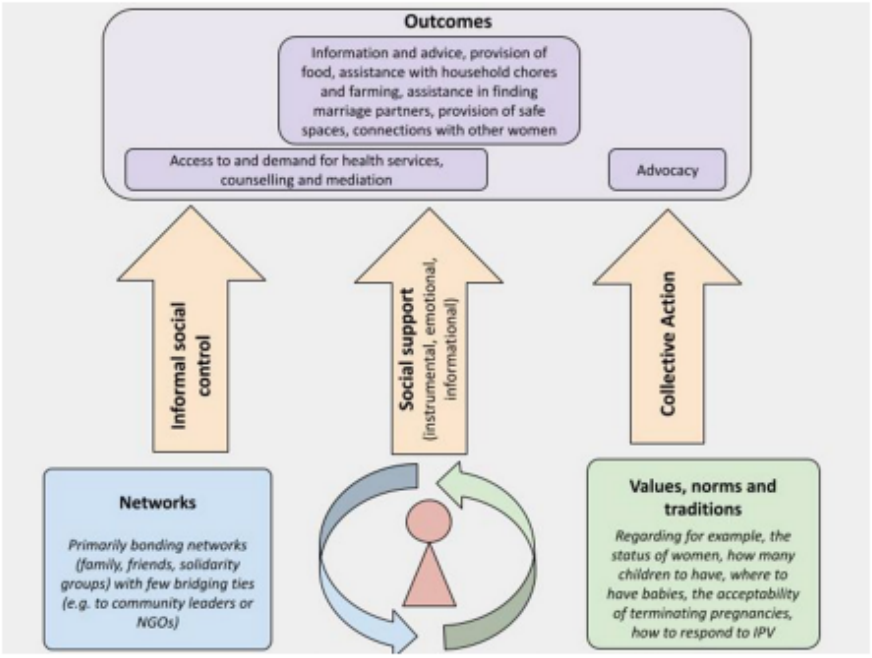

Fig. 2 Relationships between social capital and outcomes identified in reviewed studies

recovery phases. They showed how social capital enables a bottom-up approach where community members provide instrumental, informational and emotional support for one another. The few examples of bridging capital in the findings were also consistent with broader research demonstrating its necessity in opening up "pathways to longer-term survival and wider…community recovery" [24, p. 174]. Previous research has distinguished between existing social capital and new social capital, suggesting that literature to date has focussed mainly on the value of existing social capital in relation to disaster mitigation and recovery and the creation of new social capital concerning preparedness and response [25]. In line with this, the review findings affirmed the importance of existing social capital in the context of the recovery phase. In contrast however, our review also highlighted the value of new social capital built through support groups during the recovery phase.

In the context of the existing literature, the review findings demonstrate the value in considering the role of social capital in women's SRHR across all phases of the disaster management cycle including an exploration of how the specific mechanisms and types may impact SRH outcomes. Applying a social capital framework to planning and coordination of SRH programming, such as the MISP for SRH, could provide valuable guidance in how to harness the potential of existing networks and resources. This application could also help to identify where critical gaps exist and develop appropriate interventions to address them. Importantly this should include an individual level of social capital analysis that considers the differential access to social capital *within* networks, and how the social capital of some network members can limit the potential of others, as seen in the review findings. Not including this level of analysis risks implementing health interventions that are not as effective as possible or, at worst, that reproduce forms of social capital that further constrain women's agency. This analysis should identify whose voices need to be 'in the room' when it comes to community consultation, and program implementation, developing the bridging social capital required for communities, and especially women, to build sustainable pathways to improved SRH.

In the context of the global COVID-19 pandemic the potential value of incorporating social capital into the analysis and response to crises is even more salient. Projections that warn of the serious impact that the pandemic could have on access to life-saving SRH services are now beginning to be borne out [56, 57]. Emerging research points towards the importance of considering social capital in responding to and living with COVID-19, especially in ensuring that the most vulnerable and marginalised members of society are informed about existing services and have access to the services they need when they need them [58]. Social capital could play a critical role in helping to minimise the immediate impact of service demand and disruptions, social isolation, and a weakened health system on SRHR. In the longer term, it could help facilitate the recovery of local health systems that deliver equitable access to SRH services and that are built on robust connections with the communities and people they are designed to serve.

Limitations and future research

A significant limitation of this review was the lack of studies that explicitly applied a social capital approach. Only one of the 19 studies reviewed used social capital as an explanatory framework [50]. When selecting studies to be included in the review the authors searched the studies for examples of social capital interventions, using a common definition of social capital, as outlined in the background of this paper. We addressed the potential for subjectivity through this process as far as possible by ensuring agreement from all authors regarding what constituted social capital in each paper. As most of the included studies did not set out to specifically identify or measure the role of social capital in women's SRHR in humanitarian settings, it is likely that there are some gaps in the picture this review presents. Another limitation lies in the heavy weighting of included studies towards conflict-related humanitarian settings, with only one conducted in a natural disaster context. Though both humanitarian, there are differences in some of the issues, for example, conflict-driven sexual violence, which may be more prevalent in one than the other. The small sample of studies in natural disaster settings did not enable any themes or patterns to be identified specific to that context. There is a need for further research that explores the link between social capital and women's SRHR in humanitarian contexts, especially natural disaster settings. This review was also limited to peer-reviewed studies, and future research could benefit from exploring grey literature.

This review highlights a significant area for further research, exploring how a social capital analysis can be incorporated into SRHR crisis preparedness, response, mitigation and recovery efforts. As part of addressing this question, research is needed to identify the pathways through which social capital influences SRHR in humanitarian settings. Whilst this review elicited some insights, further research is required to provide a more complete picture which would reveal the barriers and opportunities, relating to social capital in strengthening the demand for and quality of SRH services in humanitarian settings. Another important element of future research, which was not explicitly addressed in this review, would

be investigating how crises break down social capital in relation to SRHR and how the health of women, who have lost most, or all of their social capital, is impacted.

Conclusions

Understanding how social capital influences health in humanitarian settings can offer important insights for professionals and communities in terms of service delivery, access and demand, from preparedness planning through to response and recovery. To date, little research has been conducted that focuses specifically on SRHR and future studies would be of great benefit to enhancing SRH responses in crisis settings. A more comprehensive picture of the relationships between social capital and SRHR in humanitarian contexts could enable more effective design and implementation of interventions resulting in improved SRHR for women in crisis settings worldwide.

Abbreviations

MISP: Minimum initial service package; SRH: Sexual and reproductive health; SRHR: Sexual and reproductive health and rights; PRISMA: Preferred reporting items for systematic reviews and meta-analyses; LLMIC: Low and lower-middle income countries; CASP: Critical appraisal skills programme; WB FCS: The World Bank list of Fragile and Conflict Affected Situations; ANC: Antenatal care; IDP: Internally displaced person; IPV: Intimate partner violence; GBV: Gender-based violence.

Supplementary Information

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Additional file 1. CINAHL Search Strategy.

Additional file 2. Embase Search Strategy.

Additional file 3. Medline Search Strategy.

Additional file 4. Proquest Search Strategy.

Additional file 5. PsychInfo Search Strategy.

Additional file 6. Web of Science Search Strategy.

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Authors' contributions

HI led the literature search and screening with input from AD and NTT. HI and AD appraised the studies and all authors participated in the analysis of the data. HI led the writing of the manuscript with critical input from AD and NTT. All authors approved the final version.

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Availability of data and materials

All data is in the public domain. Samples of search strategies are available in the supplementary material.

Declarations

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Not applicable.

Consent for publication

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Competing interests

The authors declare that they have no competing interests.

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Appendix 16: Social capital and sexual and reproductive health and rights in Fiji: a scoping review of humanitarian preparedness and response planning and guidance documents

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Social capital and sexual and reproductive health and rights in Fiji: a scoping review of humanitarian preparedness and response planning and guidance documents

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Abstract

Background Social capital, the resources embedded in social networks, has been identified as a key determinant of sexual and reproductive health outcomes, yet its role in crisis contexts, particularly in shaping access to sexual and reproductive services and influencing policy and planning, remains underexplored.

Methods We undertook a scoping review to examine the incorporation of social capital into policy and guidance documents related to women's sexual and reproductive health services in humanitarian crises, specifically focusing on Fiji and the Pacific region.

Results The review identifies eight interconnected dimensions of social capital in two groups. The first group outlines approaches that service providers can take to harness and build social capital (community involvement, linking to existing services, and identifying community resources). The second group includes existing social capital mechanisms (trust, social norms and values, social power, social support, and the integration of traditional knowledge) that have the potential to both improve, and hinder access to information and services.

Conclusions Findings indicate that while these dimensions are referenced in policy documents, there is often a lack of detailed implementation guidance. The findings underscore the importance of detailed guidance on leveraging existing social networks and understanding the nuanced nature of social capital and how it can impact sexual and reproductive health outcomes. Research is required to provide a deeper understanding of social capital and how such capital can be brought to bear to optimise sexual and reproductive health service preparedness and delivery in disaster recovery, particularly in Fiji and the broader Pacific region.

Keywords Sexual and reproductive health and rights, Social capital, Humanitarian, Natural disaster, Scoping review, Qualitative

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Background

Humanitarian crises, including conflicts and natural disasters, exert a profound impact on populations globally, with a significant portion of those affected being women of reproductive age [1]. Such crises often exacerbate existing vulnerabilities, adversely affecting women and girls' access to sexual and reproductive health (SRH) services and subsequently their health outcomes. Despite considerable improvements that have been made in the coordination and delivery of SRH services in crisis environments, highlighted by the development, implementation, and update of the Minimum Intervention Service Package for Sexual and Reproductive Health in crises (MISP), challenges persist in fulfilling the SRH needs of women in crises globally.

Social capital, defined here as the resources accessible through one's social and interpersonal networks [2], is acknowledged as a critical social determinant influencing women's sexual and reproductive health and rights (SRHR) [3–5]. It encompasses social support systems, information channels, and the ability to exert social control, all of which play pivotal roles in health outcomes. While research has linked social capital to broader health metrics and has explored its impact during disaster cycles, particularly concerning mental health [6–8], there remains a notable gap in understanding how social capital affects women's access to SRH information and services in crisis settings including how policies, plans and guidelines take social capital into consideration. For example, do SRH emergency response policies, plans and guidelines consider the role of informal networks in disseminating health related information? Do they take into account social norms that might impact on women's decisions to access health services?

Service providers, including government agencies, non-government organisations (NGOs) and international non-government organisations (INGOs) draw on a range of policies, plans and guidelines to conduct their work, including multi-laterally developed, well-recognised guidelines such as the *Sphere Handbook* [9] and guidelines developed by and for specific organisations, such as the *CARE Emergency Toolkit – SRH* [10]. These guidelines assist service providers by offering structured protocols and evidence-based practices for effectively delivering emergency SRH responses. They provide crucial frameworks that help practitioners navigate the complex challenges of delivering care in crisis situations, ensuring that the services are not only timely and efficient but also culturally sensitive and rights-based.

For the most part, these guidelines do not directly mention 'social capital' as a concept. This omission might overlook the significant role that existing social networks, community trust, and local resource mobilisation can play in the effectiveness of humanitarian interventions [11]. Though not a new concept, current trends in the humanitarian sector are increasingly emphasising the importance of localisation in response strategies [12]. This shift towards localisation recognises the value of community-led responses and the need to leverage local resources and capacities [13]. Successful activation of localised responses heavily depends on the capacity of communities, which is intrinsically linked to their social capital [14]. Hence, there is a growing need for these guidelines to incorporate social capital considerations to enhance the effectiveness of localised humanitarian efforts, ensuring that the responses are not only aligned with international best practices but are also rooted in the realities and strengths of the local communities they serve.

There is also a gap in research investigating social capital in the context of humanitarian crises in Pacific Island countries (PICs) [15] which are usually precipitated by acute, rapid-onset natural disasters, and especially its influence on health outcomes [16]. PICs not only rank high on the World Risk Index for disaster proneness [17] but also grapple with significant SRHR issues, such as high unmet needs for contraception and elevated levels of sexual and gender-based violence [18]. This scoping review seeks to address part of the knowledge gap relating to social capital and health in Pacific humanitarian contexts and identify opportunities for strengthening SRH crisis preparedness, response and recovery efforts by investigating if and how social capital is considered in relevant planning and guidance documents. Through a review of grey literature it aims to develop a knowledge base and provide background and context for subsequent research phases by addressing the question: What dimensions of social capital are incorporated into Fijian national, Pacific regional and international Disaster Risk Reduction (DRR), preparedness and response planning and guidance documents relating to SRH? Giving an answer to this question will provide an overview of how social capital is incorporated into planning and guidance documents and will enrich the body of scientific research on this topic.

Methods

The research question guiding this scoping review emerged from an earlier systematic review which identified the need for research exploring how a social capital analysis is, and could be further, incorporated into SRHR planning, response and mitigation efforts [8]. Fiji was chosen as the national level focus for the research question as it experiences frequent natural disaster-related humanitarian crises. Additionally, Fiji serves as a regional hub in the Pacific region hosting several NGOs and INGOs who developed some of the guidelines under consideration in this review. A scoping review was chosen as

it offered an appropriate method to "identify and map the breadth of evidence available" across a heterogenous set of primary policy and guidance documentation [19]. We followed the Joanna Briggs Institute (JBI) approach to the conduct of scoping reviews informed by the Arksey and O'Malley framework [20] which was further enhanced by Levac, Colquhoun and O'Brian [21]. This process is summarised in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Statement [22]. The protocol is registered with Open Science Framework [23].

Search strategy and document selection

The search for documents was conducted on the websites of: (1) Fijian and international organisations, networks and federations working in the area of SRH emergency response; (2) Pacific regional organisations and networks; and (3) Fijian government ministries and offices involved in health and, or emergency response.

On each of these websites, the following search terms were used to identify potential documents to be included:

> *(Sexual and reproductive health OR Sexual violence/Gender-based OR Violence/Intimate Partner Violence OR Maternal Health OR Newborn Health OR Contraception/Family Planning OR HIV) AND (Emergency OR Humanitarian OR Crisis)*

After an initial search, the identified websites and documents were shared amongst all authors and additional potential websites and documents were added. The review included English-language National (pertaining to Fiji), regional (Pacific Region) and international DRR preparedness and emergency response planning and guidance documents, which also focused on SRH. Included documents were all published since 2009, when the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* was first published (republished in 2010 as the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*). There was considerable variance in the types of documents identified. For this review, 'planning and guidance documents' were defined as documents outlining current information, mandates, recommendations and best practices for practitioners and decision-makers involved in delivering emergency responses. This also included policies.

The initial search found 68 documents from 30 different organisations and institutions. Of these, four were duplicates. A preliminary review excluded a further 36 documents due to them not being a planning or guidance document; having an insufficient focus on implementation, SRH, or humanitarian settings (i.e. only including a mention of these without any further description or information); or having a particular focus on one country, other than Fiji. Figure 1 shows the results of the search and document selection process, resulting in 28 documents being included for review.

Quality assessment

Included papers were appraised using the AACODS checklist (Authority, Accuracy, Coverage, Objectivity, Date, Significance) developed specifically for grey literature [24]. The included documents all met the criteria outlined on the checklist. No studies were excluded through this process.

Data extraction and analysis

We followed a directed approach to content analysis [25], using existing theory [26] to inform the initial codes which guided data extraction. A set of pre-determined social capital indicators, outlined in Table 1, were used to code the data representing five dimensions of social capital. These dimensions were chosen as they had been effectively used in a similar study and represented aspects of social capital that have been shown to influence the impact of natural disasters on communities [26]. We undertook this coding process manually and extracted all relevant findings into an Excel document. We then undertook a content analysis to map the findings and provide more detailed descriptions of the social capital elements identified, as recommended by Pollock et al. [19] for scoping reviews that have the purpose of identifying key factors related to a concept.

Results

Twenty-eight documents were included in the review (see Table 1 in Additional file 1). The included documents were mostly produced by INGOs and international multilateral organisations between 2000 and 2022. Although Fijian government documents were initially found, they were high-level and did not include sufficient attention on the review's focus areas. Five of the included documents considered conflict contexts, two focussed on epidemic contexts, one on refugee camp contexts, one on natural disaster contexts and the remaining majority took a generic approach, not specifying one particular type of humanitarian context. Thirteen of the documents considered SRH generically, and the remainder focussed on a particular SRH issue, including adolescent SRH, maternal health, contraception, sexual violence, lesbian, gay, bisexual, transgender, intersex, queer/questioning, and others (LGBTIQ+) SRH, and sexually-transmitted infections (STIs). The target audiences for these documents span all levels of involvement in emergency SRH service delivery from decision makers to implementers including policymakers, advisers, program managers, donors, community stakeholders and those at the face of service provision.

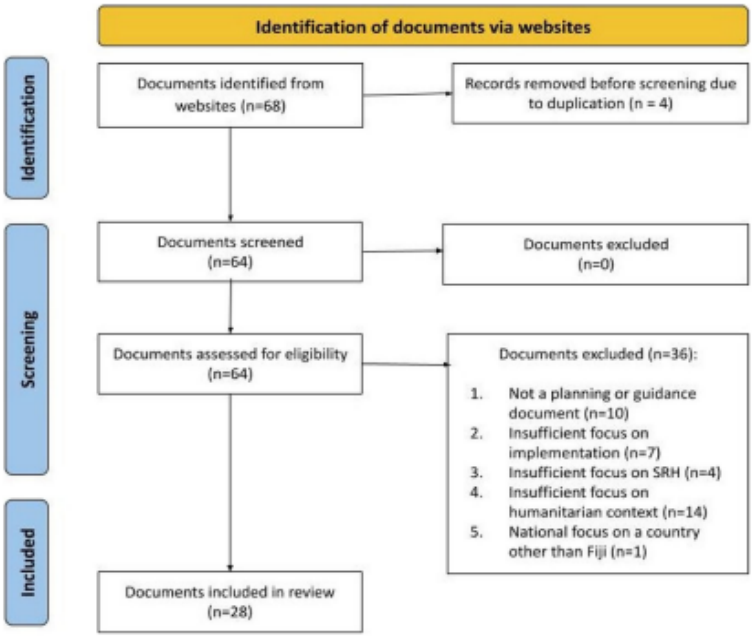

Fig. 1 PRISMA-ScR flow-chart showing search and selection results

Table 1 Predetermined social capital indicators [26]

Community participation	Identification and engagement of community members, local groups, local leaders, community resources
Social organisation	Identification of capabilities of social organisations, coordination between NGO and governmental institutions
Social relations	Indication of the importance of social relations (e.g. reciprocity, trust) for the exchange of information and resources, identification of how to overcome social barriers that may lead to inequality of access to resources (e.g. linguistic and cultural)
Social network	Indication of the importance of social networks for dissemination of information, identification of relationships between communities and organisations and how they can be utilised
Shared narratives and knowledge	Identification of how to incorporate existing knowledge and experiences into planning and responses, identification of ways to encourage collaborative learning

Our content analysis of the extracted data identified eight final categories: linkages to existing formal services and local organisations; community participation; identification of informal community resources; social support; trust; social power; social norms and values; and integration of traditional knowledge and experience. Table 2 in (see Additional file 2) shows these categories and their link to the original social capital indicators used to code them.

Community participation

The concept of 'community participation' was found throughout almost all of the documents that were analysed. This theme encompassed any references or descriptions relating to identifying community stakeholders and their participation and involvement in preparedness and response efforts.

The extent to which this was focussed on and how it was included ranged considerably throughout the documents. All the documents, apart from two more clinically focussed sets of guidelines [27, 28], included at the very least a statement affirming the importance of involving local people, and especially marginalised groups, throughout the process, such as,

> *"Meaningfully engage and include people of diverse LGBTIQ + as leaders, participants, staff, and volunteers in all aspects of humanitarian action and disaster risk reduction actions..." [18].*

Several documents expanded on this and provided more detailed suggestions on implementing this type of participation [10, 29–35]. Some common, practical

guidelines provided were to ensure local community members, including those from marginalised groups, were appointed to working and consultation groups or trained as staff and volunteers in the operationalisation of programs [30, 35–38]. In the context of preparedness measures, another document referenced specific participatory development tools such as storytelling for collecting data and co-analysis [29].

Identification of informal community resources

Across many of the documents, the identification of informal community resources was highlighted as an important part of effective planning and response activities. This category encompassed the identification of existing informal resources in communities, for example, people with particular roles or skills, networks or groups that could be used in preparedness and response efforts. Most commonly, documents made high-level statements in relation to this, such as, "identify existing community capacities to respond to crises" [39], or "interventions… should be based on assessment of capacities and needs, and build and strengthen existing resources…" [40]. More specifically, several documents emphasised the importance of identifying and drawing on influential individuals, groups and community leaders [35, 36, 39, 41, 42]. Some mentioned particular community members, such as Traditional Birth Attendants, who could be an important resource for linking with pregnant women in humanitarian settings [32, 37, 41].

Many documents noted the importance of identifying and strengthening informal community networks [9, 18, 30, 32–35, 37, 38, 41, 42]. In particular, informal networks were mentioned in relation to vulnerable groups such as youth, women and girls, people living with HIV, LGBTIQ + and people with disabilities [9, 18, 33, 37, 38, 41, 42]. Several documents noted the importance of tapping into these networks, and others went further in providing guidelines on how networks could be used and, or developed to improve service access and delivery [9, 18, 30, 38]. Informal networks were noted as important channels for disseminating information [30], for example, the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* emphasised the importance of informal youth networks for sharing information about SRH services [37]. Similarly, the *Down By the River (Oxfam)* report highlighted the importance and effectiveness of networks of friends and 'chosen family' in helping LGBTIQ + people access information and services [38]. Other documents noted the potential effectiveness of informal networks in the distribution of commodities [9, 18]. In the context of gender-based violence the *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (IASC)* noted the role of community protection mechanisms including family and kinship networks and how these can help monitor risks of gender-based violence against children and adolescents [35]. Where these informal networks do not already exist, some documents suggested the need for cultivating them, for example the *Women and Girls' Safe Spaces (IRC, IMC)* document outlined the need for safe spaces where women's networks can form and be channels for support, information and service delivery [34].

Linking to existing services and local organisations

The third category identified across the review of documents was connecting with existing formal groups and organisations and services in affected communities. Whilst this has been separated as a distinct category it has significant overlap with both categories previously outlined. By building partnerships with existing formal service providers, their resources, knowledge and expertise can be utilised to improve outcomes and maximise the impact of preparedness and response initiatives. If and to what extent this was included as an approach varied across the documents, some did not mention it [10, 27, 28, 31, 35, 43–49], and others simply acknowledged the need to coordinate with other organisations [9, 18, 39, 40, 50]. In addition to this, several documents listed potential formal community groups and organisations to connect with, such as youth groups, schools and churches [36, 37, 39, 42]. Others had a more significant focus on this area and went into detail about the impact of linking with local groups, including increased ownership, sustainability, tapping into local expertise and contextual knowledge [29, 30, 34, 38, 41, 42, 51]. For example, the *Down By The River (Oxfam)* report emphasises that local organisations "…are most likely to understand these contextual factors. They should be at the centre of decision-making, and more funding should flow directly to them." [38]. Several documents highlighted the importance of working with community health workers (CHWs) and what an asset they can be during preparedness and response activities [37, 41, 42]. For example, the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* includes the following,

> *Given the barriers communities face in accessing health services, CHWs play a crucial role in bridging this gap, particularly for rural communities, as CHWs are often well-regarded members of their communities. CHWs can broaden access and coverage of health services in remote areas and take actions that lead to improved health outcomes, including for adolescents. [37]*

Beyond outlining the importance of, and need for, connecting with local level services, groups and organisations, most documents did not include significant detail

on the mechanics of such processes. The few that did included a reference to mapping exercises for understanding what services existed including those already providing SRH services and other potential linkages that might be used for distributing information, commodities or making referrals [30, 37, 41, 51]. Linking via the formal cluster group was also suggested as a practical strategy [18, 37, 41].

Social support

The findings relating to social support significantly overlap with the findings relating to informal networks because the former is provided through networks and in turn helps create them resulting in a web of shared resources, knowledge, and support. For example, the importance of family, or 'chosen family' support during disasters is stressed in many of the documents [32, 37, 38, 40, 41, 51], as the presence of informal family and friend networks can provide emotional and practical assistance. Some documents acknowledge and emphasise the importance of maintaining and strengthening protective social support mechanisms, such as women's support groups or other community support mechanisms for survivors of domestic violence, while being cautious not to increase social stigma [34, 40, 41].

Several documents noted how significant the loss of social support can be, when networks, families and communities are disrupted through humanitarian crises [10, 32, 37, 39, 41]. For specific groups, such as adolescents or pregnant women, loss of social support can have a detrimental impact on their access to SRH services and lead to higher risks such as unsafe abortions and unsafe sexual practices [41]. These documents promoted the creation of support groups to fill possible gaps that arise in humanitarian situations. For example, the *Women and Girls Safe Spaces Toolkit (IRC, IMC)* provided detailed guidance on how to set up safe spaces so they could be a source of social support, including accessing information and resources [34]. Similarly, the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG)* outlined how to facilitate forming adolescent peer groups as alternative sources of social support to help mitigate the impact of separation from their families [37].

Trust

Trust was acknowledged throughout some of the reviewed documents, primarily as a facilitator for delivery of and access to SRH services in humanitarian settings [34, 36–38, 41]. Of note, mentions of trust were mainly limited to guidelines that included a focus on working with adolescent groups or minority groups such as LGBTIQ + communities. These documents emphasised the need to develop trust to work effectively with these groups and the time needed to establish trust. Guidelines suggest that the trust-building process is often facilitated by leveraging existing trusted relationships, such as the bonds between adolescents and their teachers, who may be regarded as trustworthy figures [36].

Several documents suggested the involvement of peers for specific groups as an effective strategy, primarily because of the pre-existing trust they have within their peer groups [30, 32, 36, 37]. Their role can be pivotal in disseminating information and services, capitalising on the trust they've already established. Furthermore, documents noted the role of community gatekeepers and other trusted community members, who can hinder or facilitate other community members' access to SRH services, especially for adolescents and minority groups [32, 37, 39, 41]. Earning their trust is imperative, as they serve as influential decision-makers. Following this, guidelines highlighted the importance of a robust referral system, understood by those trusted community members, to ensure that those who confide in them are appropriately supported and guided to relevant services [32, 37, 41, 51]. Lastly, references to trust were not limited to individuals but extended to local organisations as these entities play a vital role in delivering essential services and building community resilience [29, 34, 38].

Social norms and values

Most of the documents reviewed identified, to varying extents, the impact of social norms and values on SRH and SRH service delivery in humanitarian settings. Many of the reviewed documents acknowledged that these social dimensions, rooted in the opinions, expectations, attitudes, and beliefs of both informal and formal leaders, be they community, religious, or youth figures, play a critical role in shaping the ability of community members to seek and obtain SRH services [9, 29, 32, 35–37, 39, 41].

The findings focussed almost solely on the negative impacts of social and cultural norms and the ways they can restrict access to SRH services. Stigma and negative attitudes were identified as major barriers to accessing health services, especially for minority groups [29, 34, 35, 37, 40, 41, 50]. Accordingly, many documents outline the need for a culturally sensitive approach that not only understands and respects but also critically engages with existing norms and values, aiming to challenge and transform harmful practices and attitudes [9, 30, 32, 41, 50]. A few guidance documents proposed proactive measures for mitigating potentially harmful norms. They suggested employing strategies like values clarification and attitudes transformation activities [37] and engaging community stakeholders to foster a more supportive environment for adolescents and other minority groups needing SRH services [37, 38]. There were, a few documents which also

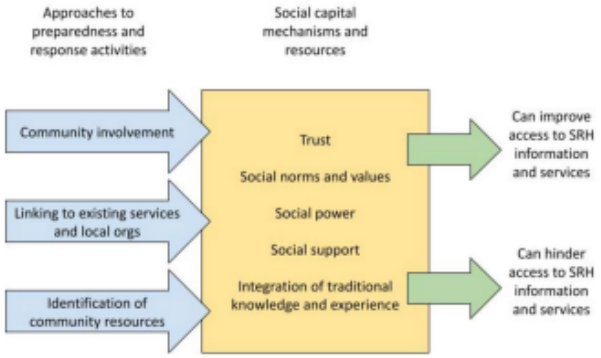

Fig. 2 Interconnected social capital dimensions represented in reviewed documents

noted the existence of positive norms and the importance of promoting and strengthening these [32, 35, 41].

Social power

Another grouping that emerged from the reviewed documents was 'social power'. Only one of the reviewed documents directly referenced the concept and defined it as "the capacity of different individuals or groups to determine who gets what, who does what, who decides what, and who sets the agenda" [34], using the term to explain gender inequality. This and other documents noted that men often occupied decision-making roles in families and communities, giving them a form of social power that could impact women's access to SRH services [32, 34, 41, 42]. Although social power was not directly referred to in other documents, it was taken into consideration in several ways. Some documents noted the importance of identifying communities within communities to understand social relationships across different groups, for example, different ethnic or tribal groups within a refugee community [36, 37, 51]. The significant influence of the opinions, expectations, and beliefs of families and communities on adolescents' decision and ability to access SRH services was highlighted, as was the significant barrier presented by stigma and negative attitudes in the community [29, 36, 37]. For example, family's expectations, together with stigma from the community often stop unmarried girls from accessing contraceptive services [29].

Integration of traditional knowledge and experience

Few reviewed documents identified traditional knowledge and experience as a resource available in community networks which could be integrated into planning and responses [32, 39, 41]. One of the documents emphasised the expertise of community members in disaster risk reduction processes, due to their lived experience, and outlined some strategies for harnessing that knowledge into planning [39]. Two other documents referenced drawing on traditional knowledge in relation to working with sexual violence survivors where traditional healing processes might be beneficial [32, 41], with the important caveat that these processes did not risk leading to victim-blaming or further harm to the survivor. *Reproductive Health During Conflict and Displacement (WHO)* also noted more broadly the role of traditional methods of healing and the importance of identifying and drawing on the respected community members who hold those roles and who "…have vital knowledge of traditional coping mechanisms and systems of support" [32].

Discussion

Policy and guidance documents are critical mechanisms to optimise resources and ensure the delivery of high-quality, appropriate SRH service in crisis settings. This review sought to understand if and how social capital is incorporated into such documents to support local, national and international responders to augment SRH care, services and information provision.

This scoping review found that social capital is indirectly incorporated into the reviewed documents to varying extents across eight, interconnected dimensions. These dimensions can be broken down into two groups, as illustrated in Fig. 2. Firstly, we identified three approaches (community involvement, linking to existing services and local organisations, identification of community resources) outlined in the included documents that were suggested as ways providers can harness, and, or build social capital in preparedness and response activities to improve the delivery of SRH information and services. These approaches have been explored in the literature in the context of the intersection between social capital and community development and, in some cases, health promotion [52–55]. The three approaches to preparedness and response activities relate

to structural forms of social capital, "externally observable objective aspects of social organisation" [3]. These approaches were readily identified throughout most of the documents, with 'community involvement' being the most prevalent, followed by 'identification of community resources' (especially in relation to the identification of community networks) and then 'linking to existing services'. Of note was the prevalence of high-level statements with few documents describing the steps required for effectively implementing said approaches.

The second group of social capital dimensions identified in the reviewed documents consisted of existing social capital mechanisms, or resources that can be drawn on to improve information and services or that may hinder the delivery of and access to information and services. These include trust, social norms and values, social power, social support and the integration of traditional knowledge and experience, and can be seen in the middle box of Fig. 2. Primarily cognitive facets of social capital, these dimensions are mostly intangible and relate to people's perceptions rather than their actions [2]. However, social support and traditional knowledge and experience also have some elements of structural social capital, indicating a level of overlap. A distinguishing characteristic of these social capital elements lies in their capacity to either improve or hinder access to services. Social capital is often referenced in the broader health literature in relation to its positive impacts. However, it can also negatively impact health outcomes [56, 57], a nuance acknowledged by certain reviewed documents, which offer suggestions for mitigating these negative impacts.

The social capital mechanisms and resources, depicted in the middle box in Fig. 2, were less commonly referenced across the reviewed documents compared to the approaches highlighted in the arrows. This suggests that the policy and guidance documentation may not consistently provide sufficient insight into the need for understanding existing community resources and capacities. This finding echoes similar work in this area [26] and holds significance in light of the established importance of existing community resources and capacities in disaster recovery [58, 59] and specifically health during disaster recovery [6]. In addition to providing limited guidance on the potentially beneficial impact of understanding existing social capital mechanisms and resources, there is also insufficient attention paid to the potential for some of these mechanisms to hinder access to information and services. Failing to understand and mitigate this possibility poses a risk that social capital could negatively impact post-disaster SRH outcomes [56].

The findings from this scoping review have identified some potential implications for policy and practice. The inclusion of social capital in the reviewed documents is largely limited to specific approaches to service delivery, such as 'community involvement'. Most commonly, though not exclusively, these approaches are simply referenced without much detailed guidance on implementation. There are many examples across the development and humanitarian sector of this type of detailed guidance. For example, though not specifically health related, the UNICEF *Minimum Quality Standards and Indicators for Community Engagement* [60] document or the Australian Council for International Development *Good Practice Toolkit* [61] both provide a number of basic standards for community engagement in development and humanitarian settings and concise actions for achieving them. Many of the reviewed guidelines would benefit from including or referencing similar content, tailored to an SRH context, which could facilitate the harnessing and building of social capital, potentially leading to increased access to information and services.

Another area in which guidelines could provide more detail is in identifying and understanding formal and informal pre-existing networks which research has shown are important in aiding community recovery after disasters, including in relation to health [7, 58, 62]. Guidance that included practical steps to identify and leverage existing networks could maximise the potential of this community resource for improving access to SRH information and services. A relevant example of this is the International Rescue Committee's *Social Network Analysis Handbook* which provides step-by-step guidelines to map relationships, analyse network structures and the influence of different actors [63]. In addition, access to SRH information and services in a post-disaster setting could be optimised through a more thorough situational analysis of existing social capital in the community. Disaster recovery responses which employ an Asset Based Community Development approach, such the Adaptation for Recovery project following bushfires in East Gippsland, Victoria, Australia, go some of the way to doing this in identifying and building on community assets such as individuals' knowledge, community groups and connections between people [64]. Importantly however, a social capital analysis should include the potential for both positive and negative social capital. This kind of analysis could inform emergency responses regarding particular cultural sensitivities, ways to support minority groups and strategies to gain the trust of community gatekeepers, among other considerations.

Limitations

This scoping review's primary limitation was the documents' heterogenous nature. The reviewed policy and guidance documents represented a variety of institutional authors and had a range of different focuses and purposes. Although the scoping review aim and methodology allowed for this sort of heterogeneity, it did not facilitate direct comparison or evaluation across the documents, which might have elicited further insights. This represents a potential

area for further research. An additional limitation lies in the subjective nature of social capital, a conceptual framework that has undergone multiple definitions by numerous scholars [65]. Despite employing a broad understanding of the term and addressing subjectivity by clearly articulating the initial social capital indicators, along with involving all authors in data verification, certain grey areas persist, limiting the replicability of the review.

Conclusion

In conclusion, this scoping review highlights the crucial yet nuanced role of social capital in shaping the delivery and effectiveness of SRH services in humanitarian crises, with a focus on the Pacific region. While policy and guidance documents acknowledge social capital, its incorporation often lacks depth, particularly regarding implementation strategies. The findings demonstrate the need for a more comprehensive understanding of both the positive and negative influences of social capital on women's access to SRH information and services following a crisis. Policies and practices that effectively harness community involvement, leverage local resources, and navigate complex social norms and power structures can significantly enhance SRH service accessibility and effectiveness in crisis settings. Future efforts should aim to provide more detailed guidance on utilising social capital mechanisms, recognising their potential to both facilitate and hinder SRH service delivery in disaster recovery scenarios. This approach is essential for developing resilient, culturally sensitive, and inclusive SRH interventions that address the unique challenges faced by communities in crisis.

Abbreviations

SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
MISP	Minimum initial service package
NGO	Non-government organisation
INGO	International non-government organisation
PIC	Pacific Island Country
DRR	Disaster risk reduction
JBI	Joanna Briggs Institute
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
AACODS Checklist	Authority, Accuracy, Coverage, Objectivity, Date, Significance Checklist
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, and others
STI	Sexually-transmitted infection
CHW	Community health worker

Supplementary Information

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Additional file 1: Table 1. Documents included in the review.

Additional file 2: Table 2. Categories emerging from the content analysis.

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Authors' contributions

HI led the document search and screening with input from AD, NTT and RD. HI and AD appraised the studies and all authors participated in the analysis of the data. HI led the writing of the manuscript with critical input from AD, NTT and RD. All authors approved the final version.

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Data availability

All data is in the public domain. The datasets identified, from the publicly available data, and analysed during the current study are available from the corresponding author on reasonable request.

Declarations

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Competing interests

The authors declare no competing interests.

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