Women's SRHR Through Crisis: A Feminist Field Study in Flood-affected Communities of Gilgit-Baltistan

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Introduction

Floods in Gilgit-Baltistan (GB)are no longer isolated emergencies. For many communities, they have become recurring events that reshape everyday life, health, and safety, particularly for women and girls. Pakistan is consistently ranked among the world's most climate-vulnerable countries, with floods accounting for a significant proportion of disaster-related displacements each year. Recent assessments indicate that women, young girls, and children make up over **70% of those displaced by climate-related disasters in Pakistan**, deeply reflecting gendered vulnerabilities in crisis settings. *(UNFPA Pakistan.)*

Following the completion of Phase II under the BehnChara Fund initiative, Baithak - Challenging Taboos conducted a series of field visits across flood-affected areas of GB in October 2025. The purpose of these visits was to understand the evolving realities of communities affected by recent floods, reconnect with women and groups previously supported through relief efforts, and assess current and emerging needs to inform future programming over the next two to three years.

The visits focused on women's sexual and reproductive health and rights (SRHR), menstrual health management, maternal health, and psychosocial wellbeing in post-disaster settings. Existing research highlights that humanitarian responses often deprioritize SRHR. A rapid assessment in Pakistan's flood-affected areas reported that **about 77% of women had limited access to sexual and reproductive health services** and had not received any sanitation, hygiene, or delivery supplies. *(Ashraf, M., et. al., 2024).*

Particular attention was paid to how displacement, damaged infrastructure, and limited access to gender-sensitive services continue to shape women's experiences long after the immediate flood response has ended. Mental health issues in northern Pakistan's mountainous regions are largely unspoken because of social stigma, even though symptoms like anxiety, sleeplessness, and depression are noted by local health workers and community members. *(Ebrahim, 2022).* Empirical evidence from Pakistan indicates that female gender is associated with a higher likelihood of developing mental health conditions such as Post-Traumatic Stress Disorder (PTSD), anxiety, and depression following flood exposure. *(Yousuf, J., et. al., 2023)*

The assessment also sought to understand local response mechanisms and governance structures, including engagement with community leaders and government officials. Early observations revealed that women remain largely excluded from local flood relief and decision-making committees, despite bearing a disproportionate burden of caregiving, health management, and recovery work within households and communities. This gap in representation has significant implications for the design and effectiveness of relief, recovery, and resilience-building efforts.

The field visits were carried out by Baithak's team, along with a clinical psychologist. Each visit involved direct engagement with women, community mobilizers, and local health workers,

creating space for participants to share experiences that are often overlooked in formal assessments. These conversations form the foundation of this report and guide its recommendations for sustained, gender-responsive, and community-led interventions.

This report is intended for humanitarian and development practitioners, government and disaster management authorities, public health professionals, feminist and women-led organizations, researchers, and donors working at the intersection of gender, climate justice, and community resilience. It also serves as an evidence base for policy dialogue and advocacy spaces seeking to design gender-responsive disaster preparedness, relief, and recovery systems. While grounded in specific communities of GB, the insights are relevant for broader regional and global conversations on climate-induced displacement and women's wellbeing.

Background and Context

Gilgit-Baltistan (GB) is a predominantly mountainous region characterized by rugged terrain, climatic extremes, and geographical isolation. Communities in these areas are often dispersed across valleys and high-altitude settlements, making access to basic services such as healthcare, education, roads, and communication infrastructure limited even under normal conditions. Seasonal weather patterns, including heavy monsoon rains, glacial melt, and landslides, further exacerbate vulnerabilities, frequently cutting off entire villages.

These structural and infrastructural challenges are compounded by increasing impacts of climate change. According to estimates by the Aga Khan Rural Support Programme (AKRSP), the frequency and intensity of climate-related disasters in GB are projected to increase significantly, with communities facing approximately **23% higher risk of disasters with each passing year**. Floods, Glacial Lake Outburst Floods (GLOFs), landslides, and avalanches have become recurring threats, undermining livelihoods, food security, and physical safety.

Beyond environmental exposure, these regions face long-standing governance and political challenges that shape disaster vulnerability and response. GB remains a disputed and historically neglected region within Pakistan, with limited constitutional recognition and no representation in the National Assembly or Senate of Pakistan. This political marginalization has contributed to underinvestment in public infrastructure, disaster preparedness systems, and social protection mechanisms. As a result, disaster response often remains reactive, delayed, and heavily dependent on humanitarian actors rather than robust state-led systems.

Within this context, women and girls experience layered vulnerabilities. Pre-existing gender inequalities such as restricted mobility, limited decision-making power, and uneven access to healthcare, intersect with geographic isolation and weak service delivery. During disasters, these structural gaps become more pronounced, leaving women and girls disproportionately affected by displacement, loss of livelihoods, health risks, and psychological distress.

Understanding the intersecting realities of geography, climate risk, governance gaps, and gender inequality is critical to contextualizing the findings of this assessment. The challenges observed during field visits are not isolated incidents but manifestations of deeper structural and systemic issues that shape everyday life in GB, and that intensify during climate-induced crises.

Methodology

This study was conducted through qualitative methods during field visits to flood-affected communities across Gilgit-Baltistan. A total of seven sites were visited in Gilgit-Baltistan. The primary methods of data collection included Focus Group Discussions (FGDs) with women and adolescent girls affected by the floods, Key Informant Interviews (KIIs) with community mobilizers and Lady Health Visitors, and direct field observations.

FGDs were designed to capture women's lived experiences of the floods and their aftermath, with particular attention to sexual and reproductive health, menstrual health management, pregnancy and maternal care, displacement, access to health services, and psychosocial wellbeing. Discussions were conducted with women from different age groups and life stages, including pregnant and lactating women, adolescent girls, and elderly women, to reflect the varied ways in which disasters impact women across the life cycle.

KIIs were conducted with local health workers and social mobilizers to better understand service availability, referral pathways, and gaps in health and relief responses at the community level. In addition to formal discussions, the team documented observations related to living conditions, sanitation facilities, shelter arrangements, and community dynamics in post-flood settings. Each site visit lasted approximately three to three and a half hours. Below is the list of all the locations:

Province	District/Area	Site/Community	Data Collection Method(s)	Number of Participants
GB	Skardu	Kharpitu	FGD, KII, Observation	55 women (including young girls); 4 KII
GB	Ghanche	Khaplu (District-level)	FGD, KII, Observation	8 Lady Health Visitors (LHVs) + 1 District Health Officer (DHO) KII
GB	Ghanche	Jaffarabad (Kondus Valley)	FGD, KII, Observation	32 women (including young girls); 5 KII
GB	Ghizer	Talidas (Gupis)	FGD, KII, Observation	25 women (including young girls); 5 KIIs
GB	Ghizer	Thangi	FGD, KII,	53 women

		(Gupis-Yasin)	Observation	(including young girls); 2 KIIs
GB	Ghizer	Thoi/Thui (Yasin Valley)	FGD, Observation	26 women
GB	Ghizer	Daein (Ishkoman Valley)	FGD, KII, Observation	30 women (including young girls); 10 KIIs

Total (Approx.):

- Women and adolescent girls engaged: 288
- Key Informant Interviews: 22 (DHO, mobilizers, LHVs, and volunteers)

All qualitative data collected through Focus Group Discussions, Key Informant Interviews, and field observations were analyzed using a manual thematic analysis approach. Field notes were systematically reviewed to identify recurring patterns, shared experiences, and priority concerns across sites. Codes were developed inductively based on participants' narratives rather than pre-defined categories, allowing themes to emerge organically from women's lived experiences. These themes were then clustered into cross-cutting areas of analysis such as menstrual health, mental wellbeing, leadership exclusion, and care work to ensure that interpretation remained grounded in community voices while enabling comparative insights across locations.

Ethical considerations were central to the assessment process. Verbal consent was obtained from all participants prior to discussions, and participants were informed about the purpose of the visit and how the information would be used. No audio or video recordings were made. Instead, detailed notes were taken manually to ensure confidentiality and create a safer space for women to speak openly, particularly on sensitive topics related to reproductive health and mental wellbeing.

The field team comprised three members: the Lead Researcher, Ayesha Amin; a Research Assistant, Aaiysha Siddiqa; and a mental health professional, Roohi Ghani. The mental health professional contributed additional lines of inquiry related to emotional wellbeing, stress responses, and coping mechanisms, and conducted individual check-ins with participants at several sites where distress was evident. These interactions were informal and supportive in nature, rather than clinical interventions. The mental health professional followed a trauma-informed and participant-centered approach. Conversations were paused if participants became uncomfortable, and participation remained voluntary at all times, allowing women to skip questions or step away without consequence.

Key Findings and Insights

This section presents site-wise insights gathered from findings from each location visited during the assessment. The reflections below capture women's first-hand experiences of the 2025 floods and their aftermath; their losses, coping strategies, health challenges, and the emotional toll of disaster recovery. Each site revealed different layers of vulnerability shaped by geography, gender roles, and local infrastructure, yet shared patterns emerged around fear, isolation, inadequate healthcare, and disrupted menstrual and reproductive health practices.

1. Kharpitu, Skardu

District Skardu, Gilgit-Baltistan

The floods in Kharpitu were described by community members as sudden and devastating. Women recalled that the water arrived in August during the afternoon and evening hours, leaving families with very little time to respond. As floodwaters rose rapidly, people climbed onto rooftops in an attempt to protect themselves while homes, livestock, stored food, and standing crops were washed away. Four to five houses collapsed completely, and maize fields, a primary source of livelihood, were destroyed.

> ***"The water came suddenly in the afternoon. We did not have time to think or take anything. People ran to the rooftops to save their lives as the water entered our homes."***
>
> – FGD Participant

Although the floodwaters receded, women shared that the sense of fear has persisted months later. Many described ongoing anxiety, disturbed sleep, and heightened alertness, particularly during rainfall or at night. Several women linked this prolonged stress to physical symptoms such as increased blood pressure, loss of appetite, chronic fatigue, and frequent crying. These experiences indicate that the psychological impact of the floods has extended well beyond the immediate emergency period.

Women reported severe challenges related to menstrual health management during and after the floods. With no access to sanitary pads, clean water, or private spaces, many relied on torn bedsheets or pieces of cloth. These materials were difficult to wash or dry and, in some cases, were swept away by floodwater. Even two months after the floods, women reported irregular menstrual cycles, heavier and prolonged bleeding, infections, and general weakness, which they associated with stress, unhygienic conditions, and poor nutrition.

"When the flood came, there were no pads and no clean water. We tore our bedsheets and used cloth, but even that was washed away. Even now, many of us are facing infections and irregular periods." – FGD Participant

Case Study: Barriers to Maternal Care During Floods

Context: Flood-damaged roads and disrupted transport systems significantly limited access to healthcare in Kharpitu, particularly affecting pregnant women who required urgent and routine maternal services.

Experience: One woman, in the final stages of pregnancy when the floods struck, described how rising water and blocked roads made travel impossible. With no vehicles able to reach the area, her husband carried her on foot to access medical assistance. Other women shared that antenatal check-ups became irregular or stopped entirely, as health facilities were far and difficult to reach. The absence of female doctors further discouraged women from seeking care, particularly for reproductive and pregnancy-related concerns.

Impact: These barriers increased health risks for pregnant women and highlighted how infrastructure damage and gender-sensitive service gaps can delay or prevent access to essential maternal health care during disasters.

Why this matters: The experience underscores the need for accessible, gender-responsive maternal health services and emergency referral systems in disaster-prone and geographically isolated regions.

Cultural and social barriers compounded these challenges. Women noted that relief camps and medical spaces were often mixed-gender, limiting their ability to speak openly about menstrual, reproductive, or urinary health issues. As a result, many health concerns remained untreated. Adolescent girls who had recently begun menstruating relied almost entirely on their mothers for guidance, as no external information or support was available. Some women shared that girls avoided bathing for several days during menstruation due to myths, lack of privacy, and fear.

Community members participating in FGD at Kharpitu

Mental and emotional exhaustion was evident across discussions. Women expressed a deep sense of hopelessness and frustration linked to repeated losses and uncertainty about the future. Several participants described feeling emotionally worn down by the constant threat of another flood. These sentiments were further intensified by environmental concerns, including deforestation in surrounding areas, which residents believed had increased the community's vulnerability to flooding.

> ***"After losing our homes again and again, it feels better to spit and leave than to keep living here in fear"***, one woman shared, reflecting the exhaustion many participants expressed.

Some families have since left Kharpitu entirely, while those who remain continue to live with persistent fear of another disaster. The experiences of women in Kharpitu illustrate how floods disrupt not only physical infrastructure, but also bodily health, emotional wellbeing, and access to care. In contexts where gender norms restrict mobility, voice, and decision-making, the long-term impacts of such disasters are borne disproportionately by women.

2. Jaffarabad, Kondus Valley

District Ghanche, Gilgit-Baltistan

Women in Jaffarabad described the floods as sudden, unprecedented, and deeply destabilizing. Unlike previous experiences of rainfall or seasonal water flow, this flood arrived without warning. As one participant explained, the water surged into the area before the rain had fully

begun, leaving families with little time to react. Within approximately six hours, large parts of the village were submerged, washing away homes, household belongings, livestock, and critical infrastructure, including the local hospital.

"There was no warning at all. The flood came first, and the rain started later."

– FGD participant

Around 30 families were displaced, many of whom fled toward the Khaplu road in search of safety. Women, elderly people, and pregnant women were among those forced to escape on foot, carrying children and whatever belongings they could carry. Several families are still living with relatives or in temporary arrangements, as rebuilding has been slow and uncertain. Elders in the community noted that even glacier-fed floods in the past had not caused destruction of this scale, underscoring the severity of the event.

Case Study: Loss, Debt, and Weight of Recovery

Context: The floods caused widespread destruction of homes and household assets in Jaffarabad, leaving many families without shelter or financial security.

Experience: One woman shared that the floods destroyed her home completely, washing away household belongings and the savings her family had accumulated over years. Despite losing everything, she remained responsible of paying a significant home loan taken to build the house. With no stable income and limited external support, the burden of rebuilding and repaying debt became an ongoing source of stress and uncertainty.

"My home was destroyed, everything was washed away. I still have an unpaid loan of around three lakh rupees, and now we are living in my uncle's home."

Impact: The loss of physical assets combined with financial liabilities deepened economic vulnerability, particularly for women managing household recovery and caregiving responsibilities.

Why this matters: This experience illustrates how disaster can trap families in prolonged financial hardship, highlighting the need for recovery support that includes housing reconstruction assistance, debt relief considerations, and targeted support for affected women.

Field visit at Kondos

Sexual and reproductive health concerns were prominent in discussions. At the time of the visit, there were an estimated 11 to 12 pregnant women in the village, including at least one in her final trimester.

Case Study: When the Health System Collapses

Context: Flooding caused severe damage to public infrastructure, including health facilities that communities relied on for maternal and reproductive healthcare.

Experience: Women shared that the local hospital was destroyed during the floods, and the nearest alternative facility remained poorly equipped and difficult to access. In the absence of functional services, pregnant and postpartum women relied largely on family members, traditional practices, and informal advice for care. A small local dispensary continues to operate voluntarily, without salaried staff, consistent medical supplies, or the capacity to handle complications.

Impact: The collapse of formal healthcare services left women without reliable antenatal and postnatal care, increasing health risks during pregnancy and childbirth.

Why this matters: This case highlights how fragile health systems in remote areas can break down entirely during disasters, underscoring the urgent need to restore and strengthen local health facilities, ensure trained female providers, and integrate maternal healthcare into disaster recovery planning.

Menstrual health management remained a challenge despite the distribution of hygiene kits during earlier relief efforts. While women appreciated receiving pads, many noted that these supplies were short-term and insufficient for prolonged displacement. During menstruation, women described remaining seated for long hours due to lack of privacy and limited access to

toilets. In some cases, women had to defecate near the river, with another person standing guard to ensure privacy. Several women reported itching, burning sensations, and symptoms consistent with urinary tract infections, yet hesitated to seek medical care.

> ***"During menstruation, we would sit in one place all day because there was no private space. We wore extra layers and avoided moving because there were no toilets."***
>
> – FGD participant

Women also described widespread psychological distress. Symptoms such as sleeplessness, irritability, sudden sweating, stomach pain, and persistent fear were commonly reported. Many expressed a constant anxiety about future floods, particularly at night, fearing that another surge of water could bury them alive. Stress was also linked to disruptions in menstrual cycles, including irregular bleeding during periods of lactational amenorrhea.

Early marriage remains prevalent in the community, with many girls married between the ages of 15 and 18 years. Contraceptive use was inconsistent; while some women accessed injections or IUCDs, health facilities often lacked proper equipment, and condoms were unavailable despite expressed demand. Women also noted that relief kits rarely included essential personal hygiene items such as bras, razors, moisturizer or petroleum jelly, highlighting gaps in how women's needs are understood during disaster response.

> ***"If the flood comes at night, when we can't see and no one can help us, we will be buried alive."*** – FGD participant

Despite ongoing hardship, women demonstrated resilience and openness to learning. Discussions reflected a willingness to engage in conversations around health, wellbeing, and preparedness, suggesting opportunities for longer-term, community-based interventions that go beyond emergency relief. The experiences in Jaffarabad underscore the need for sustained health services, mental health support, and gender-responsive recovery planning in flood-affected communities.

3. Talidas, Gupis Tehsil

District Ghizer, Gilgit-Baltistan

Women in Talidas described the floods as sudden and disruptive, destroying approximately 80-84 homes. Many families relocated to nearby towns, including Gilgit and Gahkuch, while some continue living in temporary shelters. Relocation decisions were largely guided by the desire to maintain children's education, as the community has a literacy rate of around 98%.

Currently, about 30-40 women remain in the settlement. Following the floods, the community established a volunteer relief committee of 10-15 men to coordinate aid and liaise with external organizations. Our team noticed that despite women's energy and willingness to participate, they were excluded from any roles within this committee.

The flood was triggered when a lake in the upper grazing area burst its banks around 2 a.m., allowing families only 15-20 minutes to evacuate after being alerted by local shepherds. The floodwater continued for several hours, blocking the downstream river for nearly eight hours.

> ***"Within 20 minutes, we had to leave everything behind to move uphill. It was terrifying."*** – FGD participant

Women highlighted challenges related to privacy and hygiene in the temporary shelters. There were no proper toilets, forcing open defecation, and while initial distribution of pads had occurred, supplies quickly ran out. Many returned to using cloth, which they either burned or buried after use. To bathe, women relied on relatives' homes, and pregnant women often moved to their parents' houses for safer care.

Community members participating in FGD at Talidas

Some women reported that female doctors had been present at earlier medical camps, which facilitated access to health services; however, availability has since become limited. Many noted changes in menstrual patterns since the floods, including heavier and more frequent bleeding,

which they associated with stress. Sleep disturbances, increased irritability, and frequent crying were also common.

Some women reported that male household members often lacked awareness about menstrual health. One participant shared:

> ***"My son received the menstrual pads during relief distribution and threw them away because he didn't know what they were for or why we needed them."*** – FGD participant

Ongoing daily challenges include the absence of private washrooms, inadequate menstrual supplies, and interrupted schooling for children. Limited internet access and poor communication networks leave women feeling isolated and unable to seek consistent support. Despite these hardships, women displayed resilience and a willingness to engage in discussions on health, preparedness, and community recovery.

4. Thangi, Gupis Tehsil

District Gupis-Yasin, Gilgit-Baltistan

Around 300 people from 28 families are currently living in tents after the flood that struck on August 22. The entire village was submerged after a glacier burst in the early morning hours, forcing families to flee abruptly to higher ground. Many escaped without shoes, warm clothing, or essential belongings and spent three to four nights under the open sky before temporary tents were arranged.

During discussions with women, two local volunteers assisted the assessment team by translating from the local language (Gilgiti/Khowar) into Urdu. Their support was essential in enabling women to express their experiences in their own words, particularly on sensitive topics related to health, safety, and dignity.

Although humanitarian organizations such as the Red Crescent and the Aga Khan Development Network (AKDN) provided emergency support, government assistance has been limited. Community members shared that the Deputy Commissioner (DC), Assistant Commissioner (AC), and Tehsildar visited the site and announced a monetary relief package of PKR 3,00,000 per family. At the time of the visit, however, no follow-up or disbursement had taken place. Women described living in prolonged uncertainty and emotional exhaustion.

> ***"Living in tents for months has exhausted us. The sky feels far, the ground is hard, and we keep asking ourselves where we are supposed to go."***
>
> – FGD participant

Living conditions in the tent settlements remain inadequate, particularly for women. There is a severe shortage of safe, gender-sensitive washrooms. Families queue from early morning until noon to access the few available facilities, and many women reported going at night, accompanied by daughters, due to concerns about safety and privacy. Poor sanitation, cold weather, and overcrowding have contributed to widespread health issues, including diarrhea, urinary tract infections, and persistent burning sensations.

A temporary tent settlement at Thangi

Menstrual health management continues to be a major challenge. During the floods, women reported burning or burying used menstrual materials due to lack of water and disposal options. While some menstrual supplies were initially distributed, these have since run out. Many women expressed a preference for disposable pads, as washing cloth remains difficult in cold conditions. Women also specifically identified the absence of basic personal hygiene items, such as undergarments, hair removal tools, and skincare products, as ongoing unmet needs that affect comfort and dignity.

Several women shared that their menstrual cycles have become irregular since the floods, with increased frequency and heavier bleeding, which they associated with stress and physical exhaustion. Lactating mothers make up a significant proportion of the female population in the settlement, and one recent delivery was facilitated through an AKDN ambulance. However,

access to family planning services remains inconsistent; while injectable contraceptives are sometimes available, condoms and other options are frequently out of stock.

> ***"After the floods, our bodies changed. Bleeding became heavier, sleep disappeared, and the stress never left."*** – FGD participant

Beyond health concerns, women highlighted broader challenges related to displacement. Children now walk long distances to attend school in Gupis or Talidas, and the absence of temporary learning spaces has disrupted education. Despite limited connectivity, harsh weather, and ongoing trauma, women expressed a strong desire for stability and recovery.

The situation in Thangi illustrates how prolonged displacement, inadequate infrastructure, and limited follow-through on relief commitments compound women's physical and psychological vulnerability. At the same time, the willingness of women to engage, speak openly through translators, and articulate their needs underscores the importance of sustained, community-informed, and gender-responsive recovery efforts.

5. Thui (Thoi) Village, Yasin Valley

District Gupis-Yasin, Gilgit-Baltistan

Floods struck Thui village on 14th August following heavy daytime rainfall that triggered sudden water surges. The flooding destroyed approximately 10 houses and displaced an estimated 60-70 people. In the immediate aftermath, families sought refuge in nearby fields and with relatives. Two days later, emergency tents were provided by Focus Humanitarian Assistance (FOCUS - an AKDN agency for disaster relief & resilience). However, a subsequent and more severe flood event forced further displacement, compounding instability and loss.

Women described floods as abrupt and disorienting, leaving little time to secure belongings or prepare for evacuation.

> ***"The water came so fast in the daytime that we didn't understand what was happening. One moment we were at home, and the next we were running to the fields."*** – FGD participant

Sanitation infrastructure was severely damaged. Most household washrooms were destroyed, and women now rely on the few surviving facilities or open fields. Many reported using torches at night to maintain a degree of safety and privacy. The lack of functional washrooms remains a persistent concern, particularly as rebuilding is not possible without financial assistance.

Community members participating in FGD at Thui, along the debris of the recent floods

Menstrual health management remains inconsistent. Menstrual hygiene materials were distributed by certain organizations, though several women reported not receiving supplies. Prior to the floods, many relied on cloth, which continues to be used when disposable pads are unavailable. Women reported noticeable changes in their menstrual cycles following the floods, including heavier or irregular bleeding, which they associated with physical strain, emotional distress, and disrupted routines.

> ***"After the flood, my bleeding did not stop for months. I don't know if it was stress or the family planning medicine, but my body never returned to normal."*** – FGD participant

Access to health services remains limited. The nearest health facility is approximately one hour away, and while deliveries do take place there, reaching the facility is often difficult due to distance and transport constraints. During temporary medical camps, the presence of female doctors allowed women to seek care more comfortably. However, women noted that male practitioners and community members nearby often discouraged open discussion of sensitive issues such as urinary tract infections and leucorrhea, leading many to remain silent.

Psychological distress was widely evident among women and children. Women described persistent anxiety during rainfall, sudden panic, crying spells, and urges to flee, even in the absence of immediate danger. These reactions were often mirrored in children, who remain fearful during storms and loud sounds.

Case Study: Grief, Trauma and the Body

Context: The floods caused not only material destruction but also profound personal loss for many families, with long-term impacts on women's physical and emotional wellbeing.

Experience: One mother shared that she lost her young daughter during the floods. In the months that followed, she began experiencing continuous menstrual bleeding that had not stopped. She described how the shock and grief of losing her child deeply affected her body and overall health, leaving her feeling physically weak and emotionally exhausted.

"When it rains, my heart starts shaking. I feel like I have to run again, even though there is nowhere to go."

Impact: The prolonged bleeding, combined with unresolved trauma, affected her daily functioning and wellbeing. Like many women in remote areas, she had limited access to specialized medical care and psychosocial support.

Why this matters: This case shows the intersection of psychological trauma and reproductive health, highlighting how disasters can leave lasting and often untreated impacts on women's bodies. It underscores the urgent need for integrated mental health and reproductive healthcare services as part of disaster response and recovery.

Relief supplies and essential items are now primarily accessed from Harap, located across the river, with men typically crossing on foot to collect materials. While clothing donations have been received, women noted persistent gaps in relief packages. Undergarments were occasionally included, but essential items for women's personal comfort and dignity were largely missing.

Although educational activities have resumed, women emphasized that emotional recovery has lagged behind physical rebuilding. Memories of the flood continue to shape daily life, influencing sleep, mobility, and perceptions of safety. The experiences in Thui underline how repeated displacement, limited health access, and unresolved psychological trauma intersect to deepen women's vulnerability in post-disaster settings.

6. Daein Village, Ishkoman Valley

District Ghizer, Gilgit-Baltistan

In Daein village, the floods completely destroyed 42 homes, affecting approximately 172 individuals across more than 105 families. Around 25-30 women and girls participated in FGD conducted during the visit.

Residents described the flood as sudden and entirely unexpected. The last major flood recalled by the community occurred in 1982, and many said there was no indication that such devastation

would occur again. The flood struck around 2 p.m. on 14 August while women were engaged in routine household activities. Strong winds and storm-like conditions preceded the disaster, leading families to flee their homes out of fear that trees might collapse. While some residents evacuated early, others were rescued during the flood as water surged into the village from two directions. Families remained on the nearby hills for three to four hours, searching for missing relatives once the water subsided. Two fatalities were reported: an elderly man who suffered a heart attack during the chaos and a young girl who lost her life in the flood.

> ***"We were cooking when the wind became very strong. We thought the trees would fall, so we ran. Then the water came from both sides, and everything happened at once."*** – FGD participant

Women shared that fear has persisted long after the floodwater receded. Children now panic even when light clouds appear, and women described ongoing anxiety, disturbed sleep, and physical exhaustion. Several participants reported changes in menstrual cycles since the floods, including heavier bleeding, increased frequency (sometimes occurring up to three times in a single month), and heightened pain. Low blood pressure and general weakness were commonly reported, alongside symptoms consistent with urinary tract infections, such as burning sensations during urination, which women linked to unsafe water and inadequate hygiene facilities.

> ***"After the flood, my periods came again and again in one month, and the pain is much worse. My blood pressure also stays low most of the time."*** – FGD participant

Menstrual hygiene practices have shifted since the floods. Prior to the disaster, all women relied on cloth. Following the distribution of hygiene kits, women transitioned to disposable pads and shared that guidance on their use made this transition easier. However, sanitation infrastructure remains severely limited. Only one functional washroom, constructed by AKRSP, is currently available for displaced families. While some households initially fetched water from the river while living uphill in tents, many families have since moved to relatives' homes or rented accommodation in safer areas. Electricity has not been restored, and households rely on battery-powered torches, with community-led efforts underway to raise funds for solar energy solutions.

The aftermath of recent floods

Pregnant women faced significant risks during and after the floods. Two childbirths occurred shortly after the disaster; one woman delivered within two days and had to be carried across the river to reach help due to absence of a community midwife. Older family members, particularly those over 80 years of age, reported incontinence following the floods, increasing caregiving responsibilities for women within households.

Personal hygiene needs remain inadequately addressed. Women commonly use *rakh* (ash), razors, or wax for hair removal, yet these items are not consistently included in relief kits. Before the floods, a local health worker provided basic medicines and injections; however, access to these services have since been disrupted.

Case Study: Youth-led Community Recovery Restores Connectivity

Context: The floods caused severe destruction to critical infrastructure in Daein, isolating the community and disrupting access to healthcare, education, and livelihoods.

Experience: The 612-foot Daein-Chatorkhand suspension bridge, the only crossing point connecting residents to nearby villages, schools, and health facilities, collapsed during the disaster. Its loss cut off families from essential services and daily necessities. Women described how the isolation made it difficult to access medical care, purchase supplies, and ensure their children could continue attending school.

Response: In the absence of immediate government reconstruction, local volunteers (most of them young people from the community) mobilized resources and labor to build a smaller but durable temporary bridge. This restored essential movement for the entire community, enabling access to healthcare, markets, and schools. Recognizing the heightened risks for adolescent girls who previously had to cross long and unsafe routes, the same youth volunteers also established a temporary girls' hostel on the other side of the river. Staffed with a female warden, cook, and security guard, the hostel enabled girls to safely continue their education.

Why this matters: This case illustrates the critical role of youth-led, community-driven action in disaster recovery, particularly when formal disaster response systems are absent or delayed. Restoring safe connectivity not only enabled access to services and livelihoods for all residents, but also helped protect girls' education and safety, demonstrating how locally led solutions can address both immediate survival needs and long-term gender equity.

The temporary bridge constructed by local volunteers

Cross-Cutting Themes of Analysis

1. Gendered Health Impacts in Flood Recovery

Across all sites visited, floods intensified existing gender disparities in access to health services, with women's sexual and reproductive health needs remaining largely unaddressed beyond the immediate relief phase. While emergency responses focused primarily on shelter, food, and basic supplies, women's bodily health and wellbeing received limited sustained attention during recovery. The findings below highlight how disruptions to menstrual health, combined with inadequate sanitation and lack of privacy, significantly shaped women's post-flood experiences.

2. Disruptions to Menstrual Health After Floods

A majority of women across sites reported noticeable changes in their menstrual health following the floods. These included increased menstrual flow, prolonged or continuous bleeding, heightened pain, and irregular cycles. Women consistently linked these changes to prolonged stress, physical exhaustion, poor nutrition, and exposure to unhygienic conditions during displacement.

Several women shared experiences of bleeding almost continuously since the floods, in some cases lasting several weeks or up to two months. These symptoms were often accompanied by weakness, dizziness, and fatigue. Despite the severity of these experiences, most women had not sought medical care due to long distances to health facilities, the absence of female healthcare providers, and social barriers to discussing reproductive health concerns.

One woman described how her body had not returned to normal even months after the disaster:

> ***"After the floods, my periods started and they never stopped. I have been bleeding continuously since then. I feel weak all the time, my body has no strength, but there is no female doctor nearby and I cannot talk about these things easily. Even now, I am still suffering."***

Other women reported similar experiences, suggesting that menstrual disruptions were widespread. These findings point to a critical gap in post-disaster health responses, where menstrual health is rarely monitored or treated as a priority beyond the distribution of hygiene kits.

3. Lack of Wash Facilities and Privacy in Menstrual Management

Flood-induced displacement severely restricted women's access to safe and functional wash facilities. Across temporary shelters and tent settlements, toilets were either absent or shared by

large numbers of people, often lacking doors, lighting, or water. Women described long waiting times, the need to access toilets at night, and reliance on family members for safety and privacy.

These conditions significantly constrained women's ability to manage menstruation with dignity. In the absence of private bathing spaces and clean water, many women remained seated for long periods during menstruation, limited their movement, or avoided changing menstrual materials as frequently as needed. Adolescent girls were particularly affected, with several avoiding bathing for days due to lack of privacy, fear, and social restrictions.

For elderly women and those with mobility challenges, managing menstruation and personal hygiene became especially difficult. The physical discomfort and emotional stress associated with these conditions compounded women's sense of vulnerability and loss of dignity during displacement.

These findings underscore that menstrual health challenges during disasters cannot be addressed through supplies alone. Without adequate sanitation infrastructure, privacy, and water access, women remain unable to manage their bodies safely and with dignity, even when hygiene kits are available. Integrating gender-responsive sanitation and menstrual health services into disaster recovery is therefore essential for protecting women's health and wellbeing.

4. Mental Health and Unaddressed Trauma

Psychological distress emerged as one of the most pervasive impacts of the floods. Women across all sites described ongoing fear, anxiety, sleep disturbances, emotional exhaustion, and heightened sensitivity to rainfall or environmental cues associated with flooding. These responses were not confined to the immediate aftermath of the disaster but persisted months later, indicating unresolved trauma.

Mental health support, where available, was largely temporary and informal. Structured psychosocial services were absent in most communities, particularly in remote areas of Gilgit-Baltistan. Women often relied on informal support from family members or other women, while continuing to shoulder caregiving responsibilities. The lack of sustained mental health care reflects broader gaps in disaster response systems, where emotional and psychological recovery is rarely treated as a core component of resilience.

5. Displacement, Safety, and Dignity

Displacement significantly altered women's everyday lives and sense of safety. Living in tents or temporary shelters exposed women and adolescent girls to heightened risks due to overcrowding, lack of lighting, and inadequate sanitation facilities. Accessing toilets, bathing, or managing menstruation often required women to travel at night or depend on others for protection, undermining privacy and dignity.

Field visit at Kharpitu, Skardu

In colder regions, harsh weather further exacerbated physical strain, particularly for pregnant women, elderly women, and children. While relocation to relatives' homes offered some relief, it also disrupted social networks and increased women's unpaid care and emotional labor. These conditions underscore the importance of integrating safety, privacy, and dignity into shelter and settlement planning from a gender perspective.

6. Cultural Barriers and Silences Around Women's Bodies

Cultural norms and gendered expectations shaped how women experienced and responded to health challenges during and after the floods. In mixed-gender relief and medical spaces, many women hesitated to speak openly about reproductive, menstrual, or urinary health concerns. This silence was compounded by the limited presence of female healthcare providers, particularly in rural and remote areas.

Adolescent girls were especially affected by these barriers, often relying exclusively on mothers for information about menstruation and bodily changes. The absence of structured, culturally sensitive health education contributed to misinformation, fear, and harmful practices. These findings highlight how disaster contexts amplify existing taboos around women's bodies, further marginalizing their health needs.

7. Environmental Vulnerability and Climate Injustice

Communities consistently described floods as more sudden, frequent, and destructive than in the past, often linked to glacial lake outbursts, cloudbursts, or environmental degradation such as deforestation. Women, who spend more time managing household resources and caregiving, experienced these environmental shifts most acutely.

Despite their central role in coping and recovery at the household level, women were rarely included in discussions around disaster preparedness, environmental management, or risk reduction. This exclusion reflects broader patterns of climate injustice, where those most affected by climate impacts have the least influence over decision-making processes.

8. Women's Exclusion from Leadership and Decision-Making

Across multiple sites, local flood relief and recovery committees were formed in response to the disaster. However, women were largely absent from these structures. Decisions regarding aid distribution, relocation, shelter construction, and coordination with authorities were predominantly made by men, despite women bearing the primary responsibility for household recovery, caregiving, and health management.

This exclusion limits the effectiveness of disaster response and recovery efforts, as women's priorities related to health, safety, sanitation, and childcare remain underrepresented. It also reinforces existing power imbalances and missed opportunities to build women's leadership in crisis contexts. Meaningful inclusion of women in community-level decision-making is not only a matter of representation but a prerequisite for gender-responsive and sustainable recovery.

9. Informal Care Work and the Burden on Women

Women across all sites assumed significant unpaid care work following the floods. In addition to managing their own health challenges, women cared for children experiencing fear and anxiety, elderly family members with mobility or continence issues, and pregnant or postpartum relatives. This caregiving burden intensified in displacement settings, where resources were limited and support systems fragmented.

Despite this, women's care work remained largely invisible in formal relief and recovery planning. The absence of support mechanisms such as childcare, mental health services, or respite spaces further compounded women's physical and emotional exhaustion. Recognizing and addressing unpaid care work is essential for any long-term recovery strategy.

10. Gaps Between Relief and Recovery

A clear gap emerged between emergency relief efforts and longer-term recovery. While initial assistance, including tents, food, and hygiene kits, was provided in several sites, sustained support was limited. Communities were often left to navigate rebuilding, health access, and psychosocial recovery on their own once emergency actors withdrew.

This gap disproportionately affected women, whose needs related to health, safety, and wellbeing require continuity rather than one-off interventions. The findings underscore the need for recovery models that bridge immediate relief with longer-term, community-led, and gender-responsive programming.

11. Rigid Gender Stereotypes and Unequal Burdens in Flood Recovery

Across all sites, rigid gender norms strongly shaped how responsibilities, risks, and recovery labor were distributed within households and communities. While men were generally expected to engage in physically demanding tasks such as evacuations, debris removal, and interactions with authorities, women were simultaneously expected to manage caregiving, household recovery, emotional support, and hygiene under severely constrained conditions.

Women consistently described how, even after men completed heavy physical labor, it was women who undertook the extensive and prolonged work of cleaning homes, washing utensils, salvaging household items, restoring kitchens, and reestablishing domestic order. This labor, though essential for recovery, remained invisible and undervalued, reinforcing the perception that women's work is "natural" rather than laborious or deserving of support.

Rigid gender expectations also limited women's mobility and access to assistance. In several communities, women could not independently collect relief items, attend meetings, or seek medical care, relying instead on male family members to act on their behalf. This dependence delayed access to essential supplies, including menstrual hygiene materials, and further silenced women's specific needs within relief systems.

These gender norms were particularly restrictive in moments of crisis, when flexibility and shared responsibility are critical. Rather than being temporarily relaxed, traditional roles often became more entrenched during displacement, increasing women's physical and emotional exhaustion. Women continued to shoulder caregiving responsibilities even while experiencing ill health, psychological distress, or menstrual complications, with limited recognition or accommodation.

The persistence of rigid gender stereotypes during disaster response and recovery highlights a structural barrier to gender-equitable resilience. Without actively challenging these norms and

redistributing care and recovery responsibilities, disaster interventions risk reinforcing existing inequalities and placing disproportionate burdens on women's bodies, time, and wellbeing.

12. Climate Education and Community Preparedness

Differences across sites suggested that prior exposure to climate awareness or disaster-related education influenced how communities responded to the floods. In areas where some form of climate education or preparedness work had previously taken place, residents appeared more alert to environmental warning signs and more proactive in evacuation and early response.

Women in these communities were better able to articulate the causes of flooding and engage in household-level coping and recovery strategies. Informal coordination and mutual support also emerged quickly, easing immediate relief and early recovery. In contrast, communities without such exposure reported greater confusion, delayed responses, and heightened fear, particularly among women and children.

While these efforts were limited and uneven, the contrast highlights the value of localized climate education in strengthening community preparedness and resilience in flood-prone areas.

13. Absence of Government Disaster Management Authorities

Across nearly all sites, communities reported minimal presence or follow-up from government disaster management authorities during both the immediate response and recovery phases. While visits by district officials were occasionally noted, these were largely symbolic and rarely translated into sustained assistance, compensation, or coordinated recovery support.

The absence of formal disaster management structures meant that relief efforts were largely driven by non-governmental organizations, local volunteers, and community networks. This reliance on informal systems resulted in uneven aid distribution and left significant gaps in health services, shelter, sanitation, and psychological support - gaps that disproportionately affected women.

Women's health needs, safety concerns, and caregiving burdens remained largely invisible in the absence of gender-responsive government intervention. The lack of coordination between authorities and humanitarian actors also contributed to delays, uncertainty, and prolonged displacement, undermining trust in public institutions and compounding communities' sense of abandonment during recovery.

Recommendations: Toward Gender-Responsive and Climate-Resilient Recovery

Based on findings across flood-affected communities in GB, the following recommendations highlight priority areas for strengthening disaster preparedness, response, and recovery through a gender-responsive lens.

First, disaster response systems must integrate women's sexual and reproductive health and mental wellbeing as core components of recovery, rather than treating them as secondary or short-term concerns. This includes sustained access to menstrual health supplies, maternal healthcare, and psychosocial support beyond the emergency phase.

Second, community-level disaster preparedness and risk reduction efforts should be strengthened through accessible climate education, early warning awareness, and locally grounded preparedness planning. Women, who are often primary caregivers and first responders within households, must be actively included in these efforts.

Third, mental health and psychosocial support should be institutionalized within disaster response frameworks. Training community-based first responders in emotional first aid and psychological support can help address trauma early and reduce long-term harm, particularly in remote and underserved areas.

Fourth, gender norms and patriarchal beliefs that restrict women's mobility, voice, and leadership must be addressed as part of disaster recovery. Male engagement initiatives are essential to shift attitudes around women's participation in decision-making, leadership, and public life, especially in crisis contexts.

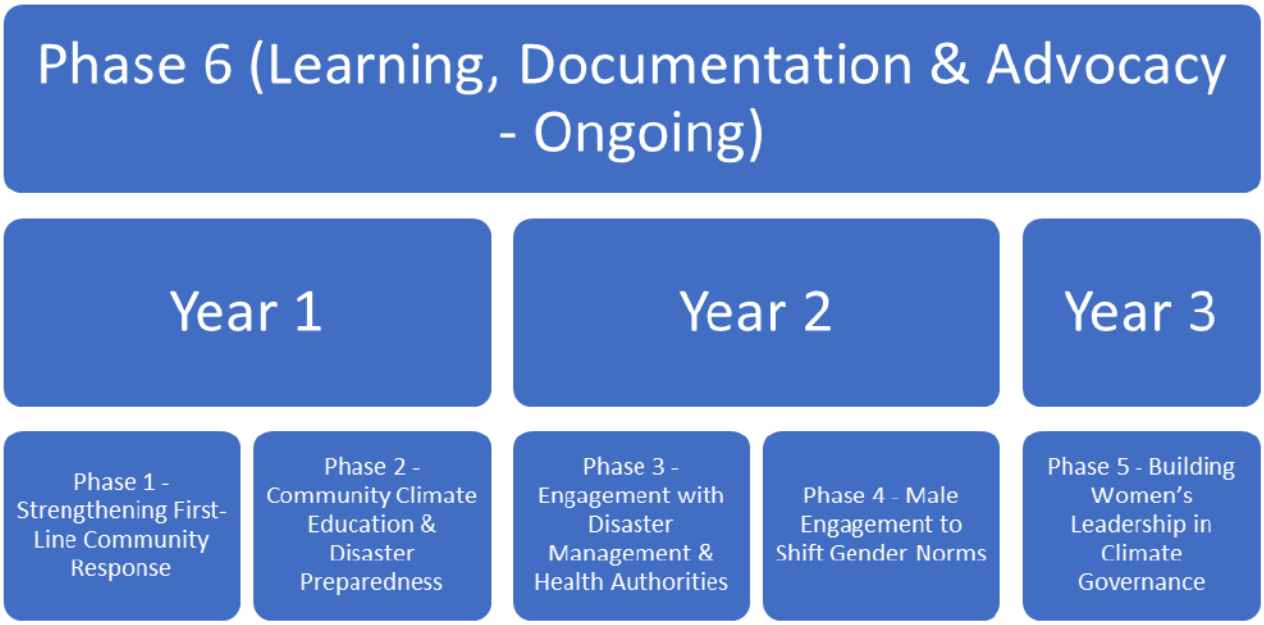
Fifth, government disaster management authorities must play a more active, accountable, and gender-responsive role throughout both relief and recovery phases. This includes timely follow-through on compensation commitments, coordination with humanitarian actors, and the integration of women's health, safety, and psychosocial needs into district-level disaster planning. Clear accountability mechanisms and community feedback channels are essential to ensure the affected populations (particularly women) are not left without sustained support once emergency actors withdraw.

Finally, women's leadership must be strengthened at multiple levels, from household and community decision-making to engagement with local governance structures. Inclusive leadership is critical for ensuring that disaster preparedness and recovery efforts respond to the lived realities of women and girls.

Baithak's Proposed Plan of Action (3 Year Horizon)

Recognizing its role as a feminist, grassroots-led organization, Baithak's approach focuses on depth rather than scale, prioritizing sustained engagement, capacity strengthening, and community ownership over one-off interventions. The proposed plan of action follows a phased and incremental model, with each stage building on the foundations laid in the previous phase, allowing learning, trust, and local leadership to grow over time.

Phase	Focus Area	Key Activities	Primary Actors	Timeline
Phase 1	Strengthening First-Line Community Response	Virtual training on Emotional First Aid and psychosocial support; followed by in-person community trainings	Women mobilizers, volunteers, teachers, health workers	Year 1
Phase 2	Community Climate Education & Disaster Preparedness	Climate education sessions, early warning awareness, household preparedness planning, participatory risk mapping	Women, adolescent girls, community members	Year 1-2
Phase 3	Engagement with Disaster Management & Health Authorities	Gender sensitization, SRHR, maternal health, menstrual health, and mental health integration, technical inputs to response plans	GBDMA/DDMA, Health Departments	Year 1-3
Phase 4	Male Engagement to Shift Gender Norms	Dialogues with men and boys on masculinity, care work, women's leadership in crises	Men, boys, community leaders	Year 2-3
Phase 5	Building Women's Leadership in Climate Governance	Leadership workshops, peer learning circles, mentorship, participation in committees	Women leaders, adolescent girls	Year 2-3
Phase 6	Learning, Documentation & Advocacy	Documentation of learning, evidence-building, advocacy with stakeholders	Local authorities, humanitarian actors, and networks	Ongoing



Phase 1: Strengthening First-Line Community Response and Care

Focus: Emotional first aid, psychosocial awareness, and trust-building
Timeframe: Year 1 (In progress)

Baithak will begin by working with existing community actors, including women mobilizers, local volunteers, teachers, and frontline health workers, who are often the first point of contact for affected individuals during and after disasters. While trusted locally, these actors frequently lack structured tools to respond to emotional distress.

In the first year, Baithak will conduct Emotional First Aid Psychological Supportive Approaches training to enable them to recognize signs of distress, ethical listening, provide immediate emotional support, and refer individuals when needed. A virtual training will be conducted first followed by an in-person, community-based training to deepen learning through practical application and context-specific discussions.

These trainings will equip communities with basic tools for care, listening, and support, particularly for women, adolescents, and caregivers. This phase lays the foundation for trust and sustained engagement, while directly responding to the widespread psychosocial distress identified during the assessment.

Phase 2: Community Climate Education and Disaster Preparedness

Focus: Disaster risk reduction, preparedness, and climate awareness
Timeframe: Year 1–2

Building on established community relationships, Baithak will facilitate climate education and disaster preparedness sessions tailored to local contexts. These sessions will focus on understanding flood risks, early warning signs, household-level preparedness, and community response planning, with a strong emphasis on women's roles and knowledge.

Baithak will prioritize participatory methods, encouraging communities to map risks, identify safe spaces, and develop simple preparedness plans that reflect local realities. Women and adolescent girls will be actively engaged as knowledge holders and planners, not just beneficiaries. This phase shifts communities from reactive response toward preparedness and resilience.

Phase 3: Engaging Disaster Management Authorities and Health Departments

Focus: Gender-Responsive Disaster Response and Recovery
Timeframe: Year 1–3 (ongoing)

Drawing on its previous experience working with disaster management authorities in other regions, Baithak will engage with provincial and district-level Disaster Management Authorities and relevant Health Departments to strengthen the gender responsiveness of disaster response systems.

This engagement will focus on:

- Sensitization and capacity-strengthening sessions on gender, SRHR, maternal health, menstrual health, and mental health in disaster contexts.
- Technical inputs on integrating women's health needs, menstrual health, and psychosocial support into disaster response plans.
- Supporting authorities to identify and address gaps between relief and recovery, particularly for women and girls.

Baithak's role will be facilitative and advisory, aiming to influence policy and practice without taking on implementation responsibilities beyond its capacity.

Phase 4: Male Engagement to Shift Gender Norms in Crisis Contexts

Focus: Challenging patriarchal beliefs and enabling women's participation
Timeframe: Year 2 - 3

The assessment highlighted rigid gender norms that limit women's participation in leadership and decision-making, particularly during disasters. In response, Baithak will implement male

engagement initiatives that work with men and boys to reflect on masculinity, power, caregiving, and women's leadership in times of crisis.

Activities will include:

- Dialogue sessions on shared responsibility, safety, and collective recovery.
- Creating spaces for reflection on gender norms that limit women's participation in decision-making and leadership.

The aim is not to position men as gatekeepers, but to reduce resistance to women's participation and support more equitable community structures.

Phase 5: Building Women's Leadership in Climate and Disaster Governance

Focus: Leadership development and collective action
Timeframe: Year 2–3

As attitudes begin to shift and preparedness structures strengthen, Baithak will support women to step into leadership roles related to climate action and disaster response. This may include leadership workshops, peer learning circles, and mentorship programs for women interested in participating in community committees, disaster response groups, or advocacy spaces.

Rather than creating parallel structures, Baithak will work to strengthen women's presence within existing community and local governance mechanisms. This phase centers women not only as survivors of disasters, but as leaders shaping preparedness, response, and recovery.

Phase 6: Learning, Documentation, and Advocacy

Focus: Evidence-building and influence
Timeframe: Ongoing across 2–3 years

Throughout all phases, Baithak will document learning, community experiences, and emerging models of gender-responsive disaster work. This evidence will be used to inform advocacy with local authorities, humanitarian actors, and networks, amplifying grassroots women's voices and pushing for more inclusive disaster policies and practices.

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