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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.

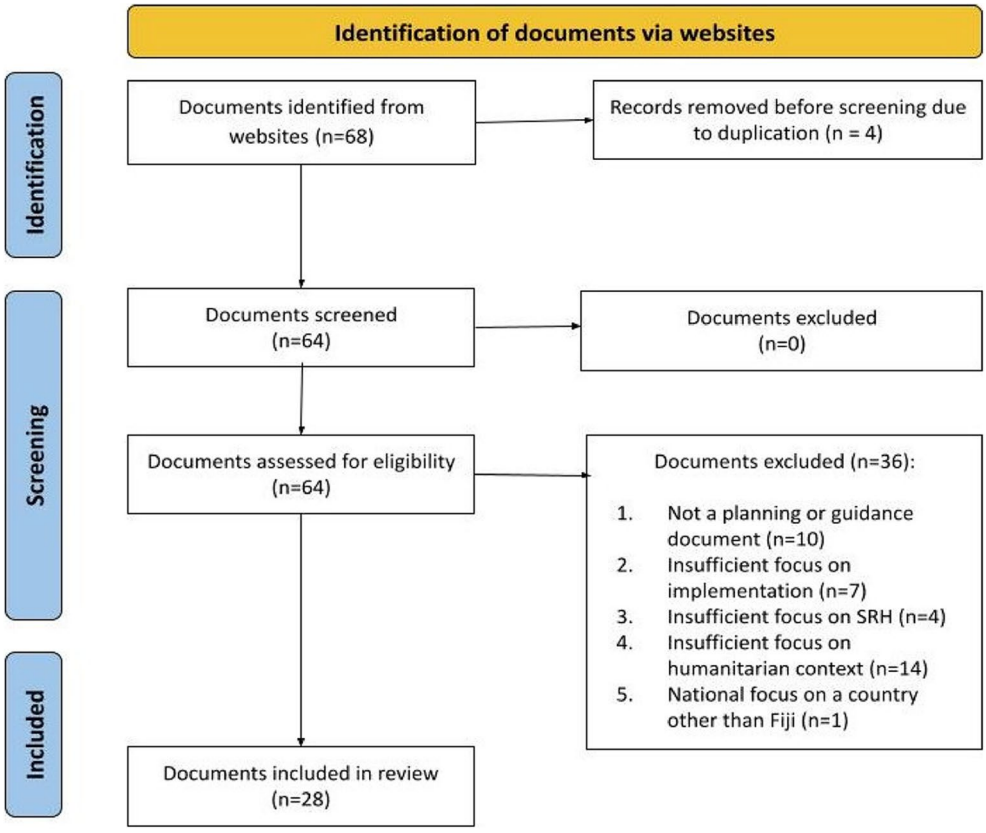

Fig. 1 PRISMA-ScR flow-chart showing search and selection results

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

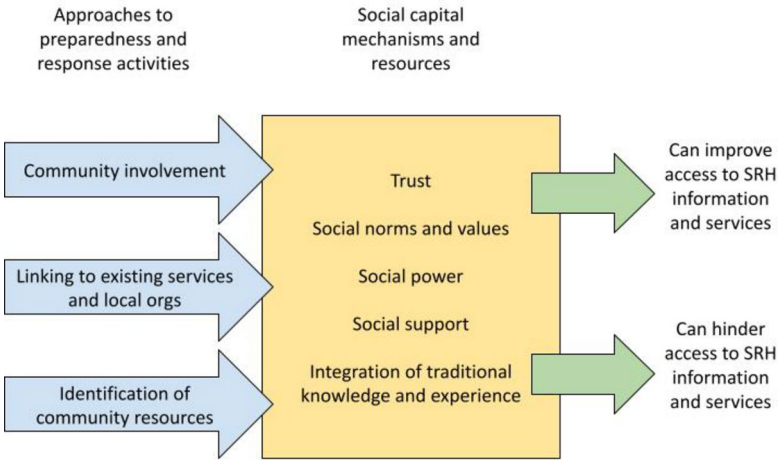

Fig. 2 Interconnected social capital dimensions represented in reviewed documents

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

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12836-0.

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

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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