only from current emergencies, but also from future ones. We must protect the gains we have made and invest resources that will allow us to build on our work to protect health and improve lives.

I am the Director for the Centers for Disease Control and Prevention and the Administrator of the Agency for Toxic Substances and Disease Registry. I declare no other competing interests.

Mandy Cohen
director@cdc.gov

Centers for Disease Control and Prevention, Atlanta, GA 30329, USA

1 National Center for Emerging and Zoonotic Infectious Diseases. CDC & malaria. June 13, 2024. https://www.cdc.gov/malaria/cdc-malaria/index.html# (accessed Dec 2, 2024).
2 US Centers for Disease Control and Prevention. About COVID-19. June 13, 2024. https://www.cdc.gov/covid/about/index.html (accessed Dec 2, 2024).
3 National Center for Emerging and Zoonotic Infectious Diseases, Division of Foodborne, Waterborne, and Environmental Diseases. Burden of foodborne illness: questions and answers. Nov 5, 2018. https://www.cdc.gov/foodborneburden/questions-and-answers.html (accessed Dec 2, 2024).
4 Office of Public Health Data, Surveillance, and Technology. Healthcare facilities live for eCR. Nov 13, 2024. https://www.cdc.gov/ecr/php/healthcare-facilities/index.html (accessed Dec 2, 2024).
5 US Centers for Disease Control and Prevention. Strengthening response to public health threats through expanded laboratory testing and access to data. 2024. https://www.cdc.gov/laboratory-systems/media/pdfs/2024/11/ExpandedLaboratoryTesting_508.pdf (accessed Dec 2, 2024).
6 National Center for Injury Prevention and Control. About mental health. Aug 8, 2024. https://www.cdc.gov/mental-health/about/?CDC_AAref_Val=https://www.cdc.gov/mentalhealth/learn/index.htm (accessed Dec 2, 2024).
7 US Department of Health and Human Services. 2024 national strategy for suicide prevention. Sept 5, 2024. https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html (accessed Dec 2, 2024).
8 National Center for Chronic Disease Prevention and Health Promotion. Promoting mental health and well-being in schools: an action guide for school and district leaders. December, 2023. https://www.cdc.gov/healthyyouth/mental-health-action-guide/pdf/DASH_MH_Action_Guide_508.pdf (accessed Dec 2, 2024).
9 National Center for Injury Prevention and Control. About overdose data to action. May 2, 2024. https://www.cdc.gov/overdose-prevention/php/od2a/about.html (accessed Dec 2, 2024).
10 National Center for Health Statistics, National Vital Statistics System. Provisional drug overdose death counts. Nov 13, 2024. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (accessed Dec 2, 2024).
11 US Centers for Disease Control and Prevention. Biden-Harris administration awards over $558 million to improve maternal health, including $440 million to support pregnant and new moms, infants, and children through voluntary home visiting programs proven to improve maternal and child health, child development, and school readiness. Aug 27, 2024. https://www.cdc.gov/media/releases/2024/p0827-maternal-health.html#:~:text=The%20CDC's%20new%20%24118.5%20million,territories%20and%20freely%20associated%20states (accessed Dec 2, 2024).
12 US Department of Health and Human Services. Four in 5 pregnancy-related deaths in the U.S. are preventable. Sept 19, 2022. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html#:~:text=More%20than%2080%25%20of%20pregnancy,care%20at%20the%20right%20time.%E2%80%9D (accessed Dec 2, 2024).
13 Trost S, Njie F, Harvey A, et al. Pregnancy-related deaths: data from maternal mortality review committees in 36 U.S. states, 2017–2019. May 28, 2024. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html (accessed Dec 2, 2024).
14 US Department of Health and Human Services. Hypertension in pregnancy change package. May 10, 2024. https://millionhearts.hhs.gov/tools-protocols/action-guides/hypertension-pregnancy-change-package/index.html (accessed Dec 2, 2024).
15 National Center for Chronic Disease Prevention and Health Promotion. PLACES interactive map. Oct 29, 2024. https://www.cdc.gov/places/tools/interactive-map-tool.html (accessed Dec 2, 2024).
16 US Centers for Disease Control and Prevention. CDC moving forward. Aug 15, 2024. https://www.cdc.gov/about/cdc-moving-forward.html (accessed Dec 2, 2024).
17 Wong CA, Houry D, Cohen MK. Integrating public health and health care—protecting health as a team sport. *N Engl J Med* 2024; **390:** 1739–42.

Violence against women and girls in conflict: progress and priorities

Published **Online**
Novemeber 29, 2024
https://doi.org/10.1016/S0140-6736(24)02625-4

Armed conflict is increasing throughout the world and disproportionately affects the lives of women and girls. In 2023, an estimated 612 million women and girls lived within 50 km of a conflict, an increase of 41% since 2015.[1] These women and girls face many challenges, including an increasing likelihood of experiencing gender-based violence (GBV). In 2023, 3688 incidents of conflict-related sexual violence were verified by the UN, with women and girl survivors making up 95% of these incidents.[1] However, this figure might be a substantial underestimate of the true number of women and girls experiencing violence during conflict. A forthcoming meta-analysis of prevalence data (pooling data from 11 studies from conflict-affected contexts with 7948 participants) found that over one in ten of the women surveyed (11%) had experienced sexual violence perpetrated by a non-partner during a conflict; estimates of the lifetime prevalence of non-partner sexual violence from women in conflict settings (21%; based on data from 16 737 participants from eight studies) were triple WHO global estimates (6%).[2,3] Recent reports from areas of conflicts, such as Sudan, indicate that the scale of this brutality is increasing, not abating.[4]

Although public perception of conflict-related GBV is often focused on the use of rape as a weapon of war, a more nuanced understanding of GBV during armed conflict is emerging. Exposure to armed conflict and displacement is known to be associated with an increased likelihood of experiencing intimate partner violence (IPV)

in contexts as varied as Colombia, Liberia, and South Sudan.[5,6] Nine of the ten countries with the highest child marriage prevalence rates are also experiencing humanitarian crises; risk factors for child marriage increase during conflict and child marriage prevalence is 35% in fragile states, compared with 19% globally.[7] Humanitarian aid workers, who are charged to reduce GBV risks, can also perpetrate or experience violence; male aid workers are most often the perpetrators and female individuals from the affected population, or female aid workers, are those who it is most often perpetrated against. Examples of individuals in power who have sexually exploited aid recipients in the Democratic Republic of the Congo, Haiti, and elsewhere have highlighted the importance of efforts to prevent sexual exploitation, abuse, and harassment within the aid sector, as well as its gendered nature.[8] Women and girls have increased risks of mental health challenges due to gender discrimination and violence, which can lead to psychosocial distress through both direct harm and secondary impacts, such as stigma, shame, and discrimination when seeking support. These risks are compounded by challenges in conflict and displacement contexts, creating further vulnerability to conditions, such as post-traumatic stress disorder and depression, and requiring services tailored to the needs of survivors.[9,10]

For more on the **Inter-Agency Standing Committee** see https://interagencystandingcommittee.org/

Despite the need, funding for humanitarian programming is decreasing overall and GBV programmes are not often prioritised in global emergency responses.[11] In 2023, less than 1% of UN consolidated appeals funding was allocated to GBV programming, showing the stark reality that, despite increased attention and global advocacy, GBV programming is still not prioritised in emergencies.[11] Efforts to integrate GBV risk mitigation activities through humanitarian action have increased since development of the Inter-Agency Standing Committee's guidelines for integrating GBV interventions in humanitarian action, published in 2015.[12] However, these efforts still suffer from the weak commitment of UN and non-governmental organisation staff and leadership to prioritise GBV risk mitigation activities in the course of their work.[13] Furthermore, the international humanitarian aid system often ignores or minimises the root causes of GBV—gender inequality and power imbalances—which are deemed to be beyond their mandate to deliver life-saving aid.

-/AFP via Getty Images

Amid this challenging landscape, there are examples of women taking up leadership positions and working to prevent and respond to GBV occurring in their communities. When women meaningfully contribute to peacebuilding efforts, there is an increased likelihood that gender-related provisions are included in peace agreements.[14] In addition, women's rights organisations and women-led organisations advocate for legal and policy advancements that promote their rights even in crisis settings.

Women's engagement and leadership are essential to the delivery of effective programming in humanitarian responses. Despite the humanitarian system's prioritisation of acute emergency response, there is increasing evidence that efforts to prevent GBV are feasible and effective, particularly during protracted emergencies. Although public perception, reinforced by short media cycles, views humanitarian crises as primarily sudden-onset conflicts, more than 80% of crisis-affected populations are located in contexts of protracted crises.[15] Community-based prevention programming is being implemented in these settings and emerging evidence is showing their impact. For example, in Somalia, the Communities Care programme improved social norms related to family honour and sexual violence among intervention communities, compared with the control communities who were offered the programme only after the study had finished.[16] In Haiti, a Beyond Borders adaptation of the Raising Voices' SASA! Approach, which was complemented by new focuses on preventing violence in adolescent girls (ie, the Power to Girls approach) and people with disabilities (ie, the Safe and

Capable approach), saw the prevalence of past 12 month physical or sexual IPV halve in intervention communities after programme implementation, despite the presence of armed groups in these areas.[17] These examples push against the prevailing narrative that prevention programming is too complex to implement during crises and highlight how community-based change initiatives can effectively prevent violence, even in unstable settings.

Centring women and girls and creating humanitarian programming that is responsive to their needs and recommendations is also possible in more acute emergency settings. For example, the Empowered Aid programme uses a participatory approach to work with women and girls to identify risks of sexual exploitation, abuse, and harassment; create strategies to mitigate these risks; and develop accountability mechanisms that make the humanitarian aid system more responsive to the feedback of women and girls.[18] Although originally developed in protracted crisis settings, the model is now being used in emergencies around the world, including the ongoing crises in Gaza and Lebanon, showing how women's leadership can be prioritised, even during acute emergency responses.

Looking ahead, the number of women and girls affected by humanitarian crises is likely to continue to increase as conflicts proliferate around the world. Efforts to promote a survivor-centred approach in these contexts should seek to prevent various forms of GBV, including those not traditionally seen as conflict-related, and should promote healing and justice for survivors by expanding access to multisectoral GBV response services, such as health-care services, mental health and psychosocial support, law enforcement, legal services, and livelihood or economic empowerment programming.[19] Innovative ways to break down barriers that prevent access to care, such as the establishment of community emergency rooms in Sudan to bring food, health, and GBV services to survivors, should be supported.[20] Investing in GBV prevention and response programmes and working throughout the wider humanitarian architecture to ensure that all humanitarian aid programming seeks to mitigate the risks of GBV and sexual exploitation, abuse, and harassment is essential. Finally, recognising the leadership roles that women and girls already have in their communities, and better resourcing and deferring to the leadership of women's rights organisations and women-led organisations in humanitarian response mechanisms, are key actions that the international community can and must take to both prevent and respond to conflict and its gendered impacts.

We declare no competing interests.

Maureen Murphy, Alina Potts, Gabriella Nassif, Limiaa Abdelgafar Khalfalla, Jihan Kaisi, Anny T Modi, Emanuela Paul, Sheuly Sharma, Anna Tazita Samuel, Mary Ellsberg

maureenmurphy@gwu.edu

The Global Women's Institute, George Washington University, Washington, DC 20052, USA (MM, AP, GN, ME); Sudan Family Planning Association, Cairo, Egypt (LAK); Union of Relief and Development Associations, Saida, Lebanon (JK); Afia Mama, Kinshasa, Democratic Republic of the Congo (ATM); Beyond Borders, Haiti (EP); Jago Nari Unnayon Sangstha, Cox's Bazar, Bangladesh (SS); Women for Change, Juba, South Sudan (ATS)

1 UN Women. Progress on the sustainable development goals: the gender snapshot 2024. https://www.unwomen.org/en/digital-library/publications/2024/09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2024 (accessed Nov 6, 2024).

2 Murphy M, Smith ER, Chandarana S, Ellsberg M. Experience of intimate partner violence and non-partner sexual violence in conflict-affected settings: a systematic review and meta-analysis. *Trauma Violence Abuse* (in press).

3 WHO. Violence against women prevalence estimates, 2018. March 9, 2021. World Health Organization, 2021.

4 Ahmed K. 'We will make you have Arab babies': fears of genocide amid rape and torture in Sudan's Darfur. The Guardian, Nov 3, 2024. https://www.theguardian.com/global-development/2024/nov/03/we-will-make-you-have-arab-babies-fears-of-genocide-amid-and-torture-in-sudans-darfur (accessed Nov 6, 2024).

5 Ellsberg M, Murphy M, Blackwell A, et al. "If you are born a girl in this crisis, you are born a problem": patterns and drivers of violence against women and girls in conflict-affected South Sudan. *Violence against Women* 2021; **27:** 3030–55.

6 Kelly JTD, Rubin AH, Ekhator-Mobayode UE, Arango, DJ. The risk that travels with you: links between forced displacement, conflict and intimate partner violence in Colombia and Liberia. World Bank Group, 2021.

7 Harrison A, Casey J, Sadd E. Child marriage in conflict- and crisis-affected settings: evidence and practice. October, 2024. https://www.girlsnotbrides.org/learning-resources/resource-centre/child-marriage-conflict-crisis-affected-settings-evidence-practice/ (accessed Nov 6, 2024).

8 Westendorf JK, Bian J, Daigle M, et al. Sexual exploitation, abuse and harassment in humanitarian contexts. Sept 25, 2024. https://cdn.who.int/media/docs/default-source/bulletin/online-first/blt.24.291655.pdf?sfvrsn=718309a9_3 (accessed Nov 11, 2024).

9 Barada R, Potts A, Bourassa A, Contreras-Urbina M, Nasr K. "I go up to the edge of the valley, and I talk to God": using mixed methods to understand the relationship between gender-based violence and mental health among Lebanese and Syrian refugee women engaged in psychosocial programming. *Int J Environ Res Public Health* 2021; **18:** 4500.

10 Haering S, Seligowski AV, Linnstaedt SD, et al. Disentangling sex differences in PTSD risk factors. *Nat Mental Health* 2024; **2:** 605–15.

11 Dupraz-Dobias P, Goldberg J. Services under threat after UN emergency funding for gender-based violence runs out. The New Humanitarian, Jan 29, 2024. https://www.thenewhumanitarian.org/investigations/2024/01/29/gender-based-violence-un-funds-services-threatened (accessed Nov 6, 2024).

12 Inter-Agency Standing Committee. IASC guidelines for integrating gender-based violence interventions in humanitarian action, 2015. Aug 28, 2015. https://interagencystandingcommittee.org/working-group/iasc-guidelines-integrating-gender-based-violence-interventions-humanitarian-action-2015 (accessed Nov 22, 2024).

13 Raftery P, Howard N, Palmer J, Hossain M. Gender-based violence (GBV) coordination in humanitarian and public health emergencies: a scoping review. *Confl Health* 2022; **16:** 37.

14 True J, Riveros-Morales Y. Towards inclusive peace: analysing gender-sensitive peace agreements 2000–2016. *International Political Science Review* 2019; **40:** 23–40.

15 Development Initiatives. Global humanitarian assistance report 2023. 2023. https://devinit.org/resources/global-humanitarian-assistance-report-2023/executive-summary/#downloads (accessed Nov 6, 2024).

16 Glass N, Perrin N, Marsh M et al. Effectiveness of the Communities Care programme on change in social norms associated with gender-based violence (GBV) with residents in intervention compared with control districts in Mogadishu, Somalia. *BMJ Open* 2019; **9:** e023819.
17 Bourassa A, Murphy M, Wilson R, Contreras-Urbina M. Shifting power and reducing violence in Haiti: initial results of an impact of the rethinking power and power to girls programs in southeast Haiti. 2022. https://globalwomensinstitute.gwu.edu/sites/g/files/zaxdzs6206/files/downloads/Rethinking%20Power%20Evaluation2022.pdf (accessed Nov 8, 2024).
18 Potts A, Kolli H, Hedge E, Ullman C. Empowered aid: participatory action research with refugee women & girls to better prevent sexual exploitation and abuse—Uganda results report. The George Washington University and Uganda, 2020.
19 Ligiero D, De Angulo B, Gatera G. Prevention, healing, and justice: a survivor-centred framework for ending violence against women and children. *Lancet* 2024; **403:** 595–97.
20 Youth-led 'emergency rooms' shine rays of hope in war-torn Sudan. UN News, Feb 3, 2024. https://news.un.org/en/story/2024/02/1146187 (accessed Nov 15, 2024).

Primary health-care practices for deaf children should include early incorporation of a signed language

Published **Online** August 28, 2024 https://doi.org/10.1016/S0140-6736(24)01564-2

For the optimal care of deaf and hard-of-hearing children, primary care paediatricians and family practitioners should consider signed language acquisition normal and healthy. Early acquisition of a signed language is a crucial part of primary multilingual treatment strategies for maximising development.

When deaf children cannot adequately access spoken language, the late addition of a signed language does not reverse negative effects on function and neurolinguistic areas of the brain.[1] Known as language deprivation syndrome in severe cases, inconsistent and partial access to language negatively affects memory, understanding of cause and effect, executive functioning, and mood regulation, and causes a general language dysfluency.[2] Neurological correlates can be seen in cerebral cortex organisation[1,3] and decreased myelination of language pathways.[4] These permanent sequelae have lifelong effects on every facet of life, including employability, general health, social relationships, emotional stability, and more. Furthermore, adverse childhood communication experiences are associated with an increased adult risk of hypertension, diabetes, lung diseases, and mental ill health.[5]

Still Huntstock via Getty Images

The majority of deaf infants are born to hearing parents who do not know a signed language.[6] Language provision is currently embedded in a medical model of care in which the lived experiences of deaf people are ignored, and families are offered services typically framed as a dichotomous choice of signed or spoken language with a strong preference for spoken language only.[7–10] The false binary is a vestige of the 19th century, when eugenic philosophies dominated medical practice and societal perspectives of disability.[11] This eugenicist legacy is still visible today in a medical community and assistive technology industry that continue to be ideologically opposed to signed language acquisition, signed–spoken language bilingualism, and the cultural capital of shared Deaf wisdom.[7,10–13]

The ongoing ableist perspective towards deaf people, often labelled as audism, is rooted in the belief that superiority is based on hearing ability and the behaviours typical of hearing people, which includes not using signed languages.[9] Around the world, organisations are beginning to recognise the ableist underpinnings of dismissing signed languages as inferior, unwanted, and unnecessary. New clinical guidelines published by the American Academy of Pediatrics acknowledge a role for signed languages in healthy development.[14] More than 40 countries have granted legal status to their regional signed languages.[15] The UN Convention on the Rights of Persons with Disabilities recognises signed languages,[16] and specifically requires the provision of "services designed to minimize and prevent further disabilities,