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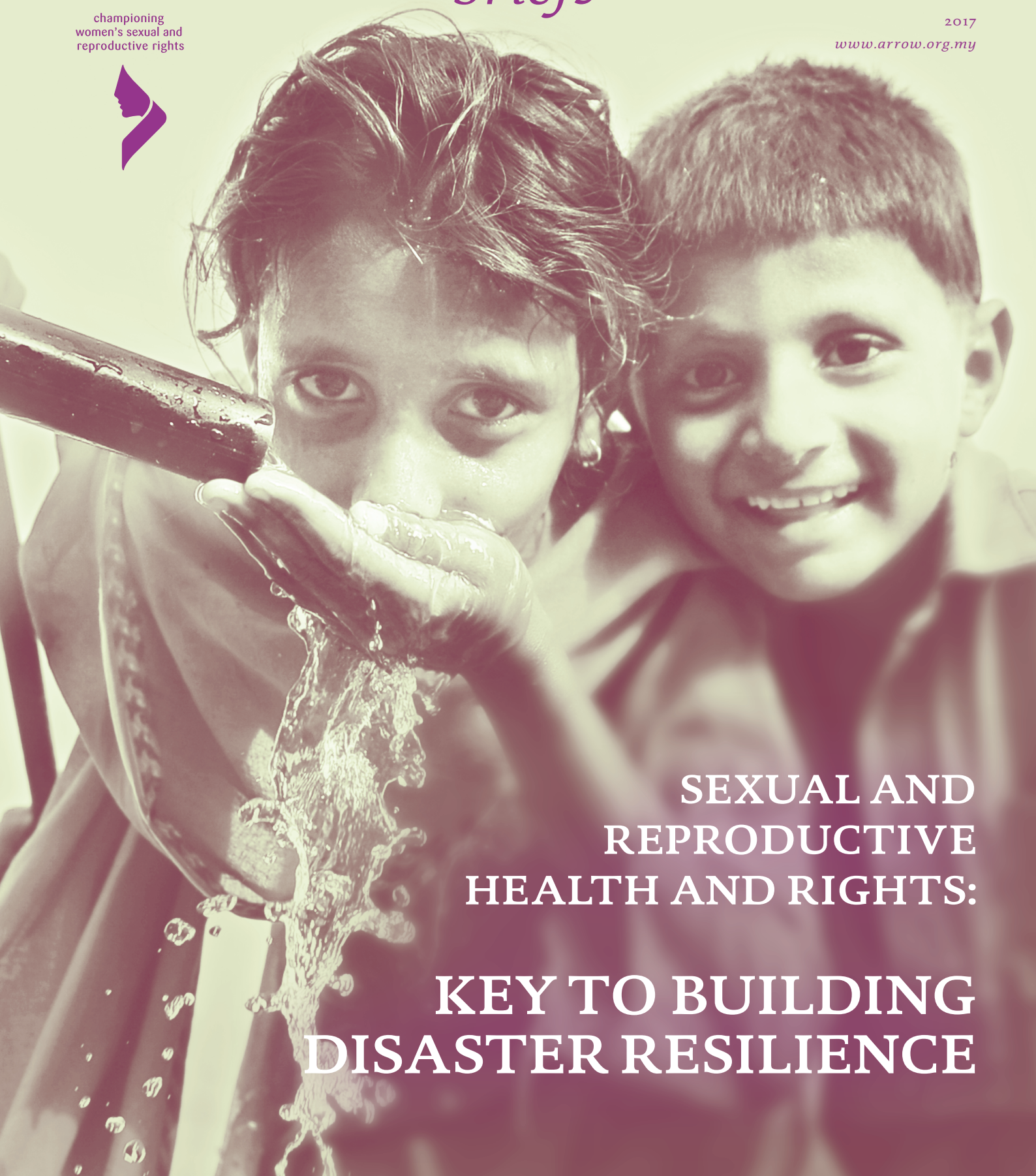

# SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:

# KEY TO BUILDING DISASTER RESILIENCE

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: KEY TO BUILDING DISASTER RESILIENCE

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ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)

1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

**Telephone** (603) 2273 9913/9914
**Fax** (603) 2273 9916
**E-mail** arrow@arrow.org.my
**Web** www.arrow.org.my
**Facebook** http://www.facebook.com/ARROW.Women
**Twitter** @ARROW_Women
**Youtube** youtube.com/user/ARROWomen
**Pinterest** arrowomen

PRODUCTION TEAM

**Overall Supervision:** Sivananthi Thanenthiran
**Production Coordinator:** Lim Hwei Mian
**Author:** Ambika Varma
**Reviewers:** Azra Abdul Cader, Biplabi Shrestha, Chaman Pincha, Dr. Subatra Jayaraj, and Maria Melinda Ando
**Publications Technical Support:** Maria Melinda Ando
**Copy Editor:** Paroma Sadhana
**Graphic Designer:** Nicolette Mallari
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# PREFACE

Despite decades of work in disaster management through research, innovation, advocacy and capacity building, the challenge of reducing people's vulnerabilities to disaster risks remains. Even as continuous attempts are being made to understand and address the root causes of vulnerabilities; global politics, markets, and religion are simultaneously colluding to create new vulnerabilities through neo-nationalism, neoliberal capitalism and religious fundamentalisms. These have not only created new challenges, such as climate change, inequality, conflicts, and insecurity, but have corroded the basic human values of respect and compassion, resulting in human rights violations.

Gender discourses highlighting the differential impact of disasters on men and women, and the specific vulnerabilities of women and girls in disaster situations, came to the fore in the 1990s. While it succeeded in drawing global attention to the issue, it also contributed towards masking the numerous capacities, resilience, and contributions of women before, during, and after disasters. The attention on gender, inadvertently and at times due to necessity, predominantly was on women. This lens however, obfuscated the heterogenous and intersectional nature of human realities that are manifested through power, age, class, caste, sexual orientation, gender identities, health status, migrant status and (dis)abilities, among others. These manifestations cause unequal opportunities and are responsible for placing people in risky situations and put them in positions to make risky choices.[1] This also resulted in excluding a large population from the disaster discourse and practice, leading to a gender-blind approach to disaster management.

While issues related to sexual and reproductive health have received some attention in disasters and development; issues around sexual and reproductive rights (barring violence against women) have largely been missing from the scholarships, plans and practices in disaster management. The shift in paradigm from disaster management to disaster risk reduction, founded in development practices, opens opportunities for revisiting gender through a broader lens of rights, inclusion, social and gender justice, and empowerment of women and girls. It also puts the spotlight on women's capacities.

In 2015, three long-term global plans were launched — the 2030 Agenda for Sustainable Development (SDGs), the Sendai Framework for Disaster Risk Reduction (SFDRR) and the Paris Agreement on Climate Change (COP21) — all endorsed by most countries' leaders across the world. As we move towards implementing the plans, we need to ensure that the promise of inclusiveness, non-discrimination and the highest standards of human rights are upheld. As citizens and civil society organisations, our task is to work together and build alliances across movements to hold governments accountable in delivering on these commitments.

The Asian-Pacific Resource and Research Centre for Women (ARROW) sees value in a holistic approach to sustainable development, which necessitates both generating evidence through intersectional research, and cross-movement advocacy and alliance building. One of our first forays into intersectional work was looking at sexual and reproductive health and rights (SRHR) in disaster contexts, in 2008.[2] In the light of the new proposals for development, disaster risk reduction and climate change, this regional brief presents further evidence on the links between SRHR and disasters, and the importance of an inclusive and rights-based approach towards development and disaster risk reduction frameworks.

**Sivananthi Thanenthiran**
Executive Director

# I. INTRODUCTION

Disasters cause immense loss of human lives and assets and derail years of development gains. They impact people and nations disproportionately, with the burden of losses being borne by the poor and the marginalised groups within nations, and especially so in low- and middle-income countries. Between 2006 and 2015, an estimated 1.3 billion people in the Asia-Pacific region have been affected by disasters, resulting in economic losses of up to USD 379,000 billion.[3] As nations struggle to recover from frequent and recurring setbacks from disasters, the emergence of climate change poses new challenges and uncertainties for the future.

The Asia-Pacific region continues to be the epicentre of catastrophes, accounting for 49% of the world's disasters.[4] Several factors — diverse geography, exposure to multiple hazards, high population, rapid urbanisation, poor infrastructure development, poverty, wide socio-economic inequalities, and weak legal and institutional mechanisms — contribute to build ideal disaster conditions. In 2015 alone the region experienced 264 of the 574 disaster events recorded globally, that resulted in 21,836 deaths, affected 70,462 people, and incurred an economic loss of USD 37,376 million.[5] Weather-related disasters contributed to 92% of all disasters.[6] While large-scale geophysical hazards resulted in higher number of deaths, human mortalities from weather-related hazards have seen a downward trend, but an increase in economic and livelihood losses. Furthermore, small island developing states (SIDS), such as the Maldives and countries in the Pacific, are likely to more severely experience the negative impact of climate change.[7] As per the 2016 World Risk Index, nine of the top 15 countries (Vanuatu—1, Tonga—2, Philippines—3, Bangladesh—5, Solomon Islands—6, Brunei Darussalam—7, Cambodia—9, Papua New Guinea—10, and Timor-Leste—12) ranked most at risk worldwide, fall in this region.[8]

Disaggregated data by age, sex, gender, social and economic status, physical and mental abilities, and ethnicity is not systematically gathered in disasters. However, some estimates show that women comprised about 61% of casualties after cyclone Nargis hit Myanmar in 2008, and about 70% of casualties after the 2004 Indian ocean tsunami in Banda Aceh.[9] Marginalised groups, including the poor, women, girls and boys, the elderly and infirm, persons with disabilities, and indigenous groups are reportedly disproportionately affected by disasters.[10]

It should be noted that in gender and disaster literature, gender often refers to women, within a heteronormative framework, and women are painted as being vulnerable. Such framing excludes people with diverse sexual orientation and gender identities, overlooks the vulnerabilities of boys and men in disasters and masks the capacities and contributions of women, girls among others, before, during and after disasters.[11]

The evolution of the disaster discourse, from response and preparedness to prevention, risk reduction, and resilience-building, provides an avenue to reframe our vision of the role of women as key agents in reducing risks and strengthening community resilience to disasters. While sexual and reproductive health (SRH) occupies some space within disaster preparedness and response, sexual and reproductive rights (SRR) of women (key to achieving women's empowerment) is conspicuously missing from disaster risk reduction (DRR) debates. The launch of the three long-term global policy agreements in 2015 — the 2030 Agenda for Sustainable Development (SDGs), the Sendai Framework for Disaster Risk Reduction (SFDRR), and the Paris Agreement on Climate Change (COP21) — offers renewed opportunities to fill the gaps in theory and practice, and to break the silence on issues such as SRR that have been left out of the discourses, and DRR planning and implementation.

The objective of this brief is to highlight the links between disasters and SRHR. It attempts to present an understanding of the concepts in this thematic area, and if the SDGs and SFDRR goals are to be achieved, it recommends that DRR must be rights-based and inclusive, and integrate sexual and reproductive rights of all, especially women and girls. While the brief advocates for SRHR of all, because data on sexual minorities is sparse, the focus is mainly on women of reproductive age (which includes girls). Wherever possible, references to sexual minorities are presented in the discussions.

The key takeaways from the brief are:

- Disasters are not natural, but a result of unmanaged risks and vulnerabilities
- Development should be risk-informed to offset the impacts of old risks, and to avoid creating new risks
- Socio-economic and cultural factors augment vulnerabilities of women, girls and marginalised groups in disasters
- Gender equality and women's empowerment cannot be achieved without bodily autonomy and therefore SRHR must be a critical condition in building women's resilience in disasters
- An inclusive and rights-based approach to DRR is the way forward

## Box 1: Definitions of SRHR

**Reproductive Health** implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. *(WHO)*

**Reproductive Rights** embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. *(ICPD)*

**Sexual Health** implies a positive approach to human sexuality and the purpose of sexual healthcare is the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases. *(adapted, UN)*

**Sexual Rights** embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decision to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life. *(WHO working definition)*

***Source:***
*Sivananthi Thanenthiran, Sai Jyothirmai Racherla and Suloshini Jahanath, Reclaiming and Redefining Rights: ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia (Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW), 2013), 22, accessed April 10, 2017, http://arrow.org.my/wp-content/uploads/2015/04/ICPD-20-Asia-Pacific_Monitoring-Report_2013.pdf.*

# II. UNDERSTANDING DISASTER RISK REDUCTION AND CLIMATE CHANGE ADAPTATION

In common parlance disasters are understood as natural events that demand a response upon their occurrence. Following in the same vein, in recent literature, 'disasters' are found to be replaced with 'climate change.' While both climate change and DRR are linked, and have similar objectives, one cannot replace the other. Moreover, a sole focus on climate change and weather related hazards, consequently leaves out other hazards and risks, which further influence policy framing, planning and implementation of risk reduction initiatives. This section attempts therefore to provide better clarity on the concepts.

**Disasters are defined as a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources.**[12] While disasters can be triggered by natural hazards, such as floods, storms, droughts, earthquakes and landslides, among others, they are neither natural nor inevitable. It is deemed a disaster only when hazards impact people because of their vulnerabilities, and vulnerabilities are socially constructed.[13]

Disasters are neither natural nor inevitable. They are a result of unmanaged risk and vulnerability.

There is a wide acceptance today that disasters are not external shocks, but are situated within the development processes; and that a disaster event exposes the fault lines in the human, economic and political development, and the readiness of a community or nation to deal with it. This acknowledgement has given way to the understanding that while hazards cannot be fully managed, as they are partly embedded in nature, their negative impacts, such as mortalities, morbidities, displacement and financial and infrastructural losses, can be significantly reduced by addressing the risks before they become disasters.

**Disaster risk is the potential loss measured in lives, health status, livelihoods, assets, and services, which could occur to a particular community or a society over some specified future time period.**[14] In other words, it is the disaster that is yet to happen. The risk of a disaster is greater where the exposure and vulnerability to a hazard is high. Risks can be intensive and are often low-probability, high-impact events, such as earthquakes; or they can be extensive with high-probability and lower impacts, as in the case of floods and storms.[15] Risks are deemed **acceptable/tolerable or unacceptable** based on everyday life experiences, known probabilities of hazards, socio-economic, political, technical and environmental conditions, cultural beliefs and stakeholder perceptions of risks. While it is only possible to plan for an optimum level of risk, communities need to prepare for dealing with **residual or remaining risks** and emergencies.[16] These are risks that remain unmanaged or are unanticipated, even when mitigation and preparedness measures are taken. It also signifies that risk reduction is an ongoing effort.

**Hazards are dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption or environmental damage.** It may be natural such as geo-physical (for e.g. earthquakes, tsunamis, volcanic eruption or landslide and mudslide triggered by an earthquake), hydro-meteorological (for e.g. floods, tropical cyclones, storms or landslides triggered by heavy rainfall), climatological (for e.g. heat wave, cold wave and wildfires) or anthropogenic

(for e.g. complex emergencies including violent conflicts, industrial accidents or traffic accidents, among others).[17]

**Exposure relates to people, property, systems or other elements present in hazard zones that are thereby subject to potential losses.**[18] It could mean people living in highly hazard prone areas, a poorly constructed hospital in a seismic zone or the lack of an evacuation plan.

**Vulnerability is the condition determined by physical, social, economic and environmental factors or processes, which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.**[19] More recently, culture — ways in which risks are perceived, experienced, adapted and responded to and even produced by people — has been added to the list of causes that lead to vulnerability.[20] Vulnerability is determined primarily by one's social status and its influence on natural hazards to create differential impacts. Several factors rooted in social and economic structures, ideology, politics, physical setup, and environment determine how big the impact of a hazard can be on a community.

**Capacity is the combination of all the strengths, attributes and resources available within a community, society or organisation that can be used to achieve agreed goals.**[21] It is the ability of a community to offset risks through their coping mechanisms and the access to, and ability to use, resources. Resources may not just include physical means or infrastructure, but also knowledge, skills, social relationships, leadership and management. Depending on the resources at one's disposal, coping strategies may differ. They may not always have positive outcomes and may even put one further at risk. The notion that everyone has capacities and that even excluded groups present strengths to cope in adverse situations, shifts the focus from victimhood to empowerment and resilience. While it may be more difficult to reduce vulnerabilities in the short-term, actions towards building capacities, especially at the community level, presents opportunities for reducing risk.[22]

**Disaster risk reduction (DRR) is both the concept and practice of reducing disaster risks through systematic efforts to analyse and reduce the causal factors of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events.**[23] Such a comprehensive approach to risk entails that development must use sustainable approaches. Therefore, addressing the underlying risks would entail reducing poverty, tackling socio-economic and gender inequalities and exclusions, protecting and restoring natural ecosystems, doing away with unsustainable production and consumption, improving institutions and governance, and, more importantly, redistributing power. Much of the catastrophic outcomes of hazards can be minimised or avoided if risks are factored into the development planning and implementation, and if community capacities are developed to cope with adversities.

## Development should be risk-informed to offset the impact of old risks and to avoid creating new risks.

**Climate change is defined as a change of climate, which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and, which is, in addition to natural climate variability, observed over comparable time periods.**[24] The variability and unpredictability of weather conditions adds a new dimension of uncertainty of the intensity and frequency of certain disaster risks. It may also raise new risks in populations that have not previously experienced such risks. Not all weather-related hazards are caused by climate change, and many disasters such as flooding, especially in the cities, occur because of not factoring risks in urban planning.

**Climate change adaptation (CCA) is the adjustment in natural or human systems in response to actual or expected climatic stimuli or their effects, which moderates harm or exploits beneficial**

**opportunities.**[25] While people have always learned to adapt to climate change over time, the current changes in its frequency and intensity are additional stressors to existing vulnerabilities of people and assets. Adaptation is not always a defence strategy but can also lead to positive short- and long-term benefits for the communities and economies as it opens new opportunities for livelihoods.[26]

**Resilience is the ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.**[27] It includes a community's ability to absorb long-term stresses and short-term shocks and their capacity not just to recover after a disaster event, but to emerge better and stronger from it. Closely related to vulnerabilities and capacities, resilience can be implemented and measured through DRR. A resilient system is characterised by inclusive decision-making, availability of livelihood options and access to assets, knowledge and skills, political structures and processes, infrastructure, and technological capacity among others.[28]

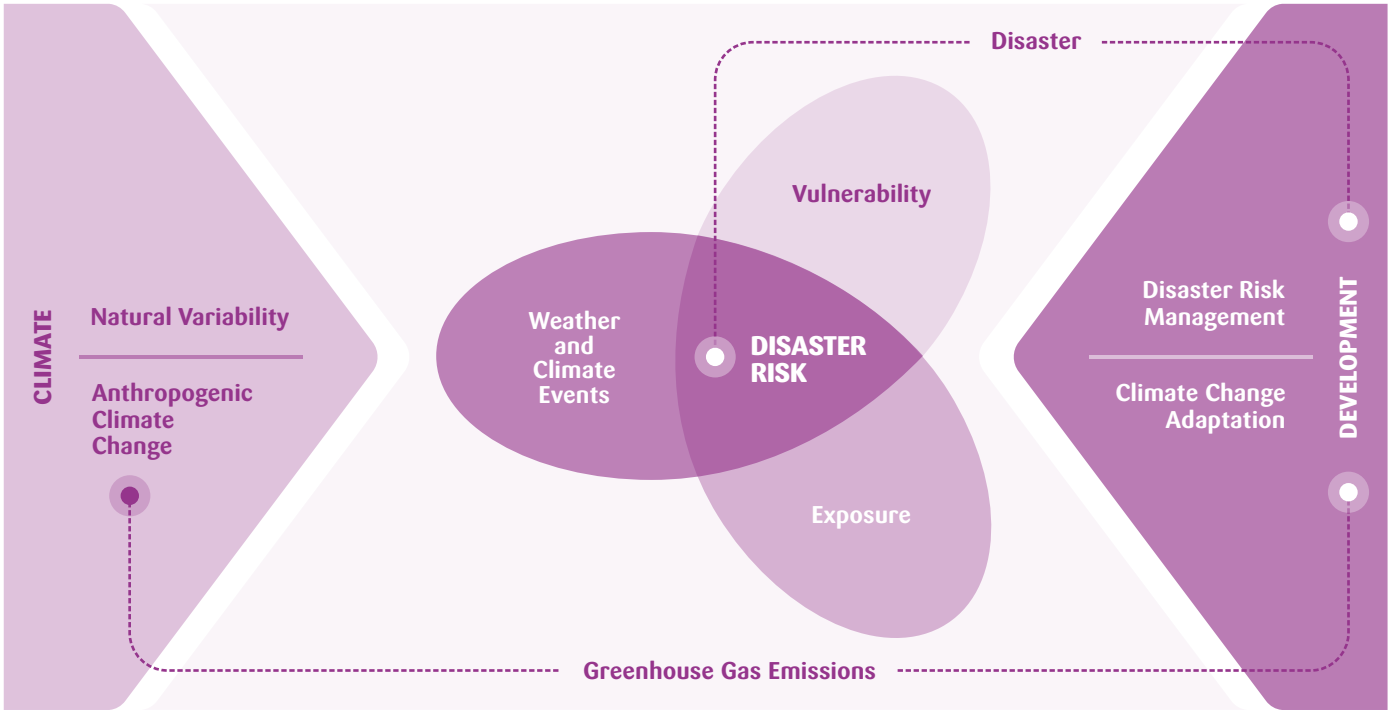
## III. LINKAGES BETWEEN DISASTER RISK REDUCTION AND CLIMATE CHANGE ADAPTATION

There are many conceptual commonalities between DRR and CCA, despite independent evolution stemming from different disciplines. DRR grew out of disaster management and CCA comes from environmental science and scientific theories. Both concepts aim at reducing the impact of shocks by reducing vulnerabilities and anticipating risks. The overlap between the two concepts lies in the weather-related hazards. While DRR is concerned with all types of hazards and focusses largely on climate extremes, CCA is concerned solely with hydro-meteorological and climatological hazards, the long-term adjustments to climatic changes and the opportunities they provide.[29]

However, despite considerable purchase for convergence in the two fields, at least at the conceptual level, the difficulty lies in bringing synergies at the operational level. In many countries in the region there continues to be a divide in institutional mechanisms, wherein disaster management comes under the purview of the ministries of home or interior, and CCA under the ministries of environment. Each field has different entry points in terms of international agreements (United Nations Framework Convention on Climate Change (UNFCCC) and the SFDRR) and likewise different funding streams. Both DRR and CCA have also seen limited integration into development planning and implementation. Today, climate change enjoys relatively high political interest and attention and therefore more funding in comparison to the ad hoc funding DRR receives, mainly following a disaster event.[30] Therefore, by building synergies in the implementation of the two concepts, duplication of efforts can be reduced and the limited funds can be effectively used in mitigating risks.

Figure 1 illustrates how socioeconomic development interacts with natural variability and anthropogenic climate change to influence disaster risk. Increased vulnerability and exposure, and increases in frequency and severity of climate events, increases the risk of disasters. Conversely, DRR and CCA can reduce the impact of extreme events.

Figure 1: Synergy Between DRR and CCA




***Source:*** *Intergovernmental Panel on Climate Change (IPCC), Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation. A Special Report of Working Groups I and II of the Intergovernmental Panel on Climate Change (Cambridge and New York: Cambridge University Press, 2012), 4.*[31]

## IV. VULNERABILITY LINKED TO GENDER AND SRHR

This section looks at how vulnerabilities are created based on gender and SRHR, which determine the negative outcomes in disasters.

**Sexual and reproductive health and rights (SRHR)** (see Box 1) include four interlinked concepts that cover both the health aspects of sexuality and human reproduction, and the right to make informed choices related to sexuality and reproduction.[32] These rights include the freedom to — choose one's partner, marry or not; have children or not, and if yes, then to decide on the number, spacing, and timing of children; the right to be free from coercion and violence; and the right to attain the highest standards of sexual and reproductive health. Like all human rights, they are indivisible, universal and interrelated to all other human rights.

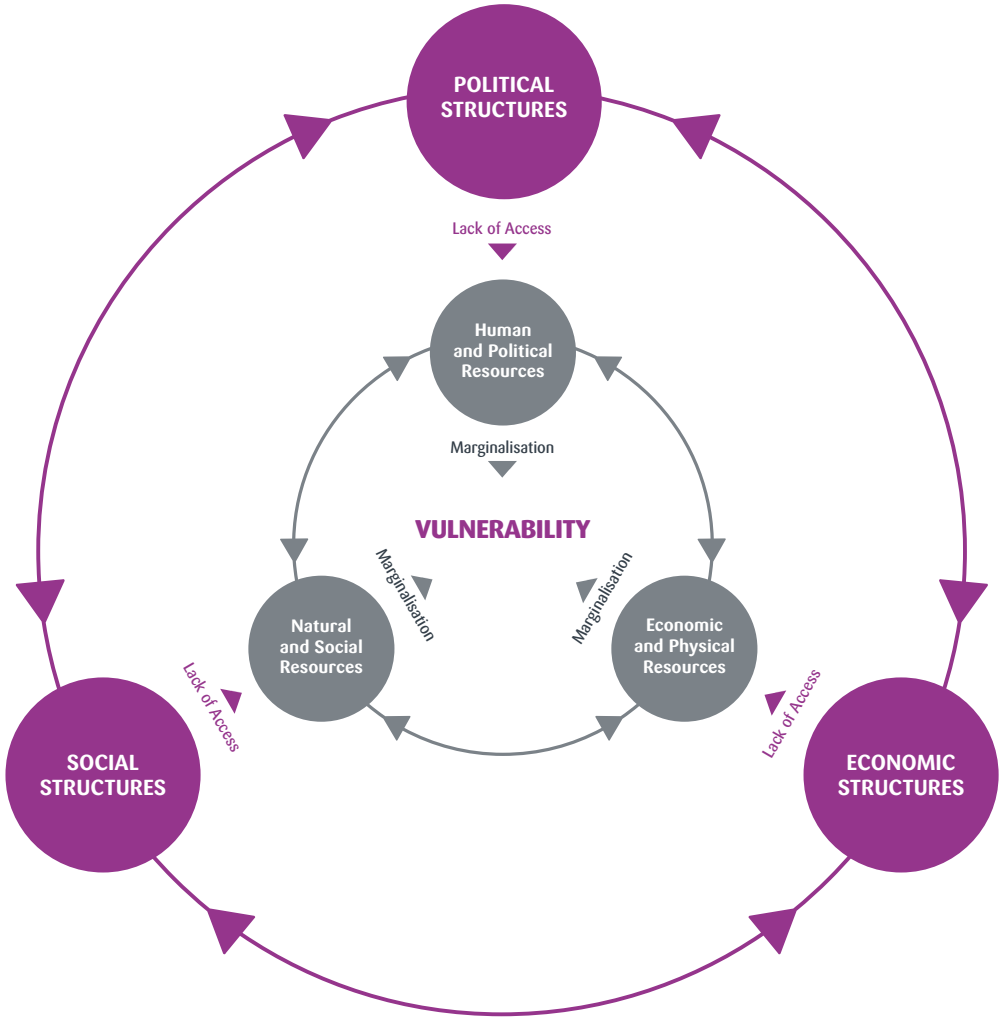
Figure 2 represents the root structural causes of vulnerabilities — social, economic, political — and limited access to resources even when they are available locally, which when compounded leads to marginalisation, thus creating vulnerabilities.

Women's vulnerability to risks is rooted in socially ascribed roles within reproduction and caregiving, which form the basis of the many structural discriminations they face throughout their lifecycle. While some socially perceived vulnerabilities can be intrinsic in nature as in the case of persons with special disabilities, because of the stage in the lifecycle (i.e., children or older people),[34] or those related to reproductive functions (such as pre-puberty, adolescence, pregnancy, and lactation), they become vulnerabilities only because of the exposure to risks, and the lack of systems that will offset the risk

that increases the vulnerability. For example a pregnant woman needs care during, at the time of delivery and after delivery, as every pregnancy can potentially go wrong if adequate and timely care and interventions are not made. A woman who is not pregnant, is better equipped to evacuate and save herself in times of a disaster event, as compared to a pregnant woman. Being pregnant is the physical condition that increases the risk of a woman to death and disability, delivering prematurely or experiencing pregnancy complications during disasters.

According to an assessment by the United Nations Population Fund (UNFPA), one in five women of reproductive age is likely to be pregnant in emergencies.[35, 36] In the 2015 Nepal earthquake, an estimated 1.5 million pregnant women experienced obstetric complications in the 14 most-affected districts.[37] The breakdown of the health system during disasters greatly hampers healthcare provision, particularly the vital SRH services, to save lives and reduce morbidities. In Nepal, close to a thousand health facilities were destroyed or damaged, including those providing maternal and neonatal care, after the same earthquake.[38]

## Figure 2: Root Structural Causes of Vulnerability




**POLITICAL STRUCTURES**
E.g. Form of Government; Governance; Conflicts

**Human and Political Resources**
E.g.Lack of political representation; Poor social protection; Fragile health including SRH; Limited skills and formal education; Lack of legal representation and limited access to justice systems and rights

**ECONOMIC STRUCTURES**
E.g. Distribution of wealth; Economic priorities; Government Debt; Patron-client relations

**Economic and Physical Resources**
E.g. Low income; Lack of savings; Limited access to formal credit;Unprotected buildings and infrastructure; Fragile homes

**SOCIAL STRUCTURES**
E.g. Class; Caste, Race; Majority-minority relationships; Heteronormativity and gender-rower relations; Age; Religion; Culture and traditions

**Social Structures**
E.g. Lack of arable land and water; Limited social networks, Lack of biodiversity resources

***Source:*** *Adapted from Ben Wisner, JC Gaillard and Ilan Kelman, "Framing Disaster Theories and Stories Seeking to Understand Hazards, Vulnerability and Risk," in The Routledge Handbook of Hazards and Disaster Risk Reduction ed. Ben Wisner, JC Gaillard and Ilan Kelman (London: Routledge, 2012), 27.*[33]

According to Sen, Ostlin and George, women are also predisposed to certain health vulnerabilities because of **biological factors**.[39] For instance, women are more susceptible to be infected by HIV compared to men. In disasters, with the disruption of normal life, and many colluding factors such as higher insecurity and unprotected sex, the risk of infection in women increases.

Likewise, it has been noted that pregnant women living in malaria-infested areas are more vulnerable to being infected, compared to non-pregnant women, because of physiological and behavioural changes in pregnancy. A study on pregnant women's predisposition to malaria found that due to some physiological factors such as increased body temperature, moist convection, body odour, visual stimuli, increased exhalation (wherein more components are released that help mosquitoes detect a host), increased blood flow to the skin, made them more attractive to mosquitoes. In addition, pregnant women tend to urinate more than non-pregnant women during the night, and leave the protection of the bed-nets, exposing them to night-biting mosquitoes. Malaria in pregnancy leads to risks of miscarriages, premature deliveries, stillbirths and low birth weight.[40] However, the biological detriments do not cause vulnerability on their own, but it is their intersection with the **social, economic and political markers** that increase the vulnerabilities of women.

**Social factors** linked with SRHR include, but are not limited to, gender discriminatory practices and gender stereotyping, which restrict mobility of women, limit access to resources (such as food, land, assets, jobs and livelihood options) and skills and knowledge. It also reduces decision-making and bargaining power. In some Asian countries, intra-household distribution of food can result in girls and women eating last and the least, resulting in undernutrition.[41] In addition, they may also eat less nutritional food leading to micronutrient deficiency. Anaemia during and after pregnancy can cause pre-eclampsia, obstetric complications, maternal mortality, sepsis and perineal infections.[42] Poor nutrition leads to a weak immune system, making one prone to several infections. In a major disaster, with people living in crowded evacuation centres, the risk of infections spreading is high if proper hygiene and sanitation is not maintained, especially with poor immunity and a predisposition to infections.

**Shame associated with menstruation** is particularly prevalent in many Asian countries. Cultural practices of seclusion during menstruation arise from the notions that consider menstrual blood impure. Restriction in girls' mobility at the onset of puberty is one of the reasons for school dropouts or absenteeism.[43] Women carry the weight of these socialised notions and practices, even during disasters, making it difficult to manage menstruation, especially when living in crowded shelters and using public toilets. Women also carry the **burden of family honour** linked to the fear of pregnancy, sexual abuse and violence. The social perception that girls and women need to be protected, and the best way of doing so is by restricting them at home, leads to spatial demarcation. Thus, access to public spaces remain limited and unsafe especially for those women and girls who are viewed as defying or challenging gender norms.

Rendered a lower status because of their sex, women, especially if they are adolescents, have **little bargaining and decision-making powers** within and outside the household. This may have negative consequences such as early and forced marriage, delays in health-seeking behaviour, lack of decision making on reproduction, negotiating condom use etc., which may lead to unwanted pregnancy, unsafe abortion and mortality. One of the reasons for high maternal mortality is the lack of timely access to emergency obstetric care. The delay in accessing care is greatly dependant on one's ability to recognise danger signs and to seek and receive timely interventions. As noted in a study done by United Nations Children's Fund (UNICEF), in parts of South Asia these decisions are either made by the mother-in-law or husband.[44] These disempowerments are heightened and made worse in disasters, especially when separated from family and those who they depended on for making these decisions.

**Violence against women** and girls is a manifestation of gender inequalities and unequal power relations. Age, levels of education, economic status etc. have a deep correlation with the violence, especially sexual violence, which women face. Often it is the younger girls, women who are less educated, have lesser social and financial resources and networks, who become vulnerable to intimate-partner violence. The systems of justice and societal ethics contribute towards creating an environment that allows the prevalence of violence against women and girls. Violence against women is reported to increase during disasters due to a further breakdown of security systems and safety networks provided by family members. With increased psychosocial and economic stresses that follow deaths, economic losses and loss of livelihoods, men are found to vent their frustration on women. In Vanuatu, the Tanna Women's Counselling Centre reported that new cases of domestic violence increased by 300% after the 2011 tropical cyclones that hit Tafea Province.[45] Apart from sexual and physical violence, women and girls may experience other forms of violence such as **trafficking, forced and early marriage**. Marriage is also used as a coping strategy among the poor, as was reported in some communities in Tamil Nadu after the 2004 Indian ocean tsunami.[46] These findings are further corroborated by country studies conducted by ARROW partners in Bangladesh, Nepal, Pakistan and the Philippines. For instance, in Bangladesh, young girls were married off after the floods to escape poverty.[47]

Women are not a homogenous group. Social constructions are amplified if other markers such as age, class, caste, disability, migrant status, sexual orientation and gender identities, among others, intersect. Ariyabandu refers to it as the "vulnerable among the vulnerable."[48] Because they do not fit into the norms ascribed by society, they are often excluded from the social, economic and political processes within a society, and therefore find themselves **in the margins** with access to fewer resources, networks and power, as compared to other women or men. In disasters, likewise, they tend to face worse outcomes.

**Disabled women** are seen only through the lens of their disability and are perceived as being helpless, and therefore a burden to their families and society at large. In many societies where women are valued only for the utilitarian worth of their reproductive roles, when they become disabled, they are further devalued. A research done in 2008 that looked at the long-term impact of disabilities of the 2005 Pakistan earthquake, found that many of the paraplegic women were either abandoned by their husbands or received little or no support from their families. On the other hand, men who became disabled during the earthquake continued to be cared for by their wives and families. The husbands of the disabled women were found to have married again. Instances of school dropouts among girls whose mothers were disabled in the earthquake, and early marriage, were also found.[49] Often, sexual and reproductive rights of women with disabilities are ignored, as they are either viewed as being sexually unattractive or even sexually dormant.

**Internally displaced people and migrants** are particularly vulnerable as they lack social networks and their rights to access vital aid, resources and livelihoods are constrained. For instance, internally displaced women and girls in Afghanistan were found to be at higher risk of forced marriage and sex work.[50]

One's marginalisation extends even during crises, as in the case of transgender people, who may be excluded during disaster response and face further stigma. During the 2004 Indian ocean tsunami, at a time when transgender persons had not been recognised by the Indian and Tamil Nadu governments, the Aravanis (biologically male who dress as women but who claim neither male nor female identity) of Tamil Nadu were excluded from relief and social security schemes for the tsunami-affected population.[51] Similar cases of discrimination against transgender women have been noted after the 2011 floods in Sindh, Pakistan, where transgender people were denied entry at the relief camps because of communal discomfort in sharing the shelters. Further, they were denied aid for not possessing a valid national identity card.[52] Upon facing discrimination and indignity after the 2011 Great East Japan earthquake, the

lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) people and allies in Iwate, developed guidelines on survival and post disaster life with dignity for all, called the Rainbow Disaster Risk Reduction and Management Guide.[53]

**Religion and culture** play a significant role in shaping gender norms and by falsely invoking moral and cultural values, religious texts and fear, they ensure that these norms sustain. In everyday life, it is played out by enforcing 'appropriate' dress code and behaviour, especially with regards to sexual behaviour. The causes of disasters and calamities have also been attributed to women's morality and their 'immoral' dressing code. For instance, a senior Iranian cleric is said to have noted that, "many women who do not dress modestly lead young men astray and spread adultery in society, which increases earthquakes."[54] In Indonesia too, the tsunami in Aceh was claimed to be, "God's revenge against women for their wicked ways"[55] by a Sharia judge. These notions are not limited to Islam alone, and are echoed in other religions as well. Religious beliefs also constrain access to contraception and abortion leading to disability and death. For instance, in the Philippines, access to contraception is constrained because of Catholic beliefs. As a result one of the highest rates of teenage pregnancy is among Filipino adolescents. As per the 2013 National Demographic and Health Survey report, one in ten adolescents (aged between 15-19 years) had started childbearing, eight percent were mothers and two percent were pregnant with their first child.[56] After the introduction of the Reproductive Health (RH) law in the Philippines, contraception is freely available at health centres. Yet, because of staunch Catholic beliefs, access to contraception is restricted for many. Several health centres were destroyed in the aftermath of typhoon Haiyan, causing a disruption of contraceptive services, leading to unplanned pregnancies, especially among the youth.[57]

In times of disaster, like in other times, access to contraception (especially the barrier method) is critical to avoid unintended pregnancies and contraction of sexually transmitted infections (STIs) as not everyone is reached by relief services such as the Minimum Initial Service Package (MISP) for Reproductive Health in Crises. People may resort to sex to combat disaster induced stress, which may be unprotected if contraception is not easily available and accessible. Stress can also lead to violence, especially sexual violence, leading to unwanted pregnancies and unsafe abortion. Abortion being a controversial issue, is often not provided during disasters even when it is legal in a country. Emergency contraception and long-acting contraceptive methods are often not available in disaster situations.[58] Similarly, lack of post-abortion care and management of complications due to unsafe abortions in times of disasters can lead to death and/or lifelong disability.

In the case of **HIV and AIDS and STIs**, a weakened immune system, the inability to absorb food, and being in unsanitary environments in disasters, increase the risks of opportunistic infections. With disruption in healthcare service delivery, access to medicines and treatment may be limited or even unavailable putting the lives of many in danger.

**Economic factors** stem from the social barriers mentioned above and increase and sustain vulnerabilities in people. According to UN Women, two-thirds of the poor in the Asia-Pacific region are women.[59] Low levels of education fetch them low-paid jobs in the informal sector, with little or no social security and savings for retirement. Women are also disproportionately found occupied in the agriculture sector. About 40-50% of the agricultural labour force in Asia is made up of women, and yet they represent smallholders, have limited access to land, markets, credit, agricultural extension services, risk management tools and social protection.[60] Women in most of the countries in the region earn lesser than men. As of 2015, the gender wage gap in the region was more than 20%.[61] Even in cases where women are educated, pregnancy and childcare may be reasons to discontinue jobs. Women may also lose their jobs when they become pregnant, are in many cases the first to be fired in times of recession, and because of the lower pay may put their husband's career before theirs. The burden of care and reproductive work, combined with low pay,

leads to time poverty and poor mental and physical health. During slow-onset and ongoing crises, such as droughts and seasonal flooding, women may experience increased workload to cope with the stress, especially as they are responsible for fetching water and fuel for cooking. In cases where men migrate to cities, women need to take on additional responsibilities, further adding to their time poverty.

Data on the poverty of sexual minorities (LGBTQI) in the region is hard to find. However, based on the marginalisation and discrimination faced by the LGBTQI community in education and employment, we can safely conclude that many people belonging to sexual minority groups are poor. Like women they too are found taking up low-paying jobs in the informal sector with little or no social protection.

Many single (unmarried, divorced or widowed) women, because they have not fulfilled their reproductive 'duty' of being married or have not followed the social norms, may find themselves isolated. Infertility or not having delivered a male child may also lead to marginalisation of women in many countries in this region. In disasters, one of the stereotypes, especially in reporting, is seeing women as mothers. For this reason, unmarried women's SRH are often ignored both in normal and disaster situations.

The poor are also found to inhabit hazardous locations and unsafe buildings, and may have little access to clean water and sanitation facilities. Such locations may also have a higher prevalence of diseases. Women living in such sites experience several **morbidities** such as urinary and reproductive tract infections, which are not just health discomforts but also result in social exclusion.[62] During disasters when functional toilets are not accessible — whether because of long distances, safety concerns, non-segregation, being poorly lit and designed, lack of water and locks or because they are unhygienic — women and girls abstain from using the toilets that can lead to urinary tract infections. Managing menstruation becomes difficult during disasters when private spaces, appropriate sanitary napkins and innerwear, water and toilets are not available to women and girls. A study from Bangladesh found that women perceived emergency shelters not to be women-friendly as they had to share them with men.[63] Looking beyond violence and morbidities, limited privacy and poor living conditions hamper sexual pleasure — be it in their everyday lives or during disaster situations.[64]

When health centres and hospitals are not functioning at their optimal levels in disaster situations, vital services such as antenatal screening and the opportunity it provides in identifying and managing obstetric complications such as hypertension, diabetes, infections (like malaria, HIV and AIDS) and other STIs, and the provision of vital information on contraception, breastfeeding, postnatal care and other services, is negated. Furthermore, screening for cervical and breast cancers are also interrupted. Reinstating screening services depend on the impact of the disaster and how quickly services can be restored.[65]

**Political factors** have a great bearing on women, especially with regards the kind of governance, political representation and their capacity to influence decisions. In addition, policies and practices of governments may not be pro-women, which have repercussions on their health, especially their SRH, rights, access to social protection schemes and other resources. One example is the way budgets are allocated for health. Government expenditures on health in the region is low, increasing the individual's out-of-pocket (OOP) expenses. Even within the better-off Southeast Asian countries, the average health expenditure was 1.9% of the GDP in 2014, which is way below the 5% recommended by the World Health Organisation (WHO). In countries like Bangladesh and Myanmar, the OOP expenditure was estimated to be as high as 63.3% and 71.3% respectively.[66] The trends towards privatisation of health reduces the governments' role and responsibility in providing basic healthcare for all.

Furthermore, the rise of neonationalism[67] has had its negative consequence on the health system in terms of a drainage of skilled health providers from the public

to the private sector, and even out-migration, reduced public insurance and increase in private for-profit insurance. Women are reported to incur higher OOP costs for health than men.[68] While health systems are fragile before a calamity strikes, their resilience to disasters is also poor. Moreover, laws that discriminate and criminalise people based on their sexuality, sex-work and for having an abortion, institutionalise violence and injustice. Poor governance and social injustices within countries determine how communities are enabled to deal with unanticipated events.[69]

The South Asia Women's Resilience Index (WRI), a tool that assesses women's involvement in a country's disaster preparedness and recovery efforts, shows that overall women score poorly in all the countries assessed. On a scale of 0-100, the average WRI score of Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka was 43.35, while that of Japan, which was used as a benchmark measure, was 80.6. Of the seven South Asian countries, Pakistan scored lowest with 27.8.[70] Similar indexes are not available for other subregions to make across region comparisons.

## V. CURRENT INTERNATIONAL SRHR INITIATIVES IN DISASTER RESPONSE

Many targeted interventions in responding to SRH needs during emergencies have been underway in the past two decades. Over the years with many organisations working in disaster response, attempts have been made to standardise the provision of SRHR services in humanitarian settings. Some of these initiatives are briefly summarised below.

Following an Inter-Agency Symposium on Reproductive Health in Refugee Situations held in 1995 in Geneva, the Inter-Agency Working Group on Reproductive Health in Crises (previously in Refugee Situations) was established, which — with its wide network of individuals and member organisations — is responsible for providing critical SRH services in humanitarian settings (disasters and conflicts). These include the **Minimum Initial Service Package (MISP) for Reproductive Health in Crises**, a set of priority activities implemented at the onset of an emergency, which includes adolescent reproductive healthcare, family planning, maternal and new-born healthcare, safe abortion care, protection from and response to gender-based violence and prevention and treatment of STI/RTI/HIV and AIDS.[71] Two complementary programmes to MISP are – the **Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations (SPRINT)** by the International Planned Parenthood Federation (IPPF), currently in its third phase;[72] and the **Reproductive Health Access, Information and Services in Emergencies (RAISE)** initiative by the Heilbrunn Department of Population and Family Health in the Mailman School of Public Health and Marie Stopes International's (MSI), which provides reproductive health services in conflict settings.[73]

The **Interagency Emergency Health Kit 2011** is a WHO initiative that started in 1990 and has since been adopted by several organisations called to respond to the health needs of people in disasters. The kit includes essential medicines and medical devices required in responding to priority health needs of 10,000 people in emergencies for a period of three months. The kit is constantly updated keeping with the health priorities of the time, and includes essential medicines and policies, such as emergency prophylaxis to prevent human immunodeficiency virus (HIV) infection after sexual violence, injection safety policy, and the latest inclusion being mental healthcare in emergency settings and the special needs of children.[74]

The **Inter-Agency Standing Committee (IASC)**, established in 1992, consists of key UN and non-UN agencies working on humanitarian issues, and ensures coordination among the different players in providing humanitarian assistance. To improve humanitarian response, the agency has published a number of field-tested guidelines, such as the **IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings**,[75] **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery**[76] **and the Guidelines for HIV/AIDS Interventions in Emergency Settings**.[77]

The Sphere Project, initiated in 1997 by a group of humanitarian non-governmental organisations and the International Red Cross and Red Crescent Movement, is meant to ensure quality and accountability in humanitarian response. **The Sphere Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response**, presents a set of common principles and universal minimum standards in life-saving areas of humanitarian response such as water supply, sanitation, hygiene promotion, food security and nutrition, shelter, settlements and non-food items, and health action.[78]

However, gaps remain in implementation, as is noted in the 2014 Inter-Agency Working Group (IAWG) evaluation of reproductive health delivery in humanitarian situations. Some of the gaps highlighted are — lack of full and systematic implementation of MISP services especially for adolescents, people with disabilities, sex workers and LGBTQI populations; emergency obstetric care; new-born care; comprehensive abortion care, including safe abortion and post-abortion care at the primary care level; provision of long-acting and permanent contraceptive methods, emergency contraception (provided only in cases of rape), but not included in the regular service provision as a family planning method; prevention of sexual violence and comprehensive clinical management of rape;

The aim of emergency responders is to save lives and address the immediate needs of the population – food, shelter, water and sanitation, and security... little attention is paid to the rights and sexual needs of the affected population in the rollout of the response.

administration of antiretroviral therapy at the primary care level; diagnosis and treatment of STIs and of cervical cancer. The cultural, ideological and financial barriers, among others, that restrict access to SRH care and services prior to the emergencies, are accentuated in crises.[79] From the sexual health and rights perspective, the other gaps are the lack of attention given to Sexual Orientation, Gender Identity and Expression (SOGIE) in disaster response, and the importance of looking at sexuality and intimacy beyond physical health.

The aim of emergency responders is to save lives and address the immediate needs of the population — food, shelter, water and sanitation, and security. With the focus being pinpointed on the speed of delivery, little attention is paid to the rights and sexual needs of the affected population in the rollout of the response. Sex can also be difficult in crowded shelters with limited private spaces. Its value as reducing psychological stress is known, but it receives little attention from responders and government officials. However, a Governor in the Philippines is noted to have advocated for the continuation of normal life, which includes intimacy with one's spouse, during risks.[80]

## VI. WOMEN'S LEADERSHIP, CAPACITY AND RESILIENCE IN DISASTER CONTEXTS

Despite the many disadvantages women face in the region, they have also shown immense resilience in the face of disasters, with their ability to adapt, survive, learn, contribute, and when a suitable environment is provided, to show leadership before and after disasters.

When women are provided the necessary skills and resources, they have shown better resolve in responding to disaster risks, as in the case of Bangladesh. Disaster management plans are fairly evolved in Bangladesh, yet its implementation has not reached many far-flung coastal villages that are at-risk with little resources and capacities. A project by Action Against Hunger (ACF) in a remote cyclone-prone coastal village in southern Bangladesh implemented a disaster risk reduction pilot project in 10 villages between 2011 and 2013. The project was a community-led initiative and addressed the most vulnerable population, especially the poor, landless, female-headed households and girls. Village disaster management committees (VDMCs) and Women's Committees (WCs) were established, DRR skills provided, and the local communities were linked to the local government authorities. Gender issues, particularly SRHR issues, were also considered such as reproductive health, sexual harassment, nutrition, pregnancy and menstrual hygiene and reproductive health problems of adolescent girls. The women's forums served as a venue to discuss and address specific health concerns of the women. Towards the end of the project, when the villages were hit by the Tropical Storm Mahasen in May 2013, the newly acquired DRR knowledge and skills were used to save their lives and livelihood. Much of the project's success was attributed to women's leadership and capacity to act when the cyclone struck.[81]

Women's knowledge of their environment, natural resources and farming are valuable assets. Many examples have been cited showing women's ability to adapt in crises such as droughts. For example, women in Iran developed methods of producing food in tunnels and underground;[82] in Rwanda women are reported to have produced over 600 varieties of beans;[83] and in Micronesia women farmers have acquired the wisdom of the island's hydrology, which has enabled them to find water in times of drought.[84]

Between 2002 and 2004, Oxfam and Chamroeun Cheat Khmer (CCK) implemented a flood mitigation programme in a drought- and flood-prone area in the Takeo province in southern Cambodia that borders Vietnam. With a strong component of building women's empowerment through creating leadership spaces within the community, the project linked disaster response to mid- and long-term livelihood, skills development and other strategies in DRR. The Village Committee for Disaster Management (VCDM) included women and established a forum for women leaders to come together and share experiences. Men were part of the gender-sensitisation process and the entire community was made aware of the importance of gender equality and women's full participation in community DRR activities. While health was not an integral component, the project resulted in improving the nutrition and health of the community. The VCDMs have been institutionalised and are functioning even after the two organisations phased out in 2007.[85]

Perceiving a drought in funding for grassroots women's resilience building, Huairou Commission and GROOTS International initiated the Community Resilience Fund (CRF) and implemented resilience practices in over 21 countries in Asia, Africa, Latin America and the Caribbean. It uses "Resilience Diamond," which is a bottom-up framework for grassroots-led resilient development with four objectives —strengthen grassroots women's organising and leadership, promote local development and awareness, build constituencies and networks, and influence public policy and

processes.[86] The model and the initiative has been lauded for its success in developing women's leadership in risk reduction.

Although this section talks about resilience of women, leadership qualities of the Warias[87] in Indonesia and the Bakla community in the Philippines have also been noted. The Warias made significant contributions after the Mount Merapi erupted in 2010;[88] and the Bakla[89] community have displayed initiative and leadership roles post-disasters. Although the Bakla community is accepted in Filipino society, they continue to face discrimination, such as being assigned demanding tasks that span across the gender spectrum. In disasters too, these marginalisations are played out in the form of being assigned cleaning tasks after flash floods, looking after young children, fetching water and fuel amid deep waters, like in the post 2011 cyclone. As has been noted by Gaillard et al, the Bakla have volunteered to collect relief goods post disasters, and organised large relief operations after the consecutive cyclones in 2009 in Quezon City. In Irosin they have been included in a DRR project and their contributions to the community have been recognised.[90]

However, these examples are few and far in between and have not received formal recognition by governments. Also, very little has been written about the contribution of the LGBTQI to society before and after a disaster, invisibilising their efforts.

In summation, despite the many vulnerabilities, when women are given the opportunity they show great capacities in not just dealing with the risks, but also in finding creative ways to thrive. Evidence showing integration of SRHR in DRR is hard to find. The above examples highlight efforts that are few in number, and need scaling-up in order to create a big wave of change towards inclusiveness. To achieve transformation there is a need for women to realise their full potential by enabling them to make critical life choices in terms of their body, fertility and sexuality. As per research studies, investing in contraception and safe abortion can potentially reduce future costs of pregnancy-related and HIV care,[91] and education.[92] This will also have a cascading effect on strengthening the resilience of women in the face of disasters and climate change, and in reducing pressures on the environment.

## VII. FINDING COHERENCE IN THE POST-2015 UN FRAMEWORKS: DRR, CCA AND SRHR

In 2015, in addition to the pledging of global commitments of SDGs, SFDRR, COP21, the reviews of Beijing+20 and the ICPD+20 (in 2014) were done with the renewal of the Beijing and International Conference on Population and Development Programme of Action (ICPD PoA)

**The 2030 Agenda for Sustainable Development (SDGs)** is a road map for development adopted by 193 UN member states with its overall vision of "a world free of poverty, hunger, disease and want, where all life can thrive."[93] The 17 goals and 169 targets present a broader and more inclusive framework compared to its predecessor, the Millennium Development Goals (MDGs), and include a comprehensive goal for gender equality and women's empowerment (Goal 5). The target 3.7 of achieving universal access to sexual and reproductive health is included specifically under the health goal (Goal 3) — including family planning, information and education, and the integration of reproductive health into national strategies and programmes, while retaining the MDGs targets of reducing maternal mortality, ending the AIDS epidemic, universal access to health. Target 3.8 of universal coverage of health, and target 5.6 (Goal 5) of universal access to SRHR are in line with the ICPD PoA and the Beijing Platform for Action (BPfA).[94] There is no mention of sexual rights and the rights of people of diverse sexual orientation and gender identities. However, the promise of protecting human rights and dignity, the inclusion

of SRHR in line with ICPD and BPfA, and the assertion of 'leaving no one behind,' present arguments for the inclusion of sexual rights in the implementation phase. The 2030 Agenda also allows for breaking the previous silos in development and to do intersectional work.

**Disaster risk reduction (DRR)** is present within 10 goals and 25 targets in the SDGs — poverty (1.5), hunger, food security and agriculture (2.4), health (3.d), education (4.7/4.a) water and sanitation (6.6), built infrastructure (9.1/9.a), safer cities and human settlements (11.1/11.3/11.4/11.5/11.b/11.c), climate change and disasters (13.1/13.2/13.3/13.a/13.b), conservation of oceans/resources (14.2) and ecosystems (15.1/15.2/15.3/15.4/15.9).[95] Target 11.b makes specific reference to the SFDRR.

However, risk reduction, as well as SRH, should not be viewed only within these specific goals, but needs to be applied to other goals as well.

In March 2015, at the **Third UN Conference on Disaster Risk Reduction held in Sendai, the framework for disaster risk reduction (SFDRR)** was adopted. With an overall goal of reducing disaster risks and strengthening resilience, the framework presents four priority actions to achieve the objective – understanding disaster risk, strengthening disaster risk governance to manage disaster risk, investing in DRR for resilience, and enhancing disaster preparedness for effective response to 'Build Back Better' in recovery, rehabilitation and reconstruction. The seven targets of SFDRR spell out the specifics – substantially reduce mortality, number of affected people, direct economic losses, disaster damage to critical infrastructure, disruption of basic services such as health and educational facilities, increase country capacity of planning for DRR, increase the availability of and access to multi-hazard early warning systems and disaster risk information and assessments of people, and enhance international cooperation to developing countries. The framework includes some aspects of SRH, such as, "access to basic healthcare services, including maternal, new-born and child health, and sexual and reproductive health…" under the third priority for action of investing in disaster reduction for resilience.[96] Because the framework is non-binding, the failure and success of the agenda rests solely on the political commitments of the country and the ability of the citizens and the international community to pressure them into action.

**The Paris Declaration** on climate change, ratified by 153 countries, states "…that climate change is a common concern of humankind. Parties should, when taking action to address climate change, respect, promote and consider their respective obligations on human rights, the right to health, the rights of indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations and the right to development, as well as gender equality, empowerment of women and intergenerational equity."[97] While SRHR is not specifically mentioned, a rights framework presents an entry point to address SRHR issues in climate change.

The outcome document of the **Third International Conference on Financing for Development, the Addis Ababa Action Agenda**, acknowledges disasters as a challenge to sustainable development and promises to "develop and implement holistic disaster risk management at all levels in line with the Sendai Framework." Specifically, it commits to invest in national and local strategies towards DRR. Similarly, it also avows to strengthen systems to achieve universal health coverage.[98]

The timing that allows a confluence of these goals present immense opportunities for addressing the issues of poverty, hunger and inequalities, among others, in an interconnected manner; and to integrate SRHR into the fabric of the planning and implementation of these processes. In addition, with limited funding available for women's SRHR, a holistic approach in addressing the issues is rational, effective and cost-beneficial.

# VIII. ACTIONS FOR INTEGRATING SRHR INTO DRR

Increasing women's meaningful participation in DRR and resilience building, integrating gender equality and women's empowerment, and promoting women's leadership roles are key issues in the development and DRR discourse these days. Efforts of women's organisations have been commendable but progress has been slow because of the many challenges they face. The questions then are — can women be empowered without fully being able to exercise their bodily rights? Are we still addressing only women's practical needs or are strategic gender needs being achieved? Can women think of empowerment only after they have fulfilled their reproductive duty to society, or can an adolescent or unmarried young woman consider empowerment? The answer perhaps already lies somewhere in these questions.

**If women are to fully participate shoulder to shoulder with men, as is the desire, then we need to be open to talk and write about SRR, including in discourses around disasters and climate change; and then to address the challenges of heteronormativity.**

While organisations advocate gender equality and women's empowerment, they seldom directly refer to the very root cause of these disadvantages, i.e., the lack of sexual and reproductive choices, and the rights of women of all ages to make them. The many choices women make in life — education, career and others — are based on the very foundation of their SRHR. Therefore if women are to fully participate shoulder to shoulder with men, as is the desire, then we need to be open to talk and write about SRR, and then to address the challenges of heteronormativity. There need to be more open conversations about it, including in discourses around disasters and climate change.

While endorsing and reaffirming all the recommendations made by gender and DRR scholars and practitioners elsewhere, on gender-sensitive approaches to disaster management, recognising women's capacities, promoting women's leadership, gender equality and women's empowerment and addressing discriminations, specific recommendations for integrating SRHR in DRR, to reduce disaster risks and to achieve gender equality and women's empowerment, are presented below.

## STRENGTHEN PUBLIC HEALTH SYSTEM'S RESILIENCE TO DISASTERS

The role of the health sector is perhaps the most vital, especially in the initial period after disasters, to save lives and reduce morbidities. It also plays a significant role in averting emergencies, especially those related to health. However, the health systems of most countries in this region are neither fully equipped to address the post-disaster nor pre-disaster health needs of its population. The health systems need to better target their response to the local needs of the people based on their specific vulnerabilities by factoring the hazards, disease and demographic profiles to reduce disaster risks, without compromising the delivery of essential SRH care and services.

**Specific actions:**

- Include SRH as an essential component of primary health
- Expand and improve the quality of the primary healthcare services
- Pursue the goal of universal access to SRH and coverage, by removing all supply side barriers to access such as costs, strengthening existing vital health facilities and ensuring that the new facilities are built to a highest standard possible factoring in all—hazards, ensure gender-sensitive healthcare provision, build and maintain cadre of healthcare providers proportionate to the population, improve supply—

chain of medicines, contraceptive and other products especially reproductive health commodities
- In addressing the financial burden and OOP expenditure, governments need to make a sincere effort to increase their expenditure on healthcare, and not let privatisation take over the delivery of essential SRH services
- Health systems need to be gender-sensitive and non-discriminatory to respond to the special needs of young girls, survivors of violence, women living with HIV and AIDS, sex-workers, and people with diverse sexual orientation and gender identities. Therefore, health personnel need to set aside personal religious and cultural beliefs when they deliver healthcare to all

### Box 2: Universal Access to SRH

Universal access to SRH is the equal ability of all persons according to their need to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity to – decide freely how many and when to have children and to delay or to prevent pregnancy; conceive, deliver safely, and raise healthy children, and manage problems of infertility; prevent, treat and manage reproductive tract infections and STIs including HIV/AIDS, and other reproductive tract morbidities, such as cancer; and enjoy a healthy, safe and satisfying sexual relationship that contributes to the enhancement of life and personal relations.

*Source: Adapted from World Health Organization, "National-level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and Practical Considerations and Related Indicators," Report of a WHO/ UNFPA Technical Consultation, 13–15 March 2007, Geneva. (WHO, 2008), accessed May 10, 2017, http://apps.who.int/iris/bitstream/10665/43920/ 1/9789241596831_eng.pdf.*

## IMPROVE DISASTER RISK GOVERNANCE

Good governance is a prerequisite in reducing risks and averting the creation of new ones. For instance, ending poverty and hunger and attaining sustainable development will require governments to make changes in their economic policies that continue to follow a neoliberal paradigm. These policies have proved to be unsustainable and unjust leading to poor development outcome for all. It has also created new risks in terms of climate change, food crises, inequalities and weak health systems that are unable to meet the needs of all. Development and DRR policies need to be rights-based and must recognise and safeguard the rights of all, especially those whose rights are at-risk — young people, people with different SOGIE, single women, sex-workers, persons with disabilities, women from ethnic groups and migrant women, among others.

**Specific actions:**
- Initiate legal reforms to remove discriminatory laws based on sexuality; institutionalised violence by the police and health providers, among others; laws that restrict access to safe abortion services, especially for young people
- Revise DRR laws, plans and policies to ensure that no person is excluded in any phase of disaster management, especially the historically marginalised groups such as sexual minorities
- Governments need to assume more responsibility towards all its citizens ensuring that the human rights of all are upheld at all times. Therefore, good governance and justice should be held above cultural and religious sentiments that tend to erode the rights of individuals
- SRHR needs to be built into the multi-sectoral plans and policies of countries. Only by having it written down, will it be officially considered, and the chances of its disappearance will be minimised
- Regular gender-focused monitoring and reporting mechanisms need to be in place to ensure governments are held accountable, and that the human rights of women are promoted and protected. These could be integrated in existing reporting mechanisms

## DEVELOP CAPACITIES OF GRASSROOTS WOMEN AND WOMEN'S ORGANISATIONS

Disasters are context-specific and therefore a clear understanding of the localised context of risks, including hazards, vulnerability, exposure of population and assets, and the capacity in terms of knowledge, skills, and resources available to anticipate, cope with and recover from disasters, is essential. Communities are first-responders in any disaster and therefore their capacity to understand, recognise the different risks, heed to warnings and take necessary actions is critical in saving lives, livelihoods and assets. Women have a critical role to play in both mitigating the impact of disasters and responding to crises. Grassroots organisations, especially women's organisations, are better equipped to understand the risk context, the SRHR status and the political and community dynamics. Therefore, their capacities need to be strengthened to reduce vulnerabilities and exposure to risks.

**Specific actions:**

- SRHR concepts and issues need to be included in DRR awareness and training curriculum and vice versa, to address the gaps in understanding of SRHR issues among DRR practitioners, SRHR groups and people in general
- Gender trainings need to potentially create awareness about gender inequalities, challenge gender norms and put women's practical and strategic needs, and their interconnectedness, in perspective. It should thus address the demand side barriers such as lack of access to SRHR information, stigma, discrimination and marginalisations, especially those related to people's sexual choices, and women's sexual and reproductive roles, and restrictions on mobility, that are essential to achieving equity in access to healthcare and women's empowerment. Addressing these issues will enable women and many disenfranchised people to exercise their agency
- DRR training modules should mandatorily address matters related to sexuality, emphasising on affirmative views of sexuality and sexual rights, SRH, gender relations and stereotypes. Further, they should familiarise women on MISP, emergency kits, and other SRHR services post-disasters. Knowledge of the response will help to provide inputs to customise the kits and services to the needs of the local women, and additionally it will help them in recognising the shortfalls in the response and thereafter demand better services
- Local women's organisations and self-help groups need to be fully engaged and linked to state and local government bodies dealing with DRR and development. Such coordination will help women in voicing their concerns, including their SRH concerns, make them visible and enable them to be equal partners in the decision-making processes

## MAKING SRHR A COMPONENT OF DRR INVESTMENTS

While governments and donors have committed to sustainable development, DRR and CCA, and SRHR is integrated into the agenda, to operationalise the plan, investment in SRHR is critical within DRR and disaster management. Specifically,

- Invest in and ensure sustainability of SRHR services and address the gap in overseas development funding in SRHR in addition to increasing government health, particularly SRH expenditure
- Invest in grassroots women's and civil society organisations to ensure sustainability of delivery of SRHR services
- Continued support of regional and international work in SRHR to ensure the momentum around research, monitoring and advocacy on SRHR for all is maintained

## ADDRESS THE RESEARCH GAPS IN GENDER, DRR AND SRHR

As has been said before there is very little research on gender and DRR that looks at SRHR, even when much of the research on gender focuses on women. There is a need therefore to fill the gaps in research to inform policy making and implementation.

**Specific actions:**

- Develop disaggregated data on age, gender, sex and disability, to assess the SRH related requirements in a realistic manner, for prepositioning and ongoing disaster response and risk reduction strategies
- Studies on gender and DRR need to go beyond the binaries and look at the experience of the sexual minorities before and after the disasters. A more nuanced understanding to the specific needs, vulnerabilities, capacities and contributions of the marginalised groups is needed to showcase the diversity and fluidity in sexuality and to break stereotypical norms
- Solidarity across movements is necessary to ensure the goals of sustainable development are achieved. Therefore, inter- and intra-movement alliances need to be built, through research, advocacy and information sharing

### INTEGRATE SRHR IN DISASTER MANAGEMENT AND PREPAREDNESS PLANNING

Preparedness to manage residual risk and disasters is necessary.

- Planning for disasters must include the participation of women, and their vital knowledge and skills in community mobilisation must be utilised
- Women must be made part of the warning of risks and evacuation procedures
- Essential medicines, reproductive and emergency health kits need to be stockpiled and prepositioned in strategic locations
- Health teams need to be trained in responding to the specific health needs of all women, girls and sexual minorities in disasters
- Women need to be involved in all post-disaster response and recovery, such as in building-back better. All these require financial support, human resource and technical inputs, and women must be equal recipients of these inputs.

## IX. CONCLUSION: FROM RHETORIC TO ACTION

A paradigm shift from disaster management to risk reduction offers opportunities for looking at women and marginalised groups, especially sexual minorities, beyond their vulnerabilities, as agents of change. To achieve the vision of social transformation, there is a need to put the commitments of sustainable development, universal access to SRH, DRR and climate change mitigation and adaptation, to action through strong political will.

DRR demands inclusive development, which necessitates meeting the needs and upholding the rights of all women and sexual minorities, which includes their right to SRH. Bodily autonomy is a basic human right and when women are free to make critical life choices they become truly empowered. A rights-perspective enables women, as rights holders, to demand accountability from governments who have the primary responsibility to roll-out the comprehensive agenda for sustainable development. When rights of all people are upheld before a disaster event, the chances of the rights being violated after, and during, disasters is minimised.

Finally, the spirit should be of collaboration and not competition amongst the above-mentioned agendas, especially in funding and implementation. Donors have a strong role to play in ensuring integration of implementation through joint/collaborative funding, monitoring and implementation. If the foundation of human development is expanding human opportunities and freedom, it is unlikely to be attained without achieving SRHR for all.

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ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, engagement, advocacy, and mobilisation.

ARROW envisions an equal, just and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

This publication is a three-part series publication on climate change and women, namely (i) climate change and women's health, (ii) climate change and women's sexual and reproductive rights, and (iii) women in the face of disasters. This publication is produced as part of ARROW's project on "Building New Constituencies for Women's Sexual and Reproductive Health and Rights (SRHR): Working with Rights-based Climate Change/Environment Groups and Faith-based Groups to Build Momentum for SRHR in the Lead-Up to the New Development Framework." One of the objectives of the project is to generate evidence for interlinkages in climate change and SRHR issues/solutions in the Asian region beyond the current discourse of population dynamics and to identify areas of policy and programme interventions in climate change adaptation and advocacy work specifically related to improving women's health, including SRHR. Eight partners from eight countries in Asia were involved in this project, namely, Khan Foundation (Bangladesh), Yayasan Jurnal Perempuan (Indonesia), University Health Sciences (Lao PDR), Penita Initiative (Malaysia), Huvadhoo Aid (Maldives), Women's Rehabilitation Centre (WOREC) (Nepal), Sindh Community Foundation (Pakistan), and PATH Foundation (Philippines).

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**Asian-Pacific Resource & Research Centre for Women (ARROW)**
1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

| | |
|---|---|
| **Telephone** | (603) 2273 9913/9914/9915 |
| **Fax** | (603) 2273 9916 |
| **E-mail** | arrow@arrow.org.my |
| **Web** | www.arrow.org.my |
| **Facebook** | https://www.facebook.com/ARROW.Women |
| **Twitter** | @ARROW_Women |
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