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Women's, Gender and Rights Perspectives in Health Policies and Programmes

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Feminist and Rights-based Perspectives:
Sexual and Reproductive Health and Rights in Disaster Contexts

Photo courtesy of BBC World Service

A family amidst the rubble after a cyclone in Bangladesh. At such times, gender and SRHR issues matter more than ever.

The Asia-Pacific is one of the most disaster-prone regions in the world. According to the *World Disaster Report 2009*, 40.5% of global disasters between 1999 and 2008 occurred in Asia, and 84.5% of those affected during the same period lived in the region. While comparative statistics for the Pacific is low given these island nation's smaller sizes,[1] their fragile economies and other factors make them vulnerable to the impact of disasters. Most are also vulnerable to rising impacts of climate change. Given the scale of disasters in the Asia-Pacific region, it is extremely crucial that governments and other actors respect, promote and fulfil the sexual and reproductive health and rights (SRHR) of women, adolescents and people of diverse gender and sexual identities in disaster risk reduction, response and recovery (*see* Definitions, p.11).

There have been endeavours to address some aspects of SRHR in disasters within global agreements and standards. The 1994 International Conference on Population and Development (ICPD) recognised the importance of addressing reproductive health (RH) in disasters by calling for governments and donors to address "basic health care needs, including [RH] services and family planning," of internally displaced persons due to conflicts and disasters. The *Inter-agency Field Manual on Reproductive Health in Humanitarian Emergencies*,[2] which includes the Minimum Initial Service Package (MISP) of priority RH activities in the first three months of new emergencies and comprehensive RH services as the situation stabilises,[3] has had some success in placing RH in the disaster response and recovery agenda. In addition to the MISP in RH, there is also an inter-agency emergency health kit, inter-agency guidelines for HIV/AIDS interventions in emergency settings, and inter-agency guidelines on addressing gender-based violence (GBV) in emergency settings (*see* Resources, pp.8-9).

At the national level, a review of legal frameworks on disaster of six Asia-Pacific countries (Bangladesh, Fiji, Indonesia, Pakistan, the Philippines and Papua New Guinea; see Factfile, p.12) reveals that four refer to targeting women in disaster response (Bangladesh, Indonesia, Pakistan and the Philippines), two to promoting non-discrimination against women (Indonesia and Pakistan), and one to addressing special needs of pregnant and lactating women (Indonesia). Some governments have done well in providing some aspects of SRH services post-disaster. For example, the Government of China prioritised restoration of family planning, maternal health and HIV/AIDS services post-2008 earthquake, as well as promoting 'supportive family planning services' for families who lost their children (*see* pp.4-5). However, it is the government's draconian one-child policy that led in the first place to the huge demand for services to restore fertility post-disaster.

While these government initiatives are laudable, they fall short of addressing the SRHR needs, interests and rights of women, adolescents and people of diverse gender and sexual identities in disaster contexts from a 'rights-based and feminist perspective' (*see* Definitions, p.11).[4] National legal framework and plans on disaster risk reduction, response and recovery are often couched in the language of needs of 'vulnerable' women and people affected by disasters, and not as holders of 'rights' and agents of change who have resilience even in disaster situations. Moreover, laws and plans often do not recognise the needs and rights of unmarried adolescents (and women) and of people who are not heterosexual. Most do not emphasise promoting the leadership of these groups in disaster risk reduction, response and recovery committees. Government initiatives often do not uphold the MISP in RH in Emergencies, which itself requires strengthening (*see* p.11).

But one may ask why is addressing SRHR of women, adolescents and people of diverse gender and sexual identities in disaster risk reduction, response and recovery important in the first place? There are at least three reasons, with the first two being closely related:

• *Ignoring SRHR in disasters violates human rights:* Lack of access of adolescent girls and women to services and counselling for sudden stoppage of menstruation, miscarriages, premature delivery, post-partum haemorrhage or breast engorgement (when infants who are being breast-fed die) in the aftermath of disasters is a violation of their right to non-discrimination in health under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as these are sex-specific health needs affecting only females. Such violations have been observed in Fiji post-2008 floods, in India post-2004 tsunami and in Myanmar post-2008 cyclone. Not having a separate toilet or bathing space for transgendered and inter-sexed people in temporary shelters post-2004 tsunami in Tamil Nadu, India (or of non-sex designated toilets elsewhere, where appropriate) violated their right to adequate standards of living under Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and exposed them to discrimination and harassment as well as urinary tract infections (since they suppress the urge to defecate and urinate.) Absence of measures to protect adolescents girls in India and Indonesia against early marriage post-2004 tsunami, due to lack of safety in temporary shelters and well-meaning government policies which backfired (*see* Spotlight, p.3), is a violation of Article 24 of the Child Rights Convention on protecting children from sexual exploitation and abuse.

• *Ignoring SRHR in disasters violates the right to the highest attainable standard of health (General Comment 2000 to ICESCR):* Toilets in slums of Dhaka, Bangladesh were not flood-proof. As a result, in 2000, flood waters mixed with faecal matter, causing reproductive and urinary tract infections in women and adolescent girls. In Sri Lanka, there were occasional cases of women and adolescent girls being subject to sexual violence by rescue workers. This not only violated their right to bodily integrity, but also exposed them to STIs, unwanted pregnancies and unsafe abortions (since abortion is only permitted to save the woman's life). In China, ante-retroviral services were temporarily disrupted after the 2008 earthquake. Given that the incidence of HIV was higher amongst gays, they were particularly vulnerable to secondary infections.

• *Incorporating SRHR in disaster risk reduction, response and recovery leads to greater efficiency and effectivity:* Making health and maternal and child health facilities disaster-proof and training healthcare providers (including midwives and community health workers) on disaster preparedness is central for effective disaster risk-reduction. There would have been a human-made disaster if safe delivery care and emergency obstetric services were not made available in Fiji, Myanmar and the Solomons Islands (*see* p.6-7). In Pakistan, fear of violence was a deterrent to single women standing in lines to access food relief post-2005 earthquake. In the same country and context, widowed pregnant women's access to safe abortion services contributed to their recovery, as was the case with a 28-year pregnant woman who already had six children and whose husband died in the earthquake. Further, SRH has a close relationship with the ability to resume livelihoods, which is central to the recovery process.

Disasters in the region have had an adverse impact on the SRHR of women, adolescents and people of diverse gender and sexual identities. Particularly affected are those who are landless and living as marginalised castes, ethnic groups and religious minorities, migrants, conflict-affected and displaced, living with HIV and with disabilities, and working in marginal occupations. They are affected not only because their rights are sidelined in disaster risk reduction, response and recovery but also as a result of their marginalisation in the whole development process. The extent and form of detrimental impact on SRHR varies with pre-existing gender and social relations, legislation, policies and services. It also varies with the level of attention to SRHR and social determinants in disaster legislation and policies and the nature and outcome of the disaster itself. Much more needs to be done to improve integration of SRHR in disaster risk reduction, response and recovery plans of government, UN and INGOs. Failing which, human rights in general and rights to health in particular would be violated, and importantly disaster risk reduction, response and recovery strategies would fail.

In the long run, there is a need for a UN international human rights instrument on protection and rights of people at risk of and affected by disasters and a monitoring body which can hold governments accountable and to which civil society can report violations. In the short run, it is recommended that SRHR of women, adolescents and people of diverse gender and sexual identities are integrated into the Hyogo Framework of Action (2000-2015), which deals with disaster risk reduction. In addition, minimum standards in emergencies should be revamped to include a broader range of SRHR concerns in dialogue with rights-holders (*see* p.11). There is also a need to integrate SRHR into disaster laws and plans of governments, as well as to build the institutional capacity of governments, INGOs, NGOs and UN agencies to implement SRHR-aware and rights-based disaster plans and programmes. Beyond these, however, these actors need to be held accountable in genuinely implementing international agreements, guidelines, and national and local legislations and translating these to programmes and services that change ground realities and improve lives of women, adolescents and people of diverse gender and sexual identities. There is a need for activists and organisations to come together and continuously demand for a voice in critical decisionmaking activities, including in international meetings and in disaster risk reduction, response and recovery. Similarly, a platform to link survivors of disasters within and across countries needs to be created so that they can learn from each other and articulate a feminist and rights-based perspective to SRHR in disasters from bottom to top!

Endnotes

1 *2.3% of disasters from 1999 to 2008 occurred in the Pacific, and 0.03% of those affected were from this region. International Federation of Red Cross and Red Crescent Societies. 2009. World Disaster Report 2009. Switzerland.*

2 *Formerly Inter-Agency Field Manual on Reproductive Health in Refugee Settings. This manual was originally developed by the Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG) in 1996 and is currently being revised.*

3 *The 10 RH sub-kits to be available as part of the 'minimum' RH services are kits for condom (male and female), blood transfusion, post-rape, delivery (individual and health facility), management of complications of abortion, suture of tears and vaginal examination, and vacuum extraction for delivery, as well as administrative and referral level kits for RH. The three kits to be part of 'comprehensive' RH are the IUD, oral and injectable contraception and STI kits.*

4 *There is little critique in international guidelines on SRHR and disasters, as well as national disaster legislation and plans, of 'whether 'natural' disasters are entirely natural or partly/wholly a result of development models which are based on exploitation of natural resources. A study by Law Trust in Tamil Nadu, India notes that the coastal areas of Tamil Nadu where mangroves and sand dunes were not destroyed were less affected by the 2004 tsunami than areas where they were destroyed. (Arunachalam, et al. 2007. "Impact on tsunami on coastal ecology and coastal communities." Nagapattinam, Tamil Nadu: Law Trust.) Climate change brought about by human-made damage to environment also leads to the so-called 'natural' disasters.*

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Indian Grassroots Women Create Sustainable Change in Post-Tsunami Health Service Provision

The December 2004 Indian Ocean tsunami took away the lives of 12,000 people, displaced 650,000 and injured over 5,000 in Tamil Nadu, India.[1] It destroyed housing, sources of livelihood, schools, primary health care centres, drinking water supply systems and other community assets.

In the aftermath of the tsunami, Swayam Shikshan Prayog (SSP, "Self-Education for Empowerment" in Hindi)[2] engaged tsunami-affected communities in Tamil Nadu, especially grassroots women, to rebuild their communities and to address their specific needs in the health sector. Drawing on their experience following destructive earthquakes in the states of Maharashtra (1993) and Gujarat (2001), SSP convened a team of grassroots women leaders from these states to mobilise women in tsunami-affected villages of Tamil Nadu.[3] Realising that women's self-help groups (SHGs) were not formally recognised as key actors in post-disaster relief and rehabilitation, SSP partnered with local women leaders to assess whether relief processes were responsive to their needs.

The participatory assessment found that temporary shelters were insufficient due to excessive heat, the spread of contagious diseases and the lack of proper sanitary facilities, including toilets. Shelters proved particularly problematic for women (especially pregnant and nursing women), who lacked privacy and stayed at home while their husbands were seeking employment. As family caregivers, women also reported facing a higher level of post-disaster stress and trauma than men. Pregnant women were particularly vulnerable; inadequate nutrition and health services resulted in higher levels of anaemia and miscarriages. Government emergency health services at the village level effectively limited the spread of diseases but often only offered general health care, and did not serve women's unique health needs (e.g., gynaecological care). Women also often felt embarrassed to use government health services in the village due to lack of privacy and appropriate check-up facilities. Compounding this, from May 2005 onwards, these services were gradually withdrawn, as the 'emergency' period was coming to an end. Consequentially, women expressed the need to bring government health services closer to the needs of communities, particularly grassroots women.[4]

SSP responded by facilitating the creation of women-led local health governance groups (HGGs), called ASHAA, through mobilising women as health volunteers.[5] ASHAA approached the issue from two angles: driving grassroots demand for better health and health services and collaborating with health service providers in improving service quality and delivery. Within one year, 41 of the 80 worst tsunami-affected communities in two districts of Tamil Nadu[6] had formed HGGs, which are now federated. Reaching beyond the federation's 800 women leaders to all SHG members and larger communities, these groups have been running a community health fund since 2007; collaborating with government primary health centres (PHCs) and hospitals to organise health awareness talks and village-level health camps;[7] providing referral services; growing and distributing herbal medicines; and linking community members to PHCs, village health nurses, hospitals and government services. They also contribute to formal decisionmaking and planning arenas with PHCs through weekly planning meetings.

Aside from community health issues like seasonal illness and sanitation, ASHAA addresses women's unique health needs. They raise awareness on women's and girl's sexual and reproductive health (SRH), address other critical health issues (such as anaemia) and hold SRH camps where women and girls can undergo examinations and be referred for specialised care. Groups also educate pregnant women on maternal health and encourage accessing pre- and post-natal health care. Additionally, ASHAA leaders are trained to counsel those suffering from post-disaster trauma. The groups are also a platform to collectively address women's issues. For example, by working with its village government to close liquor businesses in the area, an ASHAA group from a village in Nagapattinam district addressed a post-tsunami increase of domestic violence against women in its community, which the group identified as indirectly caused by loss of livelihoods and which in turn they associated with increased alcohol consumption by men.

ASHAA's impact is well-recognised by communities, local authorities and service providers. Women now demand more knowledge and better services and ask critical health-related questions, including those associated with SRH. HGGs address demands for better health by collaborating with PHCs and government, thus increasing their accountability. As a result, communities increasingly use public over private health services, thereby decreasing health expenditures.[8] In the long term, by addressing critical vulnerabilities of disaster-prone communities, HGGs have strengthened community disaster resilience.

Endnotes

1 *Burnad, Fatima. "The tsunami exacerbates Dalit women's sufferings from caste discrimination." www.aprwld.org/tsunami_dalitwomen.htm*

2 *SSP is a learning and development organisation based in Mumbai which has over 15 years of experience in mobilising women from disaster-prone communities to sustainably rebuild their lives and transform disaster recovery processes into development opportunities. Founded in 1989 by Prema Gopalan and registered as a society in 1998, SSP's operations in 10 of the most disaster-prone districts of Maharashtra, Gujarat and Tamil Nadu reach out to over 300,000 families.*

3 *The villages where the initial assessments took place were: Keelamoovarkarai, Poombukar, Koniyampattinam, Puthukkuppam, Madathukkuppam, Naickerkuppam, Melamoovarkarai, Servadikkuppam, Vanagiri, Sonankuppam, Singarathoppu, Akkarai gori, Sothikuppam, Rasapettai, Samiyarpettai, Pudukuppam, Indra Nagar, Pudupettai. The assessment began in January 2005 and refers to a process that took place over a series of peer exchanges that would be held throughout the year in order to encourage a process of grassroots sharing of expertise and capacity building.*

4 *It was also found over the year that there was an increase in incidence of child marriage in some of the villages. This was attributed in part to a well-meaning government policy which provided monetary support to engaged couples for the completion of their marriage (as many had lost all their assets and income during the tsunami), as well as due to reconstruction efforts funded by NGOs and government which intended to give each individual family a new home. This ended up being a misplaced incentive that encouraged some families to marry their girl children early.*

5 *'ASHA' literally means hope in several Indian languages. The acronym ASHAA stands for 'Arogya Sakhis ["Health Friends" or loosely interpreted as "Health Guide"] for Health Awareness and Action."*

6 *Cuddalore and Nagapattinam districts of Tamil Nadu, two of the three worst tsunami-affected districts of the state.*

7 *Today the health department and primary health centres have begun holding village health camps regularly (typically 10 to 20 on a monthly basis), with the promotion and assistance of HGGs who mobilise between 40 to 80 people to turn up for each village check up. HGGs are also promoting and helping communities to access special health camps through a state preventative health program called Varumom Kappom Thittam wherein HGGs help to mobilise over 200 community members from four to five villages to attend each camp (one per group of villages per year). In the past one year, HGGs have independently organised over 30 health check-up camps in both districts and have also co-organised over 25 specialist health camps for those requiring further treatment in collaboration with PHCs and a local, well-recognised private medical institute.*

8 *ASHAA members have remarked that their health expenditures have decreased significantly (by approximately 72%) since joining the group.*

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SPOTLIGHT

The Wenchuan Earthquake and Government Policies:

Impact on Pregnancy Rates, Complications and Outcomes

Photo courtesy of authors

Women and children post-earthquake, Mianzhu County, Sichuan Province

Background. On 12 May 2008, an earthquake measuring 8 on the Richter scale struck Wenchuan County, Sichuan Province, China. The earthquake had adverse impacts on 51 counties in Sichuan, Shaanxi, and Gansu Provinces. As of 25 April 2009, 69,225 people had died, 374,640 people were injured, and 17,939 people were missing.[1] China's health infrastructure also suffered from the earthquake. Maternal and child healthcare (MCH) hospitals and clinics at province, city, townships and county levels, which also provided reproductive health (RH) and sex education for couples and women,[2] were partially/fully damaged. For example, in Mianyang City, which covers nine counties, 13% of MCH buildings collapsed while 46% needed to be dismantled. Moreover,409 out of 2,287 medical equipment were damaged, and of 456 MCH workers, 12 were injured while five died.[3] Family planning clinics and contraceptive infrastructure and services were also adversely affected. Public provision of anti-retroviral services for people living with HIV was disrupted in the earthquake-affected areas.[4]

The study. This article focuses on the findings of a study by the authors on the impact of the 2008 earthquake on pregnancy rates,[5] pregnancy-related complications and on pregnancy outcomes in Mianzhu County and Mianyang City of Sichuan province. The study was carried out eight to 10 months after the earthquake. The findings have to be located in the context of reproductive health indicators and policies before the earthquake, which are outlined in Box 1. The study covered 1,323 women, of whom 607 had delivered before the earthquake (the comparison group) and 716 had delivered after the earthquake (the research group). In the research group, 61% were less than 12 weeks pregnant at the time of the earthquake, 8% were more than 12 weeks pregnant at the time of the earthquake, 21% became pregnant during the first 12 weeks after the earthquake, and 10% became pregnant more than 12 weeks after the earthquake. The study explored the impact of the earthquake on pregnancy rate, pregnancy complications and pregnancy outcomes. The pregnancy complications included acute appendicitis, acute viral hepatitis, anemia, diabetes associated with pregnancy, heart disease, hyperthyroidism, phthisic,[6] pre-eclampsia, pregnancy with kidney disease, sexually transmitted infections and others.

Findings. The findings of the study are as follows:

- The pregnancy rate increased 12 weeks after the earthquake. During the first 12 weeks after the earthquake, the pregnancy rate declined, and was lowest between 4 to 11 weeks. It then began to resume after 12 weeks. The pregnancy rate among over 35 year old women rose quickly after 12 weeks. This may be due to the government's 'supportive family planning policy,'[7] which will be detailed later.
- Pregnancy complications were higher amongst those women who were pregnant at the time of the earthquake. The incidence of pregnancy complications (including anaemia, diabetes, heart disease, nephropathy, hepatitis and others) was

14.6% amongst the members of the control group and slightly higher at 18.6% amongst the women in the research group. This difference was not statistically significant. However, the difference in incidence of pregnancy complications (22.06%) between the women who got pregnant before the earthquake was significantly more than those who got pregnant after the earthquake (10.6%).

- A slight, but not statistically significant, increase in newborn babies with malformations was noted after the earthquake. Newborn malformation incidence was 1.2% before the earthquake and 2.1% after.

The trauma over loss of life, assets and livelihood, as well as less space for intimacy in tents, may explain the interruption in the pregnancy rate in the first 12 weeks after the earthquake. The increase in pregnancy rate after 12 weeks can be attributed to several factors. The Chinese government's relief policy ensured that most victims settled in temporary habitation (with greater privacy than tents) and started resuming some of their normal activities. The government's 'supportive family planning policy'[7] post-earthquake, which came into effect on 25 July 2008, also had a role to play in increasing the pregnancy rate. Couples whose legal child/children died or were injured to the extent they could not work; and wherein one of the spouses had died and the other had remarried and the new family had less than three children in total, were eligible for supportive family planning and re-fertility services. As soon as the policy came into effect, many women came forward to have another child. In fact, 80% of the women who lost their child/children accessed services in the areas visited by the team.

The fact that pregnancy-related complications were higher amongst the women who were pregnant at the time of the earthquake (in particular, the first trimester) when compared to those who became pregnant after the earthquake supports evidence from other countries about the association between abdominal injury and psychological stress in the first trimester and pregnancy outcomes.[8,9]

The impact of the earthquake on reproductive choices and pregnancy rate post-earthquake are shaped by 'supportive family planning' policies introduced by government post-earthquake, rehabilitation policies in other sectors (example, shelter which gives privacy), and perhaps the length of time post-earthquake (which is a healing factor for psychological stress). Pre-existing population policies may also have a role to play, as there may have been a lesser increase in pregnancy rates if the family size was larger.

Recommendations. The study highlights the importance of services and policies that are affirming, that respond to the reproductive needs and rights of women, and contribute to their recovery (e.g., policies and programmes that enable making informed choices with regards to reproduction, including for contraceptive and re-fertility services; continued provision of anti-retrovirals; protecting women from gender-based violence). It also points to the need for emergency obstetric care and maternal healthcare services, as well as psychosocial care, in times of disaster. While the study was not able to go to the details of variables such as age, class, ethnicity, disability, location, sexual orientation, socioeconomic status and others, it should be noted that access to health and psycho-social services should be made available to all women, regardless of the groups they belong to. Further research are needed to assess women's needs and rights related to sexual and reproductive health and rights in disasters contexts (including gender-based violence, miscarriage and abortion, adolescent sexuality, and others), particularly considering the variables mentioned above. It is hoped that the government will set up a research fund to support these studies. It is also critical that disaster risk reduction strategies are put in place, such as ensuring that health infrastructures are quickly restored and made disaster-proof. All these need to be considered in earthquake restoration and reconstruction plans, as well as in amending the China's Earthquake Law of 1997.

Endnotes

1 *"Wenchuan Earthquake." http://baike.baidu.com/view/1587399.htm#1 Note that sex disaggregated data on fatalities was not available.*

2 *"The responsibility of maternity and child healthcare (MCH) hospitals." www.37c.com.cn/literature/literature06/manage03.asp?filename=023/02/0230203.htm*

3 *Fang Chen. 2009. "The investigation of women and children's health post 5.12 Wenchuan earthquake in Mianyang, Internal Meeting Report, 2009.4."*

4 *United Nations HIV Emergency Task Team. 2008, August 6. Newsletter. Volume 3.*

5 *Pregnancy rate refers to the ratio of the number of conceptions including live-birth, still birth, foetal losses, to the mean number of females of reproductive age in population during a set time period (http://medical.webends.com/kw/Pregnancy%20Rate).*

6 *A disease characterised by wasting of a part or all of the body, including tuberculosis (www.thefreedictionary.com/phthisis).*

7 *Standing Committee of Sichuan People's Congress Decision about supportive family planning policy to the families whose children were maimed or lost in Wenchuan earthquake disaster. www.sc.gov.cn/zwgk/ffjg/dffg/200809/t20080917_360687.shtml*

8 *Glynn, L.M. et al. 2001. "When stress happens matters: Effects of earthquake timing on stress responsivity in pregnancy." American Journal of Obstet Gynecol. pp.637–642.*

9 *Hseu-Ling Chang et al. 2002. "Psychiatric morbidity and pregnancy outcomes in a disaster area of Taiwan 921 earthquake." Psychiatry and Clinical Neurosciences. Vol. 56, pp. 139–144.*

10 *UNFPA. 2008. The Status of the World Population 2008. New York.*

11 *Department of Population and Employment Statistics National Bureau of Statistics of China. 2008.China Population & Employment Statistics Yearbook 2008. Beijing:China Statistics Press.*

Box 1: Demographic and maternal health indicators before the 2008 earthquake

China has had a one-child policy norm since 1979, which has been critiqued by women's and human rights groups as coercive. As per the *Status of the World Population Report 2008*, the total fertility rate per woman was 1.73 and the contraceptive prevalence rate (modern methods) was 86%.[10] The same report notes that maternal mortality ratio in China was 45 and that 98% of deliveries were conducted with skilled birth attendance.[10] According to the *National Family Planning Demographic Statistics of 2007*, IUD had become the main method of contraception in China, accounting for 52.3% of the contraceptive methods, followed by sterilisation with 38.3%.[11]

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Regional

The *Public Health in Complex Emergencies* training programme (PHCE) is a two-week residential course that aims to enhance the capacity of humanitarian assistance workers and their organisations to respond to the health needs of internally displaced persons and refugees affected by complex emergencies. The Reproductive Health (RH) module, specifically, describes the rationale for providing RH services to affected populations as an essential component of the emergency response, including the provision of the Minimum Initial Service Package in RH in emergency settings. The module also identifies effective RH programme strategies to be used in stable settings, including sessions on the following: safe motherhood (including emergency obstetric care), sexual and gender-based violence, prevention and care of STIs/HIV and family planning. The module also helps participants assess the gaps in RH services and collect, analyse and present RH data to guide programmatic decisions. In addition, the Communicable Diseases module of the course focuses on the epidemiology, risk factors specific to emergency settings and issues on surveillance and assessment of HIV and AIDS.

PHCE courses for 2009 was offered in Bangkok, Thailand on 6-18 July by the Asian Disaster Preparedness Center (ADPC) and will be conducted in Kampala, Uganda by Makerere University on 2-14 November. Details of the application procedures can be accessed at www.phcetraining.org

Source: Janette Lauza-Ugsang, ADPC, Thailand. Email: janette@adpc.net

Bangladesh

Bangladesh is considered to be one of most vulnerable countries to natural disasters and climate change impacts by the International Panel Committee on Climate Change (IPCCC). Increased salinity of water as sea level rises, changes in inter-seasonal weather and rainfalls, frequent flooding and cyclones all affect Bangladeshi people's lives, including their livelihoods and sexual and reproductive rights.

The BRAC Development Institute (BDI) at BRAC University is undertaking research initiatives on impacts of climate change on the urban poor, as part of its aim to promote rigorous academic research on poverty alleviation. In January 2009, BDI co-hosted an international conference with the Department of Architecture, BRAC University and the Brooks World Poverty Institute, University of Manchester to address the issues of impacts of climate change on rapid urbanisation trends in Bangladesh. Urban issues have seldom received attention from policymakers even though, with over 15 million residents, Dhaka is already considered to be one of the world's mega cities. The conference was held in two parts, the "Rajendrapur Conversation" and the international conference. At the conversation, experts presented on the different dynamics and consequences of climate change impacts on the urban population.

An important paper presented at the conversation was on climate change impacts on urban health by Sabina Rashid Faiz of the School of Public Health, BRAC University. Faiz's working paper highlighted the severe health concerns that arise every rainy season in urban centres. The lack of access to basic sanitation facilities, especially due to flooding, leads to several types of health problems for women. Unhygienic defecation and disposal of menstrual cloths and inaccessibility to condoms are factors leading to different types of diseases, including sexually transmitted infections. The paper also discussed women and young girls' vulnerability to sexual harassment and assault due to the distance between their residence and sanitation facilities set up during the inundation period.

Gender considerations need to be factored in research and policy interventions on climate change and urban poverty challenges. Within that context, a strong focus on sexual and reproductive rights of women is required, an area that has not received adequate research attention. The working paper by Faiz provides a basis for BDI and partner organisations and think tanks to prioritise issues that can easily be transformed into policies. The extreme conditions under which women and young girls survive during periods of inundations is a matter of immediate policy attention. Further action research on this area will help design effective policies for sustainable adaptive measures for women and young girls to survive climatic hazards.

Source: Shahana Siddiqui, Senior Research Associate, BDI, BRAC University. Email: sshahana@bracuniversity.ac.bd

Myanmar

Cyclone Nargis, which killed over 140,000 lives and devastated Myanmar in early May 2008, posed huge challenges to existing humanitarian and development actors as well as to the international response. In the immediate aftermath, the government response was slow, access to affected areas was restricted, and the survivors' needs were poorly understood. In the midst of these challenges, Marie Stopes International Myanmar (MSIM) capitalised on its existing capabilities and mobilised new resources to respond effectively and address needs post-disaster.

In the early days of the response, MSIM was on the ground providing primary care and distributing vital goods such as personal hygiene kits. It quickly established fixed centres and regular mobile teams, in order to provide family planning services. It supported emergency obstetric care facilities and provided referral support to the women, thus facilitating access to and utilisation of emergency obstetrics (EmOC) services by over 600 women, and saving the lives of mothers and babies. Moreover, demand created for family planning and other sexual and reproductive health services through community awareness-raising and strengthened capacity of EmOC facilities will provide ongoing health benefits.

Further, MSIM's cyclone response activities have strengthened the organisation, which is now better prepared for such events. Support teams for staff were established as team members coped

with new hardships. The activities evolved from emergency relief to a medical response towards recovery and rebuilding and integrating SRH with basic medical and psychosocial support. MSIM participated in a range of coordination work and collaborated with various stakeholders and communities to ensure that services reached the highly vulnerable populations.

In summary, much has been achieved, despite many challenges. We have demonstrated that life-saving SRH care can be effectively mobilised in a disaster response, even when conditions are far from ideal.

Source: Moe Moe Aung, Senior Programme Manager, MSIM. Email: mmaung@mariestopes.org.mm

Pacific

Pacific countries are scattered widely on an ocean covering a third of the surface of the earth. Most are small, scattered and isolated, with populations ranging from 1,500 to 6 million. They are vulnerable to hurricanes, flooding, occasional droughts, sea level rise (affecting atoll-based countries), tsunami and earthquakes. Distance from global markets, poorly developed transport and other infrastructure in many countries adds to their vulnerability.

In 7-14 January 2009, heavy rain fell over Fiji, resulting in the worst flooding in living memory which led to the loss of 11 lives, relocation of 9,000 people and animals, and significant damage to bridges, houses, roads and other infrastructure. Two weeks later, heavy rains that continued until the first week of February caused flooding in Guadalcanal and Savo Island in the Solomon Islands. Many houses were damaged leading to the evacuation of people from villages to schools on high ground. Eight bridges were washed away and roads were damaged, making some areas accessible only by sea. There were nine confirmed deaths, including a women who died from post-partum haemorrhage with a retained placenta following a home delivery; 11 people were reported missing. Four health clinics were affected by the floods with two badly damaged and inaccessible.

The United Nations Population Fund (UNFPA) in Suva, Fiji has delivered reproductive health (RH), gender and population and development funding, programmes and services to 14 Pacific countries since 1971. Along with other UN agencies, during and following emergencies, UNFPA is responsible for the provision of contraceptives, RH commodities and drugs and, if required, gender and population assistance. It was in this role that UNFPA responded to the flooding in Fiji and the Solomon Islands.

UN and non-UN agencies, such as the Red Cross, responded to the disaster initially by conducting assessments in their mandate areas. Women and young people did not take part in the assessment but for UNFPA were an important group to consider, especially for humanitarian assistance. In Fiji, 2,500 'dignity' kits for women and girls (containing clothes, toiletries, sanitary wear and others) were provided to the Fiji Red Cross for distribution within affected communities. Meanwhile, in the Solomon Islands, 2,200 dignity kits were supplied for distribution through the health ministry. UNFPA also provided the Fiji Ministry of Health with RH Kit 6 (clinical equipment for deliveries and pregnancy complications dealt with in health facilities). In the Solomons, because of difficulties in pregrant women's access to health facilities, Kits 2A and 2B (basic equipment and supplies for home deliveries) were flown from Fiji. Kit 6 was freighted to Honiara, the capital, directly from UNFPA's bulkstore in Copenhagen.

The determination of the assistance to be delivered on each occasion was the responsibility of UNFPA personnel who had attended the SPRINT Workshop on the Minimum Initial Package (MISP) for Reproductive Health in Crises. This was organised by IPPF ESEAOR and UNFPA, and held in Suva for Pacific participants in 2008.

Source: Wame Baravilala, Adviser in RH, UNFPA Pacific Sub-Regional Office, Suva, Fiji. Email: baravilala@unfpa.org

Pakistan

Shirkat Gah's (SG) involvement in disasters and SRHR issues within them was triggered by the devastating earthquake of 8 October 2005 that struck northern Pakistan and left over 86,000 dead and more than 3 million homeless. While the objective of SG's intervention in the broader context is humanitarian, the focus is on addressing women's issues and specifically SRHR needs. SG's interventions among earthquake/disaster-affected areas have so far have been post-disaster, with initial relief and then mitigation/rehabilitation. They are focussed on grassroots women and adolescent girls belonging to the poor economic strata. The objective is to capitalise upon the opportunity that such situations provide to expand women's space for action and decision making.

SG's strategy, moulded by the concerns of the poor and marginalised, is to work with other like-minded organisations in the disaster-affected area. It begins with establishing the immediate and medium-term needs of affected women and adolescent girls. Immediate needs entail relief measures, including for sex-based violence and harassment or threat of it from husbands and outsiders, non-availability of contraceptives and sanitary towels, lack of privacy and of accessible toilets and bathing areas; medium-term needs focus on rehabilitation.

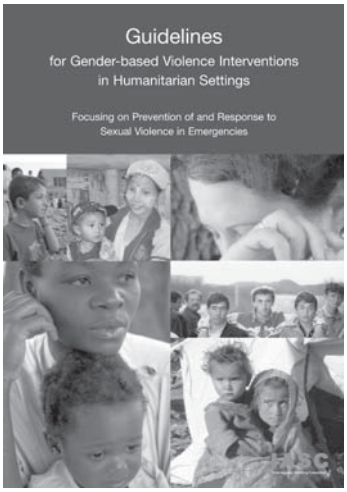
Local groups and organisations are given training to address identified needs, and are assisted in mapping available SRHR services and organisations in the vicinity and in relevant local administration. SG also facilitates creating inter-linkages among them. The training has ranged from socio-psychological counselling to upgrading the skills of traditional birth attendants and adult literacy. Community women's awareness has been raised on issues of sexuality and reproductive health (including abortion, contraception and choice in marriage), and on health and hygiene. Women have mobilised for collective action in many places, testifying to the success of the strategy.

Major constraint for relief measures is that of funds, while for mitigation/rehabilitation, the challenge includes overcoming custom-based constraints of mobility and women's independence.

Source: Khawar Mumtaz, CEO, SG. Email: khawar@sgah.org.pk

Inter-Agency Standing Committee (IASC). 2003 (currently being revised). *Guidelines for HIV/AIDS Interventions in Emergency Settings.* Geneva. 54p. Available at www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=9

The *Guidelines* were developed to help governments and cooperating agencies respond to the special needs of people living with HIV/AIDS in emergency situations. The publication is divided into four chapters, the first three providing background information, and the final one containing the actual guidelines. The *Guidelines* are fairly comprehensive, not just covering interventions in the minimum and comprehensive response phases of disaster, but also at the preparedness stage. They also cover HIV interventions in various sectoral response, not just health (e.g., education and food aid). Women, children, mobile populations and rural people are given special priority, and amongst them, those living with HIV/AIDS. Some areas for improvement include adding continued availability of antiretroviral (ARV) drugs for those undergoing treatment before the emergency as part of the minimum response; recognising vulnerabilities of transgendered people, men who have sex with men and inter-sexed people to HIV/AIDS; and strengthening access to treatment of groups such as sex workers.



IASC. 2005. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies.* 124p. Geneva. Available at www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv Also available in Bahasa.

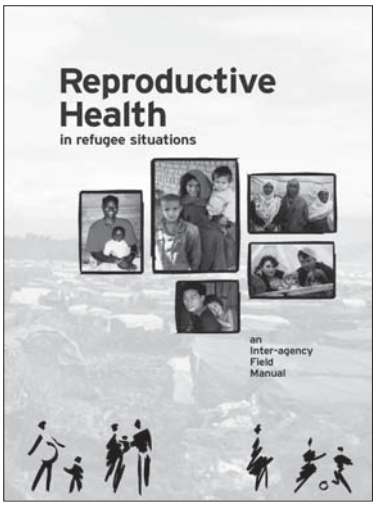
These *Guidelines* serve as tools to for field actors to establish a multisectoral coordinated approach to gender-based violence (GBV) programming in emergency settings. The *Guidelines* provide practical advice on how to ensure that programmes for displaced populations are safe and do not directly or indirectly increase women's and girls' risk to sexual violence, as well as identify what services should be in place to meet the need of people who have experienced sexual violence. The main focus of the *Guidelines* are on interventions during the minimum response phase (e.g., adequacy and safety of latrines for each sex, provision of shelter and healthcare for GBV survivors, recruitment of staff to prevent abuse and exploitation). However, the publication also outlines interventions during emergency preparedness (e.g., assessment of the magnitude of GBV, training of community leaders and humanitarian workers on GBV interventions) and the stabilised phase (e.g., representation of women in disaster-related committees, involving men to prevent GBV). The *Guidelines* are particularly concerned with interventions on GBV against women and girls (including adolescents), while recognising that men and boys may be vulnerable to GBV in some situations. However, there is no mention of addressing GBV against transgendered and inter-sexed people in disaster contexts. The terms reproductive rights, sexual health and sexual rights are not used in the *Guidelines*.

Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations. 2008 (4th ed.). *Manual: Inter-Agency Reproductive Health Kits for Crisis Situations.* 44p. Available at www.rhrc.org/resources/index.cfm?type=guidelines

This manual was produced for the effective use of the IAWG *Reproductive Heath (RH) Kits*. The RH Kits are a set of specially designed pre-packaged kits containing the essential drugs, equipment and supplies necessary to provide appropriate RH services in the early phase of emergency and refugee situations. They are complementary to the *Interagency Emergency Health Kit 2006* (see below) and are necessary for the implementation of the Minimum Initial Service Package (MISP) for RH (*see* entry for MISP). In addition to providing the MISP, this edition recognises the importance of initiating complementary RH services, including the provision of contraceptives in order to respond to the demands of women with prior experience with contraceptives, and the provision of antibiotics to treat people who present with symptoms of sexually transmitted infection (STI). It is hoped that these items will be considered part of the MISP itself. It would also be good if the manual would recommend that the assessment, which is a prerequisite for ordering the kits, be made participatory and involve communities (including women, young people and people of diverse sexualities) affected by the emergency.

UNCHR, et al. 1999. *Reproductive Health in Refugee Situations: An Inter-agency Field Manual.* Geneva, Switzerland: UNHCR. 143p. Available at www.iawg.net/resources/field_manual.html

The result of collaborative efforts by UN agencies, NGOs and refugees themselves, this publication aims to serve as a tool to facilitate discussion and decision-making in the planning, implementation, monitoring and evaluation of RH interventions; to guide field staff in introducing and/or strengthening RH interventions in refugee situations; and to advocate for a multi-sectoral approach to meeting the RH needs of refugees and to foster coordination among all partners. The manual has a comprehensive coverage of RH issues. Aside from a chapter on the Minimum Initial Service Package (*see* MISP entry), it devotes a chapter each on the following: safe motherhood; sexual violence; sexually transmitted diseases, including HIV/AIDS; family planning; other RH concerns; and young people's RH. However, it would also have been good if provision of medical abortion and safe abortion services was covered as part of the constellation of RH services (rather than limiting it to the management of complications arising from unsafe abortions). The manual recognises reproductive health as a right of refugees and emphasises the importance of involving the affected communities at all stages of programming. It does not, however, mention sexual



rights and sexual health (although it does cover sexual violence and STIs.) Even as the manual recognises young people's RH, it also should affirm the needs and rights of lesbians, transgenders and other people of diverse gender identities and sexual orientations.

Women's Commission for Refugee Women and Children. 2006. *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module.* Available at http://misp.rhrc.org

MISP was initially developed in 1995 as a set of priority reproductive health services to be implemented on the first three months of a crisis brought on by conflict or natural disaster. The 1999 *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* devoted a chapter to MISP. This self-instructional learning module was another initiative to popularise MISP and build the capacities of members of emergency response teams and other first humanitarian responders in crisis situations. MISP's aims include reduction of HIV transmission by enforcing respect for universal precautions against HIV/AIDS and guaranteeing the availability of free condoms. It also aims to prevent and manage the consequences of sexual violence, as well as prevent excess neonatal and maternal morbidity and mortality by providing supplies for clean and safe deliveries and initiating the establishment of a referral system to manage obstetric emergencies and other complications of pregnancy. It also plans for the provision of comprehensive reproductive health services as soon as the situation permits. While this is one of the most comprehensive standards on RH, some SRH services are not considered in MISP, including safe abortion services and medical abortion (or even just management of complications from unsafe abortions during the critical phase of the emergency). Nor does it automatically include contraceptive services (including re-fertility services), treatment for STIs and continued access for antiretrovirals.

World Health Organization (WHO), et al. 2006 (3rd ed.). *The Interagency Emergency Health Kit* (IEHK). Geneva, Switzerland: WHO. 88p. Available at www.who.int/medicines/publications/WHO_PSM_PAR_2006.4.pdf

The IEHK 2006 is designed to serve the primary healthcare needs of a displaced population without medical facilities, and specifies the essential medicines and medical devices to serve a population of 10,000 in the first three months of an emergency. The kit consists of two different sets of medicines and medical device. The basic unit is to be used by primary healthcare workers, while the supplementary unit is for use by professional health workers or physicians. This updated third edition takes into account the global HIV/AIDS epidemic, the increasing parasite resistance to commonly available anti-malarials and the field experience of agencies using the emergency health kit. The kit is not designed for reproductive health services and communicable diseases such as HIV/AIDS. However, some elements of RH are covered in the IEHK. These include instruments and medicines for professional midwifery care, a small quantity of magnesium sulfate for severe pre-eclampsia and for eclampsia, and a limited quantity of medicines for presumptive treatment of STIs, prevention of transmission of HIV and prevention of pregnancy (emergency contraception) for survivors/victims of sexual assault. Additionally, the IAWG has also designed a number of RH kits for all levels of the health care system during an emergency, which can be separately ordered based on needs assesment. The concept of reproductive rights and sexual rights are not mentioned in the document.

Other Relevant Guidelines and Tools

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Gomez, S. 2006. *Guidelines for Gender-Sensitive Disaster Management.* Bangkok, Thailand: Asia Pacific Forum on Women, Law and Development (APWLD). 77p. Available at www.apwld.org/pb_gendersensitive.htm Email: apwld@apwld.org

IASC. 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva. 103p. Available at www.euro.who.int/pregnancy/esscare/20051103_3

The Sphere Project. 2004 (currently being revised). *Humanitarian Charter and Minimum Standards in Disaster Response.* Geneva, Switzerland: International Federation of Red Cross and Red Crescent Societies (IFRC). Available at www.sphereproject.org

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Lehman, Aimee. 2002. "Safe abortion: A right for refugees?" *Reproductive Health Matters*. Vol. 10, No. 19, pp. 151-155. Email: aimeelehmann@mindspring.com

Pincha, Chaman & Harikrisna, N. 2008. "*Aravanis*: voiceless victims of the tsunami." *Humanitarian Exchange Magazine*. Issue 41. Available at www.odihpn.org/report.asp?id=2975

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Shresta, B.; Wisecarver, J.; K.Murthy, Ranjani; Hyder, T. 2008. *Non-discrimination in Emergencies: Training Manual and Toolkit*. New Delhi, India: Save the Children India. 150p. Available at www.reliefweb.int/rw/lib.nsf/db900SID/ASAZ-7RYBGF?OpenDocument

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VIRTUAL RESOURCE COLLECTIONS
Gender and Disasters Network www.gdnonline.org/resources.php
Gender and Disaster Sourcebook gdnonline.org/sourcebook/
RAISE Library www.raiseinitiative.org/library/introduction.php
RHRC Consortium www.rhrc.org/resources/index.cfm
Virtual Health Library for Disasters www.helid.desastres.net

ARROW Publications

ARROW. 2008. *Advocating Accountability: Status Report on Maternal Health and Young People's SRHR in South Asia*. 140p. US$10.00

ARROW. 2008. *Surfacing: Selected Papers on Religious Fundamentalisms and Their Impact on Women's Sexual and Reproductive Health and Rights*. 76p. US$5.

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights; Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project*. 216p. US$10.00

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ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific; Health Resource Kit*. v.p. US$10.00

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1*. v.p. US$10.00

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Definitions[1]

Disaster : "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." It is a "result of the combination of: the exposure to a hazard; the conditions of vulnerability that are present; and insufficient capacity or measures to reduce or cope with the potential negative consequences."[2]

Disaster Risk Reduction (DRR): "The concept and practice of reducing disaster risks through systematic efforts to analyse and manage 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."[2] The paradigm shift from disaster management to DRR occurred as practitioners realised the need to go beyond 'managing' disaster events towards carefully addressing the risk processes that drive these disasters in the first place. "Effective disaster risk reduction roots itself in driving down prevailing vulnerability conditions through ongoing development programmes, rather than limiting itself to a major response once a crisis becomes apparent."[3]

Feminist and Rights-based Approaches : A feminist approach to interventions in disaster contexts would call attention to the extraordinary resilience of disaster-affected communities—often under the leadership of women, youth and people with diverse gender identities/sexual expressions—to survive, negotiate and rebuild.[4] Rights-based approaches (RBA) usually integrate the norms, standards and principles of the international human rights system or other international agreements,[5] but they could also derive strength and legitimacy from national law, socially acknowledged ethical principles of equity and justice or from struggles of people's organisations. Central to RBA is examining issues of power, exclusion and structural injustice and changing these positively. It views people as active choice-making agents and views people as rights-holders with entitlements. It affirms that "the state is the primary agency for the enforcement of people's rights, security and well-being, for ensuring their just and adequate access to social services and other public goods,[6] and for securing redistributive justice."[7]

Recovery: "The restoration, and improvement where appropriate, of facilities, livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors."[2]

Response: "The provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected."[2]

Endnotes

1 *For the definitions of capacity, disaster risk management, hazard, risk, resilience, vulnerability and other terms, see 2.*
2 *UN International Strategy for Risk Reduction (UNISDR). 2009. "UNISDR Terminology on Disaster Risk Reduction (2009)." www.unisdr.org/eng/terminology/terminology-2009-eng.html*
3 *Holloway, Ailsa. 2003. "Disaster risk reduction in Southern Africa: Hot rhetoric, cold reality." African Security Review, Vol.12, No.1. www.saferpn.org.za/documents/d0000483/P446_ISS_Holloway.pdf*
4 *Adapted from Petchesky, Rosalind. 2008. "Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights." Reproductive Health Matters. Vol. 16, No. 31, pp.4–9.*
5 *Including CEDAW, FWCW PfA, ICCPR, ICESCR, ICPD PoA and Yogyakarta Principles.*
6 *For ARROW, "public goods" go beyond the definition promoted through World Bank-imposed health sector reforms, that limits this to services which benefit the most people, and are 'non-excludable' (i.e., it is impossible to exclude those who do not pay for the good from consuming it) and 'non-rival' (i.e., a person's consumption of the good has no effect on the amount available for others). This limits the "essential" services to be provided by the State to items like immunisation and health education. It runs contrary to the goal of comprehensive and integrated health services.*
7 *Adapted from Mander, Harsh. 2005. "Rights as a struggle—Towards a more just and humane world." In Reinventing Development, Edited by Paul Greedy & Jonathan Ensor. Zed Books.*

Recommended Additional Standards on SRHR in Emergencies (from pp.1-2)

Stage	Recommendations
Risk Reduction	• *Participatory mapping of SRHR needs of marginalised women, adolescents and people of diverse gender and sexual identities related to risk reduction, immediate response and recovery* • *Advocacy on comprehensive SRHR policies and legislation for the above groups* • *Integration of health and SRHR issues in disaster risk reduction policies* • *Training of rescue, relief and rehabilitation personnel, diverse community leaders, marginalised women, adolescents and people of diverse gender and sexual identities and the public on SRHR issues* • *Increasing proportion of women and people of diverse gender and sexual identities in risk reduction committees and rescue teams*
Response stage	• *IUD, RTI/STI and oral and injectable contraception kits, as well as ante-natal care and post-natal care, as part of 'minimum' RH services* • *Culturally appropriate material for absorbing menstrual blood and urinary and faecal incontinence* • *Promotion of non-discrimination in access to toilets and bathing spaces based on sexual/gender identities and orientation* • *Access to safe abortion services, including medical abortion* • *Treating conditions like uterine prolapse, breast engorgement, irregular menstrual cycles and others* • *Enforcing protocols for protection against child marriage and commerical sexual exploitation in the aftermath of disaster* • *Providing urgent sexual and reproductive health services to women and men irrespective of marital status, to adolescents and to people of diverse gender and sexual identities*
Rehabilitation	• *Restoration of pre-existing health/SRH infrastructure and services, and making them disaster resilient* • *Provision of safe re-canalisation surgery and re-fertility services where demanded by women and men and advisable given their age and health conditions* • *Advocacy for comprehensive SRHR services and legislation for women, adolescents, and people of diverse gender and sexual identities*
Cross-cutting	• *Training, behaviour communication change/IEC and education*

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Disaster Legislations in Six Asia-Pacific Countries:

A Review from an SRHR and Feminist Lens

Are sexual and reproductive health and rights (SRHR) issues considered at all in disaster legislation in the region? Do they reflect a feminist and rights-based perspective? To answer these questions, this fact file reviews the legal framework on disaster in six countries: Bangladesh, Fiji, Indonesia, Pakistan, Papua New Guinea (PNG) and the Philippines. (*see* Table 1). Of these six countries, Fiji, Indonesia and PNG have passed laws, Pakistan a national level ordinance, and Bangladesh and the Philippines have tabled draft bills. The periods of drafting/passing range from 1984 to 2009. Other than PNG's legislation, which stops at risk reduction and relief stage, the legal framework for the other countries covers aspects of risk reduction, response and recovery.

National disaster policy framing bodies of four of the five countries on which information was available included the health ministry. Medicines, basic health services and sanitation are part of relief packages in the legal framework of four of the six countries. In rehabilitation stage, the Bangladesh bill provides for treatment for disability, the Bangladesh bill and Indonesian act provide for psychosocial counselling, and the Bangladesh bill and Fiji act emphasise restoration of health infrastructure. However, only the draft Philippine bill mentions integrating disaster risk reduction into the health sector.

The record on attention to SRHR within the legal framework on disaster in these six countries is dismal. None pay attention to 'reproductive rights,' 'sexual health' and 'sexual rights.' The attention to reproductive health (RH) is far from comprehensive. The Indonesia act mentions that pregnant and lactating women should be given priority during evacuation, rescue and relief. However, menstrual pads or pads for absorbing urine for those with urinary incontinence are not automatically part of relief packages. Moreover, there is no mention of restoring/strengthening maternal health services, safe abortion services, HIV and STI prevention and management services, contraceptive and emergency contraceptive services, access to condoms, access to ante-retroviral therapy or reproductive cancer treatment, preventing and addressing gender-based violence and respecting sexual rights. Providing safe re-fertility services where demanded is not mentioned. Restoring livelihoods, shelter, food and clothing, on the other hand, receive the attention they deserve, but not necessarily with a gender perspective. There is no mention of adhering to the minimum initial service package in RH, or aspiring to provide comprehensive SRH services.

From a more feminist and rights-based perspective, it is positive that disaster frameworks of Bangladesh, Indonesia, Pakistan and the Philippines refer directly/indirectly to women. Unfortunately, they are often seen as solely 'vulnerable' groups, with their participation in shaping disaster policies or monitoring their implementation from a gender or SRHR lens not being envisaged (except in Fiji where the Women's Ministry is included in the national disaster council). The term 'community participation' or 'citizens' participation' is found in five of the six legal frameworks (other than PNG). While there is provision for NGO participation in disaster management structures in five of six legal frameworks, in one it is optional and in the other four there is no specific provision for participation of NGOs working on women's rights, youth rights, sexual rights or SRHR. On a positive note, the Bangladesh and Indonesian legal framework mention non-discrimination on the basis of sex, religion, caste, ethnicity, disability and others. However, they do not mention non-discrimination on the basis of gender identity and sexual orientation. The words 'adolescent' and 'LGBTT' do not figure in any of the legal frameworks.

The challenge in the coming years is for marginalised community women, youth, people of diverse gender and sexual identities and NGOs working for their rights to advocate for changes in disaster legislation so that they address SRHR issues comprehensively and reflect a feminist and rights-based perspective. The opportunities are immense in Bangladesh and the Philippines where the legislation has not been finalised. Even in others, the above groups and donors that uphold SRHR can advocate for changes. Moreover, disaster legislation has to be reviewed in tandem with laws on abortion, age of marriage, contraception, gender-based/sexual violence, property rights and sexual rights of women.

Features under Assessment	ASSESSMENT OF LEGAL FRAMEWORKS ON DISASTER					
	Bangladesh	Fiji	Indonesia	Phillippines	Pakistan	PNG
Disaster Act passed	*Draft (2008)*	*Act passed (1998)*	*Act passed (2007)*	*Draft (2009)*	*Ordinance passed (2007)*	*Act passed (1984)*
Scope	*Risk reduction to recovery*					*To relief*
Reference to women – # of times – Nature of reference	*2x; as a vulnerable group; priority during evacuation; elderly women priority during rehabilitation*	*None*	*2x; priority in evacuation, rescue & relief; non-discrimination*	*1x; as a vulnerable & marginalised group*	*1x; mentions no discrimination on the basis of sex in providing compensation and relief to victims*	*None*
Reference to groups	*No references to adolescents, people of diverse gender and sexual identities; One reference each in Bangladesh bill and Indonesia act to people with disability*					
Attention to health/SRHR in risk reduction	*None*			*Maintaining hospital list; Integration of risk reduction into health sector*	*None*	
Attention to health/SRHR in relief/ response	*Provision of medicines/ equipment; sanitation & public health, clean up & epidemic control*	*Public health interventions to control epidemics*	*Health services (including for pregnant & lactating women) & sanitation*	*None*	*Medical/ healthcare services and sanitation*	*None*
Attention to health/SRHR in recovery	*Restoration of physical wellbeing; trauma counselling, rehabilitation of disabled*	*Restoration of health infrastructure & services*	*Restoration of health services & infrastructure & psychosocial recovery*	*None*		
Participation in disaster management structures						
Women's Ministry	*Not specified*	*Yes*	*None*			
Health Ministry	*Not specified*	*Yes*	*None*	*Yes*		
Community women, adolescents and transgender	*Representatives from the community can become members where appropriate (local)*	*None*	*Citizen (local)*	*Not specified, but individuals can serve as volunteers (local)*	*None*	*None, although any person can be co-opted at the provincial level*
NGOs	*Where appropriate (local)*	*Yes (national)*	*None*	*Yes (national, regional, local)*	*Yes (national, district)*	*Mission & voluntary organisations can be coopted at provincial level*
Reference to international standards re: SRHR in disasters	*None*					

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