



state of world population 2015

A photograph of a woman wearing a beige headscarf and a dark blue long-sleeved top, holding a young child in a pink shirt and blue floral dress. They are standing in front of a barbed wire fence. The background is slightly blurred, showing other people and a hazy landscape.

SHELTER FROM THE STORM

A transformative agenda
for women and girls in a
crisis-prone world

The State of World Population 2015

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UNFPA

Delivering a world where
every pregnancy is wanted
every childbirth is safe and
every young person's
potential is fulfilled

A woman with long dark hair, wearing a colorful patterned jacket and a purple skirt, holds a baby in her arms. The baby is wearing a blue jacket and a patterned hat. They are standing in front of a large pile of rubble, which appears to be the remains of a stone building. In the background, there are green mountains under a cloudy sky.

SHELTER FROM THE STORM

A transformative agenda for women and girls in a crisis-prone world

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Foreword

More than 100 million people are in need of humanitarian assistance—more than at any time since the end of the Second World War. Among those displaced by conflict or uprooted by disaster are tens of millions of women and adolescent girls. This report is a call to action to meet their needs and ensure their rights.

While remarkable progress has been achieved during the past decade protecting the health and rights of women and adolescent girls in humanitarian settings, the growth in need has outstripped the growth in funding and services. Yet, these services are of critical importance, especially for very young adolescent girls, who are the most vulnerable and least able to confront the many challenges they face, even in stable times.

Under normal circumstances in some developing countries, a 10-year-old girl, for example, may be married off against her will, trafficked, separated from her family and all social support and have limited access to education, health or opportunities for a better life. When a crisis strikes, these risks multiply, and so do that girl's vulnerabilities. Her prospects go from bad to worse. She may become the target of sexual violence, infected with HIV, or pregnant the moment she reaches puberty. Her future is derailed.

Every 10-year-old girl, no matter where she is, has a right to health, dignity and safety, and 179 governments pledged in 1994 at the International Conference on Population and Development to uphold that right—in any

and every situation. Yet for too many years, humanitarian assistance has left the 10-year-old girl behind, vulnerable to unsafe childbirth, and violence with devastating consequences. Sexual and reproductive health and access to information are essential for any girl's safe transition from adolescence to adulthood. Imagine that 10-year-old 15 years later with her rights and health intact; now imagine her in a world where armed conflict, devastation and displacement deny her every human right, every opportunity, every dignity.

Abandoning her, or her community or country, is not an option. We are, in the end, one world, and governments have a responsibility to protect human rights and abide by international law. As global citizens, we have a duty to provide support and solidarity.

Today about three fifths of all maternal deaths take place in humanitarian and fragile contexts. Every day 507 women and adolescent girls die from complications of pregnancy and childbirth in emergency situations and in fragile States. And gender-based violence continues to take a brutal toll, shattering lives and prospects for peace and recovery.

Together we must transform humanitarian action by placing the health and rights of women and young people at the centre of our priorities. At the same time, we must invest heavily in institutions and actions that build girls' and women's human capital and agency and in the resilience of communities and nations over the long run so that when a new crisis strikes, disruption and dislocation may be minimized and recovery may be accelerated.

For its part, UNFPA remains committed to the full realization of the sexual and reproductive health and rights of all women and girls, wherever they live, and under all conditions, crisis or otherwise, at all times. The surfeit of conflicts and disasters all around us today means that UNFPA is delivering a larger share of its services in crisis settings.

When women and girls can obtain sexual and reproductive health services, along with a variety of humanitarian programmes that

deliberately tackle inequalities, the benefits of interventions grow exponentially and carry over from the acute phase of a crisis well into the future as countries and communities rebuild and people reclaim their lives.

Together we must strive for a world where women and girls are no longer disadvantaged in multiple ways but are equally empowered to realize their full potential, and contribute to the development and stability of their communities and nations—before, during or after a crisis.

Dr. Babatunde Osotimehin

United Nations Under-Secretary-General and
Executive Director
UNFPA, the United Nations Population Fund



Photo © UNFPA/Nezih Tavlas

Overview

More than a billion people alive today have seen their lives upended by crisis. War, instability, epidemics and disasters have left a long trail of turmoil and destruction.

Right now, more people are displaced by crisis than at any time since the cataclysm of the Second World War: an estimated 59.5 million. Natural disasters now affect 200 million people a year.

For some, the setbacks are temporary. For others, they may consume a lifetime. Refugees now spend an average of 20 years away from home.

Pregnancy and childbirth are additional vulnerabilities for women and girls in conflicts and crises. Sixty per cent of preventable maternal deaths take place among women struggling to survive conflicts, natural disasters and displacement.

In a series of international agreements, the world has affirmed the sexual and reproductive health and rights of women and girls. That promise

encompasses upholding and delivering on these rights in all cases, at all times; humanitarian crises do not diminish this responsibility. Keeping that promise means guaranteeing that women and girls have access to comprehensive services before, during and after a crisis. What's needed in many crisis-affected countries are scaled-up commitment and action.

In a fragile world, women and girls pay a disproportionate price

By many measures, more countries are considered fragile than five or six years ago, leaving them more vulnerable to conflict or the effects of disasters. Many factors make people and countries vulnerable. Being poor is one—over 1 billion people still live



Photo © UNFPA/Sawiche Wamunza



in extreme poverty. This traps individuals and even whole countries so far down the ladder of development as to make any upward climb the most distant dream. It means decent work is unavailable, and the quality of services is unpredictable.

Geography is another factor. Some countries lie squarely in the path of natural disasters, which are increasing dramatically through climate change. Historic levels of urbanization have raised risks for city dwellers, especially the poor, many of whom live in poorly constructed informal settlements in fragile areas, such as on hillsides prone to mudslides.

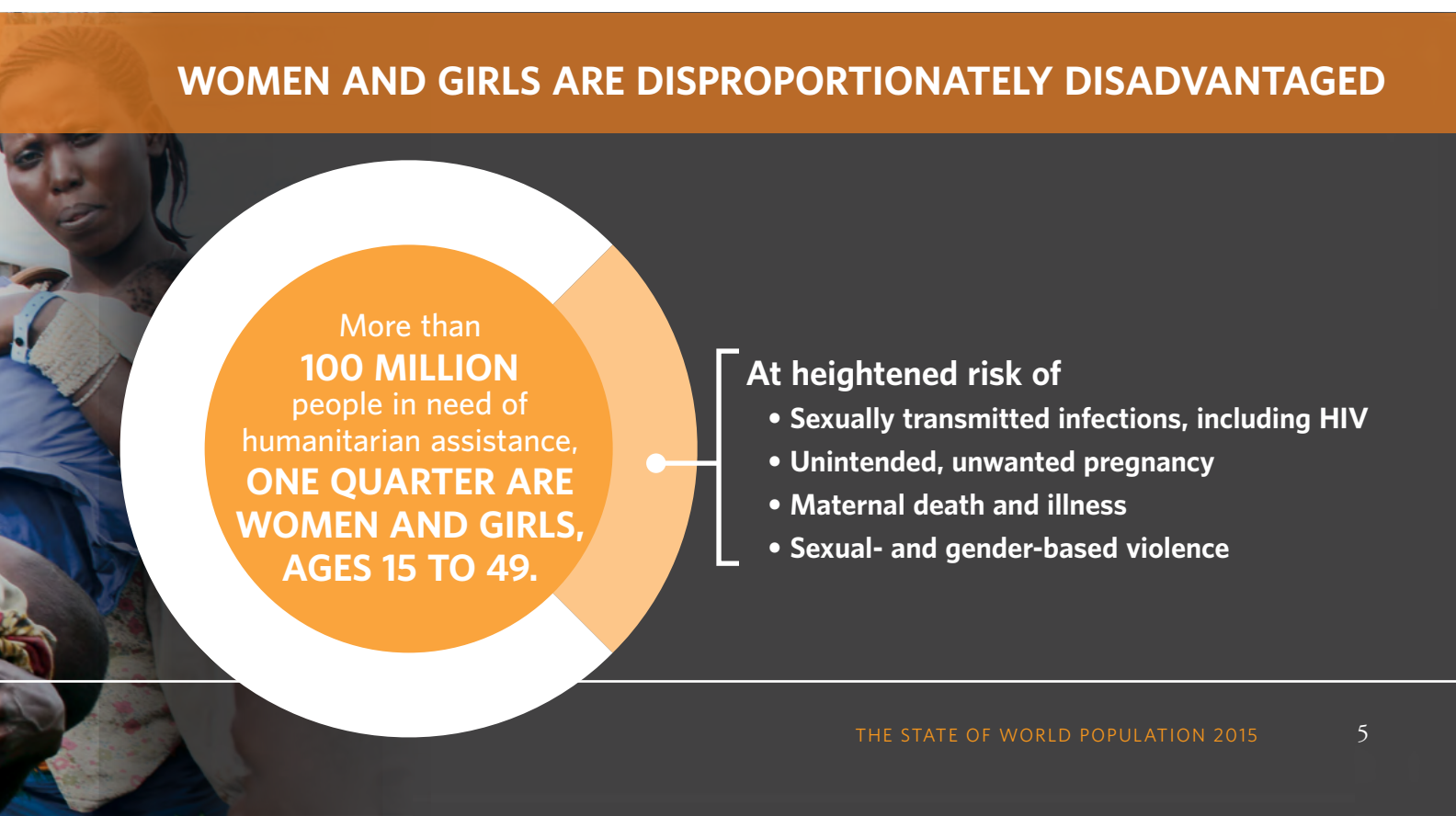
For women and girls, compounding these and other factors are discrimination and gender inequality. To start with, women and girls have less of almost everything: income, land and other assets, access to health services, education, social networks, a political voice, equal protection under the law, and the realization of basic human rights.

When a crisis strikes, they are thus disproportionately disadvantaged and less prepared or empowered to survive or recover. During and after any kind of crisis, gender-based violence may soar, including in its use as a weapon of war.

Extreme financial hardship stemming from disaster or conflict can lead women to transactional sex or make them vulnerable to trafficking. A lack of even basic sexual and reproductive health

When a crisis strikes, women and girls are disproportionately disadvantaged and less prepared or empowered to survive or recover.

WOMEN AND GIRLS ARE DISPROPORTIONATELY DISADVANTAGED



More than
100 MILLION
people in need of
humanitarian assistance,
**ONE QUARTER ARE
WOMEN AND GIRLS,
AGES 15 TO 49.**

At heightened risk of

- Sexually transmitted infections, including HIV
- Unintended, unwanted pregnancy
- Maternal death and illness
- Sexual- and gender-based violence

services makes giving birth in crisis settings a potentially deadly proposition, even more so for adolescent girls.

All of these dangers share a common cause: a lack of respect for the human rights to which everyone is entitled, no matter their sex, age or any other distinguishing characteristic. These rights include the reproductive rights agreed by 179 governments at the 1994 International Conference on Population and Development, culminating in a groundbreaking Programme of Action, which guides the work of UNFPA, the United Nations Population Fund.

Women and girls face obstacles to sexual and reproductive health before, during and after crises

Of the more than 100 million people in need of humanitarian assistance in 2015, an estimated one quarter were women and adolescent girls of reproductive age. Assistance that fails to meet all of their needs, including those specific to gender and age, can hardly be considered effective.

To date, the supply of assistance aimed at meeting the sexual and reproductive health needs of women and girls has not kept pace with the demand. Remarkable progress in targeting humanitarian services to women and girls has been achieved in the past decade. Still, large gaps remain, in action and in funding.

Gender inequality and discrimination—by sex, age or other factors—are among the explanations, manifesting even in well-intentioned humanitarian responses. Interventions that fail to account for the different ways disasters and conflicts can affect different groups can end up perpetuating inequalities, such as when general health care is provided in a crisis, but not services related to pregnancy, childbirth or contraception, leaving already-disadvantaged women and girls in an even more precarious situation.

In the tumultuous early phase of a crisis, food, shelter and care for acute physical trauma often seem the most compelling needs, with gender or any other kind of discrimination something that



RESPONSE

Photo © Panos Pictures/Chris de Bode



can be put off for a safer day. Thinking this way, however, can make a response blind to realities on the ground—including those that shut women and girls off from assistance or leave them vulnerable to violence.

A lack of concerted attention is fed in part by a very limited amount of data broken down by sex or other parameters, and by a lack of gender expertise among many first responders.

Given the scale of crisis in the world today, and given who most victims are, it is time to transform the conventional approach into one that takes account of diversity in crisis-affected populations, and wields that diversity for the benefit of reduced risk, faster recovery and greater resilience.

Move sexual and reproductive health to the centre of humanitarian action

Until only 20 years ago, sexual and reproductive health took a back seat to priorities such as water, food and shelter in humanitarian response. But

Remarkable progress in targeting humanitarian services to women and girls has been achieved in the past decade. Still, large gaps remain, in action and in funding.

a wealth of research and evidence since the early 1990s has helped make the health of women and girls far more visible. Many humanitarian interventions now meet needs associated with pregnancy and childbirth, and seek to prevent and address vulnerabilities to sexual or gender-based violence and sexually transmitted infections, including HIV.

Not only is it more widely accepted that meeting these needs is a humanitarian imperative and a matter of upholding and respecting human

ESSENTIAL ACTIONS AND SERVICES FROM THE ONSET OF A CRISIS

PRIORITY SERVICES

- Emergency obstetric and newborn care
- Referral system for obstetric emergencies
- Supplies for clean and safe deliveries
- Contraception
- Condoms
- Anti-retrovirals
- Clinical care for survivors of rape

OBJECTIVES



Prevent maternal and infant mortality



Reduce transmission of HIV



Prevent and manage the consequences of sexual violence

rights, but it is also clear that ensuring access to sexual and reproductive health is a pathway to recovery, risk reduction and resilience. The benefits extend to women and girls—and beyond. When they can obtain sexual and reproductive health care, along with a variety of humanitarian programmes that deliberately tackle inequalities, positive effects ripple throughout all aspects of humanitarian action.

Unsustainable funding calls for the transformation of humanitarian action

The lion's share of humanitarian action is coordinated and managed by major international players, including the United Nations, and has been traditionally funded by donor nations that are members of the Organisation for Economic Co-operation and Development, but other countries and private donations are beginning to play an important role too. The demand for humanitarian assistance has grown every year since 2011, but funding has not increased at the same pace, leaving unprecedented

A fundamental shift is needed: away from reacting to disasters and conflicts as they unfold and sometimes linger for decades, towards prevention, preparedness and empowerment of individuals and communities to withstand and recover from them.

gaps, translating into inadequate or insufficient responses for millions of people in need.

The ever-enlarging gaps suggest current funding arrangements may be unsustainable. So, too, may be a business-as-usual approach to humanitarian action.

RESILIENCE

Photo © UNFPA/Ben Manser



Crises will continue to happen; acute needs will always need to be met. But a fundamental shift is needed: away from reacting to disasters and conflicts as they unfold and sometimes linger for decades, towards prevention, preparedness and empowerment of individuals and communities to withstand and recover from them.

Tip the balance from reaction and response towards preparedness, prevention and resilience

We must aim for a more resilient, less vulnerable world. Such a world would be one where development, within and across countries, is fully inclusive and equitable, and upholds all rights for all people. Where women and girls are no longer disadvantaged in multiple ways but are equally empowered to realize their full potential, and contribute to the development and stability of their communities and nations.

It would be a world where every country can manage its economy and its polity to guarantee

everyone's access to decent work and high quality essential services, including sexual and reproductive health care. Among those who set the course of public policies, there would be a sound understanding that investment in equitable, inclusive development is about the best and certainly the fairest and most humane investment that can be made. Far-reaching benefits include reducing the risks and impacts of crisis.

Transformation to a more resilient, less vulnerable world also depends on better management of risks and institutions with sufficient capacities in place long before a crisis strikes. Risks first need to be comprehensively understood; only then can effective investments be made in measures to reduce them.

For those risks not fully avoidable, proactive preparation is critical to limit the worst consequences. One of the most central strategies in reducing risks in all countries is making sure people are resilient in the face of them. Those who are healthy, educated, have adequate income and enjoy all human rights have far better prospects when risks become reality.

PREVENTION, PREPAREDNESS AND EMPOWERMENT



Manage risks better



Rectify gender inequality



Foster individuals' resilience through education and health



Build capacities of institutions before disaster strikes



Enable realization of sexual and reproductive health and rights



Strive for long-term, inclusive and equitable development

Break the vicious cycle of discrimination and inequality

One of the weakest areas of resilience currently is among women and girls, and the institutions that serve them. As long as inequality and inequitable access short-circuit their rights,

As long as inequality and inequitable access short-circuit their rights, abilities and opportunities, women and girls will remain among those most in need of humanitarian assistance and least equipped to contribute to recovery or resilience.

abilities and opportunities, women and girls will remain among those most in need of humanitarian assistance and least equipped to contribute to recovery or resilience.

Transformation can begin, in part, in the aftermath of a crisis, but that largely depends on the response. If it mainly replicates existing discriminatory patterns, such as by failing to provide quality sexual and reproductive health services from the first moments, it is not transformative. It will fail as well on all scores of effectiveness and human rights. All humanitarian issues involve some kind of gender perspective, because men and women, girls and boys experience the world in markedly different ways. All types of humanitarian action therefore need to recognize and respond to these differences, and actively correct any disparities.

Wherever feasible, humanitarian assistance can challenge existing forms of discrimination, such as through providing comprehensive services for survivors of gender-based violence.



MOVING FORWARD

Photo © Panos Pictures/Sven Torfinn



It can enlist men and boys in building acceptance of new social norms, such as around women's inherent rights and the peaceful resolution of differences.

Tear down the artificial divide between humanitarian action and development

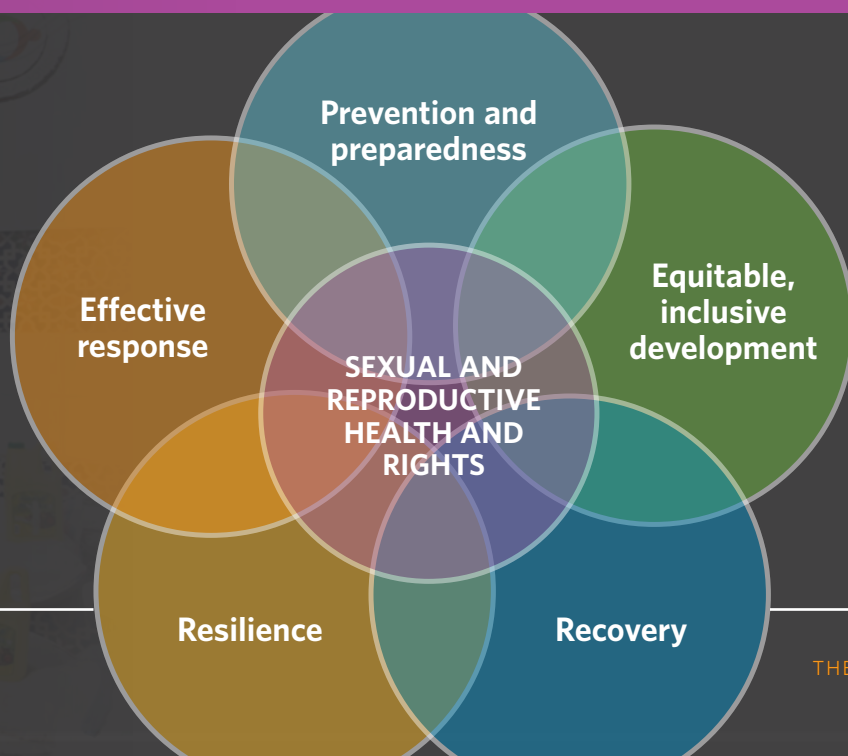
The surfeit of crisis and upheaval around the world today demands that we do much better. We need better development, better humanitarian action, better risk management, better attention to prevention, preparedness and resilience, and better connections among all of these. Running through them is a common thread: gender and all other forms of equality, achieved in part through full realization of sexual and reproductive health and rights, leads to far less vulnerability and much greater resilience for individuals and societies as a whole.

The distinction between humanitarian response and development today is a false one. Humanitarian action can lay the foundations

for long-term development. Development that benefits all, enabling everyone to enjoy their rights, including reproductive rights, can help individuals, institutions and communities withstand crisis. It can also help accelerate recovery.

Equitable, inclusive and rights-based development, and the resilience fostered by it, can in many cases obviate the need for humanitarian interventions. As the globally agreed Agenda 2030 for sustainable development begins, and the World Humanitarian Summit approaches in 2016, now is the time to act on this understanding and re-envision humanitarian action, with the health and rights of women and girls at its core.

A NEW VISION FOR HUMANITARIAN ACTION



At the core of the interrelated elements of humanitarian action, from response to resilience and development, are sexual and reproductive health and rights

CHAPTER 1

A fragile world

Natural disasters, especially floods and storms, occur twice as frequently today as 25 years ago. Conflicts, especially those within national boundaries, are driving millions from their homes.

Conflict, violence, instability, extreme poverty and vulnerability to disasters are deeply interrelated conditions, which today prevent more than 1 billion people from enjoying the massive social and economic gains achieved since the end of the Second World War.

When time won't wait: meeting basic health needs for pregnant women on the move



Ashur and family, Gevgelija.

Photo © UNFPA/Nake Batev

"I was three months pregnant and worried about what this trip would do to my baby, but I didn't have a choice. We had to go," says Leyla Ashur, one of the few hundred Syrians allowed to cross into the former Yugoslav Republic of Macedonia from Greece one day in August.

Ashur, 35, says she, her husband and their four sons had fled fighting in their home town of Dayr Az-Zawr, Syria, in 2012 and lived for about a year in Iraq. But the fear of violence from the self-proclaimed Islamic State in Iraq and the Levant, or ISIL, drove them across yet another border, into Turkey, where they stayed for three years until even that situation became untenable. She says not only were they afraid of escalating violence along the border, but they also

felt exploited and unwelcome in their host community.

"When they saw we were Syrians, we had to pay three times the rent everyone else was paying," she says. "And everyone kept telling us, 'Go away, go away.'"

And so the family of six left with a few belongings crammed into backpacks. The journey across Turkey took 10 days, with little rest and very little to eat along the way. "We didn't receive help from anyone," Ashur says.

When she and her family reached the Turkish coastal city of Bodrum, they and about 20 others together paid a smuggler €10,000 to carry the group in a rubber raft across the Aegean Sea to



Leyla Ashur and family.
Photo © UNFPA/Nake Batev

the Greek island of Ios. From there, they made their way to the former Yugoslav Republic of Macedonia.

From the southern city of Gevgelija, Ashur and her family began the next leg of their journey north, with the aim of crossing through Serbia and Hungary and then on to Belgium, where her husband's sister lives.

"We will reach our destination or die on the way."

While hundreds piled onto overcrowded trains and buses, or simply walked the 178 kilometres to the northern frontier city of Kumanovo, Ashur and her family found a taxi to take them for €100. Her two younger sons waved goodbye from the back window.

Syrians like Ashur and her family account for about 80 per cent of the people transiting through the country. Afghans and Iraqis each account for about 5 per cent. The others are from Pakistan, Somalia, Palestine and five countries in sub-Saharan Africa.

Between June and August 2015, an average of 700 refugees and migrants followed the same path to northern Europe through the former Yugoslav Republic of Macedonia every day. Of that number, about one in four is a woman, and on average, 6 per cent of those women are pregnant.

Many of the pregnant women have health concerns stemming from walking long distances in the heat, poor nutrition, dehydration and the absence of sanitation, all

of which can lead to pregnancy complications or even miscarriage. And many are traumatized, says Suzana Paunovska of the Red Cross in the capital, Skopje. "You see it immediately in their faces."

The Government in June declared that refugees and migrants could access health care, including obstetric and gynaecological services, for free from public health centres and hospitals, including the one in Gevgelija.

But because refugees and migrants are in a hurry to reach the border with Serbia within the 72 hours the Government allows for transiting through the country, most choose not to take advantage of free services rather than risk missing one of the few trains or buses traveling north.

Our world is in the midst of a paroxysm of violence, instability and upheaval not seen since the end of the Second World War. Over the past two decades, disasters, including ones related to extreme weather events, have affected billions of people. Today, crises, such as mass movements of people in response to extreme poverty and unstable societies, are increasingly visible. Whole regions of the world seem to be in turmoil, and in a more connected world, even people in the stable zones feel more insecure than they once did.

Many crises linger for decades, with no real solutions in sight. Refugees are living away from home for 20 years on average, with no access to durable solutions and sustainable livelihoods. In some cases, crises have persisted over generations (Milner and Loescher, 2011).

Each crisis, whether a war, a deadly epidemic, earthquake or flood, brings unique challenges to the health, safety, livelihoods and rights of individuals, families and communities.

Today's conflicts, devastation from disasters, instability, and environmental and economic vulnerability have triggered an unprecedented demand for humanitarian action from governments, civil society and international organizations.

Floods and storms: most frequent natural disasters

The number of natural disasters tripled between 1980 and 2000, followed by a slight decline, but still double the number today than what was recorded 25 years ago, according to data from the Centre for Research on Epidemiology of Disasters.

In most years, there are between one and three large-scale disasters that cause a level of death far greater than other events. In most decades, there are also one or two disasters so large and shocking to public consciousness they are labeled mega-disasters.

For each person who dies in a disaster, there are hundreds more who are affected by it and require

Pregnant women will only use services that are fast and within easy reach of transit hubs near border crossings, says Bojan Jovanovski, who heads the Association for Health Education and Research, or HERA, in the capital, Skopje.



Lidija Jovcevska

Photo © UNFPA/Nake Batev

HERA deploys its only mobile health clinic to the border with Greece, a few hundred metres from Gevgelija, one day a week to provide free, quick, basic gynaecological services for refugees and migrants. UNFPA, the United Nations Population Fund, helps cover the clinic's operating expenses.

Lidija Jovcevska is an obstetrician-gynaecologist based in Kumanovo. She volunteers one day a week for the mobile clinic. The five or six women she sees in a day mostly want to know whether their foetuses are healthy. She uses an ultrasound machine to reassure most expectant mothers but also lets them know about any potential complications. Some women who have traveled for days and sometimes months also ask for vitamin supplements to increase the

chances they will deliver healthy babies. Vaginal and urinary tract infections are common. Jovcevska prescribes antibiotics and other medications.

On occasion, there is a serious problem requiring attention at a hospital. Jovcevska refers these cases to the nearby hospital, which can handle emergencies as well as deliveries.

Jovcevska says the risks of traveling under such extreme conditions while pregnant are high. "It is unclear to me, as a mother of two myself, how they can even contemplate such a trip," she says, while acknowledging the desperation that many of these women feel. "One woman I saw today told me, 'It's all right if I die on the way.'"

immediate basic survival needs, such as food, water, shelter, sanitation or immediate medical assistance. Those affected by a disaster often lose their homes and livelihoods, become separated from families, face a lifetime of illness, disability or restricted opportunities, and are displaced from their communities.

Controlling for population growth, the likelihood of being displaced by a disaster today is 60 per cent higher than it was four decades ago. Over the last 20 years, there have been an average of 340 disasters per year, affecting 200 million people annually, taking an average of 67,500 lives a year.

Flooding caused 43 per cent of reported disasters in the Centre for Research on Epidemiology of Disasters' EM-DAT database between 1994 and



For each person who dies in a disaster, there are hundreds more who are affected by it and require immediate basic survival needs, such as food, water, shelter, sanitation or health care.

2014, affecting nearly 2.5 billion people. Storms were the second most frequent type of disaster, killing a total of more than 244,000 people and costing \$936 billion in recorded damage over that

nine-year period. This makes storms the most expensive type of disaster during the past two decades and the second most common killer.

Earthquakes (including tsunamis) killed more people than all other types of disaster combined, claiming nearly 750,000 lives between 1994 and 2013.

Tsunamis were the most deadly sub-type of earthquake, with an average of 79 deaths for every

1,000 people affected, compared to four deaths per 1,000 for ground movements. This makes tsunamis almost 20 times deadlier than land-based earthquakes.

The mobile clinic also offers contraception, though few take advantage of it, says Vesna Matevska, a programme coordinator for HERA. The refugees and migrants she sees tend to be very private people who are reluctant to ask for or accept condoms or the pill, even though they are free of charge and available from non-judgmental service providers. She says this sense of privacy, along with language barriers, also make it difficult for many women to talk about or report gender-based violence.

In addition to services provided by non-governmental organizations and the country's ministry of health, there are those offered informally by individuals like Lence Zdravkin, 48, a self-described activist, who says she has helped hundreds of pregnant women as they

walked north across the country to reach the Serbian border.

Until June 2015, it was illegal for refugees and migrants to use trains, buses or taxis, so most simply walked the distance, usually along the main railway tracks, which pass 10 metres from Zdravkin's home.

Zdravkin began offering refugees and migrants food and water and opened her home to people who simply needed a rest. She brought pregnant women to a local clinic for checkups or to treat the injuries that are inevitable when walking for days in the summer heat.

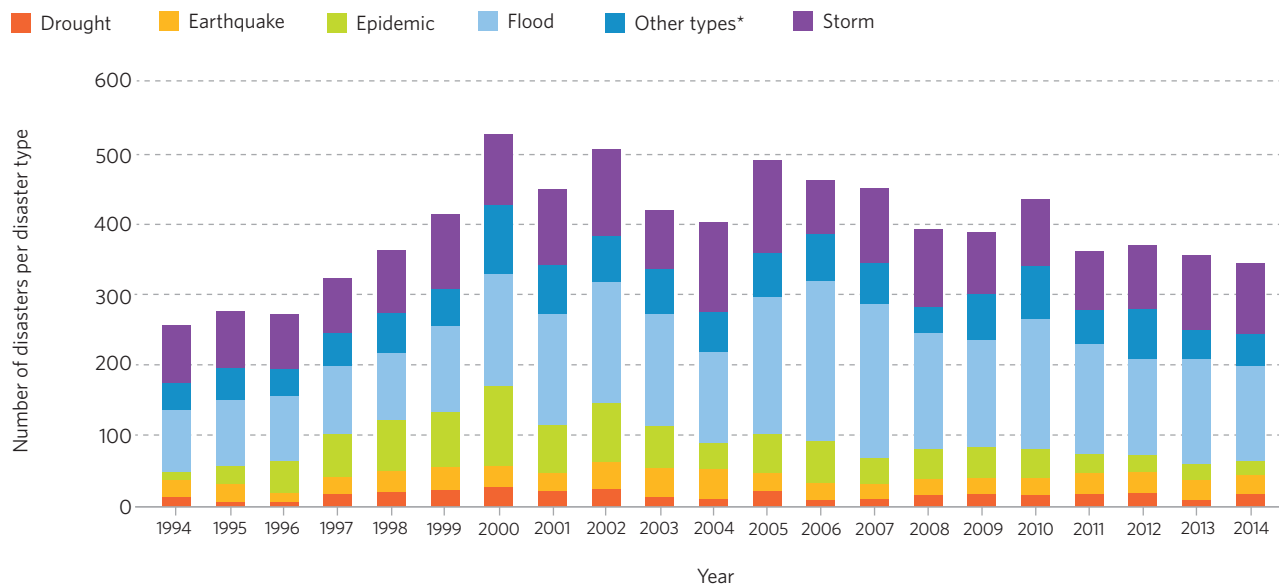
"Everything was happening right in front of me," Zdravkin says. "I couldn't just close my eyes."

Lence Zdravkin

Photo © UNFPA/Nake Batev

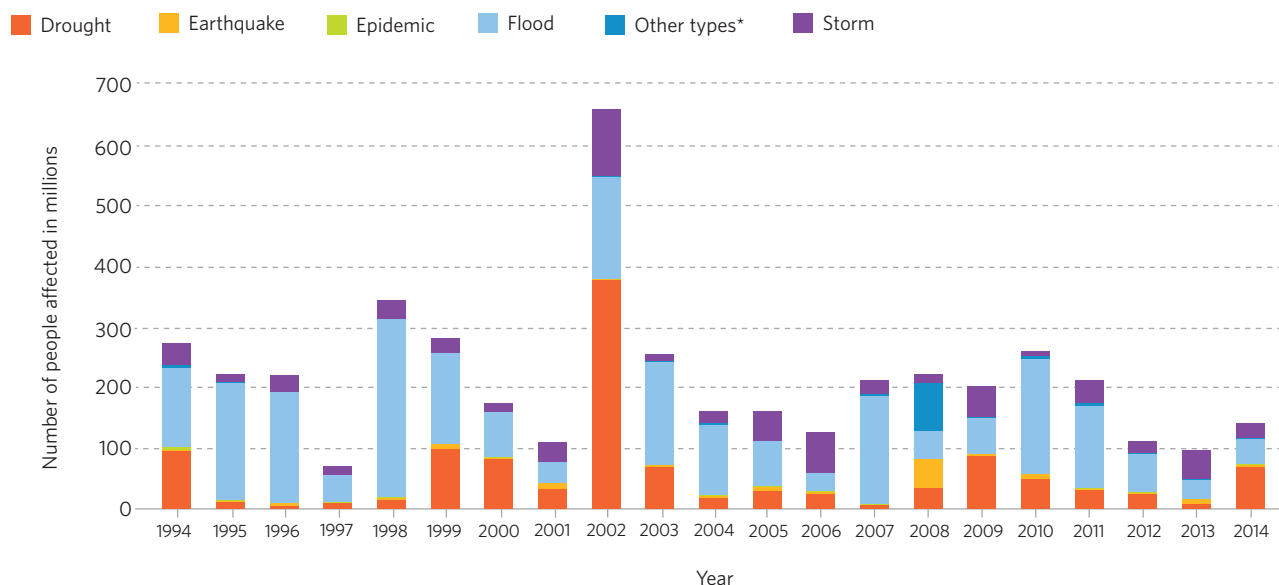


RECORDED NATURAL DISASTERS, WORLDWIDE, BY TYPE 1994 TO 2014



*Figures include disasters such as insect infestation, extreme temperature, landslide, volcanic activity and wildfire.
(CRED, 2015a)

ESTIMATED NUMBER OF PEOPLE AFFECTED BY NATURAL DISASTERS, BY TYPE 1994 TO 2014



*Figures include disasters such as insect infestation, extreme temperature, landslide, volcanic activity and wildfire.
(CRED, 2015a)

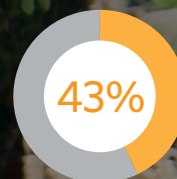
Drought affected more than 1 billion people between 1994 and 2014, or about one in four people affected by all natural disasters. Yet droughts accounted for just 5 per cent of disaster events. Some 41 per cent of drought disasters in that period were in Africa.

In absolute numbers, the United States and China recorded the most natural disasters between 1994 and 2014, due mainly to their size, varied landmasses and high population densities. Among the continents, Asia bore the brunt of disasters, with 3.3 billion people affected in China and India alone. If data are standardized to reflect the numbers of people affected per 100,000, Eritrea and Mongolia were the world's worst-affected countries that are not island States. Haiti suffered the largest number of people killed both in absolute terms and relative to the size of its population due to the toll of the 2010 earthquake.

While disasters have been recorded more frequently during the past 20 years, the average number of people affected has actually fallen from one in 23 between 1994 and 2003, to about one in 39 between 2004 and 2014.

Disaster-related deaths higher in poorer countries

The Centre for Research on Epidemiology of Disasters' data also show how income levels impact disaster death tolls. On average, more than three times as many people died per disaster in low-income countries (332 deaths) than in high-income ones (105 deaths). A similar pattern is evident when low- and lower-middle-income countries are grouped together and compared to high- and upper-middle-income countries. Taken together, higher-income countries experienced 56 per cent of disasters but lost 32 per cent of lives, while lower-income



Flooding caused
43 per cent of reported
disasters between 1994
and 2014, affecting nearly
2.5 BILLION PEOPLE



Drought affected more
than **1 BILLION** people
between 1994 and 2014, or
about **ONE IN FOUR PEOPLE**
affected by all natural
disasters



TSUNAMIS
79
DEATHS

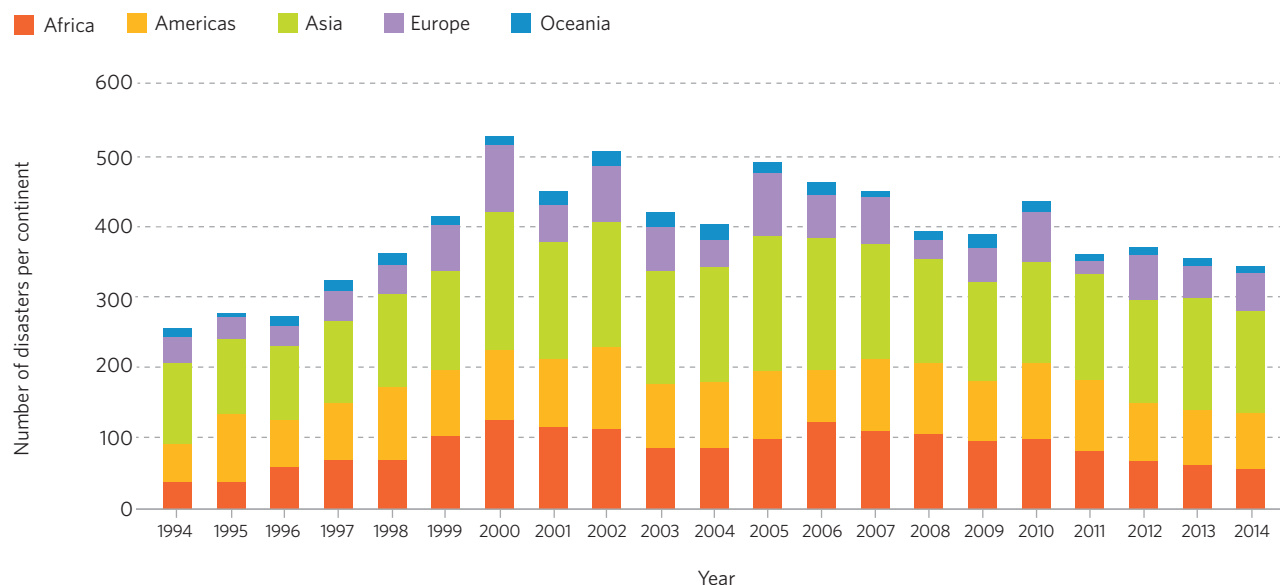


EARTHQUAKE
4
DEATHS

per
1,000 people affected

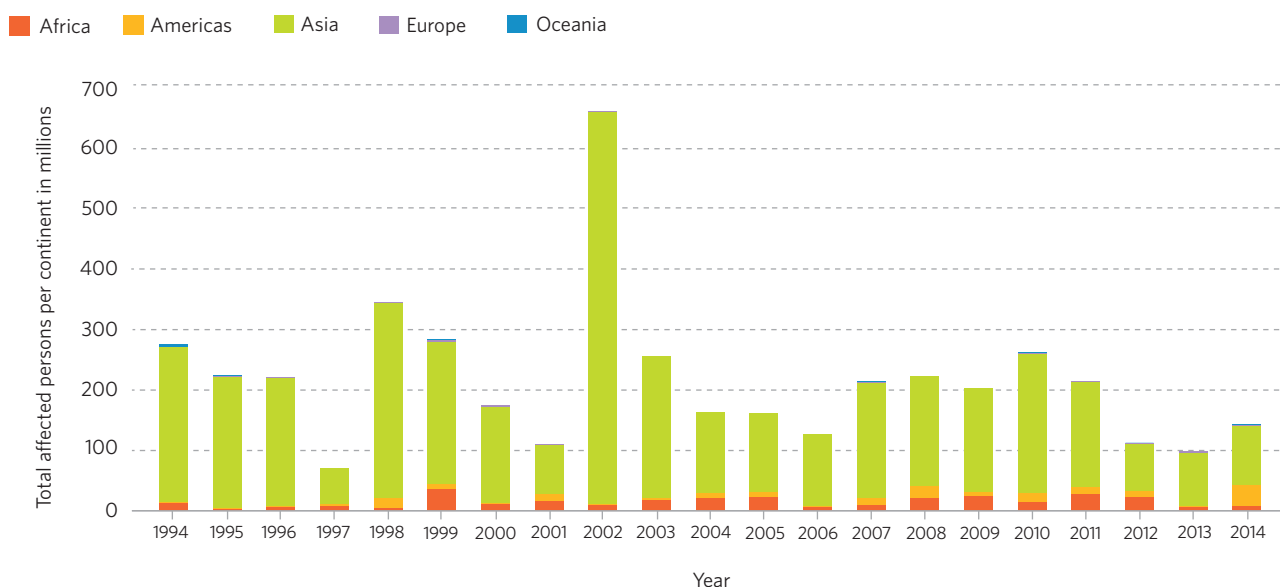
Making tsunamis almost
20 TIMES deadlier than
land-based earthquakes,
over two decades

RECORDED NATURAL DISASTERS, BY REGION 1994 TO 2014



(CRED, 2015a)

ESTIMATED NUMBER OF PEOPLE AFFECTED BY NATURAL DISASTERS, BY REGION 1994 TO 2014



(CRED, 2015a)

countries experienced 44 per cent of disasters but suffered 68 per cent of deaths. This demonstrates that levels of economic development, rather than exposure to hazards per se, are major determinants of mortality.

Rise in conflicts within borders pushes civilian death toll upward

The Second World War, the largest conflict in the modern world, remains humanity's reference point for mass harm. About 3 per cent of the world's people died as a direct result of that conflict or its prelude and aftermath. Meanwhile, more than one third of the world's people were *affected* by it. For each death, therefore, 10 other lives were radically disrupted.

After the Second World War, the number of international conflicts declined dramatically, while conflicts within national boundaries and wars of decolonization increased in the 1950s and 1960s.

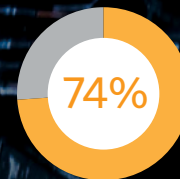
The increase in intra-State conflicts and the decrease in international wars help explain an increase in civilian deaths and a decrease in deaths among combatants. Regardless of whether a conflict occurs within or across a national boundary, it invariably has an insidious impact on the lives of many people, through chronic insecurity and uncertainty, which in turn affect the quality of life, social cohesion, livelihoods, rights and development potential for all.

At the end of the Second World War, 940 million people—or 40 per cent of the world's population at that time—lived in areas of conflict. By 1956, the number fell precipitously to 210 million, or 8 per cent of the world's population. Afterward, the number continued to rise, reaching about 1 billion people today (Garfield et al., 2012).



Today, about **ONE IN THREE** refugees resides in a camp. Two in three live in urban areas

Today **1 BILLION PEOPLE** or about 14 per cent of the world's population live in areas of conflict

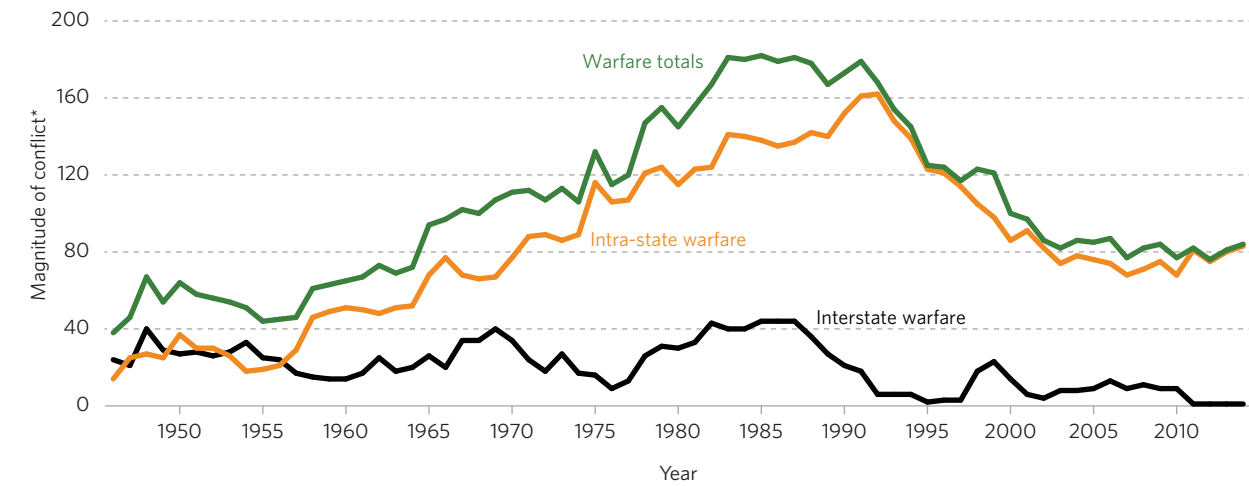


Seventy-four per cent of direct conflict deaths between 1989 and 2008 occurred in Central Africa, East Africa, the Middle East and North Africa and South Asia

Photo © Panos Pictures/Mikkel Ostergaard

GLOBAL TRENDS IN ARMED CONFLICT

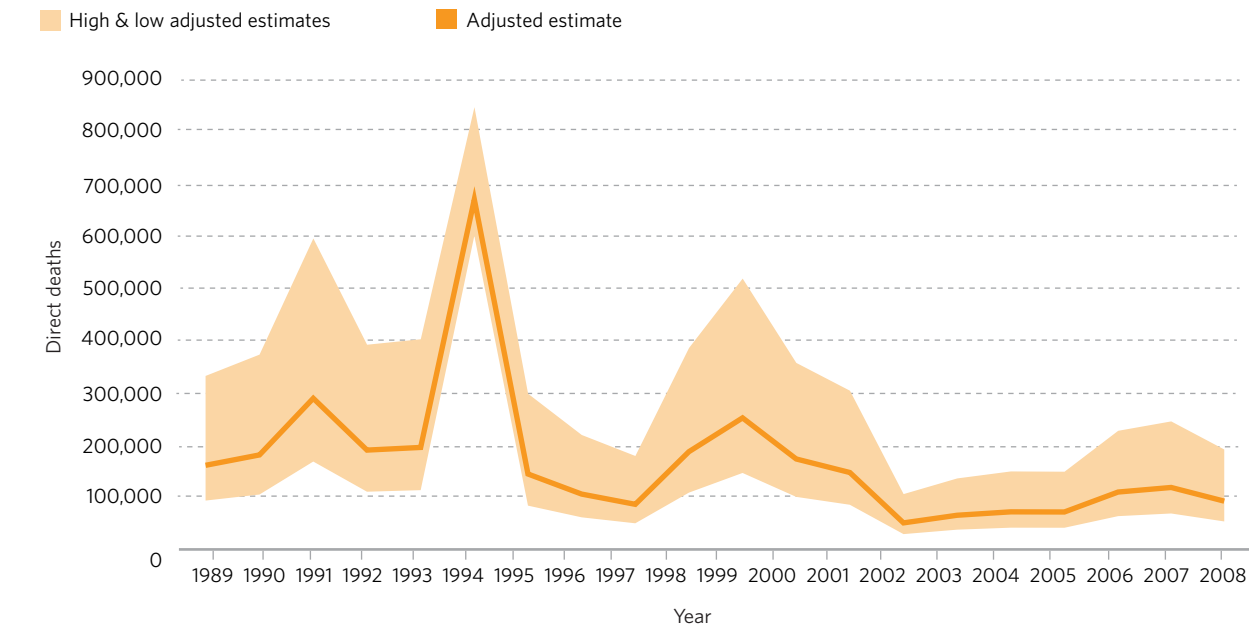
1946 TO 2014



(Center for Systemic Peace, 2015)

* The magnitude of a conflict is measured by the comprehensive effects on the State or States directly affected by warfare, including numbers of combatants and casualties, affected area, dislocated population and extent of infrastructure damage.

DEATHS DIRECTLY RELATED TO CONFLICT



(Garfield and Blore, 2009)

CONFLICT'S IMPACT ON WOMEN AND MEN

Global conflict-related data disaggregated by sex are scarce, and when they are available, they are often unreliable. Still, small area-specific surveys yield some insights showing that men are much more likely to die *directly and during* conflicts, whereas women die or are otherwise harmed more often of *indirect* causes *after* a conflict (Ormhaug, 2009). Every estimate of direct conflict deaths suggests that more than 90 per cent of all casualties occur among young adult males (Cummings et al., n.d.).

	DIRECT IMPACTS	INDIRECT IMPACTS
MEN	- Higher rates of morbidity and mortality from battle deaths - Higher likelihood to be detained or missing - Sexual and gender-based violence: sex-selective massacres; forcibly conscripted or recruited; subjected to torture, rape and mutilation; forced to commit sexual violence upon others - Higher rates of disability from injury	- Risk of ex-combatants' involvement in criminal or illegal activities and difficulties in finding livelihoods - Increased prevalence of other forms of violence—particularly domestic violence
COMMON	Depression, trauma and emotional distress	- Asset and income loss - Tendency towards increased migration - Disrupted patterns of marriage and fertility - Loss of family and social networks, including insurance mechanisms - Interrupted education - Eroded well-being, particularly poor health and disability from poverty and malnutrition
WOMEN	- Higher likelihood to be internally displaced persons and refugees - Gender-based violence: being subjected to rape, trafficking and prostitution; forced pregnancies and marriages	- Reproductive health problems - Women's reproductive and care-giving roles under stress - Changed labour market participation from death of family members and "added worker effect" - Higher incidence of domestic violence - Possibility for greater political participation - Women's increased economic participation due to changing gender roles during conflict

(Anderlini, 2010)

Direct conflict deaths average 168,100 a year

The number of deaths is one indicator for intensity or magnitude of a conflict. A generation of researchers has tried to establish reliable estimates of the number of people killed in conflict. Arriving at such estimates is especially complicated because conflicts are increasingly waged by non-State actors in remote areas and often in countries with institutions ill-equipped to accurately track casualties.

Between 1989 and 2008, there were an estimated total 3,362,000 direct conflict deaths, or an average of 168,100 deaths per year (Garfield and Blore, 2009). Seventy-four per cent of direct conflict deaths between 1989 and 2008 occurred in Central Africa, East Africa, the Middle East and North Africa and South Asia.

Since 2008, increasing conflict in the Middle East raised the total level of direct conflict deaths to more than 200,000 per year (Price et al.,

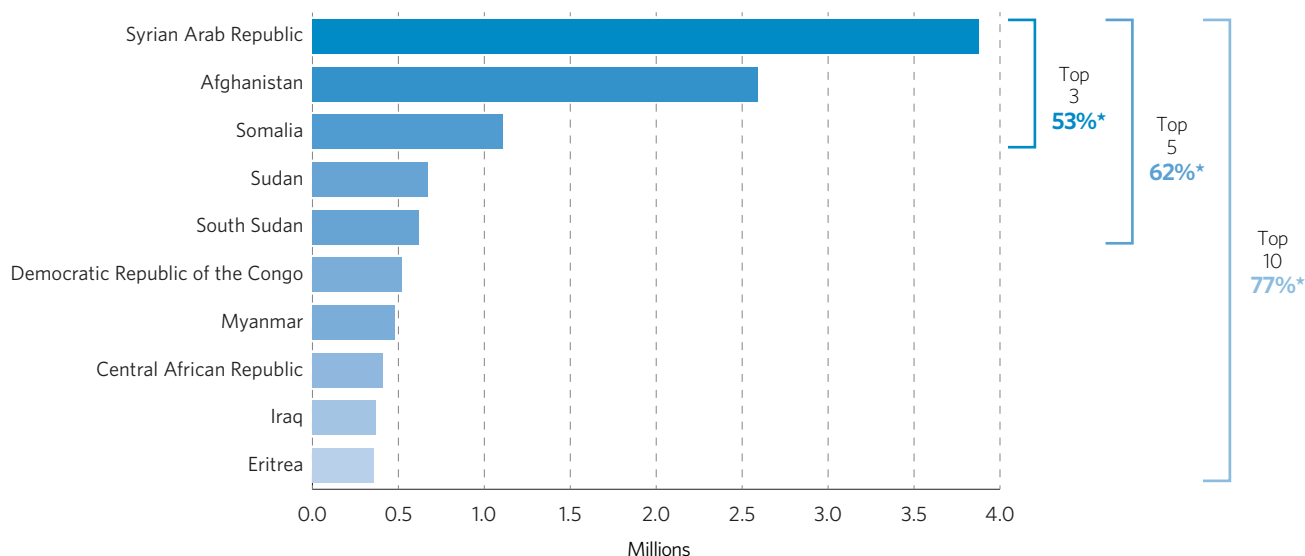
2014). In 2012, two out of five people worldwide who died in battle were in Syria.

In addition, deaths that result from conflict but are not directly due to fighting outnumber direct conflict deaths, in some countries by a rate of three to one. Most of these indirect deaths occur in low-income countries, where vulnerable civilians are cut off from vital lifelines to immunization, child nutrition and clean water.

Other armed violence

Armed violence not associated with conflict also takes a heavy toll on lives. The Global Burden of Armed Violence in 2011 attempted to account for all deaths due to firearms recorded through civil systems in countries throughout the world, arriving at an estimate of 400,000 firearms-related deaths outside of conflict situations. Insecurity and fear of armed violence have been major drivers of displacement and migration in some countries in recent years, sparking a situation that resembles a humanitarian crisis.

MAJOR SOURCE COUNTRIES OF REFUGEES



Displacement from conflict

In 2014, the total number of refugees and internally displaced people worldwide reached 59.5 million, the highest number since the Second World War (UNHCR, 2015). The number of internally displaced people doubled from 2010 to 2015.

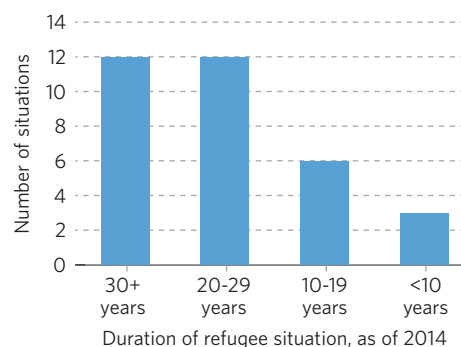
More than half of all new refugees in 2014 came from Syria, Afghanistan, Somalia and Sudan. More than half of all internally displaced people reside in Syria, Colombia, Iraq and Sudan (Internal Displacement Monitoring Centre, 2015). Today, about one in four people in Lebanon and one in 10 in Jordan is a refugee.

Today, only about one in three refugees resides in a camp. Two in three today live in urban areas.

About two-thirds of the world's refugees are in "situations of seemingly unending exile" (Milner and Loescher, 2011). The 25 countries most affected by a prolonged refugee presence are all in the developing world. Today, there are some

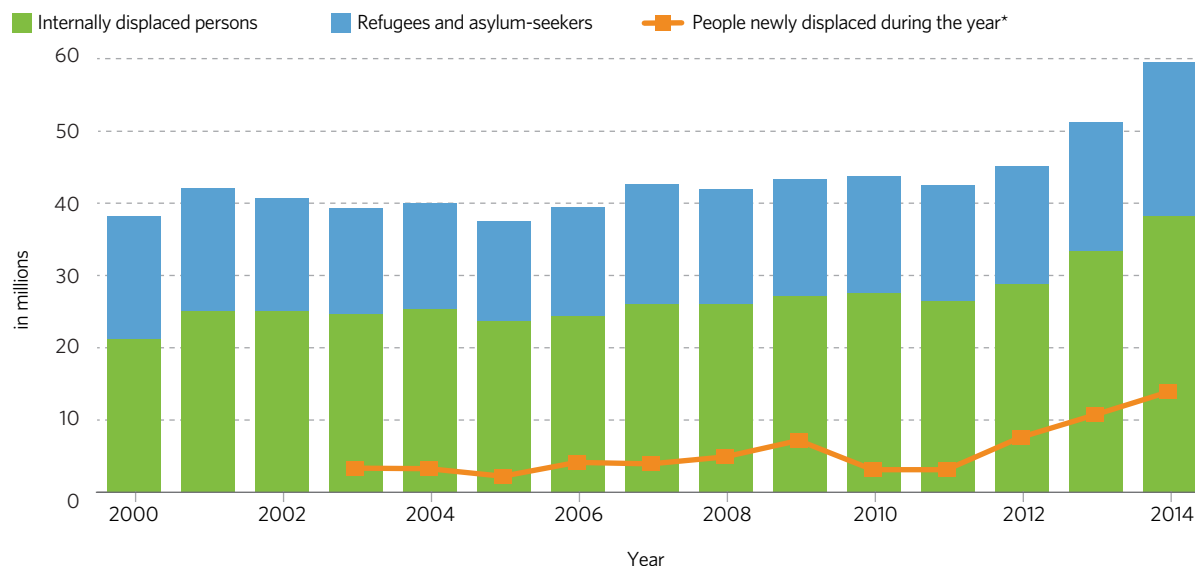
30 major protracted refugee situations, with the average length of time in this state approaching 20 years. This average, however, does not include many of the most chronic and long-term displaced populations, such as those in urban settings or those displaced in rural areas. It also does not

PROTRACTED REFUGEE SITUATIONS BY DURATION



(UNHCR, 2015)

DISPLACEMENT IN THE 21ST CENTURY 2000 TO 2014



(UNHCR, 2015)

* Displaced internally and across international borders. Newly displaced data available only since 2003.

include millions of Palestinian refugees under the mandate of the United Nations Relief and Works Administration.

Disasters displace 26.4 million people annually

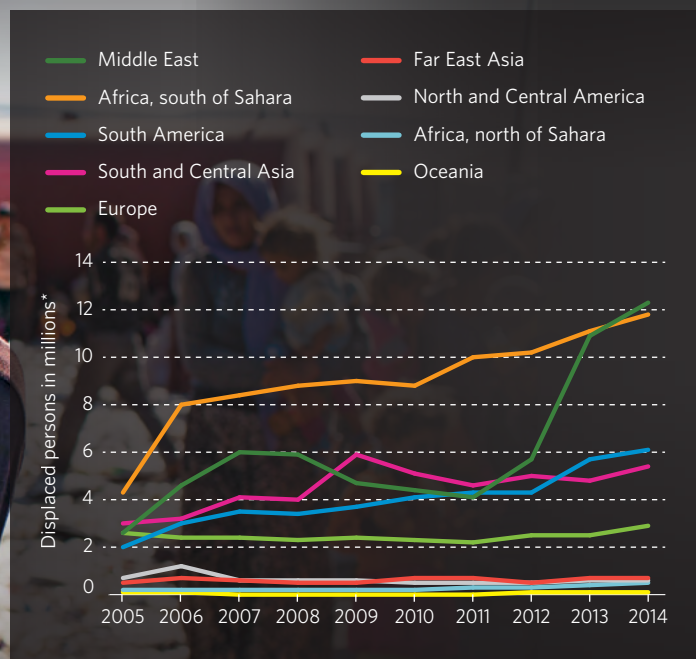
According to the United Nations High Commissioner for Refugees, an average of 26.4 million people worldwide have been displaced by disasters per year since 2008. Most of the displacement occurred in low- and middle-income countries.

While the frequency of geophysical disasters—earthquakes, tsunamis, volcanic eruptions—has

remained broadly constant in recent years, climate-related events, such as floods and storms, are increasing. From 2000 to the present, there have been an average of 341 climate-related disasters per year, up 44 per cent from the average recorded between 1994 and 2000.

The Centre for Research on the Epidemiology of Disasters estimates that 19.3 million people were displaced because of disasters in 2014. Over the last seven years, 85 per cent of these disaster-induced movements have been caused by weather-related events, mainly flooding and storms. About 15 per cent are due to earthquakes.

NUMBER OF DISPLACED PERSONS BY REGION 2005 TO 2014



(Development Initiatives, 2015)

*'Displaced persons' includes refugees and people in refugee-like situations, internally displaced persons and asylum seekers. Internally displaced persons include only those persons protected/assisted by United Nations High Commissioner for Refugees. Data are organized according to definitions of country/territory of asylum. Countries are organized according to the Organisation for Economic Co-operation and Development's classification of regions.

Photo © Ali Arkady/VII Mentor Program

The forces of fragility

Why are there so many crises in our world today?

Why does the world suddenly seem so fragile?

There are many explanations of fragility and its causes. But regardless of the definition, fragility is closely linked to forces such as poverty, inequality and exclusion, which disproportionately affect women and girls.

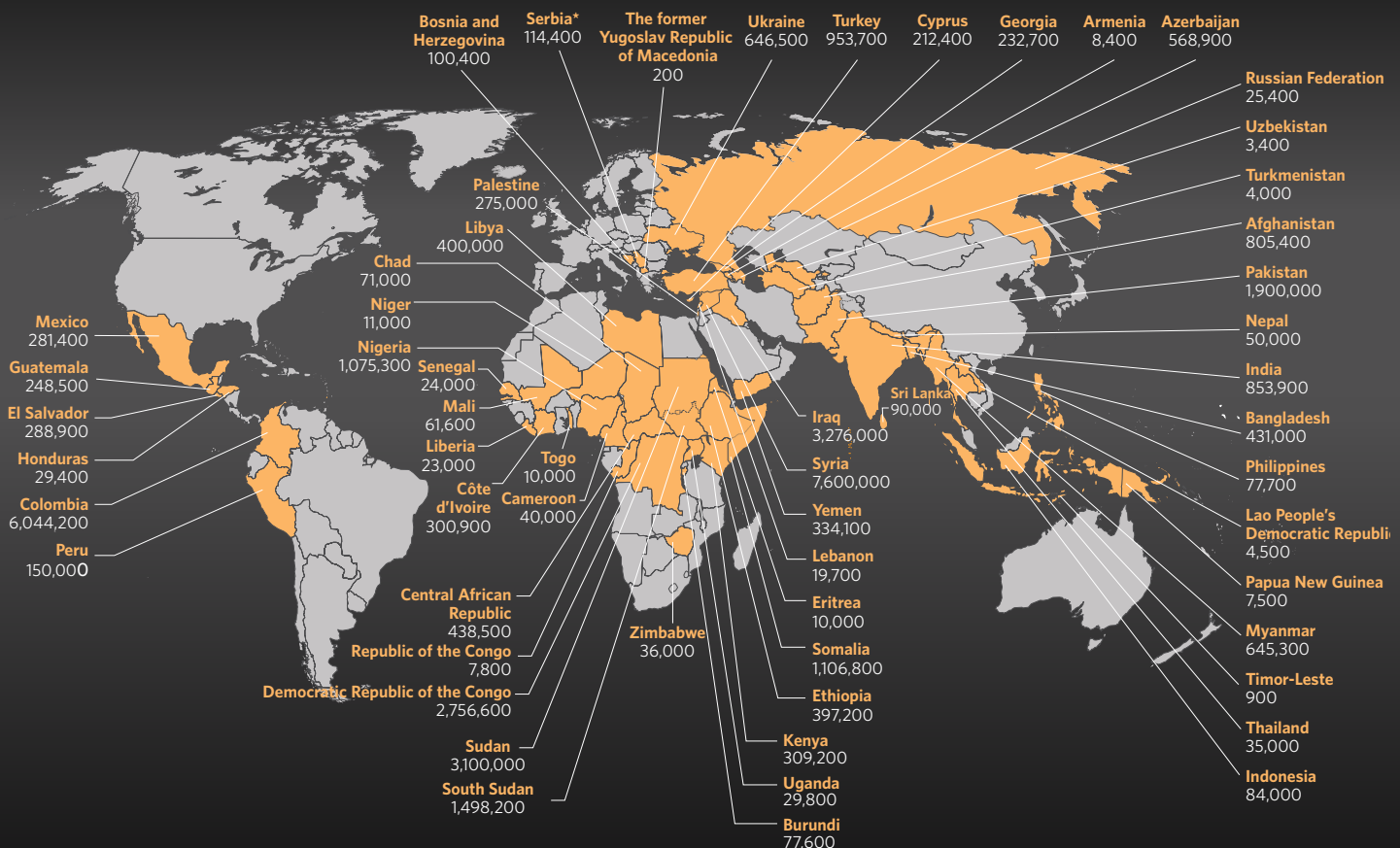
Fragile States home to one in three poor people

Fragility can manifest in several different forms and in countries at any income level. According to the Organisation for Economic

Co-operation and Development, “a fragile region or State has weak capacity to carry out basic governance functions, and lacks the ability to develop mutually constructive relations with society.” Fragile States are more vulnerable to internal or external shocks, such as economic crises or natural disasters (OECD, 2013). The relationship between state and society can break down as a result of both internal and external stress factors including demographic shifts, technological innovation and climate change.

A decade ago, most fragile States were low income. According to recent estimates, about half of fragile and conflict-affected States are now

PEOPLE INTERNALLY DISPLACED BY CONFLICT AND VIOLENCE IN 2014



(Norwegian Refugee Council, Internal Displacement Monitoring Centre, 2015a)

*Figure includes Kosovo

middle-income countries. Despite this change in income level, poverty remains concentrated in fragile States (OECD, 2013). Fragile middle-income countries share common characteristics such as high levels of urban and criminal violence, growth of violent megacities and large, underemployed youth populations (Castillejo, 2015).

Fragile States are home to one third of the world's poor. More than 1 billion people, or about 15 per cent of the world's population, are in extreme poverty, according to estimates from the World Bank (World Bank, 2015a). Extreme poverty, previously concentrated in East Asia, has shifted to sub-Saharan Africa and South Asia, which today accounts for 80 per cent of the world's poor, the majority of which are women and children (World Bank 2015b).

The poor are especially vulnerable to the effects of conflict, and various measurements of fragility suggest that high levels of poverty and income inequality can contribute to instability. The poor have fewer economic, social and other resources to help them withstand or recover from conflicts, which can in turn exacerbate poverty.

Two of three unattended births are in fragile States

Despite global economic and social progress in recent decades, there is a large and growing portion of humanity living with greater insecurity and instability. It is from these countries that the major challenges to stability, development, and achievement of social progress exist. Gates et al. (2010) summarized the impact with data showing that close to half the people in low-income countries in 2010 were in States that are fragile, in conflict, or recovering from conflict. These same areas accounted for 60 per cent of the world's people who are undernourished, 77 per cent of the children not attending primary school, 70 per cent of infant deaths and 64 per cent of unattended births.

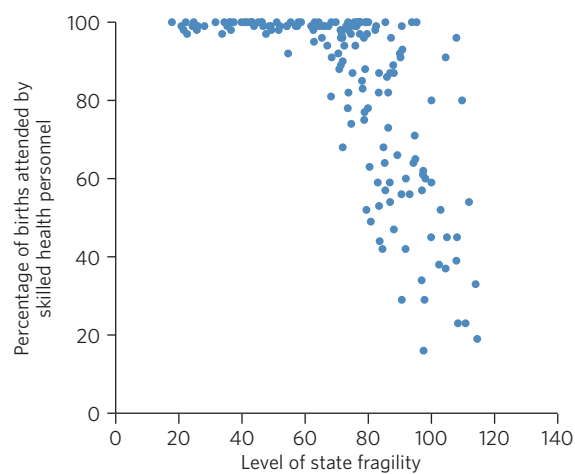
When States' fragility is matched against key reproductive health indicators, correlations emerge, showing that extremely fragile countries are likely to have fewer births assisted by skilled attendants, higher rates of adolescent pregnancy and greater unmet need for family planning.

Measuring fragility

A number of groups have developed means for measuring whether a State is fragile, and thus vulnerable to conflict or the effects of disasters. (OECD, 2015).

The Organisation for Economic Co-operation and Development (OECD) each year issues a Fragile States Index, which shows countries' and territories' vulnerability to conflict and disaster by looking at five key dimensions: the level of violence, the extent to which there is access to justice and rule of law, whether national institutions are effective, accountable and inclusive, the level of economic stability, and the level of resilience to withstand and adapt to shocks and disasters.

PERCENTAGE OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL LOWER IN FRAGILE STATES

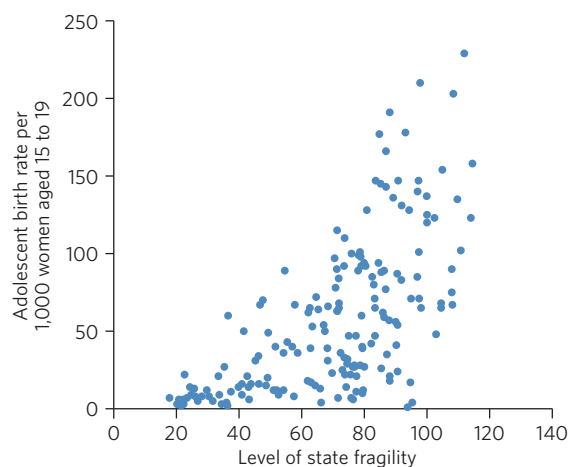




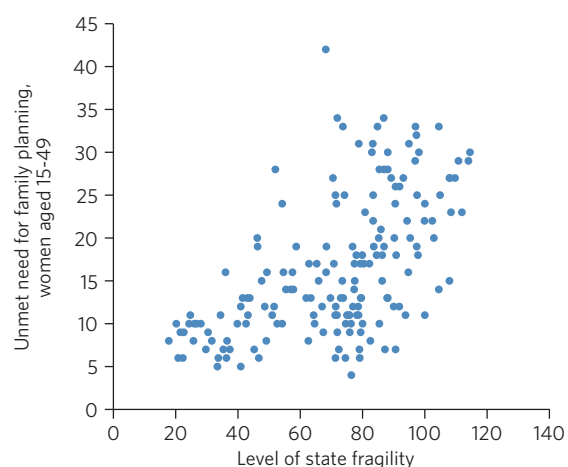
Sapana Suwal, 25, with her children in shelter for earthquake survivors, Bhaktapur, Nepal

Photos © Panos Pictures/Brian Sokol

ADOLESCENT BIRTH RATES TEND TO BE HIGHER IN FRAGILE STATES



UNMET NEED FOR FAMILY PLANNING GENERALLY GREATER AMONG MORE FRAGILE STATES



DIMENSIONS OF FRAGILITY

THE ORGANISATION FOR ECONOMIC CO-OPERATION FRAGILE STATES INDEX 2015

This index shows countries' and territories' vulnerability to conflict and disaster by looking at five key dimensions: the level of violence, the extent to which there is access to justice and rule of law, whether national institutions are effective, accountable and inclusive, the level of economic stability, and the level of resilience to withstand and adapt to shocks and disasters.

VULNERABILITY IN DIMENSIONS:



VIOLENCE



JUSTICE



INSTITUTIONS



RESILIENCE



**ECONOMIC
FOUNDATIONS**

9 COUNTRIES



Central African Republic
Chad
Democratic Republic
of the Congo
Côte d'Ivoire
Guinea
Haiti
Sudan
Swaziland
Yemen

5 DIMENSIONS

13 COUNTRIES



Equatorial Guinea
Eritrea
Guinea-Bissau
Mauritania
Togo
Zimbabwe



Afghanistan
Burundi
Nepal
South Sudan



Ethiopia
Nigeria
Somalia

4 DIMENSIONS

26 COUNTRIES



Algeria
Syrian Arab Republic



Cameroon
Lao People's Democratic
Republic



Angola
Liberia



Kenya
Uganda



Comoros
Madagascar
Republic of the Congo
Sierra Leone



Bangladesh
Libya
Myanmar
Pakistan
Venezuela



Gambia
Malawi
Mozambique
Niger
Timor-Leste



Honduras
Lesotho
Mali
Palestine

3 DIMENSIONS

22 COUNTRIES



India
Panama
Serbia (Kosovo)



Iran
Iraq



Djibouti



Papua New Guinea
Solomon Islands
Zambia



Benin
Burkina Faso
Kiribati
São Tomé and Príncipe
Suriname



Cambodia
Fiji
Tajikistan
Turkmenistan



Colombia
Guatemala
Paraguay
Rwanda

2 DIMENSIONS

Nine of the 50 most fragile places have low rankings in all five dimensions (OECD, 2015).

Another measurement, the Global Peace Index, gauges the level of peace in 162 countries. The index, published by the Institute for Economics and Peace, looks at the level of safety and security in society, the extent of domestic and international conflict and the degree of militarization. Between 2013 and 2014, 78 countries have become less peaceful, according to this index (IEP, 2014).

The Fund for Peace's Fragile States Index looks at 12 dimensions of vulnerability, including whether economic development is uneven or equitable, whether there is respect for human rights and liberties, the extent of poverty and economic decline, frequency of disasters, and whether key services, particularly education and health, are available to all. According to this index, four countries are on "very high alert," with South Sudan at the top of the list, followed by Somalia, Central African Republic and Sudan. Between 2013 and 2014, measures of fragility on this index worsened to some degree in 67 countries (FFP, 2015).

Regardless of the index, more and more countries are considered fragile and therefore likely to be more vulnerable to conflict or to the effects of disasters.

Assessing risk

Humanitarian crises and disasters cannot always be prevented but their impact can be greatly reduced. Understanding crisis and disaster risk is a critical step in reducing and managing it. Risk assessment aims to identify and prioritize the people and places most at risk of disaster and find ways to reduce and manage the risks they face (INFORM, 2015).

The Index for Risk Management (INFORM), a joint project of the United Nations, international and bilateral organizations and research institutions, uses 50 different indicators to measure hazards and people's exposure to them, vulnerability and the



Residents of Union Balsalito, Colombia.

Photo © UNFPA/Daniel Baldotto

amount and type of resources available to help them cope (INFORM, 2015).

INFORM data show the risk of humanitarian crises has risen in three low-income countries, six lower middle-income countries, four upper middle-income countries and two high-income countries that are not members of the OECD (INFORM, 2015).

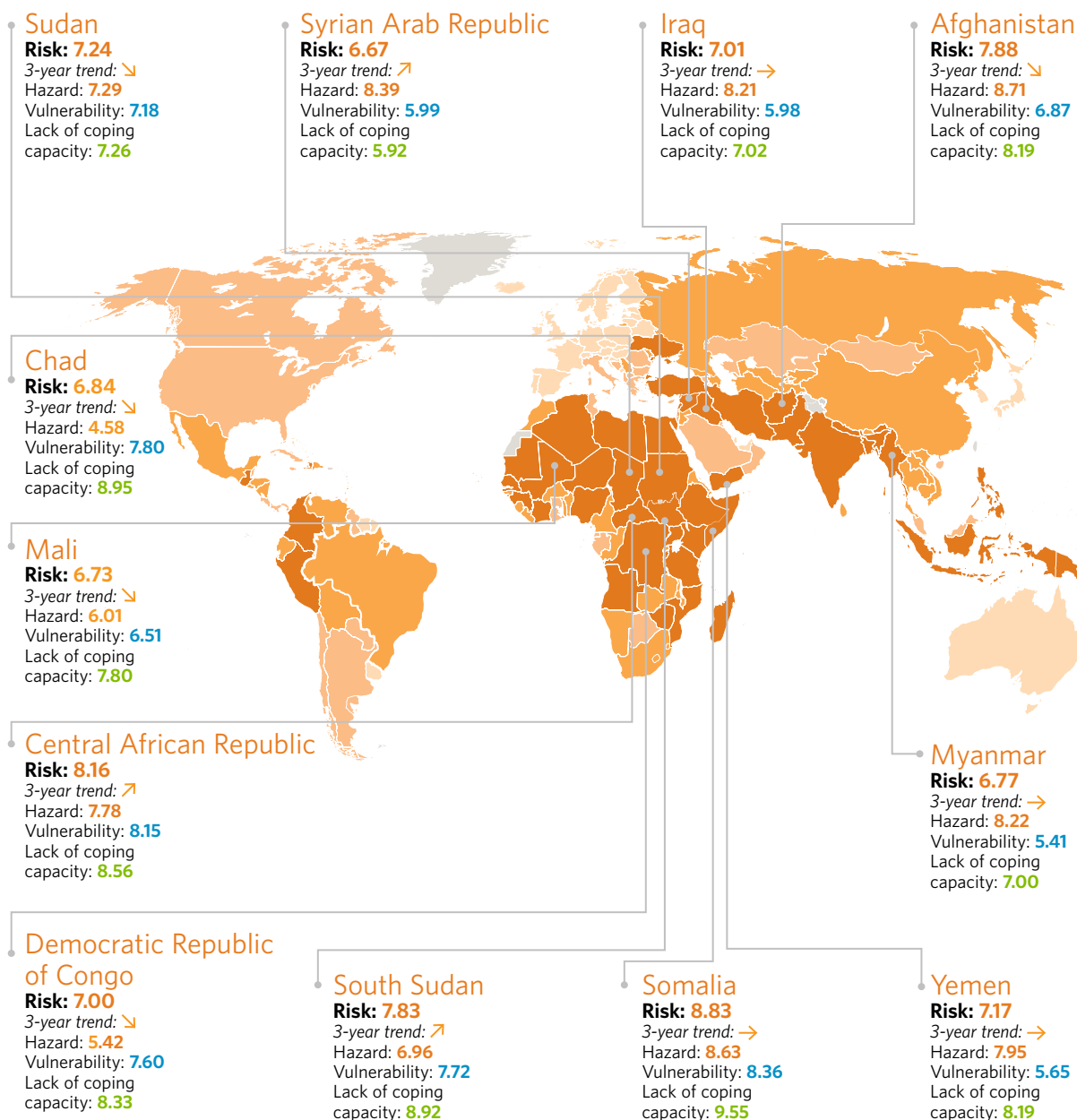
INFORM also shows that the risk has decreased significantly in 22 low-income countries, 28 lower middle-income countries, 43 upper middle-income countries, 16 high-income countries that are not OECD members and 29 high-income OECD members (INFORM, 2015).

The 11 countries most at risk of disaster-induced poverty are Bangladesh, Democratic Republic of Congo, Ethiopia, Kenya, Madagascar, Nepal, Nigeria, Pakistan, South Sudan, Sudan, and Uganda, according to the Overseas Development Institute (ODI et al., 2013).

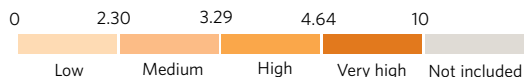
Discounting earthquake and cyclone exposure, and assessing just drought, extreme temperature and flood hazards alone, reveal that as many as 319 million extremely poor people will be living in the 45 countries most exposed to these hazards by 2030. This is a major concern as drought and flood

2015 RISK

The overall risk index identifies countries at risk from humanitarian crises and disasters that could overwhelm national response capacity. It is made up of three dimensions—hazards and exposure, vulnerability and lack of coping capacity. This map shows details for the 12 countries with the highest overall risk.



INFORM RISK INDEX

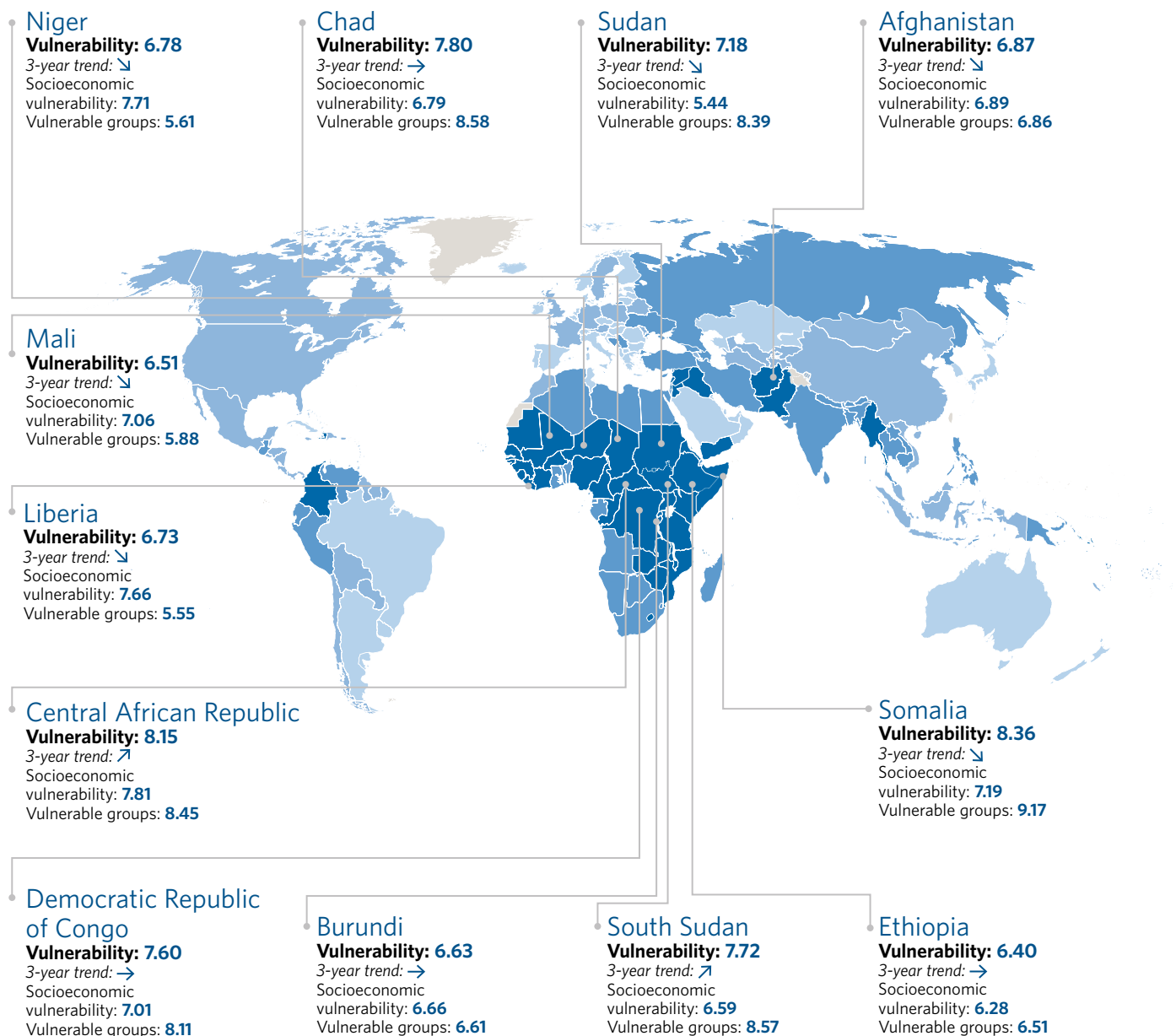


KEY ↗ Increasing risk → Stable ↘ Decreasing risk

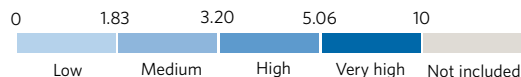
(INFORM, 2015)

2015 VULNERABILITY

This dimension measures the susceptibility of people to potential hazards. It is made up of two categories—socio-economic vulnerability and vulnerable groups. This map shows details for the 12 countries with the highest values in the vulnerability dimension.



INFORM VULNERABILITY INDEX



KEY ↗ Increasing risk → Stable ↘ Decreasing risk

(INFORM, 2015)

FIVE-YEAR RISK TRENDS BY WORLD BANK INCOME GROUP, 2011 TO 2015

	5 Year Inform Risk Trends By World Bank Income Group 2011-2015				
	Low income (35)	Lower middle income (47)	Upper middle income (55)	High income: non OECD (22)	High income: OECD (31)
Significant increase (>0.5)	3	6	4	2	0
Stable (<0.5 / >-0.5)	10	13	8	4	2
Significant decrease (<-0.5)	22	28	43	16	29

(INFORM, 2015)

hazards are among the most potent shocks when it comes to causing long-term impoverishment (ODI et al., 2013).

Worldwide, natural disasters are increasing in severity and becoming more costly. Classified as either climate-related or geophysical, natural disasters occur when natural hazards affect human lives and livelihoods. Natural disasters today are mainly attributed to rising climate-related disasters, including storms and floods (CRED, 2015).

A World Bank report, *Turn Down the Heat*, highlights the dramatic effects of global climate and weather extremes as global temperatures rise (World Bank, 2013). The impact of rising global temperatures is disproportionately concentrated in low- and middle-income countries and small island developing States. The poor and most vulnerable populations are likely to be the hardest hit and have the least capacity or access to resources to enable them to adapt and recover.

The frequency of droughts has gradually increased in East Africa over the past 50 years, but has declined in West Africa. Somalia, Burundi, Niger, Ethiopia, Mali and Chad were classified as countries with highest relative vulnerability to drought based on a drought vulnerability indicator (Shiferaw et al., 2014).

In sub-Saharan Africa, 90 per cent of food and fodder is produced through rain fed agriculture, which also accounts for more than 70 per cent of the population's principal livelihood (Shiferaw et al., 2014). The lives and livelihoods of poor populations, especially women, who account for up to 70 per cent of food production in the region, are most threatened by drought as they possess the lowest adaptive capacities to drought as a result of high levels of chronic poverty. (Gawaya, 2008).

Gender, urbanization and humanitarian crises

Urbanization is reshaping our world and the nature of humanitarian crises and response. For the first time in history, more than half of the world's population lives in cities. As more people settle in the slums of megacities in developing countries, they are in turn increasingly on the front lines of disaster. The rapid growth of urban populations, unprecedented influx of displaced populations and increasing possibility of severe weather events increase the risk of urban humanitarian disasters.

Urban population growth has become increasingly concentrated in developing countries, where 1.2 million people are migrating to cities every week (UN-HABITAT, 2013). Sub-Saharan Africa and Asia

are experiencing unprecedented levels of urbanization but are also the least developed regions and are most unprepared and ill-equipped to manage the influx.

Rapid urbanization, inadequate planning and scarce land have forced poor and vulnerable populations to live in slums or informal settlements in areas with greater vulnerabilities to disasters.

An estimated 1 billion people live in informal settlements, 90 per cent of which are located in developing countries (Norwegian Refugee Council, Internal Displacement Monitoring Centre, 2015a).

Migrants, refugees and internally displaced people represent a significant and increasing proportion of urban informal settlers as they are unable to afford better housing. Many of the settlements are located in poorly serviced areas that lack basic infrastructure such as health services, access to fresh water and sanitation.

Informal settlers are more vulnerable to the consequences of natural hazards such as earthquakes than the general population as they are often forced to live in poor-quality housing not built to withstand shocks. These makeshift dwellings are mostly located in hazardous areas more likely to be affected by natural disasters such as industrial waste lands, flood plains and unstable cliffs.

A trend is emerging whereby increasing numbers of women are migrating from rural areas to urban centres on their own. The underlying driving forces of urban migration for women and its consequences are related to issues of social inequality and gender. Both men and women migrate to cities in search of a better life, in terms of economic opportunities and access to services. Several gender-specific factors may push women to migrate to cities, ranging from forced eviction, to increased domestic violence, harmful practices such as child marriage, or health problems associated with HIV and AIDS (COHRE, 2008).

Women and girls are disproportionately affected by the poor living conditions of urban slums and the substandard housing as they spend more time in the home and community caring for their families. Women's health and security is a major issue in urban informal settlements as they are exposed to poor sanitation conditions, security risks, increased sexual violence, and the impact of disasters such as floods and fire outbreaks (COHRE, 2008). Poor street lighting, inadequate public transport, a lack of security patrols and an absence of doors with locks on dwellings contribute to gender-based violence and make women more vulnerable to rape (UN-HABITAT, 2013).

The proportion of the urban population living in slums continues to grow in countries affected by or emerging from conflict. A recent study found that in 41 of 75 countries where sex-disaggregated data were available, women are more likely to live in poverty.



Magbenteh Ebola Treatment Centre, Sierra Leone.
Photo © UN Photo/Martine Perset

Weak health sectors and fragility

Fragile countries have the poorest health indicators, and poor health outcomes can contribute to fragility. But State fragility can in turn cause high disease and mortality rates as a result of ineffective service delivery (Haar and Rubenstein, 2012).

The largest Ebola epidemic in history hit West Africa in 2014. The worst-affected countries, Guinea, Liberia and Sierra Leone are fragile States (UNDP, 2015a).

A devastating 14-year conflict destroyed much of Liberia's infrastructure, so by the time the Ebola epidemic began, the health sector was ill-equipped and understaffed to manage the crisis (UNDP, 2015a).

Reproductive health indicators are poor in fragile contexts as a result of weakened health service infrastructure and understaffed facilities, which together can lead to reduced access to reproductive health services, supplies and information. Only \$1.30 per

capita was spent annually on reproductive health in 18 conflict-affected countries between 2003 and 2006 (Patel, et al. 2009).

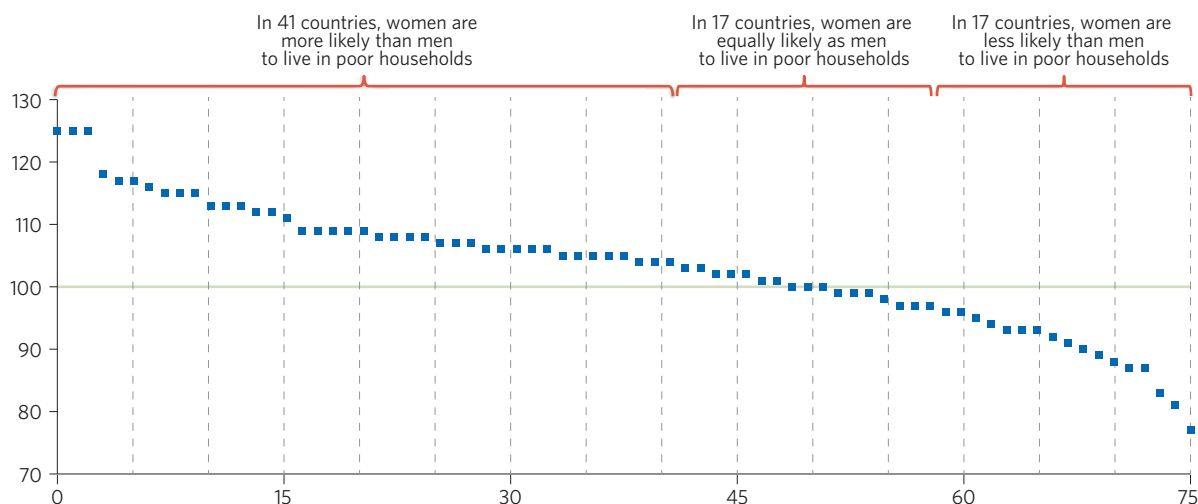
Crises hobbling development and leading to profound vulnerability

Conflict, violence, instability, extreme poverty and vulnerability to disasters are deeply interrelated conditions, which today prevent more than 1 billion people from enjoying the massive social and economic gains since the end of the Second World War.

A complex mix of overlapping hazards contributes to displacement and determines patterns of movement and needs in fragile and conflict-affected countries. Other additional aspects of vulnerability—gender, ethnicity, income and residence—appear to be associated with heightened chances for long-term harm and complicate

WOMEN FACE A GREAT RISK OF LIVING IN POVERTY

Ratio of women to men of working age (20 to 59) in the lowest wealth quintile of all households, selected developing countries, 2000–2013



Notes: This indicator is weighted by the ratio of females to males aged 20–59 in all households to reflect the fact that women may be overrepresented in the entire population. It uses the wealth asset index in the Demographic and Health Surveys and Multiple Indicator Cluster Surveys as a proxy measure for poverty. Values above 103 indicate that women are overrepresented in the lowest wealth quintile while values below 97 indicate that men are overrepresented in the lowest wealth quintile. Values between 97 and 103 indicate parity.

(United Nations, 2015a) Reprinted with permission of the United Nations.



Boat in the Strait of Sicily, 40 miles from the Libyan coast.
Photo © Franco Pagetti/VII

recovery. And overlaying all aspects of social exclusion, poverty and low educational achievement create profound vulnerability.

It is mainly the fragile, conflict, or disaster-affected countries that fell short in their pursuit of the Millennium Development Goals. And, it is among fragile States where the majority of maternal deaths in the world occur, as emergent life-saving care or access to it is lacking.

The refugee and migrant crises of 2015 and the Ebola epidemic are reminders of how crises and emergencies take, disrupt and undermine lives, jeopardize prospects for countries' development and can have an impact on the entire international community. Abandoning the countries and communities wracked by conflicts and disasters is not an option.

While the number of disasters and conflicts has not risen in recent years, the scale, complexity and impact have, particularly in the poorest countries,

and women and girls have been disproportionately affected because they are disproportionately disadvantaged in terms of their access to services, including sexual and reproductive health and family planning, and their access to economic and social resources and institutions they need to build their social capital and better equip them to withstand and recover from crises.

Fragility and vulnerability to conflict or the effects of disaster are exacerbated by many forces, including poverty, unequal development, denial of human rights and weak institutions. Fragility is a multi-dimensional challenge, requiring a multi-dimensional response.

One way or another, we are, finally, one world, and our progress in moving forward will be forever hobbled until instability, conflict, and disaster are better mitigated or prevented and managed.

CHAPTER 2

The disproportionate toll on women and adolescent girls

A crisis can heighten women's and girls' risks and vulnerabilities to HIV infection, unintended and unwanted pregnancy, maternal death, gender-based violence, child marriage, rape and trafficking.

Vicious cycle of conflict, poverty and isolation undermines health and rights of women and girls in Colombia



"I started working as a midwife 37 years ago," says Neida Waitotó, one of four midwives in Docordó, a river community with about 1,200 residents, mostly Afro-descendants, in a remote jungle area of Colombia two hours by boat from the nearest city.

"In 1978, the nuns came and taught us how to deliver babies and gave us supplies." Since then, she says, the midwives of Docordó have had some additional training but no new equipment. Still, they have managed to safely deliver hundreds of babies over the years. "And no mothers have died," says Waitotó, who, a week earlier, helped deliver twins.

Nimia Teresa Vargas

Photo © UNFPA/Daniel Baldotto

Midwives are critical to the survival of women and babies in Docordó and dozens more remote Colombian communities that have been effectively cut off from government health services not only because of geography but also because of armed conflict and violence, which have plagued large swaths of the country for more than 50 years. Conflict has so far displaced about 7 million people. 9 in 10 of the displaced are from indigenous groups.

Non-state actors including the Revolutionary Armed Forces of Colombia, or FARC, the National Liberation Army, or ELN, paramilitaries, groups involved in organized crime and the Colombian military have clashed for decades, leaving many communities literally caught in the crossfire and many



Neida Waitotó, left, and María-Estela Ibargüen, Docordó, Colombia.
Photo © UNFPA/Daniel Baldotto

more vulnerable to coercion, exploitation, intimidation and abuse.

Fighting and violence have taken a heavy economic toll on communities in a number of provinces, or “departments,” including Chocó, where Docordó is situated, causing and exacerbating poverty and underdevelopment in the region. Four of five people in Chocó live in extreme poverty.

Maternal deaths higher in conflict-affected zones

Conflict and violence—and the isolation stemming from them—have also taken a heavy toll on the health of women. Maternal deaths are almost eight times higher in communities where armed groups are present. Other health indicators also illustrate the negative impact

security problems have on the sexual and reproductive health of those who live there: deaths from HIV and AIDS are three times higher than the national rate, and pregnancies among adolescent girls under age 15 are twice that in other parts of the country.

Waitotó says there are some births in Docordó that are too complicated for her to handle on her own; a doctor's intervention is needed to save lives. But because of the security situation in the area and the extreme isolation, the community routinely lacks access to a doctor. “When doctors do come, they never stay for long,” she says. Recently, the community went four months with no physician or other medical professional.

So that means some women have to travel hours by boat to a hospital in Buenaventura, at a cost prohibitively high for most. And if the complications arise at night, travel to a hospital is not even an option because of the threat of violence after dark. Medicines that can help save a mother and baby are mostly unavailable, even before the local health station closed because of a lack of resources.

María-Estela Ibargüen is another Docordó midwife. She and Waitotó delivered each other's babies. She worries that the community's midwives are growing old, with no young people stepping forward to take their places. “What will the future look like once the old generation is gone?”

Humanitarian crises disproportionately impact women and adolescent girls. Whether sudden or protracted, crises expose women and girls—and their sexual and reproductive health and rights—to layers of disproportionate risk.

Conflicts and disasters can make a bad situation worse. For women and adolescent girls, the advent of a crisis can lead to an even greater risk of sexually transmitted infections, including HIV, unintended and unwanted pregnancy, maternal morbidity and death, as well as other risks to the health of mothers and newborns. Women and adolescent girls are also at greater risk of gender-based violence, including intimate partner violence, rape, early marriage and trafficking.

Breakdown of services and gender inequality compound vulnerability

Women and young people do not all have the same story to tell. Their experiences are influenced by a complex intersection of factors, such as age,

sex, marital status, economic status or place of residence. Other vulnerabilities depend on whether they are members of an ethnic minority, living with HIV or disability, refugees or internally displaced persons or poor, or have the support of family or have dependents.

The intersection of these factors, often in complex and multiple combinations, influence the risks and vulnerabilities faced by individuals.

Research and experience are contributing to a deeper understanding of these differences and a more nuanced perspective on how women and young people, especially adolescent girls, are affected by crises. Still, unpacking these differences of experience is often complicated by a dearth of robust data, the collection of which can be very difficult in crisis-affected settings.

Although there are important differences among women and young people in any given crisis, there are two common overarching factors that contribute to heightened risk: The first is

Health conditions for women are even more troubling directly across the river in Union Balsalito, an indigenous Wounaan community with about 360 residents. There, midwives use traditional birthing methods but lack the most basic supplies, such as rubber gloves.

For the women of Union Balsalito, accessing services, even in Buenaventura, is particularly difficult: most do not speak Spanish and have even fewer resources than their neighbours across the river. And some who have managed to travel to cities in search of services have faced discrimination from providers.

The Government deploys roving health brigades throughout the country to provide basic services to the poor and

marginalized in places like Docordó. But the security situation in many parts of the country makes it impossible to reach many of the communities most in need.

Access to supplies, medicines and services, including emergency obstetric care and family planning, is routinely blocked by conflict and violence as well as natural disasters, especially floods and landslides in this area, which receives an average of 400 inches of rain annually.

In the first six months of 2015 alone, an estimated 2 million people “suffered limitations on access or mobility” as a result of “122 events related to armed actions, natural disasters or mass protests,” according to the United Nations.

Wielding the weapon of sexual violence

While conflict has impeded access to health services, it has also taken a direct toll on the health, lives and survival of thousands of women and girls.

A study by Oxfam and House of Women estimates that 500,000 women and girls have been raped or suffered other forms of sexual violence in the course of the country’s decades-long conflict. Sometimes rape has been deployed as a weapon of war. Other times, it has been used to intimidate whole communities, with perpetrators threatening to attack others in a community that refuses to pledge its allegiance to one armed group over another. And, available data suggest that one in 10 survivors of sexual violence in conflict-affected areas is male.

gender inequality, which not only continues during humanitarian crises but often increases.

Many societies are characterised by deeply entrenched gender inequality and gender-based discrimination, in which women and girls have less power and status in their families and communities than men and boys. The inequality manifests itself in less access to education, economic and political resources and social networks. It can also be fatal—when parents facing food shortages direct most or all nutrition to boys.

In contrast to adolescent boys, adolescent girls typically have less access to information about sexual and reproductive health, peer networks and opportunities and resources that would help them develop skills, capacities and capabilities (Women's Refugee Commission, 2014). Gender inequality places women and girls in situations of heightened risk and vulnerability and limits their ability to safely navigate the crisis-affected environment (Women's Refugee Commission, 2014; Plan International, 2013).

“Natural disasters and armed conflict are...deeply discriminatory processes that affect women, men, girls and boys in significantly different ways.”

Mazurana et al., 2011

The second overarching factor leading to heightened risk is the breakdown or disruption of critical sexual and reproductive health infrastructure and services that occur in crisis settings, and the difficulties in accessing these services, where they still exist, as a result of chaos or insecurity.

Nimbia Teresa Vargas runs the Departmental Network of Chocoan Women, headquartered in Quibdó. The network, which receives technical and financial assistance and supplies, such as clean birth kits, from UNFPA and other parts of the United Nations, began in 1991 as a women's empowerment group but has since evolved into a human rights advocacy organization that also provides services to survivors of sexual violence.

“As women began learning about their rights in our discussion groups, more of them started talking about having survived sexual violence,” Vargas says. “Cases started coming to light about armed actors trying to take control over communities, using sexual violence as a strategy to show they had power.”

She says often a perpetrator would rape a woman in front of her husband or a girl in front of her father to assert control and to show what might happen to others if the community did not acquiesce to the demands of whichever armed group was threatening them.

In response, Vargas' organization started organizing support groups for survivors, but also began systematically reporting incidents to Government authorities and making sure Chocoan women gained access to not only quality health care and psychological support, but also to justice.

Armed groups responsible for the sexual violence have repeatedly threatened Vargas' life and, in one instance, killed a woman who participated in one of her network's training programmes and later became an outspoken activist.

New support for survivors

In 2011, Colombia enacted the Victims and Land Restitution Law 1448, which aimed to support the country's estimated 7.3 million victims of armed conflict.

Waitotó, left, with mother whose child she helped deliver.

Photo © UNFPA/Daniel Baldotto



“It is a plain and simple truth that disasters reinforce, perpetuate and increase gender inequality, making bad situations worse for women.”

Margareta Wahlström
Special Representative of the Secretary-General
for Disaster Risk Reduction

Limited access to sexual and reproductive health services when they are needed most

Humanitarian crises often mean a loss of access to critical quality sexual and reproductive health services. This may be due to a variety of factors. The health infrastructure may be disrupted or destroyed. Health workers may be killed, injured, too distressed to work, displaced, or they may have fled. In crisis-affected environments affected

by violence, health facilities may be subject to air strikes and small arms fire and health providers exposed to physical assault, threats and sexual violence (International Committee of the Red Cross, 2015).

Services, where they do exist, may be delayed or disrupted, with stock-outs of medicine and other supplies, or they may be impossible to access given insecurity and limitations on movement. These circumstances can have severe, even fatal, consequences for survivors of gender-based violence, those who are forced to adopt risky survival strategies such as transactional sex, HIV positive populations, married girls, pregnant women and girls, and new mothers and their babies.

Access to sexual and reproductive health services varies widely across and within crisis-affected settings (Casey et al., 2015). Women and young people may face significant variation in access and quality of emergency obstetric and newborn care, clinical post-rape care, and family planning

This law also led to the establishment of a Government Unit for Attention and Integral Reparation to Victims, or UARIV, which targets support to victims of armed conflict, including survivors of sexual violence.

Survivors who report their cases to UARIV are entitled to cash restitution, but also to integrated health, psychological, rehabilitation and other support services, all provided in ways that respect privacy. Those who come forward also learn, usually for the first time in their lives, about their rights.

According to Licet Ciénfuegos, in UARIV's women's and gender group, survivors accessing UARIV's services "recognize that they aren't alone, that they are citizens with rights and that

they are change agents." She said many have gone on to create their own advocacy or support groups. "We are trying to help women see themselves as actors of change and capable of shaping the futures of their own communities."

As of September 2015, 9,892 women, 863 men and 53 people who identified themselves as lesbian, gay, bisexual or transgender have reported acts of sexual violence against them. Some of these acts occurred in the past two years but many occurred years ago.

UNFPA collaborated with UARIV in developing training for first responders



Wounaan woman, Union Balsalito, Colombia.

Photo © UNFPA/Daniel Baldotto

to deliver culturally sensitive psychosocial support. "We teach them how to speak to victims in a way that doesn't revictimize them," Ciénfuegos says.

The conflict has also had an indirect but perhaps more insidious impact on the health—and rights—of women and girls in Chocó.

services, including contraception, depending on if they are in a stable refugee setting, an urban or rural setting, a host population or a camp for internally displaced people. Residents in stable refugee camps may have better access to care than neighbouring host communities or refugees' home countries prior to the crisis (Chynoweth, 2015). Further complicating the picture, not all refugee camps provide the same level of access and quality, and the same can be said for camps for internally displaced people.

Within displacement settings, access also varies depending on factors such as age and disability. Populations with physical, psychological or developmental disabilities have greater difficulty accessing services. For refugee women and girls with disabilities, negative attitudes and lack of respect expressed by health providers has been identified as the "most significant barrier deterring" access to health and sexual and reproductive health services (Consortium, 2015).

Women and girls are particularly vulnerable to malnutrition and disease, which are exacerbated by the loss of sexual and reproductive health support. For example, the United Nations Office for the Coordination of Humanitarian Affairs estimates that there are almost 1 million pregnant and lactating women in the Democratic Republic of the Congo who are affected by acute malnutrition (Save the Children, 2014).

Women are physiologically more prone to vitamin and iron deficiencies, including anaemia. These deficiencies are exacerbated in a crisis situation where there is a scarcity of food, because women and girls are often the first to go hungry. For pregnant and lactating women and girls, who have greater food needs to begin with, malnutrition or undernourishment can lead to birth complications and problems with breastfeeding, which can present health risks to newborns. For pregnant women and girls, anaemia heightens the risk of maternal mortality,

Conflict-driven poverty's impact on health

Violence or the threat of it has choked off local economies in the region, leaving many individuals and families with few or no opportunities for jobs or livelihoods. Poverty multiplies vulnerabilities, especially for women and adolescent girls.

In some instances, women and girls engage in transactional sex with armed groups to obtain food or other survival items. In other instances, women and girls are forced into prostitution.

There have also been cases where an armed group will engage in what seem like goodwill gestures with a community by providing food or other goods. But after a while, favours are expected to be repaid, sometimes by giving away

daughters, who may end up as sex slaves or as armed combatants.

Poverty stemming from conflict also drives men from remote communities to cities to look for work. When they return home, some also return with sexually transmitted infections, which they in turn transmit to their spouses. The dearth of health care in most of these communities means that sexually transmitted infections may go undiagnosed and untreated.

"Conflict has affected everyone in some way," says UNFPA Representative Jorge Parra. "But it has disproportionately affected women and girls and denied them their basic rights to health, to security, and to have the power and the means to decide whether,

when or how often to have children," he adds. "The task ahead is monumental, but with the right resources and political will, we can reach the most vulnerable women and girls across the country."

Residents of Docordó, Colombia.

Photo © UNFPA/Daniel Baldotto





Mother and children,
Domiz Camp, Iraq.
Photo © UNFPA/Aral Kaki

premature delivery and low birth weight (Save the Children, 2014).

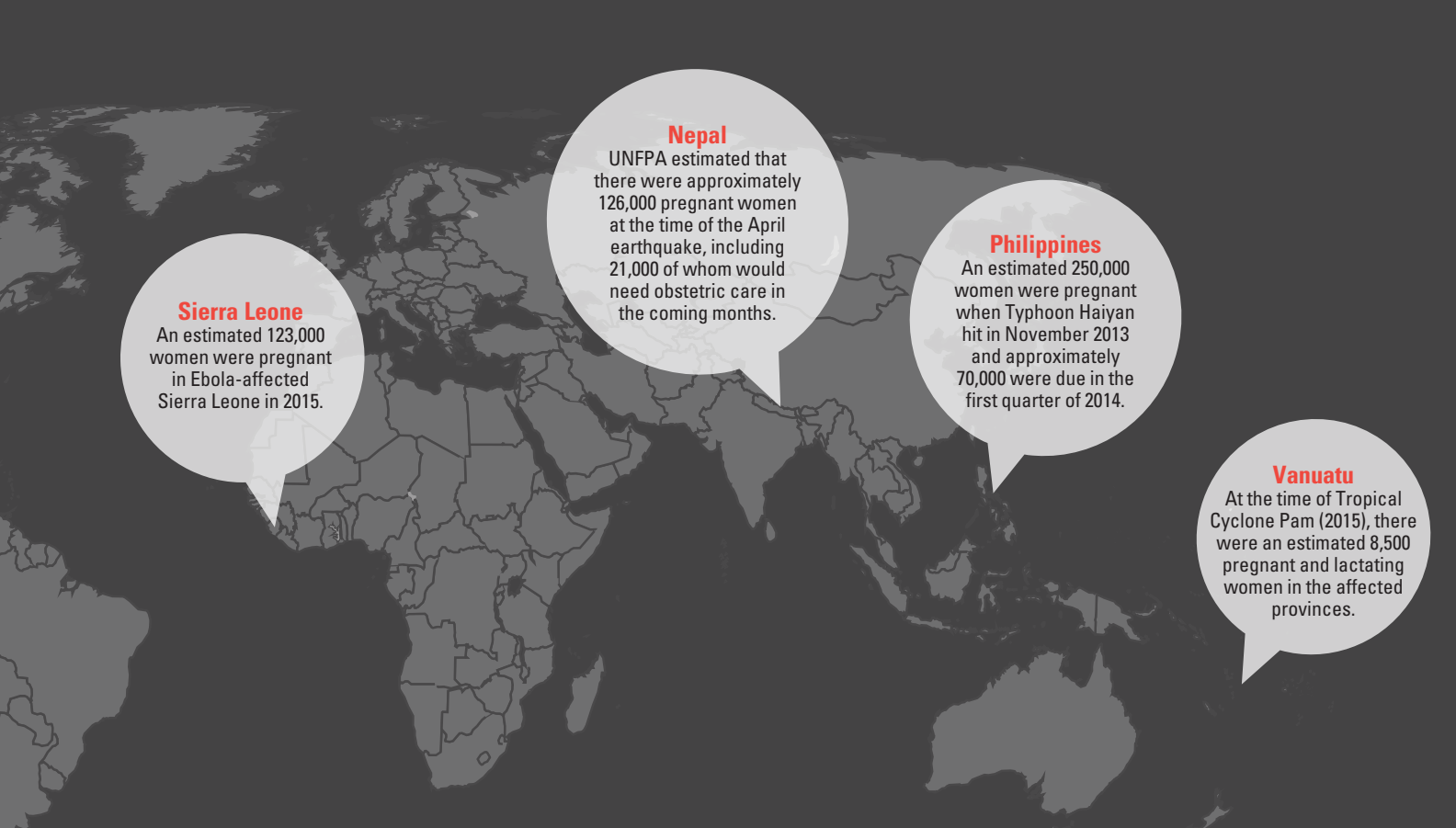
Unmet need for family planning

Family planning is a life-saving intervention: it prevents unintended and unwanted pregnancy and in turn reduces health risks of childbirth and recourse to unsafe abortions. Some of its methods also reduce the risk of sexually transmitted infections (Save the Children, 2014).

This type of intervention is critical in humanitarian crises, often characterised by sexual violence, intimate partner violence, early marriage and high risk behaviour such as survival, transactional and commercial sex. Yet, across and within crisis settings, family planning services, including contraception are often limited, inadequate or even non-existent (Casey et al., 2015).

Even where family planning services do exist, the subordinate status of women and girls within the family in many societies may deny them access to family planning services because they are unable to negotiate use with their partners (Klasing, 2011; Plan International, 2013). Unmarried and adolescent women may face particular difficulties accessing family planning services, including contraception, as a result of gender norms that consider sexual activity and interest inappropriate female behaviour (Casey et al., 2015). These norms can also influence the behaviour of healthcare providers and undermine the care they provide (Casey et al., 2015).

Schools, even in displacement settings, are an important avenue for comprehensive sexuality education and raising awareness about contraception. Yet, schooling can be severely disrupted in a crisis, resulting in significant gaps and limitations in comprehensive sexuality education.



Vulnerability to unintended and unwanted pregnancy

Women and girls are at increased risk of unintended and unwanted pregnancy in crisis-affected environments. Women and girls may find themselves with a pregnancy they do not want as a result of rape, resorting to sex for survival, a lack of access to family planning, including contraception, and an inability to negotiate contraceptive use, including condom use, with their partners. Unaccompanied girls are particularly vulnerable, especially in displacement settings (Plan International, 2013). A study in Haiti after the earthquake found the pregnancy rate three times higher in the camps compared to the average urban rate before the crisis, with approximately 66 per cent of pregnancies unwanted or unplanned (Klasing, 2011). In many countries, unintended and unwanted pregnancy exposes

women and especially adolescent girls to the dangers of unsafe abortion.

Pregnancy and childbirth without adequate prenatal care and delivery services

Being pregnant in a humanitarian crisis is often a life-threatening condition. Pregnant women may find themselves without access to clean and safe facilities, antenatal and obstetric services, critical equipment and supplies, such as for blood transfusions, and skilled health workers to assist them (Casey et al., 2015). Without access to prenatal care and delivery services, women and girls are vulnerable to infection, miscarriage, premature delivery, stillbirths, unsafe abortions, severe long-term morbidity and mortality, such as obstetric fistula, and death. Without emergency obstetric care, complications, which are otherwise largely preventable and treatable, may become life threatening to both

the mother and baby. The stress of crises can also physically affect pregnant women and girls and can push women into premature labour. In the Philippines, for example, unusually high rates of preeclampsia—high blood pressure in pregnancy—were attributed to the stress of Typhoon Haiyan (Save the Children, 2014).

Girls, especially under 16, have immature pelvises which make childbirth more difficult and dangerous. Their lack of physical maturity can lead to obstructed labour, and, where emergency obstetric care is unavailable or delayed, obstetric fistula, uterine rupture, haemorrhage and death of the mother and the baby (Save the Children and UNFPA, 2009). For adolescent mothers, they are also at increased risk of spontaneous abortion, premature births and stillbirths (Save the Children and UNFPA, 2009).

During humanitarian crises, antenatal and obstetric care infrastructure and services that pregnant women and girls need may be destroyed, damaged or disrupted. In the Philippines, Typhoon Haiyan devastated reproductive health facilities in the affected areas. Leyte province lost most of its birthing centres. In an assessment of 52 reproductive health facilities, more than half had severe structural damage (Save the Children, 2014). In Gaza in 2014, six hospitals were damaged, and six maternity facilities were closed (UNFPA, 2014).

In the Democratic Republic of the Congo, nearly two decades of conflict decimated the health care system. According to Save the Children, many—if not most—health facilities in conflict-affected areas lack the capacity to perform Caesarean sections (Save the Children, 2014).

Pregnant women and girls need skilled health workers to ensure their own safety and that of their babies during pregnancy and childbirth. Yet health workers are also personally affected by crises. They may be injured or killed. In West Africa, health workers risked infection from Ebola when assisting births, and conversely, assisting women in childbirth was one avenue through which patients contracted the virus (UNDP, 2015).

Crises can lead to increases in unassisted births

Given the damage, disruption, distress, loss and fear brought by humanitarian crises, many pregnant

women and girls are giving birth without assistance from a skilled health worker. This lack of assistance is a major contributing factor to maternal mortality. In Syria before the conflict, skilled birth attendants assisted 96 per cent of deliveries. Now, access to antenatal care, safe delivery services and emergency obstetrics has become extremely limited, and some areas, including parts of Homs, have no reproductive services at all (Save the Children, 2014).

In West Africa, where maternal mortality ratios were already among the highest in the world, the Ebola epidemic led to an escalation in maternal mortality (Diggins and Mills, 2015): A recent United Nations report described access to sexual and reproductive health services as “drastically diminished” (United Nations Security Council, 2015). In Liberia, assisted deliveries decreased significantly from 52 per cent in 2013 to about 38 per cent in May through August 2014, and, over a similar period in Guinea, from 20 per cent to 7 per cent (IASC, 2015).



Given the damage, disruption, distress, loss and fear brought by humanitarian crises, many pregnant women and girls are giving birth without assistance from a skilled health worker.

Postnatal and newborn care often limited

Postnatal and newborn care, including breastfeeding support, are limited across many crisis settings. New mothers also require postnatal care for themselves especially where there have been complications during childbirth.

Being a new mother and recovering from childbirth are daunting enough without the risks and vulnerabilities associated with humanitarian crises. The situation is especially difficult for young mothers. Crises can present “obstacles and disincentives” to breastfeeding (Save the Children, 2014). These obstacles and disincentives explain why breastfeeding rates decrease in some crisis environments. Effective breastfeeding requires instruction, guidance and individual, tailored support. These are often lacking or limited in a crisis-affected environment.

Lactation problems can also increase in humanitarian emergencies. Severe malnutrition can reduce milk production. Stress can also disrupt milk flow (World Vision, n.d.). Crises can also disrupt the supply of breastmilk substitutes. This disruption, along with breastfeeding and lactation problems, can lead to malnutrition in babies and place them at heightened risk of disease and death.

Crises increase risk of sexually transmitted infections

Humanitarian crises are fertile ground for the transmission of sexually transmitted infections, including HIV, and women and especially young girls are disproportionately vulnerable. Sexual and gender-based violence, including rape and sexual slavery, is one of the most significant risk factors for HIV transmission: for women and especially



girls, violent or forced sex facilitates HIV transmission (UNFPA, n.d.). Other factors leading to increased risk of HIV infection among women and girls include trafficking, intimate partner violence, and high-risk survival strategies, such as transactional sex and commercial sex work.

Even before a crisis hits, women and girls are disproportionately vulnerable to sexually transmitted infections due to biological susceptibility and pervasive gender inequality that exists in many societies (UNFPA, n.d.). Their subordinate status denies them power within their relationships and in other interactions to influence their sexual activity and that of their partners as well as their use of condoms, in particular where the relationship is between a girl and older man (Plan International, 2013; UNFPA, n.d.). Gender norms about appropriate female behaviour can deny unmarried and adolescent girls access to information about sexual health and about preventing sexually transmitted infections (Plan International, 2013; UNFPA, n.d.). An assessment of displacement settings in Burkina Faso, the Democratic Republic of the Congo and South Sudan found young unmarried women to be the “least knowledgeable” of HIV, other sexually transmitted infections and ways to minimize transmission, including condom use (Casey et al., 2015). Gender norms can also make young men and boys vulnerable to infection by encouraging risky, dominant and aggressive sexual behaviour (UNFPA, n.d.).

Crises can compromise access to prevention treatment and information and thus exacerbate vulnerability to sexually transmitted infections, including HIV. Even in previously stable environments, as a result of a humanitarian crisis, access to prevention can be often limited, inadequate and even non-existent (UNAIDS, 2015).



Humanitarian crises are fertile ground for the transmission of sexually transmitted infections, including HIV.

Data collected by the United Nations High Commissioner for Refugees showed 56 refugee camps from 2007 to 2013 with inconsistent provision of condoms (Chynoweth, 2015). The existence of services does not guarantee prevention; women and girls who have been raped may choose not to seek out post-exposure prophylaxis against HIV transmission because of fear they may be stigmatized for having been assaulted (Chynoweth, 2015).

For HIV-positive populations in humanitarian emergencies, the impact of the crisis can deny them access to necessary life-saving treatment. Maintaining a treatment regime can be

difficult in a crisis when there is only sporadic availability of antiretroviral therapy, and often only at large referral hospitals rather than at the primary care level (Chynoweth, 2015).

Drug stocks and safe blood supply may be destroyed or unavailable, especially during flight and later displacement (Plan International, 2013; UNFPA, n.d.). Displacement also disrupts treatment regimes. Other sexually transmitted infections, such as chlamydia, gonorrhea and syphilis, left untreated, can lead to complications in pregnancy, infertility, reproductive cancers, and enhanced transmission of HIV (Chynoweth, 2015).

Pregnant women and new mothers who are HIV-positive need access to antenatal care and medicine to prevent mother-to-child transmission of the virus, yet crises can disrupt these critical services and availability of drugs. In an assessment conducted in the Democratic Republic of the Congo, none of the health centres surveyed provided adequate services for prevention of mother-to-child transmission, as a result of a lack of supplies and trained staff (Casey et al., 2015).

Women and adolescents with disabilities and HIV

Women and adolescents with disabilities face particular vulnerabilities in relation to HIV transmission in crisis-affected environments yet may have limited access to the sexual and reproductive health services and information they need to protect themselves, including antiretroviral drugs. During research conducted on women with disabilities in northern Uganda, Human Rights Watch spoke to two women with disabilities who had been raped and “said that they did not undergo HIV testing afterward because they were unable to reach a health clinic” (Human Rights Watch, 2010).

Societal perceptions about women and girls with disabilities as “non-sexual beings” can restrict their access to sexuality education, including information about how to identify inappropriate behaviour (United Nations Human Rights Council, 2012). Women and young people with intellectual disabilities face particular challenges in developing awareness of sexually transmitted infections and contraception (Women’s Refugee Commission, 2014a).

Increased risk of gender-based violence

Gender-based violence against women and girls often thrives in humanitarian crises. In settings as diverse as Myanmar, Somalia and Syria, sexual violence is described as “widespread,” “prevalent,” “a dominant feature,” and a “significant threat and a crisis” (United Nations Security Council, 2015). Gender-based violence is not, however, a new phenomenon that emerges in crises; it is part of a continuum of violence that women and girls experience in their everyday lives but that can become more prevalent in crises.

Refugee and internally displaced women and girls are particularly at risk, including in refugee camps, temporary shelters or evacuation centres.

In armed conflict situations, women and girls may experience gender-based violence during house searches, sweeps of residential neighbourhoods, at checkpoints and in detention, during armed attacks on their villages, to force displacement, and as part of systematic campaigns of domination, intimidation and terror by armed groups. Perpetrators may be partners, relatives, State and non-State armed forces, camp officials, teachers, and in some instances, even peacekeepers and aid workers. And they may be male or female.

Risks of gender-based violence rise when rule-of-law and infrastructure have broken down or weakened. In protracted conflicts, a culture of violence and impunity often emerges, supported by the easy availability of small arms and light weapons. Familial and community support systems and networks are often weakened or destroyed and families separated. Where families have previously served as sources of protection, separation or the death of parents can create a protection vacuum. Poverty, food insecurity, financial hardship, distress, trauma, loss, and boredom, lack of privacy and overcrowded

“ From January to September 2014, UNFPA recorded 11,769 cases of sexual and gender-based violence in the provinces of North Kivu, South Kivu, Orientale, Katanga and Maniema; 39 per cent of these cases were considered to be directly related to the dynamics of conflict, perpetrated by armed individuals.

United Nations Security Council, 2015

”

conditions become everyday realities that influence behaviour within the family and wider community, including the adoption of negative or extreme coping mechanisms.

Armed groups may establish military bases near population centres, and may establish sexual violence as an institutionalized and intentional practice as part of their wider strategic and tactical efforts (United Nations Security Council, 2015). Underlying many acts of sexual and gender-based violence is a profound disrespect for the rights of women and girls.

Double and triple discrimination

Multiple and intersecting forms of discrimination, based on sex, age, economic status or ethnic minority status and other factors can increase women's and girls' vulnerabilities to sexual and gender-based violence in crisis-affected settings (United Nations Human Rights Council, 2011).

For adolescent girls, being young and female, described by Plan International (2013) as "double discrimination," places them at heightened risk of gender-based violence in crisis settings, including rape, early marriage, sexual exploitation, abduction and trafficking (Women's Refugee Commission, 2014).

Children under the age of 18 often make up the majority of victims of sexual violence in conflict-affected countries (Save the Children, 2014).

“The starting line is not the same for all. Almost everyone has a head-start compared to adolescent girls.”

Women's Refugee Commission, 2014a

The United Nations Secretary-General described sexual violence against adolescent girls in conflict situations in 2014 as a “disturbing trend” (United Nations Security Council, 2015). Being a refugee or displaced girl adds a range of other layers of risk to the equation. Unaccompanied girls who have lost or been separated from their parents face additional layers of risk, since they lack the protection often provided by family members. This type of risk was observed during the Ebola epidemic where some children were left unprotected in their homes when their parents had died or were incapacitated (IASC, 2015). A similar situation can occur in a context of food insecurity if the parents are forced to leave children at home, especially with older girls in charge, to go in search of food or income (Plan International, 2013).

Women and girls with physical or developmental disabilities are particularly vulnerable in crises, when community and family support erodes and rule of law collapses (Women's Refugee Commission, 2013; Ortoleva and Lewis, 2012). According to the United Nations High Commissioner for Refugees, 49 per cent of all



Ayan, 16, Minkaman Camp, South Sudan: "I feel unsafe when I go to the bush because there are often men who rape women."

Photo © Panos Pictures/Chris de Bode

LACK OF PRIVACY HEIGHTENS RISKS

The lack of privacy across many displacement settings can have serious implications for the sexual and reproductive health of women and girls. Without privacy, many women and girls may refrain from going to the latrine or bathing facilities until it gets dark; this is especially the case for adolescent girls who are menstruating (Plan International, 2013). This places them at increased risk of gender-based violence (UNIFEM, 2010; Plan International, 2013). Inadequate lighting and a sense of insecurity may prevent women and girls from using the latrines at all at night (Child Protection and Gender-Based Violence Sub-Working Group, Jordan, 2013). Whether due to lack of privacy, insecurity or lack of cleanliness, women and girls may suppress their need to use latrines or toilets, sometimes resulting in urinary tract and other infections (Pincha, 2008; Plan International, 2013).

Menstruating women and girls may feel unable to properly clean themselves, change and clean their sanitary napkins, which can cause perineal rashes and urinary tract infections as well as affect their sense of self and confidence (WHO, 2002; Plan International, 2013). Lack of privacy can also cause discomfort and stress in breastfeeding mothers, which can disrupt milk flow, undermine a mother's confidence, and consequently impact a baby's nutrition, health and survival (World Vision, n.d.). After the 2005 earthquake and the 2010 floods in Pakistan, reports suggest that many women stopped breastfeeding as a result of a lack of privacy and discomfort due to breastfeeding in front of distant male relatives or other men in shared shelters (Bradshaw and Fordham, 2013; UNIFEM, 2010).

adult rape survivors in the Bhutanese refugee camps in Nepal between 2009 and 2011 were persons with physical or developmental disabilities or impairment (Women's Refugee Commission, 2013). Women and girls with disabilities are identified as a particularly at-risk group for sexual violence because of their limited mobility and ability to communicate, and their social exclusion and greater likelihood of poverty (UNHCR, 2011a; Consortium, 2015; Women's Refugee Commission, 2013; Human Rights Watch, 2010). Within this group, there are sub-groups that can

face particular risk, due to what might be called triple discrimination: older women with disabilities, female members of ethnic, linguistic or religious minorities with disabilities, and lesbian, gay, bisexual or transgender persons with disabilities (UNHCR, 2011a; United Nations Human Rights Council, 2012).

"We don't have any doors to lock"

When earthquakes, cyclones, floods, violence and war force people out of their homes and communities, many seek safety in refugee and displacement camps, temporary shelters, make-shift houses, spontaneous settlements, urban slums, evacuation centres and transit sites. Risk factors for gender-based violence are often found in many of these settings. Even in established refugee camps, sexual violence occurs. In Dadaab refugee camp in Kenya, for example, the population increase has outpaced the establishment of lighting and fencing in new sections of the camp,

“ I was shamed because after the disaster I couldn't wash and I had leaks that everyone could see.

Mirasol, age 16, Philippines

leading to an increase in sexual violence (United Nations Security Council, 2015). The living conditions and physical features in these displacement environments are a very real source of danger for women and girls.

In settings catering to disaster and conflict-displaced populations, there tend to be a number of characteristics that are commonly identified as risk factors for gender-based violence: overcrowding, the lack of privacy, doors that have no locks, shared latrines and sleeping facilities, inadequate bathing and latrine facilities, and inadequate lighting or power outages (Women's Refugee Commission, 2014; CARE, 2014, 2015b; Plan International, 2013; Internal Displacement Monitoring Centre and the International Rescue Committee, 2015; Inter-cluster Coordination Group for the Humanitarian Country Team, 2014; UNFPA, 2014; Child Protection and Gender-Based Violence Sub-Working Group, Jordan, 2013). "We don't have any doors to lock," said one female resident of Za'atari refugee camp in Jordan (Save the Children, 2014).

After Cyclone Pam in Vanuatu in March 2015, evacuation centres on Emae Island were "overcrowded, lacked privacy and lighting, particularly around toilet facilities..." (CARE, 2015b). In areas of the Philippines affected by

Typhoon Haiyan in 2013, women and children were housed in "overcrowded" sites with "limited security, inadequate bathing and latrine facilities as well as a lack of privacy" (Inter-cluster Coordination Group for the Humanitarian Cluster Team, 2014). Plan International (2011) has reported that in Bangladesh, cyclone shelters "do not usually provide separate dormitory rooms for men and women, nor access to separate safe sanitation facilities."

"We could not protect her, so we had to marry her"

The impact of armed conflicts and natural disasters can lead to an increase in child marriage in crisis sites as well as in camps following displacement. According to World Vision, fear is a "major cause of early marriage" in fragile contexts, including fear of sexual violence and hunger (World Vision UK, 2013). Given their age and gender, girls are uniquely vulnerable to this practice. In Syria, early marriage is a traditional and widely accepted practice by women and men alike (UN Women, 2013). While the practice predates crises, there are indications that crises can exacerbate the practice, especially in protracted displacement settings, including expanding the practice among families that would not have considered it before, and threatening even younger girls (CARE, 2015).

Where food is scarce, due to extreme poverty or drought, families may marry off their daughters so they have fewer mouths to feed, and as a form of income generation, where the practice of bride price compensates the bride's family (Save the Children, 2014; CARE, 2015). It can also be viewed as a means to protect a daughter's "honour," which may be at risk if food insecurity forces her to resort to survival or transactional sex (Plan International, 2013).

“My daughter is 16...we were too worried for her. They were attacking women. We could not protect her, so we had to marry her...She did not want to get married, she wanted to study.”

Syrian mother in Lebanon

The crisis in Syria has led to an increase in early marriages among Syrian refugee girls in Jordan, as well as Lebanon and Egypt (CARE, 2015). Among Syrian refugees, the perpetration and fear of sexual violence, especially against girls, are cited as reasons for fleeing Syria in the first place (CARE, 2015; International Rescue Committee, 2013).

For girls, early marriage brings significant risks and disadvantages to their reproductive rights, their health and their children's and their own well-being. Given their age and gender, married girls have limited power and influence to determine what happens to their bodies. They are often unable to make decisions about using contraception, how often they have sex, the spacing of their pregnancies and how many children they have (CARE, 2015). The repercussions of this lack of power are significant and sometimes fatal. It places them at risk of sexually transmitted infections, maternal morbidity and mortality.

Intimate partner violence

Crises often lead to changes in gender relations within the family, which in turn can increase the risk of intimate partner violence. These changes are especially prominent in displacement settings (UNFPA, 2010). While men face unemployment, the loss of their livelihoods, idleness and frustration, women may assume breadwinning responsibilities. As the preferred recipients of food aid, they may face new opportunities previously unavailable through programmes offered by humanitarian organizations (International Rescue Committee, 2015). This shift may lead to a "crisis of identity" among some men (Anderlini, 2010). In eastern Democratic Republic of the Congo, where this shift in gender roles has been observed and reported, Congolese men have described feelings of humiliation, failure and "loss of personal value" (Lwambo, 2011). Inflicting violence against their



At Bachid Kendal Camp, Zakho, Iraq.

Photo © Ali Arkady/VII Mentor Program

partners, as well as children, is seen by some men as a means to reassert their power, dominance and masculinity.

Feelings of stress, loss, boredom and frustration among men in displacement settings may also lead to alcohol and drug abuse and other negative coping mechanisms. These in turn fuel intimate partner violence. For married girls, their position of "extreme" dependence and lack of power, made acute by their age and gender, places them at great risk of intimate partner violence (International Rescue Committee, 2015; CARE, 2015).

A growing body of evidence suggests that intimate partner violence is the most common type

of violence women experience in humanitarian settings (International Rescue Committee, 2015). In some conflict-affected environments, intimate partner violence, including marital rape, and domestic sexual violence by family members are more frequent than sexual violence by combatants (Wood, 2015; Human Security Report Project, 2012). In an assessment in Za'atari Refugee Camp in Jordan in 2013, for example, community members and service providers identified domestic violence as the “most prevalent type of violence” and “emerging as a prominent issue” among Syrian refugees, with girls between ages 12 and 18 the most affected (Child Protection and Gender-Based Violence Sub-Working Group, Jordan, 2013).

An increase in intimate partner violence is often observed following a natural disaster, including recent ones:

- **Nepal earthquake:** Although there are no official numbers, counsellors and others involved in humanitarian response in Nepal observed a “dramatic increase” in sexual and domestic violence against women since the earthquake (UN Women, 2015).
- **Cyclones Vania and Atu:** In Vanuatu, which already has high rates of gender-based violence including intimate partner violence, a counselling centre recorded a 300 per cent increase in referrals following Cyclones Vania and Atu in 2011 (CARE, 2015b).
- Increased intimate partner violence was also reported following the Black Saturday bushfires in **Australia** (2009), the Christchurch Earthquake in **New Zealand** (2011), Hurricane Katrina in the **United States** (2005), the **Indian Ocean** Tsunami (2004), in **Japan** following the earthquake (2011).



At a camp in Dohuk, Iraq.

Photo © Ali Arkady/VII Mentor Program

“What can you do?”

The risk of transactional sex increases in crisis-affected environments and in particular displacement settings where livelihood opportunities are particularly limited. In crisis-affected settings, sex becomes a survival strategy and an extreme and negative coping mechanism for some women and girls. Facing extreme financial hardship and food insecurity, with no access to income generation, it is not uncommon for women, adolescent girls and also boys to sell their bodies to ensure their own survival and that of any dependents, whether their own children or those of deceased relatives (UNHCR, 2011). Sex is traded for essential items such as food, medicine or sanitary materials, gifts, or access to distributions (Klasing, 2011; UNHCR, 2011).

Crisis-related transactional sex has been observed, for example, in the Democratic Republic of the Congo, South Sudan, the Philippines, Haiti and Somalia (UNAIDS, 2015; CARE, 2014; The Inquirer, 2015; Inter-cluster Coordination Group for the Humanitarian Country Team, 2014; Klasing, 2011).

Women and girls may also enter the commercial sex trade as a source of income generation. A presence of peacekeeping forces or international humanitarian workers increases the risk of sexual exploitation, given the disparity in wealth (Human Rights Watch, 2015b). Unaccompanied girls and women and girls with disabilities are especially vulnerable (Women's Refugee Commission, 2013). Research by Plan International found that, during periods of drought in Ethiopia, girls have been resorting to prostitution to earn a living (Plan International, 2011). In Haiti, following the earthquake, girls, in particular unaccompanied girls, established relationships with men specifically for economic security (Klasing, 2011).

Increased risk of trafficking

Conflicts and natural disasters create opportunities for those involved in human trafficking to exploit the vulnerabilities of crisis-affected populations. The International Organization for Migration (2015) describes refugee and displaced persons camps as a “breeding ground of new victims for traffickers” and informal settlements and host communities as “particularly at-risk locations” (2015). Women and girls are particularly targeted by traffickers who may force them into sex work in brothels, sexual slavery and forced labour (International Organization for Migration, 2015). They may be lured with the promise of a job or abducted. Those who resort to risky survival strategies such as survival and transactional sex, unaccompanied girls who lack the protection of families, and children in general, lacking the structure and protection of schooling, are at heightened risk of trafficking (International Organization for Migration, 2015). Discrimination can also be an important risk factor, reflected in the targeting of ethnic and religious minorities, such as the Yazidi group in Iraq (International Organization for Migration, 2015).

The United Nations has reported a surge in the trafficking of adolescent girls in areas of Myanmar affected by conflict (United Nations Security

“ People will try to survive by the way they can. Women have relationships with men so they can feed their children. That happens a lot...It's not good to make prostitution, but what can you do? You have to eat. ”

Resident of camp in
Croix-de-Bouquets, Haiti



Khokhana, on the outskirts of Kathmandu after earthquake.
Photo © Panos Pictures/Vlad Sokhin

Council, 2015). Trafficking has also been reported in the aftermath of recent disasters in Nepal (Burke, 2015) and the Philippines (Inter-cluster Coordination Group for the Humanitarian Country Team, 2014). In the Philippines however, UNICEF found no significant increase in incidence as a result of the typhoon (Erakit, 2014). Understanding of the relationship between trafficking and crises remains limited: its prevalence is not well documented, and data are limited (International Organization for Migration, 2015).

Sexual violence survivors need post-rape care but may not get it in a crisis

Survivors of sexual violence need access to quality clinical post-rape care, which includes post-exposure prophylaxis (within 72 hours) to minimize the chance of HIV transmission, emergency contraception, antibiotics to prevent sexually

transmitted infections, broader medical care, as well as mental health and psychosocial support and legal support (Casey et al., 2015).

However, crises can prevent survivors from receiving quality clinical management of rape. Care may be unavailable due to destruction of primary care facilities, restricted humanitarian access or the lack of relevant training for the medical workers who are available. Care may be compromised by the lack of sufficient supplies, including drugs. Survivors may be unable to reach the services due to restrictions on movement. Even where services exist, survivors may be unaware of their availability or may choose not to seek out health services given the climate of fear and silence that continues to surround sexual violence across many societies (United Nations Security Council, 2015; Casey et al., 2015).

“Spoils of war”

In northern Iraq and eastern Syria, the self-proclaimed Islamic State in Iraq and the Levant (ISIL) has institutionalized sexual violence, in particular rape, sexual slavery and forced marriage, against “unbelievers” in areas under its control (Reinl, 2015). Women and girls of the Yazidi religious minority have been singled out (Amnesty International, 2014), though other non-Arab and non-Sunni Muslim communities such as Christian, Turkmen Shi’a and Shabak Shi’a minority groups also appear to be vulnerable to these violations of human rights (United Nations Iraq, 2014).

Women and girls are abducted as “spoils of war,” raped by ISIL fighters, forced into “marriage,” sold in auctions to local and foreign ISIL fighters, sometimes multiple times, and given as “gifts” (Human Rights Watch, 2015a; OHCHR, 2015). The practice is not only seen as “spiritually beneficial” but also has become an

established practice for recruiting fighters to ISIL (Callimachi and Limaug, 2015).

Trauma

Interest in the effects of trauma on individuals, populations, between generations and on peace and security are growing. Ideas about how unresolved trauma and collective trauma may lead to intergenerational impacts and new cycles of violence and conflict are gaining currency. The mental health and well-being of people are at higher risk following conflict and crisis, and much more needs to be understood about the mental health impacts, intergenerational violence, how experience of violence may or may not lead to future perpetration, and how psychosocial needs interconnect with peacebuilding at a community-level (Searle, n.d.).

A need for change

Despite everything we know about gender inequality, gender-based violence and discrimination, women and girls continue to be disproportionately affected by disaster, conflict and displacement.

Whether in the home, in displacement settings or in their wider communities, women and girls experience much greater risks to their sexual and reproductive health and rights than men and boys.

However their exposure to harm and experiences are not the same. Women and adolescent girls experience *additional* layers of risk, depending on their ethnicity, age, their health and disability status, their economic situation and factors such as displacement and migration.

Humanitarian actors involved in policy-making and programme implementation need to live up to commitments to unburden women and adolescent girls of overwhelming risks that exacerbate the already-overwhelming experience of being uprooted

and losing the support of family, community and government after a crisis occurs.

Changes are needed in some aspects of humanitarian response to make sure the acute sexual and reproductive health needs of women and adolescent girls are met through, for example, immediate restoration of access to services and supplies, such as contraception.

While crisis conditions may lead to reduced access to contraception and family planning, they may also create opportunities for improved access through targeted humanitarian programming (Plan International, 2013).

But reducing risk also requires long-term investments and political will to rectify gender inequality, which can multiply risks.

While some factors in crisis situations lead to heightened risk, they may also present opportunities for change. With HIV, for example, crises may be opportunities for improved care or for reaching those who had not previously been able to access it (UNAIDS, 2015). In well-managed and resourced camps, displaced populations may actually have better protection, health education and services than they experienced before the crisis.

Adolescent girls have special vulnerabilities, and humanitarian actors must recognize from the start the risks compounding these vulnerabilities and prioritize actions that address their needs, ensure their safety and preserve their dignity.

CHAPTER 3

Evolving response: from basic to comprehensive

When women and girls can obtain sexual and reproductive health services, along with a variety of humanitarian programmes that deliberately tackle inequalities, the benefits of interventions grow exponentially and carry over from the acute phase of a crisis well into the future as countries and communities rebuild and people reclaim their lives.

Saving the lives of Syrian women and adolescent girls in Jordan



Reema Diab with client.

Photo © UNFPA/Salah Malkawi

On one August morning at the Za'atari camp in Jordan, thousands of Syrian refugees began their routines before the peak of the midday heat.

By 11 a.m., the temperature outside was already 30°C. But inside one of UNFPA's four reproductive health clinics in the camp, air conditioning was keeping five expectant mothers cool as their contractions intensified.

On an average day, 10 babies are born in Za'atari's labour and delivery centre, according to obstetrician-gynaecologist Reema Diab. The centres are designed, managed and monitored by UNFPA, the United Nations Population Fund, working with a local non-governmental organization, the Jordan Health Aid Society, and with donor funding from

the European Commission and the United States.

Diab is one of five doctors who, with the help of 17 midwives, deliver hundreds of babies every month despite the challenging conditions of a refugee camp. So far, no mother has died in pregnancy or while giving birth in Za'atari.

But there have been plenty of close calls.

Diab says that one of the five women in labour that August morning had pre-eclampsia, a potentially life-threatening condition, and had to be transferred to a hospital equipped with an operating room, anaesthesia and other essentials for complicated deliveries and caesarian sections. Sometimes cases are referred to a nearby Jordanian hospital. But in



Family health clinic, Deir Allah, Jordan.
Photo © UNFPA/Salah Malkawi

most instances, women are transferred within the camp to a hospital run by the Moroccan military. That hospital performs an average of three Caesarean sections a day, and the surgeons are also trained to repair cervical tears and obstetric fistulas.

Sajah, 25, is one of many who have benefited from the specialized care available at the Moroccan hospital. She was recently referred there for a high risk delivery, after experiencing five miscarriages. A Caesarean section resulted in a safe, healthy, delivery.

Integrated, comprehensive care

The labour and delivery centres are just one aspect of the comprehensive sexual and reproductive health services available to the residents of Za'atari, where

one in four is a woman or adolescent girl of reproductive age.

Women in the camp are also able to receive antenatal care and post-partum follow-up services. Women, men and young people can obtain information about family planning and free modern contraception. The centres' health-care staff have been trained to identify and provide clinical management of sexual and gender-based violence and to make referrals to the camp's counselling and case-management centres.

Still, life in the camp is a struggle. Even with readily available services, refugee women and girls face a host of barriers to good physical and psychological health, from the lingering trauma of their displacement to the impact of negative

coping mechanisms, to forced child marriage.

Heaping loss upon loss

That morning at the labour and delivery centre, two 16-year-old girls gave birth. Adolescent pregnancies are commonplace in Za'atari. Omar Laghzaoui, the lead obstetric surgeon at the Moroccan hospital, says that about one in three of the births he assists are to girls 15 years or younger. "The youngest I've seen was 12," he says. With early pregnancies come heightened risks of complications and, often, the need for Caesarean sections.

Special challenges for adolescents and young people

These early pregnancies are usually linked to child marriages in the camp,

Imagine being nine months pregnant, alone, separated from family and friends, miles from a doctor or anyone who can help, and contractions begin. You are faced with the prospect of delivering on your own.

Such an unimaginably frightening scenario was a reality for untold thousands of women living through a conflict or disaster only 20 years ago.

Until recently, humanitarian response was mainly about meeting basic needs including water, food, and shelter. Other needs, including those related to sexual and reproductive health and childbirth, were seen by many as secondary.

But to the woman delivering on her own, the need for a midwife or for clean environment and instruments to help her avoid an infection are primary.

The absence of sexual and reproductive health in crises was the norm, not the exception. For example, one review in 1994 showed virtually no sexual

and reproductive health services in multiple refugee and internally displaced persons sites in eight countries (Wulf, 1994).

Since then, however, humanitarian actors have come to recognize the importance of ensuring sexual and reproductive health and rights in crises, not only as an essential part of humanitarian response, but also as a lever to more effective humanitarian programming across sectors and as a foundation for long-term recovery, rehabilitation and resilience.

The Programme of Action of the 1994 International Conference on Population and Development, endorsed by 179 governments, helped draw attention to the unmet sexual and reproductive health needs of women and girls in humanitarian settings: “Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming

says Asma Nemrawi, a psychologist serving the camp’s young people. Parents often arrange marriages for their young daughters to eliminate the financial burden of caring for them, or out of the misguided notion that a husband will better protect them from sexual violence. Nemrawi routinely sees girls who are, or are about to be, married. Some are as young as 14. “Some want to learn how to have children,” she says. “Others are already pregnant and want psychological support.”

Nemrawi says that some girls tell her they want to have children to make up for the losses they’ve experienced in their lives. Some also say they fear their husbands will become violent or divorce them if they don’t have children. For these difficult situations, she tries to

meet with both the girl and her husband at the same time to talk about the health, psychological and economic benefits of delaying pregnancies until later in life, drawing attention to the challenges of raising a child in a refugee camp.

Nemrawi also talks to the camp’s youth about family planning. “At the beginning, they didn’t want to hear about family planning,” she says. But her efforts to explain how it works and how it is good for the health of the mother are paying off. About 60 per cent of the young people who came to one of her sessions leave convinced they should use it.

Reaching those not in the camps

Za’atari is home to about 80,000 Syrian refugees; four other camps house another 30,000. But these camp

residents combined account for only about 18 per cent of all Syrian refugees in Jordan. The other 82 per cent live in cities, towns and rural areas throughout the country, where many of them struggle to obtain access to sexual and reproductive health care.

Providing services to refugees outside the camps is complicated. The populations are dispersed, and many are beyond the reach of the institutions serving Jordanian citizens.

In addition, services in Jordan’s public hospitals and Government-run clinics are free only to insured citizens. Syrians and refugees from other countries have to pay a fee, which is not high compared to the cost of private services, but is still often unaffordable for most.

IN TYPHOON'S TERRIBLE WAKE, WOMEN IN THE PHILIPPINES CONTINUED GIVING BIRTH SAFELY

When the warnings were issued for Typhoon Haiyan, the chief of the Felipe Abrigo Memorial Hospital wasted no time. Dr. Lilia Daguinod gathered essential medicines from her hospital and set up a small pharmacy in the front room of her small house.

As an obstetrician, Dr. Daguinod knew that women would continue to give birth and be at risk no matter what happened. "I had to be ready," she said.

In the first days after the typhoon's ferocious winds shredded this city and left her hospital in ruins, Dr. Daguinod delivered three babies in that room. "Thank God, there were no complications."

After a makeshift birthing facility was set up next to a roofless health centre, she continued to host post-partum mothers and their babies in her home.

Four million people were left homeless by Haiyan, known locally as Yolanda, which struck in November 2014.

Hundreds of displaced women were giving birth every day, and scores of them faced potentially life-threatening complications. Most damaged health centres restored some services soon after the crisis, but staff in many places struggled to serve patients without equipment or electricity and with few ambulances and scarce supplies.

In response to this crisis, UNFPA prioritized services to ensure the safety of pregnant women and those who recently gave birth. UNFPA provided critical medical equipment and supplies, including medicines, clean delivery kits and hygiene packs, to government and non-governmental partners to support health care in the worst-affected regions.

One alternative is to access services from non-profit providers, such as the Institute for Family Health, or IFH, which has a nationwide network of clinics offering sexual and reproductive health services to Syrians and Jordanians alike. IFH implements programmes supported by UNFPA.

Hanin Zoubi is the IFH-UNFPA programme manager. "We take an integrated approach," offering free antenatal and postnatal care, family planning counselling and services, treatment of sexual transmitted infections and psychosocial support for survivors of gender-based violence and trauma, all under one roof, she says.

But not everyone is able to come to the clinic, so IFH also provides community

outreach. "We go to where the people are," Zoubi says. They go, for example, to schools to provide information to adolescents, or to community-based organizations to offer life-skills training to young people.

People welcome the information, she says, noting that vulnerable populations in the country often lack access to the Internet and are unable to find out on their own about how to prevent a pregnancy or a sexually transmitted infection.

The refugee population living outside the camps is different in key ways. Their demand for family planning is greater, according to Zoubi, and there are fewer adolescent pregnancies.



Newborns, Za'atari Camp.

Photo © UNFPA/Salah Malkawi

Haya Badri, the IFH clinics coordinator, says up to 65 Syrians and Jordanians patients come to the facility in Amman for services every day. Most of the clients come for check-ups, including ultrasound examinations, but some

with universally recognized international human rights” (United Nations, 1994). This approach was further endorsed in the Beijing Platform for Action of the 1995 World Conference on Women (United Nations, 1995).

In 1995, UNFPA and the United Nations High Commissioner for Refugees led the formation of the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) in response to the increasing recognition of sexual and reproductive health needs among refugees and internally displaced persons and the general lack of response. Since then, IAWG has grown into a global coalition of United Nations, donor and academic organizations, local and international non-governmental organizations and ministries of health to expand and strengthen access to quality sexual and reproductive health services for people affected by conflict and natural disaster (IAWG, 2014).

Today, *more* refugees and internally displaced persons have *more* access to *more* services than in the

past. In 2014, UNFPA provided 8,437 reproductive health kits with essential supplies, medicine, contraceptives, and equipment, targeting more than 35 million women, men and adolescents in humanitarian settings. But continuously growing populations in need and increasing commitment to providing them with comprehensive services mean that gaps still exist and could become larger without concerted effort to meet the challenge.

The humanitarian community has come a long way over the past 20 years. In many of today’s humanitarian settings, a full range of services and support are available. But in others, some or many aspects are still lacking. Sexual and reproductive health is not yet comprehensive or universal across all crises.

One hundred seventy-nine Governments agreed in 1994 at the International Conference on Population and Development that reproductive rights are human rights. The international community has an obligation to uphold these rights, even in crises.

also receive treatment for anaemia or request contraception. Many also come in to report or receive treatment and counselling for sexual and gender-based violence. One-to-one counselling sessions and support groups are also available for traumatized adults and children and even for torture survivors.

Confidentiality and respect

Whatever the service being provided, privacy is critical. All staff have been trained and have signed a code of conduct, committing to provide confidential services to all without judgment. The guarantee of confidentiality helps clients overcome fear and maintain dignity in seeking help.

At another centre, in Deir Alla in the Jordan Valley, Nadia om-Hassan, 35,

comes for family planning, to see counsellors and participate in social support groups. Three years ago, when she was still in Syria, she had just given birth to her fifth child by Caesarean section and was still groggy from anaesthesia when bombs struck the hospital, forcing an emergency evacuation. In the following days, her surgical incision became infected. Despite her condition, she, her husband, their newborn and four other children all fled to Jordan.

Afterward, om-Hassan’s husband pressured her to become pregnant again. “He wanted more boys, to help support the family,” she says. “I did get pregnant after three months, [but] had a miscarriage.” IFH staff in Deir Alla told her about family planning and explained how it was important to her health.

“Now I explain to my husband that it’s also good for the health of the whole family.”

“When I come to the clinic and have a chance to talk about my problems, I feel so happy and relieved,” om-Hassan says.

The Deir Alla centre also supports adolescents. Malak, 15, came to Jordan from Damascus four years ago with her parents, grandparents and three siblings. She attends secondary school, where science is her favorite subject, but says she wants to become a police officer one day. Earlier this year, her aunt approached her parents to arrange a marriage with her 20-year-old son. “I wasn’t happy, but I couldn’t refuse. I didn’t want to give up my education,” Malak says.

Establishing a standard for the essentials

In 1998, the IAWG introduced what is now considered the essential package of reproductive health services and supplies that should be available at the outset of every crisis. This minimum initial service package is the international standard for protecting the sexual and reproductive health and rights of women and girls in the acute phase of conflicts and disasters.

The objective of this is to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent maternal and newborn death and illness, and integrate sexual and reproductive health care into primary health care.

Even though these essential services are now widely accepted as the baseline for critical services and actions in crises, some responses have fallen short, endangering the health of women and adolescent girls and denying their reproductive rights.

Comprehensive services after the initial phase

The IAWG identified additional important sexual and reproductive health services that should be made available as soon as possible as a crisis situation stabilizes.

The full range of family planning options

Although it is not possible to prevent disasters, it is possible to prevent unintended pregnancies in the aftermath of a crisis.

Since the April 2015 earthquake in Nepal, for example, UNFPA and partners restored women's access to family planning in areas where health facilities were damaged or destroyed.

UNFPA-trained health workers and community volunteers spread the word about how to access family planning and use it effectively. Outreach is undertaken with health posts in village development committees, the smallest administrative units, to closely analyse local-level family

Then one day Malak accompanied her mother to the centre and found out about information sessions on child marriage, which they both attended. Her mother, and later her father, came to accept that it would be better for Malak to stay in school and finish her education. The engagement ended after a month.

According to Daniel Baker, who coordinates the UNFPA effort to support Syrian refugees in Jordan, Egypt, Iraq, Lebanon and Turkey as well as Syrians who have not yet fled the country, "The situation of Syrian refugees is dire in spite of the generosity of the neighboring host countries. As the war in Syria goes on with no end in sight, their situation is becoming even more desperate as they deplete all of their resources. The provision of basic

services, like maternal health care, is the responsibility of the international humanitarian community so that life can be sustained and that there is some hope for a better future when the war ends."

Malak, Deir Alla, Jordan.

Photo © UNFPA/Salah Malkawi



UNITED NATIONS HUMANITARIAN ACTION

More than two thirds of all humanitarian emergencies to which the United Nations responds today are natural disasters. In 2014 alone, the United Nations responded to 60 disasters, compared with seven complex emergencies or conflicts.

Since 2013, the United Nations has rated the magnitude and type of emergencies on a three-point scale, with the most severe Level 3 designated to need system-wide mobilization because of their scale, complexity and urgency. Level 2 emergencies may require predominantly a regional response. Level 1 emergencies are those that may be addressed by a given country or managed and supported by agencies in that country.

As of September 2015, the United Nations was responding to four Level 3 emergencies: in Iraq, where the surge in violence between armed groups and Government forces has resulted in an estimated 1.9 million internally displaced people; in Syria, where millions are in need of assistance and trapped in hard-to-reach areas; in the Central African Republic, where over the past year, the country has experienced a major political crisis that has left 2.5 million people—over half the population—in dire need of assistance; and in South Sudan, where 1.7 million people have been displaced and an estimated 4 million people face food insecurity (UNOCHA, 2015).

Over the last 12 months there have been 30 United Nations humanitarian funding appeals, nearly half of which were for countries in sub-Saharan Africa.

According to the Assessment Capacities Project (ACAPS), there are “severe” humanitarian crises in: Afghanistan, the Central African Republic, the Democratic Republic of the Congo, Eritrea, Iraq, Niger, Nigeria, Somalia, South Sudan, Sudan, Syria, and Yemen. ACAPS is a non-profit initiative of Action Contre la Faim, the Norwegian Refugee Council and Save the Children International that together supporting the humanitarian community with needs assessments.

According to ACAPS, there are also humanitarian crises in Cameroon, Chad, Colombia, the Democratic People’s Republic of Korea, Djibouti, Ethiopia, Gambia, Haiti, Kenya, Lebanon, Liberia, Libya, Malawi, Mali, Mauritania, Nepal, Pakistan, Palestine, Senegal, Sierra Leone and Ukraine.

UNITED NATIONS HUMANITARIAN RESPONSE, 2007–2014

● Disasters ● Conflicts

2007

124

33



© UN Photo/Eric Kanalestein

2008

115

40



© UN Photo/Martine Perret

2009

122

36



© UN Photo/Sayed Barez

2010

121

60



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SETTINGS OF CONFLICT, DISPLACEMENT AND NATURAL DISASTERS ACCOUNT FOR:



53 PER CENT
of under-five deaths



THREE IN FIVE
preventable maternal deaths

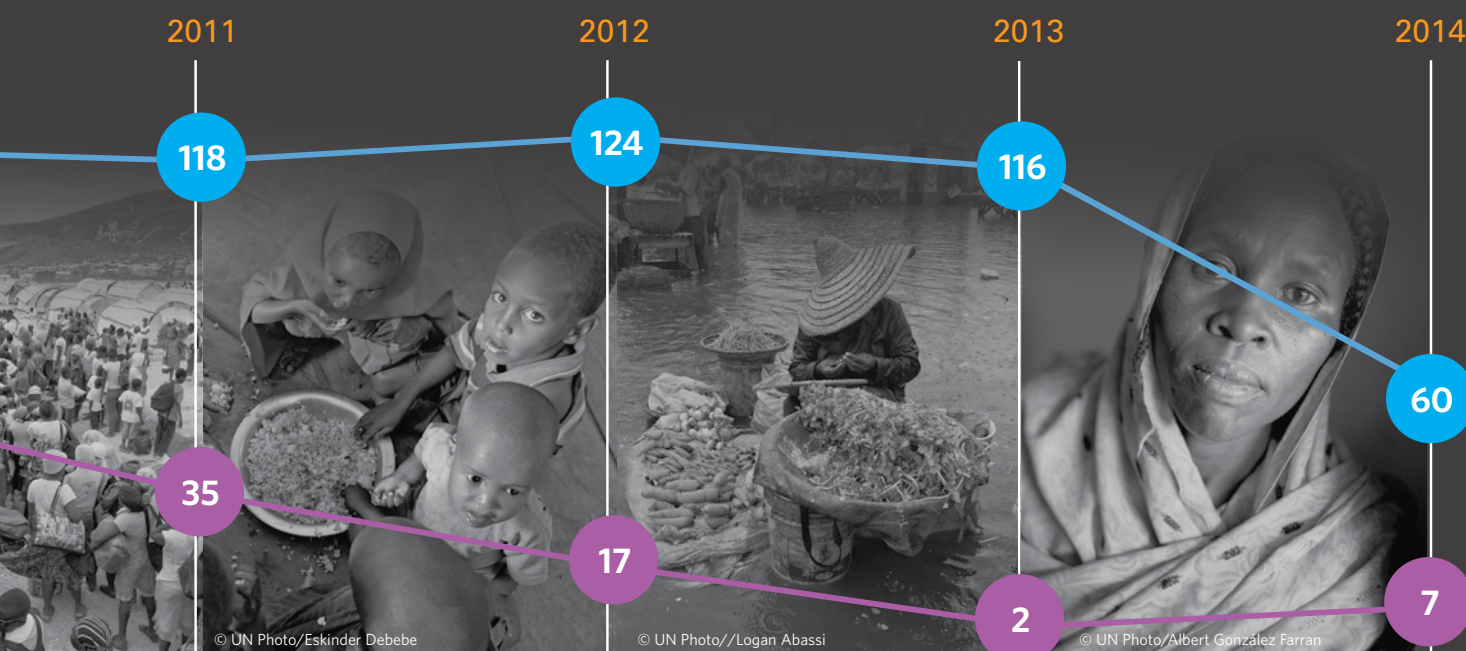


45 PER CENT
of neonatal deaths



Of the more than **100 MILLION PEOPLE** in need of humanitarian assistance in 2015, an estimated **26 MILLION WERE WOMEN AND GIRLS, AGES 15 TO 49**

More than **80 PER CENT** of the countries that did not achieve the MDGs for mothers' and children's survival have endured a recent conflict, recurring natural disasters or both. Indeed, most of the Millennium Development Goal targets in fragile states were not met, and the 10 countries at the bottom of Save the Children's Mothers' Index are all defined as conflict-affected or fragile.



WHERE UNFPA PROVIDED HUMANITARIAN SUPPORT IN 2015

UNFPA's role in any humanitarian situation is to ensure that women have access to safe delivery services, no matter what the circumstances, in order to protect the lives and health of both mothers and babies.



*The estimates of the number of women who are likely to be pregnant within a country or territory as a whole—not only the areas specifically affected by conflict or disaster—are drawn from nationally generated data. The total number of pregnant women at any given time in each place would be lower if the estimates were restricted only to the crisis-affected parts of each country or territory.

**Due to data availability, estimation for Vanuatu is using the total fertility rate instead of the general fertility rate.

Data Sources

Demographic and health surveys: Burkina Faso, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, Jordan, Malawi, Mali, Mauritania, Nepal, Niger, Nigeria, Peru, Rwanda, Senegal, Tanzania, Uganda, Yemen; Censuses: Central African Republics, the People's Democratic Republic of Korea, South Sudan, Sudan, Vanuatu; Registration: Chile, Guatemala, the former Yugoslav Republic of Macedonia, Turkey, Ukraine; Pan Arab Project for Family Health: Djibouti, Lebanon, Palestine; Multiple indicator cluster surveys: Iraq, Somalia; National statistics: Myanmar, Syrian Arab Republic.

Photo © Panos Pictures/Abbie Trayler-Smith

	Estimated number of pregnant women at any given time*
Burkina Faso	598,610
Burundi	373,871
Cameroon	695,698
Central African Republic	150,727
Chad	472,898
Chile	193,042
Democratic Republic of the Congo	2,753,898
Democratic People's Republic of Korea	276,175
Djibouti	21,836
Egypt	1,991,512
Eritrea	134,236
Ethiopia	2,711,606
Guatemala	365,965
Iraq	934,973
Jordan	157,846
Lebanon	74,572
Malawi	555,483
Mali	573,961
Mauritania	103,372
Myanmar	609,344
Nepal	517,850
Niger	763,201
Nigeria	5,366,797
Palestine	128,179
Peru	473,691
Rwanda	310,901
Senegal	432,879
Somalia	373,756
South Sudan	244,317
Sudan	860,404
Syrian Arab Republic	355,706
Tanzania	1,605,941
The former Yugoslav Republic of Macedonia	17,611
Turkey	945,434
Uganda	1,304,798
Ukraine	306,902
Vanuatu**	6,839
Yemen	687,058
Total	28,451,889

planning use and develop strategies to meet unmet need. A Government review of 30 facilities covered by the initiative found that the contraceptive prevalence rate had increased from 34 per cent to 45 per cent.

In humanitarian crises where funding for life-saving interventions is limited, family planning is a sound investment. In general, each \$1 spent on contraceptive services saves between \$1.70 and \$4 in maternal and newborn health care costs.

Last year, UNFPA provided contraceptives and other family planning supplies in emergency reproductive health kits, which targeted the delivery of services to 20,780,000 women, men and adolescents of reproductive age in humanitarian settings worldwide.

Access to family planning services is a human right, and neglecting to provide it can have serious health consequences, especially in humanitarian settings. In May 2013, UNFPA and the International Planned Parenthood Federation established a partnership aimed at providing access to family planning and information to 22 million women in countries and territories affected by conflicts and natural disasters.

The initiative focuses on filling the gap in health-care infrastructure, boosting the quality of the health workforce, developing efficient family planning distribution systems, and ensuring affordable family planning supplies. Target countries, which have low contraceptive prevalence rates and considerable unmet need for family planning, are Bolivia, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Liberia, Myanmar, Nigeria, Pacific Islands, Pakistan and South Sudan.



UNFPA provided contraceptives and other family planning supplies in emergency reproductive health kits, which targeted the delivery of services to 20,780,000 people of reproductive age.

Family planning is an indispensable element of response, as well as rebuilding and recovery, and directly benefits women and girls through increased family savings and productivity, as well as better prospects for education and employment. It also improves health outcomes as fewer unintended pregnancies result in fewer complications during childbirth and fewer maternal deaths.

Data show different fertility desires of people affected by crisis; both high and low fertility have been observed in response to war, natural disaster, economic decline, political upheaval and forced marital separation (McGinn, 2000). However,

a tenet of human rights and the right to health is that health services must be available, accessible, acceptable and of the highest possible quality for those who choose to use them (Foreman, 2015). A fundamental principle of family planning programmes is that clients make decisions based on full, free and informed choice (Foreman, 2015; IAWG, 2010).

Good programming requires that *all* effective contraceptive methods be made available to women and men. Experience in programmes that offer the full range of long- and short-acting contraceptives has demonstrated that women will choose long-acting intrauterine devices and implants when they are available and when services are of good quality.

Family planning programmes serving crisis-affected women and adolescents primarily offer short-acting methods of contraception, if they provide contraceptives at all (Casey, 2015).

But programme experience suggests that women will use long-acting methods when they are available. In the Democratic Republic of the Congo's North Kivu Province, an area of chronic

conflict and insecurity, all reversible methods are offered in some Ministry of Health facilities supported by international non-governmental organizations. Not only was contraceptive prevalence higher than the national rate, but the use of long-acting reversible methods in North Kivu was more than twice that of Kinshasa. (Ministère du Plan et al., 2014).

Additional measures to save the lives of mothers and newborns

The 10 countries with the highest maternal mortality ratios in the world are affected by, or emerging from, conflict.

UNFPA's role in any humanitarian situation is to ensure that women have access to safe delivery services, no matter what the circumstances, in order to protect the lives and health of both mothers and babies. UNFPA does not necessarily provide these services through its own operations: typically some public and private health facilities continue to function and there are many non-governmental organizations that also specialize in maternity services. But when there are gaps, UNFPA fills them.

Creative means have sometimes been used to ensure access to maternal and newborn health services to women who are distant or dispersed.

Community health workers responding to Ebola in Guinea, for example, used smartphones to register people exposed to the virus and relay critical information to health officials.

In Somalia, nurses used global positioning systems to facilitate the delivery of health services to internally displaced persons in remote areas (Shaikh, 2008).

Also in Somalia, UNFPA is supporting 34 maternity waiting homes for pregnant women with complications to provide care and protection until it is time for delivery at a health facility.

In the Philippines, after Typhoon Haiyan, UNFPA helped establish an emergency maternity unit, in a “hospitainer,” where health care professionals assisted 14 normal births and performed 83 Caesarean sections. UNFPA also provided clean delivery kits, which were used in emergency deliveries for as many as 26,000 women in makeshift facilities in places such as municipal buildings.

Refugees themselves have led on many initiatives. In Guinea, for example, refugee women led maternal health education in communities and facilitated delivery and use of other services (Howard et al., 2011). In Syria, where nearly 7.6 million people are internally displaced, reproductive health vouchers were introduced to enable vulnerable women to obtain essential services, including antenatal, delivery, postnatal and emergency obstetric care for free at designated health centres and hospitals. Of the women benefiting from UNFPA-supported reproductive health services in Syria since the crisis began, more than 810,000 went through safe deliveries and 93,000 internally displaced women benefited from the voucher system.

In Gaza, four maternity centres and five primary health care facilities used by 50,000 people a year faced chronic shortages of essential medicines since 2006, but stocks dwindled to critical levels after the 2014 conflict. UNFPA replenished medicines and other supplies, which have so far enabled about 35,000 pregnant women to have healthy pregnancies and safe deliveries.

Also in Gaza, the Harazeen Hospital, the only facility serving the community of Shejaiia, was severely damaged by fighting in 2014. UNFPA funded repairs. The Hospital provides antenatal, delivery and postnatal care to as many as 300 women a month.

UNFPA SUPPORTS ACCESS TO SERVICES BY WOMEN AND GIRLS

Services and supplies provided January to September 2015
in Lake Chad Basin countries affected by Boko Haram crisis

NIGER

53,312 condoms distributed
10,913 women and adolescent girls accessed **family planning**
1,458 women assisted for **safe deliveries**
1,407 **dignity kits** were distributed to refugees
906 women received **antenatal care**
118 adolescents and youth received training as reproductive **health educators for refugees**
40 **health providers** were trained
22 women survivors of gender-based violence received **psychological support**

CHAD

28,000 condoms distributed
2,500 women, men, young people attended awareness-raising about **gender-based violence**
1,500 women received **antenatal care**
1,500 women received **gender-based violence services**
510 women assisted for **safe deliveries**
500 women accessed **contraception**

NIGERIA

2,108,441 people's awareness raised about preventing and responding to **gender-based violence**
27,293 women assisted for **safe deliveries**
22,000 women and adolescent girls received **dignity kits**
214 **reproductive health kits** (1,759 cartons) distributed, containing a range of life-saving medical equipment, drugs and other supplies
213 **health workers and programme managers were trained** in providing reproductive health services in humanitarian settings
56 **midwives and nurses were trained** in administering long-acting reversible contraception

CAMEROON

4,075 **kits for safe delivery** distributed to health posts in camp and centres
5,400 **dignity kits** delivered to pregnant and vulnerable women and girls
10,000 **male condoms** distributed
110 women accessed **contraception**
11 cases of **rape clinically managed**
30 district health staff and 40 community health agents **trained and deployed**
22 newly **trained midwives** deployed
5 **youth centres equipped** for skills development and adolescent counselling
4 public health facilities serving refugees equipped to provide **quality reproductive health services**
4 **youth- and women-friendly spaces** created in Minawao camp

Girls who escaped Boko Haram,
Chibok, Nigeria.

Photo © Panos Pictures/Sven Torfinn



In addition, UNFPA funded mobile clinics to serve Gaza's internally displaced pregnant women in camps for internally displaced persons, makeshift shelters and caravans in remote border areas where an estimated 100,000 people remain homeless. In July 2015 alone, mobile clinics brought services to 389 women, including 156 who were pregnant.

Some humanitarian programmes have made noteworthy progress in extending access to reproductive health services to all in every setting. Maternal and child health centres are accessible to all residents of the Za'atari refugee camp in Jordan, for example, and additional centres are reaching Syrian refugees not in camps (Krause et al., 2015).

Post-abortion care to save lives

Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion due to higher levels of rape and disrupted contraceptive use due to displacement (IAWG, 2010). Although national abortion laws and access to safe abortion care vary by country, 99 per cent of the world's population lives in countries where abortion is permitted under certain circumstances; six States prohibit abortion under all circumstances (RAISE, 2015; Center for Reproductive Rights, 2014).

Post-abortion care is a life-saving service that prevents death and illness from complications of miscarriage or abortion. UNFPA's policy on abortion is guided by the Programme of Action of the 1994 International Conference on Population and Development: where abortion is legal, it should be safe. Where it is illegal, post-abortion care should be available to save lives.

An evaluation by the IAWG found that in three crisis-affected countries of sub-Saharan Africa, hospitals were deemed capable of providing post-abortion care but the actual availability of care was limited (Casey et al., 2015).

Preventing and treating sexually transmitted infections, including HIV

HIV has received progressively greater attention in humanitarian settings during the last two decades and receives greater funding and targeted assistance than other sexual and reproductive health topics (Tanabe et al., 2015). An evaluation by IAWG in 2014 found that many countries had made notable progress in increasing access to antiretroviral therapy and prevention of mother-to-child transmission but progress lagged in providing services to prevent or treat other sexually transmitted infections (Chynoweth, 2015).

In 2014, the United Nations Office on Drugs and Crime and the United Nations High Commissioner for Refugees developed a programme comprising comprehensive HIV prevention and harm reduction as well as HIV testing and counselling and HIV treatment for Afghan refugees in Iran and Pakistan and returnees in Afghanistan. The programme distributed condoms and syringes and supported HIV services across borders, thus promoting continuation of services after refugees' return. In Afghanistan, the programme reached approximately 3,000 people who inject drugs, including some 500 women (UNAIDS, 2015).

Protecting adolescents' right to health

Humanitarian settings are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse and exploitation. Moreover, childbearing risks are compounded for adolescents, due to increased exposure to forced sex, increased risk-taking and reduced availability of, and sensitivity to, adolescent sexual and reproductive health services (Women's Refugee Commission et al., 2012).

There is little evidence that adolescent sexual and reproductive health receives adequate attention in humanitarian contexts.

Still, there are several programmes with promising approaches, providing adolescent sexual and reproductive health services within school-based programmes, working with urban displaced populations and incorporating adolescent sexual and reproductive health into disaster risk reduction (Women's Refugee Commission et al., 2012).

A topic of concern to all women of reproductive age in crisis, but that has special resonance for adolescent girls, is menstrual hygiene management. The IAWG has called for safe, sex-specific hygiene facilities in schools and the provision of cloth or other culturally appropriate sanitary materials for use during menstruation. UNFPA was one of the first agencies to provide sanitary napkins in humanitarian settings and has been distributing “dignity kits,” which include sanitary napkins, since the early 2000s.

Young people can be agents of positive change, capable of advancing reconstruction and development in their communities. But to be engaged in the process, they need access to an array of programmes including formal and non-formal education, life skills, literacy, numeracy, vocational training and innovative strategies to address insecurity and staff shortages (IAWG, 2010). The intersections among education, livelihoods and protection for adolescents, however, are generally overlooked (UNFPA, 2015b).

Preventing and addressing gender-based violence

Response to gender-based violence in humanitarian settings requires services and support to prevent and protect affected populations, to reduce harmful consequences and prevent further injury, trauma, harm and suffering. United Nations guidelines for addressing the problem emphasize that all “humanitarian personnel ought to assume gender-based violence is occurring and threatening affected

CHARACTERISTICS OF SUCCESSFUL ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

- stakeholder involvement
- adolescent participation and engagement to build adolescent buy-in and increase demand for services
- responsiveness to the different needs of adolescent subpopulations
- qualified and dedicated staff to serve adolescents
- provision of comprehensive services for adolescents at a single site
- holistic, multi-sectoral approaches to programming
- structured supervision, recognition and ongoing mentorship to peer educators
- flexible outreach strategies, as well as the inclusion of transportation budgets
- consideration of adolescent sexual and reproductive health during emergency preparedness emergencies

(Women's Refugee Commission et al., 2012)

populations; treat it as a serious and life-threatening problem; and take actions...regardless of the presence or absence of concrete evidence” (IASC, 2005).

Gender-based violence includes sexual violence, including rape, sexual abuse, sexual exploitation and forced prostitution; domestic violence; forced and early marriage; harmful traditional practices such as female genital mutilation, honour crimes and widow inheritance; and trafficking (IAWG, 2010). Thus, in humanitarian settings, response to gender-based violence requires a multi-sectoral approach.

In August 2015, the Inter-Agency Standing Committee (IASC), which helps coordinate humanitarian assistance by the various United Nations bodies and humanitarian partner organizations, issued updated guidelines on integrating gender-based violence interventions into humani-

tarian action, calling on national and international actors to protect crisis-affected populations: “failure to take action against gender-based violence represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations” (IASC, 2015).

Local women are usually the first to respond and the first to find solutions, sometimes simple ones that can make the difference between life and death. When an earthquake rocked Haiti in 2010, the incidence of rape increased markedly, as the institutions that might normally protect them collapsed, women mobilized within displacement camps to protect each other and support survivors. The non-governmental organizations MADRE and KOFIVIV distributed whistles to women in displacement camps, which helped reduce the incidence of rape by 80 per cent in one camp. The installation of lights powered by solar batteries also contributed to a reduction in gender-based violence in the camps.

Women themselves also took the lead in the Philippines after Typhoon Haiyan by forming watch groups and “women-friendly spaces” to protect themselves from gender-based violence. In July 2014, when another typhoon was forecast to strike the country, women dispatched watch groups to evacuation centres in coordination with female police officers and local authorities.

Shortly after Haiyan struck, the Philippines Department of Social Welfare and Development and UNFPA organized town halls in evacuation centres in Tacloban to give women and girls a forum for reporting risks to their health and safety. Many cited a lack of privacy, crowded living conditions and inadequate lighting as key threats. Adolescent girls said they were afraid to use toilets at night. In response to a request for more protection, the Philippines National Police

deployed more female officers and trained them in responding to gender-based violence. The presence of female officers not only helped reduce the risk of gender-based violence but also increased the reporting of it.

Many programmes to address gender-based violence in humanitarian settings have used innovative measures to ensure an effective response. Chad, for example, established shelters for single women (Women’s Refugee Commission, 2004) and safe spaces for survivors, who may access psychosocial support and skills training (UNFPA, 2015c). In Jordan, and many other countries, safe spaces enable women and girls to disclose sexual violence incidents and access safe and non-stigmatizing response services (UNFPA, 2015a).

The establishment of safe spaces for women and girls affected by crisis is increasingly recognized as a good practice of emergency response and recovery, and a key strategy for the protection, leadership and empowerment of women and girls. Distinct from shelters, safe spaces are formal or informal places where women and girls feel physically and emotionally safe and can socialize, receive social support, acquire skills, obtain gender-based violence-response services and receive information on issues related to women’s rights, health and services.

The creation of community task forces and patrols has proved to be an essential step in the provision of protection services in humanitarian settings. In Malawi, for example, following devastating floods earlier this year, women reported fear of being assaulted while walking alone to the toilets. The Ministry of Gender, Children, Disability and Social Welfare and UNFPA helped procure some 50 tents to serve as safe spaces for women and girls, and supported officials in establishing task forces to address gender-based violence.



Girls dance at the Za'atari Camp, Jordan.

Photo © Panos Pictures/Mads Nissen

In many countries, “psychological first aid” has been used to mitigate the effects of gender-based violence. CARE, for example, provided this service to nearly 800,000 people affected by conflict and disasters in 2014. Psychological first aid was piloted in Haiti, resulting in positive improvements among participants suffering mental distress (Schafer et al., 2010). In Tonga, front-line service providers working with the Ministry of Health and non-governmental organizations were trained in mental health and psychosocial support. In Fiji, UNFPA led the development of psychosocial first aid responses by government and non-governmental organizations.

Programmes to involve men and boys in gender-based violence-prevention are critical and have included, for example, International Rescue Committee’s “Men’s Action Groups” in Liberia and CARE’s youth-led school-based campaign, “Be a man,” in the Balkans (Holmes and Bhuvanendra, 2014; Shteir, 2014).

Most attention to gender-based violence has focused on rape, but the growing spotlight has

expanded also to include early and forced marriage, domestic violence, female genital mutilation, and trafficking.

A systematic analysis of efforts to discourage child marriage identified five core approaches:

- Empower girls by building their skills and enhancing their social assets
- Mobilize communities to transform detrimental social norms
- Improve girls’ access to quality formal education
- Enhance the economic situation of girls and their families
- Generate an enabling legal and policy environment (UNFPA, 2012b).

Agencies have engaged in mass community education to promote awareness around the detrimental health impacts of child marriage; these include CARE’s Information Volunteer programme in Turkey and Oxfam’s Integrated Action on Poverty and Early Marriage programme in Yemen (CARE, 2015; Oxfam, 2008; UNFPA, 2012a).

Most programmes focus on changing the underlying social norms through community education efforts; few programmes target law and policy surrounding early marriage and even fewer serve girls who are already married (UNFPA, 2012a; Feldman-Jacobs and Ryniak, 2006a).

The chaos and family separation that occurs during crises may make women and girls more vulnerable to trafficking. ECPAT International (End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes) developed a guide specific to emergency situations that advises families to establish meeting places and identification measures with children in the event of separation (Delaney, 2007).

Adapting to changing demographics of refugees

Today an estimated six in 10 refugees globally live in cities, not in refugee camps. The percentages vary according to the context, with more than eight in 10 refugees from Syria living in urban areas. Understanding the growing trend of refugee

urbanization is important to refocus protection and programming strategies to meet the needs of refugees in diverse locations. In response, UNFPA and the office of the United Nations High Commissioner for Refugees developed a sexual and reproductive health toolkit to help aid workers and partners in planning and programming for urban refugees. The toolkit comprises tips for decision-making, analysis, mapping of health facilities and services, planning, monitoring and evaluation, advocacy, coordination, community mobilization, and options for the provision of health care.

Preparedness saves lives

More and more emergency preparedness and disaster risk reduction initiatives today are including sexual and reproductive health as an essential service before, during and after a crisis. In 2014, UNFPA strengthened rapid response capacities in 48 countries to provide the minimal initial service package of sexual and reproductive health services and supplies in the event of a crisis. The pre-positioning of sexual and reproductive health supplies in Nepal before the April 2015 earthquake, for example, enabled humanitarian actors to distribute them immediately after the disaster.

In Pakistan, monsoons of the past few years have repeatedly inundated the Jhang district, destroying local health facilities and uprooting thousands of people in about 250 villages. After each disaster, UNFPA and Muslim Aid joined forces to restore critical reproductive health services. But they also helped communities and health providers in 2015 to prepare for future disasters by mobilizing women to lead local disaster risk reduction committees. The committees include health outreach workers, midwives and community members who raise awareness about the threat of natural disasters and explain what individuals can do to mitigate the effects.



At a camp in Dohuk, Iraq.
Photo © Ali Arkady/VII Mentor Program

Youth-led disaster risk reduction committees were also established. These groups are in charge of canvassing communities about individuals' blood types, in case donors are needed and coordinating with government health departments to come up with plans for reaching pregnant women in the event of another disaster.

Women- and youth-led committees together also identified locations that are less vulnerable to flooding for the storage of clean delivery kits, neonatal-care supplies and even boats to transport women in need of medical assistance.

Access to comprehensive services increasing but gaps remain

Vast improvements have been made in sexual and reproductive health response in humanitarian settings, from its virtual absence in 1994 to more comprehensive services and coverage today. The current response in Jordan's Za'atari is a case in point: services available to Syrian refugees include family planning; antenatal, delivery and emergency obstetric and newborn care; gender-based violence response; prevention and treatment of sexually transmitted infections, including HIV; and attention to adolescents.

The success of sexual and reproductive health response to date is a result of collaboration among humanitarian and development organizations, ministries of health and communities. More women and girls who are refugees or displaced have more access to services today than any time in the past.

But it is also clear that few such populations have access to the full range of services to which they have a right. The growing populations in need signal a need to increase both depth and scope of services to ensure these populations can exercise their right to reproductive health, even in crises. Strategic action to prioritize support for reproductive health is fundamental to human

dignity. Such action must be more context sensitive, adapted to changing circumstances and across the life course. The health interventions and overall response to crises in humanitarian and fragile settings must be better anticipated, planned, and resourced.

As the world embarks on a new sustainable development agenda for the next 15 years, it does so in a period of emergent and protracted crises with the majority of those affected being women, children and adolescents, lacking access to lifesaving services, facing grave exclusion, exploitation and perishing in higher numbers.

In countries emerging from conflict, continued lack of access to health care, psychological and social support, and justice, coupled with ongoing gender-based violence, impede recovery and development. Often countries' longer-term development planning processes fail to include preparedness, response and recovery. Meeting many of the United Nations Sustainable Development Goals will require tailored attention to sustainable, inclusive development for women and adolescent girls in humanitarian crises.

To help address the challenges ahead, experts from United Nations agencies, governments, civil society, academia and foundations converged in Abu Dhabi in February 2015 and called for a new global strategy to protect the health of every woman and every child in *every setting*, including disasters and conflicts. The group's "Abu Dhabi Declaration" stated that building resilience and accelerating recovery of communities affected by crisis depends on meeting reproductive, maternal, newborn, child and adolescent health needs and human rights in humanitarian contexts, reducing preventable maternal and child deaths as well as preventing and responding to gender-based violence, while addressing fundamental needs for nutrition, water, sanitation and hygiene (UNFPA, 2015).

Resilience and bridging the humanitarian-development divide

The profound human impact of disasters and conflicts on people, communities, institutions and nations highlights the critical importance of building resilience so all may better withstand the effects of crises and recover from them more quickly. Building resilience can also help mitigate the potential negative effects on the sexual and reproductive health of women and adolescent girls.

The collateral damage of Liberia's Ebola crisis: women and girls of reproductive age



Dr. Jallah at hospital in Paynesville, Liberia.

Photo © Abbas Dulleh/AP Images for UNFPA

Comfort Fayiah is one of the lucky ones.

As the late-September 2014 due date for her twin babies approached, the Ebola crisis in Comfort's native Liberia was reaching a fever pitch. Since the first Ebola patient presented in Monrovia in June 2014, the number of new cases was growing every day: By August, it was topping 400 per week. The Ministry of Health and Social Welfare was forced to suspend virtually all non-Ebola-related activities to focus on managing the crisis. The unintended result was that women of reproductive age in Liberia experienced some of the worst fallout from Ebola, regardless of their own infection status.

"The national health supply chain abruptly ceased all its routine

operations, preventing health facilities from accessing essential medical supplies and commodities," says Woseh Gobehe, national programme officer for reproductive health for UNFPA, the United Nations Population Fund. "Even in counties considered less affected by the outbreak, health facilities suffered massive stock out of drugs and medical supplies."

It was not just a supply issue: Liberia's already-scarce medical personnel (at the start of the crisis, there were only 45 physicians practicing in the public sector in the entire country, according to a Ministry of Health estimate) were being crippled by Ebola. By May 2015, an astounding 8.07 per cent of Liberia's doctors, nurses and midwives would die from Ebola, compared to 0.11 per cent of



Comfort Faiyiah and children.
Photo © Abbas Dulleh/AP Images for UNFPA

the general population. Fear of becoming infected—particularly because it is difficult to determine whether a patient has Ebola without a lab test—led many health workers to turn people away.

“Health-care workers started getting afraid and started refusing patients,” says Dr. Wilhelmina Jallah, the chief executive officer and medical director of Hope for Women International, a medical non-governmental organization, and a practicing physician based in Paynesville, Liberia. “No healthcare worker wanted to touch a pregnant woman even with personal protective gear.”

For pregnant women like Comfort, now 29, that meant prenatal care was scarce—while one common indicator of

positive maternal outcomes, completion of four antenatal care visits, had been on the rise in Liberia, it declined from 65 per cent in 2013 to 40 per cent in August 2014. And delivering in an appropriately appointed medical facility became impossible. When Comfort’s time for delivery came, she went from place to place but was unable to find a hospital or clinic that would admit her. “They refused me; they said they could not help me,” Comfort says. “I cannot blame the health workers who refused to assist me, because everyone was afraid of the disease.”

And while expecting mothers without Ebola (like Comfort) had trouble finding care, those who were infected had almost no chance of a good outcome. “It is more dangerous to treat pregnant

women with Ebola because the effect of Ebola in pregnancy is not understood and there are no set guidelines to follow. Pregnant women have blood and body fluids that could expose health workers to the virus,” Jallah says.

With no other choice, Comfort took shelter from the pouring rain, lying down in the dirt to labour under a corrugated tin roof. “I suffered a lot and was afraid I was going to die. The only thing I hoped for was for a miracle to happen,” she says. One did: Comfort gave birth to two healthy baby girls with the assistance of a nurse aid who happened to pass by at the right time.

Other women have not been so lucky. Across the region, doctors reported an increase in pregnant women dying

A conflict or disaster can erase in a moment a generation of economic and social gains. It can also permanently undermine an individual's prospects for a better life, shattering opportunities and limiting choices.

And it can exacerbate existing inequalities in society, resulting in even greater hardship for the poor and marginalized, exacting a disproportionate toll on women and young people, particularly under the age of 20, who constitute about half the population in many conflict and post-conflict settings (OECD, 2015).

The profound human impact of disasters and conflicts on people, communities, institutions and nations highlights the critical importance of building resilience so all may better withstand the effects of crises and recover from them more quickly. Building resilience can also help mitigate the potential negative effects on the sexual and reproductive health of women and adolescent girls.

Who lives, dies and recovers during or after a conflict or disaster depends in part on the policies, programmes and social, economic and political contexts prior to the crisis.

Development that is inclusive, equitable and that respects and protects everyone's human rights, including reproductive rights and the right to health, including sexual and reproductive health, is central to resilience. The principles of inclusiveness, equity and rights are also the foundation for the new generation of United Nations Sustainable Development Goals, which will guide the international community in navigating the economic and social challenges of the coming 15 years.

Guaranteeing the sexual and reproductive health and rights of women and adolescent girls will go a long way towards achieving the goal of inclusive, equitable development, and can lead to more resilient societies, more capable of withstanding crises and rebuilding in ways that lead to even greater resilience.



Woseh Gobeh.

Photo © Abbas Dulleh/AP Images for UNFPA

from preventable causes, including haemorrhage, ruptured uterus and hypertensive disease. And because healthcare workers cannot be instantly replaced (consider the many years it takes to educate and train a surgeon), the impact will only expand: According to a recent World Bank report, the loss of health workers in Guinea, Liberia and Sierra Leone may result in an additional 4,022 deaths of women each year from complications of pregnancy and childbirth. Maternal mortality could increase by 38 per cent in Guinea, 74 per cent in Sierra Leone, and 111 per cent in Liberia.

That's not to mention the impact on women's ability to determine whether, when or how often to become pregnant. According to UNFPA estimates,

nearly half the health facilities in Liberia were completely out of stock of injectable contraceptives during the height of the Ebola crisis. Little more than a third of health facilities were providing family planning services, according to the Ministry of Health. Noticeable pre-crisis gains in contraceptive use have all but been wiped out.

"The number of women and girls who continue to die from preventable health conditions is unacceptably high," Gobeh says. "It's a human rights issue to deny a woman or girl access to quality reproductive health services."

Efforts to improve the situation have had some impact, however. UNFPA

But the new vision for sustainable development for the coming 15 years may only be realized if all of the world's people are engaged and have a stake in its success. This means that women and adolescent girls must play a central role in leading and contributing to efforts to improve health and sustainable development at all levels—household, community, institutional and government—and not be left behind or relegated to a secondary role.

The road to resilience, from Hyogo to Sendai

Resilience, from the Latin verb, *resilire*, to rebound or recoil, has been used in diverse contexts, ranging from the field of ecology to explain how an ecosystem responds to changes, to the field of psychology to describe how individuals respond to trauma (McAslan, 2010; Manyena, 2014; Matyas and Pelling, 2015). A common feature of these terms, regardless of the discipline, is the focus on coping with, and responding to, shocks.

Resilience today occupies a central space in the conceptualization of response to natural disasters, conflict, emergencies and other hazards (Twigg, 2009, Matyas and Pelling, 2015; DFID, 2011) and informs the design and delivery of sexual and reproductive health services and the health outcomes for women and girls.

Two global plans to make the world safe from natural disasters, the Hyogo Framework of Action for 2005 to 2015 and the Sendai Framework for 2015 to 2030, cite priorities for building resilience.

A key strategic goal in the Hyogo Framework was the development and strengthening of institutions, mechanisms and capacities at all levels, in particular at the community level, which can systematically contribute to building resilience to hazards (UNISDR, 2005). The Framework states that a gender perspective should be integrated into all disaster risk-management policies, plans and decision-making processes, including those related to risk assessment, early warning, information management, and education and training.

and others are working to add workers to the healthcare ranks by, for example, encouraging retired midwives to return to the workforce. "With this effort, health facility-based deliveries have increased from an average of six to 10 monthly to between 30 and 40 monthly in only two months," Gobeh says. UNFPA also launched a nationwide condom promotion and distribution campaign to help educate young people about the importance of preventing sexually transmitted infections including Ebola. And the dwindling numbers of new Ebola cases

in the region can only spell relief for women of reproductive age.

"I give credit to Liberia and the international community for winning against Ebola in a relatively short period of time," Gobeh says. But now, "the most

important responsibility and appeal to the government of Liberia, the donor community and all partners is that the need to rebuild the health care delivery system is now greater than ever."

Comfort Fayiah and family at home.

Photo © Abbas Dulleh/AP Images for UNFPA





Birth attendant Christine Yakoundou examines client at Centre de Santé, Central African Republic.

Photo © Panos Pictures/Jenny Matthews

Building on the Hyogo Framework, the Sendai Declaration broadened the definition of resilience to explicitly include the importance of resisting, absorbing and recovering from hazards and to echo the importance of resilience at multiple levels: community, society and individual. Resilience is defined as:

“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” (UNISDR, 2015a).

The Sendai Declaration expands the Hyogo Framework’s gender perspective by including women in planning and designing approaches to disaster preparedness. It also stresses the need for strengthening the design and implementation of inclusive policies and social safety net mechanisms like sexual and reproductive health.

Resilience is both a process and an end state, which enable vulnerable communities and households to prevent, prepare for or respond to stresses

and shocks without compromising their long-term prospects.

Pre-empting poverty and inequality

The socioeconomic and structural factors that determine the capacity of communities to be resilient are critical preconditions to the effect of a disaster or conflict and require unwavering attention by governments. While resilience may be seen as an end state, it is also an ongoing process, requiring continuous efforts to address the socioeconomic and structural factors—poverty, harmful gender norms and even food insecurity—that can influence whether communities may withstand or recover from a crisis or shock. Resilience-building as a process must be prioritized at every level and guided by local adaptation strategies, culture, heritage and knowledge. This requires the involvement of actors across the humanitarian and development continuum, but the process must be owned by the community (Twigg, 2009).

Humanitarian emergencies, such as natural disasters and conflicts, can lead to a broadening and deepening of poverty and inequality (UNISDR, 2015). Resilience can mitigate those effects.

Building resilience involves addressing underlying causes of vulnerability, such as poverty and inequity, and initiating pre-emptive measures to build positive adaptation before a crisis strikes (Hillier and Castillo, 2013; IFRC, 2012). Investments in reproductive, maternal, newborn, child and adolescent health, and reproductive rights will protect those most affected by disasters.

Investing in youth to boost shock-absorbing capacities of communities and nations

Sexual and reproductive health and rights are a cornerstone of young people's transition to adulthood. When governments take steps to ensure the transition is safe and healthy, they are also taking steps to boost the "shock-absorbing" capacities of communities and nations, thereby creating

RESILIENCE AND SEXUAL AND REPRODUCTIVE HEALTH FROM MILLENNIUM DEVELOPMENT GOALS TO THE SUSTAINABLE DEVELOPMENT GOALS

Goals which refer to resilience	Goals that address SRH
MDGs (2000–2015)	
None	Goal 5: Improve maternal health Target 5A: Reduce maternal death Target 5B: Achieve universal access to reproductive health
SDGs (2016–2030)	
1.5 By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters. 11b By 2020, substantially increase the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change, resilience to disasters, develop and implement, in line with the Sendai Framework for Disaster Risk Reduction 2015-2030, holistic disaster risk management at all levels. 13.1 Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries. 14.2 By 2020, sustainably manage and protect marine and coastal ecosystems to avoid significant adverse impacts, including by strengthening their resilience, and take action for their restoration in order to achieve healthy and productive oceans.	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

environments where individuals can also become resilient.

Building resilience can also help rectify and transcend longstanding inequities (UNSDR, 2015a). For example, building health systems' resilience in countries can help expand access to quality sexual and reproductive health services for those excluded from them before the onset of a disaster.

To succeed, building resilience must be gender transformative, challenging unequal power structures (Winderl, 2014). It must include women and girls, not only as the recipients of health and social protection services, but also as advocates, as health workers, as active members, representatives and leaders of communities.



Nyantit, 10, South Sudan: "I want to look nice on the photo, so I went home to change my shirt. It is the only nice shirt I have, because I had to leave everything behind when we had to flee."

Photo © Panos Pictures/Chris de Bode

Resilience linked to robust development that takes individuals' vulnerabilities into account

The impact of natural disasters and conflict on individuals and communities depends in large part on the extent and nature of poverty and social deprivation before a crisis occurs (United Nations International Strategy for Disaster Reduction, 2015). Building resilience and protecting communities from the negative effects of a disaster must therefore be connected to a robust development agenda that takes into account individual, social, economic and cultural vulnerabilities.

The United Nations Sustainable Development Goals for 2015 to 2030, and other efforts to reduce social deprivation and poverty, within a robust international human rights framework, provide a pathway for states and their development partners to engage in building resilience (United Nations, 2015d). This pathway was also highlighted in a General Assembly resolution on the Sendai Framework for Disaster Risk Reduction for 2015 to 2030:

"States also reiterated their commitment to address disaster risk reduction and the building of resilience to disasters with a renewed sense of urgency within the context of sustainable development and poverty eradication, and to integrate, as appropriate, both disaster risk reduction and the building of resilience into policies, plans, programmes and budgets at all levels and to consider both within relevant frameworks."

Connecting efforts to build resilience to sustainable development ensures that resilience is not defined through a separate set of standards, but rather is integrated into the process of countries' overall achievement of a range of development goals. Achieving health goals, for example, depends

on improving the quality and scope of sexual and reproductive health and on ensuring universal access, including in emergencies, crises and refugee settings. Given that high maternal and child mortality are concentrated in countries with conflict and natural disasters, establishing robust connections between resilience-enhancement programmes and development targets will be essential to both achieving the Sustainable Development Goals and mitigating the effects of disasters.

Investing in disaster risk reduction to improve maternal, child and adolescent health

Disaster risk reduction is a critical element in resilience. While humanitarian response is a short-term intervention, disaster risk reduction is a long-term undertaking that addresses the root causes of vulnerability during a crisis (Plan International, 2013). Though some crises, such as earthquakes and tsunamis, cannot be prevented, their impact can be mitigated by pre-crisis investment in the building of sexual and reproductive health systems that are resilient and focused on the needs of the most vulnerable segments of the community.

To improve preparedness and reduce disaster risk, the Sendai Framework for Disaster Risk Reduction calls for the prevention of new disasters and the reduction of existing disaster risk through the implementation of integrated and inclusive economic, structural, legal, social, health, cultural, educational, environmental, technological, political and institutional measures. This integrative approach can prevent and reduce hazard exposure and vulnerability to disaster, increase preparedness for response and recovery, and thus strengthen resilience (UNISDR, 2015a).

Reducing risk and building resilience begins with knowledge of the changing hazards and physical, social, economic and environmental vulnerabili-

ties to disasters that most societies face, followed by action taken on the basis of that knowledge, according to the Hyogo Framework for Action.

The scale of disasters has expanded due to increased rates of urbanization, deforestation, and environmental degradation and to intensifying climate variables such as higher temperatures, extreme precipitation, and more violent wind and water storms (Leaning and Guha-Sapir, 2013). Thus, efforts to strengthen disaster resilience require a detailed understanding of the socioeconomic and political factors that cause people to be at risk, and a sound understanding of how mortality and morbidity differ across population groups and over time (Leaning and Guha-Sapir, 2013). This understanding can seed systems that tackle and decrease the underlying drivers of risk and vulnerability, taking into account differentials of gender, class, caste, race, age, ethnicity, disability and income that generate the geography of risk inequality and of social and political exclusion (UNISDR, 2015).

Disaster risk reduction must also recognize, include and respond to gendered risks and have gender equality as a key goal (Bradshaw, 2015).

Coping capacities vary within and across countries

Analyses of risk should take into account variations across and within countries. The Inter-Agency Standing Committee's Index for Risk Management (INFORM) shows the coping capacity of countries based on a measure of: disaster risk reduction efforts, governance, communication, physical infrastructure and access to the health system.

In West and Central Africa, women have a one in 32 chance of dying a maternal death. This is nearly five times the risk facing women in South

Asia and almost 150 times the risk women in industrialized countries face (Save the Children, 2014). If data within countries are meaningfully disaggregated, further evidence would emerge on how different communities begin from different places on the risk reduction spectrum; the effect of a disaster on a woman in the highest income quintile living in an urban environment is different from the effect of a disaster on a woman in the lowest income quintile living minutes away. Efforts to build resilience are urgent in these unequal contexts and disaggregated data should serve to influence national policies and resource allocation by helping to identify risks, build resilience and prepare better for crises.

Inequality of access to services and safety nets affects the resilience of different disaster-impacted groups and individuals, especially women and girls. And, inequality of access to land, income and asset bases affects how households and communities can manage their own disaster risks. Inequality of protection through established rights, laws and regulations, and inequality in voice and accountability will impact any disaster risk reduction programme, and the capacity of countries to address the underlying drivers of disaster risk (UNISDR, 2015).

A commitment to those who are least likely to receive care or access services is also echoed in the United Nations Secretary-General's Every Woman Every Child Global Strategy. Disaggregated data allow resilience-building to move away from relying solely on aggregate measures of health and well-being that do not differentiate the impact of conflicts and disasters on youth, women, migrants and low-income or marginalized populations. Mainstreaming disaggregated data collection into routine data collection systems, and strengthening

civil and vital registration systems would enable more nuanced understanding of risk.

Developing robust early warning systems that are responsive to gender, age, and disability is a crucial way to ensure equitable access to information before a crisis occurs (Development Initiatives, 2015).

Building resilience in conflict-related emergencies

While much early-warning innovation has focused on weather-related events, early warning and action for conflict remain more difficult, for both technical and

political reasons. Building resilience in humanitarian emergencies arising out of conflict requires a different, multifaceted set of prevention strategies, including implementation of robust anti-discrimination and violence-reduction measures, in addition to attention to structural inequalities affecting sexual and reproductive health (Harris et al., 2013). Increasingly, humanitarian emergencies are both disaster and

conflict related, with one set of factors interacting with the other.

Ebola

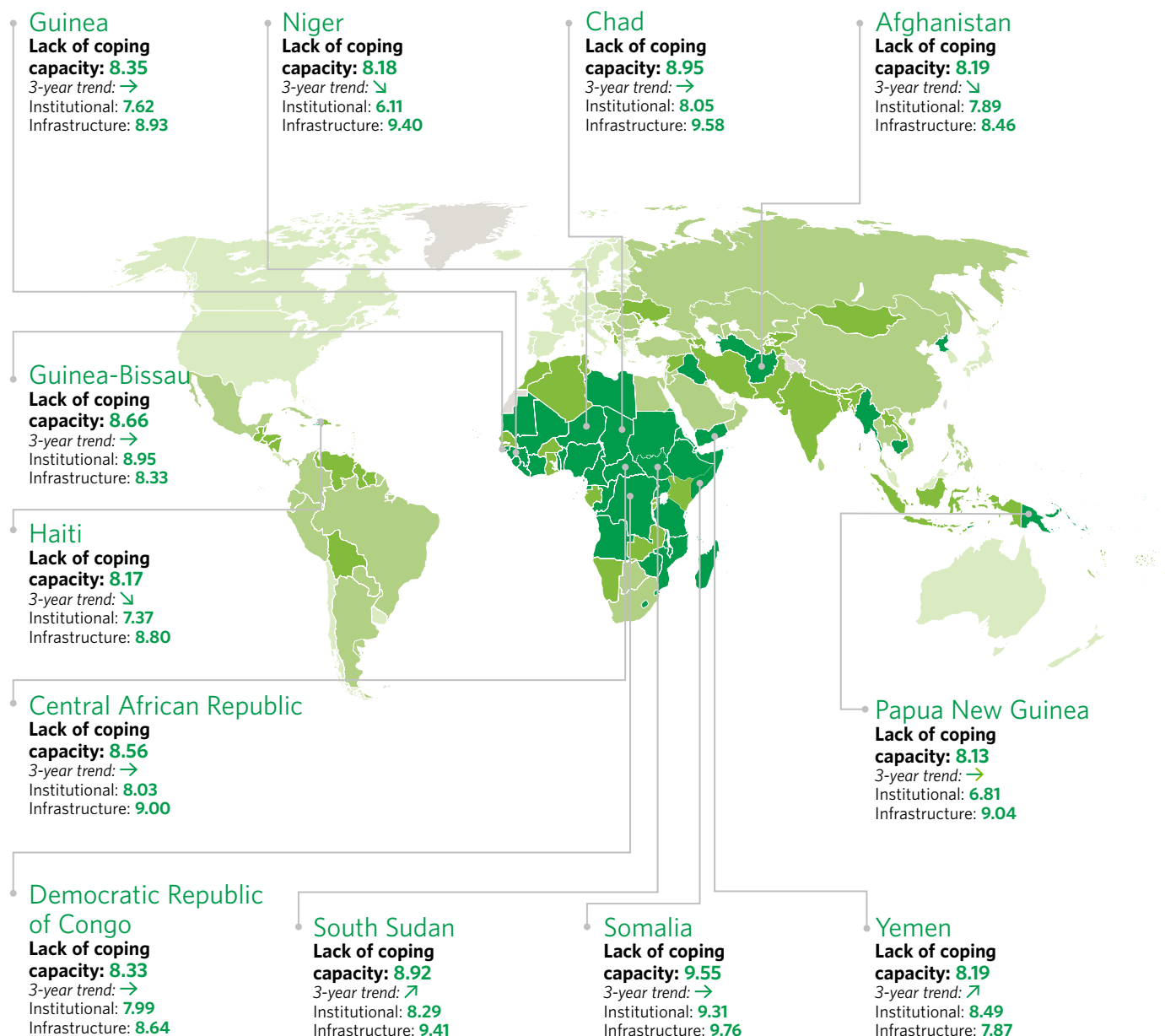
The Ebola crisis affected an estimated 18.7 million people, including 9.8 million adolescents and children (UNICEF, 2015). The epidemic shone light on how health systems with weak primary care are not resilient to shock. In these contexts, resilience would have entailed building capacities, strengthening subnational health systems, improving access to and exchange of information, developing systems for engaging actors across all levels of government, in addition to the health sector, and building trust (Kieny and Dovlo, 2015).



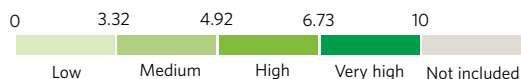
In West and Central Africa, women have a one in 32 chance of dying a maternal death. This is nearly five times the risk facing women in South Asia and almost 150 times the risk women in industrialized countries face.

2015 LACK OF COPING CAPACITY

This dimension measures the lack of resources available that can help people cope with hazardous events. It is made up of two categories—institutions and infrastructure. This map shows details for the 12 countries with the highest values in the lack of coping capacity dimension.



INFORM COPING CAPACITY INDEX



KEY ↗ Increasing risk → Stable ↘ Decreasing risk

(INFORM, 2015)

A resilient health system can respond to the changing epidemiological profile of a population, and adapt to adverse conditions. Rather than operating in isolation, a resilient health system has connections to regional and global partners that allow Governments to trigger rapid deployment of a wider set of resources (Kruk et al., 2015). Working across sectors to situate humanitarian plans, priorities and processes within sustainable development frameworks is an essential element of resilient health systems (Kieny and Dovlo, 2015).

Integrating sexual and reproductive health into primary health critical to resilience

Sexual and reproductive health services within national health policies are an essential pre-requisite for building resilience in the face of emergencies and ensuring reliable and secure access to lifesaving treatment, reproductive health services and supplies necessary to protect women and adolescent girls from preventable death, including during complicated deliveries or unintended pregnancies. The quality of maternal health services and maternal mortality ratios are indicators of the overall quality, functioning and inclusivity of the health system.

Sexual and reproductive health should be integrated into health risk assessment and early warning systems for communities and vulnerable groups. The World Health Organization reiterates the importance of ensuring strong primary health care facilities so they can sustain sexual and reproductive health services, including emergency obstetric and newborn care. Further, existing sexual and reproductive health services should be strengthened to mitigate the impact of, adaptation to, and recovery from emergencies. The World Health Organization also recommends that disaster preparedness planning take into account the needs of vulnerable populations—women, adolescents, newborns,

people with disabilities and displaced populations (WHO, 2012).

Strengthening comprehensive reproductive health care and integrating it into primary care before a crisis can facilitate or help ensure the provision of a minimum initial service package, or MISp, when a crisis occurs. A set of political and legal structures that allow women and youth to benefit from the right to reproductive health make it harder for these rights to be infringed during crisis.

As the United Nations General Assembly affirmed in 2015, “meeting sexual and reproductive health needs is critical for the resilience and more rapid recovery of affected communities overall” (United Nations, 2015c).

Social protection and disaster risk reduction

The Sendai Framework for Disaster Risk Reduction calls for social protection policies and programmes that meet the needs of the most vulnerable. Such interventions could, for example, aim to prevent or respond to chronic malnutrition, provide access to identification documents, ensure women have access to inheritance, or prevent child marriage. An inclusive, broad-based social protection system is needed to protect the poorest households and children from extreme deprivation and to provide opportunities for the promotion of livelihoods and productive activities for both women and men.

Given that most of the countries with the highest rates of child marriage are considered fragile States or at high risk of natural disasters, existing efforts to protect girls from child marriage and gender-based violence—enabling girls to stay in school, providing targeted financial support to families, providing comprehensive sexuality education and other measures—must be strengthened to ensure these efforts continue during a crisis or shock (Plan International, 2013).

Strengthening anti-trafficking measures is also an important way to build the resilience of communities and countries facing exploitative and predatory behaviour, often particularly targeted at children and adolescent girls in the aftermath of a disaster.

The International Organization for Migration has called for the adoption and implementation of national counter-trafficking laws. Counter-trafficking measures should be integrated into governments' emergency preparedness and contingency planning (International Organization for Migration, 2015) and will also contribute to fulfilling the commitment the Sustainable Development Goals made to abolishing human trafficking.

Measures to address gender-based violence are needed before, during and after crises

Post-conflict, adolescents, especially girls, are at heightened risk of abuse, exploitation and exposure to risky behaviour, situations that increase their vulnerability to early sexual initiation, unwanted pregnancy, and sexually transmitted infections, including HIV.

Young adolescents between ages 10 and 14, pregnant adolescent girls and marginalized adolescents are at higher risk and require targeted interventions (UNFPA and Save the Children, 2009). Girls who have survived gender-based violence often experience lifelong psychological and physical problems, and social stigma (DFID, 2013).

Inter-Agency Standing Committee guidelines emphasize the need to integrate gender-based violence interventions in humanitarian assistance as a core action for building resilience (IASC, 2015).

Building resilience must both prevent and respond to gender-based violence and work at the community, institutional, and national level to implement laws, policies and programmes that prevent and mitigate gender-based violence, allow survivors of gender-based violence and those at risk of it to access care and support.

Failure to address gender-based violence both before and at the start of a crisis provides a poor foundation for women's resilience and health in the medium and longer term and is a barrier to reconstructing the lives and livelihoods of individuals, families and communities (International Rescue Committee, 2012).

Educating girls reduces vulnerability

Many studies have shown that educating girls is one of the most effective investments a country can make to lift families out of poverty and build a better future. When educated girls grow up and become mothers, they tend to have healthier and better-educated children. Recent evidence suggests there is another powerful reason to educate girls: empowering women through improved education reduces vulnerability to death and injury from weather-related disasters (Save the Children, 2014). Schools can impart an important sense of normality and provide lifesaving information and services. Increasing access to school for all may also reduce feelings of injustice that have fuelled conflicts. Importantly, ensuring future generations are well educated is vital for overcoming conflict, aiding recovery, and ensuring future development and security (Global Coalition to Protect Education from Attack, 2015).

Education about sexual development, sexuality and reproductive health and rights for adolescent boys and girls is a critical element of comprehensive educational access. Disaster-specific education is also essential to promote resilience: children who are uninformed regarding hazards, warnings, evacuation and other protective behaviours are at greater risk of death and injury when disaster strikes (Wisner, 2006). Broader legal and policy measures, for example, to prevent the use of schools by armed groups during conflict will also contribute to building resilience (Global Coalition to Protect Education from Attack, 2015).

Engaging women, young people, ethnic minorities builds a solid foundation for resilience

Engaging a diversity of communities and actors in building resilience creates a more solid foundation for positive outcomes. This engagement should include ethnic minorities, women, adolescents and youth, people with disabilities and the elderly. While most disaster risk reduction laws provide a mandate for the involvement of women and vulnerable groups, this often consists of general aspirational statements without specific mechanisms for implementation (UNISDR, 2015).

In many instances, young people are ignored in disaster risk reduction and resilience-building. Yet, it is the same young people who are excluded from these pre-crisis processes who may end up playing vital roles post-crisis, by assisting with evacuation and healing after a disaster (Peek, 2008), clearing rubble, sharing news and information, distributing food, and teaching or caring for younger children. The meaningful participation of young people is vital to the localization of humanitarian action to ensure improved effectiveness and resilience. Young people can be important allies in the design and implementation of emergency preparedness and response (UNFPA and Women's Refugee Commission, 2015; Osotimehin, 2015).

When young people, including adolescents, are empowered and supported, they can contribute to reducing intergenerational poverty and to building a demographic dividend of inclusive and durable economic growth. In other words, many countries, including a number of those currently in crisis, may gain from the transition of large numbers of young people into working age. Seizing and maximizing a demographic dividend could spark precisely the fast-track development that post-crisis countries need to recover and move forward.

Resilience in the humanitarian-development continuum

Building resilience requires a sustained partnership of humanitarian and development actors. Given that 43 per cent of the world's poor now live in fragile States (OECD, 2015) and that countries exposed to the risk of disasters and shocks receive lower levels of official development assistance per capita (OECD, 2015), a bridge between these actors is more critical than ever. Such a bridge is also necessary to ensure that investments towards the new United Nations Sustainable Development Goals do not neglect disaster risk reduction, emergency response and the transition from recovery to sustainable development.

A number of countries have carried out institutional reforms to support the integration of disaster risk financing into a broader, strategic approach to disaster risk management (UNISDR, 2015). Ministries of finance are increasingly taking the lead in the development of national and regional insurance and credit schemes, and governments are developing new institutional arrangements such as national risk boards that include insurance supervisors, disaster management agencies and the relevant line ministries (UNISDR, 2015).

Sexual and reproductive health as a pathway to poverty reduction and risk mitigation

An increasing share of the sexual and reproductive health services supported by the international community is now being provided in humanitarian settings. Achieving the objectives of the Programme of Action of the International Conference on Population and Development increasingly means delivering services and information and protecting rights in the midst of conflict, large-scale population movements

and epidemics or in the aftermath of a natural disaster or climate-change-related catastrophe.

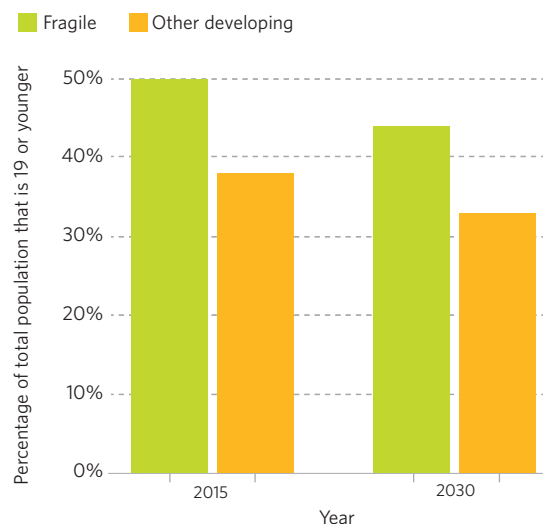
Protecting the sexual and reproductive health and reproductive rights of women and adolescent girls in crisis settings is essential and a matter of human rights, but becomes complicated, costly and unsustainable in the absence of preparedness and resilience building.

Therefore, steps must be taken to address the underlying causes of crises, especially underdevelopment and inequity, and to promote the resilience of countries, environments, communities and individuals to help mitigate the impact of crisis. Resilience depends in part on development and how equitably economic and social gains are realized in a society. Where resilience is low, vulnerability to conflict and disasters is high. Preparedness is another critical variable in the resilience equation.

Sexual and reproductive health is a human right and is also key to achieving sustainable development. The more a country is able to reduce poverty and social deprivation, the more resilient it becomes, and the more likely it is to withstand or recover from a crisis with lower social, economic, and human loss. Emergency response is always more expensive than preparedness and risk mitigation.

A framework for disaster-risk-reduction was endorsed by the international community in Sendai, Japan, earlier this year. The framework cites four priorities: understanding disaster risk; strengthening disaster-risk governance to manage disaster risk; investing in disaster-risk-reduction for resilience; and enhancing disaster preparedness for effective response and “building back better” in recovery, rehabilitation and reconstruction. The framework relates directly to the UNFPA mandate. Paragraph 30(j) of the Sendai Framework States that at the national and local levels, there is a need to strengthen the design and implementation of inclusive policies and

AVERAGE POPULATION BELOW AGE 20 AS A PERCENTAGE OF TOTAL POPULATION IN FRAGILE STATES COMPARED WITH OTHER DEVELOPING COUNTRIES, 2015



(OECD, 2015)

social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including maternal, newborn and child health, sexual and reproductive health, food security and nutrition, housing and education, towards the eradication of poverty, to find durable solutions in the post-disaster phase and to empower and assist people disproportionately affected by disasters (UNISDR, 2015a).

Investing in the sexual and reproductive health of women and girls—before, during or after a crisis—contributes to development and will be pivotal to the achievement of new Sustainable Development Goals. It will also help reduce vulnerabilities to some crises.

Women can play a central role in crisis recovery and rehabilitation, but their participation depends in part on whether they are in good health and



Susila Bora, 19, Saurpani-4 village, which was destroyed when a 7.8 magnitude earthquake struck Nepal in April 2015.

Photo © Panos Pictures/Vlad Sokhin

have the power to decide whether or when to become pregnant.

More lives can be saved if humanitarian, development and sexual and reproductive health communities come together to support each other and work in more complementary ways. Activities to manage risks and build resilience must be simultaneous, instead of following a linear approach of transition from relief to development. Cooperation among actors with various areas of expertise can help bridge the gap between humanitarian and development objectives.

Resilience-building is a cumulative process that works across levels—global, regional, national, community and individual—over time. It is also an outcome that pre-emptively addresses the inequitable distribution of risk in emergencies by developing institutional capacity and systemic functions beyond their original baselines.

Resilience is also central to what UNFPA describes as the “humanitarian responsibility to protect the rights and address the specific needs of young people, including adolescents, and to engage them and their unique capacities in humanitarian preparedness, response and recovery” (UNFPA and Women’s Refugee Commission, 2015).

Laying the foundations for long-term gains in gender equality

A 2015 study by UN Women shows that gender-equality programming in humanitarian settings can multiply the impact of interventions and has “the potential to embed the foundations of longer term gender equality gains” (UN Women, 2015a).

Gender-equality programming recognizes that the needs and vulnerabilities of women, men, girls and boys in any given crisis-affected population will be specific and different.

According to the study, gender-equality programming in crisis-affected areas of Kenya, Nepal and the Philippines, for example, had a positive impact on improving access to and use of services, increasing the effectiveness of humanitarian outcomes and reducing gender inequalities.

This type of programming also had a “strong impact” on health outcomes, especially for women and girls, but extending to all household members. In Nepal, for example, gender-equality provision of health-related infrastructure, awareness-raising campaigns about health and hygiene and encouragement to access health facilities “greatly improved” maternal and child health and decreased death during pregnancy or childbirth. In addition, this type of programming was found to reduce some forms of gender-based violence.

Natural disasters can also provide opportunities for women to challenge and change their gendered status in society, often by taking on “traditionally male” tasks, such as building houses and digging wells.

Achieving synergies

Investing in disaster risk reduction for resilience-building means public and private, multi-sectoral investments to address the root causes that determine who survives and recovers in a disaster, to save lives and livelihoods, and prevent and reduce losses and ensure effective recovery and rehabilitation (UNISDR, 2015a).

A humanitarian-development continuum is essential to make a sustained commitment to advancing sexual and reproductive health and rights. Humanitarian crises halt, and in some cases, reverse development gains. Development investments soften the impact of crisis and natural disaster, and can provide a solid foundation for rebuilding a society (UNFPA, 2010). Humanitarian and development action needs to be coherent, mutually reinforcing and contiguous and underpinned by a common understanding of shared longer-term outcomes that ensure effective risk management (United Nations, 2015b). Women and young people must remain at the centre of their communities' preparedness response and at the core of the transition from crisis to development. If the rights and needs of the most vulnerable are not at the center of development planning, programmes and funding, it

will be impossible to achieve the United Nations Sustainable Development Goals by 2030.

From aspiration to reality

The challenge policymakers face in 2015 and beyond is to transform the aspiration of resilience into reality. New models for integrated development that include a commitment to disaster risk reduction are needed. Such models might include building strong primary health care systems with integrated sexual and reproductive health services, taking a multi-sectoral approach to adolescent health, using schools to disseminate disaster preparedness information, or mainstreaming climate adaptation, ensuring a commitment to inclusion, consultation and equity forms the core of integrated development.

Integrated approaches that can manage conflict and natural disaster risk are increasingly needed. If natural disasters can exacerbate or trigger conflicts, then they should be considered within conflict and state building frameworks. Conversely, if conflict and fragility increase vulnerability and exposure to natural disasters, epidemics, or famine then they should be considered in disaster risk assessments and natural disaster frameworks.

New directions in financing sexual and reproductive health in humanitarian settings

The number of people in need of humanitarian assistance is growing as is the amount of funds provided by institutional, governmental, corporate and individual donors. But funding gaps are also growing, suggesting that current funding arrangements may not be sustainable.



Mother and newborn, Tierkidi Camp, Ethiopia.

Photo © UNFPA/A. Haileselassie

Protecting the health of South Sudanese mothers and adolescents

An average of 45 women give birth each week at the health centre in the Tierkidi refugee camp in Ethiopia.

The number wasn't always so high, according to health centre manager Yonas Zewdu. Until recently, most women were delivering in their own living quarters, without the help of a skilled birth attendant.

Zewdu says the centre has deployed outreach staff to visit women where they live, encourage them to come for antenatal care and make arrangements for them



Mothers and children at Tierkidi health centre.
Photo © UNFPA/A. Haileselassie

to give birth in the centre, where two midwives manage all deliveries.

One of the midwives, Lelisa Bekele, says whenever a pregnant woman who has come in for one antenatal care visit does not turn up for a follow-up visit, outreach staff check on her to make sure she is all right.

To pregnant women who live far from health centres, UNFPA, the United Nations Population Fund, distributes clean delivery kits, consisting of a towel, blade, gloves, plastic sheets, cord ties and soap.

UNFPA stocks the centre with emergency reproductive health kits, which include everything from

equipment and medicines for safe deliveries, surgical repair of cervical and vaginal tears, as well as treatments for sexually transmitted infections, and a variety of contraceptive methods.

According to Peter Lam Gony, who oversees community outreach for sexual and reproductive health, more and more women are learning about and choosing to use family planning, often against the wishes of their partners.

"Their husbands think that their wives will be seeing other men if they use family planning," Gony says.

An increasing number of adolescents are also choosing to use contraception in the camp. Those who avail themselves

of the confidential services also learn that aside from condoms, contraceptives only prevent a pregnancy, not a sexually transmitted infection, such as HIV.

The centre also makes free condoms available through free dispensers available throughout the camp.

Tierkidi camp houses about 52,000 refugees from South Sudan.

More than 100 million people were in need of humanitarian assistance in 2015, up from 88 million in 2014 and 78 million in 2013. Women and adolescent girls between the ages of 15 and 49 account for about one in four of the total.

As the world's crises multiply and become increasingly complex so do the sexual and reproductive health needs of women and girls.

Because of the large quantity and scale of crises around the world, an increasing share of total sexual and reproductive health needs is being met by the international community in humanitarian settings. Achieving the sexual and reproductive health and rights objectives of the Programme of Action of the International Conference on Population and Development, therefore increasingly means delivering services and information in the midst of conflict, large-scale population movements, epidemics or in the aftermath of a natural disaster or climate-change-related catastrophe.

Protecting the sexual and reproductive health and reproductive rights of women and girls in

crisis settings is essential and a matter of human rights, but it is also complicated and unsustainable without a change in the way humanitarian assistance is provided and funded.

An imperative for a long-term shift in the way the international community and affected governments themselves approach and fund humanitarian action is emerging. In addition to mobilizing resources to address acute humanitarian needs, all stakeholders must also increase attention to long-term investments that can help address underlying causes of crises, especially underdevelopment, and build the resilience of individuals, communities and nations to help mitigate the impact. Resilience depends in part on development and how equitably economic and social gains are realized in a society. Where resilience is low, vulnerability to conflict and disasters is high. Preparedness is another critical variable in the resilience equation.

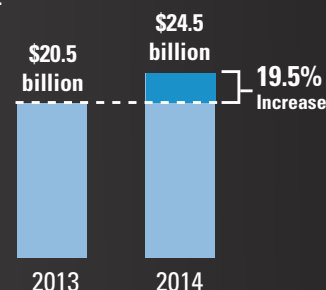
Sexual and reproductive health is not only a human right but it is also key to achieving sustainable development. The more a country develops, the more resilient it becomes, and the more likely

Students in shelter established after school in Damsijhang, Nepal, was destroyed by earthquake.

Photo © Panos Pictures/Brian Sokol

CONTRIBUTIONS

In 2014, a year marked by multiple large-scale emergencies, contributions rose to new heights, totalling \$24.5 billion, a 19.5 per cent rise from the previous record \$20.5 billion in 2013. This is the third consecutive year that international humanitarian assistance has substantially grown.



it is to withstand or recover from a crisis at lower cost. Emergency response is always more expensive than preparedness and risk mitigation.

A framework for disaster-risk-reduction was endorsed by the international community in Sendai, Japan, earlier this year. Parts of this framework relate directly to the UNFPA mandate because it cites a need to strengthen the design and implementation of inclusive policies and social safety-net mechanisms, including through community involvement, integrated with livelihood enhancement programmes, and access to basic health care services, including maternal, newborn and child health, sexual and reproductive health, food security and nutrition, housing and education, towards the eradication of poverty, to find durable solutions in the post-disaster phase and to empower and assist people disproportionately affected by disasters.

Also this year, a declaration of experts who converged in Abu Dhabi called for a more strategic focus on reproductive, maternal, newborn, child and adolescent health and well-being across within a development and humanitarian “contiguum,” and for national and subnational strengthening and increased resilience of health systems so that quality services are more likely to be available in crisis settings and in the context of disasters and conflicts.

Record need for humanitarian funding

Conflicts and natural disasters, including extreme weather events, along with other protracted crises and extreme poverty have together led to the largest number of people forcibly displaced from their communities or countries since the Second World War, in turn driving international humanitarian funding requirements to record levels (Kim et al., 2015; Bond for International Development, 2015).

UNFPA's funding requirements for humanitarian action in the areas of sexual and reproductive health

and rights has also reached an all-time high, rising from about \$78 million in 2006 to about \$175 million in 2014.

Today's challenge is to meet the wide and multidimensional needs of more people affected by humanitarian crises. Today's opportunity is to leverage new donors, partnerships with the private sector and other innovative strategies to find sustainable solutions.

International humanitarian assistance totalled \$24.5 billion in 2014

International humanitarian assistance worldwide averaged \$19.8 billion annually between 2009 and 2014 (Development Initiatives, 2015). However in 2014, a year marked by multiple large-scale emergencies, contributions rose to new heights, totalling \$24.5 billion, a 19.5 per cent rise from the previous record \$20.5 billion in 2013. This is the third consecutive year that international humanitarian assistance has substantially grown.

Major donor governments and institutions led financing responses to large-scale humanitarian crises, providing \$18.7 billion in 2014. About 90 per cent—\$16.8 billion—came from the 29 member States of the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC, 2014b; UNFPA, 2015). These same countries accounted for 94 per cent of reported international humanitarian assistance from governments over the last decade. The United States accounted for about 32 per cent of all international humanitarian assistance in 2014.

Also in 2014, Saudi Arabia and the United Arab Emirates joined the list of 20-largest humanitarian donors. Contributions by Arab States rose 120 per cent between 2013 and 2014, from \$764 million to \$1.7 billion, mostly in response to crises in Iraq and Syria. Most of the funding came from

Kuwait, Qatar, Saudi Arabia and the United Arab Emirates.

Turkey's contributions have also considerably increased, making it a leading donor to the Syrian crisis, allocating \$1.6 billion towards Syrian refugees (Start Network, 2014).

East Asian donors increased their humanitarian funding 11 per cent between 2013 and 2014, with Japan contributing \$882 million, followed by the Republic of Korea and China, contributing \$81.7 million and \$53.7 million, respectively.

Contributions from emerging national economies are also increasing. Brazil's contributions rose, for example, from \$2.6 million in 2005 to \$14.9 million in 2014. Sierra Leone mobilized \$17.2 million of its own resources for the Ebola response.

Other sources of humanitarian funding

The private sector and the general public are other important sources of humanitarian assistance, channeled mainly through international non-governmental organizations. This diverse group of donors comprising individuals, trusts and

foundations and corporations, funded about 27 per cent of international humanitarian assistance between 2009 and 2013 (Stoianova, 2013; Gingerich and Cohen, 2015; Development Initiatives, 2015).

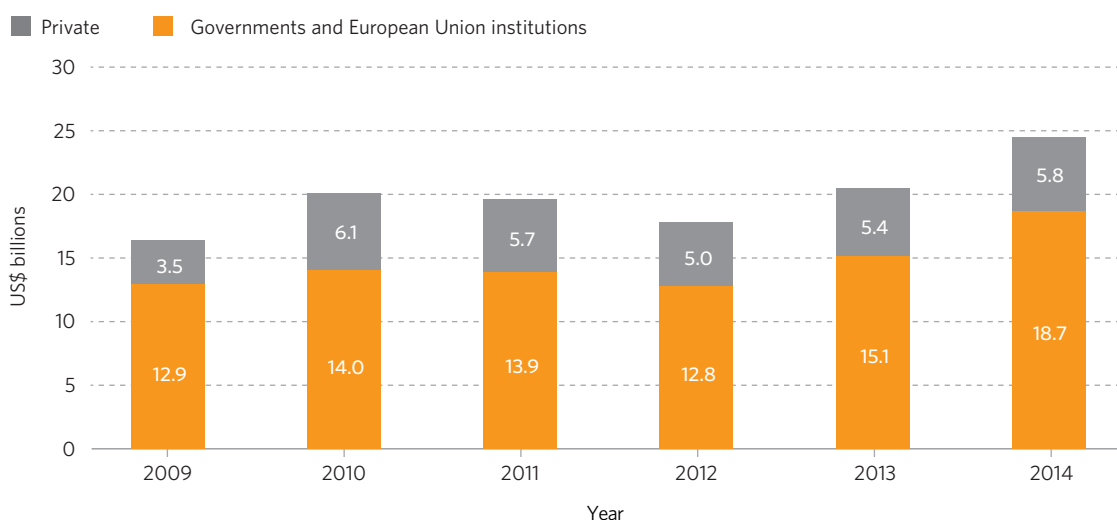
Private donors as a group were the largest international humanitarian contributor to the Typhoon Haiyan response in 2013 and the third largest to the Ebola response in 2014 (Stoianova, 2013; Development Initiatives, 2015).

Diasporas provide assistance through the return of remittances. Religious organizations, some acting independently of the humanitarian system, also provide assistance. Faith-based organizations play a key role in humanitarian financing, accounting for 16 per cent of all assistance channelled through non-governmental organizations.

United Nations consolidated appeals

United Nations-led consolidated appeals are based on the needs assessed and responses planned by United Nations agencies and international

INTERNATIONAL HUMANITARIAN RESPONSE 2009–2014



non-governmental organizations active in specific countries or responding to specific emergencies.

In 2014, the United Nations requested an unprecedented \$19.5 billion in 31 appeals. Donors contributed \$12 billion towards this total, leaving an unprecedented gap of \$7.5 billion, or 38 per cent of the total needed.

United Nations-managed “pooled” funds, such as the Central Emergency Response Fund (CERF), consist of un-earmarked resources to meet surges in humanitarian need. In 2014, the CERF allocated \$290 million to rapid response projects and \$170 million to under-funded projects. In addition, Country-Based Pooled Funds, which rely on contributions from governments and private donors, allocated \$386 million to 19 countries in 2014. Pooled donor contributions in 2014 came primarily from Denmark, Germany, the Netherlands, Norway, Qatar, Sweden and the United Kingdom.

Funding gaps widening

International humanitarian assistance alone has not kept pace with the rising needs and increasing complexity of today’s humanitarian crises, let alone the underlying drivers, such as instability, poverty and vulnerability (Gingerich and Cohen, 2015; Development Initiatives, 2015).

Over the past 10 years contributions towards international humanitarian appeals have risen 300 per cent (Bond for International Development, 2015). Meanwhile, funding gaps are growing wider (Development Initiatives, 2015).

These shortfalls are further exacerbated by the lack of resources and capacity in the places most vulnerable to crisis, especially in conflict-affected contexts where domestic response is limited or non-existent. Furthermore, pressures on the system are sure to intensify in the years ahead due to the effects of climate change, vulnerabilities

THE ECONOMIC TOLL

In 2013, the combination of direct consequences (damage to infrastructure, housing, crops) and indirect consequences (loss of revenues, loss of production, market destabilization and loss of employment) from natural disasters were valued at an estimated \$118.6 billion (UNOCHA, 2014).

In 2014, economic damages due to heavy rainfall, storms, flooding and harsh winter conditions alone resulted in economic losses valued at \$110 billion (UNISDR, 2014). Since 2000, economic losses from disasters are estimated at \$2.5 trillion (UNISDR, 2014).

The numbers of multi-billion-dollar natural disasters are becoming more and more common.

Global statistics on economic loss due to conflict and other protracted emergencies are more difficult to ascertain. Complex and chronic humanitarian emergencies usually take place in highly insecure and impoverished environments, with failed or failing States and State-based institutions and in a context of devastated infrastructure.

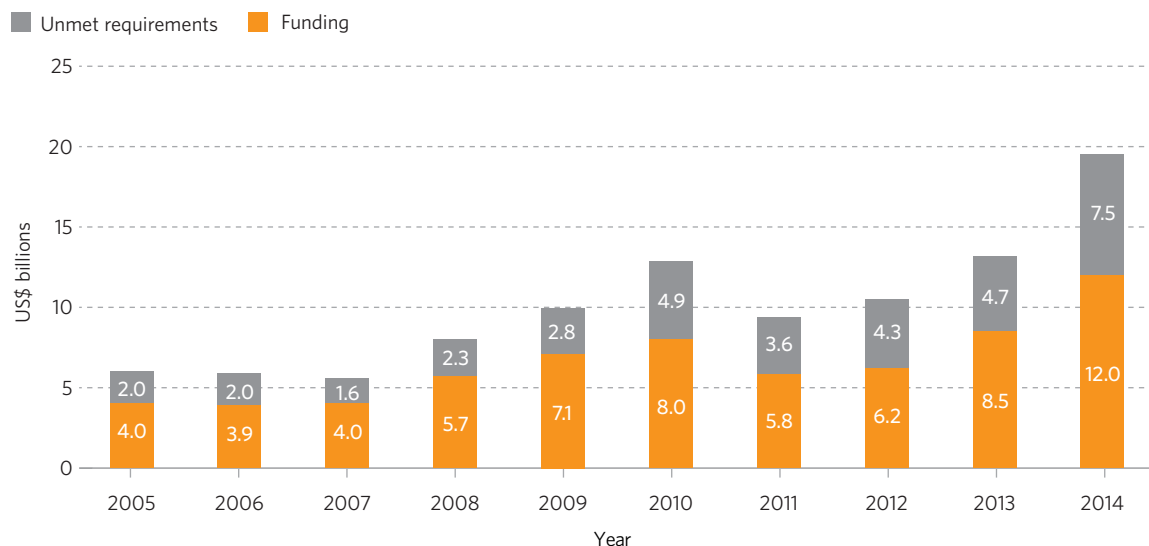
associated with urbanization and the need arising from fragile or conflict-affected States. Of the 20 countries that received the majority of international humanitarian funding in the last decade most have experienced conflict, most are highly vulnerable to the effects of climate change and have little capacity to adapt, prepare or cope with the impact, and all are considered fragile States (Inomata, 2012).

The widening gaps suggest that current funding arrangements for humanitarian action may be unsustainable.

Funds are unequally distributed

Some countries and emergencies faced greater funding gaps than others in 2014. Smaller humanitarian

FUNDING AND UNMET REQUIREMENTS, UNITED NATIONS-COORDINATED APPEALS 2005 TO 2014



(Development Initiatives, 2015)

appeals tended to have a lower percentage of their needs met. With the exception of the high-profile crisis in Ukraine, all were less than 50 per cent funded. In contrast, South Sudan, Iraq and the Ebola response, which each requested over \$1 billion, were 90 per cent, 75 per cent and 81 per cent funded, respectively (Gingerich and Cohen, 2015).

Relatively little humanitarian assistance goes directly to national and local actors in crisis-affected countries. Between 2007 and 2013, these actors received less than 2 per cent of total annual humanitarian assistance (Gingerich and Cohen, 2015).

Smaller share allotted for preparedness and early recovery

Humanitarian funding is mainly directed towards the response to crises, with relatively little directed to prevention and preparedness. Approximately 60 per cent of humanitarian assistance goes to emergency relief, 35 per cent to reconstruction and rehabilitation and only 5 per cent to disaster

preparedness and mitigation. Over the past five years, the biggest donors have allocated between 3 per cent and 6 per cent of their total humanitarian spending on reducing the risk and impact (Gingerich and Cohen, 2015).

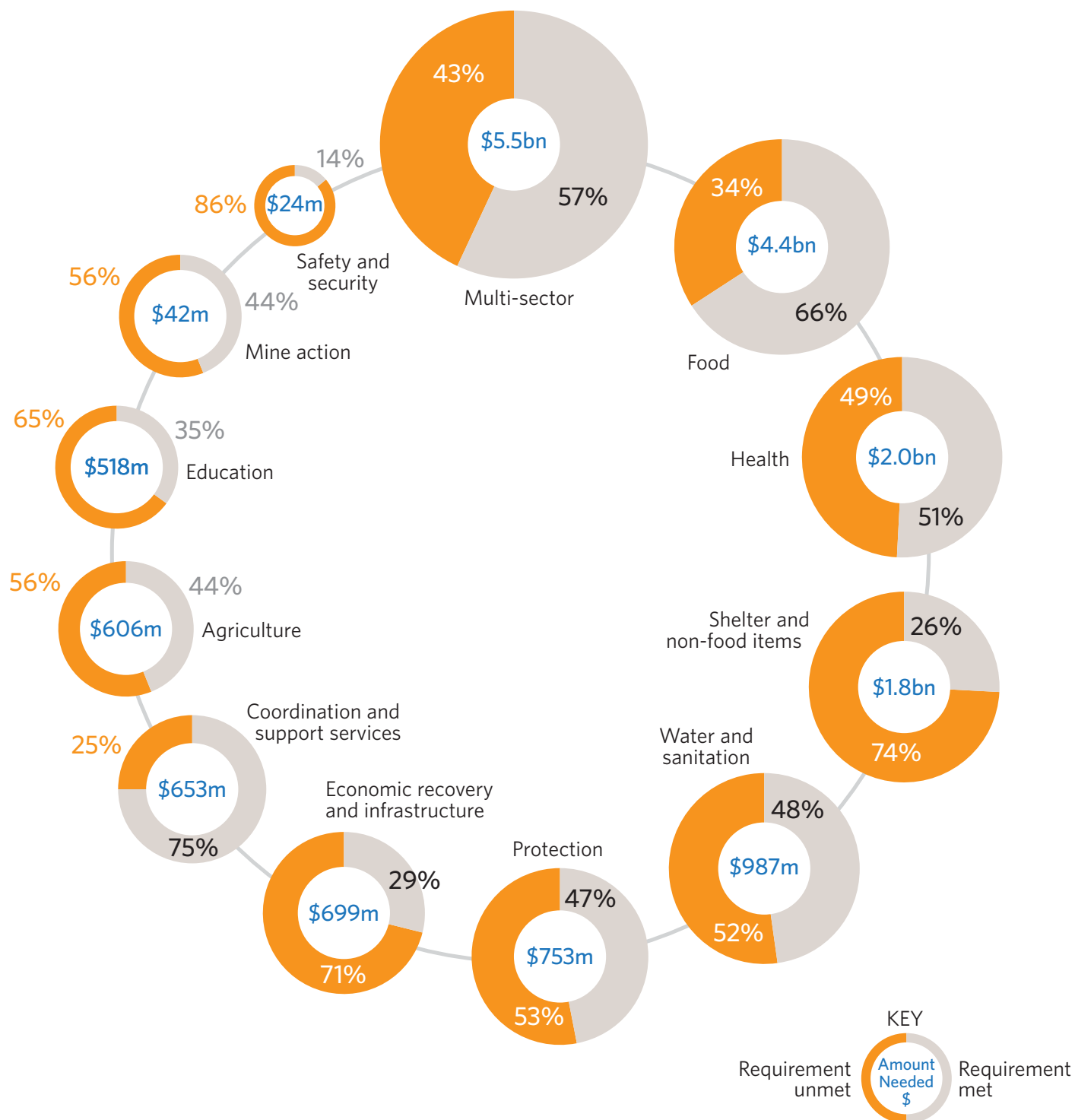
The 2015-2030 Sendai Framework for Disaster Risk Reduction demonstrates a growing recognition of the importance of investments to prevent and better prepare for disasters caused by natural hazards.

Over the last decade, there has been an evolution in humanitarian financing. But the bulk of funding continues to be allocated to responses to protracted emergencies, rather than prevention and preparedness (Inomata, 2012).

Funding targeted to sexual and reproductive health accounts for small share of total

Funding for sexual and reproductive health in humanitarian emergencies is relatively low, both in amount and share of all humanitarian resources.

FUNDING REQUIREMENTS COMPARED TO FUNDING RECEIVED, BY PURPOSE, 2014



(Development Initiatives, 2015)



Family health clinic, Sweileh, Jordan.
Photo © UNFPA/Salah Malkawi

Although requests for funding and absolute funding received for reproductive health in humanitarian appeals have increased since 2002, only 43 per cent of the need was met between 2002 and 2013, compared to 68 per cent for total humanitarian sector funding (Tanabe et al., 2015).

Among the 11,347 funding proposals presented to the international donor community for support for health and protection in 345 emergencies between 2002 and 2013, 3,912—34.5 per cent—were relevant to reproductive health (Tanabe et al., 2015). The *number* of proposals containing specific reproductive health activities increased by an average of 22 per cent per year, while the *proportion* of health and protection sector appeals with reproductive health activities increased by only an average of 10 per cent per year.

In recent years, the donor community has stepped up its support for services to address sexual and gender-based violence, especially in conflict settings,

with contributions more than doubling from \$50 million in 2012 to \$107 million in 2014. However, despite the increase in funding to address this problem in humanitarian emergencies, the share of total humanitarian assistance remains low, at only 0.5 per cent in 2014 (Development Initiatives, 2015).

Tanabe et al. (2015) show that 57 per cent of all funding appeals for “gender-targeted” humanitarian assistance between 2002 and 2013 included specific proposals for maternal and child health. About 46 per cent included funding requests to address sexual and gender-based violence, 38 per cent for HIV and sexually transmitted infections, 27 per cent for general reproductive health, and about 15 per cent for family planning. For the same period, proposals that included all of the components of a minimum initial service package, or MISP, for reproductive health in crisis situations increased about 40 per cent (Chynoweth, 2015).

There is a marked lack of attention to adolescent reproductive health in terms of funding, access to services, programming and programme evaluation (Women’s Refugee Commission, 2014). Since 2009, proposals for adolescent sexual and reproductive health and rights through United Nations Flash and Consolidated Appeals have constituted less than 3.5 per cent of all health proposals per year, and 68 per cent of them have gone unfunded (Women’s refugee Commission, 2014).

More than half of refugees, internally displaced persons and asylum seekers are women and young girls, with a need for access to essential reproductive health care. Displacement increases their need for reproductive health services. The lack of services and lifesaving interventions, such as obstetric care, results in increased unintended pregnancies and unsafe abortions and in an increase in morbidity and mortality from gender-based violence and pregnancy-related complications (International Rescue Committee, 2012).

Looking at humanitarian funding in a new light

The needs for humanitarian action are growing every day, as protracted conflicts displace record numbers of people for years and sometimes even decades, and as water scarcity, food insecurity and extreme weather have a greater impact on lives of people, particularly the poor in densely populated urban areas.

With the growing need comes an even greater imperative to support women and girls and meet their sexual and reproductive health needs, which in the past were seen by the international community as secondary to meeting basic needs for water, food and shelter.

In recent years, a new understanding has emerged about the critical importance of ensuring sexual and reproductive health in humanitarian settings and a realization that achieving humanitarian objectives in other sectors, such as education, food security and child survival depends in part on whether women and girls have the power and the means to determine whether, when or how often to become pregnant, whether and when they will marry, and how to protect themselves from sexually transmitted infections, including HIV.

Also emerging is an understanding of how sexual and reproductive health and rights are critical to disaster preparedness and risk reduction, recovery, rehabilitation and resilience.

Everywhere, but especially in the poorest countries, women and girls are disproportionately disadvantaged, even in stable settings. They have reduced access to services and opportunities, have less economic power, are less likely to exercise their rights and face additional health risks related to pregnancy and childbirth. When a disaster strikes or a conflict erupts, inequalities are exacerbated.

A fundamental shift in the humanitarian business model

Like humanitarian funding in general, funding targeted to sexual and reproductive health has not yet kept pace with the rapidly growing need.

Gaps in humanitarian financing—for humanitarian action in general and sexual and reproductive health—persist, suggesting that current arrangements may not be able to meet needs in the years ahead. Innovative approaches to funding are needed, but so are innovations in overall approaches to humanitarian action in general.

The independent Future Humanitarian Financing (FHF) group advises the United Nations Inter-Agency Standing Committee, a coordinating body with nine full members, including UNFPA. FHF's 2015 report, *Looking Beyond the Crisis*, recommends a number of major changes to the way humanitarian action is financed and carried out, starting with a “fundamental shift in the humanitarian business model,” moving away from “a culture and set of practices that tend towards insularity, reactiveness and competition towards an enterprise rooted in anticipation, transparency, research and experimentation, and strategic collaboration.”

A radical global agenda for meeting humanitarian funding needs

According to FHF, humanitarian actors need to focus not only on meeting humanitarian needs today but also need to work towards a future in which, wherever possible, international humanitarian response is unnecessary or exceptional, and the majority of needs are met by local actors. This shift requires “long-term vision and strategic alliances with a broad range of actors who can deliver transformative

changes to vulnerability and the management of risk.”

It also requires “a radical global agenda” to meet the humanitarian financing challenges of the future by engaging and enabling a wider range of actors in meeting costs associated with managing risk and by approaching post-crisis situation as a matter of “shared responsibility and a public good.”

Fundraising is no longer a “Western” prerogative. In January, for example, a Red Crescent telethon in Dubai for Syrian refugees fleeing a deadly snow-storm raised \$40 million in six hours. In the future it is likely that regional organizations and donors will take more of a leading role in responding to disasters where they share high levels of cultural and geographic affinity.

Linking humanitarian funding to development

The United Nations Secretary-General, in a report to the General Assembly in 2015, called for more predictable funding for humanitarian action and for improved efficiency in response by prioritizing resources for the most urgent needs and for strengthening links to development financing with the aim to build resilience of vulnerable populations and institutions before, during and after crises (United Nations, 2015c).

The United Nations Economic and Social Council earlier this year issued a resolution with similar recommendations: Member States, the United Nations system, the private sector and other relevant entities to provide adequate funding and investment in building preparedness and resilience-building, including from humanitarian and development budgets, as well as unearmarked core funding and flexible funding for multi-year appeals, in order to bridge the divide between humanitarian and development financing (United Nations, 2015c).

Another important challenge ahead is the short-term nature of humanitarian funding cycles within the United Nations. The Secretary-General stated that the arrangement makes it difficult to undertake effective, risk-informed, multi-year humanitarian planning: “Raising money on a yearly basis for crises that are protracted is not cost-effective and does not allow humanitarian agencies to benefit from the potential efficiencies to be gained from multi-year planning” (United Nations, 2015c).

Data shortcomings hamper targeting of funds to sexual and reproductive health

One of the challenges in mobilizing resources specifically for sexual and reproductive health in humanitarian settings—and indeed, for humanitarian action in general—is a dearth of sex- and age-disaggregated data on individuals affected by crises. But reliable or complete data are also scarce about which and how many funds are being targeted to actions for sexual and reproductive health and from where the funds are coming. While there are some data on contributions from the private sector, foundations and others, the figures are often incomplete. Without a complete picture of funding from all sources in any given humanitarian setting, developing coordinated responses is more difficult, and opportunities for achieving synergies are sometimes missed.

Towards predictable funding with more attention to preparedness and risk reduction

Over the past decade, the numbers of people in need of humanitarian assistance have grown and, while actual funding provided has also grown, so too have the gaps in funding needed. This same trend applies to humanitarian action in the area of sexual and reproductive health.

At the same time, the cost of providing critical sexual and reproductive health services and supplies has grown, largely because an increasing share of these services and supplies are being provided in crises and emergency settings.

The current funding arrangements for humanitarian action may therefore be unsustainable, requiring new approaches not only to funding, but also to humanitarian assistance in general. Funding modalities that allow for longer-term planning, coupled with measures to improve predictability of financing and flexibility in allocating resources, could result in more effective programming and better targeting to where resources are needed most. Also, monitoring and reporting systems should be strengthened and transparency improved so that donor countries may better demonstrate to their constituencies that contributions are making a difference in the lives of individuals affected by disasters and conflict.

While continuing to meet acute humanitarian needs, the international community and governments themselves should invest more in capacity-building to increase resilience, as well as in disaster preparedness and risk reduction, with the aim to reduce vulnerability to conflicts and disasters and to accelerate recovery if or when they do occur.

The international humanitarian system may find suitable models for sustainable financing in the development sector. Emergency assistance should be provided in ways that will be supportive of long-term development, in order to ensure a smooth transition from relief to rehabilitation and development. Meanwhile, development assistance organizations should integrate disaster-preparedness, risk reduction and resilience-building measures into their programming (United Nations Intergovernmental Committee of Experts on Sustainable Development Financing, 2014).



Afghan refugees in Shiraz, Iran.

Photo © UNHCR/Sebastian Rich

Earlier this year, the Secretary-General appointed a high-level panel on financing for humanitarian assistance to review current and future challenges and identify ways to close funding gaps.

The upcoming World Humanitarian Summit will present donor countries, international organizations and governments an unprecedented opportunity to revisit how humanitarian action is carried out and financed, and to align future interventions so they reinforce and are aligned with the United Nations Sustainable Development Goals for 2015 to 2030 (United Nations, 2015c).

A transformative vision for risk reduction, response and resilience

Humanitarian action can lay the foundations for long-term development. Development that benefits all, enabling everyone to enjoy their rights, including reproductive rights, can help individuals, institutions and communities withstand crisis. It can also help accelerate recovery.



Ishwori Dangol.

Photo © UNFPA/Santosh Chhetri

From despair to hope in Nepal

When Nepal's worst earthquake in almost a century struck on April 25, Ishwori Dangol's life changed forever.

Seven months pregnant at the time, the 30-year-old woman frantically searched for her seven-year-old son who was playing in her neighbour's home in Betrawati village in Nuwakot district, only to realize that he was among the almost 9,000 people who lost their lives in the disaster that day.

Consumed by grief, Ishwori also worried about the health of her foetus and whether



Dangol (centre).
Photo © UNFPA/Santosh Chhetri

she would have to deliver on her own, since the 7.8 magnitude earthquake damaged or destroyed 70 per cent of the birthing centres in Nepal's 14 most affected districts, including Nuwakot.

Thousands of pregnant women like Ishwori were left with little or no access to crucial health services to ensure safe deliveries.

Sushila, a local female community health volunteer, told Ishwori about a reproductive health camp supported by UNFPA, the United Nations Population Fund, and run by Manamohan Memorial Community Hospital and the Adventist Development and Relief Agency in

coordination with the Ministry of Health and Population.

The camp provided Ishwori and more than 400 others lifesaving information and services in the first three days of operation. UNFPA supported and secured funds for 109 such camps and distributed reproductive health supplies to 124 health facilities, reaching an estimated 1.8 million people in the first five months after the earthquake.

Camp services included antenatal to postnatal care, safe delivery, family planning, testing and treatment for sexually transmitted infections, including HIV, psychosocial support

and health care for survivors of gender-based violence.

Dr. Suman Panta, the camp doctor who examined Ishwori said her foetus was in an abnormal position in her womb. Ishwori was referred to the nearby Trishuli Hospital, which continued providing services despite damage to the facility. Ten weeks after losing her first child in the earthquake, Ishwori gave birth via Caesarean section to a healthy baby boy.

We live in a world where humanitarian crises extract mounting costs from economies, communities and individuals. Wars and natural disasters make the headlines, at least initially. Less visible but also costly are the crises of fragility, vulnerability and growing inequality, confining millions of people to the most tenuous hopes for peace and development.

All crises, whether those that strike in the hours of a ferocious storm, or that keep peace at bay for decades, destroy prospects for development, often profoundly. People lose their lives and livelihoods, their homes and communities, sustain profound injuries and may become disabled. Education and health services disappear, depriving people of their rights to them, and setting in motion long-term consequences that make eventual recovery ever more difficult.

Foremost among the losses are those to sexual and reproductive health. While sexual and reproductive health services are increasingly provided in humanitarian responses, striking gaps remain. For the woman giving birth or the girl who has been raped in the chaos of fleeing the bombs falling on her city, the consequences, including death and disability in the worst cases, can multiply harms many times over.

The world has repeatedly affirmed the sexual and reproductive rights of women and girls. Now it needs to deliver in all cases, including humanitarian crises.

Conflicts and disasters do not exempt any government or humanitarian actor from obligations, embodied in the Programme of Action of the 1994 International Conference on Population and Development, to uphold the right of the individual to sexual and reproductive health, including the right to decide freely and responsibly whether, when or how often to become pregnant.

Eliminate silos preventing integrated action

A time of burgeoning crisis has demanded a ballooning humanitarian response. While humanitarian “fires” will always need to be fought, particularly as natural disasters accelerate in a time of climate change, much more could be done to cut root causes of crises and reduce underlying vulnerabilities.

The sources of risk are many. Political marginalization and economic inequity can explode into conflict. A slum built by the poor on the cheap land of a floodplain will suffer the worst damages from a violent storm. Gender discrimination may leave women without enough income or education to protect themselves from catastrophe.

Many risks stem from development that is poor in quality—because it excludes groups of people from decent work and essential services, for instance, or destroys shared natural resources. Around the world, people and countries at higher levels of development typically have a better capacity to withstand the worst fallout from crisis. In natural disasters, three times as many people die in low-income countries as in high-income ones.

For women and girls, gender discrimination further undercuts development prospects. They are often more vulnerable than men and boys in natural disasters, sometimes for reasons as simple as the inability to swim. Their abilities to seek refuge and eventual recovery are hobbled by more limited access to income and assets, social networks and transportation, among other issues, leading to a “double disaster.”

Despite strong links between development and crisis, much of the humanitarian world remains concentrated in “response” mode, acting only once a crisis begins. Emergency operations may remain entirely separate from development assistance in global organizations offering both, even where emergency intervention proves far more expensive

than development investments, which can reduce risks.

This approach is questionable in terms of its adequacy and, from the perspective of inclusion, its fairness. It is time to make closer connections and act across the continuum that stretches from development to humanitarian response, a notion that reflects the United Nations Agenda 2030 emphasis on integrated, interdependent actions. Doing so could reduce risks and vulnerabilities, and build resilience. It would imply embedding all major elements of people's rights and development in all humanitarian responses, including sexual and reproductive health care. Agenda 2030 is the international plan of action for people, planet and prosperity for the coming 15 years that recognizes eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development.

Food and shelter have traditionally been seen as “primary” humanitarian needs. But sexual and reproductive health care saves lives, protects families and speeds recovery, on top of upholding commitments to human rights made by 179 governments at the historic International Conference on Population and Development. All people affected by crisis, particularly women and girls, need quality services related to pregnancy, contraception, prevention and treatment of sexually transmitted infections, including HIV, and protection from gender-based violence along with support services for survivors.

Be proactive, not reactive

Understanding risks can help guide better development choice for individuals, communities and nations. It can inform advance preparation and build resilience, so that if a crisis does occur, the consequences are fewer, the need for humanitarian intervention is lower, and recovery is faster.



Family health centre, Sweileh, Jordan.

Photo © UNFPA/Salah Malkawi

Establish comprehensive disaster risk management

The Sendai Framework for Disaster Risk Reduction for 2015 to 2030 outlines core priorities in understanding and managing disaster risks, revisiting financing arrangements and bolstering disaster preparedness. Its success depends on adequate resources and institutions as well as inclusive practices such as participation by all potentially affected groups. Globally, humanitarian actors must better prepare for crisis response through more sophisticated, coordinated analysis of capacities and dynamics, since these can heavily influence the success of interventions (ALNAP, 2015).

Aim for continuity in essential services

Efforts to address crisis risk should be situated within actions to reduce social deprivation and poverty, including under Agenda 2030 and the new United Nations Sustainable Development Goals for 2015 to 2030. Services should be designed



People displaced by Typhoon Haiyan, Tacloban, the Philippines.

Photo © Panos Pictures/Andrew McConnell

to maintain continuity, including through applying integrated models that may help extend availability. Examples include strong primary health care systems that incorporate sexual and reproductive health services, and adolescent health care that links to education, sexual health and livelihoods services.

Plans should be in place to manage potential gaps in personnel and supplies. Measures to preposition commodities for emergencies should by default involve those essential for sexual and reproductive health, such as contraceptives.

Invest in social protection now

Social protection programmes offer a hedge against diverse risks, particularly for the most vulnerable people—among them children and youth, women and the poor. They can make vital contributions to resilience and survival in a crisis. In the wake of catastrophe, they may offer critical support during the transition from reliance on external humanitarian assistance, ensuring continued ability to meet needs for food and health care, among other essentials.

Tackle intersecting risks

Too often, risk is assumed to be the same for different people. Everyone in the path of a landslide is at risk of losing their home, for instance. Yet many factors influence the level of risk, the ability to prepare and the capacity to recover. Sex, age, race, disability and many other issues intersect in complex ways. These need to be better reflected in data used to assess risk, as well as planning for preparedness.

The direct participation of women and young people, especially adolescent girls, in framing emergency preparedness plans helps ensure their rights and needs will not be overlooked during emergency response. Engaging men and boys in initiatives to reduce risks of gender-based violence can foster greater respect for women's rights and thus increased resilience.

Muster the will and resources for better urban planning

Rapid urban development has concentrated populations and taxed environmental resources, making cities epicentres of risk. Disaster preparedness planning needs to better reflect the

likelihood that the face of crisis will be increasingly urban. As part of managing risks, city and national planners need the capacities, resources and political will to orchestrate growth well. Slums in remote locations with poor hygiene may pose health risks and cut people off from essential public services.

Integrate disaster risk financing

Disaster risk financing often remains inadequate, so efforts by some countries to make it a centerpiece of a strategic approach to disaster risk management should be shared and encouraged (UNISDR, 2015). National risk boards that bring together insurance supervisors, disaster management agencies, and relevant ministries, including those working on health and gender equality, are also a step forward.

Meet acute needs

A number of priorities stand out in the early days of a humanitarian prevention. While some of these have appeared in many crisis responses, they are all essential across all situations.

Save lives from day one through internationally agreed essential services

In the acute phase of a crisis, the minimum initial package of essential services for reproductive health in crisis situations should be immediately applied to stop and respond to sexual violence, reduce HIV transmission, and prevent maternal and newborn death and illness. The package also assists in planning to provide comprehensive sexual and reproductive health care as soon as conditions allow. An accepted international standard and applicable to any context, the package is still not used by some providers of humanitarian assistance. Greater reach and effectiveness depend on improved coordination and a common commitment to applying it.

Close emergency health care deficits

In providing health services in humanitarian crises, care for physical trauma is often prioritized. Yet, this can create dangerous gaps, including in sexual and reproductive health care services, which are critical to saving lives. There is also scope for increased investment in early interventions with psychosocial services, particularly for the most acute cases, since psychological trauma can drive rising rates of gender-based and other forms of violence, and result in multiple forms of risky behaviours, ill-health and disability.

Protect women from unintended pregnancy

Where sexual and reproductive health services are provided as part of a crisis response, attention to family planning tends to be limited (Casey et al., 2015). This persists despite obvious links to reducing the transmission of infections, unintended pregnancies, the health risks of childbirth and unsafe abortions. People affected by crisis need access to the full range of family planning supplies and services, which, among other issues, requires greater attention to reliable supply chains and avoidance of shortfalls.

Prevent gender-based violence

Gender-based violence is prevalent in societies that are not in crisis, and often increases once people are displaced or otherwise under extreme stress. A failure to address gender-based violence in the beginning of a response undercuts women's and girls' resilience and health later on, and is a barrier to recovery. Specific efforts may be needed to counteract the stigma that usually keeps large numbers of women and girls from reporting violations. Outreach and services targeted to men and boys recognizes that sexual violence is perpetrated against them too.

Engage and reach youth

All humanitarian crisis responses should build in interventions for youth, responding to their right to be included, and the reality that half of all forcibly displaced people are under the age of 18. Other risks arise when adolescents are sexually active but protective services are unavailable. Young people need to be engaged as participants and leaders in all aspects of humanitarian action—policies, programmes and budgets. This builds their buy-in, makes it more likely that they will use services, and increases responsiveness to their actual needs.

Shift from response to recovery and resilience

While some links between development assistance and humanitarian action are made before a crisis, as part of efforts to prevent it or mitigate risks, others can be forged as the acute phase of an emergency eases into recovery. Early recovery can open new opportunities to mitigate future risks and enhance resilience, such as by instituting better protections for people's rights, improving the quality of services, and encouraging moves towards more equitable, inclusive development overall.

Move early and quickly to comprehensive services

As recovery begins, provision of the internationally agreed package of essential services should cede to the provision of comprehensive sexual and reproductive health services, based on a detailed needs assessment and longer-term programme planning. Comprehensive family planning, emergency obstetric and newborn care, training of service providers, community awareness, preventing and addressing all forms of gender-based violence, antenatal and postnatal care, comprehensive services to prevent and treat sexually

transmitted infections, including HIV, and addressing adolescent sexual health are among the top priorities.

Tear down barriers to urgently needed services

Multiple barriers can prevent access to sexual and reproductive health services, many of which may stem from discrimination related to age, sex, disability or other issues. Obstacles that may need to be addressed include the need to travel long distances to service points, the lack of adequate transport, safety concerns, a perception of “unfriendliness” to groups such as unmarried women and youth, language barriers and a lack of knowledge that services exist.

Challenge discriminatory gender roles

The social disruption imposed by a crisis may yield some positive results, including in breaking long-standing gender roles and practices. In modeling new and valued roles, women and girls diminish earlier assumptions that they are less capable of acting in the public arena.

Where women and girls take on new roles themselves, they should be encouraged, and where they do not, providers of humanitarian assistance can create opportunities, such as through equal opportunities for job training.

Achieving gender parity in leadership in disaster management should be a goal of all national and international efforts. United Nations Security Council Resolution 1325 already recognizes women's central participation across all aspects of peace and security.

Leave no aspect of gender-based violence unaddressed

Gender-based violence takes many forms, and no society can be understood as fully at peace or free from crisis until all forms are prevented. A variety

of essential health, legal and psychosocial services are necessary to shield women and girls from gender-based violence, and to care for survivors. Often these are best provided as an integrated package, reducing burdens on survivors who need to access them. Judicial services need to be restored as soon as possible. Some legal systems may still include discriminatory statutes and legal practices, such as insufficient penalties for perpetrators; these should be early priorities for judicial reform.

The recovery process may allow scope to question social norms that permit different forms of violence, like the acceptability of men arguing with their fists within their home. These efforts might involve community conversations aimed at building awareness and establishing new norms, and the engagement of men and boys in encouraging new thinking and behaviours.

Other opportunities to stop gender-based violence can come through peace dialogues and negotiations, as has now been done in multiple instances around the world. This process can raise awareness, allow survivors a voice, produce reparations, and lead to formal commitments in peace agreements to establish laws and institutions effective in stopping all forms of violence.

A priority in some contexts will be stopping early marriage. It can be a shattering consequence for young girls in crisis, caused by reasons ranging from protecting honour to having one fewer mouth to feed. Understanding child marriage as a negative coping mechanism and planning to prevent it should be in place early in a crisis response. Prevention may require careful work around changing social norms, backed by greater guarantees of safety, such as through protected



Syrians leaving Gevgalija, the former Yugoslav Republic of Macedonia.
Photo © UNFPA/Nake Batev

spaces for girls in schools and safe houses or spaces.

Some economic drivers may be eased through the extension of livelihood activities equally available to women and men; these may also offer opportunities to communicate, for instance, the risks of early marriage and the value of girls remaining in school.

Acknowledge and respond to the reality of trauma

While much of the focus of humanitarian response is on people's immediate physical needs, trauma counselling also should be viewed as a primary and potentially life-saving intervention. Trauma produced by the extreme mental stress of displacement, conflict and loss has multiple implications and costs. It can lead to suicide, drug and alcohol abuse, and higher rates of gender-based violence, and it may be transmitted across generations, dampening prospects for full recovery, possibly for decades. As recovery gets under way, it may mean people cannot return to being productive workers and business people engaged in rebuilding their economy. Or it can fuel unresolved grievances that eventually spill into conflict.

Counselling should be readily accessible and integrated into other health services to ease referrals and reduce stigma incurred by visiting a separate facility. To be most effective, it must be grounded in a close understanding of local contexts and norms, and available to and welcoming of all individuals.

Brighten long-term prospects for women and girls: say no to business as usual

The imperative of making humanitarian responses to crises both more effective and sustainable underlines new ways of operating. The system as it stands today, with scattered funding and weak links to development, will not suffice to meet mounting needs.

End paternalistic response and action

States have the primary role in humanitarian preparedness and response (Gingerich and Cohen, 2015). Where the engagement of international actors becomes necessary, they can do much more to engage with local systems and groups.

Working with local partners, including those where relationships may already be long established through earlier development assistance, can be one way forward. They offer local knowledge that external actors may find impossible or time-consuming to duplicate. Establishing referrals for emergency obstetric and newborn care, for example, could build on existing networks. Reproductive health education led by displaced people might be more effective in using terms and communication styles most appropriate to a given context.

Through the use of technology, some local groups are mounting increasingly sophisticated responses, as in Nepal, where they used cell phone GPS data to map earthquake-affected areas and guide relief efforts (Barnett and Walker, 2015)

Engaging with a variety of local and national actors is also part of supporting more inclusive societies that underpin resilient states. Some, such as women's and youth groups, deserve specific emphasis as part of reducing discrimination and related vulnerabilities.

The potential pitfalls of expanding engagement include increased fragmentation in relief efforts, norms that may contradict international standards, and leaders who in some contexts will be mostly male. But the process of working together can begin to address these.

It may also foster understanding of different comparative advantages—including those of international organizations. With some developing countries now spending much more on humanitarian responses than traditional



Mother and daughters outside new home built after tsunami inundated her community in Lhoknga, Indonesia, in 2004.

Photo © Panos Pictures/Abbie Trayler-Smith

aid agencies (Gingrich and Cohen, 2015), organizations within the United Nations system in particular may increasingly be looked to as sources of expertise and bearers of agreed standards, rather than implementers of on-the-ground actions.

In some respects, humanitarian actors need to work towards a future where their responses are exceptional or unnecessary, since local actors meet most needs. Equitable and sustainable development will be the foundation for progress in this direction.

End the false distinction between development and humanitarian action

While the resolution of a crisis very rarely takes a linear path, connections between development and humanitarian issues may be relevant along the way, helping to steer the recovery process overall. Some humanitarian interventions can build on pre-crisis development initiatives, as is now the case with 55 per cent of gender-based violence programming. By the same token, activities begun during a crisis can carry over afterward, as has happened with

81 per cent of gender-based violence programmes initiated through humanitarian assistance.

A sense of continuity is built, particularly, where feasible, through consistent relationships with national partners. This may expand the scope for cultivating greater capacities that will sustain progress over the long term. Other benefits include bolstering perceptions of normalcy and stability.

When the Ebola crisis struck West Africa, countries such as Guinea, Liberia and Sierra Leone had only 10 per cent to 20 per cent of the internationally recommended health workforce (WHO). What suddenly erupted as a humanitarian crisis had clearly long been a development crisis for countries trapped in poverty and unable to pay for basic services. The roots of that inability extend in many directions, including inequities built into the global economy.

The experience underscores the false divide between humanitarian and development work. That recognition needs to filter into the ways that international and national institutions operate, such as through more integrated institutional

structures and policies, links across different sectors, and longer term planning and financing geared towards reducing risks and building resilience. Systematic partnerships can help break down silos. Within the United Nations system, humanitarian response plans could be aligned with development assistance frameworks, and jointly embedded in national planning.

Such an approach might have slowed Ebola at a much earlier stage in West Africa, perhaps obviating the need for a massive humanitarian intervention.

It would have achieved a higher level of justice and inclusiveness, one of the main promises of Agenda 2030. In other cases, it might prove more acutely sensitive to slow onset crises like drought, which currently tend to receive a slower response (Gingerich and Cohen, 2015).

Fill the data deficit gap

The use of targets, indicators and data is a major part of Agenda 2030, and a significant shortfall in humanitarian work. With short response



Photo © Panos Pictures/Mads Nissen/Berlingske

times and funding cycles, data are frequently not collected, leaving little evidence of which interventions work best and which actors are best positioned to collaborate on them.

The absence of data, especially sex- and age-disaggregated data, obscures links across humanitarian sectors that might prove mutually reinforcing. Data on sexual and reproductive health indicators, for instance, might be valuable for education measures, such as those to improve life skills and raise awareness of risks such as early pregnancy that can result in girls leaving school.

Overhaul entrenched funding arrangements

Current patterns of financing humanitarian assistance explain some of its challenges and shortfalls. Driven internationally by donors, finance is often reactive, inefficient and poorly coordinated, despite growing emphasis on improved performance. Earmarking pushes forward issues that do not necessarily correspond closely to priorities in countries struck by crisis, and funds tend to flow to more visible emergencies, or those viewed as strategically significant. So-called “donor accountability” has reduced tolerance for risk because it links primarily to mandates and funding conditions, not always to what people actually need (IASC, 2014)

The concentration of funds in a few large grants deepens the tendency for humanitarian action to be the province of a few large players. Amounts being spent are often unclear. No marker currently tracks spending on sexual and reproductive health interventions, a gap that should be redressed.

Donors need to reevaluate these issues. In tandem, an inclusive intergovernmental process to regularly review all sources of humanitarian

financing could bring different perspectives to light.

There is also a clear case for more investment in some areas of humanitarian assistance. Both national and international finance should prioritize disaster risk reduction and preparation, which currently attracts minimal amounts. More money should go to sexual and reproductive health. An increasing number of countries are equipped to provide domestic resources, but for those that are less developed, international funding should be provided within a framework of common but differentiated responsibility. This underscores the obligation of those with more resources and capabilities to assist those with less. The same principle might be applied within countries in terms of vulnerable groups, such as poor women and youth.

Private financing can be explored, but with caution. Private actors play active roles in development and humanitarian assistance, yet there is also a history of private interests resulting in imbalances, as in the dominance of in-kind food aid and some health issues (Gingerich and Cohen, 2015). All forms of private involvement must align with international standards. They could be better tracked and measured for effectiveness against agreed global norms.

Reform laws and policies that perpetuate violence and discrimination

A number of legal reforms are important to build resilience in countries prone to crisis, such as those that bar gender discrimination and penalize gender-based violence. But with a record number of people now on the move, within and across borders, and in light of the universal nature of Agenda 2030, other legal measures may be needed even in countries that are not experiencing crisis.

Laws against trafficking—such as the recent Modern Slavery Act in the United Kingdom—

reflect how what starts as displacement in one country ends up a human rights violation in another. Women, in this case, are the primary victims. Other issues revolve around the management of refugees, including the isolation of people for years in camps, where they are unable to find legal employment and services in surrounding communities.

A new platform for humanitarian action

In 2016, the World Humanitarian Summit will convene, providing an opportunity for countries around the world to share ideas and set new

directions. The process should commit to greater investment in sexual and reproductive health services as a primary element of all humanitarian responses, in line with existing agreements outlined in the Programme of Action of the International Conference on Population and Development. It should uphold the high ambition and hopes of Agenda 2030. Aiming for a transformed world, where development is inclusive, sustainable and sufficient to forestall crisis or resist its worst consequences, would render many forms of humanitarian assistance progressively obsolete.



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Indicators

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Monitoring ICPD goals: selected indicators

Country, territory or other area

Country, territory or other area	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 ⁱ	Contraceptive prevalence rate, women aged 15-49, modern method 2015 ⁱ	Unmet need for family planning, women aged 15-49 2015 ⁱ	Proportion of demand satisfied, women aged 15-49 2015 ⁱ	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014		Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014		Gender parity index, secondary education 1999-2014
	male	female								male	female	
Afghanistan	39	90	29	24	27	52	–	–	–	60	33	0.55
Albania	99	18	66	19	13	84	93	90	0.96	66	64	0.96
Algeria	97	12	59	51	13	82	98	96	0.98	–	–	–
Angola	47	191	19	13	28	40	97	74	0.77	15	12	0.81
Antigua and Barbuda	100	67	63	60	14	82	87	85	0.98	88	94	1.07
Argentina	97	70	62	58	15	80	100	99	0.99	86	92	1.07
Armenia	100	23	59	30	13	82	89	98	1.10	83	96	1.16
Aruba	–	34	–	–	–	–	94	98	1.04	73	81	1.10
Australia	99	14	68	65	10	87	97	98	1.00	85	86	1.01
Austria	99	8	68	65	10	87	–	–	–	–	–	–
Azerbaijan	97	47	57	22	14	80	90	88	0.98	88	86	0.98
Bahamas	98	40	67	65	12	85	94	99	1.06	80	86	1.07
Bahrain	100	15	66	43	11	85	100	98	0.99	95	92	0.97
Bangladesh	42	83	64	57	12	84	94	98	1.05	44	51	1.16
Barbados	98	49	60	57	16	79	97	97	0.99	84	96	1.15
Belarus	100	22	65	54	11	86	92	94	1.02	96	97	1.01
Belgium	–	8	69	67	9	88	99	99	1.00	96	97	1.01
Belize	96	64	58	54	17	78	100	100	1.00	72	77	1.08
Benin	77	98	17	10	31	36	100	88	0.88	50	34	0.68
Bhutan	75	28	68	66	11	86	89	92	1.03	56	64	1.15
Bolivia (Plurinational State of)	85	89	63	40	18	78	82	81	0.99	71	72	1.02
Bosnia and Herzegovina	100	11	48	17	17	74	–	–	–	–	–	–
Botswana	95	39	56	55	17	77	90	92	1.02	56	65	1.16
Brazil	98	65	79	75	8	91	–	–	–	–	–	–
Brunei Darussalam	100	17	–	–	–	–	95	95	1.00	91	93	1.02
Bulgaria	100	43	67	48	14	83	96	97	1.00	89	86	0.97
Burkina Faso	66	136	19	18	27	41	69	67	0.96	23	20	0.87
Burundi	60	65	28	23	30	48	100	90	0.90	22	21	0.93
Cabo Verde	78	92	62	58	15	81	99	97	0.98	65	75	1.14
Cambodia	89	57	58	40	13	82	100	97	0.97	40	36	0.92
Cameroon, Republic of	64	128	29	17	22	56	100	89	0.89	43	37	0.87
Canada	98	13	73	71	8	90	99	100	1.01	–	–	–
Central African Republic	54	229	24	13	23	50	81	64	0.79	18	10	0.52
Chad	23	203	6	3	23	21	96	75	0.78	16	5	0.33
Chile	100	50	65	62	13	83	92	92	1.00	86	89	1.03
China	100	6	83	83	4	96	–	–	–	–	–	–
China, Hong Kong SAR	–	4	80	75	5	94	100	99	0.99	87	87	1.00
China, Macao SAR	–	3	–	–	–	–	–	–	–	77	80	1.04
Colombia	99	85	78	72	8	91	91	91	1.00	71	77	1.08
Comoros	82	71	24	17	31	43	86	81	0.95	46	49	1.07

Monitoring ICPD goals: selected indicators

Country, territory or other area

	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 [†]	Contraceptive prevalence rate, women aged 15-49, modern method 2015 [†]	Unmet need for family planning, women aged 15-49 2015 [†]	Proportion of demand satisfied, women aged 15-49 2015 [†]	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014	Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014	Gender parity index, secondary education 1999-2014		
	male	female					male	female	male	female		
Congo, Democratic Republic of the	80	135	23	9	27	45	37	35	0.95	–	–	–
Congo, Republic of the	93	147	47	23	18	73	88	96	1.09	–	–	–
Costa Rica	99	67	79	76	6	93	90	91	1.01	71	76	1.07
Côte d'Ivoire	59	125	20	15	24	46	81	75	0.93	–	–	–
Croatia	100	12	66	42	11	85	98	100	1.02	92	95	1.03
Cuba	99	50	74	72	9	90	96	97	1.00	88	89	1.01
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	99	4	–	–	–	–	98	98	1.00	91	93	1.02
Czech Republic	100	11	78	69	7	92	–	–	–	–	–	–
Denmark	98	2	71	66	9	88	98	99	1.01	90	93	1.03
Djibouti	87	21	24	23	30	44	69	60	0.86	29	21	0.72
Dominica	100	47	63	60	14	82	96	99	1.03	76	82	1.07
Dominican Republic	98	90	72	69	11	87	90	88	0.98	58	66	1.15
Ecuador	94	100	73	61	9	89	96	98	1.02	82	85	1.04
Egypt	92	56	60	58	12	83	100	97	0.97	86	85	1.00
El Salvador	98	63	71	64	12	86	92	92	1.01	61	64	1.03
Equatorial Guinea	68	177	16	11	33	33	62	62	0.99	25	19	0.77
Eritrea	34	85	20	16	29	41	–	–	–	–	–	–
Estonia	99	16	65	59	13	84	97	97	1.01	88	90	1.02
Ethiopia	16	71	36	36	25	59	69	63	0.92	18	11	0.61
Fiji	100	28	50	43	19	72	98	100	1.02	79	88	1.11
Finland	100	7	75	72	8	91	99	99	1.01	94	94	1.01
France	97	9	74	72	6	92	99	99	1.01	97	98	1.02
French Guiana	–	84	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	40	–	–	–	–	–	–	–	–	–	–
Gabon	89	115	34	21	25	57	–	–	–	–	–	–
Gambia	57	88	11	10	28	28	67	72	1.07	–	–	–
Georgia	100	40	52	37	17	75	96	97	1.01	92	92	1.00
Germany	99	8	67	62	10	87	99	99	1.00	–	–	–
Ghana	68	65	22	20	34	40	89	89	1.00	55	54	0.97
Greece	–	9	69	46	10	87	99	100	1.01	99	99	1.00
Grenada	99	53	64	60	13	83	98	98	1.00	80	81	1.02
Guadeloupe	–	21	58	51	16	78	–	–	–	–	–	–
Guam	–	60	54	45	17	76	–	–	–	–	–	–
Guatemala	63	92	57	48	17	77	88	88	0.99	49	45	0.92
Guinea	45	154	8	5	25	23	82	71	0.86	37	23	0.63
Guinea-Bissau	45	137	17	13	22	44	73	69	0.95	11	6	0.56
Guyana	92	97	45	44	27	63	70	80	1.14	86	100	1.16
Haiti	37	65	38	34	33	53	–	–	–	–	–	–
Honduras	83	99	73	64	11	87	89	91	1.02	45	53	1.19
Hungary	99	20	75	68	8	90	96	96	1.00	92	92	1.00
Iceland	–	7	–	–	–	–	98	98	1.01	89	89	1.00
India	52	39	60	52	13	82	92	89	0.97	–	–	–
Indonesia	87	47	63	59	11	85	95	96	1.01	77	76	0.98

Monitoring ICPD goals: selected indicators

Country, territory or other area	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 ^c	Contraceptive prevalence rate, women aged 15-49, modern method 2015 ^c	Unmet need for family planning, women aged 15-49 2015 ^c	Proportion of demand satisfied, women aged 15-49 2015 ^c	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014		Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014		Gender parity index, secondary education 1999-2014
							male	female	male	female	male	female
Iran (Islamic Republic of)	96	35	77	59	7	92	98	96	0.98	84	79	0.95
Iraq	91	68	55	38	14	79	97	86	0.89	49	40	0.81
Ireland	100	9	67	62	11	86	100	100	1.00	99	100	1.01
Israel	–	10	71	53	9	89	97	98	1.01	97	100	1.03
Italy	100	6	65	49	11	85	99	98	0.99	91	92	1.01
Jamaica	99	72	72	68	10	88	92	91	1.00	72	76	1.05
Japan	100	4	57	50	16	78	100	100	1.00	99	100	1.01
Jordan	100	27	62	43	12	84	98	96	0.98	86	89	1.03
Kazakhstan	100	31	56	52	16	78	98	100	1.02	91	92	1.01
Kenya	62	101	57	56	19	76	83	87	1.04	57	55	0.97
Kiribati	80	49	28	22	27	51	–	–	–	66	73	1.11
Korea, Democratic People's Republic of	100	1	70	63	11	87	–	–	–	–	–	–
Korea, Republic of	100	2	79	69	6	93	98	97	0.99	98	97	0.99
Kuwait	99	8	56	44	16	78	99	98	0.99	86	88	1.03
Kyrgyzstan	98	42	42	39	17	71	99	98	0.99	82	83	1.00
Lao People's Democratic Republic	42	94	54	46	18	75	98	96	0.98	46	43	0.95
Latvia	99	15	68	60	12	85	97	98	1.01	86	88	1.01
Lebanon	–	18	63	40	13	83	99	93	0.94	67	68	1.00
Lesotho	78	94	60	59	18	77	78	82	1.05	27	42	1.56
Liberia	61	147	20	20	32	39	39	37	0.95	18	15	0.83
Libya	100	4	49	28	20	71	–	–	–	–	–	–
Lithuania	100	14	63	53	13	83	97	97	1.00	97	96	0.99
Luxembourg	100	6	–	–	–	–	95	96	1.01	84	87	1.04
Madagascar	44	147	46	37	19	71	77	78	1.00	30	31	1.02
Malawi	87	143	58	56	19	75	90	97	1.07	32	30	0.96
Malaysia	99	13	57	42	15	79	98	95	0.96	71	67	0.95
Maldives	99	14	42	34	25	63	93	94	1.01	46	53	1.14
Mali	56	178	12	11	27	31	78	68	0.88	39	32	0.80
Malta	100	16	81	59	5	94	95	95	1.00	80	84	1.05
Martinique	–	20	60	54	15	80	–	–	–	–	–	–
Mauritania	65	71	14	13	31	31	72	75	1.05	23	20	0.87
Mauritius	100	31	76	53	7	92	98	98	1.00	80	81	1.01
Mexico	96	84	73	67	11	87	97	99	1.02	66	69	1.04
Micronesia (Federated States of)	100	33	–	–	–	–	82	84	1.02	–	–	–
Moldova, Republic of	99	25	63	45	13	83	91	91	1.00	77	78	1.01
Mongolia	99	40	58	52	14	80	96	94	0.98	78	86	1.11
Montenegro	99	12	34	10	24	59	98	99	1.01	–	–	–
Morocco	74	32	68	58	10	88	99	98	0.99	59	53	0.90
Mozambique	54	166	18	16	28	39	90	85	0.95	19	18	0.98
Myanmar	71	17	52	49	16	76	–	–	–	46	48	1.05
Namibia	88	78	57	57	17	77	87	90	1.04	45	57	1.27
Nepal	56	87	52	48	24	69	98	97	0.99	58	62	1.06
Netherlands	–	5	68	65	10	87	97	97	1.00	92	93	1.01

Monitoring ICPD goals: selected indicators

Country, territory or other area	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 [†]	Contraceptive prevalence rate, women aged 15-49, modern method 2015 [†]	Unmet need for family planning, women aged 15-49 2015 [†]	Proportion of demand satisfied, women aged 15-49 2015 [†]	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014	Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014	Gender parity index, secondary education 1999-2014		
	male	female					male	female	male	female		
New Caledonia	–	23	–	–	–	–	–	–	–	–	–	–
New Zealand	97	22	71	67	9	89	98	98	1.00	97	98	1.01
Nicaragua	88	92	80	75	7	92	93	94	1.01	42	49	1.14
Niger	29	210	15	10	18	47	69	58	0.84	15	10	0.66
Nigeria	38	123	16	11	22	42	71	60	0.84	–	–	–
Norway	99	6	79	72	6	93	100	100	1.00	95	95	1.00
Oman	99	12	37	25	28	57	97	98	1.02	77	91	1.19
Pakistan	52	48	39	28	20	65	77	67	0.87	43	32	0.74
Palestine ¹	100	67	57	43	15	79	93	94	1.01	77	84	1.10
Panama	92	89	61	58	16	80	92	91	0.99	74	79	1.08
Papua New Guinea	53	65	37	29	25	60	90	83	0.92	–	–	–
Paraguay	96	63	77	68	6	92	81	81	0.99	63	68	1.07
Peru	90	68	74	52	9	89	95	94	1.00	76	77	1.01
Philippines	73	59	55	38	18	75	91	91	1.00	60	70	1.16
Poland	100	14	69	48	10	87	97	97	1.00	92	93	1.01
Portugal	–	12	77	70	7	92	95	97	1.01	93	97	1.04
Puerto Rico	–	45	78	69	6	93	83	87	1.05	72	77	1.07
Qatar	100	16	44	37	19	69	99	95	0.96	91	100	1.10
Reunion	–	43	72	70	9	89	–	–	–	–	–	–
Romania	99	36	69	54	10	88	90	90	1.00	–	–	–
Russian Federation	100	27	69	56	10	88	97	98	1.01	–	–	–
Rwanda	91	41	54	47	20	73	92	95	1.03	–	–	–
Saint Kitts and Nevis	100	75	59	55	16	79	81	84	1.04	82	88	1.07
Saint Lucia	99	50	57	54	17	77	95	93	0.97	80	81	1.01
Saint Vincent and the Grenadines	99	70	65	62	13	84	97	95	0.98	84	87	1.03
Samoa	81	39	32	31	42	43	95	97	1.03	75	84	1.12
San Marino	–	1	–	–	–	–	93	93	1.00	–	–	–
São Tomé and Príncipe	82	110	41	36	33	55	93	92	0.99	46	53	1.17
Saudi Arabia	97	7	37	31	24	60	96	99	1.03	101	101	1.01
Senegal	59	80	18	17	30	38	76	83	1.08	24	18	0.76
Serbia	98	22	58	22	13	81	96	97	1.01	92	94	1.03
Seychelles	99	62	–	–	–	–	96	95	0.99	61	66	1.07
Sierra Leone	60	131	17	15	26	39	–	–	–	40	36	0.92
Singapore	100	3	66	58	11	86	–	–	–	–	–	–
Slovakia	100	21	71	59	10	88	–	–	–	–	–	–
Slovenia	100	5	75	64	8	90	97	98	1.01	94	95	1.01
Solomon Islands	86	62	39	32	21	64	82	79	0.97	33	29	0.88
Somalia	33	123	24	6	29	44	–	–	–	–	–	–
South Africa	94	54	65	64	12	84	95	95	1.00	62	69	1.10
South Sudan	19	158	7	3	30	19	48	34	0.71	–	–	–
Spain	–	9	67	63	12	85	98	99	1.00	95	97	1.02
Sri Lanka	99	24	72	56	7	91	94	94	1.00	83	87	1.05
Sudan	23	102	16	13	29	36	53	56	1.05	–	–	–

Country, territory or other area	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 ^c	Contraceptive prevalence rate, women aged 15-49, modern method 2015 ^c	Unmet need for family planning, women aged 15-49 2015 ^c	Proportion of demand satisfied, women aged 15-49 2015 ^c	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014		Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014		Gender parity index, secondary education 1999-2014
	male	female					male	female		male	female	
Suriname	91	66	52	51	19	73	80	81	1.01	48	57	1.20
Swaziland	82	89	64	62	15	81	84	86	1.02	32	39	1.20
Sweden	–	3	70	62	10	88	100	100	1.00	95	94	0.99
Switzerland	–	3	77	72	6	92	100	100	1.00	82	80	0.97
Syrian Arab Republic	96	75	58	41	15	79	66	65	0.98	44	44	0.99
Tajikistan	87	47	33	30	22	60	100	97	0.97	88	79	0.90
Tanzania, United Republic of	49	128	41	34	23	64	83	86	1.03	–	–	–
Thailand	100	60	79	77	6	93	96	95	0.99	77	82	1.06
The former Yugoslav Republic of Macedonia	98	19	49	17	18	73	92	92	1.00	79	77	0.97
Timor-Leste, Democratic Republic of	29	54	29	26	26	53	92	91	0.98	36	40	1.11
Togo	59	77	21	19	34	39	98	87	0.89	32	15	0.48
Tonga	98	30	35	30	28	56	83	86	1.03	67	71	1.05
Trinidad and Tobago	100	36	50	44	19	72	99	98	0.99	70	75	1.07
Tunisia	99	7	64	53	11	86	100	100	1.00	–	–	–
Turkey	97	29	74	48	6	92	96	95	0.99	90	87	0.97
Turkmenistan	100	21	57	51	15	79	–	–	–	–	–	–
Turks and Caicos Islands	–	29	–	–	–	–	77	84	1.08	–	–	–
Tuvalu	98	42	34	27	28	55	85	87	1.02	70	89	1.28
Uganda	57	140	30	28	33	47	90	93	1.03	23	22	0.95
Ukraine	99	27	67	51	10	87	97	99	1.02	87	87	1.00
United Arab Emirates	100	34	48	39	20	71	99	97	0.98	73	79	1.09
United Kingdom	–	21	81	80	5	94	100	100	1.00	98	98	1.01
United States of America	99	27	75	69	7	92	92	92	1.00	86	88	1.02
United States Virgin Islands	–	59	69	62	11	87	–	–	–	–	–	–
Uruguay	98	60	77	74	8	91	100	99	0.99	68	76	1.12
Uzbekistan	100	26	67	61	10	88	93	90	0.97	–	–	–
Vanuatu	89	78	47	37	24	66	98	97	0.99	51	53	1.04
Venezuela (Bolivarian Republic of)	96	101	70	64	12	85	95	93	0.98	72	78	1.09
Viet Nam	94	36	77	65	7	92	–	–	–	–	–	–
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	45	67	38	28	27	58	95	81	0.85	51	34	0.66
Zambia	64	145	51	45	20	72	93	93	1.01	–	–	–
Zimbabwe	80	120	66	65	11	85	93	95	1.02	44	44	1.01

World and regional data

	Maternal and Newborn Health		Sexual and Reproductive Health				Education					
	Births attended by skilled health personnel, per cent ^a 2006-2014	Adolescent birth rate per 1,000 women aged 15-19 1999-2014	Contraceptive prevalence rate, women aged 15-49, any method 2015 [†]	Contraceptive prevalence rate, women aged 15-49, modern method 2015 [†]	Unmet need for family planning, women aged 15-49 2015 [†]	Proportion of demand satisfied, women aged 15-49 2015 [†]	Adjusted primary school enrolment, net per cent of primary school-age children, 1999-2014	Gender parity index, primary education 1999-2014	Secondary school enrolment, net per cent of secondary school-age children, 1999-2014	Gender parity index, secondary education 1999-2014		
	male	female					male	female	male	female		
Arab States	75	56	51	43	17	76	86	82	0.95	64	58	0.92
Asia and the Pacific	71	33 b	69	63	10	87	95	95	1.00	69	65	0.94
Eastern Europe and Central Asia	98	30	65	47	11	86	95	94	1.00	89	89	0.99
Latin America and the Caribbean	93	76 c	73	67	11	87	93	94	1.00	73	78	1.06
East and Southern Africa	56	112	39	34	24	62	86	84	0.97	35	33	0.93
West and Central Africa	48	128	18	13	24	42	78	69	0.89	38	31	0.83
More developed regions	–	18	70	61	10	88	96	96	1.00	90	91	1.01
Less developed regions	70	56	63	57	12	84	91	90	0.98	64	61	0.95
Least developed regions	–	113	40	34	22	64	–	–	–	–	–	–
World	71	51	64	57	12	84	92	90	0.99	67	65	0.96

NOTES

– Data not available.

[†] Women currently married/in union.

^a Figures include surveys conducted between 2006-2014 only. Live births for 2010-2015 is used as this is the mid-year of the included surveys.

^b Figures exclude Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

^c Figures excludes Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, and Turks and Caicos Islands due to data availability.

¹ On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine “non-member observer State status in the United Nations...”

Demographic indicators

Country, territory or other area

Country, territory or other area	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
Afghanistan	32.5	3.0	35	44	54	3	87.0	59	61	5.1
Albania	2.9	0.0	25	19	69	12	44.8	75	80	1.8
Algeria	39.7	1.9	24	29	66	6	52.6	72	77	2.9
Angola	25.0	3.3	33	48	50	2	99.9	50	53	6.2
Antigua and Barbuda	0.1	1.0	25	24	69	7	45.7	73	78	2.1
Argentina	43.4	1.0	24	25	64	11	56.5	72	80	2.3
Armenia	3.0	0.4	20	18	71	11	41.3	71	78	1.6
Aruba	0.1	0.4	21	18	70	12	44.0	73	78	1.7
Australia ¹	24.0	1.6	19	19	66	15	50.9	80	84	1.9
Austria	8.5	0.4	17	14	67	19	49.2	78	84	1.5
Azerbaijan ²	9.8	1.4	23	22	73	6	38.0	68	74	2.3
Bahamas	0.4	1.5	23	21	71	8	41.2	72	78	1.9
Bahrain	1.4	1.8	22	22	76	2	31.4	76	77	2.1
Bangladesh	161.0	1.2	30	29	66	5	52.5	70	72	2.2
Barbados	0.3	0.3	20	19	67	14	50.4	73	78	1.8
Belarus	9.5	0.0	16	16	70	14	43.0	65	77	1.6
Belgium	11.3	0.7	17	17	65	18	54.2	78	83	1.8
Belize	0.4	2.2	32	33	64	4	56.8	67	73	2.6
Benin	10.9	2.7	32	42	55	3	82.0	58	61	4.9
Bhutan	0.8	1.5	29	27	68	5	46.9	69	69	2.1
Bolivia (Plurinational State of)	10.7	1.6	30	32	61	7	63.7	65	70	3.0
Bosnia and Herzegovina	3.8	-0.1	16	14	71	15	40.7	74	79	1.3
Botswana	2.3	2.0	29	32	64	4	55.3	62	67	2.9
Brazil	207.8	0.9	25	23	69	8	44.7	70	78	1.8
Brunei Darussalam	0.4	1.5	25	23	73	4	38.0	77	80	1.9
Bulgaria	7.1	-0.7	14	14	66	20	51.9	71	78	1.5
Burkina Faso	18.1	2.9	33	46	52	2	92.2	57	59	5.6
Burundi	11.2	3.3	31	45	53	3	89.7	54	58	6.1
Cabo Verde	0.5	1.2	31	30	66	5	52.0	71	75	2.4
Cambodia	15.6	1.6	30	32	64	4	55.6	66	70	2.7
Cameroon, Republic of	23.3	2.5	33	43	54	3	84.3	54	56	4.8
Canada	35.9	1.0	18	16	68	16	47.3	80	84	1.6
Central African Republic	4.9	2.0	33	39	57	4	75.2	48	51	4.4
Chad	14.0	3.3	34	48	50	3	100.7	50	52	6.3
Chile	17.9	1.1	22	20	69	11	45.2	78	84	1.8
China ³	1376.0	0.5	19	17	73	10	36.6	74	77	1.6
China, Hong Kong SAR ⁴	7.3	0.8	15	12	73	15	37.0	81	87	1.2
China, Macao SAR ⁵	0.6	1.9	16	13	78	9	28.2	78	83	1.2
Colombia	48.2	1.0	26	24	69	7	45.6	70	77	1.9
Comoros	0.8	2.4	32	40	57	3	75.6	61	65	4.6
Congo, Democratic Republic of the	77.3	3.2	32	46	51	3	95.9	57	60	6.2
Congo, Republic of the	4.6	2.6	31	43	54	4	86.2	60	63	5.0
Costa Rica	4.8	1.1	24	22	69	9	45.4	77	82	1.9
Côte d'Ivoire	22.7	2.4	33	43	55	3	83.5	50	52	5.1

Country, territory or other area	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
Croatia	4.2	-0.4	16	15	66	19	51.1	74	80	1.5
Cuba	11.4	0.1	18	16	70	14	43.4	77	81	1.6
Curaçao	0.2	1.3	19	19	66	15	51.1	75	81	2.1
Cyprus ⁶	1.2	1.1	20	17	71	13	41.6	78	82	1.5
Czech Republic	10.5	0.1	15	15	67	18	49.5	75	81	1.5
Denmark	5.7	0.4	19	17	64	19	55.9	78	82	1.7
Djibouti	0.9	1.3	31	33	63	4	58.5	60	63	3.3
Dominica	0.1	0.4	–	–	–	–	–	–	–	–
Dominican Republic	10.5	1.2	28	30	63	7	57.8	70	76	2.5
Ecuador	16.1	1.6	28	29	64	7	55.6	73	78	2.6
Egypt	91.5	2.2	27	33	62	5	62.3	69	73	3.4
El Salvador	6.1	0.3	30	27	65	8	54.3	68	77	2.0
Equatorial Guinea	0.8	3.0	30	39	58	3	72.9	56	59	5.0
Eritrea	5.2	2.2	32	43	55	3	83.2	61	65	4.4
Estonia	1.3	-0.3	15	16	65	19	53.5	72	81	1.6
Ethiopia	99.4	2.5	35	41	55	4	81.6	61	65	4.6
Fiji	0.9	0.7	26	29	65	6	52.8	67	73	2.6
Finland ⁷	5.5	0.5	17	16	63	21	58.3	78	83	1.7
France	64.4	0.5	18	19	62	19	60.3	79	85	2.0
French Guiana	0.3	2.8	27	34	61	5	63.2	76	83	3.5
French Polynesia	0.3	1.1	25	22	70	8	42.2	74	79	2.1
Gabon	1.7	2.2	31	37	58	5	73.1	63	64	4.0
Gambia	2.0	3.2	32	46	52	2	94.2	59	61	5.8
Georgia ⁸	4.0	-1.2	18	17	69	14	45.7	71	78	1.8
Germany	80.7	0.1	15	13	66	21	51.8	78	83	1.4
Ghana	27.4	2.4	31	39	58	3	73.0	60	62	4.2
Greece	11.0	-0.4	15	15	64	21	56.2	78	84	1.3
Grenada	0.1	0.4	27	27	66	7	50.7	71	76	2.2
Guadeloupe ⁹	0.5	0.5	20	22	63	15	57.6	77	84	2.2
Guam	0.2	1.3	26	26	66	9	52.0	76	81	2.4
Guatemala	16.3	2.1	33	37	59	5	70.9	68	75	3.3
Guinea	12.6	2.7	32	43	54	3	83.8	58	58	5.1
Guinea-Bissau	1.8	2.4	32	41	56	3	78.4	53	57	5.0
Guyana	0.8	0.4	34	29	66	5	51.1	64	69	2.6
Haiti	10.7	1.4	31	34	62	5	62.3	60	64	3.1
Honduras	8.1	1.5	33	32	63	5	57.8	70	75	2.5
Hungary	9.9	-0.3	16	15	68	18	47.9	71	79	1.3
Iceland	0.3	0.7	21	20	66	14	51.6	81	84	2.0
India	1311.1	1.3	28	29	66	6	52.4	66	69	2.5
Indonesia	257.6	1.3	26	28	67	5	49.0	67	71	2.5
Iran (Islamic Republic of)	79.1	1.3	23	24	71	5	40.2	74	76	1.7
Iraq	36.4	3.3	31	41	56	3	78.7	67	71	4.6
Ireland	4.7	0.3	18	22	65	13	53.7	78	83	2.0
Israel	8.1	1.7	23	28	61	11	64.1	80	84	3.1
Italy	59.8	0.1	14	14	64	22	56.5	80	85	1.4

Demographic indicators

Country, territory or other area	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
Jamaica	2.8	0.4	28	24	67	9	48.6	73	78	2.1
Japan	126.6	-0.1	14	13	61	26	64.5	80	86	1.4
Jordan	7.6	3.1	30	36	61	4	64.8	72	76	3.5
Kazakhstan	17.6	1.6	22	27	67	7	50.3	64	74	2.6
Kenya	46.1	2.7	32	42	55	3	80.9	59	62	4.4
Kiribati	0.1	1.8	29	35	61	4	63.0	63	69	3.8
Korea, Democratic People's Republic of	25.2	0.5	23	21	69	10	44.3	66	73	2.0
Korea, Republic of	50.3	0.5	18	14	73	13	37.2	78	85	1.3
Kuwait	3.9	4.8	19	22	76	2	32.1	73	76	2.2
Kyrgyzstan	5.9	1.7	27	31	64	4	55.3	66	74	3.1
Lao People's Democratic Republic	6.8	1.7	33	35	61	4	62.8	64	67	3.1
Latvia	2.0	-1.2	15	15	66	19	52.2	69	79	1.5
Lebanon	5.9	6.0	28	24	68	8	47.3	77	81	1.7
Lesotho	2.1	1.2	34	36	60	4	67.3	49	50	3.3
Liberia	4.5	2.6	32	42	55	3	82.9	59	61	4.8
Libya	6.3	0.0	25	30	66	5	52.4	69	74	2.5
Lithuania	2.9	-1.6	17	15	67	19	50.1	67	79	1.6
Luxembourg	0.6	2.2	18	16	70	14	43.7	79	84	1.6
Madagascar	24.2	2.8	33	42	56	3	80.3	63	66	4.5
Malawi	17.2	3.1	33	45	51	3	94.5	60	62	5.3
Malaysia ¹⁰	30.3	1.5	27	25	70	6	43.6	72	77	2.0
Maldives	0.4	1.8	28	28	68	5	47.4	75	77	2.2
Mali	17.6	3.0	32	48	50	3	100.2	57	57	6.4
Malta	0.4	0.3	18	14	66	19	50.8	79	82	1.4
Martinique	0.4	0.1	19	17	64	19	57.0	78	84	2.0
Mauritania	4.1	2.5	31	40	57	3	76.1	61	64	4.7
Mauritius ¹¹	1.3	0.4	23	19	71	10	40.6	71	78	1.5
Mexico	127.0	1.4	28	28	66	7	51.7	74	79	2.3
Micronesia (Federated States of)	0.1	0.2	36	34	62	4	62.4	68	70	3.3
Moldova, Republic of ¹²	4.1	-0.1	19	16	74	10	34.6	67	75	1.3
Mongolia	3.0	1.7	24	28	68	4	47.6	65	73	2.7
Montenegro	0.6	0.1	20	19	68	14	47.7	74	78	1.7
Morocco	34.4	1.4	26	27	67	6	50.1	73	75	2.6
Mozambique	28.0	2.8	33	45	51	3	94.8	53	56	5.5
Myanmar	53.9	0.8	28	28	67	5	49.1	64	68	2.3
Namibia	2.5	2.3	32	37	60	4	67.3	62	67	3.6
Nepal	28.5	1.2	33	33	62	6	61.8	68	70	2.3
Netherlands	16.9	0.3	18	17	65	18	53.3	79	83	1.8
New Caledonia	0.3	1.3	23	22	68	10	47.9	74	79	2.1
New Zealand	4.5	0.7	21	20	65	15	54.0	80	83	2.1
Nicaragua	6.1	1.2	30	30	65	5	54.1	71	77	2.3
Niger	19.9	4.0	31	51	47	3	113.0	60	62	7.6
Nigeria	182.2	2.7	31	44	53	3	87.7	52	53	5.7
Norway ¹³	5.2	1.3	19	18	66	16	52.2	79	83	1.8

Country, territory or other area	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
Oman	4.5	8.4	21	21	77	3	30.0	75	79	2.9
Pakistan	188.9	2.1	30	35	61	5	65.3	65	67	3.7
Palestine ¹⁴	4.7	2.7	34	40	57	3	76.0	71	75	4.3
Panama	3.9	1.6	26	27	65	8	53.4	74	80	2.5
Papua New Guinea	7.6	2.1	31	37	60	3	67.1	60	64	3.8
Paraguay	6.6	1.3	30	30	64	6	56.6	71	75	2.6
Peru	31.4	1.3	27	28	65	7	53.2	72	77	2.5
Philippines	100.7	1.6	30	32	64	5	57.6	65	72	3.0
Poland	38.6	0.0	16	15	70	16	43.8	73	81	1.4
Portugal	10.3	-0.4	16	14	65	21	53.5	77	84	1.3
Puerto Rico	3.7	-0.1	22	19	67	15	50.0	75	83	1.6
Qatar	2.2	4.7	19	16	83	1	20.1	77	80	2.1
Reunion	0.9	0.7	23	24	66	10	51.2	76	83	2.2
Romania	19.5	-0.8	16	16	67	17	48.9	71	78	1.5
Russian Federation	143.5	0.0	16	17	70	13	43.1	64	76	1.7
Rwanda	11.6	2.4	32	41	56	3	78.1	60	66	4.1
Saint Kitts and Nevis	0.1	1.2	-	-	-	-	-	-	-	-
Saint Lucia	0.2	0.8	26	23	68	9	47.3	72	78	1.9
Saint Vincent and the Grenadines	0.1	0.0	26	25	68	7	46.8	71	75	2.0
Samoa	0.2	0.8	31	37	58	5	74.0	70	76	4.2
San Marino	0.0	0.7	-	-	-	-	-	-	-	-
São Tomé and Príncipe	0.2	2.2	32	43	54	3	84.2	64	68	4.7
Saudi Arabia	31.5	2.3	24	29	69	3	45.9	73	75	2.9
Senegal	15.1	3.1	32	44	53	3	87.6	64	68	5.2
Serbia ¹⁵	8.9	-0.5	19	16	67	17	50.1	72	78	1.6
Seychelles	0.1	0.7	21	23	70	7	43.5	69	78	2.3
Sierra Leone	6.5	2.2	33	42	55	3	81.9	50	51	4.8
Singapore	5.6	2.0	19	16	73	12	37.4	80	86	1.2
Slovakia	5.4	0.1	17	15	71	14	40.8	72	80	1.4
Slovenia	2.1	0.1	14	15	67	18	48.7	77	83	1.6
Solomon Islands	0.6	2.1	32	40	57	3	75.1	66	69	4.1
Somalia	10.8	2.4	33	47	51	3	98.1	53	57	6.6
South Africa	54.5	1.1	29	29	66	5	52.1	55	59	2.4
South Sudan	12.3	4.1	33	42	54	4	83.7	54	56	5.2
Spain ¹⁶	46.1	-0.2	14	15	66	19	50.8	79	85	1.3
Sri Lanka	20.7	0.5	23	25	66	9	51.2	71	78	2.1
Sudan	40.2	2.2	32	41	56	3	78.0	62	65	4.5
Suriname	0.5	0.9	26	27	66	7	50.8	68	74	2.4
Swaziland	1.3	1.5	35	37	59	4	69.3	50	49	3.4
Sweden	9.8	0.8	18	17	63	20	59.3	80	84	1.9
Switzerland	8.3	1.2	16	15	67	18	48.8	80	85	1.5
Syrian Arab Republic	18.5	-2.3	33	37	59	4	70.0	64	76	3.0
Tajikistan	8.5	2.2	30	35	62	3	60.9	66	73	3.6
Tanzania, United Republic of ¹⁷	53.5	3.2	32	45	52	3	93.8	63	66	5.2
Thailand	68.0	0.4	19	18	72	11	39.2	71	78	1.5

Demographic indicators

Country, territory or other area	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
The former Yugoslav Republic of Macedonia	2.1	0.2	20	17	71	12	41.4	73	77	1.5
Timor-Leste, Democratic Republic of	1.2	2.3	32	42	52	6	92.3	66	70	5.9
Togo	7.3	2.7	32	42	55	3	81.8	58	60	4.7
Tonga	0.1	0.4	32	37	57	6	74.3	70	76	3.8
Trinidad and Tobago	1.4	0.5	20	21	70	9	43.2	67	74	1.8
Tunisia	11.3	1.1	23	23	69	8	44.8	72	77	2.2
Turkey	78.7	1.7	25	26	67	8	49.7	72	78	2.1
Turkmenistan	5.4	1.3	28	28	68	4	47.9	61	70	2.3
Turks and Caicos Islands	0.0	2.1	–	–	–	–	–	–	–	–
Tuvalu	0.0	0.2	–	–	–	–	–	–	–	–
Uganda	39.0	3.3	34	48	49	3	102.3	56	59	5.9
Ukraine	44.8	–0.4	15	15	70	15	43.3	66	76	1.5
United Arab Emirates	9.2	1.9	17	14	85	1	17.8	76	78	1.8
United Kingdom	64.7	0.6	18	18	65	18	55.1	78	82	1.9
United States of America	321.8	0.8	20	19	66	15	50.9	76	81	1.9
United States Virgin Islands	0.1	0.0	20	20	62	18	61.2	77	83	2.3
Uruguay	3.4	0.3	22	21	64	14	55.9	73	80	2.0
Uzbekistan	29.9	1.5	27	29	67	5	49.7	65	72	2.5
Vanuatu	0.3	2.3	29	37	59	4	68.7	70	74	3.4
Venezuela (Bolivarian Republic of)	31.1	1.4	27	28	66	6	52.4	70	78	2.4
Viet Nam	93.4	1.1	24	23	70	7	42.5	71	80	2.0
Western Sahara	0.6	2.2	25	26	71	3	40.2	66	70	2.2
Yemen	26.8	2.6	34	40	57	3	75.6	62	65	4.4
Zambia	16.2	3.1	33	46	51	3	95.4	57	60	5.5
Zimbabwe	15.6	2.2	33	42	55	3	80.4	54	56	4.0

World and regional data

	Population							Life expectancy		Fertility
	Total population in millions 2015	Average annual rate of population change, per cent 2010-2015	Population aged 10-24, per cent 2015	Population aged 0-14, per cent 2015	Population aged 15-64, per cent 2015	Population aged 65 and older, per cent 2015	Dependency ratio 2015	Life expectancy at birth (years), 2010-2015		Total fertility rate, per woman 2010-2015
								male	female	
Arab States	339	2.0	29	34	61	5	63.9	67	71	3.5
Asia and the Pacific	3865	1.0	25 b	25 b	68 b	7 b	46.3	68	72	2.2
Eastern Europe and Central Asia	265	0.8	22	22	68	10	47.7	68	76	2.0
Latin America and the Caribbean	629 a	1.1	26 c	26 c	67 c	8 c	50.1	71	78	2.2
East and Southern Africa	547	2.7	32	42	54	3	84.2	58	61	4.8
West and Central Africa	403	2.7	32	44	53	3	87.3	54	56	5.5
More developed regions	1251	0.3	17	16	66	18	51.5	76	82	1.7
Less developed regions	6098	1.4	26	28	66	6	52.5	68	72	2.6
Least developed regions	954	2.4	32	40	57	4	77.1	63	66	4.3
World	7349	1.2	25	26	66	8	52.3	69	74	2.5

NOTES

– Data not available.

a Figures exclude Netherlands Antilles due to data availability.

b Figures exclude Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

c Figures exclude Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, and Turks and Caicos Islands due to data availability.

1 Figures include Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

2 Figures include Nagorno-Karabakh.

3 For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

4 As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

5 As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China.

6 Figures include Northern-Cyprus.

7 Figures include Åland Islands.

8 Figures include Abkhazia and South Ossetia.

9 Figures include Saint-Barthélemy and Saint-Martin (French part).

10 Figures include Sabah and Sarawak.

11 Figures include Agalega, Rodrigues and Saint Brandon.

12 Figures include Transnistria.

13 Figures include Svalbard and Jan Mayen Islands.

14 Figures include East Jerusalem. On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine “nonmember observer State status in the United Nations...”

15 Figures include Kosovo.

16 Figures include Canary Islands, Ceuta and Melilla.

17 Figures include Zanzibar.

Technical notes

Data sources and definitions

The statistical tables in *The State of World Population 2015* include indicators that track progress toward the goals of the Programme of Action of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analyzing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data. In some instances, therefore, the data in these tables differ from those generated by national authorities. Data presented in the tables are not comparable to the data in previous issues of *The State of World Population* due to regional classifications updates, methodological updates, and revisions of time series data.

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates, and inter-agency estimates. They also include the latest population estimates and projections from World Population Prospects: The 2015 revision and Model-based Estimates and Projections of Family Planning Indicators 2015 (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources, and notes. The statistical tables in *The State of World Population 2015* generally reflect information available as of August 2015.

Monitoring ICPD goals: selected indicators

Maternal and newborn health

Maternal mortality ratio, per 100,000 live births. Updated maternal mortality ratios are not included in this report because they were not yet available when this publication went to press.

Births attended by skilled health personnel, per cent, 2006/2014.

Source: United Nations Inter-Agency and Expert Group on Millennium Development Goals Indicators. Regional aggregates calculated by UNFPA based on data from United Nations Inter-Agency and Expert Group on Millennium Development Goals Indicators. Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a short training course, are not included.

Adolescent birth rate, per 1,000 women aged 15-19, 1999/2014.

Source: United Nations Population Division and United Nations Inter-Agency and Expert Group on Millennium Development Goals Indicators. UNFPA regional aggregates calculated by UNFPA based on data from United Nations Population Division. The adolescent birth rate represents the risk of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

Sexual and reproductive health

The United Nations Population Division produces a systematic and comprehensive set of annual, model-based estimates and projections for a range of family planning indicators for a 60-year time period. Indicators include contraceptive prevalence, unmet need for family planning, total demand for family planning and the percentage of demand for family planning that is satisfied among married or in-union women for the period from 1970 to 2030. A Bayesian hierarchical model combined with country-specific time trends was used to generate the estimates, projections and uncertainty assessments. The model advances prior work and accounts for differences by data source, sample population, and contraceptive methods included in measures of prevalence. More information on family planning model-based estimates, methodology and updates can be found at <<http://www.un.org/en/development/desa/population>>. The estimates are based on the country-specific data compiled in World Contraceptive Use 2015.

Contraceptive prevalence rate, women currently married/in union aged 15-49, any method and any modern method, 2015.

Source: United Nations Population Division. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of married women (including women in consensual unions), aged 15-49, who are currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods.

Unmet need for family planning, women aged 15-49, 2015.

Source: United Nations Population Division. Unmet need for family planning. Women with unmet need for spacing births are those who are fecund and sexually active but are not using any method of contraception, and report wanting to delay the next child. This is a subcategory of total unmet need for family planning, which also includes unmet need for limiting births. The concept of unmet need

points to the gap between women's reproductive intentions and their contraceptive behavior. For MDG monitoring, unmet need is expressed as a percentage based on women who are married or in a consensual union.

Proportion of demand satisfied, women currently married/ in union aged 15-49, 2015. Source: United Nations Population Division. Percentage of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied.

Proportion of demand satisfied (PDS) = Contraceptive prevalence (CPR) divided by total demand for family planning (TD).

Where total demand = Contraceptive prevalence rate plus unmet need for contraception rate (UNR), that is

TD = CPR + UNR and

PDS = CPR / (CPR + UNR)

Education

Male and female adjusted primary school enrolment, net per cent of primary school-age children, 1999/2014. Source: UNESCO Institute for Statistics (UIS). The adjusted primary school net enrolment ratio indicates the percentage of children of the official primary age group who are enrolled in primary or secondary education.

Male and female secondary school enrolment, net per cent of secondary school-age children, 1999/2014. Source: UNESCO Institute for Statistics (UIS). The secondary school net enrolment ratio indicates the percentage of children of the official secondary age group who are enrolled in secondary education.

Gender parity index, primary education, 1999/2014. Source: UNESCO Institute for Statistics (UIS). The gender parity index (GPI) refers to the ratio of female to male values of adjusted primary school net enrolment ratio.

Gender parity index, secondary education, 1999/2014. Source: UNESCO Institute for Statistics (UIS). The gender parity index (GPI) refers to the ratio of female to male values of secondary school net enrolment ratio.

Demographic indicators

Total Population, in millions, 2015. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. These indicators present the estimated size of national populations at mid-year.

Average annual rate of population change, per cent, 2010/2015. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population

Division. These figures refer to the average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population aged 10-24, per cent, 2015. Source: UNFPA calculation based on data from United Nations Population Division. These indicators present the proportion of the population between age 10 and age 24.

Population aged 0-14, per cent, 2015. Source: UNFPA calculation based on data from United Nations Population Division. These indicators present the proportion of the population between age 0 and age 14.

Population aged 15-64, per cent, 2015. Source: UNFPA calculation based on data from United Nations Population Division. These indicators present the proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent, 2015. Source: UNFPA calculation based on data from United Nations Population Division. These indicators present the proportion of the population between age 65 and older.

Dependency ratio, 2015. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. These indicators present the ratio of dependents (people younger than 15 or older than 64) to the working-age population (those ages 15-64). Data are shown as the proportion of dependents per 100 working-age population.

Male and female life expectancy at birth (years), 2010/2015. United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. These indicators present the number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Total fertility rate, 2010/2015. United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. These indicators present the number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Regional Classification

UNFPA averages presented at the end of the statistical tables are calculated using data from countries and areas as classified below. The regional classifications include only the countries where UNFPA works.

Arab States Region

Algeria; Djibouti; Egypt; Iraq; Jordan; Lebanon; Libya; Morocco; Oman; Palestine; Somalia; Sudan; Syrian Arab Republic; Tunisia; Yemen

Asia and Pacific Region

Afghanistan; Bangladesh; Bhutan; Cambodia; China; Cook Islands; Fiji; India; Indonesia; Iran (Islamic Republic of); Kiribati; Korea, Democratic People's Republic of; Lao People's Democratic Republic; Malaysia; Maldives; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Nepal; Niue; Pakistan; Palau; Papua New Guinea; Philippines; Samoa; Solomon Islands; Sri Lanka; Thailand; Timor-Leste, Democratic Republic of; Tokelau; Tonga; Tuvalu; Vanuatu; Viet Nam

Eastern Europe and Central Asia Region

Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Bulgaria; Georgia; Kazakhstan; Kyrgyzstan; Moldova, Republic of; Romania; Serbia; Tajikistan; The former Yugoslav Republic of Macedonia; Turkey; Turkmenistan; Ukraine.

East and Southern Africa Region

Angola; Botswana; Burundi; Comoros; Congo, Democratic Republic of the; Eritrea; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; Seychelles; South Africa; South Sudan; Swaziland; Tanzania, United Republic of; Uganda; Zambia; Zimbabwe

Latin American and the Caribbean Region

Anguilla; Antigua and Barbuda; Argentina; Aruba; Bahamas; Barbados; Belize; Bermuda; Bolivia (Plurinational State of); Brazil; British Virgin Islands; Cayman Islands; Chile; Colombia; Costa Rica; Cuba; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Montserrat; Netherlands Antilles; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Suriname; Trinidad and Tobago; Turks and Caicos Islands; Uruguay; Venezuela (Bolivarian Republic of)

West and Central Africa Region

Benin; Burkina Faso; Cameroon, Republic of; Cape Verde; Central African Republic; Chad; Congo, Republic of the; Côte d'Ivoire; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; São Tomé and Príncipe; Senegal; Sierra Leone; Togo

More developed regions comprise Europe, Northern America, Australia/New Zealand and Japan.

Less developed regions comprise all regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43) included 49 countries in June 2013: 34 in Africa, 9 in Asia, 5 in Oceania and one in Latin America and the Caribbean. The group includes 49 countries —Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, São Tomé and Príncipe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Sudan, Sudan, Timor-Leste, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen and Zambia. These countries are also included in the less developed regions.

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HUMANITARIAN GLOSSARY



COMPLEX EMERGENCY

A multifaceted humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from internal or external conflict and which requires a multi-sectoral, international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country programme. Such emergencies have, in particular, a devastating effect on children and women, and call for a complex range of responses.



DIRECT AND INDIRECT EFFECT

A direct effect is a death or other outcome which occurred directly and primarily because of a catastrophic event. An indirect effect is a death or other outcome which occurred as an eventual, but not immediate, result of a single destructive act. Often these outcomes can be identified only on a population basis, where direct effects can be specified to the individual. For example, if the mortality rate rises after an event and there is no other cause identified, these additional deaths are considered the indirect effect of the event.



HUMAN RIGHTS

All human rights derive from the dignity and worth inherent in the human person. The concept of human rights acknowledges that every single human being is entitled to enjoy his or her human rights without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.



HUMANITARIAN ACTION

Humanitarian action provides life-saving services and facilitates the return to normalcy for people and communities affected by natural and human-made disasters. It also seeks to lessen the destructive impact of disasters and complex emergencies.



HUMANITARIAN CRISIS

An event or series of events that represents a critical threat to the health, safety, security or well-being of a community or other large group of people, usually over a wide area. Armed conflicts, epidemics, famine, natural disasters and other major emergencies may all involve or lead to a humanitarian crisis.



HUMANITARIAN RESPONSE

Material and logistical assistance to people due to needs created by conflict or disaster, and provided on the basis of an appeal by the government or international organizations.



INTERNALLY DISPLACED PERSONS

Individuals who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid, the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.



NATURAL DISASTER

A large-scale event where life and/or property is destroyed. For an event to be recorded as a disaster in the internationally recognized Centre for Research on the Epidemiology of Disasters database, at least one of the following criteria must be met:

- Ten or more people reported killed.
- One hundred or more people reported affected.
- A declaration of a state of emergency.
- A call for international assistance.

Natural disasters include droughts, earthquakes, epidemics, extreme heat or cold, floods, storms, tsunamis, volcanic eruptions and wildfires.



PEOPLE AFFECTED BY CONFLICT OR DISASTER

Individuals requiring immediate assistance during a period of emergency, i.e., requiring basic survival needs such as food, water, shelter, sanitation and immediate medical assistance as the result of the emergency.



REFUGEE

A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality, and is unable to, or owing to such fear, is unwilling to avail himself or herself of the protection of that country.



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