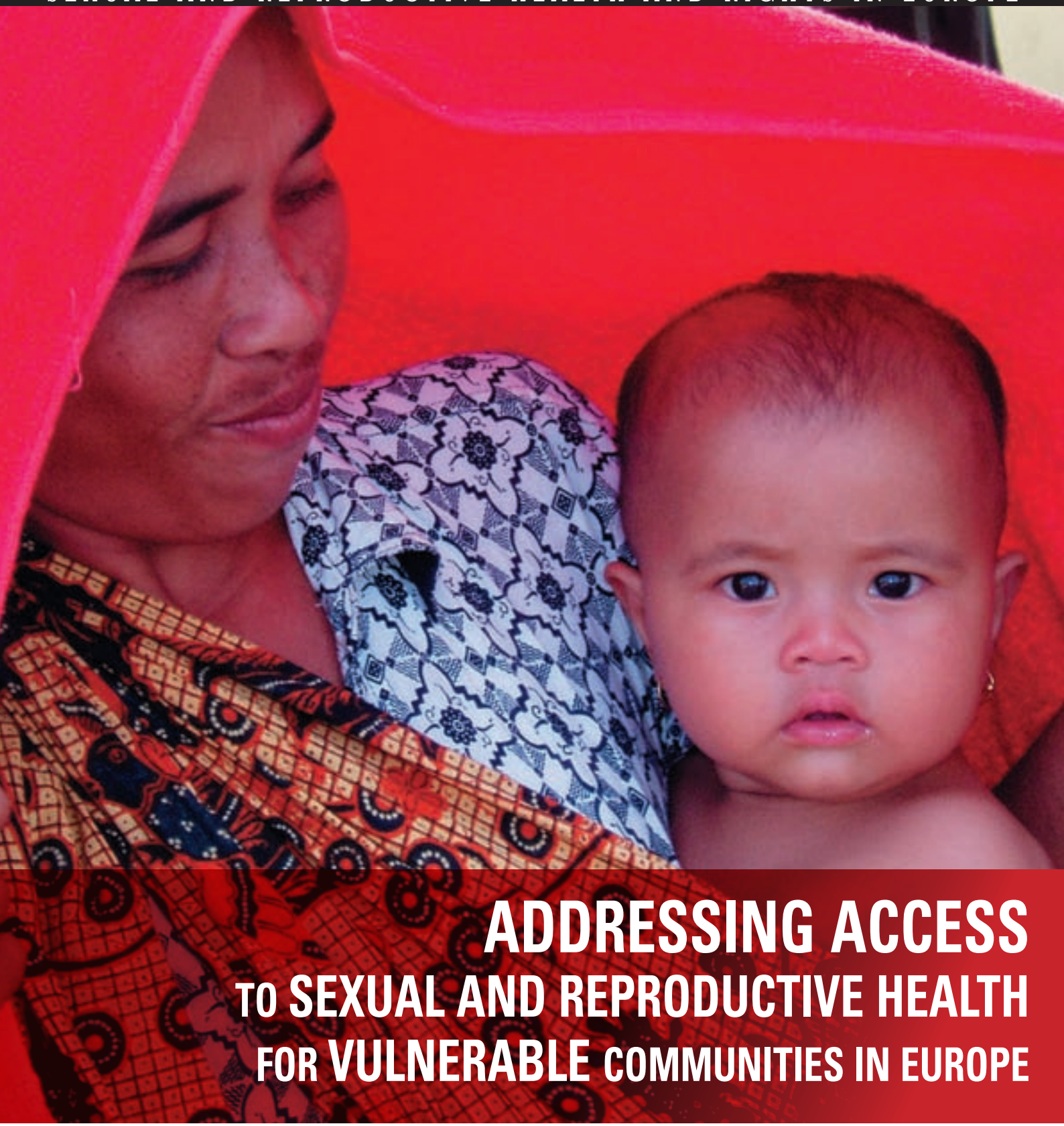
CHOICES

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE



ADDRESSING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH FOR VULNERABLE COMMUNITIES IN EUROPE

IPPF International Planned Parenthood Federation
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Responding to challenges in and internally displaced persons

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Every year, millions of people around the world flee their homes to escape conflict and violence. Exposure to violence, lack of protection, education and health care, poverty without livelihood opportunities and separation from families and communities cause refugees and internally displaced persons (IDPs)[1] to face extraordinary difficulties that affect their reproductive health and rights.

Rape, increasingly used as a weapon of war, as well as sexual exploitation, put refugee and IDP women and girls at risk of sexually transmitted infections (STIs), including HIV/AIDS, unwanted and high-risk pregnancies, unsafe abortions and death. Lack of access to reproductive health (RH) services, including safe motherhood and emergency obstetric services, family planning, protection from violence and care for survivors of sexual violence, and prevention of the transmission of HIV/AIDS and care for people living with AIDS, also put refugees and IDPs at heightened risk of sexual and reproductive morbidity and mortality. Uprooted adolescents, who are especially vulnerable to sexual violence, exploitation and HIV/AIDS, often face multiple barriers to accessing RH services and information.

The Women's Commission for Refugee Women and Children (Women's Commission), founded in 1989 under the support of the International Rescue Committee, is an expert advocacy organization which works to improve the lives and defend the rights of refugee and IDP women, children and adolescents. The Women's Commission first documented the lack of RH services for refugees and IDPs in its seminal report, *Refugee Women and Reproductive Health Care: Reassessing Priorities* in 1994.The findings from this report were advocated and corroborated by refugee women themselves at the International Conference on Population and Development (ICPD) in 1994 where the rights of refugees and IDPs to RH were specifically recognized in the Programme of Action.

reproductive health for refugees

In 1995, two key consortia, the Reproductive Health Response in Conflict (RHRC) Consortium[2], a network of seven NGOs, and the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Settings[3], composed of approximately 40 United Nations, government and international organizations, were established to improve refugee and IDPs' access to comprehensive good quality RH services. The RHRC Consortium implemented a strategy to address RH advocacy, service delivery, research, documentation, training and small grants support for local and international organizations, while the IAWG developed the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*[4] which outlined both the initial minimum and comprehensive services in refugee and IDP settings, and also served to coordinate efforts among humanitarian actors to improve refugee and IDP's access to comprehensive good quality RH services.

Progress, Gaps and Challenges Ahead

A recent UN inter-agency global evaluation of RH for refugees and IDPs shows that significant progress has been made in raising awareness and advancing RH for refugees in all areas of RH in stable camp settings. However, gaps do remain, particularly components of safe motherhood and emergency obstetric care, family planning, treatment of STIs and the newer areas of gender-based violence (GBV) and HIV/AIDS programming. In addition, more services are needed to meet the needs of youth and address male involvement[5].

The current US government is taking a more restrictive stance on women's reproductive heath and rights. This is having an alarming effect on refugees and IDPs – some international agencies that receive US funding are avoiding public endorsement of RH. This is particularly evident with any activity that would demonstrate a public endorsement of the RH services that have recently become more controversial, such as emergency contraception (EC), post-abortion care, use of condoms and adolescent RH. Diminished political support for RH combined with reduced funding for these programmes is devastating to the lives of millions of refugees and IDPs around the world.

Safe Motherhood

Every year more than 525,000 women die from maternal causes[6]. The desperate circumstances of refugee and IDP women fleeing conflict place them at further risk of pregnancy-related illness, disability and death. Childbirth may take place in a ditch alongside the road, in the forest or in a makeshift shelter. Once they arrive in an area of relative safety, whatever health services displaced women were familiar with before their flight are no longer available to them.

A decade of war and ethnic fighting in Bosnia and Herzegovina destroyed a large part of the health infrastructure, health services and systems that existed before the war. The International Rescue Committee, in collaboration with local staff, implemented one pilot project to improve comprehensive emergency obstetric care (EmOC) at Bihac, Mostar and Gorazde hospitals in three cantons of Bosnia and Herzegovina. Specific activities and outcomes included: provision of medical equipment and essential medications; establishment of a sustainable revolving fund for essential medicines; provision of in-service training for health professions on skills such as manual vacuum aspiration and contraceptive services; upgrade of laboratory facilities; and improved systematic data collection. At the end of the project improved utilization of facilities was demonstrated through increased numbers of deliveries and EmOC complications managed by staff at Bihac hospital though the numbers remained unchanged for Mostar and Gorazde hospitals.

Contraception

Recent global evaluations show that contraceptives are much more widely available than a decade ago, particularly for refugees in stable camp settings. However, it is essential to address the remaining challenges of ensuring quality service provision and increased usage, particularly among IDPs. It is also important to plan to make contraceptives available at the start of a crisis, because displaced women are known to request these supplies early in an emergency, as they did in Indonesia following the Tsunami.

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[1] Refugees have crossed an international border while IDPs have not, but their circumstances are similar.
[2] Reproductive Health Response in Conflict Consortium, formerly known as the Reproductive Health for Refugees Consortium, comprises seven agencies: American Refugee Committee, CARE International, Columbia University Heilbrunn Department of Population and Family Health, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International, Women's Commission for Refugee Women and Children.
[3] Inter-agency Working Group on Reproductive Health was established by UNHCR, UNFPA and WHO.
[4] United Nations High Commissioner for Refugees (UNHCR), Reproductive Health in Refugee Situations: An Inter-agency Field Manual. Geneva, UNHCR 1999.
[5] UNHCR, Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, November 2004, Geneva.
[6] WHO, UNICEF and UNFPA, Maternal mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA, 2000.

Although emergency contraception (EC) is not a form of abortion and does not work if a woman is already pregnant, it is politically controversial in the United States and there is an unfortunate chilling effect on its use in conflict-affected settings where there are even more compelling reasons for its use. For example, displaced populations are vulnerable to sexual exploitation, and unintended sexual intercourse or breakage of a condom could be especially dire for displaced women and their families in the desperate circumstances of emergency settings.

STIs/HIV/AIDS

In crisis situations, refugees and IDPs may be especially vulnerable to STIs, including HIV/AIDS, and if not addressed, STIs can spread rapidly among the displaced population.

Effective measures for the prevention and treatment of STIs and HIV/AIDS are available but often poorly implemented. The lack of training, skills and user-friendly guidelines for humanitarian workers contribute to the problem.

Gender-based Violence

Throughout history, gender-based violence (GBV) has been an integral component of armed conflict. Sexual violence is often systematic, for the purposes of destabilizing populations and destroying bonds within communities and families, advancing ethnic cleansing, and expressing hatred for the enemy. Protecting conflict-affected women from sexual violence and ensuring survivors of sexual violence receive appropriate care is not adequately addressed in humanitarian emergencies.

The Women's Commission is addressing, in collaboration with the RHRC Consortium and IAWG, RH service gaps such as adolescent reproductive health, emergency contraception, STI/HIV/AIDS and emergency obstetric care by supporting technical capacity-building on RH for humanitarian service providers.

We also aim to prevent rollbacks in US government support and policies, and to increase Canadian and European Union governments' support of RH for refugees and IDPs. We are working with a broad coalition of partners, deliberately going beyond the "usual suspects" in the RH field to include human rights, faith-based, research and academic organizations to garner a united response in support of RH for refugees and IDPs, as needed. We are also working to increase attention to key RH issues and services at the field level, such as EC and adolescent RH – controversial issues that are vulnerable to cutbacks if pressure is not maintained.

In collaboration with the RHRC Consortium, IAWG and others, the Women's Commission has produced and continues to globally disseminate numerous advocacy documents, guidelines, training materials and resources that address the specific gaps in the technical areas of RH for refugees and IDPs. Other activities that facilitate RH technical support and services at the field level include piloting "model" projects to demonstrate the feasibility of specific RH programming in humanitarian emergencies in order to facilitate replication by humanitarian actors.

Conclusion

Significant achievements have been made in advancing RH for conflict-affected populations over the past decade, yet there are still major gaps in RH technical areas, in RH programming in the early days and weeks of new emergencies, and for IDP populations. The challenging political and economic climate threatens this progress. Scientific-based policies and funding are essential to realize the use of the relevant RH technical resources in the field and to ensure good quality, comprehensive reproductive health services are provided in conflict settings by adequate numbers of well-qualified staff.

For more information about the Women's Commission for Refugee Women and Children, visit: www.womenscommission.org

Photos: Julia Matthews and Mary Diaz/Women's Commission