

Sexual and Reproductive Health, Rights and Services

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Sexual and reproductive health, rights and services (SRH R&S) are important for everyone. Men and boys often suffer from a lack of sexual and reproductive rights through inadequate access to information, services and care, but women and young girls of childbearing age are generally more vulnerable to sexual assaults and reproductive ill-health. This is exacerbated in situations of conflict when women are exposed to increased levels of violence, lack of security and poor access to safe medical health services.

In the early 1990s, a number of factors focused global attention on the provision of reproductive rights, health and services to refugees and displaced populations. Crises in the **former Yugoslavia** and **Rwanda** heightened awareness of the specific reproductive health needs of refugee women. As a response, the Women's Commission for Refugee Women and Children published a report highlighting the increased health risks women face in refugee settings.¹ The report noted the serious neglect of many aspects of reproductive health care in these situations and called for increased international attention to the provision of full reproductive health services.

In 1994, at the **International Conference on Population and Development (ICPD)** in Cairo, 179 countries agreed on a plan to transform and fund reproductive health programmes. The final document and **Programme of Action (PoA)** call for universal access to basic reproductive health services and specific measures for fostering human development and the social, economic and health status of women.² Despite sound arguments based on public health concerns, human rights and social justice, in many countries comprehensive reproductive health care is still insufficiently understood or applied. The situation is even worse in conflict and post conflict situations.³ This chapter examines reproductive health issues, rights and services that affect populations primarily within conflict and post conflict situations.

1. WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH, RIGHTS AND SERVICES?

Reproductive health is defined by the PoA of the ICPD as “a state of complete physical, mental and social well-being in all matters relating to the reproductive health system and to its function and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so.”⁴ Reproductive health is not merely about the absence of disease or infirmity.

Reproductive and sexual rights, according to the ICPD, include human rights already recognised in national laws and in international human rights documents such as the Universal Declaration on Human Rights. They include a person's right to:

- information, education, skills, support and services needed to make responsible decisions about sexuality consistent with their own values;
- bodily integrity and voluntary sexual relationships;
- a full range of voluntary and accessible sexual and reproductive health services;

- express one's sexual orientation without violence or discrimination;
- decide freely and responsibly the number, spacing and timing of their children and the information and means to do so;
- attain the highest standard of sexual and reproductive health; and
- make decisions concerning reproduction free of discrimination, coercion or violence.

Sexual and Reproductive Health Rights and Services (SRH R&S) covers a wide range of services and rights defined in the PoA that contribute to reproductive health and well-being by preventing and solving reproductive and sexual health problems. These include family planning, counselling, information, education, communication and services; education and services for prenatal care; infant and women's health care; prevention and appropriate treatment of infertility; prevention of abortion (although prevention of unwanted pregnancies is given the highest priority); provision of safe abortion services (where legal) and the management of the consequences of abortion; treatment of infections of the reproductive organs; sexually transmitted infections (STIs) including HIV/AIDS; breast cancer and cancers of the reproductive system; and active discouragement of harmful traditional practices such as female genital mutilation (FGM).⁵

REPRODUCTIVE HEALTH OF WOMEN AND GIRLS

Reproductive behaviour is governed by complex biological, cultural and psychosocial relations; therefore, reproductive health must be understood within the context of relationships between men and women, communities and societies. Women bear the greatest burden of reproductive health problems and their vulnerability to reproductive ill-health is increased by biological, cultural, social and economic factors.⁶

The challenge often starts in childhood. For example, a female child who is malnourished from birth, or who is subjected to harmful traditional practices such as FGM,⁷ may enter adolescence and adulthood with anaemia and other physical problems as well as psychosexual trauma related to the traditional

practice. This can cause problems during pregnancy and childbirth. Women who have undergone FGM can have problems relating to menstruation, pregnancy and childbirth.

Adolescent girls are often at risk of unwanted pregnancies and are vulnerable to STIs, including HIV/AIDS, due to their lack of accurate information about reproduction and access to reproductive health services, including contraception.⁸ In conflict-affected societies, adolescent girls are particularly vulnerable to sexual abuse and rape. Pregnancy and childbirth during this period carry considerable risks. Girls 15–19 years old are twice as likely to die in childbirth as women in their twenties. An estimated 46 million abortions are carried out annually across the world. Approximately 20 million are considered to be unsafe,⁹ and between 25 to 30 percent are carried out on adolescent girls.¹⁰

FAMILY PLANNING, CONTRACEPTION AND PREGNANCY

A woman's ability to space or limit the number of her pregnancies, as well as the outcome of her pregnancy, has a direct impact on her health and well-being. In enabling women to exercise their reproductive rights, family planning programmes can improve the social and economic circumstances of women and their families. The World Health Organization (WHO) estimates that about 123 million women around the world, mostly in developing countries, do not use contraception despite their expressed desire to space or limit the number of pregnancies and births they may have.¹¹ Family planning needs are often not met due to poor access to quality services, a limited choice of contraception methods, lack of information, concerns about safety or side effects or a partner's disapproval.

Pregnancy and childbirth bring their own particular problems. Every day it is estimated that 1,600 women in developing countries die from complications during pregnancy. In addition to maternal deaths, half of all the estimated eight million infants born each day die in the first month of life, due primarily to inadequate maternal care during pregnancy. If women were healthy during pregnancy and had access to basic medical care before, during and after childbirth, the majority of mother and infant deaths could be prevented.¹²

An estimated 28 percent of all pregnancies occurring around the world every year are unintended.¹³ According to WHO, millions of women around the world risk their lives and health to end unwanted pregnancies. Every day, 55,000 unsafe abortions take place with 95 percent of them occurring in developing countries. This can lead to the deaths of more than 200 women daily. Globally, one unsafe abortion takes place for every seven births.¹⁴ WHO estimates that globally, one maternal death in eight is due to abortion-related complications. In some settings a quarter or more of all maternal deaths are abortion-related.¹⁵

Many women are afraid to seek treatment for abortion-related complications, leading to countless deaths outside of hospitals. Between 10 and 50 percent of all women who undergo unsafe abortions need immediate medical care for related complications including haemorrhages. Long-term health problems range from chronic pelvic pain to infertility. Such problems can limit women's productivity inside and outside the home, hinder their ability to care for children and adversely affect their sexual and reproductive lives.¹⁶

Yet unsafe abortion is one of the most easily preventable and treatable causes of maternal death and injury. During the ICPD, governments recognised unsafe abortion to be a major public health issue and called for prompt, high quality and humane medical services to treat the complications resulting from unsafe abortion. They also called for compassionate post-abortion counselling and family planning services to promote reproductive health, reduce the need for abortion and prevent further unsafe abortions. Governments also called for the provision of safe abortion services where they are not against the law.¹⁷

REPRODUCTIVE ILL HEALTH

Research has shown that reproductive ill health accounts for approximately 36 percent of the total disease burden among women of reproductive age (15–44 years) in developing countries, compared to an estimated 12.5 percent in men. For women, three conditions are particularly relevant: pregnancy-related deaths and disabilities, STIs and HIV/AIDS.¹⁸ A number of factors increase women's vulnerability to reproductive ill health, including:

- restrictions on information about sexuality, condoms and other contraception, disease, prevention and healthcare;
- harmful traditional practices such as ritual intercourse with a male relative after the death of a husband, FGM, ritual scarification, tattooing and bloodletting;
- early marriage;
- inability to negotiate safe sex;
- discrimination against women in education, employment and social status;
- laws that reinforce women's economic dependency on men and reliance on prostitution for economic survival (of adults and children); and
- war, famines, natural disasters, political oppression, poverty and displacement.

2. HOW DOES CONFLICT AFFECT THE DELIVERY OF REPRODUCTIVE HEALTH AND SERVICES?

During conflicts, health services and health facilities may be destroyed and health personnel may become targets. During the genocide in **Rwanda**, over half of the health workers were killed. In **Bosnia and Herzegovina**, 40 percent of physicians left the country and did not return. Sanctions against countries in conflict may also affect women's reproductive health and their access to health care and services. In **Iraq**, after the Gulf War, women's access to gynaecological care decreased and in **Serbia**, during the sanctions period, more women between the ages of 25–44 years died than in the previous years.¹⁹

Conflict also adversely affects the safe and effective delivery of SRH R&S in various ways, including the breakdown of health services, forced mobility of refugees and internally displaced persons (IDPs) and malnutrition and epidemics that diminish the strength and immunity of ill and breast-feeding women. Women's vulnerability is exacerbated in situations of conflict because of increased levels of violence, lack of security and poor access to safe medical health services. For example, much of **East Timor's** medical facilities were destroyed during the violent conflict and unrest there, thus affecting the

reproductive health of countless women.²⁰ In **Bougainville**, the blockade by the **Papua New Guinean Defence Force (PNGDF)** and the destruction of hospitals and health clinics severely affected maternal and child health.²¹ In **Afghanistan** in 2001, hundreds of Afghans crossed the **Iran** and **Pakistan** borders, among them thousands of pregnant women fleeing violent conflict.²² Poor Afghan health services and the rise of malnutrition increased the dangers to women during pregnancy and childbirth. Additionally, the **United Nations Development Fund for Women (UNIFEM)** reports that African countries with the highest maternal death rates—including the **Democratic Republic of the Congo (DRC)**, **Sierra Leone** and **Eritrea**—are also countries that have experienced years of conflict and instability.²³

THE VULNERABILITY OF WOMEN: SEXUAL AND GENDER-BASED VIOLENCE (GBV)

The term sexual- and gender-based violence (GBV) includes a variety of abuses, sexual threats and coercion, exploitation, molestation, humiliation, incest, trafficking, smuggling, forced marriage and forced prostitution²⁴ (see chapters on HIV/AIDS and peace support operations). This section focuses primarily on rape and domestic violence.

The United Nations High Commission on Refugees (UNHCR) has stated that “during war and armed conflict, violations of human rights and gender-based violence increase dramatically. Gender-based violence and persecution are often adopted as tactics of war and terrorism. Indeed, recent history has all too often seen sexual violence and rape used deliberately and strategically as a weapon of war. Sadly this kind of abuse can follow a refugee woman throughout her life as a refugee.”²⁵ Additionally, the **United Nations Special Rapporteur on Violence Against Women** has highlighted the continuum of violence from the private to the public sphere. This was reinforced by many speakers at the recent high-level conference, *Gender Justice in Post Conflict Situations: Peace Needs Women and Women Need Justice*, organised by UNIFEM and the **International Legal Assistance Consortium (ILAC)**.²⁶

Rape and sexual violence as a weapon of war: Rape can be used as a symbol of domination, as a means

of instilling terror, as an instrument of torture, to dehumanise sections of the community, to impregnate as a means of ethnic cleansing, to infect with STIs and to destroy family and community relationships. It is estimated that in **Sierra Leone**, over 50 percent of women experienced sexual violence during the war and, during the collapse of the **former Yugoslavia** in the 1990s, over 20,000 **Bosnian** women were raped.²⁷

Between 2003 and 2004, the unprecedented level of violence, degradation and humiliation experienced by women in the **DRC** led many to call such actions “a war within a war and a war against women.”²⁸ In 2004 in **Darfur, Sudan**, the rape and sexual assault of women has been widespread and systematic.²⁹ In **Haiti**, research by the **Centre Haitien de Recherches et d’Actions pour la Promotion Feminine** highlighted that in 1996, 60 percent of women reported experiencing violence, 37 percent of whom had suffered sexual violence, including rape, sexual harassment and sexual aggression.³⁰

Women face sexual violence during all phases of the conflict and displacement. For example, during the years of conflict in **Bougainville**, both women and girls were at risk of rape.³¹ Perpetrators of violence often include:

- police, military, guerrilla forces, peacekeepers or prison officers in detention centres, concentration camps and rape camps. Male camp leaders use women as exchange for arms, ammunition or other benefits;
- bandits, pirates, smugglers and border guards. Members of the security forces can also demand sex in exchange for women’s safe passage into countries where they seek asylum or when they try to return to their homes;
- camp residents, the local population and international and national camp staff. Limited resources and lack of protection from male members of the family can leave women vulnerable to sexual exploitation; and
- hostile communities, government and security officials in post conflict situations.³² In addition, there may be a resurgence of FGM as a way of reinforcing cultural identity.

Women raped in conflict and post conflict settings may become pregnant, but often do not want to give birth to the children conceived in such circumstances. Some **Bosnian** and **Kosovar** women who became pregnant as a result of sexual violations chose abortion or abandoned their babies at birth.³³ One viewpoint within the health service community is that access to emergency contraception or the morning-after pill may be an inexpensive and effective means of ensuring that unsafe abortions are avoided.

Domestic violence: In conflict and post conflict situations, the roles undertaken by men and women are often reversed due to the breakdown of societal structures. Men who are not employed may be stressed and frustrated and may spend most of their time socialising or drinking. In such situations, the incidence of domestic violence also surges.³⁴ Surveys of **Sudanese** refugees in **northern Uganda** have highlighted a high rate of domestic violence due to inadequate employment opportunities for men. In **Angola**, during 1997–99, there were 3,550 cases of violence of different types against women, with 60 percent registered as domestic violence.³⁵ In some instances, this is related to men's stress and the humiliation they experience in the public sphere, often at the hands of state or official security forces.

In other cases, as men return home from war, they are often traumatised, accustomed to violent behaviour and not equipped to resolve issues non-violently. As a result, women are forced to live with the threat of violence on a daily basis. In many places, domestic violence in particular is still not regarded as a serious offence. Effective prevention strategies, therefore, must focus on men, changing their attitudes to gender-based violence (GBV) and building their support against such violence. In **Cambodia** and **South Africa**, for example, men's networks against domestic violence have emerged and, have begun campaigns to end violence against women.³⁶

THE VULNERABILITY OF MEN AND BOYS

As in the case of women, the SRH R&S of men and boys are affected in situations of conflict, displacement or detention. Sexual violence against adult males, adolescents and boys escalates. In conflict situations, men, like women, may experience humiliation and confusion about their sexuality. In some societies where men have been discouraged to be open about their feelings, they may find it very

difficult to recognise what has happened to them. With little or no services, they are often forced into silence and ignorance. In conflict situations, adult men and older boys may also be victims of sexual violence and gender-based abuse, such as sex-selective massacre and forced recruitment.³⁷

THE IMPACT OF MEN AND BOYS' ACTIONS ON THE REPRODUCTIVE HEALTH OF WOMEN

WHO has categorised men's impact on women's reproductive health as the following:³⁸

Men as service users: Men and boys are at risk of contracting STIs and HIV/AIDS during conflict and displacement as they may develop risky sexual relationships that increase their vulnerability. It is important that education on safe sex, STIs and HIV/AIDS counselling and services are accessible to all. Family planning programmes should deliberately target men, not only to inform them of the dangers associated with risky sexual behaviour, but also about effective family planning and how to care for their partners and children. Condom distribution programmes should also target men directly.

Men as recipients of education and social-behaviour programmes: There is a growing perception of the need to focus resources on programmes seeking to educate men and boys to change their attitudes and behaviour concerning SRH. Men's improved knowledge and access could protect and promote women's reproductive health and rights.

Men as decision-makers: Men may have an influential role in decision-making related to the provision of sexual and reproductive health care and services to communities and to their own families. In many cultures, men often make the final decisions about family planning, economic spending on SRH medical services or even on the type of ante-natal, pregnancy and breastfeeding care that their partners receive. At the community level, men as political, religious or other leaders, may also influence the type, quality and quantity of services and rights the community in general is allowed to receive.

REFUGEES, INTERNALLY DISPLACED PERSONS (IDPs) AND REPRODUCTIVE HEALTH CARE

While their need for comprehensive reproductive health care and services remains, refugees and

internally displaced persons (IDPs) often have limited access to such care. Where it does exist, it is often basic and for emergency purposes. In such situations women's vulnerability is increased. In **Colombia**, violence and displacement are leading causes of an increase in unsafe abortions,³⁹ while in IDP camps in **Sri Lanka**, births are less well-spaced, resulting in worse outcomes than before displacement.⁴⁰

During displacement, women also suffer a variety of mental health problems caused by the violence they experience, and this can affect their reproductive health. Studies conducted with **Afghan** women during the Taliban rule found that 97 percent of women suffered from depression, 86 percent displayed significant anxiety, 42 percent suffered post-traumatic stress disorder (PTSD) and 25 percent frequently contemplated committing suicide and did not want to become pregnant.⁴¹ Additionally, women's childbearing role exposes them to a range of potential problems including:

- stress and malnutrition, which endangers the health of pregnant and lactating women and their children;
- loss of the extended network of family support when a woman is pregnant and breast-feeding;
- lack of practical or emotional support for traumatised women;
- young, single, widowed or disabled women may be at particular risk of sexual violence;
- the breakdown of family and social networks can result in many female-headed households. These women may be forced to offer sex in exchange for food, shelter or protection; and
- social changes associated with conflict may erode women's authority to control their own reproductive lives. For example, women may be pressured to become pregnant to produce children to replace those who have died.

THE IMPACT OF CONFLICT ON THE SEXUAL REPRODUCTIVE HEALTH, RIGHTS AND SERVICES OF ADOLESCENTS

During conflict, the destruction of social structures adversely affects the emotional and psychological growth as well as the sexual development of adolescents. The absence of traditional forms of

guidance in the transition to adulthood may result in earlier and increased risk-taking behaviour, including the use or abuse of tobacco, drugs and alcohol. Poor nutrition and violence can be inflicted both by and on adolescents.

Their desire to plan for the future may diminish, affecting adolescents' motivation and ability to take the necessary steps to avoid STIs, HIV/AIDS and unwanted pregnancies. Adolescent girls, both married and unmarried, who become pregnant may find themselves without the support to cope with pregnancy, childbirth and raising a child.

The risks of unsafe abortion may also increase when both social support networks and health services are disrupted. The WHO representative in **Liberia** estimates that up to 80 percent of displaced girls have an induced abortion by the age of 15.⁴² Unaccompanied minors, whether boys or girls, are especially vulnerable to violence and other forms of sexual exploitation. They may turn to prostitution in order to survive. They are also far more vulnerable to poor health in general. In **El Salvador**, studies show that there is a high rate of suicide among refugee adolescents.⁴³ Additionally, the ideas of aggressive masculinity learned by child and adolescent soldiers can have a profound and long-term negative impact on their own reproductive health and on that of the communities with which they come into contact.

ADDRESSING SEXUAL REPRODUCTIVE HEALTH, RIGHTS AND SERVICES

Since the ICPD and the PoA, attention has focused extensively on women's SRH R&S. The rights of women in situations of conflict have been strengthened by **United Nations (UN) Security Council Resolution 1325** and other developments at the international level that condemn violence against women and call for effective care. Ongoing debates centre on the merits of comprehensive health care, including affordable, equitable and rights-based reproductive health that will take account of the needs of women and girls in refugee settings. However, the effective delivery of SRH services, especially during conflict, depends on political commitment as well as sustained and adequate funding.

Insufficient funding is made worse by the policies of some governments. The US government, the largest supporter of reproductive health services for refugees

and IDPs, has currently withdrawn or restricted the use of funding for some UN agencies and other organisations. The **Mexico City Policy** (also known as the Global Gag Rule) restricts **United States Agency for International Development (USAID)** funding to organisations that are involved in abortions and abortion-related cases that have not received prior approval.⁴⁴ Other donors such as the **European Union (EU)** have tried to fill the gap, but as the funding priorities of donors shift, the ability to maintain current levels of SRH services is threatened. Moreover, an estimated 37 million displaced persons are also at risk. Many programmes, including HIV/AIDS prevention, have been reduced and family planning, the provision of contraceptives and other services, have been cut. This increases health risks and endangers the lives of the many women, men and children living in conflict-affected situations.⁴⁵

With the increased focus on HIV/AIDS, there is also the danger that attention will be focused primarily on this disease, rather than on a comprehensive address of health care needs that also includes attention to other infectious STIs such as chlamydia, syphilis or gonorrhoea.⁴⁶

3. WHAT INTERNATIONAL MANDATES AND POLICIES EXIST TO ADDRESS AND DELIVER SRH R&S ?

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Article 12 of CEDAW requires states to eliminate discrimination against women in access to health services throughout their life cycle, particularly in the areas of family planning, pregnancy and childbirth. The Convention stressed that access to health care, including reproductive health, is a basic right.⁴⁷ It also calls on governments to provide appropriate services relating to pregnancy, birth and breast-feeding.⁴⁸

The Convention on All Forms of Racial Discrimination promotes the right to the highest standard of health, including reproductive health in paragraph 5e (IV).⁴⁹

The **International Conference on Population and Development (Cairo, Egypt, 1994)** resulted in the PoA that sets out the context of health promotion

and protection in all situations, including reproductive health. Paragraphs 7.2–8.35 calls on governments to take a number of actions to promote the right of an individual to the highest standard of health, including reproductive health and rights. The Review of the ICPD deals with the issue in paragraphs 52–72.⁵⁰

The Beijing Platform for Action (BPFA, 1995) and Beijing +5 (2000): The BPFA incorporated much of the ICPD language on reproductive rights. The platform states that “good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.” It further states that “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”⁵¹

International Covenant on Economic Social and Cultural Rights (ICESCR): Article 12 of the ICESCR recognises the right of everyone to the highest standard of physical and sexual health. Governments are required to take all steps necessary to reduce stillbirths and maternal deaths.⁵²

The Convention on the Rights of the Child (CRC) recognises the responsibility of governments to promote the rights of children (see chapter on children’s security). It also promotes the right to family planning services. Article 24 requires government to ensure appropriate prenatal and postnatal health care for mothers. Article 34 requires governments to protect the child from all forms of sexual exploitation and sexual abuse, and asks governments to take all effective and appropriate measures with a view to abolishing traditional practices that harm the health of children. Nearly all governments have signed this convention. It is therefore a strong tool for holding governments accountable.⁵³

United Nations Special Rapporteur on Violence Against Women: Since the appointment of a Special Rapporteur on violence against women in 1994, the UN has received regular reports on the prevalence of different forms of violence, the legal responses that exist and recommendations for action. These

reports, available in English, French and Spanish, address violence within the family, including battery, marital rape, incest, forced prostitution, violence against domestic workers, child abuse and female infanticide; violence in the community, including rape, sexual violence and sexual harassment; trafficking in women and forced prostitution; violence against migrant workers and refugees; violence against women in wartime and in the criminal justice system; and religious extremism. The Special Rapporteur on Violence Against Women has also addressed policies and practices that have an impact on women's reproductive rights.⁵⁴

UN Security Council Resolution 1325 (October 2000): While this resolution does not specifically mandate the protection of women's SRH R&S, it does call on all parties to armed conflict to take specific measures to protect women and girls from gender-based violence.⁵⁵

4. WHO IS INVOLVED IN THE PROVISION OF SEXUAL AND REPRODUCTIVE SERVICES?

Many organisations and agencies are involved in the provision of sexual and reproductive health care services. They include UN agencies, bilateral aid agencies, governments and international and national non-governmental organisations (NGOs), some of which are noted below.

UN AGENCIES

United Nations High Commissioner for Refugees (UNHCR): This agency leads and coordinates international action to protect refugees and resolve their problems worldwide (see chapter on refugees and IDPs). Its primary purpose is to safeguard the rights and well-being of refugees. In addition, UNHCR has produced practical guides such as *Sexual Violence Against Refugees: Guidelines and Prevention, A Response* (UNHCR 1995) and *An Inter-Agency Field Manual on Reproductive Health in Refugee Situations* (UNHCR 1999).⁵⁶

United Nations Population Fund (UNFPA): UNFPA is the world's largest international source of funding for population and reproductive health programmes. UNFPA works with governments

(including of countries affected by conflict) and NGOs in over 140 countries, at their request and with the support of the international community. UNFPA support programmes that help women, men and young people to plan their families and avoid unwanted pregnancies; to undergo pregnancy and childbirth safely; to avoid STIs, including HIV/AIDS; and to combat violence against women. UNFPA has produced a reproductive health kit for emergency situations to facilitate the implementation of the *Minimum Initial Service Package (MISP)*. These kits contain basic reproductive health materials for use at care centres. They include condoms, oral and injectable contraceptives, drugs for the treatment of STIs and kits with emergency contraception for women.⁵⁷

World Health Organization (WHO): WHO promotes the attainment by all peoples of the highest possible level of health and health care. WHO has designed a management guide titled *Reproductive Health during Conflict and Displacement: A Guide for Programme Managers* (2000). The Guide provides tools to assess, plan, implement and evaluate reproductive health within the broader context of planning and preparation for conflict and emergencies. It includes guiding principles. The WHO Guide also endorses a core package of reproductive health care measures and provides details of the implementation and actual delivery of the package of services. This guide is an orientation, awareness-raising and training tool for health care providers.⁵²

The Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG): IAWG was set up in 1995 to strengthen reproductive health programmes in refugee situations. It is made up of about 30 organisations, including NGOs, UN agencies and academic institutions. The IAWG has produced the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* to facilitate the introduction of reproductive health services in all refugee settings.^{59 60}

At the regional level, there is **The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**. Article 14 on Health and Reproductive Rights requires that governments respect and promote women's right to health. This includes control of their fertility, the right to decide

whether and when to have children and, protection against sexually transmitted infections—including HIV/AIDS—as well as the right to information about their own and their partners' health.⁶¹

Within the EU there is the *Communication from the Commission to the Council and the European Parliament: Health and Poverty Reduction in Developing Countries*.⁶² The European Commission adopted its Health and Poverty Communication in March 2002. This commits the EU to protect the most vulnerable people from poverty through support for equal and fair health. The EU's development policy on sexual and reproductive health is based on the ICPD's PoA. The EU policy also reflects the specific targets of the Millennium Development Goals (MDGs) that call for the empowerment of women and the reduction in maternal and child mortality.

Bilateral agencies such as the **Canadian International Development Agency (CIDA)** support empowering girls and women through better access to education, more economic and political participation in their communities and health services geared toward reproductive health and fewer and safer pregnancies. Protecting women against violence is also becoming an increasingly important health and development issue. The **Swedish International Development Cooperation Agency (SIDA)** has produced an Issue Paper on *Health and Human Rights*, which sets out SIDA's Department for Democracy and Social Development Health Division's policy on an individual's health.⁶³

Additionally, USAID, one of the most influential funders of reproductive rights and services, has a Global Health programme that includes a focus on, and funding for, child survival and maternal health, HIV/AIDS, infectious diseases, family planning and reproductive health.⁶⁴

NGOs AND OTHER AGENCIES

The **Marie Stopes International (MSI) Global Partnership** is at the forefront of worldwide initiatives to institutionalise reproductive health care in refugee settings. Active in 37 countries worldwide, the initiative collaborates with national governments and non-governmental actors, providing training in a range of issues and health care services to target populations.

The **Women's Commission** was founded in 1989 and is an independent affiliate of the International Rescue Committee (IRC). It works to improve the lives and defend the rights of refugee and internally displaced women, children, and adolescents. The Women's Commission's reproductive health projects promote quality comprehensive reproductive health care for refugee women, men and adolescents in the areas of safe motherhood, family planning, HIV/AIDS, STIs and sexual and gender-based violence. The Women's Commission also undertakes advocacy work to ensure that reproductive health is on the agenda of humanitarian assistance organisations, policy-makers and donors.⁶⁵

The **Reproductive Health Response in Conflict Consortium (RHRC Consortium)** This consortium is made up of the American Refugee Committee (ARC), CARE-America, the International Rescue Committee (IRC), John Snow International Research and Training Institute (JSI), Marie Stopes International (MSI) and the The Women's Commission. It is dedicated to the promotion of reproductive health among all persons affected by armed conflict. The RHRC Consortium promotes long-term access to comprehensive, high-quality reproductive health programmes in emergencies and advocates for policies that support the reproductive health of persons affected by armed conflict. Its three fundamental principles are to use participatory approaches to involve the community at all stages of programming, to encourage reproductive health programming during all phases of an emergency and to employ a rights-based approach as defined by the PoA of the ICPD.⁶⁶

KEY INITIATIVES TO DELIVER REPRODUCTIVE HEALTH, RIGHTS AND SERVICES

While the challenges remain, advocacy on the part of international NGOs and agencies dedicated to the protection of women and subsequent international resolutions, debates and policies have led to increased media and political attention to gender-based violence in conflict situations. This heightened profile has encouraged the development and implementation of gender-aware programmes and successful initiatives. The initiatives listed below provide examples of the range of activities that are taking place to address reproductive rights and can stimulate women peacebuilders to replicate or adapt the most appropriate ideas to their specific conflict or post conflict setting.

- Enlisting the Armed Forces to Protect Reproductive Health and Rights: Lessons from Nine Countries (UNFPA, 2003)—The organisational and human resources of military institutions are being drawn on to protect reproductive health and rights in both peacetime and conflict situations. UNFPA has worked with the military sector to reach out to men with information, education and services on family life, family planning and other sexual health concerns, including maternal health, HIV/AIDS prevention and the reduction of gender-based violence.⁶⁷
- Reproductive Health Care for Afghan Refugees in Pakistan (The Women's Commission, October 2003): The Women's Commission conducted a reproductive health assessment focused on the implementation of priority reproductive health activities among **Afghan** refugees in the Northwest Frontier, Baluchistan and Punjab provinces of **Pakistan** from August 2002 through June 2003. The assessment of these priority activities, also known as *Minimum Initial Services Package (MISP)*, revealed that while isolated efforts have been made to improve the quantity and quality of reproductive health care for Afghan refugees in Pakistan, many programmes are limited to traditional maternal and child health care services and the quality of RH care is a significant concern.⁶⁸
- Increasing leadership and action to prevent GBV: In the displaced camps of **Burmese** refugees on the **Thai** border, UNHCR has provided training to NGOs and Burmese women's organisations to prevent and address gender-based violence. The training focused mainly on building capacity and has resulted in a GBV response protocol known as the *Automatic Response Mechanism (ARM)*, a step-by-step guide for assisting survivors.⁶⁹
- Providing reproductive health services to the internally displaced: Population Services Lanka (PSL), with the assistance of MSI and USAID, has carried out a project to provide integrated reproductive health care to communities affected by armed conflict in the northern and eastern parts of **Sri Lanka**. Initiated in 1995, the programme provides clinic and outreach services to IDPs.⁷⁰
- Saving Women's Lives—Hope after Rape is a programme in **Uganda** that counsels and assists abused women and children, including refugee children abducted into sex slavery. This NGO was set up by a female psychiatrist to counsel rape victims, who in Uganda were traditionally shamed. They are referred to the programme through police and health care facilities. The programme has developed a manual for community volunteers to use in abused families, including those in which women abuse men. Hope after Rape focuses on research, training, advocacy, networking and providing psychosocial support.⁷¹
- Skills development for health professionals: A joint project on the reproductive health needs of women victims of violence in **Rwanda** was initiated by the Ministry of Family, Gender and Social Affairs, WHO and the Ministry of Health. As a result, a training-of-trainers course was conducted in January 1998. During the ten-day course, participants received increased knowledge about the medical and psychological results of violence and how to recognise post-traumatic stress disorder (PTSD).⁷²
- Marie Stopes Mexico is providing affordable reproductive health services for **Guatemalan** refugees and internally displaced Mexicans. The programme provides information, education and communication as well as family planning and maternal child health services.⁷³

5. TAKING STRATEGIC ACTION: WHAT CAN WOMEN PEACEBUILDERS DO?

Almost all countries struggle to expand access to health services. Because of insufficient resources, many countries initially offer a core package of basic services that are expanded as more resources become available. For the convenience of health users and state management, reproductive and sexual health services should be integrated into primary health care initiatives as well as services that cater to more specialised health needs. In order to ensure that governments and other actors comply with international policies and mandates, women's groups, NGOs and others could:

1. Advocate and lobby for adequate funds to support family planning and birth spacing services.
2. Develop alliances across sectors to promote information, education and communication on reproductive health services for men, women and adolescents.
 - Consider developing alliances with youth to lobby and advocate for the effective provision of services to adolescents and youth.
 - Initiate networks of men to support advocacy, public awareness-raising and education about reproductive health care issues among men. For example, in **South Africa**, they have set up a South African Men's Forum (SAMF) to address men's violence against women.⁷⁴
3. Reach out to traditional leaders, faith-based organisations and religious leaders, to gain support for public campaigns against gender-based violence, or for promoting safe sex and family planning etc.
4. Educate women on their reproductive health rights and policies that address services so that they may be able to demand their rights.
5. Educate women, girls, men and male youth about safe contraception methods and family planning services.
6. Launch a campaign together with other organisations on the impact of GBV on women. Include young girls, men and boys.
7. Document women's experiences with sexual and other gender-based violence. Develop a photo exhibition that you can show around the community on the dangers of reproductive tract infections and STIs, including HIV/AIDS.
8. Support breast-feeding initiatives and advocate to women of its benefits. Emphasise the importance of good nutrition before, during and after the birth of the child.
9. Organise round-table discussions with relevant officials of your government, community or regional policy-makers on gender-responsive delivery of sexual and reproductive services. Raise awareness of cultural issues such as FGM that can negatively affect women's reproductive health.
10. Work with traditional birth attendants, midwives and community-based women who perform FGM to raise awareness about the dangers and encourage prevention.

WHERE CAN YOU FIND MORE INFORMATION?

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARC	American Refugee Committee
BPFA	The Beijing Platform for Action
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
CRC	The Convention on the Rights of the Child
DRC	Democratic Republic of the Congo
EU	European Union
JSI	John Snow International Research and Training Institute
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IAWG	The Inter-Agency Working Group on Reproductive Health in Refugee Situations
ICESCR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
ILAC	International Legal Assistance Consortium
IRC	International Rescue Committee
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MSI	The Marie Stopes International Global Partnership
PNGDF	Papua New Guinean Defence Force
PSL	Population Services Lanka
PTSD	Post-Traumatic Stress Disorder
PoA	Programme of Action
RHRC Consortium	Refugee Health Response in Conflict Consortium
SIDA	Swedish International Development Cooperation Agency
STIs	Sexually Transmitted Infections
SRH R&S	Sexual Reproductive Health, Rights and Services
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organization

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