SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF REFUGEE WOMEN IN EUROPE

Rights, Policies, Status and Needs

Literature Review
June 2005

Kristin Janssens
Marleen Bosmans
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“United in diversity”

The motto of the European Union,
European Constitution, 16 December 2004, Part I, Article I-8

“The Assembly considers that the right to health associated with access to health care is one of the basic universal human rights and should be equally applied to all people, including migrants, refugees and displaced persons.”

Council of Europe, Parliamentary Assembly
Recommendation 11503 (2001) on ‘Health conditions of migrants and refugees in Europe’

“…I regret to say, there are some indications that Europe is losing sight of its duty to protect refugees under international law, as set out in the 1951 Convention. This is a source of deep concern to me, and risks having enormous impact on other regions who look to Europe as an example.”

From a speech made by Kofi Annan
at the Stockholm International Forum on Combating Intolerance, 29 January 2001

“A burning problem remains the access to reproductive health care for refugees and in emergency contexts, as refugees, and in particular women, are highly vulnerable, and this results in higher maternal mortality and morbidity, increased (often unsafe) sexual activity with an increased risk of STI and increased infertility rates.”

European Parliament Annual Report on human rights in the world in 2003
and the European Union’s policy on the matter (2003/2005(INI))

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Kristin Janssens
Marleen Bosmans
Prof. Dr. Marleen Temmerman

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASTRA	Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights
ASRW	Asylum Seeking and Refugee Women
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women (1979)
CRSR	Convention relating to the Status of Refugees (1951)
ECFR	European Charter of Fundamental Rights (2000)
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
EP	European Parliament
ESC	European Social Charter (1961, revised in 1996)
ERF	European Refugee Fund
EU	European Union
EU MS	European Member States
FGM	Female Genital Mutilation
FP	Family Planning
FWCW	Fourth World Conference on Women (Beijing, 1995)
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development (Cairo, 1994)
ICECSR	International Covenant on Economic, Social and Cultural Rights (1966)

ICERD	International Convention on the Elimination of All Forms of Racial Discrimination (1965)
IOM	International Organisation for Migration
IUD	Intrauterine Contraceptive Device
MEP	Member of European Parliament
MS	Member States
NEWR	Network for European Women's Rights
NGO	Non-governmental Organisation
SGBV	Sexual and Gender-based Violence
UK	United Kingdom
UN	United Nations
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United High Commissioner for Refugees
PTSD	Post-traumatic Stress Disorder
SGBV	Sexual and Gender-based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
WHO	World Health Organisation

Executive Summary

This literature review is part of a wider research project into the *Integration of Refugee Women in Europe through the Promotion of Their Sexual and Reproductive Health Rights*, conducted by the International Centre for Reproductive Health at the Gent University and supported by the EC/European Refugee Fund. The project was carried out from February 2004 until June 2005, and consisted of three main parts: a literature review, a survey analysis, and an international workshop. The main assumption of the study is that promoting and improving refugee women's sexual and reproductive health and rights (SRHR) in Europe, will contribute to their integration in European host societies. The research has been conducted based on the principle that refugee women's SRHR are women's rights and that the promotion, protection and fulfillment of these rights should be endorsed by the European Union (EU) and the respective European Member States (MS).

Chapter 1 looks at relevant definitions and terminology, and explains why the focus of this study is mainly on asylum seeking and refugee women (ASRW) in the broader context of migrant health. ASRW and migrant women have both similar and specific needs. Specific risks and needs are particularly related to ASRW's background of forced migration and their situation in the host country. In this context, the main emphasis in this study is on group-specific vulnerabilities, to identify barriers that prevent ASRW in getting access to affordable and acceptable sexual and reproductive health services. Refugee health is not only a public health and human rights issue, but is also recognised as an important factor for integration. The authors argue that the improvement of ASRW's SRH through the provision of a wide range of accessible, affordable and acceptable SRH services, may highly contribute to the improvement of their overall physical and mental health and well-being, which will facilitate their participation in the social and economic life of the host country and their integration in European host societies.

Chapter 2 explores asylum seekers' and refugees' right to health, and more specifically the recognition of their SRHR. An overview is given of the main

international human rights standards, important international conferences and European human rights instruments that address the right to health, and in particular the right to SRH. Within the human rights instruments of the Council of Europe and the EU, there is no explicit reference to SRH in any text. Within the EU, public health, including SRH, is governed by the principle of "subsidiarity", and it is therefore the responsibility of the MS. The EU's asylum and immigration policy provides new legislative tools that are legally binding, which oblige EU MS to provide medical care to asylum seekers and displaced persons who need temporary protection. These tools, however, do not guarantee asylum seekers and refugees full enjoyment of their SRHR, since the obligations are mainly limited to emergency care and essential treatment of illness. In many EU MS asylum seekers have (very) limited access to the national health system. The extent of the limitations varies greatly.

Chapter 3 looks at relevant policy developments within the EU in the field of SRH, with a specific focus on policies that take the specific needs of asylum seekers and statutory refugees into account. So far, the EU has no explicit policy on SRH for the EU MS. This is partly the result of the fact that public health, including SRH, is high on the national political agendas and that most governments do not want the EU to interfere with it. The EU, however, has many opportunities to address and advance SRHR. Recent developments, such as the Resolution on Sexual and Reproductive Health and Rights (2002) and the European Strategy for the Promotion on Sexual and Reproductive Health and Rights (2004), create opportunities to promote SRHR in EU MS. Despite the efforts of the EU, however, no specific reference to SRH is made in the EU Public Health Policy (2003-2008), except for the threat of HIV/AIDS.

National governments of the European MS do not have clear and separated SRH policies. In general, national health policies in the European MS show a wide range of insufficiencies and inconsistencies when it comes to addressing the specific needs of asylum seekers and refugees. There are still many differences in legislation and implementation of policies, which cover specific SRH aspects such as abortion, violence against women and female genital mutilation. Specific attention for vulnerable groups such as migrants and ethnic minorities, including ASRW, is highly needed.

Chapter 4 gives a state of the art of the SRH status of migrant and refugee women in the EU. In order to identify ASRW's SRH needs in a European context, some general health issues are highlighted in the broader context of migrant health. Asylum seekers and refugees are not homogeneous groups of

people: they have different needs, expectations of health and of health care. ASRW often face particular difficulties, which are not acknowledged. This chapter explores their SRH needs, focusing on the following SRH key issues: safe motherhood; aspects related to unwanted pregnancy; family planning; sexually transmitted infections (including HIV/AIDS); and sexual and gender based violence, including harmful traditional practices such as female genital mutilation.

ASRW's SRH status and needs in European settings have hardly been explored. However, research findings indicate that the provision and use of SRH services by ASRW in European MS are inadequate. This is due to several factors at different levels, both at the national level (provision of and entitlement to SRH services) as at community level. Different obstacles hinder access to SRH services, such as a lack of knowledge and poor perception of SRH related issues, a lack of information about the host country's national health system, and ignorance about their SRH rights; a lack of accessibility, affordability and acceptability of the services provided, inadequate training of service providers who attend refugee women and of interpreters who may assist them. In addition, refugee women's SRHR are also violated as a result of xenophobia, discrimination and racism against migrants, refugees and asylum seekers.

Chapter 5 concludes with a set of recommendations for the promotion of ASRW's sexual and reproductive health and rights in Europe. Likewise, recommendations for further research are formulated aimed at improving the impact and quality of SRH service provision for ASRW in Europe.

A rights-based approach should be integrated in European legal standards, policies, programmes and guidelines. Europe can take an important lead in sensitising the European MS about the importance of SRH, and to encourage them to develop policies and strategies for improving SRH of both asylum seekers and refugees. Clear guidelines on SRH care provision for ASRW should be developed, in order to provide SRH services, which are accessible, affordable and acceptable. There is a great need for further research in the broad field of ASRW's sexual and reproductive health in Europe in order to enable EU Member States to identify needs, to define priorities and to develop effective responses.

Chapter 1	Looks at relevant definitions and terminology and clarifies the broader framework of this literature review.
Chapter 2	Explores asylum seekers' and refugees' right to health, and more specifically the recognition of their SRHR.
Chapter 3	Looks at relevant policy developments within the EU in the field of SRH, with a specific focus on policies that take the specific needs of asylum seekers and statutory refugees into account.
Chapter 4	Gives a state of the art of the SRH status of migrant and refugee women in the EU and explores the SRH needs of ASRW in the EU MS.
Chapter 5	Concludes with a set of recommendations for the promotion of ASRW's sexual and reproductive health and rights in Europe, and for further research.

Wherever appropriate, readers are directed to additional sources for more detailed information on specific topics. References will be made under "Further reading". A detailed list of suggested resources can be found at the end of this review.

Introduction

At the end of 2003, the number of refugees worldwide was estimated 9.7 million persons. About half of them are female (49%), but the ratio of female refugees varies greatly, depending on the characteristics of the refugee situation, the region of asylum, age, etc. In countries with mass refugee situations for instance, the proportion of female refugees tends to be around 50 per cent. Among asylum seekers the percentage of females is significantly lower, with women over-represented in the older age category of 60 years and over.[1]

In Europe, asylum application levels have decreased by 21 per cent, from 396,800 in 2003 to 314,300 in 2004. In 2004, the 25 EU countries recorded 19 per cent fewer asylum requests. UNHCR reports: "In 38 industrialised countries with historical data, the number of applications submitted in 2004 (368,000) was the lowest since 1988 (347,000). In Europe as well as in the 25 EU countries, the number of asylum seekers in 2004 was the lowest since 1997."[2]

According to UNHCR, the EU hosts 25% of all refugees. During 2003 most claims for asylum or refugee status were registered in Europe (511.000). Only 51.000 asylum seekers were granted individual refugee status and 37.400 asylum seekers were allowed to remain on humanitarian ground. In the EU, 6% more asylum claims were submitted in the second half of 2004, but 20% less compared to the same period in 2003. The enlarged EU currently receives 75% of all asylum claims submitted in the 36 countries studied covered by a UNHCR report of 2004.[3]

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1 UNHCR, 2003 *Global Refugee Trends, Overview of Refugee Populations, New Arrivals, Durable Solutions, Asylum Seekers and Other Persons of Concern to UNHCR*. Geneva, Population Data Unit/PGDS, Division of Operational Support, UNHCR, 15 June 2004.

2 UNHCR, *Asylum levels and Trends in Industrialized Countries, 2004, Overview of Asylum Applications lodged in Europe and Non-European Industrialized Countries in 2004*. Geneva, Populations Data Unit/PGDS Division of Operational Support UNHCR, 1 March 2005 (http://wwww.unhcr.ch/statistics, accessed 15 March 2004).

3 Ibid. UNHCR 2004, and UNHCR, *2003 Global Refugee Trends, Overview of Refugee Populations, New Arrivals, Durable Solutions, Asylum Seekers and Other Persons of Concern to UNHCR*. Geneva, Population Data Unit/PGDS, Division of Operational Support, UNHCR, 15 June 2004.

Since the 1990s, awareness of the importance of SRH services for refugee and internally displaced persons, mainly in refugee settings, has started to grow gradually. In particular, the International Conference on Population and Development (ICPD, Cairo 1994) set an important landmark in the recognition of SRH rights and needs of women and displaced populations. At its 3rd Council Meeting in Lisbon on 26-27 May 2003, the Inter-European Parliamentary Forum on Population and Development made a commitment to take a leading role in creating an enabling environment for the implementation of the ICPD Programme of Action and to ensure universal sexual and reproductive health.

However, there are serious indications that so far the SRH rights and needs of refugee women in the EU have not been dealt with in the same way as Europe is promoting SRH policies in its development cooperation and humanitarian programmes. Research findings indicate that refugees in the EU suffer higher maternal morbidity and mortality, experience poorer pregnancy outcomes, have less access to family planning services and counselling, show higher prevalences of sexually transmitted infections (STI), including HIV/AIDS, and run an increased risk of gender-based violence (GBV). They may also have suffered physical and sexual abuse - including rape - in their country of origin, during travel or even in countries of destination.

The aim of this literature review is to identify the specific sexual and reproductive health needs and rights of refugee women, and the existence of relevant SRH policies and practices, in the 15 old EU MS.[4] This report is based on a wide range of data sources, including electronic data, journal articles and books dealing with migrants' health care and needs, specifically focussing on key issues in SRH, addressing the specific needs of female asylum seekers and refugees. Literature and documents related to asylum seekers', refugees' and migrants' health needs and rights, asylum legislation and policies, were examined. In addition, grey literature, such as unpublished documents, reports, theses, statistics and policy papers have been gathered. The research documents explored to write this review were based on qualitative, quantitative, and combined research methods.

This literature review focuses on asylum seeking and refugee women (ASRW) in their reproductive age, within the age group between 18 – 49 years.[5]

4 At the start of this project the 15 EU Member States were: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Portugal, Spain, Sweden, The Netherlands, and the United Kingdom.

5 Adolescents have specific rights and needs under the Convention on the Rights of the Child (CRC), 1989, which are not addressed in this study.

1

WHY FOCUS ON SEXUAL AND REPRODUCTIVE HEALTH OF REFUGEE WOMEN IN EUROPE?

Eighty percent of the world's refugees and internally displaced persons (IDPs) are women and children. Refugees by definition have crossed international borders to seek a safe haven, and are eligible for international protection and assistance under the mandate of the United Nations High Commission for Refugees (UNHCR).

Women's Commission for Refugee Women and Children, 1999 – 2004[6]

6 See http://www.womenscommission.org/reports/platform.html, accessed 11 October 2004.a

1.1. Definitions and Terminology

This report aims to give an overview of current issues related to refugee women's SRH needs and rights in Europe. In order to identify the specific SRH needs of refugee women, this report focuses on asylum seeking and refugee women (ASRW) within the broader framework of migrant health.

Terminology in migrant health research varies in different reports and publications. Some authors speak about immigrants, others about migrants or foreigners, and others about black and minority ethnic groups. Other publications focus on more specific groups such as (migrant) commercial sex workers and (elderly) women for example. A limited number of references can be found relating to asylum seekers' and/or refugees' health. The following sections are meant to clarify terminology and definitions used in this study, in order to be able to frame SRH and rights of refugee women in Europe.

1.1.1. Asylum Seekers and Refugees

Under the UN Convention Relating to the Status of Refugees 1951, a refugee is a person "who, owing to well-founded fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality or being outside the country of his/ her former habitual residence, is unable or, owing to such fear, is unwilling to return to it."[7] Once a refugee meets the refugee definition in the 1951 Geneva Convention he or she is sometimes called a "convention refugee" or "statutory refugee". This definition is used in European law and is internationally widely accepted.[8]

Asylum seekers are defined as "persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments."[9] Asylum seekers are those individuals who formally request permission to live in another state because they (and often their families) have a 'well founded fear of persecution' in their country of

7 "The 1951 Convention relating to the Status of Refugees is the key legal document in defining who is a refugee, their rights and the legal obligations of states. The 1967 Protocol removed geographical and temporal restrictions from the Convention." Addapted from UNHCR website, see link below: http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id=3c0762ea4&ID=3c0762ea4&PUBLISHER=TWO)

8 For more specific information see http://www.unhchr.ch/html/menu3/b/o_c_ref.htm

9 IOM, *International Migration Law. Glossary on Migration.* Geneva, IOM, 2004.

origin. This distinguishes them from migrants in general.[10] But strictly speaking, it is impossible to say whether the asylum seeker is a refugee or not, until his/her refugee status has been officially granted.

The rights position and living conditions of statutory refugees are very different from those of asylum seekers. These differences have a great impact on their health and other basic needs. Many asylum seekers were forced to leave their country, just as statutory refugees, because they felt a certain amount of threat in their existence. This background of forced migration distinguishes them from other migrants. Therefore, the term "refugee" is often used for both asylum seekers and statutory refugees.[11] In this report we will distinguish between asylum seekers and refugees where possible, since asylum seekers have specific needs and often limited rights in the context of their host country.

1.1.2. Voluntary and Forced Migration

Migrants are persons who have left their home country for economic reasons or for reasons not covered under the limited definition of "refugee". Within the category of "migrants" a distinction is made between *regular (documented)* and *irregular (undocumented) migrants*. Regular or documented migrants are "those people whose entry, residence and, where relevant, employment in a host or transit country has been recognised and authorised by official State authorities." Irregular or undocumented migrants (sometimes inappropriately referred to as "illegal" migrants/immigrants) are "people who have entered a host country without legal authorisation and/or overstay authorised entry as, for example, visitors, tourists, foreign students or temporary contract workers".[12]

Another distinction that is made is the one between "*voluntary*" or "*forced*" migrants. Voluntary migrants are "people who have decided to migrate of their own accord (although there may also be strong economic and other pressures on them to move). These include labour migrants, family members being reunified with relatives and foreign students".[13] Forced migration on the other hand, refers to "movements of refugees and internally displaced people (those displaced by

10 *Glossary of terms related to the experiences of refugees*. Online, adapted from Refugees and Forcibly Displaced People by Mark Raper SJ and Amaya Valcarcel, 2000 (http://www.uniya.org/education/refugees_glossary.html, accessed 1 March 2004).

11 See also Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen*. Utrecht, Pharos, 2003: 115-159.

12 WHO, *International Migration, Health and Human Rights*. Health & Human Rights Publication Series Issue No.4, December 2003:9.

13 Ibid.

conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects".[14]

According to the International Association for the Study of Forced Migration: "Forced migration is distinguished from voluntary (sometimes called economic) migration by the original absence of a desire or motivation to leave the place of residence. Changes in the environment that are detrimental to the individual or collectivity deprive the collectivity (or various members of it) of security and establish new, more dangerous conditions. People who would have remained where they were under the earlier conditions now must leave or face insult, injury, imprisonment, or death. Migration becomes a means of escaping from a threatening situation, but the forced migrant is more oriented towards retention or re-establishment of past conditions than is the voluntary migrant".[15]

Forced migration implies that refugees are uprooted; they experience a combination of traumatic experience(s), loss, it marginalises them in the host society and makes them more vulnerable than the rest of the population.[16] Forced migration distinguishes refugees from the situation of migrants. Refugee women face health risks before, during and after the flight. Moreover, the involuntary character of their stay in their host country can be a hindrance for their adaptation to the new society, due to the longing for a future in their country of origin. Nostalgia is often deepened because of the confrontation with cultural differences in the host community.[17]

1.1.3. Vulnerability

Migrants, refugees and asylum seekers – and women in particular – are often referred to as "vulnerable groups". Since the mid-1990s, the notion of vulnerability has often been referred to in the context of social policy. The term "vulnerability" has a wide variety of meanings. Vulnerability can be linked to multiple factors rooted in physical, environmental, socio-economic and political causes. In essence, "vulnerability can be seen as a state of high exposure to certain risks and

14 International Association for Study of Forced Migration, Mission Statement of the International Association for Study of Forced Migration (online), IASFM (*http://www.uni-bamberg.de/~ba6ef3/iasfm/mission.htm*, accessed 13 April 2005).

15 Ibid.

16 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen.* Utrecht, Pharos, 2003:124.

17 Groen M., *Geweld en Schaamte Richtlijnen voor de eerstelijnshulpverlening bij relationeel geweld in gezinnen van migranten en vluchtelingen [Violence and Shame. Guidelines for primary aid to address relational violence in migrant and refugee households]*. Utrecht, Vrouwenopvang Utrecht, 2001:60.

uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences".[18]

It should be noted, however, that many civil organisations have expressed their uneasiness with the term "vulnerable groups" in (policy) documents. Reference to the overall vulnerability of social groups is increasingly found to be socially and politically inaccurate and misleading, with the common argument that no social group is inherently vulnerable. Nevertheless, all social groups face vulnerabilities, which are mainly the outcome of economic, social and cultural barriers and restrictions that impede the social integration and participation of the members of these groups.[19] The poor among them are usually the most vulnerable and constitute the most marginalised sector of the population. Refugees, and more specifically refugee women, are commonly regarded as a vulnerable group.

Although situation-specific vulnerabilities are very important, the main emphasis in this report is on the group-specific vulnerabilities, to identify specific barriers that prevent refugee women in getting access to affordable and acceptable SRH care services.

1.1.4. Sexual and Reproductive Health and Rights

Sexual and reproductive health (SRH) is often referred to as "reproductive health", since it also includes sexual health. Some documents, however, distinguish between sexual health and reproductive health, and respectively between sexual rights and reproductive rights. In this study we refer to these rights as sexual and reproductive health rights (SRHR).

18 United Nations, *Report on the World Social Situation 2003. Social Vulnerability: Sources and Challenges*. New York, 2003.
19 Ibid.pp. 8-9.

Sexual Health

Sexual health is "a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled."[20]

Reproductive Health

Reproductive health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with best chance of having a healthy infant. (…) reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. *It also includes sexual health* the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[21]

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20 Worl Health Organisation (WHO) Draft Working Definition, October 2002. See Girard F., Do We Need Sexual Rights? *Choices*, Autumn 2003:9. In 1975 WHO defined sexual health as "the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love, and thus the notion of sexual health implies a positive approach to human sexuality. The purpose of sexual health care should be the enhancement of life and personal relations, and not merely counselling care related to reproduction and sexually transmitted diseases." See WHO, *Education and Treatment in Human Sexuality: The training of Health Professionals, Report of a WHO meeting, Technical Report series Nr. 572. Geneva*, WHO, 1975.

21 United Nations — ICPD 1994, *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. UNFPA, United States of America, 1996, Art. 7.2. This definition is also endorsed by IPPF.

Sexual and Reproductive Health Care

"In line with the definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases". [22]

Sexual Rights

Sexual Rights embrace "human rights that are already recognised in national laws, international human documents and other relevant UN consensus documents. These include the right of all persons, free of coercion, discrimination and violence to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for the bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life."[23]

Reproductive Rights

Reproductive Rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly about the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[24]

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22 Ibid.

23 Worl Health Organisation (WHO) Draft Working Definition, October 2002, In: Girard F., Do We Need Sexual Rights? *Choices*, Autumn 2003:9.

24 United Nations — ICPD 1994, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. UNFPA, United States of America, 1996, Art. 7.3.

1.2. Justification and Background

Many studies have shown that the impact of poor SRH is worse for the most disadvantaged groups, especially women and children, and disproportionately affects people of low-income countries.[25] The recent creation of EU funded networks such as ASTRA (Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights)[26] and NEWR (Network for European Women's Rights)[27] shows a growing awareness in the EU about the need for the enhancement of women's (SRH) rights.

The ICPD Programme of Action recognised refugee women as "particularly vulnerable" in their SRH.[28] International organisations such as the International Organisation for Migration (IOM) and the World Health Organisation (WHO), also underscore the particular vulnerability of migrant women, in terms of their SRH. In international policy making practice, however, the link between SRH and refugees is mainly dealt with in terms of relief services for refugee and displaced women living in refugee camps in developing countries. The situation in European settings, has hardly been explored so far.

Looking at the SRH needs of refugee women within the broader context of migrant health, it appears that SRH needs of migrants in Western Europe[29] are usually much more pressing than those of the rest of population.[30]

For more than a decade now, wars in nine European countries have caused large increases in refugee and internally displaced populations, often women and children. Traditionally, humanitarian assistance in these countries has focused on food, shelter and prevention of communicable diseases. WHO points at the fact that only recently efforts have started to focus on the SRH needs of these populations.[31]

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25 United Nations Population Fund (UNFPA), *State of World Population 2002: People, Poverty and Possibilities*. New York, UNFPA, 2002:35-37; The Allan Guttmacher Institute and UNFPA, *Adding It Up. The Benefits of Investing in Sexual and Reproductive Health Care*. New York, Alan Guttmacher Institute and UNFPA, 2003; WHO, *World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva, WHO, 2002; and WHO, *World Health Report 2003: Shaping the Future*. Geneva, WHO, 2003.

26 ASTRA Website: http://www.astra.org.pl/

27 NEWR Website: http://www.newr.bham.ac.uk/

28 United Nations — ICPD 1994, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. UNFPA, United States of America, 1996, Chapter X.D.

29 According to figures of WHO, between 5% and 10% of the population in Western Europe are migrants. In: WHO, *Regional Strategy on Sexual and Reproductive Health*. Copenhagen, WHO (Reproductive Health/Pregnancy Programme), November 2001:8.

30 WHO, *Regional Strategy on Sexual and Reproductive Health*. Copenhagen, WHO (Reproductive Health/Pregnancy Programme), November 2001:8.

31 Ibid.: 6.

Access to SRH care for refugees has been recognised by the European Parliament as a "burning problem", stating that they are "highly vulnerable", and recognising that they suffer "higher maternal mortality and morbidity, increased (often unsafe) sexual activity with increased risk of STI and increased fertility rates".[32]

1.3. Refugee Women's Health as an Important Factor for Integration

Refugee health is not only a public health and human rights issue, but is also recognised as an important factor for integration.

Asylum seeking and refugee women (ASRW), who have been forced to leave their home country, often fleeing from war and armed conflict, become very vulnerable having lost their possessions, their jobs, their social status and personal dignity. Refugees usually experience a sudden and potentially definitive break with their family, land and environment. As a consequence of their migration process, they are often physically, mentally, emotionally and psychologically strained. The separation from their family members, negative experiences in their country or region of origin as well as adapting to their new life situation often weighs heavily on them, affecting their physical and mental well-being. Being cut off from support of traditional values, extended families, friends and familiar ways of life they become highly dependent on outside aid. Most refugees have faced situations of physical hardship and poverty, putting at risk their overall health, including their SRH, in a situation where access to health care services has become very difficult or is even being denied.

Because of this stressful history of forced migration - their flight and exile - refugees suffer specific problems that might turn into serious physical and mental troubles. Social and health aspects are deeply related to these experiences, but also to the asylum country, where "unhealthy accommodation, prolonged inactivity, as well as some adaptation difficulties might compromise the integration process. Illness can accordingly be a clear sign of missed integration".[33]

Asylum seeking and refugee women's background of forced migration has an important impact on the process of adaptation, so-called "acculturation". Different ways of acculturation can be identified. 'Integration' means that the 'newcomer' (asylum seeker/refugee) clings to a way of life that corresponds to

32 Council of the European Union, *EU annual report on human rights*. Brussels, Council of the European Union, 2003: 30.

33 See also website http://www.refugeenet.org (health); http://www.caritas-europa.org/code/en/speeches.asp?pk_id_speeches=20

one's own culture, with acknowledging the dominant culture in the host country. 'Assimilation', on the other hand, is a process where the migrant has to adapt completely to the dominant culture of the receptive society, whereby the own cultural identity is eventually not recognisable. 'Segregation' means that the dominant culture is rejected, and in case of 'marginalisation', groups loose contact with both their own cultural background and with the receiving society.[34]

In line with one of the main outcomes of the *Health and Migration Seminar*, 9-11 June 2004, in Geneva, it is clear that refugees in a state of well-being would be more receptive to education and employment, and more inclined to contribute to their host societies. In addition, it is reported that migrants (including refugees) "who are not perceived to be a health threat to their host communities would be less exposed to discrimination and xenophobia, and more likely to be included as equal participants." [35]

The improvement of refugee women's SRH through the provision of a wide range of accessible, affordable, and culturally acceptable SRH services, may highly contribute to the improvement of their overall physical and mental health and well-being, and will facilitate their participation in the social and economic life of the host society and their integration in the European society.

34 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen.* Utrecht, Pharos, 2003: 124-125.

35 IOM, *Health and Migration Seminar, Report of the Meeting, Conference Room Paper/14, 88th Session of the Council, Geneva, 30 November - 3 December 2004.*

1.4. CONCLUSIONS

Many studies have shown that the impact of poor SRH is worse for the most disadvantaged groups in society, especially women and children. Although there seems to be growing awareness in the EU about the need for the enhancement of women's SRH rights, international organisations underscore the particular vulnerability of migrant women, in terms of their SRH. In Europe, migrants' SRH needs are usually more pressing than those of the general population. The European Parliament has recognised access to SRH care for refugees, women in particular, as a major problem, highlighting their vulnerability in the context of SRH. However, refugees' SRH concerns are mostly considered in the context of developing countries, and refugee women's SRH status and needs in European settings have hardly been explored.

This review will discuss ASRW's SRH status, risks, and needs within the broader framework of migrant health, as they have both similar and specific needs. Migrants, refugees and asylum seekers, and women in particular, are often referred to as "vulnerable groups". The main emphasis in this study is on group-specific vulnerabilities, to identify barriers that prevent ASRW in getting access to affordable and acceptable SRH care services.

Refugees' background of forced migration distinguishes them from the situation of migrants. Refugee women face health risks before, during and after the flight. Moreover, the involuntary character of their stay in the host country can be a hindrance for their adaptation to the new society, due to the longing for a future in their country of origin. Refugee health is not only a public health and human rights issue, but is also recognised as an important factor for integration. It is argued that refugees in a state of well-being would be more receptive to education and employment, and more inclined to contribute to their host societies. The improvement of refugee women's SRH through the provision of a wide range of accessible, affordable, and culturally acceptable SRH services, may highly contribute to the improvement of their overall physical and mental health and well-being, and will facilitate their participation in the social and economic life of the host society and their integration in the European society.

2

A RIGHTS-BASED APPROACH TO SEXUAL AND REPRODUCTIVE HEALTH OF REFUGEE WOMEN

"Reproductive health is a state of complete physical, mental and social well-being (...) in all matters relating to the reproductive system and to its functions and processes... It also includes sexual health the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (...)."

ICPD Programme of Action (Cairo, 1994, Art. 7.2.)

This Chapter explores asylum seekers' and refugees' right to health, and more specifically the recognition of their sexual and reproductive health rights. An overview will be given of the main international human rights standards, important international conferences and European human rights instruments that address the right to health, and in particular the right to SRH.

2.1. A Rights-based Approach to Sexual and Reproductive Health

The right to health is a human right, which is recognised by a whole body of international treaties and agreements. It does not imply that everyone has the right to be healthy, but that everyone has the right to the highest attainable standard of health. The recognition of the right to health imposes an obligation upon states to *respect*, *protect and fulfil* the aspirations implied in the World Health Organisation's definition of health.[36]

The central notion of human rights is the implicit assertion that certain principles are true and valid for all people, in all societies, under all conditions of economic, political, ethnic and cultural life. The basis of the concept of human rights is that they are *universal* – they apply everywhere and to everybody; *indivisible* – for example, in the sense that political and civil rights cannot be separated from social, cultural, and economic rights; and *inalienable* – they cannot be denied to any human being.

Over the past years the right to SRH has also gained attention and growing recognition. United Nations conventions and world conferences have paved the way to the recognition of SRH as a basic right, and more specifically, as a woman's right. The right to SRH implies that women are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy. It also implies that individuals, men and women, should able be to regulate their fertility without adverse or dangerous consequences.[37]

36 WHO was the first international organization that defined health in terms of a human right, and stated: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." See http://www.who.int/about/definition/en/ (Accessed on December 10, 2004).

37 Available at http://www.ippf.org/charter/PDF/IPPF_Charter.pdf

States have the obligation to respect, protect and realise the aspirations implied in WHO's definition of health, including SRH.

Respect

Governments have the duty to take steps to promote sexual and reproductive health and rights. Governments can respect these rights by changing policies that obstruct access to care, such as those requiring husbands' permissions to use services.

Protect

Governments can protect rights "by taking action to prevent violations of rights by others, such as enforcing equitable marriage laws or birth registration laws, and developing gender and rights training for health providers to address gender-based inequities."[38]

Fulfil

Governments can fulfil rights by taking necessary measures, including allocating sufficient resources to ensure for example, that women and newborns can realise their rights to care.

Source: http://www.who.int/reproductive-health/gender/rights.html (accessed 3 December 2004).

2.2. International Legal Framework: International Conventions

SRH rights are embedded in a wide range of international conventions, conference documents and declarations in the area of humanitarian law, human rights, women's rights and children's rights. Human rights declarations and international law also establish principles such as non-discrimination and equality before the law.[39]

38 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948. See WHO website, *http://www.who.int/reproductive-health/gender/rights.html* (accessed on December 3, 2004).

39 In cases where persons are entitled to health care, acts of discrimination can profoundly affect the quality of health care they receive. Principles of non-discrimination and equality before the law are therefore recognised as relevant in this analysis.

2.2.1. Universal Declaration of Human Rights (1948)

On December 10, 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights, laying down the right to "a standard of living adequate for the health and well-being of himself and of his family (…), and stating: "Motherhood and childhood are entitled to special care and assistance. (…)" (Art. 25). Although the Declaration is not legally binding, it has a great moral and political value.

Universal Declaration of Human Rights (1948)

"***Everyone (****…****), without distinction of any kind****, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" is entitled to all the rights set forth in this Declaration. Furthermore, "no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation or sovereignity*."(Art.2).

"***Everyone*** *has the right to a standard of living adequate for the* ***health and well-being*** *of himself and of his family (...).* (Art. 25.1)

"***Motherhood*** *and childhood are entitled to* ***special care and assistance****. (...).*" (Art. 25.2)

2.2.2. Convention Relating to the Status of Refugees (CRSR 1951)

The *Convention Relating to the Status of Refugees* was adopted on 28 July 1951, and entered into force on 22 April 1954.[40] Articles 23 and 24 of the CRSR accord refugees lawfully staying in their host country the same treatment as is accorded to nationals. According to Dent this includes health care,[41] although the

40 Office of the High Commissioner for Human Rights (OHCHR), *Convention relating to the Status of Refugees*. Geneva, 1951 (http://www.unhchr.ch/html/menu3/b/o_c_ref.htm, accessed 4 May 2004).

41 Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998:83.

Convention does not specifically mention the right to health care as such.[42] Article 24 accords to refugees the same rights to social security, comprising maternity and sickness, as to nationals.

One can argue that the term 'lawfully staying' can be interpreted to mean "officially sanctioned, ongoing presence in a State Party". The term 'lawfully staying' clearly encompasses recognised refugees (also called Convention refugees or statutory refugees), and arguably also refugees who are granted temporary protection, but it clearly does not encompass asylum seekers whose claims have been rejected, nor those granted a subsidiary or humanitarian status.[43]

In contrast with international human rights conventions, the CRSR has no mechanism for scrutinising states' compliance with the stipulated rights. Although article 35(2) might have provided a basis for a system of periodic reporting, the CRSR is not subject to a formal process of interstate scrutiny. The supervisory mechanisms of the European Social Charter could be a potential avenue for the enforcement of CRSR rights within a European context. The European Social Charter explicitly binds contracting states "to grant to refugees as defined in the CRSR, who are lawfully staying in their territory, treatment not less favorable than that required by the CRSR".[44]

Convention Relating to the Status of Refugees (CRSR, 1951)

"The Contracting states shall accord to refugees lawfully staying in their territory ***the same treatment*** *as is accorded to nationals in respect of (...) social security (legal provisions in respect of (...) maternity, sickness (...).*" (Art. 24.1.b)

42 Dent explains in chaper B that the drafters "did not enumerate the instances in which refugees should be entitled to assistance, but intended that the provisions be given a wide interpretation, covering at least such areas as medical assistance and hospital treatment, emergency relief, and relief for the blind and unemployed." (1998:65).

43 See e.g. Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998: 83.

44 Appendix to the ESC (Revised): "Each Party will grant to refugees as defined in the Convention relating to the Status of Refugees, signed in Geneva on 28 July 1951 and in the Protocol of 31 January 1967, and lawfully staying in its territory, treatment as favourable as possible, and in any case not less favourable than under the obligations accepted by the Party under the said convenion and under any other existing international instruments applicable to refugees."(§2)

2.2.3. International Convention on the Elimination of All Forms of Racial Discrimination (ICERD 1965)

On 21 December 1965, the UN General Assembly adopted the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD), which entered into force on 4 January 1969. Under this Convention, states parties have the obligation to guarantee the civil, political, economic, social and cultural rights of everyone, not only of citizens.[45] It should be noted though, that ICERD provides the possibility of treating citizens and non-citizens differently, depending on the states parties' legal provisions concerning nationality, citizenship or naturalisation. States may not differentiate between non-citizens; as such provision may not discriminate against any particular nationality.[46]

Under ICERD everyone has the right to security of person and protection by the state against violence or bodily harm, whether inflicted by government officials or by any individual group or institution, "the right to marriage and choice of spouse; and the right to public health, medical care, social security and social services" (Article 5, resp.b, d (iv), e (iv)).

International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1965)

"(...) States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone (...) to equality before the law (...) in the enjoyment of (...) ***the right to public health, medical care, social security and social services****."* (Art. 5.e.iv)

2.2.4. International Covenant on Economic, Social and Cultural Rights (ICESCR 1966)

On 16 December 1966, the *UN International Covenant on Economic, Social and Cultural Rights* (ICECSR) was adopted, which came into force on 3 January

45 Office of the High Commissioner for Human Rights (OHCHR), *International Convention on the Elimination of All Forms of Racial Discrimination*. Geneva, 1965 (http://www.unhchr.ch/html/menu3/b/d_icerd.htm, accessed 4 May 2004). Article 5. See also the statement by CERD, which was established to monitor the implementation of CERD: UN Doc CERD/226/Add.9 paragrapgh 314.

46 ICERD, Article 1.

1976.[47] ICECSR provides that states parties to the Covenant recognise that special protection should be accorded to mothers during a reasonable period before and after childbirth (Art.10.2). Article 12 on the right to health recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Art.12.1). Although article 12 does not refer specifically to SRH, it should be noted that in 2000, the Committee on Economical, Social and Cultural Rights recognised the right to sexual and reproductive freedom, the right to access education and information on sexual and reproductive health, and the availability, accessibility, acceptability and quality of health care facilities, goods and services (see also 2.4.2.).

The rights of the Covenant are to be granted to 'everyone', and are therefore not limited to nationals of the states parties. Dent argues that all non-nationals possess ICESR rights. Article 2(3), however, is one exception, as it states: "Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognised in the present Covenant to non-nationals." As argued by Dent: "The very fact that developing countries are permitted to restrict the economic rights of non-nationals indicates a prohibition on such restrictions by developed States, and a prohibition on restrictions on non-economic rights by all States".[48]

International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966)

"Special protection should be accorded to ***mothers*** *during a reasonable period before and after childbirth."* (Art. 10.2.)

"The States Parties to the present Covenant recognise the right of everyone to the enjoyment of ***the highest attainable standard of physical and mental health.***" (Art. 12.1.)

47 Office of the High Commissioner for Human Rights (OHCHR), *International Covenant on Economic, Social and Cultural Rights*. Geneva, 1966 (http://www.unhchr.ch/html/menu3/b/a_cescr.htm, accessed 4 May 2004).

48 Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998:4.

2.2.5. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW 1979)

The *UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* was adopted in 1979. The Convention entered into force on 3 September 1981, and, as of March 2004, 176 states are party to it.[49] All 15 old EU MS are parties to the Convention.

Article 12 of the Convention addresses some inadequacies of the ICESCR (Art. 12) in relation to women's rights. Article 12.1 ensures equal access of men and women to health care services, including those related to family planning. The UN Centre for Human Rights explains the obligations of states under Article 12, paragraph 1: it "requires the removal of any legal and social barriers which may operate to prevent or discourage women from making full use of available health care services. Steps should be taken to ensure access to health care services for all women, including those whose access may be impeded through poverty, illiteracy, or physical isolation."[50]

CEDAW provides that states shall ensure men and women "…the same rights to decide freely and responsibly on the number and spacing of their children…" (Art.16.1.e); guarantee access to necessary information, education and advice on family planning (Art.10.h., Art. 14.2.b), and entitle women and men to the means to control their family size (Art.16.1.e.). According to CEDAW, General Recommendation 21, "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention", in order to make an informed decision about safe and reliable contraceptive measures.[51]

The aim of CEDAW is to eliminate discrimination against women on the basis of sex. The beneficiaries of CEDAW are women and no distinction is made between citizens and aliens. There appears to be no reason to exclude women who are asylum seekers, rejected asylum seekers, de facto or Convention refugees, refugees granted a subsidiary or humanitarian status, and refugees under temporary protection.[52]

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49 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), (http://www.un.org/womenwatch/daw/cedaw/cedaw.htm, accessed 13 May 2004).

50 United Nations Centre for Human Rights, *Discrimination Against Women, supra*, at 23. In: Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998:85.

51 Equality in marriage and family relations: 04/02/94, General Recommendation 21, Comment 22, see http://www.bayefsky.com/general/cedaw_genrecom_21.php; UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), (http://www.un.org/womenwatch/daw/cedaw/cedaw.htm, accessed 13 May 2004).

52 Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998:30, 85.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)

States Parties shall take appropriate measures

(...) to ensure equal rights of men and women (...) in particular to ensure ***"access** to specific **educational information** to help to ensure the health and well-being of families, including **information** and **advice** on **family planning."*** (Art. 10.h)

(...) to ensure, "*on a basis of equality of men and women, to have access to **adequate health care facilities**, including **information**, **counselling** and **services in family planning.***" (Art.14.2b)

(...) to ensure, "*on a basis of equality of men and women, equal **access** of men and women to health care services, including those related to **family planning.***" (Art.12.1.)

(…) to ensure to women "*appropriate services in connection with **pregnancy**, **confinement** and the **post-natal period**, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.*" (Art.12.2)

(...) to ensure, on a basis of equality of men and women, "*the same rights to **decide freely and responsibly on the number and spacing of their children** and to have **access** to **information**, **education** and **means to enable them to exercise these rights.***" (Art. 16.1.e)

2.3. International Conferences: Paving the Way for Recognition of Sexual and Reproductive Health Rights

A significant history of rights-oriented conventions and conferences paved the way for the integration of sexual and reproductive rights health (SRHR) into the international rights discourse. Global conferences have played a key role in making progress in the field of SRHR and in ensuring the human rights of migrants.[53] The international women's movement of the 1960s and 1970s was

53 See also WHO, *International Migration, Health and Human Rights*. Health & Human Rights Publication Series Issue No.4, December 2003:35-36.

crucial in advancing the notion of women's SRH as a right. Women's organisations and networks worldwide contributed to a major shift from a strictly medical approach to women's health to a more integrated and focused approach aimed at meeting women's SRH needs and promoting their SRH rights.

At the *First World Conference on Human Rights* in Teheran, 1968, the focus of SRH issues was limited to the freedom of deciding on family size and birth spacing, affirming the right "to determine freely and responsibly the number and spacing of one's children." 25 Years later, the second World Conference on Human Rights in Vienna, 1993, marked the official recognition of women's rights as human rights. At this World Conference the human rights of women and of the girl-child were recognised as "an inalienable, integral and indivisible part of universal human rights (...)"(Art. 18). The Conference further recognised "the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span (…)" and "a woman's right to accessible and adequate health care and the widest range of family planning services (…)" (Art. 41).

The United Nations *International Conference on Population and Development (ICPD)* in Cairo, 1994, was a landmark, as for the first time, a comprehensive definition of SRH and rights was adopted. In the ICPD Programme of Action the definition of reproductive health was expanded and put in a wider human rights' context: "Reproductive health is *a state of complete physical, mental and social well-being* (...) *in all matters relating to the reproductive system and to its functions and processes*. (...) Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (…) Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes *sexual health*, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases."[54]

54 United Nations, Report of the International Conference on Population and Development (Cairo, 5-13 September 1994), 94-E40486 (E) 091194. Programme of Action, Chapter VII. 7.2.

The ICPD Programme of Action also recognised reproductive rights as human rights: "Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their rights to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents."[55]

The *Fourth World Conference on Women* (FWCW) in Beijing, 1995, reaffirmed and extended the definition of SRH and rights as formulated at ICPD: "The human rights of women include their right to have control and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[56] The FWCW Platform for Action focused explicitly on the human rights of women, and reaffirmed the position taken at the ICPD conference, that "human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights".[57]

Before ICPD and FWCW, SRH issues were exclusively dealt with in terms of population growth and demographic policies. In Cairo and Beijing (ICPD, FWCW) sexuality and reproductive health were for the first time looked at from a human rights' perspective. The new, broader definition of reproductive health also implies that reproductive health care includes services and information that people need "in order to manage their sexuality and sexual behaviour in a healthy way, such as education and counseling, access to a wide range of contraceptive choices, safe, legal abortion and protection against STIs. It includes work with young people on self-esteem and relationships, and care for women during pregnancy and after delivery. It also includes a concern increasingly, about the cancers related to reproduction, especially in women: breast cancer and cancer of the cervix".[58]

On 21 June 2001, the *Declaration of Commitment on HIV/AIDS* was adopted at the UN General Assembly Special Session on HIV/AIDS *(UNGASS)*, which explicitly recognised the interrelationship between human rights and the fight against HIV/AIDS. The Declaration states: "By 2003, enact, strengthen or enforce, as

55 Ibid., Chapter VII. 7.3.
56 United Nations, *Beijing Declaration and Platform for Action*, September 1995: *FWCW Platform of Action, Chapter IV.C.96* (http://www.un.org/womenwatch/daw/beijing/platform/, accessed 16 May 2005).
57 Ibid., *Chapter IV. I.213.*
58 Germain A., Editorial, *Entre Nous,* No.51, 2001:3.

appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the *full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS* and members of *vulnerable groups*, in particular to ensure their access to ... health care, social and health services, prevention, support and treatment, information and legal protection (...).[59]

First World Conference on Human Rights (Teheran, 1968)

The right "*to **determine freely and responsibly the number and spacing of one's children***." (§ 16)

Second World Conference on Human Rights (Vienna, 1993)

"The human rights of **women** and of the **girl-child** are an **inalienable, integral and indivisible part of universal human rights** (...)." (Art. 18)

"*The World Conference on Human Rights recognises the importance of the enjoyment by **women** of the **highest standard of physical and mental health throughout their life span** (…)*" and recognises "*a **woman's right** to accessible and adequate health care and the widest range **of family planning services** (…).*" (Art. 41)

ICPD Programme of Action (Cairo,1994)

"*Reproductive health is a state of **complete physical, mental and social well-being** (...) in all matters relating to the reproductive system and to its functions and processes... It also includes **sexual health** the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (...).*" (Ch. VII, Art. 7.2.)

"***Reproductive rights embrace certain human rights** that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their rights to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. (…).*" (Ch. VII, Art. 7.3)

59 United Nations, Special Session on HIV/AIDS, 25-27 June 2001, *Declaration of Commitment on HIV/AIDS*, 2001, *§ 58.* (http://www.icaso.org/ungass/dclonofcommnt.pdf, accessed 19 May 2005).

Fourth World Conference on Women (Beijing, 1995)

"*The **human rights of women** include their right **to have control and decide freely and responsibly** on matters related to their sexuality, including **sexual and reproductive health**, free of coercion, discrimination and violence (…).*" (Art. IV.C.96)

"*Human rights of women and the girl child are **an inalienable, integral and indivisible part of universal human rights**.*" (Art.IV.I.213)

UNGASS Declaration of Commitment on HIV/AIDS (2001)

"*By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure **the full enjoyment of all human rights and fundamental freedoms** by people living with HIV/AIDS and members of **vulnerable groups**, in particular to ensure their **access to ...health care, social and health services, prevention, support and treatment, information and legal protection** (...).*" (§ 58)

2.4. Progress after ICPD 1994

2.4.1. Committee on the Elimination of Discrimination Against Women (CEDAW): General comment 24 on Article 12 (1999)

In 1999, the Committee on the Elimination of Discrimination Against Women (CEDAW) recognised that there are societal factors, which are determinative of the health of women, and therefore explicitly called for attention to the "health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women (…)." The Committee recommends governments of states parties to implement "a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services." States parties should "ensure the removal of all barriers to women's

access to health services, education and information, including in the area of sexual and reproductive health (…)".[60]

Committee on the Elimination of Discrimination Against Women (CEDAW), General Comment 24, Article 12 on "Women and Health" (1999)

"(…) special attention should be given to the ***health needs and rights*** *of women belonging to vulnerable and disadvantaged groups, such as* ***migrant women, refugee and internally displaced women*** *(…)."* (§ 6)

"*States parties should implement a comprehensive national strategy to promote women's health* ***throughout their lifespan.*** *This (..) will ensure* ***universal access for all women*** *to a* ***full range of health care****, including* ***sexual and reproductive health services.***" (§ 29)

2.4.2. Committee on Economic, Social and Cultural Rights (ICESR), General Comment 14 (2000)

In 2000, the Committee on Economic, Social and Cultural Rights (ECESR) recognised the right to sexual and reproductive freedom, the right to access to education and information on SRH, and the availability, accessibility, acceptability and quality of health care facilities, goods and services in its General Comment (no.14, 2000) on article 12 dealing with the right to the highest attainable standard of health. Specific mention is made of the importance "to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional practices and norms that deny them their full reproductive rights."[61]

With regard to the accessibility of health facilities, goods and services, specific reference is made to the need to make them *accessible to all*, "especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds." The same provision accounts for physical accessibility: "health facilities, goods, and services, must be within

60 United Nations, General comment 24 on Article 12: Women and health (1999), Committee on the Elimination of Discrimination Against Women (CEDAW). 20th session, 1999 (http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24, accessed 7 April 2005).

61 UN Economic and Social Council, *The right to the highest attainable standard of health: .11/08/2000, E/C.12/2000/4, General Comment No 14 (2000) – I. 21 on Women and the right to health.*

safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS." The Commission further comments on the acceptability of health facilities, goods and services by stating that they must be culturally appropriate, "i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements (…)". [62]

The Committee also refers to the importance of gender in relation to health, and recommends states to adopt a gender-based approach in health-related policies, planning, programmes and research, recognising that both biological and sociocultural factors play an important role in influencing the health of women and men.[63]

Specific reference is made to asylum seekers and illegal immigrants: "In particular, states are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting access for all persons, including (...) asylum seekers and illegal immigrants, to preventive, curative and palliative health services; (...) and abstaining from imposing discriminatory practices relating to women's health status and needs." In addition, "States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, (...) including sexual education and information (...)".[64]

In general, the world health situation has changed considerably since the adoption of the Covenant, and the Committee recognises that "the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict." States are obliged to take measures "to protect all vulnerable or marginalised groups of society, in particular women, children and older persons, in the light of gender based expressions of violence.[65]

62 Ibid.
63 Ibid.
64 General Comment 14 (2000), Specific legal obligation 34.
65 UN Economic and Social Council, *The right to the highest attainable standard of health: .11/08/2000, E/C.12/2000/4, General Comment No 14 (2000) – I. 21 on Women and the right to health*, I .10 and II.35.

Committee on Economic, Social and Cultural Rights (ICESR), General Comment 14 (2000)

"*The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including* ***sexual and reproductive freedom*** *(…).* " (I. §8)

"***Accessibility***. *(…) Non-dicrimination: Health services, goods and services must be* ***accessible to all****, especially the most vulnerable and marginalised sections of the population, in law and in fact, without discrimination (…).*" (I. §12 b)

"Physical accessibility: health services, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ***ethnic minorities****,* ***women****, (…) and* ***persons with HIV/AIDS****. (…).*" (I. §12 b)

"***Acceptability***. *All health facilities, goods and services must be (…)* ***culturally appropriate****, i.e. respectful of the culture of individuals, minorities,* (…)" and "*sensitive to gender (…).*" (I. §12b)

"*States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting* ***access for all persons****, including (...)* ***asylum seekers and illegal immigrants****, to* ***preventive****,* ***curative*** *and* ***palliative health services****; (...) and abstaining from imposing discriminatory practices relating to* ***women's health status and needs***." (Specific legal obligation 34)

States should "*refrain from limiting* ***access*** *to* ***contraceptives and other means of maintaining sexual and reproductive health****, (...) including* ***sexual education*** *and* ***information*** *(...).*" (Specific legal obligation 34)

2.5. European Legal Framework

The current situation and attention to SRH in the European region needs to be understood in the light of the Declarations and Programmes of Action of both the UN International Conference on Population and Development (ICPD, Cairo, 1994) and the UN Fourth World Conference on Women (FWCW, Beijing, 1995),[66] that have marked a turning point in ways of thinking about sexuality and reproductive matters. Reproductive health, as it was defined in Cairo, has become a much broader concept than it was before.

At present, the EU has not explicitly recognised sexual and reproductive rights within its general human rights dialogue. *The Charter of Fundamental Rights of the European Union* (2000) calls for all residents to have the "right of access to preventive health care and the right to benefit from medical treatment". However, it makes no specific reference to SRH rights. More recent initiatives such as the *Council Directive 2001/55/EC* of 20 July 2001 and the *Council Directive 2003/9/EC* of 27 January 2003 deal with refugees and asylum seekers directly, setting out minimum standards for their care. The 2003 Council Directive goes on to ensure access to at least emergency care and treatment of critical illness, with specific attention paid to victims of sexual violence and vulnerable groups such as pregnant women (see also 2.5.4).

The European Parliament has played an important role in advancing human rights and in the promotion of SRHR in particular. This role, however, has been mainly limited to advancing SRHR within the EU development policy and has not been effectively applied to policies and practices within the EU MS themselves. [67]

The European human rights instruments, of both the Council of Europe and the EU make no explicit reference to SRH in any text. Within the EU, public health, including SRH, is governed by the principle of "subsidiarity", and it is therefore the responsibility of the MS.[68] In the following sections attention is paid to relevant European human right instruments and their relevance for the promotion of asylum seeking and refugee women's SRHR.

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66 1994 International Conference on Population and Development in Cairo (www.unfpa.org/icpd/icpd.htm) and the 1995 World Conference on Women in Beijing (www.un.org/womenwatch/daw/beijing/platform).

67 ASTRA Network, *Sexual and Reproductive Health and Rights in the European Union (EU) Present status and potential directions for advancement*. Warsaw, ASTRA Network, June 2004:3.

68 European Women's Lobby, *EWL Position paper: Women's sexual rights in Europe*, 28/02/2005 (http://www.womenlobby.org/Document.asp?DocID=864&tod=104834, accessed 7 May 2004); See also Treaty establishing a Constitution for Europe, Protocol 2, 16 December 2004. *Consolidated version of the treaty establishing the European community.* Official Journal of the European Communities, 24.12.2002 (http://europa.eu.int/eur-lex/lex/en/treaties/dat/12002E/pdf/12002E_EN.pdf, accessed 17 September 2004).

2.5.1. European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR 1950)

The *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR, 1950), also curtly referred to as the "European Convention on Human Rights", is particularly significant since each EU Member State has ratified the Convention and is therefore bound by the provisions of this Convention. However, the rights guaranteed in the Convention do not play a formal role in the EU institutions, because the EU as a regional body has not yet acceded to the Convention.

Although no specific reference is made to the right to health, several cases of the European Court of Human Rights have had significant health dimensions. Dent gives an example of a case concerning the consequences of sudden withdrawal of medical treatment, where the State was found liable under article 3 (inhuman and degrading treatment).[69] Nevertheless, the ECHR's relevance for SRH is very limited.

Article 14 states that the *rights and freedoms laid down in the Convention* should "be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status." Protocol No.12 to the ECHR goes a step further, as it contains a general prohibition of discrimination, which is not limited to the enjoyment of rights and freedoms laid down in the ECHR (Article 1). Protocol no. 12, however, has only recently been opened for signature, and is not yet ratified by all EU MS.[70]

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69 Article 3 Prohibition of Torture: "No one shall be subjected to torture or to inhuman degrading treatment or punishment". Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE). York University, Toronto, ECRE, November 1998:88-89.

70 University of Minnesota, *Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedom, E.T.S. 177, opened for signature April 11, 2000* (http://www1.umn.edu/humanrts/euro/z31prot12.html, accessed 1 June 2005). Article 1: "The enjoyment of *any right set forth by law* shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status" (§1). "No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1" (§2).

European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950)

The **rights and freedoms laid down in the Convention** should "*be secured **without discrimination** on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*" (Art.14)

No specific reference to the right to health.

Protocol No.12 to the ECHR

"*The enjoyment of **any right set forth by law** shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*" (Art. 1.1)

2.5.2. European Social Charter (ESC, 1961, revised in 1996)

In the revised *European Social Charter* (ESC, 1996), no reference is made to the right to SRH, and specific needs of asylum seekers and refugees are not taken into account. The ESC recognises the right to health care by stipulating that the MS should remove as far as possible the causes of ill health and that they should provide educational facilities for the promotion of health (Part II, Art. 11).[71] Part I of the Charter further states: "Everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable (Part I, Art. 11), and "anyone without adequate resources has the right to social and medical assistance" (Part I, Art. 13).[72] With regard to the right to social and medical assistance, parties should ensure that "any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security system, be granted adequate assistance, and in case of sickness, the care necessitated by his condition".[73]

71 Council of Europe, *European Social Charter (revised), Strasbourg, 3.V.1996*, Article 11 (http://conventions.coe.int/treaty/en/treaties/html/163.htm, accessed 3 May 2005).
72 Council of Europe, *European Social Charter, Turin, 18.X.1961* (http://conventions.coe.int/treaty/en/treaties/html/035.htm, accessed 4 May 2005).
73 Ibid. Article 13, equal to Article 13 of the Revised Charter (1996).

The rights of the ESC are only guaranteed to nationals of contracting states. Although the enjoyment of the rights set forth in the Charter should be "ensured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status" (Part V, Art. E), it should be noted, that as a general rule, no national of any non-contracting state is a beneficiary of the ESC's rights, whether they are asylum seekers, rejected asylum seekers, refugees granted a subsidiary or humanitarian status, refugees under contemporary protection, or refugees granted status under the 1951 UN Refugee Convention. As explained by Dent: "To the extent that they are 'lawfully resident', or 'working regularly' within the territory of a contracting state, any person falling within the above categories who is a national of a contracting state would benefit form ESC rights." Since few refugees come from contracting states, this means that the relevance of the ESC to people in these categories is very marginal.[74]

The Charter prescribes that the provisions in the Charter should not "prejudice the provisions of domestic law or of any bilateral or multilateral treaties, conventions or agreements which are already in force (...) under which more favourable treatment would be accorded to the persons protected" (Art. 31).

European Social Charter (ESC, 1961, revised in 1996)

"***Everyone*** *has the right to benefit from any measures enabling them to enjoy the* ***highest possible standard of health attainable***." (Part I, Art. 11)

"***Anyone without adequate resources*** *has the right to* ***social and medical assistance***." (Part I, Art. 13)

These provisions "*shall not prejudice the provisions of domestic law or of any bilateral or* ***multilateral treaties, conventions or agreements which are already in force (...) under which more favourable treatment would be accorded to the persons protected.***" (Art. 31)

74 See also Dent J. A., *Research Paper on the Social and Economic Rights of Non-nationals in Europe*, Commissioned by the European Council on Refugees and Exiles (ECRE).

HOWEVER

These provisions only apply to foreigners ***"insofar as they are nationals of other Contracting Parties*** *lawfully resident or working regularly within the territory of the Contracting Party concerned.*" (Appendix to the Social Charter, Art.1)

2.5.3. European Charter of Fundamental Rights (ECFR 2000)

The *European Charter of Fundamental Rights* (ECFR, 2000) could be used as an instrument to advance SRHR, although it does not include any reference to SRHR. This Charter was drafted in 1999-2000 and officially proclaimed in December 2000. It lays down the equality before the law of all people (Article 20), prohibits discrimination on any ground (Art. 21), and requests the Union to protect cultural, religious and linguistic diversity (Art. 22). The European Commission's actions in the field of external relations are guided by compliance with the rights and principles contained in the ECFR, but for the present it carries no formal legal weight. The Constitution of the EU[75], which is still in the phase of ratification, "enshrines citizens' rights by incorporating the European Charter".[76] This would pledge member countries to follow the Charter's provisions when they make decisions in the context of Community Law.

The Charter contains different human rights that can be adopted in the field of SRH, especially Article 3 on the right to respect the physical and mental integrity of the person, and the need to respect the free and informed consent of the person concerned in the fields of medicine and biology (Art.3.2). In article 35 on health care, the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices are laid down. The Charter reaffirms these rights, which exist in current treaties, including the European Convention for the Protection of Human Rights and Fundamental Freedoms, and in the case law of the European Court of Justice and the European Court of Human Rights.[77]

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75 For more information on the European Constitution see: http://www.unizar.es/euroconstitucion/Treaties/Treaty_Const.htm

76 *Rome Declaration v. Giscard D'Estaing Chairman of the European Convention*. Rome, 18 July 2003 (http://european-convention.eu.int/docs/Treaty/Rome_EN.pdf, accessed 25 June 2004).

European Charter of Fundamental Rights (ECFR, 2000)

"***Everyone has the right of access to preventive health care and the right to benefit from medical treatment*** *under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.*" (Art.35)

No specific reference to SRH rights.

Not (yet) legally binding.

2.5.4. European Directives on Asylum Seekers and Refugees (2001, 2003)

The EU's asylum and immigration policy is based on three main directives. Two directives are relevant to ASRW living in EU host countries.[78] The European Parliament has been a pioneer in introducing the gender dimension into asylum policy. This is important, as almost half of the world's refugees are female (49%).[79] The implementation of the European Asylum Policy, however, is still in its early phase.

On 20 July 2001, the Council of the EU adopted the Council Directive 2001/55/EC "on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between MS in receiving such persons and bearing the consequences thereof." [80] The Directive obliges MS to provide medical care for persons enjoying temporary protection. The assistance necessary for medical care should include "at least emergency care and essential treatment of illness". In addition,

77 ASTRA Network, *Sexual and Reproductive Health and Rights in the European Union (EU) Present status and potential directions for advancement*. Warsaw, ASTRA Network, June 2004:2.

78 One legislative tool, which is not discussed here, is the Council Directive 2004/83/EC of 29 April 2004, on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted. This directive establishes the minimum norms to be classified as a refugee and establishes the benefits that come with obtaining the official refugee or asylum status.

79 UNHCR, 2003 *Global Refugee Trends, Overview of Refugee Populations, New Arrivals, Durable Solutions, Asylum Seekers and Other Persons of Concern to UNHCR*. Geneva, Population Data Unit/PGDS, Division of Operational Support, UNHCR, 15 June 2004.

80 Available at http://europa.eu.int/comm/justice_home/news/prot_tempo/documents/dir-2001-55-ce_en.pdf. Note: Ireland is not participating in the adoption of this Directive.

MS are obliged to provide necessary or other assistance to persons who have special needs, such as persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence (Art.13).

On 27 January 2003, the Council of the EU adopted the Council Directive 2003/9/EC, which laid down minimum-standards for the reception of asylum seekers, a second important legal instrument within the EU.[81] The establishment of minimum standards for the reception of asylum seekers is a further step towards a European asylum policy[82], as agreed on in Tampere in October 1999.[83] By August 6, 2006, the European Commission shall report to the European Parliament and the Council on the application of the Directive.[84]

The provisions regarding health care for asylum seekers are broadly similar as for persons requiring temporary protection. Medical care, with as a minimum standard emergency care and essential treatment of illness, should be ensured by all MS (Art.15). The Directive further states that the national legislation of MS should take the specific situation of vulnerable groups into account. Relating to material reception conditions and health care this includes " (…) pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence" (Art. 17.1). As with regard to victims of torture and violence, according to the Directive, MS should ensure that "if necessary, persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment of damages caused (…)" (Ch. IV, Article 20).

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81 COUNCIL DIRECTIVE 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof. *Official Journal of the European Communities*, 7.8.2001 (http://europa.eu.int/comm/justice_home/news/prot_tempo/documents/dir-2001-55-ce_en.pdf, accessed 8 November 2004).

82 COUNCIL DIRECTIVE 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers. *Official Journal of the European Communities*, 6.2.2003 (http://www.ecre.org/eu_developments/reception/recdirfinal.pdf, accessed 8 November 2004). It is important to note that the Council has accepted the fundamental principle that all asylum seekers will be covered by this Directive, unless they explicitly ask for a protection different from the Geneva Convention refugee status.

83 On October 15 and 16, 1999, the European Council had a special meeting in Tampere where it agreed "to work towards establishing a Common European Asylum System, based on the full and inclusive application of the Geneva Convention relating to the Status of Refugees of 28 July 1951, as supplemented by the New York Protocol of 31 January 1967, thus maintaining the principle of non-refoulement." In: Council Directive 2003/9/EC, 27 January 2003 (2).

84 See also Ch. VII, Article 25, Council Directive 2003/9/EC of 27 January 2003, laying down minimum standards for the reception of asylum seekers.in the Member States of the European Union.

Both directives are an important first step towards providing health care for asylum seekers and persons under temporary protection. Nevertheless, these directives do not include access of ASRW to SRH care such as antenatal and/or postnatal care, family planning and counselling, prevention of mother to child transmission of HIV, HIV screening and treatment and cervical cancer screening and treatment.

Council Directive 2001/55/EC of 20 July 2001

Member States shall ensure "***at least***, ***emergency*** *care and* ***essential*** *treatment of* ***illness***" and "*shall provide necessary medical or other assistance to* ***persons*** *(...) who have* ***special needs***, *such as (...) persons who have undergone* ***torture***, ***rape*** *or other serious froms of* ***psychological***, ***physical*** *or* ***sexual violence***." (Art.13.2 and 13.4)

Council Directive 2003/9/EC of 27 January 2003

Member States shall ensure "***at least***, ***emergency*** *care and* ***essential*** *treatment of* ***illness***." (Art.15)

Member States "*shall take into account the* ***specific situation of vulnerable groups*** *such as (…)* ***pregnant women***, ***single parents with minor children*** *and persons who have been subjected to* ***torture***, ***rape*** *or other serious forms of* ***psychological, physical*** *or* ***sexual violence*** *(...).*" (Art. 17.1.)

2.6. Entitlement to Health Care for Asylum Seekers and Statutory Refugees

Health and human rights are proven to be at risk among the most vulnerable groups of society, such as asylum seekers and refugees.[85] National regulations, laws, and policies regulate entitlement to health services in the EU MS. These entitlements may vary greatly, particularly where asylum seekers are concerned.[86]

85 See for example Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003; Consiglio Italiano Per I Refugiati (CIR), *Good Practice Guide on the Integration of Refugees in the European Union, The Good Practice Guide on Health*. Rome, ECRE Task Force on Integration, 2002. See also www.refugeenet.org; UNAIDS/IOM, *Migrants' Right to Health*, Paper prepared by Margaret Duckett for UNAIDS and the International Organization for Migration. Geneva, UNAIDS, 2001.

86 As part of this wider research project into the *Integration of Refugee Women in Europe through the Promotion*

At a basic level, migrants' entitlement to social protection in Western Europe depends on whether benefits are provided primarily as a result of being employed and having contributed to the social insurance system – as is the case in labour-importing countries of Western Europe –; or are granted on the basis of residence – such as the Scandinavian countries or the United Kingdom.[87]

Throughout Europe, statutory refugees are fully entitled to access to national health services under the 1951 UN Convention Relating to the Status of Refugees (Art. 23). The right to health for asylum seekers in Europe, on the other hand, varies greatly according to national legislation. Asylum seekers have limited access to the national health system in the EU MS and the extent of limitation varies greatly.[88] In some countries asylum seekers are only entitled to emergency care (e.g. Austria, Italy, Portugal, Sweden). A few countries make some exceptions, such as Finland for children and pregnant women. In some countries it remains unclear and in other countries asylum seekers have "full access" to the NHS (e.g. the Netherlands, Luxembourg).[89]

As a result, the scope and quality of SRH services to which refugees and asylum seekers have access vary greatly. Rights of people and standards regarding access to care are unclear. Many care and support providers are not duly informed about possibilities to support migrants, refugees, and asylum seekers. In the EU MS policies that take the needs of these population groups into account are varied. In countries like Greece and Italy, which have specific regulations on access to health care, there is a gap between policy and practice. Despite some positive trends, such as the HIV anti-discrimination law and comprehensive access to health care for young migrants under eighteen in Spain, a general rights-based access to services and appropriate standards are still missing in most European countries (see also 3.2.1.).[90]

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of Their Sexual and Reproductive Health Rights, ICRH conducted a survey analysis, based on the outcomes of a widely disseminated questionnaire in he 15 old EU MS. This survey provides more information on asylum seekers' and refugees' entitlement to SRH services in the EU MS. See Janssens K., Bosmans B., and Temmerman M., *Sexual and Reproductive Health and Rights of Refugee Women in Europe. National Policies on Sexual and Reproductive Health for Asylum Seekers and Refugees (Survey Analysis)*. Ghent, Academia Press, June 2005.

87 United Nations, *Report on the World Social Situation 2003. Social Vulnerability: Sources and Challenges*. New York, 2003:35.

88 See for more specific information on entitlement to health in the old European Member States: http://www.refugeenet.org/health/grids_1.html (accessed on November 17, 2004).

89 Based on data of the ECRE Task Force on Integration, Theme "Health" (1997-2000). For more specific information on entitlement to health in the old European Member States see http://www.refugeenet.org/health/grids_1.html

90 Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003.

2.7. CONCLUSIONS

SRH rights are human rights, which are inextrincably linked with women's rights. Like all human rights, SRHR are universal, inalienable, indivisible, interdependent and interrelated. SRH rights are embedded in a wide range of international conventions, conference documents and declarations.

Despite great progress with the integration of SRH rights into the international human rights agenda, so far the EU has not explicitly recognised SRH rights as human rights. The European Parliament has played an important role in advancing human rights and in the promotion of SRHR in particular. This role, however, has mainly been limited to advancing SRHR within the EU development policy and has not been effectively applied to policies and practices within the EU MS themselves.

The European human rights instruments, of both the Council of Europe and the EU, make no explicit reference to SRH in any text. In the European Social Charter (ESC), where the right to "benefit from any measures enabling them to enjoy the highest possible standard of health attainable" is recognised, this right is only guaranteed to nationals from contracting states to the ESC, excluding nationals from any non-contracting state, whether asylum seekers, rejected asylum seekers, refugees granted a subsidiary or humanitarian status, refugees under contemporary protection, or refugees granted status under the 1951 UN Refugee Convention. Within the EU, public health, including SRH, is governed by the principle of "subsidiarity", and it is therefore the responsibility of the MS.

The EU Directives are legally binding and oblige EU MS to provide medical care to asylum seekers and displaced persons who need temporary protection. This requirement, however, is limited to emergency care and essential treatment of illness, which does not guarantee their access to the full range of SRH services in EU MS. The Directives prescribe national legislation of MS to take the specific situation of vulnerable groups into account, including pregnant women, single parents with minor children, and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence.

The right to health, including SRH, for asylum seekers and refugees in Europe varies greatly according to national legislation in EU MS. In many EU MS asylum seekers have (very) limited access to the national health system. The extent of the limitations varies greatly. New legislative tools do not guarantee asylum seekers' and refugees' full enjoyment of their SRHR. Obviously, this seriously affects their overall health, including their SRH.

3

SEXUAL AND REPRODUCTIVE HEALTH OF ASYLUM SEEKERS AND STATUTORY REFUGEES: EUROPEAN POLICIES

"It's about time that the Member States and Candidate Countries acted upon what has been a long-standing issue in international forums, especially knowing the important disparities between the experiences of European countries. Europe can help reduce the inequalities in the areas of sexual and reproductive health. It is about time we learn from each other."

Anne Van Lancker, rapporteur welcoming the outcome of the vote of 3 July 2002 [91]

91 IPPF European Network, *Sexual and Reproductive Health and Rights in Europe. A Landmark Resolution of the European Parliament* (Thematic Publication). Brussels, IPPF EN, September 2002 (http://www.ippfen.org/site.html?page=34&lang=en, accessed 5 April 2004).

This Chapter looks at relevant policy developments within the EU in the field of SRH, with a specific focus on policies that take the specific needs of asylum seekers and statutory refugees into account.

So far, the EU has no explicit policy on SRH for the EU MS. This is partly the result of the fact that public health, including SRH, is high on the national political agendas and that most governments do not want the EU to interfere with it. The EU, however, has many opportunities to address and advance SRHR.[92]

3.1. European Health Policy Developments

The European Parliament has been very active in putting the issue of SRHR on the European political agenda, particularly with respect of the regulations on aid policies and actions in developing countries. Considering the important efforts made towards developing countries, it is especially striking to see that the EU did not take up a similar role in the implementation of a coordinated SRHR policy within Europe.[93]

3.1.1. Resolution on Sexual and Reproductive Health and Rights (2002)

The Committee on Women's Rights and Equal Opportunities in the European Parliament is responsible for monitoring and evaluating the implementation of women's rights in the Union, and the follow-up and implementation of international agreements and conventions concerning women's rights. In June 2002, Anne Van Lancker, Member of European Parliament (MEP), presented a report from the Committee on SRHR, based on the commitments that were made during the UN Cairo and Beijing Conferences. The aim of the report was to reinforce the commitments made by EU MS and Accession Countries at the ICPD and Beijing Conferences through stimulating the exchange of information and good practices regarding SRH care between the different MS.[94] On 3 July 2002, the European Parliament adopted the report and voted in favour of the Resolution on Sexual and Reproductive Health and Rights. The Resolution pays

92 The ASTRA Network highlights the fact that it is important to stress that "an inter-sectoral approach will be most effective as SRHR issues are complex and will only be effectively addressed if all the relevant EU institutions acknowledge their responsibility to tackle SRHR and coordinate efforts to advance and promote SRHR in the European Union." In: ASTRA Network, *Sexual and Reproductive Health and Rights in the European Union (EU) Present status and potential directions for advancement*. Warsaw, ASTRA Network, June 2004.

93 Lancker, A. Putting Sexual and Reproductive Rights on the EU Agenda. *Choices*, Autumn 2003: 24-26.

94 Van Lancker A. (rapporteur), *Report on sexual and reproductive health and rights (2001/2128 (INI))*. Committee on Women's Rights and Equal Opportunities, 6 June 2002.

specific attention to the SRH needs and rights of vulnerable groups within the EU. It urges MS to provide contraceptives and SRH services free of charge, or at low cost, "for underserved groups, such as (…) ethnic minorities and the socially excluded" and calls upon the governments of the MS to provide specialised SRH services "which include high quality and professional advice and counselling adapted to the needs of specific groups", such as immigrants.[95]

A resolution from the European Parliament, however, does not constitute a legal basis for action by the European Commission. The Commission is not authorised to engage in health care delivery, including SRH care in the EU MS. The EU competence in this field consists of providing guidelines and useful initiatives to encourage cooperation.[96] Nevertheless, Commissioner Byrne (Health, Environment and Consumer Protection) emphasised that SRH will be part of the new EU Health Strategy. This resolution is a resource and advocacy tool to bring SRH issues to the attention of their national governments and the EU.[97]

Resolution on Sexual and Reproductive Health and Rights (2002)

Urges the governments of the MS and the candidate countries "*to strive to provide* ***contraceptives*** *and* ***sexual and reproductive health services free of charge, or at low cost****, for underserved groups, such as (…)* ***ethnic minorities*** *and the socially excluded*." (§ 4)

"*Calls upon the governments of the MS (…) to provide* ***specialised sexual and reproductive health services*** *which include high quality and professional advice and counseling* ***adapted to the needs*** *of specific groups (****e.g. immigrants****), provided by a trained, multidisciplinary staff; (…).*" (§ 11)

One of the methods that can be used by the EU in the promotion of SRHR in the EU MS is the "Open Method of Coordination". This is a strategy to reinforce the engagements of the MS and to encourage the exchange of best practices and information based on strategy reports, common objectives and indicators to measure the situation and the results of policies. It is "a horizontal approach for

95 Resolution on Sexual and reproductive health and rights (P5_TA (2002) 0359).

96 European Parliament, *Resolution on Sexual and reproductive health and rights (P5_TA (2002) 0359).* (http://www2.europarl.eu.int/omk/sipade2?PUBREF=-//EP//TEXT+TA+P5-TA-2002-0359+0+DOC+XML+V0//EN&LEVEL=3&NAV=X, accessed 5 April 2004).

97 Claeys V., New EU Resolution on Sexual and Reproductive Health and Rights, *Entres Nous*, No.54, 2002:17 (http://www.euro.who.int/document/ens/en54.pdf, accessed 5 April 2004).

policy areas where the competence remains primarily with the MS, such as the organisation of health care. The aim is to achieve some degree of convergence between MS' policies through a process of mutual learning, based upon common indicators and benchmarks, exchange of best practices and comparison of data and policies." According to Van Lancker, MEP, the EU could extend this approach to SRH.[98]

Until now, this open method of coordination does not focus on SRH. With regard to access to health care, the overall aim is to guarantee access to high quality care, based on the principles of universality, equity, and solidarity, and to anticipate poverty or social exclusion as a result of illness, an accident, a handicap, or health care needs in consequence of high age, to care receivers and their family alike. One of the specific commitments of the MS – depending on the specific determinants of the national health system – is to provide good quality care to the population, adapted to their needs. *Specific attention* should be paid to persons and groups who have particular problems in accessing health care, such as *ethnic minorities*, *migrants*, and people with low income.[99]

3.1.2. EU Public Health Policy (2003 – 2008)

The Maastricht Treaty of 1992, which changed the European Economic Community into a more politically oriented EU, paved the way for compromise and cooperation in areas that were previously under the mandate of the national governments. The Maastricht Treaty included a mandate of "encouraging cooperation between member states" and if necessary "lending support to their actions" in public health (Art. 129(1)). The Amsterdam Treaty of 1997 revised the EU's mandate regarding health policy, and strengthened it considerably.[100]

Nevertheless, Article 152, Paragraph 5, of the Amsterdam Treaty states: "Community action in the field of public health shall fully respect the responsi-

98 Van Lancker, A. Putting Sexual and Reproductive Rights on the EU Agenda. *Choices*, Autumn 2003: 24-26.

99 Commissie van de Europese Gemeenschappen, *Mededeling van de Commissie aan de Raad, het Europees Parlement, het Europees Economisch en Sociaal Comité en het Parlement, het Europees Economisch en Sociaal Comité en het Comité van de regio's. Modernisering van de sociale bescherming voor de ontwikkeling van hoogwaardige, toegankelijke en duurzame gezondheidszorg en langdurige zorg: steun aan de nationale strategieën door middel van een "open coördinatiemethode" [Communication from the Commission to the Council, the European Parliament, the European Economical and Social Committee of the regions. Modernization of the social protection for the development of high quality, accessible and lasting public health care and prolonged care: support to the national strategies through a "method of open coordination"]*. Brussels, 30.04.2004, COM(2004) 304 definitief.

100 ASTRA Network, *Sexual and Reproductive Health and Rights in the European Union (EU) Present status and potential directions for advancement*. Warsaw, ASTRA Network, June 2004.

bilities of the Member States for the organisation and delivery of health services and medical care." [101] Health *promotion* falls within the competence of Europe even if health *care* remains within the competence of the MS. One of the policy areas where an "Open Method of Coordination" could be used is the European Public Health Policy. One of the objectives of the Public Health Programme is to develop comparable information on health, including information on health systems (indicators on access to care, on quality, etc.). The development of these data will be based on European wide health indicators.[102] In this context, the European Commission has already started a project on EU reproductive health indicators that is based on the specificities of the European region.[103]

On 23 September 2002, the European Parliament and the Council adopted the *Community Action Programme in the field of Public Health (2003-2008)*[104], which is aimed at fulfilling Article 152 of the Maastricht Treaty. The overall aim of the public health programme is to "contribute towards the attainment of a high level of physical and mental health and well-being and greater equality in health matters throughout the Community (…)" (§ 18). In the Programme there is no specific reference to SRH needs and rights, except for the threat of HIV/AIDS (§ 10), nor to other specific health needs of vulnerable groups.

For the future, the intention of the European Commision is to develop a EU System of Information on Health and Knowledge, fully accessible to all European experts and public. One of the main outputs will be a EU Health Portal, supporting easy access for citizens and professionals to thematic information resources on public health on the EU level.[105] The role of the European Parliament should be to make sure that the SRH indicators are part of this system, so that data become comparable and needs can be better defined.

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101 Consolidated version of the treaty establishing the European community. In: Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Related Acts. *Official Journal C 340, 10 November 1997* (http://europa.eu.int/eur-lex/en/treaties/dat/amsterdam.html#0145010077, 17 September 2004).

102 European Commission, *Developing health indicators and data collection* (online) http://www.europa.eu.int/comm/health/ph_information/indicators/indic_data_en.htm, accessed 9 August 2004).

103 Oliveira da Silva M. (Project Co-ordinator), *REPROSTAT, Reproductive Health Indicators in the European Union (Final Activity Report)*, August 2003 http://europa.eu.int/comm/health/ph_projects/2001/monitoring/fp_monitoring_2001_exs_02_en.pdf, accessed 9 August 2004).

104 European Parliament and European Council, *Decision No 1786/2002/EC of the European Parliament and the Council of 23 September adopting a programme of Community action in the field of public health (2003-2008)*, 9.10.2002.

105 European Commission, *Developing health indicators and data collection* (online) http://www.europa.eu.int/comm/health/ph_information/indicators/indic_data_en.htm, accessed 9 August 2004).

Treaty of Amsterdam Amending the Treaty on European Union (1997)

"*Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. (…).*" (Art.152.5)

Programme of Community Action in the Field of Public Health (2003-2008)

"(…) Infectious diseases, such as ***HIV/AIDS****, and anti-microbial resistance are also becoming a threat to the health of all people in Europe."* (§ 10)

No specific reference is made to SRH needs and rights, except for the threat of HIV/AIDS. (§10)

No reference is made to other specific health needs of vulnerable groups.

3.1.3. European Strategy for the Promotion of Sexual and Reproductive Health and Rights (2004)

On 5 October 2004, the Parliamentary Assembly of the Council of Europe adopted a resolution on a *European strategy for the promotion of sexual and reproductive health and rights*. Although many Council of Europe MS have high standards of SRH, the Assembly points at an enormous disparity of standards regarding SRH issues between MS and within MS, and addresses the need for appropriate SRH information and services, particularly in many eastern European countries, where contraceptive use remains low, leading to unwanted pregnancies and high abortion rates.[106]

The Resolution calls upon MS to collaborate in order to design a European strategy for the promotion of SRH and rights, and to prepare, adopt and implement comprehensive national strategies for SRH. MS are also urged to respond to the specific needs of vulnerable population groups, including migrants and minorities and "to engage in a dialogue with young people and vulnerable population

106 Parliamentary Assembly Resolution 1399 (2004), European Strategy for the promotion of sexual and reproductive health and rights, Adopted on 5 October 2004. Available at Council of Europe, *Parliamentary Assembly Resolution 1399 (2004), European Strategy for the promotion of sexual and reproductive health and rights*, 2004 (http://assembly.coe.int/Documents/AdoptedText/ta04/ERES1399.htm, accessed 6 April 2004).

groups in the formulation of appropriate strategies and programmes, which respond to these groups' sexual and reproductive health needs".[107]

Nevertheless, the EU does not have the mandate to actually enforce the formulated recommendations in the EU MS, since the subsidiarity principle means that health issues are dealth with at national level.

European strategy for the promotion of sexual and reproductive health and rights

The Parliamentary Assembly of the Council of Europe calls upon MS to "*work together to design a European strategy*" for the promotion of SRH and rights, and to "*prepare, adopt and implement* ***comprehensive national strategies***" for **SRH** (…). (11.i)

(...) calls upon the member states to "*respond to the* ***specific needs of vulnerable population groups, including migrants*** *(…).*" (11.vii)

3.2. Focus of National Health Policies in Europe on Migrants

3.2.1. National Health Policies and Migrants

Although the protection of persons belonging to minorities is an inherent part of the EU policy on human rights, it seems that insufficient attention is paid to the health needs of migrants and ethnic minorities in EU MS. In 2001, the Council of Europe expressed its serious concern that few countries in Europe had developed "comprehensive health policies concerning migrants and refugees", noting that "in general, migrants and refugees are not provided with health services that are socially and culturally adjusted to their needs."[108]

Health policies and internal national policies cannot be separated. Entitlement to health care for migrants is related to their residence status, and this implies that it is related to social health insurance entitlement.[109] In the area of (health) policies for migrants and ethnic minorities a wide range of insufficiencies and inconsistencies can be identified. Dispersal policies, which exist in Ireland and

107 Ibid.

108 Council of Europe, *Parliamentary Assembly Recommendation 11503 (2001) Health conditions of migrants and refugees in Europe*, 2001 (http://assembly.coe.int/Documents/AdoptedText/ta01/EREC1503.htm, accessed 14 December 2004).

the United Kingdom, make access to care and support services more difficult for asylum seekers with health problems in general and with HIV in particular. In some countries, such as Finland and Portugal, health policies taking migrants and ethnic minorities into account are insufficient or entirely missing. In countries like Greece and Italy, which have specific regulations on access to health care, there is a gap between policy and practice.[110] In Greece, for example – which has developed comprehensive health policies concerning migrants, refugees and asylum seekers – asylum seekers receive a 'pink card' as proof of their asylum application, which entitles them to free medical care, including antiretroviral treatment. Despite this regulation, a large number of asylum seekers do not, in practice, receive a pink card and therefore do not have access to free medical care.[111]

The ongoing privatisation of health care, as is the case in Portugal, particularly affects the access to health services of migrants and ethnic minorities. In many European countries the increasing importance of private insurances and patient contributions affects in particular those who live on the margins of society and who have very limited financial resources. In Austria, for example, gaps in health insurance regulations for migrants were reported.[112] In general, the Austrian health care system does not take refugees' and migrants' specific needs into account. Especially asylum seekers do not have access to medical treatment, since they are frequently not supported by official authorities and consequently have no health insurance. These asylum seekers only receive emergency care.[113]

In addition, the European Council on Refugees and Exiles (ECRE) reported in 2001 that there is little co-ordination between the legislative process at the national level and the process of harmonisation of European asylum and immigration legislation. "Constant changes at the national level hinder progress at the EU level and drive down the standards under negotiation. The development of national legislation should be in line with the European asylum legislative process. Within this context, ECRE supports the proposal by the Belgian Presidency for a loyalty clause whereby MS would commit themselves not to pass national laws that conflict with EU proposals under discussion."[114]

109 Putter J., De (ed.), AIDS & *STDs and Migrants, Ethnic Minorities and other Mobile Groups; The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 1998: 13, 19.

110 Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:155-157.

111 Zacharouli E., Mavraki A., Country Report Greece, in: Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:59-69.

112 Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:156.

113 Berger E.C., and E. Glanzer, Country Report Austria. In: Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:14-27).

114 European Council on Refugees and Exiles (ECRE), *The Promise of Protection: Progress towards a European Asylum Policy since the Tampere Summit 1999*. ECRE, November 2001.

3.2.2. National Sexual and Reproductive Health Policies and Migrants

In 2002, the Committee on Women's Rights and Equal Opportunities reported that none of the national governments in the EU has "a clear and separate policy on sexual and reproductive health, but the majority of countries support family planning services, which are, on the whole, widely available through health systems, mostly through general practitioners."[115] So far, national governments of EU MS have not adopted and implemented comprehensive national SRH policies. European wide, however, attention is paid to specific SRH related issues, such as abortion, violence against women, and female genital mutilation. In all three issues the vulnerability of migrants and ethnic minorities is highlighted.

Abortion

Abortion policies are diverse in the EU MS. In August 2004, the Center of Reproductive Rights and Policy reported: "A woman's right to control her own body remains elusive in many countries." Both old and new EU MS - Ireland, Malta, Poland, and Portugal - still impose severe restrictions on abortion, with serious consequences for the health, social status and quality of life of many women. In Portugal, women are still being prosecuted for having abortions. In most countries in Central and Eastern Europe, women do not have access to the full range of family planning methods and access to SRH information and services, including unbiased sexuality education, are identified as a problem. In these countries – but also in Western Europe (see Chapter 4) - adolescents and *certain ethnic and (im)migrant minorities* face particular discrimination and other barriers to exercising their SRHR.[116]

Violence Against Women

Legislation on different aspects of violence against women has improved in the EU MS. National action plans to combat violence against women are important tools for comprehensive action. Crimes against women such as those committed in the name of honour, are being addressed through policy and awareness-raising measures. In order to expand and create support services for victims of violence,

115 Van Lancker A. (rapporteur), *Report on sexual and reproductive health and rights (2001/2128 (INI))*. Committee on Women's Rights and Equal Opportunities, 6 June 2002:14.

116 Center of Reproductive Rights and Policy see http://www.reproductiverights.org/pub_bp_ECHR.html (accessed on 22 November 2004). With regard to safe abortion, it is important to note that the ICPD Programme of Action highlights: "In no case should abortion be promoted as a method of family planning"

governments have worked with different stakeholders - with research institutions and NGOs in particular - to improve the quality of such services, and to support specific "*vulnerable groups of women such as (im)migrant women*." [117]

In the Netherlands, for example, a policy and measures have been developed to provide "greater insight into the nature and scale of crimes committed in the name of honour and honour-related violence in the country, to support the integration and emancipation of *women and girls from ethnic minorities*, and enhance their awareness of their rights, inter alia, in relation to honour crimes. Sweden, as part of its immigration and integration policy, had developed guidelines to give more adequate attention in the asylum process to women's need for protection, and as part of the implementation of those guidelines, personnel had been trained regarding the concept of honour. Assistance was provided to Swedes in distress abroad, including girls and young women abducted for forced marriages abroad, and their return was facilitated."[118]

Although progress has been made thus far, governments are urged by the UN Secretary General to "accelerate the preparation of comprehensive legislative frameworks to criminalize all forms of violence against women, put in place adequate penalties for perpetrators, and ensure that violence against women is prosecuted and punished. (…) Women victims of violence, or women who are at risk of repeated acts of violence in the home, should have immediate means of redress and protection, including protection or restraining orders, access to legal aid, and shelters staffed with personnel who are sensitive to victims' needs. Priority attention must be given to ensuring that implementation of legislation and of policies and programmes is adequately funded throughout the territory of a State."[119]

Female Genital Mutilation (FGM)

Interest in FGM is increasing steadily at the EU policy level, yet general strategies applicable in all MS are not available.[120] In 2001, the European Parliamentary

117 United Nations, *Violence Against Women*, Report of the Secretary-General, A/59/281, 20 August 2004 (http://daccessdds.un.org/doc/UNDOC/GEN/N04/465/59/PDF/N0446559.pdf?OpenElement, accessed 20 May 2004).

118 Ibid.

119 Ibid.

120 Powell RA, Leye E, Jayakody A, Mwangi-Powell FN, Morison L, Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy*, 2004, 70:151-162; Leye E, Deblonde J. and M. Temmerman, Vrouwenbesnijdenis in Europa. Enkele knelpunten bij de aanpak van de gezondheidszorg, wetgeving en preventiewerk. *Ethiek & Maatschappij*, 2004, 7 (4): 40-53; Leye E., Strategies of FGM prevention in Europe. In: Comfort C (ed.). *Female genital mutilation*. Radcliffe Publishing Ltd. (in press).

Committee on Women's Rights and Equal Opportunities developed a report on FGM, which included a resolution on FGM of the European Parliament.[121] The European Parliament has adopted the Resolution on FGM in September 2001 (2001/2035 (INI)), and although not legally binding, the Resolution shows the commitment of the European Parliament to act against FGM. The Resolution urges MS – among others – to develop specific legislation with regard to FGM, in cases where general laws are not effective.[122]

Legal provisions pertaining to FGM are found in a variety of sources, including criminal laws and child protection laws. European countries that have developed specific laws include: Austria, Belgium, Denmark, Spain, Sweden and the UK. In all other old MS (Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Portugal and the Netherlands) FGM is forbidden under general criminal law. [123]

3.3. CONCLUSIONS

Worldwide, there is growing awareness about the SRH needs and rights of refugee and internally displaced women. Apparently, international policies for the protection of the SRH rights of women displaced by war and armed conflict are mainly considered when operating in developing countries, rather than when dealing with these populations within the EU.

The EU has played a major role in putting SRHR on the European political agenda. Recent developments in the EU, such as the Resolution on Sexual and Reproductive Health and Rights (2002) and the European Strategy for the Promotion of Sexual and Reproductive Health and Rights (2004), create opportunities to promote SRHR in EU MS. Reference is made to the needs of ethnic minorities and migrants, but not specifically to the needs of ASRW.

Despite the efforts of the EU, no specific reference to SRH needs and rights is made in the EU Public Health Policy (2003-2008), except for the threat of HIV/AIDS. The EU could adopt the "Open Method of Coordination" in its pro-

121 Valenciano Martínez-Orozco E. (Rapporteur), *Report on female genital mutilation (A5-0285/2001).* Committee on Women's Rights and Equal Opportunities, 17 July 2001 (http://www.radicalparty.org/fgm/rep_valenciano_e.doc, accessed 8 September 2004).

122 European Parliament, *Resolution on female genital mutilation* (2001/2035 (INI)) (http://europa.eu.int/eur-lex/pri/en/oj/dat/2002/ce077/ce07720020328en01260133.pdf, accessed 3 September 2004).

123 See also Leye E., Deblonde J., *Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK.* Ghent, International Centre for Reproductive Health, April 2004.

motion of SRHR, which also addresses the need for MS to provide good quality care, adapted to the needs of specific population groups such as ethnic minorities and migrants. Nevertheless, the EU has no mandate to actually enforce their recommendations in the EU MS, since the subsidiarity principle means that health issues are dealt with at national level.

In general, national health policies in the EU MS, however, show a wide range of insufficiencies and inconsistencies, and in some countries the needs of asylum seekers and refugees are not taken into account at all. National governments of the EU MS do not have clear and separated SRH policies. Different policies are being implemented, which cover specific SRH aspects such as abortion, violence against women, and female genital mutilation. It is clear that there are still many differences in legislation and implementation of such policies in the EU MS, and that specific attention is still needed for vulnerable groups such as (im)migrants and ethnic minorities, including ASRW.

4

REFUGEE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH: STATUS AND NEEDS IN EUROPE

Asylum seekers and refugees are not homogeneous groups of people, and have different needs, expectations of health and of health care. Asylum seeking and refugee women (ASRW) often face particular difficulties, which are not acknowledged. This chapter explores their SRH needs, focusing on the following SRH key issues: safe motherhood; aspects related to unwanted pregnancy; family planning; sexually transmitted infections (including HIV/AIDS); and sexual and gender based violence, including harmful traditional practices such as female genital mutilation.

This chapter gives a state of the art of the SRH status of migrant and refugee women in the EU. The health status of (forced) migrants is related to different determinants, which have an impact on their overall health, including their SRH. In order to identify ASRW's SRH needs in a European context, first some general health issues will be highlighted in the broader context of migrant health.

4.1. Sexual and Reproductive Health Status of Refugee Women in Europe

In the EU there is currently a big contrast in health and health care status between the old European MS and the new European MS (formerly referred to as Accession Countries), and particularly so in the field of SRH.[124] Adolescents and migrants are recognised by the WHO to be at particular risk in their SRH. Migrants, including asylum seekers and refugees, run a higher risk of reproductive morbidity, of STIs (including HIV/AIDS), and unwanted pregnancies are common. Some migrants are forced into unprotected sexual relations, and migrant women in particular are at risk of violence.[125]

A literature review on the health status of refugees in Europe shows that attention is primarily paid to mental health and the care of traumatised refugees (with specific attention for Post-Traumatic Stress Disorder). Even though this is an important issue of concern, this focus has overshadowed the identification of other risk factors in the post migration phase. Possibilities to track down health benefits by early notice and timely treatment of physical affections have been underexposed.[126] Some mental problems could be related to SRH aspects as well. This is most obvious in the case of victims of sexual and gender-based violence.

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124 Van Lancker A. (rapporteur), *Report on sexual and reproductive health and rights (2001/2128 (INI))*. Committee on Women's Rights and Equal Opportunities, 6 June 2002; WHO, *Regional Strategy on Sexual and Reproductive Health*. Copenhagen, WHO (Reproductive Health/Pregnancy Programme), November 2001.

125 WHO, *Regional Strategy on Sexual and Reproductive Health*. Copenhagen, WHO (Reproductive Health/Pregnancy Programme), November 2001:2.

126 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen*. Utrecht, Pharos, 2003:138-139.

Therefore, a holistic approach to the health of refugees is required, since physical and psychological health issues are interwoven.[127]

According to Bartels, international research into the health status of refugees can roughly be subdivided in three approaches. First, a few publications describe the results of screening for infectious diseases, mostly at arrival in the host country. Secondly, a majority of international publications report on quantitative research into the prevention of psychiatric diseases in refugees. Recently, the focus in this kind of research has shifted from prevalence to determinants of mental illness. Qualitative research into refugees' health is very limited. Only a few articles and other publications in the international literature can be found. According to Bartels, this might be due to a certain "publication bias": in this time of "evidence based medicine", she says, qualitative research has a low score on the scale of the scientific burden of proof and will therefore seldom be published.[128] However, as this literature review will show, available resources that are qualitative in nature reveal a wide range of needs in the field of SRH care provision for asylum seeking and refugee women in EU MS. Finally, a number of studies in the Netherlands focus on the experience of health care providers and to a lesser extent on the help seeking behaviour and experiences of refugees with Dutch health care.[129]

4.2. Assessing Sexual and Reproductive Health Needs of Refugee Women in Europe

First of all, it should be clear that the population groups referred to as migrants, ethnic minorities or refugees are not homogenous groups. Differences may be identified in their culture, language, the level of education, the reason for migration, the socio-economic situation, the duration of residence with respect to various generations, and the degree of integration.[130] Refugee populations described in different publications are characterised by a diversity of social, economic and legal backgrounds and by a diversity of needs. A main distinction can be made between the more traditional migrants (from former colonies, and labour migrants for example) who are usually fairly integrated in the host society and the so-called 'new arrivals' (asylum seekers, undocumented migrants) who often live in precarious conditions.[131]

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127 See e.g. Burnett A., and Fassir Y., *Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers.* Department of Health, 2002:35.

128 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen.* Utrecht, Pharos, 2003:127.

129 Jukema 1996, Du Pree 1998, Vera 1998, in: Grotenhuis R. (2003:127).

130 Putter J., De (ed.), AIDS & *STDs and Migrants, Ethnic Minorities and other Mobile Groups; The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 1998.

131 See also Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003.

In order to be able to generalise research results, information is needed with regard to group characteristics and the specific context. Often these specific data about the research group and their circumstances in the host country are missing, so that possibilities for interpretation of the results are limited.[132] A qualitative study of the sexual attitudes and lifestyles of five ethnic minority communities in Camden and Islington, United Kingdom, has shown this importance very clearly. And even more importantly, remarkable diversities within the different ethnic groups have been observed in this study as well.[133]

Asylum seekers and refugees in European host countries face the effects of poverty, dependence, and lack of cohesive social support. This has a negative impact on their overall health, including SRH. In order to fully address the SRH needs of refugee women in Europe, attention should also be paid to attitudes towards refugees within the health care system and the host society as a whole, as they can have a negative impact in providing qualitative SRH care. Refugee women in Ireland for example, are often confronted with racism and xenophobia in the health care system, which may severely limit the quality of care they may receive.[134]

There are different views on how to address the health needs of ASRW. According to Burnett, the basic health needs of asylum seekers and refugees are broadly similar to those of the population in the host country. She also emphasises, however, that previous poor access to health care may have left many conditions untreated. In addition, many refugees experience difficulties in expressing their health needs and in accessing health care.[135] There is a tendency amongst writers on multicultural societies to formulate a strong argument that each ethnic group has special and specific needs in relation to health. Paradoxically, it is also argued that a needs-based approach is needed, instead of a 'cultural' approach, stemming from the experiences of these groups in contemporary societies. According to Kennedy and Murphy-Lawless, it is important to be aware of cultural factors and specific cultural needs, but it is even more important to implement a coherent systematic approach for collating such information and to set up adequate information flows. The authors argue for a system to be set in place, which can rapid-

132 See also Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen.* Utrecht, Pharos, 2003:132.

133 Elam G., Fenton K., Hohnson A., Nazroo J. and J. Ritchie, *Exploring Ethnicity and Sexual Health*. London, University College London Medical School, Social Community Planning Research, Policy Studies Institute, 1997:103. See also Loeber O., *Vier vrouwen: anticonceptiehulpverlening bij specifieke groepen allochtone vrouwen*. Utrecht, Rutgers Nisso Groep, 2003.

134 See for example Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities*. Dublin, Irish Family Planning Association, 2002 (Unpublished).

135 Connelly J., Schweiger M., in: Burnett A., and M. Peel, Health Needs of Asylum Seekers and Refugees. *British Medical Journal*, 2001, 322: 544-547.

ly collate and re-direct information as new needs arise from ethnic groups who begin to face the process of becoming a refugee.[136]

4.3. Migration and Health

There is growing attention for migration and health,[137] which has become a topic of heated debates. Complex questions of public health and poverty have been influenced by ethnocentric and racist creations of reality, such as nightmare images on television and in (horror) movies of terrible, incurable, wasting diseases (such as Ebola fever), originating in unknown places and penetrating the borders of the Western world.[138] A few years ago, considerable public and media attention was devoted to the relationship between migrants and HIV/AIDS. More recently, the focus has shifted to the health threat posed by undocumented migrants.[139] These kinds of images have contributed to the heated discussion about migrant health as a potential threat to European host societies.

136 Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Dublin, Eastern Regional Health Authority (ERHA), March 2002.

137 Growing attention for the issue of migrant health is also reflected in the different conferences and workshops focussing on this issue, which were organised in 2004.

138 In: Edubio A., Sabanadesan R., *African Communities in Northern Europe and HIV/AIDS. Report of Two Qualitative Studies in Germany and Finland on the Perception of the AIDS Epidemic in Selected African Minorities*. Tampere, University of Tampere, October 2001:8.

139 United Nations, *Report on the World Social Situation 2003. Social Vulnerability: Sources and Challenges*. New York, 2003:34.

Apart from concerns with pre-existing and untreated conditions such as infections and communicable diseases, there is also some speculation about the possibility that a significant number of migrants may be motivated by the health care entitlements in host countries in order to get treatment which is not available or affordable in their country of origin. In this light it is argued that the provision of health care to migrants would be an extra burden on already overstretched and underperforming public health systems. [140]

But the health risks that migrants face should be placed in a broader context for discussion, as formulated by De Putter: "It is important to acknowledge that vulnerable groups are not automatically related to risk behaviour. Vulnerable groups are not only subject to health risks but also to discrimination, stigmatisation, a lack of information, bad economic circumstances, to illegal residence, etcetera".[141] Compounding the difficulties due to language and cultural barriers to access health care and social services, refugees and asylum seekers have to endure acts of racial discrimination, xenophobia, and related intolerance. Women and girls, who are already subject to gender inequality, also face racial, ethnic or national discrimination, an additional burden that has been recognised by the UN World Conference on Racism, Xenophobia and Related Intolerances. Depending on the context, this is referred to as 'intersectionality' or 'double discrimination'.[142]

The United Nations have identified three elements as the source of health-related vulnerability among migrants. In line with the arguments above, there is evidence that migrants' health risks are compounded by discrimination and restricted access to health information, health promotion, health services, and health insurance. In addition, migrants as a group run a disproportional risk to be exposed to occupational and environmental hazards. And thirdly, migrants are at a greater risk because some of their specific health needs are not well understood or ignored, and therefore not adequately addressed.[143]

ASRW require specific attention: they are particularly vulnerable due to their insecure economic and social situation. A different culture, language barriers, and the insecure position in the host society, make it difficult to access health services and SRH information. Furthermore, refugee women fleeing from

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140 For more information see e.g. United Nations, *Report on the World Social Situation 2003. Social Vulnerability: Sources and Challenges*. New York, 2003:3436.

141 Putter J., De (ed.), AIDS & *STDs and Migrants, Ethnic Minorities and other Mobile Groups; The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 1998.

142 Anker, C., van den, Intersectionality or "Double Discrimination", Centre for the Study of Global Ethics, University of Birmingham, UK, *NEWR Newsletter*, Issue Three, December 2004.

143 United Nations, *Report on the World Social Situation 2003. Social Vulnerability: Sources and Challenges*. New York, 2003: 34.

conflict settings often endure traumas, which often have a great impact on interpersonal relations and which may result in gender-based violence and/or sexual exploitation both before and after arrival in the destination country.

Refugees' health is often discussed within the broader framework of "migrant health". However, even though there are similarities in the health status, risks, and needs of migrants, asylum seekers and statutory refugees, it is important to pay attention to specific needs, relating to ASRW's background of forced migration and the situation in their host country (e.g. social, economical, legal).

4.3.1. The Need for a Gender Specific Approach

> *The feminisation of the AIDS pandemic is very apparent in sub-Saharan Africa, where close to 60 percent of those infected are women - and 75 percent of young people infected are girls aged 15 to 24. Women are more physically susceptible to HIV infection than male because of their biological make up.*
>
> Moyiga Nduru[144]

Women's health needs are shaped both by sex and gender. Biological differences between women and men relating to sex, such as childbearing, breast cancer, and menopause, create specific health issues for women. Gender and (related) socio-cultural differences between women and men have shown to place burdens on women's health. The roles, rights, responsibilities, and status assigned to women by society often leave women vulnerable to unwanted and unprotected sexual intercourse, and physical and mental abuse; they also limit women's access to health care. The importance of sex and gender in women's health was emphasised at the United Nations conferences in Cairo (1994) and in Beijing (1995).[145]

Research findings indicate that there is a need to recognise that living conditions and the provision of (health) care and services to refugees are *gendered* areas of concern.[146] SRH needs in particular provide an important example of the

144 Nduru M., *Health-Southern Africa: AIDS Initiative Focuses on Women*. Inter Press Service News Agency, END/2004 http://www.ipsnews.net/new_nota.asp?idnews=26557, accessed 8 December 2004).

145 Reproductive Health Outlook, Topics: Gender and Sexual Health (*http://www.rho.org/html/gsh_overview.htm#Gendersensitive*, accessed 3 December 2004).

146 Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4: 372-393. And see YWCA-Antwerp, *Reception and guidance of refugee women: the need for a gender-based approach. Conclusions and recommendations resulting from the survey "Living conditions and social status of refugee women in Belgium.", YWCA Antwerp, November 2001*. Antwerp, Young Women's Christian Association – Antwerp (YWCA-Antwerp) & Nederlandstalige Vrouwenraad (NVR), June 2003.

gendered needs of refugees. With this specific context in mind, refugee women are recognised as "particularly vulnerable" in the ICPD Programme of Action.[147]

Refugee women are often most seriously affected by displacement: they are specifically vulnerable to physical assault, sexual harassment and rape. Many refugee women flee due to gender-based persecution or sexual violence. Rape has been increasingly used as a weapon of war and has contributed to the increase of refugees worldwide.

For these reasons, a gender perspective needs to be incorporated into health and health care - also called "gender mainstreaming". It is therefore important to understand and distinguish between gender, sex and sexuality. In order to incorporate a gender perspective in health, all these concepts need to be applied to health and health care in order to provide health care in accordance with women and men's needs.[148]

In order to achieve the aims set out in the conclusions of the Cairo and Beijing Women's Conferences (1994, 1995) and to improve women's SRH, it is recommended to promote women's empowerment and to increase the involvement of men and boys.

4.3.2. Barriers to Health Services

Promoting the SRHR of ASRW is not enough. It does not necessarily mean that ASRW will be able to fully enjoy these rights. In many European countries the social and health care service provision is not aimed at providing many basic social and health care services for refugees and migrants, let alone culturally appropriate services. There are many reasons for this: a lack of political will, new policies to return migrants to their countries of origin as quickly as possible, insufficient training in culturally competent service provision, the absence of migrant representatives as stakeholders in the decision making process, etcetera. According to some authors, social workers and health care providers sometimes operate as the frontline agents of exclusion.[149]

147 United Nations — ICPD 1994, *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. UNFPA, United States of America, 1996: Chapter X.D.

148 See Medical Women's International Association, *Training Manual for Gender Mainstreaming in Health*. Medical Women's International Association, 2002, for further reading.

149 Edubio A., Sabanadesan R., *African Communities in Northern Europe and HIV/AIDS. Report of Two Qualitative Studies in Germany and Finland on the Perception of the AIDS Epidemic in Selected African Minorities*. Tampere, University of Tampere, October 2001:8.

Barriers to Access Health Services for Asylum Seekers and Refugees

Asylum seekers and refugees face a number of difficulties in gaining access to quality health care. Different barriers with regard to accessing health care services in the old EU MS can be identified: 1) communication problems, 2) language and cross-cultural barriers, 3) lack of information on how the national health system functions, 4) lack of training/awareness by health personnel about refugee issues and their specific needs and care expectations, 5) mutual lack of understanding, 6) lack of trust on the part of refugees, and 7) economic and administrative obstacles.[150] In addition, geographical and legal obstacles in receiving adequate SRH care have been identified.[151] Asylum seekers and refugees, in general, also experience problems in getting access to information on patient's rights and entitlements to health services.[152]

Asylum seekers and refugees might be further constrained by the need to fulfil practical and social needs first, which might compromise their overall health, including SRH. Racism, social isolation, access to legal employment, essential language skills, education, transportation and adequate housing are issues that need to be addressed by governmental agencies, social and health service providers, and law enforcement officials. Once refugee women are able to fulfil their most immediate practical and social needs, they may experience better accessibility and comfort in seeking and using SRH care services.[153]

Experienced Difficulties Among Health Care Providers

In most of the old EU Member States NGOs and community based organisations have become intermediaries between specific target groups, such as refugees and ethnic minority groups, and the health care and prevention sector. Initiatives are taken by these intermediaries in the field of material development and forms of interactive, culturally appropriate health promotion.[154]

From the perspective of health care providers, language barriers and related communication problems are one of the most clearly perceived barriers in providing

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150 Consiglio Italiano Per I Refugiati (CIR), *Good Practice Guide on the Integration of Refugees in the European Union, The Good Practice Guide on Health*. Rome, ECRE Task Force on Integration, 2002. See also www.refugeenet.org

151 E.g. Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities*. Irish Family Planning Association, 2002 (Unpublished).

152 E.g. Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities*. Irish Family Planning Association, 2002:17-18; Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Eastern Regional Health Authority (ERHA), March 2002; Hinton T., *Working with Refugees and Asylum Seekers in Lambeth, Southwark and Lewisham: A review of the work of the Refugee Health team*. Crisis, London, 2001 (http://www.asylumsupport.info/publications/crisis/working.pdf, accessed 13 April 2004).

153 Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities*. Irish Family Planning Association, 2002:17-18; Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Eastern Regional Health Authority (ERHA), March 2002.

154 Putter J., De (ed.), AIDS & *STDs and Migrants, Ethnic Minorities and other Mobile Groups. The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 1998:19.

care to migrants.[155] However, recent research in the Netherlands shows that being able to speak the national language or getting help from a professional translator does not guarantee that communication problems are solved. According to Richters and Van Vliet communicating from different perspectives also causes communication problems. Miscommunication should not be reduced to language barriers. It also stems from not understanding each other and differences in expected health care.[156] It should also be pointed out, however, that some migrant women might not experience language problems as a big barrier in getting health care and are found to deal with their language difficulties in a very active and creative way.[157]

Health practitioners might also lack awareness about the refugee experience and have constraints that limit their ability to better serve refugee patients. They may be reluctant to provide services for a population group that may have complex needs. Often time, language, and difficult requests are beyond their scope or capacity. In order to deal with SRH needs of ASRW, general practitioners will need multi-disciplinary assistance with regard to the background of the refugee and possibilities for further assistance.[158]

Lack of continuity in health care

Asylum seekers often (have to) change residence, which disrupts the continuity and quality of health care. A lack of continuity in health care can be especially problematic in relation to SRH issues, as for many refugee women a basic level of trust is needed to discuss issues related to sexuality and reproductive health. The fact that in the Netherlands many unwanted pregnancies were reported to following a transfer to another asylum centre might serve as an indication that there is a need for continued access to reproductive health services. Also with regard to safe motherhood, research indicates that refugee women's reproductive health suffers from the lack of continuity of care and this is particularly so for homeless women and dispersed asylum seekers.[159]

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155 Van Duursen et. al. 2002, Bruijnzeels M., 2001, cit. in: Çinibulak L., *Zwanger worden en bevallen op Nederlandse bodem, Een antropologisch onderzoek naar de ervaring van verloskundige zorg onder vrouwen van Turkse afkomst [Getting pregnant and giving birth in the Netherlands, An Anthropological research into the experience of obstetric care among women of Turkish origin]* [thesis]. Amsterdam, University of Amsterdam, August 2002.

156 Richters A. and K. Van Vliet (ed.), in: Çinibulak L. (2002).

157 Çinibulak L., *Zwanger worden en bevallen op Nederlandse bodem, Een antropologisch onderzoek naar de ervaring van verloskundige zorg onder vrouwen van Turkse afkomst [Getting pregnant and giving birth in the Netherlands, An Anthropological research into the experience of obstetric care among women of Turkish origin]* [thesis]. Amsterdam, University of Amsterdam, August 2002.

158 Van Willigen (1992:207), cit. in Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4: 388; Hinton T., *Working with Refugees and Asylum Seekers in Lambeth, Southwark and Lewisham: A review of the work of the Refugee Health team*. Crisis, London, 2001 (http://www.asylumsupport.info/publications/crisis/working.pdf, accessed 13 April 2004).

159 Vries, De, L.E., Bakker R.H., Burgerhof J.G.M., Abortus provocatus onder asielzoekers. *Tijdschrift voor Gezondheidswetenschappen*, 1999, 77, No. 6: 341-347; Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:384; Consiglio Italiano Per I Refugiati (CIR), *report of the Refugee Panel* – Health Working Group, Dalfsen, The Netherlands, 1st and 2nd July 1999; Thorp S., Born equal. *Health Development Today*, 2003, 18:21-23.

4.4. Ethnicity and Health

4.4.1. Ethnicity and Health Determinants

The health status of migrants, including asylum seekers and refugees, can be related to different determinants: factors that have an impact on the prevalence of an affection, illness or disease in a population.[160] These determinants can be categorised in four main groups: lifestyle/behaviour, biological/genetic factors, environmental factors (physical, economical, social, cultural) and availability, accessibility and quality of health care.[161]

The explanation of ethnically determined health differences is usually sought in the different risk factors in different ethnic populations. Research into ethnicity and health starts from this principle of determinants that have an impact on health. In later research the determinant psychological stress was added. Different contextual mechanisms affect the influence of these determinants on migrants' health, such as migration, acculturation, social-economical position, and the societal context.[162]

160 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen*. Utrecht, Pharos, 2003: 115-159.
161 Tulchinsky, T.H. (2000), Cit. In Bartels K., (2003).
162 Bartels K., Gezondheidstoestand. In: Grotenhuis R. (ed.), *Van pionieren tot verankeren. Tien jaar gezondheidszorg voor vluchtelingen*. Utrecht, Pharos, 2003: 115-159.

An important discussion in ethnicity and health research is the influence of socio-economical status on someone's health status. Generally, the living conditions of migrant people are more unfavourable because of their lower economical position in the host society. It has an impact on their life style, living conditions, social environment and the use of health services. This explains the existence of considerable socio-economical health differences. There are, however, also other factors that have an impact on health. It might also be possible that a lower socio-economical position of ethnic minority groups, such as refugees, has a different effect on them than would be the case for nationals.[163]

Social exclusion, poverty, migration and public health are clearly interrelated.[164] At EU level, research has been undertaken and pro-poor policies regarding health, AIDS and population, have been formulated, based on a clear understanding of the links between poverty and health. The European Commission stated in its communication of 26 October 1999: "Investment in health is widely accepted as a cornerstone of poverty reduction strategies. Better health is recognised as both a consequence and an engine of economic growth and poor health seen as both a consequence and cause of poverty and inequality in opportunity or gender. The poor, *especially women and children*, have the worst health indicators, the least access to quality services and jointly financing, the highest fertility and the largest burden of infectious diseases." [165]

4.4.2. Ethnicity and Sexual Lifestyles

A study on ethnicity and sexual health found that factors such as gender, ethnic origin, religion, degree of acculturation, and individual interest in sexual matters and sexuality, were the most important factors to determine for the sexual lifestyles of individuals. But each factor has its own unique effect and acts at particular point(s) within an individual's lifetime (see the box below for further components of these factors). It should be noted, however, that social class or socio-economic status was not central to this specific study, even though the authors acknowledged these as important factors as well.[166]

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163 Stronks 1999, in: Grotenhuis R. (2003:121). And see Bartels K., in: Grotenhuis R. (2003:140-141).

164 Edubio A., Sabanadesan R., *African Communities in Northern Europe and HIV/AIDS. Report of Two Qualitative Studies in Germany and Finland on the Perception of the AIDS Epidemic in Selected African Minorities*. Tampere, University of Tampere, October 2001.

165 Caritas Europa, Poverty has faces in Europe. *The Need for family-oriented policies. 2nd Report on Poverty in Europe*. Brussels, Caritas Europa, February 2004. See also Doorslaer E., van, and C. Masseria, *Income-related Inequality in the Use of Medical Care in 21 OECD Countries. DELSA/ELSA/WD/HEA(2004)5*. OECD, OECD Health Working Papers 14, 2004 (http://www.oecd.org/dataoecd/14/0/31743034.pdf, accessed 3 March 2004).

166 Elam G., Fenton K., Hohnson A., Nazroo J. and J. Ritchie, *Exploring Ethnicity and Sexual Health*. London, University College London Medical School, Social Community Planning Research, Policy Studies Institute, 1997:105-106.

Ethnic background was found to have a profound impact on sexual attitudes and lifestyles. Although diversities between and within different ethnic groups can be found, it is argued in general that ethnicity influences how individuals learn about and first experience sex, and how individuals access and use sexual health services. It also shapes the development of sexual attitudes and behaviours.[167]

Factor	
Gender	• Male • Female
Ethnic origin	• Country of origin • Tribal groups • Community norms • Accepted behaviours • Prohibited behaviours • Ignored behaviours
Religion	• Religious group, e.g., Hindu, Muslim • Religious sub-group, e.g., Catholic
Acculturation	• Migration history • Location of secondary school education • Availability of sex education in schools • Exposure to, and mixing with, members of the opposite sex • Exposure to, and mixing with, members of other ethnic (majority and minority) groups • Exposure to, and mixing with, individuals with other sexual relationships and lifestyles • Penetration of different cultures within the home-life (e.g. media) • Community expectations
Individual interest in sexual matters	• Keenness to learn about sexual matters and to experiment • Individuals own sexual drive and enjoyment of sex • Individual attitude towards sexual relationships and lifestyle • Individuals' sexuality

Source: Adapted from Elam, et al., ibid.: 105.

167 Elam G., Fenton K., Hohnson A., Nazroo J. and J. Ritchie, *Exploring Ethnicity and Sexual Health*. London, University College London Medical School, Social Community Planning Research, Policy Studies Institute, 1997: 103. See also Loeber O., *Vier vrouwen: anticonceptiehulpverlening bij specifieke groepen allochtone vrouwen*. Utrecht, Rutgers Nisso Groep, 2003.

4.5. Key Issues in Sexual and Reproductive Health of Refugee Women in Europe

Availability of SRH services for ASRW is closely related to overall health care provision for migrants in EU MS. In the countries of the EU different models are used to provide health care for asylum seekers and refugees. Some states take direct responsibility; other states delegate the responsibility of the health check and medical assistance to an NGO. There is also a so-called 'southern European model', where NGOs and charitable organisations (such as Caritas in Italy, Médecins du Monde in Greece, Le Comède in France, the Red Cross in Spain) offer free medical care to migrants in general, including undocumented migrants, asylum seekers and refugees who are not yet able or not allowed to access the national health system. The Netherlands appear to be the only country that guarantees asylum seekers full access to health care services ("except for in vitro fertilisation and treatment for transexuality").[168]

In the large scope of SRH issues, this report focuses on the following SRH key issues: 1) safe motherhood, including aspects related to unwanted pregnancies; 2) family planning; 3) sexually transmitted infections, including HIV/AIDS; and 4) sexual and gender-based violence, including harmful traditional practices such as female genital mutilation (FGM).

4.5.1. Safe Motherhood

4.5.1.1. Maternity Care Needs

Asylum seeking and refugee women are confronted with several major problems concerning pregnancy and delivery in their host countries. A Dutch study revealed that these were mainly related to dealing with a different medical system, getting necessary information on the national health system, language and communication difficulties, the development of social and support networks, poor socio-economic status, legal status, and experiences in the asylum seeking procedure. For some refugee women pregnancy is also a period of major psychological stress, adding to the overall difficulties they experience, and they might feel particularly vulnerable, both during pregnancy and after giving birth.[169]

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168 Consiglio Italiano Per I Refugiati (CIR), *Good Practice Guide on the Integration of Refugees in the European Union*, *The Good Practice Guide on Health*. Rome, ECRE Task Force on Integration, 2002. See also www.refugeenet.org

169 See e.g. Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:384; Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Eastern Regional Health Authority (ERHA), March 2002.

Two major reports in the UK showed that women from disadvantaged groups, including women living on a low income or who are homeless, asylum seekers and women from black and minority groups, are unlikely to receive the required attention to see them through pregnancy, labour and the postnatal period.[170] Pregnant asylum applicants may be in a particular vulnerable position. Their future in the country of asylum is not certain; they are unlikely to have family or friends around them for support, and they may not speak the national language.[171]

Information provision

Asylum seeking women who have recently arrived in the country of asylum have very little knowledge about the available health services. Information on available maternity services is particularly important for these women. Research undertaken by the Maternity Alliance in the UK revealed that many asylum seeking women had not been given any information about the kinds of maternity services and support available to them.[172]

It is important to note that the needs of ASRW for information on pregnancy and delivery may vary. Making assumptions about the extent to which a refugee woman understands her own condition can have serious consequences. Pregnant refugee women in the Netherlands for example, said they needed information about "the role of doctors, nurses, and especially midwifes, those involved in the system of care immediately following birth (…), and home birth and hospital birth options".[173]

Health care provision

In a study conducted in Ireland, primary reasons identified by ASRW women for not attending antenatal education were language difficulties and feelings of being 'different'. Although most of the women in this study reported high levels of satisfaction in relation to the medical treatment they received in the maternity hospitals, some specific issues were raised as problematic: language, diet, lack of privacy, having to return for the heel prick test on the fourth day, lack of circumcision services for male infants. Attending antenatal care in hospital proved to be difficult, particularly for asylum seeking women, due to difficulties in getting

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170 Gwyneth L., Drife J., et al., *Why Mothers die 1997-99: The fifth Report of the UK confidential inquiries into maternal deaths*, RCOG Press, London, December 2001; House of Commons Health Committee, Eighth Report of Session 2002 – 03 Parliament Health Select Community, House of Commons London: The Stationery Office Limited23 July 2003. Discussed in: Thorp S., Born equal. *Health Development Today*, 2003, 18:21-23.

171 House of Commons Health Committee, *Inequalities in Access to Maternity Services*, Eighth Report of Session 2002 – 03 Parliament Health Select Community, House of Commons. London, The Stationery Office Limited, 23 July 2003:19.

172 Ibid.

173 Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4: 372-393.

there, arranging childcare, being unaccompanied by their partner or a friend, and language problems. Some women were constrained by their poor health or were too exhausted and stressed. It should be noted though, that in Ireland, like in other European countries, many asylum seeking women often do not have the opportunity to access antenatal care, because they are very late in pregnancy when they arrive in the host country.[174]

Likewise, in the Netherlands, refugee women often come to the clinic very late in their pregnancies (sometimes when they are already eight months pregnant), due to a lack of funds or information about available services. As a result, medical complications requiring attention very early in pregnancy, such as venereal diseases or high blood pressure, are left untreated, which can result in more serious complications. According to Ascoly *et al*. fear can also be a factor preventing women to reach out to get the care they need, but it is also supposed that "there are women who get no medical assistance at all during their deliveries – women who don't seek help, who don't see a midwife, and women who go through childbirth on their own, or accompanied by family members".[175]

174 Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Eastern Regional Health Authority (ERHA), March 2002.

175 Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:384; See also Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women: a Research Study Conducted for the Women's Health Unit, Northern Area Health Board*. Eastern Regional Health Authority (ERHA), March 2002.

Communication problems, such as ignorance or bad communications on the part of gynaecologists, have negative implications for all aspects of (maternity) health care. Refugee women often have to depend on their husbands or other male interpreters, which makes it especially difficult for women who come from cultures where strict gender roles prescribe that pregnancy and childbirth are not discussed in mixed company. As a result, medical consultations can become problematic, especially if all information is canalised through male interpreters.[176] Ascoly *et al*. further note in this regard: "Issues like rape or sexual abuse, which are relevant to a pregnant women's physical and psychological health, can easily be ignored due to a woman's reluctance to speak about such matters in the company of men. Or, as a midwife noted, in some cultures these things are simply not spoken about at all."[177]

Refugee women often feel uncomfortable with the organisation of health services; for example, when they would have to go to a male doctor. A well-educated Sudanese, Muslim woman in Austria explains her uneasiness as follows: "Once I went to the radiologist for an examination. He asked me to take my blouse off. I was shocked. How could I take my blouse off in the presence of a strange man? For me it was not logical but for him it was normal." Another Sudanese woman in the UK talked about the problem of having a smear test and why it is difficult for women with her cultural background to just open their legs.[178]

A small-scale study about Somali refugee women's experiences of maternity care in West London confirmed much of the available research evidence on other ethnic minorities' experiences with maternity services. Many of these women were reported not to gain access to maternity services, due to inadequate provision of interpreting services, stereotyping and racism on the side of health care staff, and a lack of understanding among health care staff with regard to cultural differences. Poor management of FGM in pregnancy and labour was another issue found to affect the Somali refugee women.[179] Refugee women's experiences of maternity care partly depend on the attitudes of individual staff. Prejudice related to class, race or ethnic background, profoundly affects women's experiences of pregnancy, birth and motherhood.

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176 In the Netherlands, translation services (over the phone) for medical service providers, including midwifes, are available from the Netherlands Interpreter and Translation Centre at no cost; a service subsidized by the Dutch government. In: Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:391.

177 Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:386.

178 Mestheneos E., Gaunt S., Ioannadi E., *Bridges and Fences: Refugee Perceptions of Integration in the European Union*. Brussels, ECRE Task Force on Integration, OCIV, 1999: 51.

179 Bulman K.H. & C. McCourt, Somali refugee women's experience of maternity care in west London: a case study. *Critical Public Health*, 2002, Vol.12, No.4: 365-380.

But examples of good practice exist as well. Experiences in the UK show that taking services into the community and allocating midwives their own caseload of clients provides the kind of care refugee women need. Unlike traditional, hospital based services, a midwifery group set up in different neighbourhoods of Southampton in the UK, provided health care within the community. Each midwife had a caseload of 36 women per year - including asylum seekers, homeless women and sex workers. They are responsible for their clients throughout pregnancy, birth and the post-labour period, which gives them the chance to bond with the mother and to provide continuity of care.[180]

In West London, the caseload approach was also used. Initially it was available to all local women, but in response to a recommendation of the Royal College of Midwifes, it later focused on vulnerable groups, concentrating in particular on women from black and minority ethnic communities, travellers and teenagers.[181] The "One to One Young Mum's group of midwifes" looked after women under the age of 18. By providing individual support, mainly at home, issues such as poor attendance at clinics can be addressed, and it gives midwifes a better insight into any problems that young mothers may be facing, such as unsuitable accommodation or family breakdown. In this scheme, antenatal and postnatal support groups were organised to foster peer support. [182]

Accommodation

In Ireland, accommodation was identified as the most urgent issue in the field of maternal health care for ASRW. Pregnant women who have recently given birth experience tremendous difficulty in accessing suitable accommodation. Major inadequacies were found with regard to the supply and the standard of accommodation. Even though accommodation for all asylum seekers and refugees is problematic in Ireland, ASRW identified very urgent needs in connection with pregnancy and caring for new babies. These needs are related to personal hygiene, privacy, rest, and sharing accommodation with new babies as well as toddlers.

Reception facilities for asylum seekers may be inadequate to take care of pregnant asylum seekers and mothers with young children. In the UK for example, most people who seek asylum are allowed to live in the community (in the future they may be required to live in an "Accommodation Centre"). Some asylum seekers, however, are held in detention centres, which are effectively dedicated prisons run on behalf of the Home Office, although they have not been convicted of any

180 Thorp S., Born equal. *Health Development Today,* 2003, 18:21-23.
181 *Vision 2000*, Royal College of Midwifes, 2000, in: Thorp S., Born equal. *Health Development Today,* 2003, 18:21-23.
182 Thorp S., Born equal. *Health Development Today,* 2003, 18:21-23.

criminal offence. A small-scale study on the impact of immigration detention on pregnant asylum seekers, new mothers and babies in the UK shows many pressing needs, both very basic needs and needs related the provision of good maternity care. The women who took part in this study all suffered "enormous emotional psychological distress as well as serious physical discomfort as a result of being detained while pregnant or with a baby. The daily reality of their lives in detention was one of isolation, fear and depression; having to cope alone with pain and sickness; unreliable and seemingly unaccountable medical care with only ad hoc liaison with external maternity services and failure to provide essential interpreting; inadequate food; gratuitously petty rules on access to basic necessities such as baby milk and nappies."[183]

Continuity in health care

As mentioned before, the fact that asylum seekers often (have to) change accommodation disrupts the continuity and quality of health care. Dispersal of asylum seekers constitutes an additional barrier to access health care services. In the UK, Jenny McLeish of the Maternity Alliance reported that dispersal could happen at short notice, interrupting maternity care. For health professionals who see pregnant asylum seekers for the first time at short notice and who are not provided with adequate information and resources, the experience can be equally frustrating. The House of Commons in London highlights that better communication between maternity and child health services and accommodation providers

183 McLeish J., Cutler S., Stancer C., *A Crying shame: pregnant asylum seekers and their babies in detention*. London, The Maternity Alliance, 2002.

during dispersal is needed in order "to ensure that members of maternity care teams are forewarned of the arrival of asylum seekers who will need their services and that their test results and notes are forwarded." [184]

Social isolation

ASRW are often deprived from the traditionally strong systems of social support they could rely upon in their country of origin. The lack of access to social support networks often enhances the feelings of isolation and loneliness during pregnancy and following childbirth.[185] This isolation might even increase after delivery, when women become even more bound to their homes due to childcare responsibilities. For single ASRW, who are pregnant or who have small children, the difficulties evolving from being isolated are even more pressing. The lack of a social network of family and/or friends is also reflected in an extra financial burden, because it often means that they cannot afford essential items, especially when asylum seeking women are not allowed to work or when refugee women are unemployed and/or retraining. [186]

4.5.1.2. Unwanted Pregnancies and Abortion

There is some evidence that ASRW's difficulties in accessing family planning services might lead to unwanted pregancies and induced abortion.

Little is known about the prevalence of abortion among migrant and refugee women in European host countries. The scarce data that are available are mainly limited to the Netherlands and Belgium. Young people and migrant women are known to be the most important risk group in the Netherlands for unwanted pregnancies and abortion.[187] National registration data from the Netherlands confirm that the abortion rate among migrant women was higher than among the rest of the population.[188] In comparison with the abortion rate among all

184 House of Commons Health Committee, *Inequalities in Access to Maternity Services*, Eighth Report of Session 2002 – 03 Parliament Health Select Community, House of Commons. London, The Stationery Office Limited, 23 July 2003:20. See also Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:384.

185 Kennedy P. and Murphy-Lawless J., *The Maternity Care Needs of Refugee ad Asylum seeking Women. A summary of research by Patricia Kennedy and Jo Murphy-Lawless*. Dublin, Social Science Research Centre, University College Dublin, 2001:18; See also McLeish J., Cutler S., Stancer C., *A Crying shame: pregnant asylum seekers and their babies in detention*. London, The Maternity Alliance, 2002. .

186 Ascoly N., Van Halsema I., Keysers L., Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001, Vol. 14, No.4:387.

187 Wijsen en Rademakers, cit. in Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals]* [thesis]. Louvain, Catholic University of Louvain, 2004:85.

188 Rademakers J., *Abortus in Nederland 2001-2002. Verslag van de landelijke abortusregistratie*. Heemstede, Stisan, 2003:24.

women in their reproductive age in the Netherlands, the abortion rate among various migrant groups was almost three to ten times as high in 2000. With respect to 1992 the abortion figures in all migrant groups had increased; among Antillean women it had more than doubled.[189]

In Belgium, although there are no specific data on the prevalence of abortion among different ethnic groups, the Belgian National Commission on abortion has recommended in its 2004 report that extra efforts are needed to improve the use and availability of contraception among women who have not mastered the national languages sufficiently,[190] in order to anticipate unwanted pregnancies among migrant women, which might be terminated through an induced abortion. A Belgian study, conducted in Flanders, revealed that first generation migrants, specifically those who are in a difficult administrative situation - such as asylum seekers without a residence permit – are an important group that requires specific preventive attention. 13,62% women in this category opted to end their pregnancies because of their insecure residence status and future (among other reasons). Little is known about this target group and health care workers in Belgium deem that knowledge and information about this group very desirable.[191]

Different factors influence the prevalence of unwanted pregnancies leading to induced abortion among migrant and refugee women. A small-scale Dutch study tells us something about such factors among women during their stay in a Reception Centre in the Netherlands. The following variables that increase the risk to an induced abortion among these women were identified: being unmarried, being at the age of 20 to 30 years, having no children, and being of African origin. It should be noted, however, that a number of refugee women got pregnant shortly after a transfer to another Reception Centre, due to the discontinuity in medical care and sex education. Almost 50% of the asylum seekers who had an induced abortion were already pregnant at the time of arrival in the Netherlands.[192]

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189 Rademakers J., *Abortus in Nederland 1993-2000. Verslag van de landelijke abortusregistratie.* Heemstede, Stisan, 2002:30-31.

190 Nationale Commissie voor de Evaluatie van de Wet van 3 april 1990 betreffende Zwangerschapsafbreking (wet van 13 augustus 1990), *Verslag ten behoeve van het parlement 1 januari 2002 – 31 december 2003 [Report on behalf of the parliament 1 January 2002 – 31 December 2003].* August 2004:68.

191 Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals]* [thesis]. Louvain, Catholic University of Louvain, 2004:94-95.

192 Vries, De, L.E., Bakker R.H., Burgerhof J.G.M., Abortus provocatus onder asielzoekers. *Tijdschrift voor Gezondheidswetenschappen*, 1999, 77, No. 6: 341-347.

Information provision

Some evidence indicates that lack of information and inadequate medical care may cause a higher prevalence of abortion among refugee women. Many ASRW have to rely on knowledge and practices from their country of origin, when it comes to contraception. Knowledge about modern methods of contraception is not always sufficient, which might lead to ineffective use.[193] The provision of adequate information is therefore of major importance.

Women's cultural background plays an important role in the request for an induced abortion. It should be noted that the composition of the abortion population appears to be very differential with regard to the country of origin.[194] In some cultures there is no strong tradition of contraceptive use, in comparison with Western conceptions. Sometimes abortion is even seen as an alternative to contraception. Rademakers and Wijsen state that it is certainly impossible to consider migrant women as a homogeneous group when it comes to behaviour and attitudes regarding pregnancy, contraceptive use and abortion. They therefore recommend further subdividing this group in future abortion registration.[195] But culture is clearly not all determining. Rademakers points to the danger of stigmatisation in this regard, if the high risk for unwanted pregancy and abortion would be explained by socio-cultural reasons only. Other factors, such as migration and living conditions, marriage patterns and existing health care provision, determine the possibilities and behaviour of women considerably as well.[196]

Health care provision

The responsibility for the prevalence of unwanted pregancies among migrant and refugee women should not be put on migrant women and girls one-sidedly. Rademakers argues that one could also say that existing insights still have not lead to sex education and care adapted to the experiences and needs of migrant women.[197] In many respects adapted approaches regarding sexual education and care would be recommended to deal with existing differences between migrants and autochthons. Since medical care in Europe, based on current notions on ill-

193 Mouthaan I., de Neef, M., Rademakers J., *Abortus in Multicultureel Nederland*, NISSO Studies nr. 21. Delft, Eburon, 1998; Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals]* [thesis]. Louvain, Catholic University of Louvain, 2004:94-95.

194 E.g. Rademakers J., *Abortus in Nederland 1993-2000. Verslag van de landelijke abortusregistratie*. Heemstede, Stisan, 2002; and see Vissers S. (2004).

195 Rademakers J., *Abortus in Nederland 2001-2002. Verslag van de landelijke abortusregistratie*. Heemstede, Stisan, 2003:24.

196 Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals] [thesis]*. Louvain, Catholic University of Louvain, 2004:86-93.

197 Rademakers 1996:23, cit. In Vissers S. (2004:85).

ness and health, has developed a certain form of consultation and health care provision, it is not necessarily in accordance with migrant and refugee women's norms and expectations.[198]

4.5.2. Family Planning

Research into family planning (FP) among refugee women in Europe is very scarce, but evidence exists that family planning services in European countries are often both inadequate and insensitive to refugee women's needs. More research is needed to get a better idea of the specific needs of ASRW with regard to FP.

Information provision

Research and experiences of asylum seekers and refugees in the United Kingdom and the Netherlands have shown that sexual health and family planning is an area in which refugees, and in particular young people, would like more information. Relevant information should therefore be made available, including where to obtain contraception.[199]

A lack of information and access to available FP services – together with insecurity and bad socio-economic conditions – may explain the lack or ineffective use

198 Vissers S. (2004:85).

199 Burnett A., and Fassir Y., *Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers*. Department of Health, 2002; Mouthaan I., and M. Neef, De, *Als je van niets weet, krijg je problemen. Haalbaarheidsstudie seksuele voorlichting en vorming in internationale schakelklassen*. Utrecht, Rutgers Nisso Groep / Stichting Pharos, 2003.

of modern contraceptives. But little is known about the circumstances and backgrounds of that ineffective use. Sometimes ASRW do not use or ineffectively use contraception because of misconceptions, distrust, or preference for a different method. De Vries gives examples of women making an interval in their uptake of oral contraception to check whether their body still functions properly, and of women, especially from West Africa, who do not trust oral contraception because they think it causes cancer. Moreover, the women in this study preferred other contraception methods, such as an IUD, while doctors had prescribed an oral contraceptive instead. Other cases were reported of women who only took the oral pill when they had sexual intercourse, or only once in two weeks.[200]

Sex education for migrant women is of the utmost importance, regardless of the period of residence or the country of origin. In some regions and countries of origin contraception is not (easily) available. It is therefore important to educate migrant women (and men) about available contraceptives and the effect of these remedies. Cultural notions and ideas should be taken into account, as they can facilitate inefficient use of contraception. Especially with regard to premarital sex there is a reasonable chance that there is a lack of sufficient knowledge regarding contraception.[201]

However, more and better information does not necessarily mean that the prevention policy will be effective. In 1996, a Dutch research project showed that asylum seeking women, who wanted abortion, lacked adequate information about FP services or access to them, even though the Central Organisation for Reception of Asylum Seekers (COA) had produced information leaflets about contraception in 24 languages.[202]

Health care provision

Prevention policies need to be improved, by reaching out to refugee women and giving better sex education and care. Different barriers can hamper qualitative care and education about FP and contraception. In order to have adequate sex education a subtle approach is needed, because FP, contraception, and sexuality in general, are sensitive topics for many refugee women. Some refugee women might not be used to discuss contraception and unwanted pregnancy openly.[203]

200 Vries, De, L.E., Bakker R.H., Burgerhof J.G.M., Abortus provocatus onder asielzoekers. *Tijdschrift voor Gezondheidswetenschappen*, 1999, 77, No. 6: 341-347.

201 Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals]* [thesis]. Louvain, Catholic University of Louvain, 2004.

202 Mouthaan I., and M. Neef, De, *Als je van niets weet, krijg je problemen. Haalbaarheidsstudie seksuele voorlichting en vorming in internationale schakelklassen*. Utrecht, Rutgers Nisso Groep / Stichting Pharos, 2003.

203 Vries, De, L.E., Bakker R.H., Burgerhof J.G.M., Abortus provocatus onder asielzoekers. *Tijdschrift voor Gezondheidswetenschappen*, 1999, 77, No. 6: 341-347.

This requires a relationship of trust and more awareness with regard to refugee women's specific preferences and to the needs on the part of health care workers.

Suspicion on the part of asylum seekers, however, creates a big obstacle in providing good information and care. Asylum seekers often neglect their physical and mental health, including their contraception, because they are so absorbed by the concern about their residence status. Their dependant and insecure position in society often leads them to mistrust everybody, which in turn leads to the ineffective use of all forms of contraception.[204]

Family planning service providers should also be aware of prevailing attitudes, beliefs and knowledge about the use of contraceptives among asylum seekers and refugees. Women's cultural background plays an important role in family planning, contraceptive use and behaviour. Refugees may not use FP due to religious or cultural reasons; however, some authors warn that this should not be assumed.[205] In many cultures a lack of understanding and communication between men and women also forms an important barrier to the utilisation of FP services. Men – and their families – are often the decision makers regarding their wives' SRH and it might be difficult for ASRW to negotiate condom use with their partner.[206] Familial and cultural pressure to fulfill traditional childbearing roles may also influence ASRW's choices.[207]

In addition, FP practices in the country of origin also play a role in ASRW's decision making. Eastern Central European countries for example, have exceptionally poor records on women's SRH care and rights.[208] Women from Russia and Eastern European countries often consider abortion to be a form of contraception and might not have much difficulties talking about unwanted pregnancy. Women from Iraq, on the other hand, might not be used to medical care that is only accessible for a few hours a week, as in Iraq they were used to have access to medical care twenty-four hours a day.[209] Service providers should also consider refugee women's status and roles in their countries of origin, as these have been found to have a direct impact on patterns of service utilisation.[210]

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204 Ibid. and Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities*. Irish Family Planning Association, 2002:17-18.

205 This also accounts for abortion, even though in many cultures abortion is unacceptable (see section on safe motherhood). And See Burnett A. and Fassir Y., *Meeting the health needs of refugee and asylum seekers in het UK: an information and resource pack for health workers.* Departement of Health, 2002.

206 Bosmans M., Leye E., Claeys P., Temmerman M., *Reproductive and Sexual Rights of Refugee and Internally Displaced Women as Cornerstone of Respect for Human Rights*. Ghent, The International Centre for Reproductive Health, Ghent University, 2002 (Unpublished); Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities.* Irish Family Planning Association, 2002 (Unpublished).

207 Arend, E.D. (2002).

208 See also Arend, E.D. (2002).

209 Vries, De, L.E., Bakker R.H., Burgerhof J.G.M. (1999: 341-347).

210 Arend, E.D. (2002).

Access to contraceptives

Although limited information is available about ASRW's access to contraceptives, in Belgium difficulties in obtaining contraceptives were identified as a factor leading to unwanted pregnancies and induced abortion. The fact that women did not have a doctor or a prescription for contraceptives at their disposal – particularly with regard to the (oral) pill – was identified as an important reason why migrant women in Belgium did not use contraception. According to this study, this could be partly related to fear for parents and/or social environment.[211]

Affordability of contraceptives

Another issue is the cost of contraceptives. Belgian findings show that some women, both migrant women and nationals, who had an unwanted pregnancy, had not used contraception because it was not financially feasible. The cost was mainly a problem for first generation migrants.[212]

211 Vissers S., *Trends Inzake de Prevalentie van Abortus bij Autochtonen en Allochtonen in Vlaanderen. Een onderzoek bij abortuscentra en gezondheidsprofessionals [Trends Concerning the Prevalence of Abortion among Autochthons and Allochthons in Flanders. A Research at Abortion Centres and Health Professionals]* [thesis]. Louvain, Catholic University of Louvain, 2004:95.

212 Ibid.: 91.

4.5.3. Sexually Transmitted Infections, Including HIV/AIDS

From the data that are available on the prevalence of STIs in migrants in Europe, it appears that STD cases are increasing among the non-European population. Epidemiological data, however, are limited. The epidemiological results mentioned in an Aids & Mobility report of 1998, for example, are based on small pilot research projects.[213] It is therefore difficult to make generalisations.

Reviewing the available literature on STIs/HIV/AIDS, it seems that the focus has shifted primarily to HIV/AIDS. This is an important trend, since there is evidence that the presence of STIs highly increases the risk of HIV/AIDS.[214] Good treatment of STIs can repel the chance for HIV infection considerably. Data on the prevalence of cervical cancer in ASRW and the needs in providing good care and treatment for ASRW in this regard are almost non-existent.[215]

According to the International Organisation for Migration (IOM), outcomes in chronically infected mobile populations need to be more accurately measured and quantified. Specific programmes need to be developed to meet the most important problems. This will require better epidemiological investigation and the follow-up of mobile populations. According to IOM, ideally, an information exchange continuum should be created, which makes basic information on the epidemiology of chronic infections in mobile populations easily available to those who plan for or provide medical care for this population group.[216] Based on EU country reports, the A&M network argues for the need for better epidemiological monitoring of the HIV subtypes, better and more comparable ethnic monitoring, and a better insight into heterosexual versus homosexual transmission.[217]

HIV/AIDS in migrants is a specific case in the disputed topic of migrants' inclusion into adequate protection systems in EU MS. Institutional health care systems lack data on HIV rates in migrant subgroups and they have next to no assessment of trends. They are unaware of the specific needs migrant women have in connection with health information, prevention and health care.[218]

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213 Putter J., De (ed.), AIDS *& STDs and Migrants, Ethnic Minorities and other Mobile Groups; The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 1998.

214 UNAIDS, WHO, *Aids Epidemic Update: December 2000*, Switzerland, 2000 (http://www.unaids.org/wac/2000/wad00/files/WAD_epidemic_report.pdf, accessed on 15 June 2004).

215 A small-scale study into the specific needs of asylum seekers attending an STI clinic in Hallamshire, United Kingdom, indicated that a considerable number of asylum seeking women were without up-to-date smears. See Rogstad, K.E., Dale H., What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients? *International Journal of STD & AIDS*, 2004, 15:515-518.

216 IOM, Infections in Mobile Populations: which are the most important? *IOM Newsletter*, 3/2000.

217 Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:156.

218 European Project AIDS & Mobility, NIGZ, *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS* (report of the Satellite Meeting held at the 3rd European Conference on the 'Methods and Results of Social and Behaviour Research on AIDS'). Amsterdam, European Project AIDS & Mobility, NIGZ, March 2000:6.

4.5.3.1. Risk factors for STI/HIV infections in migrant women

Being a migrant or refugee is in itself not a risk factor to get infected by STIs. The prevalence of HIV in migrants depends to a large extent on whether he or she originates from an endemic area. The A&M Network reports that in Austria, for instance, HIV prevalence in its migrant community (predominantly from Eastern and Central Europe) is much lower than in Belgium that has a high percentage of migrants from sub-Saharan Africa.[219] It is important to note that women are known to be more vulnerable to STIs/HIV/AIDS than men, not only due to both cultural and biological factors[220], but also because of legal and social factors.[221]

Similarly, a recent article on the issue of STIs in asylum seekers in the Netherlands, highlighted that asylum seekers are not per definition a risk group for STIs, but that they often face risk situations, which increase the risk of infection. Asylum seekers are particularly at risk of STI infection for different reasons. In the countries of origin STI prevention programmes are often non-existing. In addition, some cultural habits can be identified as risk bearing behaviour, such as initiation rituals with blood or sperm. In the case of war and conflict, health care systems are usually functioning very badly. Circumstances such as poverty, powerlessness, social instability, human right violations and both physical and sexual violence are factors that contribute to the rapid spread of STIs and HIV/AIDS in emergency situations. In the daily struggle for life, women also face the risk to be forced into prostitution in order to survive.[222]

In the asylum phase, women face additional risks of being infected with STIs. In the case of the Netherlands for example, Jak ascertains that the prolonged stay in reception centres and the feelings of loneliness and depression encourage asylum seekers to enter into (several, short-lived) sexual relations. Asylum seekers do not know very well how the health system in the Netherlands works and there are communication problems due to language and culture differences between health care providers and asylum seekers.[223] It is most probable that these risk factors also apply to other European countries.

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219 Bröring, G., Canter C., Schinaia N. and Teixeira B., *Access to Care: Privilege or Right? Migration and HIV Vulnerability in Europe*. Woerden, NIGZ, European Project AIDS & Mobility, 2003:157.

220 UNAIDS, WHO, *Aids Epidemic Update: December 2000*, Switzerland, 2000 (http://www.unaids.org/wac/2000/wad00/files/WAD_epidemic_report.pdf, accessed on 15 June 2004).

221 Putter J., De (ed.), AIDS *& STDs and Migrants, Ethnic Minorities and other Mobile Groups; The State of Affairs in Europe*. Woerden, NIGZ / European Project AIDS & Mobility, 199817. See also UNAIDS/IOM, *Migrants' Right to Health*, Paper prepared by Margaret Duckett for UNAIDS and the International Organization for Migration. Geneva, UNAIDS, 2001:28.

222 Jak L., Goede zorg begint bij heldere registratie: soa bij asielzoekers, *Phaxx*, 2003, 4:16-18.And see also UNHCR, WHO, UNAIDS, *Guidelines for HIV Interventions in Emergency Settings*, UNAIDS/96/1. Geneva, September 1995, on cit. (p.2-4).

223 Burnett A., and Fassir Y., *Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers*. Department of Health, 2002. Available at www.doh.gov.uk/london/index.htm; Jak L., Goede zorg begint bij heldere registratie: soa bij asielzoekers. *Phaxx*, 2003, 4:16-18

4.5.3.2. HIV prevention

There are few data on the prevention of STIs and HIV among asylum seekers and refugees. In order to get insight into the scale of the STI problem in asylum seekers, Jak argues that it is very important to work on the registration of STIs in asylum seekers; on a protocol for research into STIs after risk behaviour; on an active policy to test for STIs that can be treated; and on the promotion of expertise in this field.[224]

Some principles of good practice can be identified that address the specific needs of mobile populations regarding HIV prevention. First, in order to implement prevention activities that are effective, it is important to involve migrant communities. Second, relevant community based organisations, if existing, should be involved in the design of HIV interventions, and a good method to do so is through participatory needs assessment. Preventive interventions need to focus clearly on specific subgroups within the migrant community - i.e. population groups most at risk, such as ASRW - and need to take cultural and individual differences into account.[225]

Asylum seeking and refugee women are also confronted with acts of xenophobia, discrimination and racism, which are currently alarming in Europe. In some cases the anti-migrant and anti-refugee climate is reinforced by the adoption of restrictive asylum and immigration policies and legislation.[226] This creates an additional problem for prevention workers, as the increasing racism towards migrants in some European countries leads to social exclusion of migrants and makes them hard to reach by prevention workers.[227]

4.5.3.3. Access to AIDS care, support and treatment

Information provision

Migrants, including refugees and asylum seekers, are in a disadvantaged position with respect to treatment options. Appropriate and sufficient information and education are often lacking. As a result, they may not be aware of the advantages of early testing and treatment. Experiences from a Dutch community based organisation show that this leads to bad treatment choices and that possibilities

224 Jak L., Goede zorg begint bij heldere registratie: soa bij asielzoekers. *Phaxx*, 2003, 4:16-18.

225 European Project AIDS & Mobility, NIGZ, *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS* (report of the Satellite Meeting held at the 3rd European Conference on the 'Methods and Results of Social and Behaviour Research on AIDS'). Amsterdam, European Project AIDS & Mobility, NIGZ, March 2000.

226 See e.g. European Parliament, Committee on Civil Liberties, Justice and Home Affairs, *Report on the Situation as Regards Fundamental Rights in the European Union (2003), A5-0207/2004*, 22 March 2004 (http://www.ebco-beoc.org/Documents/human_rights_report_eu2003_en.pdf, accessed on 7 May 2004).

227 European Project AIDS & Mobility, NIGZ, *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS* (report of the Satellite Meeting held at the 3rd European Conference on the 'Methods and Results of Social and Behaviour Research on AIDS'). Amsterdam, European Project AIDS & Mobility, NIGZ, March 2000.

to provide health care are not used well. Often migrants seek professional help when they are already seriously ill.[228]

Stigmatisation, but also discrimination, is an important barrier to the provision of appropriate information and education. STIs and HIV/AIDS are important issues for refugees and asylum seekers - and especially for ASRW who are particularly vulnerable in this respect - but it is often hidden and difficult to address.[229] Talking about sexuality and HIV/AIDS is a taboo in many migrant communities. In addition, migrant women may be concerned about the possibility of HIV infection, but may not raise the issue because of fear, mistrust of interpreters, concerns about confidentiality and stigma. Asylum seekers might not tell their lawyers that they are HIV positive, out of fear to be stigmatised and/or expelled.[230]

Health care provision

An important issue, which deserves particular attention within a European context, is what has been called the "epidemic split between migrant and indigenous populations". In Europe, many people with HIV in the general population do not develop AIDS due to good monitoring and treatment. In contrast, this is often not the case for HIV positive migrants and individuals from ethnic minority groups. This can be ascribed to "the fact that the latter cannot access testing and treatment facilities as early and effectively as the general population". [231] Access to health care for migrant women, living with HIV/AIDS in EU MS, can be limited due to legal restrictions, socio-economic problems, lack of culturally and linguistically appropriate services, a lack of information, discrimination and stigmatisation.

Linguistic and cultural communication problems can seriously affect the effectiveness of health care offered to migrant women. Making use of interpreters to overcome this problem might cause other problems, such as the need to overcome the fear of patients that interpreters will reveal their HIV status to others, which might lead to stigmatisation and discrimination.[232]

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228 Ibid.

229 Jak L., Goede zorg begint bij heldere registratie: soa bij asielzoekers. *Phaxx*, 2003, 4:16-18.

230 European Project AIDS & Mobility, NIGZ, *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS* (report of the Satellite Meeting held at the 3rd European Conference on the 'Methods and Results of Social and Behaviour Research on AIDS'). Amsterdam, European Project AIDS & Mobility, NIGZ, March 2000: 9-10.

231 Edubio A., Sabanadesan R., *African Communities in Northern Europe and HIV/AIDS. Report of Two Qualitative Studies in Germany and Finland on the Perception of the AIDS Epidemic in Selected African Minorities*. Tampere, University of Tampere, October 2001:8; European Project AIDS & Mobility, NIGZ, *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS* (report of the Satellite Meeting held at the 3rd European Conference on the 'Methods and Results of Social and Behaviour Research on AIDS'). Amsterdam, European Project AIDS & Mobility, NIGZ, March 2000

232 European Project AIDS & Mobility, NIGZ (2000).

Legal restrictions and the dilemma of treatment

Many facilities and NGOs providing counselling for migrant HIV/AIDS patients report that these patients mainly have questions regarding their legal status and questions of "securing residence, preventing deportation, problems of covering the cost of necessary stay in the hospital, or finding accommodation in case of 'tolerated residence'". Health care workers are particularly confronted with the dilemma of providing HIV/AIDS treatment to asylum seekers who might be deported. In some EU MS, asylum seekers who are receiving HIV/AIDS treatment are deported to their countries of origin where they often cannot continue their medical treatment. In several federal states of Germany, for example, HIV tests are carried out during the first medical contacts with asylum applicants, without consent of the person concerned. A positive test result does not prevent or delay deportation. Non-compliance to the treatment, however, leads to resistance of the virus and deteriorating health conditions for the persons affected.[233]

4.5.4. Sexual and Gender-based Violence

'Sexual violence', 'gender-based violence' and 'violence against women' are terms that are often used interchangeably. They all refer to violations of fundamental human rights and to physical, sexual and psychological harm that reinforces female subordination and perpetuates male power and control. Even though men and boys are often victims/survivors of sexual violence as well, statistics confirm that women and girls are an overwhelming majority of the victims/survivors of sexual and gender-based violence (SGBV).[234]

Violence against women is increasingly acknowledged as a serious violation of human rights and a big public health concern. The previous United Nations High Commissioner for Refugees, Ruud Lubbers, recently stated: "Refugees and internally displaced people, who do not enjoy the protection of their own governments, are among those most vulnerable to acts of violence, including sexual and gender-based violence. (…) *Women and children, who are often most vulnerable to human rights abuses, are also the ones who suffer most from sexual and gender based violence.*"[235]

233 Ibid.
234 UNHCR, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response*. UNHCR Report, May 2003:6,11.
235 Ibid.: 1.

Research into the prevalence of SGBV among refugee women in Europe is very limited. It is therefore difficult to identify refugee women's specific needs related to the broad issue of SGBV within a European context. In the context of this review, we shall focus on the issue of domestic and sexual violence, and the specific issue of women and girls who have undergone female genital mutilation.

4.5.4.1. Sexual and Gender-based Violence during the refugee cycle

Refugee women's SRH is at risk during different phases of their flight, especially with regard to SGBV. Refugee women and children face high risks of being subjected to SGBV when fleeing and seeking asylum. During conflict and prior to flight, refugee women are at risk for different types of violence[236]: "Abuse by persons in power; sexual bartering of women; sexual assault, rape; abduction by armed members of parties in conflict, including security forces; mass rape and forced pregnancies". In war and armed conflict the breakdown of social structures, exertion of political power and control over other communities, ethnic differences, and socio-economic discrimination are identified as risk factors for SGBV (among others).[237] During their flight refugee women are also vulnerable to different types of SGBV: "sexual attack by bandits, border guards, pirates; capture for trafficking by smugglers, slave traders."[238]

In addition, refugee women are also confronted with different types of SGBV in the country of asylum. UNHCR names the following: "Sexual attack, coercion, extortion by persons in authority; sexual abuse of separated children in foster care; domestic violence; sexual assault when in transit facilities, (…) etc.; sex for survival/forced prostitution; sexual exploitation of persons seeking legal status in asylum country or access to assistance and resources, resumption of harmful traditional practices." [239]

4.5.4.2. Domestic violence

Violence does not recognise any 'colour' barriers, it is not tied to age, sex, or class. Early notice and a respectful, appropriate assistance are an urgent necessity. Some clear points for attention are described in a Dutch study for health care profes-

236 See also Bosmans M., Leye E., Claeys P., Temmerman M., *Reproductive and Sexual Rights of Refugee and Internally Displaced Women as Cornerstone of Respect for Human Rights*. Ghent, The International Centre for Reproductive Health, Ghent University, 2002 (Unpublished).

237 For more detailed information see UNHCR, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response*. UNHCR Report, May 2003:22.

238 Ibid.: 20.

239 Ibid.

sionals working with families from different cultures where violence occurs, which will be addressed below.[240]

Living in exile

In a certain way living in exile means a continuation of violence. Refugees, by definition, were forced to leave their countries of origin, and were forced to break (family) relations. Suffered violence and forced migration distinguishes them from the situation of migrants. Feelings of loss and disruption are paramount. The involuntary character of their stay in their host country can be a hindrance for their adaptation to the new society. Feelings of nostalgia are often strengthened because of long waiting periods during their asylum procedure, and may even cause depressive feelings.

Pressure on the family

Family life of refugees in the Netherlands, but also elsewhere in Europe, shows a number of similarities with migrant families. Both groups are treated as strangers and have to face acts of discrimination or small incidents, and they have to express themselves in a language that is not their mother tongue. In non-western cultures families are often part of a wider family system, with specific rules to regulate conflicts within the family. These rules cannot be applied in the host country since they usually have left their family members behind. Refugee women who experience domestic violence are specifically vulnerable because they often lack family and community support. Often the family is dependent on a (small) allowance and on institutions. Sometimes partners are dependent on each other for a residence permit, or for access to accommodation. This makes it even more difficult for refugee women to leave in case of violence.[241]

But there are also differences in the situation of migrant women and ASRW. Tensions in refugee families are often greater, especially when they do not have a permanent residence status, which causes feelings of insecurity about their future. Reunions also cause tensions. The husband, or male partner, might have suffered all kinds of fear, during his flight, which is difficult to share with his wife, once in the host country. When the woman has stayed in the host country for a longer time, and she has arranged things independently and perhaps has mastered the

240 Groen M., *Geweld en Schaamte Richtlijnen voor de eerstelijnshulpverlening bij relationeel geweld in gezinnen van migranten en vluchtelingen [Violence and Shame. Guidelines for primary aid to address relational violence in migrant and refugee households]*. Utrecht, Vrouwenopvang Utrecht, 2001:57-70.

241 Ibid., and Burnett and Fassir, ibid. 56. See also Kramer S., and M. Cense, *Overleven op de m2. Veiligheidsbeleving en strategieën van vrouwen in de centrale opvang voor asielzoekers [Surviving on the Square Meter, Experiences of Unsafety and Violence and Coping Strategies of Female Asylum Seekers]*. Utrecht, Pharos/TransAct, 2004.

local language, this might turn out to be a source of tensions. Power relations can shift and might bring the man in a difficult position.[242]

In case that there are children involved, tensions can further develop. Women might have more contacts through the school and in the neighbourhood. When the husband/partner is not allowed to work or if he can't find work, this can cause further isolation, which can lead to heated fights at home. Men who are traumatised form an increased risk for their women, since they might turn their frustrations and misery into violence. Refugee children, who are sometimes traumatised as well, often have to face extremely difficult circumstances. In addition, political disputes or anxiety about family members who are still in their country of origin can also cause quarrels. The latter might evoke feelings of guilt and powerlessness, which can lead again to aggressive behaviour to relieve tensions.[243]

Health care provision

When having a first intake conversation with refugees, perhaps even more so than with migrants, it is important to pay attention to suffered violence in the country of origin, as well as during the flight and in the host country. In addition, it is important to pose questions to track the possibility of post-traumatic stress dis-

242 Groen M., *Geweld en Schaamte Richtlijnen voor de eerstelijnshulpverlening bij relationeel geweld in gezinnen van migranten en vluchtelingen [Violence and Shame. Guidelines for primary aid to address relational violence in migrant and refugee households]*. Utrecht, Vrouwenopvang Utrecht, 2001:57-70.

243 Ibid.

order, and it is important to examine whether abuses or torments have caused permanent injuries. For some refugees it is difficult to talk about this. They might be restrained by feelings of guilt and shame, for example when they have revealed information during torture.[244]

The process of the first contact between a refugee and the health care provider is of decisive importance. Suspicion on the side of refugees is often more prominent than among migrants, especially when they have suffered harsh political repression and persecution. For these people questions can be very threatening. Groen explains that it is important for the health care provider to be very clear, for example about the usefulness of the information that is asked, the meaning of support, and what kind of support can and cannot be offered. Misunderstandings can be anticipated, as different cultures might clash. Apart from differences in culture between health care provider and refugees, the health care system has its own culture as well, with specific norms, values, expectations, language use, and discipline. Language problems might create a barrier for health care providers to provide counselling and care. In this case an interpreter is needed, even though the process will be slower.[245]

However, it should be noted that in some cultures, domestic violence is tolerated and/or kept within the family. Moreover, violent behaviour of a refugee's partner may also be tolerated due to the violence that the partner may have experienced himself. Refugee women may be unaware of available resources in order to break the circle of violence.[246] If a country's official approach towards the refugee population is one of "integration" and "normalisation", whereby refugees are expected to adapt to the same services as the host population, Arend argues that refugee women "may consequently be hesitant to discuss traumatic experiences in their countries of origin such as rape, domestic abuse and psychological trauma, which may be critical in addressing their health care needs and easing the transition into their new surroundings".[247]

4.5.4.3. Violence in reception centers

In the EU, entitlement to health care and reception conditions for asylum seekers vary widely. To the best of our knowledge, a European study into female

244 Ibid.
245 Ibid.
246 Burnett A., and Fassir Y., *Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers.* Department of Health, 2002:56.
247 Arend, E.D., *Framing Sexual and Reproductive Health Care for Ethnic Minority Communities.* Dublin, Irish Family Planning Association, 2002 (Unpublished).

asylum seekers' needs regarding the (prevention of) violence and increased risks to experience violence does not exist. Currently, a common European asylum system is being discussed.[248] In this section the main outcomes of a Dutch case study are presented to point at specific needs of refugee women and girls who stay at reception centres.

Factors that increase the risk of violence against female asylum seekers

Partly similar to the situation of refugees in general, but more pressing because asylum seekers are usually in the host country more recently, different stress factors that characterise asylum seekers' lives increase the risk of violence and hence the sense of insecurity among women and girls. Within this risk group, single girls and women are particularly vulnerable in reception centres, and cultural beliefs about single women enhance this vulnerability. Stress factors that were identified in the Netherlands were: "uncertainty about procedures, fear of return, uncertainty about the norms and values in the Netherlands, the prohibition to work, the long wait, living with strangers in very small spaces, being unfamiliar with Dutch health care and other cultural habits."[249]

Information provision

Asylum seeking women would benefit greatly from appropriate information on (sexual) violence, possible measures and rights. Men need information about national legislation and possible consequences of committing (sexual) violence, but also about becoming a victim, since they might be at risk for harassment too. Information should also include an explanation of the specific responsibilities of different organisations, to set refugee women's fear at rest that reporting an incident might have a negative effect on their asylum procedure.

The need for measures to protect refugee women and girls against violence

There is much diversity with regard to women's perceptions about situations of insecurity and the kind of protection strategies they use. In this Dutch case study, these appeared to be related to the level of education, whether they had an Islamic or non-Islamic lifestyle, age, marital status, and norms and habits regarding the women in the home country. Perceptions about (in)security and women's protection needs also vary, depending on the women's country of origin. Women's protection strategies could even be completely opposite.[250]

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248 For more information on agreements and developments in this regard see: http://europa.eu.int/comm/justice_home/fsj/asylum/fsj_asylum_intro_en.htm

249 Kramer S., and M. Cense, *Overleven op de m2. Veiligheidsbeleving en strategieën van vrouwen in de centrale opvang voor asielzoekers [Surviving on the Square Meter, Experiences of Unsafety and Violence and Coping Strategies of Female Asylum Seekers]*. Utrecht, Pharos/TransAct, 2004.

250 Ibid.: 94-95.

Although asylum seeking women adopt strategies to protect themselves, research findings show that more needs to be done to protect them. The situation of women in Dutch reception centers is identified as critical. Staff at reception centres needs to be trained to recognise unsafe situations, and to gain competence in intercultural and gender specific communication. It is important to build trust, as many women may be very reserved to share their experiences. Victims of violence often do not report abuse. Women's complaints and wishes need to be taken seriously. This will subsequently encourage other women to talk about their problems with staff members as well. In the Dutch case study women indicated that a careless treatment of complaints regarding safety, reduces the will to report to "less than zero". [251]

An important dilemma in the discussion about improving safety in reception centres is the delicate balance between privacy and supervision. This balance needs to be considered, as well as the diversity of women: "To one group of women supervision during male visits to the women's quarters may be a blessing while another group would feel greatly restricted (…). A particular group may benefit from contact with women of their own culture where to another group similar contacts stifle their emancipation."[252]

On the other hand, some practical measures can be taken to improve conditions at refugee centres. In the Netherlands measures are being implemented to improve reception facilities. Kramers and Cense argue that basic conditions should be taken into account: private bathrooms should be provided and people should be able to lock their bedroom. Further aspects are recommended such as a clear arrangement of premises and living units, lighting, and the connection with a social network (women from same culture nearby).

4.5.4.4. Female Genital Mutilation

Migration to Europe has brought an increasing number of women and girls from sub-Saharan African countries where female genital mutilation (FGM) is commonly practised. It is estimated that 100 to 140 million of the world's girls and women have undergone FGM, and two million girls a year are at risk of mutilation. The great majority of affected women lives in sub-Saharan Africa, some live in countries in the Middle East and Asia.[253] It also occurs in parts the Pacific,

251 Ibid.:96.
252 Ibid.:98.
253 WHO, *Female Genital Mutilation. Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide*. Geneva, World Health Organization, Department of Gender and Women's Health, Department of Reproductive Health Research, 2001:5,39.

North and Latin America and in Europe. In industrialised countries, FGM occurs predominantly among immigrants from countries where FGM is practised. According to Amnesty International, it has been reported in Australia, Canada, Denmark, France, Italy, the Netherlands, Sweden, the UK and USA.[254] Female asylum seekers and refugees, girls in particular, might also be at risk of undergoing FGM in the host country.[255]

The World Health Organisation classifies four types of FGM varying from reduction operation (the excision of part or all of the clitoris (Type 1) and/or the labia (Type 2), to closure operations that consist of FGM of Type 2 along with stitching/narrowing the vaginal opening (Type 3, or infibulation). Other procedures, such as pricking or piercing the clitoris, are categorised as Type 4.[256]

Reliable national prevalence data and systematic epidemiological data on FGM in Europe, and its related health problems, are largely unavailable,[257] and the magnitude of the problem is difficult to assess.[258] However, within the EU, FGM has raised concern in several countries, as different institutions and services (e.g. health care, social services, and the police) have been confronted with FGM related issues.

Health care provision

The WHO has documented the health consequences related to FGM. Immediate effects can include "pain, injury to adjacent tissue, shock, infection, urinary retention, and haemorrhaging resulting in death. Long-term morbidity consequences, particularly of infibulation, can be severe and include: urinary incontinence, recurrent urinary tract infection, pelvic infections resulting in infertility, menstruation difficulties, obstetric complications, fistulae of the bladder or rectum, and sexual dysfunction."[259] Although it is clear that these health

254 Amnesty International, *Female Genital Mutilation: A Human Rights Information Pack*. Amnesty International, 1997 (http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm, accessed 15 September 2004.)

255 Powell RA, Leye E, Jayakody A, Mwangi-Powell FN, Morison L, Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy*, 2004, 70:151-162.

256 WHO, *Female Genital Mutilation. Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide*. Geneva, World Health Organization, Department of Gender and Women's Health, Department of Reproductive Health Research, 2001. Cit. in Powel et al., 2004.

257 Leye E., Powell R.A., Nienhuis G., Claeys P., Temmerman M., Health care in Europe for women with genital mutilation. Accepted for publication in *Health Care for Women International*, 2005. Contact Els.Leye@Ugent.be; Powell RA, Leye E, Jayakody A, Mwangi-Powell FN, Morison L, Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy*, 2004, 70:151-162.

258 Leye E., The struggle against female genital mutilation/female circumcision: the European experience. In: Denniston G.C., Mansfield Hodges F., and Milos M.F. (eds.) *Understanding circumcision. A multidisciplinary approach to multi-demensional problem.* New York, Kluwer Academic/Plenum Publishers, 2001:113-128. Cit. in: Leye E., Powel R.A., et al., 2005.

259 WHO, *A systematic review of the health complications of female genital mutilation, including sequela in childbirth*. Geneva, Department of Women's Health, Family and Community Health, World Health Organization, 2000. Cit. in Powell et al., 2004:152.

problems can be caused by FGM, the frequency of such problems and how they can be related to different types of FGM is not well demonstrated yet, which has led to some controversy among researchers.[260]

Female asylum seekers and refugees, both women and girls, have additional health needs if they have undergone FGM. The growing number of asylum seekers and refugees from FGM practicing countries sets a difficult task for European institutional staff, such as health care professionals and educational staff. Powell et al. argue that one of the major difficulties in caring for those affected by the practice, is the degree of operational coherence in addressing asylum seekers' and refugees' needs related to FGM between health and social care services and other agencies, such as police, lawyers, and immigration officials. Apparently, services often develop their own codes of practices, without involving the multiple other agencies, which could, and should, be involved in a suspected FGM case. An attendant problem is the lack of operational coherence between these agencies, grass roots organisations, and policy makers.[261]

Caring for women who have undergone FGM, especially infibulation, requires great sensitivity on the part of health professionals.[262] In European countries, such as Sweden, Denmark, UK and the Netherlands, which have a large number of African (im)migrants from countries where infibulations are commonly practiced, health care professionals have been confronted with potential severe health complications resulting from the practice, requiring specific attention and care (e.g. during time of delivery).[263] Furthermore, deficiencies within services exacerbate existing operational disharmony. It is argued that care for women who are genitally mutilated must be provided in co-operation with other services in order to be effective.[264]

Health care professionals in Europe are facing multiple difficulties and questions in connection with FGM related complications. Apart from having to deal with the clinical management of infibulated women, European health care providers can also face ethical problems. Leye argues that due to a lack of clear guidelines and legislation, health care professionals are faced with ethical and legal questions regarding re-infibulation after delivery, the pricking or incision of the clitoris and the issue of cosmetic surgery of female genitalia.[265]

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260 In: Powell et al., 2004:152.
261 Powell et al., 2004:155.
262 Omer-Hashi K., Commentary: Female Genital Mutilation: Perspectives from a Somalian Midwife. *Birth*, December 1994, Vol. 21, no. 4:224-225.
263 Powell et al. 2004; Leye E. et al., Health care in Europe for women with gential mutilation. Accepted for publication in *Health Care for Women International*, 2005. Contact Els.Leye@Ugent.be
264 Ibid.
265 For more information see Leye E. et al., 2005.

Research in five European countries (Belgium, Denmark, Sweden,the Netherlands and the UK) has shown that the responses of health care professionals to women who are genitally mutilated are based on three health interventions: 1) provision of technical guidelines for the clinical management of women with FGM; 2) codes of conduct for health care professionals on quality of care issues (e.g. culturally appropriate care); and 3) provision of specialised health services, including medical care, psychological care, and counselling.[266]

It should be noted however, that the provision of adequate health care might be hampered by several factors, such as a lack of knowledge of FGM and unfamiliarity with the practice among health care professionals.[267] There is some evidence that a lack of technical guidance to provide appropriate care for genitally mutilated women hampers the provision of adequate care.[268] Furthermore, personal emotions and feelings regarding the subject can play an important role as well. Some health care providers are reported to be reluctant to address the issue, either out of respect or due to ignorance of different cultures. FGM can also cause feelings of powerlessness or anger among health personnel.[269] All this may hamper adequate care provision women for who have undergone FGM.

Another issue in delivering appropriate care is the lack of knowledge among health care professionals of the health care expectations and needs of affected women. A small case study among Somali women in the Netherlands, for example, showed that obstetric care is insufficiently adapted to their expectations and needs.[270] A small case study in the UK revealed a lack of knowledge and understanding of FGM, as well as poor communication with health care staff during delivery.[271]

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266 Ibid.

267 See also Bulman K.H. & C. McCourt, Somali refugee women's experience of maternity care in west London: a case study. *Critical Public Health*, 2002, Vol.12, No.4: 365-380.

268 Widmark C., Tishelman C., Ahlberg B. M., A study of Swedish midwives' encounters with infibulated African women in Sweden. *Midwifery*, 2002, 18:113-125; Chalmers B., Hashi K.O., 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth*, 2000, 27:227-234. In: Leye et al., 2005.

269 Nienhuis G., and I. Haaijer, Ignorance of female circumcision may hamper adequate care. In: Werkgroep Interculturele Verpleging (ed.), *Intercultureel verplegen*. Utrecht, De Tijdstroom, 1995:42-56. In: Leye et al, 2005.

270 Nienhuis G., Somali women tell: It's like you have to do the delivery here by yourself. *Tijdschrift voor Verloskundigen*, 1998, 23:160-166. In Leye et al, 2005.

271 Bulman K.H. & C. McCourt, Somali refugee women's experience of maternity care in west London: a case study. *Critical Public Health*, 2002, Vol.12, No.4: 365-380.

4.6. CONCLUSIONS

Worldwide, growing attention is paid to the specific rights and needs of refugee and displaced women, including their sexual and reproductive health rights and needs. They often come from countries where women have a disadvantaged position in society, which makes them very vulnerable, particularly in their SRH. A majority of refugee women in Europe are in their reproductive age and research findings indicate that they suffer higher maternal morbidity and mortality, experience poorer pregnancy outcomes, have less access to family planning services and counselling, show higher prevalences of unwanted pregnancy and induced abortion, are at a higher risk of STIs, including HIV/AIDS, and run an increased risk of SGBV.

ASRW's SRH status and needs in European settings have hardly been explored. However, research findings indicate that the provision and use of SRH services by ASRW in Europe are inadequate. This is due to several factors: 1) at the level of policies for the reception and integration of refugees, 2) at the level of provision of social and health services, and 3) at the level of the ASRW who fail to use SRH services.

The health status of asylum seekers and refugees can be related to different determinants, which have an impact on their overall health, including their SRH: 1) lifestyle/behaviour; 2) biological/genetic factors; 3) environmental factors (physical, economical, social, cultural), and 4) availability, accessibility, and quality of health care. Different contextual mechanisms affect the influence of these determinants on ASRW's health, such as migration, acculturation, socio-economical position, and the societal context.

It is important to acknowledge and emphasise that refugee health, living conditions, and provision of care and services, are gendered areas of concern. They require a gender-sensitive view and response. In order to identify ASRW's SRH needs, it is also important to note that migrants and refugees are not homogenous groups. Differences may be identified in their culture, language, the level of education, the reason for migration, the socio-economic situation, the duration of residence with respect to various generations, and the degree of integration. But attention should also be paid to diversities within ethnic groups.

Although there are similarities in SRH status, risks and needs of migrant women's and ASRW's, it is important to pay attention to the specific needs of ASRW. These are related to their background of forced migration and the situation in the host country (e.g. legal, social, economical). Asylum seeking women in particu-

lar, face additional barriers in accessing SRH care, since they have limited access to the national health system in many EU MS, and the extent of limitation varies greatly.

ASRW face a number of difficulties in gaining access to quality health care. The experience and use of SRH care services by ASRW is influenced and may be hampered by different factors such as gender, their legal status as asylum seekers or refugees, country of origin, ethnic origin, religion, sexual behaviour, accommodation (and other basic needs), feelings of loneliness and uncertainty, and socio-economic position (e.g., lack of financial resources).

Different barriers with regard to accessing SRH services in the EU MS can be identified: 1) communication problems, 2) language and cross-cultural barriers, 3) lack of information on how the national health system functions and on available SRH services, 4) lack of information on patient's rights and entitlements to SRH services, 5) lack of training and awareness of health personnel about refugee issues and their specific needs and care expectations, 6) mutual lack of understanding, 7) lack of trust on the part of asylum seekers and refugees, 8) economic and administrative barriers, 9) geographical and legal barriers in receiving adequate SRH information and services, 10) lack of continuity in health care (which is particularly problematic in countries that have dispersal policies for asylum seekers), and 11) stigmatisation and discrimination.

In addition, ASRW might also be constrained by the need to fulfill other practical and social needs first - such as acquiring legal employment, obtaining essential language skills, education, transportation and adequate housing - which can compromise their overall health, including their SRH. Once ASRW are able to fulfil their most immediate practical and social needs, they may experience better accessibility and comfort in seeking and using SRH care services.

Health care providers, on their part, are confronted with several problems in providing qualitative SRH care for ASRW. Language barriers and related communication problems, including cross-cultural barriers and differences in perception of health care, are part of the perceived barriers in providing care for ASRW. Moreover, health care providers are often not aware of issues related to the refugee experience, and might have constraints that limit their ability to serve ASRW better. Often, time, language difficulties, and difficult requests are beyond their scope or capacity. Attitudes of health care staff also play a major role in ASRW's experiences of SRH care. Ignorance, but also prejudice related to race or ethnic background, profoundly affect the quality of care that ASRW may receive.

Asylum seeking and refugee women's SRHR are also violated as a result of xenophobia, discrimination and racism against migrants, refugees and asylum seekers, which are currently most alarming in Europe. In some cases the anti-migrant and anti-refugee climate is reinforced by the adoption of restrictive asylum and immigration policies and legislation.

In order for culturally appropriate SRH promotion programmes and services to be developed, and adapted to the needs of ASRW, there is a need for a better understanding of the sexual behaviours and attitudes of different communities, particularly those at increased risk. There is a great need for more research in the broad field of ASRW' SRH in Europe in order to develop an effective response in the different EU MS. Information is needed with regard to group characteristics and the specific context in order to be able to generalise research results. Often these specific data about the research group and their circumstances in the host country are missing, so that possibilities for the interpretation of the results are limited. Different SRH aspects are interrelated, which requires a holistic and integrated research approach in order to get a better insight in the specific SRH needs of ASRW.

4

RECOMMENDATIONS

5.1. Recommendations for the Promotion of Asylum Study and Refugee Women's Sexual and Reproductive Health Rigths in Europe

1. A rights-based approach to SRH of asylum seeking and refugee women in the EU should be based on the international human rights standards concerning SRH.

2. The EU should integrate these international norms, standards and principles into the European legal standards, policies, programmes, and guidelines.

3. National governments of the EU MS need to take measures in order to respect, protect and fulfil the SRH rights of all women, including asylum seeking and refugee women.

4. The EU should take the lead in sensitising the EU MS about the importance of SRH, and in encouraging them to develop policies and strategies for improving SRH of both asylum seekers and refugees.

5. More attention should be paid to the provision of SRH services that are accessible, affordable and acceptable for ASRW.

6. Asylum seeking and refugee women's empowerment should be promoted, and the involvement of men should be increased.

5.2. Recommendations for Further Research

1. Further research into the SRH needs and rights of ASRW should be promoted and supported in order to enable EU MS to identify needs, to define priorities, and to develop effective responses.

2. A holistic and integrated research approach should be encouraged in order to get a better insight in the specific SRH needs of ASRW.

3. Interdisciplinary research into all aspects related to SRH rights and needs of asylum seekers and statutory refugees, and in particular ASRW, should be supported in order to develop adequate and innovative interventions and coherent policies.

4. The collection of comparable and compatible data on the SRH status and needs of ASRW in Europe should be supported.

5. The data collected on ASRW's SRH should be sex, group and context specific in order to be able to generalise research results.

6. Further research should also pay attention to SRH rights and needs of adolescent asylum seekers and refugees, with specific attention for the rights and needs of adolescent girls.

7. Research into ASRW's SRH rights, Status and needs in the new EU MS is recommended.

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Glossary

Asylum

The granting, by a State, of protection in its territory to a person/persons from another State who is/are fleeing persecution or serious danger. A person who is granted asylum is a refugee. Asylum encompasses a variety of elements, including *non-refoulement*, permission to remain on the territory of the asylum country, and humane standards of treatment.[272]

Asylum seekers

Asylum seekers are defined as "persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments."[273]

Antiretroviral therapy (ART):

Treatment that suppresses or stops a retrovirus. One of the retrovirus is the human immunodeficiency virus (HIV) that causes AIDS. Retroviruses are so named because they carry their genetic information in the form of RNA rather than DNA so that the information must be transcribed in "reverse" direction — from RNA into DNA.

Convention Relating to the Status of Refugees

The 1951 Convention Relating to the Status of Refugees is a convention that established the most widely applicable framework for the protection of refugees. The convention was adopted in July 1951 and entered into force in April 1954. Article 1 of the 1951 Convention limits its scope to 'events occurring before 1 January 1951'. This restriction was removed by the 1967 Protocol relating to the Status of Refugees. To date, there are 139 states who are party to the 1951 and/or 1967 Protocol. [274]

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272 Adapted from: *Glossary of terms related to the experiences of refugees* (http://www.uniya.org/education/refugees_glossary.html, accessed 1 March 2004).

273 IOM, International Migration Law. Glossary on Migration. Geneva, IOM, 2004.

274 Adapted from: *Glossary of terms related to the experiences of refugees* (http://www.uniya.org/education/refugees_glossary.html

Convention refugee

A convention refugee – sometimes also referred to as a 'statutory refugee' — is a person recognised as a refugee by states under the criteria in Article 1A of the 1951 Convention, and entitled to the enjoyment of a variety of rights under the Convention.[275]

Gender

Gender is the term used "to denote the *social characteristics* assigned to men and women. These social characteristics are constructed on the basis of different factors, such as age, religion, national, ethnic and social origin. They differ both within and between cultures and define identities, status, roles, responsibilities and power relations among the members of any society or culture. Gender is learned through socialisation. It is not static or innate, but evolves to respond to changes in the social, policitical and cultural environment."[276]

HIV-positive

A person who tests positive for the presence of antibodies to HIV (anti-HIV) is termed HIV-positive. Children born to HIV infected mothers may be HIV positive for some time because the maternal antibody crosses to the baby prior to birth and persists for up to 18 months.

Intrauterine contraceptive device (IUD)

A device inserted into the uterus (womb) to prevent conception (pregnancy). The IUD can be a coil, loop, triangle, or T-shape. It can be plastic or metal.

Refugee

Under the UN Convention Relating to the Status of Refugees 1951, a refugee is a person "who, owing to well-founded fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality or being outside the country of his/ her former habitual residence, is unable or, owing to such fear, is unwilling to return to it."[277] Once a refugee meets

275 Ibid.

276 UNHCR, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response*. UNHCR Report, May 2003:11.

277 "The 1951 Convention relating to the Status of Refugees is the key legal document in defining who is a refugee, their rights and the legal obligations of states. The 1967 Protocol removed geographical and temporal restrictions from the Convention." Addapted from UNHCRH website, see link below:

the refugee definition in the 1951 Geneva Convention he or she is sometimes called a “convention refugee” or “statutory refugee”.

Sex

Sex refers to the biological characteristics, which define humans as female or male.

Sexuality

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.”[1]

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http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id=3c0762ea4&ID=3c0762ea4&PUBLISHER=TWO)

279 http://www.who.int/reproductive-health/gender/sexual_health.html

International Centre for Reproductive Health

The International Centre for Reproductive Health (ICRH) was established in 1994 in response to the International Conference on Population and Development (ICPD, Cairo, 1994). ICRH is a multidisciplinary research centre at the Ghent University. The main objective of ICRH is to improve sexual and reproductive health in its broadest sense. Through research, training, technical assistance and development projects in Belgium, Europe and developing countries, ICRH seeks to improve the accessibility, acceptability and quality of sexual and reproductive health services from a rights-based and gender-sensitive approach.

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