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Sexual and Reproductive Health and Rights of Refugees, Asylum Seekers & Undocumented Migrants

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Sexual and Reproductive Health and Rights of Refugees, Asylum Seekers & Undocumented Migrants

Abstract

In 2006 the European Refugee Fund undertook a call for proposals, which resulted in the project presented in this report. The 18-month project started on 1 August 2007 and ran until 31 January 2009. The general aim of the project was to improve the SRH of refugees and asylum seekers in the EU, by setting up a network for the promotion of the SRH&R of refugees and asylum seekers in Europe and beyond.

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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF REFUGEES, ASYLUM SEEKERS & UNDOCUMENTED MIGRANTS

EN-HERA!
Report 1





This publication results from a common European research project funded by the EC European Refugee Fund. The project was conducted from August 2007 till January 2009 by five academic research institutions and one national knowledge centre.

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CHAPTER 1: INTRODUCTION

1.1 Background

The sexual and reproductive health and rights (SRH&R) and needs of refugees and asylum seekers have only recently begun to be recognized. In Cairo in September 1994, the objectives of the International Conference on Population and Development (ICPD) were made clear: in order to achieve equality and equity between women and men, and to ensure that all women and men are able to exercise their human rights and participate fully in all areas of life, 179 governments acknowledged that all couples and individuals have the right to attain the highest standards of SRH and make decisions concerning their sexual health free of discrimination, coercion and violence.

To this end, these governments declared that countries should take full preventive, protective and rehabilitative measures to eliminate all forms of exploitation, abuse and violence against women and adolescents, while paying special attention to protecting the rights and safety and meeting the needs of those in potentially exploitable situations. Documented and undocumented migrant women, refugee women and refugee children were specified as such. European Union (EU) Member States endorsed this action plan, as well as many other international agreements that recognize gender as a determinant of health.

However, in 2009 there are still no binding European regulations for the incorporation of these health rights in reception and integration policies that secure the entitlement of refugees and asylum seekers to a comprehensive range of SRH services. Each European country has its own policy on the health rights, services provided and financial regulations concerning this target group. This situation is in sharp contrast to the European commitment to the promotion and protection of SRH rights worldwide. Some countries know no clear distinction between refugees, asylum seekers and undocumented migrants. Also the concepts of SRH and health rights are often misunderstood, the boundaries are unclear, and, therefore, many important issues are excluded.

In 2005 the International Centre for Reproductive Health at Ghent University in Belgium initiated a first pilot project, to inquire into the actual status of implementation of these action plans. At the end of this project, the 'International Workshop on Sexual and Reproductive Health and Rights (SRH&R) of Refugee Women in Europe' was organized at the university from 17 to 19 January 2005 and funded by the European Commission (EC) European Refugee Fund. There, the decision to create a network was taken unanimously.

1.2 A European Refugee Fund Project: Aim and Objectives

In 2006 the European Refugee Fund undertook a call for proposals, which resulted in the project presented in this report. The 18-month project started on 1 August 2007 and ran until 31 January 2009. The general aim of the project was to improve the SRH of refugees and asylum seekers in the EU, by setting up a network for the promotion of the SRH&R of refugees and asylum seekers in Europe and beyond. This general aim was translated into six specific objectives:

1. To set up a network among different stakeholders
2. To gradually expand the coverage of the network
3. To develop a standardized good practice identification framework
4. To set a common research agenda
5. To organize an international seminar
6. To publish and disseminate project results.

The following five academic research institutions and one national knowledge centre acted as steering members of the project:

- ICRH - International Centre for Reproductive Health, Ghent University, Belgium
- IHMT - Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal
- ITM - Institute of Tropical Medicine, Belgium
- NSPH - National School of Public Health, Greece
- UCD - University College Dublin, Ireland
- Pharos - The Netherlands.

The steering committee met six times in one of the partner countries to realize the general aim by implementing the specific objectives.

Network

The first objective of this project was to set up a network among different stakeholders. This consisted of taking joint initiatives with universities, service providers, policymakers and refugee and asylum communities and liaising with other networks. The second objective was to gradually expand the coverage of the network from five to at least 13 EU Member States, of which three are 'new'. Additionally, in the countries of the founding members, local networking with at least three partners was planned.

To realize these two objectives, the founding members developed core principles and then chose the name EN-HERA! for the network – standing for the European Network for the promotion of Sexual and Reproductive Health of Refugees and Asylum Seekers. The core principles were not only presented to the expert panel that participated in the development of a framework for the identification of good practices, but were also used in our invitation for

partnership. We made an investigation into potential members, networked and sent those who expressed interest an invitation for partnership. All members signed the Membership Declaration, in which they stated that they would adhere to these principles in the promotion of the SRH&R of refugees and asylum seekers in Europe and beyond. An extensive overview of EN-HERA! members as of January 2009 can be found in Chapter 2.

The core principles are also the basis for the EN-HERA! Vision Text (see Chapter 3), which was discussed, reworked and finalized at the first EN-HERA! member meeting held on 22 November 2008 in Ghent. New members will be asked to endorse the Vision Text when joining EN-HERA!

Framework for the Identification of Good Practices

The third objective was to develop a standardized good practice identification framework in policy development, service delivery and in participatory approach. The framework for the identification and development of good practices for the SRH&R of refugees, asylum seekers and undocumented migrants is designed to support organizations in the field of SRH to develop and maintain the capacity to deliver SRH services, which requires participation of the targeted groups.

It is not only meant as a framework for the identification of good practices but also for the formulation of recommendations for improvement. For the framework to work effectively, the guiding principle for all organizations must be a constant improvement in SRH service delivery, sustained by an ongoing interactive process of mutual learning, so as to understand the diversity of the target group's SRH needs and problems, and solutions to them.

The steering committee decided at its second meeting to consider a participatory approach as a mandatory transversal element within service delivery and policy development itself. Between January and March 2008, we identified 188 experts in this area and sent them a call for experts, asking them to contribute to this project as an expert in a Delphi process (a technique to come to a consensus on ways to proceed). A first loop of questionnaires was sent to the experts and analysed between April and August, and a second between September and October. At the final seminar in November 2008, the third loop was held to finalize the framework.

The framework consists of a general part and a self-assessment tool. The general part provides background information regarding the rationale and objectives of the framework, the methodology used, and clarifications regarding the different concepts. Furthermore, six guiding principles and six key programmatic indicators of quality of care are elaborated. These principles and quality indicators should help to identify and/or develop best practices in the field of SRH&R for refugees, asylum seekers and undocumented migrants. The different statements and guidelines given reflect the consensus view of the international experts involved in the development of this framework.

The self-assessment tool at the end of this publication includes key statements which could assist your organization or programme to identify and/or develop good practices in SRH policy

and service delivery for refugees, asylum seekers and undocumented migrants. It should also enable you to assess what elements in your service or programme need to be strengthened to comprehensively address SRH&R issues for the target group. The self-assessment tool consists of two separate sets of statements: one for policymakers, whether at organizational or (inter) national level, and one for service providers. For both parts, the assessment takes place at two levels: the fundamental (statements regarding six guiding principles) and the programmatic (statements regarding six quality indicators).

For ease of use, the framework was published as a separate document entitled *Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants. A framework for the identification of good practices* (ISBN: 978-90-75955-69-9). It can be downloaded from the ICRH website www.icrh.org or ordered as a free printed copy by one of the steering committee members.

Common Research Agenda

A fourth objective was to set a common research agenda. At several project steering committee meetings (for example, in Athens and Ghent), the steering group members' expertise and research interests were collected, discussed and put next to global research priorities.

In addition, a literature review on the current state of the medical and social science literature was compiled which appeared to be a major milestone to identify research gaps and to achieve the project's objective. It not only highlights the most salient SRH issues that concern refugees, asylum seekers and (undocumented) migrants, but also shows the existing gaps and highlights the areas of concern not sufficiently addressed. The literature review can be found in Chapter 4.

The literature review and its conclusions in terms of identified gaps and subsequent research priorities, combined with the previously defined steering group members' expertise and research interests, resulted in the so-called 'research agenda'. This can be found in Chapter 5.

International Seminar

The fifth specific objective of this project was to organize an international seminar. There were three reasons for doing so:

- To launch the EN-HERA! network officially and to allow different members and participants the possibility to network extensively.
- To raise awareness about the SRH&R of refugees and asylum seekers in Europe and the challenges that we are still facing.
- To present the objectives and results of this project and to finalize the framework for the identification of good practices as a final loop in our Delphi process.

The seminar was held on 21 and 22 November at the Poortackere Monastery in Ghent, Belgium. The first day was open to all members and other participants. The second day consisted of two parts: the first was the first member meeting, and the second in the afternoon was the last steering committee for this project, held by the founding and steering members. The seminar proceedings can be found in Chapter 6, and the list of participants in the appendices.

Publications and Dissemination

The last objective was to publish and disseminate the project's results. First of all, we had to create our own logo and our own name. The name EN-HERA! – given by the six founding members – stands for the European Network for the promotion of Sexual and Reproductive Health of Refugees and Asylum Seekers. But HERA also refers to Hera, the Greek goddess of fertility, change, protection of women, protection of marriage and relations and women in labour. She is also the (jealous) wife of Zeus and, therefore, the queen of the gods.

To make the network visible and recognizable and to obtain an image that reflects the name and the goals of the network, a logo had to be developed. We made a call for tenders, and a logo created by an Iranian refugee was selected. It uses the image of a pomegranate, which symbolizes Hera, in combination with other symbols referring to the world, SRH, refugees and asylum seekers.

For internal communication and exchange of data, knowledge, ideas and information among the EN-HERA! members, a 'googlegroup' is used. For external communication within the project, most documents – such as questionnaires, drafts of frameworks, invitations for partnership, invitations to the seminar etc. – were sent by mail and printed for the meetings.

Finally, two documents have been published: the framework and this report. Both can be downloaded from the ICRH website (www.icrh.org) or ordered as a free printed copy by ICRH or one of the other founding members. We disseminated copies to the EN-HERA! members, to participants in the seminar and to a number of stakeholders active in the field of the SRH of refugees, asylum seekers and undocumented migrants in Europe and beyond. We will do our utmost to promote the publications, to stimulate the implementation of them and to use them actively in advocacy and lobbying. We hope you will do too.

CHAPTER 2: EN-HERA! NETWORKING

2.1 Introduction

The first objective of this 18-month project was to set up a network among different stakeholders. This consisted of taking joined initiatives with universities, service providers, policymakers and refugee and asylum communities and liaising with other networks. EN-HERA! was created by six founding members from Belgium, Greece, Ireland, the Netherlands and Portugal.

The second objective of this project was to gradually expand the coverage of the network from five to at least 13 EU Member States, of which three are 'new'. Additionally, in the countries of the founding members, local networking with at least three partners was planned.

To realize these objectives, the founding members developed core principles. These core principles were not only presented to the expert panel that participated in the development of a framework for the identification of good practices, but were also used in our invitation for partnership. We made an investigation into potential members, networked and sent those who expressed interest an invitation for partnership. The core principles are also the basis for our Vision Text, which can be found in Chapter 3. All members signed the Membership Declaration, in which they stated that they would adhere to these principles in the promotion of the SRH&R of refugees and asylum seekers in Europe and beyond.

In January 2009, the EN-HERA! network consisted of 36 members in 14 countries, of which five are 'new' (Bulgaria, Cyprus, Hungary, Malta and Romania) and eight 'old' EU Member States (Belgium, Germany, Greece, Ireland, the Netherlands, Portugal, Spain and the United Kingdom) and one non-EU Member State, Georgia. Moreover, several potential members expressed their interest in joining EN-HERA! but have not signed the Membership Declaration yet. These potential members are located in some of the abovementioned Member States as well as in the Czech Republic, Iceland, Slovenia and Turkey.

At the EN-HERA! seminar, held in Ghent, Belgium, on 21 and 22 November, the members decided to continue networking with potential new members to further expand the coverage of the EN-HERA! network. The seminar proceedings can be found in Chapter 6.

2.2 Members

Founding Members

Belgium

1. International Centre for Reproductive Health (ICRH), Ghent University – applicant and coordinating organization
2. Prince Leopold Institute for Tropical Medicine (ITM)

Ireland

3. University College Dublin (UCD)

Greece

4. National School of Public Health (NPHS)

Portugal

5. Instituto de Higiene e Medicina Tropical (IHMT)/Universidade Nova de Lisboa

The Netherlands

6. Pharos



In-country networking in the countries of the founding members

Belgium:

7. Medimmigrant
8. Fedasil
9. Dutch Women's Council (Nederlandstalige Vrouwenraad)
10. Centre for Migration and Intercultural Studies (CeMIS) – University of Antwerp

Ireland:

11. Women Overcoming Violent Experiences (WOVE)
12. Irish Family Planning Association
13. Akina Dada wa Africa (AkiDwa)
14. Doras Luimni

Greece:

15. Hellenic Centre for Infectious Diseases Control and Prevention (KEELPNO)
16. Hellenic Centre for Diseases Control and Prevention (KEEL)
17. Praksis
18. Greek Council for Refugees
19. Kenyan Women's Association

Portugal:

20. Médicos do Mundo Portugal
21. Associação para o Desenvolvimento e Cooperação Garcia de Orta
22. AJPAS

The Netherlands:

23. Verwey-Joncker Institute
24. Asylum Seekers/Refugees AIDS Control Group (ASERAG)

New Members**New Members in 'old' EU Member States****United Kingdom:**

25. School of Social Work, St George's University of London/Kingston University

Spain:

26. Hospital Punta de Europa, Migration Unit

Germany:

27. Bavarian AIDS Foundation and Catholic University of Applied Sciences/Technical University of Munich

New Members in 'new' EU Member States**Cyprus:**

28. Cyprus Family Planning Organisation

Romania:

29. Romanian Forum for Refugees and Migrants (ARCA)

CHAPTER 2

Bulgaria:

30. Bulgarian Gender Research Foundation (BGRF)

Malta:

31. Foundation for Social Welfare Services
32. Jesuit Refugee Service

Hungary:

33. Menédek – Hungarian Association for Migrants (HU)

Members outside the European Union

Georgia:

34. Women's Centre

International Networks

35. European Public Health Alliance (EPHA)

Independent Researchers

36. Aoife Gillespie (working for IOM)



2.3 Organizations that expressed interest/potential members

The Netherlands:

- SOA AIDS Nederland

Czech Republic:

- Organisation for Aid to Refugees

Slovenia:

- NGO Prima

Iceland:

- Service Center Midborg & Hlidar

Turkey:

- Sultan Ozturk, independent, working for UNHCR

Collaborating institutions/partner organizations

A International networks

- PICUM
- HIV Prevention Network
- European Network for Prevention of FGM
- ECRE

B International organizations

- UNHCR
- IPPF
- IOM
- WHO
- UNFPA
- EPHA
- LHIVING

C National organizations/institutions

- BZgA (Germany)
- Department of Justice (Ireland)

CHAPTER 3: EN-HERA! VISION TEXT

3.1 Introduction

EN-HERA! stands for the **E**uropean **N**etwork for the promotion of **S**exual and **R**eproductive **H**Health and **R**ights of **R**efugees and **A**sylum **S**eekers in **E**urope and beyond. The decision to create such a network was unanimously taken by six founding members¹ at the International Workshop on Sexual and Reproductive Health and Rights (SRH&R) of Refugee Women in Europe, organized at Ghent University, Belgium, from 17–19 January 2005 and funded by the EC's European Refugee Fund. Since then, the network has been gradually expanding by calling upon a wide range of stakeholders including refugee and asylum communities, policymakers, intermediary organizations, advocacy groups, service providers, researchers and civil society to join it.

The EN-HERA! network was officially launched on 21 November 2008 at an international seminar, organized in Ghent, Belgium, with the financial support of the EC's European Refugee Fund. At that moment, the EN-HERA! network counted 33 members, including five members from 'new' EU Member States and one from outside the EU. When signing the Membership Declaration, they agreed to endorse the EN-HERA! principles while promoting the SRH&R of refugees and asylum seekers in Europe and beyond.

A first meeting of all members of the EN-HERA! network took place in Ghent, Belgium, on 22 November 2008. During this meeting a draft Vision Text was discussed and reworked. Adding undocumented migrants as beneficiaries is one of the examples of amendments. The final version, below, was approved by all present members. New members will be asked to endorse the Vision Text when joining EN-HERA!

¹ The European partners founding EN-HERA! are: the International Centre for Reproductive Health of Ghent University, Belgium (coordinator); the Prince Leopold Institute of Tropical Medicine, Belgium; the Instituto de Higiene e Medicina Tropical at Universidade Nova de Lisboa, Portugal; the National School of Public Health, Greece; University College Dublin, Ireland; and Pharos, a knowledge centre specialized in the health of refugees and asylum seekers, the Netherlands.

3.2 Vision Text as adopted at the first member meeting, 22 November 2008

The overall aim of the network is to promote the sexual and reproductive health and rights (SRH&R) of refugees, asylum seekers and undocumented migrants² in Europe and beyond.

Core Principles

EN-HERA! endorses the following principles as core principles, and every EN-HERA! member subscribes to applying these principles in their daily activities:

1. Rights-based approach
2. Participatory approach
3. Empowerment
4. Gender-balanced and sensitive to sexual diversity
5. Cross-sectoral approach
6. Multi-disciplinary approach.

General objectives

- To become a sustainable, inclusive and empowering international player in the field of the SRH&R of refugees, asylum seekers and undocumented migrants
- To sensitize stakeholders in Europe³ and beyond about the SRH&R of refugees, asylum seekers and undocumented migrants, and contribute to the recognition and realization of these rights
- To support stakeholders in Europe and beyond in the development of strategies, policies and initiatives addressing the SRH needs of refugees, asylum seekers and undocumented migrants.

Specific objectives

- To further expand the coverage of the network at national and international level
- To network and cooperate with national and international stakeholders involved in SRH&R policy or service delivery for refugees, asylum seekers and undocumented migrants
- To participate, promote and advocate for SRH&R in international platforms promoting rights of refugees, asylum seekers and undocumented migrants
- To share good practices and country examples in the field of SRH&R for refugees, asylum seekers and undocumented migrants
- To develop and share common guidelines and tools addressing the SRH&R needs of the target group

2 The decision to include undocumented migrants in the target group was taken at the first EN-HERA! meeting in Ghent on 22 November 2008. The rationale behind this decision is that asylum seekers often become undocumented migrants and that undocumented migrants present a particularly vulnerable group in Europe at present. Though merely invisible, undocumented migrants are numerous, and their number greatly surpasses the number of refugees and asylum seekers in Europe. In some European countries the recognition of refugees is particularly low, enlarging the undocumented migrant population significantly.

3 Among all stakeholders, the European Union is considered as one of the key players.

- To set up a common research agenda and to participate in common research projects
- To develop joint initiatives that address and promote the SRH&R of refugees, asylum seekers and undocumented migrants
- To develop a common website for the dissemination of EN-HERA! ideas, resources and research results.

Addendum: Clarification of concepts

Refugees

Under the 1951 UN Convention Relating to the Status of Refugees, 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”.⁴ 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.

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”.⁵ 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 origin. This distinguishes them from migrants in general. 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.

Documented and undocumented migrants

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 recognized and authorized 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 authorization and/or overstay authorized entry as, for example, visitors, tourists, foreign students or temporary contract workers or rejected asylum seekers”.⁶

4 UNHCR. Available at www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf

5 IOM (2004) *International Migration Law. Glossary on Migration*. Geneva, IOM.

6 WHO (2003) *International Migration, Health and Human Rights*. Health & Human Rights Publication Series. Issue No.4, December 2003.

Sexual health

The ICPD definition (Cairo, 1994) states that 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”.⁷

Reproductive health

The same source holds that reproductive health is “a state of complete physical, mental and social wellbeing 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 wellbeing 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.”

7 UN (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.

Sexual and reproductive health rights

Both sexual and reproductive health rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents.

Sexual and reproductive health rights 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 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;
- pursue a satisfying, safe and pleasurable sexual life;
- decide freely and responsibly about the number, spacing and timing of children;
- have the information and means to do so.⁸

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

CHAPTER 4: LITERATURE REVIEW

Background

One of the specific objectives of this project was to set a common research agenda for future research. This is not only a project objective per se, but a common research agenda also contributes to the sustainability of the project and of the EN-HERA! network in the long run.

At several project steering committee meetings (for example, in Athens and Ghent), the steering group members' expertise and research interests were collected, discussed and put next to global research priorities.

In addition, a literature review on the current state of the medical and social science literature was compiled which appeared to be a major milestone to identify research gaps and to achieve the project's objective. It not only highlights the most salient SRH issues that concern refugees, asylum seekers and (undocumented) migrants, but also shows the existing gaps and highlights the areas of concerns not sufficiently addressed.

The literature review (below) and its conclusions in terms of identified gaps and subsequent research priorities, combined with the previously defined steering group members' expertise and research interests, resulted in the so-called 'research agenda', which can be found in Chapter 5.

Sexual and Reproductive Health and Rights of Refugees, Asylum Seekers and Undocumented Migrants

Literature Review

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EUROPEAN NETWORK FOR THE PROMOTION OF THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF REFUGEES AND ASYLUM SEEKERS IN EUROPE AND BEYOND

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4.1 Introduction

4.1.1 Background and rationale

This literature review has been compiled in the framework of the EN-HERA! research and networking project, funded by the European Refugee Fund. The project's main objective is to promote the sexual and reproductive health and rights (SRH&R) of refugees and asylum seekers in Europe.

According to United Nations High Commissioner for Refugees (UNHCR) estimates, by the end of 2006 there were more than 9.9 million refugees, the highest number in the previous four years.¹ The UN reported an overall number of refugees for Europe of 2,015,932 for the year 2005, representing about a quarter of all refugees globally.²

The concept of refugees as people fleeing persecution is central to efforts to aid and protect them. However, numbers of asylum applications in Europe have dropped during recent years, decreasing to the level of the 1980s. The 27 countries of the European Union (EU) registered 103,500 new asylum applications during the first six months of 2008. Excluding Italy, where no pre-2008 monthly data is available, the EU-26 recorded more than 96,300 new claims during the first semester of 2008, 11 per cent less than during the second half of 2007, and 3 per cent less compared to the first half of 2007.³

There has been little programmatic and policy guidance on how to ensure that refugees and asylum seekers in Europe have access to sexual and reproductive health (SRH) services that help them to achieve their SRH-related goals, while at the same time guaranteeing their human rights. It can be assumed that a dynamic relationship exists between the manner in which SRH services and programmes are being delivered, and the individuals who seek these services.³ On the policy level, there have been indications that SRH and related rights have not been dealt with in the same way as Europe is promoting SRH&R in developmental cooperation and humanitarian programmes.⁴

As it will become clear in the condensed literature overview provided here, the available literature suggests that the SRH needs of asylum seekers and refugees in Europe are usually more pressing than those of the host country's population.

1 United Nations (2008) World Migrant Stock: The 2005 Revision. Population Database. Accessed at: <http://esa.un.org/migration/index.asp?panel=1>

2 UNHCR (2008) Asylum levels and trends in industrialized countries. First half 2008. Accessed at: <http://www.unhcr.org/statistics/STATISTICS/48f742792.pdf>

3 Gruskin S, Ferguson L, O'Malley J (2007) Ensuring Sexual and Reproductive Health for People Living with HIV: An overview of Key Human Rights, Policy and Health Systems Issues. *Reproductive Health Matters*, 2007; 15 (29 Supplement): 4–26.

4 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Rights, Policies, Status and Needs*. Literature Review. International Centre for Reproductive Health, Ghent.

The scarce research findings indicate that refugees in the EU suffer from higher maternal morbidity and mortality, experience poorer pregnancy outcomes, have less access to SRH services including family planning and safe abortion services, report higher levels of HIV and other sexually transmitted infections (STIs), and are more likely to become victims of gender-based violence. Many may also suffer from post-traumatic stress disorder due to the traumatic experiences they were going through prior to or during the migration process, including physical and sexual abuse.⁴

This literature review not only highlights the most salient SRH issues that concern refugees, asylum seekers and (undocumented) migrants, but also shows the existing gaps and highlights the areas of concerns not sufficiently addressed. Within the EN-HERA! project it, therefore, serves as the basis to identify clear-cut SRH research issues that should be addressed for targeted research in the framework of the EN-HERA! network after the completion of the current project.

4.1.2 Methodology used and limitations

For this review, we identified the relevant primary research by initially searching the Medline database. Medline was chosen as it is widely recognized as the premier source for bibliographic and biomedical literature.

SRH issues on asylum seekers and refugees were considered in the broader context of migrant health, since studies specifically addressing asylum seekers and refugees are scarce.

The search terms used remained broad and were “migrants” plus “health” anywhere in the title or abstract. No language restrictions were employed. Studies were eligible for consideration in this review if the focus of the study was on reproductive health and on migrants or refugees.

The primary research results were completed by information collected from four published literature reviews, summarizing the existing evidence with regard to the SRH of refugees, asylum seekers and migrants:

- One overview has summarized some of the apparent SRH trends due to migration in the EU.⁵
- A literature review has been published on the SRH policies, needs and rights of refugee and asylum-seeking women in Europe.⁶
- Another overview summarized the existing literature on reproductive health regarding re-settling refugee women.⁷
- Another overview has been written on the reproductive health of war-affected populations.⁸

5 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) *Migration and Reproductive Health in Western Europe*.

6 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Rights, Policies, Status and Needs*. Literature Review. International Centre for Reproductive Health, Ghent.

7 Gagnon A, Merry L, Robinson C (2002) A Systematic Review of Refugee Women’s Reproductive Health. *Refuge*, 2002;21(1).

8 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–180.

Additionally, some specific articles and data were searched for in other major electronic bibliographic databases and on the Internet, based on references found in the literature reviews cited above.

It is important to be aware that this literature review is limited because it is not complete. The prime objective of this review was not to give an extensive overview or an in-depth analysis and interpretation of all SRH aspects related to refugees and asylum seekers, since this has been done before (see above). The main objective of this literature review is to identify the main research gaps in the field of SRH for refugees, asylum seekers and undocumented migrants; therefore, we retrieved the main fields of research, summarized the main research conclusions, and deducted the existing gaps.

4.1.3 Definitions of SRH&R

Sexual Health

The ICPD definition states that 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”.⁹

Reproductive Health

The same source holds that reproductive health is “a state of complete physical, mental and social wellbeing 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 wellbeing 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.”

9 United Nations (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.

Sexual and Reproductive Health Rights

Both sexual and reproductive health rights embrace certain human rights that are already recognized in national laws, international human rights 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.¹⁰

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”.

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

4.2 Why research on sexual and reproductive health and rights?

Since the ICPD in 1994 in Cairo, reproductive health has been recognized as a basic human right of all men and women, including children and adolescents, throughout life.

During this conference, governments agreed on common targets and goals in the field of reproductive health and rights. One of the commitments made is to achieve reproductive health and rights for all by 2015. Yet far too many people are denied their right to SRH.

The WHO Regional Office for Europe developed a strategic framework to be used in the development of policies and strategies in the field of SRH.¹¹

One of the recommended strategies to improve SRH in Europe is through strengthening research. WHO considers the generation of knowledge an essential element in strategies to improve health promotion and care.

WHO encourages countries to examine their health research systems to improve upon and strengthen their capacity to establish a sound knowledge base for policy and practice. A viable health research system should be able to achieve:

- knowledge generation;
- knowledge management;
- financing of research; and
- capacity-building for research.

Unfortunately, while the infrastructure for research is already advanced in most cases in the European Region, it has not been targeted much to the needs of the target groups of refugees, asylum seekers and (undocumented) migrants. In addition, there is a need for capacity-building in research, in particular when it comes to community-based research and a participatory approach. Such needs should be identified and addressed.

11 WHO (2001) *Regional Strategy on Sexual and Reproductive Health*. Available at: <http://www.euro.who.int/document/e74558.pdf>

4.3 Why research on SRH&R for refugees, asylum seekers and undocumented migrants?

Chapter VII of the Cairo Commitments states that “migrants and displaced persons have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to victims of sexual violence (chapter 7.11).”

Since the 1990s, there is a growing awareness among UN agencies, non-governmental organizations (NGOs), researchers etc. that women who migrate are particularly vulnerable and that their reproductive health needs remain often unnoticed and unaddressed.

The reproductive health and research programme of the WHO Regional Office for Europe specifically pays attention to migrant populations.¹²

The rationale behind this is that, while maternal mortality and other indicators of reproductive ill health are generally low in Western Europe, we know that the risks are significantly higher for migrant and refugee populations living in those countries than for the resident population.

WHO aims to decrease the health inequalities in migrant and refugee women, among others, through research on the health needs of migrant women in Europe.

It has been argued that research can be seen as a way to raise awareness of the sexual health issues of refugees and migrants, to encourage the development of initiatives that address their specific needs and to share good practice and profile examples of initiatives and networks that address refugee health issues.¹³

Through their work, researchers such as Carballo call for more attention at a health policy level for protection of the rights of women refugees and migrants, and for acknowledgment and promotion of their contribution to health and social development.¹⁴

12 See WHO Regional Office for Europe website: http://www.euro.who.int/reproductivehealth/areas/20071101_10

13 Wilson R, Atkin T, Shutt A (2007) Sexual health in exile. The sexual health concerns, issues and needs of refugees and asylum seekers in South and West Yorkshire: a community research report. *Publication of the Centre for HIV and Sexual Health, UK.*

14 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–180.

Theresa McGinn underscores the need for research on SRH of refugees for two main reasons:¹⁵

- Understanding the ways in which refugee women's reproductive health problems are both similar to, and different from, those of women in settled populations can help policymakers and programmers address refugees' specific needs. Service delivery models proven among settled populations in the last several decades have been and should continue to be adapted for refugees.
- As experience accumulates in refugee settings – particularly regarding sexual violence, a topic that has received limited programme attention in stable settings – the lessons learned will enrich the reproductive health services available to both refugees and settled populations.

Research can correct misperceptions and misapprehensions about the effect of asylum seekers on public health. It can help public health professionals to lobby for changes to government policy that at present leave asylum seekers vulnerable to a cycle of poverty, ill-health and limited access to health services.¹⁶

Studies on health of resettling refugee women have many limitations, but they suggest that some health issues need to be considered with regard to the health of resettling refugee women. These include conflict arising in women concerning control of their own sexuality, perinatal health, the reintroduction of female genital mutilation (FGM), mental health, health service needs, occupational health risks and discrimination¹⁷.

15 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–180.

16 Kisely S, Stevens M, Hart B, Douglas C (2002) Health issues of asylum seekers and refugees. *Australia and New Zealand Journal of Public Health*, 2002 February;26(1):8–10.

17 Gagnon A, Merry L, Robinson C (2002) A Systematic Review of Refugee Women's Reproductive Health. *Refuge*, 2002, November;21(1).

4.4 What do we know already regarding the SRH&R of refugees, asylum seekers and undocumented migrants?

4.4.1 General SRH issues

4.4.1.1 SRH data collection

According to UNHCR, there are about 15 million refugees and asylum seekers worldwide. In 2005 there were about 190 million international migrants worldwide, of which approximately half were women.¹⁸

There is a paucity of systematically collected data on health statistics as they relate to migration history. Most available reports are of small studies and do not rely on representative samples.

Another big limitation of studies regarding the health of refugee or migrant women is that most of them do not define ‘refugee’ or ‘migrant’ consistently and that both terms are used for a wide variety of ethnically and socio-culturally diverse groups.

Though big population-based studies are missing, the available evidence suggests that displaced women particularly face high maternal mortality, an unmet need for family planning, complications following unsafe abortion, and gender-based violence, as well as STIs including HIV.

4.4.1.2 Access to SRH services

Asylum-seeking and refugee women are population groups characterized by diverse social, economic and legal backgrounds and diverse needs.

In the context of refugee health, it is important to distinguish between asylum seekers and statutory refugees, as asylum seekers have distinct needs and often limited rights in their host country.

Yet both groups face many barriers in accessing national (sexual and reproductive) health services in Europe.¹⁹

18 Llacer A, Zunzunegui MV, del Amo J, Mazarrasa L, Bolumar F (2007) The contribution of a gender perspective to the understanding of migrants’ health. *Journal of Epidemiological Community Health*, 2007, December;61 Suppl 2:ii4–10.

19 Janssens K, Bosmans M, Leye E, Temmerman M (2006) Sexual and Reproductive Health of Asylum-seeking and Refugee Women in Europe: Entitlements and Access to Health Services. *Journal of Global Ethics*, 2006;2(2):183–96.

- Legal barriers

Carballo et al. state that one of the most important factors affecting the reproductive health of asylum seekers and refugees is their legal status. It determines their vulnerability to abuse in the workplace and in the street, and it can influence the extent to which they have and perceive access to health and social services, and to protection before the law²⁰.

National regulations, laws and policies regulate entitlements to health services for refugees and asylum seekers in EU Member States and cause a considerable variation in entitlement to SRH services as well as the scope and quality of those services.¹⁹

As for undocumented migrants, current regulations and legislations in EU Member States do not guarantee access to health care and tend to become more restrictive.²¹

Legal regulations have an important impact on access to and use of hospital services. For instance, illegal immigrants accounted for an average of 9.4 per cent of hospital admissions performed on an emergency basis in Italy between 1999 and 2004. This phenomenon was very frequent in 1999 (43 per cent of admissions), but dropped sharply after 2002, caused by changes in Italian law.²²

In Spain an opposite evolution took place. Legal changes made medical cards and free medical care accessible for illegal migrants on similar terms to legal migrants or the Spanish population. As a result, researchers could not find differences in the utilization of health services between legal and illegal migrants²³.

- Administrative and financial barriers

Administrative procedures to access health services are complex in most EU Member States, and health care providers often lack knowledge about asylum seekers' entitlements to SRH services and channels and support available for refugees and asylum seekers.¹⁹

Even in less restrictive EU countries, such as the UK, where the policy is to treat immigrants who fulfil specific criteria free of charge and with National Health Service resources, for others administrative and financial barriers exist. An increasing number of immigrants are being asked to pay for their treatment. This may result in many health care professionals being confused as to current legal restrictions and asking guidance on this subject.²⁴

For undocumented migrants, many administrative and financial barriers exist in Europe to access health care and even more for hospital-based care. European regulations for undocumented migrants, if they exist, are complex and use concepts such as 'urgent medical care' without providing clear definitions for these concepts. In many cases undocumented migrants are requested to prove that they can pay before they receive health care and are sent high bills afterwards.²¹

Furthermore, limited financial resources no doubt have a negative impact on their access to SRH services and supplies.¹⁹

20 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) *Migration and Reproductive Health in Western Europe*.

21 PICUM (2007) *Access to Health Care for Undocumented Migrants in Europe*.

22 Sabbatani S, Baldi E, Manfredi R (2007) Time trends in health care needs of non-EU citizens from developing countries, admitted to a general hospital in northern Italy. *Le infezioni in medicina*, 2007, December;15(4):242–9.

23 Torres-Cantero AM, Miguel AG, Gallardo C, Ippolito S (2007) Health care provision for illegal migrants: may health policy make a difference? *European Journal of Public Health*, 2007, October;17(5):483–5.

24 Hamill M, McDonald L, Brook G, Murphy S (2004) Ethical and legal issues in caring for asylum seekers and refugees in the UK. *Bulletin of Medical Ethics*, 2004, November(203):1721.

- Communication issues

Other frequent obstacles to health care that have been observed include poor language skills leading to poor communication between migrants and health care providers.

Several studies show that poor communication between migrants and health care providers, coupled with insufficient use of trained interpreters and with the health personnel's lack of knowledge about cultural background often resulted in mutual misunderstandings. In Scandinavian countries these factors have been described as key causes of poor and delayed gynaecological care and the increased risk of delayed or missing obstetrical care.^{25 26}

Refugees may bring a family member or friend to interpret. Though this may help in obtaining background information, it may result in inaccurate interpreting and also make it difficult to discuss sensitive issues such as sexual health, gynaecological problems, sexual violation, domestic violence, or torture. Using children to interpret may place inappropriate responsibilities on them.²⁷

- Socio-economic situation

Many authors report the disadvantaged socio-economic status (unemployment, difficulties in transport or inadequate housing) as an important barrier to health care. The health of refugees and asylum seekers is constrained by the need to fulfil practical and social needs first, which might compromise their own health, including SRH.²⁸ Social isolation and racism are also affecting the use of health care services in many ways.^{29 28 30}

- Personal and socio-cultural factors

Health-care-seeking behaviour is influenced by cultural background and personal experience. Cultures characterized by strict gender roles may believe that it is inappropriate to discuss pregnancy and childbirth in mixed company, and as a result medical consultations with male doctors or male interpreters can become problematic.¹⁹

German researchers assessed the knowledge of German and Turkish women about specifically female bodily functions, contraception, preventative medical examinations and menopause and found that the proportion of Turkish patients (with proven strong writing skills in German) who demonstrated less sophisticated understanding was twice as high (32.5 per cent) as that of the German group (15 per cent).³¹

The same researchers mention that traditional beliefs and the inclination to first seek non-conventional medical care are factors in the delayed health-care-seeking behaviour of Turkish women in Germany.

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- 25 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) *Migration and Reproductive Health in Western Europe*.
 26 Jeppesen EZ (1993) [Obstetric health care offered to Turkish immigrant women – a quality assessment]. *Ugeskrift for Laeger*, 1993;155(47):3849–54.
 27 Burnett A, Peel M (2001) Health needs of asylum seekers and refugees. *British Medical Journal*, 2001, March 3;322(7285):544–7.
 28 Kennedy P, Murphy-Lawless J (2003) The maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review*, 2003(73):39–53.
 29 Smaje C, Grand JL (1997) Ethnicity, equity and the use of health services in the British NHS. *Social Science & Medicine*, 1997, August;45(3):485–96.
 30 Ascoly N, Van Halsema I, Keyzers L (2001) Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001;14 (4):371–93.
 31 David M, Borde T, Kentenich H (2000) Knowledge among German and Turkish women about specifically female bodily functions, contraception, preventative medical examinations and menopause. *Ethnicity & Health*, 2000, May;5(2):101–12.

Community research conducted in the UK revealed that powerlessness is considered by refugees and asylum seekers as an important obstacle to reproductive health. This powerlessness is perceived to be a main risk factor for sexual and domestic violence. Interviewed women also talked about their powerlessness with regard to contraception, and more specifically with the inability to insist that their partner uses a condom.³²

- Lack of knowledge and information

Asylum seekers, refugees and migrants, particularly those who recently arrived in the country, often lack knowledge about the national health system in general,³³ and about available SRH services in particular.

Refugees and migrants themselves identify lack of information on SRH and a lack of awareness on sources of help and advice as an important barrier.³²

- Mental health

Many authors ask for specific attention for the psycho-social needs of refugees, asylum seekers and migrants and describe higher risk of mental disorders such as anxiety, depression, psychosis or post-traumatic stress disorder.^{34 35 36 37 38}

4.4.1.3 SRH in emergency settings

In the mid-1990s, first steps were taken towards providing reproductive health care as a component of humanitarian response, and some progress has been made. Guidelines for basic emergency and long-term reproductive health care in conflict settings have been developed and piloted,³⁹ the reproductive health status of women in some long-term refugee settings has been assessed,⁴⁰ and reproductive health programmes delivered care in some areas.⁴¹

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- 32 Wilson R, Atkin T, Shutt A (2007) Sexual health in exile. The sexual health concerns, issues and needs of refugees and asylum seekers in South and West Yorkshire: a community research report. *Publication of the Centre for HIV and Sexual Health, UK.*
- 33 O'Donnell CA, Higgins M, Chauhan R, Mullen K (2007) "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Services Research*, 2007;7:75.
- 34 Harris M, Zwar N (2005) Refugee health. *Australian Family Physician*, 2005, October;34(10):825–9.
- 35 Hobbs M, Moor C, Wansbrough T, Calder L (2002) The health status of asylum seekers screened by Auckland Public Health in 1999 and 2000. *New Zealand Medical Journal*, 2002, August 23;115(1160):U152.
- 36 Adams KM, Gardiner LD, Assefi N (2004) Healthcare challenges from the developing world: post-immigration refugee medicine. *British Medical Journal*, 2004, June 26;328(7455):1548–52.
- 37 Bhui K, Audini B, Singh S, Duffett R, Bhugra D (2006) Representation of asylum seekers and refugees among psychiatric inpatients in London. *Psychiatric Services*, 2006, February;57(2):270–2.
- 38 Sinnerbrink I, Silove DM, Manicavasagar VL, Steel Z, Field A (1996) Asylum seekers: general health status and problems with access to health care. *The Medical Journal of Australia*, 1996, December 2–16;165(11-12):634–7.
- 39 WHO, UNFPA, UNICEF (1999) *Reproductive health in refugee settings: an inter-agency field manual*. Geneva: WHO, http://www.rhrc.org/resources/general_fieldtools/iafim_menu.htm
- 40 Hynes M, Sheik M, Wilson HG, Spiegel P (2002) Reproductive health indicators and outcomes among refugee and internally displaced persons in postemergency phase camps. *Journal of the American Medical Association*, 2002;288(5):595–603.
- 41 Casey S, Purdin S, McGinn S (2003) Evaluation of coverage of reproductive health services for refugees and internally displaced persons. Paper presented at Reproductive Health Response in Conflict Consortium's Conference 2003: Reproductive Health from Disaster to Development, October 2003, Brussels.

The attention to reproductive health in emergency contexts has substantially increased since the mid-1990s, with a focus on displaced women.

Data specific to the reproductive health of migrants during the acute phase of flight are scarce, but those available suggest that rates of adverse reproductive outcomes, such as maternal and neonatal mortality, are high. Furthermore, women in settings of armed conflict are vulnerable to extraordinary human rights violations such as rape, forced participation in the sex trade, or the need to exchange sex for food or security for themselves and their children.⁴² Most of the evidence on refugee health stems from studies of refugees in stable camp settings.⁴³

Though there may be a lack of evidence in many fields, it is justified to say that the humanitarian world achieved what many others failed to in many developed countries: translate research and rights into action.

The collaboration within the field of reproductive health in humanitarian crises is notable, with many agencies working in one or more networks. Relief and development agencies and UN bodies have developed technical materials, made positive policy changes specific to crisis settings and are working to provide better reproductive health care. The readiness to use common guidance documents, develop priorities jointly and share resources has led to smoother operations and less overlap than if each agency worked independently. Trends in the field, including greater focus on internally displaced persons and those living in non-camp settings, as well as refugees in camps, the protracted nature of emergencies, and an increasing need for empirical evidence, will influence future progress.⁴⁴

Many knowledge and practical guidelines regarding reproductive health in refugee situations resulted from two big initiatives:

- **Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative⁴⁵**
The five-year RAISE Initiative brings together major UN and NGO agencies from the fields of relief and development, and builds on their experience to support reproductive health service delivery, advocacy, clinical training and research.

The initiative is a catalyst in changing how reproductive health is addressed by all sectors involved in emergency response, from field services to advocacy, from local aid providers to global relief movements. It represents a strengthened commitment to the provision of fully integrated and comprehensive reproductive health services for all.

42 Bartlett LA, Purdin S, McGinn T (2004) Forced migrants – turning rights into reproductive health. *The Lancet*, 2004;**363**(9402):76–7.

43 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;**26**(4):174–80.

44 Austin J, Guy S, Lee-Jones L, McGinn T, Schlecht J (2008) Reproductive health: a right for refugees and internally displaced persons. *Reproductive Health Matters*, 2008;**16**(31):10–21.

45 Available at: <http://www.raiseinitiative.org>

- **Reproductive Health Response in Conflict (RHRC) Consortium**⁴⁶

The RHRC Consortium is dedicated to the promotion of reproductive health among all persons affected by armed conflict. It promotes sustained access to comprehensive, high-quality reproductive health programmes in emergencies and advocates for policies that support the reproductive health of persons affected by armed conflict.

4.4.2 Maternal and newborn health

4.4.2.1 Prevalence/epidemiology

It is generally assumed that refugee women have poorer pregnancy outcomes than other women, although few data are available to refute or support this claim.

It is likely that infant and pregnancy health outcomes such as mortality are poorer in war-affected populations although perhaps no worse than in their own country of origin once re-stabilization of the country or population occurs.⁴⁷

Data from Belgium indicate that in 1983 the highest perinatal and infant mortality rates were reported for babies born of immigrant women from Morocco and Turkey.⁴⁸

In Germany as well, perinatal and neonatal mortality rates were consistently higher in foreign-born groups, especially Turkish immigrants, than in the population as a whole. In Spain, premature births, low birth weight, and complications of delivery are especially common with infants born of women who have immigrated from sub-Saharan Africa and Central and South America.⁴⁸

A Belgian study on maternal mortality tends to confirm the hypothesis that increasing maternal age is an emerging demographic risk factor for maternal mortality, though the latter effect was also partly due to the high proportion of immigrant women with continued childbearing into their later reproductive years.⁴⁹

Hospital-based studies show that there were higher rates of pregnancy complications and perinatal death among African women delivering in France and Germany than for women from those countries.⁵⁰

A UK study found that social exclusion and being non-white were among the main predictors of severe maternal morbidity.⁵¹

46 Available at: <http://www.rhrc.org>

47 McGinn, T (2000) Reproductive Health of War-Afflicted Populations: What Do We Know? *International Family Planning Perspectives*, 26, no. 4 (2000): 174–80.

48 Carballo M, Nerukar A (2001) Migration, refugees, and health risks. *Emerging Infectious Diseases*, 2001;7(3 Suppl):556–60.

49 Temmerman M, Verstraelen H, Martens G, Bekaert A (2004) Delayed childbearing and maternal mortality. *European Journal of Obstetrics & Gynecological and Reproductive Biology*, 2004;114(1):19–22.

50 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) *Migration and Reproductive Health in Western Europe*.

51 Waterstone M, Bewley S, Wolfe C (2001) Incidence and predictors of severe obstetric morbidity: case-control study. *British Medical Journal*, 2001;322(7294):1089–93; discussion 1093–4.

An Italian study found that preterm delivery occurred more frequently in migrant women, particularly of African origin, and it is not associated to delayed access to antenatal care.⁵²

On the other hand, British research documented similar or even better obstetric performance among Kosovo Albanian women who have resettled in the UK compared to their British counterparts. Kosovo Albanian women were statistically younger and had shorter duration of labour compared to controls. The rates of induction of labour, caesarean section, instrumental deliveries, premature delivery and low birth weight (< 2.5 kg) were not statistically different between the two groups. According to the authors, the similarity in obstetric and foetal outcomes between the study and control groups could be attributed to the ‘healthy immigrant effect’, where immigrant groups appear to have better outcomes due to family support and relatively lower intake of alcohol and nicotine.⁵³

A Belgian study reported higher birth weights among infants of North African immigrants than their Belgian counterparts and attributed the observed difference in mean birth weight mainly to differences in preterm birth and other risk factors.⁵⁴

4.4.2.2 Needs assessments/accessibility of services

Kennedy and Murphy-Lawless describe the difficult circumstances encountered by refugee and asylum-seeking women in Ireland and the inability of maternity care services to address such complex needs.⁵⁵

Other authors as well stress the need to recognize difficulties arising from living conditions and social isolation and plead for a gender- and culturally sensitive provision of maternal care.⁵⁶

Authors such as McLeish of the Maternity Alliance in the UK ask for special attention for the inadequateness of reception centres for asylum seekers to take care of pregnant women, new mothers and babies.

Harris et al. asked maternity services to pay attention to the specific needs of asylum seekers. In addition to the trauma and psychological effects of their experiences, many also have complex physical health needs, which may include poor general health, anaemia, high parity, closely spaced pregnancies, HIV, hepatitis B and FGM. Women seeking asylum in the UK often begin to receive support late in their pregnancy and may have had no previous antenatal care.⁵⁷

52 Sosta E, Tomasoni LR, Frusca T, Triglia M, Pirali F, El Hamad I, et al. (2008) Preterm delivery risk in migrants in Italy: an observational prospective study. *Journal of Travel Medicine*, 2008, July–August;15(4):243–7.

53 Yoong W, Wagley A, Fong C, Chukwuma C, Nauta M (2004) Obstetric performance of ethnic Kosovo Albanian asylum seekers in London: a case-control study. *Journal of Obstetrics and Gynaecology*, 2004, August;24(5):510–12.

54 Vahratian A, Buekens P, Delvaux T, Boutsen M, Wang Y, Kupper LL (2004) Birthweight differences among infants of North African immigrants and Belgians in Belgium. *European Journal of Public Health*, 2004, December;14(4):381–3.

55 Kennedy P, Murphy-Lawless J (2003) The maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review*, 2003(73):39–53.

56 Ascoly N, Van Halsema I, Keyzers L (2001) Refugee Women, Pregnancy, and Reproductive Health Care in the Netherlands. *Journal of Refugee Studies*, 2001;14 (4):371–93.

57 Harris M, Humphries K, Nabb J (2006) Delivering care for women seeking refuge. *RCM Midwives*, 2006;9(5):190–2.

Kahler and co. found that pregnant refugees had several previously undetected health problems, and suggest that further research on refugee populations is needed.⁵⁸ A study in Sweden learnt that the rate of suboptimal factors in perinatal care likely to result in potentially avoidable perinatal death was significantly higher among East African immigrants than native Swedish mothers. The most common factors were delay in seeking health care, mothers refusing caesarean sections, insufficient surveillance of intrauterine growth restriction, inadequate medication, misinterpretation of cardiotocography and interpersonal miscommunication.⁵⁹

Refugee and asylum-seeking women in Canada may have significant harmful childbearing health outcomes and unmet health and social care needs. A Canadian research team is currently undertaking a large four-year multi-site prospective cohort study (pregnancy to four months postpartum). They seek to recruit 2400 women and follow them up to answer the main research questions:

- (1) Do refugee or asylum-seeking women and their infants experience a greater number or a different distribution of harmful health events during pregnancy, at birth, and during the postpartum period?
- (2) Are the harmful health events experienced postpartum by asylum-seeking women and their infants addressed less often by the Canadian health care system?

Knowledge of the extent of harmful health events occurring to asylum-seeking, refugee, immigrant, and Canadian-born women, and the response of the health care system to those events and group differences, if they exist, will inform immigration and health policymakers as well as service providers.⁶⁰

4.4.2.3 Service delivery (care and treatment) and service use

A study in Sweden showed that pregnant women who were young, single, multipara, immigrant, not fully employed, or having an unplanned pregnancy were more likely to register late at the prenatal care centre or to visit the centre less than three times. The study concluded that access to prenatal services could be facilitated by providing access to interpreters and by improving transcultural competence among the health staff.⁶¹

In the Netherlands too, refugee women are described as attending antenatal clinics late in their pregnancies or even not attending at all.⁵⁶

A French study concluded that African immigrants more often had late HIV screening in pregnancy than French-born women but had similar access to prevention of mother-to-child transmission once the infection was diagnosed.⁶²

58 Kahler LR, Sobota CM, Hines CK, Griswold K (1996) Pregnant women at risk: an evaluation of the health status of refugee women in Buffalo, New York. *Health Care for Women International* 1996;17(1):15–23.

59 Essen B, Bodker B, Sjöberg NO, Langhoff-Roos J, Greisen G, Gudmundsson S, et al. (2002) Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? *BJOG*, 2002, June;109(6):677–82.

60 Gagnon AJ, Wahoush O, Dougherty G, et al. (2006) The childbearing health and related service needs of newcomers (CHARSNN) study protocol. *BMC Pregnancy Childbirth*, 2006;6:31.

61 Darj E, Lindmark G (2002) [Not all women use maternal health services. Language barriers and fear of the examination are common]. *Lakartidningen*, 2002;99(1–2):41–4.

62 Jasseron C, Mandelbrot L, Tubiana R, Teglas JP, Faye A, Dollfus C, et al. (2008) Prevention of mother-to-child HIV transmission: similar access for sub-Saharan African immigrants and for French women? *AIDS*, 2008, July 31;22(12):1503–11.

A Swiss study indicated that undocumented migrants, compared to women who are legal residents of Geneva, have more unintended pregnancies and delayed prenatal care, use fewer preventive measures and are exposed to more violence during pregnancy. Not having a legal residency permit, therefore, suggests a particular vulnerability for pregnant women. This study underscores the need for better access to prenatal care and routine screening for exposure to violence during pregnancy for undocumented migrants. Furthermore, health care systems should provide language- and culturally appropriate education on contraception, family planning and cervical cancer screening.⁶³

4.4.3 Sexually transmitted infections

Reviewing the available literature on STIs and HIV/AIDS shows that the focus has shifted primarily to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). For instance, data on the prevalence of cervical cancer in refugees, asylum seekers and undocumented migrants and the needs for providing good care and treatment in this regard are almost non-existent.

4.4.3.1 Prevalence/epidemiology

Refugee women appear to be at greater risk than other women for STIs, including HIV, for a variety of reasons. War-affected populations are disproportionately at risk of STIs, including HIV. Displacement promotes transmission between high- and low-prevalence groups, and exposure to the military further promotes transmission.⁶⁴

Migration appears to increase the incidence of sexual and gender-based violence, which in turn promotes the spread of STIs.⁶⁵ Rape and prostitution among migrant women can become key factors in the transmission of HIV/AIDS and STIs.

4.4.3.2 Service delivery (care/treatment) and service use

A British study examined whether there are any differences between the needs of asylum seekers and British patients attending STI clinics. The most noticeable identified are the use of interpreters, the reporting of sexual violence, the need for counselling and the number of women without up-to-date smears. A larger study may highlight more differences.⁶⁶

63 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–180.

64 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–180.

65 Gagnon A, Merry L, Robinson C (2002) A Systematic Review of Refugee Women's Reproductive Health. *Refugee*, 2002;21(1).

66 Rogstad KE, Dale H (2004) What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients? *International Journal of STDs & AIDS*, 2004;15(8):515–8.

4.4.4 HIV/AIDS

4.4.4.1 Prevalence/epidemiology

Many immigrant women face heightened exposure to HIV. According to UNAIDS, for example, 69 per cent of all HIV diagnoses attributed to heterosexual contact during 2003 in France occurred among immigrants – 65 per cent of whom were women.⁶⁷

Also in other European countries, a substantial proportion of heterosexually acquired HIV infections occur among individuals originating from countries with generalized HIV epidemics. A total of 10,199 heterosexually acquired cases of HIV were reported by 16 European countries, of which 43 per cent (4420) were individuals originating from countries with generalized epidemics. The proportion of heterosexually acquired cases of infection in persons known to originate from countries with generalized HIV epidemics varied from 21 per cent in Portugal to 66 per cent in Norway. However, it should be noted that countries assign origin of cases using different criteria, usually by nationality or place of birth.⁶⁸

Some European researchers studied the variables used to monitor HIV/AIDS in migrants and ethnic minorities in surveillance systems in Western Europe and drew some recommendations.⁶⁹

4.4.4.2 Needs assessments/accessibility of services

A special satellite meeting during the Third European Conference on the Methods and Results of Social and Behavioural Research on AIDS (2000) in Amsterdam highlighted the specific needs of migrants and refugees in the field of AIDS.⁷⁰

Peter Aggleton states the following:

“Across Europe, there are enormous variations in the responses of national authorities to immigrants who are HIV-positive. Not only may migrants find themselves in a disadvantaged position with respect to access to treatment, but also appropriate information and education are often missing. Because of lack of knowledge of the advantages of early testing and treatment, members of migrant groups often contact health care services only when they are already seriously ill. Stigmatization and discrimination remain powerful obstacles to the provision of appropriate information and education.

67 Lot et al. (2004) Cited in UNAIDS (2005) *North America, Western and Central Europe: HIV/AIDS Statistics and Features 2003–2005*, http://www.unaids.org/epi/2005/doc/EPIupdate2005_html_en/epi05_10_en.htm – Accessed on 3 April 2006.

68 EuroHIV (2006) *HIV/AIDS Surveillance in Europe. End-year report 2006, No. 75*, http://www.eurohiv.org/reports/report_75/pdf/report_eurohiv_75.pdf

69 Del Amo J, Bröring G, Hamers F, Infuso A, Fenton K (2004) Monitoring HIV/AIDS in Europe’s migrant communities and ethnic minorities. *AIDS*, 2004, **18**:1867–73.

70 European AIDS and Mobility Project (2000) *Specific needs of migrants, ethnic minorities and refugees in the field of HIV/AIDS*. Report from a Satellite Meeting at the Third European Conference on the Methods and Results of Social and Behavioural Research on AIDS, Amsterdam.

Health promotion research has an important role to play in identifying and meeting the needs of such groups. It also holds the potential to help us understand better how stigma and discrimination legitimate denial: both the denial of those who are discriminated against (and who therefore are frightened to know their serostatus) and the denial of society more generally that there is an issue here that demands a more socially inclusive response.”⁷¹

4.4.4.3 Service delivery (care/treatment) and service use

An important issue which deserves particular attention within the 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 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.⁷²

A national survey in the UK during 2001 and 2002 assessed the prevalence and demographic background of Persons with Insecure Immigration or Seeking Asylum (PIISA) attending genitourinary medicine clinics and the effect on service provision. One-third of clinics had accurate data collection systems, and less than a quarter used computerized databases to identify the associated workload. Of the HIV-positive patients attending these clinics during 2002, 1140 (42 per cent) were identified as PIISA.

Co-infection with HIV and tuberculosis was higher in patients from the PIISA group than the non-PIISA group (85 per cent vs. 15 per cent, $p = 0.001$) for both 2001 and 2002. Clinics reported many problems associated with the service for PIISA and difficulties with funding for the increased workload associated with PIISA.⁷³

A limited qualitative study in the UK revealed that asylum seekers and UK residents were equally satisfied with HIV/AIDS services at the Leeds Centre for Sexual Health. Some unmet needs of asylum seekers were identified, such as specialist services for torture victims and educational opportunities.⁷⁴

A study compared stage of disease and use of services between HIV-positive non-asylum seekers and asylum seekers in North West England. Asylum seekers did not differ in stage of HIV disease on first contact and use of specialist hospital services.

71 Aggleton P (2001) HIV/AIDS in Europe: the challenge for health promotion research. *Health Education Research*, 2001;**16**(4):403–9.

72 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Literature Review*, Ghent.

73 Rajamanoharan S, Monteiro EF, Maw R, Carne CA, Robinson A (2004) Genitourinary medicine/HIV services for persons with insecure immigration or seeking asylum in the United Kingdom: a British Co-operative Clinical Group survey. *International Journal of STDs & AIDS*, 2004;**15**(8):509–14.

74 Allan CL, Clarke J (2005) Are HIV/AIDS services in Leeds, UK, able to meet the needs of asylum seekers? *Public Health*, 2005;**119**(4):305–11.

Asylum seekers were much more likely to have accessed NGOs for support (43 per cent compared with 27 per cent: $p < 0.001$). However, HIV-positive asylum seekers rely more on NGOs at a time when such voluntary services are under increasing financial pressures.⁷⁵

A small qualitative study in the UK with immigrant women from Africa indicates that health services were highly valued as a source of advice and support and that non-judgmental, personalized health care plays a key role in encouraging migrant African women to access psycho-social support and appropriate HIV services.⁷⁶

4.4.5 Sexual and gender-based violence

Refugee women are confronted with different types of violence in countries of asylum. The UNHCR guidelines on sexual and gender-based violence (SGBV) against refugees, returnees and internally displaced persons name the following: sexual attack, coercion, extortion by persons in authority; sexual abuse of children in foster care; domestic violence; sexual assault in transit facilities; (...) 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.

The prevalence of SGBV is difficult to measure. Studies of domestic violence among refugees are less common than studies of rape.

4.4.5.1 Domestic violence

An overview of 50 population-based studies carried out in 36 countries indicates that between 10 and 60 per cent of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner.⁷⁷

A government study found that 49 per cent of married Turkish women in Germany had experienced physical or sexual violence.⁷⁸

It should be noted that in some cultures, domestic violence is tolerated and/or kept within the family. Qualitative research supports the notion that domestic violence is considered normal in everyday life by some African migrants.⁷⁹

75 Cook PA, Downing J, Rimmer P, Syed Q, Bellis MA (2006) Treatment and care of HIV positive asylum seekers. *Journal of Epidemiology and Community Health*, 2006;**60**(10):836–8.

76 Ndirangu EW, Evans C (2008) Experiences of African Immigrant Women Living with HIV in the U.K.: Implications for Health Professionals. *Journal of Immigrant and Minority Health*.

77 Heise L, Ellsberg M, Gottmoeller M (2002) A global overview of gender-based violence. *International Journal of Gynaecology and Obstetrics*, 2002;**78 Suppl 1**:S5–14.

78 Government of Germany (2004) *Health, Well-Being and Personal Safety of Women in Germany*. Federal Ministry for Family Affairs, Senior Citizens, Women and Youth. p. 27.

79 Owoaje ET, Olaolorun FM (2005) Intimate partner violence among women in a migrant community in southwest Nigeria. *International Quarterly of Community Health and Education*, 2005;**25**(4):337–49.

Many immigrant women and refugees are reported to have difficulty controlling their own sexuality.⁸⁰ Women from some African countries are not taught or socialized to refuse the sexual advances of their husbands.⁸¹

This stands in sharp contrast to many refugee-receiving countries in which a woman may refuse her husband's advances, and if he forces himself on her, he can be charged with rape.

It is impossible to quantify the degree to which refugee women are more affected than their counterparts in settled populations by rape and domestic violence. Furthermore, it is not relevant from a programme perspective, since both groups require medical, psychological and social support services.⁸²

The problem of domestic violence might be exacerbated by the relative isolation of migrant women and their inability to access support and care (even from friends) and to report violent incidents to the police.⁸³

Sometimes partners are dependent on each other for a residence permit, or for access to accommodation and an income. This makes it even more difficult for refugee women to leave in case of violence. Refugee women may also be unaware of available resources to break the circle of violence.⁸⁴

Poverty, language, and cultural differences between farm migrant worker women and American health care providers present substantial barriers to women obtaining access to the health care system. These differences are especially important in instances of domestic violence. The transient lifestyle of migrant farm workers, combined with geographic and social isolation, make it especially difficult for health care providers to meet the needs of migrant battered women.⁸⁵

A study in the USA shows that Asian women who were battered, particularly recently arrived immigrant and refugee women, have needs that differ markedly from most battered women in the general US population. The needs of the refugee women centre on language, cultural, immigration and structural issues. Moreover, there are several internal and external forces that work in tandem to keep the needs of Asian women from being formally included in the mainstream battered women's movement.⁸⁶

80 Gagnon A, Merry L, Robinson C (2002) A Systematic Review of Refugee Women's Reproductive Health. *Refuge*, 2002;21(1).

81 Simms G (1996) *Aspects Of Women's Health From A Minority/diversity Perspective. A Canadian Perspective*. Paper prepared for the Canada-USA Forum on Women's Health. Ottawa: Health Canada.

82 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–80.

83 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) Migration and Reproductive Health in Western Europe.

84 Burnett A, Peel M (2001) Health needs of asylum seekers and refugees. *British Medical Journal*, 2001, March 3;322(7285):544–7.

85 Rodriguez R (1993) Violence in transience: nursing care of battered migrant women. *AWHONN's Clinical Issues in Perinatal Women's Health Nursing*, 1993;4(3):437–40.

86 Huisman KA (1996) Wife battering in Asian American communities. Identifying the service needs of an overlooked segment of the U.S. population. *Violence Against Women*, 1996;2(3):260–83.

The process of the first contact between a refugee and health care provider is of decisive importance. During the first intake, it is important to pay attention to violence suffered in the country of origin, as well as during the flight and in the host country. Suspicion on the part of the refugees is often more prominent, especially when they have suffered harsh political repression and persecution. It is important for the health care provider to be very clear on what kind of support can and cannot be offered. If language problems create a barrier for health care providers to provide counselling and care, a neutral interpreter is needed.⁹³

4.4.5.2 Sexual violence during the refugee cycle

Refugee women and children face high risks of being subjected to SGBV when fleeing and seeking asylum.

Some attention is now being paid to the topic of sexual violence in war. Rape is recognized as a weapon of war, and the evidence suggests that refugee women experience rape and other forms of sexual violence at least as often as, and probably more often than, women in settled populations.⁸⁷

Trafficking in women and children is now recognized as a global public health issue as well as a violation of human rights. A study by Zimmerman et al. identified trafficking to be associated with health risks such as psychological trauma, injuries from violence, STIs, HIV and AIDS, other adverse reproductive health outcomes, and substance misuse. These risks are shaped by lack of access to services in a foreign country, language barriers, isolation, and exploitative working conditions. However, efforts to reduce trafficking may be making conditions worse for voluntary migrants.⁸⁸

Violence in reception centres is another topic that has been neglected for a long time. Not only other residents but also staff working in reception centres are reported to be potential perpetrators.⁸⁹ Single girls and women are particularly vulnerable, and cultural beliefs about single women enhance this vulnerability.

Although asylum-seeking women adopt strategies to protect themselves, research findings show that more needs to be done to protect them. Staff at reception centres need to be trained to recognize unsafe situations and to gain competence in intercultural and gender-specific communication. On the other hand, some practical measures can be taken to improve conditions in reception centres, like lighting, private bathrooms and the ability to lock bedrooms. The connection with a social network is also important.⁹⁴

87 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;26(4):174–80.

88 Busza J, Castle S, Diarra A (2004) Trafficking and health. *British Medical Journal*, 2004;328(7452):1369–71.

These findings were confirmed by the Hidden Violence is a Silent Rape Study in 2008. This Community Based Participatory Research project, conducted in Belgium, the Netherlands and the United Kingdom researched the nature of sexual and gender-based violence as well as the perceived risk and protective factors in refugees, asylum seekers and undocumented migrants. This study concluded that from the arrival on European territory onwards, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence.

In order to prevent further victimization, structural changes on public policy level should go hand in hand with real comprehensive and participatory approaches to multi-disciplinary and multi-stakeholder interventions creating an empowering synergy between the individual (behavioral change & enhancement of social capital), interpersonal, organizational, community (general awareness raising, social networks and active participation in host society) and public policy (more preventive legislative framework and enjoyment of rights) level. This partnership developed also a prevention tool, raised general awareness and formulated practice and policy recommendations.⁸⁹

4.4.6 Harmful traditional practices/female genital mutilation

4.4.6.1 Prevalence/epidemiology

FGM affects 100 million girls and women worldwide and is considered to be a form of SGBV.

FGM is being re-introduced in Europe and the USA by certain immigrant communities. The Centers for Disease Control in the USA, for example, estimates that approximately 168,000 women and girls living in the USA in 1990 either had or may have been at risk of FGM. An estimated 48,000 of these were under 18 years of age, and about 75 per cent of these were born in the USA.⁹⁰

In Europe, reliable national prevalence data and systematic epidemiological data on FGM and its related health problems are largely unavailable, and the magnitude of the problem is difficult to assess.⁹¹

89 Keygnaert I, Wilson R, Dedoncker K, Bakker H, Van Petegem M, Wassie N, Temmerman M (2008) *Hidden Violence is a Silent Rape. Prevention of Sexual & Gender-Based Violence against Refugees & Asylum Seekers in Europe: a Participatory Approach Report*. ICRH, Ghent.

90 Retzlaff C (1999) Female genital mutilation: not just over there. *Journal of the International Association of Physicians in AIDS Care*, 1999;5(5):28–37.

91 Leye E, Powell RA, Nienhuis G, Claeys P, Temmerman M (2005) Health care in Europe for women with genital mutilation. *Health Care for Women International*.

4.4.6.2 Needs assessments, service accessibility and service use

FGM is practised in the USA among some immigrant groups, and women who have immigrated there often need specialized medical care as a result of the mutilation. Girls and women who had to undergo FGM suffer from a number of serious health complications, including anaemia, chronic pelvic infections, infertility, abscesses and keloids, sexual dysfunction, menstrual disorders, urinary problems, and complications in pregnancy and childbirth. The psychological consequences have not been well studied. Health care providers need to be sensitive to the needs of affected women.⁹¹

Female asylum seekers and refugees have additional health needs if they have undergone FGM. 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 practice without involving the other agencies, which should be involved in a suspected FGM case.⁹⁵

The provision of adequate health care might be hampered by several factors, such as the lack of knowledge and understanding of FGM and unfamiliarity with the practice among health care professionals.⁹² A lack of technical guidance hampers the provision of adequate care. Personal feelings regarding the subject can play an important role as well. Some health care professionals are reported to be reluctant to address the issue or can cause feelings of powerlessness or anger among health personnel.⁹⁴

4.4.6.3 Service delivery and service use

In European countries, health care professionals have been confronted with potential severe health complications requiring specific attention and care, for example during delivery. Furthermore, care for women who are genitally mutilated must be provided in cooperation with other services in order to be effective.⁹²

Apart from the clinical management of infibulated women, caring for women who have undergone FGM, especially infibulations, requires great sensitivity on the part of health professionals. Health care professionals can also be faced with ethical and legal questions, due to a lack of clear guidelines and legislation.⁹⁴

92 Bulman KH, McCourt C (2002) Somali refugee women's experience of maternity care in west London: a case study. *Critical Public Health*, 2002;12(4):365–80.

4.4.6.4 Policy research/development

Legislation on different aspects of violence against women has improved in EU Member States. National action plans to combat violence against women are important tools for comprehensive action in this field. Crimes against women, such as those committed in the name of honour, are being addressed through policy and awareness-raising measures.⁹³

Interest in FGM is increasing steadily at the EU policy level, yet general strategies applicable in all Member States are not available.

Refugees and asylum seekers with additional health needs are girls and women who have undergone, or are at risk of undergoing, FGM. Across the EU, variation exists in Member States' anti-FGM and asylum legislation, the rigour of existing research programmes, and the operational coherence of the multiple agencies combating the practice. The needs of refugees and asylum seekers are, consequently, not being addressed satisfactorily.⁹⁴

4.4.7 Family planning and contraception

4.4.7.1 Prevalence/epidemiology

There are different opinions of the effects of migration on fertility and family planning. One suggests that forced migration increases fertility, as refugees satisfy their desire to repopulate to replace deceased children and soldiers, and as migration produces a healthier and more stable environment (for example, in some camp situation) with improved health care services and nutrition. The opposing opinion suggests that migration decreases the fertility rate of refugees because of perceived uncertainty of the future, economic instability and marital separation. Fertility rates have also been found to vary with knowledge and availability of contraception. In sum, there are no known common fertility patterns for refugees.⁹⁵

4.4.7.2 Needs assessments/accessibility of services

Emergency contraception is an important family planning service for refugees, including those whose access to regular contraception supplies has been disrupted and where women have been raped.⁹⁶

Research in the UK has 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.⁹⁷

93 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Literature Review*. Ghent.

94 Powell RA, Leye E, Jayakody A, Mwangi-Powell FN, Morison L (2004) Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy*, 2004;**70**(2):151–62.

95 McGinn T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000;**26**(4):174–80.

96 Goodyear L, McGinn T (1998) Emergency contraception among refugees and the displaced. *Journal of the American Medical Women's Association*, 1998;**53**(5 Suppl 2):266–70.

97 Burnett A, Peel M (2001) Health needs of asylum seekers and refugees. *British Medical Journal*, 2001, March 3;**322**(7285):544–7.

Sex education for migrant women is of utmost importance, and cultural notions and ideas should be taken into account. Especially with regard to premarital sex there is a reasonable chance that there is a lack of sufficient knowledge regarding contraception.⁹⁸

In many cultures a lack of understanding and communication between men and women also forms an important barrier to the utilization of family planning services. It might be difficult for refugee and asylum-seeking women to negotiate condom use with their partner, and familial and cultural pressure to fulfil traditional childbearing roles may also influence their choices.⁹⁹

4.4.7.3 Service accessibility and service use

As it does in all populations, the use of contraception by migrants varies according to the socio-economic background and experience with family planning.

Psycho-socio-cultural determinants do influence contraceptive use patterns, but physicians seldom take them into account when prescribing modern contraception.¹⁰⁰

In general, data suggest that ‘migrants’ are often unaware of the availability of contraceptive services, and they access these services far less than nationals do.¹⁰¹

The fact that women did not have a doctor or a prescription for contraceptives at their disposal was identified as an important reason why migrant women in Belgium did not use contraception. Another important issue is the cost of contraceptives, which makes them financially inaccessible.⁹⁹

4.4.7.4 Quality of service delivery

Research into family planning among refugee women in Europe is scarce, but evidence exists that family planning services in European countries are both inadequate and insensitive to refugee women’s needs.

Swiss researchers conducted an action research among an immigrant Portuguese community, which aimed to establish conditions that would allow women to prevent unwanted pregnancies and STIs. The use of same-culture family planning counsellors and a Portuguese-language telephone hotline appeared to be effective.¹⁰²

98 Vissers S (2004) *Trends inzake de prevalentie van abortus bij autochtonen en allochtonen in Vlaanderen: een onderzoek bij abortuscentra en gezondheidsprofessionals*. Katholieke Universiteit Leuven.

99 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Literature Review*. Ghent.

100 Newell A, Sullivan A, Halai R, Boag F (1998) Sexually transmitted diseases, cervical cytology and contraception in immigrants and refugees from the former Yugoslavia. *Venereology*, 1998;11(1):25–7.

101 Newell A, Sullivan A, Halai R, Boag F (1998) Sexually transmitted diseases, cervical cytology and contraception in immigrants and refugees from the former Yugoslavia. *Venereology*, 1998;11(1):25–7.

102 Fontana E, Beran MD (1995) [Sexuality and exclusion]. *Revue Medicale de la Suisse Romande*, 1995;115(6):495–7.

The contraceptive behaviour of immigrants is not reliable enough if the great number of abortions is considered. Within the practical guidelines for transcultural contraceptive counselling, the most important points are a low access limit, the use of translators and mediators familiar with the subject, enough time and a high motivation.¹⁰³

4.4.8 Abortion

4.4.8.1 Prevalence/epidemiology

While the requests for abortion appear to be falling in much of Western Europe and other European countries, evidence suggests that migrant women continue to be placed in situations where abortion is often seen as the only option.¹⁰⁴

A study in Norway found that refugees and labour migrants had significantly higher rates of termination of pregnancy than non-migrants.¹⁰⁵

Another Norwegian study confirmed that non-Western women were over-represented in all age groups of women requesting induced abortion; this was most pronounced in the age groups over 35 years.¹⁰⁶

Similarly in Switzerland, abortion rates for non-Swiss women were two to three times higher than those for Swiss women.¹⁰⁷

An Italian study found that the risk of induced abortion is approximately three times higher (34.8/1000 women) among foreign-born women than among all resident Italians (10.5/1000).¹⁰⁸

Also in Belgium, young people and migrants are known to be the most important risk group for unwanted pregnancy and abortion. Research in the Flanders and Brussels regions revealed that more than one quarter (27.5 per cent) of the clients attending seven abortion centres over a period of five months were first-generation migrants.¹⁰⁹

103 Spycher C, Sieber C (2001) [Contraception in immigrant women]. *Therapeutische Umschau*, 2001;**58**(9):552–4.

104 Carballo M, Katic B, Miller R, Gebre-Mehdin J, Van Halem J (2004) *Migration and Reproductive Health in Western Europe*.

105 Vangen S, Eskild A, Forsen L (2008) Termination of pregnancy according to immigration status: a population-based registry linkage study. *BJOG*, 2008;**115**(10):1309–15.

106 Eskild A, Helgadóttir LB, Jerve F, Qvigstad E, Stray-Pedersen S, Loset A (2002) [Induced abortion among women with foreign cultural background in Oslo]. *Tidsskrift for den Norske Laegeforening*, 2002;**122**(14):1355–7.

107 Narring F, Roulet N, Addor V, Michaud PA (2002) Abortion requests among adolescents in comparison with young adults in a Swiss region (1990–1998). *Acta Paediatrica*, 2002;**91**(8):965–70.

108 Medda E, Baglio G, Guasticchi G, Spinelli A (2002) [Reproductive health of immigrant women in the Lazio region of Italy]. *Annali dell'Istituto Superiore di Sanita*, 2002;**38**(4):357–65.

109 Vissers S (2004) *Trends inzake de prevalentie van abortus bij autochtonen en allochtonen in Vlaanderen: een onderzoek bij abortuscentra en gezondheidsprofessionals*. Katholieke Universiteit Leuven.

4.4.8.2 Service accessibility and service use

Unfortunately, existing insights still have not led to sex education and care adapted to the experiences, norms and expectations of refugee women.¹¹⁰

4.4.8.3 Policies/programmatic issues

Abortion policies are diverse in the EU Member States. Both old and new EU Member States – such as Ireland, Malta, Poland and Portugal – still impose severe restrictions on abortion, with severe consequences for the health, social status and quality of life of many women. For instance in Portugal, women are still being prosecuted for having abortions.¹¹⁰

4.4.9 Gynaecology, infertility and cancers

4.4.9.1 Prevalence, epidemiology

A retrospective cohort study in Denmark showed that overall cancer incidence did not differ significantly between migrants from Eastern Europe and native Danes, whereas migrants from the Middle East and North Africa had a significantly lower incidence. All migrants had a significantly lower incidence of breast cancer.¹¹¹

4.4.9.2 Service accessibility and service use

The findings from a number of different studies suggest that migrant women do not access gynaecological care services in the same way or to the same extent as nationals. As a result, they suffer the following consequences:

- Less screening on cervical cancer and more abnormal smears¹¹²
- Lower participation in the mammography screening programme.¹¹³

110 Center for Reproductive Rights and Policy – see World Abortion Laws Map at http://www.reproductiverights.org/wn_abortion.html

111 Norredam M, Krasnik A, Pipper C, Keiding N (2007) Cancer incidence among 1st generation migrants compared to native Danes – a retrospective cohort study. *European Journal of Cancer*, 2007;43(18):2717–21.

112 Newell A, Sullivan A, Halai R, Boag F (1998) Sexually transmitted diseases, cervical cytology and contraception in immigrants and refugees from the former Yugoslavia. *Venerology*, 1998;11(1):25–7.

113 Holk IK, Rosdahl N, Pedersen KL (2002) [Acceptance of mammographic screening by immigrant women]. *Ugeskrift for Laeger*, 2002;164(2):195–200.

4.4.10 General health issues related to refugees, asylum seekers and migrants

4.4.10.1 EU health policies and rights

4.4.10.1.1 Right to sexual and reproductive health

The European Parliament has been very active in putting the issue of SRH&R on the European political agenda, particularly with respect to the regulations on aid policies and actions in developing countries. But it is striking to see that the EU did not take up a similar role in the implementation of a coordinated SRH&R policy within Europe.¹¹⁴

So far the EU has not explicitly recognized SRH rights as human rights, and the European human rights instruments, of both the Council of Europe and the EU, make no explicit reference to SRH in any text.

Despite some positive trends, such as the HIV discrimination law and comprehensive access to health care for young migrants under the age of 18 in Spain, general rights-based access to services and appropriate standards are still missing in most European countries.¹¹⁵

4.4.10.1.2 Right to health for refugees and asylum seekers

Statutory refugees are fully entitled to access national health services under the 1951 UN Convention relating to the status of refugees.

The EU directives, which are legally binding, oblige EU Member States 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.¹¹⁶

The right to health for refugees and asylum seekers varies greatly according to national legislations, and only a minority of EU Member States provide refugees and asylum seekers with 'full access' to the national health system.¹¹⁷

Norredam et al. studied and compared current standards of health care provision for asylum seekers in the 25 EU Member States. They concluded that health policies towards asylum seekers differ significantly between the countries and may result in the fact that the health needs of asylum seekers are not always adequately met. Medical screening was provided to asylum seekers upon arrival in all EU countries but Greece. The content of screening programmes, however, varied as well as whether they were voluntary or not. They found legal restrictions in access to health care in 10 countries. Asylum seekers were only entitled to emergency care in these countries. A number of practical barriers were also identified. Legal access to health care changed during the asylum procedure in some countries.¹¹⁸

114 Van Lancker A (2003) Putting Sexual and Reproductive Rights on the EU Agenda. *Choices*, 2003, Autumn:24–6. Brussels: International Planned Parenthood Foundation European Network.

115 Bröring G, Canter C, Schinaia N, Teixeira B (2003) Access to care: privilege or right? Migration and HIV vulnerability in Europe. *Woerden*, 2003, October.

116 Janssens K, Bosmans M, Temmerman M (2005) *Sexual and Reproductive Health and Rights of Refugee Women in Europe: Literature Review*. Ghent.

117 Janssens K, Bosmans M, Leye E, Temmerman M (2006) Sexual and Reproductive Health of Asylum-seeking and Refugee Women in Europe: Entitlements and Access to Health Services. *Journal of Global Ethics*, 2006;2(2):183–96.

118 Norredam M, Mygind A, Krasnik A (2006) Access to health care for asylum seekers in the European Union—a comparative study of country policies. *European Journal of Public Health*, 2006;16(3):286–90.

4.4.10.1.3 Right to health for undocumented migrants

While it may be assumed that undocumented migrants are deprived of rights, their human rights are articulated within a variety of instruments and treaties on both the international and regional levels. Therefore, the Platform for International Cooperation on Undocumented Migrants (PICUM) developed a guide which provides an overview of the human rights which apply to undocumented migrants in international humanitarian law.¹¹⁹

But even if Europe subscribed to most of the human rights, undocumented migrants in Europe face serious problems in gaining access to health care services. PICUM published a report which resulted from a two-year European project with 19 EU Member States. The report gives an overview of access to health care in Europe for undocumented migrants in terms of law and practice through 11 country profiles.¹²⁰

The authors state that there is a growing tendency in Europe to restrict access to health care for undocumented migrants and to reinforce the link between access to health care and immigration control policies. Such policies not only undermine fundamental human rights but also overburden migrant communities who are already marginalized and living in precarious conditions.

PICUM is lobbying for improving access to health care for undocumented migrants and for addressing the health care needs of particularly vulnerable groups of undocumented migrants, such as pregnant women, children, people with HIV/AIDS.

4.4.10.2 National health policy research

Most other policy research has been conducted in the USA, Canada and in Australia – three main migrant-receiving countries. Policy research in European countries other than the UK is scarce.

Research in the UK has been conducted to identify at which point in the process of the asylum-seeking procedure individuals are entitled to free National Health Service care, how current legislation and the government stance on immigration may exert a negative effect on the health of people seeking asylum while they are in the UK, and to what extent nurses and other health professionals can alleviate such effects.¹²¹

Other researchers studied health policies and services targeting asylum seekers in the UK in order to strengthen these.^{122 123}

119 PICUM (2007) *Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework*.

120 PICUM (2007) *Access to Health Care for Undocumented Migrants in Europe*.

121 Joels C (2008) Impact of national policy on the health of people seeking asylum. *Nursing Standard*, 2008;22(31):35–40.

122 S. Ghebrehewet S, Regan M, Benons L, Knowles J (2002) Provision of services to asylum seekers. Are there lessons from the experience with Kosovan refugees? *Journal of Epidemiology and Community Health*, 2002;56(3):223–6.

123 Hamill M, McDonald L, Brook G, Murphy S (2004) Ethical and legal issues in caring for asylum seekers and refugees in the UK. *Bulletin of Medical Ethics*, 2004, November(203):17–21.

4.4.10.3 Guidelines on (reproductive) health for refugees, asylum seekers and migrants

Several guidelines emerged regarding reproductive health in humanitarian settings, for instance developed by the RAISE Initiative and the RHRC Consortium (see also paragraph 4.1.3).

A handbook was published for people working with refugees and asylum seekers in the UK in the field of SRH. In this handbook Ruth Wilson emphasizes the need for trained and confidential interpreters. The communication skills of health professionals also need to be improved. Health professionals need to be aware of different cultures and backgrounds and need to treat refugees and asylum seekers with respect.¹²⁴

Many European countries have developed specific guidelines and manuals related to health care and health service delivery for refugees, asylum seekers and undocumented migrants.

Taking the UK as an example, the British Medical Association (BMA) has produced a guidance note that addresses the rights of asylum seekers and the eligibility of overseas visitors to receive medical treatment in the UK.¹²⁵ Again in the UK, good clinical practice has been identified in a number of papers, as well as the crucial services that need to be available to meet the needs of refugees and asylum seekers,^{126 127} and there are several guidelines and standards against which services can be judged.

For instance, a simple framework was developed for primary health care services to meet the recognized health needs of refugees and asylum seekers in the UK that can be used for the planning and evaluation of services for this group.¹²⁸

Guidelines for refugees and asylum seekers were also developed for paediatric care. Nevertheless, in many European countries, national health policies regarding immigrants are missing. There is an urgent need to recognize that migration has many implications not only for the health of the migrants, but also for the societies and communities into which they move and work. In some cases, morbidity and mortality rates are exacerbated by a lack of policies. For ethical as well as public health reasons, the health of immigrants is an area that calls for much more attention.¹²⁹

124 Wilson R, Sanders M, Dumper H (2007) *Sexual health, asylum seekers and refugees. A handbook for people working with refugees and asylum seekers in England.*

125 British Medical Association (2001) *Access to health care for asylum seekers.*

126 Burnett A, Peel M (2001) Health needs of asylum seekers and refugees. *British Medical Journal*, 2001, March 3;322(7285):544–7.

127 Adams KM, Gardiner LD, Assefi N (2004) Healthcare challenges from the developing world: post-immigration refugee medicine. *British Medical Journal*, 2004, June 26;328(7455):1548–52.

128 Feldman R (2006) Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. *Public Health*, 2006;120(9):809–16.

129 Carballo M, Nerukar A (2001) Migration, refugees and health risks. *Emerging Infectious Diseases*, 2001;7(3Suppl):556–60.

4.4.10.4 Use of health services by (undocumented) migrants

Regarding the use of services, SRH issues constitute a big burden of disease and an important reason for hospitalization.

An Italian study examined the hospitalizations of foreign patients from developing countries outside the EU for the period 1999–2004. The prevalent diagnoses of women were obstetrical/gynaecological: voluntary interruption of pregnancy, spontaneous abortion or pregnancy complications in 30.6 per cent of cases, and childbirth or controls of pregnancies with a favourable outcome in 18.2 per cent of patients. Together, these diagnoses covered nearly 50 per cent of hospitalizations of migrant women.¹³⁰

Different countries, such as Denmark,¹³¹ report frequent inappropriate use by primarily the socially disadvantaged and ethnic minorities.

A German study, though, found that the patient's ethnicity played no significant role with respect to the appropriateness of use of emergency outpatient services or the likelihood of subsequent hospital admission.¹³²

A study in the Netherlands indicates that the utilization of more specialized health care is lower for immigrant groups in the Netherlands, particularly for Turkish and Moroccan people and, to a lesser extent, people from the Netherlands Antilles. This suggests that ethnic background in itself may account for patterns of consumption, potentially because of limited access.¹³³

It is a constant feature throughout Europe that health care providers who are more 'undocumented friendly' tend to become overloaded. They are increasingly involved in advocating for undocumented migrants' rights, and health authorities normally listen to them.¹³⁴

130 Sabbatani S, Baldi E, Manfredi R (2007) Time trends in health care needs of non-EU citizens from developing countries, admitted to a general hospital in northern Italy. *Le infezioni in medicina*, 2007;15(4):242–9.

131 Norredam M, Mygind A, Nielsen AS, Bagger J, Krasnik A (2007) Motivation and relevance of emergency room visits among immigrants and patients of Danish origin. *European Journal of Public Health*, 2007, October;17(5):497–502.

132 David M, Schwartau I, Anand Pant H, Borde T (2006) Emergency outpatient services in the city of Berlin: Factors for appropriate use and predictors for hospital admission. *European Journal of Emergency Medicine*, 2006, December;13(6):352–7

133 Stronks K, Ravelli AC, Reijneveld SA (2001) Immigrants in the Netherlands: equal access for equal needs? *J Epidemiology and Community Health*, 2001;55(10):701–7.

134 PICUM (2007) *Access to Health Care for Undocumented Migrants in Europe*.

4.5 Challenges in research on SRH for refugees, asylum seekers and migrants

4.5.1 Research questions/determinants of health

When reviewing literature on the health of refugees and asylum seekers in Europe, we notice that attention is primarily paid to mental health and the care of traumatized refugees with specific attention for post-traumatic stress disorder. Though this is an important issue of concern, this focus might have overshadowed other health needs in the post-migration phase.

According to Bartels, international research into the health status of refugees can roughly be divided into three approaches. A first set of publications describes the results of screening for infectious diseases, mostly on arrival in the host country. Secondly, a majority of international publications report on quantitative research into prevention of psychiatric diseases in refugees. And recently, the focus has shifted from prevalence to determinants of mental illness. Qualitative research into refugees' health is very limited.¹³⁵

Measuring the burden of disease and understanding the determinants of health among male and female migrant populations requires access to relevant information through health information studies and/or ad hoc studies, in order to develop appropriate preventive and health care services with a gender perspective. While there is an obvious need for data for administrative, political and health policy purposes, there is also an inherent risk of possible misuse and abuse of such data.¹³⁶

While the concepts of race and ethnicity have been abused historically, they are potentially invaluable in epidemiology and public health for refining public health and health care policy, and offering insights for medical science. The prerequisite for their responsible use is a society committed to reducing inequalities and inequities in health status. When this condition is met, it is irresponsible not to utilize these concepts.¹³⁷

Three dimensions – gender, ethnicity and social class – form the basis of social inequalities in health.¹³⁸ The relation between ethnicity, socio-economic position and health is complex. Socio-economic circumstances and ethnic differences in health should be taken into account when studying determinants of health among migrant populations.¹³⁹

135 Bartels K. Gezondheidstoestand. In: Grotenhuis R (Ed.) (2003) *Van pionieren tot verankeren: tien jaar gezondheidszorg voor vluchtelingen*. Utrecht: Pharos.

136 Llacer A, Zunzunegui MV, del Amo J, Mazarrasa L, Bolumar F (2007) The contribution of a gender perspective to the understanding of migrants' health. *Journal of Epidemiology and Community Health*, 2007, December;61 Suppl 2:ii4–10.

137 Bhopal R (2006) Race and ethnicity: responsible use from epidemiological and public health perspectives. *Journal of Law and Medical Ethics*, 2006, Fall;34(3):500–7, 479.

138 Cooper H (2002) Investigating socio-economic explanations for gender and ethnic inequalities in health. *Social Science & Medicine*, 2002, March;54(5):693–706.

139 Smith GD (2000) Learning to live with complexity: ethnicity, socioeconomic position, and health in Britain and the United States. *American Journal of Public Health*, 2000, November;90(11):1694–8.

Llacer et al. address the need to integrate a gender perspective into epidemiological studies on migration and health. They highlight important gaps in our knowledge of the possible differential health effects of factors such as poverty, unemployment, social networks and support, discrimination, health behaviours and use of services.¹⁴⁰

Other researchers, such as Hyman, underline the need for more research on the health determinants among immigrant women, since they represent a diverse group who often face multiple cultural, linguistic and systemic barriers to adopting and maintaining healthy behaviour. More research is also needed on the relevancy and the applicability of commonly used health promotion approaches for this group.¹⁴¹

Much research regarding health in relation to ethnicity has been carried out at local level, but this is often not disseminated in peer reviewed literature and does not become part of everyday practice. More research is needed into the causes of health inequalities affecting members of ethnic communities.¹⁴²

A systematic review of studies conducted with female refugees, asylum seekers or other immigrants revealed that few high-quality tools are available to measure concepts relevant to resettling refugee women's health.¹⁴³

4.5.2 Main gaps identified in research regarding SRH of refugees, asylum seekers and migrants

Quality in research

- Large high-quality population-based studies using representative sampling methods and good definition of immigration status, to describe and compare SRH indicators between refugees, asylum seekers, undocumented migrants and the host population.

Forgotten groups

- Undocumented migrants
- Adolescents/young people: Almost no literature could be identified on the specific needs of adolescents. One British article was found that drew attention to the specific needs of young asylum seekers and the need for special programmes to increase their access to health services, especially for those aged 16 to 18.¹⁴⁴
- Men and boys

140 Llacer A, Zunzunegui MV, del Amo J, Mazarrasa L, Bolumar F (2007) The contribution of a gender perspective to the understanding of migrants' health. *Journal of Epidemiology and Community Health*, 2007;61 Suppl 2:ii4–10.

141 Hyman I, Guruge S (2002) A review of theory and health promotion strategies for new immigrant women. *Canadian Journal of Public Health*, 2002 May–June;93(3):183–7.

142 Hayles A, Adu D (2004) Transcultural medicine: race, ethnicity and health. *Clinical Medicine*, 2004;4(4):366–8.

143 Gagnon AJ, Tuck J, Barkun L (2004) A systematic review of questionnaires measuring the health of resettling refugee women. *Health Care for Women International*, 2004;25(2):111–49.

144 Lynch MA, Cuninghame C (2000) Understanding the needs of young asylum seekers. *Archives of Disease in Childhood*, 2000;83(5):384–7.

Forgotten themes

- STIs other than HIV, including human papilloma virus (HPV)
- Prevention: prevention of unwanted pregnancies and unsafe abortions, of STIs, of SGBV etc.
- Sexual education and how to promote healthy sexual behaviour
- Policy research on specific SRH topics, with a focus on policy development
- Health promotion research
- Quality of services and how to improve SRH services: for example, health staff attitudes
- Better understanding of health determinants and their interaction:
 - Socio-cultural factors
 - SRH locus of control
 - Cultural taboos such as incest
 - Socio-economic factors
 - Political/legal factors
 - Personal factors such as gender, education

Forgotten geographical areas

Since the late 1990s, there has been some attention to research in conflict or post-conflict settings. European research is scarce and seems to be almost limited to the 'old' EU Member States such as UK, Ireland, Germany, Belgium, the Netherlands, Italy, France, Spain and the Scandinavian countries.

Forgotten types/methods of research

- Large population-based studies of reproductive health indicators
- Operational research: from research to action
- KAP studies (Knowledge, Attitudes and Practices) among service providers
- Community-based participatory research (CBPR): this type of research can inform and stimulate the development of client-centred care networks
- Little (qualitative) research has been done on the SRH needs and concerns from the perspective of asylum seekers and refugees¹⁴⁵

¹⁴⁵ Wilson R, Atkin T, Shutt A (2007) Sexual health in exile. The sexual health concerns, issues and needs of refugees and asylum seekers in South and West Yorkshire: a community research report. *Publication of the Centre for HIV and Sexual Health, UK.*

4.6 Challenges in conducting SRH research with refugees, asylum seekers and migrants

Refugees and asylum seekers who resettle in industrialized countries are an ethnically very diverse group. Therefore, several bio-psycho-social factors need to be considered when doing research with this target group.

Approaches to research in newcomer populations must, therefore, include a consideration of the insider-outsider status of the researcher(s), sample selection and recruitment strategies, and attention to language barriers. Potential research participants need to be identified, approached, and made to feel safe before, during and after participation in research. Interpersonal relationships need to be negotiated with awareness of potential power imbalances, institutional discrimination, and trauma associated with pre-migration, migration, and settlement experiences. Embedded within these approaches should be awareness of the need to ensure the cultural safety of research participants through implementation of culturally competent research strategies.¹⁴⁶

4.6.1 Guiding principles

- The research questions to be tackled should be based on stated needs of the target group, i.e. SRH issues at stake should be relevant and meaningful to the people's lives.
- Research should be based on respect for the participants.
- Research should be designed with awareness of the sensitive and intimate nature of SRH&R.
- Sexuality should be placed in a wider context of people's lives.
- Fostering partnerships between academic institutions and the community should be a priority.
- Participation of the 'researched' people in the whole course of the research should be a priority (not as 'study subjects', but as advisors through community boards etc.). Study participants should be remunerated for their participation.
- Interviewers should be supported emotionally and structurally in work which can be demanding.
- The research should be designed to minimize possible psychological, emotional or physical harm to the participants (for example, interviewees, storytellers etc.).
- Ethical approval and informed consent procedures have to be applied to fully protect participants, even if that can be onerous. That could imply, for instance, developing a critical/adverse incident protocol (for example, when sexual abuse is revealed during an interview, emergency procedures can be applied).
- Action should accompany the research and be directed in changing policies, practices and social structures that have a negative impact on SRH&R of the targeted group.

146 Ogilvie LD, Burgess-Pinto E, Caufield C (2008) Challenges and approaches to newcomer health research. *Journal of Transcultural Nursing*, 2008;19(1):64–73.

4.6.2 Dissemination of research results

Research results should be disseminated and fed back to the target group. Ideally, this should be a two-way street. Community members can address limitations of the research, identify the implications of the results for their health, and suggest additional research topics. In this way, experience and practice can inform future research and contribute to knowledge in the community and among practitioners.¹⁴⁷

4.7 Conclusion

The limited studies available suggest that migrant women suffer from a disproportionate number of reproductive health problems.

Fundamental rights include the right to reproductive health care; they apply to everyone, including migrants.

The challenge is to translate sexual and reproductive research and rights into actions that improve the reproductive health of people whose lives have been devastated by migration.

147 Pitts M, Smith A (Eds) (2007) *Researching the margins. Strategies for ethical and rigorous research with marginalised communities*. New York: Palgrave MacMillan.

CHAPTER 5: EN-HERA! RESEARCH AGENDA

5.1 Background and rationale

The fourth specific objective of this project was to set a common research agenda for future research. This is not only a project objective per se, but a common research agenda contributes also to the sustainability of the project and of the EN-HERA! network in the long run.

At several meetings of the project steering committee (for example, in Athens and Ghent), the steering group members' expertise and research interests were collected, discussed and put next to global research priorities. In addition, the literature review on the current state of the medical and social science literature was compiled and appeared to be a major milestone to identify research gaps and to achieve the project's objective. The review of the literature not only highlights the most salient SRH issues that concern refugees, asylum seekers and (undocumented) migrants, but also shows the existing gaps and highlights the areas of concerns not sufficiently addressed.

The literature review (see Chapter 4) and its conclusions in terms of identified gaps and subsequent research priorities, combined with the previously defined steering group members' expertise and research interests, resulted in the so-called 'research agenda'.

This research agenda was presented at the first EN-HERA! meeting, organized in Ghent on 22 November 2008, with funding from the EC European Refugee Fund. The identified gaps and some suggestions for further research were discussed with all experts and members of the EN-HERA! network present. By doing so, the work done within the EN-HERA! network has been emphasized and the way forward has been interactively discussed with the whole group.

5.2 The research agenda as presented at the first EN-HERA! meeting

Different questions were addressed during the presentation of the research agenda at the first meeting of the EN-HERA! network in Ghent:

1. What is the rationale behind doing research on the SRH&R of refugees, asylum seekers and undocumented migrants?
2. What do we know?
3. What are the existing gaps?
4. What are the research interests and potentials of the EN-HERA! group?
5. What can we add and how can we move forward?

Four suggestions for further cooperation and common research emerged from these questions:

- A. Maintain and expand the EN-HERA! network
- B. SRH&R of young refugees and asylum seekers (including undocumented migrants)
- C. Access to SRH care for undocumented migrants
- D. Prevention of SGBV among refugees and asylum seekers

These research topics were interactively discussed with all present members of the EN-HERA! network. At the same time some concrete projects were highlighted, and funding possibilities were openly explored.

5.2.1 *Why should research on the SRH&R of asylum seekers, refugees and undocumented migrants be conducted?*

The following documents stress the need for research in the area of SRH among refugees and asylum seekers:

- **Cairo commitments:** “Ensure that culturally sensitive and appropriate [reproductive health] services are available to migrants and displaced persons” (Chapter 7.11)
- The reproductive health and research programme of the **WHO Regional Office for Europe** aims to decrease health inequalities in migrant and refugee women through research on their health needs
- **Rationale:** maternal mortality and other indicators of ill reproductive health are generally low in Western Europe, but risks are significantly higher for migrant or refugee populations

Several researchers stressed that research on SRH&R can:

- raise awareness and/or correct misperceptions and contribute to (health) policy changes;
- encourage development of initiatives that address specific needs of refugees and migrants as identified by research; and
- enrich existing reproductive health services for refugees and settled populations by sharing of good practices or lessons learned (for example, on sexual violence).

5.2.2 *Literature review of SRH&R issues related to refugees, asylum seekers and (un)documented migrants*

A literature overview of the current state of the SRH&R of refugees, asylum seekers and (un)documented migrants (see Chapter 4) was produced and presented at the EN-HERA! meeting.

Because the aim was to identify the main research gaps in the field of SRH for refugees, asylum seekers and undocumented migrants, we retrieved the main fields of research regarding different SRH&R topics and summarized the main research conclusions in the review.

In general, we found that there is a paucity of systematically collected data, since most of the studies are on a rather small scale with unrepresentative sampling. A common feature is the poor definition of the migrant status within the existing studies. Much of the existing knowledge stems from emergency contexts (such as stable camp settings, which eases data collection), and much of this mostly operational research has been used to establish technical guidelines and operational procedures. In Europe only little research has been carried out, with a focus on needs assessments among selective populations and selected mental health issues.

The main conclusions of the existing literature regarding different SRH&R topics are summarized below (for the more extensive and in-depth review, see Chapter 4):

Accessibility of SRH services for refugees, asylum seekers and migrants

- **Legal barriers:** A big variation between different EU Member States exists.
- **Administrative and financial barriers:** Issues such as complex administrative procedures, little knowledge among health professionals, and limited financial resources among the target group limit access to SRH services.
- **Communication barriers:** Besides poor language skills, communication is poor due to an insufficient use of trained interpreters and the fact that health care providers are usually culturally incompetent.
- **Socio-economic barriers:** Unemployment, inadequate housing and social isolation are some examples.
- **Cultural/personal barriers:** Strict gender roles, traditional beliefs and the feeling of powerlessness are among frequently cited barriers.
- **Lack of knowledge and lack of information on available resources** is a significant obstacle for refugees, asylum seekers and migrants to access SRH services.
- **Mental health concerns:** Refugees and asylum seekers suffer more from conditions such as post-traumatic stress disorder and depression than the host population.

EU health policy and rights

- Right to SRH
So far there is no recognition of SRH rights as human rights by the EU. The lack of SRH&R policies and actions within Europe is in sharp contrast with the EU aid policies and actions in developing countries in which SRH&R are given priority.
- Right to health care for refugees and asylum seekers
EU directives oblige Member States to provide medical care to refugees and asylum seekers. However, big variations exist, and the medical care is limited to emergency care in some countries.
- Right to health care for undocumented migrants
Serious problems exist regarding access to health care for this population group, and there is growing tendency to restrict access for undocumented migrants in the EU.

Maternal and newborn health

- Though clear evidence is missing at the moment, it is likely and generally assumed that refugee and migrant women have poorer pregnancy outcomes and higher mortality rates than other women. A large prospective cohort study in Canada is currently being conducted and should bring more data to support or refute this claim.
 - Data from Belgium and Germany suggest higher perinatal and infant mortality rates among babies born of immigrant women from Morocco and Turkey.
 - There is a higher proportion of immigrants among maternal deaths in Belgium.
 - More pregnancy complications were observed among African women delivering in France or Germany.
 - Premature births and babies with low birth weight are especially common among African and South-American migrants in Spain.
- Several studies pointed out that the European maternity services are not adapted to the specific needs of refugees and asylum seekers. Reception centres in particular are inadequate to take care of pregnant women and newborn babies.
- Studies in Sweden and the Netherlands observed that migrant women present late at antenatal care services.
- Little policy research has been done so far, which might explain the current poor policy development at EU level in the field of maternal and newborn health for refugees, asylum seekers and undocumented migrants.

STIs/HIV

- Prevalence studies
 - There is a higher risk of STIs and HIV linked to migration.
 - A total of 10,199 heterosexually acquired cases of HIV were reported in 2006 by 16 European countries, of which 43 per cent (4420) were individuals originating from countries with generalized epidemics. This figure varied from 21 per cent in Portugal to 66 per cent in Norway.
 - Specific data regarding the prevalence of HPV or cervical cancer among the target group are missing.

- Epidemiology
 - Research in the UK found more co-infection of HIV and TB among PIISA.
 - Another important issue is the so-called ‘endemic split’. HIV-positive migrants develop AIDS more and sooner than the general population.

This can be ascribed to:

 - Less access to testing and treatment services for refugees, asylum seekers and migrants
 - Lack of information and knowledge
 - Within the target group, stigmatization and discrimination of HIV-positive individuals are important barriers to health care.

This underscores the need for more health promotion research.

- The most noticeable differences between the needs of asylum seekers and British patients attending STI clinics are the use of interpreters, the reporting of sexual violence, the need for counselling and the number of women without up-to-date smears. But the satisfaction regarding the services offered appeared to be equal.
- Some European policy research has been or is currently being conducted, especially in the field of barriers towards HIV testing.

SGBV

- The prevalence of intimate partner violence varies between 10 and 60 per cent in the general population (data from 50 population-based studies carried out in 36 countries).
- Studies of domestic violence among refugees and migrants are less common than studies on sexual violence or rape. It has not been quantified whether refugee and migrant women are more affected than women in settled populations by domestic violence. But the question is not really relevant either, given the high general prevalence.
- Less access to support services has been described for refugee, asylum-seeking and migrant women because of:
 - Relative isolation of migrant women, poverty etc.
 - Lack of awareness on available resources
 - Language barriers to counselling and care
 - Inability to report violent incidents to the police
 - Cultural differences: in some cultures it is difficult to refuse the sexual advances of their husbands, and domestic violence is considered as normal in some communities.
 - Suspicion on the part of refugees is often more prominent, especially when they have suffered harsh political repression and persecution. Therefore, the first contact between a refugee and health care provider is of decisive importance.

- At policy level, legislation on different aspects of violence against women has improved in the EU Member States, and there are national action plans to combat violence against women in most EU Member States, however they rarely focus on refugees.
- Some attention is paid in the literature to the topic of sexual violence during the refugee cycle:
 - Rape is recognized as a weapon of war, and the evidence suggests that refugee women experience rape and other forms of sexual violence probably more often than women in settled populations.
 - Refugee women and children, especially single girls, face a high risk of sexual violence when fleeing, seeking asylum and integrating in the host country.
 - Trafficking in women and children is another problem which is now recognized as human rights violation.
 - Violence in reception centres has been neglected for a long time. Recent studies (conducted by partners of the EN-HERA! network) report that not only other residents but also staff working in reception centres are potential perpetrators, and that more staff training and improvement of the living conditions in the reception centres are required.
- Extensive research exists on harmful traditional practices and especially FGM.
 - FGM affects 100 million girls and women worldwide.
 - FGM has been re-introduced in Europe and the USA by certain immigrant communities.
 - The Centers for Disease Control estimate that 168,000 girls underwent or are at risk of FGM in the USA (1990).
 - Yet no reliable data are available for Europe.
- FGM can have many health implications, such as anemia, infertility, chronic infections, sexual dysfunctions, urinary problems, and complications in pregnancy and delivery.
- There is a need for a coherent and multisectoral approach (with the involvement of health and social care services, police, lawyers, immigration officials).
- Health care professionals need to receive specific training on the topic of FGM. Health care workers have described a lack of knowledge and technical guidance, a lack of understanding, a feeling of powerlessness and ethical dilemmas.
- Policy research: interest in FGM is increasing steadily at the EU policy level, yet general strategies applicable in all Member States are not available.

Family planning and contraceptives

- Different opinions exist regarding the effect of migration on fertility rates (they can go up or down, depending on the context).
- Data suggest less contraceptive use among migrants.

- Frequently cited barriers include:
 - Lack of knowledge on contraception, lack of awareness on how to get contraceptives
 - Cultural barriers: difficult communication between men and women (for example, to negotiate condom use, cultural pressure to fulfill traditional childbearing roles)
 - Other barriers: cost of contraception
- Identified needs:
 - Emergency contraception is considered as an important family planning service to be provided for refugees.
 - Sex education for migrant women, taking into account cultural notions, is missing.
 - The use of translators and mediators familiar with the subject, enough time and high motivation of staff are other needs identified by researchers.
- Little interventional research has been carried out, but an action research project in Switzerland concluded that the use of same-culture family planning counsellors appeared to be effective.

Abortion services

- Data suggest much higher abortion rates among refugee and migrant women:
 - Norway: higher rates of termination of pregnancy among refugees
 - Switzerland: two to three times higher abortion rates for non-Swiss women
 - Italia: risk for induced abortion is three times higher in foreign-born women
 - Flanders and Brussels: 27.5 per cent of clients attending seven abortion centres were first-generation migrants.
- For the moment, almost no sex education and care adapted to refugee women's needs seems to exist.
- At policy level, there are very different abortion policies in EU Member States (with severe restrictions to abortion services in Ireland, Malta, Poland and Portugal).

Gynaecology, infertility and cancers

- Limited data are available and only for migrant women. Data from Denmark show no significantly different overall incidence of cancer among migrants and even a lower incidence of breast cancer in some migrant communities.
- A number of different studies suggest that migrant women do not access gynaecological care services in the same way or to the same extent as nationals. Less screening on cervical cancers and more abnormal smears have been reported, as well as a lower participation in mammography screening programmes by migrant women.

5.2.3 Identification of the existing gaps, specifying the forgotten groups, themes and research methodologies

The review of current literature revealed three main forgotten groups, i.e. target groups among which little or no research has been carried out, in the area of the SRH of refugees and asylum seekers:

- adolescents/young people;
- undocumented migrants; and
- men and boys.

In addition to underserved target groups, on the basis of the current literature review the following issues were identified as forgotten themes:

- STIs other than HIV, including HPV;
- sexual education;
- prevention of unwanted pregnancies and unsafe abortions;
- prevention of SGBV;
- health promotion research;
- policy research on specific SRH topics and policy development;
- quality of SRH services (such as health staff attitudes); and
- determinants of SRH and their mutual interaction.

The available literature allows the conclusion to be reached that, in general, SRH problems are more prevalent among refugees and asylum seekers. Therefore, the challenge lies in the translation of the scarce SRH research results into actions, and to carry out more research on those salient issues that have been untouched so far.

5.2.4 Summary of the research interests of the founding members of the EN-HERA! network

Due to the multidisciplinary composition of the EN-HERA! network, a variety of research interests and expertise exists. Existing expertise relies mainly on:

- research that contributes to transferring in-depth, practical and applicable knowledge on health care to people and organizations working for and with refugees, asylum seekers and undocumented migrants;
- operational research;
- participatory research to gain better insight on issues at stake and contribute to the empowerment of the target group; and
- expertise on both qualitative and quantitative research methods is present among different members of the EN-HERA! network, though the possibility to conduct large population-based studies is not yet available (mainly due to a lack of resources).

Members of the steering committee have worked or expressed an interest in different research issues, such as:

- determinants of SRH;
- fertility-related topics, such as abortion, unwanted pregnancies, and their psychological consequences;
- determinants in sexual and gender-based violence and prevention;
- development of adapted SRH&R tools.

5.2.5 *The way forward: potential research topics to be developed*

Discussion of the above raised four different research propositions. These propositions and their respective funding options were interactively discussed with the whole group of experts at the first EN-HERA! meeting in Ghent. It was stressed that a clear-cut division has to be made between an operational grant for the EN-HERA! network itself and research grants for specific research activities to be carried out by (part of) the network.

5.2.6 *Operational grants for funding the EN-HERA! network structure*

All EN-HERA! members expressed the opinion that core funding for the network is needed to meet the general and specific objectives of the network (see the Vision Text in Chapter 3) and to make the network sustainable. Two potential EC donors were mentioned:

- **European Refugee Fund:**
By the time the seminar was held, it was not clear whether there will be a renewed funding option or a specific call for proposals launched by the European Refugee Fund during 2009.
- **Public health/SANCO:**
Since this year (call for proposals 2008) the European Commission Public Health Programme (Public Health Strategy 2008–2013) has established a call for proposals for operating grants (in the first call for proposals launched, applicants were required to provide a 20-per-cent contribution). EN-HERA! has already participated in a consultation process, during which the topic of the SRH of refugees and asylum seekers was suggested as a topic for potential funding. Whether this suggestion will be integrated into the next work programme will become clear at the latest upon publication of the next call for proposals (work programme and call for proposals in February 2009).

5.2.7 *Submitted research proposals*

A first joint research initiative was taken in April 2008. There was a call for proposals from the EC Daphne 3 programme on SGBV, to which we submitted the proposal entitled 'Frame of reference for the prevention of sexual and gender-based violence against and among young refugees, asylum seekers and unaccompanied minors in the European reception and asylum sector'. This project was approved in November 2008 with partners in Belgium (ICRH, Red Cross Flanders, Fedasil, UNHCR, Minor Ndako and JUNA), Greece (Greek Refugee Council), Hungary (Menédek), Ireland (UCD), Malta (Jesuit Refugee Service), the Netherlands (NIVEL), Portugal (IHMT) and Spain (Hospital Punta de Europa).

The overall objective of this project is to contribute to the health protection and the health promotion of young refugees, asylum seekers and unaccompanied minors by enhancing prevention of SGBV against and among them in the European asylum and reception sector. We will develop a Frame of Reference consisting of a Code of Conduct, a Standard Operating Procedure, a Training Manual and a Prevention Tool.

Furthermore, we proposed core funding for networks such as EN-HERA! as a theme for the Public Health/SANCO consultation round. We do not know yet whether this theme will be upheld in the following public health proposals.

5.2.8 *Potential research proposals*

Sexual and reproductive health and rights of young refugees and asylum seekers (including undocumented migrants)

Potential topics that were suggested relating to this group include, among others:

- unaccompanied minors;
- adolescents as a vulnerable group with specific needs;
- prevention of unwanted pregnancies and unsafe abortions;
- prevention of HIV/STIs, and promotion of healthy sexual relations;
- access to contraception and health promotion services;
- research on determinants; and
- health promotion research and the development of (culturally competent) health promotion tools.

Funding options:

Seventh framework: In the current seventh call for proposals, family planning was included that addressed this topic. The deadline, however, was in December 2008, which was unrealistic to achieve in the framework of this project. This call for proposals also had to include countries from the South (the so-called 'SICA' countries).

International funds: It was agreed that if EN-HERA! were to open the focus to countries beyond Europe, it could be easier to get funding for these kind of topics.

Access to SRH care for undocumented migrants

Potential topics that were suggested relating to this group included, among others:

- access to maternal health care (antenatal and obstetric care);
- access to (outreach) HIV testing and care;
- research on SRH determinants;
- development of multicultural tools (operational research); and
- research on the European legal framework and its impact with the aim to contribute to European and national policy change.

Funding options:

No real funding options could be identified by EN-HERA! members at this moment, except for some smaller initiatives from some national foundations (such as the King Boudewijn Foundation in Belgium). The unwillingness of the EU to include the group of undocumented migrants in research projects was deplored.

Prevention of SGBV

Potential topics that were suggested relating to this topic include, among others:

- enhancement of social capital;
- networking;
- applying a community-based participatory approach;
- research on determinants; and
- development of operational/counselling tools.
- male abuse;
- sexual exploitation.

Funding options:

- Daphne III Programme, see Submitted Research Proposals.

5.3 *Remarks and comments from EN-HERA! members*

The presentation of the research agenda generated a general enthusiasm – in particular among the new EN-HERA! members – for conducting research together. It was strongly believed that common research projects (such as the abovementioned Daphne project) will help to strengthen the EN-HERA! network further. Additionally, joint interests of the group and some new ideas have been discussed:

- Men who have sex with men are not in the picture yet. It was advised that EN-HERA! should include research on this topic, especially with migrant communities where there is a lot of stigma against sexual diversity and same-sex orientated lifestyles.
- EN-HERA! was encouraged to try to include other research disciplines because the literature review pointed out that more qualitative studies than quantitative studies have been done in the past. Yet in the EN-HERA! research agenda even more qualitative studies were proposed. It has been argued though that, even if indeed studies among larger samples and population-based studies are missing, the critical question to be raised is whether EN-HERA! is in a realistic position to undertake them. Furthermore, the proposed research agenda focuses on operational or interventional research, using a participatory approach, which is a research discipline which has been neglected so far.
- Another proposition was made to add male involvement and sexual trafficking to the research agenda.
- It was emphasized that in particular the European Refugee Fund foresees funding for the new EU Member States. The recommendation has been made to see how EN-HERA! can address and answer the new research priorities set by the European Refugee Fund and other donors as these are changing within time.
- Other funding options suggested by the experts included:
 - Bill and Melinda Gates Foundation;
 - lobbying at EU level;
 - European social fund: EQUAL – this requires channelling through national governments: a member, who is linked with the government, could submit the proposal as main applicant; and
 - AIDS Fonds: for HIV-related issues and probably only for the Netherlands.

Conclusion and commitments made

All EN-HERA! members and potential new members expressed a shared interest in continuing research together, with a preference for further research on young people.

Another commitment made at the EN-HERA! meeting in Ghent was to build two groups to assure appropriate follow-up of the research agenda:

- A group for exploring and acquiring funds for the network as such – the suggestion was made to have shifting responsibility for coordinating the EN-HERA! network in future.
- A group for exploring and acquiring adequate funds for specific research projects – it was decided that the ‘google-group’ (i.e. online communication tools for all EN-HERA! members) will serve as a tool to exchange information on upcoming calls for proposals that may match our research interests. This enables every member of the network to follow up the proceedings of the network or to post suggestions. In addition, some specific members expressed a particular interest in grant writing and confirmed that they will have resources available in the near future to apply for funding (for the respective details, see the minutes of the meeting in Chapter 6).

CHAPTER 6: SEMINAR PROCEEDINGS

6.1 Introduction

The fifth specific objective of this project was to organize an international seminar. There were three reasons for doing so:

- to launch the EN-HERA! network officially and to allow the different members and participants the possibility to network extensively;
- to raise awareness about the SRH&R of refugees and asylum seekers in Europe and the challenges that we are still facing; and
- to present the objectives and results of this project and to finalize the framework for the identification of good practices as a final loop in our Delphi process.

The seminar was held on 21 and 22 November, at the Poortackere Monastery in Ghent, Belgium. The first day was open to all members and other participants. The second day consisted of two parts. The first was the first member meeting, and the second in the afternoon was the last steering committee of this project, held by the founding and steering members.

6.2 Programme

Seminar	
For the Promotion of Sexual and Reproductive Health & Rights of Refugees and Asylum Seekers in Europe and Beyond	
Friday, November 21, 2008	
09.00 - 09.25	Registration
	Coffee and Tea
	Saint Lucas Room
09.25 - 11.00	Context Introduction
	Introduction of key issues in sexual and reproductive health and rights of refugees and asylum seekers in Europe.
	Saint Lucas Room

09.25	Welcome speech and chair: Emilie Wiinblad Mathez (UNHCR)	
09.30	Emilie Wiinblad Mathez (UNHCR) Challenges in sexual and reproductive health of asylum seekers and refugees in Europe.	
09.45	Lydia Ogour (Kenyan Women's Association, Greece) Case study: Sexual and reproductive health of migrants and refugees in the Greek national health system.	
10.00	Marieka Vandewiele (IPPF EN, Belgium) Sexual and reproductive health as a basic human right.	
10.15	Deo Ladislas Ndakengerwa (Irish Refugee Council, Ireland)	
10.30	Case study: Campaign and lobbying on refugee health issues in Ireland	
10.45	Georg Bröring (BAP, the Netherlands) European networking on health and its impact	
	Eve Geddie (PICUM, Belgium) Case study: European networking for health promotion of undocumented migrants	
11.00 - 11.30	Coffee & tea break	Saint Lucas Room
11.30 - 12.30	PROJECT PRESENTATIONS	Saint Lucas Room
11.30	Presentation of the project – Ines Keygnaert (ICRH, Ghent University, Belgium)	
11.45	Presentation of the research results – Sonia Dias (IHMT, Universidade Nova de Lisboa, Portugal) and Elli Ioannidi (National School of Public Health, Greece)	
12.00	Presentation of the draft Framework – Patricia Kennedy (University College Dublin, Ireland) and Dorota Sienkiewicz (Pharos, the Netherlands)	
12.15	Discussion on presentations	
12.25	Introduction to the workshops – Koen Dedoncker (ICRH, Ghent University, Belgium)	

12.30 – 13.30	Lunch	Restaurant
13.30 – 15.00	WORKSHOPS	
Workshop 1:	Discussion of Framework: Identification of Good Practices in Policy Development Chair: Sónia Dias (UNL, Portugal) Speaker : Tania Gangarova & Christine Winckelmann (BZgA, Germany)	Saint Lucas Room
Workshop 2:	Discussion of Framework: Identification of Good Practices in Service Delivery Chair: Elli Ioannidi (NSPH, Greece) Speaker: Iris Shiripinda (SOA AIDS, the Netherlands)	Saint Marcus Room Erasmus Room
Workshop 3:	Discussion of Framework: Quality Indicators in Service Delivery Chair: Kathia van Egmond (ICRH, Ghent University, Belgium) Speaker: Nikolitsa Giannakopoulou (Praksis, Greece)	
15.00 – 16.00	Coffee & tea break + Café contact: Good Practices Market	Restaurant Kapittel room
16.00 – 17.00	CONCLUSION	Saint Lucas Room
16.00	Introduction	
16.05	Conclusion of Framework Workshops Recommendations – Christiana Nöstlinger (Prince Leopold Institute of Tropical Medicine, Belgium)	
16.25	Discussion	
16.40	Launch EN-HERA! Network – Marleen Temmerman & Koen Dedoncker (ICRH, Ghent University, Belgium)	
16.50 – 19.00	RECEPTION	Restaurant Kapittel room

Saturday, November 22, 2008		
09.00 - 09.15	Registration	
09.15 - 09.20	Welcome	Saint Marcus Room
Chair:	Ines Keygnaert (ICRH, Ghent University, Belgium)	
09.20	Round table: presentation of members	
09.50	Proposal of the vision and objectives of the network - Ines Keygnaert (ICRH, Ghent University, Belgium)	
10.10	Discussion and ideas for implementation	
10.50	Conclusion	
11.00 - 11.30	Coffee & Tea break	Saint Marcus Room
Chair	Christiana Nöstlinger (Prince Leopold Institute of Tropical Medicine, Belgium)	
11.30	Presentation of the research agenda - Christiana Nöstlinger (Prince Leopold Institute of Tropical Medicine, Belgium) and Kathia van Egmond (ICRH, Ghent University, Belgium)	
11.50	Discussion and ideas for implementation	
12.20	Conclusion	
12.30 - 13.30	Lunch	Restaurant

Thank you for your participation in the seminar!

6.3 Seminar for the Promotion of Sexual and Reproductive Health and Rights of Refugees and Asylum Seekers in Europe and Beyond

6.3.1 CONTEXT INTRODUCTION

6.3.1.1 *Welcome speech and challenges in sexual and reproductive health of asylum seekers and refugees in Europe - Emilie Wiinblad Mathez (UNHCR)*

Welcome speech

Good morning and welcome to this morning's opening to the seminar. My name is Emilie Wiinblad Mathez, and I'm here on behalf of the United Nations High Commission for Refugees (UNHCR). I will chair and say a small welcome this morning, as well as give a presentation. We are already a little bit behind schedule, so it is important that we kick off and try and keep track of the time, including myself of course.

I just want to say a few words as a welcome. It's a great pleasure to be here and open the seminar on behalf of the ICRH, who is organizing this seminar on the promotion of sexual and reproductive health and rights of refugees and asylum seekers in Europe and beyond.

It's also an honour to be here as a representative of the UNHCR, but also I think as a woman and as a humanitarian. In my work in Asia, Africa and Europe with refugees I have seen first-hand the challenges that are facing refugees, particularly those that are caused by their displacement. Today and tomorrow we will hear presentations on the research done as well as practices in European countries, and we will discuss the challenges and approaches to address these challenges.

I think we can all agree that this is indeed a very challenging topic, a topic that spans from human rights and legislation, but also services, and into the core of human relationships and individual choices. Like many refugees' situations, issues of sexual and reproductive health affect all of us, and through our lives in different ways and different types we have to make choices in this area. Take a moment to reflect on our own choices: who did we consult for advice? How do we address these issues? We know very well the complexity of what we are facing here, and the difficulty that we will be looking at. These are very private issues, for all of us at the end of the day. For refugees there is an added challenge posed by displacement, loss of culture, new cultural identity, trying to adapt to the newness of a core environment. Many adults and families miss the support structure they would normally rely on for guidance in these particular areas: the mother, the sister, the father, the brother, family, friends and community: the person that you normally rely on for information, for advice, what to do, and these pose an additional complexity to the issue.

It is important to mention that while, of course, to a large extent, this is rooted in the issues of human rights, tackling the challenges of sexual and reproductive health goes way beyond the recognition of rights, or even the limitation of rights and legislation. It touches as well on policy, services and the actual practices. So we must look at all of these, in an area which is touched to such an extent by taboos and the need for privacy.

This means also that a top-down approach will not bring us far. As practitioners in advocacy and advocacy groups in the area, you know this very well. We must find ways of approaching this challenge with the people that we wish to assist and focus on. This requires engagement, outreaching, participation, and an outstanding ability to listen. To back up and nourish an environment for free and informed choices on issues pertaining to this area for women, men, boys and girls, it requires above all an environment free from discrimination and caution. And that is in all layers of society. Freedom from discrimination in legislation, in policy, in services is necessary but also very important, freedom from discrimination within family, within society, within the social group. That is influencing each of us, each individual.

Programme of the seminar

The programme today will give us a very ample opportunity to listen to different experiences in this area, and to discuss in some detail the good practices engagement to policy development, service delivery, quality indicators in this area as well as participation.

I will chair this morning session, and then I will continue with my own presentation on behalf of UNHCR on the specific challenges for asylum seekers and refugees in Europe. Following that, if you turn to your programme there, you will see that we will have five presentations of about 15 minutes up till the coffee break. We will hear from Lydia Ogur of the Kenyan Woman's Association talking about experiences from Greece, from Marieka Vandewiele (IPPF) on SRH and basic human rights. Then we will hear Deo Ladislas Ndakengerwa from the Irish Refugee Council talking about campaigning and lobbying for refugee help, as well as Georg Bröring (BAP), speaking on European Networking, and Eve Geddie (PICUM) on a case study on European networking and health promotion for undocumented migrants and a case study from 11 EU countries.

After the coffee break we will have more presentations from the EN-HERA! project as well as a small discussion until we break for lunch. After lunch, we will break into workshops, and we will be presenting at that time which workshops are going where and what we are doing. We then have the café contact in the afternoon that will take place in the canteen where we had breakfast and lunch, and in the afternoon we will have conclusions from the workshops, the wrap-up discussion, the launch of the network and then ending with the reception, which will give us another opportunity for networking, talking, discussing as well as having a small dinner being served at that time. That's the programme. So thank you very much and welcome.

Challenges in sexual and reproductive health of asylum seekers and refugees in Europe

Now, I'd like to turn to my presentation here. The topic at this address is really challenges in SRH for asylum seekers and refugees in Europe. As I mentioned in my welcome speech, the challenges span from the recognition of rights, the manifestation of such rights in legislation to the implementation or provision of services and down to the individual choices and circumstances surrounding these choices.

UNHCR is mandated by the international community to lead and coordinate international actions to protect refugees and resolve refugee problems worldwide. In doing so, UNHCR works to ensure that women, men, girls and boys of concern to UNHCR have equal access to and enjoyment of their rights. The main legal framework for our work is the 1951 Refugee Convention and 1967 Protocol. But in many areas we rely on the standards and rights set up in international human rights law. These standards are relevant also for sexual and reproductive health and are relevant for asylum seekers and refugees.

The rights in relation to SRH we will hear more about later are just mentioned briefly. I will just mention briefly the different rights, or rights groups, if you like. For instance, rights related to bodily integrity. That is all the rights that have to do with right to life, right to be free from torture, right to be free from slavery. They come into play when, for instance, inadequate health facilities put a pregnant woman's life at risk, or when harmful traditional practices such as female circumcision or FGM are practised, or where women, girls, boys, orphans are trafficked into a situation of slavery. All of this impacts on their rights in this group. It can also be where other acts of violence such as rape, that happen, for instance, in relation to conflict.

But there is also another group of rights, such as the rights related to our ability to make personal choices. This can be for the individual or the family, the right to freedom of opinion and to get information are crucial for ensuring that people have access to information about their sexual and reproductive health. Lack of information is often a real obstacle to making the choices so necessary to improve in this area. The rights of privacy in family life, the right to form a family, and for that family or the individuals in it, to have the right to decide freely and responsibly the number, spacing, timing of children – all of these fundamental rights impact the lives of women and men and the health and their well-being.

Then there are social and economic rights which can impact this area, this can be the right to health or the right to development. In the 1951 Refugee Convention itself we have a specific mentioning of refugees' right to public relief and assistance, such as health and social welfare. Also important is the accepted right for everyone to the highest standard of physical and mental help, set out in this national convention on economic, social and cultural rights. These rights apply to all, also asylum seekers and refugees.

But I think it would be very wrong to talk about challenges to SRH without recognizing that women and girls often face additional challenges in this area. So women's rights issues are a separate important right area in this. Some challenges are linked to the pure physical issue of, for instance, pregnancy or birth but may be also be linked to more economic, social, cultural rights that place women in a disadvantaged or disempowered situation. Rights in relation to ensuring that women, or other groups such as asylum seekers and refugees, are not discriminated against, therefore, have an equally important role to play in ensuring good sexual and reproductive health for all. In this context for refugees all of these rights are relevant and may be challenged in different ways throughout the displacement cycle.

UNHCR's health strategies build on the recognition of these rights and have a specific emphasis on SRH for refugees. Our strategies aim to protect the reproductive health of asylum seekers and to ensure that reproductive health policies include these different rights and that refugees are in or mentioned or specifically acknowledged in health policies. It's part of UNHCR's strategy to monitor the reproductive health of refugees, but also to ensure that refugees and others of concern have access to timely, quality and culturally adapted and effective prevention and attention of services.

In the context of our work in Europe, this strategy forms the basis for our comments to legislation, or our work in relation to reception conditions, detention, integration or even the actual recognition of refugees within the national legal process. In Europe, as elsewhere, UNHCR works to increase participation for asylum seekers and refugees, in identifying their protection needs but also the solutions. In many countries UNHCR has engaged government, agencies and NGOs in a dialogue with refugees and asylum seekers, and in this dialogue, issues of SRH have come up, have been mentioned and have been clearly formulated by the refugees and asylum seekers themselves.

So needless to say that UNHCR supports all the efforts done by so many of you here today, in ensuring that indeed the voice of those affected is heard and taking into consideration when formulating national policies and national plans as well as in the service delivery in which many of you are involved.

I just turn quickly to the situation in Europe, where UNHCR covers 48 countries and responds to a very, very upset situation depending also if it is within the European Union or outside. And just to have an idea of the numbers we are talking about, around 120,000 people applied for asylum in the first six months of 2008, 103,000 just in the European Union alone. So those are fairly large numbers. It's more difficult to say who has refugee status today in Europe, because some may have returned, some may have been naturalized, and we don't have exact statistics. But for the whole of Europe the estimate is that 1.6 million people are living with refugee status in Europe.

Well, on our work in Europe, the particular importance of course is the European Union legislation in the area of asylum and refugees protection. And for the issues of SRH, it is worth mentioning two directives in particular: the Reception Condition Directive and the Qualification Directive are commonly referred to. The Reception Condition Directive sets out minimum standards for European countries in relation to conditions for people seeking asylum. They include minimum standards for the material reception conditions and health care and, of course, have a big impact on this issue. The wording used in the Reception Conditions Directive is that "the State must provide standards of living adequate for the health of applicants and provide for access to emergency care and essential treatment of illness". It also states that there must be necessary medical or other assistance to applicants with special needs. Now this particular directive is not applicable in all EU countries, but they are anyway important minimum standards, and they must and can be used to examine what the levels of services provided for asylum

seekers are. It is worth mentioning also that in 2007 the Odysseus Network published a report where they were looking at the transposition of the directive into Member States' practice and legislation and found that this posed real challenges, that there was an unequal implementation of the standards and that some standards were fairly below the minimum standards. But at least we have a set of standards also in the European Union law.

The other important directive is the Qualification Directive, which sets out among other things also the rights and entitlements for those with protection status, such as refugee status or what we call subsidiary refugee status, to access social welfare and health care. This is given to refugees on an equal footing with other EU citizens, but for people with another protection status there might be variations.

UNHCR has made substantial comments to both these directives in relation to how we see things, and we have pointed out in particular the importance of everybody, all refugees, and beneficiaries of subsidiary protection and their families to adequate health care. UNHCR has also raised concerns with the unequal implementation of the standards, and with the lack of an application within the Reception Conditions Directive of the obligation to set up mechanisms to identify who is vulnerable and in need of the special assistance that is set up. So while these directives could give us good guidance for minimum standards for asylum seekers and refugees, the interpretation should, of course, be lying with international human rights standards. And in the context of Europe it may be worthwhile also looking at the standards set up in the charter of fundamental rights of Europe as well as the work done by the Council of Europe.

I now turn to the three phases that are facing asylum seekers and refugees. The first is the reception phase; there is this status determination, the actual procedure and maybe what you could call the integration phase for people once they got refugee status. In the reception issues I think there are two distinct challenges in SRH. The first is, of course, timely assistance and assessment of the needs, for necessary health services within the asylum process. These needs can arise due to the history of the person, what happened in the host country. These can be issues of rape, of female circumcision, FGM or the person can arrive pregnant already or with a disease. They can be physical as well as psychological needs at this phase. But it can also cover, of course, the SRH needs while they are in the asylum process, when arriving in Europe, and these can be all the usual challenges: need for family planning, need for information, sexually transmitted diseases as well as gender-based violence issues. Whilst most asylum seekers in Europe have access to emergency health services, the services vary greatly between countries, and may have some very particular challenges which are not always addressed.

In addition, for instance, the issue of adequate interpretation poses itself. The issue of communication and relevant information: how do we communicate? How do we communicate with people in a different language, from a different culture, and also for people who may not access information the way we are used to? You may have a nice handbook that is very good for our own population who we are used to in a certain way, but may not meet at all the population who may not access this type of information in this manner. This also requires a cultural

competence in the way we deal with this issue: the acknowledgment that different cultures deal with these issues very differently and that not one size fits all. It may also be just the very availability of high-quality services. There may simply not be specialized services, gynaecological services for women or psychological assistance for victims of trauma or gender-based violence, etc. These services may simply not be available for asylum seekers – or for anybody, for that matter.

Another issue for asylum seekers that is very real is the geographical and sometimes emotional isolation. This may play a role again in relation to how to deal with it. Many have lost their relatives or their support structure that they would normally rely on for advice. And they are too ashamed maybe to ask strangers in a strange land about information that for most of us at the best times are very private, intimate matters that we do not discuss freely, even with people who are very close to us.

The one area that merits a particular mention in relation to reception is the issue of detention. A number of countries are using detention for asylum seekers, and here again we see that this has a particular relevance for SRH. Standards of conditions of such detention are in places inadequate, to ensure even basic rights of privacy, of health care, of hygiene, of information and services. Apart from the issues that arise in relation to the SRH, just out of being in the reception phase, and a particular issue for asylum seekers is the limitation of social and economic rights. Lack of material support and access to work, and other social exclusion issues can lead to more vulnerability for both men and women, and such vulnerabilities can have an impact on their SRH.

I think it is also important to mention a separate group within the asylum seekers, which are the separated children and adolescents who, apart from the other issues, have additional hardship and a risk in relation to SRH. We see early pregnancies, often quite high, access to information can be an issue, education about sexuality and contraception, as well as access to contraception itself and, needless to say, abortions. These can be the main concerns. Their health needs and conditions are also challenged again by the absence of family and support network. They may lack a sense of belonging in a new place, and may be particularly vulnerable to exploitation, impacting on their health. I think, while some of these issues can be addressed simply by improving services – making them more adapted, making them culturally sensitive – sometimes it may require much more structural changes in order to improve the issues of asylum seekers, and also for the separated children. UNHCR and the organization Save the Children developed a ‘statement of good practice’ on separated children under the SCEP project, which can be used as guidance for standards for separated children in particular.

I now turn to the second phase, which is the protection and status determination – the actual going through the legal process of assessing whether a person is in need of international protection. Here again we have two distinct issues in relation to SRH. Firstly, the legal interpretation of the 1951 Refugee Convention as well as the Qualifications Directive for subsidiary protection must acknowledge these rights of SRH and that they can be a reason for persecution. This can, for instance, be an issue of rape for ethnic reasons in a conflict, it can be MTM, flee-

ing this can lead to a need or requirement for protection. Now here, that whole issue is challenged by the same challenges as we see for the integrity of the whole system. So here again having adequate interpretation is key, having access to information about the legal standards of the process, having access to legal assistance. That is all important to draw out specific issues that could give rise to international protection for the person.

And also, of course, to make it gender sensitive is the other challenge. Sometimes we need access for female interpreters for female applicants, or female case workers; it is not enough that there is general access to an interpreter. And also I think it's worth mentioning that there is a need for a medical legal report to support a person's claim. Here the medical services must be sufficiently experienced and sufficiently understanding to provide the necessary information in such reports to draw out these specific issues in relation to persecution or other forms of harm that is relevant to status.

The final phase is the integration or post-decision phase. At this stage refugees have been in the country, have been through the asylum process for some length of time. Some may already have some ties to the country or learned the language. But the fact is that a lot of the asylum seekers find themselves integrated very little. They now, therefore, have refugee status, with access to things, but they may not speak the language or have very few links.

Different countries in the EU still have very different approaches to integration. And they make very different support available for the integration of refugees. One commonality is the acceptance that integration is a two-way process. That means the requirement of the refugee to adapt to the new situation, but also that the host community must be welcoming, free from discrimination etc. I think we can use this latter to improve services, simply to make sure that services are adapted, free from discrimination, and can face the challenges in the area. The former, however, the need for the refugee to adapt, has taken the form in some countries of integration contracts, courses, induction and learning the language. A lot of the countries have been focusing on this and on the respect of the core values of the society, and here it is often the equality between men and women that is highlighted as one of the core issues, as well as the restrictions on, for instance, FGM, which is often mentioned specifically in the refugee induction courses. I think there are undoubtedly many ways to approaching or making changes to people's behaviour, as well as making an environment free from discrimination and to improve service provision to ensure greater SRH for refugees.

But I think the key to progress seems to be in the method. While there are a range of rights and standards that can guide the countries and may have appropriate legislation in place to ensure sufficient health, the challenges cannot be really challenged from a top-down approach. It is crucial that refugees are included in the needs assessment as well as in the formulation of solutions. May I address here and simply express our support for the work carried out so far in the area of participatory approach by the ICRH and the important work that you are doing, as well as the other organizations here and the launch of this particular network today. So thank you all very much for your attention.

6.3.1.2 *Lydia Ogour (Kenyan Woman's Association, Greece) - Case study: Sexual and reproductive health of migrants and refugees in the Greek national health system*

Good morning. I am a member of the Kenyan Woman's Association. I am living in Greece. I have been living in Greece for some years, and I'm mostly here to tell you my experiences as a doctor and as an immigrant – like a double role – which makes me practically more the right person to discuss this issue, if you may allow me to say that.

As regards the Greek situation on the status of refugees, we rely mostly on the Geneva Convention and the New York Protocol in relation to the Greek legal system. In 1991, Greece was a different, or I could say, a difficult colony because of the geographic position of the country. It's more like a crossroads. And most people use it as transit to move on to other countries. And that makes it really difficult to apply rules and conventions. What makes it more difficult is that, every year from 1999, we could say until 2007, the numbers of immigrants coming to the country kept increasing – immigrants, asylum seekers, refugees, a great number coming in every year. So it has been difficult to note down how many they are, how many people are coming, how many people are legal, how many people are refugees, how many coming as asylum seekers. It is really difficult. What has come up so far, we have a different report from the police authority, a different report from different sections involved in this matter. The police report that we have, says that there has been a big increase from the year 2002 till 2007; we have a rise from around 58,230 in 2002 to 399,391 in 2007, and the numbers keep increasing. So that's the number that has been registered, meaning the people that have gone to apply for asylum or refugee seekers, that's the number that has been noted down. There are others that have not come in to register, so it's difficult to tell officially how many people there are. And then there is the research of a university in Greece which also gives different views on the matter. They are more concerned about the undocumented immigrants coming in, refugees and asylum seekers, and they come up with a number of about 200,000 to 400,000 that are undocumented refugees and asylum seekers that are in the country. So it's difficult to tell what the number exactly is.

So the next point is refugee status – what the Geneva Convention says on the practical side of the matter. Then there is the refugee status telling how Greece has had to adjust its law, adjust its way of looking at things year by year because of the great numbers coming in. And the latest change made for asylum seekers and the registered political refugees coming into the country was a presidential decree in 2005 which allows all asylum seekers and political refugees that have applied and have received a card. So people who have a card are entitled to free medical care and in case they need to be hospitalized, they get free hospitalization. Those are the ones that have been registered and have a particular card. But we also had people who had not been registered. So the ones that have not been registered, we usually have the NGOs that come to help them. NGOs such as Doctors of the World help a lot in cases like that, and then we have a group called Transit, of which a representative will be talking to you later about what exactly we do. So we have these two groups which help a lot the refugees and asylum seekers who are not documented or registered.

That's that about the official side of the matter. Now I will talk to you about my experiences, because apart from being in the Kenyan Woman's Association I happen to be a doctor as well. So I will talk to you mostly about my experiences in the Greek health system concerning people who fall into this group. In most cases the distinction between refugee status and non-refugee status is important, because some have the status and some do not have. The ones that do not have it have are automatically undocumented; we don't call them asylum seekers or refugees, we just mention them as undocumented. For such cases – this is my personal experience – people going to the hospital and who do not have the particular card always have a fear that: what if someone decides to check and see if I'm official? What if someone sends me to the authorities and I will have problems?

So the ones with problems do not go to the hospital. And this is where my help came in as a member of the Kenyan Woman's Association and how I could help a lot by advising people because the KWA is not an organization for immigrants or refugees, it's just the KWA, and we don't look at who has cards or not. So my main duty as a member was more like a small collaboration, offering a little help in accessing information, where to find help, where to find medical help. So I found that people who did not have refugee status had the problem also. So this is where we advise them to go to places and NGOs, such as Praxis or Doctors of the World. So I mostly work in the information access area.

And then we have the problem of cultural diversities. There was a time when I was specializing in hospital fields, especially with women with gynaecological problems, and there I saw cases where especially refugees and asylum seekers who had just come into the country had not yet been blended into the system and do not know the language. And coming into the hospital, most of the women came with their husband, not just because of the translation problem, which is only one of the problems.

Other problems are cultural, either because of religion or because of their cultural background; for example, some women are not allowed to go to the doctor if the husband is not allowed to come in. And by medical law, you do not allow the person who is being examined to bring in their husband or fathers or anyone, especially if it is something gynaecological. It is just the doctor and the patient, and the midwife who has to help the doctor. It is a difficult problem because the wife has to come in, and the husband insists on coming in when the wife is being examined. Especially if the doctor is a man it becomes a big problem. So we found that there we had my position, to see if I could explain, because I was more like a mediator in such cases. So if we could find a female doctor that could attend the lady, to not have problems like that.

But there is no law saying that we have to find a female doctor. But it all depends on the doctor's character, the way the doctor looks at things, and the doctor might suggest that we find a female doctor for the patient. In such cases there was no problem.

But then there was the problem of translation when the husband has to come because in some points, most of the women that are in such countries where a husband and wife are coming in as asylum seekers or refugees, some still have the mentality, depending on the country or

religion in most cases, that the wife stays in the house, if they have a house to stay in, and the man goes out to get things. So the man happens to blend into the society he is living in, learn the language, but the woman does not have such a privilege.

So when they go to the doctor, the woman needs the husband to translate for her. And in some cases, such as gynaecological problems, you can understand, you can imagine. If you are going to the doctor for gynaecological problems there are some things that the wife does not want to mention in front of the husband, or the doctor says something that the wife feels that the husband should not know.

So these are some of the problems and frictions that you find concerning cultural diversity. In such cases the NGOs especially have found ways to help, such as schools for learning the Greek language, for most immigrants and asylum seekers for free, and the women and men can get acquainted with the language, so that we do not have problems like that. Then the woman can go to the doctor by herself, mention what she has and talk directly to the doctor.

And then there are cases such as women with children. There are schools especially for the children as well to learn the language, to blend into the society, so they are getting schooling as well while they are living there. After applying they do not automatically get the card. Sometimes they have to wait for six months or one year. And during that time, they do not have a family with a child of six years old, sitting in the house and not going to school. They have to start from somewhere. In such cases we have NGOs as well, with schools for children. We also have a special Greek council for refugees that has places where children can sit and learn the language, to get the children going while they are waiting for their papers to be done and get involved. And the mothers can also get involved, language wise, and learn how to blend into the society, things like that. Those help a lot. And in my experience, communication is a great, great problem. I found that in most are cases I had to go with members of the Kenyan Woman's Association, if people had to go for medical care I brought groups together only for the sake of translation, so I had to go in with the women for translation before they could see a doctor.

We also had the AIDS immobility in Greece. At some point, it must have been in 2001, we had a group in the school of public health, we got women from different groups or different countries, where we talked about the sexual reproductive system and other matters. And we found that people were really, really interested, and that's when we found out that there were real problems that the government and authorities didn't think about, and it was helpful that women, not only women but men as well but mostly women, that the women could actually get to the core of the matter. We had practical problems; they mentioned what the problem was, and it helped us a lot to be able to note down what the problems are, what people are curious about, like preventive medicine, how we can get information across, how we can get into preventive medicine, like helping young girls, 16 years old, 18 years old, going for tests, women in their 40s for a mammogram, and how they can go about doing things without having problems, whether they have access to this or not. For things like increasing the use of preventive medicine, it's crucial to let the people know that it's free and that they can go any time for a mammogram or for some tests. These are things that people did not know about. So

bringing the women together and discussing issues like the sexual reproductive health system, we found that we got a lot of information from different groups, from different African societies, from Arabic societies, and it was very easy to get information, because every country, every group had different problems, different things to say and different ways to look at the problems, and that helped us a lot to get information to see exactly what problems existed.

The communication problem was very, very crucial, so that they can go in alone to the doctor. The access problem was also very, very crucial, because most people didn't know where to go with their problems, when to go or whatever checks they need. And then there was the status problem, as I mentioned before, that most people didn't know that even though they didn't have a card, there are NGOs that they could go to. So we got across to the people that we are there to give them the information. Whatever access to information they need, they could get from KWA.

Chair: Thank you, Lydia. I would like to say two things. I think this presentation shows very well exactly the inequality of the implementation of rights we just talked about. How they, in other words, are provided, and how they play an important role. Sometimes even to fill the gaps, but here also, very importantly, the cultural mediator or the outreach to the one actually involved and the participatory part in it is so crucial. But also how the lack of legal rights, the status, can have an impact on your access to health, even though this human right is for everybody.

6.3.1.3 *Marieka Vandewiele (IPPF) - SRH as a basic human right*

Good morning, everyone. First of all I would like to thank the organizers of the conference for the opportunity to speak here. I will speak about the linkages between SRH and rights as basic human rights. I'm Marieka Vandewiele, and I'm representing the International Planned Parenthood Federation (IPPF). In this presentation I will also specifically focus on how IPPF is approaching these issues, what tools we have developed and how we try to advance the basic human rights.

IPPF is the strongest global voice safeguarding SRH rights. We are working in 180 countries worldwide, where we have a member association in each country. We are divided into six regions. We have the European Network which has its base in Brussels and covers the European Region, which is a very diverse region. It's not only the EU; it's really Western Europe, the Balkan region, Central and Eastern Europe, the Caucasus, Central Asia, Russia, Turkey. So it's a very diverse region.

We are trying to work to a world where every individual is healthy, sex and sexuality is recognized as a fundamental and precious part of pure life, choices regarding SRH are respected, and diversity of values are celebrated. This is an ideal world we are working towards. How do we want to achieve this? This is really the core of our work or our vision – that we want to advance basic human rights for all people to make free and informed choices regarding their SRH

in their sexual and reproductive lives. So for IPPF SRH rights are basic human rights, and we are applying a human rights approach to these issues.

We have developed a charter on sexual and reproductive rights, which I will go on further into detail in this presentation, and then we took the sexual rights declaration.

For IPPF the rights-based approach is really key. At the time we developed the charter in 1995 there was very little guidance on how to programme rights in the right way. So we developed a five-stage strategy towards rights-based programming.

The first stage in this strategy is really to try to ensure the institutional commitments, to ensure that everyone is on the same understanding on what sexual and reproductive rights are. The second stage is to build on this institutional commitment and try to develop the capacity on dealing with the rights issues and dealing with sexual and reproductive rights.

What turned out to be very key, in our experience, in this rights-based programming is, I think everyone will agree, community involvement. If you want to advance SRH as a basic human right it's not only about the top-down approach the first presenter was telling about, but it is really about the community, or enabling the people who are entitled to the rights to participate, having the information pass through them and making sure they are empowered to hold others, not only governments, accountable to the rights they are entitled to.

The fourth stage is making awareness to the right of health and then, of course, monitoring the impact. So services are really part of the continual action.

In 1995 we developed a charter on SRH which had two main purposes. First was for the organization internally, to build the institutional commitment to SRH, to make sure that everyone had the same understanding of what human rights language was and what the key programme issues are linked to these basic human rights.

The second was to have a tool which explains what the linkages are between basic human rights and SRH. This was not something that was invented, the idea, or the vision of IPPF, that SRH is a basic human right. We listed 12 basic human rights, all of which are entwined into international human rights instruments which are actually covering a broad range of SRH issues.

This charter was adopted in 1995 and has become the ethical framework of the federations work globally. 1995 was just around the time also when the International Conference on Population Development took place. This constituted really a paradigm shift in the language regarding SRH. Before, it was really that people should have access to family planning because of population growth, and we should control it. 1994 was really the time that another language entered the SRH community. IPPF, together with other women's rights organizations, contributed to this paradigm shift.

So in this tool, the charter on SRH, we have listed 12 basic human rights which are linked to

SRH. I'm not going to go through it in detail but just to give an example on how SRH and health is linked to basic human rights: this week I was at a conference, or a meeting, on the linkages between HIV and SRH, and several cases were brought up of things that are happening today which are really astonishing and outraging. For instance, I'm just bringing several cases together into one example: women who are pregnant, who are mandatorily tested for HIV, don't get any counselling and don't get any information about what the implications are if they turn out to be HIV-positive. There are no services available that can help them, that respect them and treat them in dignity, on how to deliver a child when you're HIV-positive to prevent transmission to the child, and when they deliver the child, at the same time, without their consent, they are being sterilized. So this is happening today.

And this is linked to issues like the right of liberty and security of the person, the right to be free from discrimination, the right to choose, whether or not to plan a family, whether and when to have children, the right to health care, and high-quality health care and protection, to benefits of scientific progress. So really there are a lot of linkages between SRH and rights and basic human rights. And if you are a refugee or an asylum seeker you are even more vulnerable to these issues.

A lot of new areas of concern have emerged, and a lot of focus even within IPPF was on reproductive health, and sexual health issues and sexual rights issues were too often – also within the international community because it's such a sensitive and controversial issue – denied or neglected. And there was a feeling within the federation that there is a need to identify sexual rights that are fragile, ignored or considered ambiguous, and there was an increased awareness also that there is a difference between sexual rights and reproductive rights. And there was a need for follow-up practice within the organization: what is sexuality, what are different sexual rights, and what are the basic human rights linked to those issues?

So in this year we came up with a very new document, which is the declaration of sexual rights. We had a panel with international experts on sexual rights from within the federation and from outside. And this sexual rights declaration is a tool to pray for service provision within the organizations but also a tool for advocacy, to hold states accountable for their responsibilities, in particular in the run-up to ICPD +15. Fifteen years after the International Conference on Population and Development this is going to be a tool for advocacy.

So it shows how sexuality in all its aspects is or should be linked to basic human rights. And it's informed by bindings and regulations of several UN bodies and UN special rapporteurs. For instance, Paul Hunt, who in 2004 was the UN special rapporteur on the right to health, was part of the panel, and he wrote a report in 2004 which, among other things, stated that the correct understanding of human rights principles leads to the recognition of sexual rights as human rights. Now because of these statements in his report it was contested by several governments who were saying: you have exceeded your mandate here. So this shows that sexual rights are still a very sensitive and controversial issue.

As with the charter, we used kind of the same framework for the declaration, and we listed 10

basic human rights and explained how they are related to sexuality. I'm not going to go in detail through it but the case that I gave as an example is also linked with sexuality and not only reproductive health.

These tools are available on our website if you would like to access them and use them in your advocacy towards governments or other institutions. It's a very practical tool; in fact, the charter is accompanied with guidelines on how to use it, giving links to different human rights instruments. It has proved to be a very popular tool within the federation, but I'm sure it can be applicable for other organizations as well. If you don't find it on the website, you can always contact me.

Thank you. I forgot to mention something. I have a colleague here from Poland, from our member organization that is going to start a project in 2009 trying to reach out to refugees and asylum seekers in Poland. So this is also a very new issue for us, and we are trying to learn here from the experiences of others and trying to apply it. So if you want more information from him on this project, he's here to provide it.

Chair: Thank you, Marieka. Once again we see here an interesting approach that says, let's split it, let's focus on sexual rights and reproductive rights. But I think in making that explicit a lot of states are saying that we are going a step too far, that there may be a safety still in putting them together that advances one, sort of, on the back of the other. And in this respect also I think it is important also to look at it in relation to the integration efforts of new communities, how that can impact and how this has also an influence on education. Health education schools may be not taking the sexual rights issues into their curriculum in the way it should have been in a health education school. So it is interesting that there is a lot of debate in that area as well.

6.3.1.4 *Deo Ladislas Ndakengerwa (Irish Refugee Council, Ireland) - Case study: Campaign and lobbying on refugee health issues in Ireland*

I don't think I have much to say today, because Emily has almost said everything. I don't know if she cheated on what I was preparing, but anyway, I think I will try just to summarize my own presentation in a few words. Emily has already talked about rights of asylum seekers and refugees to health care; she has also stated the case of asylum seekers and refugees, the policies, and the views and beliefs of the UNHCR. Lydia talked already about access to information; she has mentioned already the use of cultural mediators for delivering information to asylum seekers and refugees. And Marieka has already talked about access to sexual and reproductive health as one of the fundamental rights of asylum seekers and refugees and also which apply to everyone. She has mentioned already the right to choices, when it comes to sexual and reproductive health. So I would like to tell you two words, which I like and use most.

One is participation, because when we use participation we can give out different ideas, different views. The second one is consultation, because when you consult you don't gamble. So it's kind of whatever decision you make, it's the right one. I like to use gamble as a starting word, because I think my entire life has been a gamble. I'm not a good gambler, because most of the

time I lose. But what I've learned is that when you're a good gambler, you don't count your money when you're sitting at the table, because you're inviting other people to put more money on the table so they can lose. So you keep your money in your pocket and you wait until the game is over to count it. There was one time I was stuck working with cross-border doctors in Africa, and I wanted to tell you this one story. In one of the hospitals, there was such a mystery. Every Sunday at 11.45 there was a death on one particular, specific bed. And so it was kind of a mystery: no matter what the doctors had done to make sure the person on that bed was safe, he or she would die. So they wanted to bring everyone to come and participate, and see what's happening. So they called the witch doctors, consultants, normal doctors, nuns, priests, magicians. Some of them came with big crosses, bibles and everything to see what's happening. So on that specific Sunday, 11.44, everyone was waiting: what's going to happen? They were there with their big crosses and reading the bible. Do you know what happened? When 11.45 struck, they saw one gentleman, the Sunday sweeper and cleaner, he just came in and he plugged out the life support machine and just plugged in the vacuum cleaner. This was the mystery! And so something that was very hard to discover, it just needed a close look.

Well, now we'll just go very quickly, I'm going to talk about the Irish Refugee Council (IRC). We work for asylum seekers and refugees. In Ireland I can talk about statistics, we have about 420,000 immigrants, so about 10.4 per cent of the population, and it is expected it will increase to about 18 per cent in 2030. So, we have a sort of vision with which we want to develop a kind of society where everyone can be welcomed and can have basic rights and the right to help. So we are pursuing this mission to make sure that all people, not only for Ireland, understand that immigration policy needs a change in attitude in how we look at immigrants. And then I ask myself: is sexual and reproductive health a right or a privilege? But I think we already got the answer. But I think that we have to start with a new philosophy, a new tactic, which means making sure that we have informed policies, that we have evidence, and we have to include the people from the grassroots to make sure whatever decision we take is not a gamble, but is informed and that we know that no one can tell you that the shoe is tight, more than the person wearing the shoe, who is the one that can talk. So what it needs is to bring the people to the table.

I'm now going to talk about the national intercultural health strategy. I was not paid to talk about this booklet, but I was very actively involved in the planning, design, and even just finishing up it is a very good and nice strategy which just now needs to be implemented, monitored and reviewed. So this is only the beginning because the strategy was launched only a few months ago in March. And so far I was very happy before coming here because I saw that there was a review of the implementation of this strategy, so only five months later. And it's something I am going to talk about: how did we achieve this? How did we get here? Who was involved? Groups were invited, including asylum seekers and refugees, grassroots organizations and the individuals themselves. They were invited to different tables, and they were enabled to have transport, to have accommodation and to have time, and there was someone who was paid to develop a paper, a kind of concept, for each group. Secondly, everyone was invited to the table, because sometimes some people were just there and not as representatives of some

group. But I was very happy because everyone was given an opportunity, and information which was delivered was coming not from individuals, but from the community itself. This was just a new kind of philosophy, which could be a model and easy for other countries to adapt. Normally asylum seekers and refugees living in Ireland get a screening. That screening means checking for HIV, hepatitis B or C and also other diseases. There's nothing unnoticed, and HIV is an important rich part of SRH. But I think Marieka already mentioned, there's no counselor, there's nobody that can give information or to counsel anyone who is thought to be HIV-positive. In terms of just helping the individual to keep living a healthy life, but also to avoid somebody suffering depression or something else. Also another thing is, we do not only get older people but also separated children, and they are a particular group because they are not only separate from their culture but also from their family members such as uncle and aunts, who normally in traditional settings can give some information about SRH. But most children now don't have anyone, and there is no kind of specific programme to make sure they have information so they can make informed choices.

Yes, in Ireland, we always talk about equity, about accountability; we just make sure there are no inequalities so that everyone is included. This is why we have a medical card. But guess what, the medical card, which is different for asylum seekers and refugees and some of the other immigrants with no income, could only cover the individual who is going to a hospital for an emergency or accident – that's fine. You can go to a GP if you have a cough or a physical illness, or you can go to the pharmacy to get some drugs. But it doesn't cover contraception; it doesn't cover anything that goes with SRH. I'm just very happy to see that doctor Patricia Kennedy was very much involved in the maternity needs of asylum seekers and refugees in Ireland. And that was again a very good documentary and which needs again to be implemented, because asylum seekers and refugees very much need another approach to address their needs in terms of information and culture. It happens to be in most of the cases that some hospitals will not have interpreters, and, as Lydia was talking about, the law forbids a patient from bringing someone else into the consultation room.

In some cases they can bring interpreters, but they are not available everywhere. So this means that if you don't bring your own interpreter, you don't get service unless you speak the language. But for most of the immigrants it is difficult to learn a new language; it's only the children with access to education which can now help. So imagine just a child going as an interpreter for his or her mother about sexual health, knowing their mother's secrets. Imagine someone bringing someone because they are friends, someone that kind of knows about it or a professional, who just comes and says: "You know what? Yeah, I was interpreting for Teresa; you know what they were saying?" And these kinds of issues just keep individuals away from using the service, because they are not sure about what is done with the information, if this personal information is secret or published or disclosed to other people.

Another thing I would like to talk about is the approach that we adopted. So we need to see the reality; we need to get started by adjusting the policies, or perhaps some of them. We have the national health strategy, which talks about quality and fairness for individuals. It means peo-

ple need to be involved in the planning; it means that inequality should be reduced to make sure that everyone gets equal access to services. But how do you ensure fairness if you don't look at the specific needs of a community? We had the primary care strategy in 2001, which again talks about equity and accessibility, and again how do you ensure that people have access to SRH? If they do not have information in their own language, how do they ensure they have choices if they don't have information about the system and they don't know about the services in the country? And how do you think they are committed if you don't bring everyone to the table? This was a question which we had been asking for this policy. We also have the National Health Promotion Strategy, which means every hospital and every service needs to be sensitive to the new needs and also to the culture. How do you become sensitive, if you do not have appropriate cultural training to start? How do you develop sensitive services, if the training does not take note of cultural differences? It only happens for one hour, when someone has already achieved their degree. Why can't we incorporate or include this in university training curricula?

We also have the National Health Information Strategy, and again here it means everyone should have optimum information to make sure they know how to access health services. And when I'm talking here about health, it always goes to physical; some goes to mental, so we have a very long way to go to include SRH. And the last one which I like very much is the Action Plan for People Management, which aims just to report and train people in the communities, so they can be part of the service delivery, but also recursion of both individuals, and this requires not only rhetoric, but also implementing the actions to make sure this happens. And this also requires the government to make sure hospitals can have employers.

The last one is the National Women's Strategy 2006–2017. I want to talk about asylum seekers and refugee women. I think this is the one that somehow matters most for women from different communities in Ireland. They may have some kind of less access to services, but they are also likely to be reluctant to use SRH services. Why is the group of asylum seekers and refugees much more vulnerable? Mostly because of their bad experiences before coming to a country and the negative aspect of migration. And also they have a very big and unusual role, as a cultural mediator responsible for the continuation of their cultural tradition, and also their general role. Mostly they are isolated and do not have the support of their extended family. So this is why you will see that prostitution and domestic violence are not some kind of taboo issues, and women suffering such violations are not likely to report. And again here they are in need of empowerment; they are in need of information so that they know about their rights and they can fight for them. And I'm very happy because yesterday, before coming, I saw a kind of proposition, including someone from AkiDwa (the African Women's Organization), who will be working with the national family planning office. Also there is also another issue of unwanted pregnancy, sometimes which can be a result of sexual violence and rape. But unfortunately because of the Irish legislative ban on the termination of pregnancy, some of them they can't just apply for this service. And because they are stuck in the country, they can't travel abroad just to have an abortion. And this again is influencing their health. And the last one is also information about the topic of sexual exploitation in Ireland, which is becoming an emerging issue.

Just before I finish, among other issues I have to mention here, is the issue of racism and discrimination. Some individuals from several communities are not in the position to access health services because of experiences of discrimination and racism. And of course negative experiences create a bad feeling, like being outside the society, and they just feel frustrated and can't access the services. So what do we do from here? Well, I mentioned we need a new philosophy, a new tactic, to make sure that every negative policy is addressed, that discrimination is banned from it. But we also have to make sure that positive policies are implemented, and we need to learn them all to make sure that if there is a need for review, that these policies are reviewed with outcomes. To finish up, I just have another story of an old man. This old man goes to his GP, a female doctor, for a routine check-up. And the doctor asks him: "How are you feeling?" He said: "I'm feeling very well. But, Doctor, can't you check?" So the doctor checks his blood pressure, it's very good, and she does some clinical tests and everything was fine. Then the doctor said: "I think for your age you are doing very well. But what about your mental health?" He said: "Doctor, don't even ask me about this. Because the man and God are tight. Each time when I go to the toilet at night, God just switches on the lights. And when I finish, God himself will just switch off lights. So we are in a very good relationship." So the doctor was impressed but didn't ask him much. She invited his wife and asked her: "Is it true that every night when he goes to the toilet, God just switches on and switches off the lights for him?" And then his wife answered: "This stupid husband of mine has again been peeing in the refrigerator!"

6.3.1.5 *Georg Bröring (BAP) - European networking on health and its impact*

Thank you very much, and thank you very much also for inviting me. Not very easy to speak after such a nice speech with so many funny examples, but I'll try to do my best. So my presentation will be of a slightly different kind; I will not talk too much about SRH but more in general about European networking and the experiences that we have in our European network. So I will give some short information about the background which those experiences are made on, and then I will focus more on the opportunities and the limitations of European networking. I would also like to refer to some project management tools and some nice abbreviations I would like to introduce.

I've been involved for about 15 years in the European Network for AIDS and Mobility. That is also what the presentation is based on. The European Network on HIV and Migration works with international points all over Europe, and it's very nice to see some friends colleagues, partners from that network here today also.

We focus on exchange, the monitoring of migration and HIV in Europe. And also the collection and dissemination of information – for instance, the country reports about EU Member States, and also we have developed joint interventions; advocacy was also an important part of this network. For a long time it has been in the Netherlands at the International Institution of Health Promotion. In 2007 it closed down in the Netherlands. I also left the project in 2007. Now it is restarting from a German organization, with a medical centre in Hanover. So there will be a continuation.

On the opportunities: I think that also what we see here in this meeting, that the diversity in Europe is also a very big richness, with respect to approaches and methodologies, how to respect our knowledge and context. In particular when we talk about migration populations, but also asylum seekers and refugees, we see that every country has different experiences and that some countries have a much longer history on the topic, much more history and experience on developing policies and developing interventions, information programmes etc.

So I think the learning experience is also a very important opportunity for the European network. For the development of interventions the same thing is true. Many countries have already developed activities for specific populations. For instance, small communities like Somali people may be bigger in some countries and smaller in others. If you put those people together there is a lot of winning to achieve if they were together.

And finally also, joint lobbying is also very important, I think. This country report we have developed can be a very strong lobbying tool to show your own people in your own country: look what they are doing in other countries, but also to show it on a European level to say: look, this is what is going on, these are the main issues we face, and these are the responses that are possible.

Once again I can go only very briefly through this because of the time, and I hope we have the opportunity in the seminar later today and tomorrow to go into more detail about it.

About the limitations and obstacles: the priority of SRH is still quite low. I just finished a review for the European Centre for Disease Control about migration and HIV in Europe, and the majority of the countries reported that at the national level the priorities are rather low, especially in the new EU Member States. They reported that there is not much funding available and that the priority on sexual health and migration is quite low. Also at the European level there is a big diversity of partners. We can see that there are quite big countries but also quite small countries. Look at Malta or Cyprus, countries where partners are working sometimes with very limited conditions and resources. In your work you have to take these diversities into account if you develop meetings and interventions.

Continuity of partners was also sometimes a problem in the framework of AIDS and Mobility or other networks. Especially for smaller NGOs, they have sometimes limited funding, and sometimes you start up or develop capacities which cannot be continued. And, finally, short-term funding can also be an obstacle. You can get money for one year, or two years, and not develop a sustainable project, then short-term funding is a very big obstacle for cooperation.

But out of these limitations and obstacles I would like to come to some positive aspects that have come about from European networking. I think that the most important ones are at the community level, that European networks have the opportunity to bring people from community-based organizations together to work on their capacities, their experience and their knowledge.

So I think there is a big impact on this level but also on the service-provider level. That people can exchange their experiences, can exchange their approaches, in this case towards asylum seekers and refugees and sexual health.

The impact at the policy level is also something I think we should discuss here. Where are the European points where you can make your voice heard, where you can be involved, share your experiences? That is key for HIV/AIDS on the European level but also the civil society forum at the European Commission. I think these are very important tools where you can have an impact on policy at the European level.

They are also key to diffuse awareness and knowledge but also the practical tools and interventions. Especially about awareness, our experience was that compiling country reports and going into research at the national level created a lot of awareness. For instance, when the new EU Member States joined AIDS and Mobility, in the beginning they said: “Well, HIV and mobility is not a very big issue”, but then they were asked to compile country reports, to dig into the question, and then they found that all the countries had very important issues that were not addressed properly.

So I think that is an important impact: if you address things at the European level, if you meet with other European colleagues and you come to new ideas and also go more into research. One important experience also is about linking at the European level. Some lessons we learned were: you can't do it all, so focus on those aspects you can do best and let others do the things they can do best. So I think every organization, every network has to look into its own capacities and see: what is our main issue, our main capacity, our own focus. For instance, AIDS and Mobility was very good in having access to information on the community level. These country reports were very much based on experiences of communities, but also for the lobbying party we would need other organizations who were more at work in that area. There is a wide AIDS network in Europe, for instance. Linking up with those organizations can be more efficient than starting up all the lobbying process yourself. These linkages can happen at the national level, but also at the international. So I think these must be very well linked. Your network should not be an island, not at the European level, but also not at the national level and even not in your own institute. Sometimes you are quite isolated and then you also miss opportunities to use resources in your own organization, resources at the national level, and resources at the European level.

Now this is a small formula I like a lot. The SMART formula, probably you know it from project management. Be specific, don't try to change the whole world, but say what exactly you want to do. Make activities measurable. Be ambitious – you want to make a difference with what you're doing, but at the same time don't be over-ambitious, but stay realistic. Also tell people your time-framework, tell people how much time you need, what you will achieve at the end of the road and where the road will be ending. So that is the SMART formula which we used for quite a long time.

And then I thought SMARTIES is probably sweeter and nicer so I added the I, the E and the S. The I is for information and communication. I think it is very important for European networks, for European working to have a good information and communication strategy. On the one hand, you want to inform people, for instance policymakers, health professionals etc., but also you want other people who address you to be informed and up to date. To have regular updates you must have very good information channels etc. to stay on the agenda so you don't have too long silences between different events. It's very important in communication and information, in my experience, to have transparency. Don't only talk about success but also about failures and the lessons you learn from those failures. When I had my own project management courses there was always the story about front office and back office presentation, and I personally always thought that the back office – saying you don't always have to tell everything but can keep things secret – is overestimated. I think people know that everyone has successes, failures, So make sure you learn from failures.

Also not only one-way communication, but also try to stimulate mutual communication and also get a little bit worried when you send out messages again and again and you don't get anything back. Then probably something is wrong about the strategy or about the information itself. So check if your communications are doing their work.

The E for evidence based is a very tricky one. When I made the report for the European Centre for Disease Control they wanted to have an overview about migration and HIV, but it needed to be evidence based. It's a big word that is used a lot now. Of course it makes sense, but then again, which evidence are we talking about, the evidence of the epidemiologists, the social scientists, the service providers or the affected communities? Also when you talk about migration, in this case refugees and asylum seekers, you are also talking about often small populations, so it's not very easy to say the percentages of smaller communities, to put them into hard evidence.

So, personally, I think it's a combination of all the abovementioned aspects. If it's only anecdote it will not work. You need a kind of epidemiological, scientific background to develop activities, but once again the service providers are very important informers, and, of course, the communities themselves are very important. One without the other, in my experience, will not work.

Then sustainability is also a very important point, I think. Sometimes also an obstacle in European networking, to have a longer period to work, to have an impact not on the shorter, but on the medium and the long term. So I think sustainability should be involved in all the stages of project management: it should be in the planning, the implementation, the closing and the follow-up. Dissemination of the results is also important, that you know beforehand who are you working for, who should be addressed with the experiences that you make, the publications with the scientific data you are trying to collect.

Personally, from my experience with AIDS and Mobility, sustainability was a very tricky thing. Sometimes you develop an intervention, you disseminate it to your network partners and then

the responsibility goes to the network partners, and very often you do not get enough feedback of what is actually happening at the national level, at the local level. Do the communities really get any advantage from what you did in a one- or two-year project plan?

One of my first activities when I started with AIDS and Mobility was a small flyer on sexual approaches from Eastern Europe, a nice flyer, we disseminated it, but you don't see anything afterwards, but two or three years later, you visit a small organization, and they say "We still have your flyer, and it's the only tool we have in that language to use." Finally we hear about it! Sometimes you develop these, but you don't hear much back, so you should have strategies to check the sustainability.

To close I have also two other nice abbreviations: two times P and two times F. I think in project management a lot depends on the planning and the priorities. Very often you hear there is no money, there is no time. I think a lot of the time it is a question of priorities or the planning is probably not there, or there is an imbalance between your ambition and the resources. So I think planning and priorities are very important aspects of project management, not only on the European level but also in more general terms. But then again these are very rational aspects of project management.

Therefore, the two F's in this list: flexibility and fun. I think that on the European level we work with a lot of different partners who sometimes work under very difficult circumstances, with different communication opportunities, with different secretarial support, whatever. I think some flexibility should be needed, to have not only one straight line to follow up on the project or the differences between European regions. Not everybody is the same, some flexibility is needed, and fun is also needed because many people put their own time into European working. The travelling is sometimes also very exhausting, so you also should have a nice time.

And I know the Belgians are very good at that. Because I went to an earlier meeting, and they took very good care of us. I think the fun is guaranteed here. This is what I would like to present from the experiences of AIDS and Mobility. Once again I hope we have the opportunity later in the seminar to go into more detail and share my experiences with you and the other way round. I just also would like to say something in my own name: I started a small consultancy office, and it says Bröring Advising in Project Management. Thank you.

Chair: Thank you. I think this was indeed a very, very welcome presentation. I think we all can really learn from going from SMART to SMARTIES. Especially, I think, we all know that in networking there is so much information out there, there is so much to keep updated on, to have a good communication and information strategy cannot be highlighted enough.

6.3.1.6 *Eve Geddie (PICUM, Belgium) - Case study: European networking for health promotion of undocumented migrants (1:41)*

The purpose of my presentation is to introduce the specific case of undocumented migrant women in Europe and how their status forms a significant barrier preventing their access to

sexual and reproductive health rights and highlight the findings of PICUM's two-year European project 'access to health care for undocumented migrants in Europe' and present the activities of PICUM's network in promoting the health of undocumented women.

PICUM was formed as an initiative of grassroots NGOs in 2001 to represent the humanitarian concerns of undocumented migrants during the time when migration policy in Europe was being done at EU level (following the 'Europeanization' of migration policy). It aims to promote respect for the human rights of undocumented migrants within Europe, with particular focus on basic social rights, like health care, housing, education, and fair working conditions. It represents over 180 members in 25 countries across Europe and beyond. Our activities include: research, advocacy, awareness raising and capacity-building. We give visibility to the reality facing undocumented migrants and bring our concerns to policy agendas on EU and national levels. So many people think that undocumented migrants have no rights since they are living without permission to legally reside in a country which is not their own. But this is a myth, and, therefore, in March 2007, PICUM published 'Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework'.

Undocumented migrants are those without a residence permit, who are unsuccessful in the asylum process, overstayed their visa or entered irregularly. They are denied a legal income, and their residence status is an obstacle preventing their access to basic social services. Despite their social exclusion, undocumented migrants are largely invisible in the eyes of the policy-makers, and this places an enormous strain on local actors trying to meet their basic needs. The current incriminatory discourse is creating clashes with the professional ethics of those working to save lives and relieve human suffering. Perception of undocumented migrants as an 'illegal' population presents them as outside the law, thus facilitating tolerance of violations against them and a lack of protection for their fundamental rights, which are, of course, protected by a series of international legal mechanisms.

The health needs of undocumented migrant women are similar to other immigrants, but they face far greater health risks due to their precarious legal status. While they have priority needs in the area of reproductive health and rights, there are significant legal and practical barriers preventing them from accessing information and services.

Since the mid-1980s, there has been a significant growth in the number of women migrating abroad, and the profile of these female migrants has also changed. Women now make up almost half of the world's migrants, and in some regions they are responsible for a complete turnaround in traditional gender ratios; this is known as the 'feminization of migration'. In the Philippines, for example, women migrate at a significantly higher rate than men.

Migration policy has, however, failed to adapt accordingly and remains staunchly male-biased, providing women with notably few opportunities for legal migration. Migrant women are more likely to take up employment in traditional gender roles, and policymakers consistently fail to acknowledge contributions made in female-dominated sectors to the overall economy.

As noted by the International Labour Organization, “ironically it is precisely because domestic workers are employed within the ‘private sphere’ that there is resistance to recognizing and regulating the domestic work relationship.” For example, in Switzerland, no immigration avenues are provided for domestic work, yet many undocumented women are employed in middle- and upper-middle-class homes. In Germany, the four available avenues for legal labour migration are each dominated by men.

Despite the many positive experiences of female migration, including increased economic autonomy and social position, women have significantly fewer paths available for legal migration and more frequently resort to alternative routes, increasing their dependence on unscrupulous intermediaries and thus the likelihood of becoming trapped in exploitative and coercive conditions.

PICUM has charted growing reports of violence, abuse and rape of undocumented women and girls at global borders by immigration guards, traffickers and other male migrants. The UN suggests that as many as 50 per cent of female migrants making the trip from West Africa to Europe via Morocco are either pregnant or are travelling with small children. There are increasing reports from both European and US borders about the coercion of women by other migrants or smugglers to have sex with the border guards to ensure the safe passage of the entire group. Médecins Sans Frontières has witnessed extensive accounts of sexual violence against sub-Saharan women and minors at Europe’s southern periphery by border guards, traffickers and other migrants. The organization regularly receives cases of half-completed abortions with moderate haemorrhaging and has taken numerous statements from women abused by supposed ‘protectors’ and who are subsequently abandoned, neglected or, in the worst case scenario, ‘disappear’.

European governments, while recognizing health and education as fundamental standards to improve the situation of vulnerable women abroad, implement policies which effectively strip these same women of their innate rights and entitlements should they become undocumented within EU borders. Undocumented migrant women suffer a triple bias on the basis of their gender, foreign origin and irregular status. They may be deported if their status becomes known, and this fear prevents them from upholding their rights. Undocumented migrant women are disproportionately exposed to systematic violence, abuse and discrimination, yet they lack the most fundamental services and protections. Those suffering abuse and health-related crises often have no idea of what their rights are, and they may face repercussions if they contact the police or seek assistance. Their precarious status makes them highly susceptible to violence, sexual abuse and even enslavement by those willing to take advantage of the inability and fear of these women to report ill-treatment. As a result, they are arguably the most marginalized and unprotected group in Europe today.

PICUM stresses that health care is a fundamental right, key to the realization of other rights. Guaranteeing health is a key element in breaking the cycles of abuse, fear, poverty and violence against undocumented women, and violation of the right to health serves to heighten

the vulnerability of undocumented women. PICUM's research project, Access to Health Care for Undocumented Migrants in Europe, found that across the EU, undocumented women are giving birth at home alone, or putting their lives at risk to obtain unsafe abortions as they lack entitlements or are too fearful to avail of treatment in hospitals and from doctors' clinics.

The project, co-funded by the European Commission DG Employment & Social Affairs, covered 11 EU Member States and involved 19 partner organizations (consisting of NGOs, local authorities and health care providers). The project staff conducted field trips (involving 250 people, 92 individual interviews and seven networking meetings).

The aims of the project were to improve access to health care for undocumented migrants, map the situation in 11 countries, improve the methodology for data collection, target undocumented migrants in the Social Inclusion Strategy and support and multiply good practices and partnerships at local level. Our project resulted in reporting tools, available in nine languages, to report undocumented migrants' social exclusion and health care needs. We also had an international conference in June last year and a published report, of course.

In our research findings about access to health care for undocumented migrants in the EU, we found that the competence to allow or not to allow undocumented migrants to access publicly subsidized health care is a national competence. Member States are not complying with international obligations. And the legislation and practice show that undocumented migrants' "right to the highest attainable standard of physical and mental health" is not being realized. While we found that no Member State's legislation specifically forbids access to health care to undocumented migrants, publicly subsidized health care (either partial or full) is not entirely guaranteed in Europe. In some countries, all health care (even emergency care) is provided only on a payment basis, and treatments are generally unaffordable for undocumented migrants. The most restrictive Member States shield themselves from criticism by asserting that emergency care is never denied to undocumented migrants. However, it is absolutely impossible to seriously speak about accessibility to health care as long as undocumented migrants continue to be asked to pay high and unaffordable sums in return even in situations where their life is at severe risk or when they seek to give birth, as is happening, for example, in Sweden or Austria. Access to health care is being used as an instrument of immigration control, and there is a growing tendency in Europe to restrict access to health care and reinforce the link between health care services and immigration control policies. Health care access has become increasingly restrictive for undocumented migrants in recent years. For example, in the UK, entitlements have been reduced, and France has introduced more conditions to access publicly subsidized health care.

Laws and procedures are generally complicated and need more publicity. In some countries there is not even specific legislation and only very indirect laws and regulations. Many relevant actors do not know well the legislation in force and have difficulties to accurately describe undocumented migrants' entitlements to health care. Health care legislation and immigration controls fail to take account of women's gender vulnerabilities and urgent health care needs; access is not only limited but is the lowest possible standard of available care.

Regarding undocumented migrants' access to health care, we found that they do not access care even when entitled or seek it at a very late and dangerous stage. Vulnerability caused by gender and administrative status is amplified by discriminative health care and immigration policies. Undocumented women are disproportionately prone to poverty and face increased difficulties to pay for treatment, and frequently have the added stress of caring and providing for their children.

Given the different systems existing in Europe concerning access to health care for undocumented migrants, the categorization has been very difficult. We have, however, managed to distinguish five different situations regarding legal entitlements:

Firstly, countries where all care is only provided on a payment basis. Two examples are Austria and Sweden. There are some exceptions but none relate to women's health. In Sweden, undocumented migrants tend to go to public hospitals only when facing an urgent health need and will be charged the full cost – as a result many pregnant undocumented women do not receive prenatal check-ups and only show up on the day of delivery. The cost of health care, even basic care, and medicine is disproportionately higher for undocumented migrants than for Swedish nationals, who may have their babies delivered free of charge while undocumented migrants face fees averaging EUR 2,197. The exorbitant prices constitute one of the most important barriers impeding undocumented women from seeking medical treatment in Sweden.

Other countries, such as Hungary and Germany, offer free health care in very limited cases. In Germany these very short entitlements are overridden by the duty to denounce imposed on public officials dealing with undocumented migrants' health care files. The Social Welfare Office is obliged by law to inform the Foreign Office about the presence of a patient in an irregular situation, anytime they show up or any time health care providers ask for reimbursement of medical costs. This situation causes undocumented migrants to refrain from exercising their already short entitlements.

A third category is composed of countries with somewhat wider coverage but whose legislation is rather restrictive, ambiguous and with a high degree of uncertainty. Good examples of countries in this situation are the UK and Portugal. The UK Health Department has categorized maternity care as “immediately necessary treatment”, but women remained liable for charges, and “the debt should be pursued in the normal way”. In some cases, pregnant women have been refused hospital treatment. Undocumented women diagnosed with HIV/AIDS are not eligible for subsidized care which can significantly reduce the chance of mother-to-baby transmission. British medical groups have noted the inconsistencies where a state's overseas development agency is “very actively campaigning for universal global access to antiretroviral treatment”, and a very vulnerable group is denied treatment in the UK. France, Belgium and the Netherlands have put in place a “parallel administrative and/or payment system” to specifically respond to undocumented migrants' health needs. However, undocumented migrants are still treated in the mainstream health system.

Finally, Italy and Spain are the countries providing the widest health coverage to undocumented migrants. Although there are certain conditions, gaps and failures, the spirit of the law, particularly in Spain, is to provide universal access to health care – therefore, free access to health care for all, including undocumented migrants. However, the insufficient access to reproductive health care in Spain by undocumented migrant women is remarkable. The Ministry of Health recently published that 40 to 50 per cent of abortions in Spain are undergone by migrant women. Elsewhere, reports claim that more than 50 per cent of those women are undocumented. Most women refer to their precarious economic situation as the reason behind their decisions, and half do not use any contraceptive method.

Regarding mental health care, we found that irregular migration is a very traumatic process with numerous mental health implications; many undocumented migrants experience multiple and chronic stress. It can be push factors which cause irregular migration, trauma during dangerous voyages or living in fear in Europe. Adversities, dangers and isolation are significantly heightened for undocumented women. They face a triple discrimination overexposing them to exploitative conditions and augmenting their susceptibility to systematic ill-treatment, sexual abuse and psychological trauma. They have a double fear of reporting abuse due to fear of deportation.

And most EU Member States do not grant access to mental health services for undocumented migrants, while the majority of medical professionals we interviewed stressed the urgency of such care. Undocumented migrant women are more commonly exposed to domestic and sexual violence yet rarely have access to essential medical care or support programmes focusing on psychological trauma.

Regarding STIs and HIV, we found that undocumented migrant women have increased vulnerability and exposure. Because of their precarious living conditions and de facto powerlessness or the reduced sexual and reproductive autonomy, they are also disproportionately represented in the sex industry, and it shows an urgent need for improved access to preventive and curative care. Their undocumented status increases susceptibility to a disproportionate power balance and the often lack of control over sexual rights and norms. Undocumented migrant women are over-represented in gender-defined jobs; precarious working conditions, low pay and exposure to violence hinder access to medical services and support agencies. The denial of their right to education amplifies their powerlessness and means that they lack information on sexual health and protective measures.

The WHO defines reproductive health as “physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life”. Undocumented women have a right to safe, effective, affordable and comprehensive methods of family planning, yet they experience more unintended pregnancies, more exposure to violence during pregnancy, have less access to preventive measures and are subject to delayed prenatal care.

Regarding maternal health, they are excluded from affordable and accessible care; many do not seek health care during pregnancy and jeopardize the life of mother and baby. The realization of undocumented migrant women’s sexual and reproductive health rights requires a non-

discriminatory health care system which is not bound with migration control procedures and respects patient confidentiality and privacy.

So our conclusion, based on principles of universality, non-discrimination and international human rights law, underlines the right of every person to receive health care, regardless of gender or administrative status. As PICUM's research shows, the laws and practices of EU Member States differ from these obligations, thus many undocumented women do not access health care services. Guaranteeing the normal systems of support, protections and redress on the same basis as the national population would significantly reduce the vulnerability and exploitability of undocumented women. Access to health care, adequate housing, fair working conditions and education are inextricably linked to empowering and emancipating undocumented women. PICUM is now beginning a three-year strategy to gender-sensitize its rights-based approach and represent undocumented women's concerns to successfully tackle the disproportionate discrimination against them and defend their human rights.

We would welcome the support, input and expertise of the ICRH and all of today's participants as we embark on this new strategy, and I urge you to please visit PICUM's website or subscribe to our newsletter to keep track of our work on undocumented migrant women.

6.3.2 PRESENTATION OF THE PROJECT GOALS AND RESULTS

Chair: Before we break for lunch we just have three presentations, which should be very interesting, on the EN-HERA! project, and we will see if there is still a bit of time for discussion, and then we will give information about the workshops. I'd like to give the floor to Ines Keygnaert from the ICRH, to talk about the project.

6.3.2.1 Presentation of the project - Ines Keygnaert (ICRH, Ghent University, Belgium)

Thank you, Emilie. I will try to be brief to explain how the project started, what the several objectives were and what we achieved so far.

A bit of background first. It was also already said this morning that, in 1994, at the ICPD in Cairo, a change in the paradigm on how we speak about SRH occurred. For the first time it was seen as a human right. In the action plan of the 1994 conference, it is already stated that specific attention should go to the protection and promotion of SRH of male and female refugees, prevention of violence included. Nearly all European Member States ratified this action plan. However, there is still no binding EU regulation for SRH for refugees and asylum seekers today. We also see that the implementations vary greatly from country to country and that most of the refugees and asylum seekers in the EU are of reproductive age. This means that they are vulnerable in terms of sexual and reproductive health.

In 2005 we conducted a first pilot project, to inquire on the actual status of implementation of the ICPD action plan and other international agreements in which sexual and reproductive health and a life without violence are recognized as human rights and gender as a determinant of health. At the end of this project, the International Workshop on Sexual and Reproductive Health and Rights (SRH&R) of Refugee Women in Europe was organized at Ghent University,

Belgium, from 17–19 January 2005 and funded by the European Commission (EC) European Refugee Fund. There, the decision to create a network was unanimously taken by six founding members.¹

Luckily, in 2006 the European Refugee Fund had a call for proposals to which we could submit a proposal which resulted in this project today. It is a European Refugee Fund project that started on 1 August 2007 and will take us to 31 January 2009. The general aim of the project is to improve the sexual and reproductive health of refugees and asylum seekers in the EU by setting up a network for the promotion of the sexual and reproductive health and rights of refugees and asylum seekers in Europe and beyond. It took us to the first meeting before the issue arose of including (un)documented migrants as beneficiaries. Due to several reasons – a lot of them related to gaps in national legislations – undocumented migrants cannot be omitted when you look at the real practices and services in the daily field. This reasoning, however, is not yet welcomed by European funding calls.

The first objective of this 18-month project was to set up a network among different stakeholders. This consisted of universities, service providers, policymakers and refugee and asylum communities taking joint initiatives and liaising with other networks. The second objective of this project was to gradually expand the coverage of the network from five to at least 13 EU Member States, of which three are ‘new’ EU Member States.

In order to realize these objectives, the founding members developed core principles. These core principles were not only presented to the expert panel that participated in the development of the Framework for Identification of Good Practices, but were also used in our invitation for partnership. We made an investigation of potential members, networked and sent those who expressed interest an invitation for partnership. The core principles are also the basis for our Vision Text, which we will discuss tomorrow at the Member Meeting. All members signed the Membership Declaration, in which they stated that they would adhere to these principles in the promotion of the sexual and reproductive health and rights of refugees and asylum seekers in Europe and beyond.

So the founding members are the International Centre for Reproductive Health from Ghent University and the Institute of Tropical Medicine in Antwerp, Belgium. In the Netherlands we have PHAROS, in Ireland we have University College Dublin, in Portugal we have the National Institute of Tropical Health, and the National School of Public Health in Greece. So have we reached the target of 13? We will tell you at the launch this evening.

In addition to the international networking, we have the in-country networking, in which we should try to have at least three local partners joining the network. If we reached this goal too, we will tell you at the launch.

¹ The European partners founding EN-HERA! are: the International Centre for Reproductive Health of Ghent University, Belgium (coordinator); the Prince Leopold Institute of Tropical Medicine, Belgium; the Instituto de Higiene e Medicina Tropical of the Universidade Nova de Lisboa, Portugal; the National School of Public Health, Greece; University College Dublin, Ireland; and Pharos, a knowledge centre specialized in the health of refugees and asylum seekers, the Netherlands.

The third objective was to develop a standardized good practice identification framework in policy development, service delivery and in participatory approach. It's a framework for identification of good practices but also for the formulation of recommendations – so how you can still improve, if you have a good practice, how you can become a better practice or even if you are halfway how you can still proceed. The finalization of this framework is the main reason why we invited you here today, and the workshops in the afternoon will be specifically directed to the finalization of it.

We decided at the second steering committee meeting to see participatory approach as a transversal element so not to make a framework of participatory approach itself. It should be within service delivery and policy development itself. Between January and March 2008, we identified 188 experts in this area and sent them a call for experts, asking them to contribute to this project as an expert in a Delphi process (a technique to come to a consensus on ways to proceed). A first loop of questionnaires was sent to the experts and analysed between April and August, and a second loop began in September, which we are analysing now. This seminar is in fact the third loop, so you can still provide all your input into this framework, which we would like to finalize by the end of January so that you could use it from February onwards.

A fourth objective was to set a common research agenda and to take joint research initiatives by January 2009 at the latest. There was a call for proposals from the EC Daphne 3 programme on sexual and gender-based violence (SGBV) to which we submitted a proposal with several partners from Belgium, Portugal, Ireland, Spain, Hungary, Malta, Greece and the Netherlands. Most of them are here today. And we learned a few days ago that this project has been accepted, so from January onwards we will try to develop specific tools for prevention of SGBV within the European asylum reception sector because we know that the directives are not sufficient and that prevention is urgently needed there. We also proposed a theme for public health consultation, but we don't know yet if this theme will be taken into account or not to have some more core funding for networks like EN-HERA! So tomorrow morning for the members we will discuss the research agenda. We are going to present this and discuss which future projects or which future research is really needed.

The fifth objective was to organize an international seminar. I think we are here today, so this objective is being reached at this very moment. Its main purpose is to raise awareness about specific objectives of SRH for refugees, asylum seekers and (un)documented migrants. As I said, the main purpose is a working seminar to finalize the framework. Also to improve networking between different partners and between different networks that are already present in Europe and beyond and which might have a very different background.

The last objective is to publish and disseminate project results. First of all we had to create our own logo and our own name, and when we do the official launch at five o'clock my colleague Koen will explain how we came to the name EN-HERA! and how we came to the logo as well as its significance. We had four tenders, and the chosen design was by an Iranian refugee living here in Belgium. We should try to assure that our publications don't stay just paper but that they are actively used in advocacy and lobbying, that they contribute to the identification and

development of future good practices in SRH promotion and that they can have an impact on SRH policy development and service delivery in the future.

So what could be the objective once this project is finished? We will certainly try to make EN-HERA! a sustainable, reliable, empowering and human international player in the field of promotion of SRH&R of refugees, asylum seekers and (un)documented migrants.

And we'll try to be 'SMARTIES', while endorsing our EN-HERA! principles in daily activities that we might undertake. These principles are: a rights-based approach, participatory approach, empowerment, gender-balanced approach, cross-sectoral approach, multi-disciplinary approach. You can find them in the back of your folder in the checklist that we will discuss in the workshops this afternoon

Chair: Thank you, Ines. You got some suspense there with things we'll reveal later. That's nice.

6.3.2.2 *Presentation of the research results - Sonia Dias (IHMT, Universidade Nova de Lisboa, Portugal) and Elli Ioannidi (National School of Public Health, Greece)*

We will try to make it a little bit interesting because we have a lot of results. The introduction we can skip because it was told by Ines.

We identified 188 experts, and 64 of them filled in the identification form and answered to be willing to participate. When we sent the first questionnaire, we got 34 responses. You can see that most of them are active in services, and what is interesting is also that the gender was mostly female, 22. In the second loop, we had 19 responses, and this is the profile here from those correspondents.

Now, we have the results by principle. What is interesting here is that the first four statements that you see there, they reached 100% consensus on the first loop. Information on SRH topics and risks again reached a very high percentage in the first loop, but now it only got a consensus on the second loop. The special measures for accessibility, like translating, confidentially, etc. Mainly training for SRH staff on intercultural communication and gender aspects was most asked for. We can see that in the second loop they decided that this information should be provided by institutions, media, and such and also that this information should be in appropriate language, freely accessible and avoiding stereotypes and stigmatizations.

Now the participation of stakeholders, which can be target groups, NGOs, service providers. In the first loop we had a 100% consensus that participation in policymaking is crucial. Now, they prefer organized bodies over individuals, and they want NGOs to participate in all phases, planning, implementation and evaluation. In service providers, they preferred an implementation, they preferred a collaborative participation, and their consensus was reached on the second loop.

Empowerment was the principle where we got the highest consensus for the first loop, 100%, to focus on a broad range of topics. And the two topics that were reached with 100% were family planning and contraception. For abortion, breast cancer and cervical cancer, it was reached in the second loop.

To provide special measures to improve accessibility reached 100% in the first loop again. And what was the motivation? It is important for human rights and active citizenship. How? By competence and free and accessible knowledge transfer.

The next one is the gender balance approach. Here again important for SRH services are to adopt a gender-balanced approach. The first one reached 100% consensus in the first loop and again family planning, contraception, sexual risk behaviour, acting to abortion reached a 100% consensus in the first loop, and abortion and the rest in the second group. About male involvement in a gender-balanced approach, 100% said 'yes' and active participation in medical interventions and knowledge transfer. And again 100% consensus for family planning to involve men and helping sexual relationships. The motivation here: inclusiveness, equality and efficiency.

On 'SHR should address gender-related violations of SHR rights', we had all types of sexual and gender-based violence (UNHCR) including partner choice. Rape and forced pregnancy reached 100% consensus in the first loop, and the second like partner choice, non-consensual sexual relations and non-consensual marriage was only reached with consensus in the second loop. It is interesting again that SRH should adopt the sensitive approach to diversity: 100% in the first loop. It should be evidence based. Now in service provision, the characteristics that should be taken into account, they want age, cultural background, ethnicity and beliefs, disabilities. These should be taken into account. And again we reached the highest consensus on the first loop.

About 'the quality in service delivery should be in line with international SRH policies': 100% in the first loop. And the data that we collected on their service users, referring to refugee background, religious, spiritual, philosophical beliefs, again we had high consensus. In the second loop it was only sexual orientation and disabilities. 'SRH services to guarantee confidentiality and should not be anonymous': 100% consensus in the first loop, to be monitored regularly and continuity. And, of course, it is interesting that there was no consensus on mode of provision, such as free, according to income or not according to income. It did not reach consensus on the first loop and only in the second did most of them decide that it should be free of charge.

The multi-disciplinary approach, all of these, such as gynaecologists, urologists and psychologists, should be involved, and in the second loop we had the legal advisers, counsellors, mediators. Motivation: a holistic and culturally competent approach might enhance efficiency and quality of service and might reduce boundaries and improve involvement. All of these were reached with consensus.

For the cross-cultural approach, we had a consensus that it should be on international, national, regional and local levels. Also consensus for gender-based SRH policy in political, legal, education, general migrants' health, SRH, mental health, community and voluntary (NGO) sector, reception centres and general practitioners, and other medical services should be involved in the planning process of SRH service delivery.

What is interesting here to see is that there was an agreement on principles in general but not on how and why for the implementation and principles. On empowerment we reached consensus from the beginning, 5/5. The second loop was the open question that we tried to test again, and there we also had a high consensus (3/4). Others:

- Gender-balanced approach (9/9 CQ) (11/17)
- Rights-based (13/15 CQ) (4/6)
- Multi-disciplinary (3/5 CQ) (9/10)
- Cross-sectoral approach (3/5 CQ) (3/5)
- Quality (9/13 CQ) (15/20)
- Participation (2/6) (3/8)

It is clear that respondents have a clearer idea on SRH services than on SRH policy development. Respondents are not very keen on experimenting with active participation.

Chair: After these results here we are to talk about the draft framework, prepared by Patricia Kennedy and Dorota Sienkiewicz. I believe it's Dorota that will be presenting on the framework. If we fly through we might actually get our lunch.

6.3.2.3 *Presentation of the draft framework - Dorota Sienkiewicz (Pharos, the Netherlands)*

I'm going to present a checklist which is a kind of summary of the results of the EN-HERA! network project. This checklist is drawn up of indications and developments of good practices in policy development and service delivery in the field of SRH and rights of refugees, asylum seekers and (un)documented migrants.

That's the overview of the presentation. I will tell you something of the background. What was the structure, the end etc. So, as Ines already said, this EN-HERA! network was set up for the promotion of SRH and rights for refugees, asylum seekers and (un)documented migrants. This is what Ines presented already.

One of the objectives of the project was to create a framework for identification and development of good practices on the level of policymaking and service delivery for these target groups. As Elli and Sonia already said, there was a variety of SRH and rights issues. Experts have provided a variety of issues related to SRH and rights and refugees and asylum seekers.

The aim of the checklist, which is a summary, a tool for people who want to work or are already working in the field of SRH. One of the aims is to assist these organizations or programmes in identification and development of good practices.

The second aim is to assess maybe possible gaps in the existing service programmes that still need to be strengthened to meet the SRH and rights of refugees, asylum seekers and (un)documented migrants.

This is the structure of the checklist. Just like our framework, the checklist is structured around two levels. The first level – the principles – has already been presented by my colleagues, the different approaches. But since there was nothing said about indicators of quality of SRH, I just want to bring your attention to these six quality indicators which are evidence based and in line with international guidelines. Of course, my colleagues before me already spoke about it, so I was just bringing it to your attention again. Further on confidentiality and privacy, availability, acceptability, affordability, accessibility, monitoring and evaluation, information and choice and continuity of care.

To the right you see a random page of the checklist. There were several statements per principle and per indicator, up to 70 items. They were divided into two levels: statements for organizations working at the policymaking level and statements for organizations working at the SRH service delivery level.

Some organizations or programmes are mainly for this, for example on the policy level. The items that are there are then only used for service delivery level.

These statements were taken from the two rounds of the questionnaire that was already presented by Elli, and some statements were assisted with concrete examples to avoid making it too abstract for people using this tool.

There is, of course, the scoring system, where we used a simple five-point Likert scale. There were five points that an organizational programme could get, from 1 (not at all applicable) to 5 (fully applicable).

For this one I have to refer to the draft of the checklist of the EN-HERA! framework of good practices. On the last page there are numbers and a scoring table in which the scores have to be placed. And finally a percentage and level that has been reached per principle and per indicator. These are the levels: from A, which is the best one, to E, the not so good one.

But we try not to tell people just that their programme is good or their programme is bad, but we also try to encourage people to do more or to direct them away from the level E, which is basically the worst one.

Chair: OK, Dorota. Thank you very much. That actually concludes the morning and the presentations of the speakers as well. We haven't really the time, but is anybody dying to contribute at this stage? Then I think we'll just wrap up this morning. Thanks to the speakers.

6.3.2.4 *Introduction to the workshops*

Koen: Thank you very much. About these workshops, the purpose is to check the checklist and to suggest improvements. The workshops: policy workshop, service delivery workshop and quality workshop. Now there is also café contact, that's from three to four. If you have material or information which you would like to present during the café contact, you can leave them with Nadia.

6.3.3 **CONCLUSION**

6.3.3.1 *Conclusion of framework workshops' recommendations - Christiana Nöstlinger, Institute of Tropical Medicine, Belgium*

I think we should get started because it is late in the afternoon. We are waiting for Prof. Temmerman to come and officially launch the network. I hope you enjoyed café contact. And so I welcome you to this session, in which we basically want to digest the feedback you provided during the workshops. Now just maybe a couple of basic issues: we are very happy you provided the feedback because for us it is a test with the preliminary draft instrument, to see how it meets the expectations of experts, service providers and organizations. We are very happy with the concrete suggestions we have received. Maybe it is also important to mention that the checklist, of course, will not come as an isolated document but will be integrated in a framework document which will also provide the theoretical background of the principles on which the checklist is based. But the document will also provide resources – for instance, indications of websites and other tools.

The main objective of the checklist is actually for organizations with policy or service tasks to use the checklist to help them identify them to come to good practice. It is not really a fight for points in this or that area, but it is really intended to identify areas for improvement. I think we should jump right into the concrete suggestions you made. Since I have not had the time to read all the slides, I would like to suggest that the chairs of the different workshops come up here and just report back very briefly what they have discussed in their respective groups.

Workshop 1: Identification of good practices in policy development – Jasna Loos (ITM, Belgium)

OK, of course our recommendations were made in a group with more specific questions and more specified recommendation on how we should be facing things differently. Let's try to give a very general overview of the main points that were standing out during the workshops.

In general, people found that there should be more clarification and more precision on some things. People found it necessary that principles were specified in the tool itself so that people

could read immediately what is meant by principles. Of course, it is specified in the introduction, but it should be added there as well. More precise terminology should be used. What does entitlement mean precisely? What is personal empowerment? People also thought there should be fewer instructions on how to use the tool. Some questions can be merged; some questions can be split up. People also felt that the framework should be multipurpose, so that everyone could find his own thing in it.

One of the things that was very unclear for everybody: is there a division on the level of the nation or a policy at the level of the organization? It is very unclear. It seems that questions were running from one to another. And how is the division being made? One of the suggestions was that we create a separate set of questionnaires with which you could assess the policy on a national level and assess the policy of your own organization. So that it doesn't really mean that if your nation is doing badly at policy level, that for sure you will have a bad score for your organization. That way you can see how well your organization is working with the means that you have, with the policy provided by the nation.

There should also be an individual scoring on the service delivery and on the policy delivery. Now people can score separately on the principle, but it should also be divided into policies and services. Also people thought there should be more attention for youth: in my group, for example, people said that we should specify unaccompanied minors everywhere, in all the questions. We should also go into more depth on issues that these are struggling with.

What is also very unclear in the tool is when they talk about asylum seekers, refugees or unaccompanied minors. Sometimes they are mentioned, sometimes not. We also felt that there should be something mentioned about the system of redress: we say things about what policies are being made, but can the migrant or asylum seekers actually ask from their government that they get implemented? So that migrants know that this is their right and that it is not being followed. Can migrants have access to a system like that?

Regarding participation: people also felt that there should be something about informing migrants about their rights. Because, of course, the policy is being developed, but many migrants are not being informed about it. And there's also no update on what is going on at the policy level. Actually we also found that there was no consensus on being involved in monitoring and evaluation. And on the principle level of participation, people thought this is lacking in the tool. So we think that stakeholders should be able to participate in the planning, implementation, monitoring and evaluation phase and that there should also be more attention for sustainability. This is all we have.

Workshop 2: Identification of good practices in service delivery – Eirini Kampriani (NSPH, Greece)

The second group dealt with issues relating to service delivery. We started with the presentation of good practice, which gave influence for a discussion of how you involve asylum seekers and refugees in the design and development of your interventions: in a way that instead of you

suggesting the problems they face, engage them in the process so that they speak for themselves. Once they have identified the issues and the problems, they need some kind of experts who can comment on the final product to make sure the right information is being used. It is important to involve asylum seekers and refugees in developing interventions using art and drama and peer education programmes for them so that they raise the issues and problems that concern them, but also use external experts to make sure the language, meanings and messages conveyed are correct (i.e. medical information) or appropriate (gender-sensitive). So it was very focused on the issues of participation of the community itself.

Also it was very clearly stated that there was a lot of discussion on good practices, and we are happy now to say that we had implemented the good practice, but it is also significant to look at the problems and obstacles we face and communicate them. Because it is also a way we can focus more on how we can have sustainable interventions and how we can achieve them.

The specific good practice sounded good as a good example of exchange between countries. Then going to the checklist itself: there were some general issues that came out into the discussion. First: the questionnaire was too long, implied a very big document to go through just to assess the practice. But it is obviously not something to do every day, so you could take a couple of hours to go through that. And there was, for example, the suggestion that someone in service delivery might think of filling in this checklist every now and then when they have a new strategic plan for action. So it would be good as an evaluation of their performance till then.

There was a big discussion on issues of definitions: lots of explanations and clarifications needed for different terms used in the checklist. For example, a very practical issue; the questions that involved a very different range of topics; for example, we provide this kind of information and then underneath you have 10 topics but only one 'vote'. So there should certainly be a clarification for this.

I think our slides are more practical than what has been communicated here. I think the main issue was clarification. For example, when you say "include in the participatory approach", there was a list of questions related to how you involve different kinds of stakeholders. But then in one question it says "stakeholders", the next question "NGOs and other organizations", the next one "service users". So there was an issue: who is a stakeholder? And the group decided that the most important group of stakeholders should be service users, and they should be involved in all stages of the service delivery process.

As for empowerment, there was the feeling that as a principle, empowerment needed to be re-told in some way and to make sure that its content is sort of appropriate for different audiences, for people coming from different backgrounds. So we had different alternatives for both; some proposed "ownership", "possibilities", "enhancement", and there is, of course, the question whether the service providers hold power over people or that the power is already there and how we help them use it.

Then, on the gender-balanced approach, I can report similar issues regarding terms or reformulation of questions. But this is from the other group, so I can't comment on those.

We went through every question very specifically and pointed out some recommendations. For example, question 3: there are ways that deflect the points of the question; it would be easier to divide the question into two parts to make it more specific. Also we had some comments on the score list, on how the score is clarified. On question 4 the issue was asking about adding literacy, status or urban or rural location. Also about migration services, whether they have enough support for NGOs. I think the other suggestions are written up.

Thank you. Any questions for clarification? Yes please?

Q: Erick Vloeberghs (Pharos): Why add fundraisers? We develop the following discipline for health service provision, and then we should add fundraisers?

A: Polstra Renny (SOA AIDS Nederland): I thought it is very important to have somebody who looks at the finance, fundraising for a project.

C: You are concerned about the question?

Erick: I don't see it as being influential. It is important to get a service, but...

Renny: It is difficult to get money for programmes, so we need money to go on. So for extra projects, we need extra money, and we create. So that's maybe why it is good to put it in.

C: I think we should move on. More questions?

Q: Iris Shiripinda: On the gender-balanced approach, they suggested putting footnotes about the empirical research, but I think it is better to integrate better practices.

C: So it is more a suggestion which is not on here? Not on notes. In the meantime I see that Prof. Temmerman has arrived. Welcome. So how should we proceed now? Should we continue with workshop 3. There is another question?

Magi Poppe (Dutch-speaking Women's Council): One of the suggestions was to rephrase the word 'empowerment', and I would like researchers to think about that concept of empowerment, asking if ownership is one aspect of the concept of empowerment. So I do not agree that you must change the word empowerment to ownership. Empowerment means more knowledge, ability, and ownership is one aspect. So my suggestion is to be careful when changing concepts.

Thank you.

A: Iris Shiripinda (SOA AIDS Nederland): we thought empowerment was used out of context; it kind of suggested imbalance, to enhance, to empower.

Workshop 3: Quality indicators in service delivery – Christiana Nöstlinger (ITM, Belgium) and Kathia van Egmond (ICRH, Belgium)

Christiana: We also had some general comments on the structure of the checklist. And one of these comments refers back to what was said earlier about the policymaking group. However, it was framed a little bit differently in a sense, because it suggested making two separate checklists: one for policymakers and one for service providers. Then there were also some more technical remarks, but I think this question also came up in the other groups that if you look at this document from the perspective of a person who has to fill it in, that it is difficult to answer all these questions, because not all the questions apply to the activities that you are delivering. And since there is a score given, it is difficult for some organizations which may not be comfortable with that. So a solution to that would be to add a category: not applicable. But of course, this categorization would make it possible to skip all the questions. So it would be a matter of how to use this category.

Then another remark was also on the target group, to be consistent throughout our questions, and decide on asylum seekers, refugees and undocumented migrants and to be consistent throughout the whole document. A very important comment that was also given, that applies also to all indicators and maybe to the whole document as such, that the document was written very much from a service-providing perspective and looking at the services from the client's perspective. However, for some issues you could rephrase them or add them by providing also the perspective of the service providers and which needs what service providers have. The basic idea behind that is that if the needs of service providers are fulfilled, then also the services would improve as such. So many are somehow in the document already, but there could be others as well, such as what kind of supervision is provided for the service providers? Training, for instance. We have a lot of questions on training. But it should even go beyond training, so something like work satisfaction, which could quickly improve the quality of services as well. So I think this was a valuable comment.

Now when we come to the quality indicators as such, they are listed here. So from the people who were in the group, who talked about the first three quality indicators, could someone comment on that?

Kathia: I'll try to remember about the others. Evidence-based comments were also that we need to specify which documents, guidelines they refer to, but this will be mentioned in the general part of the document. Another issue was to include the question regarding the scope of your work, and if it is really addressing the needs of the target group and if these needs need to be addressed. Regarding confidentiality and privacy, we just wanted to add a question on the protection of medical data, that they can only be accessed by health care professionals or other professionals involved in the process here. Regarding availability, accessibility, there was a discussion on which services should be provided free, would be freely available for the target

group. There was a consensus that prenatal and postnatal care should be free of charge. Also prevention and screening of STIs and HIV should be available free. There was also a consensus that these should be available free. There was no consensus whether there should be free treatment for STIs and HIV, so a question should be added about whether treatment of STIs and HIV should be free, and not freely available. I think these are the main focus.

So let me go quickly through the other three remaining indicators. There are some technical issues about splitting up one question, because it included two questions in one. It was also mentioned that whenever we talk about a participatory approach or including a participatory approach in evaluation, that also short footnotes should be provided to refer to the standards, indicating what we mean by that, because otherwise it is difficult to answer such a question. There were some concrete suggestions made in terms of rephrasing, for instance, the question on the quality indicator about information of choice, suggesting that we should rather ask about the process, so that a service is trying to encourage or is making the network to empower the clients, compared to measuring whether the clients are already empowered.

Different writing was also suggested for question 4 of this quality indicator, which again referred to how the information should be provided and counselling in making an informed choice. Then question 5 of this quality indicator again should be consistent with the principles mentioned in the beginning; mentioning all the activities that an organization potentially can provide should be included. This is because now only some selective activities are mentioned – I think only family planning and fertility services – and it does not include the others like HIV topics and other topics that were not there.

Then some additional culturally appropriate information, like language, culture and issues, things like that. And for question 6, also we should not talk about the availability as such, but we should really try to address the more proactive delivery of information, for instance. And then the last indicator of continuity of care, the same remark applies: it should either be very general, so that everyone could recognize his or her services and activities under that, or it should be very specific, and it should include all the specific activities. As for question 4, I don't have it now off the top of my head, but also here there was a specific suggestion made that training should be added.

6.3.3.2 Launch of the EN-HERA! network - Prof. Marleen Temmerman and Koen Dedoncker (ICRH, Belgium)

Koen: Good evening, everybody. Unfortunately, due to medical reasons, Professor Temmerman will be unable to give the presentation herself. I will try to be her voice. We are very happy that she is here in fact and that she is supporting us and the network. We have done a lot of work today, we have heard a lot of interesting presentations this morning, we did a lot of work on the framework, and we have already heard a little bit about the project. So it's time to officially launch the network. But before we do so, maybe I'll briefly go into the background again. Ines talked to you about it this morning already.

It all started at the European workshop on SRH and rights of refugee women in Europe in 2005.

This is where the founding members met and the decision was made to create a European network. This project was then supported by the European Commission and the European Refugee Fund. First we had to find a name for the network, so it has become EN-HERA! – you have already heard and seen it several times today. It is an abbreviation for the European Network for the Promotion of Sexual and Reproductive Health of Refugees and Asylum Seekers. But it also symbolizes or refers to Hera, the Greek goddess of fertility, of change, of protection of women, of protection of marriage and relationships and women in labour. She is queen of the God Zeus. Her symbol is the pomegranate, and this is the symbol you see here. For those who didn't know yet, this is a pomegranate. You also see the symbol of the man and woman on top, so it's gender-balanced. If you wish you can also see it as the world, out of which a chunk is taken out, which symbolizes the forced migration and all the problems that are arising of that. This logo was in fact made by a refugee herself, Baharak Pourmirzajan from Iran.

The aim of our network, as we already talked about, is to improve the SRH of refugees and asylum seekers in Europe, by setting up a network of promotion of the SRH and SRH rights of refugees and asylum seekers in Europe and beyond. Also the objectives were talked about this morning. The ones that I will go deeper into are the first two. The first objective is about the network itself. What we wish to do is take joint initiatives of universities, service providers, policymakers, and asylum seeker and refugee communities. We also would like to make liaisons with other networks.

And the second objective is to gradually expand the network. From five, we started with five members, to at least 13 EU Member States, with at least three 'new' Member States. We also have to do in-country networking, with at least three local stakeholders. So these are four objectives we talked about sufficiently. So these are our founding members in fact: the founding member organization, the International Centre for Reproductive Health, the partners University College Dublin, National School of Public Health in Greece, the Universidade Nova de Lisboa in Portugal, Pharos in the Netherlands, and the Prince Leopold Institute for Tropical Medicine in Antwerp. We have already done some in-country networking within our countries. So in Belgium the partners which have already signed the invitation for partnership are Medimmigrant, Fedasil and the Dutch Women's Council. In the Netherlands is the Verwey-Joncker Institute. SOA AIDS Nederland is not a member yet, but ASERAG is. From Portugal we have Médicos do Mundo, and let's say Garcia de Orta (Associação para o Desenvolvimento e Cooperação). Then in Greece we have the Hellenic Centre for Disease Control and Prevention, the Hellenic Centre for Infectious Disease Control and Prevention, Praksis, the Greek Council for Refugees and the Kenyan Women's Association. All of them are here, I think. In Ireland the African Women's Network in Ireland (Akidwa), the Irish Family Planning Association (IFPA), the charity that works with migrants, asylum seekers and refugees (Doras) and the Department of Justice.

So if you have a look at this on the map, these are the founding countries. So we have Ireland, the Netherlands, Belgium, Portugal and Greece. Those are the new members we already have: the School of Social Work at St George's University of London/Kingston University (UK), the

Hospital Punta de Europa Migration Unit (Spain), the Cyprus Family Planning Organisation (Cyprus), the Bavarian AIDS Foundation & Technical University of Munich (Germany), the ARCA Romanian Forum for Refugees and Migrants (Romania), the Bulgarian Gender Research Foundation (BGRF) (Bulgaria), the NGO Prima (Slovakia), the Menédek – Hungarian Association for Migrants (Hungary) and the Organisation for Aid to Refugees (Croatia). And two more: the Foundation for Social Welfares (Malta) and the Women's Centre (Georgia).

We are also trying to make liaisons with other networks; some of you are here, and with international organizations. There are as well some other organizations which have expressed some interests but who are not members yet. On the map, this is how it looks, so we have the new members: Spain, UK, Germany, Czech Republic, Slovakia, Hungary, Romania, Bulgaria, Turkey, Georgia, and Cyprus. And then those two countries, Iceland and Serbia, are the ones who have already expressed their interest. If you look at this, it looks a little bit like a belt, so it's strange, and we still have a lot of work to do.

We want this network to be sustainable, reliable, human and empowering. It will be very interesting to see how this network can be SMARTIES. Now you have all in your folder a declaration of partnership and an invitation to partnership. Some of you have already signed; others please sign. Once you sign it, you are a member of the network. And when you are member of the network, you will be invited to a website, and this website is a Google group which is our tool to communicate ideas, to communicate good practices, to share data, guidelines, and so on and so on.

But, of course, most of the work has to be done tomorrow; maybe I can go over the programme for tomorrow briefly, for those members who are staying. We'll see each other in the Sint-Martens room, the room one floor down. We'll see each other at 9.20, where all the members can first introduce themselves. And then we will do a presentation on the proposal of the vision and objectives of the network and then a discussion and ideas on the implementation of this network. In the second part we will do the presentation of the research agenda, so which research we can do together, which initiatives we can take together. This will be discussed tomorrow, and then implementation hopefully. For now I would like to thank all of you for this hard day's work, I would like to thank Professor Temmerman for being here.

ABBREVIATIONS AND ACRONYMS

EC	European Commission
EN-HERA!	European Network for the promotion of Sexual and Reproductive Health of Refugees, Asylum Seekers and Undocumented Migrants in Europe & Beyond
EU	European Union
FGM	Female genital mutilation
HPV	Human papilloma virus
ICRH	International Centre for Reproductive Health, Ghent University, Belgium
ICPD	International Conference on Population and Development
IHMT	Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal
ITM	Prince Leopold Institute of Tropical Medicine, Belgium
NGO	Non-governmental organization
NSPH	National School of Public Health, Greece
PICUM	Platform for International Cooperation on Undocumented Migrants
PIISA	Persons with Insecure Immigration or Seeking Asylum
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRH&R	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UCD	University College Dublin, Ireland
UNHCR	United Nations High Commissioner for Refugees

