

Sexual and Reproductive Health in Crisis Situations

Marie Stopes International Australia specialises in the provision of sexual and reproductive health services, information, education, training and technical assistance to low income communities in the Asia-Pacific Region. MSIA currently provides support to more than thirty projects and programs in Australia, Cambodia, China, Fiji, Kiribati, Tuvalu, Federated States of Micronesia, Mongolia, Myanmar, Papua New Guinea, the Philippines, Timor Leste, Samoa and Vietnam. It works in partnership with local Non Governmental Organisations (NGOs) and local and national government and is strongly committed to the employment and development of national capacity in each country. These indigenous program partners pioneer innovative and sustainable local Sexual and Reproductive Health projects.

MSIA worked collaboratively with Program Partners in Sri Lanka and Pakistan after the 2005 natural disasters and have just commenced a program to respond to the reproductive health needs in Timor Leste after recent conflict. In association with Australian Reproductive Health Alliance and GenderHealth at the University of NSW, MSIA has recently also formed a consortium which will aim to promote sustained access to high quality reproductive health programs in emergencies in the Asia Pacific.

This paper aims to highlight the vital need for sexual and reproductive health services within emergency situations, a sadly overlooked aspects of health in crisis.

“ While food, water and shelter remain a priority, reproductive health care is among the crucial elements that give refugees basic human welfare and dignity that is their right”.¹

The right to sexual and reproductive health (SRH), including safe motherhood, family planning, prevention and treatment of sexually transmitted infections (STIs), HIV and emergency obstetric care, including the treatment of abortion-related complications, applies to all people at all times². Lack of quality sexual and reproductive health services can lead to high infant and maternal mortality rates, an increase in the spread of STIs including HIV, an increase in unsafe abortions, and increased morbidity related to high fertility rates and poor birth spacing. Tragically, in times of crisis sexual and reproductive health needs are too often overlooked, yet it is essential that they are considered as much a human right for communities experiencing the trauma of conflict and displacement or natural disaster, as the basic essentials of security, shelter, food, water and sanitation. To ensure that sexual and reproductive health problems are not worsened by inappropriate relief responses, they must be appropriately planned and implemented to meet the needs of those affected.

¹ United Nations High Commission for Refugees

² ICPD Programme of Action (1994), paragraph 7.2

At present, of the 34 countries furthest from reaching the Millennium Development Goals, 22 are in or emerging from conflict. The Millennium Project has recently recognised the importance of meeting the SRH needs of communities during conflict;

*“Humanitarian and relief work needs to provide basic health services for women and girls, especially reproductive health services and care, and ensure security from sexual violence”*³

As a result of conflicts such as Darfur or natural disasters such as the 2005 Indian Ocean Tsunami, people are often forced to become refugees or internally displaced (IDPs). A refugee refers to a person who, through fear of persecution, is outside of their country of nationality and is unable or unwilling to be protected by that country, whilst an IDP has been forced to flee their home, suddenly or unexpectedly, and has not crossed any international borders.”⁴ Women and children account for more than 75 per cent of the refugees and displaced persons at risk from war, famine, persecution and natural disaster⁵. When such disasters strike, risk of sexual violence, unattended childbirth, STI’s, HIV and lack of family planning are multiplied.

The 1994 United Nation's International Conference on Population and Development (ICPD) was the first point at which the SRH needs of refugees were recognised. The Programme of Action stated:

“In planning and implementing refugee assistance activities, special attention should be given to the specific needs of refugee women and refugee children. Refugees should be provided with access to adequate accommodation, education, and health services, including family planning.”

Sadly, integrated sexual and reproductive health services are far from a reality in most refugee and IDP settings, compounding many of the problems faced by women and their families living under such difficult circumstances.

In crisis situations, the fact that women bear children exposes them to a range of potential problems that men do not experience, such as complications from unsafe abortion, fistula hemorrhaging and a range of other physical and mental complications from childbirth. Men also need careful consideration in relation to reproductive health as service users, as decision-makers affecting women’s reproductive health and in some instances, as perpetrators of violence against women. Adolescents are also vulnerable because new reproductive health needs are created with the breakdown of social networks that normally provide the emotional and psychological support to guide their sexual development.

Along with increased reproductive health needs for all persons affected by an unexpected crisis, there is a diminished capacity within the health service, community and family to respond to these needs.

In the immediate aftermath of a disaster or crisis, only a limited range of sexual and reproductive health care services can be offered and are often restricted to the reduction of maternal mortality and morbidity. In refugee settings, certain sexual and reproductive health are required from the moment displacement occurs, however they usually become critical seven to ten days after the crisis, where we refer to the “5 S” priorities of crisis management: 1 Security 2 Sustenance 3 Shelter 4 Sanitation and 5 Sex. Other aspects of SRH such as the provision of modern contraceptives, prevention and care of STIs including HIV, and violence against women are necessary within a longer term context and should not be neglected. Once an emergency situation stabilises it is important to expand sexual and reproductive

³ UN Millennium Project 2005. Investing in development: a practical plan to achieve the Millennium Development Goals. Overview.

⁴ UNFPA. Reproductive Health for Communities in Crisis. UNFPA Emergency Response.

⁵ Ibid.

health services beyond the basic provisions, and more comprehensive health care services can be provided and due attention given to needs assessment, community participation, quality of care, integration of services, information-education-communication activities (IEC), advocacy and coordination among relief agencies.

Recognising the need to introduce effective SRH care as early as possible in emergency situations, the concept of the Minimal Initial Service Package (MISP) for SRH has been developed by the international community. The MISP is specifically designed to facilitate the rapid and appropriate delivery of SRH services in the initial acute phase of an emergency situation and to plan for services as the situation develops. The MISP concept includes: human resources, guidelines and training for the implementation of selected interventions, material resources, including essential drugs and basic equipment. It is important to note that the implementation of the MISP is far from universal and unless the SRH services outlined within it have been introduced and planned from the outset of an emergency, their delivery will be less robust as the situation develops. Integration and provision of MISP into Australia's humanitarian response is key to addressing the SRH needs of our neighbours.

In situations where there has been conflict and people are displaced, some health personnel may be reluctant to raise sensitive issues relating to reproductive health because of lack of experience or lack of understanding of cultural considerations, for example dealing with the victims of sexual violence. To avoid compounding the problems faced by populations in emergency settings, it is crucial that health personnel have the essential knowledge, skills and attitudes needed to address the reproductive health needs. It is crucial that personnel are gender sensitive in their approach and have an understanding of religious and cultural needs within the communities affected. In many situations it will also be necessary for personnel to be able to respond effectively to sexual violence, able to treat clients medically, psychologically and emotionally. Knowledge of family planning and counselling skills are also required for reproductive health needs to be effectively addressed.

Services may sometimes be provided in ways that do not respect the dignity of the recipients and their right to make free and informed choices, or there may be opposition to the provision of some reproductive health services for religious or cultural reasons. The involvement of local community members and the use of local knowledge and resources is vital in ensuring services are appropriate. In many cultures, the gender of health providers becomes critical. In response to the 2005 Pakistan earthquake, Marie Stopes Society Pakistan provided female healthcare workers to attend the general sexual and reproductive health needs of the female population affected, many of whom were culturally and socially unable to attend clinics provided by male service providers.

When civil war erupted in north-east Sri Lanka in the early 1980s, thousands of people were uprooted from their homes. An estimated 750,000 people are currently displaced and scattered around 530 camps throughout the country. The Government of Sri Lanka aimed to provide primary healthcare for all citizens at their nearest health institution. This static approach, however, excluded a vast number of IDPs who were settled in informal camps and communities and/or in remote areas. Most IDPs had no means of transportation, affecting their ability to access health services.

Marie Stopes International's local Partner in Sri Lanka, Population Services Lanka, has been implementing a sexual and reproductive health project for the internally displaced communities. Its key feature has been community involvement from the outset, using displaced people to train as community health promoters. They have played a major role in raising awareness of sexual and reproductive health and acting as co-ordinators for the outreach clinical teams. The project has provided accessible, high-quality sexual and reproductive health care through three static centres, mobile outreach services and

community outreach workers and has been able to offer mother and child health services, as well as a full range of temporary and permanent methods of contraception, information on HIV and diagnosis and treatment of other STIs. This successful programme now operates in six areas of the island.

SRH for communities experiencing the trauma of conflict and displacement or as a result of a natural disaster ought to be considered as much a human right as the basic essentials of shelter, food, water and sanitation. It is vital that the provision of SRH services are based on the needs of the population, with particular attention paid to vulnerable groups, such as women and adolescents. As the key humanitarian donor in the region beset by natural disasters, it is essential that Australia address SRH needs as an integral part of its emergency response.