



# Sexual and reproductive health and rights of people on the move

**M**any refugees originate from conflict areas where sexual and reproductive health and rights (SRHR) are seldom prioritized, let alone in the settings where they seek refuge. In the Netherlands, SRHR is one of the main areas of focus within development policy<sup>(4)</sup>. With the increased influx of refugees to the Netherlands, medical doctors and other health care professionals are left with questions on how to deal with the special SRHR needs of refugees that include a wide scope of issues.

## SRHR IN COUNTRIES OF ORIGIN

The Netherlands has a long history of immigration and is home to migrants with diverse norms and values regarding SRHR. Currently, with more than 85,000 refugees in the Netherlands<sup>(2)</sup>, this diversity has only increased. These norms and values derive partly from laws in their countries of origin regarding (child) marriages, homosexuality, (sexual) violence etc. and partly from cultural and traditional customs. For instance, homosexuality is illegal in many conflict countries such as Somalia, Syria and Eritrea<sup>(3,4,5)</sup>. Gender-based violence is a major concern in Syria and, in addition, the lack of effective laws to address sexual violence, including marital rape, leaves Syrian women helpless in the case of violence. Awareness within the Syrian community of family planning and the health benefits of birth-spacing and pacing of births was low long before the conflict even started.<sup>(6)</sup> In Eritrea, sexual and reproductive health rights are not holding up to an acceptable standard. For instance, unmet need for fam-

ily planning is high, and childbearing starts early with one in five women (aged 25-40) giving birth before their eighteenth birthday.<sup>(7)</sup> Female genital mutilation (FGM), with all its consequences for women during sexual intercourse and giving birth, is common practice with 83% of women being circumcised.

## INCREASED VULNERABILITY ON THE MOVE: SRHR ISSUES AND NEEDS

Refugees are most vulnerable to all kind of problems arising from the lack of SRHR. Findings from Rutgers' fieldwork in Aysaita refugee camp in Ethiopia showed that the challenges with SRHR do not originate from the refugee camp itself but are brought in from home and magnified due to the population density in the camp and the lack of a future perspective.

**H**umanitarian conflicts create new risks and vulnerabilities. As existing service provision breaks down, refugees who already had poor health outcomes associated with poverty or low social status end up in even more precarious living conditions<sup>(8)</sup>. A Rutgers desk study and needs assessment among diverse humanitarian NGOs showed that SRH issues such as the lack of reproductive health care (especially post-natal care) and access to family planning services as well as (gender based) sexual violence (SGBV) are some of the reported risks and vulnerabilities that need more attention. The risk of SGBV increases during a crisis due to a breakdown in law, which may leave survivors with little support and perpetrators exempted from punishment. Sexual violence is deployed as a weapon of war, used sys-

tematically to instill terror and humiliation and destroy societies at large<sup>(9)</sup>.

**S**pecific SRHR needs that arise or increase during migration may be different for different groups. Men may have different SRHR needs than women, as well as (unmarried) girls versus married women. As is made clear in the article by Rachel Ploem, 'Men's and boys' sexual and reproductive health needs are often embedded in a context of severe gender inequality'<sup>(10)</sup>. Frustration among young men due to unmet gender role expectations and practices that are rooted in local traditions and culture, such as arranged marriages and dowry, complicate the situation for young men without an income in the country of arrival. Violence is linked to a lack of future perspective and frustration, and these individuals may have mental health problems caused by trauma and (sexual) violence as well as the feeling of hopelessness in camps. Therefore, it is important to engage boys and men to address SRHR and GBV. Girls, however, have other SRH needs than men and boys. In some crisis situations, girls are married younger because their families hope to protect them from sexual violence or to ensure that they will be provided for and cared for<sup>(11)</sup>. Awareness campaigns are needed to protect girls from becoming child brides.

## HEALTH PROVIDER'S PERSPECTIVE

In the Netherlands, several organisations working in the field of refugees have expressed concern regarding the limited attention for SRHR. The Central Agency for the Reception of Asylum Seekers (COA), responsible for the

reception, supervision and departure of asylum seekers that arrive in the Netherlands, has prioritized sexual reproductive health. Agreements have been made with the public health services in the Netherlands (GGD) for these services to provide the most urgently needed services to refugees, including sexuality education, resilience training, and contraceptives. COA has indicated that there are many problems in the area of sexual and reproductive health in emergency settings, including sexually transmitted diseases, unwanted pregnancies, abortion, sexual exploitation, sexual harassment, child marriages, homophobic behaviour etc. These problems are attributed to a lack of knowledge, different sexual ethics, unequal gender roles, and language barriers as well as unfamiliarity with the Dutch care system, rules and regulations. There is a need for information and interventions that fit the needs of the target group. A lack of cultural sensitivity on the part of the health providers has also been reported. Until 2010, each region had information officers who spoke the same language and shared the same culture as the target refugees. Due to budget constraints, these services are currently not available.

### CONCLUSIONS

Refugees are often not educated on sexual health and sexuality due to a lack of access to SRHR in the country of origin. SRHR issues should not be linked only to the refugee situation itself, as they may already be present in the country of origin. These risks affect women and girls as well as men and boys. Humanitarian aid often focuses on the needs of women and girls, while neglecting problems that men face and disre-

garding differences in need based on education, gender, age, and religion <sup>(7,11)</sup>.

Besides the most commonly mentioned SRHR needs, “unspoken” concerns are equally important. Homophobia can be as crucial in the formulation of SRHR needs as the common and frequently reported need for family planning. Attributing “Western-society-defined” SRHR needs to refugees is a dangerous process since our emancipation, gender equality and LGBT rights may not be shared by refugees or may be framed differently. We should try to understand their point of view and their confusion about “our” norms and values. It’s not easy for outsiders to adapt to a different perspective on sexuality and to adjust their attitudes regarding traditional gender roles.

Getting to know Dutch society and understanding its culture takes time. Besides cultural aspects, factors related to gender, social economic situation (SES), and illiteracy should also be taken into consideration when discussing SRHR. These factors may be even more important in solving SRHR issues than the refugee status itself. The involvement of a translator during a consultation may make it easier to communicate with the subject, but it may be distractive, as disclosure may be confrontational or troubling for the person in question. Attention to the “basics” – such as housing, work, rules and regulations, and learning the language – is essential during the naturalization process, and rightly so.

HOWEVER, THIS PROCESS IS NOT COMPLETE IF THE BASICS OF HOW TO DEVELOP OR MAINTAIN A HEALTHY SEXUAL AND REPRODUCTIVE LIFE ARE NOT EQUALLY ADDRESSED



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