Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants

A framework for the identification of good practices
Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants
Colofon

‘Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants. A framework for the identification of good practices’ is a publication of the En-hera! network.

Coordinator En-hera!  
ICRH – Ghent University  
De Pintelaan 185 P3  
9000 Ghent, Belgium  
Tel: +32 9 332 35 64  
Fax: +32 9 332 38 67  
E-mail: icrh@ugent.be

Editing, Design & Print Coordination: Pharos, Utrecht, the Netherlands  
Graphic Design: Studio Casper Klaasse, Amsterdam, the Netherlands  
Print: A-D Druk, Zeist, the Netherlands

© 2009 En-hera! network


This document is issued for general distribution. Reproduction and translations are authorised, except for commercial purposes, provided the source is acknowledged. Hardcopies can be ordered by sending an e-mail request to icrh@ugent.be (no cost, except for postage). A pdf of the book can be downloaded from the ICRH website: www.icrh.org.

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

ICRH – International Centre for Reproductive Health, Ghent University, Belgium  
Researchers: Ines Keygnaert, Koen Dedoncker, Kathia van Egmond and Marleen Temmerman

IMT – Institute of Tropical Medicine, Belgium  
Researchers: Christiana Nöstlinger and Jasna Loos

UCD – University College Dublin, Ireland  
Researchers: Patricia Kennedy and PhD students

IHMT – Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal  
Researchers: Sonia Dias, Luis Tavora Tavira and Isabel Craveiro

NSPH – National School of Public Health, Greece  
Researchers: Elisabeth Ioannidi and Eirini Kampriani

Pharos – Knowledge and advisory centre on refugees, migrants and health, the Netherlands  
Prevention workers: Najla Wassie, Dorota Sienkiewicz and Erick Vloeberghs

Funded by the European Refugee Fund

Disclaimer: The views, opinions and content of this publication do not necessarily reflect the views, opinions or policies of the European Commission. The sole responsibility of this publication lies with the authors and the European Commission is not responsible for any use that may be made of the information contained within this publication.
Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants
Contents

Abbreviations ........................................................................................................ 8

1 Introduction ........................................................................................................ 9
  1.1 Rationale and background ........................................................................ 9
  1.2 Objective of the framework ...................................................................... 11
  1.3 Target groups of this framework .............................................................. 11
  1.4 Some facts and figures ............................................................................ 12
  1.5 How can the framework contribute to the SRH and rights of asylum seekers,
      refugees and undocumented migrants? .................................................... 12
  1.6 How can this framework be used? ............................................................. 13

2 Clarification of concepts .................................................................................. 15
  2.1 Sexual and Reproductive Health and Rights .......................................... 15
  2.2 Refugees, asylum seekers and migrants .................................................. 17
  2.3 What is a good practice? ......................................................................... 18
  2.4 Principles of good practices .................................................................. 18
  2.5 Criteria for quality of care ...................................................................... 19

3 Methodology used ............................................................................................ 21
  3.1 Introduction ............................................................................................. 21
  3.2 First loop ................................................................................................. 21
  3.3 Second loop ............................................................................................ 23
  3.4 Third loop ............................................................................................... 24
<table>
<thead>
<tr>
<th>4 Guiding principles</th>
<th>26</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Introduction</td>
<td>26</td>
</tr>
<tr>
<td>4.2 Rights-based approach</td>
<td>26</td>
</tr>
<tr>
<td>4.3 Participatory approach</td>
<td>28</td>
</tr>
<tr>
<td>4.4 Empowerment</td>
<td>30</td>
</tr>
<tr>
<td>4.5 Gender-balanced approach</td>
<td>32</td>
</tr>
<tr>
<td>4.6 Multidisciplinary approach</td>
<td>35</td>
</tr>
<tr>
<td>4.7 Cross-sectoral approach</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5 Quality indicators for service delivery</th>
<th>38</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Introduction</td>
<td>38</td>
</tr>
<tr>
<td>5.2 Evidence-based and in line with international guidelines</td>
<td>39</td>
</tr>
<tr>
<td>5.3 Confidentiality and privacy</td>
<td>41</td>
</tr>
<tr>
<td>5.4 Availability, Acceptability, Affordability and Accessibility</td>
<td>42</td>
</tr>
<tr>
<td>5.5 Monitoring and evaluation</td>
<td>45</td>
</tr>
<tr>
<td>5.6 Information and choice</td>
<td>46</td>
</tr>
<tr>
<td>5.7 Continuity of care</td>
<td>48</td>
</tr>
</tbody>
</table>

Appendix 1: Data on refugees and asylum seekers in EU countries .................. 51
Appendix 2: Good, better, best practice: in search of excellence in sexual and reproductive health provisions for refugees and asylum seekers ............. 54
Appendix 3: Useful guidelines and documents in the field of sexual and reproductive health and rights .......................................................... 61

Self-assessment tool for development of SRH policy for refugees, asylum seekers and undocumented migrants ...................................................... 73
Self-assessment tool for SRH service delivery to refugees, asylum seekers and undocumented migrants ............................................................. 83
Abbreviations

AIDS  Acquired Immunodeficiency Syndrome
EN-HERA!  European Network for the promotion of Sexual and Reproductive Health of Refugees and Asylum Seekers
ERF  European Refugee Fund
EU  European Union
FP  Family Planning
GP  General Practitioner
HIV  Human Immunodeficiency Virus
HPV  Human Papilloma Virus
ICPD  International Conference on Population and Development
ICRH  International Centre for Reproductive Health
IPPF  International Planned Parenthood Federation
ITM  Institute of Tropical Medicine
NGO  Non-governmental organization
PICUM  Platform for International Cooperation on Undocumented Migrants
R, AS & UM  Refugees, Asylum Seekers and Undocumented Migrants
SGBV  Sexual and Gender-Based Violence
SRH  Sexual and Reproductive Health
SRH&R  Sexual and Reproductive Health & Rights
STD  Sexually Transmitted Disease
STI  Sexually Transmitted Infection
UK  United Kingdom
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Population Fund
UNHCR  United Nations High Commissioner for Refugees
WHO  World Health Organization
1 Introduction

1.1 Rationale and background

Sexual and reproductive health, health rights and needs of refugees and asylum seekers in the European Union (EU) have only recently begun to be recognized. However, there are no binding EU regulations for the incorporation of these health rights in reception and integration policies that secure entitlement of refugees and asylum seekers to a comprehensive range of sexual and reproductive health (SRH) services. Each EU country has its own policy as to health rights, services provided and financial regulations concerning the target group. This situation is in sharp contrast with the EU commitment to the promotion and protection of SRH rights worldwide. Some countries know no clear distinctions between refugees, asylum seekers or undocumented migrants. Also the concept of sexual and reproductive health and health rights is often misunderstood, the boundaries are unclear and therefore many important issues are excluded.

In a situation where countries are unfamiliar with sexual and reproductive health and health rights of refugees, asylum seekers and undocumented migrants, where there is no clear definition who the targeted group should be, and where legislative health procedures in reception and integration of these groups of newcomers are unregulated, we felt that a framework for identification and development of good practices had to be created. By means of this framework, organizations that already work or would like to work with refugees, asylum seekers and undocumented migrants could employ the best practices.

The proposed framework is a general framework created despite or in the face of local/national differences in each EU country with regards to certain principles or aspects of their application, which may be far from reality. But even if the proposed framework does not reflect the current situation in any of the EU countries, we are optimistic that the framework can assist stakeholders to identify and develop good practices in their respective countries.
A framework for the identification of good practices requires: an agreed understanding of good practices, agreed principles of good practice and an agreed procedure for identifying good practices. The proposed framework is based on the consensus view of experts from different European countries.

The erf project and the en-hera! network

The current framework results from a joint European research project which was funded by the European Commission through the European Refugee Fund (erf). The overall aim of this erf project was to improve the sexual and reproductive health of refugees and asylum seekers in Europe and beyond.

The erf project was carried out from August 2007 till January 2009 by five academic research institutions and one national knowledge centre:
- icrh – International Centre for Reproductive Health, Ghent University, Belgium
- IMT – Institute of Tropical Medicine, Belgium
- UCD – University College of Dublin, Ireland
- IHMT – Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal
- NSPH – National School of Public Health, Greece
- Pharos – Knowledge and advisory centre on refugees, migrants and health, the Netherlands

A steering committee was appointed to provide guidance throughout the erf project. It included researchers from all abovementioned institutions. The development of a framework for the identification of good practices in srh policy development, service delivery and participatory approach for refugees and asylum seekers was one of the specific objectives of the erf project. Another specific objective of the project consisted of the establishment of a network for the promotion of the sexual and reproductive health and rights (srh&r) of refugees and asylum seekers in the eu among different stakeholders at national and international level. Furthermore the specific objectives of the erf project included the set-up of a common research agenda on srh of refugees and asylum seekers in the eu and the organization of an international seminar on the same topic. All these project goals have been achieved. The project results have been disseminated through this as well as through another publication.4

The decision to create a European network of different stakeholders involved in srh services for refugees and asylum seekers was unanimously taken at the ‘International Workshop on Sexual and Reproductive Health and Rights of Refugee Women in Europe’, organized at the Ghent University, Belgium, from 17-19 January 2005 and funded by the EC/ERF. The abovementioned project partners acted as founding members of the network and took the decision to
call the network EN-HERA! The acronym stands for European Network for the promotion of Sexual and Reproductive Health of Refugees and Asylum seekers. But HERA also refers to the Greek goddess of fertility, change, protection of women, protection of marriage and relations, and of women in labour. Hera also is 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, an EN-HERA! logo was developed. We selected a logo created by an Iranian refugee. It uses the image of a pomegranate which symbolizes the Greek goddess Hera in combination with other symbols referring to the world, SRH, refugees and asylum seekers. The coverage of the EN-HERA! network gradually expanded and by the time this publication went to press, 27 members had officially joined, of which six are from new EU member states and one from outside the EU. The network has been officially launched on 21 November 2008 at an international seminar, organized in Ghent.

1.2 Objective of the framework

This framework document wants to provide strategic guidance to stakeholders and organizations in the field of sexual and reproductive health and rights regarding:

- the development of Sexual and Reproductive Health and Rights (SRH&R) policies
- the deliverance of Sexual and Reproductive Health (SRH) services towards refugees, asylum seekers and undocumented migrants.

1.3 Target groups of this framework

- Refugees
- Asylum seekers
- Undocumented migrants

Note

Undocumented migrants cannot be excluded from the target group, because asylum seekers often become undocumented migrants. In some European

---

1 The second publication resulting from the PRF project is the EN-HERA! report. It includes the EN-HERA! vision text, a literature review, a common research agenda and the proceedings of the seminar organized in Ghent.

2 The decision to include undocumented migrants in the target group was taken at the first EN-HERA! seminar, organized in Ghent on 21 November 2008.
countries the recognition of refugees is particularly low, enlarging the undocumented migrant population significantly.

### 1.4 Some facts and figures

While the number of refugees and internally displaced persons falling under UNHCR’s responsibility was estimated at 25.1 million worldwide, available information suggests that a total of 67 million people had been forcibly displaced at the end of 2007. Out of the total number of refugees, some 1,580,000 reside in Europe out of whom 1,396,500 in the European Union.\(^3\) Recently, however, the numbers of newcomers have been rising.

At European level, in 2007, the 27 member states of the European Union have recorded 208,585 new asylum applications,\(^4\) which is about 6 per cent more than in 2006 (197,410). This is the first increase in five years and follows a twenty-year low observed in 2006. The rise in 2007 can be largely attributed to the sharp increase in Iraqi asylum seekers.\(^5\)

Of course no official figures exist on the number of undocumented migrants in the European Union. The Organization for Economic Cooperation and Development (OECD) has estimated that ‘between 10 and 15 percent of Europe’s 56 million migrants have irregular status, and that each year around half a million undocumented migrants arrive in the EU.’\(^6\) Therefore we can estimate that there are about 6 to 9 million undocumented migrants in Europe.

### 1.5 How can the framework contribute to the SRH and rights of asylum seekers, refugees and undocumented migrants?

The framework for identification and development of good practices for 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 require participation of the targeted groups.

For the framework to work effectively, the guiding principle for all organizations must be a constant SRH service delivery improvement, sustained by an ongoing interactive process of mutual learning so as to understand the diversity of target group’s SRH needs, problems and solutions.

Preconditions:

1. The framework operates within the culture of an organization, member state, region at EU level and beyond.
2. The principles ensure that refugees, asylum seekers and undocumented migrants from diverse social and cultural backgrounds face no barriers to receiv-
ing SRH services and are treated fairly and equally regardless their gender and status within the host country.

3 Refugees, asylum seekers and undocumented migrants participate actively in SRH promotion and prevention, and these actions are coordinated with other sectors (policy making and service delivery) and disciplines.

4 SRH care for refugees, asylum seekers and undocumented migrants is sustainable and promises a certain level of continuity.

5 If you work in a policy area, you will need to deal with people’s diverse needs in all aspects of your role – whether it is policy development, programme design, budgeting, monitoring, evaluation or reporting. In this way you’ll ensure that your services are culturally responsive, rights and gender-based, customer-centred, and effective.

6 If you work directly with the target group, you will need to be aware of the variety of SRH problems your clients face with, as well as resources you can call upon to help to address their specific needs.

### 1.6 How can this framework be used?

In order to facilitate practical use, the current framework document consists of a general part as well as a self-assessment tool.

The first three chapters of the general part of the framework document provide background information regarding the rationale and objectives of the framework, the methodology used as well as clarifications regarding the different concepts.

In chapter 4 and 5, six guiding principles and six key programmatic indicators of quality of care are further elaborated. These principles and quality indicators should help to identify and/or develop good practices in the field of SRH&R of...
refugees, asylum seekers and undocumented migrants. The different statements and guidelines given reflect the consensus view of the international experts who were 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 with the identification and/or development of good practices in SRH policy and service delivery for refugees, asylum seekers and undocumented migrants. The tool should also enable you to assess what elements in your service or programme need to be strengthened in order to comprehensively address SRH&R issues for the target group.

The self-assessment tool consists of two separate sets of statements: one for policy-makers, 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 programmatic level (statements regarding six quality indicators).

Some concrete suggestions for the use of the self-assessment tool:

- It can be used by policy-makers working at organizational or (inter)national level before making a strategic planning and/or to evaluate current existing policies.
- It can be used by an interdisciplinary team, before planning of a new SRH programme and/or during the evaluation process of a SRH programme.
- It can be used by organizations working in the field of SRH&R to develop or to revise annual action plans.
- It can be used as a basis for discussion and improvement of SRH policies and services, when all members of an organization are asked to complete the self-assessment tool.
2 Clarification of concepts

2.1 Sexual and Reproductive Health and Rights

The terms sexual and reproductive health and rights are often not fully understood or used with different definitions describing different concepts. Therefore, the meaning of these concepts needs clarification. We endorse the definitions of Sexual and Reproductive Health and Rights as defined at the International Conference on Population and Development (ICPD) in Cairo 19947 and recognize Sexual and Reproductive Health Rights as basic human rights.

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’.

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

---

7 UNFPA (1996). Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, Art. 7.2. These definitions are also endorsed by IPPF.
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.'

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.

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'.
2.2 Refugees, asylum seekers and migrants

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.’

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.’ 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,

8 www.unhcr.org/protect/protection/3b66c2aa10.pdf
visitors, tourists, foreign students or temporary contract workers or rejected asylum seekers'.

### 2.3 What is a good practice?

The establishment of a framework for the identification of good practices requires first an agreed understanding of ‘good practices’. However, there is no universal definition of ‘good practice’ in the field of SRH of refugees, asylum seekers and undocumented migrants. What is good varies over time and from place to place, and it depends on someone’s point of view. Therefore it is not easy to obtain a clear idea of what is ‘good practice’, or even more complicated, ‘best practice’. For UNAIDS, for example, ‘Best Practice means accumulating and applying knowledge about what is working and not working in different situations and contexts. In other words, it is both the lessons learned and the continuing process of learning, feedback, reflection, and analysis (what works, how and why, and so forth).’

After reviewing this and several other definitions of good and best practice (see Appendix 2: definitions of UNESCO, UNFPA, Global Health Council, Advance Africa), we decided to understand good practice as ‘a Practice being Effective, Transferable and Applicable in different contexts’. In summary, the good practice process helps to identify and describe the lessons learned and the keys to success of any given project, programme, or policy.

### 2.4 Principles of good practices

The members of the steering committee of the project studied many indicators of good practices and distinguished two main groups: programmatic and fundamental indicators. All participants agreed that programmatic indicators are important especially with regard to the implementation, monitoring and evaluation of SRH policies, programmes and services. But for the identification and the development of good practices, fundamental indicators or guiding principles were judged more valuable.

After reviewing the literature, panel discussions and exchanges among the members of the steering committee, a consensus was reached that the framework would incorporate six principles to guarantee SRH for asylum seekers, refugees and undocumented migrants. These six identifiable principles are elaborated in the diagram below.
In addition to defining these fundamental principles, we also have to pay attention to the quality of service delivery. When we talk about service delivery it is not enough that they adopt a rights-based or gender-balanced approach. Whatever approach or policy is adopted, the outcome must be that the SRH services meet the basic criteria for quality service in general.

The experts in the steering committee initially selected six criteria for quality of care in the field of SRH & R of refugees and asylum seekers.

The following criteria for assuring the quality of service delivery were agreed upon:
1. Evidence-based and being in line with international guidelines
2. Confidentiality and privacy
3. The four A’s: Availability, Acceptability, Affordability and Accessibility

---

4 Monitoring and evaluation
5 Continuity of care
6 Information and choice.

Figure 2  Overview of the criteria for quality of care
3 Methodology used

3.1 Introduction

The methodology was defined by the steering committee of the EN-HERA network. This steering committee includes representatives of the National School of Public Health of Greece, Universidade Nova de Lisboa in Portugal, University College Dublin in Ireland, Pharos in the Netherlands, Institute of Tropical Medicine Antwerp in Belgium and the International Centre for Reproductive Health of Ghent University in Belgium.

In order to develop a standardized good practice identification framework in policy development, service delivery and participatory approach, the steering committee decided to carry out an expert consultation process, which involved three loops of feedback. This method derived from an applied variation of the Delphi technique. The Delphi technique is in essence a series of sequential questionnaires or ‘rounds’, interspersed by controlled feedback, that seek to gain the most reliable consensus of opinion of a group of experts. In the framework of this project, two paper-pencil feedback loops were carried out. The results of the third loop was obtained during an expert meeting (held at the final project dissemination seminar) where different European experts, advocates and field workers gathered. The final framework reflects the overall consensus achieved at the end of this consultation process.

3.2 First loop

The first loop started with the members of the steering committee issuing a call for experts in different EU countries. In total 188 potential experts were...
identified of whom 66 experts have been selected based on criteria pre-established by the steering committee.

- A first loop questionnaire was developed and mutually agreed upon by members of the steering committee.
- This questionnaire was composed of 67 questions and included statements regarding the six principles of good practice as well as questions and statements regarding the quality of care.
- 34 experts returned the questionnaire, a response rate of 52 per cent.
- Data were entered and analysed and presented to the steering committee.
- A first draft framework was created based on the results of the first loop questionnaire.

Table 1: Overview of all initially involved experts

<table>
<thead>
<tr>
<th>Experts</th>
<th>Profile of stakeholders</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of work</td>
<td>#</td>
<td>Policymaker</td>
</tr>
<tr>
<td>Austria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Belgium</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cyprus</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Georgia</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Hungary</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Malta</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Spain</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>uk</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>11</td>
</tr>
</tbody>
</table>
### Table 2 Summary of the expert profiles of respondents to first loop questionnaire

<table>
<thead>
<tr>
<th>Country of work</th>
<th>#</th>
<th>Policymaker</th>
<th>Academic/research</th>
<th>Services</th>
<th>Intermediary/Advocacy</th>
<th>Community</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cyprus</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hungary</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Malta</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>uk</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>4</td>
<td>9</td>
<td>16</td>
<td>1</td>
<td>4</td>
<td>22</td>
</tr>
</tbody>
</table>

### 3.3 Second loop

- A second questionnaire was developed on the basis of the feedback obtained during the first loop. Subjects where no consensus was reached during the first loop were retaken for further elaboration and clarification.
  
  **NB:** Consensus has been defined as more than 80 per cent agreement of the responding experts regarding an issue.
- 19 experts returned the questionnaire, reaching a response rate of 29 per cent.
- Data were entered and analysed.
- A report was established incorporating the results of the second loop.
Table 3 Summary of the expert profiles of respondents to second loop questionnaire

<table>
<thead>
<tr>
<th>Experts</th>
<th>Profile of stakeholders</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of work</td>
<td>Policymaker</td>
<td>Academic/research</td>
</tr>
<tr>
<td>Belgium</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Georgia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Greece</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Hungary</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Malta</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Portugal</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Spain</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>UK</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>1</td>
</tr>
</tbody>
</table>

3.4 Third loop

The last step in the consultation process was organized at an international seminar held in Ghent on the 21st of November 2008.

- The responses to the first and second loop questionnaires were incorporated in a self-assessment tool which was presented at the seminar.
- 49 experts from 15 different European countries attended the EN-HERA seminar in Ghent, including members of the steering committee, experts who responded to the first and second loop questionnaires as well as some external stakeholders.
- During three different workshops as well as some plenary sessions, a preliminary version of the self-assessment tool has been further elaborated, discussed and agreed upon.
- The recommendations of the experts were incorporated into the self-assessment tool.
- The framework was finalized and the final report was written by members of the steering committee.
### Table 4  Summary of the expert profiles of the seminar participants (third loop)

<table>
<thead>
<tr>
<th>Experts</th>
<th>Profile of stakeholders</th>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Country of work</td>
<td>Policy-maker</td>
<td>Academic/research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>15</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cyprus</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Czech Rep.</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Greece</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hungary</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Malta</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Portugal</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>7</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>
4.1 Introduction

As stated earlier, six guiding principles were identified which should be incorporated in all programmes and strategies aiming the promotion of SRHR of refugees, asylum seekers and undocumented migrants, both with respect to the policy level and to service delivery.

These principles are:
1. Rights-based
2. Participatory
3. Empowerment
4. Gender-balanced
5. Multidisciplinary

4.2 Rights-based approach

Introduction and definition

‘All human beings are born free and equal in dignity and rights’ 13

Good practices should aim at promoting sexual and reproductive health among refugees, asylum seekers and migrants, by applying a rights-based approach. Sexual and Reproductive Health Rights are considered as basic human rights. The fulfilment of these rights depends on access to cultural, social and economic resources.
Definition of a rights-based approach

- A conceptual framework, normatively based on international human rights standards.
- Operationally directed to promoting and protecting human rights.
- Integrates norms, standards and principles of the international human rights system laid down in international treaties and declarations.
- Universal, inalienable, indivisible, interconnected and interdependent.
- Every individual, without regard to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or status, is entitled to the respect, protection, exercise and enjoyment of all the fundamental human rights and freedoms.
- States are obliged to ensure the equal enjoyment of all economic, social, cultural, civil and political rights for women and men, girls and boys.

How can you make your service and/or policy rights-based?

- Enhance the enjoyment of human rights by all.
- Identify relevant target group and identify their entitlements.
- Get duty bearers to meet their obligations and responsibilities.
- Hold all duty bearers (target group, civil society, service providers, and policymakers) accountable to fulfil their responsibilities towards the target group, to empower the target group to claim their rights, to fight discrimination and to strengthen equality and inclusion.

Good practice identification: results of the expert consultation loops

Policy level

- Policy-makers should develop or contribute to a national gender-based policy on sexual and reproductive health.
- Policies should ensure the same entitlement to gender-based SRH services as the host population for refugees, asylum seekers and undocumented migrants, which means that there are no conditions for the target group to access SRH services.
- Special programmes should be developed to improve access to SRH services for refugees, asylum seekers and undocumented migrants:
  - Training health staff on different cultural values and increase intercultural competences
  - Promoting easy access to interpreting and translating services.
- Policies should empower the target group to claim their rights.
- Policy-makers should promote the right to judicial protection from Sexual and Gender-Based Violence (SGBV).
- Policy-makers should ensure evaluation of SRH services regarding equity of access based on a participatory approach.

13 Article 1 of the Universal Declaration of Human Rights
• A system of redress should be in place. Asylum seekers and refugees should be informed about this option and should be referred to such a system if needed. If polices exist that prevent members of the target group from accessing their entitlements, these policies need to be abandoned.

• A system should be in place that informs members of the target groups and other stakeholders about relevant policies. This system should also give a regular update on policy changes that will affect the target group.

**SRH service delivery level**

• SRH services should adopt a rights-based approach towards all clients, including asylum seekers, refugees and undocumented migrants.

• Services should empower refugees, asylum seekers and undocumented migrants to claim the following rights:
  - Right to health and reproductive health
  - Right to access to SRH services
  - Right to information on SRH and risks
  - Right to family planning and free partner choice
  - Right to equity and equality of services
  - Right to judicial protection against SGBV
  - Other related rights.

• Physical, mental and social wellbeing related to reproduction, sexual relations and sexuality should be promoted.

• Access to information regarding several SRH topics and risks for refugees and asylum seekers should be ensured (see also under quality of care).

• SRH service providers should get feedback from the service users about the information provided in a safe and confidential way.

• Providers should ensure confidentiality of services.

• Services should ensure interculturally competent services and develop special programmes to improve access for the target group:
  - Staff should be trained to understand cultural diversity and eliminate discrimination.
  - Organizations should have interpreting and translating services in place.

### 4.3 Participatory approach

**Introduction and definition**

Good practices should adopt a participatory approach and consider participation as a core value of democracy. All persons should have the right to participate actively in the decision-making, structure and organization of their community and society.
Participation enhances the quality, efficiency and effectiveness of the process and the product. Every stakeholder (target group, civil society, NGOs, service providers and policy-makers) should have equal opportunity to determine the degree and nature of his or her participation at all different phases of decision making and the implementation of the decisions taken.

**Definition of a participatory approach**
- A core democratic value.
- All persons have the right to participate actively in the decision making, structure and organization of their community and society.
- A social process in enhanced knowledge production and in collaborative decision making.
- A means of empowerment whereby needs are identified, decisions are made and mechanisms are established to improve community life, services and/or resources.

**How can you make your service and/or policy participatory?**
Several modes of participation exist:
1. Contractual: stakeholders agree to take part in a specific part of policy development or service delivery.
2. Consultative: stakeholders are asked for their opinion and advice before a policy, intervention or service is developed or planned.
3. Collaborative: stakeholders work together with policy-makers/service providers in the implementation of a policy/service which is planned, monitored and managed by policy-makers/service providers.
4. Collegiate: stakeholders and policy-makers/service providers work together as colleagues, each with different skills in all phases of the policy development/service delivery.

**Good practice identification: results of the expert consultation loops**

**Policy level**
- Policy-makers should enable stakeholders to participate in all phases of the policy-making process, being: the planning, implementation, monitoring and evaluation phase.
- The following stakeholders should be able to participate actively in all phases of the policy-making process:
  - All service users: citizens, refugees, asylum seekers and undocumented migrants
  - Service providers
  - NGOs
  - Community organizations
  - Social services frequented by the target group
  - Researchers
Intercultural mediators.

Although all modes of participation can be used in any of the different phases, agreement was achieved that the collaborative mode should be guaranteed in all phases of the policy-making process.

SRH service delivery level

- Services should enable stakeholders to participate in SRH service delivery.
- The following groups of stakeholders should be enabled to participate actively, especially in the planning process of SRH services:
  - NGOs
  - Policy-makers
  - Service providers
  - Service users
  - Other health services frequented by the target group
  - Social services frequented by the target group
  - Community based organizations.

NB: For the evaluation of SRH services, participation of other stakeholders (service users – citizens as well as refugees, asylum seekers and undocumented migrants –, intercultural mediators and researchers) was generally considered as indicative as well. Service providers and other health or social services do not need to be necessarily included in the evaluation process.

- For the implementation phase, only service providers (and NGOs) were considered as relevant.
- All modes of participation can be used in the different stages of SRH service delivery, but answers with respect to the collegiate mode of participation were split (50 per cent of respondents agreed).
- Service users, refugees, asylum seekers and undocumented migrants included, play a particularly pronounced role among the various group of stakeholders, hence they should be consulted and involved in all phases of the service delivery.

4.4 Empowerment

Introduction and definition

Good practices in both policy development and service delivery should adopt an empowering approach. The goal of empowerment is to give people the power, capacities, capabilities and access needed to change their own lives, improve their own communities and influence their own destinies.
Definition of empowerment

- Empowerment is a multi-dimensional social process that helps people gain control and transform their lives and the organization of society in order to share power and resources equitably.
- Empowerment occurs at various levels, such as individual, group, and community level.
- The goal of empowerment is to give people the power, capacities, capabilities and access needed to change their own lives, improve their own communities and influence their own destinies.

Good practice identification: results of the expert consultation loops

Policy Level

- Policy-makers should protect SRH as a basic human right and promote health for all.
- Policies should contribute to the empowerment of all citizens, including refugees, asylum seekers and undocumented migrants.
- Policies should contribute to the empowerment of refugees, asylum seekers and undocumented migrants through ensuring training of health staff.
- Policy-makers should create a legal framework against discrimination regarding gender, race, religion and sexual orientation.
- Policy-makers should ensure active involvement of all stakeholders in decision making.
- Policies should promote active citizenship.
- Policies should raise public awareness for sexual and reproductive rights through sexual education, seminars, campaigns and research.
- Policies should ensure free access to services and information regarding SRH.

SRH service delivery level

- SRH services should actively promote and contribute to the empowerment of all clients, including refugees, asylum seekers and undocumented migrants.
- SRH services should focus on a broad range of topics in order to contribute to the empowerment of refugees, asylum seekers and undocumented migrants including:
  - Family planning and contraception
  - Freedom of partner choice
  - Healthy sexual behaviour
  - Respectful approaches to sexual relationships
  - Respectful approaches to sexual diversity
  - STI prevention, sexual risk behaviour and safe sex
  - Sexual and gender-based violence, and more specifically domestic violence and harmful traditional practices (female genital mutilation, honour-related violence, etc.)
  - Abortion (informed choice, respectful care, safe procedures, post-abortion care)
- Satisfying sex life
- Cervical, breast and prostate cancer.

**nb:** The only topic that did not reach consensus was that SRH services should include transgender issues in their focus.

- **How can SRH services contribute to the empowerment of the target group?**
  - Offer culturally competent services:
    - Ensure staff are culturally competent: through training and education, seminars, etc.
    - Research with participation of the target group
    - Access to translation services.
  - Ensure free, accessible and participatory knowledge transfer: Information should be as clear as possible and use appropriate language.
  - Actively involve refugees, asylum seekers and undocumented migrants in decision making.
  - Ensure informed choice and encourage ownership of one’s own health.

- **Empowerment needs be addressed during the consultations, medical interventions at different levels (individual, group and community, local level), counselling sessions, as well as during seminars and training of staff.**

- **Specific attention should be given to unaccompanied minors with respect to all of the above-mentioned services, since their needs may differ from those of their adult counterparts.**

- **SRH services should promote freedom of partner choice and a respectful approach to sexuality and relationships.**

- **SRH services should fight stigma and discrimination related to gender, culture, race and religion, sexual orientation, STIs, HIV and AIDS.**

  **nb:** Other types of stigmatization mentioned refer to age, social and legal status.

- **SRH services need to encourage and facilitate a positive attitude towards different cultures and attitudes at all levels.**

### 4.5 Gender-balanced approach

**Introduction and definition**

A good practice should adopt a gender-based approach since equal participation of women and men is a crucial factor for lasting development. It also symbolizes the level of political maturity of societies: while democracy requires equal rights for women, this in turn guarantees democracy.

The 1993 Vienna Declaration and Programme of Action affirmed the human rights of women as an inalienable, integral and indivisible part of human rights and demanded that the equal status and human rights of women be integrated into the mainstream of United Nations system-wide activity.
Definition of a gender-balanced approach

A gender-balanced approach is defined by the United Nations as the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes, in any area and at all levels.

Good practice identification: results of the expert consultation loops

Policy level

- Policies need to ensure that SRH services adopt a gender-balanced approach towards all citizens, regardless of their legal/residence status as well as to promote gender equality.
- Policies need to ensure that SRH services adopt an approach which is sensitive to diversity.
- Policy-makers should assess the implications for SRH of women and men of any planned action, including legislation, policies and programmes, in any area and at all levels.
- Policy-makers should undertake efforts to actively involve men in SRH policy development.
  *NB:* Consensus to involve men was based on inclusiveness, equality, efficiency and acknowledgement of different roles that men potentially have in relation to SRH.
- Policy-makers should address gender-related violations of SRH rights.

SRH service delivery level

- SRH services should provide a broad range of services that are evidence-based on gender.
- Services should promote gender equality among all clients and adopt an approach sensitive to diversity.
  The following diversity characteristics of asylum seekers and refugees should be taken into consideration during service provision:
  - Age/stage of life
  - Cultural background and ethnicity
  - Religious, spiritual and philosophical beliefs
  - (Dis)abilities
  - Specific issues relating to unaccompanied minors.
  *NB:* Diversity criteria which should not necessarily be taken in consideration are social status and legal status.
- Which services should be gender balanced?
  - Family planning and contraception
  - Healthy sexual behaviour and satisfying sex life
  - Sexual risk behaviour and safe sex, HIV and STI prevention
  - Sexual and gender-based violence, and more specifically domestic violence
and harmful traditional practices (female genital mutilation, honour-related violence, etc.).

• Services need to undertake efforts to actively involve men and boys in SRH service delivery in a broad range of SRH services, except for abortion services, transgender services and services related to cervical and breast cancer. Proposed strategies for involving boys and men:
  - Knowledge transfer: target information and education
  - Involve male community leaders
  - Encourage men to make a change
  - Involvement of men during SRH consultations and counselling.

Motivation:
  - Principles of equality and inclusiveness
  - Improves efficiency and empowerment
  - Men can have different roles: as perpetrators, victims, influencers, stakeholders
  - Involving men increases awareness and contributes to prevention of SGBV.

• SRH services should address gender-related violations of SRH rights.

Which type of violations need to be addressed?
  - Sexual violence and rape
  - Forced pregnancy, forced abortion or forced sterilization
  - Domestic violence
  - Sexual exploitation
  - Honour-related violence
  - Harmful traditional practices
  - Non-consensual sexual relations and non-consensual marriage.

• How can SRH services address gender-related violations among the target group?
  - Through adequate information and training of health-care providers
  - Create space and time for listening during health-care delivery
  - Create an atmosphere of respect, trust and confidentiality
  - Free channel to denunciate and deal with sexual violations; hotline for medical information/consultation
  - Establish centres for support and assistance to victims
  - Specialized multi-disciplinary approach is needed with medical, legal and social services
  - Community campaigns.

• Why should SRH services address gender-related violations among asylum seekers and refugees?
  - Target group lacks judicial protection
  - Violations of basic human rights are unacceptable
  - Enhances quality of care.
4.6 | Multidisciplinary approach

Introduction and definition

The multi-disciplinary work in the field of sexual and reproductive health implies that the service delivering team includes members of different professions working together (e.g., medical doctors, social workers, lawyers, community workers, target group volunteers).

Definition of a multi-disciplinary approach

• A multidisciplinary approach is characterized by different disciplines working within the boundaries of their professional practice towards discipline-related goals that are part of a larger common goal.

Good practice identification: results of the expert consultation loops

**SRH service delivery level**

Overall, there was high consensus reached among the experts relating to this principle.

• **SRH services should ensure that they adopt a multi-disciplinary approach providing holistic care and services.**

• **How can SRH services adopt a multi-disciplinary approach:**
  - Involve gynaecologists, midwives, urologists, psychologists, social workers, family planning nurses, community workers and community educators.
  - In the second loop, feedback was also achieved on integrating professions as diverse as general practitioners (GPs), legal advisors, counsellors and trusted key persons in multi-disciplinary teams. In addition, respondents suggested other professions such as anthropologists, sociologists and cultural mediators be integrated.
  - The general perception is that a holistic and culturally competent approach might enhance the efficiency and quality of the services by reducing boundaries, improving the involvement of the stakeholders and giving equal importance to different groups of stakeholders, which ultimately will result in the creation of culturally appropriate services and policies.

• **SRH services should facilitate the access for refugees, asylum seekers and undocumented migrants to other services and refer the target group whenever appropriate to:**
  - GPs and other medical services
  - Social and welfare services (including housing)
  - Migration services
  - Community-based organizations
  - Legal aid
  - Education
• Violence prevention and victim support services.
• SRH services need to be involved in exchange of expertise, consultation and networking with other SRH programmes.

NB: In the second loop, consensus was also achieved on SRH services’ involvement in the planning, implementation and monitoring and evaluation of other SRH interventions and programmes.

4.7 Cross-sectoral approach

Introduction and definition

A cross-sectoral approach requires a broad perspective and partnership with other sectors than health. These sectors can include, but are not limited to: the psycho-social, the political and administrative, the legal and judicial, the educational and community development, the safety and security sectors.

Definition of a cross-sectoral approach

• A cross-sectoral approach emphasizes the need to go beyond the boundaries of individual sectors in order to enhance health promotion.

Good practice identification: results of the expert consultation loops

Policy level

• An inter-sectoral approach should be adopted on international, national, regional and local level.

NB: No consensus could be reached on the statement that one identifiable authority should be responsible for guaranteeing SRH rights.

• The following sectors should be included in the gender-based SRH national policy development process:
  • Political representatives
  • NGO sector and volunteer organizations
  • SRH service providers
  • Legal representatives
  • Education sector
  • Representatives of refugees and asylum seekers
  • Reception centres for refugees and asylum seekers
  • Human rights organizations
  • Media
  • Social inclusion services.
SRH service delivery level

- A cross-sectoral approach in the planning and implementation process of SRH service provision should be adopted.
  
  NB: Consensus was achieved to a lesser degree on the monitoring and evaluation of those services.
  
  Other sectors that should be encouraged to be involved during the planning and implementation phase:
  - Migration services
  - Community development services
  - Political representatives
  - Social services
  - Legal services.
  
  NB: General practitioners and other medical services were not considered as essential with regard to the planning process of SRH services.

- SRH services should monitor the performance of other sectors working in the field of SRH of refugees, asylum seekers and undocumented migrants in order to keep up with changes.
5.1 Introduction

As stated earlier, having principles in place is a prerequisite, but not sufficient for assuring best quality of services. Whatever approach or policy is adopted, the outcome must be that the SRH services meet the basic criteria for quality service in general.

Quality of service delivery in the field of health care requires a holistic, physical-mental-social view of health as defined by WHO: ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’

Based on the consensus view of the experts in the steering committee, six criteria for quality of care in the field of SRH for refugees and asylum seekers were defined. These criteria are:

1. Evidence-based and in line with the international guidelines
2. Confidentiality and privacy
3. Availability, Acceptability, Affordability and Accessibility
4. Monitoring and evaluation
5. Information and choice

In this chapter, we give a description of these indicators as well as guidelines on how to achieve these goals in the field of SRH for refugees, asylum seekers and undocumented migrants.

A general focus should be on the empowerment of people using SRH services and the establishment of positive ongoing relationships between service deliverers and service users.
5.2 Evidence-based and in line with the international guidelines

Introduction and definition

Definition of evidence-based health care

- Evidence-based health care takes place when decisions that affect care of patients are taken with due weight accorded to all valid, relevant information. \(^{15}\)
- Evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors. \(^{16}\)

How can good practice services assure that they are in line with evidence-based medicine and existing guidelines?

- Preferential use of sexual and reproductive health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific SRH problems.
- Identifying such evidence that there may be for a practice, and rating it accordingly to how scientifically sound it may be.
- Carefully summarize research, put out accessible research summaries, encourage and educate professionals in how to understand and apply research findings.
- When no systematic legal regulations on the national level exist, sexual and reproductive health services should be rooted in already existing international guidelines.

As for the international guidelines, we selected and listed some of the main available web resources in Appendix 3.

Good practice identification: results of the expert consultation rounds

- Before planning and designing SRH policies or services, it is important to analyse the context your organization is working in and to collect data and evi-


\(^{16}\) First Annual Nordic Workshop on how to critically appraise and use evidence in decisions about healthcare, National Institute of Public Health, Oslo, Norway, 1996.
dence regarding the SRH needs of the target group. The scope and the severity of the problems your organization is addressing or tries to address, are to be defined in order to proof that what your organization is doing is important and contributes to the improvement of SRH of refugees, asylum seekers and undocumented migrants.

- It is important that SRH services are built on an analysis of evidence-based findings. This implies and requires:
  - The set-up of an appropriate data collection system
  - Analysis of the collected data as well as reporting of the results.

- SRH services should collect data on their service users referring to the following characteristics:
  - Age/stage of life (e.g. undocumented minors and vulnerable adolescents as part of the target group)
  - Refugee background
  - Ethnicity
  - Cultural background
  - Religious, spiritual or philosophical beliefs
  - Physical and psychological disabilities.

  NB: There is no consensus among experts regarding the need to set up a data collection system which allows analysis of SRH data according to sexual orientation, socio-economic status or legal status.

- Analysis of the (above cited) diversity aspects of the service users should be used to guide SRH service provision.

- SRH services should encourage and facilitate research on diversity aspects of SRH services.

- SRH services should also collect data which allow to analyse the service delivery itself:
  - Satisfaction of service users
  - Accessibility of SRH services for refugees, asylum seekers and undocumented migrants
  - Service outcomes.

- Organizations need to develop manuals regarding SRH&R of refugees, asylum seekers and undocumented migrants that are in line with existing SRH guidelines (see Appendix 3).

- SRH service providers need to be trained on and have access to existing SRH guidelines and manuals.

- The following international guidelines were cited by some experts as relevant for SRH service providers:
  - UN declaration of Human Rights
  - UNAIDS guidelines and recommendations
  - ICPD and Beijing declarations
  - WHO guidelines and recommendations
  - EU instruments regarding SRH.
• The reasons why these resources are perceived as important are the following:
  - Contribute to equality and equal treatment
  - Prevent violations of SRH rights
  - Culturally sensitive
  - Promote multi-disciplinary services
  - Ensure continuity of care.

5.3 Confidentiality and privacy

Introduction and definitions

Definition of the concepts confidentiality and privacy

• Confidentiality can be defined as the ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure.\(^\text{17}\)

• Confidentiality is not equal to secrecy – information may be shared within a team, in certain cases there is a legal obligation to break confidentiality.

• Privacy is the ability of an individual or group to seclude themselves or information about themselves and thereby reveal themselves selectively.\(^\text{18}\) The boundaries and content of what is considered private differ among cultures and individuals, but share basic common themes. Various types of privacy can be distinguished:

  • Physical privacy could be defined as preventing ‘intrusions into one’s physical space or solitude’.\(^\text{19}\)
  • Medical privacy allows a person to keep their medical records from being revealed to others.
  • Data privacy refers to the evolving relationship between technology and the legal right to, or public expectation of privacy in the collection and sharing of data about one self.

Good practice identification: results of the expert consultation rounds

• A confidentiality policy should be in place and all persons in any way involved should be aware of this policy.

• The confidentiality policy should guarantee the non-disclosure of personal data of refugees, asylum seekers and undocumented migrants:
  - Any personal information remains confidential
  - Any personal information is accessible only to those authorized to have access: persons involved in patient care.

\(^{17}\) The American Heritage® Medical Dictionary
\(^{18}\) Wikipedia, the free Encyclopedia
Specific measures need to be taken in order to guarantee confidentiality:
- One-on-one counselling
- Anonymous HIV and STI testing should be available
  NB: Anonymous access to other SRH services can be considered though is not perceived as mandatory by the consulted experts.
- Save storage of data.
- The use of (certified) independent cultural mediators is advised in order to guarantee confidentiality.

5.4 | Availability, Acceptability, Affordability and Accessibility

Introduction and definition

Since we consider sexual and reproductive health as a basic human right, SRH services need to be obtained regardless of race, sex or sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability.

Of course, the extent to which organizations or service providers can reach this universal goal, relies merely on the existing national policies and regulations. It is in the first place the responsibility of national policy-makers to ensure that refugees, asylum seekers and undocumented migrants can easily access all sexual and reproductive health services being provided in a country. However, organizations and service providers have an important role to play as well by raising general awareness and advocacy. They can contribute in multiple ways to positive policy changes which increase the accessibility of SRH services for refugees, asylum seekers and undocumented migrants.

Definitions of the concepts Availability, Acceptability, Affordability and Accessibility

- **Availability** can be defined as the quality of being at hand when needed.\(^{20}\)
- **Acceptability** means the degree to which a service meets the cultural needs and standards of a community. This in turn will affect utilization of that service.\(^{21}\)
- Services are **affordable** when they are relatively low in price and people have the financial means to pay for these services.\(^{19}\)
- **Accessibility** can be defined as the degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health-care system. Factors influencing this ability include geographic, cultural and financial considerations, among others.\(^{22}\)

Good practice identification: results of the expert consultation rounds

- A basic package of SRH services should be freely available for all service users, including refugees, asylum seekers and migrants.
NB: It is difficult to determine which specific kinds of SRH services should be included and free of charge available to all. The exact content of a free basic package of SRH services can vary from one country to another, depending on existing policies and health-care services. However a general consensus was reached that the following SRH services should be provided to all clients, free of charge:
- Antenatal care and postnatal care
- Safe delivery and emergency obstetric care
- Family planning
- Screening for STIs and HIV
- Prevention of STIs and HIV
- Prevention of sexual and gender-based violence
- Support to victims of sexual violence.

Though the consulted experts tended to agree that most other SRH services like HIV and AIDS treatment and contraceptives should be freely available, many experts doubted whether such a policy is really realistic in the current European context. But all experts agreed that SRH services should at least be affordable to anyone.

- Affordability is needed for the following SRH services, but a fee can be (eventually) be charged as long as the income level has been taken into consideration:
  - Treatment of STIs and HIV/AIDS
  - Abortion and post-abortion care
  - Supply of contraceptives
  - Sexual counselling
  - Treatment of cervical, breast and prostate cancer
  - Prevention of cervical cancer (vaccination for HPV virus).

NB: The general opinion among the experts was that services regarding the diagnosis and treatment of infertility should not be provided free of charge.

- Access to national SRH screening programmes (e.g., annual Papanicolao test, mammography) should be facilitated and encouraged by SRH service providers.

- SRH services need to provide special measures to improve access for asylum seekers, refugees and undocumented migrants. Therefore the following measures need to be put in place:
  - Ensure interpreting and translating services
  - Training of health staff on cultural values and backgrounds of the target group
  - Ensure confidentiality and privacy
  - Ensure culturally competent services

---

20 The Free Dictionary by Farlex at www.thefreedictionary.com/availability
22 United States National Library of Medicine, National Institutes of Health
- Ensure respect for different norms and values and fight stigma and discrimination.

NB: No consensus was reached regarding the need to employ health-care staff with refugee background as one of the specific measures to increase access for the target group.

• Other measures that were mentioned in order to improve the accessibility of services:
  - Participatory approach with involvement of the target group in the planning, designing and evaluation of SRH services
  - Multi-disciplinary and cross-sectoral approach
  - Networking with other organizations and institutions
  - Facilitate the constant availability of experts which can be consulted by health staff
  - Ensure gender-sensitive services: e.g., provide the possibility for women to be examined by women and men by men.
  - The use of cultural mediators and community educators
  - Better understanding of the barriers and the stigma associated with sexual health issues
  - Training of staff on social skills and make them sensitive to socio-economic inequalities and barriers
  - Information (whether oral or written) should be assessable in a range of different languages
  - Dissemination of information on SRH services that are available in the communities as well as on the practical organization of these services, e.g., through putting brochures in different languages on existing SRH services in key places
  - The practical organization of SRH services is also important in order to match the profile of refugees, asylum seekers and migrants and to reach different cultural, gender and age groups
  - Organization of outreach services
  - Location of services and opening hours
  - Possibility for separation of men and women.

• Experts unanimously recognize the need for training of staff working in SRH services and specifically mentioned the need for training on following aspects:
  - Gender aspects
  - Legal aspects of refugees, asylum seekers and undocumented migrants
  - Intercultural communication
  - Adapting and simplifying the professional vocabulary
  - Medical health care expectations of people with different cultural background
  - Differences in health seeking behaviour and perceptions.

NB: Knowledge on the health care in refugee countries of origin, was not considered as essential for health-care workers. Furthermore it was commented by the experts that health-care staff cannot be aware of all legal aspects regarding the target group but at least they should rec-
ognize these gaps in their knowledge and more actively refer to appropriate legal and social services.

- Why training?
  Experts stated that training on the above mentioned aspects will help service providers to have a better understanding of the needs of their clients, to communicate more successfully, to raise credibility and trust in the provided services and to provide the best services for each individual.

- Apart from the need for training, service providers have other needs which must equally be addressed in order to make SRH services accessible. IPPF identified the following ten needs for service providers: 23
  - Training on technical aspects as well as on communication skills
  - Information on aspects related to the work of their colleagues and other areas of the organization’s programmes
  - An appropriate infrastructure
  - Supplies required for the provision of SRH services at appropriate standards of quality
  - Clear, relevant and objective guidance
  - Back-up: service providers may find the need to request a consultation or technical support, or to refer service users to another provider or another level
  - Encouragement
  - Feedback concerning their competences and attitudes as judged by others
  - Self-expression concerning the quality and efficiency of the SRH programme and services.

5.5 Monitoring and evaluation

Introduction and definition

Monitoring and evaluation are essential to assess the results of a programme. But in a broader perspective, these results can equally help to educate stakeholders, health staff and the broader community about the good practices and lessons learned.

Definitions of the concepts monitoring and evaluation

- Monitoring is the routine tracking of the key elements of health service performance, usually inputs and outputs, through record-keeping, regular reporting and surveillance systems as well as health facility observation and client surveys. 24

23 IPPF (International Planned Parenthood Federation), www.ippf.org
Evaluation is the episodic assessment of the change in targeted results that can be attributed to projects or interventions. Evaluation attempts to link a particular output or outcome directly to an intervention after a period of time has passed.

Good practice identification: results of the expert consultation rounds

- Everyone agreed that the quality of SRH services should be monitored regularly.
- Opinions differed though with respect to how monitoring and evaluation should be carried out in practice.
  - Some of the proposed strategies include:
    - Questionnaires of service users regarding client satisfaction
    - Professional (external) audits
    - Comparison of services with the international state of the art
    - Anonymous reporting by SRH staff regarding mistakes made or bad practices
    - Encourage SRH staff to report on obstacles and make suggestions for the improvement of services
    - Include health staff as well as all other persons around the patient (including the cleaner, etc.) in the evaluation process
    - Include other service providers, all stakeholders as well as service users (asylum seekers, refugees and undocumented migrants) in the evaluation process.
- The equity of access needs to be part of the evaluation of SRH services. A participatory approach is recommended in this perspective.

5.6 | Information and choice

Introduction and definition

With regard to sexual and reproductive health and rights, and regulation of birth in particular, the Cairo Programme states that reproductive health 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 are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.

Also IPPF states that every individual has the right to be informed about the benefits and the availability of sexual and reproductive health services, as well as the right to make a free choice.
Definition of the concept informed consent

• Informed consent can be defined as the consent to medical procedures/treatment given by a patient after the potential risks, hazards, and benefits of the treatment have been explained.\(^{26}\)

Good practice identification: results of the expert consultation loops

• Efforts need to be made to empower asylum seekers, refugees and undocumented migrants to claim the right on information on sexual and reproductive health and health risks.
• This implies that refugees, asylum seekers and undocumented migrants need to be informed and to have access to a range of safe, effective, affordable and acceptable methods of family planning and fertility regulation of their choice.
• Information regarding a wide range of SRH topics and services needs to be provided to the target group:
  - Practical information on SRH services
  - Legal and social services, including information on financial assistance and entitlements
  - Legal rights
  - STIs and HIV
  - Sexual risk behaviours
  - Healthy sexual relationships and a satisfying sex life
  - Family planning and contraceptive methods
  - Abortion and post-abortion care
  - GBV, including harmful traditional practices and the existing victim supportive services.
• Information on SRH should be provided through several channels, including:
  - institutions (schools, universities, workplace, hospitals, primary care centres, migrant information centres, etc.)
  - media (online, campaigns)
  - interpersonal modes (training and information sessions, counselling)
  - printed materials
  - other creative communication channels: e.g., using art and drama and peer education programmes for the target group, so that they raise the issues and problems that concern them.

NB: Diverse information channels are needed because the target group is difficult to reach and at the same time, it helps reduce stereotypes in the public opinion and contributes to the welfare of the entire society. Also, the right to in-

\(^{26}\) The Free Medical Dictionary by Farlex at http://medical-dictionary.thefreedictionary.com/informed+consent
formation on SRH needs to be part of a larger strategy towards the whole civil society, in which political institutions (like the EU) should be involved as well as all important stakeholders.

- Information on SRH provided through all types of channels should meet some criteria:
  - Employ appropriate language (use simple wordings, available in multiple languages, etc.) and use creative methods without language (pictures, playing materials, etc.)
  - Be accessible free of charge and available in different places
  - Integrate a bottom-up approach
  - Use external experts to make sure the language, meanings and messages conveyed are scientifically correct (medical information) and appropriate (gender sensitive)
  - Avoid stigmatization and stereotypes
  - Be adapted to different cultural backgrounds.

According to the experts, a bottom-up approach is required because of the following reasons:

- It ensures that the provided information is sensitive to cultural codes, which enables efficient transmission of knowledge
- It allows to hear all the opinions of the ones taking part in the process
- It ensures you don’t reproduce stereotypes and misconceptions
- It enables better targeting of the messages to the audience.

- With regard to specific SRH technical procedures, it is necessary to always obtain informed consent first (e.g., HIV or STI testing).

### 5.7 Continuity of care

**Introduction and definition**

Continuity of care is considered as another important quality indicator. It basically means to ensure delivery of SRH health services and supplies to each individual for as long as needed.

**Definition of the concept continuity of care**

- *Continuity* is the degree to which a series of discrete health-care events is experienced as coherent and connected and consistent with the patient’s medical needs and personal context.²⁷
- *Continuity of care* is distinguished from other attributes of care by two core elements: care over time and the focus on individual patients.²⁶
Good practice identification: results of the expert consultation rounds

- SRH programmes, policies and initiatives need to contribute the continuity of SRH services for asylum seekers, refugees and undocumented migrants.
- SRH services also need to enable access to other services.
- Whenever indicated, service users should actively be referred to:
  - Social and welfare services
  - General practitioners
  - Other medical services
  - Migration services
  - Community organizations.
- Other important referral services include: counselling and victim support services (including crisis support, safe houses, agencies offering support, etc.), legal services, advocacy groups, educational services, etc.
- Which mechanisms need to be put in place to ensure continuity of care?
  - A system which allows systematic follow-up of service users (e.g., personal medical file)
  - If a particular SRH service is not available, a system for referral to other (high) quality SRH services
  - A system to monitor and follow-up effective referral to other health and social services
  - When a facility or person considers to stop delivering SRH services, other service providers need to be informed, to be asked to take over and to be provided with all necessary information and training.

Appendices
Appendix 1 Data on refugees and asylum seekers in EU countries

Table 1  Population of concern to UNHCR: data 2007 for EU countries28

<table>
<thead>
<tr>
<th>Country/territory of asylum</th>
<th>Total refugees and people in refugee-like situations</th>
<th>Asylum seekers (pending cases)</th>
<th>Stateless</th>
<th>Total Population of Concern</th>
<th>General Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>30,773</td>
<td>38,442</td>
<td>472</td>
<td>69,687</td>
<td>*</td>
</tr>
<tr>
<td>Belgium</td>
<td>17,575</td>
<td>15,247</td>
<td>468</td>
<td>33,290</td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>4,836</td>
<td>1,012</td>
<td>0</td>
<td>5,848</td>
<td></td>
</tr>
<tr>
<td>Cyprus</td>
<td>1,194</td>
<td>11,892</td>
<td>0</td>
<td>13,086</td>
<td></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>2,037</td>
<td>2,186</td>
<td>0</td>
<td>4,223</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>26,788</td>
<td>560</td>
<td>796</td>
<td>28,144</td>
<td>*</td>
</tr>
<tr>
<td>Estonia</td>
<td>18</td>
<td>6</td>
<td>116,248</td>
<td>116,272</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>6,204</td>
<td>721</td>
<td>68</td>
<td>6,993</td>
<td>*</td>
</tr>
<tr>
<td>France</td>
<td>151,789</td>
<td>31,051</td>
<td>948</td>
<td>183,788</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>578,879</td>
<td>34,063</td>
<td>9,091</td>
<td>622,033</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>2,228</td>
<td>28,463</td>
<td>108</td>
<td>30,799</td>
<td>*</td>
</tr>
<tr>
<td>Hungary</td>
<td>8,131</td>
<td>1,565</td>
<td>241</td>
<td>9,937</td>
<td>*</td>
</tr>
<tr>
<td>Ireland</td>
<td>9,333</td>
<td>4,400</td>
<td>0</td>
<td>13,733</td>
<td>*</td>
</tr>
<tr>
<td>Italy</td>
<td>38,068</td>
<td>1,500</td>
<td>886</td>
<td>40,454</td>
<td>*</td>
</tr>
<tr>
<td>Latvia</td>
<td>29</td>
<td>15</td>
<td>372,622</td>
<td>372,666</td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>688</td>
<td>29</td>
<td>5,900</td>
<td>6,617</td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2,737</td>
<td>38</td>
<td>154</td>
<td>2,929</td>
<td>*</td>
</tr>
<tr>
<td>Malta</td>
<td>3,000</td>
<td>861</td>
<td>0</td>
<td>3,861</td>
<td>*</td>
</tr>
<tr>
<td>Netherlands</td>
<td>86,587</td>
<td>5,840</td>
<td>4,461</td>
<td>96,888</td>
<td>*</td>
</tr>
<tr>
<td>Poland</td>
<td>9,790</td>
<td>5,940</td>
<td>74</td>
<td>15,804</td>
<td>*</td>
</tr>
<tr>
<td>Portugal</td>
<td>353</td>
<td>0</td>
<td>0</td>
<td>353</td>
<td>*</td>
</tr>
<tr>
<td>Romania</td>
<td>1,757</td>
<td>166</td>
<td>257</td>
<td>2,180</td>
<td>*</td>
</tr>
<tr>
<td>Slovakia</td>
<td>279</td>
<td>584</td>
<td>911</td>
<td>1,774</td>
<td>*</td>
</tr>
<tr>
<td>Slovenia</td>
<td>263</td>
<td>55</td>
<td>4,090</td>
<td>4,408</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>514</td>
<td>0</td>
<td>20</td>
<td>5,167</td>
<td>*</td>
</tr>
<tr>
<td>Sweden</td>
<td>75,078</td>
<td>27,723</td>
<td>5,571</td>
<td>108,372</td>
<td>*</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>299,718</td>
<td>10,900</td>
<td>205</td>
<td>310,823</td>
<td>*</td>
</tr>
<tr>
<td>Total</td>
<td>1,363,279</td>
<td>223,259</td>
<td>523,591</td>
<td>2,110,129</td>
<td></td>
</tr>
</tbody>
</table>

In the absence of Government estimates, UNHCR has estimated the refugee population in most industrialized countries, based on recent refugee arrivals and recognition of asylum seekers during the past 10 years.

Table 2  Eurostat data on asylum applications in the European Union 2003-2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EU (27 countries)</td>
<td>208,585</td>
<td>p</td>
<td>197,410</td>
<td>p</td>
<td>234,675</td>
</tr>
<tr>
<td>EU (25 countries)</td>
<td>:</td>
<td>196,530</td>
<td>p</td>
<td>233,490</td>
<td>p</td>
</tr>
<tr>
<td>EU (15 countries)</td>
<td>:</td>
<td>178,640</td>
<td>p</td>
<td>210,485</td>
<td>p</td>
</tr>
<tr>
<td>EU (13 countries)</td>
<td>:</td>
<td>124,040</td>
<td>p</td>
<td>159,835</td>
<td>p</td>
</tr>
<tr>
<td>EU (12 countries)</td>
<td>:</td>
<td>123,540</td>
<td>p</td>
<td>158,285</td>
<td>p</td>
</tr>
<tr>
<td>Austria</td>
<td>11,920</td>
<td>p</td>
<td>13,350</td>
<td>p</td>
<td>22,460</td>
</tr>
<tr>
<td>Belgium</td>
<td>11,575</td>
<td>p</td>
<td>8,870</td>
<td>p</td>
<td>12,575</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>815</td>
<td>p</td>
<td>500</td>
<td>p</td>
<td>700</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1,585</td>
<td>p</td>
<td>2,730</td>
<td>p</td>
<td>3,590</td>
</tr>
<tr>
<td>Denmark</td>
<td>2,225</td>
<td>p</td>
<td>1,960</td>
<td>p</td>
<td>2,280</td>
</tr>
<tr>
<td>Germany</td>
<td>1,9165</td>
<td>p</td>
<td>21,030</td>
<td>p</td>
<td>28,915</td>
</tr>
<tr>
<td>Estonia</td>
<td>15</td>
<td>p</td>
<td>5</td>
<td>p</td>
<td>10</td>
</tr>
<tr>
<td>Ireland</td>
<td>3,935</td>
<td>p</td>
<td>4,240</td>
<td>p</td>
<td>4,305</td>
</tr>
<tr>
<td>Greece</td>
<td>25,115</td>
<td>p</td>
<td>12,265</td>
<td>p</td>
<td>9,050</td>
</tr>
<tr>
<td>Spain</td>
<td>7,195</td>
<td>p</td>
<td>5,295</td>
<td>p</td>
<td>5,050</td>
</tr>
<tr>
<td>France</td>
<td>29,160</td>
<td>p</td>
<td>30,750</td>
<td>r</td>
<td>49,735</td>
</tr>
<tr>
<td>Italy</td>
<td>:</td>
<td>10,350</td>
<td>p</td>
<td>9,345</td>
<td>p</td>
</tr>
<tr>
<td>Cyprus</td>
<td>6,780</td>
<td>p</td>
<td>4,540</td>
<td>p</td>
<td>7,715</td>
</tr>
<tr>
<td>Latvia</td>
<td>35</td>
<td>p</td>
<td>10</td>
<td>p</td>
<td>20</td>
</tr>
<tr>
<td>Lithuania</td>
<td>125</td>
<td>p</td>
<td>145</td>
<td>p</td>
<td>100</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>425</td>
<td>p</td>
<td>525</td>
<td>p</td>
<td>800</td>
</tr>
<tr>
<td>Hungary</td>
<td>3,420</td>
<td>p</td>
<td>2,115</td>
<td>p</td>
<td>1,610</td>
</tr>
<tr>
<td>Malta</td>
<td>1,380</td>
<td>p</td>
<td>1,270</td>
<td>p</td>
<td>1,165</td>
</tr>
<tr>
<td>Netherlands</td>
<td>7,100</td>
<td>p</td>
<td>14,465</td>
<td>p</td>
<td>12,345</td>
</tr>
<tr>
<td>Poland</td>
<td>7,205</td>
<td>p</td>
<td>4,225</td>
<td>p</td>
<td>5,240</td>
</tr>
<tr>
<td>Portugal</td>
<td>225</td>
<td>p</td>
<td>130</td>
<td>p</td>
<td>115</td>
</tr>
<tr>
<td>Romania</td>
<td>660</td>
<td>p</td>
<td>380</td>
<td>p</td>
<td>485</td>
</tr>
<tr>
<td>Slovenia</td>
<td>370</td>
<td>p</td>
<td>500</td>
<td>p</td>
<td>1,550</td>
</tr>
<tr>
<td>Slovakia</td>
<td>2,640</td>
<td>p</td>
<td>2,850</td>
<td>p</td>
<td>3,550</td>
</tr>
<tr>
<td>Finland</td>
<td>1,405</td>
<td>p</td>
<td>2,275</td>
<td>p</td>
<td>3,595</td>
</tr>
<tr>
<td>Sweden</td>
<td>36,205</td>
<td>p</td>
<td>24,320</td>
<td>p</td>
<td>17,530</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>27,905</td>
<td>p</td>
<td>28,320</td>
<td>r</td>
<td>30,840</td>
</tr>
</tbody>
</table>

p = provisional value    r = revised value    : = not available

NB: These figures refer to all persons who apply on an individual basis for asy-
lum or similar protection, irrespective of whether they lodge their application on arrival at the border, or from inside the country, and irrespective of whether they entered the country legally or illegally. Due to different methods of collecting the information, data from different countries may not be entirely comparable.

---

29 Provisional figure from the Eurostat database. Accessible at: http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1090,1&_dad=portal&_schema=PORTAL
Appendix 2  Good, better, best practice: in search of excellence in sexual and reproductive health provisions for refugees and asylum seekers

What is a good and best practice?

There is no universally accepted definition of good or best practice – and continuing debate over terminology and definitions can even create a roadblock to action. Many international organizations prefer the term best practice over good practice, however, it is often not clear what is the difference between those two concepts. Some state that best practice is good practice that has been rigorously evaluated, others treat both terms as equals. Given the ambitious connotation of the wording ‘best practice’, the en-hera! network prefers ‘good practice’.

After reviewing several definitions, the members of the en-hera! Steering Committee agreed that a good practice must at a minimum:

- Demonstrate evidence of success
- Have a major impact on issues of general concern
- Bear the potential to be replicable and transferable to other settings.

Some international health and development organizations also believe good or best practices must be innovative, sustainable, cost-effective, ethically sound, and/or superior to all other approaches.30

Examples of definitions

UNESCO31 states that the following four characteristics are common to all best practices related to poverty and social exclusion:

- Best practices are innovative. A best practice has developed new and creative solutions to common problems of poverty and social exclusion.
- Best practices make a difference. A best practice demonstrates a positive and tangible impact on the living conditions, quality of life or environment of the individuals, groups or communities concerned.
- Best practices have a sustainable effect. A best practice contributes to sustained eradication of poverty or social exclusion, especially by the involvement of participants.
- Best practices have the potential for replication. A best practice serves as a model for generating policies and initiatives elsewhere.

UNAIDS32 defines best practice as follows: ‘Best practice means accumulating
and applying knowledge about what is working and not working in different situations and contexts. It is both the lessons learned and the continuing process of learning, feedback, reflection and analysis.’

According to UNAIDS the criteria for whether an approach, strategy or programme qualifies as a best practice are thus related to:

- Effectiveness (an activity’s overall success in producing desired outcomes)
- Ethical soundness (follows principles of social and professional conduct)
- Relevance (in this case, how closely an activity is focused on HIV and AIDS)
- Efficiency and cost-effectiveness (an activity’s capacity to produce desired results with a minimum of expenditure)
- Replicability (the ability of a programme to be adapted to meet similar needs in other settings)
- Sustainability (the ability of a programme or project to continue being effective in the future).

A best practice can be anything that works, in full or in part and can be useful in providing lessons learned. This means that, according to UNAIDS, a best practice needs only meet one or more of the criteria mentioned above, and not necessarily all of them.

UNFPA describes best practices as ‘planned or operational practices that have been proven successful in particular circumstances and are used to demonstrate what works and what does not, with evidence on how and why they work in different situations and contexts’.

The Global Health Council states that practices are best practices if they are ‘community-based, sustainable, replicable, and have measurable outcomes to show the success of the programme’.

According to the Implementing Best Practices (IBP) Initiative in Reproductive Health, the term best practice refers to ‘an array of evidence-based tools, materials and practices, including guidelines, norms, standards, experiences and skills, among others, that have proven their worth in the field of reproductive health’.33

---

31 www.unesco.org/most/bphome.htm#1
33 www.ibpinitiative.org/best_practices.php
Figure 3  Pyramid of Practices

Figure 4  Pyramid of Practices
Advance Africa, which was funded by USAID to collect and share best practices, states: ‘A best practice is a specific action or set of actions exhibiting quantitative and qualitative evidence of success with the ability to be replicated and the potential to be adapted and transferred. A best practice is the ‘gold standard’ of practices, activities, or tools that can be implemented to support programme objectives.’

What are lessons learned? Promising practices?

The terms ‘lessons learned’ and ‘promising practices’ are both terms used to describe useful practices. These terms are often used to indicate practices or approaches that have not been evaluated as rigorously as ‘best practices’, but that still offer ideas about what works best in a given situation.34

Advance Africa differentiated a promising practice from a best practice in this way: ‘A promising practice is a specific action or set of actions exhibiting inconclusive evidence of success or evidence of partial success. It may or may not be possible to replicate a promising practice in more than one setting.’

The Pyramids of Practices on page 56 illustrate the various types of practices and the ways in which they are related.

Glossary from the UNAIDS Manual on Best Practices: HIV/AIDS programming with children and young people

Best practice (**** out of 4) is the ‘gold standard’ of practices, activities, or tools that can be implemented to support programme objectives. Evidence of impact and success is drawn from multiple settings and is based on objective data. Best practices involve limited risk because they have a good track record and evidence of success and have been successfully replicated. Programme staff can be more confident that adapting and implementing a best practice to fulfil their programme needs will help achieve desired programme objectives.

Better practices (** out of 4) are state of the art (SOTA) practices that have been improved based on lessons learned. The projects and interventions show promise for transfer to new settings. There is less risk associated with imple-
menting better practices than with sota or innovative practices because there is clearer evidence of success and more lessons learned through experience. Evidence exists in both qualitative and quantitative form, but is drawn from application of the practice in limited settings.

**State of the art** (*** out of 4) refers to practices that reflect new trends and current thinking in the field. These practices may be successful in localized settings, but much of the evidence is preliminary or anecdotal. There is a large degree of risk associated with implementation of sota practices because they may not have been replicated extensively.

**Innovations** (* out of 4) are cutting-edge approaches that reflect new, possibly untested thinking. They are sometimes variations on an old theme. Innovations come in the form of pilot programmes or experimental projects. There is little if any objective evidence that the practice will have the desired impact. The promise of an innovation is based on speculation and lessons learned from other practices. A high degree of risk is associated with applying innovations to a programme.

**Lessons learned** are cross-cutting observations and conclusions that apply to a specific practice. The lessons themselves are extrapolated from experience with an intervention or programme. Evidence supporting the lessons is clear and objective. It is through the process of lessons learned that a practice or intervention moves up the pyramid to another stage. As time progresses, more evidence is found to support the programme and to reduce the risk that it will not have the desired impact. The wealth of evidence increases as lessons are continually learned from experience and applied the next time around. As this process progresses, the risk continues to diminish.

**Principles** are ideas and concepts that are ‘essential’ to programme success. They are overriding conclusions that have general applicability across sectors, geographic boundaries, or technical areas for a programme. These might be considered ‘truisms’, usually relating to policy. There is definitive quantitative and objective evidence from multiple implementation experiences supporting the practice. Principles do not necessarily come in the form of programmes or interventions.

**Good/best practice databases and resources**

UNFPA has a toolkit, which provides guidance and options for project staff to improve planning, monitoring and evaluation activities in the context of results-based programme management.
www.unfpa.org/monitoring/toolkit.htm

The World Bank has a website for knowledge and learning, where they present their best practices. Knowledge sharing at the World Bank has evolved over time. From an early emphasis on capturing and organizing knowledge, its focus now is on adopting, adapting, and applying knowledge in a way that helps practitioners to work more effectively to reduce global poverty.
www.worldbank.org/ks

Identifying and analyzing ‘good practices’ is part of UNICEF’s search for excellence. They distil these from field experience, monitoring and evaluation of what works in programming, advocacy and management, and why.
www.unicef.org/evaluation/index_12966.html

UNESCO maintains a database on best practices in order to present and promote creative, successful and sustainable solutions to social problems arising from poverty and social exclusion in order to build a bridge between empirical solutions, research and policy.
www.unesco.org/most/bphome.htm#1

The South African Youth Development Network has a website where they publish their different manuals and resources.
www.ydn.org.za

Advance Africa has developed a Best Practice Compendium, which can be downloaded from their website. The Best Practices Compendium was created to provide an easily accessible database of proven practices to be used by programme managers who have identified gaps, needs, and opportunities in their programmes.
www.advanceafrica.org/Compendium

Background information on the Best Practice Process of Advance Africa can be found on the organization’s website.

The INFO Project, which is run by Johns Hopkins University, created a tool which explains how an organization can more effectively share its own best practices internally.
www.infoforhealth.org/practices/InternalBPs/index.shtml
The INFO Project’s Best Practices Signpost directs users to the latest information on proven practices in family planning and reproductive health. It provides annotated links to websites and online publications with information on best practices – as well as good practices, promising practices, lessons learned, and evidence-based medicine.

www.infoforhealth.org/practices/signpost.shtml

ARC, the Asylum Seeking and Refugee Children, developed a Good Practice website, a new online resource from the National Children’s Bureau (uk) targeting those working with separated or unaccompanied refugee children or young people.

www.ncb.org.uk/Page.asp?sve=881

The Implementing Best Practices (IBP) Initiative is an interactive forum aiming at sharing experiences which improve the introduction, utilization and scaling-up of evidence-based practices and/or proven effective practices in reproductive health.

www.ibpinitiative.org
Appendix 3 Useful guidelines and documents in the field of sexual and reproductive health and rights

Human rights and sexual and reproductive rights

*UN Declaration of Human Rights*
www.un.org/Overview/rights.html

*UN-ICPD Programme of Action of the International Conference on Population and Development (Cairo, 1994)*
The 20 Year Programme of Action as agreed upon by 179 countries in 1994 in Cairo can be found on the UNFPA website: www.unfpa.org/icpd/icpd.cfm

*Beijing Declaration*

*UN fact sheet: The Right to Reproductive and Sexual Health*
www.un.org/ecosocdev/geninfo/women/womrepro.htm

*UNHCR guide to International Refugee Law*
www.unhcr.org/refworld/docid/3cd6a8444.html

*UNHCR Collection of International Instruments and Legal Texts Concerning Refugees and Others of Concern to UNHCR*
UN High Commissioner for Refugees, edition June 2007. This Collection of International Instruments and Legal Texts spans four volumes and contains over 260 documents that have been compiled to support those working on issues relating to forced displacement, statelessness and related matters. UNHCR Refworld
www.unhcr.org/publ/pub1/455c460b2.html

*1951 UN Convention relating to the status of refugees*
www.unhchr.ch/html/menu3/b/o_c_ref.htm

*PICUM publication regarding Rights of Undocumented Migrants*
www.picum.org
**IPPF Charter on Sexual and Reproductive Rights**
The IPPF Charter has been designed as a tool to help NGOs to hold governments accountable for promises they have made in upholding human rights in general, and sexual and reproductive rights in particular. It includes twelve basic human rights, with examples of their relevance to sexual and reproductive rights work.


**IPPF Declaration on Sexual Rights**
www.ippf.org/en/Resources/Statements/Sexual+rights+and+IPPF+declaration.htm

**UNFPA: Human Rights-Based Programming**
www.unfpa.org/publications/detail.cfm?id=324&filterListType=1

**Inter-Agency Guiding Principles on Unaccompanied and Separated Children**
www.unfpa.org/publications/detail.cfm?id=324&filterListType=1

**ICRC publication: Women facing War**
This ICRC study is an extensive reference document on the impact of armed conflict on the lives of women.
www.icrc.org/Web/Eng/siteengo.nsf/html/p0798

**WHO: Transforming health systems: gender and rights in reproductive health**
A training resource for health trainers to use with health managers, planners, policy-makers and others with responsibilities in reproductive health.
www.who.int/reproductive-health

**WHO: Gender and Rights in Reproductive and Maternal Health: Manual for a Learning Workshop**
This manual is intended for use in facilitating a six-day workshop on gender and rights in reproductive and maternal health for health managers, policy-makers and others with responsibilities in reproductive health.
www.who.int/reproductive-health

**Health Key Issues Guide: Universal Access to Sexual and Reproductive Health Services**
A Guide produced by IDS (Health and Development Information Team) and adopted by the UN General Assembly in September 2006
www.eldis.org/go/topics/resource-guides/health/key-issues/universal-access-to-sexual-and-reproductive-health-services

**ICW Fact Sheet: Sexual and reproductive health and rights**
Fact sheet developed by the International Community of Women Living with
HIV/AIDS (ICW) and the Global Coalition on Women and AIDS (GCWA)
www.icw.org/files/srh-r-icw%20fact%20sheet-06.doc

Links to SRH in general

WHO recommendations and guidelines regarding SRH
Most SRH resources developed by WHO can be found on the website www.who.int/reproductive-health/publications.

• The WHO Regional Office for Europe developed two major strategy documents regarding Reproductive Health framework for Member States: the WHO European regional strategy on sexual and reproductive health and the Strategic Action Plan for the Health of Women in Europe.
www.euro.who.int/reproductivehealth/advocacy/20021015_1

• WHO: Engaging men and boys in changing gender inequity in health (report 2007)
www.who.int/gender/documents/Engaging_men_boys.pdf

UNFPA resources on sexual and reproductive health, human rights, gender equality and culturally sensitive approaches
www.unfpa.org/issues/

IPPF Medical and Service Delivery Guidelines and IPPF Toolkits
The IPPF guidelines offer up-to-date evidence-based guidance on a range of SRH issues, including family planning.

ICRH Sexual and Reproductive Health and Rights of Refugee Women in Europe: literature review and policy recommendations
Both reports resulted from an international research project on SRH&R in Europe
www.ggdkennisnet.nl/kennisnet/paginaSjablonen/raadplegen.asp?display=2&atoom=32785&atoomsrt=17&actie=2

Links to SRH of refugees, asylum seekers and migrants

Sexual health, asylum seekers and refugees. A handbook for people working with refugees and asylum seekers in England

An Inter-agency Field Manual: Reproductive Health in Refugee Situations (1999)
www.unfpa.org/emergencies/manual
UNHCR: Reproductive Health Services for Refugees and Internally Displaced Persons (2004)
www.unhcr.org/publ/publ/41c9384d2a7.html

Publications of the RAISE initiative
www.raiseinitiative.org/library

Field Tools/Guidelines of the RHRC (Reproductive Health Response in Conflict Consortium)
RHRC resources accessible at: www.rhrc.org/resources/index.cfm
RHRC fact sheets accessible at: www.rhrc.org/rhr_basics/factsheet.html

United Nations Population Information Network (Popin): Information About Refugees and Reproductive Health
www.un.org/popin/refugees.htm

PATH/RHO archives: Annotated bibliography on refugee reproductive health

WHO: Reproductive health during conflict and displacement: A guide for programme managers
www.who.int/reproductive-health/publications/conflict_and_displacement

UNFPA: Challenges and Good Practices In Support of Women in Conflict and Post-Conflict Situations
www.unfpa.org/publications/detail.cfm?Id=348&filterListType=1

UNFPA: International Migration and the Millennium Development Goals
www.unfpa.org/publications/detail.cfm?Id=246&filterListType=1

ICRH publication: Towards a comprehensive approach of sexual and reproductive rights and needs of women displaced by war and armed conflict. A practical guide for programme officers
www.popline.org/docs/274647

Marie Stopes International: Access to life-saving sexual and reproductive health services for refugees and internally displaced persons (IDPs)
www.mariestopes.org/Health_programmes/Refugees_%5E_IDPs.aspx

Reproductive health databases

One Source Database combines the resources of the following six unique databases from INFO (the Info for Health project which is run by Johns Hopkins University) and the Health Communication Partnership.
www.infoforhealth.org/onesource.shtml

1 **POPLINE** – the world’s largest database on reproductive health
   www.popline.org

2 The **Pop Reporter** – an electronic magazine published weekly by Info
   www.infoforhealth.org/popreporter/current.shtml

3 **Photoshare** – contains more than 13,000 photographs from international public
   health activities www.photoshare.org

4 The **M/MC Health Communication Materials Database** provides digital access to
   the world’s largest, most comprehensive collection of health communication material
   www.m-mc.org

5 **Netlinks** – an online database of over 2,000 organizations working in global
   health and development with up-to-date contact information and website links

6 **Q&As** – Q&As is designed to include USAID’s Dr. Jim Shelton’s Pearls (www.info-
   forhealth.org/pearls/parchive.shtml), Healthwise (www.hcpartnership.org/Healthwise/index.php) and other
   Frequently-Asked-Questions (FAQs) from Info.

**One Source resources** have been organized into 14 categories (child health, ado-
lescent reproductive health, family planning, gender and health, health communication, HIV/AIDS/STIs, infectious diseases, maternal health, population, and demography).
   www.infoforhealth.org/topics/hierarchy.php

The **Reproductive Health Gateway** is a search tool, powered by Google, which al-
lows you to perform a simultaneous search of more than 140 websites involved
in reproductive health and related activities worldwide
   www.infoforhealth.org/rhgateway/index.shtml

**Reproline**, information regarding reproductive health online, a service of the
John Hopkins University
   www.reproline.jhu.edu/index.htm

**European health policies**

**Health-EU: The Public Health Portal of the European Union**
The official public health portal of the European Union offers a wide range of
information and data on health-related issues and activities at both European
and international level. The main objective is to provide European citizens with
easy access to comprehensive information on Public Health initiatives and pro-
grammes at EU level.
   http://ec.europa.eu/health-eu/index_en.htm

www.picum.org

**National websites and guidelines regarding health of refugees, asylum seekers and undocumented migrants**

*AsylumSupport.Info* is a website with information, publications, policies, links, online world news, etc. regarding asylum seekers in the UK as well as worldwide.

www.asylumsupport.info

*HARPWEB* (Health for Asylum Seekers and Refugees Portal) consists of three websites designed to enable easy access to the wealth of information, practical tools, and articles that have been written by health care professionals, NGOs, academics and research bodies with expert knowledge of working with asylum seekers and refugees, both in the UK and other countries.

www.harpweb.org.uk/index.php

*Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers*


*Medimmigrant:* a Belgian organization promoting and providing information about health care for undocumented migrants

www.medimmigrant.be

*Pharos:* Dutch knowledge and advisory centre on refugees, migrants and health

www.pharos.nl

**Guidelines on STIs**

*WHO publications: Reproductive Tract Infections and Sexually Transmitted Infections including HIV/AIDS*

www.who.int/reproductive-health/publications/stis_rtis.htm

*WHO guidelines for the management of Sexually Transmitted Infections*


*WHO Sexually transmitted and other reproductive tract infections – A guide to essential practice (2005)*

www.who.int/reproductive-health/publications/rtis_gep/index.htm

*Sexually Transmitted Diseases: cdc treatment guidelines*

www.cdc.gov/std/treatment/
Guidelines on HIV and AIDS

**UNAIDS: Joint United Nations Programme on HIV/AIDS**
- UNAIDS/WHO estimates on the global AIDS epidemic (data and reports) are accessible at www.unaids.org/en/KnowledgeCentre/HIVData
- HIV and AIDS policies and (best) practices can be found at www.unaids.org/en/PolicyAndPractice/default.asp

**IASC: Guidelines for HIV/AIDS interventions in emergency settings**

www.unfpa.org/publications/detail.cfm?id=382&filterListType=

**WHO guidelines: HIV/AIDS treatment and care. Clinical protocols for the WHO European Region**
www.euro.who.int/InformationSources/Publications/Catalogue/20071121_1

**European Guidelines: HIV prevention in Europe: Action, needs and challenges**

**International Federation of Red Cross and Red Crescent Societies**
The International Federation of Red Cross and Red Crescent Societies list following and other useful documents in the field of HIV and AIDS on their website www.ifrc.org/what/health/tools/index.asp:
- **HIV prevention treatment, care and support**
  This set of eight generic training modules on HIV prevention, treatment, care and support for community-based volunteers was developed as a partnership between the International Federation of Red Cross and Red Crescent Societies, the World Health Organization and the Southern Africa HIV/AIDS Information Dissemination Service.
- **Service delivery model for access to care and antiretroviral therapy for persons living with HIV/AIDS**
  This publication aims to help National Societies support their governments’ efforts to initiate and scale up the access to antiretroviral therapy within the context of a holistic intervention.
UNESCO: Educational responses to HIV and AIDS for refugees and internally displaced persons: discussion paper for decision makers

Guidelines and tools on SGBV

www.unchr.org

WHO (2007). Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies
www.who.int

UNFPA (2007). Ending Violence Against Women: Programming for Prevention, Protection and Care
www.unfpa.org

www.unfpa.org

www.who.int

www.who.int

UNHCR (2003). Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response
www.unchr.org

www.unhchr.org/refworld/docid/439474c74.html


UNHCR (2006). The UNHCR Tool for Participatory Assessment in Operations
www.unchr.org

www.who.int


**Guidelines on maternal and newborn health**

**WHO Regional Office for Europe:** European strategic approach for making pregnancy safer

www.euro.who.int/pregnancy/20071024_1

**WHO publications regarding maternal and newborn health**

www.who.int/reproductive-health/publications/maternal_newborn.en.html

*The partnership for Maternal, Newborn & Child Health*

www.who.int/pmnch/about/en

**UNFPA Safe Motherhood programme**

www.unfpa.org/mothers/index.htm

**UNICEF resources regarding Maternal and Newborn health**

www.unicef.org/health/index_maternalhealth.html

**MIGHEALTHNET** The information network on good practice in health care for migrants and minorities in Europe

www.mighealth.net/uk/index.php

**Guidelines on family planning and abortion services**

*The European Society of Contraception & Reproductive Health*

www.contraception-esc.com/index.htm

**WHO selected practice recommendations for contraceptive use**

www.who.int/reproductive-health/publications/spr/index.htm

**IPPF information regarding contraception and contraceptive methods**

www.ippf.org/en/Resources/Contraception/Contraception.htm

**UNFPA publication: Meeting the Need: Strengthening Family Planning Programmes**

www.unfpa.org/publications/detail.cfm?ID=309
Guidelines on HPV, cervical and other gynaecological cancers

*European guidelines for quality assurance in cervical cancer screening*

*European Guidance for the introduction of HPV vaccines in EU countries*

*European guidelines for quality assurance in breast cancer screening and diagnosis*

*WHO guidelines regarding cervical cancer/HPV*
www.who.int/reproductive-health/publications/cancers.html

Guidelines on confidentiality and privacy

*European guidelines: European standards on Confidentiality and Privacy in Healthcare Among Vulnerable Patient Populations*
www.eurosocap.org

*UNAIDS Guidelines on Confidentiality and Security of HIV Information*
www.unaidso.org/en/KnowledgeCentre/hivData/Confidentiality

Web links regarding youth, adolescents and separated children

*UNHCR (2001). Protection and assistance to unaccompanied and separated refugee children*
www.unhcr.org/refworld/category,REFERENCE,ANNUALREPORT,3be124486,o.html

*Safe the Children: European Programme*

*Safe the Children: Action for the Rights of Children. Resource pack: Sexual and Reproductive Health*
www.savethechildren.net/arc/files

*Women’s Commission for Refugee Women and Children*
www.womenscommission.org
UNHCR: Work with Young Refugees to Ensure Their Reproductive Health and Well-being
www.womenscommission.org/pdf/ad_hiv.pdf

FMO (Forced Migration Online): Children and Adolescents in Conflict Situations
www.forcedmigration.org/guides/fmo008

Refugee Council Online: Claiming Asylum at a Screening Unit as an Unaccompanied Child
www.refugeecouncil.org.uk/policy/external_reports

ARC (Asylum Seeking and Refugee Children) Good Practice website
www.ncb.org.uk/Page.asp?sve=881

WHO publications: Sexual and reproductive health of adolescents
www.who.int/reproductive-health/publications/adolescents.html
Self-assessment tools
Self-assessment tool for development of SRH policy for refugees, asylum seekers and undocumented migrants

On behalf of the EN-HERA! Network we wish to thank you for your interest in the promotion of sexual and reproductive health (SRH) and rights\(^1\) of refugees, asylum seekers and undocumented migrants\(^2\) in Europe and beyond.

The purpose of this self-assessment tool is to assist your organization or programme in identification and/or development of good practices in SRH policy for refugees, asylum seekers and undocumented migrants. Moreover, by means of this tool you may be able to assess what elements in your service or programme need to be strengthened to comprehensively address SRH (rights) issues of these target groups.\(^3\)

As elaborated earlier, the assessment takes place at two levels: the fundamental and the programmatic.\(^4\) On the basis of the current literature and our own research, we suggest six guiding principles in sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants. Completing this tool will allow for assessing how much your organization or programme already employs good practices in its programmes. This, in turn, could help you decide which principles your organization or programme should concentrate on to ensure the SRH&R of these beneficiaries.

We realize that perhaps not all the elements will apply to your organization or programme. If this is the case, then you can skip irrelevant sections in the self-assessment tool. Some parts are especially applicable for organizations working on the level of national policy making, other parts are relevant for organizations working on the level of organizational policy making. In this way you can identify whether your organization or programme is doing well despite gaps in national policy with respect to SRH of refugees, asylum seekers and undocumented migrants. Also note that all statements refer to your organization or programme as a whole. Try to see your answers as a contribution of your organization or programme to the existing SRH policy. This checklist can be an-

---

1 as defined in paragraph 2.1
2 as defined in paragraph 2.2
3 see paragraph 1.6 for more detailed explanation of the self-assessment tool’s purpose
4 see paragraph 2.4 and 2.5 for explanation of fundamental and programmatic levels of assessment
swered by individuals from such organizations or programmes, but it can also be answered by any organizational or programme team, e.g. before planning a programme or implementing a strategy.5

**Instructions for scoring good practices in SRH policy development**

The answers to the statements below will help determine if and to what extent your organization or programme employs good practices for each of the charted elements. For the statements below you are requested to tick the box that corresponds with the extent of progress that you feel your organization or programme has made to this moment. You can choose from a range of five answers. The answers are:

1 = very poor
2 = poor
3 = average
4 = good
5 = very good

Then make a total of all scores at the bottom of the relevant principle or indicator. On the last page you can mark your totals on the scoring sheet that is provided and calculate your own ‘best practice’ percentage. Subsequently, you can identify the level your ‘practice’ is at. Its aim is to define how closely your programme currently fits an ideal best practice and to enable you to identify points that would need improvements.
## Guiding principles

### Table 1  Rights-based approach

<table>
<thead>
<tr>
<th>Policy-making National level</th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There is a national rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Our national policy-making reflects international rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Refugees, asylum seekers &amp; undocumented migrants* have the same access without discrimination (no conditions to fulfil) to rights-based SRH services as the host population.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Undocumented migrants have the same entitlement to SRH services as the host population.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Total scores of all statements in this section</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy-making Organizational level</th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Our organization is familiar with the national rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Our organization is familiar with the regional rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Our organization is familiar with the local rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Our organization contributes to a national rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Our organization contributes to a regional rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6</td>
<td>Our organization contributes to a local rights-based policy on SRH.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Total scores of all statements in this section</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

* Refugees, asylum seekers & undocumented migrants

---

5 see paragraph 1.6 for more detailed suggestions for the tool’s usage
6 as defined in paragraph 4.2
### Table 2  Participatory approach

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Our organization participates in the SRH policy-making process at national level.*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 NGOs and community organizations participate actively in all phases of the SRH policy-making process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Beneficiaries and service users participate actively in all phases of the SRH policy-making process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Health service and social service providers participate actively in all phases of the SRH policy-making process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Researchers and intercultural mediators participate actively in all phases of the SRH policy-making process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 In the SRH policy-making process, stakeholders participate at least in a collaborative way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Score**

Total scores of all statements in this section

---

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 In the policy-making process of our organization different stakeholders participate in a collaborative way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 NGOs, community organizations and service users participate actively in all phases of the organizational policy-making process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Score**

Total scores of all statements in this section

---

* The stages of the policy-making process are: planning, implementation, monitoring, and evaluation.
### Table 3  Empowerment

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Our SRH policies contribute to the personal empowerment of all clients, including R, AS &amp; UM.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Our policy-making empowers R, AS &amp; UM to claim their rights to SRH &amp; SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Our policy-making empowers R, AS &amp; UM to claim their rights to physical, mental and social well-being related to reproduction, sexual relations and sexuality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Score**

<table>
<thead>
<tr>
<th>Policy making</th>
<th>Total scores of all statements in this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Our SRH policies contribute to the personal empowerment of all clients, including R, AS &amp; UM.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Our organization empowers R, AS &amp; UM to claim their rights to SRH &amp; SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Our organization empowers R, AS &amp; UM to claim their rights to physical, mental and social well-being related to reproduction, sexual relations and sexuality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Score**

<table>
<thead>
<tr>
<th>Policy making</th>
<th>Total scores of all statements in this section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td></td>
</tr>
</tbody>
</table>

---

7 as defined in paragraph 4.3
8 as defined in paragraph 4.4
### Table 4  Gender-balanced approach

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level</td>
<td>1 Our policy-making promotes gender equality for all, including R, AS &amp; UM.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>2 Our policy-making addresses the following gender-related violations of SRH rights:</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual partner choice</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual sexual relations</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual marriage</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Forced pregnancy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Forced abortion/sterilization</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Sexual and gender-based violence</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Score</td>
<td>Total scores of all statements in this section</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy-making</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td>1 Our organization promotes gender equality for all, including R, AS &amp; UM.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>2 Our organization addresses the following gender-related violations of SRH rights:</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual partner choice</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual sexual relations</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Non consensual marriage</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Forced pregnancy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Forced abortion/sterilization</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• Sexual and gender-based violence</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Score</td>
<td>Total scores of all statements in this section</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 5  Multidisciplinary approach

<table>
<thead>
<tr>
<th>Policy-making level</th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>In policy-making our organization adopts a multidisciplinary approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our organization involves the following disciplines in SRH policy-making:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gynaecologists and midwives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Urologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychologists and counsellors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Legal aid advisors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Community educators and workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intercultural mediators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fundraisers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sexologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our SRH policy-making is involved in other SRH interventions/programmes, such as:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Exchange of expertise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Consultation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Referral system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Networking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Using lessons learned from service delivery to inform advocacy/lobbying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score: Total scores of all statements in this section

---

9 as defined in paragraph 4.5
10 as defined in paragraph 4.6
Table 6  Cross-sectoral approach

<table>
<thead>
<tr>
<th>Policy-making National level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our national policy-making encourages a cross-sectoral approach on (inter)national level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Our national policy-making encourages a cross-sectoral approach on regional and local level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3. In the country our organization works, the following sectors are involved in the SRH policy-making process:  
  • Political sector  
  • Legal sector  
  • Educational sector  
  • General migrants health sector  
  • SRH sector  
  • Mental health sector  
  • Community and civil society sector  
  • Reception sector |   |   |   |   |   |

<table>
<thead>
<tr>
<th>Policy-making Organizational level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our organization encourages a cross-sectoral approach on (inter)national level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Our organization encourages a cross-sectoral approach on regional and local level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3. In the country we work, the following sectors are involved in the SRH policy-making process:  
  • Political sector  
  • Legal sector  
  • Educational sector  
  • General migrants health sector  
  • SRH sector  
  • Mental health sector  
  • Community and civil society sector  
  • Reception sector |   |   |   |   |   |

Score: Total scores of all statements in this section

Score: Total scores of all statements in this section
Scoring for self-assessment tool

Your score \((A)\) = please transfer here your total score which you have counted at the bottom of each chart under Total scores of all statements in this section

Number of applicable statements \((b)\) = please specify here how many statements you answered

Maximum score \((c)\) = please multiply the number of applicable statements \((b)\) by 5 (as score 5 is the highest score possible one can obtain in each section)

Your % \((d)\) = please divide your score \((A)\) by the maximum score you could obtain \((c)\), and transform it into percentages (multiple by 100%)

Your level = please have a look at level specification and explanation below the table; each level applies to a certain percentage group

Table 7 Final scoring table

<table>
<thead>
<tr>
<th>For the element...</th>
<th>Your Score ((A))</th>
<th>Number of applicable questions ((b))</th>
<th>Maximum score ((c)) = ((A) \times 5)</th>
<th>Your % ((d)) = ((A) / (c) \times 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rights-based approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Participatory approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Empowerment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Gender-balanced approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Multidisciplinary approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Cross-sectoral approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

as defined in paragraph 4.7
Level

A = 80% to 100%  Congratulations! You are certainly doing your best to employ good practices in your work.
B = 60% to 79%  You are on the right way. Consolidate your efforts.
C = 40% to 59%  You can achieve SRH for all when trying a little harder.
D = 20% to 39%  More efforts are needed if you want to improve SRH of refugees, asylum seekers and undocumented migrants. Looking at the specific areas in which your programme performs weakly may help to identify where you should concentrate to make progress.
E = 0% to 19%  Your programme still encounters too many barriers in implementing good practices and may need support to perform better. Looking at the specific areas in which your programme performs weakly may help to identify where you should concentrate to make progress.
Self-assessment tool for SRH service delivery of refugees, asylum seekers and undocumented migrants

On behalf of EN-HERA! Network we wish to thank you for your interest in promotion of sexual and reproductive health (SRH) and rights of refugees, asylum seekers and undocumented migrants in Europe and beyond.

The purpose of the self-assessment tool is to assist your organization or programme in identification and/or development of good practices in SRH service delivery for refugees, asylum seekers and undocumented migrants. Moreover, by means of this tool you may be able to assess what elements in your service or programme need to be strengthened to comprehensively address SRH (rights) issues of these target groups.

As elaborated earlier, the assessment takes place at two levels: the fundamental and the programmatic. On the basis of the current literature and our own research, we suggest six guiding principles and six key programmatic indicators of quality in sexual reproductive health care for refugees, asylum seekers and undocumented migrants. Completing this tool will allow for assessing how much your organization or programme already employs good practices in its programmes. This, in turn, could help you decide which principles and indicators your organization or programme should concentrate on to ensure the SRH&R of these beneficiaries.

We realize that perhaps not all the elements will apply to your organization or programme. If this is the case, then you can skip irrelevant sections in the self-assessment tool. Also note that all statements refer to your organization or programme as a whole. This checklist can be answered by individuals from organizations or programmes, but it can also be answered by any organizational or programme team, e.g. before planning a programme or implementing a strategy.

---

12 as defined in paragraph 2.1
13 as defined in paragraph 2.2
14 see paragraph 1.6 for more detailed explanation of self-assessment tool’s purpose
15 see paragraph 2.4 and 2.5 for explanation of fundamental and programmatic levels of assessment
16 see paragraph 1.6 for more detailed suggestions for the tool’s usage
Instructions for scoring good practices in SRH service delivery

The answers to the statements below will help determine if and to what extent your organization or programme employs good practices for each of the charted elements. For the statements below you are required to tick the box that corresponds to the extent of progress that you feel your organization or programme has made to this moment. You can choose from a range of five answers. These answers are:

1 = very poor
2 = poor
3 = average
4 = good
5 = very good

Then make a total of all scores at the bottom of each relevant principle or indicator. On the last page you can mark your totals on the scoring sheet that is provided and you can calculate your own ‘best practice’ percentage. Subsequently, you can identify the level your ‘practice’ is at. Its aim is to define how closely your programme currently fits an ideal best practice and to enable you to identify points that would need improvements.
Guiding principles

Table 1  Rights-based approach

<table>
<thead>
<tr>
<th>SRH service delivery</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td>Our organization develops and provides relevant and appropriate information on different SRH topics and risks for R, AS &amp; UM*:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pregnancy and fertility-related topics</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family planning</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV/STIs</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sexual Risk Behaviours</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Healthy sexual relationships</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Legal rights</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Safe abortion</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social Services</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sexual and Gender-Based Violence</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Our organization gets feedback from service users about the information we provide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Our organization takes special measures to improve access to SRH services, service providers and key contact persons for R, AS &amp; UM:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interculturally competent and gender-sensitive staff</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interculturally competent and gender-sensitive service provision</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Translation and interpreting</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assuring confidentiality</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Our organization encourages R, AS &amp; UM to claim the following SRH rights:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right to health and reproductive health</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right to access of SRH services</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right to information on SRH and risks</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right to family planning and free partner choice</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right equity and equality of services</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• right to judicial protection against SGBV</td>
<td>□ □ □ □ □</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score  Total scores of all statements in this section  1  1  1  1  1

* Refugees, asylum seekers & undocumented migrants

17 as defined in paragraph 4.2
### Table 2: Participatory approach

<table>
<thead>
<tr>
<th>SRH service delivery</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organization participates actively in the planning phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs and community organizations participate actively in the planning and evaluation phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiaries and service users participate actively in the planning and evaluation phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health service providers and social services participate actively in the planning phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy-makers participate actively in the planning and evaluation phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researchers and intercultural mediators participate actively in the planning and evaluation phase of SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>Total scores of all statements in this section</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3  Empowerment

<table>
<thead>
<tr>
<th>SRH service delivery</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td>1</td>
<td>Our organization actively promotes personal empowerment of all clients, including R, As &amp; Um.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Our organization focuses on providing a broad range of services, such as:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family planning and contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pregnancy and fertility-related issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Freedom of partner choice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sexual risk behaviour and safer sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Healthy and respectful approach to sexual diversity and sexual relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prevention HIV/STIs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prevention of sexual and gender-based violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prevention of domestic and honour-related violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sexual discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Our organization contributes to free and accessible knowledge transfer at different levels.*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Our organization contributes to free and accessible medical interventions at different levels.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Our organization contributes to free and accessible psychosocial interventions at different levels.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Our organization fights stigma and discrimination related to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sexual orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HIV/STIs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score  Total scores of all statements in this section

* Such as individual, group, community and local level

18 as defined in paragraph 4.3
19 as defined in paragraph 4.4
Table 4  Gender-balanced approach

1 Our organization adopts an evidence-based gender-balanced approach in the SRH services we provide:
- Family planning and contraception
- Pregnancy- and fertility-related issues
- Satisfying sex life
- Sexual risk behaviour and safer sex
- Healthy and respectful approach to sexuality and sexual relationships
- HIV/STI prevention
- Cervical, breast and prostate cancer
- Sexual and gender-based violence
- Domestic and honour-related violence
- Sexual and (trans)gender discrimination

2 Our organization adopts an evidence-based diversity-sensitive approach in the SRH services we provide, taking into account:
- Age/stage of life
- Cultural background
- Ethnicity
- Religious/spiritual or philosophical beliefs
- Ability/disability
- Sexual orientation
- Economic status

3 Our organization undertakes efforts to involve men and boys actively in:
- Family planning
- Contraception
- Satisfying sex life
- Healthy sexual relationships
- Sexual risk behaviour
- Respectful approach to sexuality and sexual relationships
- Safe sex
- HIV/STI prevention
- Sexual and gender-based violence
- Domestic and honour-related violence
- Sexual and (trans)gender discrimination

Score  Total scores of all statements in this section
Our SRH service adopts a multidisciplinary approach.  

Our organization involves the following disciplines in SRH service provision:
- Gynaecologists and midwives
- Urologists
- General Practitioners
- Nurses
- Psychologists and counsellors
- Legal aid advisors
- Community educators and workers
- Intercultural mediators
- Fundraisers
- Sexologists

Our SRH service is involved in other SRH interventions/programmes, such as:
- Exchange of expertise
- Consultation
- Planning
- Implementation
- Referral system
- Monitoring
- Evaluation
- Networking
- Research
- Using lessons learned from service delivery to inform advocacy/lobbying

Our organization facilitates the access of SRH, as & um to other services, such as:
- General practitioners
- Other medical services
- Social and welfare services
- Migration services
- Community organizations

Score: Total scores of all statements in this section

---

20 as defined in paragraph 4.5
21 as defined in paragraph 5.2
22 as defined in paragraph 4.6
Table 6  Cross-sectoral approach

<table>
<thead>
<tr>
<th>SRH service delivery</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Our organization adopts a cross-sectoral approach in our SRH service delivery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Our organization involves the following services in the planning phase of our SRH services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Legal services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Migration services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Policy-makers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community development services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other medical services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Our SRH service monitors the performance of other sectors working on SRH for R, AS &amp; UM in order to keep up with changes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score  Total scores of all statements in this section

Programmatic Indicators for Quality of Care

Table 1  Evidence-based and in line with international guidelines

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Our SRH services for R, AS &amp; UM are in line with existing SRH guidelines.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Research on diversity aspects of our SRH services is encouraged and facilitated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Manuals for R, AS &amp; UM are developed in lines with existing SRH guidelines.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Our SRH service providers for R, AS &amp; UM are trained and informed on existing SRH guidelines.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 There is a data collection system which allows analysis of cultural background of service users.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 The accessibility of our SRH services for R, AS &amp; UM is assessed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Data are gathered on SRH needs and client satisfaction.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Evidence suggests that there is a need for the work our organization does.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total scores of all statements in this section
Table 2  Confidentiality and privacy  25

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Total scores of all statements in this section

Table 3  Availability, acceptability, affordability, accessibility  26

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Total scores of all statements in this section

23 as defined in paragraph 4.7  24 as defined in paragraph 5.2
25 as defined in paragraph 5.3  26 as defined in paragraph 5.4
### Table 4  Monitoring and evaluation

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a monitoring system in place for our SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Client satisfaction of our SRH service users is measured regularly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Our SRH services are evaluated regarding equity of access.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Evaluations are based on a participatory approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. A system is put in place for anonymous reporting of obstacles and mistakes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. A participatory method is used to continuously improve our SRH services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total scores of all statements in this section

### Table 5  Information and choice

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. R, A, as &amp; Um are encouraged to claim their rights, to be informed on and have access to safe, effective, affordable acceptable and legal methods of family planning and fertility regulation of their choice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Information on legal rights and legal services is provided to R, A, as &amp; Um.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Informed consent is always obtained from R, A, as &amp; Um with regard to specific SRH technical procedures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Clients are counselled to make an informed choice in relation to a wide range of family planning methods to choose from is being offered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Information on abortion and post-abortion services is available and provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Information on sexual gender-based violence and on victim support services is available and provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Information on sexual gender-based violence and on victim support services is provided in understandable and accessible language.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total scores of all statements in this section
### Table 6  Continuity of care

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

A system which allows follow-up of our SRH service users is put in place (e.g. personal medical file).

A system is put in place to monitor effective referral to services for:
- Pregnancy and fertility-related topics
- Family planning
- HIV/STIs
- Sexual risk behaviour
- Healthy sexual relationships
- Legal rights
- Safe abortion
- Social services
- Sexual and gender-based violence

When our organization stops delivering its SRH services, appropriate referral is organized and the service provider is given all necessary information.

#### Scoring for self-assessment tool

Your score \((a)\) = please transfer here your total score which you have counted at the bottom of each chart under Total all scores of all statements in this section

Number of applicable statements \((b)\) = please specify here how many statements you answered

Maximum score \((c)\) = please multiple the number of applicable statements \((b)\) by five (as score 5 is the highest score possible one can obtain in each section)

Your % \((d)\) = please divide your score \((a)\) by the maximum score you could obtain \((c)\), and transform it into percentages (multiple by 100%)

Your level = please have a look at level specification and explanation below the following table; each level applies to a certain percentage group

---

27 as defined in paragraph 5.5
28 as defined in paragraph 5.6
29 as defined in paragraph 5.7
### Table 7  Final Scoring table

<table>
<thead>
<tr>
<th>For the element...</th>
<th>Your Score (A)</th>
<th>Number of applicable questions (a)</th>
<th>Maximum score (c) = (a) x 5</th>
<th>Your % (A)/(C) x 100%</th>
<th>Your level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guiding principles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Rights-based approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Participatory approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Empowerment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Gender-balanced approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Multidisciplinary approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Cross-sectoral approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programmatic indicators of quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Evidence-based and in line with international guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Confidentiality and privacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Availability, acceptability, affordability and accessibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Monitoring and evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Information and choice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Continuity of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Level**

- **A = 80% to 100%**
  Congratulations! You are certainly doing your best to employ good practices in your work.

- **B = 60% to 79%**
  You are on the right way. Consolidate your efforts.

- **C = 40% to 59%**
  You can achieve SRH for all by trying a little harder.

- **D = 20% to 39%**
  More efforts are needed if you want to improve SRH of refugees, asylum seekers and undocumented migrants. Looking at the specific areas in which your programme performs weakly may help to identify where you should concentrate on to make progress.

- **E = 0% to 19%**
  Your programme still encounters too many barriers in implementing good practices and may need support to perform better. Looking at the specific areas in which your programme performs weakly may help to identify which areas you should develop further.
Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants

A framework for the identification of good practices