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Published online: 07 Dec 2006.

To cite this article: Kristin Janssens, Marleen Bosmans, Els Leye & Marleen Temmerman (2006) Sexual and Reproductive Health of Asylum-seeking and Refugee Women in Europe: Entitlements and Access to Health Services, Journal of Global Ethics, 2:2, 183-196, DOI: 10.1080/17449620600948002

To link to this article: http://dx.doi.org/10.1080/17449620600948002
Sexual and Reproductive Health of Asylum-seeking and Refugee Women in Europe: Entitlements and Access to Health Services

Kristin Janssens, Marleen Bosmans, Els Leye and Marleen Temmerman

Asylum-seeking and refugee women (ASRW) are population groups characterized by diverse social, economic and legal backgrounds as well as diverse needs. Their backgrounds of forced migration have a profound impact on their overall health, including their sexual and reproductive health (SRH). In Europe, the SRH needs of ASRW are usually more pressing than those of the host country population. In the context of refugee health, it is important to distinguish between asylum seekers and statutory refugees, as asylum seekers have distinct needs and often limited rights in their host country. Yet both groups face many barriers in accessing national health services. This article addresses the issue of entitlements to health services for asylum-seeking women in Europe, and highlights the wide range of difficulties of both asylum-seeking and refugee women in accessing (sexual and reproductive) health services.

Introduction

By the end of 2005 the total population of concern\(^1\) to the United Nations High Commissioner for Refugees (UNHCR) was 20.8 million, of which 40% were refugees. Worldwide, the number of refugees is estimated at 8.4 million persons, the lowest level since 1980. Although data by sex were only available for roughly half of the population of concern to UNHCR, they indicate that 49% of the total population of concern are female. However, the proportion of female refugees varies greatly, depending on the characteristics of specific refugee situations, the region of asylum, age, and so on. In countries with mass refugee situations, for example, the ratio of female refugees tends to be around 50%. Among asylum seekers, the percentage of females is significantly lower, in both developing as well as developed countries, with women
disproportionately concentrated in the older age category of 60 years and over (UNHCR 2006).

Since the 1990s, awareness of the importance of sexual and reproductive health (SRH) services for refugee and internally displaced persons, mainly in refugee camp settings, has grown gradually. The United Nations International Conference on Population and Development (ICPD) in Cairo in 1994 set an important landmark in the recognition of SRH rights and needs of women and displaced populations, including refugees. The ICPD Programme of Action agreed upon a comprehensive definition of SRH within the broader context of ‘physical, mental and social well-being’ and explicitly recognized the right of men and women to have access to safe, effective, affordable and acceptable SRH services (United Nations 1994, Chapter 7, §7.2). The Programme of Action pointed out that reproductive rights are human rights and also drew the attention of the international community to the specific vulnerability of migrants and displaced persons, including refugees, whose access to SRH services is often limited and who lack the power to claim their rights (United Nations 1994, Chapter 7A, §7.3, 7.11).

In 1995, the definitions and lines of action concerning SRH and rights set out in the ICPD Programme of Action were confirmed and further developed at the Fourth World Conference on Women in Beijing. The conference platform for action emphasized that SRH rights are specific human rights of women, and a universal, inalienable, integral and indivisible part of universal human rights (United Nations 1995, Chapter 4C, 96, 213, 226). Although the ICPD and Beijing documents do not create binding obligations, they have been agreed upon by governments and thus reflect political will and international consensus. They are widely used as advocacy tools and treaty monitoring bodies refer to them as standard for evaluating how states are meeting their treaty obligations (Girard & Waldman 2000).

International organizations such as the International Organization for Migration (IOM) and the World Health Organization (WHO) also underscore the particular vulnerability of migrant women, in terms of their SRH. In practice, however, the link between SRH and refugees is mainly dealt with in terms of relief services for refugee and displaced women living in refugee camps in developing countries. So far, there has been little exploration of the situation in European settings.

Existing data indicate that migrant women, including asylum-seeking and refugee women (ASRW), run higher risks of unwanted pregnancy, induced abortion and obstetric complications than the local population; that they are more vulnerable to curable sexually transmitted infections and to HIV/AIDS; and are also at an increased risk of experiencing sexual and gender-based violence, including rape and harmful traditional practices such as female genital mutilation (WHO 2001). They may also have suffered physical and sexual abuse—including rape—in their country of origin, during travel or in destination countries. At the same time, services directed at asylum seekers and refugees often lack a gender-specific approach, neglecting specific needs of women.

The purpose of this article is to simultaneously address the issue of entitlement to national health services for asylum-seeking women in Europe and to highlight the
wide range of difficulties ASRW encounter in accessing (sexual and reproductive) health services. As asylum-seeking and refugee women’s SRH rights are, in essence, women’s rights, their promotion, protection and fulfilment should be endorsed by the European Union (EU) and the respective European member states.

The data presented in this article were generated from the research project ‘Integration of Refugee Women in Europe through the Promotion of their Sexual and Reproductive Health Rights’, conducted by the International Centre for Reproductive Health (ICRH) at Ghent University and supported by the EC/European Refugee Fund. The project was carried out between February 2004 and June 2005, and consisted of three main parts: a literature review (Janssens et al. 2005a), a survey analysis (Janssens et al. 2005b), and an international workshop (Janssens et al. 2005).2 The project focused on 15 EU member states: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Portugal, Spain, Sweden, the Netherlands, and the United Kingdom.3

Migration and Health

Forced Migration: Asylum Seekers and Statutory Refugees

ASRW are population groups characterized by diverse social, cultural, economic and legal backgrounds and diverse needs. In the context of migration, a distinction is made between ‘voluntary’ and ‘forced’ migrants. Voluntary migrants are ‘people who have decided to migrate of their own accord (although there may also be strong economic and other pressures on them to move). These include labour migrants, family members being reunified with relatives and foreign students’ (WHO 2003, p. 9). Forced migration, on the other hand, refers to

a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects). (IOM 2004, p. 25)

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’ (IOM 2004, p. 8). They are 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. Legally, asylum seekers are not refugees until their refugee status has been officially granted.

Under the 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. (OHCHR 1951, Article 1.A.2)
Once a refugee satisfies this definition, he or she is sometimes referred to as a ‘convention refugee’ or ‘statutory refugee’. This definition is used in European law and is widely accepted internationally.

(Forced) Migration and Health

The health status of ASRW is influenced by various factors and circumstances, or determinants (Bartels 2003). These determinants can be categorized into four main groups: lifestyle/behaviour, biological/genetic factors, environmental factors (physical, economical, social, and cultural) and availability, accessibility and quality of health care (Tulchinsky & Varavikova 2000, cited in Bartels 2003). This article focuses on the accessibility of (SR) health-care services for ASRW.

Migration can have a significant impact on people’s health. In this context, we argue that the reason for migration is an important mitigating factor that distinguishes asylum seekers and refugees on the one hand from voluntary migrants on the other. Although there are similarities in migrant, asylum-seeking and refugee women’s health status, risks and needs, there are also unique factors which affect the health of ASRW. ASRW’s background of forced migration has a profound impact on their overall health, including their SRH. They face health risks before, during and after they flee from their home country. Asylum-seeking women are particularly vulnerable, as their legal entitlements and living conditions in EU member states are usually very different from those of statutory refugees.

Pre-migration factors include possible torture and refugee trauma, which may result in mental and physical illness. Moreover, ASRW often originate from conflict areas. In contexts of war and armed conflict, health-care systems usually function very poorly. Poverty, powerlessness, social instability, human rights violations and both physical and sexual violence are factors that contribute to the rapid spread of sexually transmitted infections and HIV/AIDS in emergency situations. Post-migration factors in the host-country context, such as detention, the long wait during the asylum procedure, uncertainty about the future, being unable to work, anxiety about family members left behind in the country of origin, language barriers, and lack of knowledge about the new health-care system, all have an important impact on their psychological and physical well-being, including their SRH (see also Norredam et al. 2005).

Although the use of existing services by asylum seekers and refugees is largely affected by the same factors and barriers as is the case with other migrants, the SRH of ASRW is often further exacerbated due to their insecure legal status and their situation of distress and isolation. Another risk factor to the sexual and reproductive health of ASRW is their low socio-economic status, which will be discussed later on in this article.

Entitlement to Health Services for Asylum Seekers and Refugees in Europe

European Level

Council Directive 2004/83/EC. Two of these directives are relevant for ASRW’s entitlements and access to national health services in EU member states, and are discussed below.

On 20 July 2001, the Council of the EU adopted the Council Directive 2001/55/EC ‘on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between member states in receiving such persons and bearing the consequences thereof’. The directive obliges member states to provide medical care for persons enjoying temporary protection. The assistance necessary for medical care should include ‘at least emergency care and essential treatment of illness’ (Art. 13.2). In addition, member states are obliged to provide necessary or other assistance to persons who have special needs, such as persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence (Art. 13).

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

The provisions in this directive regarding health care for asylum seekers are broadly similar to provisions for persons requiring temporary protection. Medical care, with emergency care and essential treatment of illness as a minimum standard, should be ensured by all member states (Art. 15). The directive further states that the national legislation of member states should take the specific situation of vulnerable groups into account. When receiving asylum seekers and refugees, member states should pay specific attention to the special needs of ‘pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence’ (Art. 17.1). It goes on to say that States should ensure that, ‘if necessary, persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment of damages caused’ (Chapter 4, Article 20).

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

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

National Level

In general, migrants’ entitlement to social protection in Western Europe depends on whether benefits are provided primarily as a result of being employed and having contributed to the social insurance system, as is the case in labour-importing countries of Western Europe, or are granted on the basis of residence, such as in the Scandinavian countries or the United Kingdom (United Nations 2003).

National regulations, laws and policies regulate entitlements to health services in EU member states. Throughout Europe, statutory refugees are fully entitled to access to national health services under the 1951 UN Convention Relating to the Status of Refugees (Art. 23). However, the right to health for asylum seekers in Europe varies greatly according to national legislation. Asylum seekers generally have limited access to most national health services in the old EU member states, but there is considerable variation. In some countries asylum seekers are only entitled to emergency care, yet there are a few exceptions. In Finland, for example, asylum seekers are only entitled to emergency care, but an exception is made for children and pregnant women, who do not have the same limitations. Only a minority of EU member states provide asylum seekers with ‘full access’ to the national health system (e.g. the Netherlands and Luxembourg).10 Not only do asylum seekers have limited access to the national health systems in most EU member states, but the scope and quality of SRH services to which they have access vary greatly as well.

At the service level, legislation regarding access to care and the rights of ASRW are unclear for many care and support providers in EU member states. Service providers targeting asylum seekers and/or refugees often lack knowledge about their respective entitlements to SRH services, as well as about channels of support available to these vulnerable populations. It is not always clear to service providers whether asylum seekers and refugees are entitled to all, some, or none of available SRH services. If health-care providers are unaware that their country may entitle asylum seekers to free SRH services, this has a clear impact on the accessibility of SRH services (Janssens et al. 2005b). Since asylum seekers often have limited financial means, it also has an impact on the affordability of SRH services (see under Economic Barriers, below).

Policies in the old EU member states that take the needs of these population groups into account are varied. In countries such as Greece, which has specific regulations on access to health care, there is a gap between policy and practice. Greece has developed comprehensive health policies concerning migrants, refugees and asylum seekers. Asylum seekers receive a ‘pink card’ as proof of their asylum application, which entitles them to free medical care, including antiretroviral treatment. Despite this regulation, a large number of asylum seekers do not, in practice, receive a pink card and therefore do not have access to free medical care (Zacharouli & Mavraki 2003, p. 64). Despite some positive trends, a basic rights-based approach to service access and appropriate standards is still missing in most European countries (see also Bröring et al. 2003).
Barriers to Access Health Services for Asylum Seekers and Refugees in Europe

In many European countries, the health-care systems are not set up to provide services to migrant populations, let alone culturally appropriate services. There are many reasons for this, including: a lack of political will, new policies to return migrants to their countries of origin as quickly as possible, insufficient training in culturally competent service provision and the absence of migrant representatives as stakeholders in the decision-making process (Edubio & Sabanadesan 2001).

Besides legal barriers, ASRW also face a series of geographical, administrative, social, cultural and economic barriers hampering their access to quality SRH services. Barriers to accessing health-care services in the old EU member states include: 1) communication problems, 2) language and cross-cultural barriers, 3) lack of information on how the national health system functions, 4) lack of training/awareness by health personnel about refugee issues and their specific needs and care expectations, 5) mutual lack of understanding, 6) lack of trust on the part of refugees, and 7) economic and administrative barriers (Consiglio Italiano Per I Refugiati 2002). In addition, ASRW face geographical and legal obstacles in receiving adequate SRH care (Arend 2002), as well as problems in accessing information on patients’ rights and entitlements to health services (e.g. Hinton 2001; Arend 2002; Kennedy & Murphy-Lawless 2002).

Asylum seekers and refugees may be further constrained by the need to address other practical and social concerns in a host country before those associated with health. Access to legal employment, essential language skills, education, transportation, adequate housing and larger issues such as racism and social isolation may affect the overall health of ASRW, including their SRH. These factors need to be addressed by governmental agencies, social and health service providers, and law enforcement officials. Once refugee women are able to address their most immediate practical and social needs, they may experience better accessibility and comfort in seeking and using SRH care services (Arend 2002; Kennedy & Murphy-Lawless 2002).

Legal Barriers

As mentioned earlier, in many old EU member states, asylum seekers have limited access to the national health system. New legislative tools, such as the Council Directives 2001/55/EC and 2003/9/EC, do not guarantee asylum seekers and refugees full access to the available national SRH services. Obviously, this seriously affects their overall health, including their SRH. Moreover, both ASRW and service providers often lack knowledge about ASRW’s SRH rights, which forms an additional barrier in seeking and providing adequate health care.

Asylum seekers’ legal status is of serious concern both to asylum seekers themselves and to health-care providers. Many facilities and NGOs providing counselling for migrant HIV/AIDS patients, for example, report that these patients often have questions about their legal status. Health-care workers might be confronted with ethical dilemmas such as whether to provide HIV/AIDS treatment to asylum seekers who...
may be deported, considering continuity of care is essential to the success of drug therapy. In some EU member states, asylum seekers receiving HIV/AIDS treatment can be deported to their countries of origin where they may not be able to continue their medical treatment. In this context, concern was expressed by one of the participants at a satellite meeting on methods and results of social and behaviour research on AIDS, that in several federal states of Germany, HIV tests are carried out during the first medical contacts with asylum applicants, without the consent of the person concerned (Beelen 2000).

Geographical Barriers

Continuity and quality of health care is often disrupted when asylum seekers have to change residence. Discontinuity in health care can be especially problematic in relation to SRH issues, as for many refugee women a considerable level of trust needs to be generated before discussing issues related to SRH. With regard to safe motherhood, research indicates that refugee women’s SRH suffers when there is discontinuity of care, and this is particularly true for dispersed asylum seekers (Ascoly et al. 2001). Dispersal policies, which exist in Ireland and the United Kingdom, make access to care and support services more difficult for asylum seekers with health problems in general, and with HIV in particular (Bröring et al. 2003).

Administrative Barriers

ASRW, particularly those who have recently arrived in the country of asylum, often lack knowledge about the national health system in general, and about available SRH services in particular. The provision of adequate and comprehensive information is a key issue to making SRH care more accessible to ASRW.

However, health-care providers themselves often lack knowledge about asylum seekers’ entitlements to SRH services and channels of support available to ASRW, which may considerably limit their access to available services.

Socio-cultural Barriers

Communication problems have negative implications for all aspects of SRH care. Findings in the Netherlands show that ASRW often have to depend on husbands or other males as interpreters, which can make it difficult to discuss SRH issues (Ascoly et al. 2001; see also Burnett & Fassir 2002). Cultures characterized by strict gender roles, for example, may believe it inappropriate to discuss pregnancy and childbirth in mixed company. As a result, medical consultations can become problematic, particularly if women acquire all information through male interpreters. Other SRH issues, such as sexual violence, might be overlooked due to a woman’s reluctance to talk about such experiences, especially in the presence of men (Ascoly et al. 2001).

In addition, ASRW often feel uncomfortable with European health practices such as, for example, seeing a male doctor. A well-educated Sudanese Muslim woman in
Austria explained her uneasiness as follows: ‘Once I went to the radiologist for an examination. He asked me to take my blouse off. I was shocked. How could I take my blouse off in the presence of a strange man? For me it was not logical but for him it was normal’. Another Sudanese woman in the UK talked about the problem of having a smear test and why it is difficult for women with her cultural background to just open their legs for a gynaecological exam (Mestheneos et al. 1999). ASRW therefore may refrain from attending SRH services if they cannot be attended by female health staff. Talking about sexuality and related issues such as HIV/AIDS is taboo in many migrant communities, which makes it difficult for health-care providers to provide the necessary information and care.

Another barrier to providing good information and care is general mistrust and suspicion among asylum seekers and refugee communities. ASRW, for example, may be concerned about the possibility of HIV infection, but may not raise the issue because of fear, mistrust of interpreters, concerns about confidentiality and stigma. Asylum seekers might not tell their lawyers that they are HIV positive, out of fear of being stigmatized and/or expelled (Beelen 2000). Asylum seekers often neglect their physical and mental health, because they are preoccupied by concern about their residence status. Their dependant and insecure position in society, coupled with their experiences from transit and their countries of origin, often leads them to be generally distrustful of people.

Compounding these difficulties further, health practitioners may also lack training in and awareness of the refugee experience, their specific needs and care expectations. They may be constrained in their ability to devote extra time to refugee patients and potentially reluctant to provide services to a population group with such complex needs. Often the extra time demands, language barriers and difficult requests are beyond their scope and/or capacity. In order to deal effectively with SRH needs of ASRW, general practitioners would ideally need multi-disciplinary assistance in assessing the background of ASR clients and options for further assistance (Ascoly et al. 2001; Hinton 2001).

Economic Barriers

An important discussion in ethnicity and health research is the influence of socio-economic status on health. The living conditions of ASRW are generally unfavourable due to their lower economic position in the host society. ASRW usually lack a social network, have a dependant and insecure position in society, and are confronted with severe restrictions (e.g. inability to legally work, receive benefits, and so on). This impacts their lifestyle, living conditions, social environment and use of health services, and explains the existence of considerable socio-economic health differences between them and the host population (see also Stronks et al. 1999, cited in Bartels 2003).

Limited financial resources no doubt have a negative impact on ASRW’s access to SRH services and supplies. Asylum seekers, in particular, often have very restricted financial means. The high cost of contraceptives, for example, may serve as a barrier for ASRW to control birth spacing and/or to protect against sexually transmitted
infections, including HIV/AIDS. Findings from a Belgian study, for example, show that among women (both migrants and nationals) who had an unwanted pregnancy, first-generation migrants disproportionately reported cost as the reason for not having used contraception (Vissers 2004).

**Summary and Future Directions**

Worldwide, growing attention is being paid to the rights and needs of refugee and displaced women, including those associated with SRH. Gender inequality is still a worldwide phenomenon, which makes women vulnerable, particularly to having their SRH rights unmet. This is especially true for refugee and displaced women. Despite limited data available in Europe, there is considerable evidence to suggest that there are pressing needs for improvement in the SRH status of ASRW and that the provision and use of SRH services by ASRW in Europe is inadequate. This is due to shortcomings at various levels: 1) the policy level (i.e. regarding the reception and integration of refugees); 2) the service level (in the provision of social and health services); and 3) the level of the individual (e.g. failure of ASRW to use available SRH services).

We have demonstrated that although there are similarities in migrant, asylum-seeking and refugee women’s health statuses, risks, and needs, there are also unique factors which affect the health of ASRW. When discussing refugee health in Europe, it is important to distinguish between voluntary and forced migrants. Asylum seekers’ and refugees’ backgrounds of forced migration have an important impact on their overall health, including their SRH. Each group has both similar and distinct needs. The latter are due primarily to asylum seekers’ limited entitlements to available SRH services, the asylum procedure and reception conditions, and often limited financial resources. Asylum seekers may also experience additional constraints as they prioritize addressing other practical and social needs first.

The right to health, including SRH, for asylum seekers and refugees in Europe varies considerably according to national legislation in EU member states. In many EU member states, asylum seekers have extremely limited access to the national health system. New legislative tools do not guarantee asylum seekers and refugees full enjoyment of their SRH rights. Obviously, this seriously affects their overall health, including their SRH.

Since asylum-seeking women are not fully entitled to all SRH services in most EU member states, they may consequently face additional barriers in accessing SRH services. Asylum-seeking women, in particular, suffer from isolation, marginalization and loneliness, and are often preoccupied with their asylum proceedings in order to obtain legal status as a refugee. In addition, the limited financial resources available to asylum-seeking women affect their access to SRH services, particularly with regard to treatment, medicines and contraceptives. These barriers have a profound impact on their SRH, and may in fact compromise their health during the time they wait to receive refugee status.

The provision of adequate and comprehensive information on SRH-related issues, and on ASRW’s rights and entitlements to such services, is a key issue in making SRH...
care more accessible to ASRW. However, health-care providers and staff at reception centres are often not properly informed about ASRW’s entitlements to SRH services and available channels for support, which limits their ability to provide adequate information. This lack of knowledge may affect the information and services delivered to asylum seekers and refugees.

In addition, ASRW fail to use SRH services due to a wide range of factors, which can be roughly categorized as legal, geographic, administrative, economic, and socio-cultural barriers. In many European countries, health-care services are not set up to provide appropriately adapted health-care services to asylum seekers, refugees and migrants.

ASRW’s sexual and reproductive health rights are women’s rights. Therefore, the promotion, protection and fulfilment of these rights should be endorsed by the European Union and the respective European member states. A rights-based approach should be integrated into European legal standards, policies, programmes and guidelines. Europe can take an important lead in sensitizing its European member states to the importance of SRH, and encouraging them to develop policies and strategies for improving SRH of both asylum seekers and refugees. Asylum-seeking women should be entitled to the full range of available national SRH services, just as statutory refugee women are. EU member states should, in turn, develop clear guidelines on SRH care provision for ASRW, in order to provide SRH services which are accessible, affordable and acceptable. There is a great need for further research in the broad field of ASRW’s sexual and reproductive health in Europe, in order to enable EU member states to identify needs, to define priorities and to develop effective responses.

Acknowledgments

The authors are grateful to the European Commission (European Refugee Fund) for funding the research project on refugee women’s sexual and reproductive health and rights in Europe. They thank Lauren Foster for proofreading and editing the article.

Notes

[1] Populations of concern to the UNHCR include refugees, asylum seekers, returnees (refugees who have returned during 2005) and internally displaced persons (UNHCR 2006).

[2] Free copies of the ICRH research reports (literature review, survey analysis, workshop proceedings, and EC Policy Recommendations) on sexual and reproductive health rights and needs of refugee women in Europe can be ordered at icrh@ugent.be (also available at http://www.icrh.org/reports.aspx).

[3] In this article, these member states will be referred to as ‘old’ member states, as these were the 15 states of the European Union prior to 1 May 2004. As of 1 May 2004, the EU was extended with 10 new member states.


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

[7] “Temporary protection” means a procedure of exceptional character to provide, in the event of a mass influx or imminent mass influx of displaced persons from third countries who are unable to return to their country of origin, immediate and temporary protection to such persons, in particular if there is also a risk that the asylum system will be unable to process this influx without adverse effects for its efficient operation, in the interests of the persons concerned and other persons requesting protection’ (Council Directive 2001/55/EC [Art.2a]).

[8] In relation to SRH, emergency care means that emergency obstetric care should be provided by the State. In discussions of the United Nations Population Fund (UNFPA), basic emergency obstetric care (EmOC) includes the following functions: ‘parenteral (intravenous or intramuscular) antibiotics; parenteral oxytocics (drugs that induce uterine contractions to stop bleeding); parenteral sedatives or anticonvulsant drugs; manual removal of the placenta (to stop haemorrhage); removal of retained products (to prevent bleeding and infection); and assisted vaginal delivery with forceps or vacuum extractor (to alleviate prolonged labour). Comprehensive emergency obstetric care includes all of the functions listed before, as well as the ability to perform caesarean sections and blood transfusions, and the other capabilities, such as administering anaesthesia, that those functions imply.’ Adapted from http://www.unfpa.org/mothers/terms.htm


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