Vol. 13 No. 3 2007 ISSN 1394-4444

ARROWs For Change

Women's, Gender and Rights Perspectives in Health Policies and Programmes

Published by the Asian-Pacific Resource & Research Centre for Women (ARROW), www.arrow.org.my

Ground Realities:
Women's Sexual and Reproductive Health and Rights in Conflict Situations

This issue of *ARROWs For Change* (AFC)[1] explores the various dimensions of the impact of conflict on the sexual and reproductive health and rights (SRHR) of women in the Asia-Pacific region. It draws on diverse experiences of women across the Asia-Pacific and looks at the direct impact of conflict on women's rights to expression and choice in their reproductive and sexual lives, as well as examines social and political attitudes and perspectives that have an indirect but often critical impact on women's capacity to enjoy these rights.

Adapated from photograph by Eduardo Lima de Oliveira

The shifts in approaches to women's health in the second half of the 20th century has led to a more integrated and life-cycle approach to reproductive and sexual health that foregrounds rights of expression and choice for all women. In the process, policymakers have begun to pay more attention to the specificity of experiences of particular groups of women who face discrimination and marginalisation because of their identity or circumstances. Women in conflict situations is one such sector.

There are situations of conflict in almost every country in the Asia-Pacific region today. Some are the result of struggles for self-determination and for recognition of rights of minorities, while others are struggles over control of land and natural resources. Many states also confront internal conflicts and communal riots. This situation has intensified the levels of militarisation throughout the region and also sharpened social polarisation. In such an environment, as Petchesky observes, there is a climate in which growing numbers of people find themselves stripped of their rights.[2]

Whatever the root cause of the conflict, the consequences are similar: large scale displacement, destruction of lives and property, rising levels of violence and violations of human rights, including the right to life and security, and denial of access to basic needs and services. Inequalities in access to as well as in the delivery of social services—which are based on socio-economic factors such as age, class, caste, disability, ethnicity, gender, location, region, sexual orientation and so on—may become more pronounced in the context of a conflict. In addition, patriarchal forms of control that lead to discrimination against women in society at every level are reaffirmed in conflict situations in a manner that makes women's opportunities to exercise choice in matters related to sexuality and fertility almost non-existent. When health facilities are destroyed and the social networks that provide some degree of support for women are eroded, this heightens the vulnerability of women affected by conflict to coercion, discrimination and violence. While women's active responses to their situation in the face of conflict bear testimony to creative interventions in peace-building and in rebuilding shattered communities, the impact of conflict on their reproductive and sexual lives can have life-threatening and often long-term consequences.

In a conflict situation, intensified levels of insecurity on roads and lack of transport may limit women's mobility and therefore their access to healthcare. Disarray in the administration may mean that supplies essential for the sexual and reproductive well-being of women are not prioritised for delivery. Lack of functioning political systems may deny women their rights to be heard in forums where decisions regarding access to reproductive and sexual healthcare are made. Women of communities that are numerical minorities may find themselves pressured and coerced into frequent childbirths due to identity-based political activism that holds them responsible for the perpetuation of the group. Community leaders and religious ideologues may stereotype women in their childbearing role.

EDITORIAL

Specific characteristics of different types of conflict also have a different impact on women and on their sexual and reproductive health and rights. For example, when the conflict is between a State and an armed group that espouses the political agenda of a specific social group or community, this fact can determine the extent to which women of that particular community are able to access information and services on reproductive and sexual health and enjoy their rights to health. The conflict may lead to the state cutting off services and access to a region of the country where the conflict is taking place. In the same way, when the conflict is between different ethnic or religious groups, the ideologies surrounding the conflict may declare women who seek contraceptive services or abortions as being 'traitors' to their community. Kandiyoti has argued that the democratisation frameworks introduced by the West into Iraq and Iran have interacted with religious extremism and militarisation to weaken state obligations under international conventions and treaties and to strengthen the hands of non-state actors. This has resulted in moves to control women's rights and lives by both parties.[3]

These are all consequences of conflict that limit women's mobility and agency, and challenging these limitations becomes a critical feature in activism for sexual and reproductive health and rights. In this issue, monitoring articles from India, Pakistan, the Philippines, Sri Lanka and Timor-Leste focus on some of these challenges.

Working on this AFC issue, we also observe the close links being forged between human rights and humanitarian law in the context of ensuring the rights of persons affected by conflict.[4] International agencies that enter into conflict situations with a humanitarian and service-delivery mandate[5] are increasingly paying more attention to the incorporation of the human rights principles of equality and non-discrimination in their work. In creating policies and guiding principles for the provision of appropriate reproductive and sexual health care services for women and girls 'at risk' in conflict situations, they adopt the rights-based approach. The Minimum Initial Service Package (MISP) for Reproductive Health, which ensures that basic reproductive health needs of women are met in emergency responses, for example, was designed and is implemented through the collaborative effort of many UN agencies, governments and community-based women's activists and NGOs (see Note from ARROW on the left). However, ensuring that the thinking behind the MISP is reflected in national level policy frameworks with regard to the particular needs of women affected by conflict remains a challenge.

Ground realities which point out the many ways in which women's healthcare needs are ignored and neglected in emergency and conflict situations bear out our contention that it is not enough to have institutional structures and legal frameworks supporting the provision of reproductive and sexual health services to women in conflict situations. For example, as the article in this issue on Indonesia highlights, despite state obligations under international treaties and conventions, reproductive and sexual health services for women caught up in the conflict in Poso remain poor.

Pittaway, in this issue, focuses on the issue of sexual violence against women in conflict situations. While there is substantive documentation of violence against displaced and refugee women in many countries, we have still not been successful in creating policies and programmes that can effectively protect women from unwanted pregnancies and sexually transmitted infections, which are often the consequences of such violations.

The focus on conflict-affected countries in the region also brings with it a focus on the need to recognise that the absence of protracted war does not necessarily indicate peace. We also need to highlight that the issues of discrimination and violation of women's rights in conflict situations, be these related to sexuality, fertility, or others, survives with us through times of transition and in a post-conflict era.

Endnotes

1 The Editor would like to thank Sunila Abeysekera and Lakshman Gunasekara for their inputs in conceptualising this issue.

2 Petchesky, R. 2008. "Conflict and crisis settings: Promoting sexual and reproductive rights." Reproductive Health Matters. Vol. 16, No. 31, pp. 4-9.

3 Kandiyoti, D. 2007. "Between the hammer and the anvil: Post-conflict reconstruction, Islam and women's rights. Third World Quarterly. Vol. 28, Issue 3.

4 International laws and conventions discussing women in conflict and post-conflict situations include the Convention for the Elimination of Discrimination Against Women (CEDAW); UN Security Council Resolution 1325, which provides a clear mandate for integration of a gender perspective in peacekeeping; and UN Security Council Resolution 1820, which calls on UN entities to develop mechanisms to protect women and girls from sexual violence in all disarmament, demobilisation and reintegration processes. On the other hand, the 1994 International Conference on Population and Development Programme of Action (ICPD PoA) calls for measures to ensure that internally displaced persons and refugees due to armed conflict receive basic healthcare services, including reproductive health services and family planning.

5 These include the Office of the UN High Commissioner for Refugees (UNHCR), the World Health Organization (WHO) and the UN Population Fund (UNFPA).

NOTE FROM ARROW:

The development of MISP and its inclusion in the international humanitarian charter for disasters are major achievements for ensuring basic reproductive health services for women and girls in crisis situations. Even as we acknowledge the practical difficulties of operating in crisis situations and the need to prioritise services, however, we must continue to advocate for the inclusion of other critical health services that would ensure sexual and reproductive rights in the priority package delivered during the first three months of crisis. This includes antenatal care, contraceptives, safe abortion services and STI management. This is even more important in conflict situations where displacement is long-term and the crisis phase may be prolonged. To ensure their rights are protected, MISP and other international standards should also spell out clearly what services are to be made available to adolescents and acknowledge the different needs of people of various sexual and gender identities (such as transgenders). It is also hoped that more organisations working on conflict and crisis issues would use the terms "reproductive rights," "sexual health," and "sexual rights," rather than just "reproductive health." The Factfile on page 12 discusses the MISP and its implementation further.

By Sepali Kottegoda, Member, Women and Media Collective, Sri Lanka. Email: sepaliko@sltnet.lk

A Lesson from Sexual and Reproductive Health Services among Displaced Women in Indonesia[1]

Violent conflict in Poso. Located in Sulawesi Island in Indonesia, Poso is a small town which was historically dominated by Christian natives in a Muslim-majority country. With the rapid growth of Muslim migrants in the area due to the Suharto regime's transmigration programme and the subsequent clashes for political and socioeconomic power, both Christian and Muslim parties were easily incited to take part in communal conflict when the Suharto regime fell. The violent conflict in Poso that exploded from 1998 to 2004 thus tends to be depicted as an inter-religious/ethnic conflict.

The neglect of sexual and reproductive health and rights (SRHR). SRHR among displaced women is one of the most neglected issue in post-violent conflict in Poso. This neglect has already been institutionalised in the absence of SRHR in the national policy on health, which was established during the Suharto era. Indeed, the policy only focussed on a family planning program in order to maintain the patriarchal-state ideology of a happy and prosperous heterosexual family. As a consequence, SRH services tended to be narrowly interpreted as maternal health services, and there was almost no room for other services to address abortion, gender-based violence, HIV and AIDS and other sexually transmitted infections, as well as SRH services particularly for displaced women.

In the Poso context, the neglect of SRH services among displaced women has been worsened by the political-economy of aid in a post-violent conflict situation. Although the new central government began to revise their policy, the issue is still not a top priority as reflected by the exclusion of SRH of displaced women in national budgeting, and the lack of local government's response towards the issue. Meanwhile, international and local NGOs have demonstrated their concern on the SRHR of displaced women. Unfortunately, only a few of them have a clear agenda on SRHR; even if SRH services became their main concern, it is not always followed by good practices in the field. This is indicated by the corruption of humanitarian aid within the local government body, unsustainable programs by international NGOs—or in some cases setting up of programmes in name only without any real action—and the difficulty of local NGOs to respond to displaced women's needs due to funding limitations. It can be said that displaced women's SRHR tends to be treated merely as a "project" of humanitarian aid loaded with various political interests.

Women's resilience and empowerment. Far from the hustle and bustle of humanitarian actions, women either as displaced persons, midwives or traditional healers did not perceive themselves as victims. In fact, the breakdown of health facilities due to riots had forced them to creatively deal with their SRH problems. Experiences from camp sites exhibit that the displaced women's life and death is often determined by the presence and skill of midwives and female traditional healers. The displaced women themselves were not passive victims, but struggled to solve their SRH problems based on local wisdoms.

Indeed, women in conflict situations have much resilience in dealing with their SRH problems. Relating to the inter-religious/ethnic conflict, women's resilience at the grassroots level could also be seen in their lack of involvement in violent conflict, and in their role in maintaining social cohesion as part of conflict reconciliation. The fact that camp sites have been geographically divided in terms of Christian's and Muslim's areas, for example, make political barriers for humanitarian agents under particular formal institutions to deliver aid freely. In contrast, the SRH services of midwives and female traditional healers are for all, going beyond religious boundaries, as they rely on personal efforts and informal networking among women.

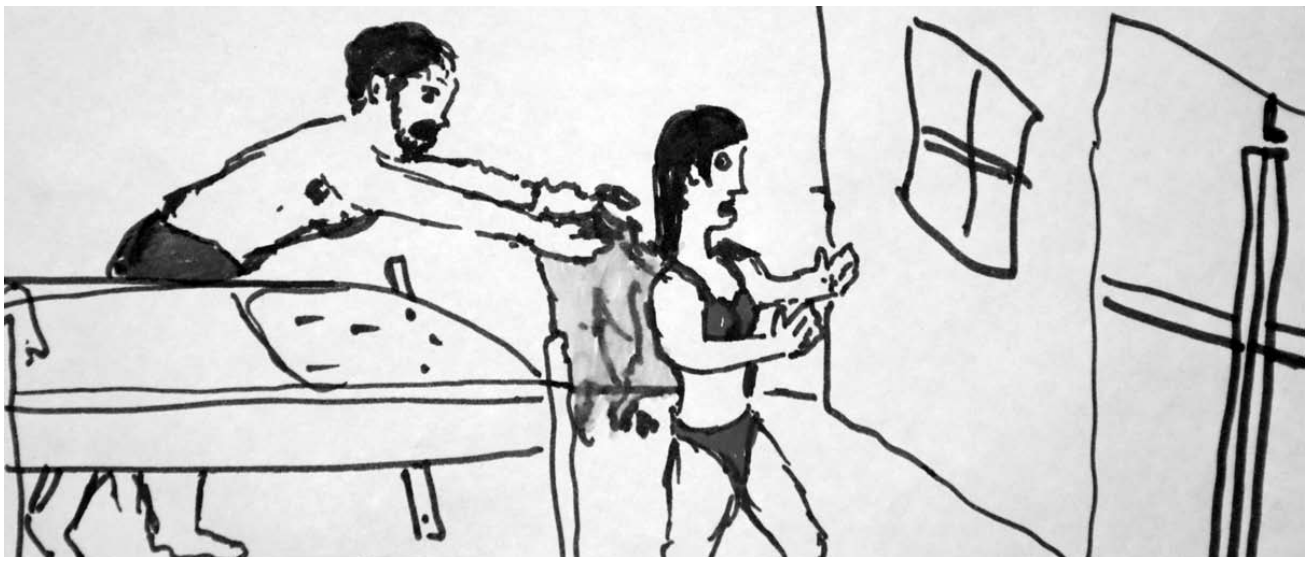
Recommendations. Learning from the Poso experience, women's empowerment in conflict situations should be seriously addressed. The study recommends acceleration of the revision of the national policy on health that emphasises facilitation of the roles of humanitarian agents and the displaced women in addressing SRH needs at the grassroots level. In revising the national policy on health, the central government must expand the scope of SRH issues beyond maternal health to take displaced women's SRH into account. The policy must also include the provision of SRH services and budgeting at the national level and ensure its implementation at local levels. The local government, especially in conflict areas, should also put displaced women's SRH as a priority by providing more operational regulations which can be integrated into the humanitarian works of the health office, international NGOs and local NGOs. On the other hand, international and local NGOs need to follow through their emergency aid with more sustainable programmes related to SRH of displaced women. Finally, all stakeholders should consider the agency of midwives, female traditional healers and displaced women in addressing SRH problems in conflict situations. This can be concretised by giving women respect and access in the decisionmaking process, not only because their personal efforts are often rooted on local wisdom, but also because they know their situation best and thus, can help ensure that the best way to deal with their SRH problems is found.

Endnote

1 *This article is based on the study Trap of Aid, Scream of Displaced Women: Sexual and Reproductive Health Services in Post-Violent Conflict of Poso, which was conducted in 2004 and published by the Centre for Population and Policy Studies, Gadjah Mada University, Yogyakarta, Indonesia in 2005.*

By Basilica Dyah Putranti, Centre for Population and Policy Studies, Gadjah Mada University. Email: basilicadyahput@yahoo.com

SPOTLIGHT



"When they have raped the girls they make them be[come] prostitutes." Drawn by a refugee from Burma living in India, 2008. Courtesy of the author.

Silenced by Euphemism:

Sexual Torture in Conflict and Refugee Situations[1]

There are currently 11 million refugees and over 20 million internally displaced people (IDP) in the world.[2,3] The majority of these are women and children, most of whom have fled from situations of armed conflict.

There has been increasing acknowledgement over the past decade about the endemic nature of systematic rape and other forms of sexual torture in conflict and post-conflict situations. Women and children are raped to humiliate their husbands and fathers, to degrade communities, and to exhort information or to create fear.[4,5,6] The atrocities range from gang rape by groups of soldiers, horrors such as rape by trained dogs and the brutal mutilation of women's genitalia. These atrocities often occur publicly and involve a level of depravity which is difficult to understand. For example, fathers and sons are forced at gun point to sexually violate mothers and daughters. Whole villages of women are raped and have their nipples mutilated with wire cutters. Forced pregnancy is used as a form of cultural genocide.

During flight, women and girls are raped by border officials and security forces who are assured of acting with impunity. However, escape to a refugee camp or settlement does not provide protection for most women and children, as they are often raped by rival groups, police, 'peace-keepers' and even by humanitarian aid workers. To quote the head of one camp, "If you can find one woman here who has not been raped [while they are in the camp], I will give you a prize."[3] The United Nations High Commissioner for Refugees (UNHCR) acknowledges that a majority of all refugee women and many children are routinely raped and sexually abused.[3,7,8,9] This has devastating consequences. Women who have been 'shamed' by their public rape in the community are shunned in the camp. Some women and girls are abused by their husbands, or expelled from their families or communities, and left to fend for themselves in situations of extreme danger. Many children are born to refugee women and girls as the result of rape. Many women and girls are forced to trade sex for food for themselves or go hungry and without medicine to feed and care for their children.[6,8,10]

"I was a prostitute and I am proud of it! My children are now studying at the university. If I had not done what I did, they would be dead."— Refugee woman from Cambodia, Centre for Refugee Research (CRR) research report

Aside from the above, refugee women may also have traumatised children who may have witnessed torture and rape. Some children have experienced it first hand; they may have also seen fathers, brothers, uncles killed, or have them 'disappear.' Children may have nightmares because they remember bombing and living on the run. Their traumatised mothers have to respond to the needs of the children as well as their own.[3,11]

It is only very recently that these issues have been placed high on the agenda of UNHCR and other UN agency meetings.[3] This situation has been acknowledged in international law, in the International Criminal Court

Statute, which declares that rape in conflict situations is a crime against humanity, a war crime and, in some cases, an act of genocide. It is included in United Nations Security Council Resolutions 1325 and 1820, which address the role of women in conflict and post-conflict situations. UNHCR has developed some excellent guidelines to assist humanitarian workers to address the issue in refugee and post-conflict situations.[9,11]

Even so, often these issues are hidden in a welter of euphemistic language. The public health system has been one of the few groups to deal with this issue and offer services to women, but this has been done under the banner of "reproductive health." At the time when these services began, it was the only way that they could breach the silence. Yet, there is so much that is lacking within this approach. The health risks to women and children, both physical and mental, from these experiences are extreme, and yet, at the field level, they are still often hidden behind a wall of silence. There is little access to contraception, or emergency contraceptive and safe abortion services to prevent continuation of unwanted pregnancies. There is exposure to HIV and AIDS and other sexually transmitted infections yet there is often inadequate prevention and management services. Women's genitalia are often severely damaged but there is no access to specialist health care. Despite the horrendous trauma experienced by many women and girls, there is seldom access to counselling or psychosocial support.[12]

In much of the literature about this issue, forced prostitution, sexual slavery, and women forced into unwanted relationships with men in order to feed their children or to survive are referred to as "engaging in transactional sex" or "exchanging sexual favours." Rapists are referred to as "boyfriends." This euphemistic language is effectively decriminalising the acts of torture and serious criminal abuse which these women are suffering.

A conspiracy of silence still exists about the true extent of the problem, and until it is fully acknowledged, women will not receive the services which they deserve. Women who have suffered rape and sexual abuse report keeping this secret from those who should be offering them redress and protection for fear of being labelled prostitutes and being denied refugee status or visas on moral grounds. This is well documented by UNHCR, Amnesty International and many aid agencies working with women refugees.[7,10] Lack of legal redress for refugee women offers impunity to perpetrators and violate the civil and political rights of the women survivors. The punishments decided by the refugee committee judges are often insufficient for the crime. For example, a man who committed rape in a camp of refugees from Burma was charged with 2,000 baht (US$56) and three weeks in detention. Women refugees recounted that he stated, "I have 4,000 baht (US$112) so I can commit rape twice."[12] Failure to acknowledge the extent of rape and sexual abuse, and the fact that these are forms of torture, human rights abuses and criminal acts belittles the experience of the women concerned and is detrimental to refugee women and their families.

Addressing sexual assault as a family problem and working with both women and their husbands to prevent the occurrence of domestic violence are also crucial to the successful resettlement of many refugee families. Many men are not able to accept that their wives have been raped. A Vietnamese saying, "I will not put my chopsticks in the rice bowl where another man has eaten," typifies the attitude of many men to their wives who have been sexually abused. Instances of women being abandoned and their husband taking a mistress or another wife have forced many women to stay silent about their experience, even to their closest family members.

It is thus critical that we challenge the notion that it is better not to talk about "these shameful issues and that women should put it behind them since legal redress will not help." Refugee women themselves from across the world are saying this is not the case. They want the issues addressed. They want acknowledgement that what they have suffered is a crime. They desperately need the increased levels of effective and appropriate services which will come with this acknowledgement. They need sexual and reproductive health services which are designed to respond to the sexual violence they have endured, and they and their children need effective and appropriate psychosocial support. As a senior official at UNHCR Geneva recently said, "Silence is complicity." We have been silent about this issue for too long.

Endnotes

1 *This paper is based on 18 years of consultation with refugee women in Ethiopia, Hong Kong, India, Kenya, Malaysia, Nepal, Philippines, Sri Lanka, Thailand, and refugee women resettled to Australia. Many of the reports can be accessed on www.crr.unsw.edu.au*

2 *A refugee is someone who has a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" within his or her own country and has had to flee to another country for protection (www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf). An IDP is someone who has suffered persecution within their own country, and has had to move from their homes to another place in their own country. IDPs are normally without the protection of their government. (www.unhcr.org/partners/PARTNERS/4371fac62.pdf)*

3 *Pittaway, E., Bartolomei, L. 2005. "The case for a conclusion on refugee women at risk." UNHCR Report. Sydney: CRR.*

4 *Karen Women's Organisation (KWO). 2004. Shattering Silences. KWO Thailand. www.karenwomen.org*

5 *KWO. 2007. State of Terror. KWO Thailand. www.karenwomen.org*

6 *Pittaway, E., Rees, S. 2006. "Double jeopardy: Domestic violence in refugee communities." Women against Violence, Issue 17.*

7 *Pittaway, E., Pittaway, E.E. 2004. "Refugee woman: A dangerous label." The Australian Journal of Human Rights. pp.119-136.*

8 *Human Rights Watch. 2005. No Protection: Rape and Sexual Violence Following Displacement. http://hrw.org/background/Africa/darfur0505/3.htm*

9 *UNHCR. 2005. "Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings."*

10 *Amnesty International. 2005. Stop Violence Against Women. web.amnesty.org/actforwoemn/index-eng*

11 *UNHCR. 2008. www.unhcr.org/basics/html*

12 *Pittaway, E., Bartolomei, L. (2004) L. Risk for Refugee Women in Mae La Camp, Thailand: Research Report. www.crr.unsw.edu.au/documents/RisksRecsStratsMaeLaCa.pdf*

By Eileen Pittaway, Director, Centre for Refugee Research (CRR), University of New South Wales, Sydney, Australia.
Email: e.pittaway@unsw.edu.au

International

The International Women's Tribune Centre organised the session 'From Outrage to Power: Using the Law as a Tool for Change in Conflict and Post-Conflict Situations' at the 11th AWID Forum held in Cape Town on 14-17 November 2008. The discussion dealt with the merits and inadequacies that international laws and conventions hold for women in conflict and post-conflict situations. It also focused on the increased physical and psychological vulnerability of women during these times. Justice for women, then, was described not only in a legal context but also in terms of its broader social and community-related ramifications.

Both social and legal justice are sorely needed by women who are increasingly victimised by the systematic use of mass rape campaigns as a weapon of war. Rape during conflict has been designated a war crime by the Statute of Rome for the International Court of Justice in Hague (2002). Yet, this advance in legal standards is not enough for women who must deal with the emotional scars of abuse, physical damage to their bodies and, in many cases, unwanted pregnancies that are a constant and brutal reminder of the rape or multiple rapes. While some participants suggested psychosocial support as a necessity for women who have experienced rape as well as legal recourse that can be used to bring perpetrators to justice, others highlighted the need for abortion and safe places to perform these procedures in conflict and post-conflict situations. It was recommended that the right to abortion be upheld and advocated for women, including to those who have been raped and impregnated during war.

Source: Joeyta Bose, Program Associate, International Women's Tribune Centre. Email: joey@iwtc.org; Website: www.iwtc.org

India

The North Eastern states in India have been engaged in protracted conflict for several decades, resulting in the displacement of thousands of people. The state of Assam alone has camps housing over 150,000 internally displaced persons (IDPs), a large proportion of whom are women. Internal displacement in the region shows diverse patterns. Some displaced persons live in camps and make-shift arrangements for years, sometimes for over a decade. However, in other areas, such as Manipur, there are repeated displacements during the escalation of armed violence in certain parts of the state.

Such situations pose serious challenges to women's sexual and reproductive health and rights. Poor nutrition, coupled with early marriage and childbirth amongst displaced women, seriously impact on women's health. Pregnant women undergo undue hardships while fleeing and whilst living in camps, resulting in a large number of miscarriages. Often, there are no medical facilities available; even if there are, women suffering from gynaecological problems are often too shy to describe their problems to the male doctors. The threat of sexual abuse and rape is high for women during peaks of violence. Poor living conditions, economic deprivation and long absence of men in male-headed households pushes some women into sex work, with few in a position to negotiate safer sex. Trafficking and/or migration of women for sex work or domestic work also happens, with returnees facing stigma and those suspected of being HIV positive being doubly victimised. Many community organisations/bodies have reacted to the situation by resorting to banning young women from going out, but this in turn restricts women's mobility and economic opportunities. In the absence of a comprehensive IDP policy in India, many of the gender-related concerns of displaced persons remain to be addressed.

Source: Sreekala MG, Executive Director, North East Network. Email: sreekala@northeastnetwork.org

Pakistan

Women were an integral part of the peasant movement that begun in 2000 in the Okara district, Pakistan. At times at the forefront, at times not, women were equal partners in the struggle. Armed with thick sticks (traditionally used in washing clothes), they would block roads and surround police stations to stump police action against their men. They attended public meetings and guarded their villages. The movement was a response against the injustice of changing the legal, moral, traditional and inalienable relationship between peasants and the land they tilled. Military owners had imposed the change.

In 2003, a peasant was killed by police for refusing to vindicate the change. Protests erupted in Pakistan: a near siege was placed around villages; and police prowled around to catch peasant leaders. As national and international media covered the protests, a pregnant woman from a village under siege journeyed to a nearby hospital but was stopped and detained at a police station. The baby was delivered at the police station and died. This infant death and unnecessary endangerment of a woman's life was reported only once in the email updates that streamed regularly into various networks. The issue did not become part of media campaigns; human rights groups did not flag it; the intense political debate ignored it. No health researcher studied the impact of the conflict; no reproductive health (RH) group voiced its concern. The 1946 Bhore Committee health survey report of South Asia recommended the advancement of the health of the tillers of the soil. This is the challenge today: politicise RH!

Source: Kausar S. Khan, Dept. of Community Health Sciences, Aga Khan University, Karachi, Pakistan. Email: kausar.skhan@aku.edu

Philippines

The recently failed peace talks between the Philippine government and the Moro Islamic Liberation Front (MILF) disregarded yet again the lessons from past failed peace processes. The peace talks purportedly aim to address the Moro people's issues of ancestral domain claim and self-rule. However, the memorandum of agreement offered by the government recognised MILF's

historical ancestral domain claim in principle but made its actualisation, including the ownership of natural resources and the exercise of jurisdictional authority, conditional.

The peace process likewise ignored critical women's concerns, particularly reproductive and sexual health and rights issues in conflict situations. These concerns include disruption of the delivery of health services due to destruction of facilities and targetting of health personnel; increased pregnancy and childbirth-related mortality and morbidity, which is exacerbated by malnutrition, stress and epidemics; increased levels of violence and lack of security; unavailability of legal, safe and accessible abortion services; and loss of the extended network of family support during pregnancy and lactation. The breakdown of social structures may also result in earlier and increased risk-taking behaviour among youth.

For the Women's Global Network for Reproductive Rights (WGNRR), peace is not just the absence of war. It is the outcome of addressing armed conflict's fundamental roots toward a just and lasting peace. It also means ensuring that women's concerns are met.

Source: Zelda DT Soriano, Communications and Information Officer, WGNRR. Email: zelda.soriano@gmail.com

Sri Lanka

***A woman six months pregnant** cannot feel any life in her tummy. Her husband had disappeared, given up for dead at the hands of....But he appears one day, with injuries that he does not want to talk about. In her sorrow for her husband, she had not thought of looking after her own welfare.... In any case, there is no gynecologist, nor any health facility in her area.* (A woman recall the flight from Muttur, Eastern Sri Lanka, October 2006)

As the war to end all wars becomes the preferred option of the State and its main protagonist the Liberation Tigers of Tamil Eelam, enforced flight and displacement become constant realities in the lives of women from the conflict-affected areas in Sri Lanka. Women deliver babies or have miscarriages in the midst of flight; women traumatised by constant shelling give birth to stillborn infants; mothers have no breast milk because of hunger and malnourishment; women are weakened by one pregnancy after another due to lack of access to contraception or safe abortion services; and girls are exposed to the dangers of early pregnancy because they are married off too young to be 'protected' from recruitment.

While the media, the politicians and the general public focus on the statistics of gain and loss and aid agencies concentrate on food and shelter, no one asks how the State as a duty bearer, prepares to meet its obligations under international humanitarian and human rights law. In this context of conflict and displacement, the State is also responsible for ensuring that women and girls enjoy the highest attainable standard of health, including access to sexual and reproductive health and rights, and UN agencies have a responsibility to ensure that these rights are met.

Source: Kumudini Samuel, The Women and Media Collective, Sri Lanka. Email: kumudini.samuel@gmail.com

Timor-Leste

Indonesia's occupation of Timor-Leste from 1975-1999, in which at least 100,000 died due to famine and armed conflict, had a grave impact on women's sexual and reproductive health. According to *Chega!*, the final report of the Commission for Reception, Truth and Reconciliation in Timor-Leste (CAVR) released in 2005, of the reported incidents of sexual violence, 46.1% were accounts of rape, 26.8% of sexual slavery, and 27.1% of sexual harassment and other forms of sexual violence.

Women's reproductive health rights were also violated through the implementation of Indonesia's birth control programme. The Family Planning Agency (Keluarga Berencana or KB) was a major pillar in the country's development scheme that linked family planning (FP) to economic welfare. KB promoted a range of contraceptive interventions directed at women and developed a regime of "incentives" to increase new acceptors. However, in many cases, the only choice women had was the type of contraception to use; not using contraception was not a choice. The military, as well as wives of civil servants and soldiers who had more than two children, were required to participate in official birth control annual drives in villages. The consequences of this coercive programme were devastating for many women. In the drive to meet targets, some women were treated as guinea pigs for the distribution of contraception whose side effects had not been well tested. Others were subjected to multiple kinds of contraception in serial fashion since a woman could be counted as a new acceptor each time she switched from one type of contraception to another.

The participation of the Indonesian military in FP promotion was a coercive measure that violated women's human rights. Yet the military's involvement was not simply to ensure that contraceptive targets were met. It was part of the military's strategy to assert control over Timor-Leste, in this case through control of East Timorese women's reproductive health. The military context in which East Timorese women were faced with contraceptive obligations contributed to Indonesia's ability to rule through fear and intimidation, but this also contributed to years of deep-seated resentment that eventually led to a majority vote in 1999 for independence.

It is nearly ten years since Indonesia released its hold on Timor-Leste, yet governments of the two countries have still failed to take lessons of the past to heart. In Timor-Leste, the government recently passed a law that criminalises abortion without exception. In Indonesia, the KB agency has signed a memorandum of understanding with the military which, once again, involves the military in the implementation of Indonesia's national family planning programme.

Source: Karen Campbell-Nelson, International Centre for Transitional Justice (ICTJ). Email: kcampbellnelson@ictj.org

Bouta, Tsjeard; Frerks, Georg. 2002. *Women's Roles in Conflict Prevention, Conflict Resolution and Post-Conflict Reconstruction: Literature Review and Institutional Analysis.* The Hague, Netherlands: Netherlands Institute of International Relations. 340p. Available at www.clingendael.nl/publications/2002/20021102_cru_bouta.pdf

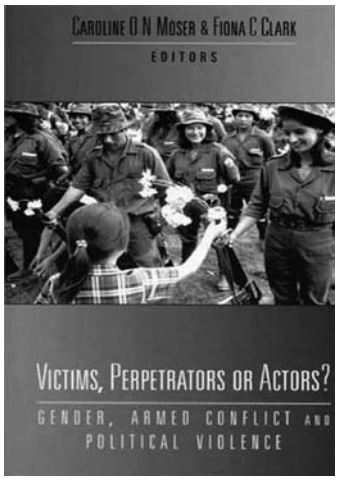
This two-part study was commissioned by the Dutch government to better support efforts related to women's roles in conflict situations. The first section, a literature review, presents a framework to guide international agencies in their analysis of women's multifaceted roles and positions in armed conflict and in the formulation of pertinent policies addressing these roles. The second part of the publication describes the results of an institutional analysis, which considers the extent and ways in which gender mainstreaming have taken place in the policy practice of 16 international organisations (including the UN Security Council). The study recommends amongst others, increasing the participation of local women in the preparation, implementation, and monitoring and evaluation of field activities focusing on women's roles in conflict prevention, conflict resolution and post-conflict reconstruction; and incorporating gender and conflict issues into the organisations' activities, instruments and tools.

Gangoli, Geetanjali. 2006. "Engendering genocide: Gender, conflict and violence." *Women's International Studies Forum*. Vol. 29, Issue 5, pp.534–538.

This article reviews three thought-provoking publications on the theme gender, conflict and violence: Giles & Hyndman's *Sites of Violence: Gender and Conflict Zones*, International Initiative for Justice in Gujarat (IIJG)'s *Threatened Existence: A Feminist Analysis of Genocide in Gujarat*, and Jones's *Gender and Genocide*. In the process, Gangoli threshes out issues related to the use and abuse of women's bodies in conflict and peacetime. She also considers the more difficult questions of women's complicity in perpetrating violence against women, and male (and female) violence against women in conflict situations, and how both relate to the gendered continuum of violence. The article also addresses the thorny issue of how feminisms are to respond to 'men as victims' and 'women as perpetrators' of violence, suggesting that a recognition that women's issues are linked to issues of globalisation, communalisation and poverty is necessary, and that collaborations between feminists and men's studies might be constructive for both parties.

Moser, Caroline O.N.; Clark, Fiona C. (Eds.). 2001. *Victims, Perpetrators or Actors? Gender, Armed Conflict and Political Violence.* New York, USA: Zed Books. 243p.

In discussing armed conflict and political violence, there is a tendency to simplistically portray men as aggressors and women as victims. The editors contend that this results in underrepresentation and misrepresentation of the gendered causes, costs and consequences of violent conflicts. The book aims to provide a holistic analysis of the gendered nature of armed conflict and political violence, and a broader understanding of the complex, changing roles and power relations between women and men during such circumstances. It presents empirical cases studies from across the globe, including on women and communal conflict in India. Two articles are particularly critical to feminist analysis: Cynthia Cockburn's paper on the gendered nature of armed conflict, and Caroline Moser's paper which introduces an operational framework on the gendered continuum of violence and conflict, to ensure that violence-reduction initiatives incorporate a gender perspective.



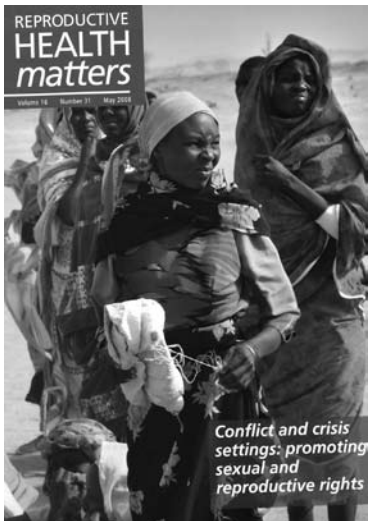
O'Reilly, M. et al. 2007. *Humanitarian Programmes and HIV and AIDS: A Practical Approach to Mainstreaming.* Oxford: Oxfam GB. 116p. www.oxfam.org.uk/what_we_do/resources/downloads/Hum_Prog_HIV_AIDS.pdf

Aiming to help field staff to mainstream HIV and AIDS in humanitarian emergencies, this manual explains how HIV affects emergencies and how the latter in turn affect HIV, as well as identifies the particular needs of potential vulnerable groups. It provides guidance particularly for managers in the planning stage, but the book also suggests how to mainstream HIV and AIDS throughout the emergency project cycle. It includes useful checklists and planning tools, with examples of trainings and awareness-raising sessions both for staff and for community members. It also has an accompanying CD-ROM, which contains additional training materials for use in the field.

Overseas Development Institute. 2004. *Disasters: The Journal of Disaster Studies, Policy and Management.* Vol. 28, Issue 3 ("Special Issue: Reproductive Health and Conflict: Experiences from the Field"). www3.interscience.wiley.com/journal/118780315/issue

This special issue offers a view of how the field of reproductive health in conflict-related situations has changed since it was first raised as a concern in the 90s. The articles illustrate reproductive health being addressed in a wide range of conflict and post-conflict settings (Afghanistan, East Timor, Iran, Iraq and the Thai-Burma border, among others). They also cover various elements of reproductive health (family planning, gender-based violence, safe motherhood and STI and HIV and AIDS) and sub-populations (adolescents, men, women, refugees and others).

All phases of conflict, from planning for emergencies to post-conflict reconsturction are also dealt with. Beyond looking at how far the field has come, the articles raise important questions on what needs to further done,including how to address the reality that even as reproductive health services are more available now than in the past, most-conflict affected people still do not have access to comprehensive services.

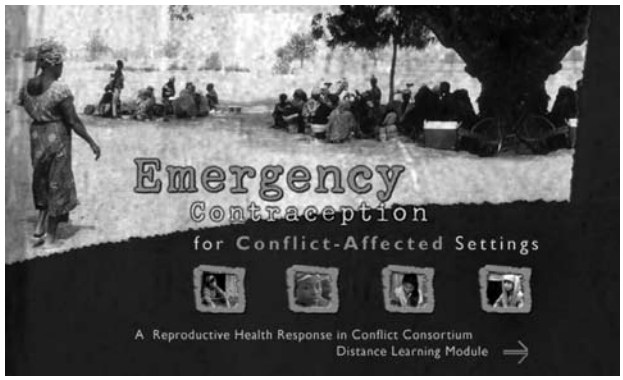


Petchesky, Rosalind P. 2008. *Reproductive Health Matters.* Vol. 16, No. 31 ("Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights"). London, UK. 254p. Tel.: +44-20-7267-6567. Fax.: +44-20-7267-2551. Email: mberer@rhmjournal.org.uk

Using a gender-sensitive lens, this journal issue examines barriers to achieving sexual and reproductive health and rights in militarised, refugee and internal displacement settings. One of the most important recent resources on the theme, it also brings together readings looking at the extent of implementation of international guidelines for programmes providing maternal health care, family planning, STI/HIV care, and addressing sexual and gender-based violence in these crisis settings. Articles with an Asia-Pacific focus include papers on the delivery of maternal health services in Eastern Burma and in Maguindanao, Philippines; on responding to sexual and reproductive health concerns in Iraq, Palestine, Sri Lanka and Timor-Leste; and on the impact of sexual violence and the responsibilities of the healthcare system in Gujarat, India. Rosalind Petchesky serves as the guest editor and contributes the editorial piece.

Reproductive Health Response in Conflict Consortium (RHRC). 2004. *Emergency Contraception for Conflict-Affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module.* Available at www.rhrc.org/resources/general_fieldtools/er_contraception/welcome.htm

"For women forcibly displaced by conflict, access to emergency contraception (EC) is not only a right, but also a critical need that can help to maintain and improve their reproductive health." This online distance learning module was developed to meet the need for increased awareness and knowledge about EC among health service providers working with refugee and internally displaced populations (IDPs). The module is very easy to understand, and has sections on emergency contraception, emergency



contraceptive pills, EC inter-uterine devices and EC service delivery in conflict settings. It also provides tools such as sample screening protocols for EC and regimen charts for different types of ECPs, as well as frequently asked questions, case scenarios, an e-quiz, a resource list and ordering information for EC supplies.

Women's Commission for Refugee Women and Children. 2006. "A resource list for adolescent reproductive health programming in conflict settings." www.rhrc.org/resources/ARH%20Master%20Resource%20List%20Dec06.pdf

This bibliography compiles relevant resources on adolescent reproductive health (ARH), including those that specifically tackle refugee, internally displaced and other conflict-affected youth. While the listing stills shows a dearth of materials on ARH programming in conflict settings, the resources enumerated can assist humanitarian actors and programme planners in their efforts to improve ARH. Resources provide some basic information about the major technical areas of reproductive health programming, different approaches and intervention strategies, both established and emerging, and specific training materials, in addition to other resources on advocacy, project funding and specific projects' experiences.

Women's Commission for Refugee Women and Children. 2006. *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module.* Available at http://misp.rhrc.org

A self-instructional learning module that helps to increase knowledge of priority reproductive health services to initiate at the onset of a crisis brought on by conflict or natural disaster, this module is particularly useful for members of emergency response teams, and other first humanitarian responders in crisis situations. It is primarily based on *Reproductive Health in Refugee Situations: An Inter-agency Field Manual,* and includes chapters focussing on MISP coordination, prevention and management of the consequences of sexual violence, reducing the transmission of HIV, prevention of neonatal and maternal morbidity and mortality, planning for comprehensive reproductive health (RH) services. The module is also available in Arabic, Bahasa Indonesia and Korean, among other languages.

Other Resources

Acquire Project. 2009. *Engaging Boys and Men in Gender-based Violence Prevention and Reproductive Health in Conflict and Emergency-Response Settings: A Workshop Module.* NY, USA: EngenderHealth. 60p. www.rhrc.org/resources/Conflict%20Manual_CARE_for%20web.pdf

Back Pack Health Worker Team. 2006. *Chronic Emergency Health and Human Rights in Eastern Burma.* 81p. Thailand. www.geocities.com/maesothtml/bphwt/index.html

BRIDGE. 2003. *Cutting Edge Pack: Gender and Armed Conflict.* UK. v.p. www.bridge.ids.ac.uk/reports_gend_con_em.htm

Cook, Rebecca; Merali, Isfahan. 2008. "A human rights approach to promoting and protecting reproductive and sexual health rights: The role of treaty bodies, United Nations agencies and NGO partnerships." ACPD. www.acpd.ca/acpd.cfm/en/section/SRResources/articleid/35

IBON. 2006. *Uncounted Lives: Children, Women and Conflict in the Philippines, A Needs Assessment of Children and Women Affected by Armed Conflict.* 224p. www.adh-geneva.ch/RULAC/news/Uncounted-Lives-Oct2006.pdf Email: media@ibon.org

International Rescue Committee. 2008. *Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool.* http://clinicalcare.rhrc.org/

Isis International Manila. 2006. *Women in Action.* No. 2: Peace Talks. 85p. www.isiswomen.org

Isis WICCE. 2005. *Women's World.* Nos. 39 & 40: Women's Voices on Armed Conflict. Kampala, Uganda. 46p. Tel.: +256-41-4543953. Fax.: +256-41-4543954. Email: info@isis.or.ug

Kvinna Till Kvinna Foundation. [n.d.] *Pushing the Limits: Young Women's Voices About War, Peace and Power.* Sweden. 74p. www.kvinnatillkvinna.se/article/3010

Melber, Henning; Jones, John. 2008. *Development Dialogue.* No. 5: Revisiting the Heart of Darkness: Explorations into Genocide and Other Forms of Mass Violence. Dag Hammarskjöld Foundation. 302p. Email: secretariat@dhf.uu.se

Pankhurst, Donna. (Ed.) 2008. *Gendered Peace: Women's Struggles for Post-war Justice and Reconciliation.* New York, USA: Routledge & UNRISD. 341p. www.routledgepolitics.com

Sheriff, Andrew. 2008. "Enhancing the EU response to women and armed conflict with particular reference to development policy." European Centre for Development Policy Management. 134p. www.ecdpm.org

Women's Commission for Refugee Women and Children. 2008. *Disabilities among Refugees and Conflict-affected Populations.* 76p. www.womenscommission.org/pdf/disab_fulll_report.pdf

Women's Global Network for Reproductive Rights. 2008. *Newsletter 91: Women's Reproductive Rights in Conflict Situations.* Vol. 25, No. 1. 36p. www.wgnrr.org

Women's Health and Human Rights Initiative, et al. 2007. *Models of Resistance, October 25-26, 2005, Menam Riverside Hotel, Bangkok, Thailand.* 48p. http://files.creaworld.org/files/MOR.pdf

ARROW Publications

Thanenthiran, Sivananthi & Racherla, Sai Jyothirmai. 2009. *Reclaiming & Redefining Rights: ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* ARROW. 162p. US$10.00

ARROW. 2008. *Advocating Accountability: Status Report on Maternal Health and Young People's SRHR in South Asia.* 140p. US$10.00

ARROW. 2008. *Surfacing: Selected Papers on Religious Fundamentalisms and Their Impact on Women's Sexual and Reproductive Health and Rights.* 76p. US$5.

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights; Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project.* 216p. US$10.00

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports.* 384p. US$10.00

ARROW, Center for Reproductive Rights (CRR). 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia.* 235p. US$10.00

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* 147p. US$10.00

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report.* 39p. US$10.00

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* 30p. US$10.00

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1-4 June 1998, Kuala Lumpur, Malaysia.* 65p. US$10.00

ARROW. 1999. *Taking up the Cairo Challenge: Country Studies in Asia-Pacific.* 288p. US$10.00

ARROW. 1997. *Gender and Women's Health: Information Package No. 2.* v.p. US$10.00

ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific; Health Resource Kit.* v.p. US$10.00

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* v.p. US$10.00

Payments accepted in bank draft form. Please add US$3.00 for postal charge. For more details, email arrow@arrow.org.my

Definitions

Stages of Conflict

Conflict may be said to have the following stages:[1]

1. Run-up to conflict (pre-conflict)
2. The conflict itself
3. Peace process (or conflict resolution)
4. Reconstruction and re-integration (or post-conflict)

El Jack[2] notes two concerns with this division, however. Planning for targetted interventions for each stage can be limited by armed conflict's shifting boundaries (i.e., what is a time of peace now can be later termed 'pre-war period,' a post-conflict period can later be reclassified as a pause between wars). As well, the breakdown creates a conceptual divide, when in fact, "what constitutes peace from a feminist perspective may differ from mainstream views because...peace does not simply mean the end of armed conflict, but a time to address the structural power imbalances that caused the conflict in the first place. What is required, then, is a more nuanced interpretation of these stages, where interventions that address gender inequality in armed conflict reflect the fact that events occur simultaneously and stages overlap."

A Feminist Approach in Conflict Situations

According to Petchesky, "[h]umanitarian relief as a model of intervention tends to be disempowering and paternalistic, treating people like passive victims," while standard human rights mechanisms "are formalistic and legalistic, requiring complaints procedures and follow-up beyond the capacity of uprooted populations in the constrained conditions of camps."[3] In contrast, a more feminist approach would "call attention to the extraordinary resilience of displaced communities—often under the leadership of women—to survive, negotiate and rebuild."[4]

Gendered Continuum of Violence and Conflict

Rather than focussing on just political violence and armed conflict, Moser[4] introduces a gendered continuum of conflict and violence. This framework categorises violence into three types: "political, economic and social violence, each identified in terms of the type of force that consciously or unconsciously uses violence to gain or maintain power....The interrelationships in this three-fold caregorisation are complex, context-specific and multi-directional." (see table) Each of these categories is gendered.

This categorisation serves several purposes: 1) "it allows for an integrated approach, both conceptual and operational, that recognises the connections among dynamics of different types of violence and their gender-related repercussion"; 2) it "highlights the need for violence-reduction approaches based on the differing motivations of the perpetrators"; and 3) it "assists in explaining why interventions to reduce one type of violence may not result in similar reductions in other types of violence."[4]

Categories of Violence[4]

Category	Definition The commission of violent acts motivated by a desire, conscious or unconscious...	Manifestation
Political	...to obtain or maintain political power.	Guerilla conflict; paramilitary conflict; political assassinations; armed conflict between political parties; rape and sexual abuse as a political act; forced pregnancy/sterilisation
Economic	...for economic gain or to obtain or maintain economic power.	Street crime; carjacking; robbery/theft; drug trafficking; kidnapping; assaults, including rape occuring during economic crimes
Social	...for social gain or to obtain or maintain social power.	Interpersonal violence such as spouse and child abuse; sexual assault of women and children; arguments that get out of control

Endnotes

1 *Byrne, B. 1996. "Gender, conflict and development," Vol. 1: Overview, Bridge Report 34. Brighton, UK: BRIDGE/Institute of Development Studies (IDS). Cited in El Jack, Amani. 2004. "Gender and armed conflict," Overview, Cutting Edge Pack. Brighton, UK: BRIDGE/IDS.*

2 *El Jack, Amani. 2004. "Gender and armed conflict," Overview, Cutting Edge Pack.*

3 *Petchesky, Rosalind. 2008. "Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights." Reproductive Health Matters. Vol. 16, No. 31, pp.4–9.*

4 *Moser, Caroline O.N. 2001. "The gendered continuum of violence and conflict: An operational framework." pp.30–51. In Moser, Caroline O.N.; Clark, Fiona C. (Eds.). 2001. Victims, Perpetrators or Actors? Gender, Armed Conflict and Political Violence. New York, USA: Zed Books.*

Compiled by Maria Melinda Ando, Programme Officer, ARROW. Email: malyn@arrow.org.my

Editorial Team
Saira Shameem, Executive Director
Sivananthi Thanenthiran, Programme Manager
Sepali Kottegoda, Consultant/Guest Editor
Maria Melinda Ando, Programme Officer, AFC Managing Editor & Designer
Rodelyn Marte, Programme Manager
Ambika Varma, Cici Lixin, Phan Uyen, Sai Jyothirmai Racherla, & *Suloshini Jahanath*, Programme Officers

Expert External Readers
Ranjani Krishnamurthy, Consultant & ARROW Programme Advisory Committee (PAC) Member; *Roshmi Goswami*, Programme Officer, India, Nepal and Sri Lanka, Ford Foundation; *Salbiah Ahmad*, lawyer; *Sunila Abeysekera*, Executive Director, IWRAW Asia-Pacific

Special thanks as well to the ff.:
Khawar Mumtaz, Neha Sood, Rowena Alvarez, Sarala Emmanuel

***ARROWs For Change (AFC)** is produced tri-annually and is primarily for Asian-Pacific decision-makers in women's rights, health, population and sexual and reproductive health and rights organisations. The bulletin is developed with input from key individuals and organisations in the Asia-Pacific region and ARROW's Information and Documentation Centre. Articles in AFC may be reproduced and/or translated without prior permission, provided that credit is given and a copy of the reprint is sent to the Editors. Copyright of photos belongs to contributors. AFC receives funding support from Oxfam Novib and the Swedish International Development Cooperation Agency (Sida).*

Print subscription is free for those based in Asia-Pacific, Africa, Eastern Europe, & Latin America and the Caribbean. There is a modest subscription fee for those based in North America and Western Europe. Publications exchange is also welcome. Please write to **afc@arrow.org.my** *for subscription matters. AFC issues can be downloaded for free at* **www.arrow.org.my** *AFC is also distributed by EBSCO and Gale through non-exclusive global distribution agreements.*

Feedback and written contributions are welcome. Please email them to: **afc@arrow.org.my** or mail to:
Asian-Pacific Resource & Research Centre for Women (ARROW)
No. 1 & 2 Jalan Scott, Brickfields, 50470 Kuala Lumpur, Malaysia
Tel.: +603 2273 9913. Fax.: +603 2273 9916.
Website: www.arrow.org.my

FACTFILE

Life-saving:
Sexual and Reproductive Health Matters in Crises

While clean water, sanitation, adequate food, shelter and primary health care are vital responses in crises, the sexual and reproductive health and rights (SRHR) of concerned populations needs to be equally addressed as well.[1] Research shows that neglecting SRH in emergency situations and their aftermath leads to serious consequences.[1] For example, the lack of access to contraceptive, safe abortion and skilled delivery services may expose women to unwanted pregnancies, unsafe abortions and childbirth in dire situations. In fact, pregnancy and childbirth complications are the leading causes of death and disability among forcibly displaced women of childbearing age.[2] The chaotic environment of crisis situations and the absence of law and order, on top of existing unequal gender relations, contribute to the increased incidence of sexual violence. The breakdown of social norms, lack of family support and collapse of sources of income, information and assistance put women and youth at higher risk of sexually transmitted infections (STIs) and HIV. Yet, despite its importance for the survival and wellbeing of the populations in crisis situations, SRH is not yet systematically integrated into emergency responses and in the management of post-crisis situations.

To address this gap in the region, the "Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East, Southeast Asia and the Pacific" (SPRINT) Initiative[3] was launched in December 2007 by the International Planned Parenthood Federation in East Southeast Asia and Oceania (IPPF ESEAOR), in collaboration with UNFPA and other international partners. SPRINT aims to mainstream SRH into national emergency preparedness plans and responses, increase capacities of agencies to implement the Minimum Initial Service Package (MISP) for SRH in crises (see box to learn more about MISP), and facilitate emergency and post-emergency responses to SRH. In 2008, SPRINT trained more than 1,700 humanitarian actors from government ministries, NGOs and academic institutions from over 30 ESEAOR countries and 30 different organisations to increase their capacity to implement MISP.[4] The in-country trainings by the national SPRINT teams are currently underway. Country partners have also implemented MISP for communities that were struck by Cyclone Nargis in Myanmar and the Sichuan Earthquake in China in May 2008, ensuring the affected population had access to basic SRH services.[5] The SPRINT country teams of the Philippines and Indonesia are planning to implement the MISP in the conflict-affected areas of Mindanao and Central Sulawesi respectively beginning mid-2009.

What is the MISP?

The Minimum Initial Service Package for Sexual and Reproductive Health in Crises (MISP) is a set of priority interventions to be implemented during the early phase of a natural disaster or conflict. Developed by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) in 1996, it has become an internationally accepted standard and is included in the Sphere Project guidelines.[6] MISP's goal is to "reduce mortality, morbidity and disability among populations affected by crises, particularly women and girls. These populations may be refugees, IDPs or populations hosting refugees or IDPs."[7] It aims to:

- *identify organisations and individuals to facilitate the coordination and implementation of the MISP;*
- *prevent excess maternal and neonatal mortality and morbidity by providing clean birth kits to promote clean home births, providing in the facilities, and establishing a referral system to manage obstetric emergencies;*
- *reduce HIV and STI by enforcing universal precautions and ensuring the availability of free condoms (male and female);*
- *prevent sexual violence and assist survivors by ensuring systems are in place to protect displaced populations, particularly women and girls, and ensuring medical services and psychological support; and*
- *plan for the provision of comprehensive SRH services that is integrated into primary healthcare as soon as the situation stabilises.*

As part of MISP implementation, 12 'Inter-Agency SRH Kits for Crisis Situations' containing medical supplies and drugs are to be made available in crisis situations.[8] While not part of the response in the acute phase of an emergency, experience has shown that it is important to meet the contraceptive needs of continuing users. There is also recognition among implementers on the importance of responding to other women's needs, such as sanitary pads during menstruation, and have included them in 'hygiene' or 'dignity' kits.[9]

The dissemination of the MISP has been at the forefront of IAWG's agenda. However, there are still challenges that lie ahead with the implementation of the MISP on a large scale.[10] These challenges include the scarcity of trainers and field worker experts in the MISP (the MISP was therefore made widely available as an online distance-learning module);[7] the difficulty of keeping track of former humanitarian actors trained in MISP; lack of financial support; and the need for updating, dissemination and promotion of training materials.

Endnotes

1 *Wulf, D. 1994. Refugee Women and Reproductive Health Care: Reassessing Priorities. New York: Women's Commission for Refugee Women and Children.*

2 *Bartlett, LA at al. 2000. "Maternal mortality among Afghan refugees in Pakistan, 1999-2000." Lancet, 23;359(9307):643-9.*

3 *For more information on SPRINT: www.ippfeseaor.org/en/What-we-do/SPRINT*

4 *For more information on participating countries and organisations: www.ippfeseaor.org/NR/rdonlyres/20DDE75F-B033-432B-8BA8-0BBB5F556103/0/SPRINTNewsletter1.pdf*

5 *For Cyclone Nargis, UNFPA supported the distribution of US$500,000 worth of RH kits to 14 affected townships through the Department of Health and the Myanmar Medical Association. It also provided contraceptive commodities and IEC materials, US$30,000 worth of clean delivery kits and US$330,000 worth of dignity kits to NGOs. For the Sichuan earthquake, country partners distributed 142 STI treatment kits including condoms, 40 kits for clinical delivery assistance at the primary health care level, 20 kits for the referral hospital level kits including blood transfusion, as well as 13,000 hygiene kits.*

6 *Humanitarian Charter and Minimum Standards in Disaster Response, The Sphere Project, 2004 Edition.*

7 *MISP for Reproductive Health in Crisis Situations: A Distance Learning Module. 2006. New York: Women's Commission. http://misp.rhrc.org/content/view/22/36/lang,english*

8 *The kits to be given during the crisis phase are on male and female condoms (1), clean delivery (2), post-rape (3), clinical delivery assistance (6), management of miscarriage and complications of abortion (8), suture of cervical and vaginal tears (9), vacuum extraction delivery (10), referral level kit for reproductive health (11) and blood transfusion (12). Kits on oral and injectable contraceptives (4), IUDs (7) and treatment of STIs (5) are part of comprehensive RH services. Kits 1-5 are to be used for 10,000 persons, kits 6-10 are for 30,000 persons, and kits 11-12 are for 150,000 persons; all are for a period of three months.*

9 *These kits are not part of the Inter-Agency SRH Kits as they are assembled locally with community input. Contents of 'dignity' kits distributed to women in conflict-affected Mindanao, Philippines include sanitary pads, underwear, malong (sarong-like cloth, that can also be used to cover the head), shampoo, soap, toothpaste, toothbrush, bucket, slippers and nail clippers.*

10 *IAWG Academic Partnership for Reproductive Health in Crisis Situations. 2006. Strategy Paper & Work Plan. Geneva: UNFPA.*

By Dr. Tran Nguyen Toan, SPRINT Initiative, IPPF ESEAOR. Email: ippfklro@ippfeseaor.org

ARROWs for Change is published with the funding support of:
Oxfam Novib Sida