Barriers to Reproductive Health and Access to Other Medical Services in Situations of Conflict and Migration

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Introduction

People living in situations of conflict and forced migration do not receive the health care they need and want, and to which they have a right. There are many factors contributing to this lack of adequate care. The purpose of this paper is to examine these factors, using reproductive health care as the lens through which barriers to providing and using health care are reviewed.

The definition of reproductive health articulated at the International Conference on Population and Development (ICPD) in Cairo in 1994 and adopted by the World Health Organization is widely accepted for its encompassing vision. The definition states:

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (United Nations, 1994; World Health Organization, 2004).

The ICPD Programme of Action continues:

> In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (United Nations, 1994).

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The barriers to reproductive health care in conflict include and often exceed barriers to other components of health services, such as preventive and curative care for children and management of infectious diseases for populations in general. This holds true for both provision and utilization of such care: reproductive health often faces greater obstacles to both supply and demand than do than other categories of care. Reviewing barriers to reproductive health care in conflict situations, therefore, allows a thorough examination of barriers to health care more generally.

Background to the Field of Reproductive Health in Conflict

Reproductive health is a relative newcomer to humanitarian response, an important consideration in the discussion of barriers to care. Traditionally, the focus of international and local relief agencies' response to complex emergencies has been the provision of adequate food, water and shelter and basic health care to reduce mortality through control of infectious diseases. Attention to reproductive health is frequently dated from the mid-1990s when, indeed, concerted interest was initiated and then maintained. However, in the 1970s and 1980s, some organizations provided reproductive health services, carried out research and formulated guidelines in response to specific needs they identified among refugee and displaced persons or others exposed to violence. For example, Lao and Hmong refugees (Chongvatana and Lavely, 1984) and Khmer refugees (Lenart and St. Clair, 1991) in Thailand in the late 1970s were offered family planning services. Research studies included a comparison of fertility levels among different groups of Hmong refugees in Thailand in 1979–1980 (Holck and Cates, 1982); an assessment of pregnancy outcomes in Chile during the civil unrest of the mid-1980s (Zapata, 1992); and the prevalence of sexually transmitted infections among pregnant Vietnamese refugees in Hong Kong in 1989 (King et al., 1990). In 1991, the United Nations High Commissioner for Refugees (UNHCR) developed the first set of guidelines recognizing that refugee women and girls faced particular protection concerns (UNHCR, 1991). While reproductive health was not specifically the focus of this document, it encouraged provision of family planning services; pregnancy, delivery and gynecological care; counseling for rape survivors; and management of sexually transmitted infections as part of a comprehensive response to the needs of refugee women and girls.

In the mid-1990s, a series of global events occurred which focused attention on reproductive health needs of war-affected populations. First, a *Lancet* editorial entitled, "Reproductive freedom for refugees," (1993) noted that, "It is *not* offering choices [to refugees] that is reprehensible." Second, a 1994 study carried out by the Women's Commission for Refugee Women and Children showed that reproductive health services were virtually absent in the eight refugee and internally displaced persons (IDP) field sites the researchers visited, except for some antenatal and basic delivery care, even though some of the populations had been displaced for long periods (Wulf, 1994). Next, both the 1994 International Conference on Population and

Development in Cairo and the 1995 Fourth World Conference on Women in Beijing highlighted the reproductive health needs of displaced populations, and of displaced women specifically (United Nations, 1994; United Nations, 1995). Finally, the scope of the atrocities, particularly sexual violence, during the conflicts in the former Yugoslavia and in Rwanda in the mid-1990s, covered extensively in the world's popular media, forced attention to reproductive health issues.

Following the sobering realization of the absence of reproductive health services to those in conflict settings, humanitarian and development agencies mobilized to address the gap. Early in 1995, five international NGOs – CARE, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children – formed the Reproductive Health Response in Conflict (RHRC) Consortium to promote sustained access to comprehensive, high-quality reproductive health care in emergencies and to advocate for policies that support the reproductive health of people affected by armed conflict. Also in 1995, UNHCR and the United Nations Population Fund (UNFPA) agreed to collaborate to address the needs of displaced populations for reproductive health information and services. One form of this collaboration was their decision to co-host a series of consultative meetings on reproductive health in conflict settings; as a result, the *ad hoc* Inter-agency Working Group on Reproductive Health in Crisis Settings (IAWG) was formed in 1995 with membership from United Nations, multi- and bilateral, non-governmental, university and donor organizations.

IAWG served, and continues to serve, as a mechanism for agencies to discuss concerns in the field of reproductive health in conflict, determine priorities and collaborate to address them. A major initiative taken by IAWG was the development of a technical manual entitled *Reproductive health in refugee situations: An inter-agency field manual* (UNHCR, 1999). The manual, endorsed by thirty-three UN, non-governmental organization (NGO), university and government bodies, was published in 1999 after two years of field testing in seventeen countries (Schreck, 2000). It is intended as a tool to encourage organizations to initiate reproductive health programming and to guide program managers in developing, implementing and evaluating interventions in the field.

Consistent with the ICPD definition of reproductive health care, the *IAWG Field Manual* describes fundamental principles for reproductive health programs in crises and contains programming guidance for both the emergency and stabilization phases. (UNHCR, 1999) For the early stages of an emergency, IAWG defined the Minimum Initial Services Package (MISP), a series of actions to be taken in all new humanitarian situations without a population-specific needs assessment. The objectives of the MISP are to identify an organization to coordinate the reproductive health response; prevent and manage the consequences of sexual violence; reduce HIV transmission by enforcing standard precautions and making condoms available; prevent excess maternal and neonatal mortality by providing clean delivery kits for use by pregnant women, providing midwifery kits to health facilities and establishing referral systems for obstetric emergencies; and

plan for the provision of comprehensive reproductive health care after the emergency phase. Programming guidance for comprehensive care is also fully described in the *IAWG Field Manual*, with comprehensive care defined to comprise safe motherhood; sexual and gender-based violence; sexually transmitted infections including HIV/AIDS; and family planning. The manual also addresses the reproductive health of young adults and surveillance and monitoring appropriate to these settings.

The rapid development, publication and wide dissemination of the *IAWG Field Manual* is an early example of the intense and collaborative nature of the young field of reproductive health in conflict. In the almost fifteen years since the field was established, additional technical manuals were developed, both by individual agencies and groups of partners, on safe motherhood, family planning, STIs/HIV/AIDS and gender-based violence (examples include: Holmes/IRC, 2003; IASC, 2005; RHRC Consortium, 2004a, b); advocacy for favorable policy change was carried out in UN, donor and NGO fora; three professional conferences were held, sponsored in 2000 and 2003 by the RHRC Consortium and in 2008 by the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and the Consortium (RHRC Consortium, 2000; RHRC Consortium, 2003; RAISE Initiative and RHRC Consortium, 2008a); research studies were carried out and journal articles published; and a standard for reproductive health was included in the 2004 revision of the *Sphere Charter and Minimum Standards in Disaster Response* (2004) – all indications of the maturation and professionalization of a field which did not exist prior to 1995. Most importantly, humanitarian agencies, supported by dedicated funding and the newly available policy and technical guidance, began to shift policies and field procedures to deliver reproductive health services to people in conflict settings.

The Reality: Barriers Block Delivery and Use of Reproductive Health Care

Three overviews of the field conducted over a decade show the improvements in the availability of reproductive health care to people in conflict settings, but also underscore the barriers to widespread coverage and use of services. The first review, the 1994 Women's Commission report discussed above, documented virtually no reproductive health services to those in the sites the researchers visited. Moreover, it documented virtually no interest in reproductive health among the agencies serving refugees (Wulf, 1994). By the time of the second overview in 1998, more agencies were providing care – primarily limited to some safe motherhood services and basic family planning – and beginning to make the institutional changes needed to include reproductive health in the standard package of services they deliver (RHRC Consortium, 1998).

The most recent overview was a large-scale effort by the Inter-agency Working Group. From 2002 to 2004, IAWG undertook a global evaluation of reproductive health services to refugees and IDPs, based on the framework for implementation

outlined in the *IAWG Field Manual*. The objectives of the evaluation were to assess the range and quality of services provided to refugees and IDPs, identify the factors that help or hinder care and identify lessons learned in the field's first decade of activity (IAWG, 2004). The global evaluation comprised six studies: a literature review; a global survey of reproductive health coverage for refugee and IDP populations in thirty three countries based on agency self-reports; an assessment of availability and quality of reproductive health care based on visits to three field sites (Uganda, Democratic Republic of Congo and Yemen); a review of prior experience and an on-site review in Chad of rapid reproductive health response in new crises; a review of NGO policy and institutional change based on key informant interviews; and a review of global resource trends over the decade based on an analysis of published and unpublished donor commitments and expenditures.

The global evaluation and other studies and programs suggest a wide range of barriers to care. For the purposes of this paper, barriers are grouped into four categories for discussion. These are: limited availability and quality of reproductive health care; variable demand for reproductive health services; structure and history of the humanitarian field; and global policy and funding constraints.

Limited Availability and Quality of Reproductive Health Care as a Barrier to Care

The most fundamental barrier identified in the global evaluation was, quite simply, the limited scope and quality of reproductive health services available. This was identified in the literature review, the global coverage survey and site visits, and corroborated earlier reviews and field studies (Palmer, 1998; McGinn, 2000; Hynes et al., 2002; Guy and Morris, 2003; McGinn et al., 2004). Specifically, the global evaluation showed variation in availability and quality of care by phase of emergencies, by specific reproductive health component, by type of site and by level of development of the host site.

As noted, the community of professionals working in reproductive health in conflict settings identified a set of basic services and activities, MISP, intended to be initiated within days of the start of new natural or man-made disasters (UNHCR, 1999). The Sphere standards, a set of minimum standards for humanitarian response to which humanitarian responders voluntarily agree to adhere, include the MISP (Sphere, 2004). Yet the global evaluation showed substantial gaps in reproductive health services during emergency response.

The retrospective study of response during past emergencies found that, of 33 sites reviewed, at least one MISP component was in place within one month of the crisis in three-quarters of sites, and that all MISP components had been implemented within three months in approximately half of the sites. However, no site reported implementing all components of the MISP within the first 30 days of the crisis (IAWG, 2004). In an on-site assessment of the active crisis in Chad in 2004 to determine to what degree the MISP had been implemented, reviewers found that most staff of responding agencies were unfamiliar with the MISP. Therefore, its

components were not put into practice: there was no overall reproductive health coordinator; limited activities to prevent sexual violence and limited availability of clinical services for survivors of sexual violence; poor observance of standard precautions to prevent transmission of infectious disease in health facilities; virtually no condoms available; incomplete distribution of clean delivery kits for visibly pregnant women; no availability of emergency obstetric care; and no planning for comprehensive reproductive health services (IAWG, 2004). The global evaluation suggests, then, that many refugees and internally displaced people in the acute phase of humanitarian emergencies do not have adequate access to reproductive health services.

In stable humanitarian settings, the most established reproductive health services at the time of the global evaluation were limited family planning methods (primarily oral contraceptives), antenatal care and condom distribution (IAWG, 2004). This is not surprising: these elements were most familiar from the development field and were introduced earliest to conflict populations. The less familiar services – a wider range of contraceptives, emergency obstetric care, response to gender-based violence, STI/HIV/AIDS services other than condom distribution and youth-friendly services – were not routinely available in most sites. In the last several years, however, observation and field reports suggest that these services, especially response to gender-based violence, HIV prevention and treatment of STIs, have expanded as more agencies in more sites gather the experience and confidence to address these needs and as donors recognize and support their efforts (RAISE Initiative and RHRC Consortium, 2008b).

The adequacy of scope and quality of some reproductive health care is a concern in the field. As reproductive health services are expanded, health care providers and their agencies raise questions about quality and, specifically, continuity of care to displaced people. Even if an agency has the technical, financial and other resources to deliver specific components of care, they may question whether it is appropriate to do so. For example, providers worry that women who opt for long-acting contraceptives such as the intrauterine device (IUD) or sub-dermal implants may be unable to obtain follow-up care or get them removed if they leave the service area. Similarly, although the Joint United Nations Program on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Refugees (UNHCR) promote equity in HIV prevention and treatment for all people and promote the inclusion of displaced populations in national anti-retroviral therapy (ART) protocols (UNAIDS and UNHCR, 2007), front-line providers are concerned about starting clients on ART if they will not have ongoing care available to them when they return home. The quality of care, cost and ethical implications of providing such care are substantial, and challenge agencies working among mobile populations.

Another imbalance in the availability of care was identified in the global evaluation: people living in non-camp settings have considerably poorer access to services of all kinds, including health and reproductive health, than those living in camps.

Concentrated populations are, of course, easier to serve than are dispersed populations, and it is not unreasonable for services to be introduced in areas of high

concentration, such as camps, first. However, if services remain only in camps, dispersed populations become or remain systematically disenfranchised. Distance may be an insurmountable barrier for dispersed populations trying to reach routine health care and may be a death sentence for those with emergencies. For example, a woman with a severe obstetric complication trying to reach a referral facility for emergency obstetric care – should such care be available – has limited time to get help which can save her life. The same is true for a person with any life-threatening health condition. Moreover, distance masks the related barrier of insecurity: the farther one must travel, the greater the risk of danger from organized military forces or bandits taking advantage of lawlessness. Travel at night is universally prohibited in insecure zones, lengthening the time patients will require to reach care.

A related disparity identified in the global evaluation was that between care available to refugees and to the internally displaced. IDPs were found to have poorer access to care than refugees, in part because they are more likely to live in dispersed areas where distance to health care may be great and security poor, as discussed above. Cost of care might also be a factor in the disparity between refugees and IDPs: refugees are provided free care, but this is not always the case for IDPs, especially in non-camp situations. Another important reason for IDPs' poorer access is that it may require an extension of humanitarian agencies' missions, often expressed as service to *refugees,* to work with IDPs. Indeed, in 2006 UNHCR articulated its commitment to IDPs to counter the assumption that they were concerned with refugees only, and also defined its mechanisms of working in IDP host countries (UNHCR, 2006). Agencies may also find it difficult to obtain necessary approvals to serve IDPs from host governments implicated in armed conflicts, and to work with authorities on the ground.

Yet another cause for variation in reproductive health services offered to those in conflict is a country's general level of development. The evaluation found that countries with good health and other systems at the start of a crisis – such as those in some parts of Asia and Latin America – can deliver more and better quality services, even in war, than can countries with poor systems. Many sub-Saharan African countries have weak health systems to start with, and they become weaker as conflict destroys what human and material resources exist. Problems include stock shortages; culturally inappropriate education and counseling; inadequate training and skills among staff tasked with providing services; and poor data systems. These problems are not unique to conflict; many of them also plague reproductive health and other health programs in stable, but very poor, countries. It is fair to state that in Darfur, for example, the generally limited scope and quality of health care predated the conflict and applied to all residents of the region, displaced or not. Nevertheless, even in countries with good general health systems, such as Colombia, care available to displaced people can be below the standard available to stable populations (Women's Commission, 1999; Krause and Morris, 2003; Profamilia, 2005).

Variable Demand for Reproductive Health Services as a Barrier to Care

The extent and speed of uptake of health services by populations affected by conflict is influenced by many individual, social, economic and political factors. Busza and Lush (1999) constructed a useful conceptual framework to illustrate how pre-conflict factors interact with the experiences of displacement to create a range of potential reproductive health outcomes. They explain that individuals, families and communities enter their displaced existence with their existing demographic profiles; reproductive health status and preferences; awareness, attitudes and beliefs about facets of life such as sexuality, marriage and gender; and experiences of health services at home. These aspects of their lives are then altered, perhaps dramatically, by their experiences of displacement. These include movement to new physical and possibly climactic environments; exposure to violence, possibly including sexual violence; changed familial and social structures and roles; altered economic systems and labor options; interactions with host populations and possibly unfamiliar groups from other conflict areas; interactions with humanitarian agencies and other official bodies; and exposure to health education, services and new service systems. As the migrants reformulate their lives, they change, and these changes may manifest themselves, over short or long periods, in altered awareness, perceptions, attitudes and behaviors related to reproductive health. The migrants' pre-existing status and the changes they experience over time may operate as barriers to care, or they may become opportunities for new ways for them to consider their health and rights.

Where the migrant populations' prior levels of awareness and use of reproductive health services are reasonably high, humanitarian agencies might expect to face relatively few barriers to demand for reproductive health care. Indeed, they may face a pent-up demand for services if care stopped during the active conflict. Thus, in Colombia where the national contraceptive prevalence rate (CPR) is 64% for modern methods and where the proportion of women who give birth with skilled attendants is 91%, displaced women are reasonably well accustomed to family planning, care during pregnancy and delivery and other elements of reproductive health services, even if not to the same extent as the general population (UNFPA, 2006). Informational and cultural barriers to demand for health care would be expected to be relatively low in such a site. A similar situation exists in Sri Lanka, another often forgotten crisis setting, where CPR is 50% and 97% of women deliver with skilled attendants (UNFPA, 2006).

Many of the world's current refugee and IDP situations, however, are in regions where the migrants' pre-existing reproductive health status is poor and pre-conflict levels of awareness and use of reproductive health services are low. In most sub-Saharan African conflict sites, indicators such as CPR and skilled attendance at delivery are far lower than in Colombia or Sri Lanka. For example, CPRs in Central African Republic, Democratic Republic of Congo and Sudan are under 10% (7, 4, and 7%, respectively) and the proportions of women who deliver with skilled

attendance in these countries are also relatively low (national rates in the three countries, likely higher than those in displaced and rural regions, are 44, 61 and 57%, respectively; UNFPA, 2006). Migrants' low awareness and limited experience of reproductive health services may therefore be a barrier to care, as they are unlikely to seek out such services and may in fact resist agencies' efforts at education and service delivery.

Ironically, it was in Africa where some humanitarian agencies were first faced with refugees' demand for family planning services: in the mid-1990s, Rwandan refugees, accustomed to a family planning program at home that made Depo-Provera and other contraceptives available, looked to health care providers in the refugee camps in Tanzania and Congo to help them obtain resupplies of their methods (Schreck, 2000). For the most part, organizations were not prepared to respond and they had to move quickly to adjust to their clients' demands.

Structure and History of the Humanitarian Field as a Barrier to Care

The challenges of delivering adequate health care on the ground and low pre-existing demand for services are barriers to care that can be addressed with humanitarian agencies' reproductive health program interventions; this is precisely what has occurred in many agencies and conflict sites in the past decade. Over 30 relief and development agencies endorsed the *IAWG Field Manual,* and these and other organizations are actively bringing reproductive health services to refugees and IDPs in the field (UNHCR, 1999). However, another set of barriers may arise as agencies shift their operations to incorporate this new sector. Their internal organizational structures and systems for responding to emergencies may themselves be a barrier to delivering good reproductive health services.

First, reproductive health is new to humanitarian agencies, and introducing any new component in an organization is challenging. By definition, there are no staff with the requisite skills, no internal policy or program guides, no technical systems in place, no institutional experience in the sector. Even when these elements are brought in – i.e., staff can be hired or trained and external guidelines adapted – each institution must determine how the new services fit in the context of its existing set of management and technical systems. While organizations can ensure that clinicians and educators acquire the specific skills they need to deliver reproductive health care, it is a more complex undertaking to make certain that generalist staff or specialists in other sectors effectively incorporate reproductive health into their responsibilities. So, in order to successfully integrate reproductive health into their operations, organizations must ensure that human resource systems recruit and hire staff with the requisite reproductive health skills; health sector supervisors provide reproductive health providers relevant support; that health sector managers design and evaluate reproductive health programs using best practices in the field; that logisticians integrate reproductive health procurement and distribution into their

systems; that data specialists add appropriate indicators to data tracking systems; that development staff expand their donor base to include those friendly to reproductive health; that advocacy staff articulate their issues to include reproductive health concerns; that senior officials incorporate the new sector in their interactions with other agencies and in their representation of their organizations. Moreover, these adjustments must occur at site, country, regional and headquarters levels.

While adding any new service would require such substantial changes in organizational structure, adding reproductive health is likely to raise additional concerns. Most health and social services in development or humanitarian response – such as child survival, provision of clean water and housing – do not provoke the partisan debate that often accompanies reproductive health. Thus, actual controversy or the fear of controversy may restrain agencies' willingness to commit to reproductive health programming, as they may believe they would risk the good will of their government donors or their public by doing so. Moreover, individual workers may feel most comfortable following their own beliefs, regardless of what their organizations prioritize. A study based on interviews with representatives of twelve humanitarian and development agencies in Europe, the US and Canada providing health care to displaced populations found that, while agencies identified material and human resources as serious difficulties in institutionalizing reproductive health, "the main challenge is to tackle ideological, managerial and policy barriers, and those related to donor influence" (Hakamies et al., 2008, p. 33).

In short, incorporating reproductive health as a routine sector within humanitarian agencies and ensuring that services function effectively require a breadth and depth of organizational commitment and change that must occur in all departments, at all levels and over time. Operating short of this goal is a barrier to good care.

Global Policy and Funding Constraints as a Barrier to Care

The shifts in service organizations from the familiar to the new – as humanitarian agencies adopt reproductive health service delivery and as development agencies respond to the needs of crisis-affected populations – are not yet as apparent in the policy and funding arenas. As is the case with provision of and demand for reproductive health services and with structural changes within humanitarian agencies, important developments have occurred in the global policy and funding domains regarding reproductive health of war-affected people in the last 15 years, but the current situation falls short of what is needed to ensure the reproductive rights of refugees and the displaced.

As noted earlier, two important policy developments occurred just as the lack of reproductive health services for war-affected populations gained notice in the mid-1990s: these were the statements on the reproductive health needs of displaced populations included in the reports of the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference

on Women in Beijing (United Nations, 1994; United Nations, 1995). The recognition of these needs at these high official levels gave impetus and credibility to the nascent field.

A further high-level policy development was the passage of UN Security Council Resolution 1325 on women, peace and security, passed unanimously in 2000 (UN Security Council, 2000). This was the first resolution ever passed by the Security Council that directly addressed the impact of war on women. It has served as a potent instrument with which women's groups, human rights activists, humanitarians and political leaders advocate for women's involvement in peace negotiations and peacekeeping, humanitarian assistance, development and political processes. It has most directly been applied to reproductive health through a focus on gender-based violence and through promotion of gender equity in humanitarian services (UN Department of Public Information, 2005).

Alongside these advances, however, broad policy gaps have been noted within the field. In their interviews with representatives of agencies serving displaced populations, Hakemies et al. (2008) found that the lack of an international legal framework to protect internally displaced people, such as exists to protect refugees, was identified as a barrier to serving IDPs. More certain and coordinated access to IDPs would facilitate the provision of all services, including reproductive health services, to these underserved groups.

In a major policy and operational reorganization of the way in which the United Nations coordinates emergency response, the cluster approach was introduced in 2005, a result of the UN's Humanitarian Response review (Adinolfi et al., 2005). In order to improve coordination and service delivery among the many responding agencies on the ground, agencies were identified as global cluster leads and made responsible for technical response in nine topical areas. The World Health Organization was named the cluster lead for health, and is thus responsible for ensuring that reproductive health is included in emergency operations. This is further complicated by coverage of some components of reproductive health by other clusters: gender-based violence sits in the protection cluster led by UNHCR, and gender, often a lens through which reproductive health programs are designed and implemented, sits in the early recovery cluster, led by the United Nations Development Program (UNDP).

A 2007 evaluation carried out for the Office for the Coordination of Humanitarian Affairs concluded, "The first two years of the cluster approach have been a mixed and often difficult experience, which on balance has demonstrated positive progress and some tangible added value." (Stoddard et al., 2007, p. 45). The report found that the greatest successes were in filling service gaps; least successful were any gains in accountability for performance by lead agencies. The health sector, in particular, was identified as one of the more challenging clusters, in part because WHO, as cluster lead, has substantial work to do to fully develop its organizational capacity to operate effectively in emergencies. In view of this situation within WHO and the newness of reproductive health to many of the humanitarian agencies active in the cluster approach, there is concern that the cluster approach could be a barrier to comprehensive reproductive health in crises (IASC, 2007). Reproductive health

response may be neglected or fragmented, with the more unfamiliar or controversial components, such as the full range of family planning choices, emergency obstetric care and post-abortion care, ignored.

The inclination to compartmentalize the relief and reproductive health sectors – with refugees and the displaced the natural sphere of humanitarian agencies, and reproductive health the domain of development groups – is a longstanding barrier to capitalizing on the best that each group has to offer. Many documents, research findings, and policy recommendations retain these conceptual divisions. For example, neither of two special series in *The Lancet* in 2006 on reproductive health and maternal mortality recognized displaced or conflict-affected women. The special series in the same journal on Health and Human Rights in 2007 had a strong though not exclusive focus on the displaced and noted the leadership of sexual and reproductive health in linking health and human rights. Strengthening conceptual linkages such as these can influence thought in practice and policy decision-making in both the humanitarian and development spheres.

Compartmentalization is also apparent in policy decisions and in funding streams, and remains a barrier to the best uses of resources and partnership. Policy and funding are linked; indeed, the amount of funding allocated to each global imperative by each donor agency is itself a policy statement. Donors traditionally linked to the humanitarian sector do not necessarily yet view reproductive health as a core humanitarian imperative. Similarly, development donors and planners do not yet routinely include displaced populations in their large-scale strategies, even in countries with substantial internally displaced or refugee populations. Even within the same funding agency, the office funding emergencies may have little communication with the health and reproductive health department(s), a barrier for programmers trying to bridge the sectors. Creating linkages may be even more difficult across donors. Yet, the best work on the ground may well be a result of forging collaborations across these professional and administrative silos.

The IAWG global evaluation (2004) demonstrated that funding for reproductive health in conflict declined from 2000 to 2004, following an increase from the mid-1990s to 2000. The evaluation identified weakened global support for reproductive health in general, not only for war-affected populations, as one factor influencing the decline. Inadequate funding, however common a complaint, is nevertheless a real barrier to adequate service delivery.

Conclusion

The barriers to providing good reproductive health care to refugees and the internally displaced are substantial, and some also apply to delivery of any health services in crisis situations. The barriers discussed here pertain to the availability of services, the demand for care, the substantial organizational shifts required and the policy and funding environments that affect what can be done on the ground.

By working through these barriers, important progress had been made in the 15 years since the absence of reproductive health care in emergency situations was

recognized. As the IAWG evaluation concluded, reproductive health services were more available in 2004 than they had been a decade before, though they were by no means comprehensive or universal (IAWG, 2004). Since 2004, more agencies have initiated and expanded services in more sites, a promising ongoing development (RAISE Initiative and RHRC Consortium, 2008).

A key reason for the achievements in reproductive health service delivery for displaced populations has been the contributions and collaboration of two separate fields: humanitarian response, with its expertise in rapid and efficient response in complex and often chaotic situations and reproductive health, with its decades of evidence-based, client-focused, politically astute experience. These fields could have worked independently of each other or, worse, competed in such a way as to create another barrier to progress. Instead, they created functional collaborative partnerships, such as the Inter-agency Working Group on Reproductive Health in Crisis Settings, the Reproductive Health Response in Conflict Consortium and, more recently, the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and the SPRINT Initiative, to develop and share resources, set field-wide priorities and implement programs (Schreck, 2000; Barnes-Brown and Butler-McPhee, 2007; Austin, et al., 2008; SPRINT Initiative, 2008).

Just as humanitarian and development agencies have increasingly recognized the value of their complementary expertise in the field, there is a need for policy-makers and donors to look beyond their specific portfolios and bridge the sectoral and administrative divides that may inhibit creative advances. These groups, as well as the service and research organizations active in the field, must also hold themselves and each other accountable, through sound measurement of accomplishments and failures, sharing of results and transparent operations. Ultimately, they are accountable to the women and men who depend on them to break through the barriers and provide them with the reproductive health services they need and want.

Notes

1. In 1998, the Consortium expanded to seven members with the addition of the American Refugee Committee (ARC) and the Heilbrunn Department of Population and Family Health at Columbia University's Mailman School of Public Health.

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