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Sustainable Development goals And Reproductive Health Care Right Of Internally Displaced Women

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ABSTRACT

The internally displaced persons (IDPs) are a frequently overlooked group, falling through the gaps of international and national commitments. Displaced women and children often face more challenges than men, as they are at higher risk and lack sufficient access to reproductive healthcare rights, leading to poor health and the threat of eviction. This paper aims to examine the reproductive healthcare situation of IDPs in India and the role of the Sustainable Development Goals (SDGs) in addressing their reproductive healthcare rights.

KEY WORDS

Internally displaced person (IDP), Sustainable development goal (SDG), SRH (Sexual and reproductive health), Minimum Initial Service Package (MISP), Urine track infection (UTI), universal health coverage (UHC)

INTRODUCTION

Every year, millions of people around the world miss their homes as a result of conflicts and disasters, development projects and become internally displaced within their own countries. A total of 41.3 million people were estimated to be living in internal displacement at the end of 2018. Internally Displaced Persons (IDPs) are those affected by natural or human-made disasters and armed conflicts. They experience a terrible life, where insecurity, fear and livelihood loss are their only companions. That's why they are considered to be one of the world's most vulnerable groups. Displaced women face even greater problems, given their special health needs. Internally Displaced Persons (IDPs) have the same health needs as non-displaced people. Women accounted for around half of the IDPs in 2010. They are usually both the primary caretakers of children and siblings and the providers of family income; their multiple responsibilities make it hard for them to access education or health services. Additionally, women and girls often face increased risk of violence and may be unable to access assistance or make their health needs met.

DATA AND SOURCES OF DATA

The study is based on available literature on reproductive rights of IDP women's, analysis of SDG-3 and other legal safeguards.. Data required for doctrinal study is based on secondary sources of data collection. The sources of data collection are mainly the government reports (NITI Aayog), e-sources (Google scholar), library, books, articles, case laws, journals, reports as well as the internet resources.

INTERNALLY DISPLACED WOMEN – HELPLESS VICTIMS

Women and children make up 80% of IDPs, and international humanitarian agencies acknowledge their needs. IDPs' sexual and reproductive needs, especially women's, must be met to regain citizenship. Reproductive health is total physical, mental, and social well-being in all reproductive system-related concerns. IDP camps' low resources and limitations have prevented adolescents and women from meeting

their reproductive health needs, according to many researches. Without contraception, camp women engage in consensual and coerced sexual activity, which can lead to unplanned pregnancies, HIV, unsafe and spontaneous abortion, and other reproductive health issues. IDP women are reluctant to discuss their reproductive health issues. Since these camps share restrooms, UTIs are prevalent. Reproductive health care has several issues, which causes these stressful situations. Humanitarian agencies encounter political or geographical barriers to IDP camps, money and manpower shortages, and security challenges. Thus, IDP reproductive health requirements in disasters and crises must be addressed by a multi-sectoral strategy encompassing protection, security, community, and health sectors.[6] Having this approach is necessary to find the probable challenges as many as possible. Then, the multi-sectoral approach should be organized with considering the extracted challenges for delivery of reproductive health care in IDPs camps. Global trends reveal that around 80 per cent of such people in the world live in Afghanistan, India, Myanmar and Pakistan. But collating their numbers in India remains a challenge as there is no central agency monitoring the number of displaced people. According to the Internal Displacement Monitoring Centre, 650,000 people in central India (Chhattisgarh, Andhra Pradesh, and West Bengal), Northeast (Assam, Mizoram-Tripura, and Manipur), Jammu & Kashmir, Odisha, and Gujarat were displaced by armed conflict and ethnic or communal violence in 2009 and the first half of 2010. Unknown displaced people lived in cities. The public forum South Asian Forum for Human Rights estimates that 42– 52% of IDPs in South Asia are women. Displaced groups in India are sometimes classified as migrants. Displaced women in India confront several challenges, according to gender studies. Gender inequality in productive asset ownership, access to resources, control, and asset use hurts them more than displaced males. Displaced women have less rights than males in relief camps. Urinary tract infections and other ailments are common in rescue camps due to unsanitary bathroom facilities shared by many women. Trips and falls by pregnant women have caused painful miscarriages.Women experience infections and septic stitches because post-C-section delivery care is inadequate. A health survey of displaced Kashmiri Pandits revealed early aging, a high incidence of serious diseases with a high mortality rate, and a predisposition to multiple disease syndromes. Similar to this, no medical care was given to women in the relief camps in Gujarat after the riots in 2002. Women were denied access to Gynecological care because of the lack of privacy. These women's are unaware of rehabilitation programs and descend into poverty. Failure to meet IDP demands in India is due to the lack of a central body to oversee displacement. State governments also handle law and order concerns within their boundaries, but primarily to advance their own political goals.

In India, a national framework is needed to manage IDP issues and monitor human rights violations. Many relocated women stay in abusive relationships because the abuser controls the rent or ownership of the property. Decreased wealth and social standing may lead to domestic violence. Due to their lack of reproductive rights, social and economic marginalization, vulnerability to exploitation, poor health, and eviction threats, displaced women's lives are considerably harder. Some 15% of displaced women require emergency obstetric care due to pregnancy or birth problems, according to the UN High Commissioner for Refugees. They have undesired, unexpected, and improperly spaced pregnancies in relief camps owing to lack of healthcare and contraceptives. Miscarriages have occurred when pregnant women trip and fall. Cesarean-delivered women also had septic sutures. The Friedrich-Ebert-Stiftung in India found that development initiatives in Odisha, Jharkhand, Chhattisgarh, Uttarakhand, and Rajasthan have displaced women from their livelihoods in 2009. Land alienation led displaced women into trafficking and sexual assault in Lanjigrah block, Kalahandi district, Odisha, according to another research. Heavy workloads in rehabilitation colonies harmed displaced women's reproductive health. IDPs often live in poverty due to unawareness of rehabilitation programs.

FUNDAMENTAL CHALLENGES FACED BY INTERNALLY DISPLACED WOMEN REGARDING REPRODUCTIVE HEALTH MANAGEMENT

Emergency obstetric care is limited for internally displaced persons (IDPs), leading to an increase in maternal mortality and morbidity. Factors such as fatigue, malnutrition, and challenging labour impact them. In IDP camps, accessing prenatal, maternal, and obstetric care is difficult. Poor health conditions, overcrowding in camps and villages, inadequate healthcare, and lack of medications all contribute to high rates of infant and child mortality. Loss of home, income, and social support can lead to substance abuse. Healthcare professionals may lack the training for complex diagnoses and treatments. Limited coping mechanisms exacerbate mental health issues like stress, depression, and anxiety. Language barriers can make it challenging to diagnose and treat problems. Sexual and reproductive health services and family planning options are scarce in camps. Ignorance among healthcare providers about integrating reproductive health programs with Sustainable Development Goals (SDG) targets often excludes IDPs. Despite laws guaranteeing free care in public health facilities under Universal Health Coverage (UHC), many illegal

IDPs are unable to access these services due to barriers.

Availability and accessibility of reproductive health services:

One of the main issues in this region was a lack of services, with some studies focusing on reproductive health services and others on access to humanitarian relief. The consequences of this lack of services could include neglect of family planning, unwanted pregnancies, preventable HIV infections, maternal and infant mortality, and violence against women. Women's reproductive health needs change over time and may include family planning, safe abortion, prenatal, birth, and postnatal care. Different humanitarian settings have varying needs for reproductive health services. Insufficient reproductive care could lead to unintended pregnancies and harm pregnant women and new borns by unequal distribution of resources, halting health services, overcrowding shelters, and restricting reproductive health care.

Sexual and gender-based issues:

Violence levels generally rise during emergencies and disasters. Vulnerable to this violence are women and children. The women and children are now supported by a number of organizations, including NGOs and international safe communities. The United Nations Sustainable Development Goals (UNSDG) are another factor that makes communities more motivated to take action to stop violence against women. Community members, policymakers, law enforcement, case managers, trauma psychologists, and family violence workers as well as the integration of disaster management and women's services programs, play a crucial role in this regard.

Human rights:

Some studies mentioned that women in IDP camps suffer diminished human rights and dignity. This is because of women lack knowledge about their rights, inadequate national laws and absence of female officers in the disaster area . National policy makers should protect vulnerable women and pay attention to the reproductive health needs, rights and dignity of IDPs . Humanitarian law, human right, and international criminal law are some examples of actions through increasing the women rights and dignity . Also, Sustainable Development Goals 3, 5 and 16 mentioned the rights of women.

Social and cultural issues: Community education is another topic. Religious institutions like churches may educate the community about calamities. Cultural norms and community beliefs impact IDP shelter women's reproductive health issues. Health care stakeholders should provide women healthcare. So, they can improve community education. Faith-based organizations may improve community education. The potential of such locations and people may be used in disaster response and recovery if policymakers enhance their preparedness and mitigation efforts.The absence of reproductive health standards was an issue. Government and humanitarian aid groups make sure IDPs have sufficient living circumstances and social security. Due to the unsuitable timing and spacing of pregnancy, women and girls are most at risk for maternal mortality. Also, monitoring and evaluation of implementation of these standards should be considered. Importance of monitoring the standards is found in previous studies.

Mental health issues: Disaster-related mental disorders have been studied in the past. It is well known that depression is a common mental disorder, especially in women. Internally displaced people have higher rates of post-disaster depressive disorders and suicide attempts. Rape, sexual assault, and violence against women can worsen the situation. Access to mental healthcare, enhancing security and using shelter surveillance systems can all be used as preventive measures in this regard.[12]

SUSTAINABLE DEVELOPMENT GOALS AND HEALTH IF IDP' INDIA'S COMMITMENT TOWARDS SDG

The most recent Synthesis Report on the post-2015 agenda suggests that the Sustainable Development Goals (SDGs) need to be transformative and operational in all countries for both citizens and non-citizens. Many countries have emphasized the importance of including individuals facing persecution, poverty, extremism, conflict, violence, humanitarian crises, natural disasters, and forced displacement in UN resolutions. It is crucial for statements to address the challenges faced by internally displaced persons (IDPs). While the SDGs mention migrants and refugees in their language, only two out of 169 objectives specifically mention them. It is essential for IDPs, refugees, and migrants to be integrated into SDG initiatives, policies, financing, and indicators to ensure equity and universality across all goals. The 2030 Agenda and Paris Climate Agreement also address internal displacement, enabling countries to translate discussions into laws and incorporate IDPs and refugees into development and humanitarian planning. SDG

3.7 calls for universal access to sexual and reproductive healthcare services, while paragraph 3.8 aims to achieve Universal Health Coverage (UHC) for all, including access to quality essential healthcare services and medicines. These targets directly tackle health issues faced by IDPs. As part of the new global sustainable development agenda to be accomplished by 2030, India is committed to eradicating poverty, preserving the environment, ensuring UHC (universal health care), and ensuring prosperity for all. The National Institution for Transforming India (NITI) Aayog is a special forum that the Indian government established in 2015 with the aim of assisting the Central and State governments in achieving these goals, with a particular emphasis on the SDGs.

The Indian government has established a high-level political forum to take part in the global assessment of the SDGs under the auspices of the UN Economic and Social Council. The issues affecting IDPs should be brought up at such high-level forums, and the necessary steps should be taken to address them. For assisting the Central and State governments in achieving these goals, with a particular emphasis on the SDGs. However, in India, providing UHC is a significant challenge; it can be politically contentious and technically challenging to achieve, due to various constraints, including the high prevalence of diseases, gender inequality issues, an unregulated and fragmented healthcare delivery system, a lack of adequate skilled human resources, a lack of funding, a lack of inter-sectoral coordination, and political pressures and interests faced at various levels by host population. According to a recent WHO report (2017a), inequality has worsened UHC in middle- and low-income countries. The most severe service coverage gaps continue to be found in the poorest quintile. Lists of the difficulties IDPs face and the results of their health under SDG 3 are necessary, both on a individual and national level.

1. The NITI Aayog can take effective measures on the SDG matrix framework and voluntary national review report to include reproductive healthcare protection of the IDPs in SDG target.

2. The SDG objective 10.2 empowers and promotes social, economic, and political inclusion for everyone, including IDPs. The Indian government should clearly include IDPs in SDG indicator plans and debates. Enhancing capacity-building support for developing nations, notably least developed countries and small island developing states, is SDG objective 17.18. This will greatly expand the availability of high-quality, timely, and trustworthy statistics by income, gender, age, race, ethnicity, migratory status, handicap, geographic location, and other national context-relevant variables. The SDG 2030 national framework for India should include an IDP database.

3. Ukraine's Displacement Tracking Matrix national monitoring system can help India track IDPs and their socioeconomic features. This technique helps comprehend the movements, location, and status of India's displaced people. SDG goal 16.7 assures responsive, inclusive, participative, and representative decision-making at all levels, including government and non

government organizations. Key international organizations, community and civil society members, and others should help formulate and monitor SDG indicators at local and national levels.

IDPs health and SDG 3 targets Selected SDG targets Health outcomes –

3.1. Reduce the global maternal mortality ratio to less than 70 per 100,000 live births IDPs lack of emergency obstetric healthcare services and tends to experience higher maternal mortality and morbidity. They are more vulnerable to poor nutrition, premature or complicated delivery and fatigue.

3.2. End preventable deaths of new borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortality to at least as low as 25 per 1,000 live births IDPs have difficulty in accessing obstetric, antenatal and maternal healthcare services in the camps Poor health outcomes and higher mortality of new borns and children under 5 are due to overcrowding in low-quality camp setting and poor sanitation (both in rehabilitated villages and IDP camps), substandard healthcare, inadequate medicines.

3.3. End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases Inadequate knowledge of the healthcare workers in complicated diagnosis and healthcare services.

3.4. Increase substance addiction prevention and treatment, including narcotics and alcohol. Stress from losing land, money, and community relationships leads to alcohol and drug misuse. Lack of coping mechanisms caused long-term stress, sadness, and anxiety. Limited local language skills makes diagnosing and treating diseases difficult.

3.5. Ensure universal access to sexual and reproductive healthcare (SRH) services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes Lack of SRH and family planning information and services in the camps and rehabilitation villages. Healthcare workers lacking understanding of the integration of the reproductive health programs.

3.6. Universal health coverage, including financial risk protection, excellent essential healthcare, and

safe, effective, quality, and cheap necessary medications and immunizations for everyone IDPs are typically omitted from SDG objectives. Due to access hurdles, illegal IDPs seldom received free public health treatments under UHC laws. Other legal safeguards for IDP health The Central and State governments of India are bound by various international human rights accords. Legal safeguards for reproductive rights have been less aggressive in addressing IDP concerns in India.

4. There are fundamental policy gaps in addressing the health needs of IDPs. International and national institutional arrangements could be improved, to facilitate dialogue and collaborative problem-solving sessions. For example, SDG target 10.7 calls for facilitation of orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies. Such initiatives can be made possible through lobbying with legal personnel in the government and facilitating services.

5. Internally displaced women in India most importantly have to believe in themselves, that they are entitled to be treated as primary decision makers of their reproductive capacities. They should acknowledge themselves as valued and respected citizens of the country. This is possible through adopting a reproductive justice framework and demands an inclusive social movement for securing reproductive rights for displaced women. The reproductive justice framework was introduced in 1994 by Sister Song, a collective of US women of colour, who found reproductive rights to be too focused on privacy, autonomy and abortion. The movement was inattentive to the concerns of immigrants and women of colour. The reproductive framework has three important components: reproductive rights, social justice and reproductive justice. The reproductive justice framework includes, the right to have children, not have children, and to parenting children in safe and healthy environments. The Guiding Principles for IDPs provide health and suitable living conditions before, during, and after relocation. IDPs in vulnerable situations are protected and assisted under Principle 4(2)[1]. Principles 18(2)(d)[2] and 19(2)[3] cover health care during displacement (Kalin et al., 2010). The International Covenant on Economic, Social, and Cultural Rights (ICESCR), International Covenant on Civil and Political Rights (ICCPR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and Convention on the Rights of the Child impact maternal healthcare. These accords require nations to respect, safeguard, and fulfill human rights. The Indian Supreme Court ruled that local laws cannot condition treaty implementation. Thus, local and national authorities can directly comply with India's international commitments (Human Rights Watch, 2009). The National Human Rights Commission (2004) advised India to create a national health sector reform action plan for universal and equal access to excellent healthcare. Plan did not acknowledge and legally safeguard IDPs' health rights. Despite such enabling legislation, the Indian government has done nothing to reduce displaced women's reproductive healthcare demands. ICESCR Articles 12[4], 10(2)[5], and 12(2) safeguard all women with appropriate pre- and post-birth protection. All women and girls should have access to reproductive healthcare under CEDAW Article 12[6]. Countries that have ratified these conventions must also offer sexual and reproductive healthcare to refugees and IDPs. India does not apply international safeguards to protect IDPs because it lacks proper arrangements for international humanitarian agencies to operate in sensitive areas, fearing that humanitarian aid would be used by larger states to interfere in its affairs. In Kashmir, international third-party mediation is denied, hurting IDPs. IDPs usually face political tensions from member nations and lack essential services. IDPs receive less international aid than refugees since their migration is less noticeable. India has no national IDP legislation or policy.

There are certain roles that international community or organization can do to protect the IDPs right to health and help in providing adequate standard of living. The SDG 16.3 promotes the rule of law at national and international levels and ensures equal access to justice for all. Furthermore, the government should remove obstacles that hinder IDPs from accessing essential services under national policies and laws.

CONCLUSION

Reproductive health is a major issue for IDPs living in camps. Important steps to lessen these difficulties include creating disaster preparedness and contingency plans, estimating the immediate needs for reproductive health using the MISP, increasing women's awareness of their rights, and addressing the mental and psychosocial needs. In addition, creating standards of living and social security for IDPs, developing referral programs, placing female officers in IDP camps, expanding access to a full range of family planning services, and planning for gender-based violence prevention are some other recommendations to lessen the challenges IDPs face managing their reproductive health during disasters. In some areas, there has been a noticeable improvement in reproductive health. Through new strategies and techniques, family planning has become more widespread worldwide. Wider service coverage and a stronger focus on quality and human rights have been sparked by a renewed commitment to family planning among donors and national governments. The need for more effective methods of reaching

adolescents with messages and services has grown in response to a recent focus on adolescent sexual health. Clinical and policy guidelines have been developed from new methods for reducing gender-based violence that have been put to the test. There is still a lot to be done, though. Less than 30% of women of reproductive age use modern contraception in 35 countries, despite advancements in family planning. Due to access issues, provider biases, and other program-related factors, there is still a wide range of methods available in many nations, even those with high rates of contraceptive prevalence. Although there are effective methods for having a safe abortion, many nations still do not offer these services due to stigma, lack of training, and legal restrictions. The Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation & Resettlement Act, 2013, is the only national law that seeks to address problems faced by people displaced due to development. But there are no provisions to address the reproductive healthcare rights for displaced women under the law. Though the UN's Guiding Principle on Internal Displacement of 1998 underlines their reproductive rights, these guidelines are not legally binding. So the issue is left entirely in the hands of the affected country to enact laws to protect and rehabilitate them. It is time India constituted a governing body not just to record the number of IDPs, but to formulate a policy to protect their basic rights, importantly, their reproductive rights. To achieve the SDGs by 2030, India needs to take into account vulnerabilities of all the people, to address their humanitarian and sustainable development needs.

REFERENCES

Bhaduri, A. (2010), "Displaced lives – personal narratives, Calcutta research group research paper, available at: www.mcrg.ac.in/PP_Aditi.pdf (accessed November 15, 2017).

Broaddus-Shea ET, Kobeissi L, Ummer O, Say L. A systematic review of monitoring and evaluation indicators for sexual and reproductive health in humanitarian settings. Conflict and health. 2019;13(1):43. [PMC free article] [PubMed] [Google Scholar]

Chandran, A. (2017), "India and internally displaced persons, live law", available at: www.livelaw.in/indiainternally-displaced-persons-idps/ (accessed April 7, 2018).

Doedens W, Burns K. Health in emergencies. Challenges to reproductive health in emergencies. WHO; 2001. [Google Scholar]

Fisher S. Violence against women and natural disasters: Findings from post-tsunami Sri Lanka. Violence against women. 2010;16(8):902–918. [PubMed] [Google Scholar]

Hanson D. The United Nations Sustainable Development Goals, the WHO General Program of Work 2019-2023 and International Safe Communities. Journal of Injury and Violence Research. 2019;11(2):4. [Google Scholar]

Larrance R, Anastario M, Lawry L. Health Status Among Internally Displaced Persons in Louisiana and Mississippi Travel Trailer Parks. Annals of Emergency Medicine. 2007;49(5):590–601.e12. [PubMed] [Google Scholar]

NITI Aayog (2015), "Sustainable development goals (SDGs), targets, CSS, interventions, nodal and other ministries, NITI Aayog development monitoring and evaluation office", available at: www.niti.gov.in/content/ goal-3-ensure-healthy-lives-and-promote-well-being-all-all-ages (accessed December 10, 2017).

Morgan, L.M. (2017), "Reproductive rights or reproductive justice? Lessons from Argentina", Health and Human rights Journal, Vol. 17 No. 1, pp. 136-47.

National Human Rights Commission (2004), Recommendation of National Action Plan To Optimize the Right to Health Care, National Human Rights Commission, New Delhi, available at: http://www.nhrc.nic.in/ dispArchive.asp?fno=874 (accessed November 22, 2017).

Nguindip NC. The Protection of Women during Armed Conflict: Crossing Legal Borders in the Application of International Humanitarian Law, Human Right Law and International Criminal Law. Journal of Human Rights Law and Practice. 2020;2(2) [Google Scholar]

NITI Aayog (2017), "Voluntary national review report on the implementation of Sustainable development goals", United Nations High Level Political Forum, available at: http://niti.gov.in/writereaddata/files/Final_VNR_report.pdf (accessed September 15, 2017)

Oliveira ACM, Botega LC, Saran JF, Silva JN, Melo JOSF, Tavares MFD, et al. Crowdsourcing, data and information fusion and situation awareness for emergency Management of forest fires: The project DF100Fogo (FDWithoutFire) Computers, Environment and Urban Systems. 2019;77 [Google Scholar]

Orach CG, Musoba N, Byamukama N, Mutambi R, Aporomon JF, Luyombo A, et al. Perceptions about human rights, sexual and reproductive health services by internally displaced persons in northern Uganda. African health sciences. 2009;9(Suppl 2):S72–S80. [PMC free article] [PubMed] [Google Scholar] Project

on Internal Displacement. Improving the Protection of Internally Displaced Women: Assessment of Progress and Challenges. Washington: Brookings; 2014. [Google Scholar]

Owoaje ET, Uchendu OC, Ajayi TO, Cadmus EO. A review of the health problems of the internally displaced persons in Africa. Nigerian postgraduate medical journal. 2016;23(4):161. [PubMed] [Google Scholar]

Petchesky, R.P. (1998), "Negotiating reproductive rights. women's perspectives across countries and cultures", Reproductive Health Matters, Vol. 6 No. 11, pp. 186-9.

Reproductive health for displaced people: investing in the future. Refugee Studies Center; 2004. [Google Scholar]

Ross, L.J. (2006), "Understanding reproductive justice, SisterSong women of color reproductive health collective", available at: https://d3n8a8pro7vhmx.cloudfront.net/rrfp/pages/33/attachments/original/1456425809/Understanding_RJ_Sistersong.pdf?1456425809 (accessed April 6, 2018).

Schaaf M, Boydell V, Sheff MC, Kay C, Torabi F, Khosla R. Accountability strategies for sexual and reproductive health and reproductive rights in humanitarian settings: a scoping review. Conflict and health. 2020;14:1–18. [PMC free article] [PubMed] [Google Scholar].

Sen, G. (2012), "Universal health coverage in India a long and winding road", Economic and Political Weekly, Vol. XLVII No. 8, pp. 45-52.

Chandran, A. (2017), "India and internally displaced persons, live law", available at: www.livelaw.in/indiainternally-displaced-persons-idps/ (accessed April 7, 2018).