Introduction

ON ANY GIVEN DAY, WOMEN, MEN AND CHILDREN are forced to flee their homes for fear of persecution or to escape the dangers of armed conflict or natural disasters. At the end of 1998, there were an estimated 13.5 million refugees and 17 million internally displaced persons worldwide according to the United States Committee for Refugees (USCR 1999). By early 2000, that number had grown to a total of 50 million, according to The United Nations High Commissioner for Refugees (UNHCR). At the start of 2001 the number of people “of concern” to UNHCR was 21.8 million, or one out of every 275 persons on Earth (UNHCR 2001). Running for their lives, they take little more than what they can carry to restart in precarious new situations which make them vulnerable to many forms of exploitation and abuse, including human rights abuses. We see scenes of their suffering and deprivation on the television: painful images of starvation, homelessness, sorrow, grief and anguish. What we do not see are the reproductive health (RH) repercussions of forced migration.

The RH of refugees is threatened by a variety of factors. Little research has been conducted in the early phase of a complex emergency but at very least people who are forced to move have to identify new health service facilities. Conflict creates a variety of risky health conditions due to the sudden lack of familial or community protection, incidents of sexual violence, and sexual bartering in order for women and children to meet their own and their families’ needs for protection, basic necessities and services (Wulf 1994). Although refugees have some of the same RH needs as other populations, a recent review of literature on refugee RH found that conflict, displacement and military presence correspond to increased rates of sexually transmitted infections (STIs) and at least as high, if not higher, rates of sexual violence (McGinn 2000).
Who is this group of “the hardly reached”?

Refugees are clearly vulnerable to social and sexual disruptions in their lives. They are people outside their country of origin who are recognized under international law as needing protection, due to a well-founded fear of persecution on the grounds of religious beliefs, political beliefs, race, nationality, or membership in a social group. Refugees fall under the mandate of the UNHCR, which is responsible for coordinating their protection and programs that meet their basic needs for food, shelter, health care and education. Three of the largest refugee groups include Palestinians, Afghans and Sierra Leonians who are seeking asylum in neighboring countries or third countries, where they await peace in their country of origin or a determination by the immigration authorities that will allow them to permanently resettle abroad (USCR 1999). This period of uncertainty can last years; Palestinians have waited for a durable solution for more than a half century.

Due to the September 11, 2001 attacks on the World Trade Centers in New York City and the Pentagon in Washington, D.C., the largest and fastest-growing refugee population in 2001 was found in Pakistan. That year the number of Afghan refugees rose by an estimated 800,000 persons, including civilians living outside established camps. This group is the largest concerned population to UNHCR with an estimated 3.6 million people or 30 percent of the global refugee population (UNHCR 2001).

Internally displaced persons (IDPs) suffer similar fears as refugees but have not crossed an international border and do not fall under the protection mandate of any specific United Nations body. Instead, IDP protection is left to the national government, which may or may not seek assistance from UNHCR or another international agency to help provide services to citizens affected by conflict. IDPs live in a variety of settings. For instance, people from Ngorno-Karabakh live peacefully in rural Azerbaijan. Southern Sudanese living in semi-urban settlements around the capital city of Khartoum frequently face the destruction of their temporary residences. Burundian Hutus are forced to live in regroupment camps by the Tutsi-dominated government of Burundi. IDPs are often at risk of governmental human rights abuses in situations where the IDPs are from groups at war with the government.

The demographic composition of refugee and IDP populations reflects the dynamics that caused their flight (Schmeidl 1997). For instance, in situations where men are combatants at war, women, children and the elderly constitute a larger percentage of the refugee population. In other cases, circumstances make it more probable or even necessary for males to seek asylum, such as in Kakuma camp in Northern Kenya, where Sudanese boys escape the ongoing war in Sudan. In this camp there are nearly twice as many males of reproductive age as females of reproductive age; 26,884 males and 14,711 females ages 15-44 (UNHCR 1999b).
What are the reproductive rights of refugees and displaced persons?

The rights of refugees are well established in international humanitarian law and conventions, with an increasing emphasis placed over the last 50 years on the rights to protection from sexual abuse and the right to health, including reproductive health. Like all human beings, refugees are entitled to the following rights: to the highest attainable standard of physical and mental health, for men and women to marry and found a family, to equal access to health care and education, to protection from maltreatment or exploitation including sexual abuse, and to an equal right in matters relating to reproductive choice.¹


The Programme of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo and the Platform for Action of the 1995 Fourth World Conference on Women in Beijing both made specific references to the reproductive health rights of refugees. The ICPD Programme of Action articulated the reproductive health and rights of refugees and other war-affected populations, noting “Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religions and ethical values and cultural backgrounds of the refugees while also conforming with universally recognized international human rights.” At the five-year review of the ICPD in 1999, the international community further agreed that: “Adequate and sufficient international support should be extended to meet the basic needs of refugee populations, including the provision of access to adequate accommodation, education, protection from violence, health services including reproductive health and family planning…”

Taken in sum, these legal and consensus documents clearly confer on refugees the right to reproductive health education and services. In order to achieve these aims, international agencies and refugee communities need to overcome service barriers and must recognize the reproductive health needs of all people of reproductive age.

In addition, refugees are fully entitled to those rights that are contained in the regional agreements or national laws of the country where they seek asylum. The UNHCR states that the laws of host governments should guide the implementation of reproductive health care and that agencies serving refugee health needs should understand and apply those policies (UNHCR 1999a).

Obstacles to Reproductive Health of Refugees

Maternal and child healthcare are well-established cornerstones of emergency health response. The Women’s Commission for Refugee Women and Children conducted a landmark study on reproductive health for refugees in 1994. In *Refugee Women and Reproductive Health Care: Reassessing Priorities*, author Dierdre Wulf concludes, on the basis of evidence from eight countries, that there was scant attention paid to the reproductive health needs of refugee women. During the 1990’s, refugee policymakers and humanitarian aid service delivery organizations began to broaden the scope of health services to provide not only basic safe motherhood services but also more family planning, STI (including HIV and AIDS) prevention and treatment, and services to address sexual violence (Schreck 2000).

Since 1995, when the first international symposium on refugee reproductive health was held in Geneva, the specific populations of concern have expanded and the spectrum of reproductive health services provided has broadened (RHR Consortium 1998). This amplification—of both the populations served and the services received—has resulted from several factors: the strong support of donors and policymakers, better needs assessments, the development of standardized refugee reproductive health guidelines and the fledgling efforts at quantitatively and qualitatively researching the reproductive health needs of refugees and IDPs.

Certain reproductive health needs in refugee settings differ from the needs of populations in ordinary circumstances and are often exacerbated by refugees’ vulnerability including their sexual vulnerability (McGinn 2000). Obviously, displaced persons have to identify new sources of health care. One problem for refugees is that they are often restricted to remote locations where health services are nonexistent prior to the arrival of humanitarian aid organizations. These aid organizations may, for a variety of reasons, opt not to provide comprehensive reproductive health services. Priority-setting often limits the reproductive health services available to refugees and IDPs. Groups facing adversity often revert to greater social conservatism, which also may restrict access to services. The needs of some groups are overlooked in deference to cultural norms that undermine the rights of individuals to reproductive health education and services. Lastly, some groups are targeted for reproductive abuses specifically because of their gender or their role in society.

**Institutional Barriers**

A major obstacle to the delivery of comprehensive reproductive health services is the policies of donors, host governments, humanitarian aid organizations and refugee communities. Any or all of these entities can create barriers to the delivery of reproductive health services, particularly those related to contraception and abortion. For example, in 1993, a UNCHR protection officer interviewed hospital staff in Croatia to determine what sup-
plies were most needed (Green 1996). The doctors requested materials and supplies for performing abortions that were in higher demand during the war. Records indicate that there were two abortions for every birth during the war in Bosnia (Carballo 1996). The hospital could get most other needed drugs and equipment, but due to donor policies the staff could not afford to purchase the materials to provide safe abortions in a setting where abortion was legal. In war-torn southern Sudan service providers stated that abortions were not taking place, but discussion with local people revealed that unsafe abortion was an issue within to the community (Palmer 1999).

Host governments are usually willing to allow refugees access to the same services made available to the local population as long as the international community is prepared to pay for the services. However, in some cases, a host government has more restrictive policies, which leave refugees with poor access to services to which they are accustomed. This was the case in Hong Kong—where abortion is restricted—by the need for two doctors to certify that having a child would cause a woman serious health consequences or be an undue burden on a woman’s physical or mental well-being. During the early 1990s, hospitals in Hong Kong imposed a monthly cap on the number of abortions that could be provided to the Vietnamese refugees as a group regardless of the individual circumstances of a woman. This was in contrast to Vietnam where families were encouraged to have no more than two children and abortion was readily accessible in government hospitals.

Humanitarian aid organizations must overcome a host of biases that inhibit the provision of reproductive health services during the initial crisis phase of an emergency response. Some organizations do not recognize any reproductive health services beyond pregnancy and delivery care as emergency health needs. This limits access to RH care during the emergency phase and becomes a protracted problem when these relief organizations take sole responsibility for the provision of health services in stable refugee situations. Often, the service package offered during an emergency defines the scope of services for months or years after the crisis subsides.

Another limitation results from the religious creed of various aid organizations or individuals responsible for health service delivery. In many refugee settings, the population is completely dependent on the health care provided by a single nongovernmental organization (NGO). If this sole agency or individual refuses to provide comprehensive RH services, including a wide variety of modern contraceptives, then the refugee population has only the black market or home remedies to help regulate their fertility regardless of their own religious beliefs or RH intentions. The Interagency Field Manual for Reproductive Health in Refugee Situations states, “Even though an agency may not provide a full range of RH servi-
ices, coordination with others would ensure that the end product is complementary and comprehensive RH care. Uncoordinated activities result in inappropriate allocations of scarce resources and reduced impact of the project” (UNHCR 1999a). This policy is necessary but not sufficient to assure refugees consistent access to comprehensive RH services. With increasing pressure to streamline operations to save money, it is more common that only one agency will provide health care. UNHCR program staff must be accountable for coordinating and monitoring health programs to minimize gaps in RH services.

**Cultural Barriers**

In several settings a resurgence of conservatism marks an attempt by the refugee community to reassert their cultural values. This was the case among the Afghan refugees in reaction to the cultural hegemony of the occupying Russian forces in the 1980s (RHR Consortium 1998). The Russian-backed government in Afghanistan promoted greater equality for women and girls’ education. Women in the capital city of Kabul were allowed to attend university and have careers. In the name of upholding traditional Afghan principles, the male Afghan refugee leadership in Pakistan prohibited girls’ education other than home schooling. The enforcement of purdah (protecting women’s honor by keeping them covered from head to toe and requiring an escort out of the family compound) created a barrier for women seeking health care in the camp clinics. The requirement that a male relative or an older female accompany women to the clinics made it difficult to protect the patient’s confidentiality, which is critical for RH education and counseling regarding family planning and STIs.

Each year in Africa, an estimated 2 million girls and young women undergo female genital mutilation (FGM). FGM includes practices ranging from Sunna, in which the clitoris is nicked by a sharp object, to infibulation where the clitoris, the labia minor and the labia majora are cut away leaving a sheath of scar tissue and health risks related to infections and obstruction of the vagina. Traditionally, Southern Sudanese populations have not practiced FGM. However, many have fled the wartorn south and now live in camps surrounding the capital, Khartoum in the North. A needs assessment conducted by the International Rescue Committee (IRC) found that the IDPs from southern Sudan were beginning to practice FGM in order to assimilate (Fain 1997). The IDP community identified the introduction of FGM as a priority RH problem that they wanted addressed in community health education.

**Other Groups Overlooked Within Refugee Populations**

In addition to the recently recognized needs of refugee and IDP women, war-affected populations also include many of the other “hardly reached” groups discussed in this publica-
tion. For instance, adolescent and unmarried refugees’ RH needs are often neglected. Refugee adolescents—especially girls—may face increased exposure to STIs, including HIV and AIDS, due to sexual violence and exploitation by fighting forces, peacekeepers and others (UNHCR 2002). Community leaders and parents struggling to maintain their culture and traditions may feel threatened by the introduction of RH education and services which they fear will encourage young people to engage in early or illicit sexual activity. This is the case in Pakistan and Thailand where RH services are provided to Afghans and ethnic minorities from Burma but the camp leadership resists any efforts for NGO staff to assess or address the needs of adolescent refugees (RHR Consortium 1998). Khmer midwives serving Cambodian refugees refused to provide contraceptive counseling or services to women who were unmarried or under age 18 (Morrison 2000).

Men’s RH needs may also be overlooked in refugee settings where health services are geared to maternal and child health care, infectious disease control (e.g. malaria, tuberculosis) and treatment of acute conditions related to malnutrition, poor sanitation, and injury. As in other settings, this has repercussions for both women’s and men’s health. In Tanzania, the IRC initiated family planning education and services in 1995. Over time, clinic records indicated high contraceptive adoption rates and high discontinuation rates. Interviews with women and men in the refugee camps identified the problem as resistance from male partners who did not participate in the classes and were ignorant of the benefits of family planning and therefore pressured female partners to discontinue contraceptive use. Thereafter, more effort was made to reach out to men in the fields, workshops, and social gathering places at the market. In addition, contraception needs to be available to men in places where they can easily access it. In Thailand, condoms were only available in the maternity ward where men did not feel comfortable requesting them (Goodyear 1998b).

**Sexual and Gender-based Violence**

Each year more forms of gross sexual and gender-based violence are documented in conflict settings. During the wars in Bosnia and Rwanda, the extensive rape of women was used as a weapon of war. Rape amounted to genocide in these cultures where ethnicity of a child is determined by that of the father (Human Rights Watch 1997). Women who did not abort their pregnancies or abandon their infants faced the social stigma of raising the child of their enemy. Documentation by the popular press and human rights organizations raised awareness of the prevalence of sexual violence in these armed conflict situations. A report by the Secretary-General of the United Nations to the Security Council specifically includes within the definition of “crimes against humanity” any acts of rape which are committed “as part of a widespread or systemic attack against any civilian population on
national, political, ethnic, racial or religious grounds.” Subsequently, it was established that systematic rape is a form of genocide in the international courts of law and can be prosecuted as such. These definitions of rape marked a fundamental change in the way the international community dealt with sexual and gender-based crimes in international law. The second advance made in the 1990s was the recognition that many women will speak about their experiences of sexual violence if given an opportunity. While some journalists and writers seeking sensationalist stories will abuse this opportunity, many approach such issues with sensitivity and attention to confidentiality, allowing women to articulate their experiences of war in profoundly disturbing detail. This has contributed to the recognition of the need for emergency RH services, notably emergency contraception (Goodyear 1998a).

**Appropriate Approaches**

One key to the provision of appropriate RH services is in-depth research conducted in the community, in partnership with community members, which examines RH-related needs, attitudes, and service capacity in the refugee setting. It is critical that research determines what was normative prior to the conflict, and how the current situation has changed the community’s RH needs.

Based on such research, the *Interagency Field Manual for Reproductive Health for Refugees* was developed, field tested and endorsed by 33 refugee relief organizations, multilateral aid organizations, research organizations, and donor government bodies. It describes a broad range of services starting with a Minimum Initial Service Package (MISP) to be implemented as soon as health care is provided in an emergency response.

The MISP includes:

- provision of free condoms;
- clean delivery kits for use by women, traditional birth attendants or midwives;
- delivery kits for midwives, nurses and doctors;
- emergency contraception in recognition of the high prevalence of sexual violence in many conflict situations;
- enforcement of universal precautions to prevent the spread of blood-borne infectious diseases; and
- dedicated RH staff to organize the MISP and plan for comprehensive RH services to be made available as soon as possible.

The MISP is a standard package of services intended for implementation prior to any assessment. Additional services will benefit from an in-depth assessment that includes
process and results indicators that can be monitored over time. The Interagency Working Group on Reproductive Health for Refugees devised a set of core indicators for use in refugee settings. These indicators are listed in Chapter 9 of the *Field Manual* (UNHCR 1999a).

Beyond the MISP, the *Field Manual* promotes the provision of prenatal, delivery, and post-partum care; management of obstetric complications including treatment of abortion complications; voluntary family planning education and services with a broad method mix; STI and HIV prevention and treatment; and services to address the medical, psycho-social and protection needs of sexual and gender-based violence survivors. Special mention is made of adolescents whose reproductive health care needs are often overlooked. The *Field Manual* does not address the right to good quality abortion services in settings where abortion is legal, cancer screening or infertility services.

The international relief community continues to develop standards for emergency response. An interagency effort by the Sphere Project led to the development of the *Humanitarian Charter and Minimum Standards in Disaster Response*. (The Sphere Project provides programmatic guidelines and indicators for achieving a minimum level of care in an emergency). Fortunately the revised standards now include the basic emergency RH care services recommended in the *Interagency Field Manual on Reproductive Health Services in Refugee Settings* (Sphere Project 1999).

**A Success Story**

The International Rescue Committee’s Sexual and Gender-based Violence (SGBV) program in Tanzania is an example of a successful RH intervention. The SGBV program builds on existing community leadership structures, applies the Guidelines for Sexual Violence Prevention and Response (UNHCR 1995), and is linked to already established safe motherhood, family planning and STI prevention program efforts.

Refugees fled Burundi in large numbers starting in 1993 and sought refuge in camps in Tanzania. By 1996, the IRC primary health services in four camps included key aspects of RH care: basic maternal care and a program called *Amis* (“friends” in French) which reached out to the community with family planning and STI/HIV education and services. There were occasional incidents of sexual violence reported at the clinics but the staff was not aware of the full scope of the problem. A Zambian social worker with experience dealing with SGBV started the program by asking women who trusted her to discuss SGBV issues. The women identified the Women’s Representatives as the women elected by women to represent them in the community courts and decision-making bodies.

The Women’s Representatives were given a five-day orientation on SGBV work and worked with the IRC staff to introduce the project to the women in the community.
Within the first two months, 68 refugee women and children (girls and boys) voluntarily came to the IRC staff to describe their experiences of violence. With technical assistance from the IRC staff, the Women Representatives conducted a survey of females (12-49 years old) and found that 27 percent reported being raped in the three years since they became refugees (Nduna 1997). Girls aged 12-18 reported the greatest frequency of attack. These results motivated the women to organize for change. They established and staffed 24-hour drop-in centers located near the maternity clinic in the medical compounds. They also used the results to lobby the male camp leadership for better security from the refugee volunteer security forces and to impose harsher sentences on perpetrators of violence against women and children (Nduna 1998).

The UNHCR, the other NGOs, and the local Tanzanian police and judge all received awareness training and within two years were all doing more to prevent or address SGBV against refugee women and children (Gurrola 1999).

The success of these efforts is due in large part to the participatory design of the entire project, from assessment to implementation and evaluation phases. The RH services in camps allowed women to receive immediate medical attention whether they were just raped and wanted to use emergency contraception or they were raped long ago but were afraid of having STIs or HIV. Having research results and UNHCR guidelines on how to respond to sexual violence added weight to the argument that these needs must be addressed.

**Recommendations for Improving Refugee RH and Rights**

Although RH services are becoming more available in refugee settings, there is still much work needed to expand them from basic to comprehensive high quality RH services (Krause 2000). It is an improvement that oral contraceptives, condoms and injectable contraceptives are available in most refugee camps. Refugee women’s needs throughout their reproductive years would be better met if they also had access to emergency contraception, long-acting contraceptives, and permanent methods of contraception. More needs to be done to make STI/HIV screening and treatment services available at least to the extent available to the local host population. Encouragingly, blood screening and counseling for HIV is increasingly available in refugee settings. Safe motherhood activities need to go beyond training traditional birth attendants to manage normal deliveries, toward providing a continuum of care that includes management of obstetric complications, provision of safe abortion services where legal, and post-abortion and post-partum care. Refugees would benefit from an increase in integrated approaches addressing sexual and gender-based violence through health, psycho-social and protection services.
Policy Actions and Recommendations
UNHCR recommends and should ensure that initial emergency response include the Minimal Initial Service Package of RH services, as described in the Interagency Field Manual on Reproductive Health in Refugee Settings. These services are to be implemented by the lead health agency or through coordination with agencies that are willing and able to provide the full range of services.

UNHCR recommends and should ensure that in a stable phase comprehensive RH services, as defined in the Field Manual, be provided to all refugees. The UNHCR has agreed to employ complementary agencies to make sure that comprehensive RH care is provided to the refugees. This needs to be monitored and consistently implemented.

In addition to the services outlined in the Interagency Field Manual, other services should be provided to refugees, consistent with the local laws governing the right to RH services, including safe abortions where legal.

Program Recommendations
- UNHCR and UNFPA need to consistently identify and support a Reproductive Health Coordinator at the outset of a new emergency to coordinate the response and plan for comprehensive RH services.
- To meet a wider range of women’s RH needs throughout the life span, the contraceptive mix (often limited to condoms, oral contraception and injectables) should be expanded to include emergency contraception, long-term and permanent methods of contraception.
- Needs assessments should be conducted as soon as the situation stabilizes in order to determine culturally appropriate means for providing comprehensive RH services.
- Refugees who choose to charge perpetrators of sexual violence must have access to sensitized police, courts and witness protection services in order to encourage the prosecution of perpetrators. This is the responsibility of the UNHCR in association with the local law enforcement and judicial systems.
- NGOs, UNHCR and host governments should identify and implement systems to enhance women’s safety from violence and abuse.
- Guidelines should be developed to teach NGOs and refugee communities how to minimize risks of sexual and gender-based violence and maximize the security, health and well-being of refugee women, men and children.
- Refugees should receive education on their human rights and reproductive rights as granted in numerous international, regional and national agreements, treaties, and laws.
References & Resources


Green, M. Personal communication, 1996.


United Nations Population Fund. 1999. The Reproductive Health Kit: Reproductive Health for People in Crisis Situations. (CD available in English, French, Spanish and Portuguese. For more information contact saunders@unfpa.org.)


