

Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: Legal and Policy Issues

By Françoise Girard and Wilhelmina Waldman

Worldwide, more than 26 million refugees, asylum-seekers and internally displaced persons are registered with United Nations (UN) agencies, and millions more remain uncounted.¹ Most refugees and internally displaced persons do not live in camps and are not under the care of the international community;² those who are internally displaced in particular are often difficult to reach and lack security. Globally, girls and women make up about 50% of refugee and internally displaced populations, although the gender composition of refugee groups varies between regions and countries.³ These women and girls are at high risk of rape, unwanted pregnancies, unsafe delivery and sexually transmitted diseases (STDs), including HIV and AIDS. Until recently, however, basic health services provided to refugees or the internally displaced have generally not addressed the sexual and reproductive health needs of these populations.

The reproductive rights of refugees and the internally displaced are firmly rooted in international law. But it was only relatively recently, at the 1994 International Conference on Population and Development (ICPD), that a full and detailed outline of reproductive rights (for all human beings, including refugees and the internally displaced) was set forth. Since that time, international awareness of the importance of addressing sexual and reproductive health comprehensively has been spurred on by the worsening of the HIV and AIDS pandemic, and by the increasing recognition that sexual violence is often used deliberately as a weapon of war.

Despite the clear obligations created by international law, many refugees and in-

ternally displaced persons today remain without effective protection and assistance with respect to their sexual and reproductive health. UN agencies and nongovernmental organizations (NGOs) alike have been hampered by extreme insecurity and inadequate funding, a lack of expertise in service delivery, insufficient political will and understanding, and problems of jurisdiction and coordination. Moreover, many of the most needed and simplest reproductive health interventions for refugees, such as emergency contraception or condom distribution to adolescents, remain mired in ideological controversies. Access to safe abortion services, which is crucial to reducing maternal mortality, is similarly hobbled. A number of other issues, such as conscientious objection and the use of cultural or religious arguments against human rights standards, also present particular challenges for the health practitioner in emergency settings.

In this article, we examine the international legal framework for the reproductive rights of refugees and internally displaced persons, as well as some aspects of UN and NGO policies relevant to refugee reproductive health. We also note areas needing further development and support.

The Legal Framework

Three interrelated fields of international law come to bear on a discussion of the reproductive rights of refugees and internally displaced populations: general international human rights law, refugee law and humanitarian law. In each field, the body of law is primarily made up of treaties, which create binding obligations for the countries that have ratified them. International law is informed by authoritative interpretations of treaty provisions, such as the Universal Declaration of Human Rights, international consensus documents and the comments and recommendations of the bodies created by each treaty to monitor implementation of its provisions.

General international human rights treaties, such as the 1966 International Covenant on Economic, Social and Cultural Rights, the 1979 Convention on the Elimination of All Forms of Discrimina-

tion Against Women (the Women's Convention) and the 1989 Convention on the Rights of the Child, benefit all human beings, wherever they find themselves, and are therefore applicable to refugees and internally displaced persons.

Refugee law, on the other hand, as contained in the 1951 Convention on the Status of Refugees (the Refugee Convention) and its 1967 Protocol (the Refugee Protocol), applies only to refugees, as they are defined below. Humanitarian law, as set forth in the four 1949 Geneva Conventions and their two 1977 Additional Protocols,* applies to noncombatants in situations of armed conflict. General international human rights law, humanitarian law and refugee law complement and reinforce each other.

Definitions

Taken together, the Refugee Convention (Article 1.A (2)) and the Refugee Protocol (Article 1.2) define a refugee as:

any person who: owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

This definition of a refugee, and the protection and assistance that comes with it, applies only to those who have crossed an international border, and thus does not formally apply to those who are internally displaced. The definition also leaves out many individuals who have fled their country but cannot prove fear of persecution, notably those who flee as a result

*Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea; Geneva Convention relative to the Treatment of Prisoners of War; Geneva Convention relative to the Protection of Civilian Persons in Time of War; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I); and Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II).

Françoise Girard is senior program officer for international policy and Wilhelmina Waldman is assistant program officer for international policy, International Women's Health Coalition, New York. The authors wish to thank the many interview respondents from nongovernmental organizations and from United Nations and donor agencies, who shared information and views with them so generously.

of natural or manmade disasters, indiscriminate attacks on their communities or generalized violence, or for economic reasons.* (These are usually referred to as non-Convention refugees.)

The United Nations High Commissioner for Refugees (UNHCR) is the agency entrusted with the task of providing protection and assistance to refugees.⁴ UNHCR's legal responsibilities allow it to intervene in most refugee situations and to help governments provide protection and assistance for refugees. Recently, it has become necessary to negotiate relief workers' access to refugees, as governments do not always guarantee access.

International law does not define internally displaced persons, but the latest authoritative definition is that put forward by the UN's representative of the secretary-general for this population, used by the UN's Office for the Coordination of Humanitarian Affairs and endorsed by UNHCR.⁵ It defines internally displaced persons as:

persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.⁶

In the absence of other mechanisms for protection, and given the refugee-like situation of many of those who are internally displaced, UNHCR has in recent years increasingly taken on responsibility for certain groups of internally displaced persons and for non-Convention refugees.

*The 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa contains a broader definition of the term refugee on the regional level. For example, the Convention's definition of refugee also includes those compelled to leave their country for reasons of external aggression, occupation, foreign domination or events seriously disturbing public order, either in part of or in the whole of the country of origin.

†It is important to remember that internally displaced persons are in their own country, and that they have the right to the full range of health services granted by a state to its nationals. However, in many countries in the developing world or with economies in transition, public and private health services are of poor quality or require substantial payment—leaving the internally displaced and refugees in equally dire situations.

‡While the comments and recommendations of treaty bodies are not in and of themselves binding law, they have strong persuasive force as the standard to which parties to a treaty are held.

However, UNHCR has been reluctant to accept full responsibility for all internally displaced populations, notably for financial reasons. The alternative solution has been to work with other UN agencies and NGOs to provide for the needs of such people.[†]

Refugee Law

Refugee protection is derived from the same philosophical base as international human rights law. The Refugee Convention and Protocol, which have been widely ratified (by 136 and 135 countries, known as states parties, respectively), provide Convention refugees with rights specific to their legal status—in many cases, rights equivalent to those accorded to a country's own citizens.

The Convention requires contracting countries to treat refugees lawfully staying in their territory the same as their nationals are treated with respect to social security schemes, including those covering maternity and sickness (Article 24(1) b). For refugees who do not meet the criterion of "lawful stay" and for non-Convention refugees, UNHCR works to guarantee that they will be treated no worse than foreigners are usually treated by that state (Article 7(1)). With respect to health, this can often mean little if any access to national health services. In the case of sexual and reproductive health care, refugees can be faced with local restrictions on certain services and on access to sexual and reproductive health information.

International Human Rights Law

In contrast to refugee law, the articulation of reproductive rights in international human rights treaties, especially as interpreted by the relevant treaty bodies, is quite comprehensive and can be useful in guiding work with refugees as well as with internally displaced populations. Furthermore, the International Covenant on Economic, Social and Cultural Rights, the Women's Convention and the Convention on the Rights of the Child are among the most widely ratified treaties (by 143, 166 and 190 countries, respectively).

Most directly relevant, as stated in the International Covenant on Economic, Social and Cultural Rights, is the right of everyone to enjoy the highest attainable standard of physical and mental health (Article 12). Further, Article 10(2) provides that "special protection should be accorded to mothers during a reasonable period before and after childbirth."

In the refugee context, the International Covenant on Economic, Social and Cul-

tural Rights states that everyone has rights with regard to health, without mention of citizenship or legal residency. Moreover, Article 2(2) states that these rights apply without discrimination of any kind as to "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

Children (defined by the Convention on the Rights of the Child as human beings under the age of 18) are guaranteed similar rights with respect to health by the Convention on the Rights of the Child (Article 24). Other human rights set out in the Convention on the Rights of the Child play an important role in realizing the child's right to health. For example, Article 13(1) acknowledges the right of the child to seek, receive and impart information and ideas of all kinds. This provides the basis for the requirement that adolescents have access to information on reproductive health, STDs (including HIV and AIDS), family planning and sexual abuse.

The phrase "reproductive health" is not used in the International Covenant on Economic, Social and Cultural Rights, but a number of its specific provisions are directly relevant. The Committee on Economic, Social and Cultural Rights (the treaty body composed of experts that was created to monitor implementation of the treaty's provisions[‡]) considers, in a recent general comment, that Article 12(2) of the treaty creates:

- a right to maternal, child and reproductive health, including sexual and reproductive health services, as well as the resources to act on that information;
- a right to prevention, treatment and control of diseases, including prevention and education programs for behavior-related health concerns, such as STDs, in particular HIV and AIDS; and
- a right to health facilities, goods and services, and health education.⁷

Furthermore, the Committee has stated that refugees, asylum-seekers and illegal immigrants are vulnerable and marginalized individuals protected by the treaty's nondiscrimination clause.

With respect to adolescents, the Committee concludes that these provisions would require countries to provide "opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counseling, and to negotiate the health-behavior choices they make..." as well as to offer "youth-friendly health care, which respects confidentiality and privacy, and includes appropriate sexual and reproductive health services."

In addition, the realization of the right to health is closely related to and dependent on the realization of other human rights embraced by reproductive rights, including the rights to life,⁸ to liberty and security of person,⁹ to freedom from torture or cruel, inhuman or degrading treatment or punishment,¹⁰ to enjoyment of the benefits of scientific progress,¹¹ or to freedom of expression, including the freedom to seek, receive and impart information.¹² For example, the right to security of person generates the commitments to end female genital mutilation and sexual violence, and to ensure that legal abortion is safe and accessible.¹³

The Women's Convention requires countries to eliminate gender-based discrimination in health care, and to address the specific health needs of women (Article 12). In addition, the Women's Convention requires countries to ensure women equal rights to make decisions about childbearing and to have access to the information, education and means to do so (Article 16(1) (e)). Other provisions of the Convention guarantee maternity protection at work (Article 11(2)), the right of women to equal access to specific educational information, including information and advice on family planning (Article 10(h)), and the right of rural women to equal access to health care facilities and family planning (Article 14(2) (b)).

In 1999, the Committee on the Elimination of Discrimination Against Women (CEDAW), which is a treaty body, issued a General Recommendation on Article 12 of the Women's Convention.¹⁴ In it, the CEDAW states outright that access to health care includes reproductive health care for all women and girls, "even if they are not legally resident in the country." The Committee noted that special attention should be given to the health needs and rights of refugee and internally displaced women.

Regarding cultural practices that have limited women's access to health services, the CEDAW says that states should not restrict women's access simply because women do not have the permission of their husband, partner, parents or health authorities, or are unmarried. Moreover, the CEDAW clearly refers to abortion when it says that "other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures." Further, the CEDAW states that "it is discriminatory for a country to refuse to legally provide for the performance of



A man waits for hydration fluid, Sudan, 1993

James Nachtwey

certain reproductive health services for women," and that if health service providers refuse to perform certain services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers."

While it provides a solid legal basis for reproductive rights, international human rights law has a number of shortcomings. Its enforcement mechanisms are notoriously weak, and in the case of the International Covenant on Economic, Social and Cultural Rights, are limited to reporting by countries to the treaty body. Additionally, the specification of human rights in a number of different agreements can make it difficult to get a coherent picture. Furthermore, treaties generally do not create legal obligations for nonstate actors (such as insurgent groups, who might control territories where many refugees or internally displaced persons find themselves), and certain human rights can be suspended in time of war or of a serious national emergency, precisely at the time when refugees and those internally displaced are most likely to need this protection. Finally, even when dealing with their own citizens, many states are unwilling or unable to observe binding obligations included in the human rights treaties they have ratified.

Humanitarian Law

Humanitarian law has been described as "the human rights component of the law of war."¹⁵ It consists principally of the 1949 Geneva Conventions and the two 1977 Additional Protocols, and applies to non-

combatants in international armed conflict, and in certain situations of internal armed conflict. Some of these may be refugees and internally displaced persons. However, humanitarian law does not cover all armed conflict situations, and its application is more likely to be disputed in cases of civil war.

The protection applicable to noncombatants under the Geneva Conventions is specified in many detailed provisions, but the basic principles include the obligation for all parties to collect and care for the sick and the wounded, as well as the obligation to respect and protect hospitals, ambulances and medical personnel. The Fourth Geneva Convention, which applies to international armed conflict where civilians are in the hands of another government or occupying power, entitles expectant women and maternity cases to special protection and assistance (Articles 16–22) and all women to special protection against rape and indecent assault (Article 27). Importantly, the occupying power is also required, if a territory is inadequately supplied, to agree to relief schemes by other countries or the International Committee of the Red Cross* and to permit them free passage and guarantee their protection (Article 59).

While humanitarian law provides an important complement to human rights law regarding the provision of health services in times of armed conflict, it contains

*The Geneva Conventions entrust the International Committee of the Red Cross, a private Swiss organization, with the task of "offering its services to the Parties to the Conflict" in a neutral manner to bring relief to civilians in times of armed conflict.

only limited mention of reproductive health, with a heavy focus on pregnant women and lactating mothers.¹⁶

International Consensus Documents

The documents agreed to at the 1994 ICPD (the Programme of Action¹⁷) and at the 1995 Fourth World Conference on Women (the Beijing Platform for Action¹⁸), and the agreements reached at the five-year progress reviews for these conferences,¹⁹ have played an important role in defining the sexual and reproductive rights of all women and men, including refugees and the internally displaced. They have also set forth the actions government should take to promote and protect these rights. While such international consensus documents do not create binding obligations, they are agreed to by governments and thus reflect political will. They are widely used by NGOs as advocacy tools and by treaty monitoring bodies as standards for evaluating how states are meeting their treaty obligations.

On the basis of universally recognized human rights standards (paragraph 1.15), the ICPD Programme of Action defines sexual and reproductive health and details the components of reproductive rights (paragraphs 7.2 and 7.3). The Beijing Platform for Action goes further in recognizing women's human right "to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (paragraph 96)."

With respect to the specific needs of refugees and internally displaced persons, the ICPD Programme of Action recognizes reproductive health on an equal footing with their other traditional needs (paragraphs 9.22 and 10.25). It also calls on states to ensure the physical protection of refugees, particularly women and children, especially against exploitation and sexual violence (paragraphs 7.11 and 10.24), and to provide victims of such abuse with appropriate and adequate services (paragraph 4.10)—a call reiterated by the Beijing Platform of Action (paragraph 147).

Both conference documents recognize unsafe abortion as a major public health concern. They call for the provision of postabortion care in all cases, and for safe abortion services where these are legal. The Beijing Platform for Action also calls on governments to consider reviewing laws that punish women for obtaining illegal abortions (paragraph 106 k).

On the relationship between religious

and cultural values and human rights, both the ICPD Programme of Action and the Beijing Platform for Action state that their provisions must be implemented in conformity with all human rights and freedoms. The latter further states that respect for various religious, ethical and cultural values and backgrounds should contribute to the full enjoyment by women of their human rights,²⁰ rather than be used to deny rights.

The five-year progress review of the ICPD places a special emphasis on ensuring that displaced adolescents receive appropriate health care, including sexual and reproductive health care and information. Governments also agreed that all health workers in relief and emergency situations should be given basic training in sexual and reproductive health care information and services (paragraphs 29 and 54).

Despite pressure from conservative lobbies, the right of conscientious objection is not recognized in the original conferences nor in the agreements following the five-year reviews, and health providers are referred to human rights standards and professional codes of ethics on this matter.²¹

Policies

While international law requires countries that have ratified the relevant treaties to provide refugees and the internally displaced with sexual and reproductive health services, in practice UN agencies and NGOs usually have to help provide these services. The level of sexual and reproductive health care that refugees and internally displaced persons thus receive depends to a large extent on the policies of these agencies and organizations. In spite of efforts to reach agreement on common guidelines, policies vary greatly and do not always fully comply with international law.

Common Guidelines

• *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. The Inter-agency Working Group on Refugee Reproductive Health (IAWG), established in 1995, comprises relevant UN agencies, many of the largest humanitarian organizations (such as CARE, the International Rescue Committee and Médecins Sans Frontières, or MSF), large donors and major research institutions, and has links with a substantial number of interested governments.

Reproductive Health in Refugee Situations: An Inter-agency Field Manual,²² developed by the IAWG, now serves as the most comprehensive and widely used manual

for refugee reproductive health programs. While compliance with the field manual's provisions remains voluntary, formal endorsement by many important actors in refugee reproductive health has given it a high profile and quasi-normative status.

Although principles outlined in both the ICPD Programme of Action and the Beijing Platform of Action serve as the manual's cornerstone, a cautious approach is taken with respect to some controversial issues. For example, the field manual discusses the provision of emergency contraception primarily in the context of sexual violence, and abortion only in connection with postabortion care.

• *Sphere Project*. The Sphere Project, which includes the International Committee of the Red Cross and other major humanitarian NGOs, was launched in 1997 to develop a set of universal minimum standards in core areas of humanitarian assistance, including health services. The Sphere standards direct refugee reproductive health care providers to the field manual's Minimum Initial Service Package (a set of lifesaving reproductive health interventions that must be provided at the outset of an emergency).²³ The field manual's more detailed recommendations on services to be provided as a situation stabilizes (such as family planning and postabortion care) are not included in Sphere standards, leaving member organizations free to deal with these issues according to their own policies.

UN Agencies

• *UNHCR*. Although UNHCR has no separate policy on reproductive health, it has made a concerted effort over the last decade to pay attention to the needs and human rights of women and girls. Its *Guidelines on the Protection of Refugee Women* give high priority to providing a comprehensive range of reproductive health services, with special attention to the needs of adolescent girls.²⁴ The guidelines further recommend counseling and mental health services for refugee women, particularly for victims of torture, rape and other forms of physical and sexual abuse; urge consultation with refugee women on the design of their health programs; and suggest that refugee women be recruited and trained as health workers.

The agency's guidelines on prevention and response to sexual violence recommend providing emergency contraception (where it is legal and once its effects have been fully and carefully explained) to women who have been raped.²⁵ The guidelines also state that treatment of

STDs (including HIV) and pregnancy tests should be offered, and in cases where sexual violence has resulted in pregnancy, all options should be discussed with the woman, "regardless of the individual beliefs of the counselors, medical staff or other involved persons."²⁶ The sexual violence guidelines further note that counselors must be aware of the legal situation with regard to abortion in the country of asylum or return, and must explain this to the woman.

While these developments are positive, UNHCR's implementation of these policies is still fraught with difficulties. In practice, UNHCR encourages but does not systematically require its partner NGOs to provide reproductive health services—or the full range of such services—during emergencies,²⁷ leaving gaps in coverage. UNHCR often has to work with NGOs already on the ground, many of which have independent funding and thus may be less amenable to UNHCR coordination. The ad hoc selection of NGOs is particularly problematic where groups have adopted blanket conscientious objections to the provision of certain services. While the *Guidelines on the Protection of Refugee Women* recognize that some NGOs cannot provide family planning services because of their "own religious or cultural constraints," it makes no recommendation on how to resolve this problem.²⁸ In cases where refugee customs violate human rights, the current high commissioner has stated that UNHCR has a duty to respect human rights and to offer refugee women choices.²⁹

• *UNFPA*. UNFPA was instrumental in the creation of the IAWG and has increasingly assisted with the provision of basic reproductive health services in emergency situations.³⁰ The agency plays a critical role with respect to the Minimum Initial Service Package, since it provides reproductive health kits for emergency situations in the initial acute stages (generally, the first three months). These preassembled reproductive health kits have helped to speed up response to emergencies and to halt case-by-case controversies about what supplies should be included. Thus, subkit three includes emergency contraception, and subkit eight includes manual vacuum aspiration equipment.

The reproductive health kit complements the standard emergency kit known as the *New Emergency Health Kit-98*, a prepackaged standardized set of medical supplies for meeting emergency refugee health needs.* Emergency contraception is also included in the *New Emergency Health Kit-98* with a note acknowledging

"that cultural and religious beliefs may preclude some women and health workers from using this treatment," but adding that health workers should nevertheless assist women in need in reaching an informed decision.³¹ Given the comments of the CEDAW regarding conscientious objection, an explicit statement requiring objecting health providers to refer women to another provider for medical care should also be included.

Nongovernmental Organizations

Several NGOs have acted as pioneers in the field of reproductive health in refugee settings. The Reproductive Health for Refugees Consortium[†] has been a vocal advocate for refugee reproductive health policies and an effective lobbyist for funding. Today, a growing number of other NGOs provide reproductive health services in emergency settings as part of their health activities. Those organizations more recently involved include:

• *International Committee of the Red Cross*. The protection and assistance activities of the International Committee of the Red Cross have always included a strong health component. Nevertheless, reproductive health has until recently not been made an explicit priority, and most attention has gone to pregnancy and delivery. This is changing, however. In 1998, the International Committee of the Red Cross started a project to examine the many ways in which women are affected by armed conflict, to identify the needs of women in conflict (including access to primary health care) and to determine how its response could be improved, particularly in connection with sexual violence. The International Committee of the Red Cross is currently in the process of developing its own guidelines on protection and assistance to women and girls in conflict situations.³²

• *MSF/Doctors Without Borders*. MSF, which now devotes substantial attention to reproductive health services in emergency settings, has issued a comprehensive refugee reproductive health policy, one that supersedes the IAWG field manual whenever the latter is deemed incomplete. MSF's policy includes specific protocols on prenatal, delivery and postnatal care; family planning; dealing with the consequences of sexual violence; the prevention and treatment of STDs, including HIV and AIDS; and responding to other reproductive health issues (such as postabortion care, female genital mutilation and other harmful practices).³³

Although MSF doctors do not general-

ly perform abortions because of the emergency nature of their services, an individual doctor may do so "if it is required to preserve the life of a woman or when the doctor and the patient agree that it is in the patient's best health interests." MSF doctors will treat women suffering from the complications of an unsafe abortion.³⁴

• *Save the Children—USA*. While Save the Children—USA has joined Sphere, it has not endorsed the IAWG field manual. Nevertheless, this organization has a comprehensive reproductive health policy that seems to conform with the field manual, although it is not tailored specifically to emergency situations. The policy encompasses a definition of reproductive health that includes, among other services, HIV prevention through universal provision of condoms and information and services designed for and by youth.³⁵ The organization does not provide abortion services, but it recognizes that postabortion care is important. Save the Children—USA is now planning to make reproductive health for refugees a program priority.³⁶

• *World Vision U.S.* Recently active in the field of refugee reproductive health, World Vision U.S. notably provided reproductive health counseling in Kosovo (with direct funding from the U.S. State Department's Bureau of Population, Refugees and Migration). The organization's stance on emergency contraception illustrates the difficulties posed by policies based on conscientious objection, however. While the organization provides family planning services and makes some contraceptive methods available, it opposes any form of emergency contraception and will not refer women to clinics where it is offered.³⁷ Thus, World Vision's policy regarding emergency contraception contradicts the CEDAW's express recommendation that health providers refer clients when they are unwilling to provide certain services.

• *Others*. Examples of other policies that appear incompatible with reproductive rights include an apparent requirement by Church World Services that a "no objection certificate" from the head of the family be produced before a woman can ob-

*The contents of the *New Emergency Health Kit-98* are determined by the World Health Organization, in collaboration with other UN agencies as well as nongovernmental organizations.

†The Reproductive Health for Refugee Consortium comprises the American Refugee Committee, CARE, the Heilbrunn Center for Population and Family Health at Columbia University, the International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children.

tain contraceptives at one of its health facilities for Afghan refugees in Pakistan.³⁸ While this requirement may reflect the reality of Afghan family structures, more flexible approaches to providing access could be explored, including taking women at their word that their husband does not object. In the same setting, the International Rescue Committee has run individual and small-group counseling sessions (for women only) on family planning, and the number of new contraceptive users has grown substantially since this work began in 1995.³⁹

Donor Governments

Donor funding for refugee reproductive health has increased since the first IAWG meeting, reflecting the growing recognition of the needs in this field.

In absolute dollar figures, the United States is the world's largest individual donor for humanitarian assistance to refugees and supports many aspects of refugee reproductive health. The U.S. Department of State's Bureau of Population, Refugees and Migration—whose mandate covers Convention refugees—has actively promoted reproductive health for refugees at the policy level since the ICPD. The Bureau is a member of the IAWG, and the Department of State is a signatory to the IAWG field manual.

Because it is responsible for administering the U.S. Department of State's Migration and Refugee Assistance budget (about \$670 million in 1999), the Bureau provides 20–25% of UNHCR's annual budget and a similar percentage of the International Committee of the Red Cross's annual budget. Both of these organizations have been encouraged by the Bureau to offer reproductive health services as an essential element of primary health care. The Bureau also provides substantial direct funding for a number of NGOs active in refugee reproductive health.

Increasingly, the Bureau is working closely with the Office of Foreign Disaster Assistance in the U.S. Agency for International Development (USAID) to coordinate responses to the reproductive health needs of victims of disasters, in-

cluding the internally displaced and many refugees. The Office of Foreign Disaster Assistance spends about \$200 million a year on issues such as security, water, shelter and medical care for victims of injuries and trauma, and has not emphasized reproductive health. As recently as the Rwanda and Burundi crises of 1993–1995, the Office did not view condoms as an emergency commodity. This has now changed.⁴⁰ While the Office of Foreign Disaster Assistance does not have a policy on reproductive health services in emergencies, USAID's description of its humanitarian work includes reproductive health care.⁴¹

A large proportion of the European Union's assistance to refugees and internally displaced populations outside the European Union is channeled through its Humanitarian Office, ECHO, which was created in 1991. ECHO is primarily a funding body, with aid expenditures of approximately 600 million Euros a year.⁴² Its main partners include UNHCR, the World Food Programme, national Red Cross organizations and MSF.

ECHO does not have a policy on reproductive health, but the Council of the European Union, whose decisions govern the work of ECHO, has issued a number of regulations on population policies, HIV and AIDS, and humanitarian aid.* The humanitarian regulation does not indicate specific areas of priority (such as reproductive health) for the European Union's aid. The regulation on population policies emphasizes individual freedom of choice for women, men and especially adolescents, and the establishment, development and increased availability of reproductive health care services. At the same time, it states that the ICPD agreement that abortion should never be promoted as a method of family planning must be "rigorously observed."⁴³

Regarding HIV, the regulations state that information and education should be directed especially to those at high risk and those most vulnerable socially and economically, in particular women and young people. Strangely enough, condoms are not mentioned in the regulation on HIV and AIDS, while safety of blood transfusions is listed in methods of protection.⁴⁴

Finally, although ECHO's Framework Partnership Agreement states that its partners must respect the culture of the communities in which they work, the regulation on population policy makes it clear that projects funded by the European Commission should provide women and

adolescents with full reproductive choice.⁴⁵ While ECHO has been able to mobilize substantial resources for emergency and postemergency relief, including health services, it does not, perhaps tellingly, track how much of its annual expenditures goes to providing reproductive health services for refugees.

Challenges and the Way Forward

Overall, international treaties and recent consensus documents provide a clear mandate for governments, UN agencies and NGOs to meet the reproductive rights of refugees and the internally displaced. In practice, activity and interest in reproductive health for refugees and the internally displaced has increased. General understanding of what reproductive health comprises, and why it is crucial in emergency settings, has evolved significantly in the last 10 years. The growing efforts aimed at consensus-building around norms of service like the Minimum Initial Service Package and Sphere are also an important development.

However, the policies of UN agencies and NGOs do not always correspond to or fully promote international human rights standards. This is quite problematic in a field where many states have, for a number of reasons, delegated or left the provision of refugee reproductive health services to the UN and its nongovernmental partners. Lack of coordination compounds the problem. When camps are assigned to different organizations without regard for whether they provide the full range of reproductive health services, refugees and those internally displaced suffer serious gaps in services.

Moreover, in practice, many programs maintain a vertical approach to reproductive health services that does not correspond to the ICPD agreements. For example, a UNHCR review of nongovernmental programs indicates that nearly half of NGOs offering reproductive health services provide few or no pregnancy and childbirth programs, and that programs for adolescents and victims of sexual violence are rare.⁴⁶

In this respect, one would argue that, as the lead agency in many situations of displacement, UNHCR should ensure that at least some NGOs assigned to each emergency will provide reproductive health services, and that the full range of services will be available directly or by referral. Donors should consider making this a requirement of their funding to UNHCR and its nongovernmental partners, and should also channel more of their funds

*All are based on Article 130w of the treaty establishing the European Community: Council Regulation (EC) No. 1484/97 of 22 July 1997 on aid for population policies and programmes in the developing countries, Document 397R1484 ("Regulation on Population Policies"); Council Regulation (EC) No. 550/97 of 24 March 1997 on HIV/AIDS related operations in developing countries, Document 397R0550 ("Regulation on HIV/AIDS"); and Council Regulation (EC) No. 1257/96 of 20 June 1996 concerning humanitarian aid, Document 396R1257 ("Humanitarian Regulation").

through UNHCR to facilitate its coordination role. Conversely, if a group refuses to abide by the requirement to refer clients when it is unwilling to provide certain services, then another group should be assigned the task of providing reproductive health care. Existing professional and ethical standards on these issues need to be disseminated and compliance made a requirement.

Continued efforts will also be required to improve health workers' understanding of the content of reproductive rights, and to identify effective strategies for promoting these rights in different religious and cultural settings.

Providing adequate protection and health services for those who are internally displaced, especially where they are dispersed and the situation is unstable or unsafe, also remains a great challenge. Another related problem arises when the internally displaced population's own government refuses to admit the problem or to give access to organizations that can provide assistance. The work of UNHCR and the International Committee of the Red Cross in intervening with governments to obtain access is therefore crucial. Moreover, the increasing attention to the needs of the internally displaced and the effort to coordinate relief for them, notably through the work of the UN's Office for the Coordination of Humanitarian Assistance, should be reinforced.

In situations where sexual and reproductive health programs have been established, providing ongoing services to the displaced and to refugees can create resentment among local populations that are not offered the same level of care. The problem can continue after refugees and the internally displaced return to their communities with assistance, or settle definitively in the host country. Involving development agencies in extending services to the local population is therefore a key element of successful, longer-term programming.

Ultimately, for the majority of refugees and those internally displaced who are not—or are no longer—in the care of UN agencies and NGOs, the crucial issue is whether they, as members of the population at large, have access without discrimination to high-quality, comprehensive sexual and reproductive health services. Governments have made substantial commitments in this respect, whether through treaties or consensus

documents, yet much needs to be done to bring national policy, budgets and programs in line with those commitments.

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