Programmatic Responses to Refugees' Reproductive Health Needs

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In a world where most people have less than optimal access to quality reproductive health services, refugees* often live in circumstances of extraordinary instability that further hinder their access. Factors that define the refugee experience compound the challenge of attaining reproductive health. Such challenges include violence, displacement and disruption of family and community, dislocation to unfamiliar and often overcrowded surroundings, lack of infrastructure and access to basic survival needs, escalations in conflict resulting in new refugee influxes and intermittent evacuation of United Nations (UN) and nongovernmental organization (NGO) personnel.

Several events occurred from the early to the mid-1990s that increased recognition of refugees' reproductive health needs and that generated programmatic responses to them. In 1994, the Women's Commission for Refugee Women and Children published a highly influential report documenting the lack of reproductive health services for refugees.[1] That was followed by the International Conference on Population and Development, held in Cairo in 1994, which recognized the special reproductive health needs of migrant populations, including refugees and the displaced. Following the Cairo meeting, the Inter-agency Working Group on Refugee Reproductive Health (IAWG) formed; it comprises representatives of UN agencies, NGOs and governments. Around the same time, representatives of a group of NGOs joined together to form the Reproductive Health for Refugees Consortium to increase refugees' access to quality reproductive health services.

The IAWG has produced a manual specific to refugee settings that serves as a basic guide to reproductive health services, beginning with the onset of an emergency.[2] The manual, which incorporates technical standards set by the World Health Organization (WHO), identifies the following programmatic areas of reproductive health care for refugees: a Minimum Initial Service Package (MISP) of interventions to be implemented at the onset of a humanitarian emergency; safe motherhood; sexual and gender-based violence; sexually transmitted diseases (STDs), including HIV and AIDS; family planning; other reproductive health concerns, such as postabortion care and female genital mutilation; and adolescents.

This article examines programs that have been implemented in varying refugee contexts. The case studies focus on the areas of safe motherhood (including emergency obstetric care), family planning, sexual and gender-based violence, and STDs (including HIV and AIDS). We describe project successes and challenges, and contextual issues that affect programs.

Program Areas

Minimum Initial Service Package

The MISP is a minimum set of priority reproductive health activities to be put into motion during the earliest days of a refugee crisis. They are aimed at reducing short- and long-term reproductive health-related morbidity and mortality. Specifically, the MISP directs those responding to an emergency to identify an organization or an individual to coordinate or facilitate implementation of the MISP; to prevent and manage the consequences of sexual and gender-based violence; to reduce HIV transmission by enforcing respect for universal precautions against HIV infection (using gloves, washing hands, decontaminating equipment and disposing of instruments and other medical waste properly) and by guaranteeing the availability of condoms; and to plan for more comprehensive reproductive health services as the situation permits.

The MISP requires an anticipatory commitment on the part of governments, policymakers, donors and NGOs to guarantee the rapid availability of financial, material and human resources when an emergency occurs. Moreover, when donors and organizations ensure that MISP services are provided at the onset of an emergency, it is more likely that comprehensive reproductive health programs will be implemented later (or when the situation has stabilized).

•*The MISP in practice.* Responding to the acute health needs of traumatized women during the Bosnia crisis in the early 1990s, Stope Nade (the local affiliate of Marie Stopes International) packaged a rapidly deployable set of basic services and supplies. The package provided appropriate medical equipment to address the needs of survivors of sexual and gender-based violence. In 1997, the United Nations Population Fund (UNFPA), in consultation with the IAWG, adapted the Stope Nade kit and developed a Reproductive Health Kit for Emergency Situations, a comprehensive set of 12 subkits to support MISP activities.[3] The subkits include condoms, delivery supplies for individual use at home and for use by professionals, post-rape supplies, contraceptives, surgical delivery equipment and blood transfusion supplies. Since 1997, UNFPA has responded to 60 orders for the kits in different crisis situations, including Afghanistan, Albania, Guinea-Bissau, Honduras, Tanzania, Turkey, Uganda and Venezuela.

In January 1998, the International Rescue Committee (IRC), in collaboration with the United Nations Development Program and the United Nations Fund for Women, implemented the prevention and management of sexual violence component of the MISP in Congo-Brazzaville. In the first phase of the project, IRC staff established a steering committee for the Program Against Sexual Violence, with representatives of relevant government ministries, women's NGOs, church groups and others.

IRC implemented a sexual violence information, education and communication campaign for community groups, students, journalists, community leaders and others to raise consciousness on the issue. The campaign included culturally ap-

*In this article, the term refugee is used for disaster-affected populations, which may include internally displaced persons, refugees or returned refugees.

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propriate images and messages about sexual violence through billboard signs, T-shirts, radio and television announcements, pamphlets, posters, speeches, traditional music and theater. Subsequently, IRC (in collaboration with the Ministries of Interior, Health and Justice) provided more intensive training to professionals on addressing the medical, psychosocial and legal aspects of sexual violence within a comprehensive reproductive health program. The project resulted in increased community awareness of sexual violence, increased reporting of incidents of sexual violence and increased services for survivors of violence.

During the 1999 exodus of Kosovar Albanians from the Federal Republic of Yugoslavia into Albania and Macedonia, many agencies implemented MISP activities in a timely manner. In anticipation of the population's reproductive health needs, UNFPA prepositioned subkits in the region, and UNFPA and the United Nations High Commissioner for Refugees (UNHCR) identified a reproductive health coordinator for the initial weeks of the emergency. But there was a gap of more than a month between when this coordinator left and a replacement was positioned in the field.

NGOs deployed emergency response teams that included people prepared to implement MISP activities, although personnel skilled in responding to survivors of sexual violence were generally not available in the early weeks of the crisis. Women representatives of local NGOs requested assistance from the Women's Commission for Refugee Women and Children to address sexual and gender-based violence. In response, the Women's Commission produced and distributed a synopsis (in English and Albanian) of the UNHCR guidelines for prevention of and response to sexual violence during refugee crises.[4]

• *Challenges in MISP implementation.* In responding to emergencies, agencies—UN agencies and NGOs alike—have found it difficult to identify and rapidly deploy experienced personnel. Persons qualified to fill the role of reproductive health coordinator with experience in the emergency relief context are rarely readily available.

There is an established concern for the lack of sanitary napkins (or locally appropriate sanitary cloth) at the onset of and throughout refugee situations. For example, Burundian women in refugee camps in Tanzania have reported that due to the lack of sanitary napkins, they have resorted to sitting over an open flame in order to slow or temporarily cease their menstrual bleeding to enable them to work for short bursts of time.

Specific supplies and materials are needed immediately in order to implement MISP activities. The Reproductive Health Kit for Emergency Situations is a great step in this direction. The challenges that remain include mobilizing resources quickly in order to get the kit into the field in a timely way and overcoming location-specific obstacles.

Safe Motherhood

The vast majority of refugee women reside in developing countries that rank among the worst in estimations of maternal mortality.[5] For example, in Sierra Leone there are 1,800 maternal deaths per 100,000 live births, and in Eritrea there are 1,000 per 100,000.[6] Thus, pregnancy can represent a serious health threat for refugee women. Ensuring medical attention throughout pregnancy and childbirth and treating obstetric complications in a timely and appropriate way play a critical part in saving lives in refugee situations.

It is assumed that 15% of pregnant refugee women will experience complications of pregnancy or delivery that require emergency obstetric care, as is the case among pregnant women overall. Furthermore, refugee women who want to terminate their pregnancy and who lack access to safe abortion services may seek an unsafe abortion and may subsequently need emergency treatment and postabortion family planning counseling.

During flight and early settlement, childbirth may take place in a ditch alongside a road, in the forest or in a makeshift shelter. A study conducted among Burundian refugees in Tanzania, one of the first studies to examine the impact of pregnancy-related morbidity and mortality on overall refugee morbidity and mortality, found that neonatal and maternal deaths accounted for 16% of all deaths.[7] There is a need for additional studies of pregnancy-related mortality in conflict situations and comparison studies with nonrefugee populations. Comparisons between services available prior to and following displacement also must be made to better understand how access under these conditions differs.

One important way to improve the general health of refugee populations is to reduce the numbers of high-risk and unwanted pregnancies, of obstetric complications and of maternal deaths from obstetric complications. At a minimum, the MISP mandates that specific interventions be available in the initial phase of a new refugee situation to prevent excess neonatal and maternal morbidity and mortality.

In stable settings, camp health centers need to be staffed with health workers who are qualified to provide basic emergency obstetric services and who can refer women to the next level of care for comprehensive emergency obstetric services. While basic emergency obstetric services should be available in a camp, it is neither practical nor desirable to set up an expensive secondary care system parallel to local facilities. Local referral hospitals should be identified and supported to enable them to respond to comprehensive emergency obstetric needs of refugee women and to reinforce sustainable systems in the host nation.

Often, however, the addition of a large influx of refugees to a local health system that cannot provide recognized standards of care for its resident population will overtax the system. Moreover, the health system itself may be crippled by the conflict, as combatants loot and destroy hospitals and staff members flee. To ensure adequate services, relief organizations need to appraise the capacity of the local hospital to meet the demands of the refugee population, and may need to seek international support to provide the emergency obstetric services that are lacking.

• *Safe motherhood in practice.* Approximately 4,000,000 people are internally displaced in Sudan, and hundreds of thousands of them live in periurban camps around Khartoum. Health services in the camps for the internally displaced are provided by local and international organizations. CARE International supports materially, technically and to a lesser extent financially most of the Sudanese agencies that are providing primary and reproductive health services in these camps.

In 1998, a multiagency health team developed a plan to upgrade camp health facilities to provide basic maternity care. Within each area, one clinic was selected and equipped to remain open 24 hours a day to handle emergencies and to transport obstetric and other life-threatening emergency cases to tertiary care hospitals in Khartoum. This effectively ensures that any woman requiring referral will have access to appropriate higher level care within two hours of the identification of an obstetric emergency.

In 1997, UNHCR conducted a review of safe motherhood services in camps in the Ngara and Kigoma regions of Tanzania. The report indicates that agencies had been delivering services without having protocols for essential safe motherhood services or the collection and use of reproductive health information. A UNHCR consultant worked

with agencies to develop and implement safe motherhood protocols, including those for emergency obstetric services and a data collection and reporting system.[8]

Most women in developing countries have limited access to referral services. Refugees may have better access, if health programs place emergency obstetric services directly in camp clinics. In Lugufu camp in Tanzania, for example, the clinic is complete with an operating theater and competent surgeons able to perform cesarean sections.

In an effort to broaden safe motherhood activities in refugee settings, the Reproductive Health for Refugees Consortium is undertaking a three-year collaboration with the Heilbrunn Center for Population and Family Health at Columbia University in New York. The goal is to avert maternal death and disability among approximately 30,000 women from war-affected populations in 12 project sites. Projects located in Bosnia, the Democratic Republic of the Congo, Kenya, Kosovo, Liberia, Pakistan, Sierra Leone, southern Sudan, Tanzania and Thailand will establish or improve basic and comprehensive emergency obstetric services at health centers and hospitals to respond to the emergency obstetric needs of refugees and others living within and around the refugee communities.

The challenges faced by women who suffer from miscarriage or seek unsafe abortions can be heightened for refugee women, who may suffer from physical and emotional stress during conflict, flight and displacement. Further, women may find themselves pregnant as new heads of households in an unfamiliar environment, with several children and while struggling to meet their family's survival needs. Refugee women who have been targets of sexual violence and other women may lack access to or knowledge of resources for emergency contraception or for continuing their contraceptive method. These circumstances put refugee women at risk of unwanted pregnancies and potentially to unsafe abortions.

Postabortion care to treat complications of miscarriage and unsafe abortions includes treatment of abortion complications, postabortion family planning counseling and referral for additional services as appropriate. At the request of refugee assistance providers, UNFPA has, since mid-1998, been distributing a reproductive health subkit with supplies for dilation and curettage and for manual vacuum aspiration (a method of treating the complications of first-trimester abortions in low-resource settings without electricity or operating facilities).

In Tanzania, postabortion care services (incorporating manual vacuum aspiration) were introduced by the Ministry of Health (with assistance from Ipas) into public-sector hospitals in the early 1990s to better manage high caseloads of abortion complications. In 1997, the International Federation of the Red Cross and the Tanzania Red Cross Society extended the training to refugee camps in the Kigoma region, with the assistance of the Ministry of Health, and conducted a one-week training session in English and Swahili and distributed manual vacuum aspiration kits. Because of high staff turn-over and to upgrade the skills of service providers, they conducted a second training session on the use of manual vacuum aspiration in April 1999; 34 providers, including Ministry of Health staff from all 15 health facilities in the camps, attended. Ongoing postabortion care services are currently provided in these camps.

In 1998 and 1999, more than 200 ethnic Burmese women and girls (averaging approximately 18–20 per month) at the Mae Tao Clinic in Thailand required treatment for abortion complications, including hemorrhage and infection. The reproductive health staff at the Mae Tao Clinic provide postabortion services directly or refer patients to the district hospital as necessary. The staff also offer training to clinic health workers and community outreach on contraception, including emergency contraception. While manual vacuum aspiration equipment is available, the staff has yet to receive training on its use, due to a lack of qualified trainers.

• *Challenges in providing safe motherhood services.* There continues to be an unfilled need for professional field staff skilled in manual vacuum aspiration. While steps have been taken or are currently underway to improve emergency obstetric care services, more needs to be done to ensure that obstetric care, including postabortion care services, are available in refugee settings.

Family Planning

Worldwide, an alarming number of women who want to space or to limit their births currently do not have accessible, affordable or appropriate means to do so.[9] This problem is equally evident in refugee settings, where family planning services are often rudimentary and where women struggle with unwanted, unplanned and poorly spaced pregnancies.

Refugees who would prefer not to become pregnant often do not have a choice; contraceptive services may be unavailable, or method choice and service delivery points may be extremely limited. Some unwanted pregnancies (and the attendant increase in unsafe abortion) in crisis situations result from the breakdown in the social order, which allows rape and sexual coercion to flourish. Even where services exist, women may be constrained from using them by cultural mores or pressure to rebuild the population. From the earliest stages of an operation, relief organizations should be able to respond to refugees' demand for contraceptives (including emergency contraception). As the situation stabilizes, a range of safe and effective modern methods of family planning should be available.

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Protocols used to manage family planning services in the country of origin may be different than those of the host country. To the extent possible, host-country protocols should be followed, although some negotiation may be necessary where differences exist. Ensuring a client's right to confidentiality and privacy is challenging in dense refugee settlements, but is essential. To encourage joint responsibility for contraceptive decision-making and to maximize acceptance of family planning programs within the community, men should receive information and be encouraged to take an active role in family planning.

• *Family planning in practice.* While many family planning programs for refugees are basic, the situation for Bosnian refugees in Croatia was not. With costs covered by UNHCR, the Croatian health system was able to meet almost all family planning needs of refugees living within the country's borders. Refugee situations are widely variable, however, and an approach that works in Croatia cannot be assumed to work in Guinea, for example.

Rwanda's family planning program was well-established before genocidal civil conflict erupted in 1994. Rwandans seeking safety in what is now the Democratic Republic of the Congo were among the first refugees to voice a demand for

family planning services; some sought to have contraceptive implants removed, while others wanted contraceptives so that they would not have another child to carry on their return journey. Access to family planning services in these camps was slow, and soon after services were established the refugees had to flee conflict in the Democratic Republic of the Congo and return to Rwanda, where family planning services were slowly reestablished.

In Kajo Keji County in Southern Sudan, the American Refugee Committee has started reproductive health programming, beginning with several meetings to raise community awareness and sessions to train health workers about reproductive health. About a year after these activities started, the organization began to offer family planning services. While estimated contraceptive prevalence is less than 5%, the program has brought oral and injectable contraceptives to a war-ravaged people who live under difficult circumstances and who had not had access to modern methods.

The Mae Tao Clinic near the Thai border provides reproductive health services to tens of thousands of Burmese refugees. Clinic staff focus especially on providing postabortion family planning counseling, in an effort to reduce the high numbers of unsafe abortions among young women. In addition, clinic staff and volunteers have conducted extensive training of providers and patients at the clinic, as well as in clinic-supported community outreach programs in Burma.

The training programs have resulted in an increased demand for commodities that the clinic was unable to provide. During a site visit by the Women's Commission in February 2000, the clinic was completely out of condoms and dangerously low on other commodities. An emergency donation of condoms from the Planned Parenthood Association of Thailand followed, and staff procured other contraceptives to meet immediate needs. The importance of logistics planning to ensure that there is a continuous supply of condoms and other contraceptives was emphasized during the site visit.

•*Challenges in providing family planning.* The major challenges in providing comprehensive family planning services include establishing them as soon as possible after the emergency phase (which requires planning during the MISP), overcoming bureaucratic resistance, maintaining a consistent supply of commodities while relying on logistics systems plagued by political uncertainty and poor infrastructure, and evaluating the effectiveness of family planning programs in refugee settings.

Sexual and Gender-Based Violence

Sexual and gender-based violence* can have numerous negative consequences for women's sexual and reproductive health, such as unwanted pregnancy, miscarriage, pelvic inflammatory disease, STDs (including HIV and AIDS) and infertility.[10] Psychosocial consequences range from guilt and depression to social stigma, ostracism, suicide and "honor killing." Sexual and gender-based violence is thought to be endemic in conflict situations, where rape and other forms of violent sexual assault are often used as weapons of war.

Many refugee women and adolescents find that their escape route is fraught with sexual violence inflicted by border guards, soldiers, the local population or even fellow refugees. Thousands of refugee women are raped or coerced into sex and often seek unsafe abortions to terminate the pregnancies that result. They may then face death or chronic complications when medical care is not available.[11]

In addition, more than 130 million women in the world today are estimated to have undergone female genital mutilation; an additional two million young women undergo it every year.[12] These practices may continue in refugee settings or may be revived by communities embracing traditions that will help them to reassert their cultural identity.

It is difficult to measure the prevalence of domestic violence in all settings. A 1999 report describes domestic violence as the most widespread form of violence against women worldwide, with 10–50% of all women having been physically abused by a current or former partner.[13] Knowledge, attitudes and practice surveys about abuse have been conducted among women in two refugee settings. In Kakuma camp in northern Kenya, home to primarily Sudanese and Somali refugees, 12% of women surveyed said they had been hit by someone in their home in the past month.

The Women's Commission for Refugee Women and Children supported a domestic violence survey by Association Najdeh (a local NGO that has been working with Palestinian refugees in Lebanon of more than 20 years) of Palestinian mothers of kindergarten students in Lebanon. Thirty percent of mothers reported having been beaten by their husbands at least once, and 68% also reported that their children had been beaten at least once by an unspecified parent.[14]

Without data, it is impossible to know whether the prevalence of domestic violence is greater among refugees than among settled populations. Regardless, it is an issue that must be addressed in refugee settings. All relief workers should utilize guidelines developed to prevent and respond to sexual and gender-based violence in refugee communities (such as the UNHCR Guidelines on the Protection of Refugee Women, the Guidelines on Sexual Violence[15] and chapter four of the IAWG field manual[16]). Prevention and response to sexual violence must be multisectoral and include protection, health and community services, psychosocial care and legal assistance.

•*Programs to combat violence.* The IRC's programs for Burundian refugees in Tanzania offer useful lessons for those responding to sexual and gender-based violence in conflict settings.[17] Refugee women participated actively in each phase of program development. They participated in an assessment in the early phase of the project, which included identifying key individuals and groups, past work in this area, relevant sociocultural issues and the prevalence of sexual violence. The women shared information and findings from the assessment in a series of community meetings, which also were conducted to facilitate community participation and ownership of a project to address sexual and gender-based violence.

Key to the project was the establishment of 24-hour drop-in centers, which were intentionally placed within multipurpose maternity sections of four camp health facilities to help survivors of violence and their families avoid being stigmatized. Survivors' rights to confidentiality were considered fundamental in all aspects of project development. The services offered by refugee women to survivors of violence include medical and psychosocial care, protection, legal guidance, appropriate referral and follow-up home visits.

While the project was initially started primarily by and for women, in later phases refugee women expressed the need to include refugee men, to further build community structures to support refugee responsibility for addressing the prevention and management of sexual violence. Beginning with male refugee leaders and

*Here, the term sexual violence refers to all forms of nonconsensual sexual intercourse, sexual threat, assault, interference and exploitation, including statutory rape and molestation without physical harm or penetration. Gender-based violence is violence that is directed specifically against a woman because she is a woman or that affects women disproportionately (for example, spousal abuse, sexual harassment and female genital cutting).

security leaders, project staff conducted meetings similar to those with women to discuss sexual violence in the community. Men then became involved in developing strategies to prevent sexual violence, supporting survivors and punishing perpetrators. Sexual violence was eventually addressed through public advocacy events involving the whole community, which reinforced the fact that sexual and gender-based violence is the entire community's problem, not just women's problem.

A series of workshops and seminars facilitated the growth of women's groups to address the issue of sexual violence. These groups interact with other women's groups involved in development activities, including a unique training program (supported through JSI Research and Training Institute and the American Refugee Committee) that integrates reproductive health content into literacy skills-building.

Association Najdeh, with support from the Women's Commission, began a reproductive health education program primarily for mothers of kindergarten students, but open to all women in the camps. After women indicated that domestic violence was a topic of great interest and concern, staff assessed the situation in depth by interviewing kindergarten mothers about violence in their homes. Currently, Association Najdeh is working with Palestinian women and men to design a domestic violence intervention program.

In 1996–1997, UNHCR supported a pilot project to eradicate female genital mutilation among Somali refugees living in Hartesheikh camp in eastern Ethiopia. The staff started with a series of workshops involving women's committees, health workers, religious leaders, practitioners of female genital mutilation, school teachers, elders and youth. The workshops featured a video on infibulation and encouraged in-depth discussions of the consequences of the procedure. As a result, local religious leaders, health staff and youth participated in broad-based community education activities. They developed a drama and local educational materials, which gave a sense of community ownership to the messages against female genital mutilation and to the movement. At the conclusion of the pilot project, many participants stated that they would continue to educate their peers, leaders expressed appreciation that the topic was now open for public discussion and women reported that no infibulations had been carried out since the project started.[18]

UNHCR has been awarded a $1.65 million grant by the UN Foundation to support a strengthened response to sexual and gender-based violence. This project will be implemented in Guinea, Kenya, Liberia, Sierra Leone and Tanzania. Kenya and Tanzania were chosen because refugee protection and assistance programs in these countries have laid the groundwork for activities to prevent and respond to sexual and gender-based violence. Such activities will be initiated in West African project countries, where extreme forms of violence, including rape, have become commonplace.[19]

Additionally, the U.S. Bureau of Population, Refugees and Migration recently authorized $2 million for fiscal year 2000–2001 for its Initiative on Sexual Violence. The Reproductive Health for Refugees Consortium has been granted a portion of these funds to conduct a global review of sexual and gender-based violence in refugee settings, to provide NGO staff with sexual and gender-based violence counseling skills and to produce a sexual and gender-based violence assessment tool for refugee service providers.

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• *Challenges in addressing violence.* In many refugee settings, sexual and gender-based violence is used to dehumanize and humiliate entire families. What might be the most significant obstacle in addressing sexual and gender-based violence is the stigma of shame and the consequent silence that is inextricably linked to this issue. Many survivors of sexual and gender-based violence are silenced by their fear of being blamed for the abuse. This stigma also tends to inhibit refugee service providers from approaching survivors of sexual and gender-based violence because of their own discomfort addressing this issue.

STDs, Including HIV

STDs, including HIV and AIDS, spread fastest in situations of poverty, powerlessness and social instability,[20] which are common in settings with displaced populations. Moreover, at every stage of flight, displaced women and girls are vulnerable to rape and sexual abuse, which may increase the prevalence of HIV and other STDs. In postgenocide Rwanda, where HIV prevalence was 11%, 17% of women who had been raped were HIV-positive.[21] Women, including adolescent girls, may be forced to sell sex to meet their needs for security, water, food and shelter, putting them at increased risk for contracting an STD.

The risk of HIV transmission may increase in emergency situations where refugees and the internally displaced do not have access to condoms, or where providers of humanitarian assistance do not take precautions against the transmission of bloodborne infections. Refugee and internally displaced adolescents are frequently idle and may be more willing to challenge traditional norms and take sexual risks in the absence of social and cultural constraints.

Finally, populations in rural areas typically have lower rates of STDs and HIV infection and a lower risk of acquiring infections than do those in urban centers. Forced migration of rural people into areas of high population density increases their exposure and their risk of infection. STDs, including HIV, affect not only refugees' physical health but also their emotional and economic well-being: People living with HIV and AIDS and their families may experience social rejection and isolation, increasing the psychological trauma that accompanies refugee life.

In the emergency phase of refugee assistance, the priority is to prevent HIV transmission by taking universal precautions against bloodborne infection and by ensuring the availability of condoms and a safe blood supply. It is also important in this phase to collect information about HIV and AIDS prevalence, and about policies and program interventions, both in the country of origin and in the host country.

STD and AIDS interventions to be implemented in more stabilized refugee settings include many of those that are appropriate for settled populations, such as information, education and communication campaigns with condom promotion and distribution, HIV and AIDS education, and implementation and monitoring of the syndromic approach to STD case management.[22] In addition, voluntary counseling and testing and the prevention of mother-to-child transmission, following UNAIDS guidelines, should be considered where national programs have established these services. Concerted efforts should be made to build partnerships and to develop multisectoral (health, education and community services) comprehensive prevention and care services to address HIV

and AIDS at the earliest opportunity.

•*STD and HIV programs in practice.* As a component of their comprehensive reproductive health programming for returning Rwandans settling in Nyagatare district in 1996, the American Refugee Committee implemented a program for the syndromic approach to treatment of STDs. Treatment protocols were based on WHO recommendations, modified to fit national policy. In preparing to implement the program, the American Refugee Committee printed booklets containing treatment guidelines for each provider's desktop, trained the health workers in the use of the guidelines and set up a logistics pipeline to ensure the availability of drugs called for in the protocols. The program was monitored with regular data collection and occasional laboratory confirmation of the sensitivities of prevalent bacterial strains to antibiotics.

The Guinean health services were the designated provider of health services to Liberian and Sierra Leonean refugees in Guinea's Forest Region. Availability of drugs for the treatment of STDs has been problematic during the entire 10 years of the refugees' residence in the area. In 1998, with a new influx of refugees, antibiotics arrived through the Reproductive Health Kit for Emergency Situations. However, the drugs included in the kit were not on Guinea's essential drug list. Although the Guinean government eventually agreed to use the available drugs, the supply was not sustained. Recently, results of the first four months of HIV testing of potential blood donors and symptomatic individuals have confirmed the presence of HIV in this population, and the site remains in need of adequate STD and HIV prevention programming.

UNFPA and UNHCR were awarded a three-year (2000–2002) grant from the UN Foundation to strengthen reproductive health services in communities in crisis. UNHCR is responsible for two components of the project: HIV and AIDS, and reproductive health for young people. The first regional project, funded in April 2000, includes the countries of Botswana, Mozambique, Namibia and South Africa. Assessments, focus groups and interviews are currently being undertaken in several sites to establish baseline information on young people's reproductive health knowledge, attitudes and practices, as well as on their access to reproductive health services. In addition, theater, music productions and training of refugees on HIV and AIDS counseling, prevention and management activities were recently implemented in Pretoria, South Africa.

The Maneeloy Burmese Student Center in Thailand is home to approximately 2,000 refugees who are dissidents, and who are generally considered likely candidates for resettlement in third countries. Until mid-1999, applicants for asylum in the United States were rejected if found to be HIV-positive, which led to an increasing proportion of camp residents who were HIV-positive. Those who were HIV-positive demanded antiretroviral therapy, but guidelines for HIV interventions in refugee settings recommended that refugees have access to the same level of care afforded to the host population. In Thailand, antiretroviral drugs are only available to people who can pay for them, and hence have been unavailable to the refugees.

During the initial phase of postconflict response in East Timor, the IRC initiated a program to address the role of foreigners, including UN peacekeepers, in the transmission of STDs. In coordination with a Reproductive Health Working Group (comprising local and international NGOs and representatives from the UN Transitional Authority Division of Health Services and interested groups), the IRC distributed 3,000 condoms (donated by UNFPA) to foreigners, including UN peacekeepers, in nightclubs and restaurants they frequent. Typically, supplies disappeared within 24 hours. Local cultural and religious sensitivities and limited UN funding constrained early program efforts.

Since distributing the first 3,000 condoms, an interagency STD assessment has been conducted, and church leaders have accepted that education in the prevention of HIV and other STDs is important for all community members and that knowledge does not promote promiscuity. Following the assessment, an international working group (with UN and NGOs as members) was established to begin to address the development of an STD program. The working group identified the importance of a national working group, which is currently being formed. With the IRC taking the lead, the international working group aims to support the national group to begin a national campaign to prevent and control HIV and other STDs. Currently, the IRC is distributing 4,000 condoms to foreigners and UN peacekeeping forces, but will maintain a low profile with distribution activities until the national education and prevention campaign is established.

•*Challenges in STD programming.* STDs, including HIV and AIDS, are a sensitive issue in most cultures and can lead to fear, discrimination and human rights violations against people found to have an STD or to be HIV-positive, making programming difficult. Humanitarian assistance providers must integrate multisectoral HIV and AIDS services into programs for more immediately life-threatening health problems in coordination with country programs, where national HIV and AIDS programs are often underdeveloped. A number of new UN and NGO HIV and AIDS initiatives, however, are under way to meet these challenges.

Adolescents

Adolescents represent a significant proportion of refugee populations. Refugee youth, however, have been forced out of their homes and may lack the security offered by their families and communities. The turmoil and insecurity faced by refugee adolescents can make for particularly difficult transitions to adulthood. On the bright side, however, young people are especially resourceful, energetic and adaptable, and these characteristics put them in a good position to help themselves and others.

Typically, camp settings lack educational services, contributing to inactivity among youth. Substance abuse—alcohol use especially—is common among adolescents in refugee settings. This is assumed to result from the breakdown in social structures, as well as a lack of jobs in camp settings.

Some problems in refugee reproductive health programs are specific to adolescents. For example, a lack of clinic hours targeted at young people may leave them hesitant to visit, as they may be reluctant to attend alongside their adult family members or neighbors. Additionally, service providers are often unwilling or unprepared to counsel youth on sensitive issues such as rape and unsafe abortion. Other obstacles include restrictive cultural and religious beliefs, lack of knowledge of where to get information and services, and language, literacy and terminology barriers to information acquisition.[23]

Programmatic approaches to providing reproductive health services to adolescent refugees include the use of peer educators, school-based programs, social marketing campaigns and health facility programs.[24] In addition, programs that offer youth opportunities to express themselves through sports or vocational counseling also address some of the factors that have an impact on their reproductive health. Despite a number of noteworthy initiatives to address the reproductive health needs of war-affected adolescents, very few reproductive health programs have focused on adolescents.[25]

•*Adolescent programs in practice.* For two

years, beginning in 1997, the World Association of Girl Guides and Girl Scouts, together with Family Health International, implemented the Health for Adolescent Refugees Project. This peer-learning and peer-counseling project, pilot tested in Egypt, Uganda and Zambia, utilized the Girl Guides' merit badge process. The girls learned about health and developed flip charts for teaching their peers. Each Girl Guide was expected to educate 25 peers, giving the program a wide multiplier effect. An evaluation has concluded that, for example, it is best to establish programs where there is existing infrastructure, such as in a church or school. Such lessons have been incorporated into proposals for extending the program to additional sites. Furthermore, inclusion of the reproductive health badge in standard Girl Guides and Girl Scouts programs is being considered.

The IRC supports community school initiatives for Liberian and Sierra Leonean refugee children who reside in Guinea's Forest Region. In 1996, the IRC added a standard health curriculum throughout the primary school system in the region. The content for younger children focuses on basic health and hygiene. Older students participate in seminars that include sex education and the transition to adult behaviors. Afterschool health clubs are open to all youth, and some have developed dramas, songs and kits on health topics including HIV and AIDS prevention.

In addition, approximately 140 peer educators from sixth to 12th grade, under the supervision of an IRC-trained school health specialist and counselors, have educated their fellow students on contraception and STDs and HIV prevention, and distribute condoms for a small fee. (No reports indicate any problems with condom distribution in this community.) In 1997–1998, peer educators conducted an average of approximately 1,500 peer education sessions and 107 group activities per month, selling an average of 2,428 condoms per month. Female health clubs have been formed that focus on issues affecting girls and young women.[26]

From 1998 to 2000, the Women's Commission for Refugee Women and Children provided support to the International Federation of the Red Cross and the Tanzania Red Cross Society for their program Meeting the Reproductive Health Needs of Refugee Adolescents in Kigoma Region of Tanzania. The project trained peer educators, constructed youth centers and surveyed adolescents on their knowledge, attitudes and practices. Key to the program's success were involving adolescents in the project's design and implementation (which enabled planners to better target their efforts toward the population's specific needs) and utilizing a multisectoral approach (which broadened the project's support). Among the lessons learned were the importance of instituting a monitoring and evaluation plan at the outset of a project, as it can be difficult or impossible to do so later on, and the need to designate key personnel to maintain project activities, or else momentum and sustainability will diminish.

•*Challenges in adolescent programming.* Without the input of adolescents in program design and implementation, it is unlikely that they will take full advantage of the services available. It is equally important to ensure that girls and diverse age-groups are represented, so that the needs of all adolescents, not just those of older boys (who are more likely to speak up), are met.

Conclusions

Safe motherhood, family planning, sexual and gender-based violence, and STDs are essential and complementary technical areas of any truly comprehensive refugee reproductive health program. Service providers must strive to meet this comprehensive standard and to make these services accessible to all refugee women, men and adolescents.

The delivery of reproductive health services to refugees and other war-affected persons is a complex endeavor. With the support of some private, government, foundation and multilateral donors, the international community has made significant strides in addressing the reproductive health needs of refugees. While the general dearth of resources, the lack of infrastructure and intractable poverty are challenging in these settings, much more needs to be done to provide and support comprehensive, quality reproductive services to refugees worldwide.

With the support of these donors, policymakers and a growing number of humanitarian providers addressing reproductive health for refugees, many new UN, NGO and government initiatives are under way, particularly in the areas of, emergency obstetrics, sexual and gender-based violence, HIV and AIDS, and adolescent programming.

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