FMO Thematic Guide: Reproductive Health
Author: Kelly MacDonald

1 Introduction: what is reproductive and sexual health?

2 Historical overview
2.1 Reproductive health background
2.2 Refugee reproductive health background
2.3 Reproductive health as a human right

3 Refugee reproductive and sexual heath
3.1 Why should reproductive and sexual health services be specifically targeted to forcibly displaced populations?
3.2 Reproductive and sexual health services in emergency versus longer-term settings
   3.2.1 Emergency RSH services
3.3 Longer-term reproductive and sexual health services
   3.3.1 Safe motherhood
   3.3.2 Family planning
   3.3.3 STIs including HIV/AIDS
   3.3.4 Sexual and gender-based violence
   3.3.5 Adolescent reproductive and sexual health
   3.3.6 Other reproductive and sexual health needs
      Men’s participation
      Harmful traditional practices: FGC and early marriage

4 Constraints to providing quality comprehensive reproductive and sexual health care
4.1 The 'Global Gag Rule'
4.2 Funding and reproductive health research

5 Case studies
5.1 Making reproductive health services a priority in emergencies: Iraq
5.2 Post-abortion care in refugee settings: Thailand
5.3 The importance of research in planning adolescent refugee reproductive health programmes: Nepal and Tanzania
   5.3.1 Nepal
   5.3.2 Tanzania

6 Key players in RSH
6.1 United Nations agencies
6.2 International non-governmental organizations (NGOs)
6.3 Research bodies
6.4 Journals
6.5 Websites
1 Introduction: what is reproductive and sexual health?
As outlined by the International Conference on Population and Development (ICPD) definition, reproductive and sexual health (RSH) is not merely about reproduction. RSH must be viewed as three interconnected domains that include universal rights, women’s empowerment, and health service provision. Firstly, RSH promotes a universal understanding that is premised on the fact that RSH as a basic human right to be fulfilled by all governments. Secondly, RSH seeks to address the underlying causes of gender inequality and inequity to promote women’s empowerment. Thirdly, the provision of universal access, utilization, and quality of RSH services addresses issues of sexual and reproductive ill-health, and possibly death.

The three concepts of rights, women’s empowerment and equality, and services must work in unison in order for individuals to achieve healthy reproductive and sexual lives. The first over-arching concept of RSH is premised on a rights-based approach. This means that everyone is entitled to the rights and freedoms set out by the Universal Declaration of Human Rights, which includes the right to health and education without distinction based on race, sex, religion, etc. Universal reproductive and sexual rights must be supported and upheld by governmental policies and laws, specifically the right for couples and individuals to decide if, when, and how many children they would like to have, as well as access to information to enable them to make these choices; the right to attain the highest standard of sexual and reproductive health; and the right to make RSH decisions without discrimination, coercion or violence (ICPD; Programme of Action, 7.3).

The second concept of RSH, women’s empowerment, is based on the fact that norms, values, and laws create an environment that influences the extent of women’s equality and power within a society. Broadly, this means: addressing issues of gender inequality and empowering women; ensuring males participate in decisions and understand their responsibilities; eliminating all forms of discrimination against the girl child (e.g. female genital cutting, forced early marriages); and accessing universal education. This second arena of RSH addresses how social and sexual behaviours and relationships affect healthy and satisfying sex lives or how they can create ill-health. Furthermore, RSH does not affect women alone and must not be solely promoted as a women’s issue. Men also have reproductive health needs in addition to the fact that the involvement of men is an essential part of protecting women's RSH health.

Therefore, in promoting women’s empowerment and addressing issues of equality and equity, relationships must not only be viewed in the context of those between men and

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1 It is known that education has an affect on health. In terms of RSH, it can contribute to reductions in fertility and morbidities. It is also known that education of girls contributes to the empowerment of women, can postpone the age of marriage, reduce the size of families, and increase a child’s survival possibilities.
women, but also of the individual and wider community. Attitudes and norms
surrounding sexuality and gender carry profound meanings in every society/culture. The
dynamics of knowledge, power and decision-making in sexual relationships, between
service providers and clients, and between community leaders and citizens all affect an
individual’s reproductive and sexual health status.

The final concept of RSH deals with service provision. Not only does this include the
ability of public and private service providers to provide a variety of quality RSH
services (as outlined by the three areas of service provision), but also addressing factors
that may inhibit an individual from accessing and utilizing these services. This may
include ensuring widespread information on services and methods of family planning and
safe sex; affordability, confidentiality, convenience, treatment of service providers, and
availability of supplies.

Website:
International Conference for Population and Development -
http://www.iisd.ca/Cairo/program/p07000.html

2 Historical overview
2.1 Reproductive health background
The concept of reproductive health arose in the 1980s with a growing movement away
from population control and demographic targets towards a more holistic approach to
women’s health2. It was not until the ICPD in 1994 and the Fourth World Conference on
Women (FWCW) in 1995 that the concept gained international acceptance and was
heralded as a turning point for women’s health. The ICPD brought to international
recognition two important guiding principles of RSH: 1) that empowering women and
improving their status are important ends in themselves and essential for achieving
sustainable development; and 2) reproductive rights are inextricable from basic human
rights, rather than something belonging to the realm of family planning. The FWCW
reaffirmed and strengthened the consensus that had emerged at the ICPD.

The ICPD conference was instrumental in formalizing the paradigmatic shift in how
women’s health was conceptualized and how services were delivered. The way in which
reproductive health was viewed began to change: the focus became the promotion of
healthy reproductive lives, rather than the prevention of sexual morbidity. Not only were
there changes in the kinds of programmes that were delivered, but also in the intended
recipients and manner of delivery of programmes. For example, men were recognized as
having an important role to play; child survival was emphasized; the integration of RSH
services into primary health care rather than their being offered as a separate service in
separate facilities was advocated; and the need for reproductive health services
specifically designed for refugees and internally displaced persons (IDPs) was
recognized. Overall, it called for a fundamental rethink of health service provision.

2For example, see Sen, A., ‘Population: delusion and reality’ New York Review of Books XLI(15), 1994;
Bongaarts, J., ‘Population Policy Options in the Developing World.’ Science 263:771-6, 1994; and
Hartmann, B., Reproductive rights and wrong: the global politics of population control and contraceptive
2.2 Refugee reproductive health background
In 1989, the Women’s Commission for Refugee Women and Children was founded as one of the first advocacy organizations monitoring the care and protection of refugee women and children. This group was instrumental in raising awareness of the paucity of RSH information and services for refugees and other forcibly displaced populations (e.g. IDPs). Early in the 1990s, a document by the Women’s Commission, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, published results of an eight-country, year-long study of availability and feasibility of reproductive health services for refugee women. It highlighted the fact that little if any priority was given to reproductive health in emergency situations. It stated that general health care was prioritized with marginal provision of maternal and child healthcare services. No emphasis was given to family planning, sexually transmitted infections (STIs) and HIV/AIDS, sexual and gender-based violence, or other obstetric needs. It was one of the first comprehensive studies to document the importance of and need for reproductive health in emergencies.

Following the ICDP and FWCW conferences highlighting the need for refugee RSH to be regarded as a distinct need within the human rights framework, various non-governmental organizations (NGOs) and United Nation (UN) bodies used this as a platform to push RSH research and policy forward, and to advocate for better service provision for refugees and IDPs. Two instrumental organizations were formed. The first, The Reproductive Health Response in Conflict Consortium (RHRC), originally established as the Reproductive Health for Refugees Consortium, brought together RSH expertise from seven organizations committed to improving RSH services and standards to populations forcibly displaced. The RHRC changed its name to reflect that the work undertaken is not only for refugees, but all people affected by conflict.

The second key group formed was the Inter-agency Working Group on Refugee Reproductive Health (IAWG). The IAWG is made up of various NGOs, UN bodies, and governments. One instrumental work put together by IAWG has been the development of RSH guidelines and a field manual specifically for refugee and conflict settings. This manual, *Reproductive Health in Refugee Situations: an Inter-agency Field Manual*, was first developed in 1997 and tested in the field for two years before the current (1999) version was finalized. The purposes of the field manual are: to advocate for providing and/or strengthening refugee RSH services using a multi-sectoral approach; to be used as a guide for field staff in refugee situations; and to be used as a tool for decision-making in all aspects of the programme cycle. The manual includes technical standards for quality RSH services as outlined by the World Health Organization. The key components include:
Websites:


2.3 Reproductive health as a human right

A healthy reproductive and sexual life is now considered to be a basic human right for all, including refugees and other forcibly displaced persons, and is protected by three bodies of law: human rights law, refugee law, and humanitarian law. The foundations for reproductive rights were first established in the two fundamental human rights treaties, the United Nations Charter, adopted in 1945, and the Universal Declaration of Human Rights, adopted in 1948, which ensured an individual’s right to health. In 1951, refugee law came into effect with the United Nations Convention Relating to the Status of Refugees; its 1967 Protocol specified refugee rights to be granted by all signing states. This means that all signing parties must grant refugees who are lawfully staying in the country the same rights as its citizens, including rights to the provision of social security, maternity, and sickness. But it also means that those refugees who are non-Convention refugees, or those illegally within the country, are not often given the same rights; and these people may have difficulty accessing health and reproductive health care and services (Girard and Waldman 2000). In 1949, the Geneva Convention Relative to the Protection of Civilians in Times of War provided the basis from which reproductive health was addressed under humanitarian law. Although not addressing reproductive health specifically, it made reference for protection and special assistance to ‘maternity cases’ as well as protecting women ‘against rape, enforced prostitution, or any form of indecent assault’ (UNHCHR 1949).

In 1976, the international community agreed on an additional covenant that provided more detail to the rights embodied in the Human Rights Declaration and the Convention of the Status of Refugees, with implications upon issues of gender, reproductive health, and refugees, including those individuals not lawfully within a host county. The International Covenant on Economic, Social and Cultural Rights (ICESC), Article 12, goes beyond the Universal Declaration’s right to health. Rather, Article 12 states ‘the
right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ and then outlines steps to the realization of this goal. While there is no specific mention of reproductive health rights, some of its provisions, such as Articles 10(2) and 12(2a), address reproductive health issues (UNHCHR 1976). However, the subsequent UN General Comment No. 14 on Article 12 (UN 2000) states:

‘The right to the highest attainable standard of health, it specifically addresses reproductive health rights of all individuals with specific reference to women and adolescents, the inclusion of refugees, asylum-seekers, illegal immigrants, and internally displaced persons, as well as state responsibilities to uphold these reproductive rights’.

In 1979, The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) set clearer definitions and standards than the earlier covenants with respect to gender equality. It expanded the protections against discrimination and called for increased attention to vulnerable groups including refugees and migrants. CEDAW is the only human rights treaty that addresses women’s reproductive health rights through acknowledgement of pervasive social, cultural, and economic discrimination against women. In particular, Article 12 of the Convention requires states to ‘eliminate discrimination in access to health services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement, and the post-natal period’ (CEDAW 1979). In 1999, CEDAW General Recommendations 24 on Women and Health (Article 12) made further recommendations according to the fact that ‘access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women’ (CEDAW 1999). It comprehensively addresses violence against women, STIs and HIV/AIDS, female genital mutilation (FGM), unwanted pregnancies, safe motherhood, provision and access to services, and quality of services provided, and declares that all of these are to be addressed by the participating states as provision of basic human rights.

The 1989 Convention on the Rights of the Child (CRC), equally guarantees children have access to basic human rights including health and access to RSH information and services. The 2002 Optional Protocol of the CRC was extended to mention the sale of children for prostitution, which endangers their RSH status.

Framed within human rights and refugee law, a Humanitarian Charter and Minimum Standards of Care in Disaster Assistance was developed by a large group of agencies in 1997. This Charter describes core principles of humanitarian actions in order to reaffirm the rights of affected populations, as well as pointing out responsibilities of warring parties or states. The Charter formed the basis of the Sphere Handbook, which sets out minimum standards of care for multi-sectoral disaster responses. In 2004, an updated version came into effect, which, in addition to other crosscutting themes, addresses RSH-related issues of protection, gender, children, HIV/AIDS, and people living with HIV/AIDS. Chapter Five of the Sphere Handbook outlines the minimal standards in health provision with a specific section addressing issues of RSH.

Finally, the most detailed documents and powerful agents of change, which draw on previous human rights treaties and various conventions, but do not have any legally
binding recourse, are the ICPD and FWCW documents. These documents are based on international consensus decisions supporting gender equality, rights, and women’s empowerment, and clearly set out the concepts of sexual and reproductive rights including refugee reproductive rights.

Websites:
The Sphere Project - http://www.sphereproject.org/
The Sphere Project on Forced Migration Online (with documents in the bibliographies presented in full text) - http://www.forcedmigration.org/sphere/

3 Refugee reproductive and sexual health
3.1 Why should reproductive and sexual health services be specifically targeted to forcibly displaced populations?
Anyone who has been forcibly displaced from their home due to conflict, natural disaster, and/or political reasons may be exposed to a myriad of risk factors that affect their reproductive health and status. For example, exposure to sexual violence, health status during the flight, health conditions in the host country/region, stress, economic and social
breakdown, and pre-flight RSH services are all contributing factors to an individual’s RSH status.

Women and girls face increased chances of reproductive health risks during migration. Violence, including sexual violence from armed forces, increases exposure to the transmission of STIs, HIV/AIDS, and unwanted and/or high-risk pregnancies. Poverty is exacerbated, and thus individuals may submit to sexual exploitation in order to meet basic survival needs. Many become separated from their families and lose traditional cultural and legal supports and protection that affect reproductive health and status. If the destinations of fleeing migrant populations do not provide adequate reproductive healthcare services, this can result in high rates of unwanted pregnancy, unsafe abortion, and preventable death and injury as a result of pregnancy and childbirth (UNFPA 2000). Poor nutrition, overcrowding, unsanitary conditions, untreated illness, violence against women, and stress all take a steep toll on women’s physical and mental health, well-being, and social participation.

Taken globally, reproductive morbidity and mortality are major problems that disproportionately affect men and women. Sex or biological differences between women and men, such as childbearing, breast cancer, and menopause, create unique health issues for women. The WHO’s World Health Report 2002 found that reproductive ill-health accounts for approximately 20 per cent of the total disease burden among women compared to an estimated 6.5 per cent in men. Comparably, in Africa, where a large proportion of the world’s forcibly displaced populations are found, the total disease burden due to reproductive morbidity is 44.5 per cent. Poor reproductive health related to sex and reproduction is due to key causal factors found within risky sexual behaviours, pregnancy, abortion, and childbirth (WHO 2002).

Websites:


3 Compiled from Burden of Disease in DALYs (Disability-Adjusted Life Year) and recalculated solely for STDs excluding HIV, maternal conditions, and peri-natal deficiencies including nutrition-related deficiencies. This list does not take into consideration other related communicable diseases.
3.2 Reproductive and sexual health services in emergency versus longer-term settings

Populations who undergo forced migration are not a homogeneous group, and this fact impacts upon service delivery, as do the length of time a camp has been established and the range of services provided. For example, services provided during the acute emergency phase will be somewhat different from those services required in stable refugee/IDP camp settings. While a standard set of services has been developed for emergency settings, as the situation stabilizes, comprehensive RSH services must be established. However, unlike emergency settings, where a standard of care is specified for RSH service providers, in long-term settings comprehensive RSH services need to be tailored to the specific context. Pre-migration contexts will result in differences in the need and demand for services. This means that previous service provision, access to services, and acceptability of services all impact upon demand and uptake, as do issues of female literacy and empowerment, and religious and cultural values (Palmer 1998).

Websites:


3.2.1 Emergency RSH services

Policy on reproductive health has been the last to come on board in emergency settings. Traditionally, food, shelter, sanitation and basic health care were first priorities. Where RSH services were seen as a priority, the emphasis was on maternal and child health care (MCH) or STI services as part of general health care (Palmer 1998). However, RSH needs of displaced populations were recognized in the early 1990s (Wulf 1994). In particular, the Inter-agency Field Manual highlighted the fact that specific RSH services needed to be delivered in acute emergency settings until full RSH services could be implemented once the situation stabilized. It was recognized that not providing emergency RSH services resulted in severe adverse consequences such as preventable maternal and infant deaths, unwanted pregnancies that could lead to unsafe abortion, and the transmission of STIs or HIV. In immediate emergencies, it is known that forcibly displaced populations have worse health outcomes than others in both their host country and country of origin (Hynes et al. 2002; McGinn 2000; Toole and Waldman 1997). However, it has been documented that in most post-emergency camps, the reproductive health outcomes are better than in their respective host country and country of origin (Hynes et al. 2002). This evidence demonstrates that quality RSH services can be provided in difficult settings with positive outcomes. Yet, despite improved awareness and mounting research, RSH service delivery has been and to a large extent remains
inconsistent, which is a reflection of donor and/or head office commitments (RHRC 2003).

The Minimal Initial Service Package (MISP) provides the basic standard of reproductive health care that must be delivered together with all other basic services during the initial days of an emergency setting. The priority is to reduce both short- and long-term RSH ill-health and mortality, with the aim that additional funding will be provided for continued services once the situation has stabilized (Krause, Jones, and Purdin 2000).

Implementation of MISP does not require the additional assessments that longer-term services do, since documented evidence has already justified the use of MISP. MISP is a package of kits and supplies together with activities to be put in place by trained staff. The reproductive health kit is designed for the basic emergency phase and is made up of twelve different sub-kits to be ordered and used according to the level of care provided. Depending on the setting, some components of the MISP kits will be more relevant to the particular situation, and assessment must be made to determine the capacity of the organizations to implement them as well as the needs within the community. One obstacle to providing MISP in emergencies is that like any other service, all components must be planned for, together with having trained staff from the onset; otherwise, fragmented and less robust service provision can occur as the situation develops (RHRC 2003).

In emergency settings, the core components of MISP to be planned for and delivered include:

- The co-ordination and implementation of MISP by identifying a lead agency and a reproductive health co-ordinator.
- Prevention and management of the consequences of sexual violence by: enhancing physical security in the camps; ensuring availability of female protection and health staff, incorporating issues of sexual violence into health meetings, making information available and widely delivered to refugees, and ensuring medical response including the availability of emergency contraception.
- Reduction in transmission of HIV that includes both in terms of safety procedures for medical staff as well as the availability of free condoms.
- Prevention of excess neonatal and maternal morbidity and mortality through the provision of clean delivery kits for mothers or birth attendants; midwife delivery kits to assist with basic obstetric emergencies (but not surgical); and get a referral system in place to provide essential obstetric care that can only be managed at hospital level.
- Plans for comprehensive RSH services to be integrated into affect the power balance in the relationship primary health care as soon as possible.

(UNHCR 1999)

One of the more controversial components of MISP is the provision of emergency contraception (EC). EC is one method used to prevent unwanted pregnancy as a result of unwanted pregnancy, which often accompanies conflict and displacement. It is available either in the form of a pill or a copper intrauterine device (IUD). The pill can prevent unwanted
pregnancy if used within seventy-two hours, and should under no circumstances be regarded as a method of contraception. Technically, it is an easier method to administer than the copper IUD. However, EC pills are contentious, as they have been (inappropriately) linked with the abortion debate. Some view it as an abortive method rather than a preventative measure against unsafe abortion. The key problems hindering effective implementation of EC pills are: 1) the lack of appropriate training for staff on how to administer the pill and attitudes towards the pill; 2) the lack of women’s awareness of EC; and 3) funding (e.g. the United States Office of Foreign Disaster Assistance does not supply contraception and thus EC cannot be funded [Goodyear and McGinn 1998]). Due to the fact that sexual violence in emergencies now plays a major role in RSH, it is imperative that EC can be provided in a timely manner, and that health staff and women are aware of its existence.

**Websites:**


RHRC: RHR basics section - [http://www.rhrc.org/media/rhr_basics/misp/index.html](http://www.rhrc.org/media/rhr_basics/misp/index.html)


### 3.3 Longer-term reproductive and sexual health services

Once an emergency situation has stabilized, there are some specific RSH concerns that must be taken into consideration and tailored for according to the population’s needs. Long-term planning includes planning RSH services for a camp setting, as well as

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4 The EC pills do not interrupt or damage a pregnancy, and thus the WHO does not consider them a method of abortion. Rather the EC pills work by interrupting the woman’s reproductive cycle (WHO 2002).
integrating them into the services of the host country/region. Longer-term RSH services in a camp setting must evolve to meet the changing RSH needs of the population including psychological and chronic problems (Hynes et al. 2002). However, there comes a point when it is not financially or politically sound to continue providing parallel services for refugees/IDPs (WHO 2000). Planning must take into consideration the comparability of services within the camp versus those of the host community or community of origin, and what this means for returning populations. The challenge not only becomes transferring standards of RSH services and care to local NGOs and/or service providers in the host area or area of return, but ensuring women can maintain access to family planning methods (condoms, the pill, IUDs, etc.).

Website:

3.3.1 Safe motherhood
Safe motherhood includes ante-natal care, safe delivery, and post-natal care. It is a pinnacle service into which other services can be integrated, such as family planning, STI and HIV/AIDS prevention and management, female genital cutting (FGC) and other RSH concerns. Averting maternal death and maternal morbidity is paramount to safe motherhood. However, statistics reveal that much work still needs to be done in this area. Globally, 600,000 women die from pregnancy-related causes each year (UNHCR 1999) and for each woman who dies, 30–100 other women will suffer from maternal morbidity (UNFPA Fast Facts).

Precautions to avert maternal death and disability are known, however they are not always available to women in developing countries and forcibly displaced populations. It is known that approximately 15 per cent of all pregnant women including refugees will develop unforeseen complications that require essential obstetric care. However, obstacles prevent women from accessing this care. For example, displaced populations have little access to transportation giving access to hospitals, in addition to the fact that timely referrals are difficult to make if traditional midwives are unskilled and referral facilities are unavailable. Therefore, in order to avert maternal death and disability the following minimum services are required: ante-natal services, minimally skilled assistance for proper delivery care (both traditional birth attendants and midwives), established referral systems and timely accessibility to these facilities, and post-partum care for the assessment of mother and child health, particularly if the woman is alone as head of family.

Other related issues that may increase in unstable migrant settings and thus need to be targeted include:

- Miscarriage (spontaneous abortions). These can be due to poor nutrition, malaria complications, fatigue and inadequate ante-natal services. Post-abortion care services must be in place to deal with these complications.
• Peri-natal and neo-natal mortality (Peri-natal deaths include deaths of infants from twenty-two weeks’ gestation to one week of life. Neo-natal mortality is the death of a newborn within twenty-eight days of birth.). An estimated 3.4 million out of 8 million infant deaths per year result from poor maternal health and inadequate delivery care (UNFPA Fast Facts). Both poor health and inadequate delivery care are characteristic of displaced environments. The most important factors leading to mortality are infections, birth asphyxia, and low birth weight resulting in difficulties keeping these babies alive. Key contributors (which are typical to a forcibly displaced person) are a change in lifestyle including maternal deficiency in specific nutrients, the lack of ante-natal care, improper care during delivery, failure to provide immediate care for the baby and appropriate post-partum care (Save the Children).

Websites:


3.3.2 Family planning
Family planning (FP) services are necessary both to persons not wanting a pregnancy and to those who desire pregnancy, but want to ensure adequate spacing. There is no conclusive evidence to specify whether fertility rates increase or decrease during displacement (Palmer 1998; McGinn 2000; John Hopkins University 1996). There have been arguments for both, but the most convincing is that fertility rates resemble those of pre-migration settings in stable or longer-term refugee/displaced conditions (McGinn 2000). However, it is imperative that migrant populations are provided with access to contraception, and as situations stabilize, that they are provided with effective, safe, and culturally appropriate methods of family planning. The most basic form of FP should be condoms, not only to assist with family planning decisions, but also to protect against STIs and HIV/AIDS.

Gender-sensitive programming is essential to address the dynamics of knowledge, power, and decision-making in sexual relationships, between service providers and clients, and between community leaders and citizens. Men must be recognized as having reproductive health needs together with the fact that the involvement of men is an essential part of protecting women's reproductive health.
The other related issue that may increase in unstable migrant settings and must be targeted is unsafe abortions. They are an outcome of unwanted pregnancies (often the result of sexual violence, especially in conflict situations). There are an estimated 20 million unsafe abortions each year, and 19 million of these occur in developing countries, of which many do not legally allow abortion for rape cases. Approximately one-third of women undergoing unsafe abortions experience serious complications, and approximately one in eight women who die each year from pregnancy-related causes do so due to abortion complications (The Alan Guttmacher Institute 1999).

While ‘in no cases should abortion be promoted as a method of family planning’ (ICPD para. 8.25), post-abortion care (PAC) services are necessary to mitigate maternal mortality and morbidity due to incomplete or septic abortions. This means that referral systems must be established, and existing facilities must be able manage minimum complications and take prompt referrals when required. To be effective, PAC services must be linked to other FP and RSH services, rather than exist as stand-alone services, in order to avoid repeat abortions (Postabortion Care Consortium 2002). Whether or not abortion is legal in the host country, PAC must be included in comprehensive RSH services (see section 5.2 for a case study on PAC).

**Websites:**
International Conference for Population and Development - [http://www.iisd.ca/Cairo/program/p07000.html](http://www.iisd.ca/Cairo/program/p07000.html)


### 3.3.3 STIs including HIV/AIDS

War and displacement, with their roots in poverty, powerlessness, and social instability, increase the transmission of STIs and HIV/AIDS (WHO/UNAIDS in Krause et al. 2000). The disintegration of family, stable relationships, and governing norms regarding sexual behaviours accelerate transmission of STIs and HIV/AIDS. This makes refugees and
IDPs vulnerable groups, especially women and adolescents, due to their disadvantaged socio-economic status. Often sex is used as a form of currency in exchange for goods/services such as food, security, shelter, and other basic needs (UNHCR 2001), and condoms are not always used, thus increasing possible transmission of STIs and HIV.

A controversial view is that refugee HIV rates are higher than a host population’s. Perpetuation of this view only further marginalizes a displaced population and can lead to discrimination and stigmatization. A recent study by the UNHCR and partners has revealed that the prevalence of HIV in three out of four refugee populations was lower than in the host country (UNHCR 2003). A study of Rwandan refugees in Tanzania revealed that HIV rates remained lower and more stable in official camp settings than rates among Rwandans living outside of camps within the host population (Mayaud 2001). There is certain to be some mixing between the host and displaced groups, and the mixing of these low- and high-prevalence populations (of both migrant and host populations) can increase transmission of STIs and HIV through increased sexual networks and risky behaviours. In instances of military presence, STIs and HIV transmission is accelerated due to the fact that the military often has a higher prevalence of these diseases than civilians, and the soldiers’ movements contribute to the spread (Healthlink Worldwide 2002).

Controlling the transmission of STIs not only helps to reduce long-term reproductive morbidities such as ectopic pregnancy and infertility, but also reduces the likelihood of HIV transmission; thus, it is an important strategy for preventing the spread of HIV/AIDS. The syndromic approach endorsed by WHO/UNAIDS has become the standard of care in many countries for management of the most common STIs. By directing treatment against the common causes of easily identified STIs, primary healthcare workers can achieve high rates of cure without the delay and cost involved with laboratories, which is not always feasible in camp settings. Contact tracing of partners should always be part of the STI treatment; however, in an unstable environment it may not always be possible.

Another main mode of transmission is mother-to-child transmission (MTCT) or vertical transmission. Integrating HIV services into general RSH care can reduce transmission to children since the spread of HIV from an infected mother can occur during pregnancy, during labour, or after delivery through breast milk. Therefore, attempts to reduce chances of vertical transmission must be tackled at multiple points.

Integrating HIV management into RSH care is an important way to avoid MTCT. The addition of voluntary HIV testing into ante-natal care can help reduce the spread of disease to the child at birth through antiretrovirals (ARVs). The WHO estimates that 15–30 per cent of HIV-infected mothers transmit HIV during pregnancy and delivery without ARVs (WHO). Post-natal care targeting breast-feeding is an extremely important part of general RSH care, but especially with HIV-positive women. The WHO estimates that 10–20 percent of mothers with HIV will transmit it through breast milk.

For forcibly displaced populations, the Inter-agency Field Manual advocates standards on HIV and infant feeding established by UNAIDS, UNICEF, and WHO. These include
the possibilities of avoiding breast-feeding and using formula or an HIV-negative wet nurse, or exclusive breast-feeding for a short period of time. However, in unstable situations some or all of these may be impractical. Especially if formula cannot be correctly stored and prepared, the infant may be at greater risk of illness and death than the transmission of HIV (UNHCR 1999). Healthcare providers must be properly trained in post-natal care to provide the best possible counselling to all mothers, especially HIV-positive mothers. Constant research is being conducted, and UNICEF/WHO should be contacted for any updates.

Websites:


UNHCR (1999) Reproductive Health in Refugee Situations: an Inter-agency Field Manual, Chapter 5 - [http://www.unhcr.org/cgi-bin/textis/vtx/protect/opendoc.pdf?bl=PROTECTION&id=403a0f6c8](http://www.unhcr.org/cgi-bin/textis/vtx/protect/opendoc.pdf?bl=PROTECTION&id=403a0f6c8)

UNHCR (2001) Sex as 'currency' makes refugee women more vulnerable to AIDS - [http://www.unhcr.org/cgi-bin/textis/vtx/home/+rwwBmeqjmV_wwwmwwwwwwwhFqnN0bItFqnDni5AFqnN0bIcFqolfUaEf5MzmAwwwwwwDzmxwwwwww/opendoc.htm](http://www.unhcr.org/cgi-bin/textis/vtx/home/+rwwBmeqjmV_wwwmwwwwwwwhFqnN0bItFqnDni5AFqnN0bIcFqolfUaEf5MzmAwwwwwwDzmxwwwwww/opendoc.htm)

UNHCR (2003) UNHCR wants refugees covered in anti-AIDS strategies - [http://www.unhcr.org/cgi-bin/textis/vtx/home/+jwwBmesDGhCwwwwwLwwwwwwwhFqnN0bItFqnDni5AFqnN0bIcFqolfUaEf5Mzm0wwwwwwDzmxwwwwww/opendoc.htm](http://www.unhcr.org/cgi-bin/textis/vtx/home/+jwwBmesDGhCwwwwwLwwwwwwwhFqnN0bItFqnDni5AFqnN0bIcFqolfUaEf5Mzm0wwwwwwDzmxwwwwww/opendoc.htm)


3.3.4 Sexual and gender-based violence

Gender is a prescribed role assigned to men and women that is defined and upheld by learned societal norms and constructs. Gender roles can vary according to different cultures, and fundamentally define status, identity, and power relations in society. Gender differences between women and men can place burdens on women's health. The roles, rights, responsibilities, and status assigned to women by society leave women vulnerable to unwanted and unprotected sexual intercourse, poor nutrition, and physical and mental abuse. They can also limit women's access to health care and attaining good RSH.

Gender-based violence is violence against a particular group based on their gender or sex, rather than indiscriminate violence (UNHCR 2003). It includes physical, mental, sexual,
verbal, and psychological abuse. While rape and sexual assault are most commonly known, it also includes marital rape, domestic violence, sexual exploitation, sexual harassment, physical assault, verbal abuse, confinement, female genital mutilation, forced marriage, early marriage, infanticide, socio-economic discrimination, and social exclusion (UNHCR 2003). Violence against girls and women throughout the world causes more death and disability among women aged 15–44 than cancer, malaria, traffic accidents, and even war, according to The World Bank (UNFPA Fast Facts). It fundamentally stems from unequal power relations, and most often the powerless are the women and children.

Sexual and gender-based violence (SGBV) can happen in all settings; however, displacement and its associated stressors can exacerbate the frequency or magnitude with which it happens. This includes the breakdown of social structures, poverty, socio-economic discrimination, psychological strains of refugee life, and powerlessness. It can happen at any stage of displacement, and thus, prevention and responses must be tailored to the different circumstances of each phase, from initial conflict, to flight, to place of asylum, through to reintegration (UNHCR 1999 and 2003). There can be fatal results of SGBV, including homicide, suicide, and infant mortality. More common are non-fatal consequences including reproductive ill-health, physical disabilities, emotional and psychosocial disorders, and negative social outcomes (UNHCR 2003). Stigma, shame, and silence are inextricably linked to this issue, which can lead to under-reporting of the crime. Therefore, preventive measures should be set up on the assumption that it is a problem, together with co-ordinated medical, psychosocial, and legal responses (UNHCR 1999; Ward 2002), as one is not an effective response without the others.

Commitment to SGBV is improving, but it is not widely implemented as a core feature of humanitarian interventions yet, despite standards and protocols (Ward 2002). A multi-sectoral intervention including the health sector, social workers, law enforcers, and legal/policy systems must work in a co-ordinated effort.

**Websites:**


3.2.5 Adolescent reproductive and sexual health

Adolescence and youth is defined as the period between approximately 10–24 years of age. It is a time of continuous change physically, mentally, and socially. This age group faces social pressures and expectations that can affect their reproductive health status; therefore, young people require information about these changes in order to make decisions that can prevent sexual ill-health. Parents can be sources of information and counselling to their children, as can other adults in and out of the family, especially political and religious leaders, who have a great deal of influence on changing social attitudes (UNFPA 2000). However, while intending to protect young people, some adults may limit young people’s access to information and health services in fear that information will promote sexual behaviour. Information is the greatest tool young people have to protect themselves against reproductive and sexual ill-health.

Displacement accentuates the turmoil typical of this period. The breakdown of family, community, social norms, loss of parental supervision, lack of schooling and recreational activities, frustration, boredom, insecurity of refugee life, and uncertainty about the future may lead adolescents to experiment with risky behaviours, including violence, drug abuse, and unprotected sex (UNHCR 1999 and 2000). Some may have gone through traumatic experiences such as armed conflict, sexual abuse, violence, and/or loss of family members, and many have to deal with these issues alone. Therefore, young displaced people are more at risk of developing sexual ill-health than settled adolescents (UNHCR 1999 and 2000), and RSH services must target the unique needs and circumstances of this group.

Working with young people to address their reproductive and sexual health requires the special skills of service providers. An understanding of the cultural sensitivities around providing information and services to young people, confidentiality, a non-judgemental environment, easy accessibility, and a service provider of the same sex are all extremely important to getting young people to accept services (UNHCR 1999). Integrating adolescent RSH services into mainstream health care may ostracize young people from seeking services due to fear of reprisal, shame, or embarrassment.

Disseminating information to young people can be difficult. In stable settings, education systems are a popular means of providing information to a large number of young people. Because education services can be limited within displaced settings, or many young people may leave school during this time, displaced young people are less likely to access health-related information through schools. Other means must be devised to ensure messages are being delivered. One common method to ensure participation of young people is to work through peers. Young people often have a culture of their own, with
their own norms. Working with peer educators helps to break down the adult–young person barriers, and allows young people access to information, ranging from the basic changes in their bodies and emotions; to avoiding pregnancy, STIs and HIV/AIDS; as well as issues that may be especially pertinent to their circumstances, such as forced sex or selling sex for survival. All of this information must be accompanied with instructions on how and where to access services (see Case studies for examples of adolescent reproductive and sexual health matters).

**Websites:**

### 3.3.6 Other reproductive and sexual health needs

**Men’s Participation**
In the past, the principle objection to male participation in sexual and reproductive health has been that adding male services will damage the quality of women's services and create additional competition for already scarce resources. However, we know now that neglecting to provide information and services for men can detract from women's overall health, but they must be integrated in a way that is beneficial to both men and women (Wegner 1998; RHO). For example, men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use and family planning; be supportive during pregnancy; and if obstetric complications arise, they will know not to delay in getting appropriate assistance. Men’s education on the protection, testing, and treatment of STIs, as well as stressing partner notification, can assist in reducing HIV transmission. Getting men to share the responsibility of good reproductive and sexual health can help to prevent disease, as well as to share the benefits of contraception decisions and avoid the risks otherwise present.

At the same time, service providers must be aware of the gender dynamic within a couple. A woman may be fearful of losing her partner or be threatened with violence if he knows she is positive for a STI or HIV. Women may feel their husband is not supportive of birth spacing or longer-term contraception and may want use it without the partner’s knowledge (Ringheim 2002). Programmes that support a couple approach must be careful
not to jeopardize a woman’s right to decision-making. Gender-sensitive programming is essential to address the dynamics of knowledge, power, and decision-making in sexual relationships.

**Websites:**
Interagency Gender Working Group (IGWG): Men and Reproductive Health Task Force - [www.prb.org/IGWG](http://www.prb.org/IGWG)


**Harmful traditional practices: FGC and early marriage**

Harmful traditional practices are those that are endorsed and practised by various cultures, but may cause lasting adverse biological and/or psychosocial effects on the individual (Toubia 1995). Included in these practices are female genital cutting (FGC) and early marriage. Reproductive and sexual health services seek to eliminate these practices while at the same time approaching them with sensitivity. Despite the fact that FGC is now on the international agenda, and is condemned by most governments, it is still common in twenty-eight countries, and it is sanctioned unofficially in many communities despite what the law may say (UNFPA Fast Facts). These are cultural practices that are ingrained into the psyche of the individuals within that society: wishes to go against these practices can lead to abuse and ostracization. Therefore, addressing issues dealing with fundamental social change may be better achieved in stable situations than in refugee/displacement settings. Changing values and challenging beliefs require long-term, ongoing support.

Each year, 2 million girls are at risk of FGC, and it is estimated that 130 million women worldwide have undergone some form of the procedure (UNFPA Fast Facts). Women with FGC need special care, and in refugee settings service providers must be aware of the cultural practices in order to appropriately address RSH needs. Care must be taken of pregnant women during delivery. The rigid scar tissue around the vaginal opening resulting from the cutting may lead to a delay in the second stage of labor, which may endanger the lives of the mother and/or the baby. Family planning options may be somewhat limited, as special care must be taken with contraceptive forms such as the IUD, and the management of unsafe and spontaneous abortion will need special attention (UNHCR 1999). While these issues can be addressed medically, the sexual and psychological negative effects can be lifelong (Toubia 1995).
Early marriage is another cultural issue that can result in severe, and sometimes fatal, biological and psychological effects. The UNFPA estimates that 82 million girls between the ages of 10-18 in developing countries will be married before their eighteenth birthday (UNFPA 2003). In cultures supporting early marriage, the power balance in the relationship is unequal. Men are generally married later than girls, and girls are expected to defer to their husband. This can leave a girl in a subservient position within the relationship that affects her ability to make decisions in the relationship including those that impact her reproductive and sexual health status, for example negotiating condom use. Early marriage leads to the discontinuation of education, which can affect her ability to make better decisions about her own health and that of her present and future children, and can reduce future employment opportunities (UNFPA 2003).

At times, the physical effects of early marriage can be fatal. Young girls who bear children before they are physically mature can suffer obstructed labour, obstetric fistulas and in some cases death of the child or mother (UNFPA 2003). Worldwide, approximately 14 million women and girls between the ages of 15-19—both married and unmarried—give birth each year, and pregnancy is a leading cause of death for young women in this age group, with complications of childbirth and unsafe abortions being the major contributing factors (UNFPA 2003).

In these circumstances, RSH service providers must be aware of the special needs facing this group. While the girls are still adolescents, they may require information relevant to their age group, but at the same time they also require access to information about specific reproductive issues pertinent to their marital status such as family planning, birth spacing, and delaying their first birth. It is not uncommon that these young girls receive little or no education from elder females upon their entrance into marriage. If elder females have died or become separated from them during displacement, it is important that these young girls receive the necessary RSH education based on their needs.

Websites:
The Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children - http://www.iac-ciaf.ch/


4 Constraints to providing quality comprehensive reproductive and sexual health care

Ensuring access to and availability of quality reproductive and sexual health care in the various stages of forcibly displaced situations technically seems straightforward: needs can be identified and services can be fit to these needs. However, there are a few key obstacles that prevent the care from being accessed by individuals who are most in need of these services.

4.1 The 'Global Gag Rule'

Anti-abortion proponents in the USA have supported the Mexico City Policy, also known as the 'Global Gag Rule' by those who oppose it, since the Reagan administration. It was dropped during the Clinton administration but continues to be strongly enforced under the current Bush administration. The rule prohibits federal funding to overseas organizations for family planning if they use any of their non-US funds to provide abortion-related activities, including providing information about abortion through counselling or advocacy. While the rule is promoted as anti-abortion in attempts to reduce the incidence of abortions, and calls for a separation between family planning services and abortion-related activities, the reality is not so clear-cut when providing comprehensive RSH services, as these two often overlap. Furthermore, evidence from The Centre for Reproductive Rights and Population Action International shows that the Global Gag Rule is detrimental to women’s lives (Cohen 2003). Studies show that providing comprehensive RSH services that include post-abortion family planning services are more effective at reducing abortion rates than not providing information or access (Cohen 2001).

Even in countries where abortion is broadly legal, the USA maintains its anti-abortion stance and is able to control and prohibit necessary funds to indigenous organizations that support all types of reproductive and sexual healthcare services including family planning, ante-natal and post-natal care, not only pro-abortion related activities. The rule forces indigenous NGOs who provide reproductive health care to choose between providing legal abortion-related services in their own country and stopping unsafe, illegal abortions, or foregoing eligibility for US funding to provide desperately needed family planning services. (US-based intermediaries are themselves not subject to the restrictions but are responsible for their overseas partners' compliance.) Fundamentally, it means that millions of women in developing countries are denied access to essential RSH care.

However, a turn for the opponents of the Gag Rule occurred when the rule was attempted to be applied to the US President’s US$15 billion global HIV/AIDS initiative. It was found that the Gag Rule could not be applied without hindering other components of RSH service provision linked to HIV prevention and management services. Therefore, the Gag Rule does not apply to organizations who legally support abortion-related activities and receive funding for HIV/AIDS activities, yet it remains in place if the same organization applies for USAID’s family planning funding (Cohen 2003).

It is easy to see how this legislation can affect reproductive and sexual health services for forcibly displaced populations. For example, while President Bush promoted his five-
year, US$15 billion anti-AIDS initiative, his administration and members of Congress successfully de-funded the United Nations Population Fund (UNFPA) for the second year, depriving developing nations of US$34 million for family planning (UNFPA 2003). The other blow was delivered by the US State Department to the RHRC, who planned to deliver a programme to young people displaced by armed conflict in Angola and the Congo. Due to the fact that one of the Consortium’s partners, Marie Stopes International (MSI), continues to provide safe abortions and is therefore ineligible for US family planning funds, the entire Consortium has been penalized (Cohen 2003). As a direct consequence to MSI, a loss of more than US$3 million to the MSI Partners in Africa has resulted in the closure of three centres in Kenya, an outreach programme servicing poor communities in Ethiopia, and further centres in Tanzania.

**Websites:**


### 4.2 Funding and reproductive health research

Short-term funding is common in emergency situations and in the post-conflict rehabilitation stage, but it can affect the level of expertise that a programme can attain. Improved donor commitments to RSH together with longer-term funding must be attained in emergency situations in order that better RSH programs are implemented rather than piecemeal approaches to service provision (RHRC 2003). The lack of donor commitment not only affects direct programming, but it can also limit an NGO’s capacity and policies for future directions in RSH (RHRC 2003). Without ongoing funding for technical assistance and capacity building, an NGO’s ability to deliver quality services and meet evolving RSH needs is severely limited. The NGO CARE is attempting to provide RSH services in Eastern Congo, and conducted a population-based survey on a variety of RSH issues in 2002 to help plan RSH services. However, the combination of poor security and short-term funding (twelve months or less) makes research into RSH needs difficult (Traore and Grant 2003). Yet at the same time, research is necessary to guide program development and advocate for additional donor support (see section 5.1 for a case study).
In post-conflict settings, many of the issues are the same. Research is desperately needed to understand the magnitude of destruction of the physical infrastructure as well as discontinuation of RSH service delivery. Yet, donors’ sense of urgency to rebuild and revitalize buildings and services has led to rapid and often uncoordinated, piecemeal programmes (UNRISD, *Rebuilding wartorn societies*, 1993, p. 21, cited in WHO 2000). The transition from emergency to development is laden with challenges for RSH providers to ensure continuity of services and quality of care that only additional research, lessons learned, and best practices can assist with. Donor support for RSH in emergencies, as well as the transitional phase afterwards, must include research as well as service delivery in order to provide the right services to individuals in need.

Ongoing research is paramount to providing quality RSH care in all stages of displacement, for all aspects of care. Some areas, such as safe motherhood, particularly linked to issues of maternal mortality have been on the international agenda longer, and thus have had more research input to various programmatic aspects and are more widely implemented. Other, newer areas, such as SGBV and services for men, where there is insufficient research and activities to thoroughly address these issues (especially in the case of SGBV), clearly require longer-term commitments (Ward 2002). With insufficient information, it is difficult to prioritize how best to use limited funds, and in the worst case, these activities may be forgone altogether in order to provide more tried and tested services.

**Websites:**

RHRC (2003) *Global Decade Report* -


http://www.rhrc.org/resources/GBV/ifnotnow.html


**5 Case studies**

**5.1 Making reproductive health services a priority in emergencies: Iraq**

Emergency situations, especially those involving conflict, require that effective co-ordination mechanisms be in place and include sufficient attention to reproductive health responses. However, findings by the Humanitarian Response Unit UNFPA indicate that this is not always the case. While there is co-ordination between UNFPA, UNHCR,
RHRC Consortium and other partners, inclusion of the RSH sector into the overall co-
ordination mechanism of the consolidated interagency appeals seems to be weak. The
appeals do not give the same visibility to reproductive health needs (not even within the
larger health sector) as they give to the sectors of shelter, food, and sanitation.
Furthermore, agencies implementing RSH programs are often excluded from the
consultative mechanisms, thus resulting in a disproportional response to the RSH sector.
Yet it is widely acknowledged that early planning for RSH services can reduce the
adverse impacts of the crisis on an individual’s RSH status (DeLargy et al. 2003).

The Iraq crisis was a positive example of effective co-ordination before the crisis erupted.
UNFPA pre-positioned basic RSH supplies inside Iraq, preparing for anticipated influxes
of Iraqi refugees in neighbouring countries, and setting up training for the proper use of
supplies and how to incorporate RSH services into the initial phase of the emergency.
Not only was the pre-positioning of RSH supplies and co-ordination with national
authorities and other NGOs in neighbouring countries an important step, but an identified
gap was addressed: the training of healthcare officials including senior government
officials and officials from the UN and other NGOs. This was an important step to
ensuring that quality services could be provided and that providing RSH services was
more than the promotion of family planning. There was a greater understanding by all
that early RSH interventions were necessary during the initial phases of conflict to avoid
preventable mortality and morbidity. Healthcare officials had not been previously trained
in these situations because they didn’t realize it was necessary (McKenna 2003).

Websites:
of Military and Ethnic Conflicts. Humanitarian Response Unit UNFPA in RHRC
Consortium Conference 2003 Book of Abstracts -

Priority. Women’s Commission for Refugee Women and Children -

5.2 Post-abortion care in refugee settings: Thailand
In countries where abortion is illegal and there are influxes of forcibly displaced
populations, post-abortion care services are especially essential. Each refugee situation
should have a protocol for reducing death and suffering from the complications of unsafe
and spontaneous abortions. This means equipment and trained staff are available and able
to deal with the situation. Systems must be in place to manage incomplete abortions and
life-threatening complications; provide family planning counselling and services; and
make links between PAC services and other RSH services.

However, while it is widely recognized that the management of abortion-related
complications is an integral component of comprehensive reproductive health care, and
UNFPA’s emergency RH Kit #8 includes equipment and supplies for management of
abortion complications, there is no mechanism to train relief workers on proper use of the
kit. Nor is there systematic training on management of abortion complications, use of Manual Vacuum Aspiration (MVA) equipment, or provision of quality comprehensive post-abortion care (PAC) services that include counselling and referral to other reproductive health services. In addition, formally trained medical staff are not always available in refugee settings.

Engender Health provides positive lessons learned in providing support for PAC in Thai refugee camps along the Thai/Burmese border. Engender Health conducted its first Post-Abortion Care (PAC) workshop for informally trained health workers in a refugee setting with equipment provided by IPAS for the training and clinics represented at the training. The need was identified through RSH service providers, particularly the Mae Tao Clinic, which has seen increasing numbers of patients requiring PAC. In 2001, 457 women visited the clinic seeking PAC services. Post-abortion care services are often urgent in refugee settings, as many delay before seeking care due to fear of arrest (abortion is illegal in both Thailand and Burma), lack of transportation and shame.

Because of the pressing need in the community and the lack of medically trained professionals, informal health workers were chosen to be trained in PAC. Most of those attending the training were refugees with no formal training, but who had already been providing health services of some sort: either they had received previous training from community health education programmes or NGOs, or had direct work experience. Key to their training was to precisely identify their skill level and target the training curriculum accordingly, in order to account for their diverse and varied levels of knowledge. The training was conducted on-site to ensure that the services could be implemented immediately. The training incorporated the PAC into the existing service system to ensure that it was not placing a burden on the site's service capacity and that the team members were integral to making the new system operational.

Post-abortion care will continue as a crucial health need in refugee situations, and the lack of formally trained doctors and nurses should not prevent services from being delivered. Organizations must creatively design programs that use available community resources, such as the training of health workers in PAC above. Such creativity can prevent the maternal death and disability that often accompany incomplete abortion (Venghaus, Maung, and Landry 2003).

5.3 The importance of research in planning adolescent refugee reproductive health programmes: Nepal and Tanzania
Adolescence can be a tumultuous period in every young person's life. This situation can become more confusing and difficult if a young person is forcibly displaced from his/her home, has lost or become separated from family members, has suffered violence and may become head of household by default. The breakdown of family and community can shift responsibilities onto the young person, often without the necessary support. The idleness, boredom and monotony of camp life can lead to increased risky behaviours, especially sexual behaviours. Without reproductive and sexual health knowledge and protection, these behaviours can lead to reproductive ill-health. Case studies of Nepal and Tanzania
reveal different programming approaches based on the different needs and levels of sexual and reproductive health awareness demonstrated by the youths.

5.3.1 Nepal
In Eastern Nepal, approximately 100,000 Bhutanese refugees have been living in a camp atmosphere for approximately ten years. Of these refugees, approximately 38 per cent are aged 10-24. The frustration, futility and stress of the general situation affect the lives of these adolescents. Because of the open border with India and the close proximity of the camps, there is frequent movement across the border by the Bhutanese refugees. Girl trafficking, cross-border trips for IV drug use and prostitution are commonly observed phenomena. These behaviours greatly increase chances of reproductive ill-health including STIs and HIV/AIDS.

The Association of Medical Doctors of Asia (AMDA)–Nepal, which has been providing RSH services since 2001, realized the need for specific interventions aimed at adolescents. In order to design an appropriate adolescent reproductive health program, (AMDA) –Nepal undertook a knowledge, attitude and practices (KAP) survey. The aim of the survey was to determine the level of understanding these youths had of general RSH, STIs and HIV/AIDS, in order to design appropriate curriculum for peer awareness education and to design appropriate RSH services for the young people.

The results of the KAP survey revealed important information for the design phase of the program, including types of information to be disseminated as well as service gaps. Key findings included that basic RSH information needed to be covered, such as signs of puberty, menstruation and pregnancy, in addition to information on avoiding pregnancy, other aspects of family planning, gender-based violence, STIs and HIV. It was identified that the topics needed to be relevant to the immediate conditions of the adolescents, rather than generalized information. In addition to peer workers, mass education of a wider audience that included community members and mothers was recognized as a supportive element. Finally, refresher traditional birth attendants (TBA) trainings were identified, as many of the girls stated they preferred home births (Rimal et al. 2003).

5.3.2 Tanzania
In Tanzania, approximately 25 per cent of all refugees in eleven refugee camps are aged 10-24 years. Umati Refugee Project has been addressing adolescent RSH health in three camps since 2000. Umati’s baseline survey in 2000 revealed that poverty, idleness and boredom were factors leading to early pregnancy and early marriages. A project was designed around these findings to provide sexual and reproductive health services to the youth centres and community. At a mid-term survey in 2002, data revealed that there were no significant changes, and this signalled that programming changes were required. Rather than directly distributing RSH messages, Umati decided to target the associated factors as a way of improving the youths’ RSH. Activities were directed at addressing idleness, boredom and poverty, such as skills training, income generation, sports and cultural activities. Within these activities were educational materials with messages addressing RSH. Peer educators were still utilized, and youths were encouraged to
discuss the RSH messages within the context of the activity or training that was taking place.

Results of the 2003 survey revealed that a positive change had occurred. The number of youths using condoms had increased, youths felt freer to discuss sexual matters and early marriage had decreased. The combination of providing targeted sexual and reproductive health messages to youths at the same time as addressing contributing factors leading to poor RSH has resulted in positive changes in regulating youths' sexuality (Muhingo and Boniface 2003).

The two case studies above illustrate the importance of using research to plan and modify RSH programmes. Planning adolescent RSH services does not have to involve a lot of extra technical input. Both studies revealed the importance of baseline information at the onset as well as throughout the programming cycle. The KAP survey is relatively easy to conduct, cost-effective and can provide rich information about the RSH needs of adolescents.

6 Key players in RSH
All of the following agencies, organizations, journals, and websites have documented information specific to refugee RSH.

6.1 United Nations agencies
UNAIDS - http://www.unaids.org/
UNFPA - www.unfpa.org
UNHCR - www.unhcr.org
UNICEF - http://www.unicef.org/
WHO - www.who.org

6.2 International non-governmental organizations (NGOs)
American Refugee Committee - http://www.archq.org/
Engender Health - http://www.engenderhealth.org
Family Health International - www.fhi.org
International Federation of Red Cross and Red Crescent Societies - www.ifrc.org
International Planned Parenthood Federation - www.ippf.org
International Rescue Committee - www.irc.org
Ipas - http://www.ipas.org
MSI (Marie Stopes International) - http://www.mariestopes.org.uk
MSF (Médecins Sans Frontières) - www.msf.org
PATH (Program for Appropriate Technology in Health) - www.path.org
Population Council - www.popcouncil.org
Reproductive Health Response in Conflict Consortium - www.rhrc.org
Save the Children UK - www.savethechildren.org.uk
Save the Children USA - www.savethechildren.org
Women’s Commission for Refugee Women and Children - www.womenscommission.org
6.3 Research bodies
African Medical and Research Foundation - http://www.amref.org/
Info for Health, Johns Hopkins Bloomberg School of Public Health - http://www.infoforhealth.org/
London School of Hygiene and Tropical Medicine - http://www.lshtm.ac.uk/
TALC (Teaching Aids at Low Cost) - http://www.talcuk.org/

6.4 Journals
AIDS - http://www.aidsonline.com
British Medical Journal - www.bmj.com/
International Family Planning Perspectives - http://www.agi-usa.org/journals/ifpp.html
Perspectives on Sexual and Reproductive Health - http://www.jstor.org/journals/15386341.html
Population Reports - http://www.infoforhealth.org/pr/
The Lancet - www.thelancet.com/

6.5 Websites
Eldis - http://www.eldis.org/static/DOC4183.htm
Reproductive Health Gateway - http://www.rhgateway.org/
Reproductive Health Outlook - http://www.rho.org/

7 Further reading


8 Non-electronic resources and bibliography


