RPN

Refugee Participation Network

Issue 20

November 1995

Women and reproductive health

Articles include:

- What is reproductive health care?
- The question of gender
- The legal protection of refugee women
- Delivering reproductive health care: an examination of the constraints
- The reproductive health needs of adolescent refugees
- Controlling STDs/HIV within dynamic refugee settings

Reports:

- The Beijing 'Platform for Action' - implications for refugee women
- Dinka women and the future of Dinka society

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The RPN aims to provide a forum for the regular exchange of practical experience, information and ideas between researchers, refugees and people who work with refugees.

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Cover photo: A refugee camp on the Turkey-Iraq border: a baby on the lap of a Kurdish refugee receives an intravenous infusion. Photo © Jonathan Kaplan, Still Pictures

From the Editor

THE PROVISION of reproductive health care for refugees is still very much at the developmental stage. Little academic research has been done on the area and the experience of individual programmes has yet to be disseminated widely for other practitioners to build upon. Debate still surrounds key issues, such as whether family planning and sexual health services should be offered as separate interventions in refugee situations - or should be integrated into existing services such as mother and child health programmes. Some experts also question the emphasis currently being given to reproductive health care (RHC), suggesting that the meeting of other more 'essential' refugee needs should take priority; asserting that the reproductive health care banner is being used by some agencies simply to promote 'old fashioned family planning'; and questioning how much reproductive health care it is logistically possible to offer in emergency refugee situations.

However debate, research and the dissemination of practice findings are helping to develop policy and practice in this area. The United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund's inter-agency symposium in June produced a list of guiding principles for RHC in refugee situations, recommendations for implementation, and an inter-agency working group to follow up work from the meeting. A number of non-governmental organisations have formed the Reproductive Health for Refugees Consortium to study, define and promote the needs of refugee women. And there is a strengthening theoretical basis for reproductive health care programmes to be placed within the broader context of women's rights and of gender-sensitive emergency programmes.

As the provision of reproductive health care for refugees develops, the most important element of all these efforts must be to involve refugee women in the design and delivery of services. As Serge Malé of UNHCR has said 'we have to approach reproductive health in the context of being more aware of listening to refugee women and giving them more room to express what they would like'. We hope that this edition of the RPN will stimulate debate on the issues of refugee women and reproductive health, disseminate some experiences and insights to researchers and practitioners, and provide a source for further information on the subject.

The theme of RPN 21 (March 1996) will be ***Education and Training*** (deadline for contributors, end January 1996) and the theme of RPN 22 (June 1996) will be ***Protection*** (deadline for contributors, end March 1996). Please contribute by sending in letters, reports or articles. The articles and reports of most use to other readers are those with a practical focus, preferably no longer than 2,500 words. It does not matter if English is not your first language; we are happy to edit material submitted. We also welcome your contributions on any other theme relating to forced migration and responses to previous material published.

With best wishes

Louie Fooks, Guest RPN Editor

RPN Editor, Marion Couldrey, is currently on maternity leave.

Spanish translation of the RPN

The Refugee Studies Programme now publishes a Spanish translation of the RPN, in partnership with HEGOA (Institute of Studies in International Development and Economics) of Bilbao, Spain. This is a significant step towards expanding RPN membership within Latin America and the Caribbean and attempting to increase the coverage of issues relating more directly to these and other Spanish-speaking areas.

If you have field offices or partner organisations in Spanish-speaking countries who would be interested in receiving a copy, please contact Carlos Puig at HEGOA (details below) or the RPN Editor at the Refugee Studies Programme.

Carlos Puig is coordinating the Spanish RPN and can be contacted at: HEGOA, Facultad de Ciencias Economicas, Lehendakari Agirre 83, 48015 Bilbao, Spain.
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Call for material on Latin America

It has proved extremely difficult to find material from Latin America on the theme of this issue of the RPN, *Women and Reproductive Health*. We are, however, particularly keen to increase the RPN's coverage of this region in view of the new Spanish translation and the fact that the region has been under-represented in the RPN in the past.

If you work on, or in, Latin America, please consider submitting a report or article to the RPN. The themes of our next two issues are *Education and Training* and *Protection*, however articles on any other topic of relevance to forced migration will be very welcome. Articles may be submitted in English or Spanish and will appear in both the English and Spanish editions of the RPN.

What is reproductive health care?

by Sara Davidson, with an introductory analysis by Louisiana Lush

The provision of reproductive health services for refugees has attracted an increasing amount of interest and controversy over the last two years. Whilst at bureaucratic and research level the issue has attracted minimal attention for years, it is now being vigorously debated in international circles among NGOs, environmentalists, donor agencies and academics. Reproductive health also became a major item on the agenda at the two recent UN conferences on women in Cairo and Beijing. In this article, Louisiana Lush examines the nature of this new emphasis on reproductive health for refugees, whilst Sara Davidson provides an overview of the key elements of reproductive health care and the issues surrounding their delivery in refugee situations.

Conventional post-natal care: Oxfam mother and baby centre for Bosnian refugees, Tuzla, 1995. Photo: Oxfam

Introduction

Until recently, the issue of reproductive health has not been seriously or comprehensively addressed by agencies working with refugees or others displaced and living under emergency conditions. Services have tended to concentrate on pre-natal and post-natal care and safe delivery, whilst family planning and birth spacing, interventions to deal with sexually transmitted diseases, and awareness of the problems of sexual violence have been limited.

This situation has arisen from a complex set of interactions: sometimes refugees themselves object to the provision of reproductive health care for cultural reasons or because they interpret it as a cynical manoeuvre to limit their population; in other cases, for whatever reason, the host country does not provide adequate reproductive health care to its own population, let alone to refugee communities; and some NGOs working in emergency situations are themselves wary of providing reproductive health care since not only may its provision be highly controversial but the agency may also experience practical constraints such as lack of resources, trained staff and logistical capacity.

Lack of provision

In 1993 *The Lancet* published an editorial lamenting the neglect of family planning services for refugee women and claiming that in refugee settings, 'there are virtually no data on fertility, abortion or desired family size'. It concluded that the 'family planning needs of refugees have been totally ignored'. In 1994, the subject received increased attention through the wide acceptance of the importance of reproductive health at the International Conference on Population Development (ICPD) held in Cairo in September. Here, for the first time at such a forum, the issue of reproductive health care for *refugees* was explicitly highlighted and taken into account in the final document and Plan of Action. The ICPD defined reproductive health as:

> 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so.'

Reproductive health within a 'rights' context

The most important outcome of the Cairo conference, however, was that 'reproductive health', while perhaps previously being a politically correct way of saying 'family planning', has come to represent the incorporation of an understanding of the rights of the individual, and in particular of women, into the provision of family planning and related services. At the recent UN Women's Conference in Beijing, this was taken one step further: while there were some problems in getting national delegations to agree to some of the issues already discussed at Cairo, the emphasis was on placing reproductive health within a context of *reproductive rights* and within the overall framework of *human rights*.

As such, the goals of any reproductive health programme must be the empowerment and enhancement of the capacity of both women and men, and not the limitation of population size for economic considerations or for reasons of resource maintenance. 'Family planning' must be part of an integrated package of services which do not relate simply to technical interventions to control the size of families or limit the

overall population, but to services which enhance the dignity and self-determination of women, men, adolescents and families. The principles of 'empowerment' and 'participation' must therefore inform all stages of the planning, design and delivery of 'family planning' and other sexual health projects, to promote effective reproductive health and enable refugees to move from being passive recipients of care to active participants in such health programmes.

Women's health needs

Women's health needs are put into focus by UNHCR's *Guidelines on the protection of refugee women.* A section discussing women's access to appropriate health care points out that:

> 'existing health services too often overlook female-specific needs. For example, gynaecological services are frequently inadequate as are child spacing services. Basic needs such as adequate cloth and washing facilities for menstruating women are overlooked. Serious problems such as infections and cervical cancer, and harmful practices such as female circumcision, go all but undetected. Counselling regarding sexually transmitted diseases is generally inadequate for both women and men. Few if any programmes focus on the needs of adolescent girls, even though early marriages and pregnancies are a reported cause of poor health. Access to family planning information and devices is limited in most refugee camps even where it is available to women and men in the host country'.

What is reproductive health care (RHC)?

Reproductive health care for refugees is characterised as including five key elements:

1. provision of safe motherhood services;
2. prevention of sexual violence, and provision of support to victims;
3. provision of family planning and contraceptive services;
4. provision of abortion-related services;
5. prevention and treatment of sexually transmitted diseases.

Few emergency relief agencies have the capacity to implement all five essential components of reproductive health in refugee situations. Effective programmes therefore require coordination by agencies to ensure all areas are covered. The five elements of RHC are briefly discussed below and explored in more detail in subsequent articles.

1. Provision of safe motherhood services It is not hard to understand the emphasis given in refugee camps to mother and child health programmes (MCH) that focus on the survival and improved health of pregnant women and children, for this is where the most dramatic and easily identifiable health need exists, especially during a camp's initial emergency phase. In developing countries, where most of the world's refugees are situated, women of childbearing age (18-45) comprise 20% of the population and 25% of this group are expectant mothers. Poor food, poor shelter, poor health, physical hardship, bereavement and trauma are likely to have preceded and followed displacement, and forced migration will have increased exhaustion. In one, Karen IDP (internally displaced persons) camp on the Burma/Thai border, it was reported in 1994 that 80% of women gave birth with the assistance of untrained birth attendants; 10% of all infants died during delivery or before the age of one; 50% died before their fifth birthday of causes that included miscarriage, birth injuries, malnutrition and infections[1].

High maternal mortality and miscarriage rates are typically causes of concern in refugee settings, and the likelihood of giving birth to under-weight babies increases. Women in most refugee sites under the mandate of the UNHCR system are likely to have access to some kind of basic pre-natal care, to maternity services to assist them when they give birth, to post-partum sessions to check the mother and child's progress, to supplementary feeding and oral rehydration programmes for their infants, and often to expanded programmes of immunisation and to other basic health services for their children.

Provision of pre-natal, delivery and post-natal care for pregnant and lactating women and programmes of MCH are essential but should not obscure the fact that programmes for refugees often fail to address other areas of reproductive health need and other sections of the community (eg adolescents, older women). Agencies risk defining women as first and foremost the mothers of new-born infants, but war and forced migration may make them rape victims or bereaved parents or widows with different, or at least additional, needs.

2. Prevention of sexual violence, and provision of support to victims
The wars in Rwanda and Former Yugoslavia have dramatised the need for protection of women against the calculated use of sexual violence as a mass instrument of war. Where protection has failed, there is not only a threat to the life of the individual but a psychological effect on victim, family and witnesses, including children. Sexual violence also has other manifestations in refugee situations, however, and the UNHCR definition of sexual violence includes torture, threat, assault, domestic violence, incest, prostitution and female genital mutilation (*UNHCR: Sexual Violence Against Refugees, Guidelines on Prevention and Response).* The World Health Organisation and the UN Commission on Human Rights regard female genital mutilation as 'a definite form of violence against women which cannot be overlooked nor be justified on the grounds of tradition, culture or social conformity'.

According to UNHCR, refugees who are at greatest risk are unaccompanied women, female heads of household, unaccompanied children, and children in foster care. Most reported cases concern male culprits and female victims, but men and boys may be victims too. The perpetrators of violence may include other refugees, security force members, civilian staff and other religious or ethnic groups. Sexual intimidation remains a constant threat throughout displacement. The fear of sexual as well as non-sexual

violence by gangs within the closed-off detention centres for refugees in Hong Kong is a telling example. Poor camp layout - eg a layout that requires unaccompanied women to walk long distances to collect fuel or water - and poor lighting also pose threats to women in refugee centres. At one centre in Sri Lanka, women in a camp guarded by security forces preferred not to use latrines at night rather than risk walking to them in the dark.

Community leaders, female protection officers, and female field staff can help agencies plan responses that may include legal enforcement of protection measures, women-only support groups and institutional support to local women's NGOs. The provision of psychosocial support requires long-term commitment and labour-intensive support that cannot be measured as easily as metric tonnes of relief goods delivered. Nevertheless, initial results from an EC study in Croatia suggest that such programmes have been effective in improving the well-being of female refugees from Bosnia[2].

The unstable environment of a refugee settlement is all that this young Guatemalan woman at Quintana Roo, Mexico, has known since childhood. When this picture was taken she had already spent 10 years as a refugee. Photo: Giorgia Doná, RSP.

3. Provision of family planning and contraceptive services

Displaced communities require access to a range of appropriate family planning services. Although little research has been done in this area, informal assessment and anecdotal evidence suggests that birth rates are frequently higher after migration than before, and are higher in refugee than in host communities. One example of high birth rates can be found among Afghan refugee women living in Pakistan. Without family planning the average married refugee woman could expect 13.6 births during her reproductive life while the average total fertility rate for all women in Pakistan is 6.2 children[3]. The reasons for increased birth rates may include: increased sexual activity through boredom, itself caused by enforced unemployment and the lack of other work or leisure opportunity; lack of contraceptives that may have been available prior to migration; rape; provision of sexual favours in return for protection, essential food or money; social pressure to replace community members killed in flight or fighting.

In talking of displaced communities, it is crucial not to overlook that the experience of displacement is an individual one, as is the experience of having children. Loss and bereavement may result in a wish to have more children. Where war continues, women may wish to marry earlier and/or bear a child as soon as possible, as has been informally reported to the author in Bosnia where some young women feel that this is the only area of their life that they can control. One researcher noted that 'In Hong Kong, as in other refugee sites, one of the reasons for having a baby is that both men and women want and need something to love when they have nothing else that gives them pleasure or happiness'[4].

The opposite may also be the case, with women wishing to delay having children in the confines of a refugee camp where food, finances, health provision, sanitation and security may all be in short supply. A 1989 study of Central American refugees, who had lived in neighbouring Belize an average of four years, found a high level of interest in family planning. Researchers interviewed Salvadorean and Guatemalan refugees living in the town of Belmopan, as well as native Belizeans living in the same areas. More than 130 women under the age of 50 were interviewed. Over half the women in the survey indicated an interest in family planning with the highest socio-economic group likely to have the most interest[5].

The contraceptives which the women and men want will be partly dictated by both their home and host community's preference, tradition and legal code, and reproductive health programmes must be guided by these too. A survey of Laotian and Cambodian refugees in Thailand during the 1980s found that contraceptive use was influenced by the cultural beliefs and teachings of the home country. Contraceptive prevalence was higher in Khao I Dang Camp, which primarily housed Kampuchean refugees from Cambodia, than in the Ban Vinai camp, which housed Hmong refugees from Laos, a country where traditional values included a large family, marriage at a young age for women, and polygyny. More than 50% of ever-married women in Khao I Dang practise contraception, compared to 24% of ever-married women in Ban Vinai. When camp residents were asked how many additional children they wanted, Khao I Dang residents said an average of 1.5, while Ban Vinai residents said 3.6[6].

Currently, limited family planning services are available for Rwandan refugees in Tanzanian camps. Plans have been

As is the case in all populations, women and children make up the bulk of refugee populations, yet women are usually excluded from the planning of relief programmes. These refugees from the 1992 civil war in Tajikistan are expected to repatriate by the end of 1995. Photo: UNHCR, A Hollmann.

priorities have to be made; relief workers recruited for their technical expertise may be on short-term contracts, so lessons learned in one emergency are less readily passed on in a new set of circumstances to a new group of people responding to the next disaster. Relief programmes designed by outsiders, involving multiple actors who are predominantly male, have often failed to involve refugees in general - and the status and capacities of women in particular have often been diminished rather than enhanced by them.

But just as poverty is increasingly a female problem worldwide, so women and children are disproportionately affected at times of crisis. An understanding of gender relations becomes particularly important at these times, for those programmes which do not take gender into account can seriously compromise the long-term future for women. Relief programmes have the potential to reinforce existing patterns of domination, or to provide space in new situations for new opportunities which can be sustained beyond the immediate crisis.

Displacement and exile: the experience of loss

Experience of displacement and exile is an experience of loss that goes to the root of an individual's being - not just loss of home and family, devastating as this is, but also loss of any kind of authority or power to control one's destiny.

Asylum seekers are in the hands of the authorities, often dependent on them for the basic necessities of life. Services are 'delivered', refugees themselves are rarely consulted or able to participate in the decisions affecting their lives. And while women may have previously enjoyed less autonomy *vis-à -vis* men in the same social group, displacement will almost invariably mean loss of even those areas where, by custom, they have exercised some authority and have held responsibility. Oxfam's staff team in Darfur, commenting on programmes for displaced communities, said that such programmes 'blatantly hand the power over traditional women's affairs to men . . . running food distribution, water programmes, blanket, jerrycan and other distribution . . . reassigning the traditional women's responsibilities of food and shelter provision to men'[6].

However, while understanding of the gender roles of the refugee community is vital, it is equally important to recognise the limitations of such roles and not to compound the gender imbalance. Another Oxfam team, discussing distribution mechanisms for displaced people, concluded that 'it would be inappropriate to target items on the basis of gender. For example, men would receive fishing equipment since they fish and women only go to fishing camps to prepare food for them'. They therefore decided that it would be more strategic to distribute a single family kit to women, who would thus have some control over resources[7].

For many women the home is the place of their traditional authority. The loss of home is serious for every refugee, but women will feel this particularly where they are not at ease in the public domain. Of the Afghan refugees in Pakistan Nancy H Dupree writes 'the overcrowded closely built dwellings afford no

private space, inside or out, for women who were accustomed to work and relax in large courtyards or secluded walled orchards. For many this lack of private space produced acute psychological distress far outweighing physical discomforts[8].'

Women in Zaire have no such tradition of purdah, but Kasaian women forced out of their homes in Shaba felt that the trauma of bereavement was compounded by the lack of private space. They worried, too, about the effect on their adolescent children who had left the cramped accommodation and were eking out a living on the streets[9]. Refugee women are concerned not only with their own needs and safety but also with the prospects for their children and those for whom they care.

A CARE-organised wheat distribution point in Sidamo Province, Ethiopia, where it is the responsibility of the women to collect the month's ration. Photo: © Hjalte Tin, Still Pictures.

Women and reproductive health

What does the experience of displacement and exile mean for women in that most personal area of their lives - their reproductive health? In most cases it means loss of control over their own bodies, often in the most basic ways.

Food may be in short supply and this scarcity impacts differentially on women and men. Women are particularly affected by deficiencies in iron, calcium, iodine and vitamin C. Inadequate iron intake can be life threatening for pregnant women. In a refugee camp in Somalia in 1987, 60 women died within seven months from complications during childbirth directly related to anaemia[10]. Malnourished women who are pregnant or breastfeeding are unable to supply sufficient nutrients to enable their children to survive, and special care is usually taken to meet the needs of these particular 'vulnerable groups'. However, food which satisfies the basic nutritional requirements will not, in itself, solve the problems of malnutrition. Food may be unfamiliar to refugees and not consistent with dietary practices. It may require preparation demanding much time or scarce fuel resources. The practice in many communities of feeding the men first will mean that women and children suffer when supplies are scarce. Above all, food distribution mechanisms must be equitable. Where food becomes one of the rare available resources there will be competition for access and control of its supply and women will often lose out. A common complaint by women in relief programmes is that they do not know what is going on, and the issue of food entitlement is at the heart of this. In a paper describing discussions with refugee women from Burundi in Tanzania, Sue Emmott, a worker with Oxfam, writes 'few actually know their entitlement . . . it is difficult for them to compete with men at the distribution'. She quotes a woman who complained 'I have no husband so I cannot go for food. Women are not allowed at distribution. The man tells me he will bring to my house, but he brings very small. My children are hungry always[11]'.

The woman quoted above did not know her entitlements and did not feel at ease in the public space of the distribution line. We have seen how the lack of physical space can cause distress. Not only should there be an attempt to provide private space but public space should be safe for women refugees - the design of shelter, the siting of water points, the provision of washing and sanitation facilities can all contribute to women's safety and well-being, or increase their vulnerability to abuse.

When refugee women seek treatment and advice they may find that health facilities are overstretched or inappropriate. Experience has shown that the main users are often men. For example, in 1984 the population of a refugee camp in eastern Sudan was 28,000 persons, of whom 75% were women and children. Of the 26 in-patients at the hospital, all were men. The majority of refugees treated at the outpatient clinic were also men[12].

There are many reasons why women do not make use of the facilities available. The location may be difficult or insecure, opening hours may be inconvenient, women may not be able to fit visits into their own timetables which may, for example, be dictated by the time needed to queue for water or rations. There may be a lack of female health workers, and/or language problems, or the health facilities may not offer women what they want. A case study of Rwandan refugees in a report from the Women's Commission for Refugee Women and Children points out that 'Most of the women do not give birth in the camp hospitals . . . we learned that this is because Rwandan women prefer the squatting position, and in the hospital not only must they lie down but their family members are not allowed to be present'[13]. Women who have suffered abuse may be reticent about seeking treatment and a sympathetic response cannot be guaranteed.

Changing the discourse

The denial of basic rights to many refugee women is surely the key factor which has caused their needs and concerns to remain unrecognised and unmet; but it is precisely this issue of rights which is now being highlighted in the formulation of policy and protection guidelines. At the beginning of this article, the shortcomings of the original legal instruments for the protection of refugee women were referred to. In the section on the Legal Framework in the UNHCR Guidelines, an important link is made between the Refugee Convention and Protocol and other international instruments relating to human rights: the Convention on the Elimination of All forms of Discrimination Against Women, the conventions relating to marriage - consent, minimum age and registration - and the Convention on the Rights of the Child.

To change the discourse from meeting basic needs to meeting basic rights is a significant step forward in promoting not only the material condition of women, but also enhancing their status.

It is within the framework of these policy guidelines that UNHCR conducts training for those engaged in the planning and implementation of programmes of refugee assistance.

The key to more equitable programming must be the refugees' participation in the planning of both their protection and assistance activities. The need for consultation is stressed in UNHCR's Guidelines, in the recommendations of a Field Studies paper of the International Federation of Red Cross and Red Crescent Societies[14], and in Oxfam's Handbooks[15]. The question remains of how practicable this is in emergency and disaster situations.

In a discussion paper on gender and emergencies written in 1993, Richard Luff, a Technical Adviser in Oxfam's Public Health team, wrote 'there are several reasons why consultation with the affected community is minimal. The early stages of an emergency are often so hectic that there is not enough time to find or establish community structures to work with/through; an emergency will often traumatise the community to such an extent that the capacity of both individuals and community structures to respond . . . is disrupted [and] this is especially true for refugees; the trend of increasing competitiveness and emphasis on quick performance amongst the NGOs in delivering emergency relief would seem to preclude an approach in which community consultation and involvement plays a role[16].'

He proposes a model for a phased emergency response combining the 'hardware' of the technical inputs with the 'software' of the social relations in which these programmes will be embedded. He suggests that 'the key to achieving a [better] gender perspective . . . is to build this into our programmes from the beginning and aim to start a process of community consultation from day one. Project proposals would need to include staff who can work specifically on liaison and consultation with the community . . . the project staff responsible for the software side would be working in parallel with the sectoral specialists, the health teams, engineers etc and linking their work into the physical inputs such as the health and water facilities'. He gives an example of this integrated approach from his experience in Bangladesh in 1992 when, although he personally had few dealings with the refugee community, a network was built into the programme to act as a two-way channel for information flow.

Conclusions

Initiatives such as these on the ground - the lobbying of women's networks, the findings of the UN conferences on women, the development of policy guidelines and frameworks for analysis and planning - all acknowledge that women's needs and rights are central to both relief and development. Disasters are times of extremes of human experience. They put communities under the microscope and reveal their complexities and their hierarchies of power. Emergency action holds the potential to deepen existing inequalities, or to make positive use of the conditions which have been created for catalytic change. Understanding gender relations is fundamental to effective disaster response: the acid test for evaluating an emergency programme is whether, despite the experience of loss, refugee women nevertheless make gains - of power and control over their bodies and their futures.

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The members of the RHR Consortium are working together to support the institutionalisation of reproductive health services in refugee settings worldwide.

Women in refugee sites throughout the world - many of them in questionable health and with few or no material resources - are having high numbers of children at closely spaced intervals. Comprehensive reproductive health services designed to serve the broader needs of a wider refugee population - not just pregnant women or mothers - are largely absent in refugee settings. Durable solutions to refugee situations may take years to achieve. Agencies must start thinking beyond the 'emergency' phase to health interventions aimed at saving lives over the long term.

The RHR Consortium is focusing on five essential and complementary technical areas of reproductive health:

- Family planning
- HIV/AIDS/STDs
- Sexual and gender violence
- Gynaecological services
- Maternal care.

Consortium members are committed to promoting the most comprehensive reproductive health programmes in refugee settings. Service provision will be based on need and include the services listed above and others where possible.

RHR Consortium members are working to:

- **ADVOCATE** for increased attention and action related to refugee women's reproductive health among policy-makers, donors and service delivery groups.
- **EDUCATE** to expand the body of knowledge currently available for the promotion of reproductive health in a refugee setting.
- **SUPPORT** an increase of funding available for refugee reproductive health.
- **IMPLEMENT** approaches to reproductive health service provision in Consortium field projects.
- **EXPAND** the number of organisations involved in promoting and providing reproductive health services in refugee settings.

Recent activities include the creation of a central information and consultant databank, administration of a Consortium Small Grants Fund, advocacy work in preparation for the 'Fourth World Conference on Women in Beijing' and preparation of a reproductive health service field manual for relief workers.

Improving gender planning in emergency operations

by Eftihia Voutira

In 1975 the First International Conference on Women in Nairobi set as its goal the promotion of women's conditions through their inclusion in the guidelines and policies of humanitarian agencies. Two decades later, the integration and implementation of these principles are still far from being realised. The original theoretical framework that supported the Nairobi Conference was 'Women in Development' (WID). The main tenet of this view is that the problem facing women in the South is the lack of opportunity to participate in development. Accordingly, increasing women's participation and improving their share in resources relative to those of men is a necessary condition to improve their living conditions.

The socio-economic situation for women has worsened considerably, however, since the Women in Development approach was adopted by most major donors; women's relative access to economic resources, income and employment has decreased, their work burden has increased, and their relative and absolute health status has decreased, as has their nutritional and educational status. Specifically:

• Female literacy rates in the South are two-thirds those of the males. Girls' work, like their mothers', remains 'invisible' since it is not revealed in national censuses. Young women, like their mothers, work longer hours, and encounter more cultural, social, legal and economic obstacles than do boys or men.

• Fewer girls enrol in school and far more drop out at an earlier stage than boys. Similarly, there is generally preferential treatment of male over female children for preventive and therapeutic health care.

In light of the failings of the WID-informed projects, 'Gender and Development' (GAD) analysis emerged as the alternative, more radical, approach to improve women's conditions through enhancing their socio-economic position within society. According to GAD, an examination of the needs and roles of both men *and* women is required before addressing the issue of women's improved access to resources and decisions over their use *vis-à-vis* men. Moving one step beyond a simple economic analysis and restoring the balance of material resources, GAD introduces the concept of social justice and the improvement of the quality of life for men and women.

The ambiguity embedded in the use of the concept of gender reflects the underlying assumptions of these two views. In most humanitarian agency literature, the concept of gender is introduced in order to refer to the improved condition only of women, but the perspective is defended on the grounds of gender sensitivity. This lack of conceptual clarity is one of the main obstacles to improving social and gender-sensitive planning and implementation of humanitarian assistance to refugees in emergency situations

Humanitarian agencies should seek to clarify their own position on placing women as a priority in emergencies. For example, in the 1980s the World Food Programme endorsed the WID approach to issues of women in the development process, on the grounds that it was 'good economics', since targeting resources at women is both cost-efficient and effective in development terms. In the 1990s WFP asserts that it subscribes to the GAD approach for reasons of social equity; however, its usage of the concept of gender remains narrowly focused on women. Consequently, this commitment is not stated explicitly in its mission statement nor is it incorporated in its field operations as a coherent framework for action.

For all that the humanitarian agencies' position is that women should be targeted for distribution in emergencies because this increases intra-household food security, their commitment to GAD and to improving the position of women in a developmental way is marginal in that it addresses neither the interrelation of gender roles nor the socio-political context within which women are disempowered. In this situation the role of NGOs and UN agencies may be reduced to that of a logistics agency whose commitment to women can only be peripherally and procedurally addressed.

If, however, agencies take the position that women should be targeted in emergencies to help improve their overall position in society, the agency commitment must then extend beyond food security in emergencies, to include concern with the relationship between men and women. In this respect, a strategy promoting women as a priority in emergency situations would require agencies to move beyond their present narrow definition of women as a 'vulnerable group' and to play a more active advocatory role in promoting the interests and rights of women overall.

Dr Eftihia Voutira is a Research Associate at the Refugee Studies Programme.

This excerpt is taken from: 'Improving Social and Gender Planning in Emergency Operations' to be published by RSP.

Refugee women

Readers are alerted to the fact that the often used statements *'Refugee women and girls constitute the majority of refugee populations around the world'* and *'the majority of refugees in the world are women and children'* are not based on empirical evidence. Moreover, with few exceptions, wherever empirical studies of refugee populations have been made, it has been found that men - very often single men and boys - outnumber women. This does not, however, negate the need for special attention to be paid to the needs of women refugees. In addition to the points made throughout this issue of the RPN, the extra burdens on women refugees arise from the fact that the demography of refugee populations is usually skewed towards broken families, many of which are headed by women.

Dr Barbara Harrell-Bond, Director, Refugee Studies Programme

The legal protection of refugee women

by Ghaith Al-Omari

'Rape, abduction, sexual harassment, prostitution, physical violence and the not infrequent obligation to grant "sexual favours" in return for documentation and/or relief goods, remain a distressing reality for many refugee women'.

The High Commissioner for Refugees

This paper reviews the existing practice of legal protection of refugee women, recognising that the 'universal and general' language in which mainstream refugee issues are presented is not gender-neutral[1]. Rather, this universal representation of what is essentially male has led to the de-legitimation of some themes, either by presenting them as women-specific and thus marginal to the central debate (eg reproductive health), or by accepting them as 'natural' consequences of being a refugee (eg rape[2]) and as such beyond legal regulation[3].

While dealing with the general human rights of refugees, as included in international human rights instruments, is beyond the scope of this discussion, it must be stressed that refugee status should not affect a person's human rights. More specific to the present context, the *Convention on the elimination of all forms of discrimination against women*, especially the principles of non-discrimination contained in sub-articles 2/c and 2/d, should be kept in mind when considering women refugees.

The most important international instruments on refugees are the 1951 Convention Relating to the Status of Refugees (Convention), its 1967 Protocol (Protocol), and the Statute of the Office of the United Nations High Commissioner for Refugees (UNHCR Statute). However, due to the near-total silence regarding women refugees in these instruments, reference is also made to 'soft law'. This term indicates non-binding instruments such as 'recommendations', 'declarations' and 'guidelines' made by different international bodies[4].

Most of the literature on refugee women, following the model set by the Convention, focuses on the determination of status. This reflects two assumptions:

i) that the individualistic approach to the problem of refugees is adequate; and

ii) that granting refugee status would automatically provide protection.

Neither of these assumptions holds true for the majority of women refugees. In most developing countries, refugees arrive *en masse* and individual criteria for the determination of status are irrelevant. The notion that holding refugee status provides protection fails to take account of the fact that persecution may persist even after status is granted[5].

Refugee women are at an added disadvantage because of their 'otherness'; not only are they 'foreigners in an alien environment', but they often have to deal with institutions that are insensitive to their particular needs. Thus more critical, comprehensive research on rules and mechanisms that would ensure actual protection *after* the granting of status is needed.

Women in international refugee law

If protection is to be understood as 'taking all necessary measures to ensure that refugees are adequately protected and effectively benefit from their rights'[6] then it would contain two components: determination of status and physical safety.

Neither the UNHCR Statute nor the 1967 Protocol contains any articles that specifically apply to refugee women. Even the Convention, the instrument containing most of the substantive rules on refugees, does not mention refugee women. The only article that could be relevant is article 12, concerning personal status. This article states that regarding 'personal status, more particularly rights attaching to marriage', the refugee 'shall be governed by the law of the country of *his* domicile' (emphasis added).

This article puts the family, which is incidentally where most violence against women occurs[7], outside the scope of refugee law, implying no concern with inequalities which may exist within the family. This is in keeping with the outdated view that the 'private sphere' is outside the domain of legal regulation.

Determination of status

The debate on status determination revolves around two points, the first concerning what constitutes persecution and the second concerning the grounds for recognising status.

Does 'sexual violence' constitute persecution for the purposes of status determination? While there seems to be little dispute that sexual violence carried out by state agents in their official capacity does constitute persecution, agreement stops there[8]. In other contexts, where violence is carried out by groups outside government control, or when the government is unable or unwilling to provide protection (ie a situation where responsibility would usually be imputed to the state)[9], there is a tendency for domestic bodies determining refugee status to characterise sexual violence as 'strictly personal'[10]. There is even less consistency in viewing actions other than rape (eg genital mutilation, serious gender-based discrimination, oppressive social norms) as persecution. However, state practice in this regard differs widely, some being more liberal than others.

Concerning grounds for recognition of status, it is accepted that persecution itself is not enough for recognition of refugee status. This persecution must be based on one of the following grounds: race, religion, nationality, membership of a particular social group, or political opinion. These grounds reflect predominantly male paradigms while presenting them as universal, thus in effect marginalising women's experiences of persecution while maintaining apparent neutrality[11].

drawn up to develop a family planning programme in Benaco, through the efforts of UNHCR and UMATI, the International Planned Parenthood Federation affiliate. Population Services International is distributing 135,000 condoms per month and AIDSCAP will develop an AIDS prevention campaign. Before the political unrest that led to the migration of thousands out of Rwanda in 1994, the nation's contraceptive programme was one of the largest in sub-Saharan Africa, reaching 21%. Without family planning services the birth rate, as well as the incidence of sexually transmitted diseases, is likely to increase[7].

'Cultural sensitivity' is sometimes cited as a cause for reluctance to provide family planning services by relief agencies, but agencies should beware of using cultural sensitivity to excuse absent or partial health provision for women whose social status may remain traditionally low but whose responsibilities toward family and community almost always increase during and after displacement.

4. Provision of abortion-related services Access by women to safe abortion remains a sensitive issue for religious and political leaders in refugee and non-refugee situations alike. In donor countries the issue may be crucial in deciding provision or allocation of funds. The practice in any refugee location will therefore be defined as much by legal protocol and environment as by the situation and by the individual circumstances of women. The Bangladeshi government in exile in 1971 permitted abortion for rape victims. In Hong Kong, however, the law on abortion for both host and displaced communities is similar to British law, which allows abortion if the continuation of the pregnancy would damage the mother's physical or mental health.

Access by female refugees to the best treatment available is an ethical and humanitarian imperative for medical personnel and support staff. Of the half million expectant mothers who die each year, 99% do so in developing countries and 14% of these deaths arise from complications due to septic, incomplete or unsafe abortions. This figure can be expected to rise in refugee settings where rape and violence have been a frequent occurrence, where availability and use of contraceptives are less than optimal, and where access to medical facilities is limited.

> Physical and legal protection of the vulnerable, particularly women and children, is essential.

The 1995 *Geneva Symposium on Reproductive Health in Refugee Situations* emphasised that the 'overriding principle of humane treatment must prevail and that health care providers have a duty to provide treatment regardless of the legal status for those women having septic and/or incomplete abortions'. Such treatment should be followed by provision of counselling and family planning services.

5. Prevention and treatment of sexually transmitted diseases (STDs)
AIDS spreads most rapidly in conditions of poverty, powerlessness and social instability, precisely the conditions that exist in forced migration. The spread of AIDS in most refugee situations is greatest through heterosexual transmission in conditions where rape, the breakdown of legal structure, the break-up of families, destitution and prostitution can force survivors of disaster to become victims and casualties of sexually transmitted disease. Factors such as lack of contraceptive availability, poor health awareness and poor infrastructure increase risk.

Physical and legal protection of the vulnerable, particularly women and children, is essential. Providing condoms at the earliest possible stage of an emergency prevents neither violence nor destitution but will stem the spread of STDs within displaced or host communities, and within - or by - military occupation or protection forces. Offering male contraceptives to communities where large numbers of women have been widowed or raped calls for considerable tact and sensitivity by aid agencies and emphasises the need for involvement by female representatives of the local community in programme planning.

Conclusion

'Good health is too big a subject to be left only to doctors' (*Handbook for Emergencies*, UNHCR, 1982). Good reproductive health needs aid administrators, donors, and policy makers who are proactive in assuring women, men and their children of access to sexual health projects, in ensuring that protection and health care programmes target women on the basis of their need, and not - even by default - of their age, creed, marital or social status, and in recognising 'the crucial role played by women in disaster-prone communities' and ensuring that this role is 'supported, not diminished, by our aid programmes' (Code of Conduct for the JRC/RCM and NGOs in Disaster Relief).

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The question of gender

by Bridget Walker

That the integration of gender considerations is essential to effective and equitable development programmes is now widely recognised. By contrast, the gender debate in response to disaster emergencies has been less developed, and it is in this 'relief mode' that programmes of assistance to refugees have frequently been devised and implemented. In this article, Bridget Walker highlights the importance of considering gender in all stages of working with refugees and draws on Oxfam's experience to suggest some ways in which this may be achieved.

The legal instruments and basic structures to ensure the protection of refugees were established in the early 50s and reflect the views and backgrounds of the men who designed them. Persecution on grounds of race, religion, nationality and political opinion was acknowledged from the start; membership of particular social groups was also recognised to give rise to persecution; but the definition did not cover the fact that being a woman might, in itself, sometimes constitute a well founded fear of persecution. It has taken more than 30 years to recognise that gender-related issues may also be a cause for fear and flight. The refugee women from Tigray interviewed by Claudia Garcia[1], had come to Sudan to escape not only war but also 'divorce or problems with their husbands', and she highlights the fact that refugee status is more often awarded to men. In general, the gender dimension of displacement and exile has frequently gone unanalysed and the needs of refugee women have been unrecognised and unmet.

The *World Refugee Survey* of 1981 wrote 'Refugee women and girls constitute the majority of refugee populations around the world. Yet their particular roles, needs and resources have largely gone unnoticed until recently. The priority given to physical survival in most first asylum situations has usually precluded data collection, research or special programming for a segment of the refugee population. And orientation and assistance in resettlement countries have primarily been aimed at developing economic and social survival skills among heads of households, who are often assumed to be men'[2].

Ten years later Tina Wallace, writing in *Changing Perceptions*, has much the same message. 'Until recently the specific problems encountered by refugee women, and the multiplicity of roles they have to play while balancing the competing demands on their time and energy, in situations where they often have no status or support, were largely invisible. Even now, while there is some recognition of the particular needs of refugee women there is very little information and data about them, about their health needs, the productive work they undertake, their experience of stress, and their subjection to many kinds of violence. But at least there is growing awareness that women make up the bulk of the refugee (and displaced) populations and that they have definable needs which arise from their roles and responsibilities as refugee women.'[3]

The Executive Committee of UNHCR first stressed the need for UNHCR and host governments to give particular attention to the international protection of refugee women in 1985[4]. In 1989 the Committee repeated its concern about the physical safety and sexual exploitation of refugee women and called for a policy framework for mainstreaming women's issues within the organisation. There is now a clear policy, based on the Nairobi Forward Looking Strategies for the Advancement of Women, and detailed protection guidelines specifically for refugee women; but the gap between policy and practice remains wide. Why is this so and what can agencies working with refugees do to address the situation?

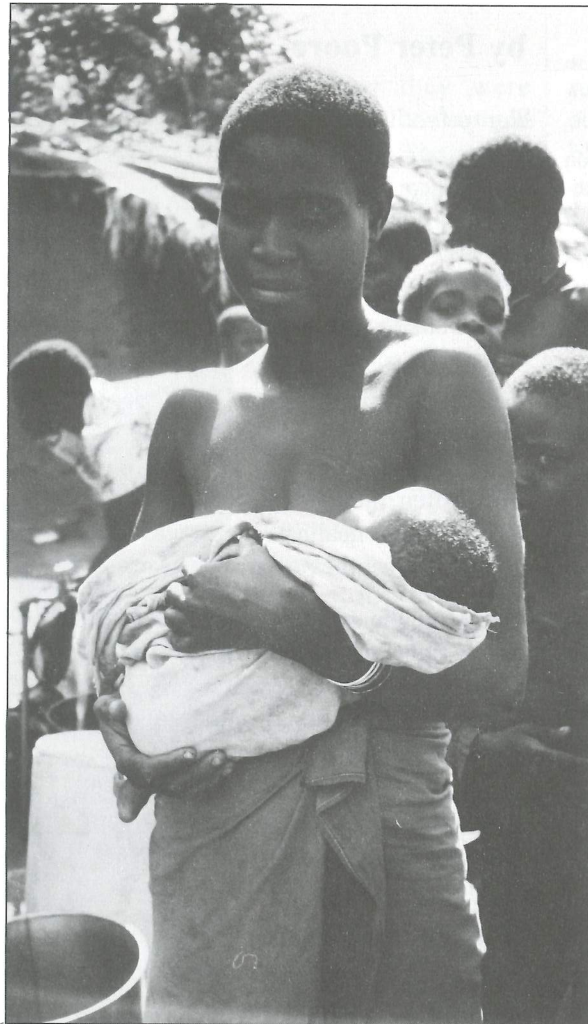
Gender and emergencies

The crisis in developmentalism has led academics and development agencies to re-examine their development models and the assumptions that underlie them. Key to this has been the critical examination of development experience over the past twenty years, informed by insights from political and social analysis and theories of change. Of these, gender analysis has been crucial in demonstrating how, and offering an explanation why, development has failed women, often leaving them worse off than before. Oxfam's Gender Policy, formally adopted in 1993, states that 'Today there is growing awareness of women's absolute and relative poverty and inequality all over the world. In spite of the significant efforts of many national governments and at international level, the situation of women has worsened'. The document goes on to explain the importance of a focus on gender, rather than on women, 'to ensure that changing women's status is the responsibility of both sexes', for development affects men and women differently and has an impact on relations *between* men and women. Women are poor because their lack of material wealth is compounded by lack of access to power, skills and resources. Fully integrating gender into relief and development programmes should tackle the causes of women's poverty and promote justice to the advantage of women as well as of men.

It is now generally acknowledged that the integration of gender considerations is essential to effective and equitable development programmes. By contrast, the gender debate in response to disaster emergencies has been less developed, and it is in this 'relief mode' that programmes of assistance to refugees have frequently been devised and implemented.

There are a number of factors contributing to the neglect of the gender dimension in emergency and refugee situations: large scale relief programmes have many different actors; there are immediate and pressing needs - for water, sanitation, shelter and food - and

There are two major positions on the question of whether persecution claims based on the gender of the victim are valid grounds for refugee status. The first is that gender could be included under the 'social group' category. This approach was adopted by the European Parliament in a 1984 resolution and by the UNHCR Executive Committee in a 1985 Conclusion. This Conclusion 'recognised that states . . . are free to adopt the interpretation that women asylum-seekers . . . may be considered as a "particular social group"'. Critics of this position argue that this is not sufficient to cover all the cases where women are persecuted, especially when the persecution is based solely on gender. Moreover, few countries opted for this interpretation of social categories, while the majority continued to exclude women from the social group category. Consequently, the second position argues for the explicit inclusion of gender as a separate ground for persecution, as the only means to ensure effective protection for women refugees.



'Physical safety' should also encompass basic needs such as nutrition and health to which refugee women, like this young Mozambican in Southern Malawi, are entitled. Photo: S Smith, Oxfam.

Another important aspect of status determination in this context is procedure. Victims of sexual violence in particular often find it very difficult to discuss their experiences with male interviewers and interpreters. Yet, even in states which do provide female staff as a matter of policy, these are not automatically available to women asylum seekers. The need for appropriate procedures for refugee women was recognised in the UNHCR *Guidelines on the protection of refugee women*. However, this recognition has not translated into legally binding instruments.

Physical safety

Physical safety of refugee women is understood here in a wide sense to include not only freedom from sexual violence, but also access to basic needs such as nutrition and health (including aspects of reproductive health). Instances of breach of physical safety of refugee women are well documented, whether during flight, at the borders, during status determination procedures, or after the granting of status[12]. Yet, as previously argued, the emphasis in jurisprudence and doctrine remains on the individualistic approach to determination of status. While this approach may be appropriate for the woman who is a 'critical intellectual, active with a high profile in illegal resistance, organised, ideologically well-versed'[13], it does not correspond to the protection needs of most refugee women.

As a consequence, issues concerning the physical safety of refugees (especially those who are women) lie outside the scope of hard international legal instruments. It seems to be generally accepted that the matter of ensuring the physical safety of refugees on the international level should be dealt with as a policy issue as opposed to a law issue. Thus, when enumerating the 'legal instruments relevant to sexual violence' the UNHCR *Guidelines* on sexual violence against refugees mentioned no refugee-specific instruments at all.

Emphasis has been placed on programmes such as the Anti-Piracy Programme established by the Royal Thai Government[14], or on a 'variety of measures' reported by UNHCR[15]. Even these 'measures' are, at best, sporadically applied. Due to the *ad hoc* nature of such measures, no consistent policy or state practice for the physical protection of refugees has emerged.

Conclusion

The major international instrument on refugees, the Convention, was drafted exclusively by men; all the international refugee law instruments are phrased in the masculine voice. The international approach to issues that affect refugee women, whether concerning status determination or protection, has at best followed the 'add-women-and-stir' model; at worst it has discarded women's specific needs and experiences as irrelevant. It is not surprising, therefore, to see that gender-specific persecution of women is still not universally accepted as valid grounds for the granting of status, and that physical safety of refugee women is dealt with in soft law instruments and *ad hoc* policies.

To make the international refugee legal system appropriate for women will require a thorough exposure of the biases inherent in the structures and assumptions of the law. Without such critical examination (and the subsequent inclusion of its results in hard legal instruments) efforts by the international refugee regime to avail women amount to no more than scattered patchwork.

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Delivering reproductive health care:

by Peter Poore

Reproductive health care (RHC) has potential benefits for individuals, families, communities and nations, and there is no doubt that such care can be effective. Peter Poore suggests, however, that the real issue in reproductive health care for refugees is how to reconcile the disparity between the services that should be offered and those that are available, given the practical, logistical, cultural and social constraints which may be operating in any particular refugee situation.

The 'right to health' of refugees is acknowledged in UN documents[1]. Securing these rights in practice, however, often falls short of the promise. Reproductive health is dependent upon more than just the provision of care.

Denial of the social, political and economic rights of women around the world perpetuates the discrepancies in health status and educational opportunity between the sexes at all ages and favours the continuing exploitation of girls and women, socially, economically and sexually. Addressing these issues is at the heart of securing the right to health.

Benefits of RHC

Reproductive health care has potential benefits not only for individuals but also for families, communities and nations. It can raise the health status of women, improve the outcome of pregnancy, lower the burden of death and disease amongst women and therefore their children, and increase the range of choices available to couples who wish to plan their families. Good care can offer some protection against sexual violence, including rape and genital mutilation, and lessen the risks of unsafe abortion.

Maternal care is an essential part of RHC. Maternal mortality rates in the countries where most refugees come from, and go to, are 200 times higher than in industrialised countries. This is unsurprising because so much of the mortality is attributable to causes which require access to skills and services which can either surgically interrupt labour, or manage severe haemorrhage, anaemia, infection, hypertensive disease, and the harmful effects of unsafe abortion. These services are expensive and rarely exist where and when they are needed in poor countries.

The constraints on delivery

There is little dispute about *what* reproductive health care should be offered to refugees, and no doubt that such care *can* be effective if delivered to the right person at the right time by sufficiently well-trained and supported staff. However, the 'menu' of services and interventions which should ideally be delivered must be reconciled with what it is *possible* to deliver at any one time, in any one refugee situation.

In poor environments there will always be a need to compromise between the quality and the quantity of care available; but if either the quality or the accessibility of the service is inadequate to address the need, then the service will be of no value. The provision of reproductive health services is clearly a priority. It is not, however, a question of what should be done, but more one of what *can* be done in a particular situation, and every situation will be different.

A number of key factors will determine the needs, including the reproductive health needs, of refugees and the opportunities which service providers will have to fulfil them.

i) The numbers of refugees, and the rate of arrival in an emergency situation. This will vary enormously and depend to some extent on the causes of flight. At one extreme, the one million people who fled Rwanda in the space of a few days during the recent civil conflict were enough to almost overwhelm the capacity of any agency to respond effectively to their immediate needs.

ii) Security, social organisation and cohesion. The provision of services will depend upon how people organise themselves within any community, and how

an examination of the constraints

The cholera epidemic which broke out in Goma (Zaire) in 1994 claimed the lives of thousands of Rwandan refugee daily.
Photo: © Howard Davies

secure that community is. A knowledge of how the community 'works' - who makes the decisions and who controls events - is essential if any intervention is to be useful. The imposition of any action on an unwilling or uncooperative community will certainly fail.

iii) Demographic composition. Refugees may comprise whole families, predominantly women and children (eg the camps in Luwero during the Ugandan civil war where most of the men were combatants) or, less commonly, may be mostly men, children, or the elderly.

iv) The well-being of refugees at any one time will depend upon why they moved from their homes, how far they moved, what state they were in when they left, and what state they were in when they arrived. It will also depend upon what services were available in their homes, during their flight, and in the host country; whether or not they are acknowledged as refugees by the host country; and how they were treated on the way and on arrival. The author reports that many of the Kurdish refugees from Northern Iraq who fled from Saddam Hussein, left prosperous homes where there were good health facilities. They drove to the border in their own cars but then had to walk over snow-covered mountains, where many died. In Turkey, they were held just below the snow line where it was extremely difficult to provide basic services. The high mortality rate was a result of a political decision rather than a lack of resources. By contrast, those Kurds who went to the Iranian border were received as refugees and dealt with efficiently by the Iranian authorities. Mortality rates were reportedly lower in Iran.

v) The capacity of the host country to provide - or coordinate - resources such as people, money, equipment and consumables will determine its capacity to respond to the needs of the refugees. The absolute amount of money that is available for the emergency relief of refugees has increased but, by contrast, the resources available for the development of health services in those countries which are both home and host to refugees have declined. As a result, host countries are increasingly unable to provide adequate services for refugees. Furthermore, some countries are unwilling to accept responsibility and are even actively hostile to refugees.

vi) The degree of competence and coordination of relief efforts varies considerably, and perhaps more than anything else determines the effectiveness of response. The number of agencies responding to emergencies has increased considerably in recent years. The problems of coordination, accountability, competence and organisation have increased as a result of this, as yet, unmanaged interest.

vii) The length of time that a refugee camp has been established may determine which services can be delivered. A well-established refugee camp, adequately resourced, will often be able to offer most, if not all, of the basic necessities. In these circumstances, health indicators such as Infant Mortality Rate (IMR) and Maternal Mortality Rates (MMR) can be reduced. Indeed there are many examples where the welfare of refugees in camps is better than that of the indigenous population. Maternal mortality has been virtually eliminated from the Bhutanese refugees in camps in eastern Nepal, although the MMR in Bhutan[2] is amongst the worst in the world and is also very high amongst the indigenous Nepali women.

viii) The presence of the international press. International response to disasters is heavily influenced by news reports. Reporting of disasters is, however, incomplete; it always seeks the dramatic and loses interest rapidly. As a result, there are many 'hidden emergencies' which go unreported and are uncared for.

Improving RHC for refugees

What can be done to improve the provision of reproductive health care amongst refugees?

1. Be prepared. A great deal is already known about the health risks to refugees in any circumstances. The immediate need for the basics is invariable - adequate safe water, appropriate sanitation, shelter, food and preventive and curative care. Awareness and utilisation of this 'background' information as well as early and rapid appraisal of the site and the situation with the full cooperation of the community and their leaders, is essential to plan an effective response.

2. Promote an international code of conduct which can be used by all agencies working in emergencies to ensure

coordination, accountability and the optimal use of resources. This will avoid the common situation today where agencies compete with one another for resources on offer from donors, without the need for accountability for the quality of service provided. This applies equally to UN agencies and NGOs.

3. Standardise the approach to the prevention, management and treatment of common conditions in reproductive health. This is relatively uncontentious. We know what to do about most conditions, and the medicines and equipment to provide interventions exist. The draft field manual which is being prepared by the United Nations High Commissioner for Refugees and the United Nations Population Fund should provide guidelines on procedure to each level of health staff in the field. Both technical and managerial guidelines will improve the quality of care and the optimal use of limited resources. A standard, common approach will also facilitate the training of health staff at all levels.

4. Acknowledge that specific reproductive health needs may present as a priority. Understand the special needs of women and girls. Clearly, in most circumstances, women will continue to have babies. Their obstetric and perinatal needs must be acknowledged and emergency care provided for in the best way possible. Most births will take place in the home and this is where any service must focus its attention if it is to establish an effective contact and referral service.

5. Protect women from sexual violence. Sexual violence is commonplace in times of conflict and social disruption. It is an acknowledged fact that rape is used as a weapon of war. Protection of women must be a major consideration when establishing services which require women to leave their homes or stay overnight in health centres. Emergency contraception following rape could prevent many pregnancies, but the circumstances in which rape may occur as a weapon of war would often preclude the availability of such a contraceptive service within a time period when it would be effective.

Kurdish refugees on the Turkey-Iraq border. Photo: P Poore.

6. Prepare for the mitigation of disasters. A number of techniques have been developed which can 'map' inherent and potential risks, and which can analyse and interpret vulnerability[3].

7. Invest in the capacity of host governments, where this applies, to coordinate responses from foreign and indigenous agencies. Review the distinction made by donors between 'emergencies' and 'development'. This often only has relevance in that donors impose the distinction for the purpose of fundraising and budgeting. It seldom has any other validity, and often means that opportunities to contribute to longer term rehabilitation and the process of development are missed. An example of this is that whilst health needs are classified as 'emergencies', educational services are considered to be 'development' and often cannot be funded from emergency budgets.

8. Invest in the social services of the poorer countries of the world so that they are better able to provide for their own people as well as for the internally displaced and refugees from other countries.

9. Reaffirm the right to health for all. Equity and the right to health, including reproductive health, is under threat. The need for cost effectiveness must not be used to deny the right to health to those, such as refugees and internally displaced peoples, who are expensive to reach.

Conclusion

The failure of governments, UN agencies and NGOs to address adequately the reproductive health needs of refugees is not technical, but organisational. Our response all too often is too late, too little, insensitive, inflexible, inappropriate, uncoordinated, unaccountable and of varying quality.

The provision of services to people who, for whatever reason, have been displaced from their homes will always depend upon setting priorities according to circumstance, need and opportunity. The ability to draw such conclusions rapidly is fundamental to good practice and effective response - as is consultation with, and participation of, the refugee community. The uncoordinated, inappropriate imposition of any 'service' on an uninformed, unwilling and uncooperative community will always fail.

These are the issues which must be addressed and resolved. If they are not, the rights of refugees to reproductive health care will continue to be denied.

Peter Poore is Senior Health Adviser for Save the Children Fund UK.

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UNFPA

United Nations Population Fund

In 1994 UNFPA began to take measures to address the reproductive health needs of refugees.

To date the agency has taken four key steps in this area.

UNFP A: key steps in providing RHC for refugees

1. In May 1994 UNFPA's policy on emergencies was established. The policies indicated the type of support which UNFPA may provide in the field of reproductive health, including family planning services.
2. On 16 June 1994, the UNFPA/UNDP Executive Board requested the UNFPA Executive Director 'to assist urgently in an appropriate way and with the collaboration of other specialised agencies, the population of Rwanda'.
3. On 1 November 1994, UNFPA created an office for Emergency Relief Operations based in Geneva, to develop and coordinate appropriate responses to the reproductive health needs of refugees.
4. An agreement was signed on 30 June 1995 between UNFPA and UNHCR to facilitate collaboration and to maximise each agency's input into the provision of Reproductive Health and Family Planning services and advocacy activities against violence towards women, among others.

UNFP A projects: type, content and duration

- In the past there have been a number of UNFPA projects in which contraceptive supplies and family planning information material have been provided.
- Other projects, although not specifically earmarked for refugees and the internally displaced, have been included as part of a national programme for the host populations.

  These projects may involve the reintroduction of an earlier maternal and child health/family programme which had ceased due to war or civil disturbance. The implementing partners belong either to host authorities or non-governmental organisations, and United Nations agencies.
- A project has been established in Bosnia/Croatia to support the psychosocial needs of women traumatised by violent events, including sexual violence.
- The elements most often incorporated into the UNFPA projects designed for refugees are clinical and counselling services in reproductive health including family planning, advising on preventing sexually transmitted diseases and HIV/AIDS, training personnel, and community self-help.

Other activities:

- In June 1995, UNFPA organised an inter-agency symposium on 'Reproductive health in refugee settings' attended by 135 participants from over 50 agencies concerned with the reproductive health of refugees.
- At the Fourth World Conference on Women in Beijing, the Executive Director participated in a panel discussion on women in situations of armed conflict.

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Mozambican women claiming recogni
observations from Tong

by Shirley DeWolf

Shirley DeWolf notes that the alarming surge in the number of people uprooted from their homes and their countries in recent years has evoked a lengthening list of policies, guidelines, charters, conventions and protocols, dealing with the human rights of refugees, and put together by governments, inter-governmental agencies, non-governmental agencies, academics, legal practitioners, aid workers in the field and other support circles.

DeWolf asserts that, important as this 'paper work' is, it plays only a

The population of Tongogara Camp in Chipinge District of southern Mozambique, which stood at 47,000 by 1994, largely comprised Ndau-speaking people who originated from Machaze and Mossurize Districts in the southern part of Manica Province, with a smaller number of Changana-speaking people originating from Massangena and Chicualacual Districts in Gaza Province. In the case of both language groups, the Zimbabwe-Mozambique border forms an artificial divide which separates people of the same families, so cross-border contact has always been common.

Most of the adult males who came to Tongogara Camp had a background as migrant labourers, both within Mozambique and in South Africa and Zimbabwe, and some in other countries of the southern Africa region. They were accustomed to being mobile, were conversant in several languages, approximately 25% were either semi-literate or literate, and they were 'street wise' in the international labour scene. In contrast, a small minority of the women who came to Tongogara Camp - those who lived within easy walking distance of the border - had been to Zimbabwe before as tea and coffee pickers. The great majority had no experience of travel either outside Mozambique or even within the country. Their knowledge, in terms of language and customs, was therefore very specific to their home locality; almost all were illiterate and few had ever made use of a formal health system. There were hardly any single teenage girls to be found, as it was customary for girls to be married by parental arrangement by the age of 14 and this meant that, apart from the exception of the very elderly, almost all had dependent children even if they did not have a husband travelling with them. There was a great deal of separation from male family members during flight and after arrival in the camp. These were to become significant factors in the way the Mozambican women conceived of their female roles in the camp society, the way they approached the claim to their human rights, and in their preparations for the future.

Flight to safety

By the time the refugees arrived in Zimbabwe in the early 1980s they were badly frightened and shocked by forced separation from their families and homes, and many were wounded. During the drought of 1992, Tongogara Camp received another wave of people from Machaze and Mossurize Districts who arrived in appalling physical condition, due to an outbreak of measles which devastated children and adults alike because of their severely undernourished state. The people's first claim was therefore to their right to life, as indicated by their persistent flight to safety against all these odds. This was not a claim made on the basis of any international human rights legislation, nor did they know then or for most of the 11 years of their lives as refugees that such legislation existed.

Settling in to camp life

Those who chose to settle down illegally within the local Zimbabwean population and to take their chances with the authorities had an easier job of re-establishing a way of life somewhat similar to the one which they had been used to at home.

For those who took advantage of the shelter offered in the designated refugee camps, reassembling order in their lives was not simply a matter of re-establishing the pattern of their normal daily activity, as the normality of camp life was entirely different from what they had known at home. While life was at least secure, the institutional order of camp life removed from both men and women the roles by which they were accustomed to having their identity and dignity measured.

Mothers were no longer the food controllers: the camp kitchens did that. They were no longer the health caretakers in the traditional methods they knew: the camp health workers did that. Fathers were no longer protectors: the camp police did that. They were no longer the decision-makers and discipliners: the camp base leaders did that. They were no longer the providers of clothing and other items that could not be provided within the immediate household: the NGOs did that.

The struggle for recognition of their self-chosen identity was one of the most important expressions of the Mozambicans' claim to their basic human rights. Central to this claim for dignity was the stabilising role which fell to the Mozambican women in exile. Camp life imposed a situation of turmoil where traditional social norms had fallen away, the cultural frame of reference was no longer recognisable and many of the menfolk had either been left behind in Mozambique or had deposited their families in the camps and left to pursue their economic activities in southern Africa, some never to return. In these circumstances women had, in addition to carrying the load of domestic work, to become the providers and preservers of stability, and the maintainers of culture and family history.

Claiming human rights: the milestones

Several milestones can be singled out as the residents of Tongogara Camp made progress in identifying and claiming respect for their human rights.

tion for the human rights of refugees: ogara Camp, Zimbabwe

secondary role. Governments and aid agencies must recognise that the greatest support for uprooted people comes from the uprooted themselves, and that the second most important level of support comes from their immediate host communities. To illustrate this point she relates the story of Mozambican women in Tongogara Refugee Camp in southern Zimbabwe who, through a programme of community development, laid claim to their basic human rights during 11 years in exile.

Problem-solving workshops

The first milestone was a series of problem identification and solution workshops which were requested by the Tongogara women in 1990 and facilitated by Christian Care. These workshops eventually came to incorporate men, youth and children.

When the women in Tongogara Camp began to gather to talk about their personal concerns this was a bold step on their part and it took some time for the few who pioneered this effort to encourage others to participate. Until this time only a small number had begun cautiously to participate in the various skills training and literacy courses offered by the NGO staff in the camp, the main reason being that husbands did not allow them to move about the camp except to fulfil basic domestic chores, so unstable was the social environment. In a 1989 study conducted by Makanya and Dhemba[1] it was noted that many of the training sessions offered were conducted by male staff members, and husbands objected to having their wives trained by other men. In addition, the domestic chores to which women were tied were very time consuming - the most tedious of them being the collection of firewood which meant travelling further and further from the camp in search of a commodity which grew more scarce as the camp population increased. Another problem was a very practical one, caused by lack of adequate sanitary material for use during menstruation and this meant that one week out of every four a woman's freedom to move about and participate confidently in public activities was severely curtailed.

The concern most commonly expressed by the women in these discussion with Christian Care was for their children who were being raised in a physical and social atmosphere which they considered unhealthy to their growth. Very closely following this concern for their children was their personal unhappiness in relation to their male partners and husbands. At first they wanted to make sure that their sharing of these painful complaints would be kept secret so that they would not suffer repercussions at the hands of the men, but later they began to invite men to attend their meetings so that answers to these problems could be found jointly. Closely connected to this was their strong expression of a desire for strengthening or empowerment so that they could be more self-reliant and the skills they already had could receive public recognition and upgrading. Concern was also expressed about issues of hygiene and health, with which they had a daily struggle.

Much practical planning resulted from these first major encounters. One of the biggest efforts was a 10 hectare vegetable gardening project which 180 women instigated, naming their group *Simba re Vanhu* (People Power). They called on the aid of some of the male well-sinker trainees in the camp to put down three wells and arranged for a course in horticulture and book-keeping to manage the programme. By the end of the first year this had become one of the most productive cash-generating ventures in the camp, due in no small measure to the enthusiasm which the women brought to the project. The problem identification workshops also assisted the aid agencies to target their programme support more carefully to meet women's needs.

The leaders of the *Simba re Vanhu* venture were active in creating a leadership committee, combining the heads of all camp projects, women and men, for the purpose of mutual strengthening, ensuring that women's issues and concerns received fair attention at least at the level of practical community programming, and providing what they termed 'an eye and an ear' in the camp. Twice a month the team would walk the length and breadth of the camp to detect problems which required a community programme-solving approach. Since mid-1987 a camp administration committee, made up of male refugees representing all the bases or housing sections, had been operating as an outreach of the camp authorities for the purpose of maintaining order in the camp. But as Makanya and Dhemba's studies revealed, some women in the camp were not even aware that this committee existed, and few had participated in the selection of the representatives from their housing units. The new projects' leadership committee, in which *Simba re Vanhu* was prominent, provided a structure by which Mozambicans could shape their own community development.

Discussions on democracy and the African 'Charter on human and people's rights'

In preparation for the first national elections which were to take place in October 1992, Christian Care and the Catholic Justice and Peace Commission were approached by the residents of both Tongogara and Nyangombe Camps to provide education for their participation in the democratic changes that were taking place in Mozambique. The request came both from men and from women through separate channels. A training series was designed based on a Shona translation of the African Charter on Human and People's Rights and a discussion booklet that had been developed for Zimbabwe entitled *Understanding Democracy and People's Rights*.

Mozambican women claiming recognition for the human rights of refugees, *continued*

It came as a great surprise to most of the exiled Mozambicans that their rights as human beings and even as refugees were globally recognised and documented, and endorsed by the signatures of governments. They wanted to know 'who is this OAU and how does it propose to promote and protect human and people's rights [Preamble] when those people are remotely located in Chintobe or Chioco in the heart of Mozambique?' They were keen to find out to what extent the Mozambican government was party to these agreements. With the discussions came a sense of power based on the authority which the Charter gives people to claim their rights. As the training sessions came to a premature stop with the rapid emptying and closure of the camps in December 1994, an essential stage in the process of claiming those rights was not covered, namely how to use that authority in their home situations and where to find ongoing advisory services.

The many personal abuses which women suffered during the war and even in the refugee camps were talked about - but not exhausted - in these human rights discussions. They said that too often they found their problems dismissed as being just an unavoidable side product of the war or part of their 'backward way of life'. The women recognised the advantages they had found in the camps in standing together for mutual support, and in a powerful two-day meeting where they identified the strengths they had gained from this experience and discussed their worries about the future as they returned to Mozambique, they talked about their fear of being alone. Some decided to continue the 'eyes and ears' strategy once they got home: to look out for women in trouble and rally to help them. 'A stick on its own is easily broken, but a bundle of sticks is hard to break', they said would be their motto.

Conclusion

Prior to their departure there was some discussion among Tongogara residents about the recording of their experiences and what they had learned throughout their period of exile.

Zimbabweans too who had the privilege to live and work among the Mozambican exiles and who grew to appreciate and respect them, are anxious to record their experiences from within their support circle. Already several observations are being articulated at this level. The first is that in staking public claim to their human rights the women's confidence was not based on faith in documents or in aid workers, but on faith in each other and on the solidarity which that created. A second observation is that it took many years in a quicksand situation of individual struggle for a dignified way of life before they could join forces and haul themselves onto solid ground. Thirdly, once the women took up leadership at community level the entire community made rapid progress in activating their rights and developing their further role as protectors of the rights of others.

If we as supporters of human rights for uprooted people are to learn from this experience, we must begin with a solid respect for the dignity of people in crisis and for their chosen means of expressing that dignity. This respect is the essential starting point for developing a method of support which endorses their efforts.

Secondly, we must understand the fundamental roles played by refugee women and other women in crisis situations, not just in keeping children alive and healthy, but in giving direction to the entire affected community. Focus on women, by taking their lead and backing it, is a crucial entry point for our support for communities in crisis.

Thirdly, the Mozambican people, whose dignity remained intact despite the hardships which threatened to destroy it, have been an example to the international community of that indomitable human spirit which gives rise to our declarations of human rights. By so doing they remind us that it is the dynamic human spirit which is the starting point, not the declarations. We must therefore avoid being so stunned by the eloquence of our words that we become deaf to the softer voices of the affected communities, who may even be trying to tell us that sometimes we are a part of the barrier against which they are struggling.

Shirley DeWolf is Refugee Services Coordinator for the indigenous Zimbabwean organisation, Christian Care, the community service branch of the Zimbabwean churches.

This article is abstracted from a paper given at the South Africa Research and Documentation Centre Seminar on Human Rights and Justice, held in Harare, August 1995.

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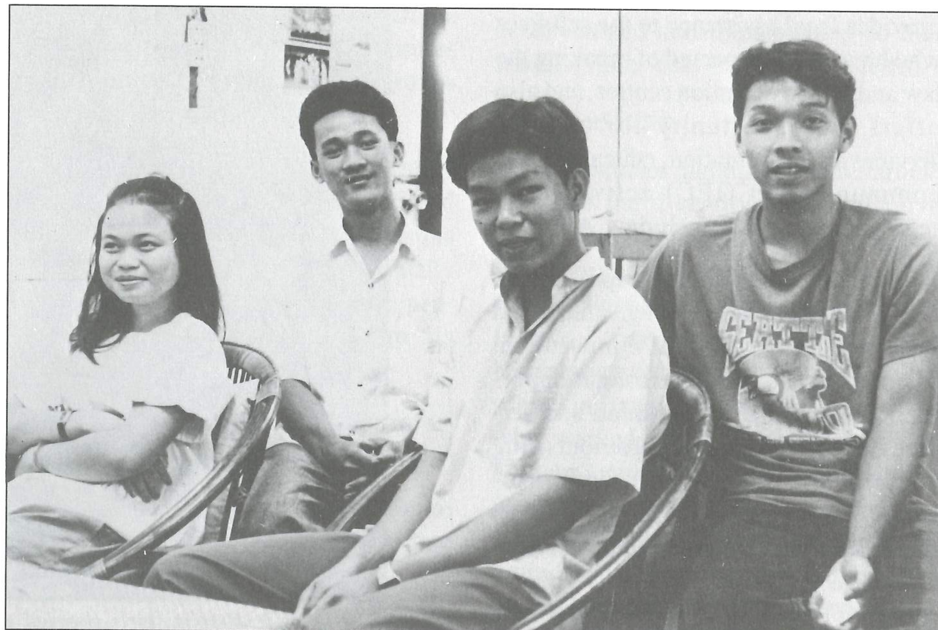
The reproductive health needs of adolescent refugees

by Cindy Waszak and Beverly Tucker

Providing reproductive health services to adolescents, especially services that acknowledge sexual activity among those who are unmarried, is often controversial. For adolescents living as refugees, the provision of any type of reproductive health services may be viewed as a luxury in comparison to immediate needs such as shelter, food, water, emergency health care, and physical security. Yet, the refugee situation itself creates an instability in the sexual and reproductive development of teenagers, which can have severe, even life-threatening, consequences.



These adolescents came from Vietnam and Cambodia as unaccompanied minors. At the time of this photograph, having lived in the camp for several years and now aged 17-19, they were working for UNHCR as translators and office staff.

The removal of adolescents from their homeland culture, and the uncertainties of their present lives, can cause confusion about sexual behaviour. This confusion may lead to activities that place the adolescent at serious risk for sexually transmitted diseases (STDs), unintended pregnancy, unsafe abortion, sexual and gender violence, or pregnancy-related morbidity and mortality. The precarious economic situation of most refugees also increases the chances that adolescents will engage in prostitution as a way of feeding themselves or their families. Adolescents, who typically lack experience and knowledge about how to gain access to family planning services in their home communities, may find access to these services even more limited in a refugee setting, where reproductive health programmes (if they exist at all) are often devoted to the care of pregnant women, or women with young children.

This paper presents two case studies of adolescent refugees now living in Thailand. One study explores the need for services to prevent sexually transmitted diseases, including AIDS, among young men. The second examines the need for pregnancy care, family planning services, and sexuality education among two groups of young women. Both case studies illustrate the fact that the reproductive health needs of adolescents are diverse. The second case study also suggests that the cultural norms of the refugees' homeland can influence their current sexual behaviour. The key conclusion of the report is therefore that it is essential to conduct an initial assessment of adolescents' reproductive health needs on which to base the design of programmes and the delivery of services.

Case study 1: the reproductive health needs of young men at the centre for non-Indochinese, Bangkok

During the past decade, thousands of students, almost all male, have fled Burma (Myanmar) across the Thai border. Many of these young men eventually moved to Bangkok to live without the benefit of legal status or access to official government services. The boredom and the loneliness of living without family and friends often leads to drug abuse and sexual activity with prostitutes, placing these young men at high risk for contracting STDs.

To help these young men survive in their new country, the United Nations High Commissioner for Refugees (UNHCR) offers a variety of social and educational services at the Centre for non-Indochinese, and young male refugees from Burma comprise more than three-quarters of the clients enrolled in this programme. Drug use is a major problem among these young men with more than 10% of them having drug problems and nearly 25% of those with drug problems being heroin addicts. The common sharing of needles among the drug users puts them at risk for AIDS, whilst a second risk factor among this population is sexual activity with prostitutes. Little is known about their use of condoms to prevent STDs, but it is likely that condom use is low.

RHC activities

Given the risk behaviours of this group, staff at the Centre for non-Indochinese have developed several strategies for the delivery of AIDS-prevention messages. One is the provision of AIDS education at the English language school, which is conducted in a separate building but affiliated with the Centre. Many teachers at this school are themselves Burmese refugees who are in the process of

repatriation to other countries. This work provides a connection to the larger community that can potentially lower risk factors for HIV infection and drug use.

In addition to education, the Centre provides legal assistance to the refugees who have been suspected of breaking the law and sent to detention centres, and also offers the opportunity for medical services and information, education, and communication (IEC) activities on reproductive health, including AIDS.

In summary, the primary reproductive health need of these young, unmarried male refugees is STD/HIV prevention. The Centre has therefore sought opportunities to provide information and services to reduce high-risk behaviour (drug abuse and unprotected sex with prostitutes) through their clinic and through their educational, mental health and legal activities.

Case study 2: Hmong 'girls married early in their teens and bore children soon afterwards'. Photo: Joe Havely

Case study 2: pregnancy care and sexuality education define the needs of two groups in Camp Panat Kikhom

This UNHCR camp, located a 90-minute drive from Bangkok, has housed as many as 20,000 Vietnamese and Laotian refugees at one time. In February of 1995, when site visits were made, its residents numbered about 3,000 as the camp prepared to close in June 1995. Two distinct cultural groups have inhabited the camp over its 20-year history: i) the Hmong from Laos, and ii) the lowland Laotians and Vietnamese. The differing characteristics of these two groups had striking implications for the types of reproductive health care needed by adolescents. Service delivery for the two groups was often separate and was usually provided by different NGOs.

The Hmong group

The Hmong were characterised as more traditionally patriarchal and less educated than their Vietnamese peers. Polygamy was practised and girls married early in their teens and bore children soon afterwards. Fertility was higher among this group and women were usually unwilling to make family planning decisions without the permission of their husbands. Family planning counselling and services were thus typically provided as part of pre-natal and post-partum care and husbands were usually present. The reproductive health needs of adolescents focused primarily on safe pregnancy care. Most women did not practice family planning until after they had achieved their desired family size.

Because of the longevity of the camp, many of the Hmong teenagers had been born in camps and knew little of life outside and much of the 'clan culture' of the Hmong had been maintained inside the camp. Domestic violence was tolerated among this culture, and service providers expressed concern about the difficulty of dealing with this problem. Physical abuse noted by the health workers could be referred to social workers for further investigation.

The Vietnamese and Laotian group

During the site visit, a discussion was held with a group of Vietnamese and Laotian teenagers ranging from 17 to 20 years of age. The discussion revealed that the adolescents in the Vietnamese group were more likely to be unmarried than the Hmong group. Often they were unaccompanied minors or minors whose parents were either left behind in the country of origin or who had moved on to a new settlement country. Most of the adolescents' reproductive health needs appeared to be educational. Without a parent close by, there were no traditional sources of sex education. Young people often relied on peers or some of the more trusted service providers for their information on pregnancy and STD prevention. There was some acknowledgment of romantic relationships among the boys and girls in this group, but they seemed relatively inexperienced. The most pressing problems discussed were those having to do with money and resettlement. Mostly, the young people were bored, lonely and unhappy, and they wanted to pursue their new lives, wherever that was going to be.

The service providers acknowledged that among this group there were some difficulties with unintended pregnancies, STD/AIDS and drug abuse, but these did not seem to be overwhelming problems. (Providers had heard of a higher incidence of illicit abortion in other refugee situations.) STD diagnosis and treatment was generally the responsibility of the

International Organization for Migration as part of the testing required for repatriation. Some IEC activities occurred in the refugee camp; these were mostly in the form of posters and signs. These posters motivated adolescents to seek out additional information.

Adolescent reproductive health needs

Recommendations for the development of youth-distinct reproductive health care programmes were identified for these three groups of adolescents in the two programmes studied in Thailand. The health needs of these groups and the implications for programme design are discussed briefly below.

- Burmese male refugees needed prevention and treatment programmes as they were at high risk for STD and AIDS because of their drug use and sex with prostitutes.
- Young Hmong women began married life at an early age and began childbearing soon afterwards. They needed pre-natal care and access to family planning services.
- Unaccompanied Vietnamese and lowland Laotian adolescents needed information about sex, pregnancy prevention, and STD prevention.

Needs assessment

The differences among these three groups illustrate that programmes for adolescent refugees must take into account cultural norms and current behaviour. A needs assessment is therefore an important part of designing reproductive health programmes for adolescent refugees.

The following criteria are suggested for conducting an assessment to determine reproductive health priorities for adolescent refugees.

- The assessment should be conducted with the cooperation of members of the refugee population, especially the potential clients (in this case, adolescents).
- The assessment should be conducted at the level at which services will be delivered.
- A person with some experience in adolescent reproductive health programmes and refugee situations should facilitate the assessment.
- Service providers from various NGOs that work with adolescents should be represented. In this way opportunities for collaboration among these groups can be identified.
- Service providers should identify adolescents who are 'natural leaders' and capable of participating in this process. These youth could eventually play a role in developing the programme and communicating its benefits to other refugees.

As part of the needs assessment, information should be gathered regarding:

- cultural norms related to sexual relationships and rites of passage into adulthood;
- current adolescent norms/practices/perceptions/attitudes related to sexuality;
- typical patterns of adult authority over adolescent behaviour within the refugee programme;
- description of services available to adolescents (and those which are restricted) and adolescents' and adults' awareness of availability of services in the camp;
- perceptions of camp service providers about services for adolescents;
- adolescents' perceptions of their own reproductive health needs.

This information can be gathered through records, interviews and focus group discussion and, possibly, through simple survey techniques. The resources needed for these types of data collection will depend on the record-keeping systems in place and the availability of computers for analysis. Once an assessment of available services and current needs has been conducted, service providers and adolescents can consider programme objectives, outline programme goals, and develop strategies to meet those goals.

A needs assessment does not necessarily require that a separate or specific programme for adolescents be established. The assessment can, however, help determine how the unique needs of adolescents can be met within existing programmes. If possible, some type of ongoing review of the programme should be developed and implemented so that modifications may be made as needed.

Conclusions

The case studies highlighted in this article illustrate the diversity of reproductive health needs among adolescent refugees. An important finding during the site visits was the presence of several 'natural leaders' among all groups, former Burmese students teaching at the English school in Bangkok, Vietnamese students who worked for the UNHCR in Panat Nikhom, and teenage Hmong girls who were responsible for the care of children from several families within the compound. These young individuals were potential collaborators in the development of reproductive health services in refugee situations and could play an important role in conducting needs assessments, gathering information, and implementing and evaluating reproductive health programmes. Programmes designed to meet the needs of adolescent refugees can be strengthened by the involvement of adolescents at all phases of development.

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This paper is based on visits made to several refugee programmes in early 1995 to document the needs of adolescents and identify strategies for meeting these needs.

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Controlling STDs/HIV within dynamic refugee settings

by Paula Nersesian and Bill Brady

Reproductive health services have typically been categorised as maternal and child health and family planning services. Only recently has the importance of including sexually transmitted diseases (STDs) on the list of reproductive health services been realised. As the linkage between STDs and human immune deficiency syndrome (HIV) infection becomes stronger, more attention is becoming focused on STDs. Control and prevention programmes for STDs/HIV are feasible to implement in refugee settings when the timing and available resources are carefully considered during programme planning. This article will present some basic information about STDs and HIV and will discuss some of the issues surrounding the implementation of STD/HIV control and prevention programmes in refugee settings.

Collectively, there are over 25 different bacteria, viruses, protozoa and ecto-parasites that comprise the list of STDs. The more classically recognised diseases include bacterial infections: gonorrhea, syphilis, chlamydia and chancroid; and viral infections: HIV, herpes and hepatitis B. Gonorrhea, syphilis, chlamydia and chancroid, four common treatable STDs, rank within the top 25 causes of healthy days of life lost in sub-Saharan Africa, demonstrating that STDs pose a significant health threat. Prevention and control measures are clearly required to slow the growing incidence of acute infection, limit complications and better define their role in facilitating transmission of HIV.

Among the global adult population, the World Health Organization (WHO) estimated in 1995 an incidence of over 333 million curable STDs. The same report also claimed that STDs collectively rank second among diseases for which intervention is possible among women of 15-44 years of age. In addition, WHO estimates that at least 18 million people worldwide have been infected with HIV, the virus which causes AIDS. Little research has been conducted on STDs or HIV in refugee settings and it is therefore more difficult to determine the magnitude of these conditions among refugees. Assessing the potential burden of HIV/STDs in a refugee population is difficult and consideration should be given to the rates of infection in their home country and within the country where they are residing. Review of the data available from country of origin and host country can help in assessing the potential seriousness of this problem in the refugee population, which will assist in determining health intervention priorities.

The consequences of STDs/HIV on individuals

Although STD/HIV rates are comparable in men and women, the major burden of complications and sequelae fall on women and their infants. Fifty to eighty percent of women with gonorrhea and chlamydia are asymptomatic and do not seek treatment. An undiagnosed case can result in long-term damage from pelvic inflammatory disease (PID), infertility or ectopic pregnancy. In fact, 80% of infertility in Africa is attributable to STDs. Untreated STDs in pregnant women affect both the woman and her child. STD complications in pregnancy include: prematurity, stillbirth, spontaneous abortion, chorioamnionitis, premature rupture of membranes, pre-term delivery and post-partum endometritis.

The consequences of HIV infection are even more devastating as there remains no cure for AIDS and the disease ultimately results in loss of life. In addition, an effective vaccine to prevent infection is not yet available and babies born to HIV-infected mothers have a 30 to 50% risk of being infected and dying in early infancy. Infection with one of the ulcerative STDs, including syphilis, herpes, chancroid and others which cause inflammation of tissues, facilitates transmission of HIV in both men and women. In many parts of the world, HIV transmission via blood transfusion has become rare, largely due to quick, easy and effective screening tests, but screening blood in some settings, such as refugee camps, may be difficult, at least early in the development of the emergency response.

Factors that place a refugee at risk for STDs/HIV

STDs/HIV spread more rapidly in conditions of poverty, powerlessness and social instability - conditions at their extremes during refugee emergencies. Refugees have few resources to protect themselves and a desire to be well-informed or well-intentioned does not necessarily offer them protection. This situation makes the refugee population particularly vulnerable to STDs/HIV.

Other factors that can enhance the rapid spread of STDs and HIV in a refugee setting could include any or all of the following points.

- War and strife place women and children at an increased risk of violence, including rape. Displaced women and girls are vulnerable to sexual abuse at every stage of their flight and some may find themselves coerced into sex to gain access to basic needs such as food and water.
- Family and community values may disintegrate, forcing the break-up of stable relationships and the loss of support networks.
- Experience from refugee camps shows that youth with too few activities to occupy their time, coupled with the uncertainty of their futures and lack of parental supervision, tend to become sexually active at a younger age.

Organisations

Palestinian Independent Commission for Citizen Rights

At the last meeting of the Board of the Palestinian Independent Commission for Citizen Rights (PICCR), Dr Eyad El Sarraj, Director of the Gaza Community Mental Health Programme and former RSP Visiting Research Fellow, was elected Commissioner General to succeed Dr Hanan Ashrawi.

The PICCR was set up by a legal presidential decree to act as an ombudsman, following the Oslo Accord between Israel and the PLO. Dr El Sarraj assumed this position on 15 August 1995. He will divide his time equally between the Gaza Community Mental Health Programme and the Palestinian Independent Commission for Citizen Rights.

Society of Afghan Residents in the UK

The Society of Afghan Residents in the UK (SAR) provides advice to Afghan refugees on immigration and welfare issues, the law, education, health and housing. It also organises social and cultural events, women's groups, religious services and publications for the Afghan community.

SAR was founded in 1982 and has now grown into an organisation serving over 30,000 Afghans in the UK. It is the sole representative body for the Afghan people in exile and through its sister organisation, Afghan Action Committee International, represents the Afghan diaspora throughout the world.

For further information, contact:
Society of Afghans Resident in UK, West Acton Community Centre, Churchill Gardens, West Acton, London W3 0JN.

Organisation for Aid to Refugees, Slovak Republic

The Organisation for Aid to Refugees (OPU) is an NGO established in 1994 to assist refugees, asylum seekers and repatriants. OPU Slovakia concentrates its activities on: social, psychological and legal services and counselling; the improvement of living conditions for refugees in humanitarian centres; and organising educational and employment programmes for the displaced. In conjunction with UNHCR, it has organised a major 'qualification or requalification' programme for refugees from the former Czechoslovakia.

For further information, contact:
Organisation for Aid to Refugees (OPU), Staromestská 6, 811 01 Bratislava, Slovak Republic   Tel/Fax: 0042 7 312869.

Spanish Commission for the Aid of Refugees

The Spanish Commission for the Aid of Refugees (CEAR) was founded in 1979 and is a non-governmental organisation concerned principally with assisting refugees in Spain. Last year there were 12,000 registered asylum seekers in Spain, of which CEAR managed to help 5,000 in some way.

CEAR is involved in six areas of activity: legal advice to refugees in Spain; programmes encouraging the social integration of refugees; campaigning work; management of volunteer programmes; projects in developing countries; and a documentation centre. CEAR is keen to encourage correspondence with other organisations working with refugees and is happy to answer requests, or receive information, on any of its main areas of work.

For further information contact:
CEAR, Avenida General Peron, 32, 2 drcha, 28020, Madrid, Spain,
e-mail: cear@ran.es.

E-mail networks

FORCED MIGRATION

RSP has initiated a discussion network entitled 'Forced-Migration' with the aim of encouraging greater exchange of information and promoting discussion on refugee and forced migration issues. The aims of the group are as follows:

- *To increase understanding of the causes, consequences and experiences of forced migration worldwide.*
- *To exchange information concerning ongoing research around the world.*
- *To inform the members of teaching and training opportunities.*
- *To inform the members of forthcoming conferences and other academic events.*
- *To provide the members with up-to-date information on refugee crises in their respective countries.*
- *To link academics from a wide variety of disciplines.*

If you have an E-mail address and you would like to join our discussion group, follow these instructions:

1. Send a message to:

mailbase@mailbase
- for JANET users in UK

mailbase@mailbase.ac.uk
- for overseas users

2. In the text of the message, and not in the subject field, type the following:

Join forced-migration first name last name
(Eg: Join forced-migration John Smith)

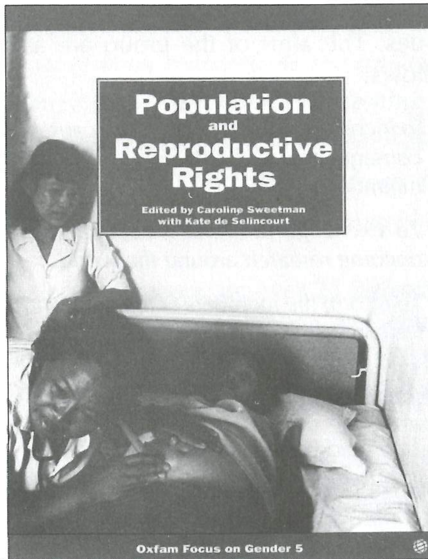
RSP and RPN on e-mail

Information about RSP and abstracts/full text of RPN articles are now available on e-mail. You can access them either via RSP's Forced Migration discussion network or via the RSP World Wide Web pages on:

http://www/ox.ac.uk/depts/rspnet

Book reviews

Gender and development (*formerly known as* Focus on gender) is an Oxfam journal which concentrates on international gender and development issues. Each issue carries its own theme. The two books in this series reviewed on this page are available from *Oxfam Publishing, 274 Banbury Road,*



Edited by Caroline Sweetman and Kate de Selincourt. 1994. 64pp. ISBN 0 85598 278 0. £7.95.

Population and reproductive rights

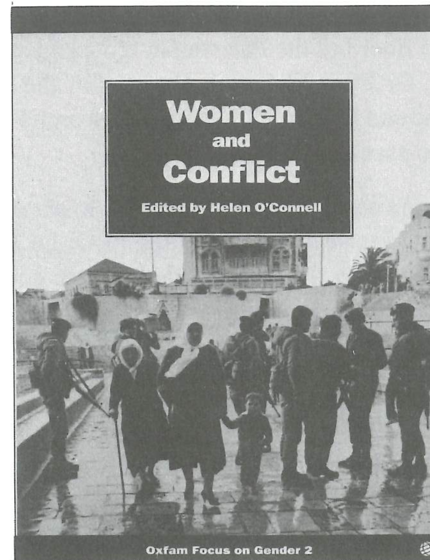
Growing concern for the environment has put the population question at the forefront of the development debate. In this edition of the 'Focus on Gender' series, Oxfam outlines its growing fear that a simplistic approach to environmental degradation, based on the idea of 'too many mouths to feed', might overlook women's rights in population control. The articles and case studies of this edition address the real complexities in linking the issues of population growth, the environment and sustainable livelihood, and advocate the reproductive rights and women's empowerment approach in family planning and reproductive health care.

The book reviews a wide range of subjects such as the role of women's health in contraceptive policies. It stresses the need for new technologies and an understanding of women's sexuality in cultural contexts from a dynamic perspective.

The editors look at maternal mortality as a consequence of illegal, unsafe abortion practices and analyse this question on the grounds of human rights. In a disturbing account of women's conditions in South Africa, Sue Armstrong discusses rape as a male assertion of power over women.

This excellent collection of articles and related information promotes an integrative approach to the population question in which fertility and contraception are strongly influenced by 'cultural and economic pressures and women's position in society'. As with the other books in this series, it includes book reviews and a further reading list as well as a list of organisations working in the field of population and women's health.

Reviewer: Juliette de Rivero, Visiting Study Fellow, Refugee Studies Programme.



Edited by Helen O'Connell. 1993. 66pp. ISBN 0 85598 222 5. £7.95.

Women and Conflict

This series of brief papers presents issues faced by women during and after conflict situations, and extends its coverage to include development projects. Many of the papers are excerpts from larger pieces, highlighting the under-reported plight of women in conflict and development situations and the programmes that are and should be implemented to address them.

Many of the articles argue that physically, socially, politically, and legally, women all too often find they are defenceless before oppression and violence. Widows in El Quiche, Guatemala, are threatened with sexual violence and even death when they seek out human rights organisations after a series of tragic massacres. Nelia Sancho-Liao tells how decreased rural resources and increased urban development force the women of Asia into prostitution, serving US servicemen and a tourist industry also offering the sexual services of some 800,000 Thai child prostitutes. And in a chilling series of personal accounts, Jo Fisher exposes Northern legal systems' ignorance of the violent coercion experienced by Colombian women 'drug runners'.

Other articles admonish planners and practitioners alike for turning a blind eye to the need for involving women in development schemes. Unrest and in-fighting ensue when women are excluded from water distribution planning at a refugee camp. In contrast, in the eastern Sri Lankan resettlement programmes where refugee women are active in all the planning processes, the projects flourish. Women are not the helpless victims depicted by the aid community, as the women of Chad demonstrate in the control of their economic destinies following civil war.

Women and conflict is directed to researchers, aid agencies, practitioners, and policy-makers alike. The wide ranging content provides compelling justification for further work into the topics raised. If a shortcoming is to be found, it is that this publication focuses on the study of women's rather than gender issues; gender interaction and even the unique role of male concerns can and should be addressed.

Reviewer: Sarah Carlson, Visiting Study Fellow, Refugee Studies Programme.

Health education programmes, like this one in Julius Nyerere village, Mozambique, should also be made available to refugee communities. Photo: © Chris Johnson.

• People are cut off from their normal sources of income which may drive them to adopt a survival strategy including selling sex for money or basic resources.

• Forced migration of rural community dwellers (with lower rates of STDs/HIV and associated lower risk of acquiring infections) to areas of high population density exposes refugees to people from a variety of backgrounds, increasing their potential for exposure and risk.

Timing of STD/HIV control and prevention

The first responsibility of responders in an emergency situation is to assist those at risk of imminent death from starvation, injury, exposure and disease. Comprehensive primary health care services are typically established later in the emergency, as the situation stabilises and more resources become available. Although control and/or prevention of STDs and HIV may not be a *prominent* feature in each stage of the emergency it should be acted upon *appropriately* at each point in the development of the emergency response, depending on the needs of the refugee population.

Until recently, STD/HIV control and prevention has not been seen as a high priority in refugee settings - particularly in the early phase of an emergency - because it is not an immediate threat to life. However, the recent diaspora of more than two million Rwandans pouring over their borders into neighbouring Zaire, Tanzania and Burundi forced a change in attitude by many of the national and international relief agencies. Never before had there been an emergency of such magnitude in a country with such a high HIV prevalence. It soon became clear that HIV control, at a minimum, must fit into the response equation during the emergency.

In the acute phase of an emergency, STD/HIV interventions typically remain a relatively low priority but some interventions should be implemented to help prevent HIV transmission, including: protection of women and children from exploitation; ensuring safe blood transfusions; access to condoms on demand; and availability of standard materials and equipment to ensure universal precautions (to protect against exposure to blood and body fluids) for health workers who care for potentially infected persons.

Stability within refugee camps begins to occur incrementally as essential needs are met and health services are established. Morbidity and mortality trends change as the relief effort progresses to stabilisation, allowing national and international relief agencies to shift their attention to other health issues such as STDs. Strategies to contain the HIV epidemic should continue in this phase and additional strategies should include the control of other STDs and implementation of behaviour modification interventions to help decrease high-risk behaviours that facilitate the spread of STDs/HIV.

Building effective STD control and prevention programmes

In general, the four objectives of an effective STD/HIV control and prevention programme are:

- to cure infections;
- to prevent further spread of the diseases;
- to prevent complications and sequelae resulting from the diseases, particularly among women and children; and
- to reduce transmission of HIV.

The WHO model of STD/HIV control and prevention recommends a comprehensive approach including components which encourage:

- the promotion of safer sexual behaviour;
- the widespread availability of affordable condoms;
- the integration of STD care into basic health care facilities;

- good quality case management of STDs including use of appropriate drugs, education and counselling;
- the provision of effective treatment for sexual contacts and availability of condoms for sexual partners;
- the promotion of early entry into the health care system for people with STDs and their partners;
- screening, when possible, for asymptomatic STDs, such as syphilis, during pregnancy.

Incorporating the above components into an STD control programme in a refugee setting can be particularly challenging. Some of the barriers to effective implementation include: limited or absent laboratory services; limited training of health personnel in STD management; inadequate supplies; and lack of appropriate examination areas. Furthermore, the stigma attached to STDs serves as a deterrent to care-seeking behaviour even in refugee settings that have stabilised and have well-established health facilities. One advantage, however, is the availability of well-trained persons due to widespread unemployment in refugee settings. These valuable human resources can be identified and trained in STD/HIV control and prevention to enhance their existing skills so they can participate in the effort to control STDs.

Making the diagnosis

STD diagnosis in a refugee setting can be complicated, but it is possible to manage using several approaches:

- clinical approach without laboratory services;
- clinical approach with laboratory services;
- syndromic management of STDs using treatment algorithms.

Clinical approach without laboratory services It is not uncommon for clinicians to make clinical diagnosis of patients who present with symptoms but have no laboratory services available to confirm their diagnosis. In this case, the health professionals or lay workers rely entirely on their clinical skills to recognise the characteristic signs and symptoms of various STD infections. An obvious limitation to this approach is that the clinician can miss non-classic presentations and concurrent infections. In addition, many infections are asymptomatic - for example, 50 to 80% of gonorrhea and chlamydia infections are without symptoms. This leads to an inability to detect the infection at all when the clinical approach is used alone.

Clinical approach with laboratory services When laboratory services are added to an STD control programme, the likelihood of more effective diagnosis is achieved since today's diagnostic tests for STDs are both sensitive - allowing identification of a patient with an STD - and specific - allowing identification of the type of infection. However, barriers can make diagnostic tests impractical for use in refugee settings: for example, the cost of the tests and equipment; the high level of skill required to perform the tests properly; and a lag time until definitive diagnosis is available, which could lead to a lost opportunity for treatment at the first patient encounter.

Diagnostic tests with the following characteristics may help overcome these barriers. Tests which:

- require minimal training for use;
- require no laboratory equipment;
- are inexpensive;
- are stable in extreme climates with long shelf life;
- are rapid to administer and interpret;
- require specimens that can be collected on the first treatment encounter.

Syndromic management Given the constraints of the methods available for STD diagnosis, a syndrome-based approach to STD management has been promoted in many developing countries. Syndromic management is based on the identification of common symptoms that can be associated with a group of organisms associated with the symptoms. Each syndrome is then treated with single or multiple drug regimens for specific groups of organisms. In order to improve the specificity of the method, common risk factors are identified by conducting a physical assessment and by taking a health history.

The common syndromes included in the WHO Sexually Transmitted Disease Guidelines with associated management algorithms are: urethritis in men and women; vaginal discharge in women; genital ulcer diseases (GUD); and lower abdominal pain (indicative of pelvic inflammatory disease). These algorithms have been accepted as valid and feasible methods for managing STDs in a variety of resource-poor settings. The algorithm for vaginal discharge has, however, been found to lack sensitivity and specificity and is therefore not well accepted in its current form.

The major limitation of syndromic case management is the inability to differentiate specific infections within broad syndromes. This inevitably results in over-treatment with relatively expensive and often inappropriate drugs. This in turn can contribute to the development of drug specific resistance and the inability to identify persons with asymptomatic infection.

The usefulness of the syndromic approach in STD/HIV management was recently reported in the medical journal, *The Lancet*. A community-based project carried out in Mwansa, Tanzania to control rapid spread of HIV demonstrated that by managing symptomatic STDs in primary health clinics using syndromic management protocols, a 42% decrease was noted in HIV incidence rate. The findings demonstrate that this diagnostic method is not only useful for STD management but for HIV control as well.

The clinical approach - with or without laboratory services - and the syndromic management of STDs using treatment algorithms must be examined for their usefulness in relation to the prevailing circumstances. The diagnostic method used will be contingent on the setting and resources available, so that one approach may be used alone or a combination of approaches may be used.

Managing the problems

An additional issue to consider for effective STD management is the importance of having the right drugs to treat the right

infection at the right time, which is during the first patient encounter. This situation requires an effective logistics system that is linked to the medical surveillance system. Coordination of these entities helps to ensure that the correct quantities of the most appropriate drugs are procured, distributed and stored properly to support the health system.

A biological obstacle to effective STD treatment is the development of drug resistance, since some STD-causing organisms have the ability to become resistant to the most commonly prescribed medications. Constant use of one drug over time to treat specific infections - such as gonorrhea and chancroid - and misuse of antibiotics - for example, not taking a complete course of medicine - often leads to pathogen mutation and adaptability. Limited resources are wasted and continued transmission of the drug resistant pathogen within the community results. STD programme managers must use care and caution when selecting drugs for their programmes. National guidelines for STD treatment can be used to guide their decisions if available.

Another important consideration is coordination of activities and the establishment of functional management and supervision systems. Clear roles and responsibilities of staff members should be identified to avoid confusion and to facilitate efficient service provision. In addition, it may be necessary to identify a group to coordinate intra-sectoral groups responsible for surveillance, supply, clinical training and monitoring/ evaluation so that their combined functions serve to address the STD/HIV control and prevention needs of the population.

Closing remarks

Although the challenges to STD control in refugee settings are numerous and appear insurmountable at times, efforts to control STDs/HIV need continued attention throughout the refugee emergency. Successful approaches to STD/ HIV control exist and can be tailored to refugee settings. The approaches need to be adjusted and augmented as the camp conditions change. The timing of interventions, resources available and the condition of the population must be taken into account throughout the crisis so that interventions are planned and implemented appropriately. The HIV pandemic continues to have grave effects on societies globally and is here to stay for decades ahead. STD/HIV control and prevention are central themes in reproductive health and must be considered essential when delivering health services. Hence, a conscientious effort to control STDs/HIV will contribute significantly to the reproductive health status of refugee populations.

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The full text of this article is available from: Paula Nersesian, JSI, 1616 N. Fort Myer Drive, 11th Floor, Arlington, VA 22209, USA.

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The Refugee Studies Programme Series on Refugees and Forced Migration Studies

The Refugee Studies Programme, Queen Elizabeth House, University of Oxford, in collaboration with Berghahn Books, publishes a series of titles on issues related to the study of refugees and forced migration. The series reflects the multidisciplinary nature of the field and includes within its scope international law, anthropology, medicine, geography, geopolitics, sociology, psychology, and economics. It includes original works, conference papers, edited volumes and new editions of classic works in the field.

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The Beijing 'Platform for Action' - implications for refugee women

by Alison Farrell

The Beijing 'Platform for Action' was agreed at the United Nations 4th World Conference on Women on 15 September 1995.

Condensed into 365 paragraphs over 175 pages, this document attempts to encompass the experience of women throughout the world whilst also setting an agenda for their equality. Although it emerged from an international consensus the document is not, however, legally binding in international law. In common with the Beijing Declaration, the Platform for Action lacks creativity and ease of comprehension; however, both do signal a shift in how the international community frames its analysis of the world. Beijing represents a definite, if limited, move towards a human rights framework.

'Refugee women, other displaced women who need international protection and internally displaced women' form the focal point of the Beijing Platform for Action under the sub-section on 'armed conflict'. This section links peace with development and equality between men and women. It also identifies the human rights abuses that often accompany armed conflict. Among other actions it calls for the ratification of international instruments on the protection of women and children in armed conflicts, and the protection, assistance and training of refugee and displaced women.

Rape as a war crime

One particular gain in the Platform for Action which should have implications for international, national and NGO policy with regard to refugee women is the recognition of rape as a war crime. This came in response to calls by NGOs attending the Conference for recognition of the need to use gender as a criterion when granting asylum, in considering the specific impact that armed conflict and war have on women.

Equal treatment in the granting of asylum

The Conference recognised that women often experience difficulty in gaining refugee status when their claims for asylum are based on issues of sexual violence and other gender-related persecution. Under 'actions to be taken', the text stresses that women and men should be treated equally when granting asylum, but it also evokes the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, including persecution involving sexual or other gender-related violence.

Sexual violence and implications on training

The delegates of the Conference have sent a clear message to agencies and host countries regarding issues of violence against women, the use of sexual violence in situations of conflict, and the need to address sexual violence, to ensure bodily integrity of refugee women. This includes the need for the training of personnel working in refugee situations to enable them to provide psychosocial support and related health care services for victims of gender-related violence.

When it comes to implementation, the language used in the document may have far-reaching implications as far as its interpretation by UN agencies and national governments is concerned. One of the most hotly debated issues was the terminology to be adopted when referring to refugee and displaced women - the question being whether internally displaced women would be given specific mention. As the document stands (the initial, unedited version), the categories given are 'refugee women', 'other displaced women in need of international protection' and 'internally displaced women'.

The question of resources

In a context of falling aid budgets and growing disaffection with the United Nations, the question of funding the implementation of the Platform for Action becomes a major issue. The document calls for a greater sharing of the burden that large populations of refugees, other displaced people and the internally displaced inflict on host countries. The resource agreement, hammered out at the last minute, causes concern on several counts. It acknowledges that new, additional funds are required in order to implement the actions to be taken. It calls for new sources of funding - particularly from the private sector - but does not identify who or what these institutions might be. Some Northern governments have clearly stated that they understand the new and additional funding to be emanating from private sources. Moreover, international financial institutions such as the World Bank and the International Monetary Fund have not been fully drawn into the resourcing equation.

With regard to funding for emergency situations, the Platform calls on the international community and its affiliated organisations to ensure the provision of financial and other resources for emergency relief and other longer term assistance. However the Conference did not set targets for such assistance - an overarching omission throughout the Platform for Action.

Outcome of the NGO Forum

The NGO Forum, which preceded the official Conference, saw thousands of women from across the world come together to debate along thematic and regional lines the issues which the Conference would cover. The World Food Programme also held a workshop on women and food aid. The main conclusion reached by the panellists - a combination of UN representatives, international NGOs, refugee rights organisations, and Conference participants - was the overriding necessity for food aid programmes to include women specifically in the planning and distribution of food aid.

Alison Farrell is a Researcher with the Gender Team of Oxfam's Policy Department.

Dinka women and the future of Dinka society

by Jok Madut Jok

Two years ago, Jok Madut Jok returned to his home country of Sudan to conduct research after a decade abroad. While researching women's reproductive health in southern Sudan he found that the Dinka culture where he grew up had undergone tremendous changes as a consequence of 12 years of civil war.

The shocking aftermath of the war in Sudan, and the response of the people to its upheavals, raised several issues which were of particular interest, including how women were coping with the situation. For when disasters occur, women are almost always the most affected group.

While conducting fieldwork in a village in northern Bahr El Ghazal region, in south west Sudan, I encountered many behavioural patterns which were disturbing. I found that when I asked a group of displaced women where the fathers of their children were the answers were invariably: i) the father has gone to the north to look for food and never come back; or ii) the father is a soldier and has been away for ten years; or iii) the father was killed four years ago; or iv) my children were fathered by the cousin of my deceased husband; or v) because my husband has been away since he joined the rebellion, his family advised me to have children with his younger brother on behalf of my husband.

Some of these answers would be unclear to an outsider, especially when the husband has been away for ten years and the woman is breast feeding a two year old. To those who are not familiar with Dinka culture, a situation like this may suggest adultery on the part of the woman. For someone like myself, the first thing that comes to mind is the Dinka system of having the woman bear children with a relative of the deceased or absent husband. However, the situation involves both.

But when I asked men what they have to say about the conditions of those women who sleep under trees in the rain, with small malnourished children in their arms, the answer was always that it was the fault of the victim. According to these men, the reason why those women are suffering is that they lead their lives in discordance with the cultural norms and values of their society. So what norms and values have these woman violated which render them 'bad' women in the eyes of Dinka men?

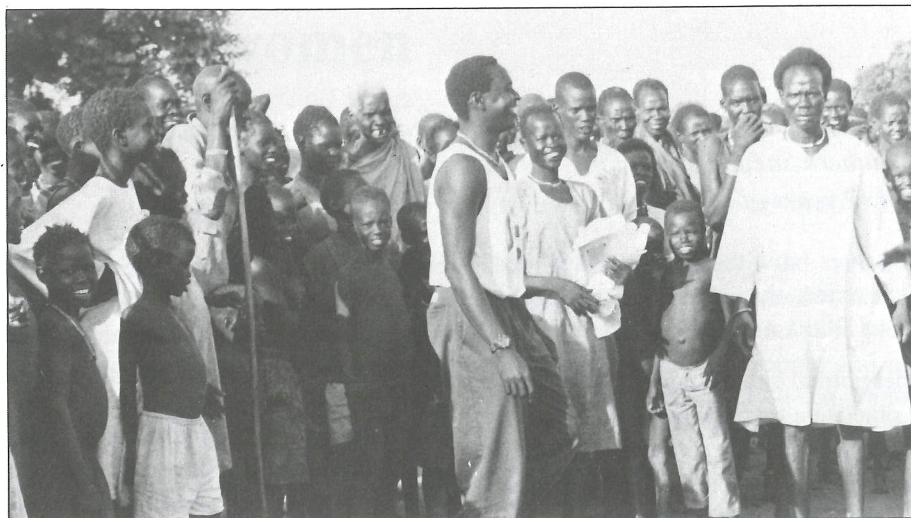
Under normal circumstances, Dinka people practise a tradition which allows for a family to maintain its name from generation to generation through what has been described as 'ghost marriage'. The tradition of ghost marriage requires that when a man dies or absents himself from home for too long, the family takes upon itself the responsibility to ensure that his name, and thus the name of his lineage, is kept up. If he was married but did not have children, his wife has to be 'levirated' by a younger relative, most preferably a brother. The Dinka institution of the levirate compels the woman and the family to find a suitable man to remarry her for the sole purpose of producing children. First cousins become the second most eligible in the absence of brothers. Sons of his older brother are also eligible. This practice is known in the Dinka language as *lahot* - entering the hut.

If the man dies before marrying, the procedure to ensure survival of his family name takes the same line. A woman is married and offered to a brother or relative to bear children in the name of the deceased. Likewise, in the case of infertility the man offers his wife/wives to his relative, be he a brother or a cousin. If the infertile man is elderly with many wives, some of whom may have adult children, this patriarch gives his younger wives to his sons in order to have children in his name. The offspring from this arrangement are basically the brothers of their biological fathers.

Dinka people believe that it is this system which has seen them through crises. It keeps the network between families strong and it strengthens political relationships with other groups. The system is normally kept intact through a strong local economy which is based on four pillars: cattle, agriculture, trade and fishing. The economy has, however, been compromised by frequent raids from government militia and the neighbouring Nuer; natural disasters have exacerbated what were already fragile economic and social conditions. The rules which governed family ties and support mechanisms have now given way to loose social networks and weak support systems amongst the Dinka.

As a result, many women with absent husbands have had to survive with little help from their communities. When a woman fails to comply with the traditional system of reproduction due to economic reasons, such as the failure of the man who fathers her children to provide for them, she is pressured into displacement. The conditions in displaced persons camps are often so bad that the woman may be pressured into what one may call forced prostitution - a situation in which a man with access to food uses this to force women into sexual relationships. When this contact results in pregnancy, the woman does not have relatives in the displaced camps to turn to for help. Her absent husband's family are not interested in anything but cows which they will receive from the adulterous man - adultery being punishable by the forfeit of seven cows - to be paid to the woman's absent husband. Her own relatives will invariably regard the situation as having brought disgrace to their family.

The other development which has brought changes in Dinka culture is the influx of relief agencies into the area. This has elicited different attitudes toward foreigners because the perceived powers of aid workers have been met with a determination to outwit them. For example, during distribution of the mostly insufficient relief items, individual community representatives provide inflated population figures to try to gain greater access to supplies. Others



The author (centre front) leading a health education session in Akon, southern Sudan.

may try to portray their particular communities as more needy than others. The behaviour of portraying oneself as poor and needy is a direct result of relief aid, because this is something Dinkas try not to show under normal circumstances. As people become poorer they resort to stigmatised behaviours such as begging, doing odd jobs, or lying about their actual conditions. This behaviour is quite demeaning and yet people continue to engage in it because, 'what does it matter in front of foreigners who do not know me personally; it does not take away my dignity if I say to a foreigner that I am poor'. These stage-managed changes in attitude and behaviour slowly make their way into the general culture and will not necessarily disappear when relief workers leave.

The result of these conditions is an increasing loss of self-determination by the people of southern Sudan through dependency on relief, and a gradual loss of cultural patterns which they have used in the past to deal with crisis. As the whole society becomes affected, women are constantly pushed to the bottom. We hear of pastoral economies being the domain of men, but when disaster strikes this economy, women suffer most.

During my stay in the Sudan I learned from 'inside' how relief threatens people's self-reliance. Provision of food relief allows people to count on things whose source they do not know. It encourages destitute families to continue to expect relief instead of trying to produce their own. It breaks down social networks which people previously relied on to take care of themselves. This happens through the targeting mechanisms which are used by relief workers. For example, food items are usually insufficient and are not given to the most needy. This causes animosity between the individuals who receive aid and those who do not, so that when relief stops those who had been receiving cannot then fall back on their communities for help.

It is in this new world - where cattle herders wear World Food Programme T-shirts, where 98% of women are illiterate, where STD/HIV/AIDS awareness is zero, where poverty has consumed the dignity of Dinka people - that most Africans of the Horn live. It is a world which people who concern themselves with equality must try to understand.

Jok Madut Jok is based at the Department of Anthropology at the University of California at Los Angeles. He is currently completing a dissertation entitled 'Culture, war and reproduction in Akon: a case from southern Sudan' for a PhD in Anthropology.

This article first appeared in the Newsletter of the James S Coleman African Studies Centre at UCLA in Spring 1995.

OBITUARY

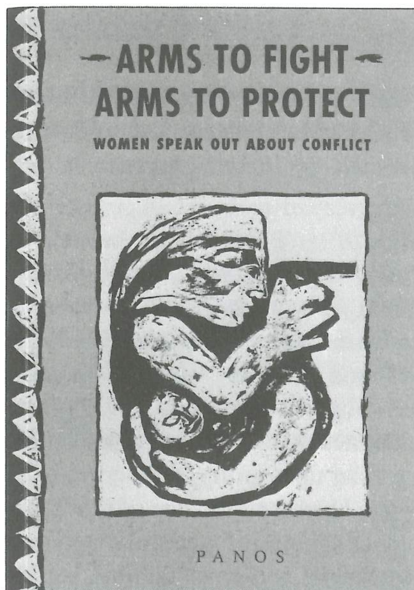
Dr Ahmed Abdel - Wadoud Karadawi

Dr Karadawi, co-founder of the Refugee Studies Programme, born on 19 October 1945, died in Khartoum on 20 November 1995. His life was dedicated to examining the structure of humanitarian assistance and interventions to improve conditions of survival for refugees, not only in his native Sudan, the centre of humanitarian aid experimentation since the 1960s, but throughout Africa. Through his influence on scholars and advocates, he has affected world refugee policy.

He returned to RSP in October, to write and publish a review of the Sudan's experience of refugees. He was satisfied with the way RSP, his 'brain child' had progressed from the time when he took an active role in shaping it.

This news will reach you too late for his Memorial Service, but if you like, please do send a tribute which, with the others, will be forwarded to his family. He is survived by his wife, Selma Mahmoud Maarouf, a son, Jehad and a daughter, Sarah. We have opened a bank account for contributions for them. The account is at Barclay's Bank, Little Clarendon Street, Oxford, 'The Karadawi Family Appeal'. Cheques can be sent c/o RSP.

We also hope to raise funds for an RSP Fellowship in his name. For this to be in pereptuity, it will require funding in the order of UK£500,000 as endowment funds at the University of Oxford yield only 4.5% interest. Annual costs are circa UK£25,000. Such a Fellowship could be earmarked for a Sudanese, for any refugee scholar/practitioner, or for a discipline, eg human rights law - protection of refugees was his major concern. There may be an individual or group of individuals amongst his friends who would want to help us ensure that his contribution to developing this unique institution in Oxford is never forgotten. Those who knew him will be sharing our unspeakable loss.



Edited by Olivia Bennett, Jo Bexley, Kitty Warnock. 1995. ISBN 1 870670 36 1. £10.95. Available from: Panos Publications Ltd, 9 White Lion Street, London N1 9PD.

Arms to fight, arms to protect

In 1993 and 1994 the Panos 'Women and Conflict' oral testimony project collected over 200 interviews from women in Liberia, Somaliland, Ethiopia, Uganda, India, Sri Lanka, Vietnam, El Salvador, Nicaragua, Croatia, Bosnia Herzegovina, and Lebanon.

Arms to fight, arms to protect presents some of these interviews: a compilation of testimonies from women who have been fighters, refugees, victims between the lines, peace activists, mothers and partners of the dead and the disappeared. They talk about their own, very personal experiences and their perceptions of what was - or still is - going on in their countries.

The introduction is a 25-page overview of women's situations in war and war-like situations, and summarises the sexual violence and exploitation that women are commonly subjected to in conflict situations. This is followed by a section outlining how women's status changes and how they adapt their coping strategies in a disrupted social environment. The interviews follow, grouped by country of origin. Each country chapter opens with an introduction to the country and the historical and social background to the conflict situation.

The aim of the 'Women in Conflict project' was to let women speak for themselves. This has definitely been achieved.

Reviewer: Anton Luger, Visiting Study Fellow, Refugee Studies Programme.

RPN readership survey of January 1995: commentary on results

RPN 19 included the preliminary results of a readership survey conducted in January 1995, seeking readers' views on different aspects of the newsletter. By August, 140 out of 2,000 questionnaires had been returned (a response rate of 7%). Below is an updated and fuller commentary on the results. For a copy of the final analysis of results, which also includes readers' suggestions for future themes, please contact the Editor.

Themes: 88% wish to retain the current format of a main theme plus additional articles/reports on other topics. Thanks for all the suggestions of themes; the list will be consulted regularly when deciding future themes.

Articles: 88% are happy with both the length and balance of authorship of articles and 100% are happy with the language level. Fewer (70%) are content with the geographical coverage. In general, readers appear to want more coverage on Asia, Europe and Latin America.

The launch of the Spanish RPN is a major attempt to improve access and participation by Spanish speakers (and increase coverage of Latin American issues). We are also actively trying to include more material on Asia. However, the RPN does depend to a great extent on you, the members, to submit reports, articles, letters, etc, on issues of importance to you and other members of the network.

Regular features: Some 70-85% are happy with the regular sections on book reviews, publications and RSP news. Some 33-38%, however, would like to see more coverage of research findings and conferences. When space allows we will expand these areas.

Presentation: 83-90% are happy with the overall length, use of photos and style/presentation. Those unsatisfied with the length tend to favour a shorter newsletter. We shall be keeping the next three issues at least to our target of 40 pages. We are starting to make use of agencies such as NGOs in order to obtain black and white photos which reproduce better. Several respondents made useful comments on the presentation, reacting favourably to recent changes and offering ideas for further improvement.

Frequency: 50% are satisfied with publication three times a year. However, 38% would prefer it to be more frequent (though not necessarily with fewer pages). The RPN originally aspired to be a quarterly publication but funding did not allow it, and indeed in several of its years of existence it was only published twice because of funding problems. We are proud that it is now published on a regular basis, with only one part-time member of staff to handle the administration, commissioning, editing, desk top publishing and fundraising! The possibility of becoming a quarterly publication would of course mean an expansion of the budget and more fundraising.

Translation of the RPN into other languages Those members who asked, via the questionnaire, to receive the Spanish translation should now be receiving it (probably six to eight weeks after the English RPN). French, Portuguese and Arabic were mentioned most often as useful translation possibilities for the future.

Many thanks to all of you who completed the questionnaire - and for all your appreciative comments!

Publications

Newsletters, journals and papers

Exodo: boletin sobre desplazamiento interno en Colombia (bilingual publication in Spanish and English). This new newsletter is the initiative of several non-governmental organisations that have worked on the issue of internal displacement in Colombia. *Exodo* is a bimonthly publication which discusses situation analysis, regional experiences, research, policy evaluations and current projects in order to see effective solutions and possibilities for the return of displaced people.

Contact: Exodo, A A 25916, Santafe de Bogota, Colombia.

The health exchange is a bi-monthly magazine exploring issues, ideas and practical approaches to health improvement in developing countries. It provides a forum for health workers and others to share viewpoints and experiences in this area.

Subscriptions: £22 standard; £15 for unemployed, students and subscribers from developing countries on local salaries.
Contact: International Health Exchange, Africa Centre, 38 King Street, London WC2E 8JT, UK.

Refugees: refugee women A special edition of UNHCR's Refugee newsletter with particular emphasis on refugee women. The issue highlights the fact that the special needs of women - ranging from rape prevention to the provision of sanitary towels - are all too often overlooked in refugee situations. One major report focuses on a reproductive health programme for Rwandese refugees in Tanzania, targeting everything from safer childbirth to the prevention of sexually transmitted diseases. Other articles look at education and skills training for Afghan women refugees, Guatemalan women standing up for their rights in Mexico, and South East Asian refugees' dependence on the state in Canada.

UNHCR. 1995. ISSN 0252 791 X.
Contact: P O Box 2500, 1211 Geneva 2 Depot, Switzerland.

Refugee survey quarterly: special issue on refugee women. Vol 14 This special edition of *Refugee survey quarterly* commemorates the Fourth World Conference on Women (Beijing, September 1995), bringing together reports, documents, and bibliographic references relating to the challenges which confront refugee and displaced women today. The *country reports* address the situation in China, Pakistan and Russia, while the *documents* section traces policy steps taken during sessions of the Executive Committee of the High Commissioner's Programme with regard to refugee women and to sexual violence against women. This edition also contains a selected *bibliography* on refugee women.

Edited by Sharon Rusu, UNHCR, Centre for Documentation on Refugees, Geneva. Summer 1995. 307pp. ISBN 0253 1445. $10 for single issue. Payment required with order and to be made by cheque payable to the UNHCR.
Contact: Centre for Documentation on Refugees, UNHCR/CDR, Case Postale 2500, 1211 Geneva 2 Depot, Switzerland.

General publications

Challenging myths and claiming power together. A handbook to set up and assess support groups for and with immigrant and refugee women *by Helene Moussa.*

This handbook is a 'tool' developed from the experience of facilitators of support groups of (and for) refugee women in Canada. The book was produced in response to concerns expressed by immigrant and refugee women such as 'how can a support group be helpful to women in my community?', 'how do I start a support group?' and 'what do I do once I get a group of women together?'. The handbook responds to these concerns by providing: guidelines that raise some of the questions to be considered on setting up a group, a description of 10 support groups to illustrate the potential range of models, a selected reading list on violence against refugee and immigrant women, and sources for anti-racist and cross cultural stories for children. It points out that it is not a blueprint to success but will act as a catalyst on readers' own knowledge and experience. The handbook will be useful to refugee and immigrant women, health care and social service staff, and community development workers.

World Council of Churches. November 1994. 170pp.
ISBN 0 920695 04 3. $18.00 plus postage.
Contact: Education Wife Assault, 427 Bloor St, West-Box 7, Toronto, Ontario, M5S 1X7, Canada.

Faith, hope and courage, the great strengths of refugees *by Diana Miserez*

This book paints a broad picture of many situations arising out of revolutions, war, armed conflict and repression. It draws on the author's long experience as a practitioner and describes the work of international agencies in the field. Testimonies from individual refugees are also included.

Adelphi Press.1995.651pp. ISBN 1 85654 918 6.
4-6 Effie Road, London, SW6 1TD

Nutrition guidelines. *Médecins Sans Frontières.*

Nutritional interventions are amongst the most essential components of an emergency relief response, of primary importance in needs assessment, information systems, preventive and curative services and public health measures. In this practical handbook fundamental concepts and principles for assessing nutritional problems are discussed, including the rationale for designing a strategy. Detailed information is given on planning, implementation and evaluation of selective feeding programmes. The methods described are based on MSF field experience. Tables and illustrations ensure that the handbook is practical and easy to use.

First edition 1995. FrF 80 (NGO reduced price).
Contact: Médecins Sans Frontières, Logistique Médicale, 8, rue Saint-sabin, 75544 Paris Cedex 11.

Research findings

List of free materials in reproductive health *Program for International Training in Health (INTRAH)*

The aim of this List is to inform reproductive health professionals, particularly in developing countries, of the large number and variety of materials available free of charge from organisations. The sixth edition contains over 1,200 entries, organised into seven categories: family planning, maternal and child health, primary health care, AIDS, population, development (including environment and development, and women in development), and information sources. Each entry contains a brief description as well as a bibliography and ordering information. Also available in French.

Sixth edition November 1994. 265pp. ISBN 1 881961 12 5.
Contact: INTRAH, The University of North Carolina at Chapel Hill, School of Medicine, 208 N Columbia Street, CB# 8100, Chapel Hill, North Carolina 27514, USA.

Refugee women and reproductive health care: reassessing priorities *by Deidre Wulf, Women's Commission for Refugee Women and Children*

This publication contains the results of a year-long study of availability and feasibility of reproductive health services for refugee women. The initial 'principal report' on general reproductive health needs among refugee women is followed by eight country reports: Liberian refugees in the Côte d'Ivoire, Rwandan refugees in Pakistan, Central American asylum-seekers in Belize, refugees on the Laos and Burma borders of Thailand, Vietnamese refugees in Hong Kong and returning refugees in Cambodia.

June 1994. 77pp. ISBN 0 96377 111 6. Free but US $2 required for shipping/handling.
Contact: WCRWC, c/o IRC, 122 East 42nd Street, New York, NY 10168-1289. Tel: +212 551 3086. Fax: +212 551 3186. E-mail: WCRWC@IRC.COM.

Sexual violence against refugees: guidelines on prevention and response *UNHCR*

Sexual violence against refugees is a global problem. These guidelines provide a primer on when and how sexual violence occurs in the refugee context and its physical, psychological and social effects. This publication highlights the fact that many (perhaps most) incidents of sexual violence remain unreported for reasons which include shame, social stigma and fear of reprisal or that the case may go to trial. The guidelines address ways to combat sexual violence and how to respond when incidents occur. The crucial need for education, training and information campaigns is emphasised, in particular the necessity for refugee women to receive legal awareness training.

March 1995. 65pp.
Contact: UNHCR, Palais des Nations, CH-1211 Geneva 10, Switzerland

Women and violence: realities and responses worldwide *edited by Miranda Davies*

Violence against women is still very much a hidden problem, the scale of which is vastly underestimated. This book highlights the extent of the problem through the experiences and analyses of individual women and groups from over 30 countries.They examine domestic violence and child sexual abuse, sexual harassment in the workplace, rape and torture in war, genital mutilation, and the effects of male violence on women's reproductive health. The authors also consider the extensive activity of grassroots women's organisations worldwide and the efforts to find global solutions. Examples include the introduction of women's police stations in Brazil and Pakistan, strategies to change the law in the USA and Bangladesh and population education projects in Canada, Jamaica and Australia.

Zed Books. 1994. 264pp. ISBN 1 85649 146 3.
Contact: Zed Books, 7 Cynthia Street, London N1 9JF, UK or 165 First Avenue, Atlantic Highlands, New Jersey 07716, USA.

Newly published by the Refugee Studies Programme and the Centre for Socio-Legal Studies, University of Oxford

An analysis of domestic legislation to regulate the activities of local and foreign NGOs in Croatia, Kenya, Rwanda and Uganda

Written by Edward Adiin Yaansah, a member of the English Bar, this book begins a discussion of great significance to the future development of governments of the South and the new 'transition' states of Europe.

Many of these states are dependent on the international aid increasingly channelled through non-governmental organisations (NGOs). This book examines legislation introduced by four governments to regulate the activities of NGOs - both foreign and national - operating within their territories.

Most literature concerning NGOs is written from the agencies' point of view. Few writers have considered the governments' legitimate interest in maintaining control of aid within their countries. Since NGOs tend to assume responsibility for policy-making and to disregard governments' own plans for development, it is understandable that governments have reacted by introducing legislation to regulate NGO activities. Identifying themselves as the voice of 'civil society', foreign and national NGOs have been able to attract funding in many countries which, in some cases, means that their combined budgets are greater than those of the government. As such, NGOs have become a force to be reckoned with. While NGOs and donors expect governments to be accountable and transparent, government attempts to require such transparency and accountability of NGOs are resisted. This book marks a starting point for real dialogue about relationships between governments and NGOs.

Copies available from Refugee Studies Programme.
Price £5.00. To cover costs of postage and packing, please add £1.00 (UK), £2.00 (rest of the world).

Published 15 August 1995. ISBN 0 9512206 3 7

RSP funding

The Ford Foundation has approved a grant of $350,000 over two years to Queen Elizabeth House to support the core activities of the Refugee Studies Programme. This is in addition to $153,500 granted by Ford Thailand, and $75,000 by Ford South East Asia, to enable practitioners and academics from the region to attend RSP's short courses.

Education Unit - Latin American participation

The Education Unit has been awarded a grant of $300,000 over three years from the John D and Catherine T MacArthur Foundation, to provide for a visiting fellowship from Latin America and two bursaries for participation in short courses from that region each year.

The 1995 Fellowship has been awarded to Ms Elsa Ballon Bendezú, an instructor at the Faculty of Social Work of the Pontificia Universidad Catolica del Peru. Ms Bendezú has been coordinating a programme for support to displaced families and has been involved in human rights work with internally displaced. She is interested in, and has written about, displacement due to violence in Peru.

Carla Tamagno Arauco, a Peruvian anthropologist, was the 1995 recipient of the bursary to attend the Summer School. Carla works with internally displaced in Peru, especially children.

News from RSP's links

The Refugee Studies Centre (RSC), University of Dar es Salaam, held an international workshop in Arusha on 'the Refugee Crisis in the Great Lakes Region', with Oxfam's support in August. RSP was represented by its Director, Dr Barbara Harrell-Bond, and Mr Ghaith Al-Omari of Yarmouk University, Jordan. During the conference, Mr Bonaventura Rutinwa, the Coordinator, held a consultative meeting to announce the RSC's re-establishment at the University of Dar es Salaam and to discuss its future. In October, under the staff development programme and funded by the Lutheran World Federation, Mr Rutinwa came to Oxford to spend one year with RSP.

Military conference

RSP organised a conference on the 'Role of the Military in Humanitarian Emergencies', in Oxford from 29-31 October. The aim of the conference was to enable military and civilian actors in humanitarian relief to understand each other's systems and limitations in order to facilitate greater collaboration. Without military support many operations could not take place, but collaboration between NGOs and the military has historically proved difficult; they frequently find themselves working in the same theatres but with separate mandates, distinct experiences, and diverse methods of operating. At the same time a series of inaccurate assumptions about each other often undermines effective collaboration.

The conference gathered over a hundred participants including high-level military officers from NATO countries, government representatives, and leading NGOs and researchers, to debate the elements hindering cooperation and to explore how these can be constructively overcome. A keynote address set the issues in a historical and contemporary context and was followed by sessions on the role of the military in humanitarian emergencies, looking at: coordination and management; infrastructure/relationship with local institutions and governments; protection roles; political roles and training; lessons learned from Somalia, Iraq, Rwanda and Bosnia; and recommendations for the future.

News of RSP fellows

Ms Lejla Somun, RSP Visiting Study Fellow 1994/5, has been appointed by the Department of International Relations, Middle East Technical University, Ankara, Turkey to introduce research and teaching on forced migration, with effect from September.

Four of RSP's 1994/5 Visiting Study Fellows have been accepted as research students by the University of Oxford this year: two will be attached to the School of Geography, one to the Department of Social Anthropology, and one to the Oriental Institute.

Completion of the Weis archive

The personal papers of Dr Paul Weis have now been archived. They comprise 371 items (mainly files) and are available for consultation in the RSP Documentation Centre.

This archive complements Dr Weis's library collection of 932 books and pamphlets also available in the Centre. These are proving to be a useful resource, especially for the period 1950-1980. The archive is a primary source for the life of Paul Weis himself, and for the study of refugee history, politics and law from the Second World War to the 1980s. With material relevant to Jewish studies and to international law in general, this collection is unique among holdings in the United Kingdom.

An online database catalogue for the Weis papers is available in the Documentation Centre, as well as a hard copy version for browsing. This comes complete with a full introduction to, and bibliography of, Weis's publications. Any enquiries can be directed to Sarah Rhodes, RSP's Documentalist.

RSP catalogue on World Wide Web

The recent conversion of RSP's electronic Cardbox catalogue to the World Wide Web has been a significant development for RSP's Documentation Centre. This now allows worldwide access to RSP's 24,500 bibliographic records.

The catalogue can be accessed through the link on the RSP's home pages on http://www.ox.ac.uk/depts/rspnet or through the address assigned to the catalogue, which is http://www.rsl.ox.ac.uk/cgi-bin/rspnew.tcl. The Web catalogue has a user-friendly interface and enables the user to conduct Boolean searches.

Accessions list on e-mail

The quarterly accessions list of new publications is now available via e-mail. Please provide the Documentation Centre with your address for the latest list.

Refugee Studies Programme Courses

The Rights of Refugees under International Law

Professor James Hathaway of the Osgoode Hall Law School

Date: Saturday 18 - Sunday 19 May 1996
Venue: RSP/Queen Elizabeth House, Oxford

This course will focus on the nature of the rights to which refugees are entitled, both in international and domestic legislation, knowledge of which is essential for those who advise refugees. Apart from the prohibition of *refoulement*, the standards that govern the *quality of protection* owed to refugees under international law normally attract little attention. This Workshop on the rights of refugees under international law provides a critical appraisal of those aspects of international human rights law that may be universally invoked by refugees and all other persons.

Fee: £100 (including coffee and lunch, excluding accommodation)

There are a limited number of places.

1996 International Summer School

1-26 July 1996
4-week residential course

The Refugee Studies Programme (RSP) International Summer School offers an opportunity for those who work in humanitarian assistance to study, learn, reflect, and share experience with others.

THE MAIN OBJECTIVE of RSP's International Summer School is to provide a broad theoretical background to the subject of forced migration, humanitarian assistance, and the rehabilitation or reconstruction of social and economic life. In this context, participants can examine, discuss, review and assess the role of aid in practice.

AN UNDERLYING THEME of the course is that the systematic study of humanitarian crises will improve the planning, efficiency and effectiveness of aid programmes. Such study aims to provide an understanding of the experience of forcible displacement in its many aspects - political, legal, cultural, socio-economic, psychological and organisational - through a multi-disciplinary and comparative approach.

RESOURCE PERSONS at RSP courses comprise academics, policy-makers, field-workers with experience and knowledge in the field, from various parts of the world. They include RSP staff, members of governments, non-governmental and inter-governmental organisations.

PARTICIPANTS - the Summer School is specifically designed for experienced managers, administrators and field-workers involved in programmes of assistance and/or policy-making in the humanitarian field.

A VARIETY OF TEACHING METHODS are used including lectures, group discussions, case studies, exercises and private study. This is an intensive course of study requiring full participation throughout.

COST : £1,950 for the four-week Summer School, inclusive of College bed and breakfast accommodation.

There are a limited number of places.

For application forms and further information on all courses, please contact:

The Education Unit
Refugee Studies Programme
Queen Elizabeth House, 21 St Giles
Oxford OX1 3LA, United Kingdom

Tel: +44 (0)1865 270723
Fax: +44 (0)1865 270721
E-mail: RSPNET@VAX.OXFORD.AC.UK

Join the Refugee Participation Network...

THE REFUGEE PARTICIPATION NETWORK is a network of some 2,200 individuals and organisations in 110 countries, bringing together researchers, policy-makers, refugees and those working on the ground with refugees. Members receive the RPN Newsletter which is published three times a year and includes articles and reports, book reviews, letters and updates on publications, forthcoming conferences, etc. Themes are advertised in advance and members are encouraged to contribute.

Membership is free but we urge all of you who can afford it to pay a voluntary subscription of £20 (US$30) a year. A subscription of £40 (US$60) would cover the subscription of someone less able to pay. (If possible, please pay by sterling cheque or draft drawn on a bank in the UK.)

If you would like to join, please complete and return the form below.

Yes, I would like to join the Refugee Participation Network!

I enclose a voluntary contribution of: **£20** ☐ **£40** ☐ **other** ☐

Please make cheques payable to Refugee Studies Programme. Tick if you require a receipt: ☐

Name ____________________ *Job title* ____________________

Organisation ____

Address ____

Town ____________________ *Country* ____________________

Tel ______________ *Fax* ______________ *E-mail* ______________

We produce directories of members to facilitate networking. ***Please tick any of the following that might apply to you:***

1. Organisation

Researcher/academic	RE	____	Inter-government agency	IA	____
Student	ST	____	Government	GT	____
Journalist/media	JQ	____	Trust/foundation	TR	____
Refugee	RG	____	Library/documentation	LI	____
Non-governmental (NGO)	NG	____	Educational institution	EI	____

2. Work

Education	ED	____	Mental health	MH	____
Community development	CD	____	Protection/asylum	PR	____
Income generation	IG	____	Emergency relief	EM	____
Agriculture	AG	____	Camp administration	CA	____
Health and nutrition	HN	____	Resettlement	RS	____
Environmental displacement	ET	____	Development-induced displacement	DD	____

3. Region of work/interest

Africa	AF	____	Middle East	ME	____
Asia	AS	____	North America	NA	____
Europe	EU	____	Pacific	PA	____
Latin America/Caribbean	LA	____	Worldwide	WL	____

***Return form to*: RPN, RSP, QEH, 21 St Giles, Oxford OX1 3LA, UK. Fax: +44 (0)1865 270721**