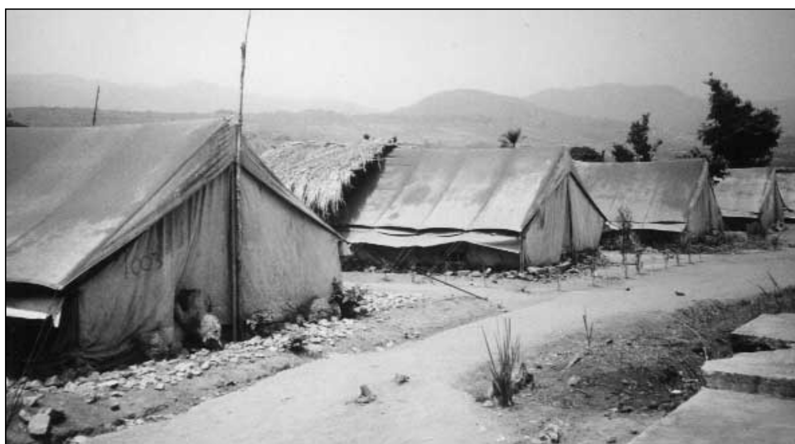
INTRODUCTION

Why Are We Here?


Meriwether Beatty

Jui refugee camp–Sierra Leone

According to UNHCR, there are some 13.2 million refugees worldwide and an additional 30 million internally displaced people living like refugees within their own countries. Approximately eighty percent of refugees are women and children. Most women who become refugees are already “at risk” in health terms. Most are from countries where life expectancy is low, maternal and neonatal mortality is high, and where women’s literacy, employment and social status is inferior to that of men’s. Before flight, they are, like men, often subjected to the horrors of war and civil or ethnic conflict, the traumas of catastrophic events. During flight, they face unique hardships, commonly including psychological abuse or sexual violence. Once they reach relative safety elsewhere, they face the prospect of an unstable life of hardship, deprived of their families, their friends, their possessions, their *home.*

There is a dearth of what demographers and epidemiologists call “hard data” on the precise RH status of refugee women. Indeed, in the case of recent mass exoduses, it is sometimes difficult even to obtain reliable information on the numbers of refugees. Refugee health professionals are trying to produce accurate rapid assessments and population-based data on RH status and needs. But it is obvious that the RH status of refugee women is unlikely to improve as they flee in terror across international borders. Given this assumption, there is ample evidence to support the need for RH services in refugee situations. The negative health consequences of unsafe delivery, lack of prenatal care, exposure to STDs, including HIV/AIDS, unwanted pregnancies and the trauma of rape are well documented in the medical and sociological literature. The global community cannot afford to ignore the RH needs of these women.

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Sandbagged protective entrance to MSI women's support center–Bihaj pocket, Bosnia-Herzegovina.

Yet, until just a few years ago, that is exactly what happened. In June 1994, the Women's Commission for Refugee Women and Children issued its first report on the status of RH services for refugees, *Refugee Women and Reproductive Health Care: Reassessing Priorities.* The findings of this international report are easy to summarize: *few refugees had access to RH services.* At the time, the relief community believed that providing basic needs (food, water, shelter, security and basic health services) was the priority, even in stable or long-term refugee settings. In the years between the publication of the first report and this Progress Review, we have found that RH care for refugee women and men is welcome and essential.

The crises in Bosnia and the Great Lakes region of central Africa highlighted the urgency of RH needs for refugees. In Bosnia, women demanded maternal health care and family planning services which had been available before the war. The media attention on the use of rape as a weapon of war helped underscore the importance of services for rape victims. In Rwanda, maternal deaths during flight, widespread rape and the enormous risk of contracting AIDS in the refugee camps forced even reluctant relief service managers to admit the need for prevention programs. The notion of a "minimum initial service package" (MISP)—lifesaving RH interventions provided at the initial, emergency phase of a refugee flow, to be followed by a comprehensive package of services as the situation stabilizes—is gradually winning acceptance. Increasingly, agencies are also launching programs to prevent infection from the virus that causes AIDS and to prevent deaths from complications of pregnancy, abortion and delivery.

The argument that services such as reproductive health and schooling for children will make refugees too comfortable and dampen their desire to go home is also losing credibility. Refugees *do* want to return home, as long as they will be safe and can secure their basic necessities. If that is impossible, they want to settle somewhere secure and be self-sufficient. What they *do not* want is to remain permanently in the limbo of a refugee camp or in hiding in a big city. Unfortunately, the reality is that most refugees will spend a long time in camps or in some similar flux before they can go home. Palestinians in Lebanon, for example, have been refugees for 50 years; Tibetans in India and Nepal have been refugees for 40 years. The "relief-to-development continuum," which involves

planning, in years rather than months, for continuity of services when refugees repatriate, argues powerfully for launching RH services as early as possible and for involving the refugee community in designing and managing those programs.

Given the need for RHR and the success of our First Step in that direction, it is useful to pause now and ask: "**How far have we come?**" and, perhaps more important, "**Where must we go from here?**"

To help answer these questions, Consortium members schematized the RHR challenge (see Figure l-circles). Institutionalization of RHR begins at the policy level within the international community. Then, non-governmental organizations (NGOs) and on-the-ground service providers commit themselves and their technical expertise to the program. Members of refugee communities– particularly male and female community leaders–are asked for their support. Then, and only then, can RH services be delivered effectively. During the past four years, we have found that as we proceed from ring to ring toward our target, our steps become slower and more labored.

The Outer Ring– The International Community: UN Organizations and Bilateral Aid Agencies

The International Conference on Population and Development (ICPD), held in Cairo in September 1994, came out with the most explicit statement to date in support of the notion of reproductive health as a basic human right *(see box).* But, as stated in the *Programme of Action* of the UN ICPD, "Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk behavior; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and children have over their sexual and reproductive lives." (ICPD 7.3) This statement is particularly applicable to many of the world's refugees and displaced persons.

In the summer of 1995, the first Inter-Agency Working Group (IAWG) on Reproductive Health for Refugees met in Geneva. Representatives from governments, multilateral agencies and NGOs agreed to promote RHR policies and inaugurated a period of accelerated activity at the home-office and field levels. During the meeting, the High Commissioner of UNHCR, Sadako Ogata, and the Executive Director of the United Nations Population Fund (UNFPA),

Figure 1—The Reproductive Health for Refugees Circles of Support

Nafis Sadik, signed a joint Memorandum of Understanding pledging UNHCR and UNFPA collaboration in and support for RHR.

The Geneva meeting also produced a draft *Inter-Agency Field Manual on Reproductive Health for Refugees.* The *Manual,* the product of broad and positive technical collaboration which included international agencies and NGOs, field officers and technical experts, is thus both a technical and consensus-building document. It was the first field-oriented RHR guide for field staff. The *Manual* was recently revised after field testing in 17 countries and is due to be published in autumn 1998.

RHR would go nowhere without the active support and participation of UN agencies. UNHCR, mandated to protect refugees, encourages refugee women to participate in planning and managing its programs, and supports projects designed to address the special needs of women. The agency coordinates the Inter-Agency Working Group on RHR, which holds annual working meetings and distributes useful program data. UNHCR also produces important policy guidelines on the protection of refugee women and children, the prevention of sexual violence, and the promotion of gender-equity programming. The agency is one of the major funders of RHR programs; and its support is crucial in negotiations with host governments on health and violence issues affecting refugees. UNHCR is active in advocating for RHR; but in the future, UNHCR should also ensure that

"Reproductive Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related 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 capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems." (ICPD 7.2)

"Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents." (ICPD 7.3)

reproductive health is part of *all* their refugee programs.

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), assists Palestinians living in Lebanon because they do not fall under UNHCR's mandate. UNRWA has attempted to launch RH programs for a number of years but with mixed results. In the Palestinian refugee setting, more attention must be focused on providing basic information. An appropriate communication strategy must be developed to take into account the attitudes and demands of the Palestinian community. This would help improve utilization of reproductive health services, particularly family planning.

Paula Nersesian

The crowded women's quarters at the Reception Center for Tibetan refugees in Dharamsala, India.

Both UNFPA and the United Nations Children's Fund (UNICEF) have gradually increased their involvement with refugees and internally displaced persons. UNFPA set aside a special fund for refugee RH programs; and last year it designed and funded a set of RH kits (which include essential equipment and contraceptives).

As the international lead agency in Safe Motherhood, UNICEF has a key role to play in RHR. UNICEF has participated in many of the international consultative groups on RHR and has committed itself to providing safe delivery kits for emergency situations. UNICEF was also the first international agency to "suffer" the consequences of its commitment to RHR. In November 1996, the Vatican withdrew its largely symbolic ($2,000) contribution to UNICEF because of its support for RH programs.

The World Health Organization (WHO) also plays an important role in the struggle for better RH services for refugees. With funding from The Andrew W. Mellon Foundation, WHO is producing RHR management guidelines. The guidelines will complement technical materials and enhance uniformity in field programs.

In recent years, the U.S. Department of State, Bureau of Population, Refugees, and Migration (BPRM) crafted policy and lobbied for funding for reproductive health within existing primary health care programs. While upholding the U.S. Government's decision not to fund abortions, both Assistant Secretary Phyllis Oakley and her successor Julia Taft and their staff argue the need for RH services for refugee women. In 1996, BPRM provided funds for the post of Senior Reproductive Health Officer at UNHCR.

The United States Agency for International Development (USAID) and its cooperating agencies house an enormous technical and programmatic capability in all aspects of RH care. The agency's Population, Health and Nutrition (PHN) Center supported a number of activities–notably sponsorship of Michigan Population Fellows, limited contraceptive supplies, and a manual on contraceptive logistics for refugee settings–which were timely and useful to field staff. Some country-level USAID projects, such as a large condom social marketing effort in Guinea, reached a considerable number of refugees with information and services. Both USAID and the Centers for Disease Control (with USAID funding) participate actively in IAWG. Still, in relation to its resources, USAID's initial RHR activities have been modest.

European donor agencies are increasingly aware of the needs of NGOs working in the field of refugee health care; and, in recent years, some of these European-based NGOs, including Marie Stopes International, have received increased funding for programs targeted at refugees, internally displaced persons and returnees. The United Kingdom's Department for International Development (DFID), for example, is a participant of the Inter-Agency Working Group and supports refugee programs.

The international community is talking more frequently and more publicly about the importance of RHR; but action–and funding–would speak louder than words. While the verbal support is certainly welcome, more active participation, both in financial commitments and in on-the-ground assistance, would make a more powerful statement.

The Second Ring–NGOs

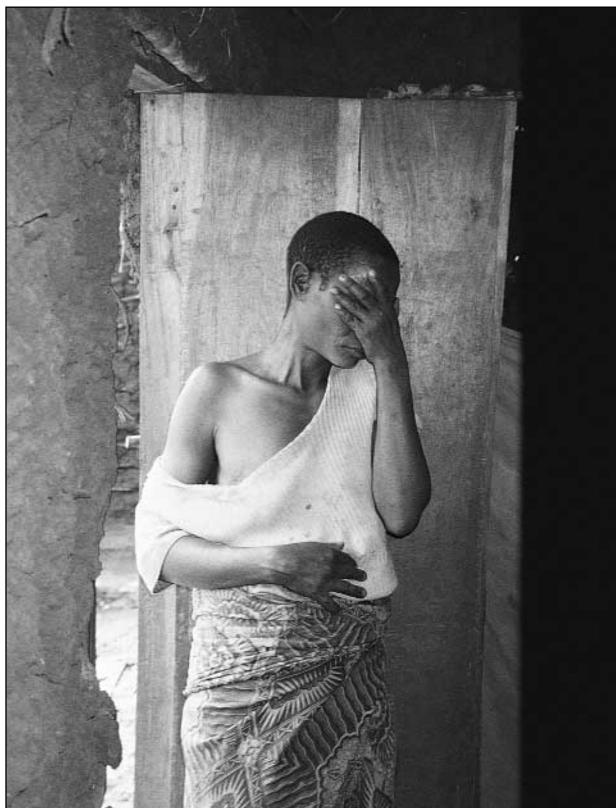
Much of the impetus for RHR initially came from the NGO community. At the moment, NGOs provide almost all on-the-ground health services for refugees. Often, they must work in volatile and potentially dangerous situations, as well as navigate through camp, donor and host-country politics.

In the best of circumstances, there is confusion during emergencies; in the worst, there is chaos. UNHCR encourages, but does not require, NGOs that offer health services to provide RH care during emergencies. As situations stabilize, there seems to be no systematic application of performance or eligibility criteria in evaluating and selecting which NGO(s) should be "assigned" which function (e.g. food distribution, health, sanitation) or in which camps they should work. This *ad hoc* approach results in severe inconsistencies in service delivery. In an attempt to solve this problem, InterAction and the Steering Committee for Humanitarian Response are spearheading a multi-agency project to identify universal standards for refugee programs and services, including reproductive health.

"It's a refugee lottery here...whether you get family planning depends on which NGO is assigned to care for your camp."

Veronika Martin,
Women's Education for Advancement and Empowerment (WEAVE), Thailand

Momentum is growing among health-care NGOs for providing RHR services. CARE began providing RH services to refugees in 1993, first to displaced populations inside Rwanda and later in the Ngara, Tanzania



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A Burundian Hutu woman reveals the scars left after she was raped and stabbed by Tutsi soldiers almost three years ago. Her husband was abducted and killed and five of six children died when their home was set on fire. She was pregnant at the time and lost the baby. She finally fled to freedom in Tanzania and has received counseling while living in the Kenembwa refugee camp since July 1996.

camps. Refugee reproductive health is now a standard part of CARE's refugee assistance program and is included in emergency-preparedness training for CARE staff and in the initial assessment and design of refugee assistance programs. The CARE Health and Population Unit provides technical support to the organization's RHR program. In 1996, Médecins Sans Frontières (MSF)/Belgium, under the auspices of the University of Brussels, analyzed the level of its programs' commitment to the "Cairo Agenda," and made specific suggestions for improvements. With the assistance of a USAID Michigan Population Fellow, the International Rescue Committee (IRC) adapted virtually all its health programs to include at least one, and sometimes several, RH components. Since 1994, IRC has added ten RH programs to its activities, and so now funds and operates 14 RH programs. In 1998, the IRC Board of Directors adopted an RH Policy Statement specific to its refugee mandate. The American Refugee Committee (ARC) hired a trainer and clinical specialist who spent six months visiting every ARC program to upgrade or initiate RH programs.

Recently, a number of health NGOs, including Marie Stopes International (MSI) and JSI Research and Training Institute, have entered the RHR field. MSI, based in the United Kingdom, has an unambiguous mission to promote family planning and reproductive choice. The organization maintained a large RH effort throughout the war in the former Yugoslavia and now runs more than half a dozen RH programs in some of the world's most difficult and dangerous locations. MSI's technical excellence complements health NGOs which are not strong in reproductive health. JSI Research and Training Institute has international experience in all aspects of reproductive health. JSI defines its role as providing technical support to field-based NGOs to raise quality-of-care standards and transfer technology.

Local and refugee NGOs are also playing an increasingly active role in providing RH information and services. Given their familiarity with the setting and population, they are often the best-suited agencies to do so. The RHR Consortium supports the involvement of these NGOs through its small grants program.

While more NGOs are launching RH programs for refugees, service delivery remains patchy. According to data gathered by UNHCR,[1] nearly half of those

1 The information is based on replies from 62 self-reporting agencies providing RHR services in 42 countries.

NGOs offering RHR services provide little or no Safe Motherhood programs. Programs specifically tailored for adolescents or for victims of sexual violence are rare. We noted these and other gaps in RHR programs ourselves during recent site visits. Although the NGOs' will to provide RHR services is strong, until that resolve is translated into more comprehensive programming, services will not be as effective as they could be.

Bull's Eye—The Refugee Community

Since our goal is to meet the RH needs of refugee women, men and adolescents, our work will not be finished until RH services are routinely accessible to them all. The Country Reports that follow provide current snapshots of some of the places visited in 1994 for the first Women's Commission for Refugee Women and Children report, plus portraits of other sites where Consortium members and small grants recipients work. We visited clinics and field sites, met with NGOs and international organizations and, most important, talked with as many refugees as possible.

In nearly every place we visited, *refugees had better access to services than they did four years ago.* A few programs we observed include comprehensive services. Most offer a limited range of services; some are barely off the ground or are floundering. All the programs we visited need, in varying degrees, more financial and technical assistance. Yet everywhere we went, whatever the technical or resource constraints, health professionals demonstrated an abiding commitment to their work. Both community involvement and NGOs' dedication to fostering that involvement is improving. While all this is encouraging, our field observations also made us realize how much more needs to be done.

The Consortium's observations and recommendations follow directly from what we have seen and been told in the field. They form a kind of programmatic map to help guide us on the Next Step toward reaching our goal.

Observations and Recommendations

1 People dedicated specifically to RHR programs are essential to their success.

This is our strongest recommendation, and one for which the evidence is clear. At the organizational level, dedicated personnel fundraise, provide technical assistance and lobby for field programs. They maintain visibility among policymakers, analyze performance data and ensure that reproductive health is included in program plans and budgets. The RH expert at UNHCR and the Michigan Population Fellow coordinating reproductive health for IRC prove our thesis; and the effect of working with a dedicated RH specialist, even for a relatively short time, was dramatic at ARC.

The *IAWG Field Manual* recommends that reproductive health coordinators be designated at camp level and regional offices and that wherever possible these coordinators be recruited locally. Programs overseen by RH coordinators advance much more rapidly than those which are not. The Shoklo Malaria Research Unit (SMRU), IRC and ARC programs in Thailand all benefit from the presence of RH coordinators. Several NGOs providing basic health services to Afghan refugees in Pakistan want to integrate RH, but are already overstretched or do not know how to do so. An RH coordinator housed at one of the NGOs would

help them set up a program and train staff, as well as coordinate RH activities in the region.

2 Referral systems, especially for obstetric emergencies, and emergency transportation must be improved.

With the exception of Bosnia and Eastern Europe, most refugee women give birth at home, usually with an untrained or semi-skilled traditional birth attendant (TBA) on hand. This is the case even when prenatal care is good. In Thailand and Ethiopia, training programs for TBAs emphasized timely referrals for complicated cases. However, community leaders and pregnant women are not routinely trained to recognize complications and to seek care early. Refugee camps are ideal sites for community-based Safe Motherhood activities, which are urgently needed. Postnatal visits are less common than prenatal visits, although most women do immunize their children.

Invariably, transportation must be improved. Many NGOs transport emergency cases to referral hospitals. Sometimes, however, this service is not available at night or on weekends. In India and Nepal, the major barriers to emergency obstetric care for Tibetan refugees are availability and cost of transportation, and the need to travel long distances to some referral facilities. Refugees in many sites say that, in emergencies, they must arrange expensive transportation themselves as well as meet the costs of relatives accompanying the patient. Frequently there are language and cultural barriers in referral hospitals and these, combined with cost considerations, result in late arrivals and treatment at the referral hospitals. As one Rwandan obstetrician said, "We can save women if they arrive in time, but too many arrive too late." Reliable data from IRC in Thailand, and anecdotal data from many other places, suggest that a significant percentage of emergency referrals are related to obstetric/gynecological problems.

Most sites we visited provided for emergency obstetric cases, usually by referral to a host country hospital. Referral hospitals varied in quality of facilities and staff and in their ability to attend to emergency obstetric cases or treat complications from unsafe abortions. Training in obstetric lifesaving skills and treatment of unsafe abortions, additional equipment, counseling and cross-cultural sensitization of hospital staff would improve the quality of services for both refugees and host-country women.

Courtesy of WEAVE/Kim Green

In a training conducted by WEAVE, TBAs learned to identify high-risk conditions.

3 **Refugee reproductive health programs must be culturally sensitive and actively involve the refugee community.**

The Consortium visited a wide variety of sites, from Bosnia, where contraceptive use is common, to Pakistan, where, among Afghan refugees, it is rare. Some cultures practice female genital mutilation; in many places, the number of HIV/AIDS cases is increasing. Sadly, we recorded violence against women, in one form or another, in every place we visited. In other words: each group of refugees has unique cultural, religious and social characteristics. And RH programs–so closely linked to custom, belief and personal morality–will not succeed unless they respect cultural norms in the communities they serve.

IAWG stresses the need for both high-quality medical services and for approaches which eliminate barriers to using those services. Medical barriers to RH access include overly-restrictive policies on prescribing contraceptives, difficulty in obtaining condoms, and cumbersome record-keeping or eligibility requirements. Community-based distribution of family planning services has proven effective and medically safe around the world. This "best practice" needs to be adapted for refugee settings.

The under-utilization of refugee health professionals is a waste of talent–and a pervasive problem. Numerous Rwandan physicians with experience in Norplant fled with their compatriots to camps during the Great Lakes crisis; yet little effort was made to locate and recruit them, even as women in the same camps were unable to have their implants removed. In Guinea, UNHCR estimates there were more than 500 underemployed refugee health personnel, many of whom had comprehensive maternal and child health/family planning training in Liberia. It is vital that people be able to maintain their skills while in exile, and use them for the benefit of the community.

4 **The experience of the wider public health/reproductive health professional community needs to be tapped so refugee programs can rapidly meet state-of-the-art medical/technical, quality-of-care and programmatic standards.**

Everywhere we visited, we found simple ways to improve programs based on existing RH experience. There are excellent technical materials and training capabilities in every RH area; often, there are health education materials in the refugees' own language. The International Planned Parenthood Federation, for example, has Arabic-language materials on Islam and family planning. *Where There Is No Doctor* is available in numerous languages. *The Essentials of Contraceptive Technology* is being translated into French and Spanish. Numerous curricula, checklists and simple record-keeping systems exist for community-based distribution programs. The Consortium is committed to assisting this technology transfer; and to that end we designed *Refugee Reproductive Health Needs Assessment Field Tools,* compiled *Reproductive Health for Refugees: A Selected Bibliography* and are emphasizing technical assistance in our planning. CARE has developed two training curricula on behalf of the Consortium. The first builds general awareness and support and can be used to educate headquarters staff, policy makers or relief generalists on the critical components of RHR programming. The second is a more technical, comprehensive training curriculum designed as a five-day refresher course for clinic staff.

Even modest increases in technical support for RHR by other public-health agencies or donors would have a dramatic effect on programs. NGOs benefit from the technical support provided by universities

Meriwether Beatty

Afghan refugee community health worker in Hangu, Pakistan. The involvement of men is essential to the success of RH programs.

and public health agencies. There is, for example, a growing partnership between Columbia University's Forced Migration and Health Program and IRC, which have conducted joint training sessions in program monitoring and evaluation.

We must also look at RHR as a continuum. NGOs working in Guinea and Thailand are training personnel and designing programs with an eye toward rapid start-up of services when refugees return home. This is obviously a winning strategy and one which donor agencies should support enthusiastically.

5 Strong advocacy from senior policymakers remains vital. Leadership, awareness and support at operational levels needs to be broadened and increased.

Although the RHR movement has made a giant First Step, now is *not* the time to relax. We must keep the spotlight on RHR over the next few years. Senior policymakers must continue to defend and advocate it. The Women's Commission for Refugee Women and Children has assembled a group of refugee women from various regions who all have some expertise in reproductive health. The eight members of this Advocacy Resource Group promote RHR at conferences, symposia, and NGO and other policy-making meetings.

Yet awareness and support for RHR at operational levels—the people who design and run programs—remains uneven. Most often, this is less because of philosophical differences than because of lack of information on how to execute these programs. Still, mid-level inertia is a major obstacle. Many field officers, for example, do not know how contraceptives or safe delivery kits can be obtained from their agencies—or to which account to charge them. Slow responses to funding requests is a recurrent problem. In many places, supportive field managers are crucial in shepherding programs around these roadblocks and getting them moving.

6 Procurement and resupply mechanisms for reproductive health equipment, contraceptives and supplies must be improved immediately if programs are to succeed.

Logistics and procurement are simultaneously the most important and the weakest part of current RHR efforts. This is a disastrous combination. It is also a puzzling fact, given that relief agencies can move large quantities of food, water, tents, pharmaceuticals and other supplies into an area in a relatively short time.

Rachel Jones

Contraceptive logistics management is an area which needs more emphasis.

NGOs either purchase their own contraceptives and supplies (sometimes at high prices) or, if they are lucky, obtain them through host-country governments. To date, the track record of international and bilateral agencies in RH supply procurement has been poor, even among organizations which are usually very responsive. Few UNHCR Program Officers know where to obtain contraceptives and in what quantities. Theoretically, NGOs could obtain contraceptives from their donor or an international source; but in practice, few have successfully negotiated what appears to be an unusually complicated procedure. There is an urgent need to assess the worldwide logistical situation for RHR and to simplify the procurement and resupply process.

In some places we visited, such as Pakistan and Ethiopia, supplies are not a significant issue because demand for services is low. But there is also little evidence that systems are in place to meet the need if demand rises. In Rwanda, some sites only had out-of-date contraceptives and little equipment. During the war in the former Yugoslavia, contraceptives were hard to come by, so women resorted to abortion as a means of contraception. In Thailand and elsewhere, clinic-level shortages are recurrent and clinic staff have only rudimentary knowledge of "reorder points," quantities to order and other logistical arrangements. JSI prepared a *Manual of Contraceptive Logistics for Refugee Settings,* but it is not widely used, nor does it cover Safe Motherhood. Logistics training for NGO field staff and access to information on sourcing supplies for headquarters staff should be a priority.

7 Multiple models for RHR delivery should be developed to reflect the variety of contexts in which they may be used.

As we have learned over the past four years, one model does not fit all situations. During the crisis in the Great Lakes, Rwandans were sheltered in large numbers in one geographic area. Health activities in the camps were generally delegated to individual NGOs. It quickly became clear that improvements in RH services in the camps rested solely on the competency of the NGOs.

The experiences of refugees from Liberia and Sierra Leone contrasts dramatically with those of the Rwandan refugees. West African refugees have been dispersed in smaller groups and attached to villages, often with populations of similar ethnic makeup. Thousands of others have made their ways to larger towns. Health services for these refugees are provided through host-country public health infrastructures,

rather than through NGOs. But this state-based approach to relief services presents its own challenges. The effort required to introduce a new program to an already-existing health infrastructure is enormous and costly. Staff must be trained; technical assistance must be provided. Community-based distribution schemes could be an effective compromise solution. These programs can be run inexpensively as part of the work of local or international NGOs and can move with the refugees when they repatriate. Community-based distribution plans would supplement, not replace, existing health infrastructures.

We must be nimble enough now to respond appropriately, as well as quickly, to the unique demands of each refugee situation.

Good Data Are Great Advocates

Recent IAWG meetings have highlighted the need for better data collection and analysis on the RH status of refugees. Universities are increasingly collaborating with NGOs to provide these resources and to train NGOs in research techniques appropriate to refugee settings. The Refugee Studies Programme at the University of Oxford received a small grant from the Consortium to focus an edition of the Refugee Participation Network to Reproductive Health for Refugees issues. Other universities actively involved in refugee work include Columbia University, Johns Hopkins University, London School of Hygiene and Tropical Medicine and the University of Amsterdam. We hope that better data collection and special studies will convince skeptics of the lifesaving nature of RHR. The importance of good data both for managing field programs and for policy decisions is broadly agreed; but most urgently needed is a short, well-defined list of sound RH indicators for measuring program progress and impact.

8 RHR programs should evolve to encompass broader refugee needs.

Providing RH services for refugees is our immediate concern. But these services should be flexible enough to address other issues of concern to refugees. For example, RHR programs should focus on preparing for repatriation and, where possible, short-term support should be provided when the refugees return home. A woman coming to a clinic with a child to be immunized should not have to wait in separate lines for RH and child health services. RH information should be integrated into literacy materials, and RH education in schools should be encouraged. RH programs should reflect the fact that, even in refugee camps, women work. The programs should employ women when possible, make services convenient for women who have household duties or paid employment, and should be effective in helping women reach their reproductive goals. Finally, more attention needs to be paid to the issue of sexual violence in refugee settings.

We believe that with a concerted effort and adequate funding, the institutionalization of RHR can be accomplished over the next couple of years. This alone will be of enormous benefit to millions of refugees.