FORCED MIGRATION review

19

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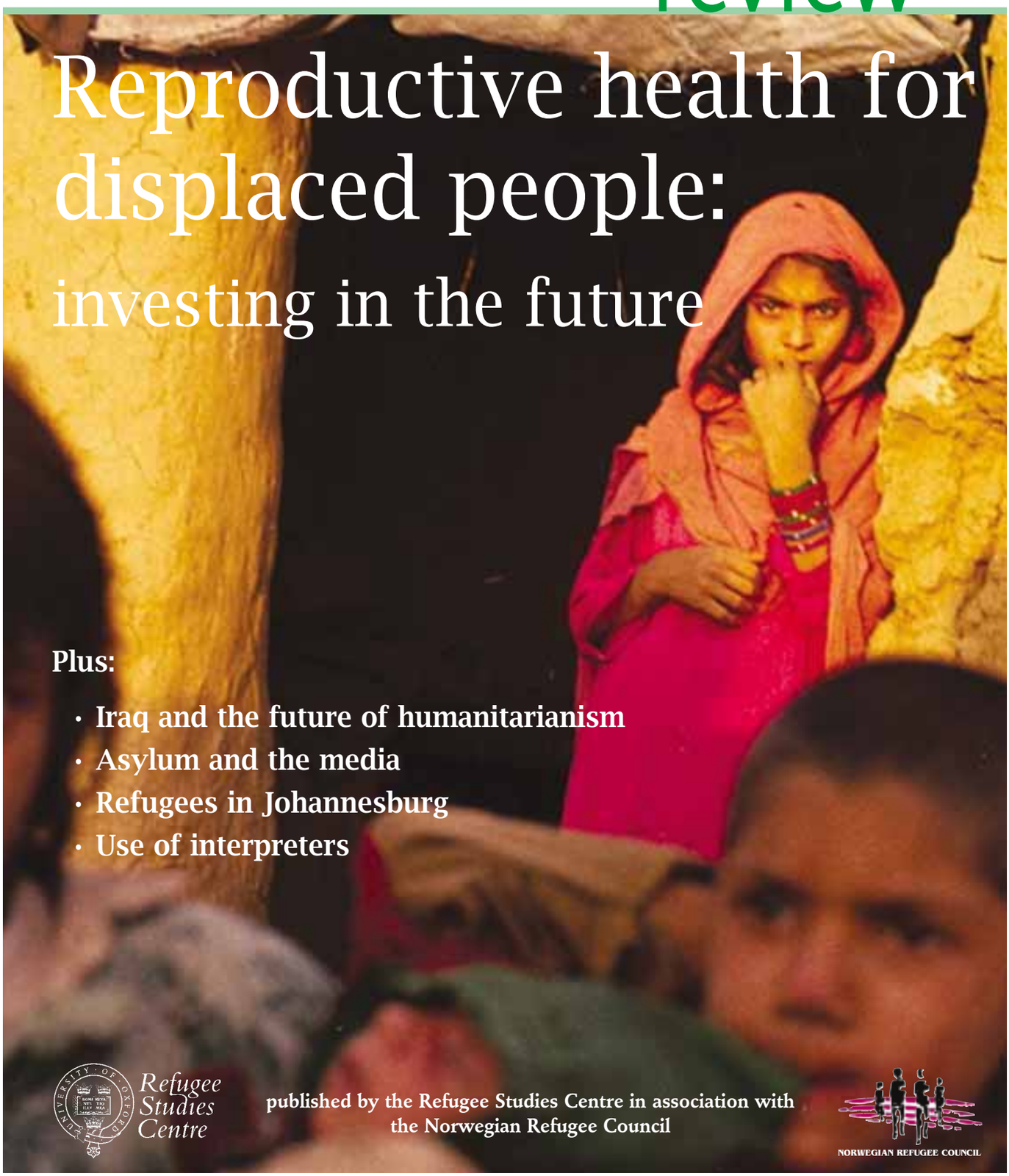

Reproductive health for displaced people:

investing in the future

Plus:

- **Iraq and the future of humanitarianism**
- **Asylum and the media**
- **Refugees in Johannesburg**
- **Use of interpreters**

Refugee Studies Centre

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NORWEGIAN REFUGEE COUNCIL

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from the editors


Corinne Owen

This issue's theme is reproductive health for refugees and IDPs. Most articles are based on presentations to a major international conference held in Brussels in October 2003 organised by the Reproductive Health Response in Conflict Consortium. We are indebted to guest editors Samantha Guy (of Marie Stopes International) and David del Vecchio (UNFPA) for their input and advice, and to UNFPA and UNHCR's Health and Community Development Section for their sponsorship of this issue.

With this FMR you will receive a copy of a ***readership questionnaire.*** *We would be extremely grateful if you would spend a few minutes completing and returning it. You can either post it, fax it or download the questionnaire as a Word document at www.fmreview.org.questionnaire and send it as an email attachment to fmr@qeh.ox.ac.uk. This questionnaire will help us ensure that FMR meets your needs. As an added incentive, each person returning a completed questionnaire will be entered into a draw – and the winner will receive a selection of publications donated by international agencies.*

If you have recently received a subscription renewal letter, please respond as soon as possible. Chasing renewals wastes precious resources!

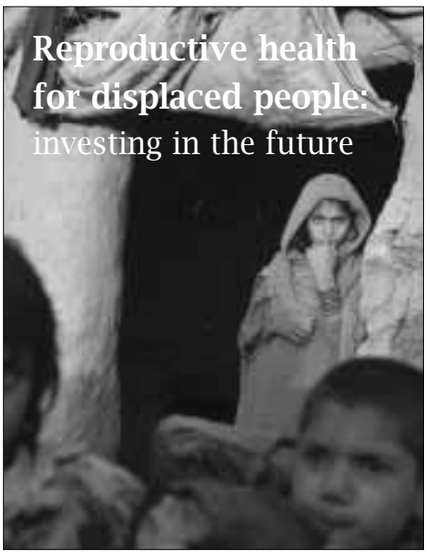
Issue 20's feature theme will be ***refugee and IDP livelihoods*** *and will be produced in collaboration with UNHCR. The feature theme of issue 21 will be the* ***return and reintegration of IDPs****, produced in collaboration with OCHA's Internal Displacement Unit and UNDP's Bureau for Crisis Prevention and Recovery (see p55 for call for papers). Deadline for submissions for FMR 21 is 15 May.*

With our best wishes for 2004

Marion Couldrey and Tim Morris
Editors, Forced Migration Review

In the previous issue of FMR we mentioned that we are short of funding for this year. Despite some new and generous pledges by agencies, we are still facing a serious shortfall. We deeply regret having to announce that production of our Arabic and Spanish editions is likely to be suspended. We will of course keep working to raise further funding and hope that we will be able to recommence production at a later date. If you have any advice or support you can offer, please contact us as a matter of urgency.

Front cover photo: *Refugee girl in Afghanistan. UNFPA.*



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Introduction

by Samantha Guy and David del Vecchio, Guest Editors

The articles in the feature section of this FMR hint at the breadth of reproductive health research and programming being carried out in conflict and post-conflict settings around the world.

Yet it is important to remind ourselves that reproductive health (RH) remains a relatively new area of attention within the humanitarian sector. Just ten years ago, there seemed to be little or no recognition of the fact that, during war and in refugee settings, women continue to have babies, sexual and gender-based violence escalates, and HIV thrives.

This began to change with the International Conference on Population and Development, held in Cairo in September 1994, when for the first time refugee women were invited to speak about their RH needs on an international stage[1]. The following year, at the Inter-agency Symposium on Reproductive Health in Refugee Settings in Geneva, more than 50 governments, NGOs and UN agencies committed themselves to strengthening RH services for refugees. The Inter-agency Working Group was formed, a joint memorandum of understanding was signed between UNFPA and UNHCR, and consensus was achieved on a Minimum Initial Services Package for RH in emergency situations.[2]

It was also around this time that the Reproductive Health Response in Conflict Consortium (RHRC Consortium), formerly the Reproductive Health for Refugees Consortium, was formed. Founder members were CARE, the International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children. Later the American Refugee Committee and Columbia University's Heilbrunn Department for Population and Family Health joined the group. These agencies, with their complementary expertise in training, advocacy, clinical services and research, contribute diverse skills to carry out a broad agenda aimed at improving the reproductive health of refugees and displaced persons around the world in addition to garnering support from the international donor community to move from rhetoric to action.

As recognition of the importance of RH as an emergency issue has evolved since the mid-1990s, so too has understanding of the magnitude of, and need for, specific research and programming related to different RH issues. After Cairo, most of the initial emphasis was on family planning and safe motherhood. But as the HIV/AIDS crisis accelerated in Africa, where the vast majority of the world's refugees live, a new understanding of the relationship between HIV, war and displacement led to increased HIV/AIDS programming related to forced migration. At the same time, the well-documented prevalence of rape as a weapon of war – in Bosnia, Rwanda, Kosovo, Timor Leste and now DRC – has raised awareness of the increasing occurrence of all forms of gender-based violence in displacement settings, of its relationship to the spread of HIV and of the urgent need for medical treatment, psychosocial support and prevention.

Important progress has been made in all of these areas over the past decade. Recent studies have shown that at least some components of RH care are available to most refugees in non-emergency settings. The collaborative efforts of organisations, big and small, have helped to expand services in many conflict settings. The unmet need for RH care for displaced persons remains enormous but a very good start has been made.

At the RHRC Consortium conference held in Brussels in October 2003, more than 150 people from 36 countries representing 70 organisations came together to share programme findings and research on conflict-affected populations around the world. Presentations highlighted new research, model programming, innovative strategies and practical tools and guidelines. The conference demonstrated how far the international community has come in recognising the rights of displaced communities to comprehensive reproductive health care while highlighting areas which need more concerted work.

Today, in comparison with ten years ago, a refugee woman has a far better chance of having a safe pregnancy and delivery, and has improved access to emergency obstetric care, information

and services for prevention of STIs and HIV/AIDS and treatment and counselling for the effects of sexual and gender-based violence. A war-affected adolescent has a much greater chance of getting appropriate information and access to services in order to grow up safely and in good health.

Yet, as we approach the tenth anniversary of the International Conference on Population and Development, pockets of ideological opposition to some aspects of reproductive health and rights, particularly in some donor countries, have begun to threaten field successes and add to the already daunting challenges faced by organisations working to safeguard the reproductive health of the displaced.

The US government, a leader in the field and the largest supporter of RH for refugees and IDPs for many years, has, under the current administration, withdrawn or restricted the use of funding in this area for UNFPA, UNHCR, the RHRC Consortium and other partners. Small but vocal opposition groups in some other countries are lobbying their own governments to follow suit. Although other donors have tried to fill the gap, unstable funding is challenging the ability even to maintain (let alone expand) the most basic RH services for the world's 37 million displaced persons. Many programmes, even HIV/AIDS prevention, have been scaled back. Others have been cut entirely, greatly endangering the health of countless women, men and children living in already precarious situations.

As we measure and celebrate what has been achieved over the past decade, we must not forget how hard we have fought to make it even this far and how much remains to be done.

We appreciate the commitment of the editors of FMR who have provided a timely opportunity to present some of the latest developments in reproductive health in conflict settings.

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1. See: www.un.org/popin/icpd2.htm

2. MISP information is online at: www.who.int/disasters/repo/7345.doc

Planetwire

Addressing the reproductive health needs of conflict-affected young people

by Julia Matthews and Sheri Ritsema

The Women's Commission's EBP Fund is exploring ways of meeting the particular RH needs of conflict-affected refugee adolescents.

Approximately 6.6 million adolescents worldwide are currently displaced by armed conflict, many of them exposed to violence and acute poverty and separated from their families and communities.[1] Like all young people, refugee adolescents have special needs during their years of development. Moreover, young people affected by conflict face additional barriers as they often lack sufficient education, health care, protection, livelihood opportunities, recreational activities, friendship and family support.

Refugee adolescents face additional difficulties that put their reproductive health (RH) at risk. Weakening of traditional socio-cultural constraints makes them more vulnerable to sexual abuse and exploitation. They may be forced to trade sex to pay school fees or feed younger siblings. Young refugees may begin sexual relations at an earlier age and are more likely to take the risk of engaging in sex without using a condom. Their RH is affected by limited access to information, unsafe sexual practices, unwanted pregnancies, unsafe abortions and increased exposure to sexually transmitted infections (STIs), including HIV/AIDS. In situations of conflict, the dearth of youth-friendly services and trained providers is also a significant barrier to ensuring young people's right to a healthy and productive life.

Recognising this dire situation, the Women's Commission for Refugee Women and Children (Women's Commission) supported a proposal to establish a fund to help meet the RH needs of adolescents affected by armed conflict. The Eleanor Bellows Pillsbury Fund for Reproductive Health Care and Rights for Adolescent Refugees (EBP Fund) was established in June 2000 to provide small grants to local and international organisations for specific adolescent RH projects.

The EBP Fund at work

During the first three years, EBP Fund-supported projects reached conflict-affected adolescents in Asia, Africa, Eastern Europe, Latin America and the Middle East.[2] Projects ranged from supporting research and documentation of adolescent RH needs in Somalia and gender-based violence peer educator training in Kosovo to funding family planning services and training for adolescents in Colombia and culturally appropriate RH workshops for mothers and daughters in the Occupied Palestinian Territories. In addition, an intensive training programme was undertaken in Nepal to prevent STI/HIV/AIDS among teenage Bhutanese refugee girls.

In Northern Uganda the youth-led Gulu Youth for Action (GYFA) is working – despite the lack of security in the region – to raise awareness and communication about RH issues. Other local and international organisations provide back-up but it is youth leaders who set the agenda and ensure activities are youth-friendly. GYFA's leaders are facing up to a dilemma common to many organisations reaching out to youth – getting as many girls participating as boys. In 2003, a consortium of 13 local NGOs working on behalf of adolescent Burmese forced migrants on the Thai-Burma border formed the Adolescent Reproductive Health Networking Group (ARHNG). The objective of ARHNG is to develop the institutional capacity and management skills of member organisations for implementing adolescent RH projects. Members share information and experience, follow up training activities and help each other access external resources. The Women's Commission began partnering with this network in 2003 by providing a small grant to Doctors of the World (DOW) Thailand which serves as the focal point for the network. Through their local office in Thailand, DOW provides the network's member organisations with the expertise of an international leader in health development and the accessibility of a field-based agency. DOW helps ARHNG to assess members' needs, plan strategically, apply for project funding and organise training. The use of networks and the designation of a lead agency for the network make it easier to incorporate a broader perspective of adolescent RH for an entire region.

Measuring impact

While it is possible to quantify specific outputs from adolescent RH projects, it becomes increasingly difficult to measure the ultimate aims of such projects – improved adolescent sexual and RH behaviour and, ultimately, improved RH and well-being. Using EBP Funds, more than 61,000 adolescents have attended events offering RH training and education on issues such as condom use, prevention and treatment of STIs, family planning techniques and protection against gender-based violence. Messages have been conveyed via seminars, workshops, drama, discussion groups and video. At least 580 adolescents have been trained as RH peer educators and more than 2,000

have participated in peer-to-peer counselling sessions. Peer educator training not only offers adolescents important information but can also serve to build self-confidence and give youth the skills to advocate for their RH rights.

The EBP Fund also supported the distribution of brochures, fliers and pamphlets with RH messages that can be used alone or as teaching aids for educators and service providers. These materials have spread information about practising safer sex, using family planning methods and avoiding exposure to STIs. At least 10,000 condoms have been distributed free of charge, giving young people a chance to protect themselves from HIV and unplanned pregnancies.

Approximately 2,250 adolescent girls have received locally-made sanitary wear materials through EBP projects. In many refugee settings the lack of sanitary wear materials keeps refugee girls from attending school. They are also often forced to quit school by their parents who fear their daughters are more vulnerable to sexual assault walking to and from school. The provision of sanitary wear allows refugee girls to live with dignity and continue their formal education.

Many young people in conflict settings lack educational and work opportunities and have lost their social support system…

Many young people in conflict settings lack educational and work opportunities and have lost their social support system, increasing their risk of exploitation and abuse. Young people want and need education and livelihood training to become self-sufficient and to build their futures. Many EBP-supported projects have responded to the need for education and income-generating skills training by integrating these opportunities with RH training. More than 300 adolescents have received educational support and income-generation skills training through the adolescent-focused projects. For example, Shuhada Organisation in Afghanistan[3] used RH educational materials to increase the literacy skills of 20 young women and girls in their community. In Kenema in Sierra Leone, the Forum for African Women Educationalists[4] sponsored 55 girls to attend school, train as RH peer educators, receive safe motherhood support, learn about gender-based violence and receive free medical services. Team of Volunteers Against AIDS in the Democratic Republic of Congo sponsored income-generation workshops for 40 adolescent girls to gain skills such as dressmaking and shoemaking, while also learning about responsible sexual practices.

Community support for adolescents

Even when RH and education services are available, communities may not want adolescents to access them. Adults may fear that information will promote youth promiscuity. Service providers may not be trained to respond to the unique concerns of adolescents or facilities may not be young-people friendly. It is essential to educate parents and the community about young people's rights to health care. EBP-funded projects trained at least 175 parents at workshops on the basics of adolescent development, reproductive rights and parental obligations to support these rights.

Lessons identified

After three years the Women's Commission reviewed EBP-supported RH projects to cull lessons to inform future capacity-building projects.

1. Effective RH projects for conflict-affected adolescents do not adhere to a set formula or model but are **varied in their approach, creatively designed to be culturally appropriate and to meet the specific, pressing needs of adolescents in a particular community.** A review of projects reveals many variations in methodological approach from peer education and cultural performances to awareness-raising workshops and establishing youth-friendly centres. Projects also vary their focus by RH technical area: safe motherhood, including emergency obstetric care; family planning and emergency contraception; sexually transmitted infections including HIV/AIDS; and gender-based violence. Adolescent RH project data show that effective projects are designed to meet the specific, pressing needs of the adolescents in each community and respond to the local context.

2. Conflict-affected communities, especially adolescents themselves, are highly motivated to improve adolescents' RH but **need capacity building, through technical guidance and support, to maximise the effectiveness of their projects.** For instance, many EBP grant recipients had difficulty in identifying specific or measurable indicators which are key to evaluating project activities and ensuring that interventions are useful. Many organisations also need assistance in designing and evaluating their training and education programmes. Organisations, especially local ones, expressed the desire to learn about best practices from other RH projects and would benefit from the creation of a network involving those organisations supporting adolescent RH on a regional or global level.

3. Adolescent RH projects must **identify and involve refugee young people in the design, implementation and evaluation of all project activities** to ensure they are full participants in programmes that affect their lives – a key recommendation of the 1994 International Conference on Population and Development. It is not enough to involve young people as peer educators; they should be included in all aspects of project design, implementation and evaluation.

4. **Peer-to-peer education strategies provide opportunities for meaningful adolescent participation**, which, with quality training and careful project monitoring and evaluation, can maximise project impact while minimising financial costs. Although the adolescent experience varies widely by culture and individual, most adolescents are highly susceptible to peer influence. Young people represent an untapped community resource; providing opportunities for youth to participate in the creation and

implementation of solutions to their own problems empowers them to become agents of change in their communities. The use of peer educators can also be a cost-efficient method of widely disseminating information. It is critical that peer educators receive sufficient and continued quality training. Careful monitoring and evaluation help ensure that training provides accurate information, via adolescent-appropriate methods that mitigate participant attrition. It is also essential to ensure that activities are supported by, rather than dictated by, adults. Peer educators need continuing support – from peers, parents or others in the community – to overcome obstacles they may face.

5. **Networks can help close gaps in service provision and strengthen limited capacities** by facilitating coordination and collaboration among numerous and diverse adolescent RH projects within a particular region. Lack of coordination and collaboration may cause gaps or duplication in service provision. Several projects may focus on one technical area, while other technical areas are overlooked. Lack of collaboration can also cause projects to 'reinvent the wheel'. This lack of inter-organisational collaboration prevents the sharing of resources and good practices, leaving each organisation to repeat similar mistakes and miss out on benefiting from already tested effective interventions.

Next steps

The approach of supporting adolescent RH projects has enabled many adolescents and their communities to increase their awareness of RH risks and of employing effective methods of protecting and improving their RH. Awareness alone, however, does not necessarily produce behavioural change. Neither does it definitively cause a clear and measurable improvement in young people's RH status, which is the overarching goal.

After three years of activity, the Women's Commission is examining new strategies for increasing efficiency and coordination in supporting the RH of conflict-affected adolescents. One possibility is an increased focus on supporting international NGOs through the network model described earlier. Another alternative is targeting specific regions, such as sub-Saharan Africa or southeast Asia, and providing more sustained funding to organisations. Although new grant making is on hold during this strategic planning process, the Women's Commission continues to support adolescents around the world through its 14 current EBP-funded projects.

As the EBP Fund is currently the only ongoing fund to focus solely on the RH of displaced and conflict-affected adolescents, the Women's Commission has a unique opportunity to highlight the importance of advancing RH services among this neglected population. It is essential to build organisational capacity, share experiences about supporting good adolescent RH practices, identify resources that can be adopted to local contexts and advocate for more attention and funding for adolescent RH projects.

Most importantly, it is essential to continue to improve the lives of conflict-affected adolescents and to involve young people in this process. Adolescents are creative, energetic and important agents for constructive change within their communities – and they are the future.

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1. The exact number of displaced adolescents is not known. UNHCR estimates that there are 40 million displaced persons worldwide and that 50% of these are young people. The Women's Commission estimates that approximately one-third (i.e. 6.6 million) of these displaced young people are adolescents (ages 10-19). Variances exist between cultures, organisations and individuals in how they define the terms adolescent, youth and young people. WHO definitions are: 'adolescent' refers to ages 10-19; 'youth' to ages 15-24; and 'young people' to ages 10-24. The terms adolescents, youth and young people are used interchangeably throughout this article.

2. For further information, visit www.womenscommission.org/pdf/ebp_.pdf

3. See www.shuhada.org

4. See www.fawe.org


Julia Matthews

Young women at Umpiem Mai refugee camp on the Thai-Burma border discuss their reproductive health concerns.

Lessons from a sexual reproductive health initiative for Tanzanian adolescents

by Naomi Nyitambe, Marian Schilperoord and Roselidah Ondeko

How should young people be involved in sexual RH programmes?

World Health Organisation assessments in 2000 of adolescent sexual and reproductive health (ASRH) activities in refugee camps in western Tanzania discovered major shortcomings. Young people complained that services did not meet their needs, service providers were judgemental, waiting times were long and confidentiality was non-existent. Lack of privacy exposed them to the risk of being spotted by parents while visiting health centres. Given the strong cultural taboos against premarital sex and child bearing outside marriage, youth were scared of being seen as challenging traditional norms. Adolescents were not involved in programmes, thought service providers were insensitive and felt their participation was not valued.

In response, UNHCR set out to create accessible, culturally-acceptable and youth-friendly ASRH activities in three refugee camps. Multi-Purpose Youth Friendly Centres are now open throughout the day and occasionally at weekends. Young people are trained in ASRH activities, encouraged to talk about substance abuse, teenage pregnancy, early marriage and family planning and receive counselling and treatment for STIs and oportunistic infections. They are given opportunities to watch videos, dance, do drama and play ball games. Nutrition and hygiene advice is offered together with training in vocational skills such as gardening, tailoring and cooking. Young people are taught how to provide home-based care to those with HIV/AIDS and, along with their parents, have been trained to become peer health educators. The training manual that is being used has been developed with the participation of youth, service providers, parents and religious leaders and is being revised annually. Language courses in English, French, Kiswahili and Kirundi are available. Centres are run by youth-led committees made up of trained peer educators.

young people… should be involved in all aspects of project design and implementation

Community involvement during pilot stages was limited. Failure to consult parents, religious leaders and influential leaders led to anxieties and grave suspicions about what was going on in youth centres. Parents were concerned that young people should not be encouraged to talk and learn about reproduction and the use of condoms until late adolescence. Parents, peer educators and community leaders had widely different expectations. Activities were targetted at boys while girls, trapped at home with domestic activities and constrained by their parents, were ignored.

Lessons learned by programme organisers include the need to:

- involve religious leaders, parents and youth before commencing any ASRH programmes
- realise that young people are highly adaptable
- establish youth-friendly spaces with trained ASRH specialists able to ensure privacy and confidentiality
- ensure that skills which are taught to youths are marketable: there is little point in teaching tailoring and basket-making when markets are saturated
- provide flexible drop-in counselling and treatment services (not forcing youth to make appointments)
- offer financial incentives to peer counsellors to ensure they do not drop out of programmes, thus demotivating other young people
- realise the importance of data collection and ongoing monitoring and evaluation and feedback in order to improve outcomes.
- listen to young people: they should be involved in all aspects of project design and implementation – there should be a transparent plan of action that clearly stipulates the roles of all stakeholders.

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The authors would like to acknowledge the contribution made by Kate Burns and Tsegereda Assebe.

The views expressed in this article are personal and not necessarily shared by UNHCR.

Beyond the *burqa*: addressing the causes of maternal mortality in Afghanistan

by Hernan del Valle

Priority must be given by national and international actors to rehabilitate health systems in Afghanistan in order to meet basic health needs.

Much has been written about the restrictions on access to health for women under the Taliban regime that controlled Afghanistan until 2001. Taliban edicts gave institutional standing to practices which limited women's movements in public unless accompanied by a male relative, obliged women to wear the all-enveloping *burqa* and denied women access to education, work and health care.

Several reports highlighted the impact of these measures on women's access to reproductive health (RH) services. In 1997 WHO reported that Afghanistan had one of the world's highest maternal mortality rates: 820 per 100,000 live births. This alarming level was widely attributed to Taliban gender policies.[1]

Almost two years after the demise of the regime, however, it is hard to see any improvement. It is believed that only 12% of pregnant women have access to emergency obstetric care. UNFPA estimates maternal mortality rate still to be around 820 per 100,000 live births while UNICEF estimates it to be 1,600 – the highest maternal mortality rate anywhere in the world. Almost half of the reported deaths of Afghan women of childbearing age are due to complications of pregnancy or childbirth, 87% of which are considered preventable.[2] Newborn children who have lost their mothers have a one-in-four chance of living until their first birthday, with the majority perishing in the first month of life. The infant mortality rate is also the highest in the world: 161 per 1,000.[3] Even after making allowance for the unreliability of statistics and different methodologies adopted by researchers, it is indisputable that Afghanistan has appallingly low levels of RH care.

Programmes implemented by NGOs and UN agencies have had limited impact on reducing maternal mortality. We need to move away from one-dimensional accounts that describe the problem only from the angle of gender inequality and RH access restrictions towards a broader understanding of factors contributing to the ongoing high levels of maternal mortality in Afghanistan.

Culture and women's access to health

The restrictive policies imposed by the Taliban had a tremendous impact on the way Western governments and donors framed the planning and delivery of post-Taliban RH care. There has been a marked tendency to focus on maternal mortality as a problem stemming from a deeply embedded gender inequality limiting women's choices and access to health services. Virtually every expatriate-generated report has pointed to the recurrent scarcity of qualified female staff as a major factor contributing to poor RH care in an environment in which it is not always acceptable for a male doctor to examine a female patient. In terms of health-seeking behaviours, the vast majority of women have been reported as having to obtain permission from their husbands to seek health care. Women, it is stressed, have no power to make decisions about contraception or birth spacing.

All of this is true. However, in the context of Afghanistan's reconstruction, the problem of maternal mortality is far more complex. There are three reasons why the rights-based approach put forward to overcome it has been only marginally effective.

Firstly, the demise of the Taliban regime brought to an end the centralised system that enforced restrictive gender policies across the country. Although some reports have highlighted the continued existence of restrictions imposed by regional warlords, on the whole current government policies and legislation uphold access to health and education for all. It goes without saying that a country's traditions are far more resilient and influential than its laws. So the battle for access to RH has shifted from the realm of government policies to the slippery slope of culture and traditions. Therefore, the current challenge in developing any kind of advocacy strategy to promote access to RH care is how to work around constraints linked to local politics, cultural attitudes and interpretations of Islam.

a country's traditions are far more resilient and influential than its laws.

Secondly, focusing solely on the promotion of women's rights has proved too easy an option. It remains true that pressures on women to marry at an early age and their lack of freedom to make birth-spacing decisions are significant factors influencing maternal mortality. However, in a context in which Western understanding of women's rights are arguably at odds with Afghan traditions, the effectiveness of the women's rights-based approach in improving access to RH and reducing maternal mortality needs to be called into question.

Finally, and perhaps more importantly, the issue in Afghanistan is arguably not so much one of access to

health services for women but rather an issue of absolute lack of facilities. As one Afghan woman said when interviewed: "Well, the question is not if I **would** go or if I would be **allowed** to go [to a health facility] by my husband, but rather where I **could** go. (...) We would certainly use those services if they were accessible and proven to be reliable".[4]

Access to what?

Since 1979, Afghanistan's roads, irrigation systems, educational facilities, health infrastructure and human capital have been destroyed. Of the millions of Afghans who fled the country during the conflict, more than two million have returned from Pakistan and Iran since February 2002. A high percentage of the returnees are residing in temporary settlements around Kabul, where they lack access to housing, employment, health services and education. In addition, there are nearly 240,000 officially recognised IDPs living in camps who receive assistance from the international community.

For the vast majority of rural Afghans, health facilities remain inaccessible, under-staffed and under-equipped. Roads and transport are rarely available, and pregnant women often have to travel several hours by donkey to seek health care. It is not surprising that almost all of them deliver at home without qualified assistance. RH programming in post-Taliban Afghanistan has focused mainly on training and capacity building of female traditional birth attendants (TBAs). RH interventions have often been limited to the safe environment of prenatal consultations and health education initiatives covering topics such as breastfeeding, family planning, nutrition, immunisation and sexually transmitted diseases.

This approach has been relatively cheap and easy to implement. It also proved to be an easy way to kill two birds with one stone: not only do these initiatives satisfy donors' gender yearnings but they also fit into the fashionable category of 'quick impact' projects. However, experience has repeatedly shown that 'quick' is not necessarily 'better'. 'Impact' remains hard to determine. Numerous studies in different countries have demonstrated that these projects, even when well-planned and implemented, are likely to have a negligible impact on maternal mortality rates unless complemented by larger-scale programmes providing quality obstetric services, postnatal care and improved infrastructure.

Access for whom?

The wide variety of ills generated by displacement is well known. The need for legal and physical protection and the hardships caused by the loss of livelihoods and support networks have been extensively reviewed by existing literature. However, experience has shown that, compared to the general population, IDPs living in camps assisted by the international community can sometimes be better off than the general population when it comes to access to health care, including RH.

The camp setting allows UN agencies and NGOs to work with a population which is concentrated in a limited geographical space and therefore easily accessible. Since RH programmes do not require separate facilities, it is feasible to integrate RH into the general health service provision if the human and material resources are available. The 'limited' environment provided by the camp could also make it relatively easier to effectively involve the population both in the planning and implementation phases. TBAs living in the camp could be identified and trained, and health education initiatives would have better chances of achieving continuity and higher levels of coverage. The camp setting could also facilitate prenatal visits by qualified outreach workers and post-partum follow-up.

However, even if all these systems were effectively put in place, the critical question of adequate referral options would remain unanswered. Even if transport to a nearby clinic were made available, the lack of staff and equipment would make it impossible to handle complicated births. For that reason, a limited focus on RH for IDPs in camps makes little sense if the goal is to reduce maternal mortality. In Afghanistan the challenge is to improve services at a hospital level and to ensure that quality obstetric care is available to both IDPs and the general population.

Tackling maternal mortality outside the camps

It is now widely acknowledged that commitment to the reconstruction of Afghanistan has been half-hearted. The amount of funds initially pledged was small compared to other humanitarian crises and they have not always been disbursed as promised. Moreover, commitment to support the Afghan administration in providing security in large areas of the country has also been ambiguous.[5]

Due to resource limitations and the impact of Afghanistan's brain drain, the fledgling Afghan Ministry of Health (MoH) is not able to undertake comprehensive planning and centralised implementation of nationwide initiatives. In the current reconstruction phase, its capacities have been further limited by donor prioritisation

of projects implemented by NGOs and international agencies. This situation has created considerable problems in terms of management and coordination of aid flows and harmonisation of agency mandates and agendas. It has encouraged an *ad hoc* approach. Strategies have not yielded anticipated results.

If maternal mortality is to be reduced in Afghanistan, at least four conditions need to be met.

1. RH must be recognised as an integral part of general health which cannot be divorced from the general well-being of women, men and children. RH must be incorporated into a comprehensive public health plan aimed at achieving free access to basic health care for the majority of the population. The current PPA (Performance-based Partnership Agreements) approach, which places responsibility on donor-selected NGOs for delivering basic health services in entire provinces, risks being neither sustainable nor accountable to the Afghan public.

2. Increased support for the Afghan administration is needed. It is unrealistic to believe that the MoH will ever be in a position to take primary responsibility for delivering health care without donor support for supplies, planning, infrastructure development and capacity building. Action must be taken to remedy the effects of inter-agency competition which has created a pull factor attracting qualified female health professionals from rural to urban centres.[6] The fact that many international agencies do not work in remote areas due to security concerns contributes to the further deterioration of RH care where it is most needed.

3. Maternity clinics and regional hospitals must be helped to obtain the equipment and trained staff needed to provide quality care. Any effective strategy to reduce maternal mortality must target all three levels: prenatal care, assistance during delivery and postnatal care. The last two have received little attention so far.

4. Priority must be given to basic needs in both rural and urban areas: safe water, nutrition, shelter, sanitation, security and education all contribute to safer motherhood.

The combination of traditions and unsatisfied basic needs is a lethal one for women of childbearing age in a country described as the most dangerous place on earth to become a mother.

Donors, agencies and the government must simultaneously address the needs of both IDPs and the general public. Overstating the role of social and cultural mores in perpetuating high levels of maternal mortality in Afghanistan risks becoming a dangerous collection of excuses to justify the failure of national and international actors to fulfil their pledge to rehabilitate health systems.

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1. See *The Taliban's War on Women*, Physicians for Human Rights (PHR), 1998. See also *Women's Health and Human Rights in Afghanistan*, PHR, 2001. See www.phrusa.org/publications/afghan.html

2. *Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability*, report published by the Afghan Ministry of Public Health, UNICEF and the Centre for Disease Control and Prevention, Nov 2002. See: www.afghanica.org/dokumente/mat%20mortality.pdf

3. *The State of World Population*, UNFPA, 2002 (www.unfpa.org/swp/swpmain.htm)

4. Interview with 30-year-old married woman in Kandahar province, Afghanistan, August 2003.

5. See FMR 18 pp38-39.

6. The draft of the 'National Salary Policy' is an attempt to overcome this problem. See 'National Salary Policy for NGOs Working in the Afghan Health Sector', by the Salary Policy Working Group (SCA, GCMU/MoH, IAM, AHDS, USAID/MSH).

UNFPA

Reducing maternal mortality among repatriated populations along the Guatemala-Mexico border

by Cristina Alonso, Laura Miranda, Sally Hughes and Lucy Fauveau

Provision of reproductive health services and training for local health workers among returned indigenous Guatemalans has proved valuable.

Guatemala has had a long and violent history of internal conflict.[1] Complex social inequalities have been exacerbated by the effects of civil war. After peace accords were signed in Mexico in December 1996, Guatemalan refugees were repatriated to areas greatly lacking in health services and basic infrastructure. Refugee communities were repatriated to Guatemala but dispersed to places that were not their areas of origin. They therefore continued to be displaced within their own country, relabelled as IDPs and no longer cared for by the international community.

Over half of the population of Guatemala lives in extreme poverty; within the rural areas this rises to 91%. The population is very young with almost 40% aged below 18 years of age. Maternal mortality rates are among the highest in Latin America and highest amongst indigenous women. The maternal mortality ratio for indigenous women is three times higher (211 per 100,000 live births) than for the non indigenous group (70 per 100,000 live births), according to the Baseline Maternal Mortality study for 2000. More than half of maternal deaths are due to excessive bleeding. Others are due to infections, hypertension induced by pregnancy, and unsafe abortion.[2] Among indigenous women, the contraceptive prevalence rate is 10% whereas the national figure is 27%. While 52% of urban women use a contraceptive method, only 27% of rural women and 10% of indigenous women do so.[3] Along with this, according to UNAIDS, Guatemala has the second highest prevalence of HIV/AIDS infections in Central America with a rate of 1% of the population aged 15 to 24.[4]

In 1999 Marie Stopes Mexico initiated a project to ensure the provision and institutionalisation of quality, affordable reproductive health (RH) services for the displaced and static populations in Chiapas, Mexico. Populations include refugees from Guatemala, internally displaced Mexicans and local Mexican communities. The programme includes centres as well as outreach work providing extensive information, education and communication (IEC) initiatives.

In response to the situation in Guatemala, this successful and innovative programme expanded in 2001 to provide cross-border services to the returned communities in the state of Huehuetenango. Via a mobile unit, Marie Stopes Mexico is providing family planning (FP) and maternal child health services and IEC activities to raise awareness of sexual and RH in remote, under-served areas.

The objectives of the project are:

- improved access to high quality sexual and reproductive health (SRH) provided by a mobile outreach programme to rural communities
- increased awareness of SRH issues amongst rural communities and local organisations.

Project activities include non-surgical family planning, maternal and child health services and information, education and communication activities. This includes the training of health promoters and traditional midwives who can both improve the access to and raise awareness about SRH services. During the two-year project the mobile unit helped 2,786 women to access RH servies and trained over 28 health promoters and 45 traditional midwives in 22 rural communities.

To evaluate the project's success, surveys were carried out before and after the main intervention by the project teams. Each survey included 400 questionnaires to men and women aged 14 to 45 years old. Survey training was provided by the mobile team members and external consultants, and included reviews of the objectives and interactive methods such as role-plays to familiarise the team with the process. For cultural and linguistic reasons local health promoters and midwives undertook the bulk of the survey work.

There were limitations to carrying out the study, such as the time of year during which it was carried out (harvest time), the presence of males inhibiting women's responses, privacy issues and Mayan cultural constraints regarding speaking about family planning.

Results and analysis

The fact that literacy levels among women did not significantly improve in the two years of the project highlights the lack of government educational programmes. It was found that barely half of the women in the study could speak Spanish. These results indicate that returned populations have a significant disadvantage in terms of access to information. Illiteracy and monolinguism may have

a direct impact on the health status of communities. Knowledge of problems during pregnancy was inversely related to literacy and knowledge of Spanish in the general population and specifically in women. Seventy per cent of women who cannot read were able to identify a problem in pregnancy compared to 50% of women who can read.

However, it is important to note that women who are not able to read have higher rates of fertility and generally tend to learn from other women who are close to them. These women may also have a higher percentage of problems during their pregnancies and births due to the fact that they are more isolated and less educated, an assertion supported by the results that women who are unable to read have almost twice as many miscarriages. This result requires further investigation as it signals important health disadvantages and risks related to literacy levels.

Since the population's return to Guatemala, there has been no change or improvement in the services available to them. Marie Stopes Mexico's services are therefore extremely valuable as they are the only place people can get information and access to RH services. After two years of the project, 93% of the community cited Marie Stopes Mexico as important or very important, signalling the acceptance of and demand for services.

Results indicate that antenatal and childbirth care given by midwives increased significantly during the project. All the women interviewed had sought an attendant during birth. In the follow-up survey, 89% of women had given birth with the assistance of a traditional midwife, as opposed to 71% at baseline.

The fact that all women had been attended in their births is an important and significant success. However, this does not guarantee the level of training of the birth attendants. Costs and logistical difficulties of transport, reluctance of women to go to hospital and the importance of the husband's decision in where a woman will birth seriously affect whether a woman will be transported to a hospital in case of high risk or an emergency. Out of the population surveyed, 88% indicated that it was the husband's decision to approve of his wife's transport to a hospital in the event of a childbirth problem or emergency.

Identification of specific problems during pregnancy increased among the population, particularly in the case of haemorrhage, mal-positioning and frequent headache, recognition of which almost doubled. Knowledge of specific problems which can occur during childbirth also increased among men and women in the communities. Recognition that women can die at childbirth also improved significantly to almost 95% from 80% in the baseline survey.

Identification of problems which can emerge during childbirth rose from 53% to 67%, indicating an important programme success. However, appropriate arrangements for transport need to be made possible as it remains a major obstacle to successful reduction of maternal mortality in rural areas, not just in terms of physical access to services but also in terms of the decision-making process. These results indicate that there is still important work to be done regarding gender equity, female empowerment and communication between men and women.

interventions need to also address male perceptions and knowledge of risk

Knowledge of all modern family planning methods doubled and family planning use increased from 9% to 30%. Over 90% of the population

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surveyed in the follow up could identify where to purchase a family planning method, and 64% correctly said that family planning methods could be purchased through health promoters.

It is significant that the presence of Marie Stopes Mexico brought local use of contraception into line with national rates. The fact that injectable contraceptives were the most popular and preferred method is in part due to women's need to use a more discreet family planning method without their husband knowing.

This signals the need to improve RH IEC directed at men. Despite increases in FP knowledge and use, there are still many ingrained fears and myths surrounding methods, reinforcing the need for IEC on RH to reach people at a much younger age.

Use of FP methods was associated with knowledge of Spanish among women and may reflect their improved access to education, resources and direct communication with all team members. In fact, women who speak Spanish were four times more likely to use an FP method then those who do not.

Regarding fertility preferences, more than half of all the respondents indicated that they would like another child. At the same time, demand for FP use almost doubled. Almost three quarters of women indicated they would like to use an FP method.

Although Marie Stopes Mexico has had an important impact on increasing FP method use, fertility rates remain high in the area. The results suggest that fertility is still highly valued and pregnancy is still considered a random, uncontrollable and/or predestined event by many. This has important implications for maternal mortality and morbidity, together with the fact that women are generally not considered as primary decision makers regarding their fertility or decisions affecting their health status.

Main lessons learned and recommendations

- To improve women's lives, decrease maternal mortality and morbidity, interventions need to also address male perceptions and knowledge of risk.

Returnee comm in Huehueten Guatemala

- Community involvement is crucial in affirming that maternal mortality is a collective issue which can be tackled with the participation of all local actors.
- The establishment of a community fund to cover emergency transport costs and improvement of roads could save lives.
- Emphasis must be placed on increasing gender equity and improving knowledge and application of reproductive rights.
- IEC activities should be expanded to include men and young people, particularly adolescent males who are less informed about reproductive risks and options. It is important that young people initiate their reproductive lives aware of SRH issues and the possibility of accessing appropriate services.
- Improved collaboration with the Guatemalan Ministry of Health is fundamental to address the comparative disadvantage of returned indigenous groups that remain isolated and ignored.
- Improved literacy provides a distinct advantage in terms of access to information; literacy programmes should be promoted and expanded.

Conclusion

Results show that provision of RH services and training for local health workers has a positive effect on knowledge and use of these services among returned indigenous Guatemalan communities. The success of the project indicates that this model would be replicable in other internally displaced or returnee settings where communities lack access and inclusion within the national health system and remain isolated in an unfamiliar land.

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1. See FMR 11 pp7-9 and FMR 7 pp16-19.

2. MSPAS, 'Línea basal de mortalidad materna para el año 2000', Ministry of Public Health and Social Welfare Baseline Maternal Mortality Study, 2000.

3. The most common family planning methods are female sterilisation (14.5%), contraceptive pills (3.5%), intrauterine devices (2.4%), hormone injections (2.3%), condoms (2.2%) and male sterilisation (1.5%). Source: PAHO 1999.

4. 'Guatemala: Epidemiological Fact Sheets on HIV and Sexually Transmitted Infections', UNAIDS, UNICEF, PAHO, WHO, 2002 (www.unaids.org)

UN Process Indicators: key to measuring maternal mortality reduction

by Janet Meyers, Samantha Lobis and Henia Dakkak

Is enough being done to provide displaced women with emergency obstetric care (EmOC)?

Every year more than half a million women die from complications of pregnancy and childbirth. Many more suffer severe disabilities. WHO estimates that 15% of all pregnant women will develop direct obstetric complications such as haemorrhage, obstructed or prolonged labour, pre-eclampsia or eclampsia, sepsis, ruptured uterus, ectopic pregnancy and complications of abortion. If left untreated, they will lead to death or severe disability. Maternal mortality and morbidity can only be reduced by ensuring women with obstetric complications receive good-quality medical treatment without delay. The desperate circumstances of refugee and IDP women fleeing conflict place them at exceptional risk of pregnancy-related death, illness and disability.

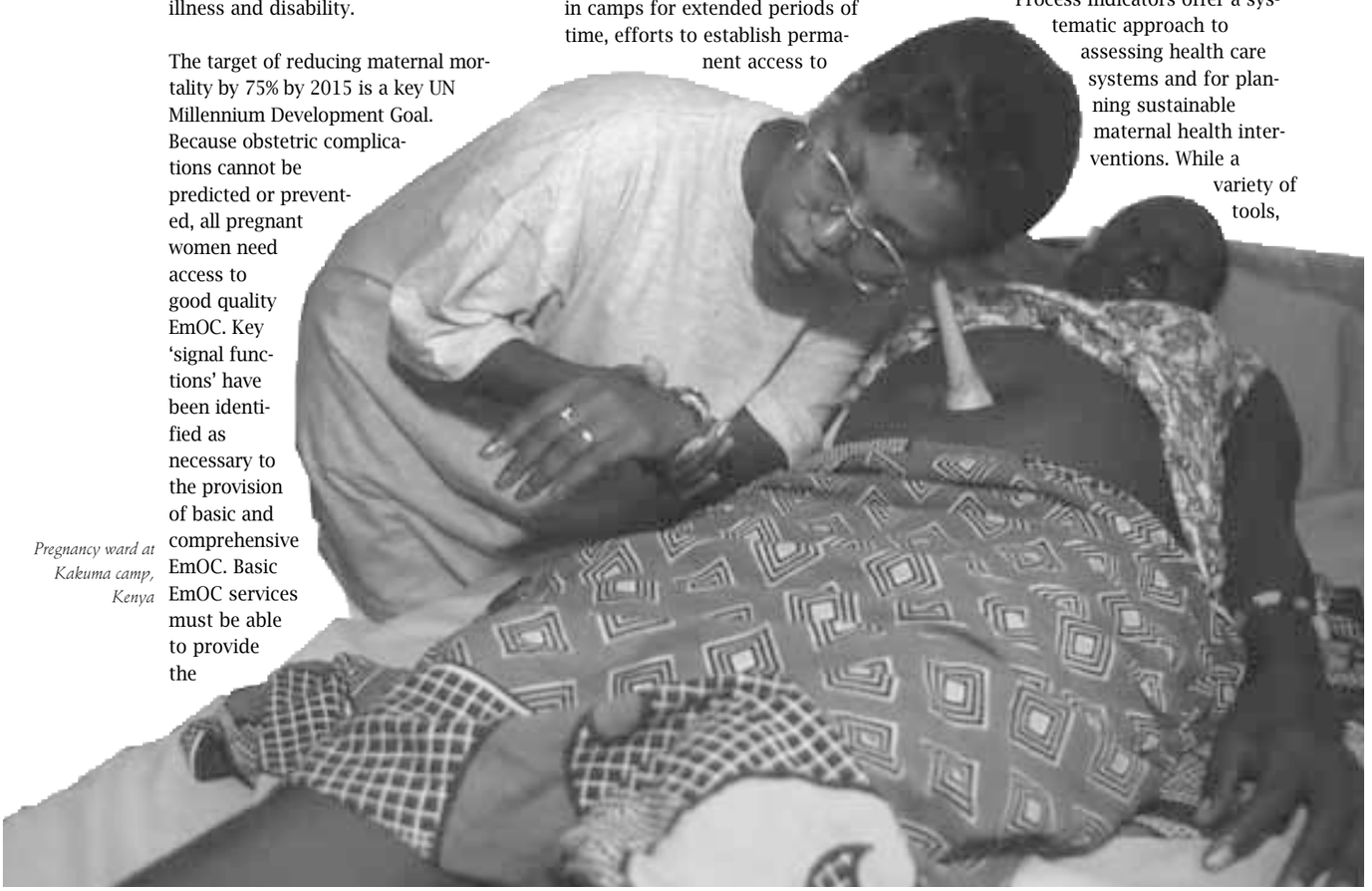
The target of reducing maternal mortality by 75% by 2015 is a key UN Millennium Development Goal. Because obstetric complications cannot be predicted or prevented, all pregnant women need access to good quality EmOC. Key 'signal functions' have been identified as necessary to the provision of basic and comprehensive EmOC. Basic EmOC services must be able to provide the following signal functions: parenteral (given intravenously or by injection) antibiotics, parenteral oxytocic drugs, parenteral anti-convulsants (for pre-eclampsia and eclampsia), manual removal of placenta, removal of retained products and assisted vaginal delivery. Comprehensive EmOC includes all these plus: ability to perform surgery (Caesarian section) and blood transfusion.

Conflict-affected populations have access to EmOC through the Minimum Initial Service Package (MISP) for RH services.[1] However, the MISP was designed and developed to prevent excess neonatal and maternal morbidity and mortality in the early phases of complex emergencies. Since most conflict-affected populations remain in camps for extended periods of time, efforts to establish permanent access to EmOC need to be made. Therefore, to reduce maternal mortality and morbidity among this population of women, it is imperative to assess the local health system and plan EmOC programmes accordingly.

UN Process Indicators

In 1997 UNICEF, WHO and UNFPA issued a set of indicators called 'UN Process Indicators' to monitor the availability, utilisation and quality of EmOC.[2] To standardise the use of the UN Process Indicators, they were published with a set of guidelines in the document 'Guidelines for Monitoring the Availability and Use of Obstetric Services',[3] commonly referred to as the 'UN Guidelines'.

Based on a specific package of medical services that must be available at health facilities in order to save women with complications, the UN Process Indicators offer a systematic approach to assessing health care systems and for planning sustainable maternal health interventions. While a variety of tools,



Pregnancy ward at Kakuma camp, Kenya

The Six UN Process Indicators and Recommended Levels

UN Process Indicator	Definition	Recommended Level
1. Amount of EmOC services available	Number of facilities that provide EmOC	Minimum: 1 Comprehensive EmOC facility for every 500,000 people Minimum: 4 Basic EmOC facilities per 500,000
2. Geographical distribution of EmOC facilities	Facilities providing EmOC well-distributed at sub-national level	Minimum: 100% of sub-national areas have the minimum acceptable numbers of basic and comprehensive EmOC facilities
3. Proportion of all births in EmOC facilities	Proportion of all births in the population that take place in EmOC facilities	Minimum: 15%
4. Met need for EmOC services	Proportion of women with obstetric complications treated in EmOC facilities	100% (Estimated as 15% of expected births)
5. Caesarean sections as a percentage of all births	Caesarean deliveries as a proportion of all births in the population	Minimum 5% Maximum 15%
6. Case fatality rate	Proportion of women with obstetric complications admitted to a facility who die	Maximum 1%

service packages and policies have been developed by UN agencies and NGOs to standardise and monitor humanitarian health services and include maternal health, most do not adequately or systematically address women's access to EmOC. This is why the UN Process Indicators would be invaluable to the humanitarian community.

The UN Process Indicators answer the following questions:

- Are enough facilities providing EmOC?
- Are they well distributed within a geographic area?
- Are enough women using these facilities?
- Are women with obstetric complications using these facilities?
- Are enough critical services being provided?
- Is the quality of the services adequate?

Manuals and guidelines under the spotlight

RHRC has reviewed five published manuals and guidelines used by humanitarian organisations to ascertain the need for and utility of the UN Process Indicators in conflict settings. The documents reviewed were:

- Sphere Project, *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response*, 2000.[4]
- Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG), *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual*, Geneva: UNHCR, 1999.[5]
- Médecins Sans Frontières (MSF), *Refugee Health: An approach to emergency situations,* 1997.[6]
- World Health Organisation, *Reproductive Health during Conflict and Displacement: A Guide for Programme Managers*, Geneva: WHO, Department of Reproductive Health and Research, 2000.[7]
- UNHCR, G*uidelines on the Protection of Refugee Women,* 1991.[8]

Four questions were used to guide the review:

1) Does the document include EmOC?
2) Does it clearly identify which EmOC services need to be in place?
3) Does it incorporate the UN Process Indicators into the assessment, monitoring or evaluation plans?
4) Does it list the UN Guidelines as a resource?

Our key findings were:

- The newly revised **Sphere Project** manual includes a section on EmOC and clearly defines basic EmOC services to be provided at the health centre and comprehensive EmOC services needed at the referral hospital level. However, the UN Process Indicators are not included and the UN Guidelines are not listed in the resources.

- While the **IAWG** manual includes the importance of good quality EmOC to reduce maternal mortality, discusses process indicators in general and refers to the UN Guidelines, it does not include the UN Process Indicators specifically.

- The **MSF** manual includes the need for EmOC, the importance of working with existing health systems and the direct link between obstetric complications and maternal morbidity and mortality. It does not include specific EmOC services and skills required, reference to UN Process Indicators or necessary variables, or reference to the UN Guidelines.

- The guide developed by **WHO** includes the importance of EmOC, quality of care, and human rights and list some EmOC services and types of skilled practitioners needed. While it has a general list of process indicators it does not include all the necessary EmOC services or skills required nor make specific reference to the UN Process Indicators or UN Guidelines.

- **UNHCR** guidelines include the need for accessible women's health services but do not include EmOC specifically.

Recommendations

There have been great improvements in defining indicators for monitoring and evaluating EmOC initiatives in humanitarian programmes. However, there is a continued need to standardise monitoring and evaluation of maternal mortality reduction programmes in a way that is understood universally. Guidelines developed by UNICEF, WHO and UNFPA[9] should be

distributed to all agencies working with war-affected populations. Improved coordination between the field and national-level partners in the collection of the UN Process Indicators would greatly improve the quality of the data and improve monitoring of maternal mortality reduction programmes.

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To respond to the needs of populations affected by conflict, the Reproductive Health Response in Conflict (RHRC) Consortium, with funding from Columbia University's Averting Maternal Death and Disability (AMDD) Project, is supporting 11 EmOC projects in the countries of Bosnia-Herzegovina, Kenya, Liberia, Pakistan, Sierra Leone, southern Sudan, Thailand, Tanzania and Uganda. Because facilities are frequently damaged or destroyed during conflict, initial activities included facility construction or renovation plus provision of equipment, supplies and medicines. Additional activities are staff training and community outreach.

1. MISP is a set of priority activities designed to: prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services. For more information, see: www.ippf.org/resource/refugeehealth/manual/2.htm#Objectives

2. A Paxton, D Maine & N Hijab, *Using the UN Process Indicators of Emergency Obstetric Services*, AMDD Workbook, May 2003.

3. See: www.eldis.org/static/DOC12421.htm

4. See: www.sphereproject.org

5. See: www.unfpa.org/emergencies/manual

6. Médecins sans Frontières, *Refugee health: an approach to emergency situations*, New York City: MacMillan Education Ltd. 1997.

7. See: www.who.int/reproductive-health/publications/RHR_00_13_RH_conflict_and_displacement/RH_conflict_introduction.en.html

8. See: www.womenscommission.org/pdf/unhcr.pdf

9. The 'Guidelines for Monitoring the Availability and Use of Obstetric Services' are available in hard copy by contacting UNFPA and WHO or online at:
- www.unicef.org/health/guidelinesformonitoringavailabilityofemoc.pdf
- www.unfpa.org/upload/lib_pub_file/188_filename_emoc-guidelines.doc
- www.who.int/reproductive-health/publications/unicef/

No product? No programme! The logistics of reproductive health supplies in conflict-affected settings

by Paul Crystal and Lisa Ehrlich

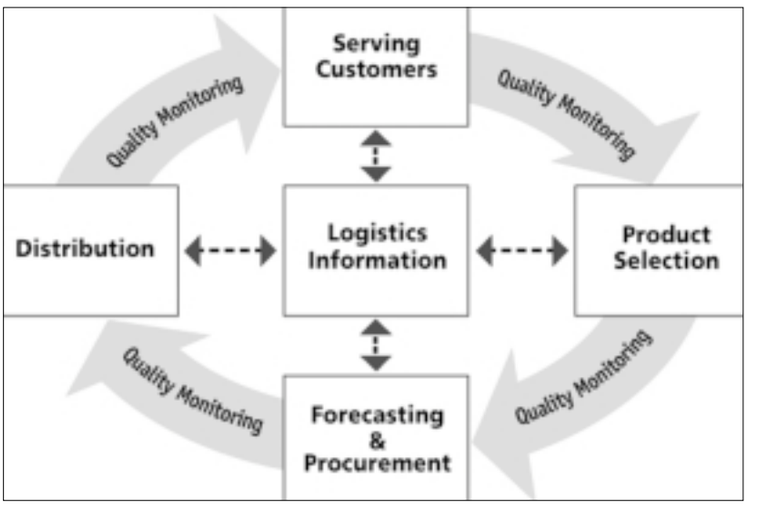
Effective RH logistics are essential and feasible.

The government of Angola is working with NGOs to initiate a series of aggressive HIV prevention activities and information campaigns. Twenty-five years of civil war, however, have robbed the country of its ability to procure enough contraceptives for these programmes, and even to guarantee a regular supply of essential medicines to meet other basic health needs of the Angolan population. A similar story emerges in the Democratic Republic of the Congo. Condoms are rarely available, particularly in the east, where population movements, military presence and the use of rape as a weapon of war contribute to the increased transmission of HIV. An OCHA assessment of health facilities in Kinshasa found stock-outs of many basic medicines, especially those needed for safe motherhood programmes. And although family planning supplies can be found in many pharmacies, they are too expensive for most women.

Health programmes are rendered ineffective when the products they require are not available to users. This is where logistics systems become critical – making sure that the right amount of the right product arrives at the right place, at the right time, in the right condition and at the right cost. Logistics planning is often overlooked in the struggle to create, support and fund reproductive health (RH) programmes for refugees and IDPs. Women without access to RH care face the increased risk of birth complications, unintended or mistimed pregnancies, unsafe abortions, infectious disease and death.

It is time to dispel the myth that logistics systems are too complicated or merely a secondary part of programme planning. True, operating a RH logistics system for refugee and internally displaced populations can be particularly challenging. But any

provider capable of running a RH programme in these settings can design and implement a simple logistics management system to help decide what to stock, how much to stock and when to reorder supplies. As shown in the following diagram, logistics management is not a one-time event but is instead a routine, cyclical process.
At the outset, the main objective of implementing a logistics system for a



RH programme for refugees and displaced persons is to move needed supplies to users without gross waste. This only requires understanding a few concepts, implementing a simple set of steps, and gathering and using information. As refugee populations grow and stabilise, logistics systems can become more robust, allowing providers to expand the range of products and improve the routine efficiency of programmes.

Ideally, the cycle begins with **use** of the products by clients. This way, information about actual consumption can be employed as the basis for deciding what products to procure and in what quantities to procure them. In new refugee or IDP settings, such data may be difficult or impossible to obtain. Without the experience of having provided RH commodities to a population, it is virtually impossible to know what methods and what brands are preferred (both are critical elements to ensuring effective and continued use of contraceptives). In the meantime, though, forecasting and procurement of supplies can be carried out on the basis of best guesses. Good estimations can be formulated using survey data from the affected population during more stable times, or perhaps extrapolated from conducting a small sample.

One of the most important concepts for a programme manager to factor into initial planning is **lead time** – the number of weeks or months that elapse between the time an order is placed and the time products are received and made available in health facilities. It is critical to have an idea of donors' lead times both in emergency response and routine order fulfillment, to avoid long gaps when essential supplies are out of stock. Although donors can often meet emergency needs quickly, their systems are best set up to conduct routine procurement and make standard shipping arrangements. So the sooner a refugee or IDP setting can shift to routine ordering, the better.

Storing and transporting products are usually thought of as the classic logistics functions. In the case of refugee RH programmes, these **distribution** functions involve hardly any complicated choices. After all, service delivery points are few in number, product quantities are generally not overwhelming, and special storage facilities are probably not available. However, this means that the programme manager must tailor the contraceptive supply chain to local conditions. To the extent possible, RH products – including oral contraceptives, condoms and injectables – should be stored securely to prevent misuse or pilferage. They should also be kept in a clean, dry area at a temperature of between 15 and 30 degrees Celsius. Clearly, these conditions cannot always be met but an effort to do so can prevent a significant amount of product damage and deterioration.

Logistics management decisions become easier and more reliable when programmes begin to function on a more regular basis. Using actual usage data from target populations is the best way to accurately estimate future needs. Thus, the primary logistics responsibility of a RH programme manager is to routinely collect information on a simple set of three essential data items:

1. stock on hand (how much of each product is in the system already)
2. stock on order (how much has already been ordered and what the lead time for delivery is)
3. average monthly consumption (how much of each product is used)

Knowledge of these three elements helps guarantee that the quantity of products ordered from a donor is not only sufficient to meet user demand but is also not so great that unnecessary wastage occurs when commodities expire on the shelves before they can be used.

Implementing logistics systems is of paramount importance for health programmes that address the needs of stable and transitional populations alike. Until the relief community truly embraces the importance and feasibility of RH logistics, all interventions are doomed to only partial success, if not outright failure.

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An in-depth description of designing a contraceptive logistics management system for refugee settings, *Contraceptive Logistics Guidelines for Refugee Settings*, is available without charge at http://deliver.jsi.com/2002/Pubs/Pubs_Guidelines/index.cfm

See page 32 for list of RH websites

The global gag on reproductive health rights

by Ulla Margrethe Sandbæk, MEP

It is of vital importance for refugees and internally displaced persons that their reproductive health needs are covered. There has been a growing understanding of this in recent decades but in the last few years there has been a stark rise in the number of campaigns aiming to erode support of reproductive health.

The problem originates in a minority of anti-choice groups – mainly US-based – who seek to hijack the reproductive and sexual health rights agenda by focusing on the controversial issue of abortion. On his first day in office in January 2001, President George W Bush reintroduced the Mexico City Policy, also known as the 'Global Gag Rule'. This stringent policy disqualifies foreign NGOs from receiving US funds for development if they in any way provide legal abortion services or if they lobby or counsel about or refer to abortion, even with funding which does not originate from the US. The law would be considered unconstitutional if imposed on US-based organisations. Therefore it is ironically only imposed on foreign NGOs.

The US must change its policy

In a worst case scenario, this will leave thousands, if not millions, of women without choices, forcing them into seeking unsafe/illegal and backstreet abortions. Such a development will only increase the problem, not diminish it.

The damaging effects are not only on the provision of family planning services worldwide (and reduction in family planning services will inevitably and ironically increase the number of unwanted pregnancies) but also on the fight against HIV/AIDS. Organisations providing family planning services – including pregnancy counselling and/or abortion services – are also at the forefront of the fight against AIDS.

The Mexico City Policy is inconsistent with international human rights standards and US legal principles, including the freedom of speech, democratic participation and reproductive autonomy. It calls into question US foreign policy objectives that encourage the building of democracy, civil society and women's participation as equals in society

Expansion of the Gag Rule

On Friday 29 August 2003, President Bush issued a Memorandum placing additional restrictions on US financial assistance to foreign NGOs that use their own funds to counsel, perform or advocate on the issue of abortion. The Memorandum extends the Mexico City Policy, which had previously applied only to programmes administered by the US Agency for International Development, to all voluntary population planning funds administered by the State Department. The State Department is still assessing which programmes and organisations would be affected by this.

Many groups are concerned that this policy will encumber efforts and slow responses in refugee situations where time is of the essence. By requiring US agencies to spend time investigating their partner agencies in the field, this policy could delay or prevent implementation of critical health care programmes proven to reduce rates of maternal and child mortality.

Members of the European Parliament like myself have a key role in contributing to an enabling environment for reproductive health and refugees, in shaping policy and ensuring commitment through the annual EU budget. The European Union decided to bridge the funding gap by paying to UNFPA and IPPF the money which was already pledged by the US.

The EU is a major funder of relief and development work, including reproductive health. Its most recent relevant financial instrument, adopted in July 2003, is the 'Regulation on reproductive and sexual health and rights in developing countries', which also provides for displaced populations.[1] This regulation implements the EU's commitment to upholding the principles agreed on at the International Conference on Population and Development (ICPD), held in Cairo 1994, and the ICPD+5, held in New York in 1999.

Women's lives around the world are tragically being lost due to unsafe childbirth, illegal and unsafe abortions and HIV/AIDS infection, in large part because they cannot access reproductive health care. The US must change its policy if it is not to become a major contributor to the tragedy.

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1. Fund of €74 million over four years.

Global Gag

The Bush Administration's 'Global Gag Rule' is negatively affecting reproductive health programmes around the world. For more information, visit:

www.heldtoransom.org

www.plannedparenthood.org/about/pr/030829_gagrule.html

www.globalgagrule.org

www.crlp.org/hill_int_ggr.html

UNHCR, HIV/AIDS and refugees: lessons learned

by Paul B Spiegel and Alia Nankoe

Inclusion of refugees in HIV/AIDS programmes reduces the spread of pandemic among refugee populations and host countries.

Conflict, displacement, food insecurity and poverty offer fertile ground for the spread of HIV/AIDS. Many of the 20 million persons of concern to UNHCR worldwide live in such conditions. As their physical, financial and social insecurity erodes habitual caring and coping mechanisms, refugees are often rendered disproportionately vulnerable to HIV/AIDS. While refugees do not necessarily have high HIV prevalence rates, they are inextricably linked to any successful effort to combat the catastrophic pandemic in the countries that host them.

Throughout history, marginalised populations have been blamed for the spread of disease. Often inadequate living and working conditions render them more vulnerable to various illnesses. Theories of disease causation versus the actual reality of a disease feed upon each other as "the poor get not only the blame, but also the disease."[1] Such a self-fulfilling prophesy has also characterised the HIV/AIDS pandemic. Refugees are often doubly discriminated against: firstly for simply being refugees and secondly for being falsely accused of bringing HIV/AIDS with them into host countries of asylum.

In order to reduce stigmatisation and to ensure that the whole population has access to HIV/AIDS prevention and care interventions, UNHCR is working to ensure that refugees are integrated into host government HIV/AIDS policies and programmes.

UNHCR's HIV/AIDS and refugees strategic objectives

HIV/AIDS prevention and impact mitigation are essential components in the overall protection of refugees. In 2002 UNHCR introduced its 2002-2004 Strategic Plan on HIV/AIDS and Refugees.[2] Based on a human rights framework, it has three main objectives:

- to ensure that refugees live in dignity, free from discrimination, with their human rights respected
- to ensure that a minimum and coordinated package of HIV/AIDS programmes is provided in refugee emergency situations (safe blood supply; adherence to universal medical precautions; condom distribution; basic health care including treatment of sexually transmitted infections and contact tracing; HIV information-education-communication (IEC) materials; orphan tracing and protection and care of survivors of sexual violence).
- to implement multi-sectoral and comprehensive HIV/AIDS pilot programmes in more stable situations that link prevention to care and reinforce surveillance, monitoring and evaluation.

These objectives are being implemented using a phased approach. In situations where there are few resources, only the first two strategic objectives can be achieved.

Although UNHCR is conducting HIV/AIDS activities globally, we concentrate our interventions in Sub-Saharan Africa, the region most affected by the pandemic. In each region, a standardised assessment is undertaken with our implementing partners. UNHCR's **Refugees and HIV/AIDS Assessment and Planning Tool** looks at:

- **policy:** existing national AIDS control programme guidelines or manuals; refugees specifically included as a vulnerable population under national AIDS control programme policy
- **protection:** no mandatory HIV testing of refugees under any circumstances; no denial of access to asylum procedure, *refoulement* or denial of right to return on basis of HIV status; when required by resettlement countries, HIV testing conducted in accordance with established standards (i.e. accompanied by pre- and post-test counselling and appropriate referral for follow-up support and services); no laws or regulations prohibiting refugee access to public sector HIV/AIDS programmes in country of asylum; specific programmes in place to combat stigma and discrimination against refugees living with HIV/AIDS; programmes in place to prevent and respond to Sexual and Gender-Based Violence (SGBV)[3]
- **coordination and supervision:** regular meetings among implementing partners in the field and in the capital; HIV/AIDS programmes specifically included in planning, implementation, monitoring and evaluation stages of programme cycle; regular attendance at meetings of UN Theme Group on HIV/AIDS and associated technical working groups at capital level
- **prevention:** safe blood supply; universal precautions; condom promotion and distribution; behavioural change and communication (including development of educational/awareness materials in appropriate languages; programmes for in-school and out-of-school youth, peer education, youth centres, sports/drama groups, programmes aimed at reducing teen pregnancy and combating SGBV); Voluntary Counselling and Testing (VCT)[3]; Prevention of Mother-To-Child

Transmission (PMTCT); prophylaxis for opportunistic infections; and Post-Exposure Prophylaxis (PEP)

- **care and treatment:** Sexually Transmitted Infections (STIs)[3]; opportunistic infections including tuberculosis; nutrition,[3] home-based care; people living with HIV/AIDS; orphans

- **surveillance, monitoring and evaluation:** behavioural surveillance surveys; AIDS clinical case and mortality reporting; blood donors; syphilis among antenatal clinic attendees; STIs (by syndrome); condom distribution; opportunistic infections including tuberculosis; VCT; PMTCT; SGBV; PEP; and SGBV.

This standardisation has proved invaluable in ensuring that all areas of HIV/AIDS are assessed as well as allowing for comparison between programmes and countries.

Following the assessment, UNHCR and its implementing partners strategically plan for the following year using the same categories.

What have we learned?

Evaluation and planning missions to Kenya, Tanzania and Uganda were undertaken between June and October 2002 culminating in a tri-country HIV/AIDS and Refugees workshop in December 2002 in Entebbe, Uganda. Key findings have included:

- wide variation of standards, quality and comprehensiveness among HIV/AIDS programmes being implemented in refugee situations

- lack of basic and culturally appropriate IEC materials in local languages

- high levels of HIV discrimination and stigma against, as well as within, refugee communities

- lack of funding and technical expertise which severely hampers HIV/AIDS programmes in refugee situations.

In early 2003 similar missions undertaken in South Africa, Zambia, Namibia and Angola showed the epidemic to be more mature and the problems deeper and more complicated. Current developments in Southern Africa reveal the unfolding scenario of impending catastrophe in East Africa and the Horn of Africa. There are significant numbers of predominantly male urban refugees with HIV/AIDS who are suffering terribly. UNHCR's self-reliance strategy for urban refugees in South Africa may need to revert to a care and maintenance phase as more refugees become vulnerable. Angolan refugees returning from such high HIV prevalence host countries as Zambia and Namibia may bring HIV/AIDS with them and increase the relatively low HIV prevalence in Angola.

Angola: repatriation and HIV/AIDS

HIV/AIDS protection and advocacy must be pursued vigorously to reduce discrimination against those returning to Angola. Promotion of the right of return as a basic human right is crucial. We must insist there should be no mandatory HIV testing, and avoid any form of discriminatory treatment and stigmatisation of refugee returnees due to HIV/AIDS.

Behavioural surveillance surveys found that refugees had better HIV/AIDS knowledge than non-displaced Angolans. Camp refugees have trained health and community workers, teachers and peer educators who will benefit Angola upon their return. UN agencies are working with the Angolan government to accredit their training in countries of asylum. Comprehensive HIV/AIDS plans to improve the HIV/AIDS programmes for Angolan refugees as well as returnees have been developed and funded. Within camps existing programmes have been strengthened with new focus on prevention interventions. For those returning to Angola, HIV/AIDS prevention measures, condom promotion and peer education are being combined with landmine awareness training. Returning health and community workers are being provided with condoms to distribute.

It is encouraging that behavioural surveillance surveys have found that refugees are better informed about HIV/AIDS than non-displaced Angolans.

HIV/AIDS programmes need to be directed towards all Angolans in refugee returnee municipalities, including non-displaced populations and IDPs. These programmes need to begin with the provision of basic HIV/AIDS interventions and then expand to more comprehensive activities.

Refugees excluded from national HIV/AIDS initiatives

Countries of asylum are ultimately responsible for the protection and well-being of people living on their soil, including refugees.

However, refugees have been systematically excluded from many host countries' HIV/AIDS National Strategic Plans (NSPs) and their needs have not been addressed in proposals submitted to major donors. Refugees and local populations interact on a daily basis. Their systematic exclusion is not only discriminatory but it also undermines effective HIV/AIDS prevention and care efforts.

Of the 29 countries in Africa that host more than 10,000 refugees, UNHCR has been able to review 22 NSPs. While 14 mention refugees, 8 fail to do so. Of those that do mention refugees, 10 NSPs mention specific activities for refugees, while 4 NSPs fail to do so. The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM: a multilateral financial instrument established by the Secretary-General of the UN, Kofi Annan)[4] and the Multi-Country HIV/AIDS (MAP) Programmes of the World Bank[5] have funded HIV/AIDS projects in 25 of these 29 refugee-hosting sub-Saharan states. Only a minority of proposals, include refugees. In the 23 states with approved GFATM proposals only five programmes have included activities for refugees. Eight of the 15 approved World Bank MAP projects have refugee-specific components.

The way forward

UNHCR and our partners have realised the need to:

- accept that each refugee situation is unique: HIV/AIDS programmes in low resource settings need to be adapted to local circumstances
- ensure that host countries always include refugees and all other vulnerable groups in their efforts to combat HIV/AIDS
- promote sub-regional approaches to address the constant movement between countries
- improve cooperation and coordination between UNHCR and other UN agencies, NGOs and governments in both host countries and countries of origin
- provide more vigorous support to such regional initiatives as the Great Lakes Initiative for HIV/AIDS[6] and West Africa's Mano River Union Initiative[7] on HIV/AIDS
- ensure that donors such as the GFATM and the World Bank include refugees and IDPs in all HIV/AIDS programmes and funding proposals
- encourage donor governments to learn from experience in Uganda and ease conditions preventing funds being simultaneously used for resident and displaced populations
- ensure that refugees are not excluded as antiretroviral medications become more widely available in developing countries.

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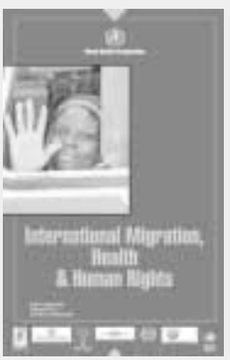
1. J N Hays *The Burdens of Disease: Epidemics and Human Response in Western History*, Rutgers University Press, 1998, p3
2. Available upon request from UNHCR: spiegel@unhcr.ch
3. This has prevention as well as care and treatment components.
4. See: www.theglobalfund.org/en/about/road/history/default.asp
5. See : www.worldbank.org/afr/aids/map.htm
6. See: www.onusida-aoc.org/Eng/GLIAEN.htm
7. See: www.onusida-aoc.org/Eng/Mano%20River%20Union%20Initiative.htm

On 10 December 2003 - Human Rights Day – three UN agencies launched an interactive cartoon booklet called ***HIV/AIDS Stand Up for Human Rights.*** The cartoon is part of a global campaign to tackle HIV/AIDS-related stigma and discrimination and other human rights violations.

The cartoon, launched by the United Nations Office for the High Commissioner for Human Rights (OHCHR), the United Nations Joint Programme for HIV/AIDS (UNAIDS) and the World Health Organization (WHO), is designed to empower young people to promote human rights in relation to HIV/AIDS, to raise awareness of the key linkages between HIV/AIDS and human rights, to demystify the disease and to combat the myths and taboos associated with HIV and AIDS. The cartoon is written in a language accessible to children and young people all over the world. It can be viewed at: www.who.int/hhr/news/en/

On the occasion of the International Day of Migrants on 18 December 2003, WHO and several collaborators launched the publication ***International Migration, Health and Human Rights.***



The issue of migrants' health is often unrecognised, and migrants themselves consequently have less access to the health care services they need. This new publication draws attention to important human rights issues that migration poses for health policy makers internationally, such as the health implications of forced migration as well as detaining and screening migrants at the borders. The book emphasises important human rights principles by which governments, policy makers and other actors can design and implement health policies and programmes in the context of migration. It also demonstrates the need for further attention, research and elaboration of policy approaches in this area. It can be viewed at: www.who.int/hhr/news/en/

Hard copies will also be available. Please contact: World Health Organization, Marketing and Dissemination, CH-1211 Geneva 27, Switzerland. Tel: +41 22 791 2476. Fax: +41 22 791 4857
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Tackling HIV/AIDS in post-war Sierra Leone

compiled by the FMR editors from submissions by CARE, IRC and ARC

NGOs are learning to talk about sex with at-risk HIV/AIDS populations.

Sierra Leone is so staggeringly poor that HIV/AIDS is not at the top of people's concerns. After decades of poor governance and ten years of civil war, its economy and social infrastructure are in tatters. Sierra Leone is rated last on the UNDP 2002 Global Human Development Index. In post-war Sierra Leone, concern about the potential for the rapid spread of HIV and AIDS is high. Although official HIV prevalence rates have been estimated to be relatively low among the general population (in the range from 0.2% to 4%) there is concern that these numbers may rise dramatically as large numbers of IDPs, returnees and ex-combatants return home.

CARE, the International Rescue Committee (IRC) and the American Refugee Committee (ARC) are among the NGOs engaged in prevention of sexually transmitted illnesses (STIs) in Sierra Leone. While their programmes are in different parts of the country and use different methods, one message is clear: when working in conflict situations, HIV/AIDS prevention messages have to compete with other more imminent survival issues. Sierra Leoneans are dealing with the daily realities of unstable housing, inadequate nutrition and major threats to personal safety. It is difficult to make the risk of dying from HIV/AIDS at some future point as great as the risk of dying from diarroheal diseases or conflict-related violence.

Auntie Stella gets kids talking

Youth stand out as perhaps the most tragic victims of Sierra Leonean conflict. Young people were abducted to serve as armed combatants and sexual slaves. Children experienced torture, mutilation, rape and separation from families. An entire generation of young people in a country with a young population (44% are estimated to be below the age of 14) has been deprived of a basic education, livelihood skills, nutrition and health.

CARE has promoted 'Auntie Stella', a participatory RH training activity for 13-17 year olds developed by Zimbabwe's Training and Research Support Centre.[1] It engages youth in discussion and problem solving on issues related to their reproductive health (RH). 'Auntie Stella' stresses that young people should learn about RH and life skills through discussion rather than didactic instruction from teachers. Small groups of students of the same age and gender are given cards with real-life questions about sex, relationships and HIV. For example:

Dear Auntie Stella,
I'm very worried because I know so many girls who have been forced to have sex against their will. Sometimes they know the boy or man, but I even know one girl who was raped by a stranger. I'm so scared it's going to happen to me. What can I do?

With the role of teacher confined to that of facilitator and resource person, students are given an hour to discuss questions and answers among themselves. Facilitators were surprised at the willingness of the students to openly discuss sex. Students were so interested in discussing the topic that some teams had to spend the first hour of their time with the students simply answering their questions about HIV before the exercises could begin.

When asked to give feedback, the students requested that additional information be included on how poverty influences sexual relationships in Sierra Leone. CARE staff have used their comments to adapt the Auntie Stella materials for the Sierra Leone context. Rebranded as 'Sisi Aminata' – a more common name in Sierra Leone – materials are being printed and will be incorporated into Sierre Leone's school curriculum.

Sisi Aminata must be part of a broader development agenda, and cannot be a 'stand-alone' in a context where so many lack so much. Talking about sex alone is not going to work. CARE will continue to address the needs and rights of the most marginalised within a livelihoods framework. RH, sex and HIV will closely link with other sector specific projects in an effort to ensure continued dialogue on sensitive topics.

Community sensitisation in Kenema District

IRC is working to support primary health care units in this war-affected eastern region. IRC's strategy to prevent and reduce HIV-related morbidity and mortality focuses on disease transmission. Using a rights-based framework, planning is based on local surveillance data and documented research. IRC has been implementing an RH monitoring and evaluation project aiming to reach 70-80% of the reproductive age population in Kenema District. Community sensitisation activities have been developed with existing Village Development Committees (VDCs). Training workshops for VDCs have discussed HIV/AIDS, STIs, family planning and condom promotion. Communities have been targetted through video presentations, drama, group meetings, promotional lectures and distribution of information materials focusing on modes of HIV/AIDS transmission and safe sex behaviours. With the support of VDCs and high-risk individuals such as commercial sex workers, new condom outlets have been developed.

Eighteen months after a baseline survey of RH knowledge, attitudes and behaviours, IRC conducted a follow-up study. It found that:

- While 89% of women and 82% of men could correctly identify three modes of transmission of HIV/AIDS at baseline, by the time of the follow-up survey 95% of women and 97% of men could do so.
- Knowledge of HIV transmission and prevention is higher for those who have attended school, grown up in towns or identify themselves as Christian.
- While the first survey found that 55% of men and a third of female respondents spontaneously stated that condom use during sex prevents HIV transmission, this increased to 65% of men and 49% of women.
- Although condom demand has increased, condom use patterns have remain substantially unchanged – men reporting having used condoms at last sexual intercourse only rose from 18% to 21%.
- The educated, urbanites and Christians reporting usage of condoms at last sex was double the rate for the non-schooled and Muslims and those in rural communities.

It is not surprising, given the short amount of time the programme has been operating, that survey results reveal so little behavioural change. The findings do, however, indicate that it is vital to continue STI and HIV/AIDS education and to target community groups as on-going sources of education and awareness. A sustained effort to work with the VDCs and peer groups and to strengthen linkages with communities is required if sustained behaviour change is to be achieved.

Targeting high-risk groups

ARC has focused its HIV/AIDS prevention efforts in the Port Loko district, working with such core transmitters as commercial sex workers, military personnel, youth, ex-combatants and transport workers. ARC has aimed to have skilled community health promoters convey information, increase knowledge of the availability of condoms and STI treatment and increase the number of core transmitters using condoms.

Among the methods ARC has used to disseminate STIs/HIV/AIDS prevention are: Information-Education-Communication (IEC) and Behaviour Change Communication (BCC) campaigns, condom distribution and STI treatment. Posters, billboards, newsletters, tabloids and radio jingles were used to deliver HIV/AIDS and STI prevention messages. Educational workshops were conducted on condom use and negotiation, HIV/AIDS transmission and prevention, and STI prevention and treatment. With support from the Ministry of Health, ARC's Health Team has distributed free condoms and condom distributors have been set up to reach target populations in Port Loko.

AIDS prevention efforts are not complete without the means to establish one's personal HIV status and receive appropriate counselling. 'Voluntary Counselling and Testing' (VCT) allows individuals to access the information needed to live as healthily as possible, regardless of test results. HIV testing is currently available in Port Loko for a fee but no counselling is offered. National and local government efforts are working towards the implementation of VCT.

ARC has noticed that:

- Levels of STIs/HIV/AIDS knowledge and condom use behaviour increased dramatically across all groups surveyed – half of all respondents reporting use of a condom at last sexual intercourse.
- Degrees of personal concern about AIDS among high-risk groups have stayed relatively low – half of the commercial sex workers surveyed are not concerned about contracting HIV.
- Young people, especially girls, demonstrate the lowest levels of knowledge of those surveyed. Lack of provision of formal education is another barrier to increasing knowledge and safer sex behaviours.
- Knowledge of adequate sources of STI care is still very low.

The way forward

Key recommendations arising from NGO experience in Sierra Leone are:

- Efforts to increase knowledge and condom use are not sufficient in themselves.
- With so many young people prevented by poverty or lack of facilities from attending school methodologies must be adapted to meet the needs of out-of-school youth.
- Behaviour change takes time: STI and HIV/AIDS sensitisation and education must be on-going in targeted communities.
- As resettlement continues and more people move back into abandoned villages, it is essential that prevention activities are not urban-focused and do not ignore outlying areas.
- Youth-focused micro-finance activities and life-skills training centres could promote healthier lifestyles.
- There is a need to decrease reliance on NGOs for condoms and to increase support for small-scale commercial condom distributors.
- Greater attention should be given to encouraging partner notification of STIs.
- There should be follow-up training for health workers on the syndromic management of STIs, and a consistent supply of drugs.
- It is important to recognise that AIDS prevention efforts are incomplete without providing the means to determine one's HIV status and receive appropriate counselling.

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1. The full text of the articles is available on the FMR website at: www.fmreview.org/info.htm

Gender-based violence in conflict-affected settings: overview of a multi-country research project

by Jeanne Ward and Jessica Brewer

Conducting GBV prevalence research in conflict-affected settings presents a host of scientific, ethical, security and methodological challenges.

Gender-based violence (GBV) describes any harm perpetrated against a person's will that is rooted in power inequities informed by gender roles. GBV encompasses physical, sexual and psychological violence, threats of violence, coercion or arbitrary deprivation of liberty. Though GBV may take many forms, it almost invariably disproportionately affects women and children. Humanitarian agencies have become increasingly concerned about the extent and effects of GBV in refugee, internally displaced and post-conflict settings. GBV is belatedly being recognised as an affront to public health and human rights principles and a major impediment to refugee/IDP reintegration.

However, increased awareness of the problem is yet to be matched by either consistent data collection or dissemination of best practices for addressing GBV. To meet these gaps and to improve international capacity, the Reproductive Health Response in Conflict (RHRC) Consortium launched the Gender-Based Violence Initiative in 2000. Major outcomes have included the first comprehensive global overview of GBV issues affecting displaced people and a manual to improve programme design, monitoring and evaluation.[1]

The GBV Tools Manual contains a working draft of a standardised population-based survey designed to measure multiple forms of GBV in conflict-affected settings. Field-tested in East Timor and Kosovo, the questionnaire was subsequently used to conduct a national survey in Rwanda and a survey among IDPs in Cartagena, Colombia. The four studies have sought both to generate reliable prevalence data for locally-based programmes to use in GBV-related planning and advocacy activities and to build local capacity to conduct population-based research. Local partners are being provided with key tools, such as a validated questionnaire in the local language, necessary to design follow-on research projects. Data are being generated to enable the first multi-country comparisons of rates of GBV in conflict-affected settings.

Methodology

The multi-agency research team, including researchers from the University of Arizona, the US Centers for Disease Control and Prevention (CDC) and the RHRC, prepared the questionnaire to facilitate comparability with existing questionnaires by including, wherever possible, previously tested questions or response options and adapting them to conflict settings. The questionnaire was designed to be locally customised without undermining the reliability and comparability of standard measurement. It is divided into sections that focus on different time periods and types of violence. Each can be removed in its entirety according to the objectives of the investigators. Prior to field use in each country, the questionnaire was reviewed by a team of local partners who made appropriate revisions. The questionnaire was then translated into the local language, back-translated into English and checked for accuracy. Further revisions were made following pilot testing.

Field-based partners… were actively involved in all aspects of research planning and delivery

Choice of country sites was determined on the basis of: 1) lack of pre-existing data on the nature and scope of conflict-induced GBV; 2) existence of local programmes with field

East Timor

IRC/Kathryn Robertson

Returnee family, Dili, East Timor

research capacity and ability to provide referral services to participants; 3) the need to ensure representative global coverage; 4) potential for local follow-up advocacy; and 5) considerations of accessibility and security.

In each country women of reproductive age were randomly selected to participate in the surveys. In East Timor, Kosovo and Rwanda, population lists were obtained from local officials and population-proportional samples were selected. In Colombia, where no population lists were available, sample selection was based on a mapping of households. For all countries, only one woman from each selected household was asked to participate.

For the field tests in East Timor and Kosovo, as well as for the national research in Rwanda, a detailed research protocol was submitted for review at CDC. A summary of the Rwanda protocol was also submitted to national government partners. In Colombia a local ethics committee reviewed and approved the protocol and questionnaire. The translated questionnaire was presented to team members for feedback. Interviewers practised administering the questionnaire among themselves and then conducted pilot tests among a sample of women. The pilot test gave the supervisors an opportunity to assess the skills of the interviewers and to make a final selection of the interview teams. Based on the pilot tests, final revisions were made to the questionnaire.

Field-based partners, including international, national and local NGOs, were actively involved in all aspects of research planning and delivery. Efforts were made to recruit all-female research teams from local women's organisations and to include representatives from target research populations. Research teams received two weeks' training. Rwandan and Colombian teams included 'psychosocial assistants' to address any issues that might arise for interviewers or participants during the interview process. Data collection forms were stored and locked each day and any potential identifiers were removed from research materials to preserve participant anonymity. All team members had to sign a confidentiality agreement.

Because of the sensitive nature of the questions and the difficulty in obtaining privacy at the participant's home, women who were willing to participate were interviewed at a central location outside the participant's home. Informed verbal consent was obtained from each woman. Where appropriate local health and psychosocial services existed, participants were informed that referrals were available and a list of organisations offering support services to survivors was provided on request. In Rwanda, participants were advised to access local women's representatives who had been apprised of the research and had agreed to provide follow-up support if necessary.

In East Timor and Kosovo the research teams concluded that the number of women agreeing to participate in the research was inversely related to the degree of visibility of the research project. The higher the visibility of the research, the less likely women were to consent to participation or to show up for the interview. The research design was adjusted with positive outcomes in Rwanda so that the researchers were only working in a village for an average of one day. In Colombia, as an additional security precaution, the interviews were conducted outside the barrios; however, this presented its own challenges as fewer women were willing to travel the distance required to be interviewed.

Field data from East Timor and Kosovo was entered and analysed at the CDC while partner organisations in Rwanda and Colombia are analysing their data in-country. Research findings from East Timor – the only country where data has been finalised – were disseminated by participating international and local agencies through focus groups and the national media.

Overview of findings: East Timor[2]

A quarter of the 288 women who participated in the East Timor pilot study reported exposure to psychological and physical violence perpetrated by a non-family member during the crisis-related violence that followed East Timor's 1999 vote for independence from Indonesia. Most GBV victims reported being threatened with a weapon and subjected to abusive sexual comments. In over two-thirds of cases, women were threatened with death by members of local militias or the Indonesian military or police.

Levels of reported non-family member violence were significantly lower for the post-crisis period, with a 75.8% decrease in physical violence and a 57.1% decrease in sexual violence, though types of violence most commonly reported stayed relatively constant. Displacement to a camp in West Timor was significantly associated with reports of post-crisis sexual violence. After the crisis had passed GBV perpetrators within East Timor were primarily identified as neighbours and other community members.

Levels of intimate partner violence were investigated for two periods: the year before the crisis and the 12 months prior to administering the interview. 46.8% of all women in relationships reported some form of intimidation and control, verbal abuse, physical assault or sexual coercion by their partner in the year before the crisis and 43.2% in the past year. Among women in relationships, 23.8% reported physical assault in the year before the crisis and 24.8% in the past year. Of the women who had ever experienced domestic violence, 41.5% sustained physical injuries but only a third of those women sought medical treatment for their injuries.

Findings on help-seeking behaviour suggest that East Timorese women most often seek assistance from family members. For crisis and post-crisis outsider violence respectively, 6.9% and 13.3% of women who experienced violence reported it to the authorities. Of those who did not tell anyone about their experience, 38.7% (during crisis) and 50% (post-crisis) did not tell because they believed nothing could be done. Domestic violence survivors were even less likely to seek assistance than survivors of violence perpetrated by someone outside the family.

In East Timor the research methodology has informed ongoing national GBV research and pilot test findings have fed into parliamentary discussions on how to address GBV. It is hoped that similar positive outcomes will follow from the release of the data in Kosovo, Rwanda and Colombia.

The way forward

This multi-agency, innovatory and global collaboration has demonstrated that:

- With sufficient planning, training of researchers and time for rigorous pre-testing it is feasible to carry out GBV prevalence research in conflict-affected settings.
- It is possible to design a survey questionnaire and conduct population-based research using methodologies meeting international standards for reliable data collection while supporting local partnerships and ensuring local ownership of knowledge generated.
- Local researchers lose their initial hesitation about asking prying questions in settings where GBV is perceived as a private issue: post-research debriefings were universally positive, with many researchers feeling that the interview provided an unprecedented opportunity for participating GBV victims to receive validation and support.
- Effective risk reduction strategies can be developed in collaboration with local partners – in none of the countries did researchers face any security incidents.

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This article is an abridgement of a longer paper, providing greater detail of the methodologies employed by the project, available online at: www.fmreview.org/pdf/Ward.pdf.

The photos accompanying this article are in no way intended to imply that these people are actual victims of GBV.

1. Available online at www.rhrc.org/resources/gbv.

2. Adapted from M Hynes *et al* 'Field Test of a GBV Survey in East Timor: Lessons Learned', Centers for Disease Control and Prevention, Oral Presentation at the RHRC Consortium Conference 2003: Reproductive Health from Disasters to Development, Brussels 2003.

Supporting displaced communities to address gender-based violence

by Beth Vann, Meriwether Beatty and Lisa Ehrlich

Gender-based violence remains one of the most challenging issues in refugee/IDP settings.

When displaced women are abused it is usually women themselves who are the first to organise help. But because women's groups are usually among the least empowered in their community, they need support and assistance from humanitarian aid organisations. However, NGO managers and staff often lack understanding, knowledge and expertise to develop accessible, effective and compassionate programmes to address gender-based violence (GBV).

GBV Global Technical Support Project

Responding to requests from the field for assistance to address violence against women and children, JSI Research and Training Institute (JSI) initiated the GBV Global Technical Support Project on behalf of the RHRC Consortium in 2001. In close collaboration with UNHCR, UNICEF and others, the project provides a range of technical assistance to refugee/IDP communities, UN agencies, international and national NGOs and host governments working with populations affected by armed conflict. Technical assistance includes on- and off-site training, consulting, advising, workshops, seminars, information dissemination and resource material distribution and training. On-site assistance incorporates both pre-planning and post-visit follow-up to ensure maximum involvement, commitment and follow-through by the key stakeholders and actors.

Prevention of and response to GBV in many of the sites involved with the

GBV Global Technical Support Project have improved. Interagency referral and coordination mechanisms have been streamlined and there is an increased number of staff on the ground who are knowledgeable about gender issues, GBV, assisting survivors and developing prevention strategies.

Noticeboard i Zambia

Addressing GBV in Thai refugee camps

In January 2002, the Global GBV Technical Advisor visited Thailand in response to a request for assistance from the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT). During visits to five refugee camps and five towns, the Global GBV Technical Advisor met representatives of UNHCR, NGOs and Burmese women's organisations. The Advisor provided training, recommendations and written resource materials to promote increased leadership and action in prevention of and response to GBV.

The training and technical assistance focused on building capacity among the interagency team (including refugees) to establish a coordinated system for assisting survivors and for developing an action plan to prevent GBV in the long term. This interagency prevention and response action required four efforts: 1) integrating issues of gender, including GBV prevention and response into the activities of all organisations working with refugees; 2) fostering an understanding that addressing GBV is part of the humanitarian responsibility of all staff concerned with health, psychosocial well-being, security and legal justice; 3) training and supervising staff and 4) formalising and increasing support to refugee women's organisations to build their capacity to take the lead in GBV interventions.

Following this initial visit, refugee women's groups in Thailand developed a GBV response protocol called the Automatic Response Mechanism (ARM). ARM is a step-by-step guide for assisting survivors which sets out required actions – including emotional support, health care, counselling, advocacy and case management – from first report through conclusion of legal proceedings if the survivor chooses the legal route. Each step in the ARM protocol describes appropriate standards of care and includes a list of possible actions to consider if those standards are not met or if services are not locally available. This framework emphasises interagency involvement and cooperation, raising awareness both in specific sectors and the community at large and the need to refer to existing laws and guidelines. Refugee women's groups in Thailand are currently working with UNHCR and NGOs to actively engage them in ARM implementation.

Pool of resource persons

GBV prevention and response may be moving forward in Thailand but elsewhere humanitarian staff lack access to GBV training programmes. For many, GBV remains an unknown, intimidating subject. The GBV Global Technical Support Project now has an added focus: to build a larger pool of knowledgeable humanitarian aid staff who can serve as local resource persons for their peers and colleagues. The number of intermediate and advanced training workshops is to be increased.

In keeping with the philosophy that refugee communities themselves should be the leaders in prevention of and response to GBV, the project will continue to assist and support displaced women to take the lead in addressing this terrible problem.

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See also: 'Gender-Based Violence: Emerging Issues in Programs Serving Displaced Populations' at www.rhrc.org/pdf/gbv_vann.pdf

Understanding the causes of gender-based violence

by Roselidah Ondeko and Susan Purdin

Surveys of Sudanese refugees in the Achol-pii refugee settlement in northern Uganda in 2000 and subsequently in the camp in Kiryandango to which they were relocated in 2002 have highlighted a high incidence of gender-based violence (GBV). Using a participatory approach, researchers from the International Rescue Committee (IRC) have investigated and assessed the causes of GBV and coping mechanisms in order to work with the communities to design appropriate intervention strategies.

Main causes of GBV

Only basic necessities are provided to camp residents. As the ordinary means of survival have been disrupted, traditional divisions of labour have broken down. Because refugees in Achol-pii had no land to cultivate male tasks disappeared while women continued to undertake their traditional tasks such as fetching water and cooking. The survey showed that the men worked only four hours a day, while women worked about 20 hours a day. Men spent most of their time socialising at the market. Domestic violence is one of the negative consequences of enforced idleness and the ensuing frustration.

Four-fifths of such valued household assets as bicycles and radios are owned by men. Women's possessions are mostly confined to low-value assets such as cooking utensils, jerrycans and food. This is often a source of conflict in the home. "*When the men are drunk they beat us and ask for good food like meat"* – which the women cannot afford. Instead they cook vegetables which are considered a poor man's food.

In Kiryandango, where refugees have access to land, alcohol abuse is rampant in October, November and January when the refugees are able to generate a bit of income by selling the food they harvest. "*The little food we get is taken by our husbands to exchange for alcohol. When they get drunk, they beat us and they expect good food."* However from April to June the rate of drinking alcohol decreases since most people are busy in their fields. Alcohol abuse is directly linked with increases in domestic violence. One woman said: *"My husband forces me to have sex with him in the presence of my daughters due to the influence of alcohol."*

Defilement – a term used in Ugandan law to describe sexual relations with an adolescent – is widespread. Girls as young as ten may be forced into marriage. Insufficient shelter increases exposure to abuse. Tents are grossly overcrowded and at night parents in search of privacy may send away teenagers to spend the night with neighbours or relatives, thus exposing them to sexual exploitation.

When and where?

Informants reported common instances where the risk of GBV is particularly severe:

- At markets people not only trade goods but also gather to socialise and to drink. Many girls skip school on market days to sell alcohol in bars and discos, exposing themselves to risks of sexual abuse.
- Around water sources or boreholes, low water yields force girls and women to wait late into the night to fetch water. If not accompanied by a security guard, they are vulnerable. Girls who spend long hours at the borehole are said to get involved in 'bad company'.
- When women go out to collect firewood or to do casual labour to supplement family incomes they may be abused. Women have had to consent to sex before being paid by employers.
- When boys and girls gather together for church attendance and choir practice, many linger and do not immediately return home.
- At schools many teachers have sexual relationships with students, luring girls into relationships by promises of gifts and high marks.
- Poor girls are forced to depend on wealthy older men in the village and those lucky enough to have formal employment.
- When girls are forced by poverty to work as maids in local houses male householders may sexually abuse them or coerce them into marriage.
- When a woman loses her husband, one of his male relatives may demand sexual favours or steal her property.
- In marriages where the age difference is great, levels of domestic violence also tend to be high.

Conclusion

Through the participatory approach, it was possible to discuss GBV – a culturally sensitive issue – with the community. The data collected has been important for redesigning, monitoring and evaluating the programme. The survey results emphasise the need for:

- a multi-sectoral approach based on improved understanding of cultural norms
- community-wide participation in order to enhance community ownership and programme sustainability
- raising men's awareness and challenging the male perception that GBV only occurs outside the family
- tackling taboos preventing young people from discussing sexual matters

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The views expressed are personal and not necessarily shared by IRC or UNHCR.

Sexual and reproductive health rights of Colombian IDPs

by Carlos Iván Pacheco Sánchez and Carolina Enríquez

Meeting the sexual and reproductive needs of displaced Colombians must be part of a process of restoring their lost rights of citizenship.

Estimates of the scale of forced displacement in Colombia range between the 1.08m acknowledged by the government[1] to upwards of 2.5m identified by NGOs.[2] Colombian IDPs are far more likely to suffer significant violations of their sexual and reproductive rights than Colombians who have not been displaced:

- 30% of displaced girls between the ages of 13 and 19 have been pregnant at least once – compared with less than 20% for all Colombians in this age group.
- Pregnant IDPs have the lowest rate of access to prenatal care in health centres (44%).
- 81% per cent of sexually active young IDPs do not use any contraceptive method.
- Gender-based violence is commonplace in conflict zones. A survey by PROFAMILIA found that 52% of women report physical maltreatment by their partners; 14% have been threatened by their partners with a gun; and 9% raped by people other than their partner.[3]
- Female IDPs are usually both the primary caretakers of children and siblings and the providers of family income; their multiple responsibilities make it hard for them to access education or health services.

Forced displacement in Colombia has different impacts on different groups. Until now, there has not been a sufficiently flexible approach to deal adequately with these different impacts. For the past 18 months UNFPA has been implementing an adolescent-focused IDP sexual and reproductive health care programme in IDP settlements in the cities of Barranquilla, Cartagena and Sincelejo on the Caribbean coast and in the south-eastern city of Villavicencio. The objective of the project is to restore the displaced person as a **subject** of sexual and reproductive human rights and to provide him/her with sexual and reproductive health services. Focusing on sexual and reproductive rights is part of a strategy of restoring to the displaced person his or her original possession: the body. IDPs are being given back the possibility of deciding freely about their bodies, sexuality and reproduction. Combining humanitarian assistance with activities related to the arts, sports and skills training, the project is reducing vulnerability to sexual and domestic violence while empowering IDPs with renewed confidence to take informed social, economic and political decisions.

Guaranteeing the right to sexual and reproductive health as an element of citizenship

Forced displacement in Colombia is a phenomenon that is extensive, historic, recurrent and continuous. It happens to families and individuals. It is largely silent and invisible. It occurs, and spills into, the poor areas of cities and towns rather than in displacement camps. For this reason, delivering the Minimum Initial Services Package (MISP)[4], facilitating education, information and communication about sexual and reproductive health, and offering integrated sexual and reproductive health services in a sustainable manner require facilitating IDPs' access to existing public health services available to assist poor Colombians.

If the emphasis of activities is on the recuperation of subjects and citizens, taking action to strengthen institutions that assist displaced people helps the displaced person feel that he or she belongs to a state that guarantees his or her rights. In this way it contributes to the reconstruction of citizenship. Achieving this requires technical cooperation among the health, education and judicial systems of municipalities sending and receiving IDPs.

In terms of institutional strengthening, local health teams now exist in four cities. The team members have received training on the phenomenon of displacement and its impact on the sexual and reproductive health of IDPs. These teams are now implementing plans for improving the quality of integral sexual and reproductive health services. At the end of the project four hospitals in the four cities will be providing sexual and reproductive health services for adolescents and women. These include improved services for family planning, prevention and attention to sexually transmitted infections, HIV/AIDS, prenatal care, prevention and care for cervical and breast cancer, and prevention and treatment for cases of sexual- and gender-based violence.

The project has spawned a consultative group bringing together representatives of the Ministry of Social Protection, the Social Solidarity Network[5] and IDP associations to jointly analyse and design strategies that facilitate the revision of norms and the creation of procedures and mechanisms to monitor and evaluate sexual and reproductive rights. This includes mechanisms to enable local institutions to access financial resources that the state has set aside for the care of IDPs.

The project has consolidated alliances between local NGOs, church groups and key UN agencies such as the World Food Programme and UNHCR. Basic elements of sexual and reproductive health have been included in humanitarian interventions related to food, shelter, and basic sanitation. Groups of adolescents and women are being organised and will take responsibility for training in their neighbourhoods and creating spaces for dignified life.[6]

The way forward: recommendations

Local and international agencies working in the field of sexual and reproductive health for Colombian IDPs must:

- have a constant human rights focus
- sensitise staff of state education and legal institutions to provide education on issues of sexual and reproductive health and sexual and reproductive rights and take action when they are violated
- press the government to take over the provision of the MISP during emergencies and provide post-conflict sexual and reproductive health
- support the development of norms and procedures to enable IDPs to tap into government resources set aside for the care of people displaced by violence
- strengthen alliances between NGOs, church groups and key UN agencies such as WFP and UNHCR
- lobby for greater cooperation among health, education and legal personnel in municipalities which send and receive IDPs in order to improve services and to make IDPs feel they are valued citizens whose rights are respected and whose needs are met.

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1. Red de Solidaridad Social (RSS). *Sistema Unico de Registro de poblaciòn desplazada por la violencia en Colombia,* data published at www.red.gov.co
2. See *Consultoría para los derechos humanos y el desplazamiento* (CODHES) www.codhes.org.co and the Global IDP Project Colombia country study at: www.db.idpproject.org/Sites/IdpProjectDb/idpSurvey.nsf/wCountries/Colombia
3. See www.profamilia.org.co/ The Spanish edition of FMR 15 includes an article on Profamilia: see www.migracionesforzadas.org/pdf/RMF15/RMF15_7.pdf Both the Spanish and English editions of FMR 15 include an article on displaced children in Colombia: see www.fmreview.org/mags1.htm
4. WHO, UNFPA, UNHCR, *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual,* 1999. See www.unfpa.org/emergencies/manual
5. The Social Solidarity Network is a presidential initiative designed to foster greater inclusion of the poorest and most vulnerable Colombians, especially IDPs, in government programmes and services.
6. This means working to improve living conditions in coordination with other public and private institutions. Adolescents, for example, need to be able to access education, culture and leisure activities and to generate enough income to permit them to exercise their sexual and reproductive rights.

Reproductive Health websites

Center for Reproductive Rights
www.crlp.org

HIV InSite
http://hivinsite.ucsf.edu

International Centre for Reproductive Health, Ghent University
www.icrh.org

Marie Stopes International
www.mariestopes.org.uk

Population Council
www.popcouncil.org/asia/asia.html

Reproductive Health Response in Conflict (RHRC) Consortium
www.rhrc.org

Supply Initiative
www.rhsupplies.org/index1.shtml

UK Consortium on AIDS and International Development
www.aidsconsortium.org.uk/

United Nations Population Fund (UNFPA)
www.unfpa.org

UNAIDS Refugees
www.unaids.org/en/in+focus/topic+areas/refugees.asp

UNHCR Reproductive Health and AIDS
www.unrefugees.org/usaforunhcr/uploadedfiles/Aids.pdf

Women's Commission for Refugee Women and Children
www.womenscommission.org

Women's Global Network for Reproductive Rights
www.wgnrr.org


UNHCR/L Taylor

see page 20 for Global Gag websites

Reproductive health care for Somali refugees in Yemen

by Fowzia H Jaffer, Samantha Guy and Jane Niewczasinski

Marie Stopes faces the challenge of providing cost-effective RH services.

Reproductive health (RH) indicators in Yemen are amongst the worst in the Arab World. Infant mortality rate stands at 73.85 per 1,000 live births and the maternal mortality ratio is of 850 per 100,000 live births. Only one in five Yemeni women uses any method of contraception. Health services are limited and of inconsistent quality. Although refugees are entitled to use health and other services, the reality is that access to primary health care is insufficient both for Yemenis and the 81,700 registered and the large number of unregistered refugees – most of them Somali, Ethiopians and Eritreans.

Marie Stopes International Yemen (MSIY) opened its first RH and family planning centre in Sana'a in 1998. Further centres have been opened in Seiyun, Aden and Ta'iz. MSIY provides comprehensive mother and child health and RH care services to low-income women and their families. These include the provision of temporary methods of family planning (FP), diagnosis and treatment of sexually transmitted infections (STIs), antenatal and postnatal care, obstetrics, paediatrics, health education, and laboratory and pharmacy services.

Key findings from MSIY research into refugee RH and general health needs – after consultation with government agencies, NGOs, partners and male and female refugees – showed that:

- Women without a formal refugee registration card are not entitled to subsidised services.
- Refugees' economic constraints make accessibility to health services difficult for most women.
- Social and traditional beliefs, along with a lack of health and FP awareness within refugee families, make it difficult for them to plan or decide on their desired family size.
- Many refugees do not use any FP method and have high fertility rates.
- High levels of maternal mortality are compounded by a lack of awareness of the dangers of early pregnancy, frequent childbirth and the prevalence of unsafe abortions.
- Refugee women do not feel comfortable in Yemeni health centres.
- Younger refugees are poorly served by existing health facilities.

In response, Marie Stopes International Yemen expanded its outreach and clinic-based services to all refugees in urban Sana'a with support from UNFPA and UNHCR. Subjects discussed in health education sessions have met needs identified in the survey. Culturally sensitive health educators lead discussions on a wide range of primary health and RH subjects in addition to tackling misconceptions about family planning methods, male attitudes and female circumcision. More than 6,000 male and female refugees have attended health education sessions and 20 community leaders have been trained to lead health education sessions.

The MSIY Sana'a centre now sees over 1,500 refugee clients a month. All clients at MSIY centre have access to the same range of services. Whilst refugees are increasingly accessing family planning and STI services they tend to access more general health care services than Yemeni clients.

In line with Marie Stopes International's policy of developing sustainable services, there is a sliding scale of charges for both Yemeni and refugee clients, although the majority of refugees receive free services. Subsidised or free treatment ensures that nobody is ever turned away from MSI centres while ensuring that services are valued and will not falter when donor funding finishes.

Outcomes

The number of Somali clients accessing services at MSIY centres has risen steadily since the outset of the project in part due to increased awareness and acceptability of RH services but also in large part to the respect with which they were treated at the MSIY centre in comparison with their frosty reception at other health centres. Quality of care, short waiting times and confidentiality were highly rated by refugees and have contributed to the increase in client numbers.

At the start of the project there were concerns expressed by Yemeni clients about the development of an integrated

Female health education sessions, Yemen

facility serving both Yemeni and Somali clients. However, the MSIY team has worked hard to overcome animosities between the communities and to ensure equitable access to services. Alongside awareness-raising work with Yemeni clients about the refugee communities, the project has also undertaken changes within the centres to improve the environment for all clients.

Health education sessions have resulted in more positive attitudes towards discussing sexual and RH matters, increased knowledge and use of family planning and an increased number of clients seeking STI treatment. Cultural and linguistic appropriateness are key to the success of these sessions.

Cultural and linguistic appropriateness are key to… success

Male awareness of RH has been crucial to the increase in knowledge and uptake of RH services. A male health educator was recruited to implement the male refugees' RH education, including condom use. He also raised awareness of the new free services for female refugees and their children, convincing men to accept and encourage their families to use these services. This is vital as women often need permission from their husbands and need to be accompanied by a male family member to go to the health services.

Coordination with all key stakeholders has been crucial to the acceptability and sustainability of the project. After the needs assessment was carried out, MSIY cooperated with various organisations to discuss ways in which they could work together to provide relief for refugees, in particular to fund potential health education trainings and produce information materials with the help of interpreters who spoke both Arabic and one or more of the various refugee languages.

Recommendations:

- Increased health information and training for health education volunteers within the community are essential to ensure continued improvements in health status whilst ensuring that sexual and RH matters can be prioritised within health centres.
- Ongoing health information training will allow health education volunteers to take on further responsibilities: this increases their status, enables them to better serve their communities and frees up scarce project resources.
- Yemeni health centres need to become more welcoming and accessible to Somali communities.
- Mini centres need to be developed to take services closer to refugee communities.
- A participatory poverty assessment is required to ensure service fees are appropriate and subsidies allocated to ensure fees are not a barrier to access.
- Information and services need to be extended to young refugees.
- Effective referral networks for safe delivery and emergency obstetric care need to be in place for refugee communities.

Future plans

In the southern city of Aden, RH services for refugees are very limited. Most refugees live either in the isolated official UNHCR camp in Al Kharaz, which officially holds 10,145 Somali refugees, or in Al Basateen, a poor area of Almansoura district in Aden, where many refugees live in squatter camps. MSIY has recently been approached by UNHCR to co-finance and set up a clinic in Al Basateen which would provide subsidised RH and primary health care services. It also hopes to address the need in Al Kharaz by using existing staff from the clinic to provide outreach service to these poorer and more vulnerable refugees. MSIY is also intending to extend its current activities and services to address refugee youth between the ages of 13 to 20 and to focus on information activities.

Refugee women in MSI Yemen centre.

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The value of pastoral care in Tanzania

by Beryl Hutchison

Cooperation between church and refugee health care services helps reduce deaths in childbirth.

Reducing rates of stillbirth and maternal and neonatal mortality is one of the main challenges for agencies providing reproductive health (RH) services for refugees. Nyarugusu refugee camp in northwest Tanzania provides a full range of comprehensive maternity services with 24-hour emergency obstetric care, yet preventable deaths in childbirth were still common.

Many of the neonatal deaths and stillbirths occurring at Nyarugusu camp were attributable to delay in seeking medical intervention. Interventions were often too late to save the foetus. The majority of maternal deaths were also attributable to delay.

CORD

At a workshop held in the camp in December 2002, participants identified two main reasons for the delay in women in labour presenting at the maternity unit. Firstly, women were being encouraged by family members and/or religious leaders to rely on prayer to reverse complications of labour. Secondly, women were delaying because they were afraid of caesarean section, viewing this as something negative that would be inflicted on them rather than as a life-saving procedure.

The power of prayer

Christians represent approximately 80% of the refugee population in Nyarugusu camp. The healing power of prayer is a widely-held tenet amongst these camp residents. When problems arise in labour, their first resort is often to approach a prayer group. Whilst this can provide a valuable complementary source of support, in some cases women were being denied emergency obstetric care or were delayed in reaching the maternity unit, often with disastrous results. Additionally, several churches were themselves training traditional birth attendants (TBAs). Although the majority of deliveries were being carried out in the maternity unit, approximately 2% of deliveries were being undertaken at home. Very few of the home deliveries were carried out by TBAs who were officially recognised, assessed and supported by the RH services.

In order to introduce a more holistic approach to obstetric care and encourage cooperation between the churches and medicial staff, a Pastoral Care Service was introduced to the maternity ward in 2002. Volunteers offer healing prayer each day in the maternity ward and are on standby to provide spiritual support to women during labour, especially for those requiring a caesarean section. Their pastor liaises with other churches in the camp to explain the new service and the rationale behind it. The service has proved popular and has been extended to the antenatal clinic. Volunteers have helped to change negative perceptions about caesarean section and raised awareness of its positive outcomes for mother and baby.

While it is too early to measure the true impact of the pastoral care service, early results are promising. Since its introduction, the number of women delivering outside the maternity unit has been reduced by 40% and the neonatal mortality rate has halved.

The Sphere Project provides a set of minimum standards against which refugee health care can be measured.[1] Pastoral care initiatives have the potential to add a further dimension to RH services, by introducing a quality aspect to care that can facilitate the reduction of mortality rates in a way that is sensitive to the culture and belief structure of refugee populations.

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The author would like to thank Pastor Kawaya Andre Wa-Mwangilwa for his commitment and hard work in helping to establish the Pastoral Care Service in Nyarugusu.

Fertility and abortion: Burmese women's health on the Thai-Burma border

by Suzanne Belton and Cynthia Maung

Burmese women in Thailand are pressured from many sources to be productive but not reproductive.

In Thailand's Tak province there are 60,520 registered migrant workers and an estimated 150,000 unregistered migrant workers from Burma. Fleeing the social and political problems engulfing Burma, they are mostly employed in farming, garment making, domestic service, sex and construction industries. There is also a significant number of Burmese living in camps. Despite Thailand's developed public health system and infrastructure, Burmese women face language and cultural barriers and marginal legal status as refugees in Thailand, as well as a lack of access to culturally appropriate and qualified reproductive health information and services.

The research on which this article is based focuses on the mixed flow of migrant workers and refugees in Thailand. Some reside in camps. Those outside the camps have least resource to services and are therefore the most vulnerable. The distinction between 'migrant worker' and 'refugee' is not at all clear. In addition, Thailand is not a signatory to the Refugee Convention and 'refugee' is not an official status in Thailand, whether in camp or not.

Unwanted pregnancies and the lack of access to contraception are major public health issues in Burma. The Myanmar health department (Myanmar is the name adopted by the military regime) ranks abortion in their top ten health problems for the country and the third main cause of illness. The estimated maternal mortality is 255/100,000 and at least half of the deaths of women due to pregnancy-related reasons were related to abortion. In addition, Ba Thike recorded the complications from abortion as comprising 20% of all hospital admissions.[1] For displaced Burmese women or those who live in remote areas, the estimated maternal mortality doubles which reflects in part their lack of access to health services and their marginality in relation to the Myanmar state. In Burma it is only possible to obtain a legal abortion if the woman's life is in danger, while slightly less restrictively in Thailand, induced abortion is sanctioned to saving the woman's life as well as in cases of proven rape or incest. Thai women's maternal morality is far lower than that of Burmese women.

Modern methods of contraception are not widely used in Burma. UNFPA estimates that 28% of fertile-age women in Burma use a modern method of contraception, in contrast to Thailand where 72% of adult Thai women use modern contraception. These findings indicate an unmet need for fertility control which women meet by their own local knowledge. Although few studies have examined abortion issues for migrant workers in Thailand, the Thai health ministry has recorded a rate of abortion 2.4 times higher than that of the local Thai population. Many are performed by untrained abortionists and lay midwives.

Health services available to Burmese women

There are limited health services for migrant workers and for those refugees living outside of camps. Many migrant workers in the Tak province utilise the Burmese-led primary health service called Mae Tao Clinic. This refugee-directed clinic was established by exiled Burmese university students shortly after the 1988 democracy movement. The clinic does not support elective abortion but does provide post-abortion care and family planning services. The staff speak a variety of languages from Burma and many have similar life histories to their patients. The clinic provides a valuable health service that relieves some pressure on the Thai public health services and has been generally tolerated over the past 15 years.

Burmese refugees and migrant workers in Mae Sot also visit the local Thai public hospital and private clinics and pharmacies. Women in the market are additional sources of health information and service. The quality and accessibility of these services varies. If a Burmese migrant has a work permit, they may travel and use the universal health insurance scheme but the climate of fear and uncertainty can stop people travelling. Public transport must pass through many road blocks and checks and if passengers are discovered not to have the correct papers they are deported. While the hospital, private and public health clinic provide care of quite good quality the cost, language and cultural barriers pose problems. The medicine and advice available in the local market is often out of date and of dubious quality.

How can a woman control her fertility?

Abortion and sexual health issues are particularly difficult to research due to the associated stigma and criminal status. This is especially the case when some of the lay midwives are not only 'illegal' visitors in Thailand but carry out activities banned by Thai law. Research methods included

a retrospective review of 185 reproductive health out-patient medical records from the Mae Tao Clinic and 31 records of women transferred to the Thai public hospital for in-patient care. Further information was collected by semi-structured interviews with 43 Burmese women in-patients receiving post-abortion care and 10 of their husbands. Group discussions with Burmese traditional and modern health workers, husbands and community members were also conducted during 2002. Some informants were also asked to generate a list of answers to the open-ended question, 'How can a woman control her fertility?' Very few women receiving post-abortion care declined to be interviewed by the female interviewers.

Key findings from the research show that:

- Post-abortion care at Thai and Burmese health facilities takes large amounts of health resources.
- At least a quarter of women with post-abortion complications have self-induced abortions.
- The vast majority of women are married and two-thirds have children.
- A third of women have five or more pregnancies, which is a health risk in itself.
- Most women and lay midwives classified menstrual regulation and abortion as traditional methods of fertility control.
- Unqualified abortionists and home remedies are the only recourse women have to end an unwanted pregnancy.
- Women know of and use a wide variety of methods to end their pregnancy including self-medication with Western and Burmese medicines, drinking ginger and whisky, vigorous pelvic pummelling and insertion of objects into the sex organs.
- Women are pressured by employers, husbands and fear of unemployment to end their pregnancies.
- Some women report domestic violence as influencing their decision to abort.
- Temporary contraceptive information or methods are not offered to women during post-abortion care in the Thai hospital.
- Most women accepted a diverse range of temporary and permanent contraceptive methods from the Mae Tao Clinic staff while they were still in-patients.
- While women referred from the Mae Tao Clinic to the local Thai public hospital for post-abortion care have their treatment paid for from clinic funds, other self-referred undocumented migrant workers must pay their own bills, which are a large debt burden. (Refugees referred from camps do not have to pay.)
- Having a work permit does not necessarily offer protection to women, as there is scrutiny to ensure a woman is not pregnant when a permit is issued.
- As workers without work permits can be arrested and deported by Thai police, women are reluctant to travel to any type of health service and often wait until they are very unwell.
- Burmese women as non-citizens are not included in Thai mortality statistics at a national level so the deaths of Burmese women go unnoticed, by both Thai and Myanmar authorities.

Conclusions

Refugees and migrant workers are among the most marginalised people in Thailand[2] and therefore face the greatest health risks. Women have particular problems concerning unwanted pregnancies and often attempt to terminate their pregnancy. The general insecurity of the area and restrictions on travel exacerbate the problem. Women resort to their own traditional or local knowledge which is not always effective and sometimes dangerous. There is little reproductive security in Thailand for Burmese women and the pressure on women from many sources to be productive but not reproductive in Thailand is strong. The local policy implications are:

- Modern methods of family planning are acceptable if offered at the time of need and in culturally appropriate ways.
- Burmese workers with knowledge of Thai culture should be placed in public health facilities to assist local Thai staff to communicate with Burmese patients and provide contraceptive information and supplies to women while they are still in-patients.
- The Thai government should facilitate community outreach programmes to factories, farms and meeting points where refugees and migrant workers congregate.

These findings may be applicable to other similar situations where there are large undocumented flows of forced migrants, where work conditions are unregulated, access to health services difficult and elective abortion highly restricted.

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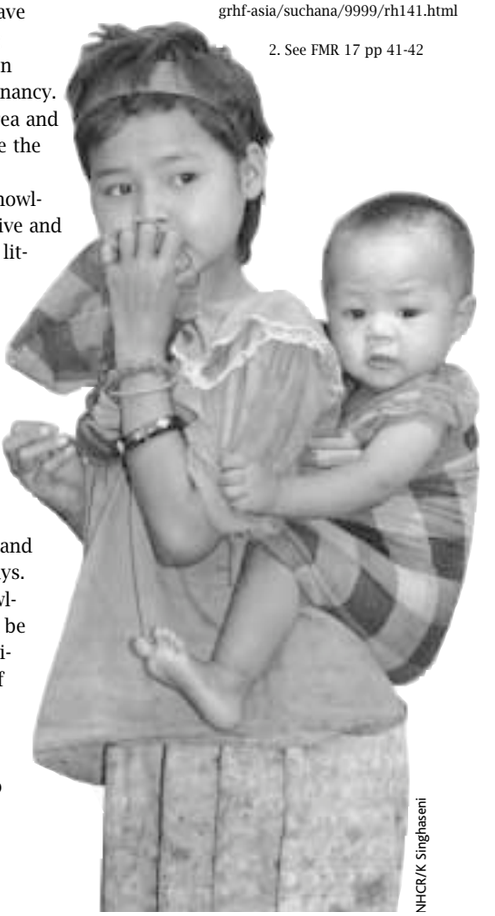

UNHCR/K Singhaseni

Taking sides: the Iraq crisis and the future of humanitarianism

by Antonio Donini

The Iraq crisis presents critical challenges to the humanitarian community.

As in Afghanistan, humanitarian agencies in Iraq are confronted with a contested environment, a security crisis, major policy quandaries and issues arising from the need to interact with coalition forces whose intervention is seen as illegitimate by significant segments of the population, in the region and beyond. The lines between political and humanitarian action have been dangerously blurred. Humanitarian principles have been eroded and the overall credibility of the humanitarian enterprise devalued. UN and other humanitarian agencies have been seen as taking sides, with tragic consequences for the security of staff and an ongoing threat to humanitarian operations in both countries.

The policy and operational choices made by humanitarian agencies in the Iraqi context, both at their headquarters and on the ground, are bound to have a lasting impact beyond Iraq. The issues of 'whether' and 'how' to work in Iraq are ones over which humanitarian agencies have agonised since well before the US-led intervention. The atmosphere in which these discussions took place was laden with political and institutional sensitivities. Views diverged widely on how to relate to the Occupying Power (OP) and on the extent to which the OP should be held to its responsibilities under international humanitarian law (IHL) to provide for the security and well-being of the civilian population as well as a secure and enabling environment for aid activities. Given the prevailing security situation, this has now become a moot point: the bulk of UN, ICRC and NGO international staff have left the country and what presence remains is largely symbolic. The Baghdad blast that killed Sergio Vieira de Mello and 21 of his colleagues and the attacks against the ICRC and NGOs have brought home the risks and the consequences of the choices made.

A deep malaise now permeates the humanitarian community. Coming shortly after the Afghanistan and Kosovo crises, the Iraq issues are seen as profoundly troubling. Many feel that humanitarian action has been politicised to an extent rarely seen and tainted by its association with the coalition intervention. Serious compromises from which it will be difficult to disentangle have been made.

Erosion of principles of neutrality, impartiality and independence

Agencies are split within and among themselves as they struggle with the contending pressures of principle versus institutional survival. Well-established NGOs, particularly those based in the US, have faced stark choices and arm-twisting from their governments as well as competition from 'for profit' contractors. In contrast with many of their European counterparts, most US-based NGOs could not afford to say no. Hardly anybody in the humanitarian assistance community was prepared to say openly before the intervention that "we should not be in Iraq – let the Occupying Power deliver on its IHL responsibilities and sort out the mess it has created". Yet in private many now question whether the UN's humanitarian apparatus should have been operational within Iraq and whether NGOs should have relied on the UN as a 'buffer' vis-à-vis the OP.

The murkiness of the situation has been compounded by two additional factors. The first is the lack of a clear understanding of the nature of the situation on the ground which was arbitrarily defined as 'humanitarian' in order to justify the presence of the UN and NGOs in the absence of a UN mandate.[1] Agencies needed a humanitarian cover in order to be present. The UN Appeal for $2.3bn in April 2003 was driven by political considerations (pressure from the coalition for UN and NGOs to be there), institutional survival ('if we don't go, someone else will') and the sheer magnitude of funds being made available. The second was the conflation of humanitarian, development and advocacy agendas to suit agency survival imperatives.[2] Both these considerations are important because they illustrate the extent to which humanitarian agencies have strayed into basically political territory.

This is not the first time that the lines between humanitarian and political action have been blurred. Afghanistan and Kosovo provided a foretaste of unpalatable pressures on humanitarian action. From Angola to Timor Leste and points in between, humanitarians have functioned in politicised landscapes or acted as fig leaves for political inaction. Iraq, however, represents a new level of intrusiveness into the humanitarian enterprise, differing not only in degree but also in kind from its predecessors. Key differences are the lack of a UN imprimatur on the attack on Iraq, the pressure to interact with an OP whom many view as illegitimate, the extraordinarily supply-driven response and the short leash on which operational agencies are being held by some donor governments.

The global war on terror casts a sombre shadow on the prospects of principled humanitarianism. In a sense, the Bush doctrine is the mirror image of al-Qa'ida: both say 'you are either with or against us'. This leaves precious little independent, neutral and impartial space for humanitarian action. Decisions on humanitarian issues by the major donors, including on where and where not to fund, are made in the context of their security agendas. This has resulted in a disturbing readiness to ignore humanitarian principles and IHL in general – as evidenced by the detentions in Guantanamo, the reported tolerance for torture and the free hand allowed to the Russians in

Chechnya. The perception that double standards are being applied by the North to suffering in the South is reinforced by the wide disparity in funding patterns. High-profile crises suck up the cash while forgotten and often more deadly crises languish.

The deepening 'us versus them' divide threatens the essence of humanitarian action. Events in Iraq and Afghanistan have confronted the humanitarian community with the increasing realisation that the humanitarian enterprise is a Northern one. There is no escaping the fact that what we call 'humanitarian assistance' is funded by a small club of Western donors and is implemented by agencies and individuals based primarily in donor countries and who, by and large, share the values of these countries. Even the UN is unable to 'multilateralise' humanitarian action: unlike peace-keeping operations which are funded by contributions assessed from the entire membership, funding for humanitarian assistance is voluntary. This means that the 170 or so member states that are not part of the donors' club have no visible stakes in the policies and implementation of UN humanitarian assistance. Moreover, even multilateral assistance is being bilateralised through increased earmarking of funds for specific countries or activities.

This calls into question the very universality of humanitarian action. The inherent linkages between Northern politics and economics on the one hand and Official Development Assistance (ODA) and humanitarian action on the other are of course not new. At the same time, however, other forms of 'humanitarian action' go unnoticed and unreported – the contributions of Islamic countries and charities, *zakat* and other forms of relief provided through mosques, the remittances of the diasporas, not to mention the contributions of countries in crisis themselves and the coping strategies of affected communities. These unrecorded flows are likely to be sizeable, perhaps even larger than the 'official' ones. The increased disaffection vis-à-vis humanitarianism in large swathes of the developing and Islamic worlds should come as no surprise. The fact that aid workers are seen as enemy targets by extremist groups is but one extreme example of the extent of this disaffection.

Quality of mercy strained to breaking point

While there may be the beginnings of some consensus on what went wrong in Iraq and how Iraq has brought into sharper focus issues which emerged in Afghanistan, the bigger picture and its likely evolution are more difficult to put into focus. Humanitarian action seems to be taking place in an increasingly murky landscape beset by manipulation and tension between policy choices and even philosophies of humanitarianism. Taking a sombre view, some have predicted that the prospects for humanitarianism in the age of terror and anti-terror will be increasingly grim.[3] Neutral humanitarian space appears to be shrinking generally and has practically disappeared in situations like Iraq and Afghanistan. Does it still make sense to use the term humanitarianism when the priests who are supposed to be the custodians of principle have, happily or reluctantly, joined the service of empire?

The future of humanitarian action is likely to be shaped by how the following questions are answered:

- Are we witnessing a temporary phenomenon – an anomaly in a more or less linear advance of humanitarian values in the post-Cold War era – or a more durable state of affairs linked to superpower domination and the war on terror?
- Is the subordination of humanitarian action to the political objectives of the sole superpower a passing aberration or the harbinger of hard times ahead for humanitarian principles?
- Has the push for 'coherence' and 'integration' in crisis management resulted in a temporary or permanent eclipse of the humanitarian dimension in the UN response to crises?
- How will the tension between the UN as Security Council and the UN as 'We the peoples…' (the opening phrase of the UN Charter)[4] be resolved? Are reforms possible that would give higher priority in the Council's deliberations to human rights and human needs, wherever they exist?
- Is a two-tiered crisis response regime emerging in which the US calls the shots and constrains humanitarian action in the high-profile situations where it is directly involved, while in less visible crises, which may well be more deadly but attract less attention and funding, humanitarians are more able to go about their principled business?[5]
- Are the devaluation of humanitarian emblems and the threats faced by humanitarian personnel qualitatively or only quantitatively different from earlier experience? What do we know about the motivations of extremist groups and their grievances? Is it possible to engage with them on IHL issues?
- What is humanitarianism's essential core and how does it connect (or not) with other forms of international involvement in developing countries – development, human rights, trade, investment and political/military action?
- Is it possible or desirable to delink humanitarian action from Western values and approaches to security?
- What are the indigenous values and traditions that a more universal humanitarianism might tap into?

The humanitarian community is divided on how to interact with the OP in Iraq or on what lessons to draw from recent experiences. The range of present positions echoes earlier debates on whether the civilian nature of humanitarian action is a *sine qua non* or simply a desirable feature. Agencies differ among themselves on whether or not it is advisable to accept funds from and cooperate with the military forces of the belligerents and whether or not these should be involved in the delivery of relief. These issues are likely to have a lasting impact on how NGOs envision their future roles in crisis settings. The pressure on US NGOs to act as a 'force multiplier' for US foreign policy goals has been especially strong. It has led to considerable internal handwringing – but little open debate – on how to confront such pressures in the future. European NGOs who, by and large, rely less on bilateral government funds have had a smoother ride.

This leads to a fundamental question for humanitarian actors. The evidence of the last few years points to the incremental emergence of integration of political and humanitarian responses as a template but only in

high-profile crises – those where the overall policy approach is driven by the Security Council or superpower interests. In low-profile crises, principled humanitarian action has a better chance of survival. The post-Bonn UN mission in Afghanistan has been the most 'coherent' and 'integrated' to date but elements of integration are present in all recent UN missions from Kosovo to Iraq. Humanitarianism in such settings has become subsidiary to a much larger and essentially political agenda which has to do with how the international community chooses to manage its overall response to crises. The push for integration thus carries crucial policy and institutional implications for the humanitarian enterprise.

The choice confronting UN humanitarian entities is two-fold. One option involves full membership in the UN conflict management and resolution machinery, with a potential loss of their independent and neutral humanitarian voice. The other embraces some degree of separation or insulation from that machinery so as to nurture policy and partnerships in the humanitarian community, with the risk of being less able to ensure that humanitarian concerns are given equal billing in the overall response. The experience with 'equal billing' so far has been mixed at best. In Afghanistan, but also in many African crises, experience has shown that the political UN does not see itself bound by humanitarian principles and often has limited appreciation of the value of the humanitarian endeavour in and of itself. Culturally and institutionally, there seems to be a reluctance to acknowledge that humanitarianism and human rights are valuable in their own right and also central to the quest for peace.

In some ways insulation would constitute a return to the clearer institutional architecture of the Cold War era when humanitarian issues and human rights were in more watertight compartments. Recognition that a new Cold War is in the offing – this time built around the global war on terror – would require humanitarian actors to be much more cautious in staking out the space in which they operate.

Regardless of whether this issue of the UN's institutional architecture will be reopened, many feel that efforts should be redoubled to influence decision makers in the Security Council and elsewhere on humanitarian and protection issues. The November 2003 establishment by the Secretary-General of the UN of his 'blue ribbon' panel on the reform of the UN's political/security role[6] provides an opportunity. The objective from the humanitarian perspective would be to 'humanitarianise' politics but without politicising humanitarian action.

Redefining 'humanitarian'

Given the blurring of the lines which everyone from the UN Secretary-General down has acknowledged, perhaps a first area to be addressed could be that of defining the term 'humanitarian'. Is humanitarian action that takes its cue from the UN Security Council still humanitarian? It is noteworthy that at least one UN agency head lamented the reality of the intrusion of the SC into humanitarian matters and advocated that the Secretary-General be the spokesman of 'we the peoples…' rather than of the Security Council.

A focus on core humanitarian activities would run counter to the trend of the 1990s when the humanitarian agenda expanded into areas that were not strictly speaking humanitarian – peace building, capacity building and aid-induced conflict resolution. Moreover, because of the demise of 'development' as a mobilising force in the conduct of North-South relations and the Byzantine vagaries of donor bureaucracies, the humanitarian label has been applied to all manner of small-scale and community-based recovery activities that would fit more neatly under a development label. This pattern has been particularly notable in Afghanistan but also in Iraq, DRC and Sierra Leone. In Iraq, the double blurring between politics and humanitarian action and between humanitarian and development work has been the source of much confusion.

Many feel that effective and principled humanitarian action requires some form of return to basics. The more one departs from the 'copyrighted' humanitarianism enshrined in the Geneva conventions, the more the risks of treading on murky ground increase. This Dunantist view[7] is countered by those who believe that too restrictive an approach does not do justice to the complex nature of current conflicts and, in particular, protracted emergencies. At the same time, there is a realisation that humanitarians have perhaps gone too far in occupying space left free by others – development actors and shrinking state involvement in ODA. Perhaps, also, some regulation of the humanitarian profession is required to ensure that the label is only applied to 'certified' humanitarians. The answer lies probably somewhere in the middle. There is no one-size-fits-all solution. Maximalist humanitarian approaches may be justified in some situations – particularly when there is a solid peace agreement and an agreed collective strategy which lends itself to some degree of an integrated response – while minimalist or Dunantist solutions may be the only way forward in extremely contested, politicised and volatile environments.

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A longer version of this paper was prepared in consultation with Peter Walker and Larry Minear of the Feinstein International Famine Center, Tufts University, Boston, MA. It guided consultations in autumn 2003 to consider the implications of Iraq and other recent crises for the future of humanitarian action. The longer paper and related materials are online at the Humanitarianism and War Project at http://hwproject.tufts.edu Email: H&W@tufts.edu

1. This is not to say that pockets of need did not exist nor that it was wrong to plan for a possible deterioration of the situation.
2. Technically speaking, according to IHL, humanitarian agencies should not 'engage in controversies'. Thus, aid agencies should not have advocated against the war, other than perhaps pointing out the likely humanitarian consequence that might eventuate.
3. See Larry Minear, *The Humanitarian Enterprise, Dilemmas and Discoveries*, Kumarian Press, Bloomfield, CT, 2002, last chapter, and Joanna Macrae and Adele Hammer, 'Humanitarian Action and the 'War on Terror': a Review of Issues', HPG Report 14, ODI, London, July 2003: www.odi.org.uk/hpg/papers/hpgreport14.pdf
4. See www.wethepeoples.org
5. According to Oxfam (IRIN, 16 September 2003) nearly half of all the funds provided by donors in 2002 in response to the 25 UN appeals went to just one country, Afghanistan. Funding patterns are likely to be skewed by Iraq to an even greater extent in 2003/04.
6. See: www.unwire.org/UNWire/20031104/449_10084.asp
7. Named after the founder of the Red Cross movement: the principle that humanitarian organisations must align themselves outside the interests of states.

What's the story? Reporting on asylum in the British media

by Sara Buchanan and Bethan Grillo

According to reporting in much of the British media, particularly (although not exclusively) in tabloid newspapers, we face an asylum crisis: ever increasing numbers of asylum seekers arriving on our shores abusing the benefit system, involved in criminal or terrorist activities and generally posing a threat to the British way of life.

ARTICLE 19 (the Global Campaign for Free Expression) has worked with the Cardiff School of Journalism's Refugees and Asylum Seekers Project[1] to research the content, structure and messages conveyed in media reporting on asylum and the impact of media myths and stereotypes on asylum seekers and refugees.

The findings revealed a significant degree of confusion over the distinctions between asylum seekers, refugees and other migrants in terms of their legal status and reasons for being in Britain. The number of articles, the issues addressed in news and feature reports, the selection of sources, the language, imagery and presentation of statistics combined to distort the scale and nature of the asylum 'problem', narrowed the parameters of the debate to concern about abuse of the system and completely disregarded the human rights and welfare of vulnerable asylum seekers and refugees.

Research methodology

A key feature of the research methodology was the direct involvement of asylum seekers and refugees as researchers and interviewees. Asylum seekers and refugees who had been living in Britain for varying lengths of time were asked about their experience of the British media as consumers and as subjects of media interviews. We monitored coverage of the asylum debate in six national newspapers (the *Guardian*, the *Daily Telegraph*, the *Daily Mail*, the *Sun*, the *Daily Express* and the *Daily Mirror*) and television news bulletins on the BBC, Channel 4, ITV, Sky News and Channel 5. The final phase of the research involved interviewing journalists and/or home affairs and political editors on most national newspapers along with the press officers of key NGOs working in the refugee sector.

Over a three-month period (October-December 2002) in the six newspapers monitored we identified:

- 51 different labels describing individuals seeking asylum in Britain, including meaningless and derogatory terms such as 'illegal refugee' and 'asylum cheat'
- consistent blurring of the distinctions between asylum seekers and economic migrants
- heavy reliance on government officials and politicians as well as Migration Watch UK (a right-wing anti-immigration think tank)[2] as sources for news reports and opinion pieces
- an almost complete absence of photographs of refugee women (four images out of a total of 82)
- repetition of stock images of male asylum seekers with their faces partially covered 'breaking into Britain'
- regular quotation of unsourced asylum statistics and lack of contextual explanation of official government statistics (particularly in the *Daily Mail*, the *Daily Express* and the *Sun*)

Perhaps one of the gravest and most unfortunate tendencies uncovered by the research was the media's failure to employ correct terminology reflecting the legal distinction between refugees and economic migrants. The terms 'illegal immigrant', 'asylum seeker' 'refugee' and 'migrant' were used as synonyms. The sheer number of misleading terms which reporters and editors use to refer to people arriving in Britain to claim asylum is mind-boggling.

The numbers debate – how many asylum seekers, refugees, illegal immigrants, economic migrants and would-be refugees were arriving in Britain every year, every month and even every minute – generated two articles per week between the beginning of October and the end of December 2002. The battle for public opinion was focused on this issue; the analysis and interpretation of official statistics and speculation about what future figures would show formed the basis of one third of opinion pieces. In addition, reporting on many other issues of the day – the state of Britain's public services, the rise in gangland crime and the distribution of funds raised by the UK's National Lottery – was introduced and contextualised with reference to the latest asylum 'shock figures'.

published in th Daily Mail, 29 November

Images

Television coverage, although seemingly less hostile than the tabloid press towards asylum seekers and refugees, nevertheless conveyed strikingly similar

messages and stereotypes. The repetitive use of particular images – groups of men hanging around in Sangatte or on the streets of Dover, the iconic image of men running along the rail tracks just outside Calais – supported the powerful thesis of invasion and threat generated by the tabloid press. Photographs in the print media showed mainly male asylum seekers and very few of the men pictured were identified by the accompanying captions which instead suggested sinister motivations for their anonymity.

There were very few photographs of refugees or asylum seekers with their families or in an everyday domestic or work setting. The heavy editorialising of images showing relieved asylum seekers arriving at Britain's shores, accompanied by jibes about luxury hotels and giant pizzas being delivered to them by BMW, conspired to generate anger among readers that these individuals were receiving benefits to which ordinary hard-working British people would never be entitled. The inclusion of supposedly 'comical' political cartoons in the press further degraded and stereotyped asylum seekers and refugees.

published in the Daily Mail, November 2002

Impact on asylum seekers and refugees

The overwhelmingly negative media coverage of asylum has a direct impact on asylum seekers and refugees who feel alienated, ashamed and sometimes threatened as a result. Many of the interviewees reported direct experience of prejudice, abuse or aggression from neighbours and service providers, which they attributed to the way in which the media informs public opinion. Some interviewees expressed their loss of confidence as a result of exposure to negative media coverage.

Many described the injustice they felt towards the media and, by extension, the British public who believe that they only came to Britain to abuse the welfare system and to seek employment. As one interviewee commented: *"…it is a no win situation because if you work, you are accused of stealing jobs and if you do not work, you are seen as scroungers".* It was felt by another interviewee that the media taps into the normal everyday pressures experienced by the average British person and uses these as a vehicle to launch attacks on refugees and asylum seekers, blaming them for everything from NHS waiting lists to stealing boy/girlfriends.

News and feature articles on asylum rely heavily on politicians, official figures and the police as sources of information and explanation. Individual asylum seekers and refugees are only quoted when they themselves are the subject of a report and rarely contribute directly to the policy debate. Direct quotes from refugees and asylum seekers were completely absent from articles about the second most reported 'asylum story' in the monitoring periods, the Immigration and Asylum Bill. While those responsible for policy formulation – politicians and government officials – understandably led this debate, refugees and asylum seekers arguably had some contribution to make considering they would be directly affected by its outcome. Indeed, they might well be knowledgeable about the wider implications in the countries, regions and groups from which they came. However, this was a dimension of the debate that was almost completely missing from print reports, which treated refugees and asylum seekers almost exclusively as mere passive objects of policy making.

In spite of the negative coverage, asylum seekers and refugees are not hostile to the media and many describe their sense of duty to speak out and highlight human rights abuses in their own countries and counter the myths about refugees in the UK. Nevertheless they are wary of 'hidden agendas' and rely on trust established by refugee organisations to facilitate contact with the media. All insist on anonymity and very few are willing to be photographed or filmed. Refugee women in particular are frustrated by the lack of interest by the media in issues which affect them and feel that misguided assumptions about their role in their own communities can act as a barrier to journalists approaching them for an interview. Both men and women think that the media fails to adequately reflect the experience of refugee women in Britain.

Asylum seekers and refugees are reluctant to complain about inaccurate or prejudicial reporting. Interviewees expressed a mixture of doubt that their views would be accurately represented and concern about the consequences of being seen to complain.

The way forward

So where do we go from here? Is the media's seeming obsession with asylum a story that will run indefinitely? As long as it continues to sell newspapers, the answer to this question is probably an emphatic yes. When the media prioritises market share over its duty to accurately and objectively inform the public, there will need to be a dramatic culture change within the industry before the asylum debate becomes genuinely constructive. However, we firmly believe the situation can be improved.

Since a seminar in May 2003, organised by ARTICLE 19 to bring together the media and the refugee sector, the Press Complaints Commission has issued a guidance note which alerts newspaper editors to the problems that can occur as a result of inaccurate, misleading or distorted terminology in reporting on asylum and refugee issues, and reminds them that pejorative or irrelevant reference to a person's race, religion or nationality is prohibited under Clause 13 of

the Code of Practice.[3] At the invitation of the BBC, ARTICLE 19 also attended an editorial meeting at the BBC in June in order to speak directly with journalists about the issues involved in reporting on asylum. In order to build upon these and other steps forward, ARTICLE 19 has made the following recommendations:

Labels and language

- **Politicians and government officials** should take the lead in using accurate terminology when speaking about asylum and immigration policy. Comments should reflect the fact that an estimated 40-50% of those who apply for asylum in Britain each year are judged to have legitimate grounds for remaining in the UK, either as Convention status refugees or as persons in need of humanitarian protection.

- **Reporters, sub-editors and editors** should be aware of the correct use of terminology in the asylum and immigration debate. They should avoid inventing labels which are essentially meaningless and should distinguish between economic migrants and refugees.

- **Refugee organisations** should develop a glossary of correct legal definitions with clear explanations of their meaning and the context in which they should be used.

- The **Press Complaints Commission** should vigorously promote the recently published guidance note on reporting on asylum and refugee issues to ensure that all editors are fully aware of its intent and meaning.

Numbers and statistics

- The **media** should take care to source all statistics and explain the origin of numbers which are quoted without a verifiable source.

- The **media** should place reportage of numbers of refugees and asylum seekers in context, both historical and in relation to immigration to other countries.

- The **Home Office,** in consultation with refugee organisations, should review the publication and presentation of statistics on asylum and immigration. They should address both the information gaps which are highlighted in this report and consider ways in which statistics can be made clearer by a more detailed and contextual accompanying analysis.

Representation of refugees and asylum seekers

- The **media** should seek to portray asylum seekers and refugees in less stereotyped ways, in particular by including more images of women and children in their reports.

- **Refugee organisations** should explore ways in which they can offer the media alternative and more representative images.

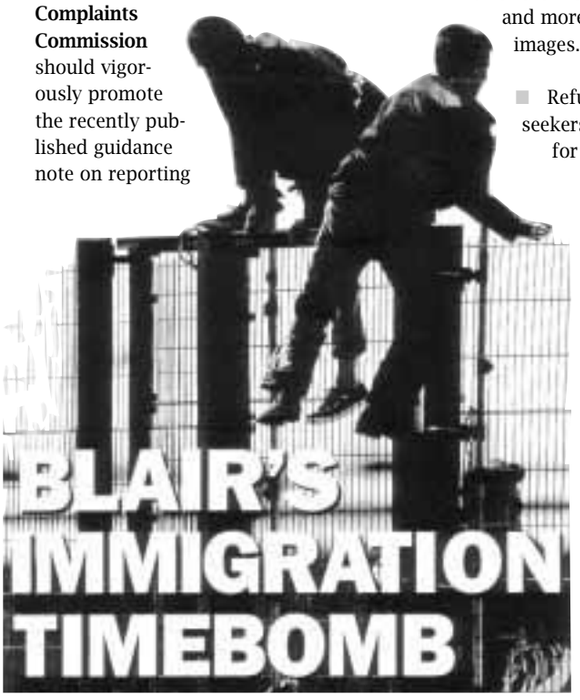
- Refugees and asylum seekers should be asked for their opinion on policy issues and given the opportunity to make a greater contribution to the debate. This requires **journalists** to seek them out as sources on a broader range of issues and for **refugee organisations** to be (even more) prepared to facilitate exchange between the media and refugees.

- The **media** should find opportunities to present refugees as individuals whose stories are worth telling, rather than merely examples of a generic 'problem'.

- **Refugee organisations** (national and community-based) should join forces to launch a **national campaign** to counter the overwhelmingly negative image of asylum seekers and refugees in the public mind and seize the initiative in the public debate.

- The **media** should consider the benefits of recruiting exiled journalists who, in addition to their professional experience as journalists, could provide specific insight into issues relating to the countries and circumstances from which they have fled. This requires proactive action by the media to create opportunities for refugee journalists and for the media to use the networks and connections with refugees which can be provided by the NGO sector.[4]

Sara Buchanan and Bethan Grillo work for ARTICLE 19. The report is available online at: www.article19.org To obtain a printed copy email: sara@article19.org



published in the Daily Express, 29 November 2002

1. See: www.cf.ac.uk/jomec/research/research_asylum.html

2. See: www.migrationwatchuk.org

3. See: www.pcc.org.uk/reports/edit_detail.asp?id=20

4. See for example, The Directory of Exiled Journalists, set up by the PressWise Refugees, Asylum Seekers and the Media Project: www.ram-project.org.uk/directory

Refugees in the new Johannesburg

by Loren B Landau and Karen Jacobsen

Unfamiliar with hosting refugees, South Africa is struggling to come to terms with their arrival.

Most of Africa's refugees live in rural areas and camps but a growing number are heading towards the cities. Since its transition to majority rule in 1994, South Africa has become the destination for tens of thousands of migrants and refugees from across the African continent, mostly settling in the country's urban centres. Their presence is not only changing the country's demography but is also having a visible effect on public attitudes and political rhetoric. While the 1998 Refugees Act demonstrates a strong and progressive commitment to refugee protection in line with international standards[1], refugees continue to be subject to discrimination, police harassment, and anti-foreigner violence.

In 2002, the Forced Migration Studies Programme at the University of the Witwatersrand in Johannesburg and the Refugees and Forced Migration Program at Tufts University (Boston) initiated a study of refugees' experiences in and influence on Johannesburg. In early 2003, researchers conducted a survey in seven central Johannesburg neighbourhoods with high densities of refugees from some of Africa's main refugee-sending countries: Burundi, Angola, Somalia and the Democratic Republic of Congo (DRC).[2] We also surveyed Ethiopians and people from the Republic of Congo, two groups with a significant presence in Johannesburg. In all, 737 people responded to the survey, of whom 53% (392 people) were South Africans and 47% (345) were migrants and refugees. Of the latter category, 14% were from the DRC, 12 % from Angola, 9% from Ethiopia, 8% from Somalia, 2% from the Republic of Congo and 1% from Burundi.[3]

Although not all of those surveyed qualify as 'refugees', 73% of the non-South African sample reported being either a refugee or asylum seeker. These ratios were highest among Somali and Congolese (DRC) communities, at 93% and 90% respectively. (For ease of reference below, the non-South African sample is referred to as 'migrants' as it comprises both refugees – forced migrants – and those who have become migrants for other reasons.)

Sample characteristics

Reflecting urbanisation trends worldwide, the migrants in our sample were considerably younger than the host population, with only 5% above the age of 40 compared with 22% of South Africans. They were also predominantly male (71% against 47% for South Africans) and far fewer had children: 64% of migrants reported no children as opposed to 35% of the South Africans.

One of the most striking features of those surveyed was the fact that they are overwhelmingly urban in origin. Just under 80% of all migrants surveyed reported living in cities for most of their lives (95% of Ethiopians) and another 17% spent the greatest part of their lives in towns. Less than 4% claimed rural origins. Although these figures varied dramatically between groups – with only 66% of people from DRC reporting coming from cities as compared to 95.4% of Ethiopians – they suggest that most of the migrants are likely to be relatively well-equipped to manage the challenges of urban living.

In addition, the study suggests that, compared with South Africans, the migrants have higher levels of education and are more skilled. 22% had finished tertiary education or earned a post-graduate degree, compared to 14% for South Africans. Another 47% reported receiving additional training or education, a proportion slightly higher but comparable with South Africans (42%).

Flight and arrival patterns

There is an assumption on the part of some international organisations and the South African government that most of Johannesburg's migrants qualify as 'irregular movers': people who for 'non-compelling reasons' leave their country of first asylum where they have obtained 'effective protection' usually in the form of refugee camps.[5] Many officials also assume that those who make it to South Africa are 'asylum shoppers': people looking for the easiest or most profitable place to make an asylum claim.[6] Preliminary analysis lends some support for this position; most of the migrants in our sample travelled through countries where they could have claimed asylum and 39% reporting staying in another country for more than a week (13% of nearby Angolans against 68% of much more distant Ethiopians). There is also strong evidence to suggest that South Africa was not always the intended destination. On leaving their home countries, half of the migrants (50%) considered going elsewhere than South Africa. Of these, 62% considered going to North America or Europe, some 10% considered going elsewhere in Africa, while about 12% reported "having no plan".

Refugees in Johannesburg

Further analysis does not, however, support the contention that those surveyed are irregular movers or asylum shoppers. To qualify as an irregular mover, they should have applied for and received asylum in another country. Only 6% of those surveyed had ever stayed in a refugee camp or settlement and just over 2% reported receiving aid, suggesting that this is not the case. Moreover, if these people were asylum shoppers, they should be attracted to South Africa by promises of easy refugee status or aid. Given delays and other difficulties associated with getting status (see below) and a generally hostile environment, few are likely to be attracted for these reasons. Instead, the primary motivations for choosing South Africa were work and education (35%) and political, religious or ethnic freedoms (35%). Another 11% indicated that South Africa might enable them to be resettled or allow them to get to a third country but less than 1% said they were in the country in search of assistance.

Harassment, the police and the Department of Home Affairs[7]

Refugee and migrant advocates in South Africa frequently criticise the police and the Department of Home Affairs for their treatment of refugees. The data indicate that such complaints are justified. For almost one-third of those surveyed, the process of obtaining an asylum decision from the Department of Home Affairs (DHA) took at least 18 months rather than the six-month period envisioned by law. Discussions with refugees reveal that cases often take three or more years during which they must actively push their applications. In follow-up interviews, many respondents report having to pay bribes to DHA officials or to private security guards just to enter the city's refugee reception centre. During this time, applicants must navigate Johannesburg's treacherous urban environment with little in the way of identity documents, limited access to employment, and almost no access to social and financial services.

Migrants are far more likely to be victims of crime or police harassment than South Africans. Despite being in the country for a limited period, almost three-quarters (72%) of the migrants surveyed reported that they or someone they live with has been a victim of crime, compared with 43% of South Africans (who have spent most of their lives in the country). Rather than helping to protect foreigners, police appear to be contributing to the problem.

When asked if the police had ever stopped them, 71% of migrants responded affirmatively compared with fewer than 30% of South Africans. Most of the time, police stop people to check immigration and identity documents but forced migrants report having their papers taken and even destroyed by the police. In follow-up interviews, many spoke of paying bribes to avoid arrest and possible deportation. Although South Africans are likely to support such activities – of the 70% of South Africans who thought crime in the city was increasing, almost three-quarters said that immigrants were among the primary reasons – there is little to justify continued police harassment. The South African Police Service's Hillbrow Police Station – located at the geographic centre of numerous migrant communities – reported that Johannesburg's foreigners are overwhelmingly the victims, rather than the perpetrators, of crime.[8]

Livelihoods: obstacles and achievements

Given the formal and *de facto* restrictions on forced migrants' opportunities to pursue livelihoods – including prohibitions on work, lack of identity documents or papers demonstrating professional qualifications and discriminatory hiring practices – it is surprising that an almost equal number of South Africans and migrants report being unemployed: 42% and 39% respectively. A more careful look at employment profiles, however, reveals forced migrants' tenuous economic position.

In the sample, one third (32%) of South Africans report working full time in either the formal or informal sector, compared with only 7% of migrants. Over a quarter (28%) of the working migrants claimed to be self-employed compared with 6% of South Africans with petty trading and hawking combining to make up forced migrants' most significant occupation (21% against less than 1% for South Africans). Another 8% report owning small businesses, compared with just over 5% for South Africans. Not only does the income from such activities tend to be limited and unpredictable but street trading also exposes forced migrants to theft, violence and police harassment. The migrants' economic position is further compromised by the fact that, despite having smaller families, they often pay more for accommodation (48% pay more than R800/month – approx. $125 – as opposed to 30% of South Africans).

One of the most significant economic problems facing refugees is their inability to access banking services (either savings or credit): 24% of migrants report having bank accounts in Johannesburg compared with 71% of South Africans. Inability to access formal financial services means that entrepreneurs have nowhere safe to keep their money, thus making them known targets for mugging and theft. Lack of credit is a serious constraint on migrants' economic activities, limiting the contribution they could make to Johannesburg if permitted to pursue entrepreneurial initiatives.

While there are widespread fears that immigrants are taking South Africans' jobs, there are good reasons to believe that migrants could make a much stronger contribution to the city's economy. On aggregate, more than 15% of all migrants surveyed (28% of Ethiopians and 26% of Somalis) report owning businesses in their country of origin, and presumably have the skills and entrepreneurial spirit to do so again in South Africa. Another 9% report having worked in a professional position (e.g. doctor, lawyer, accountant) before coming to Johannesburg. Their presence could help fill the acute skills gap facing the inner city. Indeed, even with the restrictions placed on them, forced migrants are already creating jobs. While just 20% of South Africans report having paid someone to do work for them, 34% of forced migrants surveyed had. Even more significantly, more than two-thirds (67%) of those hired by migrants were South Africans.

Policy implications

South Africa has much to gain from the migrant communities included in the sample but South Africans will only benefit from their resources if the country's leaders and urban communities welcome them:

- The city's social service agencies and businesses need to enforce South Africa's own laws, including a recent provision allowing asylum seekers the right to work and study.
- Inefficiency and corruption need to be rooted out in the Department of Home Affairs: refugees and asylum seekers require full and appropriate documentation.
- Access by migrants to preventive health care and educational opportunities needs to be improved.
- Access by migrants to bank accounts and credit also needs to be facilitated so that nationals and refugees can equally capitalise on their entrepreneurial skills for the benefit of all.
- Police and other other law enforcement agencies should be urged to treat refugees and asylum seekers with the respect due to all of South Africa's residents.

Conclusion

This piece of research was one of the first formal attempts to survey urban refugees in Africa, and it encountered many problems. While imperfect, however, it will enable us to identify and compare trends and patterns across different cities in future research; the project is currently being expanded to Maputo (Mozambique) and Dar es Salaam (Tanzania). Replicating the survey over time will reveal the changing experience of refugees in African cities. Generating data on a wide range of socio-economic and political variables will also provide opportunities for other researchers to situate their studies within a larger comparative project. Perhaps most importantly, empirical data from this project can be useful in countering unfounded accusations and rhetoric aimed at refugees, ultimately promoting a more positive policy environment.

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For more on this research project and links to other relevant sites, please visit www.wits.ac.za/fmsp/ujp

1. See: www.sahrc.org.za/regulations_to_the_south_african_refugees_act.PDF
2. See UNHCR Statistical Yearbook (2001:20).
3. For more on the project's sampling strategy and logistical challenges, see K Jacobsen and L Landau 'The Dual Imperative in Refugee Research: Some Methodological and Ethical Considerations in Social Science Research on Forced Migration', *Disasters*, Vol. 27 (3): 185-206, 2003.
4. We recognise that these are self-reported claims with possibly exaggerated education levels but this bias is equally likely to apply to South Africans.
5. See Bruno Geddo's 'Durable Solutions to the Refugee Problem: UNHCR'S Regional Strategy for Southern Africa' www.lhr.org.za/refugee/publics/perspect/geddo.htm
6. At a special session of the Migration Dialogue for Southern Africa (MIDSA) focusing on forced migration, government representatives from countries throughout the region regularly spoke of the 'widespread practice of asylum shopping' (Lusaka, Zambia, 27-29 October 2003).
7. The agency responsible for immigration and refugees.
8. Director Louw cited a recently completed review of policy statistics during an interview with Loren Landau at the Hillbrow Police Station in Johannesburg on 18 July 2003.

Women Health Volunteers in Iran and Iraq

by Emma Nicholson

Empowerment and capacity building have become aid buzzwords. The role of women in development has never been more important. Special emphasis must be given to programmes which enable women to be at the centre of decision making.

AMAR International Charitable Foundation has been running a programme for Women Health Volunteers (WHVs) since 2000. The programme is modelled on a similar one started in 1991 in the Islamic Republic of Iran. Supported and encouraged by WHO and UNICEF technical support, the WHV programme has become an integral part of Iran's primary health care plan. AMAR supported and raised funds to implement a similar programme in the Iraqi refugee camps in Iran where it provides primary health care services to those who sought refuge there in 1991. AMAR has also implemented the WHV programme as part of its emergency assistance for Afghan refugees in 2002 in the Iranian urban centres of Mashad and Robat-e-Karim (near Tehran).

The programme aims to promote better public health awareness for those living in poverty with limited access to healthcare services in both rural and urban environments. In seven camps in southern Iran, with a population of over 40,000, AMAR supports 127 WHVs. In Robat-e-Karim and Mashad 390 WHVs assist a population of 173,000.

Volunteers are normally selected from among well-respected community members who speak the local language. They must have enough spare time for training and for disseminating the messages to their communities. They must have a basic level of literacy, equivalent to completion of primary school. Volunteers are recruited principally – but not exclusively – from among married women. Consent of husbands or other family members is required.

WHVs are trained in primary health care issues through 200 modules available in both Farsi and Arabic.

Women convey messages to other household members and to the community at large. Training sessions take place on a monthly basis, although volunteer women often also meet weekly in support groups. The programme trains women in basic sanitation and hygiene requirements, with specific focus on mother and child health, immunisation, family planning, food hygiene and occupational health.

Women volunteers are empowered by their participation and enabled to act as a bridge between the healthcare services and their own communities. As they report on deaths, births, migration and minor diseases prevalent in the refugee populations they contribute useful statistical data for health centres. They mobilise ordinary people to participate directly in addressing identified health needs. Women volunteers give each other greater confidence to build on their skills and achievements. Their level of education, often low for female members of households, is raised as they acquire skills such as problem solving, observation and reporting. They have encouraged new initiatives. Thus, one group in Mashad started its own micro-financing for volunteers in financial difficulty. Others have got together to produce handicrafts. In Robat-e-Karim WHV groups run a school health programme in which women volunteers hold sessions – for parents and teachers – on subjects such as puberty, nutrition and mental health.

WHV programmes can easily be replicated with returning refugee populations in Iraq and Afghanistan. When the time is right these programmes will contribute greatly to building and consolidating nascent local healthcare infrastructures. AMAR has been operational in Iraq since the end of the 2003 war and is helping to set up primary health centres and sanitation projects and rehabilitate schools. As funding becomes available, AMAR will also replicate the Women Health Volunteer programme in Iraq where there will be a great demand for this type of network. There is already a pool of trained refugee volunteers in Iran who are anxious to return to Iraq and start WHV groups in their local communities.

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"Parlez-vous l'anglais ou le swahili?" The role of interpreters in Refugee Status Determination interviews in Kenya

by E Odhiambo-Abuya

Research undertaken in Kenya indicates that interpreters can hinder good communication in the RSD process.

The vast majority of claimants seeking asylum in Kenya are from the horn of Africa and Great Lakes region and speak a variety of languages. UNHCR Eligibility Officials, who conduct Refugee Status Determination (hereafter 'RSD') interviews, are limited in the number of languages in which they can communicate fluently. Eligibility Officials use English mostly, and Swahili sometimes, to conduct RSD interviews. Not all asylum seekers have a good grasp of English or Swahili and so interpreters are often needed.

Although interpreters play a fundamental role in the RSD process, there are instances where, instead of acting as a link between Eligibility Officials and asylum seekers, an interpreter can in fact be an obstacle to good communication. This adversely affects not only individual asylum seekers' cases but also the entire RSD scheme.

Research

From November 2002 to March 2003, while Kenya was in the throes of multi-party general elections, research was undertaken on Kenya's RSD procedures.[1] The research project examined different models for determining refugee status with a view to proposing an administrative system appropriate to Kenya's situation. Although Kenya hosts more that 200,000 refugees, it still lacks domestic legislation that would otherwise guarantee the rights promised to asylum seekers by international refugee law treaties. Current RSD procedures appeared to be inadequate in terms of fairness, efficiency and accuracy within the constraints of the rule of law.

I conducted detailed qualitative interviews with asylum seekers and refugees covering topics including: their experience of the RSD process; their expectations; whether they understood the processes through they were taken; whether they thought they were treated fairly; the problems they faced (if any); and if problems were dealt with to their satisfaction. Interviews with UNHCR, NGOs and officials of the Government of Kenya canvassed a similar set of issues but these concentrated on tapping views on how far this procedure meets international legal standards, its merits and what legal or policy changes were needed to improve the current system.

The role of interpreters

The main languages requiring interpretation in Kenya, encountered during the research, are: French (for Congolese, Rwandese and Burundians), Kinyarwanda (for Rwandese), Kirundi (for Burundians), Lingala (for Congolese), Arabic (for Sudanese, Somalis and Ethiopians), Amharic and Tigrenga (for Ethiopians) and Somali (for Somalis).

Interpreters are normally bilingual refugees who are able to speak English and a second or third language. Two UNHCR policy documents are available to assist and train interpreters in their roles: *Interviewing Applicants for Refugee Status* and *Handbook on Criteria for the Determination of Refugee Status.*[2] Employing refugees as interpreters is advantageous for two reasons. Firstly, providing paid employment for refugees reduces the number of refugees dependent on UNHCR.

Secondly, it introduces into the general status determination framework a third party who can identify with the realities of the claim:

> *One major problem [with the status determination procedures] is [Eligibility Officials] are educated and have no experience of fleeing. They are Kenyans, not refugees. If they had refugees alongside them at the interview, it will help because a refugee will know the tune of the problem.* (Baigana, a refugee from Uganda)

One of the hallmarks of a professional interpreter is possessing 'current' knowledge. Interpreters should be well informed about the past and current affairs of a claimant's state of origin and be fluent in the relevant vocabulary. Interpreters are required to keep all information revealed by a claimant stricly confidential.[3]

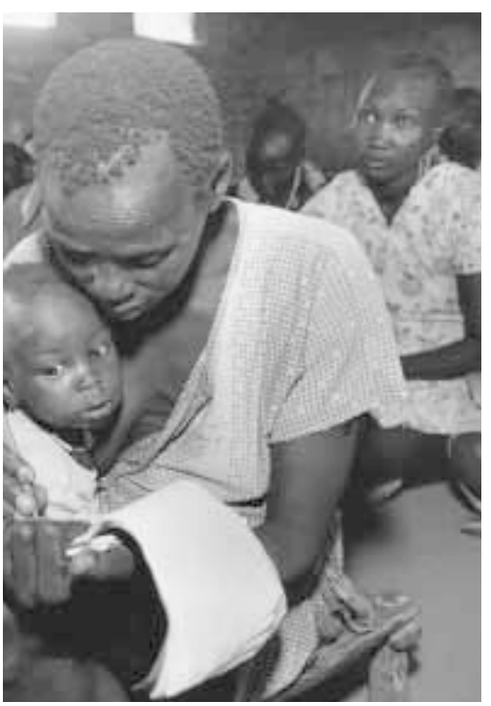
Many Eligibility Officials conduct 'ice-breaking' sessions to create an atmosphere of mutual trust and respect, in

UNHCR/L Taylor

which a claimant feels comfortable and able to respond with ease to questions. The general purpose of the interview is then explained to the claimant, as are its principal objectives and what is expected of the claimant. The claimant is then asked to divulge all relevant information regaring their case, with the assurance that what they share will be treated confidentially. According to UNHCR, this reassurance is 'indispensable' to make claimants 'feel that it is safe to talk openly about past experiences and events'.[4] Claimants are then asked if they object to the presence of any individual in the room; if they raise no objections, the interview may commence.

However, in some instances, interviews do not adhere to these procedures. Likambo, a Congolese, demonstrates the undesirable consequences of failing to observe this simple procedure:

> *I was interviewed on 1st August 2002 by a male UNHCR Official with the aid of an interpreter from Congo who I had earlier met outside the interview room. I had identified him as a "Congo man", but when I asked him if he truly came from Congo, he denied. When I entered the interview room, I was shocked to see him, and because he had earlier lied to me, I did not trust him. My heart said, "go on and be interviewed", but I hid some facts from him. I did not tell it all. …. I hid my reasons for flight because I did not trust him. Maybe he was connected with the people I was fleeing from. I was scared for my life. …. Despite the [Eligibility Official's] assurance that the interpreter was only to interpret, I still had doubts.*



Sudanese refu
in Kakuma ca
Kenya

Incompetent interpreters

A good interpreter is one who, firstly, is able to translate a claimant's words into clear and simple English, or the Swahili equivalent, and, secondly, who is able to convey this without missing the precise meaning and the claimant's original intention.

> *I was interviewed through an interpreter because I was fearing and without confidence. I wanted to tell everything in my mind and I cannot do it in English. That is why I prefer the interpreter. I was satisfied; she interpreted everything because I could hear.*[5] (Getu, an Ethiopian refugee)

In some situations, however, instead of facilitating communication, interpreters become obstacles.

i) The 'omniscient' interpreter

'Omniscient' interpreters are those who put words in the mouths of claimants or significantly filter what has been stated. Eligibility Officials, both in Nairobi and at camp level, admitted that in some instances they would pose a question to a claimant who would respond in a couple of words; the interpreted words, however, were overwhelmingly more numerous. When I came across an omniscient interpreter during my fieldwork and asked for an explanation of such a disparity, the response was simply: "I know what the claimant wished to say." This goes against the basic principle that requires interpreters to be impartial throughout the conduct of proceedings. Even more disturbing are the interpreters who abandon their disinterested role and instead take a more active part in the interview.

Alan Crouch, former Coordinator of the Interpreting Services and Migrant Advisory Bureau, Melbourne, Australia, condemns this extremely worrying practice:

> *It is not [an interpreter's] role to depart in any way from what is being said, or to leave things unsaid, however irrelevant, illogical, or indeed abusive they may appear to him. …. his prime concern should be to render accurately the entire sense of what is to be conveyed without adding to it or detracting from it.*

ii) The 'distortional' interpreter

In this second category are those interpreters who misconstrue statements made by claimants. Refugees and asylum seekers alike express concern that sometimes interpreters fail to 'do a good job'. I witnessed that not all Eligibility Officials ask claimants if they require the assistance of an interpreter. This is contrary to the clear wording of UNHCR's Eligibility Interview Form which requires Eligibility Officials to ask claimants what language(s) they speak, the language they would prefer for the interview, and if they have any objection to the interpreter being used.[6]

Some assume that all Somalis, for instance, are unable to speak, or communicate effectively, in English or Swahili. In many Somali cases, therefore, the Eligibility Officers did not bother to ask claimants if they required the assistance of an interpreter. Rukia (a Somali from Dadaab refugee camp) was forced to speak through an interpreter despite her ability to communicate in English:

> *I was not asked whether I needed an interpreter or not. I just found him in the interview room and when he asked questions, I responded. … sometimes the interpreter made mistakes. For instance, I told him I arrived in Kenya in '1999'; he interpreted it as '2000'. I corrected him but I am not sure he made the interviewer aware of this.*[7]

As far as possible, the conversation between a claimant and interviewer should be direct. Primarily, it saves time, which is a precious commodity in asylum claims.[8] Secondly, it is more likely to reduce instances of misinterpretation, particularly where it is problematic to find an English or Swahili equivalent of a word or phrase used by a claimant. Lastly, direct communication also instils confidence in the mind of asylum seekers. Ntibantinganya, from Burundi, expressed the following views in this regard:

I did not like the interpreter because he does not express well the idea I want to give. There are some [French] words, which lack an English equivalent.

Interpreters should only be used once an Eligibility Official verifies that a claimant lacks a reasonable command of English or Swahili.

iii) The 'nought' interpreter

This category describes instances where 'interpreters' are completely unable to interpret. There have been occasions where interpreters have been brought in to interpret only to discover that they speak different languages from the claimants. UNHCR standards require an Eligibility Official to ask a claimant if they 'can understand the interpreter'. Mekele's experience is a classic example:

I was not harassed during the interview. But the interpreter did not speak or express my feelings well in interview. Leave alone English, he cannot even speak Amharic, my mother tongue, well. He is Oromo and I am Tigrenga. I was not happy. When I am talking to him, he cannot [understand] me very well.

In cases such as these interpreters should admit their inability to perform the task, and step down and proceedings adjourned until a competent interpreter can be found.

The Government of Kenya has expressed concern with regard to the role of interpreters. I met an Official of the National Refugee Secretariat in the Ministry of Home Affairs, the Ministry in charge of refugee affairs in Kenya, who said that part of the problem inherent in the UNHCR status determination process was "interpreters who are very fast and interpret their own things".

Suggestions

Without effective communication between Eligibility Officials and asylum seekers, the entire protective regime is gravely weakened. I offer four suggestions to improve the current state of affairs:

- Eligibility Officials need to be vigilant during RSD proceedings, watchful for signs of omniscient interpreters as well as those who are unable to communicate with claimants.
- Hire Eligibility Officials who can speak asylum seekers' languages. Effectively, this removes interpreters from the picture, turning the interview into a one-on-one dialogue.
- Use interpreters who have no interest in the outcome of the interview such as refugees in the resettlement pipeline. In Kenya, it is impossible to find Kenyan nationals suitable to employ as Eligibility Officials who have a good grasp of all native languages spoken in neighbouring states. In cases involving asylum seekers from Lingala, Kinyarwanda, Tigrenga, Kirundi and Amharic backgrounds, neutral interpreters should be used. A UNHCR Eligibility Official explains the importance of using such interpreters:

  The problem with interpreters sometimes arises at resettlement where some tend to be biased. How do you employ a fellow refugee to interpret for a fellow who is due to be resettled? It is better to get a refugee who is similarly on the resettlement pipeline.

- Eligibility Officials must read back the Interview Report to claimants and ask, firstly, whether they wish to provide any 'additional information' in respect to the interview and, secondly, if the questions asked were 'clear' and the claimant 'satisfied' with the answers they gave. This is an official requirement (see UNHCR *Handbook*, Para 199) and yet one which is sometimes ignored. In interpreter-assisted interviews this step is crucial; without it, cases of interpreters putting words in the mouth of a claimant might escape undetected.

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1. Many thanks to UNHCR staff (Nairobi, Dadaab and Kakuma Bureau Offices), Refugee Consortium of Kenya and the Ministry of Home Affairs, Refugee Office, for assistance provided during this research. The officials, asylum seekers and refugees interviewed for this research spoke on condition of anonymity. Copies of interview reports are in my office at the Law Faculty, University of Sydney.
2. UNHCR, 'Interviewing Applicants for Refugee Status' (Geneva: 1995). Go to www.unhcr.ch, type 'Interviewing Applicants for Refugee Status' into search facility, and find: 'Training Module RLD4 – Interviewing Applicants for Refugee Status'. UNHCR *Handbook on Criteria for the Determination of Refugee Status* (Geneva: 1992) (follow same procedure to locate it online).
3. Refugee Review Tribunal, *Interpreters' Handbook* (Canberra: RRT, 1996). See also Robert M W Dixon, A Hogan & A Wierzbicka *Interpreters: Some Basic Problems* (Victoria Clearing House on Migration Issues, 1980).
4. *Supra,* note 2, UNHCR, *Interviewing Applicants for Refugee Status;* UNHCR, *Handbook on Criteria for the Determination of Refugee Status.*
5. Interview with refugee, Kakuma Refugee Camp, Kenya, 25 January 2003.
6. See UNHCR, *Eligibility Interview Form*, Checklist.
7. Interview with asylum seeker, Daadab Refugee Camp, Kenya, 6 February 2003.
8. Interpreter-assisted interviews last about twice as long as they would were the conversations conducted in English or Swahili.

update

UNHCR/Jesuit Refugee Service

Call for international action as Nepal/Bhutan bilateral talks fail to solve refugee crisis

More than 100,000 Bhutanese Hindus of Nepalese origin – an estimated one-sixth of the population of Bhutan – have been living in refugee camps in southeastern Nepal since the early 1990s when they were arbitrarily stripped of their nationality and forcibly expelled from Bhutan in one of the largest religious/ethnic expulsions in modern history.[1]

Amnesty International, Human Rights Watch, the Lutheran World Federation, the Jesuit Refugee Service, Habitat International Coalition and the Bhutanese Refugee Support Group have called on donors to urgently convene an international conference involving the two governments, refugee representatives, UNHCR and other UN agencies to devise a comprehensive and just solution to the 12-year-long refugee crisis.

The agencies argue that the pilot screening programme to determine eligibility to return (started by the governments of Bhutan and Nepal in Khudunabari camp in 2001) is deeply flawed. The screening process excludes UNHCR, fails to comply with international human rights and refugee standards and risks leaving tens of thousands of refugees stateless. Bilateral negotiations have failed to address refugees' key concerns regarding repatriation to Bhutan – guarantees of safety and security, citizenship rights and restitution of property.

In a move criticised by the NGOs, UNHCR has announced it is to begin phasing out assistance to the refugee camps in the absence of a just and lasting solution by Nepal and Bhutan and to explore possibilities for local integration in Nepal and resettlement in third countries.

The NGOs have called on donors to apply new pressure to Nepal and Bhutan and insist that the two governments uphold the refugees' rights and allow UNHCR to monitor the repatriation process.

"For too long donor governments have offered tacit support to the bilateral process between Nepal and Bhutan," said Eve Lester, refugee coordinator at Amnesty International. "Now they must recognise that this strategy has failed and international efforts are needed to find a comprehensive solution."

The joint NGO statement is at: http://hrw.org/press/2003/10/nepal101303.htm A report from Human Rights Watch examines the uneven response of UNHCR and the government of Nepal to rape, domestic violence, sexual and physical assault, and trafficking of girls and women from refugee camps. See www.hrw.org/press/2003/09/nepal-bhutan092403.htm

1. See FMR 7, pp20-22.

UNRWA and ICRC scale back operations in occupied Palestinian territories

UNRWA has warned that lack of donor response to its emergency appeal is forcing cutbacks in its efforts to lesson the pain of the effects of violence on the Palestinian refugees in the West Bank and Gaza. While donor responses to UNRWA emergency appeals at the beginning of the current *intifada* exceeded 100%, as a result of donor fatigue there is now only a 40% response.

Since October 2000 nearly 14,000 UNRWA-registered refugees in the West Bank and Gaza have been made homeless by house demolitions carried out by the Israeli army. UNRWA faces a bill of $30.5 million for the cost of its re-housing efforts in the Gaza Strip alone. UNRWA has only been able to offer replacement homes to 228 families in Gaza, the remainder having to make do with tents and blankets. Work to rebuild the Jenin camp, ravaged by the Israeli offensive in April 2002, has fallen behind schedule.

Insufficient funding has also forced UNRWA to curtail the number of employees in temporary positions in the West Bank by a quarter. In Gaza the agency has had to forego expenditure on construction and maintenance projects that would have generated job and training opportunities for Palestinian workers.

Almost 230,000 families depend on UNRWA food parcels. As a consequence of lack of funding and Israeli restrictions on distribution activities, UNRWA reduced the tonnage of food delivered in the third quarter of 2003 by 17%. With a 25% malnutrition rate in Gaza and almost as much in the West Bank, the agency has had to cut back food distributions to half of what had been foreseen for 2003. UNRWA has reduced its nutritional norm from providing 60% of each family member's daily nutritional requirements to 40% of these requirements

In November the International Committee of the Red Cross (ICRC) announced the end of relief distributions to around 300,000 people in the West Bank. Noting that "humanitarian aid cannot be a viable solution to the crisis in the West Bank", the ICRC reminded Israel of its primary responsibility under the Fourth Geneva Convention to ensure that the population of territories it occupies has sufficient access to food, water, health services and education. The ICRC will intensify its efforts to monitor the humanitarian impact of curfews, movement restrictions and accelerating confiscation of land and property along the separation wall.

UNRWA's annual report is online at www.un.org/unrwa/news/releases/pr-2003/ga-30october03.pdf Information on how to donate to UNRWA is at www.un.org/unrwa/emergency/donation/index.html A donation of US$30 can provide one month's food parcel for a family of eight.

The ICRC press release announcing an end to large-scale humanitarian operations is at: www.icrc.org/web/eng/siteeng0.nsf/html/5TGCYH?OpenDocument

UNHCR/Jesuit Refugee Service

New legislation endangers refugee protection in UK

A new Asylum and Immigration Bill (the fifth in 11 years) has been condemned by refugee and human rights organisations. They fear that plans to remove the right to a second tier appeal and limits on legal aid would remove a vital check on notoriously poor initial decisions (over 15,000 orders to deny asylum were overturned on appeal in 2003). Support will be withdrawn from families ordered to leave the UK who fail to take up a paid route home. Their destitute children could be taken into care. The proposed law could also result in families being imprisoned for arriving without travel documents – despite the fact that Refugee Convention states that refugees should not be penalised for arriving without appropriate documentation.

Amnesty International UK Director Kate Allen described the bill as "devastating for thousands of refugees seeking protection in the UK … the appeals process can be the only barrier between a refugee and the secret police waiting to torture them on their return." Refugee Legal Centre Chief Executive Barry Stoyle complains that "the proposed one-stop appeal tribunal … will make life-or-death decisions without anyone being able to question them."

For further information, see the Refugee Council press release at: www.refugeecouncil.org.uk/news/dec03/relea144.htm

Refoulement from Panama

The Panamanian government is planning to repatriate refugees who have entered Panama to escape from the violence and civil war in Colombia. Most are Afro-Colombians from Colombia's north-western coastal department of Chocó. The Panamanian border province of Darien is home to 1,515 refugees and persons registered as requiring special protection. According to the Organizaciones de Derechos Humanos Panamá, the Panamian government is planning to force the Colombians back to Colombia, despite the continuation of the violence which forced them to flee to Panama in the first place.

Although Panama is a signatory to the 1951 Refugee Convention, it has *refouled* Colombian refugees on a number of occasions. In April 2003, 109 Colombians (63 of them children) were taken from their place of residence in Darien and deported to Zapzurro, on the Colombian side of the border. When some refused to move or tried to escape they were reportedly manhandled by the National Guard and forced into helicopters. Some of the refugees were forced to sign a document declaring that their return to Colombia was voluntary.

Amnesty International has produced evidence that previous repatriations have been far from voluntary and that returning refugees are placed at risk of attack if they refuse to collaborate with paramilitaries backed by the Colombian army. Amnesty complains that "cooperation between Panama and Colombia seriously undermines the civilian and humanitarian nature of refugee protection."

See: http://web.amnesty.org/library/Index/ENGAMR230782003

Distress of deportation from Morocco to Nigeria

by Dr Yahya Yahyaoui

The history of Morocco's Mediterranean coastline is inextricably linked with the history of migration, whether flight is for economic reasons or from conflict.

The current route taken by potential migrants from sub-Saharan Africa to Europe leaves from Oujda, in the far north-east of Morocco and on the Algerian border. This phenomenon has attracted greater attention in recent months because of the methods used by the Moroccan authorities in detaining and deporting significant numbers of these migrants. With the discreet support of, and doubtless under pressure by, the Spanish authorities, those detained have all been deported – in aeroplanes chartered by Spain – from Oujda's Angad airport to one sole destination: Nigeria. This is being done without any administrative formalities and with no regard as to where the migrants/asylum seekers actually originate from. Huge distress is being caused.

These hundreds of potential immigrants, dreaming of a more secure life in Europe, no doubt believed they would be doing no more than passing through Moroccan territory. But since Europe has barricaded its borders, there has been a greater migratory movement from the south towards Morocco and as a result, Morocco itself has come under pressure to act as a filter – one that now retains the majority of those entering the country.

If one takes into further consideration the political pressure and economic blackmail exerted by Europe on Spain to contain and curb population movements, one can begin to understand that this is a very complex situation, characterised by grave abuses of individuals' human rights.

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According to a report in the *Guardian* in October 2003, every year thousands of people attempt to cross the 30-mile Strait of Gibraltar which separates Spain from Africa, while thousands take the long trip west from Morocco to the Canary Islands. A Moroccan immigrants' group said that in 2002 4,000 people had died or disappeared in the attempt. In 2002 Spain repatriated 74,467 immigrants – 58% more than in 2001 – of whom 23,381 were Moroccan.

See www.guardian.co.uk/spain/article/0,2763,1063682,00.html

For more information about Spain's treatment of migrants and asylum seekers from Morocco and other African countries, see Human Rights Watch reports at: www.hrw.org/doc?t=europe&c=spain

The state of UNHCR's organisational culture

by Jeff Crisp

Over the past 20 years, a voluminous literature – much of it somewhat critical in tone – has been published on the policies, programmes and activities of UNHCR. During the same period, the concept of 'organisational culture' has gained wide acceptance amongst sociologists and anthropologists as a means of understanding human systems and the way in which they behave. But curiously, very few analysts have endeavoured to combine these fields of study, bringing an organisational culture perspective to the work of the UN's refugee agency.[1]

In an attempt to address this neglected issue, UNHCR's Staff Development Section, supported by the Evaluation and Policy Analysis Unit, has launched a new research project titled 'The state of UNHCR's organisational culture'. Led by Barb Wigley, an experienced management consultant and health practitioner who is studying for a PhD at the University of Melbourne, the project seeks to determine how UNHCR's culture influences the organisation's activities and performance and its capacity to implement change.

It is hoped that the study will enable the organisation to provide better support to its staff, to enhance the training programmes provided to senior and middle managers, and, more generally, to reinforce UNHCR's capacity for individual and organisational learning. For, as one scholar has argued, "UNHCR has an organisational culture that makes it extremely difficult to learn from past mistakes, and therefore some of the same mistakes are repeated from one operation to another."[2]

This is a regular page of news and debate from UNHCR's Evaluation and Policy Analysis Unit (EPAU). For further information, or suggestions regarding this feature, contact Jeff Crisp, head of EPAU. Email CRISP@unhcr.ch

Drawing upon existing literature in this field, the study defines organisational culture as the set of assumptions, values, customs and myths which guide the perceptions and behaviour of UNHCR staff members and which are passed on to new members of that group by both formal and informal means.

The study recognises that many of these assumptions and values are socially embedded within UNHCR but have never been officially articulated. The project will also take due account of the fact that large international organisations such as UNHCR tend to be characterised by a plethora of 'micro-cultures', a manifestation of interlocking social networks based on the nationality, regional origin, function, gender, grade and career history of staff members.

A variety of different methods will be used to conduct this analysis, including participant observation, one-to-one interviews with a cross-section of Headquarters and field staff, and the analysis of data gathered from participants in UNHCR's management learning programmes. Field visits are planned to East and West Africa, the Balkans and South-East Asia. A report of the project will be placed in the public domain, most probably in the second half of 2004.

According to specialists in this area, the culture of any organisation serves two important purposes: the integration of individual staff members and the adaptation of the institution to its external environment. If it is to examine the latter of these two purposes, this new UNHCR study will evidently need to solicit the opinions and perceptions of other stakeholders, including subscribers to *Forced Migration Review*. We therefore invite interested readers to contact Ms Wigley in relation to her research. She can be reached by email at: bwigley@bigpond.net.au

1. For an exception to this rule, see Mark Walkup 'Policy dysfunction in humanitarian organizations: the role of coping strategies, institutions and organizational culture', *Journal of Refugee Studies*, vol. 10, no. 1, 1997.
2. Gil Loescher *The UNHCR and World Politics: A Perilous Path*, Oxford University Press, 2001, p19.

New working papers

UNHCR is pleased to announce the publications of nos. 93-100 in the working paper series *New Issues in Refugee Research.* The papers can be accessed under 'Publications' on the UNHCR website (www.unhcr.ch) or ordered in hard copy from hqep00@unhcr.ch.

No. 100. A new asylum paradigm? Globalization, migration and the uncertain future of the international refugee regime, by Jeff Crisp

No. 99. From 'protective passports' to protected entry procedures? The legacy of Raoul Wallenberg in the contemporary asylum debate, by Gregor Noll

No. 98. The issue of 'trust' or 'mistrust' in research with refugees: choices, caveats and considerations for researchers, by Tricia Hynes

No. 97. Bosnian refugees in Australia: identity, community and labour market integration, by Val Colic-Peisker

No. 96.A bitter pill to swallow: obstacles facing refugee and overseas doctors in the UK, by Emma Stewart

No. 95. Forced migrants as an under-utilized asset: refugee skills, livelihoods, and acheivements in Kampala, Uganda, by Michela Macchiavello

No. 94. Refugees, forced resettlers and 'other forced migrants': towards a unitary study of forced migration, by David Turton

No 93. Local integration as a durable solution: refugees, host populations and education in Uganda, by Sarah Dryden-Peterson and Lucy Hovil

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Resumption of martial law in Aceh

by Eva-Lotta Hedman

On 6 November 2003, the Indonesian government announced that the existing state of emergency and the massive military offensive in Aceh were to be extended for a further six months. Meanwhile, international media and humanitarian organisations remain virtually barred from Aceh and their Indonesian counterparts are intimidated and harassed. The extension of martial law in Aceh, while hardly surprising to many observers, will further impede any outside assessment of the need for protection and assistance and resultant distribution initiatives.

The Indonesian armed forces (TNI) have made the management of IDP camps and the distribution of relief goods to IDPs a high-profile component of their military campaign, which has also featured 'embedded' journalists. Such efforts, however, must be viewed in the wider context of TNI campaigns in Aceh, involving forced displacement of villagers, compulsory participation in mass loyalty oaths and rallies, and 'special screening' of civil servants and others for new national identity cards. These campaigns suggest that, in the current climate in Aceh, forced displacement is perhaps best understood as a strategy of war deliberately pursued by the TNI.

The problems of forced displacement due to the conflict in Aceh go beyond mere numbers, which have tended to fluctuate and, in recent months, have declined to an estimated 9,000 IDPs in designated camps. However, these numbers do not necessarily reflect the reported and sometimes repeated movements of people in and out of villages and towns due to the conflict. Within the refugee camps, it also remains unclear what kind of medical assistance is available, not least in view of the Indonesian government's vice-like grip on humanitarian assistance to IDPs in Aceh. (The budget for humanitarian assistance for Aceh is about $45 million – compared to an estimated $200 million for the military operation.)

Elsewhere in Indonesia, Acehnese have also found themselves the target of new forms of government surveillance and control. For example, the Indonesian military has established checkpoints to monitor the internal border between Aceh and North Sumatra. Such checkpoints, where travel documents and the new national identity card are required for inspection, create considerable difficulties for those seeking to leave war-torn Aceh for North Sumatra. There are also reports of a wider climate of fear and intimidation for the many thousands of Acehnese currently living in North Sumatra as IDPs. The Indonesian security forces have reportedly been keen to monitor Acehnese communities in many parts of the country, and the police have been particularly active in conducting regular 'sweep operations' in the capital city of Jakarta.

In neighbouring Malaysia, where the largest number of Acehnese outside Indonesia have sought refuge, the government has adopted a notably punitive regime on migration. Not a signatory to the 1951 UN Convention on Refugees, Malaysia introduced an amended Immigration Act in 2002 under which illegal immigrants may face mandatory whipping, considerable fines or five years in jail. More recently, during a joint press conference with President Megawati Sukarnoputri in late August 2003, (former) Prime Minister Dr Mahathir Mohammad declared that "Malaysia will not grant asylum to those who flee here from the war-torn Indonesian province of Aceh…. They will be treated as illegal immigrants, hence subject to arrest and deportation." Indeed, 232 Acehnese were reportedly arrested and detained outside the UNHCR office in Kuala Lumpur, and others were targetted in raids on several homes in Penang. Some reports have expressed concern that deportees from Malaysia to Indonesia are met at port by the TNI, only to be returned to Aceh, despite the ongoing armed conflict.

Despite abundant evidence of human rights abuses, violations of international law and a continuing humanitarian crisis in Aceh, the response of the international community has been muted. A recent joint US-EU-Japanese statement of concern over the extension of martial law in the province earned a sharp rebuke from Jakarta, their criticisms and demands for greater transparency and access quickly brushed aside. Against the backdrop of the global 'War on Terror', it appears that Jakarta remains free to wage a brutal campaign to reassert control over Aceh.

Eva-Lotta Hedman is Senior Research Fellow at the RSC. Email: eva-lotta.hedman@qeh.ox.ac.uk

Short courses at the Refugee Studies Centre in 2004

The Law of Refugee Status
15-16 May 2004
with Prof James C Hathaway (University of Michigan)

Palestinian Refugees and the Universal Declaration of Human Rights
22-23 May 2004
with Dr Randa Farah (University of Western Ontario) and Fiona McKay (Lawyers Committee for Human Rights)

Cross-Cultural Psychology, Forced Migration and Peace Building
23-24 October 2004
with Prof Michael Wessels (Randolph Maco College, USA, and Psychosocial Advisor for the Christian Children's Fund)

New RSC Working Papers

The RSC has recently added six new titles to its Working Paper Series. They can be accessed free of charge via the RSC website (www.rsc.ox.ac.uk). Bound hard copies of the working papers are also available (£5 plus p&p): contact the RSC (address opposite) or order via the RSC website.

No. 16. When forced migrants return 'home': the psychosocial difficulties returnees encounter in the reintegration process, by Tania Ghanem
No. 15. Narrating displacement: oral histories of Sri Lankan women, by Jesse Newman
No. 14. Financing matters: where funding arrangements meet resettlement in three Mexican dam projects, by Jason Stanley
No. 13. Refugees and 'other forced migrants', by David Turton
No. 12. Conceptualising forced migration, by David Turton
No. 11. Addressing the root causes of forced migration: a European Union policy of containment?, by Channe Lindstrom.

Forced Migration Online : www.forcedmigration.org

Several new Research Guides have recently been added to FMO including ones on thematic issues such as 'Camps versus settlements', 'Urban refugees', 'Forced migration and electoral participation' and 'Development-induced displacement and resettlement'. New regional guides include Algeria and Palestinians in Jordan, Lebanon and Syria. Go to: www.forcedmigration.org/guides/

In collaboration with the Sphere Project (Humanitarian Charter and Minimum Standards in Disaster Response), FMO will put online (in full text) most of the documents in the bibliographies in the revised edition of the handbook in early 2004.

FMO welcomes all suggestions, comments and contributions to the Digital Library. Email: fmo@qeh.ox.ac.uk

Forthcoming conferences

2nd Annual Student Conference on Forced Migration
15 March 2004 : University of Warwick

The 2nd Annual Forced Migration Student Conference will give postgraduate students the opportunity to meet, discuss their research and share their experience within a relaxed and supportive environment. The event is entirely coordinated by students. All post-graduate students studying any aspect of Forced Migration are welcome.

For more information, contact fmsc04@hotmail.com

The Search for Solutions: Achievements and Challenges

9th Biennial IASFM Conference
9-13 January 2005 : São Paulo, Brazil

For the first time, the IASFM's Biennial Conference will be held in South America, hosted by the Pontifical Catholic University of São Paulo. The conference will focus on the search for solutions to forced migration (see the call for papers at www.iasfm.org for details of sub-themes and panels). It will present an important opportunity to broaden the scope of the IASFM by including issues and perspectives of importance to Latin America, such as involuntary economic migration, the emerging role of Southern countries in third-country resettlement, conflict-induced displacement, and development- and environmentally-induced displacement. This conference will bring together academics, practitioners, policy makers, government representatives and forced migrants.

Visit www.iasfm.org for full details, including registration and grant application forms. Applications must be received by 31 July 2004.

All correspondence concerning the conference should be to: Heidi El-Megrisi, IASFM Secretariat, c/o Refugee Studies Centre (at address opposite).
Email: heidi.el-megrisi@qeh.ox.ac.uk
Fax: +44 (0)1865 270721.

FMR 21- Call for papers

FMR 21 will focus on the return and reintegration of IDPs and will be produced in collaboration with the Internal Displacement Unit of the UN's Office for the Co-ordination of Humanitarian Affairs (OCHA) and UNDP's Bureau for Crisis Prevention and Recovery (BCPR). The issue will focus on lessons learned from recent return movements as well as policy issues relating to the creation and maintenance of enabling environments for sustainable returns. It will also include some case-studies of recent or current returns. Among the topics to be addressed are:

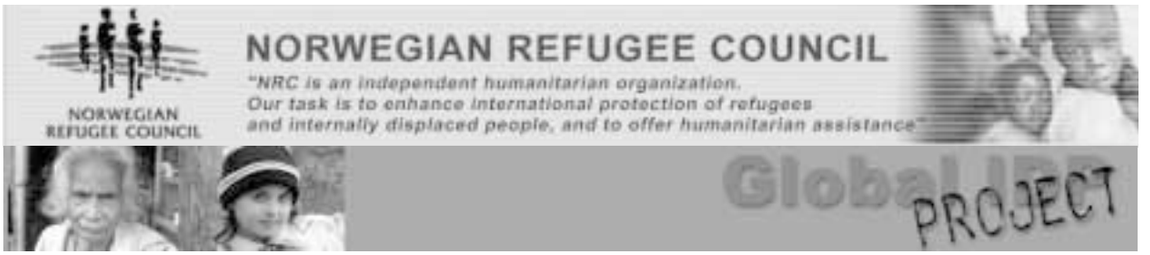
- restitution of lands and property
- reconciliation and peace building
- the rule of law and return
- protection of IDPs after return
- re-establishment of livelihoods
- psychosocial needs and rehabilitation
- special needs of women and children
- capacity building among local authorities

These topics can be presented either as lessons learned from recent experience or as discussion papers. Papers having relevance to field practice, charting innovations which could be translated into implementation, would be preferred. Widening of discussion to include refugees is also welcomed as are papers that look at how post-conflict communities 'rebuild' and can be strengthened and supported to sustainably reintegrate those coming back (refugees, IDPs and ex-combatants).

Deadline for submissions: 15 May 2004

Length: maximum 3000 words (including maximum of 10 endnotes)

Contact the FMR Editors at fmr@qeh.ox.ac.uk



Pre-ExCom 2003

The consultations which precede the annual meeting of UNHCR's Executive Committee ('Pre-ExCom', in UN jargon) are an important forum for NGOs to raise concerns with UNHCR about the protection of refugees and IDPs. The report of Pre-ExCom is presented to the Executive Committee.

The 2003 Pre-ExCom, held on 24-26 September, marked another step forward in enhancing the partnership between the refugee agency and NGOs. The 228 participants from 160 NGOs in 65 countries discussed a broad range of issues and country/regional situations. Three main themes dominated the meeting: improving refugee and IDP protection, strengthening UNHCR-NGO partnerships and the security implications for humanitarian action following the bomb attack on the UN in Iraq on 19 August 2003.

Enhanced partnership

"Partnership is an attitude and should not be discretionary." This remark by one of the UNHCR representatives at the meeting reflects, in the view of many NGOs, the refugee agency's changing approach to partnership. NGOs welcomed UNHCR's stronger commitment to improving relationships with non-governmental actors. They underlined, however, that in order to institutionalise partnership, more regular coordination between UNHCR and NGOs is needed both at field and headquarters level. They also made clear that the quality of partnership must not depend on the amount of funding NGOs are able to contribute to joint activities.

Improving protection

NGOs emphasised the importance of making use of existing human rights mechanisms to enhance refugee protection. "There is a greater recognition that human rights instruments and bodies can be used to further the rights of refugees", the rapporteur's report says. "NGOs can, and should, bring strong cases before regional human rights bodies and international UN treaty monitoring bodies to uphold and protect the human rights of refugees and asylum seekers."

NGOs also stressed their role in ensuring that the process of developing new protection tools to complement the 1951 Convention genuinely reflects the protection needs of refugees. Currently, this initiative, launched by UNHCR in October 2002 and dubbed 'Convention Plus', is widely perceived to be controlled by states, with UNHCR under pressure to tag along. The concerns and interests of states dominate the debate. "Given the close relationship that NGOs have with refugees, we can provide the necessary reality check", the Pre-ExCom report points out.

Protection versus state security concerns

Since the terrorist attacks of 11 September 2001, many states have introduced security measures that often infringe upon the right of refugees to international protection. One of the Pre-ExCom working sessions, moderated by NRC, took a closer look at the situation in Latin America and discussed what could be done to ensure the protection of refugees while at the same time taking into account the security concerns of states.

The intensification of the conflict in Colombia, for example, and its spill-over effects on neighbouring countries have led governments in the region to step up the presence of police and army personnel in border areas. This legitimate – though in many cases disproportionate – response has led to harassment of local populations as well as of Colombian refugees.

The main challenge for people in need of international protection is access to asylum determination procedures. States have introduced border control measures, more restrictive visa regimes, narrowed interpretations of asylum regulations, detention, deportation, interception and provision of only temporary protection as a means of separating out armed actors and migrants from those in need of international protection. These are all measures that impede access to asylum determination procedures.

NRC, which runs a refugee protection project working with Colombian refugees in Venezuela, Panama and Ecuador, is also concerned about the tendency to adopt increasingly restrictive refugee legislation. In Panama, UNHCR-facilitated talks on bringing the country's refugee legislation into line with international standards have stalled due to concerns about the security situation in the border areas. Colombian refugees in Panama rarely have access to asylum determination procedures. The temporary protection

IDP news

IDP news is a weekly summary of news on IDPs in conflicts. It is compiled by the Global IDP Project, based on public information. Subscribe by email to: idpproject@nrc.ch or visit our website **www.idpproject.org.**

they are given falls short of international standards because neither eligibility criteria nor the rights it entails are clearly defined. Panama has also forced Colombian refugees to return to insecure conditions in Colombia, a direct violation of the principle of *non-refoulement* in the Refugee Convention.

These are only a few examples of the challenges faced by UNHCR and NGOs in their work with refugees. What can be done to ensure that people in need have access to international protection?

In the case of Colombia's neighbours, NRC, in close collaboration with UNHCR, works with the governments to ensure that national law is based on the Refugee Convention and its intentions, and that the asylum determination process secures refugees' rights in accordance with these instruments.

At the field level, the focus must be on:

- removing refugees from border areas to avoid confusion with armed actors
- disseminating information about the plight of refugees as well as their obligations
- concentrating on non-combatants and protection networks
- improving registration procedures
- training of border officials
- assisting states in speeding up refugee status determination processes.

In addition, NGOs at Pre-ExCom recommended a more global approach by developing, as a starting point, comparative studies of state security measures and their consequences for refugee rights in different countries and regions.

Changed security environment

The consultations focused on the impact of the bombing of the UN's Baghdad headquarters on humanitarian work. There was general agreement that the context in which humanitarian action is carried out has changed irreversibly. Dennis McNamara, UNHCR's Inspector General, posed a number of provocative and pertinent questions that have formed the basis of further discussions and initiatives on ways forward to revitalise humanitarian principles. It was concluded that humanitarian agencies should respond by strengthening their capacity to better understand the environment in which they operate and to improve security.

Participants noted, however, that as many of the actions needed are political they are beyond their capacity. The decision of tasking international military forces with providing humanitarian assistance, for example, may well increase the popularity of the military but comes at the expense of the security of humanitarian workers.

Protecting IDPs: does the 'Collaborative Approach' work?

Although more numerous than refugees, the world's 25 million IDPs have no single UN agency to turn to for assistance and protection. In lieu of a better solution, the UN came up with the so-called Collaborative Approach, a formula designed to ensure that the various agencies dealing with IDPs at the field level coordinate their activities and develop a coherent response. The Approach tasks the UN's Resident and Humanitarian Coordinators with responsibility for monitoring the IDP situation and developing a strategy to address IDP issues. They are also charged with establishing mechanisms for cooperation among in-country humanitarian actors. Within this framework, responsibilities for different IDP-related tasks are delegated to whoever is best placed to address them.

There still is a long way to go to make the Collaborative Approach work. While UNHCR has confirmed its intention to "be fully engaged with other partners in pursuing activities for IDPs", it noted in its report to this year's UN General Assembly that the Collaborative Approach is presently suffering from too many *ad hoc* decisions. Discussions in the Pre-ExCom working group on IDPs, moderated by the Global IDP Project, revealed that the Collaborative Approach is often seen as a purely theoretical concept which is yet to be effectively operationalised.

During the discussion, UNHCR underscored the need for the Collaborative Approach to be based on a clear division of labour, reflecting the special competences of the individual partners. Others argued that UNHCR needs to be more proactive in ensuring the inclusion of IDP needs in overall humanitarian response strategies and encouraging inter-agency cooperation at the field level.

Several speakers pointed to the problem that the success of the Collaborative Approach presently relies too much on the personalities, skills and management styles of individual Humanitarian Coordinators, rather than on established structures. Its functioning also depends on the level of motivation of the UN partners involved and requires a culture of cooperation among them.

NRC and other participating agencies drew attention to the limited representation of developing country NGOs at Pre-EXCOM and urged governments and international NGOs to assist more NGO representatives from the South to attend the 2004 meeting.

Elisabeth Rasmusson, NRC's Resident Representative in Geneva, was Rapporteur for Pre-ExCom 2003. Email: elisabeth.rasmusson@nrc.ch

UNHCR's Pre-ExCom 2003 report is online at www.unhcr.ch (use search engine to locate URL). The International Council of Voluntary Agencies (ICVA) has a number of documents relating to Pre-ExCom at: www.icva.ch

1. UNHCR's 'Convention Plus: Questions and Answers' is online at www.unhcr.ch
2. For further discussion, see FMR 18 pp38-39.

The **Norwegian Refugee Council** (NRC) works to provide assistance and protection to refugees and displaced people in Africa, Asia, Europe and the Americas. NRC was founded in 1946 in Oslo.

www.nrc.no/engindex.htm

The **Global IDP Project** is part of NRC and is an international non-profit organisation that monitors internal displacement caused by conflicts. The IDP Database provides public information about internal displacement in 50 countries.

www.idpproject.org

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The Brookings-SAIS Project on Internal Displacement

Internally Displaced Persons in Uganda – a forgotten crisis

by Francis M Deng

Uganda is currently facing an internal displacement crisis of catastrophic proportions but one that is little known to the outside world. The most recent estimates suggest that approximately 1.3 million people are displaced inside the country. In August 2003, I travelled to Uganda to assess the situation and, through discussions with the government, UN agencies, NGOs and the donor community, to identify appropriate responses to the crisis.

I was profoundly saddened to witness the desperate situation of these children.

By far the largest displacement situation is in the northeastern part of the country. For the last few years, the 'Lord's Resistance Army' (LRA) has been engaged in a vicious and violent opposition to the government. The LRA has been targetting civilians and abducting children to act as child soldiers, porters or sex slaves. The conflict has recently increased in intensity following a government offensive in March 2002, code-named Operation Iron Fist, resulting in a deepening of the humanitarian crisis.

The millions of IDPs affected by this conflict are accommodated in a number of camps established by the government where they are in dire need of humanitarian assistance and protection. Food stocks are scarce, water supply is severely insufficient, sanitation is very poor and the provision of health and education services is minimal. Fear of the LRA stops people from farming, the economic mainstay of livelihoods in the area. The IDPs living in camps receive practically no physical protection. Normally, only a handful of government soldiers are assigned to protect a camp hosting approximately 20,000 IDPs. Insecurity along the roads has rendered many of the camps inaccessible for delivery of vital food and other humanitarian assistance, except with heavy military escort.[1]

The phenomenon of the so-called night-commuters is a particularly tragic aspect of this conflict. In order to protect their children from abduction by the LRA, parents in the northern districts send their children to spend the nights in Gulu, Kitgum and Pader towns. During the past seven months, an estimated 25,000 persons – most of them children – have commuted distances of up to 5 km each way between the towns and villages during the late afternoon hours and early morning hours of the next day. During my visit to Gulu town, I was profoundly saddened to witness the desperate situation of these children.

All actors – national and international – have so far been slow in responding to the crisis. A more concerted and consistent effort is needed to address the situation. In September, following my visit, I made this point when I briefed the Inter-Agency Standing Committee Working Group on my findings and emphasised the need for urgent response. It now seems that both the international community and the national authorities are beginning to respond to the crisis. Jan Egeland, the newly-appointed UN Emergency Relief Coordinator, travelled to the country and has devoted much of his time to galvanising the international response and strengthening the international presence in northern Uganda. A positive development at the national level has been the process of drafting a national policy on internal displacement (based on the Guiding Principles on Internal Displacement). The policy is rich and comprehensive, and the Government expects it to be adopted by the Cabinet in the next few months. It is absolutely critical that every effort be made to adopt the policy and implement its provisions.

Donor countries have a key role to play – in terms of both financial and political support. The recently released 2004 Humanitarian Appeal for Uganda asks for $128 million to address the most immediate humanitarian needs. Donor support will be absolutely essential to avoid a humanitarian disaster. At the political level, the international community can play an important role in finding a resolution to the conflict in the north. Given its regional dimension and links to the conflict in the Sudan, the anticipated achievement of peace in the Sudan might have a positive impact on the Ugandan situation.

The international community and the Government of Uganda jointly have the responsibility and the capacity to address this crisis. It is my hope that the encouraging moves recently taken towards a more comprehensive response, the development of a national policy and increased international presence in the North will provide a basis for an effective remedy to the situation.

Francis M Deng is Representative of the UN Secretary-General on Internally Displaced Persons.

See the Global IDP Project's case study on Uganda: www.db.idpproject.org/Sites/idpSurvey.nsf/wCountries/Uganda

1. See FMR 18 pp25-27.

publications

Refugees and Reproductive Healthcare: Global Decade Report

Reproductive Health Response in Conflict Consortium. 2004. 60pp.

This report charts almost ten years of worldwide conflict and its impact on the reproductive health of those forced to flee. The country chapters – on Angola, Colombia, DRC, East Timor, Pakistan & Afghanistan, Sri Lanka and Zambia – provide an overview of the RH status of millions of displaced people.

The report (plus full country reports) can be accessed at www.rhrc.org/resources/general_reports/index.html
Hard copies are available free of charge. Contact Sam Guy at Marie Stopes International, 153-157 Cleveland Street, London W1T 6QW, UK.
Tel: +44 (0)20 7574 7400.
Fax: +44 (0)20 7574 7417.
Email: sam.guy@mariestopes.org.uk

Reproductive Health: From Disaster to Development

Reproductive Health Response in Conflict Consortium. 2004. 143pp.

Full proceedings from the RHRC Consortium Conference held in Brussels, Belgium, October 2003.

See www.rhrc.org/pdf/conf_procdings_forWEB.pdf

Hard copies available from Sam Guy as detailed above.

Refugees and Forced Displacement: International Security, Human Vulnerability and the State

Eds Edward Newman and Joanne Van Selm. 2003. 402pp. ISBN 92-808-1086-3. $38.

In seeking to address the nexus between security concerns and migratory flows, the book argues for a reappraisal of the legal, political, normative, institutional and conceptual frameworks through which the international community addresses refugees and displacement.

Contact: Sales & Marketing, United Nations University Press, 53-70, Jingumae 5-chome, Shibuya-ku, Tokyo 150-8925, Japan.
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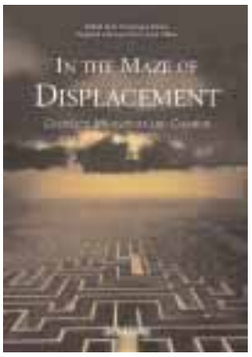
Website: www.unu.edu/unupress.

In the Maze of Displacement: Conflict, Migration and Change

Eds N Shanmugaratnam, Raghnhild Lund & Kristi Anne Stølen. 2003. 229pp. ISBN 82-7634-540-9. 298 NOK/€36 (Plus €12 p & p)



This book draws on the disciplines of geography, anthropology, political economy and environmental/development studies to study diverse situations of displacement in Asia, Africa and Latin America and how those affected perceive and cope with them.

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The Migration-Development Nexus

Eds Nicholas Van Hear & Ninna Nyberg Sørensen. International Organization for Migration. 2003. 317pp. ISBN 92-9068-157-8. $38.

This collection of eleven articles reviews the relationship between migration and development – discussing issues such as remittances, return, conflict situations and livelihood of refugees – and analyses policy options. Three country studies (Afghanistan, Somalia and Sri Lanka) examine the theories in practice, while some of the articles discuss possible policy options regarding immigration and asylum, development assistance and emergency relief.

Labour Migration in Asia: Trends, Challenges and Policy Responses in Countries of Origin

International Organization for Migration. 2003. 184pp. ISBN 92-9068-177-2. $35.

This volume looks at recent trends in labour migration in Asia, the issues and challenges faced by migrants and countries of origin, and policy responses by the state.

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Building a future in Sierra Leone

Women in Crisis participants with UNFPA programme assistant Priya Marwah.

Sierra Leone's decade-long civil war, which displaced more than half the population, left thousands of people deeply scarred, psychologically and physically. Two years after the end of the fighting, Sierra Leone is beginning the long process of healing and reconstruction.

Khadija Bah is still a teenager, yet her experience belies her youth. Made to watch her parents being killed before her eyes, she was then raped in front of her husband, who was promptly executed. After that, Khadija said, she was abducted by the rebels and taken as a bush wife, forced to meet their every need. When the conflict ended, she managed to escape and made her way to Freetown, the capital, but had to sell her body to survive.

UNFPA (the United Nations Population Fund) is supporting the work of an extraordinary woman to make sure that Khadija and others like her – destitute women and girls who have been forced into sex work to survive – are not forgotten.

"I was living a bad life before I found this place," says Khadija. *"But then I met Auntie Juliana."*

'Auntie Juliana' is Juliana Konteh, a 42-year-old Evangelist missionary who founded the Women in Crisis project in 1997. Women in Crisis does extensive outreach work including in brothels. "I met some ladies in a brothel and decided to help them," Auntie Juliana explained. "They needed food, clothing, care and attention."

Today, hundreds of girls like Khadija receive care and attention at the project's hilltop site on the outskirts of Freetown. Two drop-in centres have been established where women and girls can learn how to protect themselves against HIV and AIDS and how to earn a living by sewing and craftwork. Those with sexually-transmitted infections receive treatment, care and support. Women learn to read and acquire basic mathematical skills – and have a safe place to talk about their problems. Their new skills and renewed faith give them the possibility and the strength to move forward with their own lives – and in so doing they can contribute to their country's reconstruction as well.

As 14-year-old Christiana, who was repeatedly raped after watching her mother being tortured, says, "I lost my parents and my two brothers. But now I have a family again."