

**Inter-agency global evaluation of reproductive
health services for refugees and internally displaced
persons**

November 2004

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FOREWORD

Every year, millions of people around the world flee their homes to escape persecution, conflict and violence. Some become refugees when they cross international borders, while many others become internally displaced within their own countries. During complex emergencies, refugees and the internally displaced are placed under great pressures which can affect their health. In addition, women and girls are often the victims of sexual and gender-based violence, both during and following periods of acute conflict. The burden of reproductive health problems is undeniably greater for women; for refugee and internally displaced women, this burden is compounded by the uncertainty of their situation.

In 1994, the seriousness of the reproductive health problems faced by refugee women was the focus of a report released by the Women's Commission for Refugee Women and Children. In the same year, attention was drawn to the reproductive health needs of refugees and displaced persons at the International Conference on Population and Development (ICPD) held in Cairo, Egypt. Since then, two groups have played a leading role in addressing the reproductive health needs of conflict-affected populations, namely the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) and the Reproductive Health Response in Conflict Consortium (RHRC Consortium, formerly known as the Reproductive Health for Refugees Consortium). Both groups, and many other organizations, have worked tirelessly for almost a decade to make reproductive health services available in situations of conflict and displacement. The aim has been to ensure that these services are based on the needs of refugee and displaced populations, with particular attention to women.

In 2002, the IAWG endorsed a plan to evaluate the efforts made since 1995 to institutionalise reproductive health in programmes serving refugees and internally displaced persons. The overall objective was to evaluate the provision of reproductive health services, based on the framework outlined in *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. The IAWG formed a Steering Committee to guide the evaluation process, which began in October 2002.

We are pleased to bring you this report, which marks the conclusion of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons. The report highlights the status of reproductive health services for refugees and internally displaced persons, identifies gaps in these services, and outlines the way forward with respect to strengthening and/or expanding services. Unquestionably, significant progress has been made since 1995; however, consistent interest, participation, and support will be required from United Nations agencies, governments, and non-governmental organizations to continue to move forward.

*The Evaluation Steering Committee
November 2004*

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Centers for Disease Control and Prevention

Department of Population and Family Health, Mailman School of Public Health, Columbia University

International Centre for Migration and Health

International Federation of Red Cross and Red Crescent Societies

Population Council

United Nations High Commissioner for Refugees

United Nations Population Fund

Women's Commission for Refugee Women and Children

World Health Organization

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Executive Summary

Executive Summary

Since its formation in 1995, the Inter-agency Working Group on Reproductive Health of Refugees (IAWG) has worked relentlessly toward the institutionalization of reproductive health care for refugees and the internally displaced. In 2002, the IAWG endorsed a plan presented by the United Nations High Commissioner for Refugees (UNHCR) to evaluate efforts made thus far. The aim was to evaluate the provision of reproductive health (RH) services to refugees and internally displaced persons (IDPs), based on the framework for implementation outlined in the Inter-agency Field Manual on Reproductive Health in Refugee Situations. Specifically, the objectives for the evaluation were to take stock of the range and quality of the RH services provided to refugees and IDPs and identify factors that facilitate or hinder the provision of these services; identify factors that facilitate or hinder access to, use of, and satisfaction with the RH services, from the perspective of the beneficiaries of these services; and explicate the lessons learned since 1995 and recommend ways in which RH services for refugees and IDPs can be strengthened and/or expanded.

The IAWG established a Steering Committee to guide the evaluation process, and UNHCR hired a part-time consultant in October 2002 to coordinate the evaluation activities. The evaluation covered seven components, the first four of which focused on the field level, including a review of literature related to reproductive health services for refugees and IDPs (Component 1), evaluation of coverage of reproductive health services (Component 2), evaluation of quality, access to, and use of reproductive health services (Component 3), and evaluation of the use of the Minimum Initial Service Package (MISP) and RH kits (Component 4). Component 5 focused on the agency/institutional level and involved assessment of changes over time within agencies/institutions involved in reproductive health for refugees and IDPs, and Component 6 entailed a review of resource availability over time at the global level. The seventh component focused on dissemination of the evaluation results.

Many agencies and individuals were involved in the implementation of Components 1 through 6 and various evaluation methods were used. These included questionnaire surveys, administered electronically, (Components 2, 4 Part A, and 5), telephone interviews (Component 6), and focus group discussions with refugees and IDPs, interviews with field staff, and health facility observations/checks (Components 3 and 4 Part B). The latter methods were used during evaluation activities undertaken in Uganda, Republic of Congo (RoC), Yemen (Component 3), and Chad (Component 4 Part B).

The findings presented for Components 1 through 6 attest to the progress made since 1995 with respect to the institutionalization of reproductive health programmes. The evaluation findings also indicate particular aspects of reproductive health services that need to be strengthened and/or expanded, as outlined below. It should be noted here, however, that the findings from the field relate primarily to stable camp settings and therefore do not necessarily reflect the situation in acute complex emergency settings where information is particularly difficult to collect due to security constraints.

At the field level, Components 1 through 4 of the evaluation indicate that the services being provided are consistent with those outlined in the Inter-agency Field Manual.

For example, past assessments and/or evaluations, such as those included in the literature review (Component 1), report the availability of services for safe motherhood, sexual and gender-based violence (GBV), sexually transmitted infections (STIs), including HIV/AIDS, and family planning. These services were found to be generally favourable for refugees living in stable settings, although there were gaps noted in most areas. For example, while services for safe motherhood were generally good, there is still a need to ensure that antenatal care includes all of the recommended elements, particularly syphilis screening and treatment and intermittent preventive treatment for malaria, where indicated. In addition, access to emergency obstetric care (EmOC) for all pregnant women needs to be ensured. Although family planning services were widely available, there were gaps related to the availability of methods and the skills and abilities of service providers. Services for STI/HIV/AIDS and, to an even greater extent, those for gender-based violence in refugee settings, were less comprehensive and in greater need of strengthening. However, it is imperative to note that, in contrast to the services for refugees, those for internally displaced populations appeared to be severely lacking and in need of urgent attention if the reproductive health needs of these populations are to be met.

The findings from the coverage study (Component 2) reinforce those from previous assessments and/or evaluations. For example, the findings by technical area suggest that coverage is fairly good. However, services for the prevention and response to GBV were weak and other services such as those for HIV/AIDS prevention and obstetric emergencies could (and should) be stronger. Coverage was found to decrease with the newness of the technical area; GBV is the newest, least familiar and most difficult area and has the lowest coverage, whereas antenatal care, the most familiar, most standard and easiest to provide, has the highest coverage. These findings relate primarily to refugee populations; although attempts were made to gather information on IDPs too, information about them was more difficult to access. Nevertheless, given the status of reproductive health for populations affected by armed conflict in the mid-1990s, the results of the coverage study are promising. Even if the availability of services has been overestimated, it is clear that a wide range of services and a meaningful absolute number of sites provide services, which is impressive given that ten years ago there were few services available for refugees and IDPs.

The findings from the evaluations conducted in Uganda, RoC and Yemen (Component 3) were variable, although similar gaps were identified to those outlined above. Services for safe motherhood were, for example, reasonably good, with the exception of those for obstetric emergencies, which need strengthening in the three study countries. Referral for the management of obstetric complications was difficult because of transport, communication, and personnel issues. In addition, some referral centres were unable to provide the services needed. Family planning services at the evaluation sites in Uganda and Yemen were found to be of good quality in terms of commodities and trained staff, but there was cultural resistance to the use of these services. In contrast, in RoC, health care providers were found to have limited expertise in family planning and there were inadequate supplies. The supply of drugs for treating STIs was described as variable in Uganda, poor in RoC, and limited in Yemen. In addition, the use of syndromic case management was problematic at some sites. While GBV was prevalent in the three study countries, there appeared to be very little available in terms of programming to address this problem. Although the evaluation was to cover services for both refugees and IDPs,

the study team appears to have had limited access to the latter. Hence the evaluation findings apply primarily to refugee populations.

The general recommendations, applicable to the three country studies, include, but are not limited to, formalizing referral networks and strengthening referral systems through strategic planning; ensuring the availability of essential drugs for treating STIs and obstetric emergencies; ensuring the availability of the equipment needed for post-abortion care; providing GBV awareness raising activities in all refugee camps and with all staff working in the camps; building on the capacity of Traditional Birth Attendants (TBAs); and improving data collection methods relevant to reproductive health.

The findings from the evaluation of the use of the MISP and RH Kits in post-emergency situations (Component 4, Part A), suggest that, based on retrospective data from more than 40 countries covering the years 2000-2002, the MISP was better used than in the past and the RH sub-kits were found to be generally useful. Suggestions were made, however, to add and/or change some of the items in the kits and to provide more training on the correct use of the kits. In addition, many of the survey respondents indicated that they had encountered problems with in-country transport and storage of the kits. In relation to this, it was concluded that, in some countries, poor road conditions, irregular flights, extreme heat and humidity, and other factors might continue to pose a serious challenge to the distribution and storage of the kits and, therefore, delay or prevent their use.

In contrast to these findings, those from the assessment of the MISP during the Sudanese refugee emergency in Chad (Component 4, Part B) indicate that most of the humanitarian actors in Chad were not familiar with the MISP and did not know its overall goal, key objectives and priority activities. There was no overall reproductive health coordinator and only one agency had a designated reproductive health focal point. While several protection activities supporting the prevention of sexual violence had been implemented in some camps, the protection needs of the majority of refugees in spontaneous refugee sites on the dangerous border area were unmet. With the possible exception of one agency, humanitarian actors in Chad were not prepared to address the clinical management of rape survivors. Although the assessment team heard widespread reports of women and girls abducted and raped in Darfur, Sudan, there was no initiative to provide the necessary health services to women and girls who had survived sexual violence and escaped to Chad.

There were significant problems related to the prevention of transmission of HIV/AIDS, including inconsistent practise of universal precautions and no provision of free condoms. None of the three priority interventions to prevent excess maternal and neonatal mortality and morbidity – provision of clean delivery kits for mothers and TBAs, midwifery delivery kits for health facilities, and establishment of a referral system for obstetric emergencies – were fully established.

The final MISP objective – to begin planning for comprehensive reproductive health services integrated with primary health care as the situation stabilizes – was not evident. Other factors that hindered timely implementation were lack of awareness on the part of donors and UN agencies, and delays in funding.

These findings point to the need for increased awareness and understanding of the MISP amongst donors and humanitarian actors; the need for better health

coordination and the appointment of a reproductive health coordinator early in an emergency; the allocation of funds to support the use of the MISIP; and the need for a network of experienced reproductive health coordinators.

At the agency/institutional level, the findings of the assessment of changes over time within agencies/institutions involved with reproductive health services for refugees and IDPs (Component 5) were generally positive. For example, since 1995, improvements were noted in all areas of reproductive health for refugees (RHR), technical support, and reproductive health strategy. Moreover, there was overwhelming evidence that collaboration and exchange amongst organizations involved in RHR had increased since 1995, due in large part to the vital roles played by the IAWG and the RHRC Consortium, as well as other key groups. While these achievements are impressive, the majority of organizations involved in RHR also feel that their work is hampered by inadequate funding and, frequently, too few technical staff to support all of their functions.

Notwithstanding these concerns, the growth in collaboration through a variety of exchange mechanisms among RHR organizations over the past decade was seen to provide momentum for extensive activities to promote future connections. It was suggested that encouraging new partnerships that draw on the increasing interest and expertise of development organizations would expand the base of support for RHR and facilitate smoother transition from emergency situations to longer-term development assistance. In addition, it was suggested that the various academic centres and institutes throughout the world, some of which already have programmatic involvement related to refugees and health, should also be actively engaged.

To facilitate this goal, it is suggested that the IAWG consider developing an outreach committee to take responsibility for seeking out and engaging peripherally involved organizations, and raise awareness throughout the larger community, especially toward potential new entrants in the field. In addition, the IAWG might also establish and oversee a central repository/database to contain membership, reports, documents, and other information relevant to the operation of the IAWG and the field of RHR.

At the global level, the review of resource availability over time in support of reproductive health services for refugees and IDPs (Component 6) raises important questions regarding reproductive health programmes in conflict situations and suggests some useful lessons for the future. While the funding sources for these programmes remain unchanged, funding has actually declined since 2000 and seems unlikely to increase in the near future. The major reasons suggested for this are weakening political support for reproductive health programmes in general, the continuing perception at some levels that reproductive health is not an essential part of emergency response, and the absence of a strategic advocacy plan on behalf of the IAWG. It was further suggested that the IAWG's advocacy strategy should focus on providing evidence to donors and the public of reproductive health needs in conflict settings; integrating reproductive health into the UN system's humanitarian response mechanism; involving senior staff in advocacy and fundraising; and working with media to increase the visibility of the problem. The review concluded that better coordination, exchange of information and experience and joint

operational planning are required if the IAWG is to impact on resource mobilization in a competitive humanitarian environment.

The summary of findings presented above provides a comprehensive picture at field, agency/institution, and global levels with respect to providing reproductive health services for refugees and IDPs, highlighting the progress made since 1995 and emphasizing the gaps that need to be filled. Based on the findings, the main challenges for the future include: implementing the MISP in new emergencies; establishing GBV programming in all situations where it is required; ensuring access for IDPs to the full range of reproductive health services; and improving access to and quality of EmOC, family planning services, and services for the prevention and management of STIs, including HIV/AIDS, for refugee and other displaced populations, male and female adolescents included. Additional challenges include improving the collection and appropriate use of data, nurturing the growth of inter-agency collaboration, and the development of an advocacy strategy aimed at ensuring that reproductive health for refugees and IDPs remains securely on the agendas of donors and relevant international agencies and organizations. Collectively, these challenges will provide direction for the future work of the IAWG.

Introduction

Introduction

During the late 1980s and early 1990s, the response to populations affected by complex emergencies was, in general, to provide food, water, shelter, sanitation, and basic health care. However, toward the mid-1990s, increasing recognition was given to the reproductive health needs of refugees, particularly in connection with the conflicts in the former Yugoslavia and Rwanda.¹

In June 1994, the Women's Commission for Refugee Women and Children released a landmark report indicating that reproductive health services, apart from those for basic maternal and newborn care, were rarely provided for refugees or displaced persons. The report had a very significant impact on developments within the field of reproductive health for refugees.² Additional recognition of the limited access refugees had to reproductive health care was provided, also in 1994, through the Programme of Action adopted at the International Conference on Population and Development (ICPD).³

In 1995, the RHRC Consortium was formed when the International Rescue Committee (IRC), CARE, Marie Stopes International and JSI Research and Training Institute joined with the Women's Commission for Refugee Women and Children to lobby for commitment to and funding for reproductive health for refugees.⁴ The Consortium, which was later joined by the American Refugee Committee and Columbia University, represents a combination of skills and expertise, including humanitarian assistance and reproductive health technical expertise and, since its inception, has been involved in running programmes, providing grants to a variety of local and regional NGOs, and developing technical materials such as needs assessment tools and training curricula. Overall, the advocacy efforts of the Consortium have helped to raise awareness amongst policy makers, relief agencies and the public about the reproductive health needs of displaced populations.

Another significant event in 1995 was the Inter-agency Symposium on Reproductive Health in Refugee Situations, sponsored by UNHCR and the United Nations Population Fund (UNFPA), in association with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). There were three preparatory meetings leading up to the symposium, at which participants began to assess the reproductive health services required for refugees and discuss the best ways to strengthen these services. It was agreed that the technical components of reproductive health in refugee settings should include safe motherhood; family planning; STIs, including HIV/AIDS; sexual and gender-based violence; and post abortion care. In addition, a refugee-specific field manual was drafted in preparation for the symposium, covering these components of reproductive health, together with a Minimum Initial Service Package (MISP) which incorporates the basic reproductive health services needed during the initial phase of an emergency. The symposium,

¹ Schreck L, Turning Point: A Special Report on the Refugee Reproductive Health Field. *International Family Planning Perspectives*, 2000, 26 (4): 162-166.

² Wulf D, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, New York: Women's Commission for Refugee Women and Children, 1994, in Schreck, 2000.

³ United Nations, *Programme of Action of the United Nations Conference on Population and Development*, New York: United Nations, 1994.

⁴ Reproductive Health for Refugees Consortium (RHRC), *Refugees and Reproductive Health Care: The Next Steps*. New York: RHRC, 1998.

which was held in Geneva and attended by more than 50 representatives from UN agencies, governments and non-governmental organizations, was the forum at which UNHCR and UNFPA signed a Memorandum of Understanding, assuring collaboration between the two agencies on the issue of reproductive health for refugees.

Following the inter-agency symposium, almost 30 agencies, non-governmental organizations, research organizations, and governments formed the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG), in which UNHCR played a co-ordinating role. The IAWG was to be responsible for organizing and facilitating reproductive health services for refugees through the exchange of information, advocacy, planning, training, assessment, monitoring, coordination, research and evaluation.⁵

The draft manual – *Reproductive Health in Refugee Situations: an Inter-agency Field Manual* – was distributed, following the inter-agency symposium, for field-testing in 17 countries over a two-year period. The revised version of the manual was then made available in 1999, supporting the provision of quality reproductive health care, based on technical standards set by WHO, and including the MISP. The objectives of the MISP are to: identify organization(s) and individual(s) to facilitate and coordinate the implementation of the MISP; prevent and manage the consequences of sexual violence; reduce HIV transmission through the use of universal precautions and guarantee the availability of free condoms; prevent excess maternal and neonatal mortality and morbidity by providing clean delivery kits for mothers and/or birth attendants to use for home deliveries and midwife delivery kits for clean and safe deliveries at health facilities, and by initiating a referral system to manage obstetric emergencies; and, finally, plan for the provision of comprehensive reproductive health services, integrated into primary health care, when the situation permits.⁶ However, one of the main challenges related to the implementation of the MISP has been the limited availability, when needed, of persons qualified to fill the role of reproductive health coordinator.⁷

The material resources necessary for implementing reproductive health services in emergency situations have been assembled by UNFPA into a kit – *The Reproductive Health Kit for Emergency Situations*.⁸ The Kit, which complements WHO's *New Emergency Health Kit – 98*,⁹ is made up of 12 sub-kits, including those for clean and safe delivery, management of obstetric complications, management of complications of spontaneous and unsafe abortion, prevention and management of STDs, and family planning. During the two years or so following the introduction of *The Reproductive Health Kit* it was used in 34 countries, and the sub-kits most frequently

⁵ United Nations High Commissioner for Refugees (UNHCR) and United Nations Population Fund (UNFPA), *Proceedings of the Inter-Agency Symposium on Reproductive Health in Refugee Situations*, Palais des Nations, Geneva, 28-30 June, 1995.

⁶ UNHCR, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. Geneva: UNHCR, 1999.

⁷ Krause S, Jones R and Purdin S. Programmatic Responses to Refugees' Reproductive Health Needs. *International Family Planning Perspectives*, 2000, 26 (4): 181-187.

⁸ UNFPA, *The Reproductive Health Kit for Emergency Situations*. Geneva: UNFPA, 1998. (In 2003, the Kit was renamed *Reproductive Health Kits for Crisis Situations*).

⁹ World Health Organization (WHO), *The New Emergency Health Kit 98 (WHO/DAP/98.10)*. Geneva: WHO, 1998.

ordered were those designed for deliveries – i.e., sub-kits 2 and 6.¹⁰ At the end of the first year following introduction, an evaluation questionnaire was sent to 18 users of the Kit. More than half responded, indicating that they found the contents of the Kit useful, but suggesting that some additional items be added to some of the sub-kits; for example, larger surgical gloves to the sub-kits that include these, and a foetoscope to sub-kits 2 and 6. There were some problems noted with respect to procurement, shipping and import, and helpful suggestions were provided for overcoming these problems.¹¹

Evaluation of progress

Since its formation in 1995, the IAWG has met annually (with the exception of 2001) to exchange information, identify challenges, gain from the experience of others, build partnerships, and collectively work toward the institutionalisation of reproductive health care for refugees and the internally displaced, based on agreed terms of reference that focus on the identified gaps in care.¹² At the meeting held in 2002, the IAWG endorsed a plan presented by UNHCR to review efforts made thus far. The aim was to evaluate the provision of reproductive health services to refugees and internally displaced persons, based on the framework for implementation outlined in the *Inter-agency Field Manual*. Specifically, the objectives for the evaluation were:

1. To take stock of the range¹³ and quality of the RH services provided to refugees and IDPs and identify factors that facilitate or hinder the provision of these services;
2. To identify factors that facilitate or hinder access to, use of, and satisfaction with the RH services, from the perspective of the beneficiaries of these services.

¹⁰ Pierotti D, *The RH Kit: A useful tool to implement reproductive health services during an emergency*. Conference Proceedings 2000: Findings on Reproductive Health of Refugees and Displaced Persons, Washington DC: December 5-6, 2000.

¹¹ UNFPA, *The Inter-agency Reproductive Health Kit for Emergency Situations: UNFPA review of one year of field experience*. Geneva: UNFPA, 1999.

¹² UNHCR, Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, First Meeting, Geneva, 4-5 November 1996; Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, Second Meeting, Geneva, 23-24 June 1997; Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, Third Meeting, Geneva, 26-28 January 1998; Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, Fourth Meeting, New York, 28 June, 1999; Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, Fifth Meeting, Geneva, 14-17 February 2000; Final Report, Inter-Agency Working Group on Reproductive Health in Refugee Situations, Sixth Meeting, New York, 16-17 April 2002.

¹³ The components of RH which formed the basis of the evaluation are those described in the *Inter-agency Field Manual*: Minimum Initial Service Package (MISP), Safe Motherhood, Sexual and Gender-based Violence, Sexually Transmitted Diseases, including HIV/AIDS, Family Planning, Other Reproductive Health Concerns (managing complications of spontaneous and unsafe abortion, and eliminating the practise of female genital mutilation and caring for women who have undergone this procedure), and Reproductive Health of Young People.

Note that the term post-abortion care refers to the strategy to reduce death and suffering from the complications of spontaneous and unsafe abortion, as described in the *Inter-agency Field Manual*. The elements of post abortion care are emergency management of incomplete abortion and potentially life-threatening complications; post abortion family planning counselling and services; and making links between post abortion emergency services and other RH services.

3. To explicate the lessons learned since 1995 and recommend ways in which RH services for refugees and IDPs can be strengthened and/or expanded.

The IAWG established a Steering Committee¹⁴ to guide the evaluation process, and UNHCR hired a part-time consultant, in October 2002, to coordinate the evaluation activities. The evaluation included seven components, the first four focused on the field level, including a review of literature related to reproductive health services for refugees and IDPs (Component 1); evaluation of coverage of reproductive health services (Component 2); evaluation of quality, access to, and use of reproductive health services (Component 3); and evaluation of the use of the MISP and RH kits (Component 4). The fifth component involved assessment of changes over time within agencies/institutions involved in reproductive health for refugees and IDPs; and the sixth component involved a review of resource availability over time at the global level. The seventh component focused on dissemination of the evaluation results.

Various evaluation methods were used, including questionnaire surveys, administered electronically, (Components 2, 4 Part A, and 5), telephone interviews (Component 6), and focus group discussions with refugees and IDPs, interviews with field staff, and health facility observations/checks (Components 3 and 4 Part B). The latter methods were used during evaluation activities undertaken in Uganda, Republic of Congo, Yemen (Component 3), and Chad (Component 4 Part B).

The findings of Components 1 through 6 are presented in the corresponding sections of this report and the various agencies and individuals that were involved are indicated at the beginning of each section. At the end of the report, the findings from the evaluation components are summarized, conclusions highlighted, and future directions outlined.

¹⁴ The IAWG Steering Committee consists of the following agencies/organizations/institutions: CDC, Columbia University, ICMH, IFRC, Population Council, UNFPA, UNHCR, WHO, and Women's Commission for Refugee Women and Children.