RIGHTS IN DISPLACED SITUATIONS: CHALLENGES AND PROSPECTS FOR THE ENFORCEMENT OF REPRODUCTIVE RIGHTS OF REFUGEE WOMEN AND GIRLS IN ETHIOPIA

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Declaration

I, Mulugeta Tesfaye, hereby declare that this thesis is my original work. It has not been presented for a degree in any other University, and all sources of material used for the thesis have been duly acknowledged.

Mulugeta Tesfaye ----------

Signature

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ACRONYMS

ACHPR/Banjul Charter- African Charter on Human and Peoples' Rights
ACRWC- African Charter on the Rights and Welfare of the Child
ARRA- Administration for Refugee and Returnee Affairs

ART- Antiretroviral Therapy

CEDAW -Convention on the Elimination of All Forms of Discrimination Against Women

CRC- Convention on the Rights of the Child

CESCR -Committee on Economic, Social and Cultural Rights

COCs - Combined Oral Contraceptives

DICAC- Ethiopian Orthodox Church Development & Inter-Church Aid Commission

DRC- Danish Refugee Council

EPI- Expand Program of Immunization

ECP- Emergency Contraception Pills

FP- Family Planning

FDRE- Federal Democratic Republic of Ethiopia

FGM- Female Genital Mutilation

HIV/AIDS- Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

HEP- Health Extension Program

HEWs- Health Extension Workers

IASC-Inter Agency Standing Committee

ICPD- International Conference on Population and Development

IUDs- Intra Uterine Devices

IYCF- Infant and Young Child Feeding

IPs- Implementing Partners

ICCPR - International Covenant on Civil and Political Rights

ICESCR- International Covenant on Economic, Social and Cultural Rights

IPPF- International Planned Parenthood Federation

IRC- International Refugee Committee

JRS- Jesuits Refugee Services

LWF- Lutheran World Federation

MCH- Mother and Child Health

MCDO-Mother and Child Development Organization

MISP- Minimum Initial Standard of Services

MoH-Ministry of Health

MDGs- Millennium Development Goals

NRDEP- Natural Resources Development and Environmental Protection

NGOs- Non-Governmental Organizations

OAU- Organization of African Unity

PICT- Provider Initiated Counselling and Testing

PLWHA- People Leaving with HIV/AIDS

PEP- Post Exposure Prophylaxis

PNC- Postnatal Care

PoPs- Progestin only Pills

PMTCT- Prevention of Mother to Child Transmission

PACHPR- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

RaDO- Rehabilitation and Development Organization

SGBV- Sexual and Gender Based Violence

STDs- Sexually Transmitted Diseases

SeE- Save the Environment Ethiopia

SOP- Standard Operating Procedures
STIs- Sexually Transmitted Infections

TBA- Traditional Birth Attendant

UN- United Nations
UDHR- Universal Declaration on Human Rights
UNHCR- United Nations High Commissioner for Refugees

VCT- Voluntary Counselling and Testing

WFP- World Food Program/Organization

ABSTRACT

Three factors inspire the development of this research in to a currently developing area of human rights law. Reproductive rights in Situations of Displacement: Reproductive

Rights-currently developing human rights-full of challenges further exacerbated by Displacement but with prospects as well.

The first is the world wide pity life of women and girls: the mothers, wives, sisters and daughters of some one, it can be me and/or you. Their life even in the normal situations of life is full of challenges. But they suffer more the consequences of conflict, the main cause of displacement, in which they are not part, because of their status in society and their sex, and their vulnerability. They are victims at the hands of any one, the family, the society, the state or any one else.

The second factor is the fact that reproductive rights are currently developing human rights. Despite the significance of the rights in women's life, as the rights embrace core human rights-the violations or non-enforcement of which would heavily affect the life of women and girls' with long term negative effects, it is very recently, a decade and half before, that the rights get the international community's attention. Even after 17 years, it is still currently developing legal issue which requires a close, thorough and continuous study.

The third motivating factor is the grasp in the paramount significance of enforcing reproductive rights for the betterment of women and girls' life in general and those displaced in particular. While displacement exacerbate the challenges in the enforcement of the rights, durable solutions prospects for refugees residing in Ethiopia looks dim. The war in Somalia seems with out end; the Eritrean refugees' influx is increasing from time to time; and the Sudanese refugees' repatriation looks gloomy. Resettlement opportunities are limited: for example, one Somali camp, *Kabrebayah* Camp, got resettlement after 20 years of protracted situation. There are no prospects for local integration: refugees can not work in Ethiopian as the country has reservation, to the 1951 Convention Relating to the Status of Refugees, on wage earning employment. As a result, ensuring the full implementation of the rights in Ethiopia has great significance in the betterment of refugee women and girls' life residing in the Country.

The research is, therefore, a sincere comprehension of the problems of refugee women and girls and an aspiration to contribute for the betterment of their life with prospects relying on the international community and states recent increase of interest and efforts made on legal and policy developments on the subject.

"Reproductive health conditions are the leading cause of death and illness in women worldwide." (UNFPA, Reproductive Health Fact Sheet, 2008)

"Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees, while also conforming to universally recognized international human rights standards." (Reproductive Health in Refugee Situations: An Inter-Agency Field Manual 1999)

INTRODUCTION

I. Background

The Horn of Africa is characterized by insecurity, political instability and escalating conflicts. These problems, compounded by the prevailing poverty and the absence of a strong government in Somalia, expose the region to a high exodus of peoples.[1] As a result, the area is one of the highest concentrations of humanitarian emergencies in the world, with all the countries in the region hosting refugees.

There are about 779,211 refugees in the region which is almost half of the total population of refugees in Africa which is 2,216,035.[2] In Ethiopia, according to the United Nations High Commissioner for Refugees, as of 30 November 2010, there are about 150,177 refugees from morethan 9 countries including, Somalia, Eritrea, Sudan, Kenya, Democratic Republic of Congo, Burundi, Djibouti, Ruwanda and Uganda.[3] These refugees live in 10 camps and 4 different places other than camps. Eritrian refugees live

1 Joëlle Moret, Simone Baglioni, Denise Efionayi-Mäder, The Path of Somali Refugees into Exile, A Comparative Analysis of Secondary Movements and Policy Responses, P 276 Swiss Forum for Migration and Population Studies No. 46, available at http://www.migration-population.ch. (accessed on May 2010)

2 UNHCR 2009 Global Trends Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons; Division of Program Support and Management, 15 June 2010, p 2

3 Source: UNHCR Representation in Ethiopia, Addis Ababa, Information Section (November 2010)

in *Adi Harush, Mai-Aini and Shimelba*; Sudanise in *Fugnido and Sherkole*; Somalies in *AwBarre, Kabribayah, Sheder, Bokolmanyo, Melkakedi and Dolo Ado* transit center.[4] Two groups, Eritrean-Afar in *Afar* region and Kenya-Borenas in *Oromia* region are not in camps. The rest mainly live in Addis Ababa. Three groups of refugees are the largest in the country; Somali 52.02%, Eritrean 28.88% and Sudanese 16.79%, as of 30 November 2010.[5]

Out of the total population of refugees in the country, almost half, 72,219, are women, making 48.09%. More than half of these women refugees, about 42, 301 are girl children below the age of 18.[6]

While entire displaced communities suffer the consequences of armed conflict, women and girls are particularly affected because of their status in society and their sex, as parties to conflict often rape women with impunity, sometimes using systematic rape as a tactic of war and terrorism.[7] Refugee women and girl children's life is usually crammed with difficulties including violence, displacement and disruption of family and community, dislocation to unfamiliar and often overcrowded surroundings, lack of infrastructure and access to basic survival needs.[8]

Refugee women and girls live in a world where twenty two thousand women die every year in childbirth or of related causes, world wide.[9] Worldwide, 99% maternal deaths occur in poor countries like Ethiopia.[10] For each death 20 women suffer from illness or permanent injury like fistula. The major issue for these problems is health systems and access.[11]

4 Ibid

5 Ibid

6 Ibid

7 UNHCR Handbook for the Protection of Women and Girls, Geneva, 2008, p. 329

8 Ibid

9 Ibid

10 See http://genderacrossborders.com (accessed on May 2010)

11 Ibid

As indicated above, the major causes of refugees' displacement in the horn are conflict and persecution which often serve to exacerbate discrimination and violence against women. The enforcement of reproductive rights, in the normal situations of life, is full of challenges and most people have less than optimal access to quality reproductive health services, while these causes of displacement coupled with difficulties that exist in normal situations pose challenges in enforcing human rights of displaced individuals.

Reproductive Rights

Reproductive rights, which relate to the concept of sexual reproduction and reproductive health, provide the legal framework that recognizes, *inter alia*, the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and able to have a satisfying and safe sex life. Bodies of international and regional agreements, women and children rights, national laws, etc recognize different rights that relate to the concept of sexual reproduction and reproductive health. For instance, the right to life, to a standard of living adequate for the health and well-being of himself and of his family, to have access to adequate health care facilities, including information, counselling and services in family planning, etc are human rights that are already recognized in different human rights instrument that relate to sexual reproduction and reproductive health.

The laws of these fields are mainly made up of treaties, which create binding obligations on countries that have ratified them. Different soft laws including, authoritative interpretations of treaty provisions, comments and recommendations of bodies created by treaties to monitor the implementation of agreements and conference documents and guidelines on refugee law also make part of the international law.

Ethiopia is a party to most of the international human rights instruments. In enforcing its obligations, the Ethiopian Government's Administration for Refugee and Returnee Affairs (ARRA) jointly with the United Nations High Commissioner for Refugees (UNHCR) and other UN Agencies and partner NGOs are working on refugee reproductive rights, among other aspects of the refugee's life.

II. The Problems Stated

The challenges ARRA and UNHCR are facing in enforcing refugee's reproductive rights for refugees in the country are perhaps the most daunting as they involve not only diseases but also other components of life such as sexual reproduction and pregnancy surrounded by legal, political, economical, cultural, social, ethical and religious considerations.

Economic Factors

Economic factors are often considered as the main challenge on enforcement of the rights. However, in addition to the economic problem, the international and the host state political and legal deliberation and situations of displacement in the horn region intertwined with social, cultural and religious considerations pose the core challenges.

Limitations of the International Law

International law albeit its significance, fails to recognize any synergy amongst reproductive rights. The failure of the binding instruments to create synergies among the rights creates difficulty in finding a single binding source. This creates problems in having a good understanding of the scope of the rights and their corresponding obligations also requiring linking the soft and hard laws developed in the area of these rights.

Further, its enforcement mechanisms are notoriously weak. In the case of the International Covenant on Economic, Social and Cultural Rights it is limited to reporting by countries to the treaty body.

Lack of Political Deliberation

Many states are unwilling or unable to observe binding obligations included in the human rights treaties they have ratified, even when dealing with their own citizens.

Reproductive Rights are currently Developing Human Rights

Reproductive rights are currently developing rights, the standards, principles, strategies and plans of action are dotted in different international conferences. This has a negative effect in developing effective national policies, in line with international standards, principles, strategies and plans of action, as it requires examination of the different consensus documents, understanding and creating a smooth link and binding source.

Limitations of International Agencies and Non-Governmental Organizations

United Nations Agencies and non-governmental organizations face extreme political and physical insecurity and inadequate funding, difficulties in service delivery, insufficient political will and understanding. In addition, despite efforts to reach agreements on common guidelines, policies vary greatly and do not always fully comply with international standards.

Absence of a Single Monitoring Organization of the Enforcement of Reproductive Rights

The absence of a single international organization that monitors the enforcement of reproductive rights creates problems of jurisdiction and coordination among the UN Agencies and its partner NGOs. In case of refugees, camps are assigned to implementing partners regardless of whether they enforce the full range of the rights. Refugees therefore suffer serious gaps in services, particularly where there is lack of coordination.

Likewise, harmful practices backed by legal, social, cultural or religious outlooks also present particular challenges on the enforcement of reproductive rights of refugees. These factors are often knotted to each other and identifying the problems they create and finding possible solutions requires a good understanding of the factors.

Socio-cultural and Religious Outlooks

The challenges in enforcing refugee's reproductive rights also involve components of life such as cultural, social, ethical and religious considerations. As a result, the types of challenges on the enforcement of reproductive rights that exist in each refugee society residing in Ethiopia differs with the difference in the socio-cultural and religious make up of the different ethnicities of the refugees. Thus, addressing the challenge requires a close look on the socio-cultural and religious outlooks of each ethnic of refugees; as developing similar policies and plans of action for all ethnicities would not help much.

Opportunities

International law in concept and practice was a gendered system that marginalized women. This is evident from the realities of women's lives worldwide in the context of international women's human rights that, inter alia, women suffer from health and well being due to inequality, both between men and women and among women in different social classes and ethnic groups.

However, there are developments on the subject that provide a positive future for the enforcement of these rights. The general understanding of what reproductive rights comprises, and why it is crucial in displaced situations is developing. In addition, the activity and interest of the government and UN agencies and NGOs in the enforcement of reproductive rights of women and girls refugee in Ethiopia is increasing.

Further more, at the international level, in the effort to advance women human rights with a holistic approach, since the 1990s a series of United Nations Conferences were held on the advancement of women human rights. It is with this holistic approach for the advancement of women human rights that reproductive rights come to picture. As a result, though reproductive rights have their root in the already existing human rights instruments, they are currently developing human rights.

Holistic Approach

The definition adopted at the 1994 International Conference on Population and Development (ICPD) represented a major step forward in the current thinking about human sexual reproduction and reproductive health. Whereas previous views revolve around abortion rights, the ICPD, embracing certain human rights that are already recognized in different human rights instruments in its definition of reproductive rights, placed the rights at the centre of the human rights agenda. Not only did it extend the domain of reproductive rights beyond abortion rights, it situated the rights within a broader socio-cultural context that included gender roles, respect and protection of human rights.

This holistic approach has provided a useful framework for understanding the complexity of reproductive rights and the multiple factors that give rise to them. However, enforcing reproductive rights in the normal situations of life is full of challenges and most people have less than optimal access to quality reproductive health services, because of its breadth and inclusiveness among other things, while causes of displacement further challenge the enforcement of reproductive rights of refugees.

This study focuses on these aspects, i.e. examining the legal, political, economical, cultural, social, ethical and religious challenges stakeholders are facing in their effort to enforce reproductive rights of refugee women and girls in Ethiopia and its prospects.

III. Objective of the Study

Reproductive rights are currently developing rights. So far, the important sources of the rights are the different international conferences documents. Understanding the nature and contents of the rights helps to understand the corresponding obligation which is a key to address the challenges in its enforcement.

Over all Objectives

Given the aforementioned problems, the crux of the objectives of the research is to show the current understanding of the nature and contents of the rights and examine the nature of challenges in enforcing the rights in Ethiopia.

Specific Objectives

- ✓ To show the development of reproductive rights and thereby present the international legal framework that recognizes refugee women and girls' reproductive rights;
- ✓ To raise awareness on the nature, contents and current understanding of reproductive rights and the extent of states and the international community corresponding mandate and obligations;
- ✓ To analyze the gaps between the extent of the efforts of the government and humanitarian actors and the expected international minimum standards to meet refugee women reproductive rights in Ethiopia;
- ✓ To examine the challenges and prospects on the enforcement of refugee women and girls reproductive rights in Ethiopia and provide possible solutions; and
- ✓ To ssuggest possible solutions for the challenges that affects the implementation.

IV. Why the Topic (Study)? Significance of the Study

Reproductive rights embrace core human rights. The violations or non-enforcement would heavily affect the life of women with long term negative effects. Despite this significance of the rights in women's life, most people in the world still have less than optimal access to quality reproductive health services. The situation is worse in displacement and in the case of refugee women and girls, who live in extraordinary instability and at the sympathy of their host State and the international community. The research, therefore, focus on the significance of enforcing reproductive rights in refugee

women's life, taking in to consideration the prevalence of extraordinary instability in situations of displacement that further challenge the enforcement of the rights.

The research is expected to show the legal, political, economical, cultural, social, ethical and religious factors that challenge stakeholders in their effort to enforce reproductive rights of refugee women and girls in Ethiopia. The level of influence of each factor in the difference of ethnics of refugees in Ethiopia will be pinpointed.

This research will also attempt to explore the development and current understanding on the domain of reproductive rights. By so doing, the research will identify the legal and policy challenges that affect the enforcement of the rights and its prospects.

Notably,

Reproductive rights enforcement in situations of displacement has been examined by different scholars, UN agencies and different NGOs working on different beneficiaries like refugees, women, children etc., at the international and national level. However, the issue of reproductive rights is a newly developing subject and the challenges in the enforcement of the rights in each ethnic group of refugees residing in Ethiopia have not been closely looked at the international or national level; despite the understanding of the legal, economic, social, cultural and religious outlooks (which differs from society to society and/or with difference of ethnicity requiring a close examination of the influence in each society/ethnic of refugees) great influence on the enforcement of the rights.

The fact that little or no empirical research has been carried out in Ethiopia in the area on such a crucial issue on women and girls' life and in situations of displacement (which often serve to exacerbate discrimination and violence against women and girls) makes the study pertinent and timely.

The researcher has an opinion that reproductive rights enforcement programs need not be the same for the different ethnic refugees in the country and should be based on a

thorough analysis of the local needs. As a result, the research has significance as it provides understanding of the legal, social, cultural, religious and economic factors that challenge enforcement of the rights and provide a pragmatic recognition of the technical, financial and human resources available locally to meet those needs.

Further, the nexus among these processes, the study will try to establish in to vulnerability, entitlement and efforts of enforcing the rights, is expected to depict a clear picture of the problems in the study areas in general and in Ethiopia in particular.

Generally, the research can enhance the knowledge on the area of reproductive rights of refugee women and girls and the factors that affect the enforcement in Ethiopia to interest groups like academicians, policy makers, law enforcement bodies including judges, public prosecutors, and police, advocators of human rights, students who pursue their research, NGOs working on refugee, women and children and other institutions, groups and/or individual persons.

V. Methodology

The research involves both primary and secondary sources.

Primary Sources

Personal Observation: the primary sources include personal observation of 3 camps. Refugee camps were visited in order to fully understand the nature and type of the existing challenges the stake holders face with the difference of the social, cultural and religious make up of each refugee society residing in Ethiopia. The research, therefore, examines the situation on the ground in each ethnic of refugees separately. Further, the researcher has been working with refugees for more than 3 years in different capacities; as a protection and community services staff for UNHCR. The researcher professional experience, therefore, will be reflected in the research. The knowledge the researcher has

acquired in different workshops and trainings related to the issue at hand have also contributed significantly for the research.

Interview and Discussion with Stake Holders: interview and discussion with more than 20 key informants and stakeholders is done to enrich the research. These include ARRA, UNHCR, and NGOs staffs and refugees. This has contributed significantly to understand the situation on the ground from different perspectives.

Questioner: In order to obtain balanced information, more than 20 questioners were distributed among the refugees and service providers. The questioner incorporated four parts: (1) actual/basic information on the available reproductive health services; (2) prevalent challenges in service provisions; (3) SGBV incidents; and (4) availability of legal and other remedies for SGBV survivors. (See Annex for details of the Questionnaire).

Secondary Sources

Legal Analysis: the international, regional and national legal frameworks and international conferences documents stand at the core of the analysis. They do so because, they provide definition, detailed outline and binding source for reproductive rights of refugees. The documents discussed also provide justifications for emphasizing reproductive rights as women human rights.

Literature Reviews: the legal and political challenges are examined through extensive literature reviews of policies, refugee guidelines, books, articles, electronic media, etc. International Conferences Documents and Guidelines on Women, Children, Population and Health are also important supplies that enrich the research, as these are of crucial importance not only for the purpose of analysis but also because they are the sources from which reproductive rights mainly develop.

VI. Scope of the Study

This study examines the challenges and prospects for the enforcement of refugee women and girls reproductive rights in Ethiopia. In doing so, it involves, desk research, analysis of the different United Nations International Human Rights Conference Documents, Human Rights Instruments, the Ethiopian national legislations and reproductive health policies and strategies in order to understand the legal framework promoting refugee women and girls reproductive rights.

The research generally tries to cover issues on the sources, nature, and contents of reproductive rights of refugee women, including girl children, and to examine the extent of the corresponding obligations of the State and the international community in light of the national laws and policies and the international human rights legal frameworks.

The research also entails empirical research by visiting of refugee camps to fully understand the nature of challenges in practice. In order to achieve this task, it involves interviews with women refugees; refugee social representatives; relevant government office representatives; relevant UN Agencies and NGOs representatives. To evaluate the extent of enforcement, the study thoroughly examines the work of the government and NGOs and their plan of action and budget allocation.

VII. Limitations of the Study

Reproductive rights pertain to all couples and individuals. However, the violations mainly affect the lives of women and girls. For this reason as it is limited in the topic, unless a reference is needed, the research is limited to women and girls. Though the rights also pertain to non-refugees as well and the enforcement in normal situations of life is full of challenges and it is similar to internally displaced persons, for time and other limitations it is limited only to situations of displacement in Ethiopia.

Further, the listing of reproductive rights in this research does not seek to exhaust the full range of reproductive rights theoretically subsumed under the rubric of reproductive rights. It is, instead, a guide to the concept and current understanding of the rights. This is due to the fact that reproductive rights are currently developing rights and the related limitation of reference materials.

In addition, while the most of the findings is relevant in any displaced situations and the empirical research is designed to examine the reproductive rights of refugee women and girls in Ethiopia, for economical, practical reasons and material and time limitations, it is limited to visiting refugees settled in camps. But urban refugees in Addis Ababa are also examined as most refugees from different other countries reside there. Further, the research is limited to visits to three camps out of the 10 camps, indicated above. This is because the 10 camps are occupied by three groups of refugees, namely, Somali (in 5 camps), Eritrean (in 3 camps) and Sudanese refugees (in 2 camps).

All refugees in the different camps from each group have the same country of origin, social, cultural, religious, etc backgrounds and they receive the same assistance from the host government and the international community. As a result, the researcher believes that the factors that challenge enforcement of the rights and the prospects would be the same to the other comps as well. As the research covers visits only to refugees in camps, by selecting one camp from each group, it meets its scope since we have only the Somali, Eritrean and Sudanese refugees in camps.

The three camps are selected considering factors like their accessibility, costs of visits, etc. These three camps are *Sheder* refugee camp -*Somali refugees, Mai-Aini* refugee camp -*Eritrean* refugees and *Sherkole* refugee camp- *Sudanese* refugees.

VIII. Structure of the Study

The research detailed in the following chapters shows three overriding areas in the enforcement of reproductive rights of refugee women and girls in Ethiopia. In the first

chapter, the notion, source and development of reproductive rights in general and that of refugees in particular are discussed.

The second chapter deals with states and the international community obligations. It also provides general view of the challenges in enforcing reproductive rights in situations of displacement. It, therefore, examines the rights in four groups; accessing and enjoying the highest attainable standard of health; reproductive health; HIV/AIDS; and mental health and psychosocial support. Each reproductive right is not discussed separately as the rights are currently developing and also due to time limitations; hence the grouping. However, the four groups cover the entire areas of reproductive rights.

On the other hand, the last chapter- chapter three examines the efforts of ARRA, UNHCR and the implementing partners in enforcing reproductive rights of refugee women and girls in Ethiopia and their challenges on the ground. It also looks the financial and policy challenges the stake holders face. Here, attempts are made to show the challenges and corresponding opportunities.

Finally, conclusion and some feasible recommendations are put forward to help stakeholders address the challenges they face and better enforce reproductive rights of refugee women and girls in the country.

CHAPTER ONE: THE NOTION, SOURCE AND DEVELOPMENT OF REPRODUCTIVE RIGHTS

1.1. GENERAL CONSIDERATION

The term reproductive rights are commonly understood to refer to legal developments in the area of abortion. Because of this, when the term reproductive rights is employed the first thought that usually comes to mind is 'abortion right'. Abortion right is often associated with the pro-choice position 'the ability to choose to have an abortion,' as a legal option for any pregnant woman.[12] Thise issue certainly fall within the general category of reproductive rights but there are a host of other important issues related to the rights. Contraception, sex education, condom availability programs, involuntary sterilization, surrogacy, in-vitro fertilization and so on are among the issues that are often associated with reproductive rights.

The development of the rights owes its beginning to the United Nation's International Conference on Human Rights held, in Teheran in 1968, to review the progress of the UN made in the twenty years, since its establishment, and to formulate a programme for the future. The Final Act of the Conference states that '[p]arents have a basic right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect.'[13]

However, the significant international commitment to address reproductive rights was generated in the 1990s with a series of United Nations Conferences. For instance, the World Conference on Human Rights (Vienna, 1993) made reference to the human rights of women and the girl child. However, the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women, (the Beijing Plat Form for Action), held in Beijing in 1995 further put reproductive rights firmly on the human rights agenda.

12 Reproductive Rights or Reproductive Justice? http://thecurvature.com (accessed on July 2010)

13 United Nation International Conference on Human Rights, Teheran, 1968, Tehran Proclamation, Article 16

It is the International Conference on Population and Development held at Cairo, 5-13 September 1994 that provides a comprehensive definition of reproductive health, reproductive health care and reproductive rights for the first time. This conference helps as a basis to newly developed human rights instruments.

The ICESCR recognizes everyone's 'right to the enjoyment of the highest attainable standard of physical and mental health' while universal access to health-care services, including those related to reproductive health care which includes family planning and sexual health, is recognized under the CEDAW.[14] Holding these principles, reproductive health is defined as:

> *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*[15]

Further, in line with this definition of reproductive health, reproductive health care is defined as:

14 The International Covenant on Economic, Social and Cultural Rights, 1966, Art.12 (1) and the Convention on the Elimination of All Forms of Discrimination against Women, 1979, Art.14 (2)

15 The International Conference on Population and Development, Cairo, 1994, paragraph 7.3

> *the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.*[16]

Bearing in mind these definitions, ICPD program of actions state that:

> *[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.*[17]

As a result, reproductive rights are often defined as a set of rights that recognize the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children/people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Accordingly, the rights generally include:

- ✓ The right to have the information and means to do so/the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law;

16 Ibid

17 Ibid

- ✓ the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth/the right to attain the highest standard of sexual and reproductive health; and
- ✓ The rights to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[18]

These rights can be categorized in to four groups:

- ✓ access to primary health-care services- accessing and enjoying the highest attainable standard of health;
- ✓ reproductive health care services including family planing and condom distribution/information on sexual reproduction and reproductive health/family planning education/protection from discrimination, harassment and gender-oriented harm and self-protection (SGBV);
- ✓ to be protected from HIV/AIDS and other sexually transmitted infections; and
- ✓ Mental health and psychosocial support.

Generally, the concept of reproductive rights relates to sexual reproduction and reproductive health the framework within which sexual and reproductive well-being can be achieved. The term reporductive rights is not directly employed in the international human rights documents except in the African Women's Protocol and the Disability Rights Convention. However, reproductive rights embrace certain human rights already recognized in different human rights law. As a result, the rights are universal, applicable to all human beings, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Therefore, the reproductive rights listed above are applicable to refugees too. The human rights embraced by reproductive rights are discussed in the following section.

18 Reproductive Rights, http://en.wikipedia.org/wiki/Reproductive rights (accessed on June 2010)

1.2. REPRODUCTIVE RIGHTS OF REFUGEES

Reproductive rights of refugees are already recognized at the different international and regional human rights laws, national laws, refugee laws, international conference documents and United Nations Executive Committees recommendations and states national laws. The relevant instruments and recognized rights are discussed below separately.

1.2.1. THE INTERNATIONAL LEGAL FRAMEWORK

The reproductive rights of refugees are firmly rooted in international law. A set of rights, recognized in different international human rights instruments, which relate to the concepts of sexual reproduction and reproductive health, provide the general legal framework for the enforcement of reproductive rights for all, including refugees. Twelve human rights recognized in different international human rights instruments are often considered to be relevant to reproductive rights. These include:

> *the right to life, the right to liberty and security of the person, the right to equality, and to be free from all forms of discrimination, the right to privacy, the right to freedom of thought, the right to information and education, the right to choose whether or not to marry and to found and plan a family, the right to decide whether or when to have children, the right to health care and health protection, the right to the benefits of scientific progress, the right to freedom of assembly and political participation, the right to be free from torture and ill treatment.*[19]

Many of these rights are in the domain of reproductive rights, while some have only indirect application. The realization of reproductive rights is closely related to and dependent on the realization of these human rights. For example, the right to liberty and

19 See The International Planned Parenthood Federation Charter on Sexual and Reproductive Rights, available at http://www.IPPF.org (accessed on July 2010)

security of a person generates the commitments to end female genital mutilation and sexual violence and to ensure that legal abortion is safe and accessible.

All of these twelve rights appear in international human rights law in general (including regional human rights agreements) and refugee law. The laws of these fields are mainly made up of treaties, which create binding obligations on countries that have ratified them. Other documents include soft laws including executive committee recommendations, consensus documents and UN agencies policies relevant to refugee reproductive rights.
These legal frameworks recognizing refugee reproductive rights are discussed in detail below. However, this discussion is not intended to be exhaustive, only selected provisions from major international and regional instruments and other soft laws including executive committee recommendations and consensus documents are examined. The purpose of the discussion is mainly to indicate that reproductive rights of refugees have basis on international law.

1.2.1.1. INTERNATIONAL HUMAN RIGHTS LAW

Different international human rights instruments have provisions that relate to reproductive rights of refugees. However, documents like the 1948 Universal Declaration on Human Rights (UDHR), the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the 1989 Convention on the Rights of the Child (CRC) are most relevant. These instruments benefit all human beings, wherever they find themselves, applicable without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, applicable to refugees too.[20]

The ICESCR recognizes a set of rights most directly relevant being the right of everyone to enjoy the highest attainable standard of physical and mental health.[21] It also provides that 'special protection should be accorded to mothers during a reasonable period before and after childbirth.'[22] The principle that everyone has rights with regard to health, without mention of citizenship or legal residence and without discrimination of any kind as to 'race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, extends the application of the rights to refugees as well.'[23]

The term 'reproductive rights' is not used in the International Covenant on Economic, Social and Cultural Rights, but a number of its specific provisions are directly relevant as pointed above. The Committee on Economic, Social and Cultural Rights (CESCR) (the treaty body, composed of experts, which was created to monitor implementation of the treaty's provisions) considers the right of everyone to enjoy the highest attainable standard of physical and mental health, recognized under Article 12(2) of the treaty, to include:

20 Atle Grahl-Madsen, The Status of Refugees in International Law, Volume I, A.W. Sijthoff-Leyden, 1966, P. 44

21 ICESCR, Supra note 3, Article 12

22 Ibid, Article 10(2)

23 Ibid, Article 2(2)

> *a right to maternal, child and reproductive health, including sexual and reproductive health services, as well as the resources to act on that information; a right to prevention, treatment and control of diseases, including prevention and education programs for behavior-related health concerns, such as STDs, in particular HIV and AIDS; and a right to health facilities, goods and services and health education.*[24]

Furthermore, the CESCR has stated that refugees and asylum-seekers among other groups are protected by the treaty's nondiscrimination clause. With respect to adolescents, the Committee concludes that these provisions, article 12 (2), would require countries to provide 'opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counseling, and to negotiate the health-behavior choices they make...,' and to provide 'youth-friendly health care, which respects confidentiality and privacy, and includes appropriate sexual and reproductive health services.'[25]

Children, human beings under the age of 18, are guaranteed similar rights with respect to health by the Convention on the Rights of the Child.[26] Other human rights set out in the Convention on the Rights of the Child play an important role in realizing the child's right to health. This includes the right of the child to seek, receive and impart information and ideas of all kinds.[27] This provides the basis for the requirement that adolescents have access to information on reproductive health, STDs (including HIV and AIDS), family planning and sexual abuse.

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24 The Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000)

25 Ibid

26 Convention on the Rights of the Child, 1989 Article 24

27 Ibid Article 13(1)

The CEDAW requires countries to eliminate gender-based discrimination in health care and to address the specific health needs of women.[28] In addition, it requires countries to ensure women equal rights to make decisions about childbearing and to have access to the information, education and means to do so.[29] Other provisions of the Convention guarantee the right of women to equal access to specific educational information, including information and advice on family planning and the right to equal access to health care facilities and family planning.[30]

In 1999, the Committee on the Elimination of Discrimination Against Women, which is a treaty body, issued a General Recommendation on Article 12 of the Convention, regarding access to health care services, including those related to family planning, indicating that access to health care includes reproductive health care for all women and girls, 'even if they are not legally resident in the country.'[31] The Committee noted that special attention should be given to the health needs and rights of refugees among other groups.

However, the Convention on the Rights of Persons with Disabilities (Disability Rights Convention) is the first comprehensive international human rights instrument to specifically identify the right to sexual reproduction and reproductive health as a human right. The convention, clearly state that:

> *States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. . . . In particular, States Parties shall: Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes . . . .[Further, it call states parties to] take effective and appropriate measures to eliminate*

28 the Convention on the Elimination of All Forms of Discrimination against Women, 1979, (CEDAW), Article 12

29 Ibid , Article 16(1) (e)

30 Id, Article 10(h) & Article 14(2) (b)

31 The Committee on the Elimination of Discrimination Against Women (CEDAW), General Recommendation No. 19

> *discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure . . . [t]he rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided.*[32]

This convention, for the first time put the issue of reproductive rights at the level of the binding international instruments with clear outline of the rights and corresponding obligations of states.

Ethiopia has ratified the ICESCR and the International Covenant on Civil and Political Rights (ICCPR) in 1993; the CEDAW in 1981 and the CRC in 1991. The Universal Declaration on Human Rights has assumed the status of customary international law and is binding on Ethiopia.

32 Rights of Persons with Disabilities, (entered into force May 3, 2008), article 25 & article 23 (1)

1.2.1.2. REFUGEE LAW

Refugee laws provide the legal framework for the protection of refugees. The 1951 Convention Relating to the Status of Refugees (the Refugee Convention) and its 1967 Protocol (the Refugee Protocol) has world wide applications. The 1969 African Convention Governing the Specific Aspects of Refugee Problems in Africa (the OAU Refugee Convention) is also applicable in the context of this study. The 1951 Refugee Convention and its Protocol, define refugee as:

> *any person who: owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.*[33]

These instruments which have been widely ratified, provide rights, to any person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, specific to their legal status; in many cases, rights equivalent to those accorded to a country's own citizens.[34] But this definition of refugee and the protection and assistance that comes with it leaves out many individuals who have fled their country but cannot prove fear of persecution, notably those who flee as a result of natural or manmade disasters, indiscriminate attacks on their communities or generalized violence, or for economic reasons.

However, the OAU Refugee Convention broaden the definition and extends the protection and assistance to persons ‘who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his/her country of origin or nationality, is compelled to leave his place of habitual

33 The 1951 Refugee Convention Article 1.A (2) and the 1967 Refugee Protocol Article 1.2

34 The 1951 Refugee Convention, Article 23

residence in order to seek refuge in another place outside his country of origin or nationality.'[35]

These refugee laws do not specifically talk about refugees' reproductive rights. But the documents generally require contracting countries to treat refugees lawfully staying in their territory the same way as their nationals are treated with respect to social security schemes, including those covering maternity and sickness.

Ethiopia has ratified the Refugees Convention and its Protocol in 1969 and the OAU Refugee Convention in 1973.

35 Convention Governing the Specific Aspects of Refugee Problems in Africa, 1969, Article 1 (2)

1.2.1.3. RELEVANT REGIONAL INSTRUMENTS

African human rights documents are also relevant and applicable to refugees in Africa. Moat relevant instruments are the 1981 African Charter on Human and Peoples' Rights (Banjul Charter), the 1990 African Charter on the Rights and Welfare of the Child (ACRWC) and the 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol on the Rights of Women in Africa).

The Banjul Charter mainly repeats the rights recognized under the international instruments discussed above. Rights recognized in this Charter that has relevance to reproductive rights and refugees include its non discrimination and the right to information clauses.[36] The ACRWC recognizes significant rights that relate to reproductive rights. The rights recognized provide protection from customs and practices prejudicial to the health or life of the child and child marriage.[37] Other provisions of the Charter guarantee the right of the child to health and non-discrimination.[38]

However, the Protocol on the Rights of Women in Africa has made a breakthrough in the development of reproductive rights at the regional level. It dedicates an article on 'Health and Reproductive Rights' guarantying:

> *the right to control one's fertility; the right to decide whether to have children including the number of children and their spacing; the right to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections including HIV/AIDS; the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally*

36 African Charter on Human and Peoples' Rights (Banjul Charter), 1981, Aarticle 2 & 9

37 The African Charter on the Rights and Welfare of the Child, 1990, Art 21 (1) a) (a) 2.

38 Ibid, article 3 & 14

recognized standards and best practices; and the right to have family planning education.[39]

This protocol, particularly, require state parties to take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women.[40]

Ethiopia has accessed to the Banjul Charter in 1998, the ACRWC in 2002 and has signed to the Protocol on the Rights of Women in Africa in 2004.

All the human rights instruments have a number of limitations albeit their significance in providing a solid legal basis for enforcement of reproductive rights. First, it fails to recognize any synergy amongst reproductive rights, except the Protocol on the Rights of Women in Africa and the 2008 Disability Rights Convention. This failure causes the need to look here and there in the instruments to find binding source for reproductive rights.

Second, the instruments do not provide a detailed outline of the rights. This causes the need to often rely on soft laws, executive committee recommendations and consensus documents, which are not binding by themselves, to understand the scope of reproductive rights and the corresponding states and the international community obligations.

Third, its enforcement mechanisms are notoriously weak. In the case of the ICESCR it is limited to reporting by countries to the treaty body. Fourth, many states are unwilling or unable to observe binding obligations included in the human rights treaties they have ratified, even when dealing with their own citizens. Enforcing most of the reproductive rights greatly depend on the availability of budget. While some scholars still hold on the old argument, reproductive rights or reproductive justice, which has ended on the affirmation of the UN that human rights are universal, inalienable and interrelated, states

39 The Additional Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003, Article 14

40 Ibid

unwillingness or unable to observe the binding instruments, however, still has budgetary issue. This is particularly true in poor countries like Ethiopia.

1.3. NATIONAL LAW

Ethiopia is a party to most of the binding international human rights instruments, as indicated above. These instruments often require states to adopt legislative or other measures as may be necessary to give effect to the rights recognized at the national level. As a result, the domestic implementation of international instruments requires the domestication (incorporation in to the domestic legal system and policies of the country) of the instruments.

Domestication of international human rights treaties may take two forms. Either the international instruments would be incorporation into constitutions of the country or a law may simply give the instruments the status of domestic law.[41] In the FDRE Constitution, for example, we found both forms of domestications. Its chapter on fundamental rights and freedoms discusses human rights. On one hand, as its fundamental principles, the constitution states that the international agreements ratified by the country are integral part of the law of the land.[42] However, in practice, only laws published in the *Negarit Gazetta* in Amharic have final legal authority and direct application. While few international instruments, like the Convention on the Rights of the Child (may be it is the only one), have direct application, there are no human rights instruments published in the *Negarit Gazetta* in Amharic or English. Therefore, it is better to look in to the domestic laws of the country to find applicable national laws for the enforcement of reproductive rights of refugees in the country.

I. Constitutional Guarantees

The constitution has recognized every person's right to life, the right to liberty and security of the person, the right to equality, the right to privacy, freedom of thought, marital, personal and family rights, freedom of assembly and prohibition against inhuman

41 Yuan, Domestication of International Human Rights Standards, (2002) see, http://www.gio.gov.tw (accessed on July 2010)

42 Federal Democratic Republic of Ethiopia Constitution, 1994, Article 9 (4)

treatment. These rights are in the domain of human rights embraced by reproductive rights as indicated at above.

The state assumes the obligation to allocate resource to provide public health, education and other social services.[43] Accesses for all Ethiopians to public health and education, is also put as objectives of the government.[44]

In addition to these, the constitution under article 35 lists rights that are strictly women rights with the heading "Rights of Women". This article has sexual reproduction and reproductive health issues including:

A. Freedom from Discrimination

The constitution recognizes the equal rights of women with men in the enjoyment of the rights and protections provided.[45] Freedom from discrimination is one of the sub set of reproductive rights, as indicated above.

B. The Right to Liberty and Security

It is discussed that the realization of reproductive rights is inconceivable without the full protection of bodily and sexual integrity. The constitution protects the right to liberty and security. It also prohibits harmful customs, laws and practices that oppress or cause bodily or mental harm to women.[46]

C. The Right to Marry and Found a Family

The constitution protects the rights of men and women, without any distinction, above the age of 18, to marry and found a family. They have equal rights while entering into, during marriage and at the time of divorce.[47] This right includes the freedom to enter into marriage only with the free and full consent of the intending spouses without interference

43 Id, art. 41

44 Id, art.90(1)

45 Id, article 35

46 Ibid

47 Id, article 34

whatsoever. Obviously, the right also refers to the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children too.

D. The right to Access to Health Care, Information and Education

The constitution imposes, on the state, the obligation to allocate resource to provide public health, education and other services. With a view to protect women from risk arising from pregnancy and childbirth and to safeguard their health, it also recognizes women's right to access to family planning education, information and capacity.[48]

E. Rights of Women

The Constitution under article 36 recognizes reproductive rights of women. While it guarantee, On one hand, the equal right of women with men including in marriage, it also entitle women to affirmative measures, taking in to account the historical legacy of inequality and discrimination suffered by women in Ethiopia.[49] The purpose of such measures is "to provide special attention to women so as to enable them to compete and participate on the basis of equality with men in political, social and economic life as well as in public and private institutions."[50]

Other reproductive rights of women recognized in the Constitution include:

> *(a) Women have the right to maternity leave with full pay. The duration of maternity leave shall be determined by law taking into account the nature of the work, the health of the mother and the well-being of the child and family. (b) Maternity leave may, in accordance with the provisions of law, include prenatal leave with full pay. Women have the right to full consultation in the formulation of national development policies, the designing and execution of projects, and particularly in the case of projects*

48 Supra note 33

49 Supra note 31, article 36

50 Ibid

affecting the interests of women. Women have the right to acquire, administer, control, use and transfer property. In particular, they have equal rights with men with respect to use, transfer, administration and control of land. They shall also enjoy equal treatment in the inheritance of property. Women shall have a right to equality in employment, promotion, pay, and the transfer of pension entitlements. To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity[51].

F. Rights of Children

Regarding children, the constitution, recognizes the right of children to be free of corporal punishment or cruel and inhumane treatment in schools and other institutions responsible for the care of children. This could be interpreted to include Female Genital Mutilation (FGM), though it is addressed in detail in the criminal code.

It is difficult to argue that the rights recognized under the constitution are applicable to refugees as well, as rights recognized under constitutional law are usually applicable to citizens only. But, the FDRE Constitution seems to consider most of the rights, though not all, particularly the human rights to benefit all human beings in the territory, with out any restrictions as to nationality or any other ground. This is because it refers to every one, any one, etc., with out referring to citizenship, like the international human rights instruments or the countries penal law.

However, the constitution has not put most of the rights related to reproductive rights as entitlements even for its own citizens but only as objective to be achieved or obligation of the state to allocate resource. Therefore, most of the reproductive rights which have particularly budgetary implications can not be directly claimed by anyone.

51 Ibid

But, while some of the rights which only require legal protection are fully protected under the penal law, as discussed below, for the other rights, which have budgetary implication, obligation of the state can be sought from the country refugee proclamation, as discussed below, or generally from the international human rights instruments the country is party to, as discussed above.

II. Criminal Law Protections

In 2004, the country has reviewed its criminal law. The revisions made on abortion and harmful practices are significant in the enforcement of reproductive rights in the country.

A. Abortion

Termination of pregnancy is allowed where it is done:

> *by a recognized medical institution within the period permitted by the profession… where: a) the pregnancy is the result of rape or incest; or b) the continuance of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or c) where the child has an incurable and serious deformity; or d) where the pregnant woman, owing to a physical or mental deficiency suffers from or her minority, is physically as well as mentally unfit to bring up the child.*[52]

Generally, other than in these situations, any abortion is considered as intentional termination of pregnancy, at whatever stage, and is punishable.

B. Forced Marriage

Forced marriage jeopardizes reproductive rights like the freedom to enter in to marriage with full and free consent and the right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in the constitution and human rights documents. Thus, the provision of the criminal law criminalizing abduction of a woman

52 Federal Democratic Republic of Ethiopia, Criminal Law, 2004, Article 551,

with intent to marry her by violence, or after having obtained her consent by intimidation, threat, trickery or deceit,[53] has a profound effect on the enforcement of reproductive rights.

C. Harmful Traditional Practices

It is said that, reproductive rights can be realized where bodily integrity of a person is secured. Practices like female circumcision and infibulations of the female genitalia violates reproductive rights with deep health risks. The criminal law has made a fundamental progress by criminalizing female circumcision and infuriation and other harmful traditional practices even at the degree of participation or incitement.[54] These traditional practices were not crimes in the country before 2004.

Generally, the protection of reproductive rights by the criminal law has a significant progress since 2004, though some argue that there is still a need to revise the law particularly in the area of the degree of the punishment to be imposed. In most cases the punishment is lenient entailing only simple imprisonment.

D. Sexual and Gender Based Violence (SGBV)

Though there is no legally set minimum age required for valid consent to sexual activity, the new criminal law criminalizes sexual intercourse with a person under 18 years old. A wide range of acts generally referred as SGBV are punishable under the new criminal law. These includes: Abduction of a Minor; Rape; Sexual Outrages on Minors and Infants; Homosexual and Other Indecent Acts Performed on Minors; Traffic in Women and Minors; Pornography Involving Minors; etc.[55]

E. Early Marriage

There is no legislative definition of a child until recently. It is the domesticated Convention on the Rights of the Child under Proclamation No. 10/1992 that define a child as any person under the age of eighteen for the first time.

53 Id, article 587

54 Id, arts. 561-570

55 Id, arts. 589-644

Minimum age for marriage for girls is set at 18 years in the different family laws of the regional states. For boys all except one region has the same minimum age as that of girls. In one region in the country, that is Tigray, the minimum age for boys is 22 years. At the same time, under the criminal law any marriage with a minor is punishable.[56]

III. Reproductive Health Policies

In 2006, the Federal Ministry of Health (MoH) has developed a 10 year, 2006-2015, National Reproductive Health Strategy. The National RH Strategy reflects three overriding priorities.

The first is the nation's commitment to achieving the Millennium Development Goals (MDGs), a framework for measuring progress towards sustainable development and eliminating poverty. Of the eight MDGs goals, three-

- ✓ improving maternal health,
- ✓ promoting gender equality, and
- ✓ Combating HIV/AIDS are at the core of the strategy document.[57]

The second priority is the need to respond to the socioeconomic and demographic realities of Ethiopia today. The contents of this strategy, is mainly to reflect the cultural, socio-demographic and political terrain that defines Ethiopia today.[58]

The third priority is to build on the advances realized in the health sector over the past decade.[59]

56 Id, art. 648

57 Ethiopia Ministry Of Health National Reproductive Health Strategy, 2006-2015, (2006), p. 1-2

58 Ibid

59 Ibid

The 10 year strategy provides five areas of the larger social and institutional contexts that influence RH in Ethiopia and set its strategies to address key reproductive health outcomes generally around these areas as follows.

a. Poverty

Ethiopia is one of the poorest countries in the world. Underlining that poverty is one of the most important factors influencing the RH status of Ethiopians, the strategy proposes to increase the budgetary allocation for the health center.[60]

b. Education

Investments in education, particularly for women, lead to better child health, lower fertility and reduced maternal mortality.[61] For that reason, the strategy relies for its success heavily on ensuring high levels of awareness and education among the population at large.[62] To meet this end, the strategy aims at providing eight years of primary education for all by the year 2015.[63]

c. Legal Environment

While the Government of Ethiopia has adopted numerous laws and policies that advance women's social and reproductive rights and is party to international instruments guaranteeing such rights, the implementation of these protections is constrained by low implementation capacity, low awareness among the general public and especially women. On this the strategic plan states:

> *Strengthen the legal frameworks that protect and advance women's reproductive health rights. To ensure the full application of existing laws, and the development of further protection, this strategy encompasses efforts to institutionalize women's rights at the local level, integrate them into regional-level planning activities, and to develop*

60 Id, p.3
61 Ibid
62 Id, p.4
63 Ibid

synergistic opportunities with women's groups to ensure that courts and police enforce such protections.[64]

d. Status of Women

The low status of women in Ethiopia underpins and often directly undermines each of the negative RH outcomes. Most Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights – a condition that, in turn, perpetuates their low RH and social status. Basic indicators clearly demonstrate the disadvantaged position of women within Ethiopian society.

e. Health Care System

The strategy indicate that recent assessments have identified systemic shortcomings that hamper the delivery of all health services, but especially those pertaining to RH, particularly in remote areas.[65] To address these, it plans to strengthen the health care system with a strong community-based component centered on the Health Extension Program (HEP).[66] The HEP is to make essential health care universally available through a package of preventive, promotive, minimum curative and rehabilitative services provided by Health Extension Workers (HEWs).[67]

The 10 year reproductive health strategy does not talk about refugees. However, its application can be sought through the obligation of the state put at the international human rights instruments and the country's refugee proclamation, discussed below.

IV. Refugee Proclamation

The 1951 Refugee Convention has no provision on health or sexual reproduction and reproductive health issues. It, however, require states to accord to refugees lawfully

64 Id, p.10

65 Id, p.5

66 Ibid

67 Ibid, Frequently described as a "flagship program", the HEP includes four major components: i) Family Health, ii) Disease Prevention and Control, iii) Personal Hygiene and Environmental Health, and iv) Health Education and First Aid

staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.[68]

The 2004 refugee proclamation of Ethiopia also has no specific provisions on sexual reproduction and reproductive health. However, it entitled recognized refugees specifically to protection from refoulement, be issued with identity card and be issued with travel documents.[69] It also entitled refugees generally to other rights contained in the refugee convention and Organization of African Unity (OAU) refugee convention.[70] While this means that every recognized refugee is entitled to all the rights contained in the refugee convention and OAU refugee convention, the countries reservation on three areas limit this general entitlement. These areas includes, article 26 on freedom of movement, (refugees are required to live in an area specified by the government provided that the places are at reasonable distance from the border of their country or former habitual residence), article 17 on wage earning employment and article 22 public education of the refugee convention.[71]

However, while refugees are entitled the same treatment to foreigners on the area of wage earning employment and public education, they are still entitled the same treatment with respect to public relief and assistance, including reproductive health services, as is accorded to Ethiopian nationals.

The proclamation also confers especial protection to vulnerable groups. It identifies women refugees, refugee children, elderly refugees and persons with disabilities as persons who need special protection and require the country's refugee authority to take measures to ensure their protection.[72]

68 Supra note 23, artic. 23

69 Federal Democratic Republic of Ethiopia Refugee Proclamation, (2004), article, 21(1)

70 Ibid

71 Id, article 21 (2)

72 Id, article 22

These groups of refugees are the one whose reproductive rights are violated often during displacement because of their vulnerability (reproductive rights in situations of displacement are discussed in detail in the next chapter). As a result, these special treatments of the proclamation for the vulnerable groups further guarantee the enforcement of the rights for refugees in the country.

1.4. INTERNATIONAL CONSENSUS DOCUMENTS

The United Nations Decade for Women (1976-1985) was a world-wide effort to examine the status and rights of women and to bring women into decision- making at all levels.[73] It was a turning-point in that it put women's issues on the agenda and since then there has been important progress in achieving equality between women and men. For example, in 1979, the General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women, which entered into force in 1981 set an international standard for what was meant by equality between women and men. Further, in 1985, the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace adopted the Nairobi Forward-looking Strategies for the Advancement of Women.

Further, since 1994, different international Conferences have come up with issues of reproductive rights. The ICPD which set a full and detailed outline of reproductive rights for all human beings, including refugees, is one of such conferences with issues of reproductive rights. It underlines that the ability to address one set of reproductive rights has a direct impact on the general enforcement of human rights of individuals. The out come of the conference, the program of action, recognizes that women human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.[74]

The other conference that has significance in the advancement of reproductive rights for all, including refugees, is the Fourth World Conference on Women. The final act of the Conference, the Beijing platform for action, incorporating the definitions and outline of reproductive rights set under the ICPD, urges governments to:

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73 Reproductive Freedom: In the Context of International Human Rights and Humanitarian Law, Kluwer Law International, The Hague, the Netherlands, 2000, p.4

74 International Conference on Development and Population, Program of Action, 1994, principle 8

> *Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls, reduce ill health and maternal morbidity and achieve world wide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015; ensure that the necessary services are available at each level of the health system; and make reproductive health care accessible, through the primary health-care system, to all individuals of appropriate ages as soon as possible and no later than the year 2015 . . .* [75]

In these two conferences, 'governments have specifically agreed to take all necessary measures to ensure the physical protection of refugees, particularly women and children, especially against exploitation and sexual violence'[76] and 'to provide victims of such abuse with appropriate and adequate services.[77]

75 The Fourth World Conference on Women Beijing Platform for Action, 1995, Paragraph 106 (i)

76 Supra note 58, paragraph 7.11 and 10.24 and the Beijing Platform of Action, paragraph 147

77 Id, paragraph 4.10

1.5. UN AGENCIES POLICIES

UNHCR, the United Nations refugee Agency, is mandated by the United Nations to lead and coordinate international action for the world-wide protection of refugees and the resolution of refugee problems. Its primary purpose is to safeguard the right and well-being of refugee mandated by the organization's Statute,[78] guided by the Refugee Convention and its Protocol, which provides an essential framework of principles for its humanitarian activities.

Protecting refugees is primarily the responsibility of states and host governments are responsible for the security and safety of, assistance to, and law and order for refugees on their territory.[79] Though UNHCR's legal responsibilities allow it to intervene in most refugee situations, its role is mainly limited only to help governments provide protection and assistance for refugees and it is not to replace states primary obligations.[80]

Despite the primary responsibility of states, in practice UNHCR and its implementing partners (IPs) usually have to help to provide reproductive health services for refugees. This is particularly true in developing countries, as the countries are too poor to provide the services. The level of sexual and reproductive health care that refugees, thus, receive depends to a large extent on the policies of UNHCR and the IPs in developing countries like Ethiopia.

Although UNHCR has no separate policy on reproductive health, it has made a concerted effort to pay attention to the needs and human rights of women and girls. Its Guidelines on the Protection of Refugee Women give high priority to providing a comprehensive range of reproductive health services, with special attention to the needs of adolescent girls.[81] The guidelines further recommend counseling and mental health services for

78 General Assembly Resolution No. 428 (V) 1950

79 UNHCR, Refugee Protection: A Guide to International Refugee Law, 2001, p. 21

80 Ibid

81 UNHCR Handbook for the Protection of Women and Girls, 2008, page 271

refugee women, particularly for victims of torture, rape and other forms of physical and sexual abuse.[82]

The agency's Guidelines on Prevention and Response to Sexual Violence recommend providing emergency contraception (where it is legal and once its effects have been fully and carefully explained) to women who have been raped.[83] The guidelines also state that treatment of STDs (including HIV) and pregnancy tests should be offered, and in cases where sexual violence has resulted in pregnancy, all options should be discussed with the woman, 'regardless of the individual beliefs of the counselors, medical staff or other involved persons.'[84] Further abortion services should be provided in accordance with the legal situation, with regard to it, in the country of asylum with the consent of the woman.[85]

Despite efforts to reach agreements on common guidelines, IPs policies vary greatly and do not always fully comply with international standards. In addition, the absence of a single international organization that monitors the enforcement of reproductive rights creates problems of jurisdiction and coordination among the UN Agencies and its IPs. In case of refugees, camps are assigned to implementing partners regardless of whether they enforce the full range of the rights. Refugees therefore suffer serious gaps in services, particularly where there is lack of coordination. UNHCR and its IPs also face inadequate funding and difficulties in service delivery.

82 Id, p. 275

83 UNHCR, Sexual and gender based violence against refugees, returnees and internally displaced persons; Guide lines for prevention and response, Geneva, 2003, P.21

84 Ibid

85 Ibid

1.6. REPRODUCTIVE RIGHTS ARE WOMEN HUMAN RIGHTS

Reproductive rights are human rights pertaining to individuals as well as to couples generally. However, international law in concept and practice was a gendered system that marginalized women. Women's issues had simply been 'at the periphery of international human rights'.[86]

The realities of women's lives worldwide in the context of international women's human rights show governments' exploitation of women's fertility to increase or decrease the population in order to meet perceived state needs.[87] In addition, the concept of "women as wombs" is also a pervasive worldwide phenomenon and is central to the universal failure to recognize the plethora of issues attendant to women's health, which include, but are not limited to, bearing children.[88]

To address these obstacles that block the advancement of women, the International Women's Conference was started by the U.N in 1975. Since then, there have been four successful conferences including the 1975 Mexico City, the 1980 Copenhagen, the 1985 Nairobi and the 1995 Beijing World Conferences on Women, respectively.

Further, several human rights issues of significance for women's advancement have recently received renewed interest and moved to the top of the international human rights agenda. The interest to re-conceptualize the international norms to reach issues that concern individuals such as sexual harassment, gender-based violence, reproductive freedom, and so on grows significantly.[89]

Most important is the Beijing Conference. This conference, recognizes the exclusion of women from the enjoyment of human rights that exists in all three of the so-called generations of human rights, first (civil and political), second (economic, social, and

86 Supra note 57, p.3

87 Women's Rights as Human Rights-Rules, Realities and the Role Of Culture: A Formula for Reform, Brooklyn Journal of International Law, 1996

88 Ibid

89 Ibid

cultural), and third (solidarity).[90] As a result, it proposed a woman-centered analysis, pointing that "in no society today do women enjoy the same opportunities as men", as a solution to the failure of the international human rights legal regime to protect women's rights.[91] In line with this argument, it marked that:

> *The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.*[92]

The Beijing Platform for Action also recognizes that women's right to the enjoyment of the highest attainable standard of physical and mental health.[93] This recognition is important as the enjoyment of this right is vital to women's life and wellbeing and their ability to participate in all areas of public and private life.

While human rights are universal, this perspective incorporates a culturally sensitive analysis that embraces the realities and voices of women from different cultures, religions and traditions to ensure that the new inter national human rights construct is egalitarian in both principle and application. Although these concerns and issues are not new, it is only at this time that women have gained access to domestic and international arenas that the gender dimensions of human rights norms explored and that a feminist critique of international law emerges.

90 Supra note 67

91 Supra Note 59, Paragraph 96

92 Id, article 97

93 Ibid

CHAPTER TWO: REPRODUCTIVE RIGHTS IN SITUATIONS OF DISPLACEMENT

2.1. ENFORCING REPRODUCTIVE RIGHTS OF REFUGEES

At the end of 2009, some 43.3 million people worldwide were forcibly displaced due to conflict and persecution.[94] From these displaced people, 27.1 million are Internally Displaced Peoples (IDPs) and close to 1 million individuals are asylum seekers whose asylum application had not yet been adjudicated by the end of 2009 while refugees who fled for reasons stated in the 1951 refugee convention are 15.2 million.[95]

The total number of refugees under UNHCR's care is 10.4 million; the rest, 4.8 million are Palestinian refugees not under UNHCR mandate.[96] Women and girls represented on average 49 per cent of persons of concern to UNHCR, while children below 18 years of age make forty-one per cent of refugees and asylum-seekers, globally.[97]

In Africa, there are about 2,216,035 refugees, second to Asia which hosts 4,418,605 refugees.[98] Almost half of these refugees, 779,211, are in the East and horn of Africa.[99] Most of these refugees, in Africa, reside in camps; 6 out of 10 refugees in sub-Saharan Africa reside in camps close to borders.[100]

The major causes of displacement of these refugees are insecurity, political instability, escalating conflicts and persecution which often serve to exacerbate discrimination and

94 UNHCR Global Trends Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons; Division of Program Support and Management, Geneva, 15 June 2010, p 2

95 Ibid

96 Ibid

97 Id, p. 1

98 Id, p. 2

99 Ibid

100 Ibid

violence against women.[101] They often lack sufficient protection, safety and security, access to health care and education, livelihoods and community support, which, in turn, expose women and girls to:

> *unsafe deliveries which causes death among women and lifetime risk of maternal death; absence of minimal, reliable and affordable family planning services; unwanted pregnancies, unsafe abortions, close birth-spacing, high risk pregnancies; transmission of sexually-transmissible infections including HIV/AIDS; gender-based violence including rapes, attended rape, sexual abuse, forced pregnancy, forced marriage, domestic violence; harmful practices including early marriage, polygamous marriage, female genital mutilation, widowhood and others.*[102]

These all affects different aspects of the refugee women's life, significantly violating their reproductive rights.

Globally the enforcement of reproductive rights, even in the normal situations of life, is full of challenges.[103] For example, "each year more than half a million women die world wide during pregnancy, giving birth, or in the critical few weeks following birth. That is one woman in every minute, most die from preventable causes."[104] Situations of displacement further hinder the enforcement of reproductive rights, particularly of refugee women. The challenges in the enforcement of refugees' reproductive rights involve not only diseases but also other components of life such as sexual reproduction and pregnancy surrounded by legal, economical, cultural, social, ethical and religious considerations compounded by situations of displacement.[105]

101 UNHCR Handbook for the Protection of Women and Girls, Geneva, 2008, p7

102 Id, p272

103 See http://genderacrossborders.com (accessed on September 2010)

104 Ibid

105 Supra note 8

However, the international community has made particularly concerted efforts since the early 1990s to promote and protect reproductive rights of women and girls wherever they are. Of critical importance has been the recognition that women's and girl's rights are human rights; violence against women and girls, whether in war, in peace, at the hands of family members, the community or the state, is a human rights violation that should incur individual criminal responsibility.[106] States and other actors, including UNHCR, have clear responsibilities to ensure that these are respected.

The following topics examine in detail states and the international community obligations and also provide general view of the challenges in enforcing reproductive rights in situations of displacement.

106 Volker tu¨rk and Frances Nicholson, Refugee protection in international law: an Overall Perspective, P 56, available at http://www.unhcr.ch. (accessed on October 2010)

2.1.1. ACCESSING AND ENJOYING THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Some of the main challenges to ensure women and girls access and enjoy the highest attainable standard of health include those resulting from conflict and displacement, gender roles and inequalities and being unaccompanied and separated.[107] The impact of conflict and displacement on health is profound. Health and sanitation systems are often destroyed and health services are unavailable or overwhelmed.[108] Quality health services, including reproductive health services, are often not available and when they are available, women and girls may not be able to access to them.[109] Situations of displacement also favor the transmission of infectious diseases, such as HIV and other sexually transmitted infections.[110]

Women and girls face particular health risks because of their sex and because of gender inequalities. Since women are usually the family's caregivers, they are often responsible for tending sick family members.[111] Their efforts to care for others in particular children and their capacity to care for themselves is often hampered by their reduced mobility and possibility to sick care due to cultural or religious reasons.[112]

Unaccompanied and separated children outside their country of origin "have undergone separation from family members and have also, to varying degrees, experienced loss, trauma, disruption and violence".[113] While refugee children, many of whom "have further experienced pervasive violence and the stress associated with a country afflicted by war", "girls are particularly susceptible to marginalization, poverty and suffering

107 E. Johnson-Sirleaf and E. Rehn, Women, War, and Peace: The Independent Experts Assessment, Progress of the World's Women, 2002, vol. 1, pp. 35–43.

108 Ibid

109 Joan M. Fitzpatrick (editor), Human Rights Protection for Refugees, Asylum-Seekers, and Internally Displaced Persons: A Guide to International Mechanisms and Procedures, Transnational publishers. Inc, Ardsley, New York, 2000, P 342

110 Ibid

111 UNHCR, WHO, UNFPA, Reproductive Health in Refugee Situations: An Inter-Agency Field Manual, 1999, p77

112 Ibid

113 Convention on the Rights of the Child Committee, General Comment No. 6, 2005, Treatment of Unaccompanied and Separated Children Outside Their Country of Origin, paras. 46–49.

during armed conflict, and many may have experienced gender-based violence in the context of armed conflict. The profound trauma experienced by many affected children calls for special sensitivity and attention in their care and rehabilitation."[114]

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health and to non-discriminatory access to health care services. As the Committee on Economic, Social and Cultural Rights has indicated,

> *the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.*[115]

States have a responsibility to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning'.[116] The right to the highest attainable standard of health entails a corresponding obligation of states to 'respect, protect and fulfil' this right. This obligation requires, amongst other things, that states should 'not restrict women's access to health services … on the ground that women do not have the authorization of husbands, partners, parents or health authorities'.[117] To this end, states have the obligation to:

> *enact and effectively implement laws that prohibit female genital mutilation and marriage of girl children; ensure adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees; ensure,*

114 Ibid

115 Committee on Economic, Social and Cultural Rights, General Comment No.14, 2000, the Right to the Highest Attainable Standard of Health, Para. 4.

116 CEDAW, Convention on the Elimination of All Forms of Discrimination against Women, 1979, Article 12.

117 Committee on the Elimination of Discrimination against Women, General Comment No. 24, 1999, Article 12 of the Convention (Women and Health), Paras. 13–27.

> *without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country; and ensure women's right to safe motherhood and emergency obstetric services.*[118]

Moreover, the Committee on Economic, Social and Cultural Rights recommends sates to "integrate a gender perspective in their health-related policies, planning, program, and research".[119] This recognizes that biological and socio cultural factors play a significant role in influencing the health of men and women. It also affirms that states should intervene to prevent and treat diseases affecting women and develop policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services.

Regarding children, the Committee on the Rights of the Child affirms that states must assess and address the particular plight and vulnerabilities of unaccompanied and separated children outside their country of origin.[120]

The international community through UNHCR has a responsibility to support states in fulfilling their responsibilities to ensure refugees can enjoy the highest attainable standard of physical, mental health and adequate nutrition. The activities of states and other stake holders should aim to minimize mortality and morbidity and to increase respect for the human rights and dignity of refugees, including women and girls.[121] This includes working to improve access to, and utilization of, health services, in particular primary health care and reproductive health services. Securing women's and girls' access to health care services and improve health-seeking behavior involves ensuring quality, privacy and adequacy of health service provision and ensuring family and community awareness and support.[122]

118 Ibid
119 Supra Note 21, paras. 20-27
120 Supra Note 19
121 Supra note 8, p. 270
122 Ibid

2.1.2. REPRODUCTIVE HEALTH

Reproductive health conditions are the leading cause of death and illness in women worldwide.[123] Many women and adolescent girls, not only those who are displaced, have no access to reproductive health care. Lack of access to reproductive health includes "inadequate levels of knowledge about human sexuality, inappropriate or poor quality reproductive health information services, the prevalence of high risk sexual behavior, discriminatory social practices, negative attitudes towards women and girls, and the limited power that women and girls have over their sexual lives."[124] Generally, as each of these issues reflects, the main challenge is women's and girls' unequal situation in society.

Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees, while also conforming to universally recognized international human rights standards.[125] This requires mainly implementation of the Minimum Initial Standard of Services (MISP) at the onset of emergencies.[126] The MISP includes, identifying an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP; Preventing and managing the consequences of sexual violence; Reducing HIV transmission; Preventing excess neonatal and maternal morbidity and mortality; and planning for the provision of comprehensive reproductive health services, integrating into primary health care.

Other measures proposed includes ensuring capacity of health facilities to address basic reproductive health services in an accessible, friendly, quality and comprehensive manner, and empowering women and adolescents to take control over key moments and events of their sexual and reproductive life.[127]

123 UNFPA, Reproductive Health Fact Sheet. See http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm. (accessed September)

124 Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, para. 96.

125 UNHCR, WHO, UNFPA, Reproductive Health in Refugee Situations: An Inter-Agency Field Manual, p.11-14

126 Ibid

127 Supra note 8, p. 271

The reproductive health of women and girls is at great risk during displacement due to continuous and increase reproductive health needs during crisis. Lack of access to emergency obstetric care increases the risk of maternal and newborn death and disability, malnutrition, stress and epidemics. It also increase the risk of complications, babies may be born by the wayside during flight, the danger of SGBV increases when there is insecurity and social instability and harmful practices such as genital mutilation.[128] As a result, women and adolescent girls fleeing violence and conflict often do not have access to quality maternal health care and emergency obstetric care. Preexisting malnourishment, anemia and poor health status and infectious diseases are often prevalent during displacement which compromise reproductive health further.[129]

Moreover, delay in deciding to seek care, the delay in reaching the health facility and the delay in receiving appropriate care after arrival in the facility have a high impact on maternal and newborn mortality and morbidity. Lack of safe-motherhood appropriate services can lead to maternal mortality, miscarriages, still births and infant mortality.[130] It can also lead to low birth weight, disabilities and ill health for the newborn child. Similarly, lack of access to quality reproductive health services during pregnancy and delivery can further result in serious health and protection consequences, such as permanent injuries, infertility and disabilities for the woman or girl.[131]

In particular, unattended deliveries and childbirth at an early age can result in obstetric fistula. Women and girls with fistula often live an isolated existence, abandoned by their husbands and shunned by society.[132] They risk death through neglect, medical complications, and suicide.[133] Although fistula can normally be treated with reconstructive surgery, many health personnel neither know about fistula nor is that surgical repair possible.[134]

128 Ibid

129 Ibid

130 Supra note 29

131 Ibid

132 see Centre for Reproductive rights at http://centre for Reproductive Rights. (accessed November 2010)

133 Ibid

134 Ibid

High fertility rates and low contraceptive use contribute to women's and young children's ill health while family planning can prevent 25–30 per cent of all maternal deaths.[135] Unwanted pregnancies, including those from rape, are causes of serious protection risks in particular among adolescents and unmarried women. These include school drop out, domestic violence, unsafe abortion which can lead to death or permanent disabilities, abandonment of the baby and infanticide and reduced possibilities for girls and women to achieve personal development, empowerment and full potential.[136]

Sexual and gender-based violence (SGBV) remains the most widespread and serious protection problem facing refugee women and girls. Particularly when women and girls are unable to enjoy other rights, the risk of exposure to SGBV increases.[137] SGBV refers to violence that is directed against a person on the basis of her or his gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty, whether occurring in public or in private life.[138] While women, men, boys, and girls can all be victims of gender-based violence, women and girls are the main victims.[139]

SGBV during and after conflict, including domestic violence, can result in sexual exploitation and unwanted pregnancies, complications from unsafe abortions, severe risks to their health and that of their children and an increase in sexually transmitted diseases, including HIV/AIDS.[140] Displaced adolescent girls are particularly at risk of SGBV, including forced and early marriage, sexual exploitation, unwanted pregnancies, and pregnancies at a young age. This poses severe risks to their health and that of their children and increases the risk of becoming infected with HIV/AIDS. These challenges are compounded by lack of knowledge about reproductive health and lack of access to

135 Ibid

136 Ibid

137 UNHCR, Sexual and Gender Based Violence Against Refugees, Returnees and Internally Displaced Persons; Guide Lines for Prevention and Response, Geneva, 2003, P23-24

138 Ibid

139 Ibid

140 Beijing Plat Form for Action, paragraph 14

basic and fundamental necessities, such as sanitary materials, condoms, and HIV-testing.[141]

Gender inequality and discrimination are the root causes of SGBV. Such violence may result from discriminatory legislation or persecution by authorities, from circumstances such as conflict, or from prevailing societal norms and practices, which may discriminate against or persecute particular groups in that society or discriminate against or persecute individuals who oppose norms which violate their rights.[142] Young girls are especially at risk; nearly 50 per cent of all sexual assaults worldwide are against girls aged 15 years or younger.[143]

Displacement increases the risks to which women and girls are exposed at the hands of armed groups, the host community, other displaced persons, smugglers and/or traffickers.[144] Disability also increases the risk of SGBV. Higher numbers of women with speech and hearing difficulties are among reported rape cases.[145]

The consequences of SGBV are devastating and can lead to a whole range of further rights violations. Women and girls exposed to SGBV face possible death, including from HIV and AIDS, or acute and chronic physical injury, reproductive health problems, emotional and psychological trauma, stigmatization, rejection, isolation, increased gender inequality, and further exposure to other forms of SGBV.[146]

Securing legal redress is often very difficult and in some cases women and girls who have been raped may be treated as criminals. In *Darfur*, Sudan, for instance, some women and girls who have been raped have been imprisoned and fined by police for "illegal pregnancy".[147] In camps, traditional dispute resolution systems generally do not

141 Ibid

142 Jan Macadam, Complementary Protection in International Refugee Law, P 89

143 See http://www.unfpa.org (accessed November 2010)

144 Supra Note 44

145 Ibid

146 Supra note 41

147 Médecins sans Frontières, The Crushing Burden of Rape: Sexual Violence in Darfur, 2005, p. 6.

provide adequate redress to women and girls. Under traditional justice mechanisms, women and girls may be accused of "offences" that are not, in fact, offences under national or international law, such as witchcraft, eloping, non-performance of marital and family duties, and opposing other social norms, and customs, which violate their rights.[148]

Generally, rape and other forms of SGBV may provoke flight, especially when such violence is used as a weapon of war, including in the context of ethnic cleansing. SGBV may also be perpetrated during flight at the hands of bandits, traffickers, border guards, and other individuals in authority. As pointed above, disability and age are factors that increase the risk of such attacks. But it may continue during displacement, where prior exposure often leads to continuing problems, including further violence.

In urban and rural settings, displaced women and girls may be sexually harassed or abused when looking for employment and/or if they are obliged to work in unsafe conditions.[149] Girls may also face violence at school; particularly, they may be harassed or attacked on their way from or to their homes by members of the displaced or the host community.[150]

During displacement, refugees bring with them their customs and traditions. Among these are harmful practices, such as female genital mutilation (FGM), early or forced marriage, killing and maiming in the name of honor, infanticide and/or neglect, and denial of education for girls or women.[151]

FGM is defines as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons".[152]

148 Ibid

149 Supra note 41

150 Ibid

151 Id, p.18.

152 The 1997 WHO, UNICEF and UNFP Joint Statement on Female Genital Mutilation

Girls sometimes as young as five or six may be subject to FGM.[153] The practice can have severe health consequences for the girls concerned and can result in death. FGM reinforces the subordination of girls and women in the communities where it is practiced. While often viewed as a cultural tradition that should be respected, these harmful practices are human rights violations. Sometimes, such practices are not criminalized under national laws, for instance, it is only in 2004 that such practices are criminalized in Ethiopia.

However, states should condemn violence against women and should not invoke any custom, tradition or religious considerations to avoid their obligations with respect to its elimination.[154] Despite the fact that the practice is banned in law in many countries, there may be few, if any, prosecutions. Such practices may be the very reason why women and girls flee and may constitute grounds for refugee status. During displacement, these practices are not reduced and may even be exacerbated.

Additional reasons for lack of access to reproductive health care during displacement include:

> *loss of income reducing the ability of the displaced to make choices; the focus on life-saving measures coupled with failure to consider reproductive health as a priority; limited access, e.g. because women are not able to get health care without their husband's permission; limited or no access to female doctors and nurses; lack of privacy and/or confidentiality in health care facilities; poor or no roads, insufficient transport, great distance to health facilities; lack of security en route to health facilities; perceived low quality of health services and inconvenient hours of operation; humanitarian workers who do not think that reproductive health care generally and family planning in particular are a priority; and humanitarian workers who do not want to offer family*

153 Ibid

154 The 1993 Declaration on the Elimination of Violence against Women, Article 4

planning services because it is against their own religious beliefs or because they believe it is against the culture of the communities concerned.[155]

Women's and girls' right to the highest attainable standard of physical and mental health includes the right to reproductive health, including to safe motherhood and emergency obstetric services as "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."[156]

The Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination Against Women and the Committee on the Rights of the Child have all emphasized the particular health care needs of refugee women and children. Executive Committee on ESCR recommends that States, UNHCR and other relevant agencies and partners "make all efforts to ensure access … for adolescents … to age-sensitive reproductive healthcare as well as health and HIV information and education".[157] As part of states' obligation to ensure women and girls are able to enjoy the highest attainable standard of health on an equal basis to men and boys, governments have a responsibility to ensure their access to health care services, including those related to family planning.[158] They also have a responsibility to ensure women and adolescent girls have access to appropriate services in connection with pregnancy, confinement and the post-natal period, through free services where necessary, as well as adequate nutrition during pregnancy and lactation.[159]

Further, states are obliged to respect the right to health including by, inter alia, refraining from denying or limiting equal access for all persons, including asylum-seekers and refugees, to preventive, curative and palliative health services and by abstaining from

155 Supra Note 8, p. 274

156 International Conference on Population and Development, Program of Action A/CONF.171/13, 18 October 1994, Principle 8. At the regional level, see 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14.

157 ExCom Conclusion No. 107 (LVIII), 2007, para. (h)(x).

158 CEDAW, Article 12.

159 Ibid

imposing discriminatory practices relating to women's health status and needs.[160] States have also a responsibility to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.[161] These include the practices of female genital mutilation and early child or forced marriage, which not only harm girls, but may also adversely affect their future offspring.

Reproductive health care is a human right and a requirement for psychological and health. UNHCR's protection responsibilities include the promotion of the rights of all persons of concern, including women and girls, to the highest attainable standard of physical and mental health. As stated in the inter agency field manual on reproductive health in refugee situations, the cornerstone of UNHCR's interventions should be that reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognized international human rights.

2.1.3. HIV and AIDS

The global HIV pandemic is a serious problem for everyone. The conditions that characterize displacement, i.e., conflict, social instability, food insecurity, poverty, and

160 Supra Note 21, para. 34

161 Convention on the Rights of the Child, Article 24(3).

powerlessness, are also conditions that favor the rapid transmission of HIV and other sexually transmitted infections. The long-term consequences of HIV and AIDS are often more devastating than the conflict itself, as the number of deaths from AIDS each year exceeds the number of those killed during conflicts.[162] HIV and AIDS are not just health issues, but a problem that affects societies and cultures, human rights, and the long-term social and economic well-being of displaced persons and the local population with whom they interact.[163]

Women account for nearly half the 40 million people living with HIV worldwide.[164] In sub-Saharan Africa, 57 per cent of adults with HIV are women, and young women aged 15 to 24 are more then three times as likely to be infected as young men.[165]

Despite this alarming trend, women often know less then men about how HIV is transmitted and how to prevent infection.[166] Women and girls are more susceptible to HIV infection than men and boys because of gender discrimination and violence, biology (male-to-female transmission of HIV during sex is about twice as likely as female-to-male transmission),[167] insufficient access to HIV prevention information and services, inability to negotiate safer sex and the lack of female-controlled HIV prevention methods make girls further susceptible to HIV.[168]

They also bear the burden of the pandemic in many other ways. They are more likely to take care of children orphaned due to AIDS and to care for sick relatives and neighbors. Older women, whose own children have died of AIDS, often care for their grandchildren or take in orphans.[169] In such circumstances, in order to compensate for loss of income, girls tend to be removed from school, or may themselves become child heads of

162 UNAIDS, UNFPA, UNIFEM, Women and HIV/AIDS: Confronting the Crisis, 2004, Preface.

163 Ibid

164 Ibid

165 Ibid

166 Ibid

167 See WHO, "Number of women living with HIV increases in each region of the World", 2004, athttp://www.who.int/mediacentre/news/releases/2004/pr_unaids/en/print.html. (accessed November 2010)

168 UNICEF, The State of the World's Children, 2005, pp. 70–71

169 Ibid

household.[170] This in turn, prevents them from obtaining information about HIV prevention and transmission, and increases the risk that they will be infected. Education is often referred to as the "social vaccine" for preventing transmission of HIV and mitigating the impact of AIDS.[171] There is a growing body of evidence that links the lack of education, particularly for women, with the spread of HIV.

These factors may present greater challenges for displaced women and girls because of their vulnerability to exploitation and violence throughout displacement, food insecurity and lack of livelihoods may oblige women and girls to turn to survival sex to gain access to food and other fundamental needs and the breakdown of communities and families can result in high-risk behavior.

The correlation between the spread of HIV and sexual violence and exploitation of women and girls in conflict situations is complex. For instance, when rape is used as a weapon of war, the consequences for women and girls are often deadly and can include HIV infection. Men, women and children who are living with and affected by HIV and AIDS may face discrimination in relation to housing, property, health care and risk of *refoulement*, denial of access to asylum procedures, lack of access to durable solutions, and restrictions on their freedom of movement due to their HIV status.[172] Mandatory testing, which violates international human rights standards, and lack of confidentiality regarding health status also create protection risks.[173]

Further, women are often the primary targets of stigmatization related to HIV and AIDS blamed for introducing the disease into the household or community, even if their male partners may be the true source of infection.[174] Women who are HIV positive may be

170 Ibid

171 Ibid

172 UNICEF and UNHCR, HIV/AIDS, Conflict and Displacement, Conference Report on the XVI International AIDS Conference Affiliated Event, 2006, at http://www.unhcr.org/protect/PROTECTION/45a4bf224.pdf. (accessed November 2010)

173 Ibid

174 Ibid

more susceptible to violence or the threat of violence by their partners and/or families and fear of such violence causes some women and girls to avoid testing.[175]

Women and girls have the right to the highest attainable standard of physical and mental health, which includes the right to HIV and AIDS prevention, treatment, care and support. Women and girls who are living with HIV and AIDS are entitled to live their life in dignity, free from discrimination and stigmatization and should not be subject to discriminatory measures. Like other refugees, refugees living with HIV and AIDS are entitled to the same treatment as nationals as regards public relief and assistance.

The UN Declaration of Commitment on HIV and AIDS recognizes that gender equality and the empowerment of women are fundamental preconditions if women and girls are to be less vulnerable to HIV and AIDS infection.[176] Realization of women's and girls' right to the highest attainable standards of health requires states to take steps which are necessary for "the prevention, treatment and control of epidemic, endemic … and other diseases", for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" and to ensure that these rights are respected, protected and fulfilled without discrimination.[177]

States have also a responsibility to address the gender and age-based dimensions of the HIV and AIDS epidemic.[178] They must integrate a gender perspective into efforts to combat HIV and AIDS and ensure that women must participate in developing programmes to prevent the spread of HIV.[179] Central to this approach is the development of strategies that promote the advancement of women and women's full enjoyment of human rights, including their right to have control over their health and sexuality and to decide freely and responsibly on those matters so that they can protect themselves from HIV infection. This approach involves providing health-care services, including for

175 Ibid

176 UN General Assembly, Declaration of Commitment on HIV/AIDS, A/RES/S-26/2, 2 August 2001, in particular paras. 58–67.

177 Ibid

178 Ibid

179 Ibid

sexual and reproductive health, that promote gender equality within a culturally and gender-sensitive framework. HIV and AIDS awareness, prevention, care and treatment must be incorporated into programmes and actions that respond to emergency situations.

Generally, states in cooperation with UNHCR have a responsibility to ensure that HIV and AIDS gender-sensitive programs are made available together with national programmes in situations of displacement.

2.1.4. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

It is widely recognized that forced displacement, conflict and human rights violations have a significant negative impact on the mental health of those affected. Displaced persons often suffer from anxiety, depression, and post-traumatic stress disorders after experiencing the traumas of seeing family members and neighbors die or seeing their homes and villages destroyed.[180] Further to this, sexual violence, either when used as a strategy of war or in its aftermath, has severe psychological effects on women and girls.[181] If this left untreated, the psychological scars can destroy a woman's or girl's quality of life.

Mental health and psychosocial support are defined as a composite term to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.[182] Although the terms mental health and psychosocial support are closely related and overlap, they reflect different, but complementary, approaches. Aid agencies outside the health sector tend to speak of supporting psychosocial well-being while health sector agencies tend to speak of mental health or psychosocial rehabilitation and psychosocial treatment to describe non-biological interventions for people with mental disorders.[183]

Action to enhance mental health and psychosocial support may involve interventions to provide support, counselling and healthcare to individual survivors. It can also include working with communities to discern their own coping mechanisms, help rebuild them and support them, thereby strengthen the confidence and trust of community members.[184]

There are challenges in protecting women and girls subjected to SGBV and other trauma as they often do not come forward to ask for psychosocial support. They may not know it exists, may fear ostracism stigmatization, fear retaliation by perpetrators against them or

180 Supra note 13

181 Ibid

182 IASC, Inter Agency Standing Committee, Guidelines on Mental Health and Psychosocial Support in Emergency Settings, June 2007, p. 1, at http://www.humanitarianinfo.org (accessed on November 2010)

183 Ibid

184 Ibid

other family members, feel helpless, be suspicious of authority, have experienced insensitivity and egoistic motives on the part of individuals persuading disclosure, and/or may not feel able to speak to a stranger when such issues have traditionally been resolved within the family.[185] Such women and girls may refuse therapeutic treatment for trauma, even though they may seek medical help for physical ailments, including forced pregnancy.[186] Their social and cultural background can frustrate participation in psychosocial programmes.[187]

Women and girls have the right to psychosocial support as part of their right to the highest attainable standard of physical and mental health. Mental health and psychosocial support requires various levels of interventions involving broad programmes to provide basic services and security issues, community and family support interventions increasingly focused non-specialized support and specialized mental health services.[188]

States have a responsibility to ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, including women refugees.[189] Psychosocial support must be made available from the beginning of an emergency. Early and adequate mental health responses during a humanitarian emergency limit the impact of these events and help those affected to cope and speed their return to normal functioning.[190]

All humanitarian actors are expected to contribute to non-specialized responses and to ensure that coordinated referral and response mechanisms are put in place when a more specialized intervention is required.[191] Coordination among actors is therefore crucial to ensure broad and effective prevention and response mechanisms. UNHCR, therefore, has a responsibility to support the provision of adequate and culturally appropriate

185 Ibid

186 Ibid

187 Ibid

188 Ibid

189 Supra Note 17, papa. 16.

190 Ibid

191 Ibid

psychosocial care for women and girls. This includes provision of appropriate psychosocial care and services to survivors of violence and of different forms of exploitation and abuse.

CHAPTER THREE: THE SEXUAL REPRODUCTION AND REPRODUCTIVE HEALTH LIFE OF REFUGEE WOMEN IN ETHIOPIA: CHALLENGS AND PROSPECTS

3.1. THE CASE OF SOMALI, ERITREAN, SUDANESE AND URBAN REFUGEES IN ETHIOPIA

Ethiopia hosts refugees from morethan 9 countries including Somalia, Eritrea, Sudan, Kenya, Democratic Republic of Congo, Burundi, Djibouti, Ruwanda, Uganda, etc.[192] As indicated in the introduction, the main causes for the displacement of these refugees are insecurity, political instability, escalating conflicts and persecution.

It is also indicated that, as of 30 November 2010, there are about 150,177 refugees in Ethiopia. out of the total population of refugees in the country, almost half, 72,219, are women, making 48.09%. More than half of these women refugees, about 42, 301 are girl children below the age of 18.[193]

Refugees in Ethiopia mainly reside in camps established close to borders, near the refugees' country of origin. The camps are grouped in to three based on their location in the country, western, eastern and northern camps; Sudanese refugees in the west, Somali and Eritrean in the east and north, respectively. Others mainly live in Addis Ababa. As a result the refugees in the country are grouped in to three, Somali, Eritrean and Sudanese refugees. Each group resides in more than one camp; the biggest with about 20,000 populations and the smallest with nearly 3,000 populations. [194]

The sexual reproduction and reproductive health of these refugees is full of difficulties. For instance, these refugees live in a country where, among other things:

192 Source: UNHCR Representation in Ethiopia, Addis Ababa, Information Section (November 2010)

193 Ibid.

194 Ibid.

> *less than 1 percent of mothers received antenatal care from trained and untrained traditional birth attendants; more than seven in ten mothers did not receive antenatal care; one in every 13 Ethiopian children dies before reaching age one, while one in every eight does not survive to the fifth birthday; infant mortality is 77 deaths per 1,000 live births.*[195]

These figures are generally less than the average even in Sub-Saharan Countries and it is also reported that:

> *The country [Ethiopia] of 77 million has only around 200 gynecologists. The government is trying to address the gap recruiting a large number of "health extension workers," but even they can't provide all the necessary services to the 15% of women who experience complications due to pregnancy or birth.*[196]

These situations coupled with difficulties that exist in situations of displacement pose challenges in enforcing the reproductive rights of refugees in the country. For example UNHCR report that among refugees,

> *Only 10 per cent of births in Ethiopia are attended by skilled health workers. In addition, alternative safe delivery opportunities such as community midwife services fall short of attaining the goal of safe delivery practices overall. It is reported that the lack of qualified midwives, ill-equipped delivery rooms, and cultural beliefs often prevent deliveries from taking place in health centers. It is also indicated that reporting is problematic for highly sensitive and stigmatized issues like sexual violence. In general, it is reported that reproductive health priorities like family planning and sexual and gender based violence suffer from lack of data availability and inconsistent reporting.*[197]

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195 Ethiopian Central Statistical Agency Survey, 2006

196 see http://genderacrossborders.com (accessed November 2010)

197 UNHCR Statistical Year Book, 2006

To address these and other problems of refugees, ARRA, UNHCR and its partner organizations are working jointly with refugees in Ethiopia.

In the enforcement of reproductive rights, while all the three groups of refugees share similar problems in most cases, like economical and legal challenges, they also have different problems as the challenges are very intricate involving not only diseases but also other components of life surrounded by cultural, social, ethical and religious considerations, which obviously differ from society to society. For these reasons, the three groups of refugees are examined separately below to effectively understand the cultural, social, ethical and religious challenges in each society. Below, only one camp from each group is examined for the reasons discussed in the introductory part.

3.1.1. SOMALI REFUGEES: *SHEDER* REFUGEE CAMP

At shedder refugee camp, there are 10,332 refugees, of which more than half are female.[198] While the camp is, occupied by Somali refugees with same religion and culture, there are about 8 Somali clans including Hawiye, the majority, Darod, Shekhal, Ashraf, Dir, Bantu, Rahan-Weyn and Midgan/Gaboye.[199]

ARRA in collaboration with UNHCR and its implementing partners, Rehabilitation and Development Organization (RaDO), International Refugee Committee (IRC), World Food Organization (WFP), Ethiopian Orthodox Church Development & Inter-Church Aid Commission (DICAC), Lutheran World Federation (LWF), Save the Environment (SeE), Mother and Child Development Organization (MCDO) and Danish Refugee Council (DRC) provide protection and assistance to these refugees.[200]

ARRA, RaDO to some extent, and IRC are involved in health care, reproductive health services and HIV/AIDS prevention and response.[201]

A. Access to Appropriate Health-Care Services

The camp has one health center run by ARRA. The health center has one doctor, 6 clinical nurses, 2 public health officers, 1 laboratory technician, three midwives, 2 druggists, 2 nutritionists, 1 sanitarian and 20 health social workers (social workers are incentive workers, not employees, selected from the refugee community).[202] It is reported that the health centre is accessible to all the refugee community free of charge and on a basis of equality of men and women irrespective of their race, religion, political opinion or gender.

198 Supra note 1

199 Ibid.

200 Interview with Ato Dereje Wubeshet, Program Officer, UNHCR Sub-Office Jijiga

201 Ibid.

202 Interview with Dr. Chala, Sheder Refugee Camp ARRA Health Centre, Statistics in this part covers the period of 1st January-30 November 2010. Social Workers are individuals with some skill or knowledge who provide services to the community for free. Due to the country's reservation on wage earning employment, refugees can not work in Ethiopia unless they meet the conditions expressed in the country law, see chapter one for more on this. UNHCR and its IPs, however, assist the social workers giving 300-400 birr/month as incentive.

At the health centre, health care services, including Mother and Child Health (MCH), Family Planning (FP), HIV and AIDS prevention and response and mental health and psycho-social counselling are provided.[203]

In the camp there are 491 pregnant and lactating women in the period under report.[204] On MCH, antenatal care (ANC) and postnatal care (PNC), immunization (EPI), Prevention of Mother to Child Transmission (PMTCT), Infant and Young Child Feeding (IYCF), syphilis testing, De-worming, and delivery services are provided.[205]

Information collected shows that family planning services provision includes Combined Oral Contraceptive (COCs), inject able contraceptive, Progestin Only Pills (POPs), Intra Uterine Devices (IUDs), provision of Emergency Contraception Pills (ECP), Post Exposure Pills (PEP) and abortion care (in accordance with the host country law where the pregnancy endangers the life of the woman or it is a result of rape and if the women requires it).

In addition to the health services provided at the camp patients with complicated health problems beyond the capacities of the clinic are often referred to higher health institutions in the host country for further treatment.[206] Refugees are also referred for resettlement to a 3rd country, but it takes one or more years to resettle them, on medical grounds, if a certain health problem, inter alia, is not treatable in the host country.[207] However, resettlement opportunity is very limited. For instance, 15 children who suffer with hydrocephalus referred for resettlement two years ago have not yet resettled though three of them died in the camp.[208] It is reported that their resettlement case is under process still. UNHCR policy is that the resettlement should be done in two weeks time if the medical case is classified as urgent by medical doctors.[209]

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203 Ibid.

204 Source: UNHCR, Sheder Refugee Camp Data Base (October 2010)

205 Supra Note 11

206 Ibid.

207 Interview with Senait Kebede, Senior Protection Assistant, UNHCR Sheder Refugee Camp

208 Ibid.

209 UNHCR Resettlement Handbook, Department of International Protection, 2004, p.10

Similarly, mental health support is also provided at the health centre to the extent of its capacities.[210] While patients are usually referred to a higher health institution for further treatment, where necessary, if the number of persons with mental health problem is high in the camp, specialist will be invited to treat them at the camp level.[211] RaDO also provides health care services to refugees with disability inviting specialists for eye, nose and throat patients.[212]

In addition, it is reported that health educations on IYCF, immunization (EPI), Hygiene and sanitation, mother and child health, family planning, nutrition, communicable diseases, diarrhea, etc are provided by the health centre staffs and the social workers, three times a week, through house to house visits, at the health centre-at the reception and mass awareness raising campaigns-at public gathering places and group discussion.

Patients in need of treatment at higher health institutions are not transferred with in a reasonable period of time due to shortage and some times delay of budget. In the camp there are about 1493 individuals with serious medical conditions of which female are 952 and male 541.[213] Most of these patients need treatment beyond the camp health centre. However, due to budgetary reasons, they have never been referred to a higher health institution, though some have been treated at Karamara Hospital in Jijiga town which further refer them to Addis Ababa. However, they have been waiting for a year or more to go to Addis Ababa.[214] Rather than need, quota is often used as a ground for patients transfer, as other camps also refer patients for further treatment. The camp is allowed only to transfer to a higher health institution 120 patients per year while practically 4-5 or less patients are transferred with in a month for budgetary reasons.[215]

210 Supra Note 11

211 Ibid.

212 Interview with Ato Samuel, Program Coordinator, RaDO Sheder Refugee Camp

213 Supra Note 13

214 Supra Note 11

215 Ibid.

B. Reproductive Health

IRC provides reproductive health services in the camp. It has one reproductive health centre run by one reproductive health officer and 20 social workers.[216] Information collected shows that services provided include reproductive health education and awareness raising activities on family planning, safe motherhood, prevention of unsafe abortion, education on prevention of Sexually Transmitted Infections (STIs), harmful practices, quarterly sanitary napkin and other sanitary material provisions-for women refugees between the ages 13-49. The organization provides services through house to house visits and at public gatherings.

The information from this camp shows that religious and social factors greatly affect the provision of reproductive health services in this refugee community. The community is not prone using family planning services, because of their religious values; all the refugees are *Muslims*.[217] Rather than controlling the number and spacing of children, they prefer to have more children, up to 10 or more, though they have low economic status and the mothers face related health risks. Interview done with 3 mothers, who have 9 children each, show that they believe terminating or preventing pregnancy is forbidden, *haram*, by Islamic law.

The family planning services and education provided also face challenges of social values. While a woman with many children is respected and admired by the society, she may face divorce if she is unable to have any children or the husband would marry another one, up to four, if his wife is unable to give birth to more than three children.[218] Interview done with four fathers, who have more than 11 children and two wives each, reaffirms the above statement. While their reason to remarry is grounded on religious grounds, their reasons for having many children are mixed with both religious and social values. They say "children are gifts of GOD, *Allah*, and anyone should not interfere in his work by preventing or terminating pregnancy". However, they also confess that they

216 Interview with Asia Abdullahi, Reproductive Health Officer, IRC Sheder Camp

217 Ibíd.

218 Ibid.

want more children because a man who has many children is feared and respected by the society.

These all shows that there is lack of awareness on family planning among the entire community requiring a lot to do in the area of awareness creation.

On SGBV, ARRA, UNHCR and IRC collaboratively provide psycho-social, medical and legal counselling. ARRA and UNHCR provide legal counselling and follow up on legal remedies.[219] ARRA, the health centre also provides medical services while IRC do the psychosocial support.[220] These agencies have Standard Operating Procedures (SOP) for SGBV referrals. They have a coordination meeting once every month.[221] If SGBV incident is reported to one of these agencies, the victim will be referred to the other agencies for a coordinated services provisions, where the victim's consent is secured.[222]

Service is provided either when a victim/survivor or any other person, depending on the type of SGBV, report to any of the agencies.[223] At the health centre, rape survivors are provided with ECP within 120 hrs, PEP within 72hrs and STI presumptive treatment in less than 2 weeks.[224] On the psycho-social counselling, IRC has two officers for response to and prevention from SGBV and 21 social workers.[225] While the response to SGBV officer provides psych-social counselling to victims/survivors and the social workers do the follow up, the prevention from SGBV officer together with the social workers works on awareness creation.[226]

Information gathered shows that female genital mutilation (FGM) is prevalent in this refugee community. The practice involves circumcision and infibulations.[227] Usually

219 Sheder Refugee Camp, Inter-Agency GBV SOP

220 Ibid.

221 Ibid.

222 Ibid.

223 Supra note 17

224 Supra note 11

225 Supra note 26

226 Ibid.

227 Infra note 43

FGM is done to children between the ages of 6-9, secretly.[228] While it is generally believed that the practice of infibulations is not undergoing in the camp any more and circumcision is diminishing, there is no means to prove this as there is no assessment made on this. However, 7 girls, between the ages 13-15, were interviewed and they report that they are circumcised, though not infibulated. While only 2 say they are circumcised in the camp, 2 years before, the others report that they are circumcised before flight 5 or more years before. Interview with 3 mothers show that, FGM, particularly the *Suna* type, cutting only small part of the clitoris is required in the *Koran*.

Incidents of domestic violence, rape and early marriage, to some extent, are also the other types of SGBV incidents that happen in the camp.[229] Causes of SGBV in the camp are social and religious values. While gender inequality, the community believes that men are superior to women, causes domestic violence, early marriage and rape, religious values highly influence the practice of FGM.[230] However, as discussed in chapter two, FGM also reinforces the subordination of girls and women in the communities.

There are police at the camp and 17 community police/watchmen, called '*shurtas*'.[231] Usually perpetrators will be arrested at the beginning once reported. However, there is delay in collecting evidence and most cases fail to reach to court at the hands of the police for reasons of luck of evidence.[232] In addition, there is lack of awareness among the law enforcement bodies in considering domestic violence, attempt rape, early marriage and FGM as crimes because, in addition to lack of legal knowledge, the host community has the same culture, social values, language and religion with the refugees and share the social and religious values of the refugees.[233]

228 Ibid.

229 Infra note 17

230 Ibid.

231 Interview with Ato Abdirahman Farah, UNHCR Senior Comminity Services Assistant, Sheder Refugee Camp

232 Supra Note 17

233 Ibid.

In the camp, there are about 491 unaccompanied and separated children, female 269 and male 222.[234] Under age children are also significantly reported to be both victims and perpetrators of rape.[235] Police, however, has never taken child perpetrators to courts, though they detain them for few days at the police station, on the ground that they are generally irresponsible for criminal liability.[236] Information collected shows that such child perpetrators are usually detained, some times for weeks, with adults as the police stations usually do not have sufficient rooms to separate the children.

In the period under discussion, 23 domestic violence and 27 rape incidents, of which 11 cases involves children as victim or perpetrator, were reported.[237] However, no case has reached to the courts and a single perpetrator has not been punished. [238] Perpetrators are usually arrested by police immediately after the incident is reported but will be released unpunished on the ground of luck of sufficient evidence.[239]

While domestic violence and rape are condemned by the community, cases remain unreported in most cases as the community often prefers to avail the traditional justice system.[240] Once the victim, in most cases her family or her clan, is given monetary compensation through the traditional justice system, she will not report the violence to the police or she will deny that the violence has happened or refuse to cooperate with the police in providing testimony, even if she had reported before she avails the traditional justice system.[241] In addition, incidents of rape remain unreported for fear of social discrimination by the society. All 5 sexual violence survivors, between the ages 13-15, report that they face discrimination by the society, including women of their age and even by their family. If the woman has a child out of sexual violence or out of marriage, the child will also face the discrimination. [242]

234 Supra Note 13

235 Ibid.

236 Ibid.

237 Supra Note 43

238 Supra Note 13

239 Ibid.

240 Supra Note 26

241 Supra note 43

242 Ibid.

Though services are provided in a confidential manner, victims of rape often do not report fearing that the information may reach the community.[243] UNHCR protect women known by the community as a victim of rape by referring for resettlement to a 3rd country and/or relocating to Addis Ababa.[244]

Regarding early marriage, parents usually do not give children for marriage but in some cases with a view to avoid pregnancy with out marriage, where they believe that the girl child is involved in some love affair, fearing the social discrimination the girl child may face, parents arrange children's marriage.[245] While most of such marriages remain unreported, 7 early marriages were prevented from conclusions in the year 2010.[246] However, it is a challenge in the camp, as in most cases it is not reported and children also conclude marriage secretly even with out their parents' knowledge. A simple marriage pronouncement by a person with religious background in the presence of two witnesses is sufficient to conclude a marriage in the community.[247]

C. HIV/AIDS Prevention and Response

ARRA, the health centre, and IRC jointly work on HIV/AIDS Prevention and Response. There are one HIV/AIDS coordinator and 15 social workers providing HIV/AIDS Prevention and Response services.[248]

It is reported that the health centre provides VCT, PMTCT, PICT, ART and care and support services. IRC, on the other hand, work on prevention through awareness creation on HIV and AIDS at the community level through coffee ceremonies, etc and community based condom distribution through condom outlets in the camp-health centre, retail shops, café etc. there is also a monthly HIV and AIDS coordination meeting among the IPs involved in the related service provision.

243 Ibid.

244 Supra note 13

245 Supra note 43

246 Ibíd.

247 Ibíd.

248 Interview with Ato Geneti Erana, HIV and AID Coordinator, ARRA Sheder Refugee Camp

Social, cultural and religious factors mainly challenge the services in the HIV and AIDS Prevention and Response. The information collected shows that the community has a very law rate of condoms usage. This is due to the religious belief that preventing pregnancy is against Islamic religion. Cultural values also hinder free mass communication and discussion on HIV and AIDS, as the community considers such educations are for persons who do adultery.[249] It is also reported that fear of stigma and discrimination results in high level of unwillingness of People Leaving with HIV and AIDS (PLWHA) disclosure. There is also lack of interest and awareness among the community on HIV and AIDS prevention and response. Generally, strong social, religious and cultural values highly affect the HIV and AIDS prevention and response services provision in the camp.

249 Ibid.

3.1.2. ERITREAN REFUGEES: *MAI-AINI* REFUGEE CAMP

There are 11, 971 refugees in *Mai-Aini* camp, of which female refugees are 3, 448 while the rest 8,523 are male. [250] In the camp, there are different ethnicities including *Afar, Belin, Sahow, Tigre* and *Tigrinya*.[251]

The government's Authority on Refugees and Returnee Affairs, ARRA, in collaboration with UNHCR and its implementing partners, Jesuits Refugee Services (JRS) and the International Refugee Committee (IRC) provide protection and assistance to these refugees.[252] ARRA and IRC are specifically involved in health care services, reproductive health services and HIV and AIDS prevention and response.

A. Access to Appropriate Health-Care Services

The camp has one health center run by ARRA. The health center has one doctor, 12 nurses, 1 laboratory technicians and 21 social workers.[253] The health centre is accessible to all the refugee community free of charge and on a basis of equality of men and women irrespective of their race, religion, political opinion or gender.

At the health centre, health services, including MCH and FP are provided.[254] On MCH, ANC and PNC, EPI, PMTCT, syphilis testing and delivery services are provided.[255] Family planning includes COCs, inject able contraceptive, POPs, IUDs, provision of emergency contraception pills ECP, PEP and abortion care (in accordance with the host country law where the pregnancy endangers the life of the woman or it is a result of rape).[256]

250 Supra Note 1

251 Ibid.

252 Interview with Ato Kefelegn Ketybelu, Senior Program Assistant, UNHCR Sub-Office Shire

253 Interview with Dr. Fekadu Abdisa, ARRA Health Centre, Mai-Aini Refugee Camp

254 Ibid.

255 Ibid.

256 Ibid.

There has not been any abortion case but about 17 sexual violence/rape victims have been provided with PEP and ART.[257] Abortion cases do not exist as mothers are provided with antenatal and postnatal care and rape victims with PEP.[258] The information collected shows that all deliveries in the camp were attended.

The health services provided are similar to *Sheder* Camp. Refugee patients with complicated health problems beyond the capacities of the clinic are often referred to higher health institutions in the host country for further treatment.[259] Refugees are also referred for resettlement to a 3rd country on medical grounds if a certain health problem is not treatable in the host country.[260]

Mental health support is also provided at the health centre. While patients are usually referred to a higher health institution for further treatment, where necessary, some times specialist will be invited to treat them at the camp level.[261]

In addition, health educations on IYCF, EPI, hygiene and sanitation, mother and child health, family planning, nutrition, communicable diseases, diarrhea, etc are provided by the health centre staffs and the social workers through house to house visits, at the health centre-at the reception and mass awareness raising campaigns-at public gathering places, group discussion, etc.[262]

Similar to *Sheder* camp, the health centre mainly faces budgetary challenges in providing its services. There are 756 refugees with serious medical problem in the camp.[263] These patients need treatment at higher health institutions but are not being transferred with in a

257 Ibid; the data in this part covers the periods of 1st January- 30 November 2010

258 Ibid.

259 Ibid.

260 Interview with Ato Melaku Gutema, Senior Protection Assistant, UNHCR Mai-Aini Refugee Camp

261 Supra Note 82

262 Ibid.

263 Source: UNHCR MaiAini Refugee Camp Data Base

reasonable period of time. The reason is shortage and delay of budget.[264] Similar to *Sheder* camp, quota is often used as a ground for patients transfer.[265]

B. Reproductive Health

IRC is the leading agency on reproductive health services provision in the camp. According to the information gathered, it has one reproductive health centre run by one reproductive health officer and 23 social workers. The organization provides home based family planning services provision and awareness raising activities on: family planning, safe motherhood, prevention of unsafe abortion, education on prevention of Sexually Transmitted Infections (STIs), harmful practices, etc. and sanitary napkin and other sanitary material provision-for women refugees between the ages 13-49.[266]

Education on family planning is given by social workers during house to house visits, at reproductive health center, at the HIV and AIDS VCT centre and at the sanitary napkin distribution cites.[267]

The information collected shows that economic, religious and social factors greatly affect the provision of reproductive health services in this refugee community. Due to religious values, the *Sahow* community, for example, majority of them are Muslims, are not prone using family planning services.[268] Majority of the refugees are at reproductive age and there is high sexual behavior resulting in unwanted pregnancies. This is caused by, in most cases, girl's economical dependence to engage in unprotected sex.[269] Generally, the information collected shows lack of awareness on family planning among the entire community.

On SGBV, ARRA, UNHCR and IRC collaboratively provide services. The available services are psycho-social, medical, safe house provision and legal remedies. ARRA and

264 Supra note 82

265 Ibid.

266 Interview with Wrt. Mesert Bijiga, Reproductive Health Officer, IRC, Mai-Aini Refugee Camp

267 Ibid.

268 Ibid.

269 Ibid.

UNHCR provide legal counselling and follow up on legal remedies. ARRA, the health centre, as stated above, provide medical services while IRC do the psychosocial support.[270] There is a referral path way among the agencies to provide a victim or survivor all the services.

At the health centre, rape survivors are provided with ECP within 120 hrs, PEP within 72hrs and STI presumptive RX in less than 2 weeks.[271] On the psycho-social counselling, IRC has two officers for response to and prevention from SGBV and 21 social workers.[272] While the response to SGBV officer provides psych-social counselling to victims/survivors, the prevention from SGBV officer works on awareness creation together with the social workers.[273]

Service is provided either when a victim/survivor or any other person, depending on the type of SGBV, report to any of the agencies.[274]

Information collected shows that domestic violence, sexual exploitation and abuse and rape are among the prevalent SGBV types in the camp. Causes of SGBV in the camp includes gender inequality, the community believes that men are superior to women, the significantly high number of men than women in the camp, lower economic conditions of women and absence of light in the camp at night.[275]

According to information collected, there are police at the camp and 15 community police/watch men. Usually perpetrators will be arrested in the beginning once reported. However, there is delay in collecting evidence and most cases fail to reach to court, at the hands of the police for reasons of luck of evidence.[276] In addition, there is lack of

270 Mai-Aini Refugee Camp, Inter- Agency GBV SOP

271 Supra Note 62

272 Ibid.

273 Ibid.

274 Interview with Ato Arikew Gashaw, Community Services Associate, UNHCR, Mai-Aini Camp

275 Ibid.

276 Supra Note 76

awareness among the law enforcement bodies in considering domestic violence as a serious crime.[277]

C. HIV/AIDS Prevention and Response

ARRA, the health centre, and IRC jointly work on HIV and AIDS Prevention and Response. There are one HIV and AIDS officer and 23 social workers providing HIV/AIDS Prevention and Response services.[278]

Services are provided at the facility and community level. The information collected shows that at the health centre, VCT, PMTCT, PICT, ART and care and support services are provided. It is also reported that IRC is working on prevention through awareness creation on HIV and AIDS at the community level and community based condom distribution through condom outlets in the camp-health centre, retail shops, bars, café etc.

Social and economical factors mainly challenge the services in the HIV and AIDS Prevention and Response. As pointed above, majority of the refugees are at reproductive age and due to economical dependence girls engage in unsafe sexual activity at early age. Further, due to fear of stigma and discrimination, there is high level of unwillingness of PLWHA disclosure.[279] There is also luck of awareness among the community on HIV and AIDS and its prevention and response.[280]

277 Ibid.

278 Interview with Ato, Zerihun Bogale, HIV and AIDS Coordinator, ARRA Mai-Aini Refugee Camp

279 Ibid.

280 Ibid.

3.1.3. SUDANESE REFUGEES: *SHERKOLE* REFUGEE CAMP

In *Sherkole* refugee camp, there are 3, 671 refugees, of which 1, 487 are female and the rest 2,184 are male.[281] ARRA and UNHCR with its implementing partners RaDO, IRC, WFP and Natural Resources Development and Environmental Protection (NRDEP), work closely with the refugees proving protection and assistance.[282] While ARRA provides health care services, RaDO to some extent, IRC work on reproductive health services and HIV/AIDS prevention and response.

A. Access to Appropriate Health-Care Services

The camp has one health center run by ARRA. The health center has one doctor, 9 nurses, 3 community midwives, 1 laboratory technician, TBA and CHA and 15 social workers.[283] The health centre is accessible to all the refugee community free of charge and on a basis of equality of men and women irrespective of their race, religion, political opinion or gender.

The health centre provides, similar to the other camps, medical services, including MCH, ANC and PNC, EPI, PMTCT, syphilis testing and delivery. On FP, COCs, inject able contraceptive, POPs, IUDs, ECP, PEP, and abortion care (in accordance with the host country law where the pregnancy endangers the life of the woman or it is a result of rape) are provided.[284]

It is reported that in the past, women used to give birth at their houses without midwives attendance. But through awareness creation this is not the case at this time and awareness is far better than it used to be and unattended birth is not reported.[285] While abortion is

281 Supra Note 1

282 Infra note 96

283 Interview with Dr. Mulugeta Abera, ARRA Health Center Sherkole Refugee Camp

284 Ibid.

285 Ibid; The information in this part shows the situation in the camp between the periods of 1st January- 30 July 2010.

provided when it is evident that the health of the mother is in danger or the pregnancy is caused by rape, illegal abortion out of the camp is a challenge.[286]

It is reported that in addition to the camp health centre, RaDO some times provides treatments for people with disability, particularly those with sights and hearing impairment, inviting specialist to the camp. Further, medical service is provided to refugees through referral to higher health institution and resettlement to a 3rd country where the medical problem is not treatable in the country.[287] Information shows that mental health support is also provided at the health centre similar to other camps.

It is also reported that health educations and teaching methods are similar to other camps. on IYCF, EPI, hygiene and sanitation, mother and child health, family planning, nutrition, communicable diseases, diarrhea, etc are also provided by the health centre staffs and the social workers through house to house visits, at the health centre-at the reception and mass awareness raising campaigns-at public gathering places, group discussion, etc.

Similar to the other camps, the health centre mainly faces budgetary challenges in providing its services. There are about 175 patients with serious medical problems waiting for transfer in the camp.[288] Patients in need of treatment at higher health institutions are not transferred with in a reasonable period of time for budgetary reasons and quota is used as a ground for patients transfer.[289]

B. Reproductive Health

IRC is again the leading agency on reproductive health services provision in the camp. According to the information gathered, it has one reproductive health centre run by one reproductive health officer and 17 social workers. The organization provides home based family planning services provision and awareness raising activities on: family planning,

286 Ibid.

287 Interview with Ato Mohamed Tahir, Assistant Protection Officer, UNHCR Sherkole Refugee Camp

288 Supra Note 99

289 Ibid.

safe motherhood, prevention of unsafe abortion, education on prevention of Sexually Transmitted Infections (STIs), harmful practices, etc. and sanitary napkin and other sanitary material provision-for women refugees between the ages 13-49, similar to other camps.[290]

It is reported that education on family planning is given by social workers during house to house visits, at reproductive health center, at the HIV and AIDS VCT centre and at the sanitary napkin distribution cites.

According to the information collected, religious and cultural factors greatly affect the provision of reproductive health services in this refugee community as well. Due to religious values, the community is not prone using family planning services.

On SGBV, ARRA, UNHCR and IRC collaboratively provide services.[291] It is reported that the available services are psycho-social, medical safe house for victims, open 24 hours and legal remedies. ARRA and UNHCR provide legal counselling and follow up on legal remedies.[292] ARRA, at the health centre provide medical services while IRC do the psychosocial support.[293]

Similar to other camps, the health centre provides rape survivors ECP within 120 hrs, PEP within 72hrs and STI presumptive treatment in less than 2 weeks.[294] It is reported that on the psycho-social counselling, IRC has two officers for response to and prevention from SGBV and 13 social workers.

Information show that rape, domestic violence and early marriage are among the prevalent SGBV types in the camp. There are about 17 SGBV cases under follow up

290 Interview with Ato Gebeyehu Hailu, Reproductive Health Officer, IRC Sherkole Refugee Camp

291 Sherkole Refugee Camp, Inter-Agency GBV SOP

292 Ibid.

293 Ibid.

294 Supra Note 99

between the months of April- July 2010.[295] Causes of SGBV in the camp include a combination of social, legal, cultural, economic, religious, etc factors. For example, there is unequal power sharing between women and men; women are considered as an asset for her family.[296] It is reported that it is taboo for a woman to be seen in public and they are required to remain at home. Parents have power over their daughters to give them away for any one whom they want her to marry in order to get dowry in return.

Cases are under reported. Interview with rape survivors show that it is difficult for a woman to report when raped as she will be outcaste by the community and will not get married once she reports that she is raped.

Victims of SGBV often face fistula and other related health problems. In the period under discussion, about 27 girls have been relocated to Addis Ababa for fistula treatment.[297] A number of SGBV victims and survivor women are also referred for resettlement to avoid discrimination by the society.[298] Though there are police at the camp, a single perpetrator has not get trial before court of law and punished, mainly due to luck of evidences. [299]

C. HIV/AIDS Prevention and Response

ARRA, the health centre, and IRC jointly work on HIV/AIDS Prevention and Response. It is reported that there are one HIV and AIDS officer and 31 social workers providing HIV and AIDS Prevention and Response services.

Services are provided at the facility and community level. At the health centre, VCT, PMTCT, PICT, ART and care and support services are provided. IRC, on the other hand, work on prevention through awareness creation on HIV and AIDS at the community

295 Supra Note 103

296 Interview with Workwuha Midekessa, GBV Officer Sherkole Refugee Camp

297 Supra note 99

298 Supra note 103

299 Ibid.

level and community based condom distribution through condom outlets in the camp-health centre, retail shops, etc.[300]

There are a lot of individuals infected with HIV and AIDS in the camp who have not disclosed themselves fearing stigma and discrimination.[301] Sexual violence is prevalent in the camp, as shown above, and is one of the causes for the increase of HIV and AIDS transmission in the camp, as in most cases victims do not report and get ART.[302]

300 Interview with Ato, Eshetu Gebre, HIV and AIDS Coordinator, ARRA Sherkole Refugee Camp

301 Ibid.

302 Ibid.

3.1.4. URBAN REFUGEES: ADDIS ABABA TOWN

The 1951 refugee convention recognizes refugees' freedom of movement in a host country.[303] However, Ethiopia has reservation on this right.[304] Refugees in Ethiopia are primarily required to live in camps which are established close to borders, as discussed above. However, the government allows urban settlement for medical needs and other grounds. The only urban program in the country is at Addis Ababa. But the government has also recently introduced a so called 'out-of-camp' scheme for Eritrean refugees. This new policy essentially allows Eritrean refugees to live outside camps and in any part of the country, provided that they are able to sustain themselves financially or have a close or distant relative or a friend in Ethiopia who commits to supporting them.[305]

As a result, there are about 2,257 urban refugees residing in Addis Ababa town; female 932 and male 1,325.[306] As indicated in the first part of this chapter, these refugees are from more than nine countries including Somali, Eritrean, Sudanese, (the largest in number even in Addis Ababa), Democratic Republic of Congo, Burundi, Djibouti, Rwanda, Uganda, and Kenya.[307]

ARRA, UNHCR, DICAC (Ethiopian Orthodox Church Development & Inter-church Aid Commission) and JRS provide protection and assistance to these refugees. While primary health care and psycho social counseling is provided by DICAC, social counseling is provided by JRS. At times, emergency medical assistance is provided by ARRA and JRS.

A. Access to Appropriate Health-Care Services

It is reported that DICAC has a working arrangement with different health centers, one of which being *Megbare Senay* Clinic. For patients who need further referral, they are referred to a number of hospitals in Addis Ababa.[308] Information shows that there are two clinical nurses and one medical doctor employed by DICAC. These nurses also work as

303 1951 Refugee Convention, article 26

304 Federal Repub;ic of Ethiopia Refugee Proclamation, 2004, article 21(2)

305 Refugee News, UNHCR Representation in Ethiopia, New Approach to Hosting Refugees in Ethiopia, July 2010, VI, No. III

306 Supra note 1

307 Ibid.

308 Interview with Ato Girma Yadeta, Community Services Associate, UNHCR Addis Ababa

counselor including in the SGBV programs. There are also two counselors, one being a trained psychologist and the other is a psychiatrist.

In addition, refugees who are solely referred to Addis by ARRA health centers from the camps, ARRA provides medical assistance through its working arrangement with a number of health care facilities in the town. [309]

It is also reported that services provided include medical services, maternal health care prevention and response to HIV and AIDS.

B. Reproductive Health

DICAC and UNHCR provide reproductive health care services. There are five social workers and one officer. The staffs are degree holder in sociology and psychology and some are nurses.

Information gathered shows that services provided include maternal health care, education on family planning STD, prevention and response to HIV and AIDS and prevention and response to SGBV. Services are provided through continues concealing and health services.

Provisions of services are challenged by lack of awareness among the refugee community.[310] Compared to services available at the camps, there is less number of health services that dealt with reproductive health issues. Further, for religious and social values, majority of the refugees resist on accepting family planning methods.[311] In addition, information show that the leading agency on reproductive health services in the urban program, DICAC, is a church based organization and do not advocate family planning at all. Issues like abortion are not entertained openly and exceptionally, through the opening of the law, few cases are done regards to abortion in secret.

309 Ibid.

310 Interview with Helona Asrat, Senior Protection Assistant, UNHCR Addis Ababa

311 Ibid.

For these reasons, generally, reproductive health issues are not being implemented appropriately in the urban program.

On SGBV, it is reported that ARRA, UNHCR, JRS and DICAC jointly provide services. DICAC provides medical and psycho-social services to survivors of SGBV. It has one psychiatrist and one psychologist but it is reported that they don't mainly work on SGBV. There are also 2 clinical nurses who give counseling. However, except the training they get on counseling once in a while, they are not licensed to give counseling.[312]

Survivors also get social counseling from JRS. With a view to provide holistic SGBV programming in the urban program, survivors are given skills training that are at times provided by DICAC and JRS.[313] Information show that services are provided to survivors of SGBV to either self-identified refugees, those referred from UNHCR or finally those who were identified by the refugee committee and were referred for treatment.

It is also reported that challenges in the SGBV program include absence of frequent participatory assessment made in collaboration with UNHCR, lack of means to identify SGBV cases, lack of frequent training to service providers, lack of training on psycho-social counselling, lack of awareness raising about SGBV especially in the Eritrean refugee community and lack of communication with UNHCR and IPs. For instance, there is no information sharing between DICAC and JRS which leads survivors to not receive holistic support on SGBV. On the same note, there is weak information sharing between the IPs and ARRA. This is evident as there is no SOP for prevention and response to SGBV in the urban program among the agencies.

Information gathered shows that the majority of the refugee community in Ethiopia has been exposed to SGBV in different stages of their flight; they have been made victims in their country of origin, at the counties of transit and in Ethiopia, the host country. Given

312 Ibíd.

313 Supra note 117

that SGBV is a sensitive issue from the social, cultural and religious point of view, survivors find it hard to come forward and openly explain the violence.

Particularly, the Eritrean refugees who are benefiting from the out-of-camp scheme are the most disadvantaged and need the greatest support. Even though there is the presumption that they are self-sufficient, in reality, however, they find it hard to deal with SGBV due to their economic disadvantage other than those obstacles already mentioned.[314]

It is reported that rape including marital rape and domestic violence are more prevalent in the urban program. It is mostly due to the social, cultural and economic and health related reasons. Information shows that male refugees who are currently being assisted on the urban program were working and were self-sufficient in their country of origin. However, now, they are forced to live on the assistance they receive. They have also been through a lot of trauma which leaves them with a lot of negative emotions. Culturally as well, most refugees are from a society which represses women. These, therefore, makes the men take out their anger, frustrations and negative emotions on their wives or partners.[315]

ARRA takes the legal follow up. It is reported that once an SGBV incident is reported, the police gets involved to get convict the perpetrator. However, challenges including lack of evidence/witnesses, language barrier, lack of awareness on how to proceed or get a legal service, lack of awareness on the legal service providers about SGBV.

C. HIV/AIDS Prevention and Response

It is reported that DICAC and UNHCR work on HIV and AIDS. One unit leader and five social workers from DICAC and five officers from UNHCR provide services. Services provided includes continues counseling on ART, follow up on HIV positive pregnant women's, special diet supply (Nutrition), sanitary materials supply, other medical support, psychosocial support, etc. Information gathered show that lack of awareness,

314 Ibíd.

315 Ibíd.

tradition (community resistance/denial), stigma and discrimination highly affect the services.

3.2. CHALLENGES AND OPPORTUNITIES

ARRA and UNHCR with its IPs enforce reproductive rights of refugees in Ethiopia. Their effort, however, is challenged by intertwined financial, legal, social, cultural and religious factors. However, there are opportunities on the other hand as well. The legal development at the national and international level and the increase of interest among the international community on women human rights in general and reproductive rights of women in particular are among the opportunities in the enforcement of reproductive rights of refugees.

The challenges the government, UNHCR and the implementing partners are facing in their effort to enforce reproductive rights of refugees in Ethiopia can be generally classified in to three factors. These are financial; legal; and socio-cultural and religious factors.

Financial constraint greatly affects the right to access to the highest attainable standard of health in the refugee context in Ethiopia. As indicated in each part at above, *Sheder*, *Sherkole* and *Mai-Aini* camps combined, there are 2424 refugees with serious medical problems referred for better treatment by the camp doctors before a year or more but these refugees are not yet transferred. Even if some are transferred to the local hospitals, they are further referred to Addis Ababa. In the eastern camps, UNHCR's budget for medical needs of refugees is a total of 50, 000 US Dollars per camp per year.[316] However, the budget allocation is not based in need assessment. As a result, the findings in the research shows that the health centers are facing shortage of budget and patients are waiting transfer with little medical assistance provided at the camp health centers for years.

To ensure refugees right to access to the highest attainable standard of health in Ethiopia, the budget for medical needs of refugees has to base on need assessment and increased. As, discussed at chapter two, the cornerstone of UNHCR's interventions should be that

316 Supra Note 13

reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, it, therefore, should undertake need assessment in each camp and at the urban program. In addition, it should also look for additional funding using the opportunity, indicated in chapter two, the different international conferences, including the ICPD and Beijing Platform for Action, create committing the international community for the implementation of reproductive rights, among other rights, for all human beings, including refugees, irrespective of nationality, race, or other factors.

Moreover, resettlement of persons with medical needs is challenging as resettlement opportunities are limited. UNHCR identify cases with the most serious problems that can only be addressed through resettlement, where, for instance, the health problem is not treatable in the host country. However, in Ethiopia, refugees referred for resettlement to a 3rd country on medical ground wait in the country for a year or more before they resettle, though they should be resettled with in two weeks according to UNHCR policy as discussed above. During this period, despite their right to accessing and enjoying the highest attainable standard of health, they live with little or no medical assistance, as their problem can not be handled with the available health facilities and health personnel in the host country; hence the resettlement referral.

In *Sheder* camp, for example, as indicated above, 15 hydrocephalus patients, all are children, are referred for resettlement two years before on medical grounds but none has resettled so far. Out of these 15 children, 3 have deceased because the treatment they are getting at the camp is not even mitigating their medical problems.

As indicated in chapter two due to the increase of displacement caused by multiple and complex factors, including massive violations of human rights, in to developing countries, which has caused great burdens on those states, the international commitment includes the need to increase developed countries granting resettlement for refugees. UNHCR has the responsibility for ensuring that the protection and immediate material needs of refugees are met effectively and appropriately. Therefore, UNHCR, through

these opportunities, has to ensure that the international community and its international organizations provide financial and other resources and negotiate with developed countries for more resettlement opportunities.

Generally, these financial problems and limited resettlement opportunities common to the three camps under discussion can be applied to the other 7 camps in the country. This is because, the three camps represents the situations in the other camps, for reasons discussed in the introduction part. It is also because UNHCR's principle requires offering protection and assistance to refugees in an impartial manner irrespective of their race, religion, political opinion or gender, and it should provides the same treatment for all the refugees in all the camps in the country.

Reproductive rights violation, particularly SGBV, suffer highly from weak law enforcement while under reporting of sexual violence is also a significant factor. The findings of the research on SGBV matters show that the legal remedy is far beyond expectation. The interviews from all the three camps and Addis Ababa show that perpetrators are usually released with out court trial. Lack of evidence is one of the main reasons for perpetrators release. Lack of knowledge on the country's criminal law, evidence collection, social and cultural values among the low enforcing bodies, particularly the police combined with lack of awareness, fear of discrimination, etc among the refugee communities are other factors that challenge the legal remedy.

In addition, the information collected on the sexual reproduction and reproductive health challenges shows that lack of awareness, socio-cultural and religious values are the main factors that challenge enforcement of reproductive health services in the refugee communities.

The legal development in the country, particularly with the 2004 Ethiopian penal law, on the area of abortion and SGBV including FGM and Rape is significant. While it is the enforcement that has a gap, as indicated in chapter one, the 2006-2015 national reproductive health strategy has plans to address this gap. It plans to:

- ✓ strengthen the legal frameworks to protect and advance women's reproductive health rights,
- ✓ ensure the full application of existing laws and the development of further protection through efforts to institutionalize women's rights at the local level, integrate them into regional-level planning activities, and
- ✓ Develop synergistic opportunities with women's groups to ensure that courts and police enforce such protections is another good opportunity.

On family planning and HIV/AIDS the findings shows that social, cultural and religious values affect the use of contraception and condoms. Similarly, SGBV cases including domestic violence, rape and FGM have their grounds on social, cultural and religious values of the refugee communities. While a certain type of SGBV is most prevalent in one of the refugee community, FGM among the Somali, rape among the Sudanese and Domestic Violence among the Eritrean, the information collected proves that unequal power relation between men and women is prevailing as a common cause for all these SGBV types in all the refugee communities.

The social, cultural and religious challenges on reproductive health services provision mainly require family planning education for the refugee community. This should, however, be backed by promotion and education of women human rights as unequal power relation between men and women is the main cause of SGBV among the refugee community.

The education given by IRC to the refugee community in *Sherkole* Camp, indicated in chapter three, has eliminated the practice of home based unattended delivery. Therefore, the work of IPs on family education for the refugee community is a good opportunity to change refugee communities' social, cultural and religious values that challenge the enforcement of reproductive rights.

Moreover, the findings also show that IPs involved in reproductive health services provision, religious background also affect enforcement of the rights. While family planning services including contraception, condom distribution, abortion, etc., are central to reproductive rights, organizations backed by churches do not advocate such services.

According to the information collected DICAC is reported to be directly involved in reproductive health services provision at the urban program. The information also shows that DICAC is not prone to FP services and the reproductive health services provision in the urban program is not addressed properly.

It is indicated, in the previous sections, that IRC is the leading agency in reproductive health services provision in all the three camps. Whether this is the same in the other 7 camps is open for further research. However, there are organizations, other than DICAC, working with refugees in Ethiopia which are either established by Churches or backed by them. This is evident from their names. Such organizations include, Jesuits Refugee Services (JRS), Lutheran World Federation (LWF) and the Ethiopian Orthodox Church Development & Inter-church Aid Commission (DICAC).

In this respect, while it is generally better not to involve such organizations in the reproductive health services, UNHCR, as the lead agency in many situations of displacement, should ensure that the full range of reproductive health services will be available directly or by referral.

CONCLUSION AND RECOMMENDATIONS

Women human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality, free of coercion, discrimination and violence. Overall, international treaties and recent consensus documents provide a clear mandate for governments, UN agencies and NGOs to meet the reproductive rights of refugee women and girls.

However, enforcement of reproductive rights is full of challenges even in normal situations of life, while situations of displacement further hinder the enforcement of refugees' rights. Week law enforcement, absence or limited access to health care services, refugee communities lack of awareness on the human rights of women and girls and on reproductive health, social, cultural and religious outlooks are among the factors that challenges enforcement of refugee women and girls reproductive rights.

In Ethiopia, ARRA, UNHCR and IPs provide health care services, reproductive health services including MCH, FP and HIV and AIDS prevention and response and mental health and psycho-social support for refugees in the country. However, these stake holders effort is challenged by intertwined financial, legal, social, cultural and religious factors.

Inadequate funding highly challenges the effective provision of health care services. Limited resettlement opportunities for refugees with serious health problems, which can not be treated in the country, further, augment this problem.

Moreover, factors like the prevalence among women of poverty and economic dependence, experience of violence, negative attitudes towards women and girls, harmful practices, discrimination, the limited power women have over their sexual and reproductive lives and lack of influence in decision-making are generally the social realities that challenge the efforts of the stake holders in enforcing reproductive rights of refugee women and girls in the country. Weak law enforcement also contributes for the

prevalence of these problems, while unequal power relation between men and women among the refugee communities is a common ground for SGBV.

These problems compounded with, social, cultural and religious values of the refugees' further challenge the provision of reproductive health services including family planning services and HIV/AIDS prevention and response. These challenges are further intensified by the attitude of reproductive health care services providing IPs, established by churches, towards abortion services, the use of condoms and family planning methods, like contraception, pills, etc.

Effective enforcement of reproductive rights of refuges in the country, therefore, requires addressing these challenges. The following recommendations are proposed:

- ✓ UNHCR budget allocation for medical needs should base on need assessment. It, therefore, should undertake medical need assessment in each camp and increase the budget accordingly;
- ✓ UNHCR should look for finance aid for the medical needs of refugees in Ethiopia to meet the right to access to health care services recognized in the international human rights instruments;
- ✓ UNHCR should find more resettlement opportunities for refugees with serious medical needs increasing its effort in negotiation with developed countries;
- ✓ UNHCR should ensure that IPs are providing the full range of sexual reproduction and reproductive health services;
- ✓ the Ethiopian government should advance the enforcement of the law through education on the country's law for the law enforcing bodies, particularly the police;
- ✓ ARRA and UNHCR should ensure that unaccompanied and separated children are protected;
- ✓ the government should create awareness among the police on the treatment and handling of child perpetrators;

- ✓ The government should also ensure the safety and security of women and girls by fully enforcing the law. Particularly it should ensure that SGBV perpetrators are punished;
- ✓ IPs providing sexual reproduction and reproductive health services including education should continue their awareness creation among the refugee communities, as it is difficult for a society to abandon centuries old believes in a short period of time;
- ✓ ARRA and UNHCR should increase their effort on the promotion of women human rights through awareness creation and eliminate discriminatory social practices, negative attitudes towards women and girls;
- ✓ ARRA and UNHCR should take integrated measures to empower women and girls to control their sexual and reproductive lives; and
- ✓ UNHCR through ARRA should coordinate with the government to benefit refugees availing the country reproductive health strategy.

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QUESTIONER

DEAR SIR/MADAM,

THIS QUESTIONER IS PREPARED TO COLLECT INFORMATION ON THE CHALLENGS THE GOVERNMENT, UN AGENCIES AND PARTNER ORGANIZATIONS ARE FACING ON THE ENFORCEMENT OF REPRODUCTIVE RIGHTS OF REFUGEE WOMEN IN ETHIOPIA. THE INFORMATION YOU PROVIDE IS CRUCIAL FOR MY MA THESIS PREPARATION AT AAU, LAW FACULTY.

THIS QUESTIONER CONTAINS ONLY OPEN ENDED TYPE OF QUESTIONS, THEREFORE YOU ARE KINDLY REQUESTED TO PROVIDE YOUR RESPONSES IN THE SPACE PROVIDED. WOULD YOU NEED ADDITIONAL SPACE PLEASE FEEL FREE TO USE ADDITIONAL PAGES AND ATTACH HEREWITH.

THANK YOU IN ADVANCE FOR YOUR COOPRATION.

QUESTIONS

1. Who is involved in assisting refugees in the camp? List the organizations.

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2. Which organizations are involved in health services?

a. What are the available health care institutions, clinic, health centre, etc?

b. How many staffs are there, doctors, nurses, social workers, etc?

c. What kinds of reproductive health services are provided in the available health institutions?

d. Are there any challenging reproductive health issues in your context? If yes, please list all those challenges

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e. Why do you think the above listed challenges are challenging?

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3. Which organization is working and/or involved on Reproductive health services other than health centers and/or clinics?

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a. How many staffs are there, officers, social workers, etc? What is their qualification?

b. What kinds of reproductive health services are provided by these organizations?

c. How are these services provided?

d. Under what circumstances is abortion service provided?

e. Are there any challenges in providing the services in your context? If yes, please list all

f. Why do you think they are challenging? Is it for social, cultural, economic, religious, etc reasons, please explain.

4. Which organization is working on HIV/AIDS prevention and response?

a. How many staffs are there, officers, social workers, etc?

b. What kinds of services are available in the HIV/AIDS program?

c. How is service provided?

d. Do you currently face challenges in providing HIV/AIDS related services? If yes, please indicate.

e. Why do you think these services are challenging?

5. Which organization is working on prevention from and response to Sexual and Gender Based Violence (SGBV)?

a. What services are available for SGBV victims/survivors?

b. How is service provided?

c. What do you think is challenging in the prevention for and response to SGBV?

d. Why do you think it is challenging? Is it for social, legal, cultural, economic, religious, etc reasons? Please explain

e. What type of SGBV is most prevalent? Please list in order, at least three.

f. Why do you think these types of SGBV are prevalent? Is it for social, legal, cultural, economic, religious, etc reasons? Please explain.

6. Which organizations work on the psycho-social counselling/support for SGBV victims or survivors?

a. How many staffs are there? What are their qualifications?

b. Which organizations are involved in legal follow up?

c. Is there any police station in or near the camp? Are there other actors, like community watch group, if any?

d. What legal services are available for SGBV victims?

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e. What is challenging in the legal service?

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f. In your opinion, what makes these services are challenging? Is it for social, legal, cultural, economic, religious, etc reasons? Please elaborate.

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