



# Adolescent Refugees and Migrants: A Reproductive Health Emergency

*“Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs.”*

Programme of Action, International Conference on Population and Development, Cairo, September 1994

Pathfinder International believes that reproductive health is a basic human right. When parents can choose the timing of pregnancies and the size of their families, women’s lives are improved and children grow up healthier.

Pathfinder provides women, men, and adolescents throughout the developing world with access to quality family planning and reproductive health information and services. Pathfinder works to halt the spread of HIV/AIDS, to provide care to women suffering from the complications of unsafe abortion, and to advocate for sound reproductive health policies in the U.S. and abroad.

**Pathfinder International**

# **Adolescent Refugees and Migrants: A Reproductive Health Emergency**

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## 1. Overview

According to the United Nations, there are currently more than 190 million people who have migrated, whether willingly or under duress. The number of people on the move has more than doubled since 1975 as people leave their communities in times of war, conflict, or natural disaster, or in search of jobs and opportunities. In fact, some estimate that as many as two billion people could be considered migrants, which would include Internally Displaced Persons (IDPs), refugees, rural-urban migrants, market traders, seasonal workers, clandestine migrants, and tourists.<sup>1</sup> Significantly, the pace of rural to urban migration has dramatically increased, especially in Africa and Asia. Local and national governments are often ill-equipped to deal with disasters and/or steady urbanization, and as a result, many refugees and migrants end up in poorly equipped and serviced squatter settlements, slums, and camps.<sup>2</sup>

Young people make up a large proportion of these refugee and migrant populations, and since the 1994 International Conference on Population and Development, the reproductive health of young people has been identified as a serious concern and a challenge for policy makers and programmers around the world. Young refugees and migrants have the same developmental needs common to all young people, but their needs are significantly affected by displacement from their homes and separation from the structure and guidance of their families. The new environments in which they find themselves are often violent, stressful, and unhealthy places to live.

As young people transition from childhood to adulthood, threats to their health shift from infectious disease that can easily be prevented or treated through vaccinations, improved hygiene, and access to antibiotics, to illnesses and injuries that are grounded in their behaviors. Unsafe reproductive health behaviors in youth, such as early age of sexual debut and low rates of condom and contraceptive use, result in high rates of unwanted pregnancies, Sexually Transmitted Infections (STIs) and HIV/AIDS. Young people who are displaced from their homes and communities may suddenly experience a lack of social support from family, friends, and mentors, as well as increased exposure to violence, coercion, and new sources of pressure. These factors can affect the ability of youth to practice safe reproductive health behaviors and create risky situations that may lead to unhealthy and potentially fatal choices.

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<sup>1</sup> Adrian Kalemeera, Anne Alan Sizomu and Julius Ssenabulya, *Migration and its Effects on Development and Reproductive Health of Young People in Uganda, A Desk Review Report*, Uganda, UNFPA, August 2006.

<sup>2</sup> <http://www.unfpa.org/6billion/populationissues/migration.htm>, retrieved May 23 2007.

## 2. Youth Movement Trends

Today's generation of young people is the largest in history. Nearly half of the world's population (almost 3 billion people) is under the age of 25. About 85 percent of the world's youth live in developing countries. Asia alone is home to 70 percent of the developing world's young people. The poorest, least developed countries tend to have the largest shares of young people as a proportion of their populations.<sup>3</sup>

Youth today are increasingly mobile, whether by choice, necessity, or force. Three of the major reasons for youth mobility in the developing world include:

**Refuge:** In recent years, the world has coped with a series of dramatic movements of people as a result of natural disaster and human conflict, such as the 2004 tsunami in Asia, the long-standing civil war in Sudan, and the massive earthquake in Pakistan in 2005. Nearly 35 million people are refugees or IDPs, a significant number of whom are youth.<sup>4</sup>

**Opportunity:** Young people make up a large part of an urban growth phenomenon as they migrate to urban areas (both within their own and in other countries) from rural communities in search of employment, education, and a perceived chance for a better life. By mid 2007, the majority of people worldwide will live in cities or towns, and UN projections suggest that the majority of world population growth will take place in the urban areas of low and middle-income countries.<sup>5</sup> It has been estimated that between 1970 and 2025, the number of urban youth will increase by 600 percent.<sup>6</sup>

**Coercion:** In over 20 countries around the world, children and youth are direct participants in war. An estimated 200,000 to 300,000 children are serving as soldiers for both rebel groups and government forces in current armed conflicts. Many are abducted or recruited by force, while others join armed groups out of desperation, including poverty.<sup>7</sup>

Young people (especially young women) who live under marginalized circumstances in refugee camps, urban slums, or as child soldiers are highly vulnerable to sexual coercion, exploitation, and violence and may have no choice but to engage in high risk or transactional sex for survival. The provision of Reproductive Health and Family Planning (RH/FP) information and services, and the development of life skills, are critical to their wellbeing and future health.

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<sup>3</sup> [http://www.unfpa.org/swp/2005/presskit/factsheets/facts\\_adolescents.htm](http://www.unfpa.org/swp/2005/presskit/factsheets/facts_adolescents.htm)

<sup>4</sup> <http://www.rhrc.org/pdf/reprohea/pdf>

<sup>5</sup> Pietro Garau, Elliott D Sclar and Gabriella Y Carolini, *A Home in the Sky*, UN Millenium Project, Task Force on Improving the Lives of Slum Dwellers, London, 2005

<sup>6</sup> Robert Blum and Kristin Nelson-Mmari, *the Health of Young People in a Global Context*, Journal of Adolescent Health, 2004:35:402-418

<sup>7</sup> <http://hrw.org/campaigns/crp/index.htm>

### 3. Mobile Youth are in Need of RH/FP Information and Services

Until relatively recently, reproductive health care has been a neglected element of emergency health care services in refugee camps, despite the fact that poor reproductive health is a major cause of morbidity and mortality once emergency health needs have been met.<sup>8</sup> And, though data suggests that urban migrants should have greater access to health information and services, (including RH/FP) since health services are usually concentrated in urban areas, disaggregated urban data where available shows that urban slum residents face many health challenges and have very limited access to health care.<sup>9</sup>

*Refugee and IDP camps* are inherently disruptive environments, which may separate young people from family and community sources of learning, recreation, and support. This alteration of community routine, normalcy, boredom, and lack of positive alternatives may precipitate young people's involvement in risky behaviors, including early sexual activity and unprotected sex. Youth are also likely to face increased exposure to sexual coercion and violence. For example, in refugee camps in Northeast Kenya, there are reports of young women as young as 10 being attacked and raped when they leave camps in search of water or firewood.<sup>10</sup>

The Inter Agency Working Group on Reproductive Health in Refugee Situations developed the first guidelines on reproductive health in refugee settings in 1997 entitled *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, which was reprinted in 1999. The *Field Manual* outlines a **Minimum Initial Service Package (MISP)** to direct the deployment of reproductive health services in emergency situations and components of comprehensive reproductive health, including safe motherhood, family planning, prevention and response to gender-based violence, and prevention and response to sexually transmitted infections, including HIV. A recent evaluation of the delivery of RH services for refugees and IDPs shows that the provision of antenatal care is fairly good, and most sites offer at least one family planning method (oral contraceptives, condoms, and injectables are the most commonly available methods). Some aspects of HIV prevention were reported to be widely available, as was treatment for STIs. The report, however, also recommended improvement in the provision of services for gender-based violence, and continued efforts to improve HIV/AIDS prevention and emergency obstetric care, and especially a greater focus on meeting the specific needs of youth.<sup>11</sup> This recommendation could, in part, be met with improved training of health care workers in the provision of youth-friendly services. Such training teaches health workers how judgmental and punitive attitudes towards youth block their access to life-saving health services,

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<sup>8</sup> <http://www.rhrc.org/pdf/reprohea/pdf>

<sup>9</sup> [http://www.makingcitieswork.org/urbanThemes/Urban\\_Health/Urbanization\\_and\\_Health](http://www.makingcitieswork.org/urbanThemes/Urban_Health/Urbanization_and_Health) (3/9/07)

<sup>10</sup> <http://www.refugeesinternational.org/content/article/detail/1110/> retrieved 4/9/2007

<sup>11</sup> Susan Purdin, Sarah Casey and Dr Therese McGinn, *Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons*, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University

and it helps the workers develop new skills, especially in communication and counseling that can improve their ability to reach young people.

Providing RH/FP information and services to youth may not be considered a priority when health workers are struggling to provide basic curative care to those who visibly need it. There is strong evidence, however, that though seemingly less urgent than other health care issues, the reproductive health of young people in camps should be a concern for health care providers and camp administrators.

***Adolescents in camps engage in risky behaviors***

- A study of adolescents in a refugee camp in Northern Kenya found that 70 percent were sexually active, but were not using any method of protection. (*RHRC Consortium*)
- Thirty percent of all births in a Congolese refugee camp in Tanzania were to adolescents aged 14 – 18. (*RHRC Consortium*)
- Rwandan and Burundian teenagers in Ugandan and Tanzanian camps routinely exchanged sex for food, shelter, and protection. (*Meeting the Reproductive Health Needs of Refugees*)
- In Liberia, nearly 80 percent of displaced girls underwent abortions by the age of 15 after exposure to sexual exploitation and violence (*Moving Young*)

***Urban slums*** are increasingly populated by youth, who are a major factor in rural to urban migration.<sup>12</sup> Many young people—especially young women—are eager to leave rural communities for what they perceive to be greater opportunities in urban areas for education and employment, or they may be fleeing undesirable situations, such as forced marriage or abusive relationships. In Latin America and Asia in particular, young female urban migrants outnumber young males. In Africa, youth predominate in urban areas.<sup>13, 14</sup>

***Why do young people migrate to urban areas?***

- Young Senegalese women migrate to cities to work as domestic servants. (*Influence of urban migration on physical activity, nutritional status and growth of Senegalese adolescents of rural origin*)
- In Ethiopia, girls migrate for education, work, and to escape early marriage. Girls are more likely to migrate to cities than boys. (*Adolescent Life in Low Income & Slum Areas of Addis Ababa Ethiopia*)
- Young Burmese women travel to cities in Thailand to work as domestics, while young men obtain work in factories, construction, and the fishing industry. (*Migrants Health and Vulnerability to HIV/AIDS in Thailand*)
- As many as 1.2 million children and adolescents under the age of 18 are trafficked each year. Lured by false promises of better lives elsewhere, they are then thrust into sex work or other exploitative work, including domestic work, marriage, armed conflict, and illegal trade. (*Moving Young*)

<sup>12</sup> Blum and Nelson-Mmari

<sup>13</sup> Annabel S Erulkar, Tekle-Ab Mekbib, Negussie Simie, Tsehail Gulema *Adolescent Health in Low Income & Slum Areas of Addis Ababa Ethiopia*, the Population Council, 2004.

<sup>14</sup> Blum and Nelson-Mmari

Rural to urban migration exposes young people to new environments and new influences on health, and the significant health risks that thrive in slums where unemployment and poverty is high, such as violence, STIs/HIV, and substance use. The interrelationships between economic development, urbanization, prostitution, and HIV/AIDS, coupled with low levels of education, fuel the HIV/AIDS pandemic, as well as other RH related concerns.<sup>15</sup> Youth are particularly vulnerable, especially regarding their reproductive health, because when migrating to urban areas, they leave family and community systems that promote, reinforce, and monitor norms of appropriate sexual behavior. While young people are more likely to be exposed to coercion or sexual violence in urban settings, they may also be more likely to engage in consensual, unprotected “survival” sex, especially to ensure access to food and shelter.

In general, poor urban women have worse sexual and reproductive health outcomes than other urban women. They are much less likely to use contraception, have much higher rates of fertility, and are much less likely to be attended by a health care provider when they give birth.<sup>16</sup> The fertility behavior of urban youth is not well documented, but evidence suggests high birth rates, especially among unmarried youth.<sup>17</sup> A 2004 report found that unmet need for contraception in urban areas of the developing world was 35.3 percent,<sup>18</sup> despite other data that suggests the proportion of married women in the developing world who have an unmet need for contraception is only 17 percent (and for unmarried women, three percent).<sup>19</sup> Worldwide, young women 15 – 24 account for one-third of unmet need, so it is highly probable that young women in urban areas also account for a significant proportion of unmet need for contraception.

While there is little specific data on urban youth reproductive health outcomes, one can extrapolate from available data and what is known about youth behavior to conclude that youth urban migrants need information, life skills, and services. HIV/AIDS prevalence rates are growing in urban areas, exceeding 50 percent in some African cities.<sup>20</sup> As was pointed out earlier, health care is theoretically more available in urban areas, but urban slum residents face many social, economic, and cultural barriers to care. Providers may be prejudiced against urban slum residents, and health outreach workers may fear working in marginalized neighborhoods.<sup>21</sup> Youth face all these barriers, as well as others that are specific to youth and include inconvenient and inflexible service delivery; financial, legal and policy barriers; lack of privacy and confidentiality; and poor quality of care, including judgmental and unfriendly service providers.

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<sup>15</sup> Blum and Nelson-Mmari

<sup>16</sup> Pietro Garau, Elliott D Sclar and Gabriella Y Carolini

<sup>17</sup> *ibid*

<sup>18</sup> Mark Montgomery and Paul Hewett, *Urban Poverty and Health in Developing Countries: Household and Neighborhood Effects*, Working Paper, Population Council, Policy Research Division, 2004 No. 184

<sup>19</sup> John Ross and William Winfrey, *Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate* International Family Planning Perspectives 23:3 September 2002

<sup>20</sup> [http://www.makingcitieswork.org/urbanThemes/Urban\\_Health/Urbanization\\_and\\_Health](http://www.makingcitieswork.org/urbanThemes/Urban_Health/Urbanization_and_Health), retrieved 3/9/07

<sup>21</sup> *ibid*



### ***Child Soldiers: A special concern***

Since 2001, the participation of child soldiers in armed conflict has been reported in almost every region of the world. Children and youth are uniquely vulnerable to military recruitment, especially if they are poor, separated from their families, displaced from their homes, living in a combat zone or have poor access to education. Once these children and youth are part of armed conflicts, they face significant threats to their physical and mental health on the battlefield as well as off, including drug addiction, sexual abuse, and exploitation. They are also at high risk of STIs and HIV. In some countries as many as one-third of child soldiers are girls, who face the additional threat of unwanted pregnancy. Pregnancy for girl soldiers can be very dangerous, as the girls are often malnourished, physically immature, and live in dirty conditions. Girls are also more likely to face additional sexual trauma from rape or as “wives” of military commanders (from *Child Soldiers, Care and Protection of Children in Emergencies* and *Facts About Child Soldiers*). Post demobilization, girls face significant stigma and discrimination in their efforts to become reintegrated into communities, in part due to their status as unmarried mothers or former sex slaves, and may even experience outright rejection. (Personal communication)

## **4. Programs for Mobile Youth**

Reproductive health care for refugees, IDPs, and migrants is not a luxury, but a necessity that saves lives and reduces illness.<sup>22</sup> As various social and development programs are increasingly implemented to reach these vulnerable segments of the population, the specific RH/FP needs of young refugees, IDPs, and migrants for high quality, youth-friendly, appropriate, and accessible information and services must be identified and met. While refugee, IDP, and migrant youth are at risk for poor reproductive health outcomes and are all separated from their communities of origin, the circumstances under which this separation occurs are clearly different. As a result, the psychosocial, economic and community-level determinants of risky behaviors should be carefully considered for each group when developing programs.

Program planners must also think about the context of young people’s lives and where they are living. Providers need to understand that not all sexual activity is consensual, as well as the fact that young people’s limited access to information and services contribute to low levels of contraceptive use. Critical services that should be made available to young women include Emergency Contraceptive Pills (ECPs), as well as post-exposure prophylaxis for HIV and STIs for both young women and men.

Another service component that must be considered is Postabortion Care (PAC). The precarious situation of young women in displaced settings, including urban slums, suggests an increased likelihood of unsafe abortions and miscarriage. In fact, UNFPA estimates that 25 – 50 percent of all maternal deaths in refugee camps are due to unsafe abortion.<sup>23</sup> In contrast, WHO reports that overall, 13 percent of maternal deaths each year

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<sup>22</sup> <http://www.rhrc.org/pdf/reprohea/pdf>

<sup>23</sup> [http://www.kit.nl/exchange/html/2000\\_2\\_improving\\_reproductive\\_.asp](http://www.kit.nl/exchange/html/2000_2_improving_reproductive_.asp)

are caused by unsafe abortion. Much of the death and illness from unsafe abortion and miscarriage could be prevented with better access to contraception, ECPs, and PAC.<sup>24</sup>

It is important to consider, however, that young people themselves may not identify reproductive health as their top priority. Regrettably, too often the views of youth are not considered by planners and funders who are trying to alleviate specific health problems, such as high rates of early pregnancy, STIs, and HIV. Youth health concerns may actually be more focused on day-to-day physical considerations such as acne, menstruation, dental care, and weight, or psychosocial issues such as relationships, education, and employment. To maximize the effectiveness, relevance, and acceptability of interventions that target young people, planners should attempt to integrate the articulated priorities of young people.<sup>25</sup> Programs that meet these stated needs can be an innovative way to integrate and link the provision of RH/FP information and services.

A number of organizations working with these under-served populations have identified key elements that contribute to success in improving youth access to and use of RH/FP information and services. Some of their lessons learned are presented below.

- Appropriate segmentation of the adolescent population in urban slums, refugee and IDP camps, or other displacement settings is critical to develop effective interventions. Program planners must pay special attention to the circumstances of youth, noting age, gender, living situation, parental involvement, employment and socio-cultural norms and influences on behavior, as well as services available to young people, perceptions of service providers, and young people's perspectives of their health needs.<sup>26</sup>
- Cultural sensitivities around the provision of RH/FP information and services to youth must be recognized. Adult gatekeepers in these communities should be sensitized to the vulnerabilities of young migrants, refugees, and displaced persons, and engaged in developing appropriate responses and programs, such as psychosocial support, education, life skills development, youth-friendly RH/FP services, counseling, and referral.<sup>27</sup>
- Young people may be living with only one or no parents. Youth need adult role models and mentors, especially positive influences who can provide emotional support and demonstrate appropriate and healthy behaviors.<sup>28</sup>
- Organized activities, such as sports programs are an effective venue for social mobilization to support health activities such as RH/FP/HIV/AIDS education. Sports can also provide employment and contribute to local development, and are a natural draw for volunteer involvement. They also offer a creative venue to reach out-of-school youth with information, services, and referral.<sup>29</sup>

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<sup>24</sup> [http://www.kit.nl/exchange/html/2000\\_2\\_improving\\_reproductive\\_.asp](http://www.kit.nl/exchange/html/2000_2_improving_reproductive_.asp)

<sup>25</sup> Blum and Nelson-Mmari

<sup>26</sup> Erulkar et al

<sup>27</sup> Kalemeera et al , Anne Alan Sizomu and Julius Ssenabulya

<sup>28</sup> Erulkar et al

<sup>29</sup> <http://mysakenya.org>

- Youth in marginal settings need access to education, job skills, economic opportunity, and employment, as well as health services. Multisectoral approaches that coordinate protection, health, community, skills-building and education offer an optimal approach.<sup>30</sup> Job creation is important, as well as helping youth develop appropriate and marketable skills.<sup>31</sup>
- Help youth cope with changes and develop new skills, competencies, and a sense of purpose by significantly involving young people in the diagnosis, planning, implementation, and evaluation of programs designed to meet their needs.<sup>32</sup> Training in peer education, leadership, programming, management, communication and decision-making skills are also important and relevant strategies.<sup>33,34</sup>
- Community involvement is essential, since changes in social norms and service delivery cannot be sustained without community participation and ownership of concepts, programs, and activities.<sup>35</sup>

## 5. Program Examples

Programs reaching refugees, IDPs, and migrants are increasingly recognizing the importance of targeting activities to youth. Below are a few examples of programs and tools that have been developed to reach these underserved groups:

*The Extending Service Delivery Project (ESD)* is working in a Sudanese refugee camp in Kakuma, Kenya, to address Gender-Based Violence (GBV), in collaboration with Lutheran World Relief and the National Council of Churches in Kenya to train 60 young male camp residents to identify, address, and prevent GBV and improve the reproductive health of young men and women.

Adolescent men are being trained, as the partners working in Kakuma feel that young men may be more receptive to new ways of addressing gender norms and GBV than older men. Young men in the camps are eager to learn and develop new skills, and they have the free time to participate in group education activities that discuss issues of anger, honor, and culture, and help them better understand the impact of gender norms and stereotypes on their own health and the health of their partners. A curriculum has been developed that is adapted from Project H

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<sup>30</sup> *Adolescent reproductive health in refugee settings Fact Sheet*, Produced by Marie Stopes International for Reproductive Health for Refugees Consortium, no date

<sup>31</sup> Moving Young, State of the World Population 2006 Youth Supplement, UNFPA

<sup>32</sup> *Adolescent and Youth Sexual and Reproductive Health Charting Directions for a Second Generation of Programming*, report on a workshop of the UNFPA in collaboration with the Population Council May 2002, New York

<sup>33</sup> *Adolescent reproductive health in refugee settings Fact Sheet*

<sup>34</sup> *Adolescent and Youth Sexual and Reproductive Health Charting Directions for a Second Generation of Programming*,

<sup>35</sup> Personal communication

materials from Promundo in Brazil and activities from Rethinking Domestic Violence, developed by Raising Voices in Uganda.<sup>36</sup>

***Mathare Youth Sports Association (MYSA)*** Mathare is a slum outside Nairobi Kenya, and many of its several hundred thousand residents are youth, who have limited opportunity for social activity, recreation, education, or employment. Along with myriad other problems related to life in urban slums, early pregnancy, STIs, HIV and sexual violence are common. The Mathare Youth Sports Association (MYSA) is a youth-founded and youth-run organization that has worked since 1987 to address the needs of young people by promoting sports, environmental improvements, community development, and RH/FP information. MYSA's programs and activities invest in youth by addressing ethics, accountability, self-improvement, self-esteem, skills development, and leadership. Through sports, MYSA programming reaches young people with information on reproductive health, risky behaviors, and prevention strategies, links young people with clinical health care services, and distributes condoms. In 1994, MYSA began HIV/AIDS prevention activities that promote behavior change among youth, which was supported by a range of Kenyan NGOs, as well as UNICEF, Family Health International, and the International Planned Parenthood Federation.

While a formal evaluation of MYSA has not been conducted, MYSA has reached more than 10,000 youth since it began in 1987, with information and opportunities to learn new skills and change their lives. Anecdotal evidence suggests that MYSA has been able to achieve the following:

- Increased openness among parents and teachers to address reproductive health with youth;
- High levels of participation in MYSA activities and increased understanding of HIV/AIDS and RH; and
- Increased levels of school enrollment through MYSA encouragement, motivation, and provision of scholarships.

For more information see <http://www.mysakenya.org>

***The Reproductive Health Response in Conflict (RHRC) Consortium*** is a group of organizations that aim to increase access to a range of quality, voluntary RH services for refugees and displaced persons around the world, including youth. Members include the American Refugee Committee, CARE, Columbia University, JSI Research and Training Institute, Marie Stopes International, and the Women's Commission for Refugee Women and Children.

The RHRC Consortium promotes sustained access to comprehensive, high quality RH/FP programs in emergencies and advocates for policies that support the reproductive health of persons affected by armed conflict. Youth are a priority population for RHRC and they have worked with youth refugees from the Congo

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<sup>36</sup> Personal communication

and Burundi in the Kigoma region of Tanzania to provide RH/FP counseling, recreational services, and educational materials. This program trained 40 peer educators to provide referrals for health services and to distribute condoms and informational materials to other youth. Frequent group education activities on RH/FP were held for youth leaders, peer educators, teachers, religious leaders, parents, and service providers to sensitize them and reduce community opposition to providing RH/FP services to youth.

The RHRC consortium has produced a number of tools and materials that specifically address youth refugees, IDPs, and RH/FP, which can be found on their website [www.rhrc.org](http://www.rhrc.org).

**Save the Children UK** has implemented a Children and War Capacity Building Initiative which target children who have actively participated in combat, as well as children used in other ways by government or opposition forces. This program aims to reintegrate children into their communities. To assist their field staff to reach children in crisis, Save the Children developed ***Child Soldiers: Care & Protection of Children in Emergencies a Field Guide***. Areas of emphasis for Save the Children include helping youth focus on transitioning to formal and non-formal education, vocational training and community mobilization; care and protection of children separated from families and steps to reunification; social reintegration and the prevention of recruitment of boys and girls as child soldiers; prevention of violence and support to sexual and gender-based violence survivors; and psychosocial care and support for all areas of children and war programming. For more information see <http://www.savethechildren.org.uk>.

**Pathfinder Peru** The Huanta province in Peru was torn apart by guerilla warfare between 1981 and 1993. Sixty percent of the population of this province lived in remote rural areas, and over one-half of the population was under the age of 19. Many youth were displaced from their homes in the countryside to larger communities. As displaced migrants, these youth had little or no access to health, education, or other social services and being loosely dispersed in the community, were difficult to reach. In an effort to provide these young people with appropriate RH/FP information, counseling, and services, Proyecto Alcance (which means Project Reach) recruited unaffiliated youth through local youth who were asked to reach out and “bring a friend” to educational activities and for clinical services. Other activities included mobile clinics and training of school staff on youth RH and community education programs. As a result of the project, more than 160,000 clients were reached and more than 92,000 contraceptive methods were distributed.<sup>37</sup>

**World Association of Girl Guides and Girl Scouts (WAGGGS)** worked with Family Health International as part of the Health of Adolescent Refugees Project, (funded by UNFPA) to implement a peer education program and merit badge

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<sup>37</sup> Mary Burket, *Improving RH through Community-Based Services: 25 years of Pathfinder International Experience* Pathfinder International, Watertown MA, October 2006

program for girls in camps in Uganda, Zambia and Egypt. Young women in these camps received training in reproductive health and in turn reached their peers with information and education on RH, including anatomy and physiology, puberty, relationships, nutrition, hygiene and disease prevention. To earn their merit badges, girls had to reach at least 25 other girls in their communities, and participate in other activities such as developing illustrations of maternal child health and keeping journals. Six hundred girls were trained in Uganda and Zambia, as well as 100 refugee girls living in Cairo. An evaluation of the activity found that the self-esteem of the participants increased significantly, as did their use of health services. Importantly, girls reported that they had ambitions and hopes for the future and that their families and other adults also learned from the young women.<sup>38</sup>

**“Hope is the best contraceptive.”**

*Laurie Zabin*

## 6. Developing Effective Programs for Mobile Youth

Adolescents and youth in slums and camps have distinct experiences and needs, yet it is apparent that they are underserved and overlooked. The Women’s Commission for Refugee Women and Children recently conducted a study to determine the patterns and practices of adolescents affected by conflict and found very limited data on adolescents and very few formal assessments or evaluations of their concerns or programs to address their concerns. There is a compelling need to identify best practices that effectively reach these underserved adolescents.<sup>39</sup>

Based on their comprehensive review of the needs of youth and programs implemented to address those needs, the Women’s Commission recommends that programmatic interventions must address the following aims:

***Expand youth access to secondary education:*** The benefits of education are clear and well-documented and include economic, social, and political outcomes. Importantly, education improves health and reduces fertility.<sup>40</sup> Education is a stabilizing force in an unstable environment, and provides opportunities for young people to build self-esteem, confidence and a sense of the future. The availability of secondary education in camps and urban slums is extremely limited,<sup>41, 42</sup> though UNHCR points out that education is a key element in helping young people escape from exile and poverty and is a human right.

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<sup>38</sup> *Programs for Adolescents: Reproductive Health Merit Badges for Scouts*, Family Health International, Network 2000, 20:3.

<sup>39</sup> *Untapped Potential: Adolescents affected by armed conflict A review of programs and policies*, Women’s Commission for Refugee Women and Children, New York, 2000.

<sup>40</sup> Joel E Cohen, David E Bloom, Martin B Malin, Helen Anne Curry, *Universal Basic and Secondary Education Educating All Children* (May 24, 2007)

<sup>41</sup> *Untapped Potential*

<sup>42</sup> [www.un.org/esa/socdev/poverty/presentation/urban\\_mboup.ppt](http://www.un.org/esa/socdev/poverty/presentation/urban_mboup.ppt)

Organizations can fill the need for post-primary education in a number of ways, by:<sup>43</sup>

- Providing educational materials, such as books, apparatus, pens, notebooks, chalk, etc;
- Helping girls and youth with special items such as clothes, soap and menstrual hygiene materials;
- Ensuring that youth have the opportunity to sit for official examinations;
- Conducting teacher training and providing incentives for teachers; and
- Constructing classrooms, schools, libraries, latrines, and laboratories.

***Address the livelihood needs of youth:*** Youth need the opportunity to develop vocational and life skills to provide for themselves in camps, slums, or upon repatriation. Vocational and skills training, as well as access to microcredit, can provide youth with a sense of self-worth, stability, and employability.<sup>44</sup>

The International Labour Organization reiterates that basic education for youth is important and further suggests that:<sup>45</sup>

<p><b>The trouble is, we have no work</b> <i>Burundian refugee youth</i></p>
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- Vocational training must be relevant to the needs of the labor market;
- Training opportunities for young women must be expanded; and
- Vocational training should be integrated with classroom experience, career counseling, and life and entrepreneurial skills development.

***Provide adolescent specific health services:*** It is critically important for health services to consider how to meet the health needs of young people who are neither children nor adults. Health services for prevention and treatment of pregnancy and STIs should consider how best to be more “youth friendly” and implement activities to improve the scope and quality of services provided to adolescents. Pathfinder International has developed a number of tools to help service providers assess the “youth friendliness” of their services. Essential elements of youth friendly services include:

- Convenient open hours for youth;
- Privacy and confidentiality;
- Respect for youth clients;
- Competent staff; and
- Minimum package of services available including counseling, contraception, STI diagnosis and treatment, HIV counseling, pregnancy testing and care, and PAC.

See the Pathfinder website at [www.pathfind.org](http://www.pathfind.org) to download the following tools: *Certification Tool for Youth-Friendly Services* and *Clinic Assessment of Youth-*

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<sup>43</sup> RET – The foundation for refugee education trust, <http://www.r-e-t.com> (5/24/07)

<sup>44</sup> *Untapped potential*

<sup>45</sup> *Decent work for young people: key messages* <http://www.ilo.org> (5/24/07)

*Friendly Services: A Tool for Improving Reproductive Health Services for Youth* which provide guidance on how to make services more youth friendly.

## 7. Summary and Recommendations

As programs and policy makers continue their efforts to expand youth access to RH/FP information and services around the world, we must remain vigilant in identifying and reaching those youth who are less visible and harder to reach, including youth in urban slums, refugee camps, and conflict zones.

**“Importantly, we must strive to ensure that youth (are) seen as part of the solution; in doing so, we increase the likelihood that not only will our interventions be accepted, but that they will be more effective because they will be more consistent with the health priorities of young people.” Robert Blum**

Adolescents must be placed squarely on the agendas of donors and governments to assure more broad-based and systematic commitment to the needs of adolescents in refugee and IDP camps and urban slums, beyond the more *ad hoc* approach that currently seems to exist.<sup>46</sup> Refugee camps must make greater investments in displaced adolescents to help them develop the necessary skills that will prepare them for repatriation and rebuilding,<sup>47</sup> while greater investment must be made by governments and humanitarian agencies in addressing the long-term needs of youth and children in urban slums, including infrastructure, schools, health services, and employment options, in addition to food and security.<sup>48,49</sup> Further, the issue of migration should be included in major demographic, health, and social surveys to provide donors and governments with adequate information for planning and allocating resources.<sup>50</sup>

Finally, there is a need for better identification, documentation, and dissemination of program efforts and best practices across multiple sectors in meeting the needs of these underserved adolescents.

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<sup>46</sup> *Untapped Potential: Adolescents affected by armed conflict*

<sup>47</sup> *From the ground up: Education and Livelihoods in Southern Sudan*, Women’s Commission for Refugee Women and Children, New York, 2007

<sup>48</sup> *Improving the lives of slum dwellers*

<sup>49</sup> *Migration and its Effects on Development and Reproductive Health of Young People in Uganda*

<sup>50</sup> *ibid*



## **Additional Resources**

*Adolescent Reproductive Health*, Reproductive Health Response in Conflict Consortium, <http://www.rhrc.org/rhr%5Fbasics/adol.html> (12/8/06)

*Facts About Child Soldiers* [http://hrw.org/campaigns/crp/fact\\_sheet.html](http://hrw.org/campaigns/crp/fact_sheet.html), Human Rights (4/9/2007)

Garnier D, Simondon KB, Hoarau T, Benefice, T. *Influence of urban migration on physical activity, nutritional status and growth of Senegalese adolescents of rural origin* <http://www.ncbi.nlm.nih.gov/entrez/> (2/26/07)

Mark Lorey, *Child Soldiers Care and Protection of Children in Emergencies a Field Guide*, Save the Children Federation 2001

*Meeting the Reproductive Health Needs of Refugees*, Outlook, Volume 17, No. 4 December 1999.

*Migrants Health and Vulnerability to HIV/AIDS in Thailand*, Raks Thai Foundation, no date

*Moving Young, State of the World Population 2006 Youth Supplement*, UNFPA  
Cindy Waszak and Beverly Tucker, *The Reproductive Health Needs of Adolescent Refugees*, <http://www.fmreview.org/rpn207.htm> (2/22/07)

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## Acronyms

ECP	Emergency Contraception Pill
FP	Family Planning
GBV	Gender-Based Violence
IDP	Internally Displaced Person
MISP	Minimum Initial Service Package
MYSA	Mathare Youth Sports Association
PAC	Postabortion Care
RH	Reproductive Health
RHRC	Reproductive Health Response in Conflict (Consortium)
STI	Sexually Transmitted Infection

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