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Reproductive Health and Repatriation of Refugee Women in Africa: A Case of Liberian Refugee Women on Bududuram Camp

A thesis submitted in partial satisfaction

of the requirements for the degree

Master of Arts in African Studies

By

Deborah Chat Dauda

2012

ABSTRACT OF THE THESIS

Reproductive Health and Repatriation of Refugee Women in Africa: A Case of Liberian Refugee Women on Bududuram Camp

by

Deborah Chat Dauda

Master of Arts in African Studies

University of California, Los Angeles, 2012

Professor Osman Galal, Chair

This thesis explores the importance of reproductive health among refugee women in Africa, particularly Liberian Refugee Women on Bududuram camp (Ghana) in respect to repatriation, using a historical backdrop of Liberia's complex history. A questionnaire was distributed to twenty-five women in eight zones using cluster sampling. Data collected from this study revealed poor reproductive health outcomes, low educational attainment, low income and limited knowledge of health related services. All of which are indicators and a reflection of the underutilization of prenatal health services and modern contraception. Evidence also suggested that the UNHCR does not adequately prioritize reproductive health services on the camp, and women were not eager to repatriate, regardless of their health status. Possible recommendation includes scaling up UNHCR's outreach efforts, increasing male involvement in family planning and importantly ensuring women have access to functional education and skills to improve their reproductive wellbeing.

The thesis of Deborah Chat Dauda is approved.

Onyebuchi A. Arah

Edith S. Omwami

Osman Galal, Committee Chair

University of California, Los Angeles

2012

To my son, Adesola Abyote Dauda-Talabi

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INTRODUCTION

Before delving into the socio-political history of Liberia, I will like to provide a short background to the situation of refugee women as it relates to their reproductive health seeking behavior. A rapid Gender Based Violence (GBV) and Reproductive Health (RH) assessment conducted by the International Rescue Committee (IRC) among Nuba refugee women and girls in Yida refugee camp in South Sudan illustrated that the women's low educational status as well as their social status on the camp, can be attributed to the low levels of modern contraceptive use, high risk of STI's and low utilization of skilled birth attendants (IRC, 2012). These negative health seeking behaviors contributes to the high maternal mortality on Yiba refugee camp, with an estimate of 2,054 deaths per 100,000 live births (IRIN, 2012). Of particular interest is why the history of social engineering has implication for political and social stratification and inequality in Liberia that spills over to camps or refugee conditions. In addition, as I continue to place the history of Liberia in context, I would like emphasize the differential socio-economic status that originally emerged out of the relationship between indigenous Liberians and Americo-Liberians, has implications for life experience of Liberian refugees wherever they will also be geopolitically positioned.

Also, because of the interest in Liberian refugees in refugee camps in Ghana, it is useful to acknowledge that the education level of an individual has a bearing within the human capital framework. For example, refugee populations that are likely to remain in refugee camps tend to be the poor and less educated, while the wealthy (regardless of their educational attainment) and more highly educated refugees tend to be of interest for resettlement purposes, since many countries don't want to re-settle people who are going to become wards of the state. Therefore, it is important to consider and appreciate the historical context of Liberia as it relates to the

reproductive health seeking behaviors of Liberian refugee women on Bududuram refugee camp, in Ghana.

Historical Context of the Liberian Modern State: The First Wave

The story of Liberia, once known as the Grain Coast (The Columbia Electronic Encyclopedia, 2007) is also referred to as Uncle Sam's step child, and America's 53rd state (Enoanyi, 1991). In Abdoulaye W. Dukule's review of the documentary "Liberia: America's Step Child" By Nancy Oku Bright, he reflects on the socio-economic ramifications of successful vis-à-vis unsuccessful "stepchildren". He asserts that successful stepchildren are "claimed by the stepparents as "their own" but are rejected in case of failure…. and psychologically, a stepchild can spend a lifetime trying to be recognized or loved by the stepparent" (Dukule, 2003). This perhaps provides an understanding to the underlying relationship between America and Liberia today.

Furthermore, Charles Morrow Wilson in 1971 describes Liberia as an "epic of interracial dependence and conflicts, an epochal, profoundly human saga of yesterday's meeting tomorrow" (Wilson, 1971). And later in 1985, Kaye Whiteman in Bill Frank Enoanyi's book "Uncle Sam's Step-Child" (1991) echoes Wilson's statement saying " Liberia's historical development, lies at the root of much of today's contradictions" (Enoanyi, 1991). That is, although Liberia was founded by freed slaves, fleeing racial oppression in the U.S., with the hopes of creating self-government, their relationship with the indigenous population ultimately led to the marginalization and disenfranchisement of the indigenous population.

The second great awakening and subsequent abolitionist movements, which begun in the late eighteenth century called for repentance of sin (slavery) (Wilson, 1971) and led to the establishment of the American Colonization Society (ACS), which sole purpose was to solve the lingering problems of slavery and its remnants. Also, the uprising of six hundred thousand slaves

in Haiti in 1791 and the subsequent establishment of the first freed slave republic in the Americas threatened the Southern slave owners that heavily depended on slave labor to maintain the huge profits from cotton export which increased from 200,000 to 40,000,000 pounds between 1793 and 1803 (Davis, 1953).

The ongoing in Haiti as well as successful runaway slaves served as motivation and inspiration to slaves still in captivity. That is, "every free Negro and runaway slaves was a source of danger to the slave holder and a source of inspiration the slave" (Davis, 1953) (Dunn-Marcos, Kollehlon, & Ngovo, 2005). Therefore, finding solutions to the problems of Blacks (free or otherwise) was both politically and "religiously" driven. On one hand to draw "wayward" Americans back to God through repentance of sin (slavery) and on the other hand to prevent slave revolts, preserve the wellbeing of the state (Clegg, 2004) (Davis, 1953) and importantly prevent Haiti from repeating itself on American soil. Thus, on December 28, 1816, leaders of missionary groups, pro-slavery groups (slave owners) and white politicians established the American Colonization Society (ACS). Implicitly, the purpose of ACS was succinctly defined by George Kieh "as to serve as a colonial proxy for the U.S. government, in the implementation of the repatriation plan" (Kieh, 2008) and their durable solutions to the problems of Negroes.

Furthermore, ACS constitution stipulates the right of ACS to colonize civilize and Christianize [Negroes]. This later plays out in the trichotomy between the settlers, the American Colonization Society and the Indigenes relationships. Further, the establishment of ACS as a modern day "Inter-Governmental Organization (IGO) legitimized the extension of Christianity in Africa (Davis, 1953) and through the same processes, the institutionalization of quasi-colonialism in Liberia from 1822-1847 (Levitt, 2005) which then ultimately led to the resettlement and emigration of over 10,000 freed slaves/re-captives to Liberia (Riley,

2010)(Clegg, 2004). By 1847, the settlers declared independence from the American Colonization Society (ACS), which then began the "advent of African settler rule" (Levitt, 2005).

Subsequently, independence from an authoritarian political apparatus invented by ACS had its consequences, as this same socio-political and economic system was equally adopted and implemented by the settlers whose politics dominated the country leaving indigenous population on the periphery of Liberian politics (Essuman-Johnson, 1994) and permanently damaging the political landscape. It further created space for the "institutionalization of ethno-political conflicts between the settlers and native groups between 1822 and 1980 and among all Liberians between 1980 and 1997, and 1999 and 2003 (Levitt, 2005) (Donald, Dunn-Marcos, Kollehlon, Ngovo, & Russ, 2005). The settlers formed the True Whig Party (TWP), which ruled Liberia from independence in 1847 till 1980 when "Master Sergeant Samuel Doe, an indigenous Liberian, led a military coup which overthrew the Americo-Liberian dominated government headed by William Tolbert" (Wilson, 1971) (Davis, 1953) (Essuman-Johnson, 1994).

In retrospect, slaves from America had not all come from West Africa- many have been taken captive from "the interior..they came from different [ethnic] groups and regions, and they had important differences of customs, culture and religion" (Davis, 1953) and to deny this facts and pretend that all Africans and descendants thereof are the same thus dumping them in one locality is damaging and contributes to Liberia's complicated history. Nonetheless, the provision of economic, military and strategic resources to the U.S. by Liberia during World War I and II in the form of human capita, harbors, air bases, minerals and natural rubber enshrines the long-standing relationship between the U.S. and Liberia (Wilson, 1971) (Carlon, 2003).

Culture, Traditions and Compromise

Liberia is an ethnically diverse nation that can be categorized into two groups: indigenous and settlers (Americo-Liberians). It is further divided into fifteen counties (Government of the Republic of Liberia, 2008), each county are subdivided into districts. Indigenous Liberians are descendants of African ethnic groups that already inhabited the Grain-Coast and Americo-Liberians consists of descendants of 19th-century "Settlers/Stateless Africans that are usually referred to in numerous literatures as Americo-Liberians and who subsequently "founded" Liberia, "freed Afro-Caribbean slaves who came to Liberia in the mid- 1800s, and Africans captured on U.S.-bound slave ships by the U.S. Navy (enforcing a U.S. law against the importation of slaves) and sent to Liberia" (Dunn-Marcos, Kollehlon, & Ngovo, 2005). Americo-Liberians may also include indigenous Liberian children nurtured by Americo-Liberian families and children of marriages between Americo-Liberians and indigenous Liberians (Dunn-Marcos, Kollehlon, & Ngovo, 2005).

Nonetheless, there are roughly 31 living languages (Lewis, 2009) spoken in Liberia and there are roughly 16 to18 ethnic groups that make up Liberia's indigenous population (Schulze, 1973) (Saha, 1998)(Levitt, 2005) (Dunn-Marcos, Kollehlon, & Ngovo, 2005)(Kieh, 2008) including but not limited to Kpelle, Bassa, Belle, Dey, Krahn, Vai, Loko, Konya, Mende, and Americo-Liberians. The Kpelle and Bassa ethnic groups were the largest in the census taken in 1972, 1974 and 1984 representing 20 % and 15 % of the total populations respectively (Dunn-Marcos, Kollehlon, & Ngovo, 2005). On the other hand, Americo-Liberians make up roughly about 3 % - 5% of the population (U.S. Department of State: Diplomacy in Action, 2011) followed by the Dey, Belle and Mende consisting of about 0.5% of the total population overall (Dunn-Marcos, Kollehlon, & Ngovo, 2005). Of importance is the extension of ethnic groups such as the Menda, Vai , Kisisi, Kpelle, Loma, Gio, Krahn and Mano into neighboring countries

such as Guinea, Sierra Leone, and Cote d'Voire which ultimately provides an insight into the precarious situation of Liberian refugees in these transitional countries today.

To mark a shift in governance and civil society participation, Liberia conducted its fourth census since 1984 in 2008. The new census did not account for or provide ethnic stratification but provided aggregate information on county and district only, perhaps to prevent the opening of lingering ethno-sensitivity wounds especially "if the census reveals shifts in the relative size of certain religious or ethnic groups that are not reflected in the power structure or distribution of economic resources" (Yin, 2011). Throughout history, the relationship between the indigenous peoples and Americo-Liberians was complex and contentious which oftentimes led to conflicts. The new settlers brought American traditions and culture to Liberia in order to transform the indigenous people from primitive religious, political, economic and cultural traditions to culture, to "appropriate American" values and institutions. The settlers superiority complex and disdain of indigenous traditions reflected in their reluctance to marry indigenous Liberian women with whom they had informal liaisons, preference to "wear western style dresses [despite the uncompromising tropical weather], the type of houses they built which bore resemblance to those of the White plantation owners, adherence to Christianity (including efforts to convert indigenous peoples), fostering English as the medium of instruction in schools and the devaluation of indigenous languages as tribal dialects.

In addition, settlers created regulations "against public nudity; aimed at indigenous Liberians, attempted to replace indigenous Liberian traditional land ownership with private ownership, and by de facto housing segregation in towns" (Saha, 1998)(Dunn-Marcos, Kollehlon, & Ngovo, 2005)- literally transporting and institutionalizing the same biased, and segregated life-experiences imposed upon them prior to their arrival to Liberia. Nevertheless,

from the very beginning, there was a process of compromise and cultural assimilation, whereby some indigenous peoples were amalgamated into "civilized" society at the expense of their cultural identity (Dunn-Marcos, Kollehlon, & Ngovo, 2005). Also, the ensuing of conflicts is reflected upon constant competition for land, trade routes, and indigenous Liberian labor. However, occasional economic and military assistance from the U.S. government from 1962 to 1980 in the gross amount of $280 million (Duva, 2002) provided leverage for Americo-Liberians which then facilitated the institutionalization of "an elaborate system of stratification in which they [Americo-Liberians] became the dominant group" (Dunn-Marcos, Kollehlon, & Ngovo, 2005), governing political, social, economic and cultural institutions while excluding indigenous participation in all processes.

Global Context of Refugees

The United Nations High Commissioner for Refugees defines a refugee as:

"A person who owing to a 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"- Article 1 of the convention on the status of refugees.

Refugee crisis has been a component of every society. However, the issues surrounding refugees became significant in the seventeenth century. In Europe, local monarchs targeted and persecuted religious minorities and others whose practices differed from the national norm (Gil Loescher, 2008). During the two world wars, the fight over territories also translated into questions of who should or shouldn't gain entry to certain states with fears of "regional security

and limited resources" (Gil Loescher, 2008). In an effort to mitigate regional instability in Europe, governments in the region created a "multi-lateral coordinating mechanism for refugees, mainly on an ad-hoc basis starting in 1921 to protect certain groups of refugees such as those fleeing the civil war in Russia (Gil Loescher, 2008).

In Europe, the end of World War I, World War II and the Russian revolution of 1917 produced millions of refugees (Renaissance London, 2011). By the beginning of 2007 in the Middle East, there were approximately seven million Palestinian refugees and 450,000 internally displaced persons (IDPs), representing 70% of the entire Palestinian population of 9.8 million (Palestinian Justice Network (PJN), 2011), on the African continent, ethnic conflict that escalated during the period of decolonization, due mainly to disputes over political representation and resource allocation et cetera, has and continue to generate large numbers of refugees. In Liberia, corruption, and the lack of political representation of the indigenous people played significant role in the civil war crisis from 1989-2003.

The African Refugee Context

Africa is witnessing an increasing incidence of political conflict. These conflicts have decimated large areas, reduced socio-political and economic relations within states, and exacted a heavy toll on the continents societies and economies, in addition to robbing them of their developmental potential and democratic possibilities (Oyeniyi, 2007), (Zeleza, 2008). Perhaps the most important and critical effects of the war are the massive displacement of women, men and children across borders compounded by various health problems.

Africa has been the center for massive refugee movements and internal population displacement. The problem of human displacement in Africa is growing in scale and highly complex, increasingly precarious and still and even those who succeed in escaping from their

own country are unable to find a safe refuge in neighboring countries (Crisp, 2002). According to the U.S. committee for Refugees, ten of the twenty-four countries with the highest ratio of refugees to local people are members of the African Union (Crisp, 2000). Essuman-Johnson, 1994 noted that Africa harbors about 5 million out of an estimated world total of 16 million refugees (Essuman-Johnson, 1994). Many were displaced during the struggles for independence and have been in refuge for over 30 years. Others became refugees during the post-independence period, when their vision of growth and development was perceived as threatening to the regimes in power (Kabera, 1989).

Although Africans represent about 12 per cent of the world population, 3.2 million of the world's 11.5 million refugees are in Africa (Crisp, 2002). At the beginning of 2010, refugees in Sub-Saharan Africa numbered 2 million, a significant reduction from the 3.4 million in 2000 (UNHCR, 2011) compared to Latin America with a total refugee population of approximately 442,000 (UNHCR, 2011). In addition, the states of Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia and Sierra Leone in west Africa; and the states of Eritrea, Angola, DRC, Congo Brazzaville, Burundi, Ethiopia, Kenya, Rwanda, Somalia, Sudan, Tanzania, Uganda and Zambia have experienced or still experiencing massive human displacement. Although the war in Liberia was declared over in 2003, Liberian refugees in Ghana have been reluctant to go home, and no clear solution has emerged to deal with the Liberian refugee problem in Ghana.

Nonetheless, as African governments attempt to solve the refugee problem, some countries have been more open and provided refugees with enormous assistance, while others have espoused unwelcoming attitude towards refugees (Essuman-Johnson, 1994). For example, Tanzania, granted Burundian refugees the status of naturalized citizens to facilitate re-integration programs (BBC, 2010). On the other hand, South Africa's hostile relationship with refugees

from countries like Zimbabwe is reflected in the government's decision to institute a new policy that requires refugees "to have work, business or study permits or face deportation" (Loom, 2011).

Other countries like Ghana have been generally generous but develop ad-hoc policies when tensions erupt between native and refugee populations- this is reflected in the events of February 2008 that led to the deportation of Liberian Refugees and more recently, an incident ensued on February 13, 2011 between Liberian camp residents and the Ghanaian police force which resulted in the deaths of five to eleven Liberian Refugees. Although there are conflicting reports on the actual number of deaths, this event continues to play a significant role in the processes of creating a rapid and durable solution to Liberian refugees. The options include: repatriation or re-integration, with repatriation being the priority option. Nonetheless, until refugees pose a threat, their stay is perceived as mutual, [they] are in limbo and are neither citizens nor residents of the host country.

The Liberia refugee process in Ghana is a peculiar case for many reasons. First, unlike other refugees in Africa, Liberian refugees in Ghana (whether or not they were descendants of Americo-Liberians) have deeply embedded feelings of interconnectedness with the U.S. and thus, are more concerned with the possibility of resettlement to the United States from Ghana than being repatriated or resettled in Ghana. Second, unlike other refugees in Africa, they have more flexibility to explore opportunities outside of the camp, without being harassed for documentation of status. This makes the Liberian refugees in Ghana a peculiar case, as it provides the case study population of this research project.

The Liberian Refugee Context

In order to understand how the conflict in Liberia evolved, the relationship between the key

parties, including their roles in the evolution of the conflict is briefly discussed.

The Economic Commission of West African States (ECOWAS) is a regional group of fifteen countries; including Liberia, founded in 1975 to promote economic integration in industry, transport, telecommunications energy, agriculture, natural resources, monetary resources and socio-cultural engagements. During the civil war, ECOWAS took diplomatic and military leads in bringing solution to the crisis in Liberia. Although efforts weren't as successful, this was an attempt to use African regional power to mitigate the effects of conflicts in the region. Nonetheless, the problem of refugees persists as a result of conflicting positions of the different groups outlined below.

The Economic Commission of West African States Monitoring Group (ECOMOG): This 6,000 peacekeeping force operating under ECOWAS was dispatched to Monrovia. Although Nigerians dominate the force, ECOMOG also includes troops from Ghana, Gambia, Guinea and Sierra Leone (Enoanyi, 1991).

National Patriotic Front of Liberia (NPFL): This is the Rebel group led by Charles Taylor who invaded Liberia in December 1989 with the intention of overthrowing the government of Samuel Doe and the Liberian Army. They mostly gained control of the rural areas with representation/membership largely from the Gio and Mano ethnic groups.

The NPFL committed many atrocities (Enoanyi, 1991).

The Independent National Patriotic Front of Liberia (INPFL): This rebel group emerged from the NPFL in 1990 and was led by Prince Johnson; from the Gio ethnic group and former ally of Charles Taylor; an Americo-Liberian with indigenous ancestry. It succeeded in gaining control of central Monrovia on July 23, 1990. Prince Johnson gave himself up to the Economic Community of West African States Monitoring Group (ECOMOG) and left the country in

October 1992.

Armed Forces of Liberia (AFL): This is the remnants of the army of the late Samuel Doe who was seized, tortured and killed by Prince Johnson. The army was widely condemned for gross human rights abuses and they were mostly made up of Samuel Doe's Krahn ethnic group.

The UNHCR in African Refugee Context

The United Nations High Commissioner for Refugees emerged in the wake of World War II to help Europeans displaced by regional conflicts and was established on December 14, 1950 under the authority of the United Nations General Assembly to provide international protection for refugees and to find durable solutions to "their plight, through repatriation, local integration or resettlement to a third country (Lawyers Committee for Human Rights, 1991) (Gil Loescher, 2008) (UNHCR, 2011). By July 28, 1951, the UNHCR adopted legal foundations of helping refugees and the basic statue guiding UNHCR's work (Gil Loescher, 2008) (UNHCR, 2011).

The beginning of the 20th century produced a shift in UNHCR's activities. That is, the UNHCR has evolved over the past [50 years] in an ad hoc method in response to a series of emergent refugee crises (Lawyers Committee for Human Rights, 1991), especially on the African continent-in conflict areas of the Democratic Republic of the Congo and Somalia (Lawyers Committee for Human Rights, 1991). In efforts to regionally contextualize refugee situations, the African and Latin American continents have strengthened the original 1951 convention of refugees and the 1967 protocol through the creation of, and the implementation of regional legal instruments. For example, the African Union (AU); formerly the Organization of African Unity (OAU) as a result of the inadequacy of the 1951 protocol that was originally "Europe" contextualized, adopted the AU Convention Governing the Specific Aspects of Refugee problems in Africa on September 10, 1969. Unlike the original instrument created by

UNHCR, the African Union protocol expanded on the definition of refugees and thus has influenced developments of similar instruments in Latin America via the Cartagena Declaration on Refugees (Okoth-Obbo & O'Connor, 2003). The AU protocol also noted that such actions were necessary to continue the close a continuous relationship between the African Union and the office of the United Nations High Commissioner for Refugees (UNHCR, 2007).

Reintegration, Resettlement and Repatriation

The UNHCR formed the term 'durable solutions' to the 'problems' of refugees, as its mandate to the solution of forced displacement (Schaffer, 1994). As stated on the website, the primary purpose of the UNHCR is to safeguard the rights and wellbeing of refugees by finding and providing them with durable solutions that will allow them to rebuild their lives in dignity and peace (UNHCR, 2011). The agency provides three solutions to the means. They are voluntary Repatriation; local Reintegration, and Resettlement. Reintegration is the integration of refugees into the host communities while Resettlement (to a third country in the western hemisphere) is an "alternative" to refugees who cannot return home, often highly skilled, and with high educational attainment- This type of resettlement is not for family re-unification purposes and it's made possible by UNHCR and the respective governments involved. Repatriation, which is the premise of this paper, is the voluntary return of refugees to their country of origin. Of the three, repatriation is the major emphasis of the UNHCR (Barry & Frederick, 1994) with the "assumption that everyone would want to go home" (Chimni, 1993) (Zieck, 1997). Importantly, repatriation is often the de-facto choice and solutions to refugees who are poor and or have low educational attainment and skill. This specific group also tends to remain on the refugee camp because of real or perceived fear of retaliation, but yet have no viable skill required for socio-economic mobility. Nonetheless, in order to achieve any of the three durable solutions, political

will and [economic] capacity are necessary, but yet, obstacles stand in the way of all three solutions (Stem, 1986).

During the Cold War and the period of decolonization, “those fleeing communist regimes and colonial oppression were granted refugee status on the assumption that repatriation was not an immediately viable option” (Gil Loescher, 2008). Subsequently, reintegration and resettlement were the principal durable solutions up until the 1980’s when governments of the global north have been increasingly concerned to limiting immigration; at least of specific group of people or from specific geographical areas. As a result of and “diminishing international assistance” (Gil Loescher, 2008), host countries in the global south have been reluctant to allow reintegration thus leaving repatriation as the most viable option for refugees. However, according to Jessica Schaffer (1994), several works begun to question the previously unquestioned assumption that repatriation involves a 'return home' and constitutes a safe and durable solution to all cases of forced migration.

Nonetheless, what shaped UNHCR’s motivation to promote repatriation as a durable solution was the voluntary repatriation of 54,000 Tigrinya refugees in 1985 who left refugee camps in Sudan and returned to northern Ethiopia despite the ongoing famine and lack of security in the area (Barry & Frederick, 1994). According to the research conducted by Barry et al., 1994, few of these repatriates died and many returned to their normal lives. This is critical to the examination of the Liberian refugee context as it provides a framework for establishing whether or not Liberian repatriates can return to normal lives amidst the current economic climate and the recent verdict of Charles Taylor by the International Criminal Court (ICC). That is why it is also important to consider providing reproductive health services for those who may be left behind or for whom repatriation is not an option. To that effect,

"Plan should establish that the conflict has abated and its attendant risks have been eliminated before promoting return. In addition to ensuring that repatriations are deferred until the armed conflict has ended, the return plan should guarantee that the risks associated with armed conflict those, which still threaten the lives, safety or dignity of the refugees, have abated" (Chimni, 1993).

It is important to note however that voluntary repatriation in some cases have been involuntary, and coerced especially in the case of specific group of people for whom repatriation has been made mandatory in bilateral agreements (Zieck, 1997). In the African context, temporary/forced migration has long occurred before the establishments of formal international and regional instruments. Events like famine, ethnic rivalry, and colonial occupations have caused the displacement of persons "across borders in search of food, shelter, security and justice, and then subsequently welcomed by Kin" (Bakwesgha, 1994). However, the type of assistance provided for them was informal and resources were shared between asylum seekers and host populations (Bakwesgha, 1994).

Unfortunately these informal systems have been fragmented due to globalization and a shift in norms or even perhaps the lack of security and spillover effects of conflicts making neighboring or kin affiliated communities inhabitable, and thus have shifted the asylum seeking processes of individuals as well as the bodies charged in their protection.

Over five million refugees in Africa are known to have repatriated since the early 1990s by the UNHCR (Barry & Frederick, 1994) (Crisp, 2000). In Mozambique, for example, around 1.7 million refugees are estimated to have repatriated between 1992 and 1996 (Crisp, 2002). Furthermore, Since the mid-1990s, significant numbers of refugees from Benin, Liberia, Mali, Niger and north-west Somalia have returned "home", in response to the signing of peace

agreements or reductions in the level of repression and violence in their respective countries (Crisp, 2002) however, many others have gone home under duress- such is the case of Rwandan refugees in Uganda (Khiddu-Makbuya, 1994).

CHAPTER 1: HEALTH AND THE REFUGEE EXPERIENCE

1.1 Reproductive Health in Liberia

The World Health Organization defines reproductive health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity (WHO, 2011). It also emphasizes sexual responsibility, sexual satisfaction and the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2011). This comprehensive definition was the result of the groundbreaking international conference on population and development in 1994 in Cairo. However, the lack of access to reproductive health services in resource constraint settings makes it difficult to achieve the goals stipulated in the above definition of reproductive health. When the concept of civil unrest is added, leading to the displacement of people especially women and children, access to reproductive health services becomes complicated and dire despite its importance.

The fourteen years protracted civil conflict in Liberia that recently ended has completely collapsed the country's health care infrastructure. Liberia has one of the highest maternal mortality rates (994 per 100,000 live births) in the world (Liberia Demographic and Health Survey, 2007) compared to sub-Sahara average of 640 per 100,000 (World Health Organization, 2010). The lifetime risk of maternal death in Liberia is 1 in 20 (UNICEF, 2010). Coupled with a strikingly low contraceptive prevalence (11%) (Liberia Demographic and Health Survey, 2007), a high fertility rate of 5.9 per woman (Populations Reference Bureau (PRB), 2010) - (an indication of limited access to reproductive health services in the country) and a broken health infrastructure, the risk for adverse pregnancy outcomes and reproductive health is increased. In 2010 Liberia ranked 162 of the 169 countries surveyed in the Human Development Index (HDI)

(UNDP, 2010) reflecting grim health, education and economic indicators. Liberia has an estimated population of 3.3 million with an average life expectancy of 54 years for men and 57 for women (WHO, 2011). Liberia population is demographically young with nearly 50% of the population under the age of 15. These grim socio-economic indicators in Liberia are also reflected in the Liberian refugee population on Buduburam camp, in Ghana, which helps to put the research project in relative context.

1.2 Refugee Women Health

Women's health especially their reproductive health is integral to national development and growth. Investing in women's health is a national imperative that continue to be pioneered by United Nations Populations Funds (UNFPA) as well as other IGO's/IGO's. In addition to slowing population growth, investing in women's health, especially maternal and child health will reverse the $15 billion lost in productivity annually to the lack thereof (Obaid, 2009). Also, the maternal health of refugees is similar to those of other women and children in developing countries, but "compounded by the refugee experience" (Martin, 2004).

Another cause of morbidity and mortality amongst refugee women is complications from pregnancies, lack of midwives or Trained Birth Attendants (TBA), post-natal sepsis, septic abortions, unsanitary conditions during birth and frequency of pregnancy due to lack of usable or general unavailability of birth controls (Martin, 2004). Refugees also face difficulties such as having witnessed and experienced violence, uncertain life, break down in education, loss of property and record, widows, orphans, and all other forms of economic and social vulnerability (Martin, 2004).

Furthermore, refugee women are among the world's most vulnerable people because they have urgent health needs, including reproductive health. Their access and use of contraceptive

are limited and they are vulnerable to HIV/AIDS and other sexually transmitted diseases (Benjamin, 2011). Furthermore, the disruption of family and community life during transitions (Martin, 2004), especially in situations of poverty and crisis, increases risky sexual behavior and exposure to STI's among refugee women (Booysen & Summerton, 2002). Subsequently, ensuring safe motherhood and childbearing among refugee can be difficult and life threatening.

During emergencies women often lack adequate food, shelter, and sanitation. In a report published by the Center for Communication Programs at the Johns Hopkins School of Public Health; People Who Move: New Reproductive Health Focus, prenatal and delivery care often are minimal, and emergency care may be hours away in many refugee settings and violence against women is frequent (Populations Report, 1996)-thus jeopardizing their wellbeing. Among refugees, rapes occur frequently and some women may have no choice but to trade sex for security, money, and food-heightening their risk of sexual violence and abuse (Benjamin, 1998), which oftentimes puts them at risk of contracting STI's and getting pregnant. Moreover, several studies have documented the increasing occurrence of domestic and sexual violence in many camp settings that results from being dependent on a male partner (Ray & Heller, 2009).

The problems associated with life on a refugee camp, such as poverty, frustration, and enforced idleness, adds pressures on families, and contributes to high incidence of domestic violence (Human Rights Watch, 2000)(Kreitzer, 2002) (Pittaway, 2004). More so, a study conducted by Dick (2002) points out the vicious cycle of self-reliance and dependency in her case study of Liberian refugee women in Ghana. She notes: "refugee women are particularly susceptible to dependency on relationships with men as a way to sustain themselves financially and to access luxury items that they value. As a result, teen pregnancy is common at the camp, giving many young women the added burden of providing for a child thus perpetuating the need

to be dependent on a boyfriend" (Dick, 2002). Subsequently, this dependency subjects them to vulnerability and demands for sexual access in exchange for such assistance (The Advocates for Human Rights, 2010).

The physical, and psycho-social injuries sustained as a result of domestic violence are a serious public health issue that needs to be addressed as well. As a result, government and private organization in some countries have established centers shelters for refugees who are victims of domestic violence and their children (Human Rights Watch, 2000). However, there has been inadequate research conducted to determine the sustainability of these types of establishments in refugee camps and "whether shelters could become targets for attacks by unhappy spouses and others-thus putting women at greater risks" (Human Rights Watch, 2000). For various reasons such as shame, guilt and helplessness amongst others, victims of sexual and domestic violence "hide behind a wall of silence" (Pittaway, 2004) despite the extreme physical and mental health consequences.

The reproductive health indicators of Liberian Refugees is a mirror image of the Liberian women population in Liberia however compounded by survival strategies that often put women's health at risk. The high incidence of teen pregnancy on Bududuram camp was illustrated in a study conducted by Shelly Dick; 2002 (Crisp, 2003). In other cases, refugee women and young girls' health are put at risk through exploitative employment-"refugee girls may be sent to work as domestic laborers in other households (Crisp, 2003) thus increasing their risk of sexual exploitation and abuse. Organizations such as the African Women's Development and Communications Network (FEMNET) have developed strategic toolkits, using men to address gender based violence. However, this socio-cultural approach to addressing GBV is not enough to address the non-social consequences of gender/sexual based violence victims endure.

As a result, the Inter-Agency Standing Committee (IASC) on Gender in Humanitarian Action and the Gender Based Violence (GBV) Area of Responsibility (AoR) working group developed a comprehensive training package called The 'Caring for Survivors' training package.

This package provides skills development and information in various aspects related to communication and engagement with victims of sexual violence in complex emergencies, including focus on medical treatment (Reproductive Health Response in Crises (RHRC) Consortium, 2010). However, the lack of infrastructures and personnel in many camp settings may prevent the appropriate response from taking place.

1.3 Background of the Study

When asked "Is the UN repatriation package sufficient for you and your child? " :if the UNHCR' repatriation package is enough" and "What suggestions do you recommend for the UN and other agencies to improve the reproductive health needs of Liberian refugee women" a respondent responded: " It is not sufficient because it cannot find me a place to live, buy me food, take care of my medication and educate me…we need free medication, good and clean environment, clean bathing water and milk." *(Respondent, Bududuram camp 2009)*

[UNHCR should]"Try to clean the environment, provide free medicine, food, education, better housing because drainage is bad and mosquitoes are flying around giving children Malaria*".* *(Respondent, Bududuram camp 2009)*

The statement above represents the multilayered issues that refugee women endure in Bududuram camp. The issues that have been raised by refugee women includes, environment concerns, waste management, food, education and malaria; which is often a major problem in war (Rowland & Nosten, 2001). Nonetheless, refugee women's health especially their reproductive health is an integral component of national development and growth in post war

Liberia, whether or not these women choose to repatriate.

1.4 Events That Activated UNHCR's Repatriation Efforts/Package

The incident that occurred in Ghana in early 2008 contributed to the rapid repatriation of Liberian refugees and thus urged the need to assess the reproductive health status and needs of Liberian refugee women living in Buduburam camp prior to taking flight back to their country of origin. That is, if they choose to repatriate, to what extent will the repatriation package have on their decision, based on their current health status and will addressing their health problems ahead of time make for a successful repatriation process?

On February 19, 2008, refugee women at the Buduburam Refugee Settlement staged a peaceful protest to urge the United Nations High Commissioner for Refugees (UNHCR) to provide an improved repatriation package and to help Liberian refugees resettle to third countries of asylum. By the 3rd of March, according to the Population Caring Organization (PCO), the protest had spread to the entire settlement. It forced the closure of schools on the camp and stopped all humanitarian activities, including the distribution of relief items (UNHCR, 2008). For several weeks, women who called themselves Liberian Refugee Women with Refugee Concerns and children stayed on the main football field in the sun and rain, taking turns holding up placards with slogans expressing their grievances and appealing to the UNHCR to rectify prior injustices in resettlement programs (Population Caring Organization (PCO), 2008).

In addition, they requested that the UNHCR create and enforce policies that would address employment discrimination, and violence against refugees in Ghana. Subsequently, Ghana's Riot Police moved onto the field and arrested hundreds of women during the early morning hours of March 10. On March 16, some of the women (mainly elderly women and children) who had been arrested were released and brought back to the camp to reunite with their families. The

following day, police came back on camp and forcefully arrested 107 refugees (mainly young men), 16 of whom were deported, 14 held for questioning, and 87 were released back to the camp (Population Caring Organization (PCO), 2008).

As a result of this chaos, the delegation from the Government of Liberia proceeded to have discussions with the Government of Ghana concerning the future of the refugees in the Buduburam settlement and on March 27, the Liberian Foreign Minister visited the camp to share with its residents, the outcome of the meeting. The Foreign Minister stated the following:

That the Government of Ghana had invoked the 'cessation clause' of the 1951 United Nations Convention on Refugees (this clause states that when conditions have improved in a refugee's country of origin, the host government is no longer obliged to host them which has the implication of stripping refugees of their refugee status;

That resettlement to a third country is no longer an option; and

Since refugees have made clear that they do not want to be locally integrated into Ghana, repatriation remains the only option for the refugees at Buduburam (even though these women are only interested of resettlement to a third country - (Population Caring Organization (PCO), 2008)

Unfortunately, the foreign minister statement and decision on repatriation does not stress or address whether these refugees, especially women are healthy to return home involuntarily. The foreign minister asserts that repatriation remains the only option for refugees regardless of their health status. However, Ghana, as a refugee host country is responsible for protecting Liberian refugee, and health related services for refugees are provided by NGO's, formally through contracts or voluntary via the UNHCR. Nonetheless, women are likely to remain refugees than repatriate since there might be no meaningful reproductive health service provision for them in

Liberia.

1.5 The Relationship between UNHCR and NGO's

UNHCR is a donor driven Inter-Governmental Organization (IGO). Their ability to sustain or develop programs fluctuates depending on the interest of participating governments. Also, the UNHCR does not directly provide, services such as health care or education to refugees, it however, employs the partnership of NGO's as implementing partners. There are two ways this partnership takes effect. UNHCR provides financial support to an NGO to deliver specific programs to refugees, as specified in a formal project agreement (Gil Loescher, 2008). Second, the UNHCR has "operational partners where there is voluntary (unpaid partnership) coordination between the UNHCR office and an NGO's in areas such as emergency relief and refugee resettlement" (Gil Loescher, 2008). For example, NGOs such as the International Rescue Committee (IRC), CARE, and OXFAM have been crucial in areas such as camp management, water and sanitation and health (Gil Loescher, 2008).

In many instances, NGO's have been crucial in connecting UNHCR services with "hard to reach" populations. For example, a UNHCR when referring to the work of an NGO in Pakistan explains "We don't have the kind of human resources that they have at their disposal…We can't imagine even having something like that. It is an obvious plus" (UNHCR, 2003). As such, UNHCR relationship with NGO's or other bodies is essential, especially considering the need to integrate health, especially the health of women in the discussion even before the initiation of short or long term repatriation plans. Although organization such as Marie Stopes International focus on improving maternal health among repatriated refugees in Guatemala (Marie Stopes International, 2004), such efforts should be directed prior to repatriation since preventive mechanisms or treatment is cost effective, viable and perhaps will reduce the influx of returning

repatriates to host country due to health related reasons.

Nonetheless, maintaining the quality of life in a refugee camp is difficult but crucial to do so (Leaning, Briggs, & Chen, 1999). Also, reproductive health programming in refugee situations is never easy and poses special challenges. The International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) marked a policy shift and emphasized reproductive health needs and rights of the underserved, particularly refugees and internally displaced persons (Howard, et al., 2008). Further, relief efforts have traditionally been on acute-phase survival, including HIV prevention and basic emergency obstetric care but since reproductive health spans relief and development, it is therefore critical in programming of successful repatriation and long-term survival and national development in the country of flight.

1.6 Problem Statement

Women assume the role of head of household, while men go to combat. Women are forced to bare extended responsibility for the elderly, disabled, and children and in the process ignoring their health (Martin, 2004). This reflects the triple role of women in camp settings in areas of 1) reproductive work 2) childbearing and rearing responsibilities; required to guarantee the maintenance and reproduction of the labor force and 3) the productive work; as secondary income earners (Mulumba, 2010). In a survey conducted on Women's Reproductive Health in Lofa County Liberia, Over one-third of women sampled at the time of the survey were female heads of households and have low literacy and a high unemployment. (Tomczyk, et al., 2007). In addition, access to clean water and sanitation services is almost universally unavailable (Martin, 2004).

The same study also illustrates the poor maternal health of Liberian Women in Lofa

County that of the 161 reported pregnancies who did not receive Prenatal Care, 92.2% was due to the unavailability of health care providers, 63.4 % complained about the proximity of the health center from their homes, 40.8 % complained of financial constraints as a reason to not receiving prenatal care and 39.0 % states that transportation was not available (Tomczyk, et al., 2007). The reproductive health need of Liberian refugee women on Bududuram camp currently reflects the same picture of inadequate resources and poor reproductive health, therefore, the situation awaiting them in Liberia is no different.

1.7 Hypothesis

- The reproductive health status of Liberian refugee women is reflective of their income level
- The reproductive health status of Liberian refugee women is reflective of their level of education.
- The UNHCR does not offer reproductive health services as a priority service for refugees.

1.8 Objectives of the Study

The main purpose of this study is to assess the reproductive health status of Liberian Refugee women on Bududuram Camp and to see whether their health status has an effect on repatriation plans.

In doing so, the objectives of this study is to

- Assess the reproductive health of Liberian women refugee in Bududuram
- Examine the factors that affect women‘s access to reproductive health services.
- Examine the roles that women play in improving their health and that of their children.

1.9 Significance of the study

“Motherhood and childhood are entitled to special care and assistance. All children whether born

out of wedlock, shall enjoy the same social protection" (The International Bill of Human Rights, 25:2)

Maternal and child care is a major determinant of economic growth and productivity and thus should be given special attention and as result, reproductive health care should be available in all situations and should be based on the expressed needs and demands of refugees (Mulumba, 2010), especially women refugee. It widely reported that fertility is high in refugee settings and that many pregnancies are at high risk of obstetric complications (Schreck, 2000). Therefore this research aims to draw attention to the health status of Liberian women refugees and repatriation concurrently. In this regard, this study will contribute to policy debate and approaches towards improving women's health while at the same time increasing the economic output of refugee women when they repatriate. This study will also help refugees understand their vulnerabilities and how they can play a role in mitigating these vulnerabilities.

Understanding and addressing the health needs of refugee women before repatriation improves the quality of their lives and would also be a significant contribution to population health for Liberia, reducing health costs for serious and acute care, if they choose to repatriate. Finally this paper aims to provide the UN, local NGO's and other asylum countries with information that will help manage refugee crisis in the host and native country, by first addressing healthcare in respect to repatriation.

1.10 Operational Definitions

It is important to clarify concepts and definitions to make clear the meaning of the following concepts as used in this project. This research considered using the age of women 13 years above as meeting the criterion for exploring reproductive health issues. The interest was on specific questions related to abortion, contraceptive, and perinatal nutrition and supplements. They were

deemed to be of the age category considering DHS criteria and Liberia's socio-demographic context.

Refugee: The definition of a refugee is a person who, ''owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality [or of habitual residence], and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country'' (1951 Convention Relating to the Status of Refugees, Article 1(2). The OAU 1969 declaration expanded on the above definition by including " every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality"– Article I Convention Governing the Specific Aspects of Refugee Problems in Africa (UNHCR, 2007).

CHAPTER 2: RESEARCH METHODOLOGY

2.1 Research Site

The Republic of Ghana formerly known as the Gold Coast is located in West Africa. It is bordered by Ivory Coast to the west, Togo to the east, the Gulf of Guinea to the South and Burkina Faso to the North. It has a total area of 238,540 square kilometers of which the land area constitutes 230020 square kilometers (Ghana Web, 2011). In pre-colonial times, Ghana was inhabited primarily by the Great Akan Kingdoms which includes the Ashanti Empire and carious Fante and non-Akan states like the Ewe and Ga. It is relatively peaceful compared to its neighboring countries. The Republic of Ghana ultimately became the first country in Africa to gain its independence from Great Britain in 1957 and several African country followed suit thereafter. The country has a tropical climate with 40 % of the economy financed through agriculture which also employs 60 % of the workforce and accounts for 37 % of the Gross Domestic Product of 14 billion USD in 2008 (Ghana Web, 2011).

The country is currently the second leading exporter of Cocoa in the world. Furthermore, industry constitutes service 15% and 25 % of labor force respectively with the unemployment rate at 20.3% whiles the minimum daily wage stands at 10,500 Cedis (Addo, 2007). In 1960, about 100 linguistic and cultural groups were recorded in Ghana. Although later censuses placed less emphasis on the ethnic and cultural composition of the population, differences of course existed and had not disappeared by the mid-1990s (Ghana Web, 2011). Ghana's total population is 24 million (The World Bank, 2011) with women and men constituting 51% and 49% respectively (Addo, 2007). The major ethnic groups in Ghana include the Akan, Ewe, Mole-Dagbane, Guan, and Ga-Adangbe and the subdivision of each group share a common cultural heritage, history, language, and origin (ibid). In addition, Ghana is divided into ten regions which

are further subdivided into 123 districts. The Bududuram refugee camp (Where the majority of Liberian refugees live) forms part of the Central region and within the Gomoa district. Health indicators for Ghana are similar to those of other developing countries in West Africa. In 2009, the under-five mortality rate was 69/1,000 with life expectancy at birth at 57 years (UNICEF, 2010). The total fertility rate is 4.2 per woman, the contraceptive prevalence rate is at mere 24 % while the lifetime risk of maternal death is one in sixty-six with only 57 % of birth attended by a skilled professional (ibid).

2.2 Study Area: Bududuram Refugee Camp

This section presents some specific characteristics of the study area (Bududuram refugee camp) that will be very important for letter discussions. The features to be discussed here include the physical outlook of the area, history, population, social and physical infrastructure, cultural and finally the economic characteristics.

Location

This project was study was conducted mainly at the Bududuram refugee camp also known as the Liberian camp because of the high population of Liberians on the camp. The Bududuram Refugee Settlement is located in Bududuram, Gomoa District, approximately 28 miles from Accra (Ghana's Capital).

History

Bududuram refuge settlement was established in 1990 to host Liberian refugees who sought asylum as a result of the fourteen years protracted civil war (Bududuram.com). Initially, the camp was created to host about 5000 refugees; however, due to the massive outpouring of refugees, the refugee population in the settlement has stretched to nearby villages such as Feeteh, Kasoa and Awutu.

Population

The Liberian camp, as it is popularly known, has been home to over forty thousand refugees Although Liberian refugees constitute the largest percentage of refugees on the camp, refugees from people Togo and Sierra Leone also inhabit the camp including persons from Nigeria and Ghana alike. According to Essuman-Johnson, "the first batch of Liberian refugees sent to the camp were from one of the Ghana Air Force flights to Freetown to evacuate stranded Ghanaians….since then all non-Ghanaians who were evacuated from Liberia were sent to the camp" (Essuman-Johnson, 1994). By September 1990, twenty-nine refugees resided on the camp and by February 1991, the camp population reached 8,000 and by the following year in 1993, the population reached 13,000 (Essuman-Johnson, 1994) - This is primarily a reflection of the intensity of the war in Liberia during this period. By the end of 2009, voluntary repatriation to Togo and Liberia has reduced the number of refugees in Ghana to approximately 11,500 (UNHCR, 2010). The following table illustrates the current numbers of persons of concerns (refugees/asylum seekers) on Buduburam camp:

Persons of Concern					
Types of population	**Origin**	**Total**	**Of whom assisted by UNHCR**	**Per cent female**	**Per cent under 18**
Refugees	Liberia	11,500	11,500	49	35
	Togo	1,700	1,700	48	46
	Various	500	500	29	26

Asylum-seekers	Cote d'Ivoire	270	270	40	24
	Various	330	330	31	23
Total		**14,300**	**14,300**		

Source: http://www.unhcr.org/4c08f2339.html

The Administrative Structure of Bududuram Camp

Through the Ghanaian government, the office of the National Disaster and Mobilization Organization (NADMO) manages the affairs of the camp and appoints the camp Manager. The camp manager is responsible for the overall supervision of the residents and activities on the camp, and is assisted by the Liberian Refugee Welfare Council (LWFC); group of screened Liberians who represent the refugees since management policies are implemented through this organization who can interpret the needs of refugees better than Ghanaian officials, who only play supervisory roles (Boamah-Gyau, 2008) (Addo, 2007). Private, religious and public institutions such as NGO'S churches and the UNHCR uphold leadership on the camp internally and externally. As a result of the gradual decline of UNHCR's work in Bududuram, NGO's have also been withdrawing their services.

The camp is divided into 12 Zones. However, the actual settlement is divided into nine zones but due to the increasing refugee population, the remaining 3 zones extended outside the property but still within the village. Each zone has a zonal head supported by camp residents to coordinate issues at the grassroots and submit to the welfare council. In addition, some refugees reside outside the settlement in Kasoa, Awutu and even in greater Accra region and Kumasi in the Asante Region (Addo, 2007). Furthermore, research conducted by Boamah-Gyau Kouame in

2008 suggests that "there are ten standing committees operating in the camp, which include arbitration and discipline, health and sanitation, education, logistics and mobilization, zonal heads, sports department and other committees" (Boamah-Gyau, 2008).

2.3 Social Amenities on Bududuram Camp

Health

The St Gregory Catholic Clinic also known as the Bududuram clinic is the only clinic at on the camp. It was recently expanded by UNHCR in 2009 and officially handed over to the Archdiocese of Cape Coast on the May 6th 2009 (National Catholic Service) and thus received certification to operate under the Ghana Health Service. The clinic operates with a Liberian doctor, who is also a refugee trained in Ghana. According to UNHCR 2008 report, 2,500 refugees were enrolled on the National Health Insurance scheme. Currently, malaria continued to be the highest cause of morbidity among the refugees and their host communities. Medical facilities providing assistance to refugees fully implemented the New Malaria Protocol. HIV and AIDS services focused mainly on reducing stigma and encouraging free testing on the camp (UNHCR, 2008). In addition, anti-stigma and voluntary counseling and testing campaigns were conducted in collaboration with the Ghana AIDS Commission and other UN Agencies under the UN Integrated Support Plan and by 2008, more than 85 per cent refugees were reached through HIV and AIDS sensitization activities (UNHCR, 2008).

2.4 Methodology

Introduction

The target groups of this study are women regardless of their marital status. The age group chosen for this project was based on the conversation with a health personnel working at the camp clinic, who put the age at first sexual encounter at 13 years old and also by using the DHS

categorization on women of reproductive age. Moreover, according to 2007 National Ministry of Health statistics a third of Liberian mothers give birth to their first child before the age of 19, making Liberia one of the countries with the highest rates of teenage pregnancy in the world (Allen & Mallah, 2010).

2.5 Technique of Collecting Primary Data

The primary data used in this research was collected in the months of February to April 2009. Closed and open-ended questionnaire was the main method for collecting quantitative data. Interviews, discussions and direct observation were used to obtain qualitative data. Interviews were conducted with a physician assistant and a medical doctor with the aid of a questioning guide.

2.6 The Questionnaire Survey

The primary instrument used to collect quantitative data was both open and close-ended structured questionnaire. The questionnaire used in this research deals with the background characteristics of respondents and seeks to obtain information on certain socio-economic and demographic variables such as age, marital status, level of education, parity, health seeking behavior, antenatal care, health services utilization, and occupation amongst others.

2.7 Sampling Procedure

Survey data from my field work comes primarily from 25 Liberian women refugees and both primary and secondary data were made use of in this research. Cluster sampling techniques were used in selecting three respondents per household from eight out of twelve zones. However, four respondents were chosen from one zone due to the population measures of that zone. Cluster sampling was utilized because the population of Bududuram camp is divided into natural clusters/zones and each zone is representative of the total population. Generally, I started with

the structured questionnaire and after each questionnaire was completed, some refugee women opened up about some questions on the questionnaire- which discussions followed.

2.7 Data Collection and Procedure

The researcher secured a letter of introduction from the Education Abroad Program to be able to seek assistance from the relevant authorities and also met with various officials on the camp and explained to them the nature and purpose of this study. After gaining their permission, the researcher proceeded in distributing and administering the questionnaires to the respondents. In order to partake in the study, respondents must be a Liberian residing in Bududuram refugee camp and must be a female from age thirteen and above. To reduce the problem of reactivity (Bernanrd, 2006), I utilized participant observation-thus the more I frequented the camp people took less interest in my comings which allowed me to gain trust of the community. The entire questionnaire was administered by the researcher and the research assistant.

Ethical considerations regarding the subjects were adhered to. Informed consent was obtained from all respondents. All data collected was stored and no information about the respondents, including their identities, was released or disclosed to anyone. In addition, information collected was considered sensitive and confidential and no identifying data about any subject was provided. The researcher also ensured the highest sense of confidentiality, strict anonymity in attempt to adhere to the ethical principles of research conduct.

2.9 Data Analysis

Data or results gathered from the analyses of the survey was presented, explained and discussed using the techniques of descriptive statistics. The nature of the study, the sample size, and the time and financial constraints for data collection and analysis were considered during the research.

2.10 Theoretical Framework

Egon Kunz Refugee Theory and Structural Functionalism Theory

The researcher has not encountered any theory specifically addressing the health of refugees and its effect on repatriation. However, Egon Kunz theory of refugees and Talcott Parson's theory of structural functionalism may help shed some light on this issue. In discussing the important role that health plays in repatriation decision, it is critical to explain the socio-cultural and socio-economic benefit of addressing the health needs of refugees, especially refugee women. Although refugee population may be under the influence of home and the actions they experienced while there, "they rarely remain full captives of their past" (Kunz, 1981). They begin to explore their surroundings and gradually change their expectations which require resources in the forms of policy, social amenities such as food, shelter, and safe drinking water and access reproductive health services.

As the host (Ghana) and intermediary (UNHCR), both are required under the universal declaration of human rights to provide the necessary frameworks for the present and future success of Liberian refugees. If the necessary framework is institutionalized, the more refugees feel comfortable accessing information and resources and that will better address their needs and promote a positive livelihood with their host country and its populations (Kunz, 1981). Refugee women are no exception to this rule. This process is illustrated in the positive performance of Liberian refugee women in Ghana in spite of overwhelming difficulties. "It was noted that these women were especially determined against all odds to work hard and make a home away from home for themselves and their children" (Global Health.gov). In doing so, the more refugees, especially refugee women feel comfortable accessing information and resources and that will better address their needs and promote a positive livelihood.

The lack of cultural compatibility among Liberian refugees and Ghanaian natives as postulated by Kunz might result in exclusion, isolation and ultimately leads to depression. When respondents were asked if they felt welcome in Ghana, 40% of those surveyed replied they did not feel welcome, 22.7% felt somewhat welcome, 32% felt very welcome (Geueke, Doherty, & Foy, 2005). Those who do not feel welcome provided some explanations that Ghanaians discriminate against Liberians in the job-market, and another described the dismissive reaction of Ghanaians when they detect a Liberian accent (Geueke, 2005). These negative externalities will create friction and hinder positive "host-refugee" relationships. On the other hand, if refugees are not discriminated against or if they find sufficient amount of people who share their values, language, tradition, life-style, and food habits (Kunz, 1981), their relationship with the host country becomes accelerated positively and thus may contribute positively to their wellbeing including creating an enabling environment that fosters health seeking behavior such (through education) as safe sexual practices, attending pre/post natal care, and immunization of children amongst others.

On the other hand, due to the conducive and cooperative environment of accessibility in Nepal, a study conducted amongst Bhutanese refugees suggested that education as an "occupational therapy" kept refugees busy by mitigating the level of crime and preventing anti-social activities thus [health seeking behavior through education] is harnessed for positive rather than negative use.

Nevertheless, Talcott Parson's theory of structural functionalism serves useful in the examinations of the importance of the viability of reproductive health for successful repatriation efforts. Structural functionalism, is an extension of the theory of functionalism, recognizes the important role that the social structure plays in society. Parson asserts that the different parts of

the society contribute positively to the operation or functioning of the system as a whole. Therefore, institutional frameworks promoting the importance of refugee health, education and other social amenities are all important aspect of societal structure, development and growth.

A society that is illiterate and ill-health is en route to social disintegration (Lidicker, 2003). Importantly, Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence, and adulthood and affects the health of the next generation (United Nations Populations and Information Network (POPIN)) thus, the health of the newborn is a function of the maternal health and nutrition, including access to health care contributes immensely to the smooth functioning of societies.

Subsequently, reproductive health seeking behavior is affected by, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures of societies. Therefore, making certain that refugees, especially refugee women have access to education is crucial to their reproductive wellbeing. Nonetheless, the UNHCR has been undergoing financial crisis in the last few years. The lack of adequate funding is a major reason for poor quality in refugee education. It can even lead to schools closing down (Brown, 2001) and as Talcott Parsons suggest, the system becomes static, as one part of the system (lack of funding for funding for education or health services) impacts the whole system consequently creating an imbalance. For example, a senior UNHCR officer wrote concerning Nepal in May 2000:

On the issue of education, we were informed by UNHCR sub office in Jhapa that CARITAS-Germany had stopped funding secondary schools...and UNHCR was facing problems financing it.

In another report from Kenya, the UNHCR indicated the negative consequences of the financial crisis such as low-quality education due to lack of classroom supplies, non-completion of classrooms, and lack of teacher training, inadequate desks due to lack of resources and laying-off of teachers (Brown, 2001). The lack of funding does not only jeopardize the educational attainment of refugees, it compromises their future involvement in their respective countries, and it does not prepare them to partake in any economic mobilizing activities since their education have been traumatized during some point in their lives. For Liberian refugee women, the lack of educational opportunity and economic independence further enshrines them in a cycle and adoption of negative activities such as prostitution, which if not practiced safely, compromises their reproductive health well-being

2.10 Selected Works: Reproductive health and the Repatriation process.

The purpose of this section is to visit the work of some authors and organization that focus on refugee reproductive health and prioritization for UNHCR.

Hidden Suffering among Refugee women

In many camp settings, fertility rates and gender-based violence increase, and maternal and neonatal mortality can be high. Maternal mortality due to unsafe abortion among refugee women is estimated to be twenty-five and fifty percent (UNFPA, 1999), signifying considerable unmet need for contraception (Reproductive Health Response in Crises (RHRC), 2012). Bodies such as the Inter-Agency Working Group on Reproductive Health in Crisis have heightened reproductive health care for refugee women in refugee settings. However, despite moves to improve provision, barriers to access and acceptability still remain (Okanlawon, Reeves, & Agbaje, 2010). In addition, involving male partners in decision-making may reduce the threat that fertility control presents in refugee settings, and may increase the effectiveness of a reproductive

health initiative (Mullany, Becker, & Hindin, 2007) in repatriation negotiation. Nevertheless, this should not hinder the preservation of confidentiality and the rights of women to make independent decision concerning their reproductive health.

Kat Burns, Serge Male, Daniel Pierotti discuss why refugees need reproductive health services as rooted in international law. They explored prior studies conducted on refugee situation from Rural Nepal to urban South Africa. Their findings clearly indicate the needs for contraceptive services in Khau Phlo, Cambodia. It was also noted that "distances to health centers and difficulty in communication" (Burns, Malé, & Pierotti, 2000) about the availability of reproductive health services restrains the provision of comprehensive reproductive health services in refugee camps.

Who Should Care: Reproductive Health Services for Refugees by Refugees

(Howard, et al., 2008) conducted comprehensive studies in 1999 on family planning in refugee camps. They examine gender and age differences in family planning knowledge, attitudes, and practices among Sierra Leonean and Liberian refugees living in Guinea using a cross-sectional survey of 889 reproductive-age men and women refugees from 48 camps served by the refugee-organized Reproductive Health Group (RHG). Sampling was multi-stage with data collected for socio-demographics, family planning, sexual health and antenatal care (Howard, et al., 2008).

The Come-Back Factor: Why Refugees Return to Their Country of Asylum

The UNHCR (2008) collected empirical data on reasons why Iraqi refugees return back to Denmark after they repatriate. The researchers used a semi-structured approach interview guide. This study illustrates that one of the leading to the failure of repatriation, as a durable solution is a lack of public social services in the country of origin (Nielsson, 2008). That is Refugees may have become used to a relatively high levels of public, social services, such as education and

healthcare in their country of asylum (Crisp, 2003). As a result, it can lead to difficulties in readjusting to the possibly lower level of services in the home country if they choose to repatriate. Other authors also argue that the lack of security at home and fear of persecution contributes to the desire to return to their country of asylum. Crisp (2003) noted that the degree of destruction in the refugees' place of origin is so great that the people concerned do not feel that they will be able to survive. More so, in the African context, African refugees often prefer resettlement to a third country however, third country resettlement has played only a minimal role "and unlikely to become any more significant in the near future" (Allen & Morisink, 1994).

Women, Health and the Repatriation Process

Early concerns over the reproductive health of refugee populations were framed at the symposium organized by Women's Refugee Commission in 1992 (Going Home: The Prospects of Repatriation for Women and Children). The report from the symposium mentions that women should be involved in the planning of repatriation, since their re-integration will be the most important factor in making the return a success. The same report cites the importance of a continuum in the provision of family planning services on the camps and at home upon return. The 1993 editorial in the Lancet; Reproductive Freedom for Refugees, cites the lack of but importance of reproductive health needs of refugee women in Africa but only while in refuge and not during repatriation negotiation processes. Subsequently, the report by the International Conference on Population and Development (ICPD) that took place in Cairo in 1994 echoed the same sentiments, calling for comprehensive reproductive health including sound sexual health of women worldwide, regardless of status.

The UNHCR's handbook on voluntary repatriation (1997) advocates the inclusion of health issues in the repatriation negotiation process, but it does not specify the types of health

issues and whether or not they pertain to women of reproductive age. A report by UNHCR (2008); Guiding Principles and Strategic Plans (2008-2012) promises to develop and incorporate reproductive health strategies and interventions into policies and programs for durable solutions and in a 2011, UNHCR report; Guidance for Public Health Interventions for Repatriation outlines and specifies health screening and or immunizations for: pregnant women, women of reproductive age, children, and chronically ill patients, including Persons Living with AIDS (PLWA).

For non-pregnant repatriating women of reproductive age, the only viable reproductive health related option includes a 3months supply of contraceptives and a health screening a day before departure (UNHCR, 2011) and thus making no provision for coverage after the 3months supply expires. According to the UNHCR repatriation handbook (1997) the duration of UNHCR's involvement in returnee monitoring is not fixed. Therefore, the ability of the UNHCR to investigate the extent to which returnees obtain access to official documentation, to facilitate their livelihood activities (economic freedom) in order to fend for their reproductive health needs (for example, when the 3months supply of contraceptive run-out) is threatened.

Advocating continuum of care for refugees, the Women Refugee Commission symposium on women and children (1992) argues that having Skilled Birth Attendants (SBA's) at birth and the provision of family planning services in refugee camp settings while in exile and post-exile is important and should be [guaranteed] before the repatriation process begins. However, report from the second meeting of the MENA region Inter-Agency Working Group on Reproductive Health in Crises advocate continuum of services during crises (IAWG, 2012) to deal with chronic humanitarian emergencies and the Minimum Initial Service Package (MISP) for Reproductive Health in Crises Situation activities focus on the early days and weeks of an

emergency but not as part of the repatriation process (Women's Commission for Refugee Women and Children, 1996). However, provision for continuous and sustained reproductive health services for protracted refugees, especially Liberian refugee women in Ghana, is essential but often ignored, especially when refugees decide to repatriate at any point during exile.

CHAPTER 3: DATA ANALYSIS AND PRESENTATION OF FINDINGS

3.1 Introduction

This chapter attempts a presentation and analysis of the data collected from twenty-five Liberian refugee women on Bududuram refugee camp in Ghana. The chapter is divided into six sections as follows: the socio-demographic characteristics of respondents. Section two focuses on their occupation, education and income including livelihood strategies. Section three focuses on screening for breast cancer, section five explores knowledge of and access to reproductive health services and the final section examines the women's reproductive health status and possible effects on the repatriation process.

3.2 Social Demographic Characteristics

This section presents the data on age, occupation, marital status educational background, income level, and parity. This section will test my hypothesis that reproductive health status of refugees is affected by income and level of education.

Age Distribution of Respondents

Age Group	Frequency	Percentage
13-18	2	8
19-24	5	20
25-29	6	24
30-34	3	12
35 and above	9	33
Total	25	100

Source: fieldwork (Ghana), 2009

Of the twenty-five women who were interviewed, 33% (9) were from ages 35 years and above, 24 % are between the ages of 25 and 29 years old, 20 % are between the ages of 19 and 24, 12.0% of respondents are between the ages of 30 and 34 years old and a mere 8 % of respondents were from ages 13 to 18 years old. The low representation of women between the ages of 13 and

18 may be attributed to the day (Saturday) the survey was conducted. That is, women between ages 13 and 18 years old are less likely to be at home on the weekends, leaving older, less mobile women at home.

Occupation, Education and Income

Within the camp, women engaged in various livelihood strategies to support themselves and their families. Occupation amongst the women varied; however, the majority of respondents (31 %) were in business- i.e. selling oranges, laundry soap and other social amenities, including water sachets followed by cooks and students, each at 18 % respectively. Only two women listed their occupation as teachers and one woman listed her occupation as a nurse. The two women who listed their occupation as a nurse claim they received more than secondary school educational attainment (one woman attending nursing school and the other attending university) however, their reported income is less than 100 Ghana Cedis per year ($ 51). Research conducted by Joyce Addo (2007) puts the annual income of a refugee at $38, which comes in the form of material assistance.

The rest of the respondents listed their occupation as housewives and tailors. The overwhelming number of business-women is not surprising as women in refugee settings are automatically given the responsibility of the head of household, and forced to bare extended responsibility for the elderly, disabled, and children (Martin, 2004). Therefore engaging in any sort of economic activity to cater for family members in the absence of a husband or partner is paramount to survival on the camp. Moreover, more than more than half of the respondents earn less than 100 Ghana Cedis ($ 51) per year, and since UNHCR funds/assistance has been declining since the year 2000 (Addo, 2007) , refugees are now paying for utilities that were once free such as water

and electricity. This translates into less money and time being spent on preventive health services, specifically reproductive health services.

An overwhelming number of respondents (84 %) completed 13 years or less of education. This low educational attainment is reflected in the lack of economic mobility, opportunity and income earnings of less than $ 51 per year, which is also reflected in these women living conditions on the camp, employment opportunities, and their overall health status. Low educational attainment of refugee women on the camp is also reflected in the educational crisis in Liberia and Africa as a whole. That is, a DHS survey conducted on twenty-six African nations reflects illustrates that the percentage of primary school completion amongst age groups declines as the women age increases: 50.1 % (15-49), 47.2 % (20-24), 44.4 % (25-29), 39.3 % (30-34), and 32.9 % (35-39) (Lloyd & Hewett, 2006). In Liberia, secondary school enrollment ratio in 2005-2009 is 25:14 for males and females respectively (UNICEF, 2010)-clearly reflecting the inequality and inequity in education for women, which means that Liberian women on Bududuram camp will face the same or even worse outcome upon return, which will ultimately affect their reproductive health.

In addition, the average number of children per woman is two, with 36 % of the women having more than three children. The age at first child of 50 % of respondents was 13-18 years old and 45 % for respondents between the ages of 19 and 24 years old. Researches have demonstrated that early childbearing affects, and negatively correlates with educational attainment (Ranchhod, Lam, Leibbrandt, & Marteleto, 2011) (PRAMSGRAM, 1995) (Scott-jones & turner, 1990). In addition to adolescents giving birth to preterm and underweight babies, they also risk having obstetrics complication as a result of their premature physical and physiological growth (Leppert, 1985). Therefore delaying the onset of first child has many compounding benefits for Liberian refugee women on Bududuram camp, especially when

considering their position as single head of household, with multiple children and insufficient income to cater for themselves and their children.

Moreover, 85 % of respondents said that the nutritional status of their children is compromised by their income, which further jeopardizes their reproductive health. The lack of reproductive autonomy of Liberian refugee women on Bududuram camp affects their health seeking behavior and this is reflected in the response of 67 % of women who claim their decisions to access reproductive health services such as contraception, prenatal and postnatal care and abortion are influenced by their male partners, suggesting the need for male involvement strategies to support their partner's health seeking behavior and also engaging refugee women in contextual empowerment activities that foster the support of their partners in their reproductive health decisions.

Nutritional Status, Breast-Feeding and Prenatal Care

When asked how often respondents attended prenatal care 47 % of women responded "sometimes". 85 % of these women earn less than $51 per year and have only obtained 13 years or less in education. Of this group, 37 % have poor nutritional intake. Surprisingly, the breast feeding rate of these women is 87 % with majority of women breastfeeding for more than six months. However, one should note that since these women have poor nutritional status, the breast-feeding infant may not be receiving appropriate nutrients for proper development and growth via breast-milk regardless of the duration of breast feeding. Further, increased socio-economic status especially, mother's level of education has been found to be closely associated with improved child survival in Nigeria (Caldwell, 1979) and in other parts of the world. This further put the inter-relationship of refugee women's education attainment, economic mobility

and health status at play as Gagnon et.al, 2003 clearly linked limited education and inadequate utilization of prenatal care to adverse reproductive health outcomes.

Screening for Breast Cancer

Previous studies shows that refugee women do not receive adequate preventive healthcare services, especially cancer screening (Carroll, Fiscella, Volpe, Jean-Pierre, & Morrow, 2006) and research amongst African refugee women in Africa and breast cancer is dearth despite its important to reproductive health. When respondents were asked whether they have done a breast examination/mammogram, 21 respondents said "No" and only 3 respondents have knowledge of or have performed the procedure. Research conducted amongst Somali refugees in New York also paints the same picture as these women were aware of basic health promotion practices, immunizations and routine medical examinations but only few women understood cancer prevention services. That is, only six women (18%) recognized mammography (Carroll, Fiscella, Volpe, Jean-Pierre, & Morrow, 2006) suggesting that health promotion programs especially in refugee settings need to increase refugee women's knowledge about cancer screening and its purposes.

Knowledge and Access to Reproductive Health Services

To capture women's knowledge and awareness of health services provided by the UNHCR, respondents were asked whether they were registered at any clinic or hospital: 46 % and 54 % of women answered "Yes" and "No" respectively, when asked if they had knowledge of any health services provided by UNHCR, 33 % and 67 % answered "Yes" and "No" respectively and when asked whether women had access to these health services on the camp, 90 % of women responded "No". This illustrates that in addition to the need to scale up UNHCR's community outreach efforts, one should note that the St. Gregory Catholic clinic is a religious based

organization and therefore less likely to provide reproductive health services, especially contraception. Therefore, it is critical to know where these women are accessing these services, especially considering that in addition to dwindling UNHCR's funding, the presence of NGO's on Bududuram has been declining as well since the inception of the UNHCR's rapid repatriation efforts.

Reproductive Health and Repatriation Plans

The relationship between refugee women health status and repatriation plans cannot be ignored. When women were asked "does your reproductive health affect your repatriation plans?" an overwhelming 15 out of 24 respondents' answered "No" and 9 respondents answered "Yes". Of the women who answered "No" 13 women have 13 years or less of education attainment and 13 earn less than $51 per year. This suggests that women who have low socio-economic status are less likely to favor repatriation, prefer resettlement to a third region (U.S. or Europe) however, they are not favorable for resettlement programs because they lack the human capital or attractive specialize skills that would benefit the potential country, and also mitigates the chances of them becoming ward of the state. It could also mean that women were more concerned about other issues other than reproductive health such as security and their ability to return to normal lives and re-adjust to a new environment is affecting their decision to repatriate.

The historic systemic socio-economic marginalization of rural Liberians also has bearing in the current dilemma Liberian refugee women endure daily on Bududuram camp. They are in limbo; they fear the uncertain realities of going back home and also dread the constant struggle for survival on the camp, in addition to the growing hostility of their Ghanaian neighbors. In fact when respondents were asked about whether the UNHCR's repatriation package of $100 was sufficient for their family, the women cited various reasons of the package inadequacy to meet

basic needs such as paying rent “I can’t pay rentage, food and establish business for me and my children”-respondent, Bududuram camp, 2009., or fend for their general wellbeing-“it cannot find me a place, buy me a food, take care of my medication, and educate me.”- *Respondent, Bududuram camp, 2009.* Other responses by the women highlighted feelings of frustration and dis-empowerment as a result of the limited economic opportunities the UNHCR’s $100 encashment repatriation package provides. These women were worried about not being able to send their children to school, get affordable housing, purchase food, and establish some sort of sustainable economic mobilizing activity.

CHAPTER 4: DISCUSSIONS OF FINDINGS AND CONCLUSION

The first, second and third hypothesis that the reproductive health status of Liberian refugee women is affected by their income holds true. The majority of respondents engage in subsistence businesses such as hairdressing, dressmaking and petty trade and more than half complained about their income affecting their health and their children's wellbeing. Data collected from this study also revealed the poor reproductive health of Liberian refugee women, their low educational attainment, low income and limited knowledge of health related services-All these indicators are reflected in their underutilization of prenatal health services and modern contraception. Evidence suggesting that the UNHCR does not prioritize reproductive health services on the camp is reflected in the low levels of respondents who are unaware of and lack access to health services provided by the St Gregory Catholic clinic via the UNHCR and supported by the Government of Ghana.

In addition, educational attainments of respondents paints a grim picture of what the future holds for these women, as 85% only completed thirteen years or less of education, have at least two children, and had their first child between the ages of thirteen and eighteen years old. This calls for the need to establish a peer-to-peer health exchange that specifically targets adolescent women that are between the ages of thirteen and eighteen years old to improve family planning, and safer sex practices, so that they can complete more years of education and pursue lucrative economic livelihoods while improving their health.

4.1 Implications and Recommendation

The data collected in this study has many implications. It has showed that the reproductive health of refugee women is a critical component of their day-to-day life. It also shows that their socio-

economic status measure by their level of income adversely affect their health and the health of their children. The health outcome of a child is strongly associated with the mother's level of education (Caldwell, 1979) (Mullany, Becker, & Hindin, 2007). Therefore, addressing the educational needs of Liberian refugee women will also improve their health and that of their child while also providing some avenue for economic mobility. Direct recommendations made by respondents also suggest the need of ameliorate the conditions of women on the camp- "UN should advocate sponsorship for the youth and elderly women to experience a better future where they can go out there get educated and go back home to developed their war torn up country- *(Respondent, Bududuram Camp, 2009).*

Women have also voiced concerns that more vulnerable populations such as orphans, widows and disabled children should be prioritized. As one respondent suggests "women here have children with no father, widows, disable and have children. I want to make an appeal to certain group of people to see how best we can improve our lives and the lives of our children. To go back home is worst for us" *(Respondent, Bududuram camp, 2009)*. Possible implications are the refusal of these women to return to Liberia since many believe they have nothing to go back to. Therefore, when institutional bodies are planning and strategizing on ways to increase repatriation, especially in a protracted refugee situation like Liberia, other factors such as education, health, and economic mobility should all be factored into the processes so as to avoid/mitigate the effects of return to host countries if they find the condition in their native countries unbearable or incapable of addressing their respective needs.

4.2 The Women Speak

When respondents were asked "What suggestions do you recommend for the UN and other agencies to improve the reproductive health needs of Liberian refugee women", overwhelming

numbers of Liberian refugee women expressed the need of affordable health services, education, medication and improved sanitation. All these recommendations have both distal and proximal effects on women's reproductive health. As stated by some refugee women on the camp:

"Medications should be free so that those of us who don't have money can be treated" *Respondent, Bududuram camp 2009.*

"Education, educate the person and the person will be able to stay on their feet"- *Respondent, Bududuram camp 2009.*

"We need free medication, good and clean environment, clean bathing water and milk."- *Respondent, Bududuram camp, 2009.*

Based on these women assertions, it is logical to conclude that they perceive the UNHCR has having the power and means to change their lives positively but don't necessarily see themselves as agents who can also incite positive changes in their own lives. Nonetheless, from personal conversations with these women, many aspire that to be economic independent, so as to send their children to school. Possible recommendations for UNHCR and similar bodies should focus on empowerment and sustainable livelihood strategies for these women, including providing viable means for women to obtain higher level of skills and specialized training that will not only enable them to become active citizens while in exile but a valid human capital wherever they are geographically positioned.

CONCLUSION

Refugee women's health will continue to be of a critical aspect of all societies. As a result of some difficulties refugees have been through in their lifetime, it may be difficult but necessary for them to adjust to new situations and environment, however this is not always easy or straightforward. Liberian Refugee Women are not an exception to this issue, especially

considering the level of inequality and inequity embedded in the social-fabric of the Liberian modern state. The ability of Liberian refugee women on Bududuram camp was first compromised by the historical component and perils of the protracted civil wars and then later by their precarious situation in exile. Their dismal educational attainment and poor economic condition grounds them within the confine of the camp, while the better trained and more economically successful refugees have either resettled or moved to non-refugee areas of the country; Ghana. Nonetheless, addressing and fostering the reproductive health seeking behavior and needs of these women through education and economic mobilizing activities will make their transitional period more conducive, as well as improve the welfare of their children. In addition, institutional bodies such as the UN play an important role in the successful future of these women, especially when repatriation programs are introduced. The UNHCR should continue to strive for equal representation of women, community development and improve outreach of health facilities on the camp.

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