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CASE 2

The Silent Epidemic of Gender Inequality in Rwandan Refugee Camps

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It was another sunny and humid Tuesday morning at Mahama Refugee camp in Rwanda, the newest refugee camp to be established in the country (Exhibit 1). As Ramat Morrison trudged along the narrow footpath leading to Mbeki clinic, she began to dread her busy schedule for the upcoming week and month. Mbeki clinic is the sexual and reproductive health care unit responsible for the sexual health needs of refugees at Mahama. Amanda, Ramat's colleague suddenly interrupted her thoughts as she approached the entrance of the clinic. She was reminding Ramat about the impending deadline for the camp's quarterly community assessment report.

Ramat is a public health nurse in charge of the Family Planning Division of the clinic. She also serves as a community volunteer responsible for providing community-level reproductive health services specifically to refugees in Mahama. The engagement activities at this level include regular visits to the various refugee households at Mahama Camp to provide reproductive health counselling and postnatal care to refugee women and children. The staff at the clinic are required to submit quarterly reports to the Government of Rwanda's Ministry of Emergency Management about the activities of each health care division. The report must outline the different sexual and reproductive health conditions of the refugees in the camp over the past three months and the clinical management protocols that were used. The report also includes a summary of the community-based sexual and reproductive health programs that were organized and the number of refugees who participated in them.

Ramat is unhappy about the inability of the clinic to effectively engage refugee youth, especially female youth, in the clinic's sexual and reproductive health interventions. This has led to a low uptake and involvement of these youth in the sexual health programs organized by the unit. This low uptake has persisted since the clinic was established in 2015 and has been noted as a concern by the United Nations High Commissioner for Refugees (UNHCR) at the quarterly review meetings of Rwanda's refugee camp management activities. Therefore, Ramat decides to glance through previous quarterly reports to analyze the participation trends and to brainstorm about how to improve program uptake.

BACKGROUND

In 2015, the Government of Rwanda's Ministry of Health established the Mbeki clinic in collaboration with the UNHCR and other nonprofit organizations. The clinic was built a few months after Mahama was opened to cater to the sexual and reproductive health needs of the refugees. The clinic is located about 100 m from the camp and serves more than 58,552 Burundian refugees who have fled to Rwanda since April 2015. Burundi became politically

unsafe after a failed coup attempt erupted into violence in 2015 (UNHCR, 2017). The majority of the citizens of Burundi fled to neighboring countries such as Tanzania, Rwanda, Uganda, and the Democratic Republic of the Congo to seek protection and shelter. The Government of Rwanda hosted most of the refugees from Burundi in the newly developed Mahama refugee camp (UNHCR, 2017). Furthermore, the government has been successful at integrating the refugees into Rwanda's educational and health care sectors (UNHCR, 2017).

The Government of Rwanda partners with the United Nations and local and international nongovernmental organizations to provide refugee protection to families from Burundi and other countries (UNHCR, 2017). A multisectoral approach is necessary to respond to the urgent needs of vulnerable populations such as refugees. The nongovernmental organizations support the Rwandan government to improve camp coordination and camp management, deliver cash and food assistance, and improve the educational status and general well-being of the refugees (UNHCR, 2017). Some of the organizations involved in supporting the refugee integration and aid efforts in Rwanda include the UNHCR, United Nations Children's Fund (UNICEF), the World Food Programme, and the Adventist Development and Relief Agency (ADRA) (Prickett, Moya, Muhorakeye, Canavera, & Stark, 2013).

Ramat's thoughts kept drifting back to the conversation she had had the previous day with Jennifer, a 15-year-old female refugee from Burundi. Since the establishment of the camp, Ramat's health care unit has been confronted with a surge in the incidence of unintended pregnancies. This has prompted the health unit, together with a team of community health workers, to organize weekly community-level engagement visits to counsel refugee youth, females especially, and offer them family planning services. Despite the introduction of the program two years ago, the rising incidence of unintended pregnancies continues to be a major sexual health challenge in the camp.

Ramat had met Jennifer just the day before on one of her regular community engagement visits to the camp. Jennifer had arrived in Rwanda with her grandmother a year ago after fleeing from political conflict and unrest in her home country. She had lost her parents to the war, making her grandmother her only caregiver. Jennifer is currently six months pregnant with her first child and does not intend to return to school after delivering the baby. Ramat inquired further about the reasons for her decision and Jennifer tearfully responded, saying "my grandmother wouldn't be able to take care of my baby if I return to school because she is old."

Jennifer became pregnant while she was still attending secondary school. Due to her grandmother's low socioeconomic status, Jennifer had to resort to having sex with her 24-year-old boyfriend in order to meet her basic needs. Unfortunately, some female refugee youth have to engage in unwanted sexual activity in exchange for basic necessities, which is known as transactional sex (Prickett et al., 2013; UNHCR, 2017). Transactional sex has been observed to be an emergency coping measure to help refugee families survive (UNHCR, 2017). Jennifer's grandmother noticed that Jennifer was pregnant during her second year in school. She dropped out of school because of the stigma associated with adolescent pregnancy in Rwanda. Unfortunately, Ramat's unit's initiative to organize community-based counselling and family planning services for refugee youth in an effort to tackle the challenge of unintended pregnancies is not yielding its intended results. The participation rates of refugee youth are low, and Ramat is desperate for immediate short-term interventions to address this issue.

The phone rang. It was Ramat's colleague, Josephine. Josephine is the Senior Project Manager for the Training, Support, and Access Model (TSAM) for Maternal, Newborn, and Child Health project in Rwanda. The TSAM is a health profession education project comprising maternal and

child health experts from Canada and Rwanda. It is led by a research team from Western University, London, Ontario. Josephine is interested in the current best practices Ramat's unit uses to provide antenatal and postnatal care. This information will help Josephine's team update the TSAM preliminary report recommendations for maternal and child health. Josephine forwards the preliminary report to Ramat for review. After assessing the recommendations on TSAM's gender equality strategy, Ramat notices a significant omission—the absence of a comprehensive sexual and reproductive health services initiative to address gender-based violence in different contexts in Rwanda. TSAM established a working committee, Maternal and Mental Health Action Team, that comprised members from participating district hospitals in Rwanda and the University of Rwanda College of Medical and Health Sciences. The team was responsible for the design and delivery of maternal mental health training and mentoring strategies, coordination of daily activities of the project including monitoring, reporting and decision-making as well as the review of the gender equality strategy to identify gaps in its implementation. The TSAM's initial gender equality strategy was to develop a reproductive health module for young women who experience gender-based violence and eventually become pregnant. However, the TSAM project coordinators were uncertain about the overall approaches or initial steps to use to address gender equity, equality, and gender-based violence (Philip Cox & Susan Smith, personal communication, 2018). Therefore, although gender-related issues were a priority, the TSAM group had no concrete approach regarding youth-specific sexual health interventions. Ramat is disappointed because she was looking forward to adopting the proposed TSAM sexual and reproductive health module.

In addition to the sexual and reproductive health challenges the refugee youth encounter, Ramat has also observed that most of the health care workers at the Mbeki Clinic lack adequate training to meet the sexual health needs of the youth. She is convinced that a multisector collaboration among Mbeki Clinic, the Rwandan Government, the UNHCR, UNICEF, ADRA, and other relevant international organizations is necessary to improve the sexual health outcomes of refugee youth, especially females.

The United Nations High Commissioner for Refugees

The UNHCR is an international organization established in 1951 by the United Nations General Assembly. Its core mandate is to provide international protection to refugees in accordance with the 1951conventions of the status of refugees and its 1967 Protocol. This international protection consists of several rights, including the right not to be expelled, the right to work, the right to public relief and assistance, and the right to freedom of movement within the territory (UNHCR, 2011).

The UNHCR is headquartered in Geneva and has 30 branches across strategic locations worldwide. The main function of these branches is to coordinate international action for refugees and establish liaisons with governments, United Nations specialized agencies, and intergovernmental and nongovernmental organizations. The UNHCR also assists refugees to become self-supporting by giving emergency aid and providing rural settlement projects to Africa and certain parts of Asia (Office of the UNHCR, 2021).

United Nations Children's Fund

UNICEF is an international agency responsible for promoting the rights and well-being of every child across the world. UNICEF works with partners in 190 countries and territories to provide support to the most vulnerable and excluded children. UNICEF was created with the mandate of collaborating with other organizations to address limitations children encounter because of poverty, violence, disease, and discrimination.

Other UNICEF initiatives include the promotion of female education, childhood immunization, the prevention of the spread of HIV/AIDS among youth, and the creation of protective environments for children that are free from violence, abuse, or exploitation. UNICEF upholds the *Convention on the Rights of the Child* (UNICEF, 2021) and strives for equality to prevent discrimination against girls and women (UNICEF, n.d.).

Adventist Development and Relief Agency

The Adventist Development and Relief Agency (ADRA) is a global humanitarian arm of the Seventh-day Adventist Church (ADRA, n.d.). The agency is the largest worldwide integrated health care and education network, delivering relief and development assistance to people in more than 118 countries. They also partner with local communities, organizations, and national governments to deliver culturally relevant programs and build community capacity for sustainable change (ADRA, n.d.).

Associazione Voluntari Per Il Servizio Internazionale

Associazione Volontari per il Servizio Internazionale (AVSI) is a nonprofit organization that supports humanitarian aid projects through public and private donors. The core mission of the organization is to implement collaborative projects that increase educational reforms. The organization's vision is to promote the value and dignity of people through individual and community capacity building. The foundation functions via 34 networks of organizations and has more than a thousand partners globally (AVSI, 2019).

HISTORY OF REFUGEE CAMPS IN RWANDA

The Government of Rwanda has housed refugees for more than two decades, starting in 1996 with refugees from the Democratic Republic of the Congo. As of December 31, 2018, Rwanda had almost 75,740 refugees from the Republic, and most of them (74,567) live in five refugee camps: Gihembe, Kigeme, Kiziba, Mugombwa, and Nyabiheke (UNHCR, n.d.). The remaining 1,173 refugees live in urban areas in Rwanda (Exhibit 2). Females comprise 51% of the refugee population and males comprise 49%, with children (anyone younger than 18 years of age) comprising half the refugee population (UNHCR, n.d.). Since April 2015, Rwanda has also hosted more than 69,423 Burundian refugees who have been fleeing political unrest and insecurity. However, the influx of new refugees from Burundi has decreased since June 2015. Most of these refugees live in Mahama refugee camp, with 12,481 of them (18%) living in urban areas, mainly Kigali and Huye (UNHCR, n.d.). There are also 49 other refugees from other countries of origin (ten African countries and one Caribbean country) (UNHCR, n.d.).

The UNHCR supervises the Government of Rwanda's activities and efforts to establish and manage refugee camps, and to provide land and security to refugees. Because of the continuous influx of refugees fleeing Burundi, the Rwandan Ministry of Emergency Management is working with other partners to develop a multisector, interagency response to ensure an effective approach to tackling the needs of the refugees (UNHCR, n.d.).

TRAINING, SUPPORT, AND ACCESS MODEL FOR MATERNAL, NEWBORN, AND CHILD HEALTH

The four-year TSAM project started in Rwanda in February 2016 and ended in March 2020 with the goal of promoting maternal, newborn, and child health through local partnerships to improve health service access and delivery. The initial planning and implementation phase of the TSAM was supposed to commence in Rwanda and expand to Burundi during its second year. However, the Burundian Government could not meet all the requirements to secure the necessary funding for the project within this time frame.

The project was established to address the increased mortality from maternal, perinatal, and acute childhood emergencies for mothers, newborns, and children under five years of age in East Africa. The main objective was to establish a sustainable, cost-effective model for delivering training, providing continuous mentoring, and providing coaching and outreach for continuing professional development in emergency care and access in maternal, newborn, and child health. The $10.5 million initiative was funded by Global Affairs Canada in partnership with the Rwanda Medical and Dental Council, the National Council of Nursing and Midwifery, the Centre for Public Health and Development, and the College of Medicine and Health Sciences at the University of Rwanda. Furthermore, consultations were made with the following partner organizations: Ministry of Health in Rwanda and Burundi, Rwandan Pediatric Association, Rwandan Obstetrics and Gynecological Association, Rwanda Ministry of Education, Directors of the District Hospitals in Eastern Province of Rwanda, Rwanda Ministry of Education, Rwanda Family Health Project, Jhpiego in Rwanda and International Medical Corps in Rwanda and Burundi. At the end of the project, the TSAM initiative was expected to provide most health care providers in Rwanda with the knowledge, skills, and training to deliver improved emergency care to pregnant women, newborns, and mothers of infants.

The model was developed with three intersecting themes: gender, ethics, and interprofessional collaboration, with a high priority placed on gender equality in multiple areas. These priority areas encompassed three broad steps—the design and use of a gender-sensitive curriculum for training health professionals, the selection of participants for teaching and training, and the introduction of concepts emphasizing maternal mental health and gender-based violence. A mapping exercise conducted by the project management team concluded that sensitive, gender-based violence issues are usually addressed broadly. There is less emphasis on the aspects of gender-based violence related to maternal health and morbidity. Based on these findings, the Rwandan Ministry of Health and partners from the various health sectors recommended incorporating maternal health gender-based violence interventions into the overall TSAM model (Philip Cox &. Susan Smith; personal communication, 2018). Consequently, the TSAM Maternal and Mental Health Action Team believed that the gender-based violence strategy would lead to the capacity building of health practitioners, community health workers, and other related gender-based violence fields to screen, assess, identify, and refer at-risk mothers in need of adequate treatment and services (D. Cechetto; personal communication, 2018).

BARRIERS TO GENDER EQUALITY IN REFUGEE CAMPS

Ramat is aware that gender equality cannot be achieved without the empowerment of girls and women. Additionally, she has observed firsthand how female refugee youth are denied equal access to education, income, and health services because of the social constructs of gender. Ramat is optimistic that the introduction of youth-specific sexual health services will be pivotal in providing female refugee youth with the ability to lead healthy lives and to freely participate in the social, economic, and political frameworks of life, devoid of all forms of violence.

According to UNHCR (2017), certain factors have been identified as limitations to the achievement of gender equality among refugee women. These include outmoded traditional gender norms, fewer educational and employment opportunities, disparities in income levels of women, a decreased understanding of gender equality initiatives among relevant stakeholders and unequal attention from the humanitarian sector in enhancing gender equality efforts (UNHCR, 2017). Poverty is the critical social determinant that hinders girls and women from reaching their full potential and it has serious negative outcomes on the sexual and reproductive health of females (IPPF, 2015). Poverty perpetuates the vicious cycle of gender inequality and poor sexual health and makes female refugee youth more vulnerable to sexual and gender-

based violence (IPPF, 2015). Poverty has been recognized as one of the most significant reasons that many female refugee youths do not have their basic needs met. Low income often forces female refugee youth into early sexual activity and sex in exchange for basic necessities, which often results in unintended pregnancies. In some refugee households, families force their daughters to get pregnant to increase the aid they receive in the form of food rations or cash assistance (UNHCR, 2017). Generally, migrant and immigrant women have fewer employment opportunities in the formal sector. Thus, they are forced to do informal jobs that are poorly regulated. The unregulated informal sector makes migrant women susceptible to low wages, workplace discrimination, sexual assault, and inadequate access to health care (IPPF, 2015). Providing equal decision-making and economic opportunities will give women and girls the freedom to make informed choices about their sexual and reproductive health free from violence, coercion, and discrimination (IPPF, 2015)

Teenage pregnancy has been found to be a major health challenge for youth from refugee backgrounds residing in refugee camps (McMichael, 2008; UNHCR, 2017). According to Prickett et al. (2013), early pregnancy has been ranked among the top four harms refugee children in Rwanda face. Unintended pregnancies among female refugee youth increase the rate of school dropouts, which consequently leads to unequal social, economic, and political opportunities (IPPF, 2015). Isimbi et al. (2019) showed that adolescent pregnancy is one of the main reasons female refugee youth in Rwanda cannot continue their education. The Rwandan Ministry of Education in collaboration with UNHCR provides free education to children in the refugee camps from elementary school until the first three years of secondary school (Prickett et al., 2013). Subsequently, after the completion of the third year in secondary school, parents of refugee youth are often unable to pay for their children to complete the final year of secondary school education (Prickett et al., 2013). This is a result of the low-income status of refugee parents and their limited alternative sources of income (UNHCR, 2017). Dropping out of school after the third year predisposes female refugee youth to prostitution and unintended pregnancies (Prickett et al., 2013). Gender equality cannot be achieved in the absence of equal opportunities for women and girls to exercise full control over their sexual and reproductive health rights (IPPF, 2015).

Female refugee youth are at an increased risk of sexual- and gender-based violence (Isimbi et al., 2019; UNHCR, 2017; Prickett et al., 2013). The recognizable risk factors for this type of violence include economic insecurity, resource constraints, and unsafe camp communities (UNHCR, 2017; Prickett et al., 2013). Female refugee youth sometimes have to walk unaccompanied for long distances to gather firewood, fetch water and access public places of convenience. The poor living conditions of refugee camps, which are overcrowded and have inadequate lighting and security, promote an environment in which perpetrators can take advantage of innocent adolescent girls (UNHCR, 2017). Males who commit sex- and gender-based violent crimes are usually exempt from punishment because female refugee youth are reluctant to disclose the identity of their attacker (Isimbi et al., 2019; Prickett et al., 2013). Moreover, most refugee families prefer to settle sex- and gender-based violence cases out of court (Isimbi et al., 2019). The inability to prosecute violent offenders who commit these crimes perpetuates the vicious cycle of poor sexual and reproductive health and widening gender inequality.

A lack of culturally sensitive sexual and reproductive health services has also been identified as a challenge in achieving gender equality in refugee camps. In a qualitative study by Munyaneza and Mhlongo (2019), refugee women in Durban, South Africa discussed the barriers they encounter when accessing reproductive health services from public health care facilities. Some of the concerns raised include medical xenophobia, language barriers, unprofessional health

care worker attitudes, failure to obtain consent, and a lack of confidentiality. A study by Laurie and Petchesky (2008) showed that inadequate implementation of reproductive health and HIV/AIDS services leads to gender disparity among women and girls in displaced populations. The presence of viable political, economic, and health infrastructures, including sexual and reproductive health services, in refugee camps results in the safety, dignity, and empowerment of refugee women and girls (Laurie & Petchesky, 2008). Moreover, youth-specific programs that help adolescents realize their full potential, build national capacity, and increase accountability of governments to young people are significant gaps that exist in humanitarian programs for refugee youth (Maguire, 2012).

Research conducted by the UNHCR in Rwandan refugee camps identified several reasons why the majority of refugee youth do not solicit sexual and reproductive health services in health centres. The critical issues identified by both sexes were the fear and stigma associated with accessing reproductive health services (UNHCR, 2017). The UNHCR report also identified poor service quality, inadequate privacy, inconvenient opening hours for female refugees, and the unprofessional attitude of doctors and nurses in managing refugee sexual and reproductive health challenges as barriers to youth seeking sexual and reproductive health care (UNHCR, 2017). Rwandan and Burundian cultures do not favour the use of contraceptives in promoting the sexual health of youth. These cultures uphold the idea of abstinence from sex until marriage as a value every single youth should adopt (UNHCR, 2017). Furthermore, the topic of sex is taboo in many households, which prevents refugee youth from discussing reproductive health needs with their parents for fear of being stigmatized (UNHCR, 2017).

ALTERNATIVE SOLUTIONS

Ramat now has a dilemma and must work with her team to identify and engage relevant stakeholders in proposing solutions to improve refugee use of sexual and reproductive health programs. In view of the rising incidence of sexual and reproductive health challenges in refugee camps, the Government of Rwanda has partnered with national and international civil society organizations as well as NGOs to implement measures to address the situation. These measures include integrating comprehensive sexual and reproductive health education into the school curriculum, behaviour change communication initiatives through peer educators, and gender awareness initiatives by the UNHCR in refugee communities. Despite these measures, the rate of unintended pregnancies and sexually transmitted infections continues to increase in these communities.

The UNHCR in Rwanda conducts bimonthly training programs for all health care workers assigned to health units in Rwandan refugee camps. Ramat recently participated in a mandatory modular training program on effective stakeholder engagement and its relevance in community-based interventions. After undertaking the training, she is now convinced that her team will have to strategize and adopt a different approach to solving the current challenge. The elements of inclusion, participation, and collaboration will have to be employed to engage all relevant stakeholders.

Ramat anticipates she will face several challenges to addressing the gaps existing in stakeholder engagement and consultation for youth-specific sexual and reproductive health services. She needs to come up with a feasible strategy to increase the participation of refugee youth in community initiatives designed by her unit. This will involve including all stakeholders. The Rwandan arm of the UNHCR will be interested in how the Mbeki Clinic navigates this complex terrain.

The most immediate stakeholder engagement approaches available to Ramat and her team at the clinic are:

- Encouraging the parents of refugee youth to get involved in the community initiatives to make it more acceptable for their children to participate in these initiatives. This could be achieved by assigning parents some responsibility in discussing certain aspects of sexual health topics with refugee youth. Some of these topics could include discussing the cultural relevance of abstinence and addressing the myths surrounding sex. This will also improve communication between refugee youth and their families regarding their sexual health needs.

- Organizing community initiatives such as youth-friendly anti-gender-based violence clubs that integrate male refugee youth. This will help male refugee youth understand the prevailing and often inaccurate attitudes about gender equality so they can participate in developing positive solutions. Having adolescent boys actively participate in gender inequality issues and discussions promotes inclusivity, which ultimately helps them become more responsible and accountable in matters that relate to gender equality and their partner's sexual health.

- Conducting a focus group for refugee youth so they can discuss the barriers they face when participating in community-based sexual and reproductive health initiatives. These discussions will help Ramat's team gain more insight into the current challenges faced by these youth. It will also help improve the quality of the proposed solutions and help the team identify practical ways to implement the recommended measures. Finally, the youth will be able to participate in decision-making processes that will improve their sexual health.

- Partnering with heads of schools to organize monthly sexual and reproductive health symposiums. These symposiums could be used to assemble parents, teachers, refugee youth, and international organizations such as AVSI and ADRA to raise awareness about sexual- and gender-based violence. The different stakeholders can also suggest ways of incorporating vocational training and life skills into the school curriculum. The inclusion of life skills modules will empower the youth with opportunities that will improve their socioeconomic status after they finish school. The vocational and life skills training will eventually assist female refugee youth with diverse incoming generating activities critical in reducing the vicious cycle of poverty, gender inequality and poor sexual health

Ramat wonders which of these options will increase the uptake of the community-based sexual and reproductive health initiatives by the Rwandan refugee youth in the interim? How will these initiatives directly affect the surge in unintended pregnancies in the camp? Will they ultimately be able to address the silent epidemic of gender inequality? These questions and many more remain unanswered as Ramat prepares to submit her unit's quarterly report.

CONCLUSION

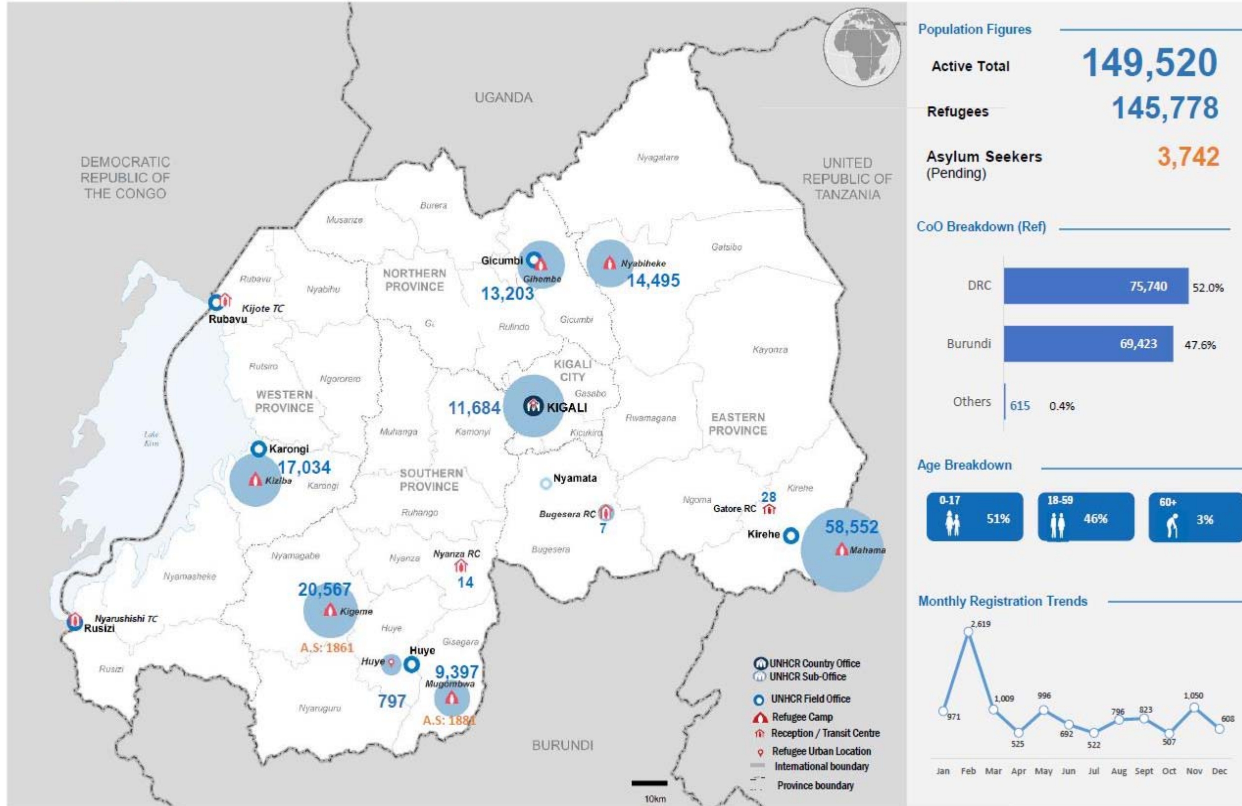
Ramat believes an enhanced stakeholder engagement and consultation approach is necessary to achieve increased uptake of community-based sexual and reproductive health programs among refugee youth. She is optimistic that this approach will improve the current sexual and reproductive challenges female refugee youth face in Mahama refugee camp. This will also ultimately improve the UNHCR's gender equality initiatives in many refugee communities. Ramat must determine which option to choose before her unit's quarterly report meeting with the Ministry of Emergency Management and the UNHCR in Rwanda in two weeks. She cannot afford to present another report about the low uptake of community initiatives among refugee youth at the Mbeki clinic without suggesting some practical interventions to mitigate this.

EXHIBIT 1
Mahama Refugee Camp in Rwanda

Source: United Nations High Commissioner for Refugees, 2017.

EXHIBIT 2
Rwandan Refugee Demographics and Camp Locations

Rwanda
Population of Concern to UNHCR
as of 31st December 2018



Source: United Nations High Commissioner for Refugees, (n.d.).

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INSTRUCTOR GUIDANCE

The Silent Epidemic of Gender Inequality in Rwandan Refugee Camps

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BACKGROUND

Ramat Morrison, a public health nurse at Mbeki clinic situated near Rwanda's Mahama refugee camp, is worried about the rising incidence of unintended pregnancies and sexually transmitted infections among female refugee youth. A community-based program designed to address these widespread sexual and reproductive health challenges has had a low uptake rate by refugee youth since its inception. Ramat now faces a dilemma of which multisectoral approach to adopt to enhance this uptake rate. She has several options she can implement to precipitate change. The role of partnership and collaboration with other refugee organizations and stakeholders is now paramount in reducing the epidemic of gender inequality in Rwandan refugee camps.

The goal of the case is to identify the relevant stakeholders required to address the sexual and reproductive health challenges faced by refugee youth in Rwanda's Mahama Refugee Camp. Additionally, the case provides students with the opportunity to describe the connection between the overall health of marginalized populations such as refugees and the social determinants of health such as gender, culture, and income. Finally, readers are able to explore how cultural values and practices affect the implementation of public health programs.

OBJECTIVES

1. Demonstrate the relationship between gender, culture, education, housing, food insecurity and income on the sexual and reproductive health outcomes of refugees in Rwanda.
2. Understand the role of youth-specific sexual and reproductive health programs in narrowing gender disparities among female refugee youth in refugee camps in Rwanda.
3. Explore the effectiveness of stakeholder negotiation and consultation in tackling the sexual and reproductive health challenges of refugee youth in Rwanda.
4. Identify and address barriers to accessing youth-friendly sexual and reproductive health services in Rwandan refugee camps.

DISCUSSION QUESTIONS

1. Why do the sexual and reproductive health challenges faced by female refugee youth increase gender inequality among refugees?
2. Who are the relevant stakeholders required in tackling the sexual and reproductive health challenges of female refugee youth in Rwandan refugee camps? Which methods can be used to increase stakeholder collaboration and participation to improve sexual and reproductive health issues in these camps?

3. What are the barriers faced by female refugee youth to accessing sexual and reproductive health services and how can this be addressed?
4. How can male refugee youth be engaged in discussions concerning the sexual and reproductive health rights of females and how can this affect gender equality in refugee camps in Rwanda?
5. How does migration affect the social determinants of health of refugees?

KEYWORDS
Gender equality; Gender-based violence; unintended pregnancy; sexually transmitted infections; refugee youth; Rwanda; sexual and reproductive health; sociocultural determinants of health; stakeholder engagement and collaboration