

OUTLOOK

Meeting the Reproductive Health Needs of Refugees

Over 30 million people around the world have fled their homes to escape persecution, war, and violence.¹ Some have crossed national boundaries to become refugees under international law, but most are internally displaced within their own countries (Figure 1). Still others are trapped in their homes as conflicts unfold around them.² Crises like these weaken people's health and disrupt their access to health services.

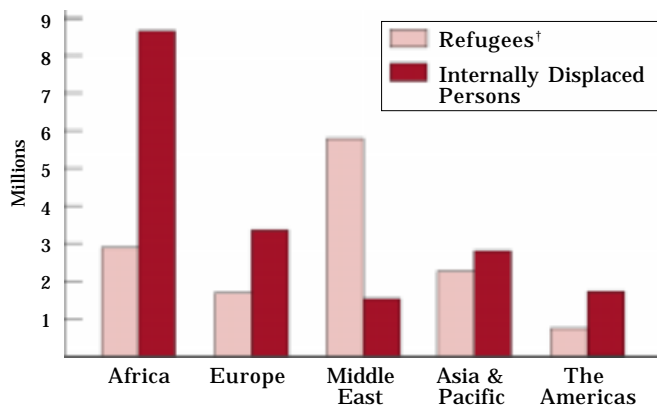
Refugees face physical hardship and poverty as they are forced from their homes. They lose their possessions and their jobs and must turn to outside aid for food and shelter.³ Inadequate food, unsafe drinking water, and increased exposure to infection in crowded camps undermine their health.⁴ Many women also face the physical and emotional burdens of becoming the sole caretakers of their children after they are widowed or separated from their husbands.⁵ Furthermore, because their health care delivery system often has been weakened or destroyed, refugees lose access to routine prevention measures such as immunizations and prenatal care, as well as to medicines and curative services.⁶

The breakdown of law and order, social norms, and family structures leads to high levels of violence against women (see box on page 4). Rape and forced pregnancy have been used as deliberate military tactics to terrorize civilian populations during ethnic conflicts in countries such as Bosnia and Rwanda.⁶ Male authorities, including police, border guards, refugee leaders, and local relief officials, may demand sexual favors from women in return for safe crossing, food, shelter, and protection.^{5,7} Refugee women also face an increased risk of domestic violence as their male partners react to the stress of their situation. A survey of Burundian women in a Tanzanian camp found that 27 percent had experienced sexual and gender violence since becoming refugees.⁸

Maternal and child health suffers as a result. Poor nutrition, fatigue, and untreated illnesses such as malaria and sexually transmitted diseases (STDs) have contributed to increased rates of pregnancy complications and miscarriages among refugees in Mozambique, Sudan, and Zaire.⁴ During the three-year siege of Sarajevo, the rates of perinatal mortality and low-birthweight babies doubled, and there were eight times as many birth defects.²

Women's needs—for reproductive health services, for protection against violence, even for sanitary pads and the equitable distribution of food—were long overlooked by aid administrators and refugee leaders.⁹ Relief organizations focused on providing food, water,

Figure 1. Estimated Number of Refugees and Internally Displaced Persons Worldwide, December 1998



†Includes asylum seekers who are awaiting a refugee status determination. Adapted from USCR, 1999.

and shelter, but women's concerns were not heard.⁵ In 1994, a landmark report by the Women's Commission for Refugee Women and Children focused attention on reproductive health needs.¹⁰ That same year, the International Conference on Population and Development (ICPD) in Cairo called for greater efforts to protect displaced and refugee populations and ensure their access to health care services.^{11,12}

Since that time, refugee relief organizations have collaborated with reproductive health professionals to develop new strategies for meeting the reproductive health needs of displaced populations.¹¹ They have produced guidelines, handbooks, and training curricula that have been tested in pilot programs around the world. While reliable data on the reproductive health status of displaced populations and the impact of new interventions are lacking,^{4,6} consensus is growing on how best to provide reproductive health services in emergency situations.

Designing Appropriate Services

Refugees' reproductive health needs depend, in large part, on their health situation before a conflict breaks out—including maternal mortality and morbidity rates, the prevalence of HIV/AIDS, knowledge and use of contraception, and availability of health care services.^{4,6} Conditions created by conflict, such as malnutrition and sexual violence, may exacerbate existing health problems or produce new ones. Culture and religion also are important in the design of appropriate services; for example, Muslim women refugees in Bangladesh, Pakistan, or elsewhere may prefer being served by female health care providers.^{3,4} Appropriate reproductive health services change over time as a crisis occurs, slowly stabilizes, and finally is resolved.^{6,13}

Responding to emergencies. During and immediately after an emergency, meeting refugees' basic

subsistence needs and preventing deaths take priority. To address life-threatening reproductive health problems in the aftermath of conflict and flight, reproductive health and relief organizations have developed the Minimum Initial Service Package (MISP).⁴ MISP is a series of activities that requires advocacy, training, and the leadership of a reproductive health coordinator, as well as emergency supplies. It includes:¹³

- identifying lead organization(s) and experienced individual(s) to coordinate and implement MISP;
- preventing and managing the consequences of sexual violence;
- reducing HIV transmission by enforcing universal medical precautions against HIV/AIDS (so that health workers do not take shortcuts under pressure of the emergency) and guaranteeing the availability of free condoms;
- reducing neonatal and maternal mortality and morbidity by providing delivery kits for use by mothers, birth attendants, and midwives, and by developing a referral system for obstetric emergencies; and
- planning for comprehensive reproductive health services, integrated into primary health care, as the situation permits.

MISP's clear guidelines have helped relief agencies respond promptly to refugees' reproductive health needs, although discussion continues over refining and possibly expanding its contents.^{4,14} Finding trained workers and emergency supplies can pose an obstacle to implementation, however. During the 1997 flight of 40,000 Cambodian refugees to Thailand, MISP supplies had to be purchased and assembled locally.¹¹ Since that time, the United Nations Population Fund (UNFPA) has developed the Reproductive Health Kit for Emergency Situations, which includes all the equipment and supplies needed to launch MISP, and supplements the materials contained in the World Health Organization (WHO) emergency health kit.¹³ The availability of the UNFPA Reproductive Health Kit ensured that 350,000 Kosovar refugees in Albania quickly had access to reproductive health supplies.¹⁵

Expanding services. Once a refugee situation stabilizes, it is important to expand reproductive health services beyond the basics. Refugee situations frequently go unresolved for many years, but refugees' reproductive health needs must be met, ideally as an integrated part of primary health care and community services.¹³ When refugees live together in camps, it becomes necessary to establish clinics and outreach programs within the camps, and to ensure reliable referral links. When refugees are dispersed throughout the community, the challenge is to increase the capacity of the existing government health system and supplement it with special services, such as counseling for post-traumatic stress disorder.^{3,11}

No matter what the setting, expanded services should be based on the results of a thorough needs assessment that explores the population's reproductive health knowledge, beliefs, attitudes, and needs.⁴ Unless program managers talk to women and men and raise sensitive questions, they may base their services on false assumptions.⁹ For example, managers of refugee camps in southern Sudan believed that women were happy with the spacing of their children, abortion was rare, and gender-based violence did not occur. Refugee women in those same camps, however, reported that they wanted fewer children, that some women resorted to abortion, and that violence in the home was commonplace.⁴

Involving refugees in needs assessment and design of services ensures that reproductive health services meet refugees' real needs, are culturally acceptable, and attract community support.^{3,4,16} The refugee community also can supply experienced health care professionals who are familiar with the refugees' language, culture, and concerns.^{11,13} Community input has increased the demand for services in Sri Lanka, where a Marie Stopes International health program for internally displaced persons serve Tamil, Muslim, and Sinhalese communities. Community representatives review educational materials and clinic hours, volunteer health educators have been recruited from each group, and medical staff have been assigned to serve members of their own ethnic group.¹⁷

Easing the return home. Careful planning and support are needed to ensure the continuity of reproductive health services when refugees eventually return home.³ For example, Guatemalan traditional birth attendants (TBAs) in Mexican refugee camps were taught to offer family planning, prenatal care, pap smears, violence prevention, and general health education. However, they returned to isolated rural areas where additional training and supplies were not available. As a result, their skills deteriorated and they ran out of key supplies.¹¹ Reproductive health programs can train and equip health workers from the refugee community to accompany the refugees home and provide ongoing support after they repatriate.

Refugees also may return to find that the health care system has been physically destroyed, with facilities damaged, supplies stolen, and records scattered. During the war in Bosnia, for example, 40 percent of the health care infrastructure was destroyed and more than 12,000 health care professionals were killed or fled.¹¹ When 650,000 refugees streamed home to Brazzaville after five months of civil war in Congo, the International Rescue Committee used MISP kits from UNFPA to begin restocking hospitals and clinics, restoring basic



Women at the Maela camp at the Thai-Burma border learn about family planning. Information about contraceptive options, STDs, and other reproductive health issues enables women to practice healthy behaviors and reduce risks. Photo courtesy of Women's Commission for Refugee Women and Children.

reproductive health services, and addressing the consequences of widespread sexual violence.¹⁸

Reproductive Health Agenda for Displaced Populations

It is important to provide key reproductive health services aimed at refugees' needs, including safe motherhood, HIV/AIDS, STDs, contraception, adolescent sexuality, and gender-based violence. Safe motherhood services are essential since 20 percent of adult refugee women may be pregnant at any one time and about 15 percent of them can be expected to develop complications.¹³ Many reproductive health programs, including those in Kenya and Thailand, have recruited, trained, and equipped TBAs from the refugee community to provide better services for pregnant women.^{3,11} Arranging a system of emergency obstetric care is even more important to reducing the high rate of maternal mortality common among displaced populations. TBAs and others who attend deliveries

need training so that they can identify complications and seek appropriate help during obstetric emergencies.¹³ Setting up an effective referral system poses a challenge, however, since refugee camps often are located far from any hospital and lack 24-hour emergency transportation.^{3,11} At some Afghan refugee camps in Pakistan, most obstetric emergencies are managed onsite at a basic surgical facility.¹¹ (For more information about safe motherhood and TBAs, see *Outlook*, Volume 16, Special Issue.)

The disruption of stable relationships and social norms governing sexuality during crises may accelerate the spread of HIV/AIDS and other STDs.^{13,19} Risky sexual behavior, sexual coercion and rape, and prostitution

“We are refugees...but our lives have continued; our need for family planning services is just a continuation of our family planning needs in Rwanda.”
—Rwandan refugee in Tanzanian Ngara camp²⁰

Protecting Burundian Women From Violence

Community participation explains the success of the International Rescue Committee's sexual and gender-based violence program for Burundian refugees in southwestern Tanzania. From the start, program managers collaborated with the elected women's representatives at the camp. These trusted and respected women were able to overcome victims' fear of being ostracized and punished if they spoke about their experiences. They designed and conducted interviews and a survey that revealed that 27 percent of women age 12 to 49 had experienced sexual violence since becoming a refugee.¹⁶

After bringing the results of the survey to the community during women-only block meetings, the women's representatives decided that a 24-hour support service for the survivors of violence was needed. The program created a drop-in center in the maternity wing of the medical center at each of the four refugee camps. The centers, which are staffed by trained refugee counselors, give women a safe, confidential setting in which to seek help.⁸ The counselors refer the women for medical care, social services, and legal guidance.

To make further progress, the women's representatives realized that they needed the understanding and support of men, beginning with the elected block leaders and volunteer security leaders at the camps. They asked these men to reflect on how their own experiences of ethnic persecution as refugees paralleled the violence women suffered because of their sex. These leaders, in turn, raised awareness of the problem among men in the community. Men and women then joined together to reach a consensus on how assailants should be punished.⁸

While the program still faces important obstacles, including inconsistent support from the medical staff and the authorities, it has made enormous strides. Over a two-year period, program staff have helped women in 394 cases of rape, 438 cases of domestic violence, 84 cases of abduction and early marriage (under the age of 18), and 66 cases of sexual harassment.²¹ Staff commitment is so strong that counselors even shelter survivors in their own homes despite the risk of reprisal. Most refugees now know that violence against women is a criminal offense, and women are more likely to report incidents and press charges. Other NGOs working in the camps have joined the initiative, for example, by altering the arrangements for food distribution and firewood collection to protect women. Perhaps most importantly, the program has empowered refugee women to assume a more active role in the community and seek solutions to their problems.

increase as refugee movements bring people from different areas into close contact. For example, when nearly two million refugees returned from Malawi to Mozambique in the early 1990s, they carried high levels of HIV back with them.^{3,4} Controlling HIV/AIDS and other STDs among displaced populations calls for a wide array of interventions: ensuring a safe blood supply, strictly enforcing precautions such as washing hands and disinfecting medical instruments, educating people about HIV/AIDS, distributing condoms, protecting vulnerable refugees from sexual violence, and providing diagnostic and treatment services.^{13,19}

Attitudes, knowledge, and prior use of contraceptives shape the demand for family planning services in refugee settings. While some refugee women want to have more children to replace those whom they have lost, others want to avoid having a child in such difficult and uncertain circumstances.^{6,12} From the start of an emergency, providers should supply contraceptives to women who request them, usually women who already are using family planning and need additional supplies. Once the situation stabilizes, managers need to build a reliable supply system and train providers to offer good quality family planning services. Refugees' future access to removal services should be considered when intrauterine devices (IUDs) and implants are offered.³

Gender-based violence continues to affect women long after the original assault because of the mental trauma and social stigma that result.⁷ Properly trained health care providers and counselors can offer victims of violence essential medical services, psychological counseling, and emergency contraception. Preventing violence and reintegrating survivors back into the community requires changing the attitudes of the refugee community, camp authorities, and providers toward gender-based violence. They must learn that violence against women is reprehensible, unacceptable, and prevalent (see box to left).^{14,21} A concerted effort to reduce violence involves many elements, for example making sure that women receive rations directly, preferably from other women; eliminating walks to isolated or dark areas to collect firewood or visit latrines; having camps designed in consultation with women and with their security in mind; training camp guards; and consistently punishing assailants.^{7,12} In some areas, programs to discourage female genital mutilation (FGM) also may be needed.^{3,4}

Adolescents endure the pressures of displacement at a time in life when they are learning about sexuality and intimate relationships. The breakdown of social norms, loss of parental supervision, lack of schooling and recreational activities, and uncertainty about the future may lead adolescents to experiment with risky behaviors, including unprotected sex.^{13,22} In addition, adolescents are especially vulnerable to sexual coercion and violence.

Rwandan and Burundian teenagers in Ugandan and Tanzanian refugee camps routinely exchanged sex for food, shelter, and protection—with the unspoken encouragement of their families.²²

It is difficult to offer adolescents the reproductive health information and services they need in a refugee setting; crowded camps make it hard to respect adolescents' need for privacy and confidentiality, providers lack training to counsel adolescents, and the psychological trauma of the refugee experience may make adolescents reluctant to seek services.¹³ The Health of Adolescent Refugees Project (HARP) is building on the Girl Guide and Girl Scout system to overcome these obstacles. Displaced girls in Egypt, Uganda, and Zambia have been recruited into new Guide groups with specially trained leaders. They are earning Adolescent Health Badges and certificates of accomplishment by learning about health issues and becoming peer educators.²³

Program and Policy Implications

Offering basic reproductive health services during the earliest stages of a crisis minimizes serious illness and death, but it is just the first step in a larger commitment to refugee health care. The challenge for relief organizations is to create comprehensive health services to meet the needs of refugees who may be exiled for years and to ease their eventual return home. Standard elements of reproductive health care (including safe motherhood, family planning, and STD services) must be augmented with services addressing the violence, stress, and social disruption that refugees endure. Actively involving the refugee community in the design and implementation of services—and making sure that women's voices are heard—can help ensure that services meet real needs, are culturally appropriate, and are acceptable to the community.^{11,14}

Emergency conditions pose a serious challenge to health care managers. Adequately trained and culturally sensitive staff, equipment and supplies, and infrastructure are all in short supply. Dozens of international, government, and nongovernmental organization (NGO) relief agencies provide fragmented and overlapping services to each refugee population.³ Short-term funding, rapid turnover of relief workers, and the unpredictable future of displaced populations jeopardize the continuity of care and the sustainability of services.⁴

Even in these conditions, organizations can create sustainable, high-quality services by drawing on local resources, tapping the experience of the wider public health community, and coordinating their efforts with other aid agencies. For example, international refugee, aid, and reproductive health organizations have joined together to create guidelines,^{7,13} needs-assessment tools,²⁴

training modules,^{25,26} and logistics management tools²⁷ to improve health care services for refugees. These kinds of collaborative approaches, together with effective advocacy and leadership, are key to ensuring that refugees and displaced persons have access to quality reproductive health care.

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This issue marks the completion of *Outlook's* seventeenth year of publication. The index on the following pages lists all articles published since 1986. Readers interested in obtaining copies can send their requests by e-mail or mail to the address listed on the back cover of this issue. Readers with Internet access also can find all issues published since Volume 13, Number 1, online at <http://www.path.org/outlook>. An asterisk (*) following an entry denotes the feature article for that issue.

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Regulatory Updates

Oral Contraceptive Pill Approved in Japan

In June 1999, the low-dose oral contraceptive (OC) pill received approval for use in Japan. Approval previously had been denied due to concerns among Japanese officials that OC approval would lead to an increased incidence of sexually transmitted infections and unwanted side effects.¹ First approved in the United States in the 1960s, the pill is used by over 90 million women worldwide.

Older, high-dose formulation pills have been available in Japan for the treatment of gynecological conditions such as bleeding, and as many as 200,000 Japanese women have used high-dose pills as contraceptives. Years of negative press about the dangers of OCs have caused many Japanese women to be reluctant to use the method. In 1998, fewer than 10 percent of women surveyed said they would use the pill.¹

Emergency Contraception

Two new progestin-only emergency contraceptive pills (ECPs) have received approval. In June 1999, NorLevo[®] was granted over-the-counter status in France. This is the first dedicated ECP to receive such status in a major market. NorLevo[®] will be marketed by Besins-Iscovesco and costs approximately US\$8.70. NorLevo[®] competes with the Shering AG product Tetragynon (also known as PC4), which was introduced in France earlier this year.² In the United States, Plan B[™], a progestin-only ECP distributed by the Women's Capital Corporation, was approved by the U.S. Food and Drug Administration (USFDA) in July.³ Plan B[™] contains two 0.75-mg tablets

of levonorgestrel, and will compete with the Gynetics, Inc. product Preven[™], an ECP that consists of four pills that contain both levonorgestrel and ethinyl estradiol. For more information about emergency contraception, see *Outlook*, Volume 17, Number 1.

Mifepristone

Mifepristone, the antiprogesterin used for early pregnancy termination, recently was approved in several European Union countries (Austria, Belgium, Denmark, Finland, Germany, Greece, the Netherlands, and Spain) and Israel. Approval in the United States is expected before the end of 1999. Women in more than 20 countries have used mifepristone and a prostaglandin as a medical method of pregnancy termination.⁴

1. Japanese Organization for International Cooperation in Family Planning (JOICFP). Finally, Japan swallows the pill. *JOICFP News* No. 301 (July 1999).
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3. Women's Capital Corporation. A new generation of emergency contraception has arrived: FDA approves progestin-only emergency contraceptive, Plan B[™] (levonorgestrel) tablets [press release]. (July 28, 1999). Available at <http://opr.princeton.edu/ec/planbpressrelease.htm>.
4. Population Council. Medical abortion with mifepristone and misoprostol. <http://www.popcouncil.org/faqs/abortion/html>. (Accessed September 1999).

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