The Reproductive Health Needs Of Refugees: Emerging Consensus Attracts Predictable Controversy

By Susan A. Cohen

In recent years, refugee advocates increasingly have come to recognize that women refugees have unique needs beyond what traditionally have been considered basic in relief programs—and, specifically, that they often face serious and even life-threatening reproductive health–related situations. Accordingly, an international initiative focusing on the critical reproductive health care needs of refugees is gaining worldwide attention and support.

As is often the case where reproductive health is concerned, however, the new initiative is attracting controversy as well. Beyond some residual concern within the relief community that adding a new array of services will divert resources from the traditional acute care needs in refugee settings, abortion politics inevitably have entered into the debate—further complicating an already difficult challenge.

Making the Case

According to the United Nation's High Commissioner for Refugees (UNHCR), there are approximately 40 million refugees[1] and other internally displaced persons in the world, the vast majority coming from and still living in developing countries. Many spend months and even years living in these "temporary" settings. Eighty percent are estimated to be women and children.

The traditional notion guiding aid to people in such emergency situations has been to concentrate on "basic" needs—food, clean water, shelter, security and primary health care. In 1994, however, a landmark report from the Women's Commission for Refugee Women and Children compellingly laid out the scope of the unique reproductive health problems refugees face—and not just when they are pregnant. *Refugees and Reproductive Health Care: Reassessing Priorities* explained how the health of women fleeing conflict or natural disaster, already in most cases at high risk because of their poverty or low social status, is further threatened by severe living conditions and, in general, the complete absence of either immediate or longer term reproductive health services.

Certainly, the reality is that in the developing world pregnancy itself can be, and often is, fatal. Most refugee women come from developing countries and are therefore already at high risk of pregnancy-related death. Upon becoming refugees, they face the added risks associated with flight such as physical trauma, endemic disease and malnutrition. Accordingly, it is no coincidence that both the highest refugee-producing and refugee-hosting countries—including Burundi, Rwanda, Eritrea, Ethiopia, Somalia, Yemen, Afghanistan and Nepal—also are characterized by some of the world's highest maternal mortality rates.

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But refugee women face other problems as well. For example, they often are victimized by sexual violence. Indeed, a 1997 survey by the International Rescue Committee found that 27% of females aged 12–49 in Tanzanian camps (mostly Rwandan and Burundian women) had been targets of sexual violence since they became refugees. Sometimes, sexual coercion takes the form of intimidation to "repopulate" their society. Situations such as these contribute to high rates of unwanted pregnancy and unsafe abortion. The World Health Organization (WHO) estimates that, worldwide, 13% of all pregnancy-related deaths are associated with clandestine, unsafe abortion; in refugee settings, however, complications from unsafe abortion account for some 25–50% of maternal deaths.

While they may survive the immediate crisis of miscarriage or a botched abortion, women refugees, living in conditions where they must depend on male authorities, may be vulnerable to rape or forced into prostitution on an ongoing basis. As a result, they not only must bear the psychological and sometimes physical scars of sexual violence but also are vulnerable to repeated high-risk pregnancies as well as increased risk of sexually transmitted disease (STD) and HIV/AIDS.

Some in the relief community still maintain that reproductive health care services, especially nonemergency contraceptive and STD-related services, are something of a luxury. Especially if they are not widely available to the general population outside the refugee camp, it has been argued that providing these services (and others such as schooling for refugee children) only creates a disincentive for refugees to want to leave. Other refugee advocates contend that the

1. According to the 1951 Geneva Convention Relating to the Status of Refugees, a "refugee" is 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 cannot return to it. An "internally displaced person" is someone similarly situated but who has not crossed an international border. In this article, the term "refugee" is used to denote both classes of people.

REFUGEE RIGHTS AND REFUGEE NEEDS

To emphasize the importance of balancing the right of refugees to receive reproductive health care with their right to accept or refuse services freely and in accordance with local cultural values, the IAWG adopted the following statement of principles, which was included in *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual* and will be reprinted in the updated field manual now nearing completion:

> ***"Reproductive health care should be available in all situations and be based on refugees', particularly women's, needs and expressed demands, with full respect for the various religious and ethical values and cultural backgrounds of the refugees, in conformity with universally recognized human rights."***

According to the final draft of the updated manual, the minimum initial array of reproductive health services available to refugees in the early phase of an emergency should address

- **preventing and managing the consequences of sexual violence;**
- **reducing HIV transmission, which includes enforcing universal precautions against the spread of the virus and making free condoms available;**
- **minimizing infant and maternal deaths and disability;**
- **planning for the provision of comprehensive reproductive health services, integrated into primary health care, as soon as possible; and**
- **ensuring that human and material resources are in place to implement these actions.**

presence of such basic services is hardly enough to outweigh the severe living conditions of the camps—or to overcome the strong natural desire of displaced people to return to their homes, as long as they can be assured of their safety and security. Unfortunately, many refugees live in a state of flux for a very long time, the most extreme examples being Tibetans in India and Nepal (40 years) and Palestinians in Lebanon (50 years).

In July 1998 key nongovernment organizations (NGOs) committed to both refugees and reproductive health (American Refugee Committee, CARE, International Rescue Committee, JSI Research and Training Institute and Marie Stopes International), along with the Women's Commission for Refugee Women and Children, published an update of the Commission's 1994 report. *Refugees and Reproductive Health Care: The Next Step* concludes that "the 'relief-to-development continuum,' which involves planning, in years rather than months, for continuity of services when refugees repatriate, argues powerfully for launching [reproductive health] services as early as possible and for involving the refugee community in designing and managing those programs."

From Rhetoric to Action

The revelations of the 1994 Women's Commission report constituted a groundbreaking international call to action. At around the same time, the growing public awareness of the widespread use of rape and other forms of sexual coercion as a weapon of war, most notoriously in Bosnia, provided an additional sense of urgency. The plight of refugees was specifically addressed at both the United Nation's (UN) 1994 International Conference on Population and Development in Cairo and its 1995 Fourth World Conference on Women in Beijing.

The first high-level *working* meeting on the subject of reproductive health for refugees took place in Geneva in June 1995 at a symposium convened by the UNHCR and the United Nations Population Fund (UNFPA). At the Geneva meeting, a preliminary report, *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual*, was approved as a technical and programmatic guide for use at the local level.

The symposium led to the formation of the Inter-Agency Working Group (IAWG), whose primary task is to implement the field manual. The IAWG, whose members include representatives of NGOs, various UN agencies and the U.S. government, is now close to completing an updated and field-tested version of the initial manual, which is planned for publication in late 1998 or early 1999.

The updated manual will outline the goals of a minimum array of reproductive health services in the early phase of an emergency. It also will provide specific guidance on care relating to sexual violence, STDs (including HIV/AIDS), family planning, the special needs of adolescents and other reproductive health concerns such as female genital mutilation and treatment for septic and incomplete abortion. As the manual stresses, all services are to be provided in accordance with a strong IAWG statement of principles (see box).

Enter Abortion Politics

While recognition of the importance of, and need for, refugee reproductive health services finally is gaining wide acceptance, the implementation of this concensus is becoming the focal point for "non-believers." The IAWG manual is being carefully scrutinized by such staunch abortion opponents as Rep. Chris Smith (R-NJ) and Senate Foreign Relations Committee Chairman Jesse Helms (R-NC), among others.

Focusing on the proposed availability of postcoital oral contraceptive pills (emergency contraception) for victims of sexual violence and manual vacuum aspiration (MVA) kits for the treatment of septic and incomplete abortions, Helms has asserted that the UN agencies involved are seeking to establish "abortion clinics" in refugee camps. Smith, who has been even more persistent on the subject, has charged that the UN is violating international conference agreements by participating in the "large-scale performance and promotion of abortion among refugees" and by urging "massive expenditures" on reproductive health supplies at the expense of other basic human needs.

Smith and his ideological allies have labeled emergency contraception a "chemical abortifacient," notwithstanding the official policy of both WHO and the United States that postcoital contraception is just that: a *contraceptive* method that prevents, but does not terminate, pregnancy (see related story, page 1). Accordingly,

Smith is attempting to pressure WHO, which will provide input on this and other technical matters, to include language in the manual stating that emergency contraception should be limited to cases involving rape. Further, he would effectively preclude the availability of MVA kits in all but the rarest of circumstances.

Smith is especially attentive to the convergence of refugee assistance and reproductive health issues because it combines two concerns of deep and abiding interest to him—though from diametrically opposed directions. A vocal advocate of refugee aid *and* a leading opponent of both abortion rights and family planning programs in the Congress, Smith appears unable or unwilling to accept the importance of women's reproductive health to their overall health status *and* to the survival and health of their children—even though the interrelationship has become increasingly clear. In developing countries, infants born less than two years apart are more than twice as likely to die in infancy as those born at wider intervals. And, estimates indicate that 20% of the almost 600,000 pregnancy-related deaths occurring each year could be averted by simply meeting the existing demand for family planning services.

Smith's blind spot is not limited to refugees. In his capacity as a child health advocate, for example, he has seen to it that the U.S. Agency for International Development not use any of its child survival program funds for "birth spacing." Similarly, he has admonished the United Nations Children's Fund (UNICEF) for collaborating on birth spacing projects on the grounds that UNICEF resources should be reserved for what he considers core activities such as immunization and oral rehydration programs. Smith is not alone; in 1996, the Holy See (the Vatican's representative body at the UN) withheld its annual $2,000 symbolic contribution to UNICEF for the same reasons—as well as for UNICEF's involvement in the refugee reproductive health initiative.

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While Smith insists from time to time he is not opposed to family planning, his actions belie the assertion. At a minimum, his view seems to be that family planning should be segregated from other forms of primary care—which is in direct conflict with the growing worldwide consensus among researchers and program planners that reproductive health care is essential to the basic health of women and families. The reproductive-health-for-refugees initiative is another step toward implementing that consensus in development assistance programming. Sooner or later the politics will have to catch up.