

The Reproductive Health Needs of Refugees and Displaced People: An Opening for Renewed U.S. Leadership

By Susan A. Cohen

The mid-1990s marked the beginning of recognition at the global level that the reproductive health needs and rights of people affected by conflict and natural disasters are urgent and deserve a response. A groundbreaking report in 1994, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, made the case for prioritizing these services and laid out the consequences of inaction. Consensus documents that emerged from the 1994 International Conference on Population and Development and 1995's Fourth World Conference on Women asserted that women living in crisis situations have the same right to reproductive health as all women do. And, multi-lateral agencies, nongovernmental organizations (NGOs) and country governments began to mobilize to develop specific sets of services and protocols to get reproductive health care to people in emergency situations. The United States was at the forefront of these efforts.

The U.S. State Department continued to support programs and initiatives to increase access to reproductive health care to refugees and internally displaced people even after the arrival of the Bush administration in 2001, but to a lesser degree and with a much lower profile than previously. In 2003—following the extension of the Mexico City policy (also known as the global gag rule) to State Department programs and the cut-off of a U.S. contribution to the United Nations Population Fund (UNFPA)—the Bush administration abruptly terminated financial support for the Reproductive Health Response in Conflict (RHRC) Consortium.

Notwithstanding the U.S. retreat, global support for and attention to delivering reproductive health services to refugees and forcibly displaced persons advanced in the intervening years, but so has the need. Now, the global gag rule is gone, the United States is contributing to UNFPA again and it is ramping up its financial commitment to sexual and reproductive health services overall. Therefore, now would be the time for the United States to reassert its leadership role, to ensure that sexual and reproductive health care is a core component of its humanitarian response for people living in emergency situations.

Putting the Issue on the Map

The 1994 report produced by what is now called the Women's Refugee Commission was a genuine landmark—the first to identify the scope of the problem and issue a global call to action. Until then, the prevailing traditional view was that reproductive health care for people in emergency situations was a relative luxury, compared with the need for food, clean water, shelter, security and primary health care. (The Women's Refugee Commission is a U.S.-based NGO providing technical assistance and advocating on behalf of displaced women, children and young people, especially with regard to gaps in lifesaving reproductive health care.)

The report detailed how the health of women fleeing conflict or natural disaster—often already precarious because of women's 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. Most are fleeing from and going

to some of the world's poorest countries. Upon becoming refugees, they bear the additional dangers associated with flight, including physical trauma, malnutrition and endemic disease. Displaced women and girls are also especially vulnerable to sexual violence, including rape as a weapon of war and sexual abuse and exploitation. All of these conditions contribute to a heightened risk of unwanted pregnancy and botched abortion, HIV and other STIs, and high-risk, life-threatening pregnancies and childbirth.

The 1994 report indeed spurred action at the global level. One of the first achievements was the creation in 1999 of *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, a technical and programmatic guide for use at the local level by health services field managers. The manual was developed and continues to be implemented by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, a wide-ranging group of UN agencies (including UNFPA, the UN Refugee Agency and the World Health Organization), donor governments and NGOs (including ones focusing on reproductive health, relief and development). The manual addresses topics such as safe pregnancy and childbirth, sexual and gender violence, HIV and other STIs, family planning and the reproductive health needs of young people.

The manual also articulated for the first time the Minimum Initial Service Package for Reproductive Health (MISP)—a set of priority activities addressing the immediate reproductive health needs of displaced people, especially women and girls, in the earliest phases of emergencies. Its five key objectives are to:

- identify an organization and individual responsible for coordinating and implementing the MISP;
- prevent sexual violence, and treat and support survivors;
- reduce HIV transmission through universal precautions, freely accessible condoms and clean blood supply;
- prevent needless newborn and maternal death and disability; and
- plan for the provision of comprehensive reproductive health services as an integral

component of primary health care beyond the emergency phase.

At around the same time that the working group came into being, the RHRC Consortium was formed to launch a coordinated effort to provide services; conduct assessments, research and training; and engage in advocacy to increase access to quality, voluntary reproductive health services to people fleeing armed conflict. The consortium members comprise the American Refugee Committee, CARE, Columbia University, International Rescue Committee, JSI Research and Training Institute, Women's Refugee Commission and London-based Marie Stopes International. The United States became the consortium's primary donor in 2002. In 2003, though, the Bush administration extended the application of the global gag rule beyond programs supported by the U.S. Agency for International Development to State Department programs, specifically to target Marie Stopes International. (Marie Stopes uses non-U.S. funds to provide safe abortion services in the context of comprehensive reproductive health care in developing countries.) For good measure, the Bush administration also alleged—speciously—that Marie Stopes was supporting abortion-related coercion by virtue of operating a family planning program in China. The United States then proceeded to cut off all support to the consortium as a whole—funding that was never replaced (related article, October 2003, page 1).

Because of the work of the consortium and the working group, numerous policy and programmatic accomplishments have occurred in the last decade. In terms of policy, the MISP is now integrated into the Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response* for humanitarian assistance providers. Due to increased awareness of the importance of reproductive health for displaced people, coordination and collaboration among agencies working on these issues has grown. Additionally, increased research and documentation of the specific needs of refugees and displaced people have been critical in improving service delivery and strengthening advocacy efforts aimed at donors, NGOs and policymakers. And in 2006,

Columbia University's Heilbrunn Department of Population and Family Health in the Mailman School of Public Health and Marie Stopes International launched a major new initiative—Reproductive Health Access, Information and Services in Emergencies (RAISE)—aimed specifically at “bring[ing] together all the tools needed to make comprehensive reproductive health care in emergencies a basic standard of care.” On the ground, reproductive health services in stable refugee settings are now fairly well-established and are generally being provided consistent with the field manual, especially basic family planning, antenatal and obstetric care.

Huge Challenges

According to official UN estimates as of January 2009, about 45 million people are deemed to be refugees, internally displaced or stateless—80% of whom are women, children or young people. Having fled conflict or natural disaster, they may either live in traditional camps or be dispersed in urban or rural areas. These situations may range from acute emergencies to longer-term, somewhat more stable conditions (see box, page 18).

In recent years, the humanitarian community has focused increased attention on the long-neglected needs of internally displaced persons who often live in noncamp settings, as they make up the vast majority of those affected by conflict and natural disaster. Moreover, as with refugees, their living situations often extend for many months or years, so relief agencies are beginning to include health services beyond immediate lifesaving interventions. In these circumstances, development agencies have larger roles to play too. As Judy Austin and her colleagues describe in *Reproductive Health: A Right for Refugees and Internally Displaced Persons*, “crisis settings are similar to the under-resourced but stable settings to which [development NGOs] are accustomed.” Indeed, the authors point out, “in many extended conflict and post-conflict settings, the distinction between ‘relief’ and ‘development’ is not clear cut.”

The IAWG and consortium have made and documented much progress relating to reproductive health services over the last decade or so, but

they have also identified serious remaining weaknesses and gaps. Even though certain reproductive services are reasonably well covered in refugee camps, services are severely lacking for internally displaced persons, by far the largest group of conflict-affected people. Even for refugees, however, the availability of services to prevent and treat HIV and other STIs has started to improve only very recently; the same is true for programs to prevent and respond to gender-based violence. Although temporary and barrier contraceptive methods are usually provided, many service providers are not well-trained, and the absence of the full range of methods and inadequate supplies impair the quality of care. Uprooted adolescents, who are particularly vulnerable to sexual exploitation and violence, continue to face unique hurdles in accessing services and information. The MISIP has gained greater acceptance but it is not yet universally implemented in the earliest days of an emergency. In-country storage and distribution of the necessary supplies to implement the MISIP can present challenges as well.

Moving Forward

Later this year, according to key NGOs and other major participants in this field, the first major update of the 1999 field manual will be published. The new manual will update a host of technical issues covering the range of topics and services in the original manual. Reportedly, it will highlight best practices in the field that have evolved over the last decade or more, reflecting the global consensus that emerged at the population and development and women's conferences in the mid-1990s and that has been repeatedly reaffirmed since then. For example, it will provide greater emphasis on HIV and STIs as separate, albeit related, critical concerns. It will include a new section on human rights, making the link between reproductive rights and human rights and calling for a rights-based approach to the provision of sexual and reproductive health services. Although the previous edition addressed the importance of emergency contraception only in the context of situations involving gender-based violence, the new edition will treat emergency contraception as a key form of protection that should be available more broadly.

Who Is Affected and What Are Their Circumstances?

The UN Refugee Agency (UNHCR) identifies six categories of persons of concern: refugees, asylum seekers, internally displaced persons, returnees, stateless persons and surrounding host populations. They live in a variety of settings under a range of scenarios. The largest affected groups and the most common settings and scenarios are described below.

The People

- **Refugees.** According to UNHCR, “refugees are people who have fled their homes and crossed an international border to escape persecution or conflict.” As of 2009, UNHCR estimates there are 10.5 million refugees worldwide, plus another 4.7 million registered refugees living in 60 camps managed by the United Nations Relief and Works Agency for Palestine Refugees. Most refugees live in rural settings, but increasing numbers are finding shelter in urban areas. More than half live in Asia, and 20% live in Africa.
- **Internally displaced people.** About two-thirds of the world’s forcibly uprooted people are displaced within their own country. According to the latest figures released by the Norwegian Refugee Council, there were 26 million such people around the world in 2008. The countries with the largest numbers of internally displaced people were the Sudan,

Colombia and Iraq. Large-scale displacements of people are also ongoing in the Philippines, Kenya, Democratic Republic of Congo, Pakistan, Somalia, Sri Lanka and India. Almost half of all internally displaced people live in 19 countries across Africa.

- **Stateless people.** About 12 million people are denied citizenship even in the country in which they were born, usually resulting from earlier conflicts or disputes over national identity. Stateless people are deprived of any rights and often live on the margins of society.

The Settings

- **Camps.** These are traditional settings usually in circumscribed areas where people register as refugees to receive services. Relatively speaking, this is the easiest setting in which to provide services to people.
- **Noncamp settings.** Alternatively, and increasingly, displaced people can be found in noncamp settings. They may seek urban areas because of educational or employment opportunities. For the most part, though, they are unskilled and live in precarious situations. They may also live outside of urban areas among the host population in villages, but this is less common due to host government restrictions.

The Scenarios

- **Acute emergencies.** The UNHCR uses numerous definitions of what constitutes the acute phase of an emergency. It could be a matter of the numbers of people displaced, the elapsed time from the onset of the emergency or the increase in mortality compared with the preemergency baseline (often a doubling). Most often in these situations, there is no access to housing, food, security or health care. The most urgent need is to ensure access to basic, lifesaving interventions.
- **Postemergency/stable settings.** This phase can last for months or even many years. It is characterized by decreased mortality rates, and usually basic needs have been met. It allows for projects to improve food security, containment of infectious diseases and the introduction of comprehensive reproductive health care.
- **Durable solutions.** In this last scenario, refugees prepare to return to their country of origin, integrate into their host country or resettle in a third country. This phase requires a high degree of coordination and planning to ensure continuity of care and smooth transitions.

The new manual for the first time will include a chapter on the provision of safe abortion services (consistent with country law) in the context of comprehensive reproductive health programming once emergency situations stabilize. The earlier version highlighted the importance of postabortion care as an acute care need, including treatment of unsafe or septic abortion. It stopped

short, however, of addressing the importance of making safe abortion services available, where permissible. With the addition of this chapter, the new manual will be taking into account the well-documented fact that unsafe abortion is a major contributor to maternal death and disability and will reflect the urgent need to reduce the incidence of unsafe abortion.

The facts are that refugee or displaced women may be even more likely to turn to unsafe abortion than others because they may have lost access to their regular contraceptive method, they may be more motivated to avoid childbearing while their living situation is in upheaval and they are more likely to be exposed to rape and other forms of sexual violence. Indeed, UNFPA estimates that up to half of all maternal deaths in refugee settings could be related to unsafe abortion.

Earlier this year, the members of the RHRC Consortium wrote to Clinton urging the new administration to:

- affirm U.S. support for comprehensive reproductive health care as central to humanitarian and early recovery assistance programs;
- restore strong U.S. support for the MISIP at the onset of a humanitarian crisis;

- prioritize the delivery of comprehensive reproductive health education and services once emergency reproductive health needs are addressed;
- facilitate the provision of such care throughout the period of displacement; and
- ensure a smooth and full transition from relief to development so that women and girls continue to have access to vital reproductive health care when they return to their home areas.

By law, the United States cannot directly subsidize safe abortion services, except when a woman's life is threatened by carrying the pregnancy to term and in cases of rape or incest. But as the consortium letter outlined and the revised field manual apparently will make clear, there are plenty of other ways for the United States to help—and even lead. www.guttmacher.org