



*Refugee
Women and
Reproductive
Health Care:*
REASSESSING
PRIORITIES

*Women's Commission for
Refugee Women and Children*

The *Women's Commission for Refugee Women and Children* is a membership organization dedicated to improving the conditions of the millions of refugees and displaced women and children in the world who have been uprooted by civil strife, war, persecution, and famine. The Commission was founded in 1989 under the auspices of the International Rescue Committee, the leading U.S. private voluntary agency assisting refugees worldwide.



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The Reproductive Health Needs of Refugee Women

Executive Summary

1. For a variety of reasons, women in refugee settings are having extraordinarily high numbers of children. Camp life often creates conditions that unintentionally result in completed fertility rates of near-record levels. These circumstances include laudable improvements in infant and child survival rates, pressure on women from their cultural, political and religious leaders to rebuild the population, the lack of a readily perceivable link between large family size and any long-term economic consequences, and the virtual absence of fertility-regulating information or services. In many refugee settings, pregnancies spaced at close intervals are often experienced by women whom international health experts would consider to be at very high obstetrical risk: women under 18 and over 40, multiparous women, women who are seriously physically depleted as a result of recent trauma and deprivation, women suffering from endemic diseases such as malaria and tuberculosis, and women with extremely poor nutritional levels.
2. The virtually exclusive emphasis given in refugee settings to maternal and child health services, and to the training of traditional birth attendants (TBAs) leaves a large number of people outside the orbit of more broadly conceived health care programs. It also sends a message that women's health is only of concern insofar as it relates to their reproductive capacity—a message dangerously similar to that implied in cultures that value women only for their ability to bear children. To assume that women are only in need of health services once they are pregnant means that women who are not pregnant, teenage women, single women, childless women and infertile women in need of preventive reproductive health education and services are excluded from consideration. Furthermore, to depend on TBAs as a way of teaching women about the benefits of birth spacing is a dubious strategy.

More emphasis on effective and adequate birth spacing as an important health issue for refugee women, should be a part of the training given to all health professionals, all paramedics, all TBAs, and all community health workers commonly found in refugee settings, since all these workers are likely to be familiar with, or should be made aware of, the grave overall consequences of women's repeated and closely-spaced childbearing.

3. In the majority of refugee sites, the more comprehensive reproductive health needs of refugee and displaced women are not being met. In many settings, certain limited aspects of good reproductive health care are available, particularly pre-natal care and the training of TBAs to make home deliveries for refugee women safer. However, sex education, family planning or birth-spacing information and services, the routine availability of contraceptive supplies in hospital and clinic pharmacies, clandestine abortion monitoring and treatment, legal abortion services, AIDS education and prevention, and the diagnosis and treatment of other sexually transmitted diseases and gynecologic conditions—not to mention the provision of supplies for menstruating women, rape prevention and counseling, or programs to assist the victims of sexual abuse and forced prostitution—are all seriously neglected.
4. Given what is known about the strong positive relationship between women's and children's health and survival and adequate child-spacing practices, serious consideration should be given to a series of initiatives aimed at increasing awareness of the problems discussed in this report and, ultimately, at improving the ability of refugee women throughout the world to plan their childbearing and to safeguard their reproductive health. These activities should include high-level inter-agency policy discussions on the issue, possible program guideline revisions, some demonstration projects in the field, and more rigorous evaluation of MCH programs in refugee settings.

Introduction

In 1993 and early 1994, the Women's Commission for Refugee Women and Children carried out an assessment of the opportunities available to allow refugee and displaced women throughout the world to plan their child-bearing and ensure their reproductive health. The impetus for the proposal came from members of the Women's Commission who had visited refugee sites in which women had begged them for help in obtaining contraceptive information, supplies and services. When the members of those delegations later tried to discover what types of family planning services were typically available to refugee and displaced women throughout the world, they found little or no information on this subject. The present report attempts to fill that gap.

The research findings are the result of two main areas of activity: a systematic bibliographic search, and travel to refugee sites in six countries of first asylum and two countries with internally displaced populations, to observe at first-hand the kind of reproductive health services available to women in various refugee-like settings. A group of advisers—made up in almost equal parts of experts in refugee assistance and experts in international health and family planning programs—were consulted at the beginning and end of the project.

The study appears to have been uncommonly timely. The very month that the research activities began saw the appearance in *The Lancet* of an editorial lamenting the neglect of family planning services for refugee women. The editorial claimed that in refugee settings, "there are virtually no data on fertility, abortion or desired family size," and that the "family planning needs of refugee populations have been totally ignored."¹ Then, in March 1993, the American Public Health Association adopted a position paper on refugee health issues that pointed out, among other things, that in refugee settings, "women . . . experience a range of problems specific to their gender. Lack of trained midwives, legal and safe abortion, and sanitary conditions combine to make pregnancy and childbirth a particularly risky venture for women displaced from their homes. Women's risk of morbidity or death is further heightened by spiraling birth rates and the lack of adequate spacing between pregnancies. Often contraceptives are unavailable or unusable in camps, and the desire of couples to replace children lost through conflict forces women to bear children in rapid succession, greatly increasing their risk of maternal mortality."²

The technical literature search proved to be remarkably

unproductive, yielding evidence of only two substantive research efforts in this area.³ A subsequent bibliographic search of the non-family planning and non-demographic literature produced a handful of articles and reports appearing in international health, development and refugee journals between 1982 and 1990. These mainly descriptive reports of general conditions in refugee settings made only passing references to the reproductive health problems of women. Frequently mentioned problems included unintended pregnancies and births, high-risk deliveries, high birth rates, poor nutrition and malnutrition among pregnant women, rape and sexual abuse, high rates of maternal, neonatal and infant mortality, and the ubiquitous lack of birth spacing and family planning information or methods.⁴ A literature search was also carried out in the library of the Refugee Studies Programme in Oxford. Again, this search produced no substantive or new research findings relevant to the study.

More disappointing perhaps than the limited output of the bibliographic research was the almost non-existent response from the roughly 50 international organizations and private voluntary agencies contacted by letter with a request for any information they might have on family planning needs, practices, and services in refugee settings. Recipients of these letters included the International Planned Parenthood Federation offices in London and New York, the United Nations Fund for Population Activities in New York, the Center for Documentation on Refugees and the International Committee of the Red Cross in Geneva, various refugee-related U.S. government offices in Washington, and the Refugee Studies Programme at Oxford University, as well as most of the European- and U.S.-based nongovernmental organizations (NGOs) involved in refugee work.

The paucity of serious research in this area is perhaps not surprising. Most aid workers are unlikely to have the luxury of the resources or time required to do good quantitative or qualitative research. There is probably just as little research going on in refugee settings in the areas of water and sanitation systems, food distribution, and general health programs as in the area of family planning. Some reports of this kind might be found in the archives of the international relief agencies, but they probably never reach a wider audience. Less charitably, the yawning gap in the literature might have to do with the general neglect and disregard for the special health concerns of women that have characterized refugee programs until quite recently.

The project advisers suggested that a standard assessment tool—a detailed inventory of the scope and quality of

reproductive health services available in refugee settings—should be created, and that that this instrument should be applied wherever it was appropriate. In addition, the advisers recommended broadening the scope of the research to reflect a more comprehensive definition of reproductive health, including pre-natal and post-natal care for pregnant women and recent mothers, maternity care, abortion needs and services, diagnosis and treatment of sexually transmitted diseases, and possible documentation of the incidence of sexual exploitation (rape and enforced prostitution, for example). This agenda turned out to be a little over-ambitious. Each site visit was brief, the contacts with the health personnel and the refugee women had to be fitted into very busy daily schedules, and topics such as abortion and rape are definitely not subjects to be lightly raised in a passing discussion. However, if mention of either of these topics occurred spontaneously, that is described in the country reports.

The design of a standard inventory was helpful because it forced the investigators to think more systematically about the precise aspects of reproductive health that would be the focus of the study. However, in practice the tool turned out to be largely unusable in many settings. For the most part, this was so for three reasons: There were few or no broadly conceived reproductive health or contraceptive services being offered in the vast majority of the locations visited. The collection of any kind of systematic data—for example, statistics on actual numbers of women of fertile age, numbers of births or deaths, numbers of trained staff—proved to be almost impossible in any of the camp settings. And finally, it became evident after a couple of site visits in widely different settings that Médecins Sans Frontières (MSF)—an NGO responsible for primary health care services in refugee sites in many parts of the world—sets up standardized physical structures and applies highly standardized service protocols wherever it operates, with little variation from one site to another (indeed, this is one of that organization's great strengths in the field). This means that an inventory of the very basic equipment, drug supplies and clinical protocols found in one MSF clinic or hospital was in fact valid for most MSF clinics and hospitals.

The following sections of the report discuss a number of important themes raised as a result of the assessment. Many of these do not necessarily relate directly to the provision or use of reproductive health services. They involve a number of important issues that provide the context within which women's reproductive health needs would be addressed in refugee settings: the organization of relief services in refugee settings; the tension between

meeting the refugees' immediate needs for emergency relief and implementing longer-term development activities that ideally would provide refugees with the skills and resources needed to improve their lives both in the camps and when they finally return home; the possible impact of long-term relief assistance on refugee populations; and the significance of children for refugee families. The final section of the main report makes some recommendations for future policy-oriented, public information or advocacy initiatives that might follow on from this preliminary research.

It should be stressed, however, that the conclusions reached in this report make no claim to be based on a systematic investigation of a comprehensive or representative sample of refugee settings. Most of the evidence presented is, by necessity, anecdotal, and documentable only in terms of what was observed in a given site on a given day. Moreover, the major perspective of the study is from the viewpoint of the health providers, rather than the women refugees themselves. This is a serious shortcoming of the study. There would be many cultural and language barriers to be overcome before women might feel confident in expressing to strangers their attitudes toward sex and reproduction, and time was far too short in every site visit to create the necessary conditions of trust and sympathy for such discussions to be of any depth. However, in every site visited, contacts were made with individual women, with groups of women refugees, women health volunteers and agency officials involved in special women's projects, and in many of these discussions, sexual, reproductive and birth-spacing issues were widely touched upon. The individual country reports describe the outcome of many of those discussions.

How Refugee Aid Is Given

The 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as a person who, "owing to well-founded fear of being persecuted for reasons of race, religion or 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, is unable, or owing to such fear, is unwilling to return to it."⁵ This definition, was broadened at a 1969 convention of the Organization of African Unity (OAU) to include any 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, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality."⁶ Although this later language is not included in the official UN definition of a refugee, most countries now accept it as the basis for any actions taken on behalf of populations in need of organized refugee assistance.

Today there are an estimated 18 million official refugees in the world, as compared with an estimated total of 11 million in 1987,⁷ and about 15 million in early 1989,⁸ In addition, there are about 24 million displaced persons.⁹ "Refugee" officially describes a person who has crossed an international border, while a "displaced person" is considered to be an individual who has remained in her own country but has had to leave her home. While displaced persons are subject to similar, if not even more dangerous, conditions as refugees (who are normally sheltered in a country that is at peace), the semantic distinction is important because in large part it determines the extent and the structure of the international relief response to the needs of these two groups. (Refugees make headlines; displaced persons do not.)

In principle, the United Nations High Commissioner for Refugees (UNHCR) is responsible for assistance to refugees, while the needs of displaced persons are addressed by rapidly formed alliances of other international agencies (such as the World Food Programme, the International Committee for the Red Cross, UNICEF and the United Nations Development Programme) and non-governmental or private voluntary organizations (NGOs and PVOs). In many cases NGOs receive funding from the UNHCR to provide relief assistance in those refugee settings in which the UNHCR has a presence. With some exceptions, the international and non-governmental organizations tend to provide expertise in a defined area of assistance, such as shelter, food and water supplies, non-food supplies, sanitation and public hygiene, education and social services, and primary health care. However, in certain cases, an international aid organization such as CARE or the International Rescue Committee may find itself involved in any or all of these areas of relief work.

The shared aims of all relief agencies are to help refugees survive their initial dislocation, and then to help them seek more "durable solutions," whether this be permanent integration into the country of first asylum (a rare outcome), resettlement in a third country, or—the most hoped for outcome—eventual repatriation. But as hopes for peaceful resolutions to many of the world's problems

become more elusive, the prospect of returning home grows ever more distant for many refugee groups. The Palestine refugees in the occupied territories were in camps for over forty years. More than five million Afghans have spent over 13 years as refugees in Pakistan and Iran. During the 1980s and early 1990s, roughly one million Cambodian refugees spent up to 13 years in refugee camps on the Thai border before finally being repatriated. In today's volatile world, the international refugee organizations are increasingly required to provide massive levels of assistance in refugee situations of unpredictable duration, rather than short-term aid for disasters with a foreseeable end.

While the vast network of international relief agencies has saved and continues to save millions of lives, one observer has called its efforts "heroic, absolutely essential, [but] inadequate."¹⁰ The reason for this bleak assessment is that worldwide relief efforts for humanitarian aid are being stretched to the limit of their capacity. Judy Mayotte has pinpointed the "'compassion fatigue' that has overtaken the international relief community. . . . We are inundated with disasters in every corner of the globe, each clamoring for immediate and substantial attention and assistance. . . . And the large donor nations are facing their own economic hardships (albeit of a different scale), turning inward to seek solutions for problems at home. Donations for humanitarian needs have taken a meteoric plunge. While there are double the number of refugees in the world in 1992 than there were a decade ago, donor contributions have not kept pace. . . . Over the past two or three years, because of cuts in assistance to refugees living in camps throughout the world, programs viewed as "luxuries," such as education, have been reduced or eliminated, and basics in food, shelter and medicines significantly reduced. Budgetary curbs frustrate the UNHCR's ability to fulfill its mandate to provide international protection and permanent solutions for refugees."¹¹

In 1992, the voluntary financial contributions of the top 22 donor countries to the UNHCR came to just over one billion U.S. dollars, up from only \$460 million in 1987.¹² That amount does not reflect bilateral aid (particularly from the European Economic Community), or the millions of dollars donated by private foundations and by church-supported and other humanitarian aid groups throughout the world. Yet a billion dollars to assist 18 million official refugees comes to only \$55 a head per year—about 14 cents a day—to cover all services, including the costly activities required to prepare for repatriation. It is obvious that relief aid for refugee and displaced populations must first focus on what is essential for

populations to survive: water, food, shelter, cooking fuel and basic medical care to forestall or eradicate epidemic diseases. It is within this context of growing worldwide demand for refugee relief and the international community's shrinking ability (and, perhaps, declining will) to meet that demand that the provision of family planning services must be viewed.

Despite the increased financial pressures experienced by the international relief agencies, a vigorous debate is being conducted over whether assistance for refugees should be limited to emergency relief, or whether, once the basic survival needs have been met, it should be expanded to include longer-term development aid that would help make refugees more self-sufficient while they remain in camp settings and better prepared for economic survival once they return home. The humanitarian and economic rationale behind the call for more assistance programs focusing on education, job and skills training, income-generating activities, and women's development projects, is not difficult to sympathize with, especially in the context of very long-term refugee settlements. On the other hand, it is not difficult to appreciate that the international relief agencies already have difficulty meeting the basic survival needs of refugees; that host countries are reluctant for refugee camps located within their borders to become more privileged settlements than those of the resident non-refugee population; and that in addition, offering refugees many of the benefits of economic and social development could create a "draw" factor that would swell the incoming tide of purely "economic" migrants, and might also provide a strong disincentive for refugees benefitting from such assistance to return home.

One advocate of increased emphasis on development (rather than relief) assistance insists that "once the immediate emergency is over, refugees can too easily become passive beneficiaries of aid, rather than active participants in a dynamic process of developing self-reliance."¹³ This argument touches on another much debated question: whether, by its very nature, relief assistance offered to refugees over many long years creates passivity and dependency among the recipient population.¹⁴ Some of the language of the debate very much resembles the tone of the long-standing argument between political liberals and conservatives in western countries over the perceived benefits or ills of the welfare state. But one aspect of the argument is particularly germane to this study. Many observers have made a link between the presumed "passivity" of the long-term refugee population in general and the possible "passivity" demonstrated by an individual refugee woman with regard to when and if she will have

a child. It is argued that if a refugee woman has no choice as to where she will live, what she or her family will eat, where she will collect firewood or draw water, or what clothes she and her family will wear, she is unlikely to feel that she has any choice as to how many children she will have, and when she will or will not become pregnant. But attitudes of reproductive fatalism may have nothing whatever to do with women's status as refugees. The Demographic and Health Surveys in many parts of the developing world also found high proportions of women who answered the question on ideal family size by saying that they wanted as many children as God sent them.

The length of time spent in a refugee setting is probably an important factor determining a refugee woman's sense of control over her life. The refugees in many sites visited in the course of the project had been there for a very long time. Many of the Afghan and Hmong Laotian refugees have been in camps for 10 or more years. For the most part, these are not women suffering the trauma of very recent flight. Rather, they are women who have become accustomed to the circumscribed routines of camp life, confident that they will at least have a roof over their heads, access to clean water, some basic food rations, and primary health care services, as long as they remain refugees. The most present enemy of many women in these circumstances is likely to be boredom, or hopelessness about the future, rather than fear of starvation or disease. In that context, the birth of a baby might reduce the monotony of women's daily routines, and provide the family with a renewed sense of hope for the future. What is more, in many camps, another child entitles the family to an increased food ration. Is this perhaps another aspect of the "dependency" syndrome among refugees so deplored by some commentators?

The Fertility and Health of Refugee Women

There seems to be little doubt that women in many refugee settings are having large numbers of children. The overwhelming impressions of high fertility gained during the site visits can be confirmed and quantified empirically in a few countries for which reliable health and demographic data on refugee populations are available. Studies in those countries document extraordinarily high fertility rates among refugee women. For example, Centers for Disease Control researchers in Khao I Dang camp in Thailand, projected on the basis of the number of pregnant Cambodian women counted that the crude birth rate between November 1979 and April 1980 was 55 per 1,000.¹⁵ And in the other Cambodian camps along the

Thai border, it was estimated by the United Nations Border Relief Operation (UNBRO) that the crude birth rate was 53 per 1,000 population in 1989.¹⁶ A fertility survey carried out in 1987 among Afghan women refugees produced estimates of a total marital fertility rate of 13.6 children per woman.¹⁷ Less formally, in the course of the site visits, on-the-spot calculations based on estimates of the size of the camp as the denominator and on the number of reported births (monthly or annual statistics) as the numerator produced estimated crude birth rates between 45 and 55 per 1,000.

Do refugee women want to have so many children? It was not easy to raise this topic freely in discussions with small groups of refugee women, health workers or TBAs. Very often the conversations had to be translated through a male interpreter. It often seemed inappropriate to ask this question outright, given the very brief contact that was possible, and before an atmosphere of mutual trust could be properly established. As a result, indirect questioning did not produce much light on the topic. Many women seemed surprised by the question itself, and instead of mentioning an ideal family size, answered that of course they loved all their children. Muslim women invariably answered that they wanted as many children as Allah gave them. No women answered definitively that they had not wanted the number of children they had, but older women often replied that they were satisfied with that number and did not want any more. When unmarried younger women were asked how many children they would ideally like to have, some made a point of saying that they did not want to get old as quickly as their mothers had, and so would like to limit or postpone their childbearing. On the other hand, women had no reservations in talking animatedly and at great length about how difficult their most recent labor had been, and how generally difficult and undesirable it is for most women in general to be pregnant, to give birth and to have a lot of children in a crowded camp setting.

Unfortunately, as both the site visits and some small research studies indicate, the high rates of pregnancy recorded in many refugee sites are often at the expense of refugee women's already fragile health status. If the World Health Organization (WHO) methodology for assessing risk levels among pregnant women in developing countries were to be applied in most refugee settings, it would undoubtedly produce very high estimates of women in need of special maternity care. The WHO typology identifies as being at high risk from pregnancy women under 19 and over 40, unmarried women and women with no accompanying family, illiterate women, women with less

than two years between births, women suffering acute chronic or medical conditions or infection, women with poor immunization status and women being served by health providers who do not speak their language.¹⁸

WHO's definition of high-risk women almost seems to have been written with refugee women in mind. Although no reliable statistics on average age at marriage are available for any refugee settings, large proportions of the populations in refugee camps come from regions of the world characterized by very early marriage and very early initiation of childbearing. This description certainly applies to women in Afghanistan and throughout the Horn of Africa. Many refugee women in camps are recent widows, separated from their husbands or without supporting family members, and this is especially true if they have not been scheduled for third country resettlement. Many have never learned to read or write. Large proportions are unable to space their pregnancies by more than two years. In terms of refugee women's general health status, the presence of many serious infectious diseases in most refugee settings is no secret. The most common are diarrheal infection and intestinal parasites,¹⁹ measles, hepatitis, tuberculosis, malaria, and sexually transmitted infections such as syphilis, gonorrhea and chlamydia.²⁰ All of these conditions can seriously compromise the health of pregnant women. Tuberculosis, hepatitis, malaria, gonorrhea, chlamydia and syphilis also place the fetus at risk. In addition, anemia and toxemia leading to pre-eclampsia create life-threatening conditions for both the mother and the newborn. And finally, it is probable that the vast majority of pregnant women in refugee sites are being served by trained medical professionals who do not speak their language.

The WHO definition of maternal risk does not mention women's nutritional status. Because food rations are small, and are based mainly on total calorie intake rather than on a population's specific nutritional needs for protein or vitamins, and because in many societies women serve the male members of the family and their children before they themselves eat, most experts believe that the vast majority of refugee women suffer from severe levels of malnutrition, especially iron deficiency. In sum, large proportions of refugee women by definition are at high risk when it comes to pregnancy and childbirth.

A whole host of other reproductive health issues specific not just to refugee women but to women everywhere—infertility, menstrual disorders, genito-urinary problems, maternal morbidity, sexually transmitted diseases, complications from clandestine abortions, sexual abuse and

exploitation, and rape, to name only a few—are not dealt with in any systematic way in any of the literature on health conditions in refugee settings. The present study was unable to make any systematic observations to fill that gap in knowledge, even though it is obviously an area of grave importance that should be addressed by any agencies contemplating the introduction of a comprehensive health project to serve the special reproductive health needs of women refugees.

Guidelines for Reproductive Health Care in Refugee Settings

The UNHCR has codified the health services to be offered in camp settings in which it has a presence, but in most places it has no powers to enforce these guidelines. As a result, there is no such thing as a standardized package of health services, or a standardized level of health care that that all refugees receive. UNHCR's 1982 *Handbook for Emergencies* stipulates that "Primary Health Care should include the following: promotion of proper nutrition, an adequate supply of safe water, basic sanitation, maternal and child care, including family planning, appropriate treatment for common diseases and injuries, immunization against major infectious diseases, prevention and control of locally endemic diseases, education about common health problems and what can be done to prevent and control them." The section of the Handbook dealing specifically with maternal health also emphasizes that "family planning information should be available. After proper education, suitable temporary methods of contraception (child spacing) should be provided on a voluntary basis ensuring that the refugees understand their free choice in the matter."²¹ However, specifications for essential drugs and standard clinic equipment listed by the WHO as part of its Emergency Health Kit have only recently started to include contraceptive drugs or supplies, and very few of the clinics visited as part of the study were observed to stock contraceptive products in their pharmacies. However, a few pharmacies did keep some small amounts of contraceptive supplies—mostly pills or condoms—but the facilities made no systematic attempt to let people know these products were available.

Women's health needs are put into even sharper focus in UNHCR's 1991 *Guidelines on the Protection of Refugee Women*. A section discussing women's access to appropriate health care points out that "existing health services too often overlook female-specific needs. For example, gynaecological services are frequently inadequate as are child spacing services. Basic needs, such as adequate cloth and washing

facilities for menstruating women, are overlooked. Serious problems, such as infections and cervical cancer, and harmful practices such as female circumcision, go all but undetected. Counseling regarding sexually transmitted diseases is generally inadequate for both women and men. Few if any programmes focus on the needs of adolescent girls, even though early marriages and pregnancies are a reported cause of poor health. Access to family planning information and devices is limited in most refugee camps even where it is available to women and men in the host country. In some cases, the refugees are reluctant to use birth control because of cultural constraints or unfamiliarity. In a number of camps, non-governmental agencies provide health services, including those relating to maternal and child health and health education, but they are unable, because of their own religious or cultural constraints, to include family planning in their programmes. Refugee women may not be given sufficient information to provide informed consent to the use of birth control."²²

There seems, therefore, to be no lack of official support for family planning in refugee settings, as well as for a wider range of women-centered reproductive health services. The first set of UNHCR guidelines mentioning the importance of birth-spacing services was drafted over 10 years ago, so it might be expected that contraceptive services, at least, would have become an integral part of the primary health care services provided in most refugee settings throughout the world. However, that does not seem to be the case. In spite of broad awareness of the high fertility levels and poor health status of many refugee women, primary health care and maternal and child health (MCH) programs in many refugee sites do not emphasize either birth-spacing or birth limitation practices for high-risk women. As will be shown, this is not because MCH programs themselves are a neglected aspect of primary health care services in refugee settings. Indeed, they are one of the major types of health care services available.

Maternal and Child Health Programs in Refugee Settings

It is not hard to understand the emphasis given in refugee camps to MCH programs that focus on the survival and improved health of pregnant women and children. This is where the most dramatic and easily identifiable health need exists, especially during a camp's initial emergency phase. In addition, UNHCR guidelines stressing the special vulnerability of pregnant refugee women have clearly influenced the type of services that are offered. As a

result, women in most refugee sites under the mandate of the UNHCR system are likely to have access to some kind of basic pre-natal care; to maternity services to assist them when they give birth; to post-partum sessions to check the mother and child's progress; to supplementary feeding and oral rehydration programs for their infants; often to Expanded Programs of Immunization (EPI); and to other basic health services for their children.

Yet family planning counseling and services as an integral part of such an MCH program was found in only one location visited as part of the project—some of the camps for displaced persons in Byumba province, Rwanda, where an integrated MCH/FP program implemented by CARE had been in operation for almost two years. In the other refugee settings in which some kind of family planning information or services were available—the detention centers in Hong Kong for the Vietnamese boat people, the Thai/Burma border, the Thai/Lao border, and Côte d'Ivoire—all these services were being offered by NGO, voluntary or ad hoc agencies other than the lead health agency assigned to provide MCH services to the refugees. There is also evidence that in the 1980s, family planning services were offered in selected Cambodian and Lao refugee camps on the Thai border. However, these services were also made available through free-standing family planning clinics organized by the Planned Parenthood Association of Thailand (PPAT) and the Population and Development Association (PDA). They were not integrated into the MCH programs of those camps.

The single instance of an integrated birth-spacing program in Rwanda is an interesting case, for two reasons. The first is that this was a displaced population in their own country, and their own country had made strenuous efforts over the past 10 years or so to expand women's access to family planning services through the government maternal and child health program. The second reason is that CARE had skilfully adopted one of the major aspects of Rwanda's existing MCH/FP strategy—the use of community-based promoters in each commune—to help inform the refugees about both the benefits of birth spacing and where they could obtain contraceptive services in the camp.

Yet apart from this single example, the striking separation of MCH and family planning programs is a significant finding. It is also not without precedent in many parts of the world, especially in developed countries. The usual connection made between reproductive health services to prevent unwanted pregnancies and reproductive health services to protect wanted pregnancies is potentially problem-

atic. To loosen that link, some experts have indeed argued for free-standing family planning services placed outside the orbit of other health services traditionally focusing on mothers and children. Support for this strategy comes from health planners who believe that when both services are offered in the same site, family planning ends up being the poor relation, receiving fewer human and material resources than are assigned to MCH programs. Critics of this view argue that providing separate services is not cost-efficient in countries with limited health budgets, and that such a separation would probably lead to duplication, overlap and waste. Some observers also believe that family planning services offered only as part of an MCH program discourage the practice of contraception by unmarried and childless women, men and adolescents.

Since a de facto separation of family planning and MCH services already seems to have taken place, it would be interesting to find out whether this has occurred because existing MCH programs in refugee settings are not in a position to add an expanded reproductive health component to their ongoing activities. What does the typical MCH program in a refugee site look like? Is it likely that family planning services could simply be added on to existing MCH services?

A Typical MCH Service

MCH services in refugee sites are typically housed in separate rooms or spaces within a larger health clinic structure. Since many such clinics have no electricity or running water, medical equipment is kept to a very basic level. The pre-natal care services offered in most refugee sites are quite simple. Such programs ensure that women receive tetanus shots, blood pressure monitoring, weight gain and fetal growth checks, and, in some cases, supplementary foods or, less frequently, vitamin supplies. Obstetric care is usually offered in an otherwise bare delivery room that would typically be furnished with a simple wooden or metal bed or raised board, inevitably lacking sheets or curtains to protect the woman's privacy. The equipment in a typical delivery room would include some basic drugs, scissors, a pair of re-usable gloves, some clean water in a container, perhaps a battery-powered autoclave, or, in some cases, a kerosene refrigerator.

Child health services focus primarily on ensuring complete immunization coverage, on supplementary feeding programs, and on monitoring developmental progress, often using standardized growth charts of the type developed by international agencies such as WHO and Save

