



*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 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 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

the Children. These sorts of growth charts are very popular among health workers because they provide a clearly understandable picture of trends in a child's weight and height during the first four or five years of life, and are an extremely useful teaching tool.

Despite the rudimentary nature of the care offered in most MCH programs, some kind of basic reporting system is maintained. Pregnant women, for example, are given numbered cards recording the dates of their prenatal visits, the number of tetanus shots they receive, their blood pressure readings, their weight gain, and their overall risk status. This is usually assessed on the basis of a standard system that measures a number of important demographic and medical indicators. Information on the course of the women's pregnancy is also recorded on patient charts kept in the clinic. If the women then gives birth in the MCH facility, her background information presumably becomes available to the attending nurse or doctor. Health statistics of this type are routinely compiled and analyzed in monthly or annual reports submitted to the implementing or funding agency involved.

Health agencies that work in many different refugee settings—Médecins Sans Frontières (MSF) or Save the Children Fund, for example—probably have in their central files a wealth of valuable epidemiologic data covering many thousands of refugee women and children. Statistics of this kind could potentially provide a rich data source for evaluation studies looking at the effectiveness or failure in emergency refugee settings of certain delivery strategies, or of particular health protocols. It is a pity that these data do not seem to have been shared with the larger international health community or made available to researchers in the wider MCH field.

The MCH services in many refugee sites, therefore, are well-run, serious programs to assist women and children, who do, after all, make up the vast majority of most refugee populations. And they are heavily used in most sites. In fact, the huge crowds of women, children, babies (and a surprising number of men carrying babies) outside every MCH post visited are an unforgettable aspect of most camps. And the staff of those facilities are kept extremely busy. A particularly onerous role is that of the usually young expatriate women nurses and doctors who have the full responsibility for MCH services: they see patients, they supervise the work of a wide range of para-professionals and medics; they deal with daily crises and emergencies; they see that the reporting system is maintained; they liaise with other sections of the primary health care system; and they attempt to create an informal system of epidemiologic

oversight. Is it realistic to expect the overburdened and rudimentary MCH services observed in the site visits to assume the added responsibilities of providing screening for sexually transmitted diseases, the treatment of women suffering from unsafe induced abortions, or high-quality contraceptive information, education and services?

The Crucial Role of Traditional Birth Attendants

The major aim of all maternal health programs involving pre-natal services and the training of traditional birth attendants (TBAs) in refugee camps is to identify pregnant women who are at high obstetric risk. However, even if this approach is successful, it cannot succeed in saving lives if medical facilities for very high-risk women are not available at the time of delivery, or if women do not use them. Even under normal conditions, very few refugee women choose to give birth in the available clinic facility. And in cases of high obstetric risk, an infinitesimal proportion of women deliver in facilities in which they can receive attention from trained midwives or doctors with access to blood transfusion supplies, intravenous equipment or any surgical capability. And even if properly equipped facilities and adequately trained health professionals are available to refugee women, these are usually located in distant provincial or regional centers many hours away from the camp site. These centers might be reachable only on rutted dirt roads that are often quite impassable by vehicle at certain times of the year. In Rwanda, for example, a pregnant woman with threatened complications would have to be carried by four men in a specially woven straw hammock to a provincial or district hospital some 10-30 miles away. In Kenya, a Somali woman refugee would have to be flown to a hospital in a specially chartered UNHCR plane.

The reasons why most refugee women prefer to give birth at home are numerous: They may not like being treated by health professionals not of their own gender or ethnic group; they are often too modest to want to expose their bodies to a person not related to them; they say the clinics are too far for them to walk; they do not like being required to deliver from a prone position; they are accustomed to having their children and other family members with them when they give birth; or they fear that in the case of an extended labor, there will be nobody at home to take care of younger children or to cook for the family.

Since very few women choose to deliver in the available clinic facility, and since births assisted by trained medical staff with access to well-equipped obstetric facilities are

rare, the major burden for safe deliveries falls on traditional birth attendants (TBAs) assisting women in their homes. TBAs are considered the world over to be front-line workers in the battle against maternal and perinatal mortality. These largely volunteer community-based health workers have been recruited by NGOs in many refugee settings to provide home-based care to women unlikely to attend or to have access to pre-natal or delivery services in a clinic or hospital setting. In almost every site visited, the training of TBAs was the major focus of the MCH program. TBAs are trained to identify and refer high-risk women to better equipped hospitals or clinics at the time of delivery, and to assist safe home deliveries using a few basic hygienic practices. All the TBAs trained in the visited camps were taught, at a minimum, how to recognize the major signs of a potentially dangerous labor and what referral steps to take, how to wash their hands carefully before delivery, to sterilize cloths for draping the woman and wrapping the newborn, to cut the umbilical cord with a sterilized blade, and to insure the complete expulsion of the placenta. They were also taught the importance of reporting births, and of encouraging the mother to bring herself and her child to the MCH unit for a check-up as soon as possible after delivery.

The training of TBAs is a major function of health agencies in refugee sites, and many NGOs have invested a great deal of time and effort in writing special TBA training manuals. The quality of these manuals ranges from poor to excellent. Many are designed to be used by women who cannot read or write. The manuals focus on a few basic principles of pre-natal care (the importance to pregnant women of good hygiene and nutrition, of receiving tetanus shots, of getting enough rest, of avoiding unnecessary exertion, for example, and of breastfeeding their babies). They usually feature attractive, simple illustrations appropriate to the cultural group in question. But has it really been necessary for almost every agency to produce a training manual unique to each refugee setting? It would perhaps be more cost-effective and less time-consuming if the NGOs had concentrated on making available one standard training text (for example, one already designed, tested and approved by WHO, UNICEF, CARE, or OXFAM) that they would have translated into the needed languages, and for which they could commission appropriate illustrations. As it is, many NGOs seem to have expended an unwarranted amount of time and effort in re-inventing the wheel. Unless it can be demonstrated that a strong feeling of "ownership" and special pertinence attaches to a TBA training manual produced within the setting in which it will be used, the adaptation of a standard manual might serve the same

purpose, and just as effectively. It might also ensure a more uniform training of TBAs, and a more uniform emphasis on birth-spacing as an important strategy to save women's lives and protect their health.

In some cases, women who have successfully completed their training are given a simple TBA kit consisting typically of a few fresh pieces of cloth, some surgical spirit or alcohol, and a new wrapped razor blade. In other cases TBAs are trained to help the mother register the birth and to stress the importance of attending the post-partum clinic with the newborn baby. However, even though the importance of post-partum counseling about the beneficial health effects of birth-spacing is featured in all the TBA training manuals, this topic was rarely mentioned by TBAs as a significant part of their responsibilities. In fact, no TBAs were found to be making a special effort to teach women or the community about the health benefits of birth-spacing practices.

Furthermore, some experts have suggested that expecting TBAs to encourage women in their communities to practice family planning creates somewhat of a conflict of interest for this group. If birth attendants rely on payment for their services as a source of personal income, they might be reluctant to encourage practices that would reduce the number of births and, thus, future demand for their services. In addition, several reviewers of this report pointed out that the results of developing country health projects outside the refugee setting that attempt to involve TBAs in the provision of birth-spacing information or supplies have been extremely mixed.

Strengthening MCH Programs

It goes without saying, however, that of course TBAs whose practices create rather than reduce women's obstetric risks should be trained to do their important work more safely. Yet emphasis on the training of TBAs to identify high-risk obstetric cases—a principle health strategy adopted in trying to save the lives of pregnant women in refugee settings—raises some serious questions. Is this the most effective way to ensure safe health outcomes for pregnant women and their infants? It is estimated that one half-million women die each year from maternity-related causes—99 percent, women from less developed countries. In recent years, an ongoing debate within the international health field over the best ways to reduce maternal deaths involves the proponents of two schools of thought: health professionals who believe that the provision of pre-natal services and of well-trained TBAs to

identify high-risk women remains the best defence against high-risk births; and those who believe that emphasis on other health strategies is more likely to help reduce the number of maternal deaths. These other strategies include improved referral facilities (including the provision of appropriate secondary- and tertiary-level obstetric care facilities), and "alarm" and transport systems for women with dangerous delivery complications.²³ This broader approach also stresses the importance of reducing high-risk pregnancies through the spread of effective family planning and safe abortion services that enable women to delay early childbearing and to space and limit their total number of births. This new approach (the Safe Motherhood Initiative) is currently being tested and evaluated worldwide by an international consortium made up of the WHO, UNDP, UNICEF, IPPF, the Population Council, the World Bank and UNFPA.²⁴ What is more, the most recent World Bank Development Report points out, studies in the Gambia and Indonesia found that "traditional birth attendants who were not backed up by skilled services were unable to decrease the risk of maternal mortality."²⁵

Because the typical MCH program found in refugee sites has never been evaluated, these services must be seen as humanistically driven acts of faith, rather than as health activities carefully designed to improve the reproductive health conditions of women. In a very real sense, the agencies providing such services have no other option. The programs are not based on the kind of demographic and health information that is needed to plan and evaluate any health intervention. It is virtually impossible to obtain the necessary epidemiologic data, or the age- and gender-specific information about the number of camp residents in any setting. Because the food ration for adults is larger than the ration allocated to children, UNHCR usually collects sex-differentiated data on numbers of children under the age of 12, and on the size of the population 12 and over. Any more detailed age-breakdown is usually not available, and even the undifferentiated totals are often difficult to obtain. Some agency representatives claim that the official numbers are likely to be exaggerated because families overstate how many members they have in an attempt to obtain larger food rations. Others believe that official population estimates are usually under-counts because, for political or other reasons, many camp residents fear or resist being documented.

UNHCR is aware of the problem, admitting that "the collection of accurate statistical data on refugees and asylum-seekers is one of the most problematic issues confronting UNHCR. . . . Refugees often come and go across international borders as well as within their countries of asylum,

according to changing levels of assistance and security. . . . A refugee population, like any other, is a dynamic rather than a static entity. Refugees die, get married and give birth. . . . However accurate they may have been at the time of their collection, statistical data about the size and composition of a refugee population can quickly become outdated. Updating this information is not a straightforward exercise either, particularly among refugees who record births, deaths, ages and family relationships in ways that do not correspond with standard Western practices."²⁶

Even more serious criticism must be directed at the standard type of MCH program seen in refugee settings throughout the world. Two major problems seem to emerge. First, a health program that focuses only on pregnant women and women who are already mothers excludes large numbers of other people in need of other kinds of reproductive health care. These women include adolescents (of both sexes) in need of sex education and counseling, single sexually active women who are at risk of unintended pregnancy and sexually transmitted diseases, women suffering complications from unsafe induced abortion, women wanting to become pregnant but unable to do so, women subjected to sexual abuse, rape victims, women forced into prostitution, and all women requiring services for the detection and treatment of severe gynecologic conditions or diseases. As one woman journalist concludes: "[B]ecause women's health needs are addressed mainly in the context of pregnancy, childbirth, and mothering, other problems often go undetected. It is not uncommon for sexually transmitted diseases, precancerous and cancerous conditions, infections, genital mutilations, and other traumas to go undetected. AIDS education and testing, as well as rape counseling, are virtually non-existent in many refugee settings."²⁷

The second problem has to do with the lost opportunities for helping women to move from being passive recipients of curative care to becoming active participants in preventive health practices aimed at improving their own and their children's health. This last failure is very much related to the philosophy and mandate of some of the leading primary health care and donor agencies, and even to the priorities set by the host countries. Many of these players see their most important mission as saving lives in emergency situations. They do not see their role as going beyond that mission toward services that could help prepare refugees for their future lives outside the camp, such as education, some basic skills training, and the communication of information that might change harmful traditional attitudes and ideas. This failure was addressed in a

1990 roundtable on migrant and refugee issues held to commemorate the 40th anniversary of the establishment of the UNHCR. The participants issued a joint statement that reminded the international community that the "experience of working with refugees requires that traditional definitions of the refugee as a passive victim, or as a welfare client, should be reviewed, to enable agencies to recognize the refugee as a positive actor in his or her own right, whose active participation in the development process is vital to his or her own well-being and identity."²⁸

Two examples of lost opportunities in MCH programs can be mentioned. In both the Somali and the Rwandan camps, where levels of health knowledge are quite poor, women with infants or children under five who were demonstrating a failure to thrive were instructed to bring them to a 12-hour or 24-hour supplementary feeding center in the camp. They would sit on mats, under a straw-roofed shelter, for 12 or sometimes 24 hours a day, being supplied with 5-6 specially prepared meals to feed to their infants and toddlers. While this was happening, no other activities were going on, even though there were often quite long, empty periods between meals. The special diets for the children were prepared in a kitchen staffed by men and women hired from within the camp, but the mothers themselves were not involved in cooking the food. The hours between meals were not used to hold discussion groups about breastfeeding, basic hygiene, the preparation of nutritious meals, or the benefits to be derived from birth spacing. Many of the women also brought their older children to spend the day in the feeding center, if they were worried about leaving them at home. The presence of these children offered a perfect opportunity for camp teachers or social workers to organize play groups for the younger children, or reading groups for the older ones. But no one in the primary health care agency had even considered those possibilities.

The second major lost opportunity has, of course, to do with the failure to use appropriate opportunities in which there is contact between a TBA, community health workers or other type of para-medic and a woman patient to talk about birth spacing. Even if the occasion were only used to mention the importance of maintaining traditional practices of post-partum abstinence and breastfeeding as a way of delaying the next pregnancy, or to discuss the period during their menstrual cycle in which they were most likely to get pregnant, it could contribute in a small way to introducing the idea that refugee women have a right to begin to take control of their reproductive lives. This understanding alone would stand women in good stead for the time when they would eventually return home.

Why Is Family Planning a Neglected Health Approach?

What explains the overwhelming absence of birth-spacing education and services as an integral part of primary health care/MCH programs in refugee settings? One explanation is that many of the population groups seeking asylum have never used modern methods of fertility regulation. Refugees coming from parts of the world lacking well-run government or private family planning programs are unlikely to have been contraceptive users. Countries such as Afghanistan, Burma, Cambodia, Laos, Mozambique, Ethiopia, Somalia and the Sudan, for example, which have all produced large numbers of refugees, have historically had extremely low contraceptive prevalence levels.²⁹ Whatever little modern contraceptive use did exist in those countries was likely to have been practiced by more educated urban residents—the groups least likely to become long-term camp residents.

Because family planning has not been part of the everyday life of many refugee men and women, the provision of birth-spacing techniques and education in many refugee settings would require the introduction of a whole new technology, involving educational approaches carefully geared to the needs, attitudes and practices of a specific cultural group. Information and service programs of this type would have to be designed with the prior consultation and full participation of women and their partners, and would have to use instructors and health workers from within the community. It would also require consultation with appropriate religious and other leaders in the refugee community. Creating this kind of support for a new health practice takes time, and in an emergency setting, there is no time. The subsequent introduction of actual services would also take a great deal of careful planning. Such a program would also need patience on the part of any program funder expecting to see significant changes in reproductive attitudes or behavior within a short period of time.

Another reason for the lack of family planning services might have to do with the circumstances that often prevail during the initial emergency phase of a camp's existence. In the first year or so, infant mortality rates are likely to be high, malnutrition among children is rampant, women are likely to have lost some children, to be more prone to miscarry, and to be physically weak and emotionally traumatized. During that phase, when some women have not regained their normal menstrual cycle, conception rates are likely to be low. Once health and nutritional standards improve, however (and in many sites

this happens with extraordinary rapidity—sometimes within months, when supplemental feeding programs are established), women are likely to want to demonstrate that they are still capable of becoming pregnant and of carrying a pregnancy to term. However, in that next phase of the cycle, birth spacing would still be an important health emphasis. Yet a number of experienced aid workers suggest that family planning services of any kind would be difficult to introduce in the context of a refugee emergency. Some go so far as to say that the last thing a psychologically and physically vulnerable population needs is health messages about limiting births. It must be noted, however, that some aid workers appear to be haunted by their experience of the appalling conditions that exist in the early stages when a new camp is being set up. These first impressions of unspeakable human suffering seem to stay so deeply etched in their memories that they are unable in some way to recognize when those conditions cease to exist, and to adapt their thinking about appropriate and inappropriate health approaches to reflect the changing conditions.

A similar inability to forget the trauma of the recent past may affect refugees themselves, especially as regards their memories of losing children. Many women might not recognize the rapid declines in infant and child mortality rates that frequently occur in camp sites, and might continue to base their reproductive decisions on infant mortality experiences from their own country. The importance of improved infant and child mortality rates goes beyond the humanitarian issue of saving lives. It also relates to refugee women's perceptions about the number of children needed for the family or the social group to survive. If women believe that their children are likely to die in infancy, they will want to bear children in excess of the number they ultimately desire. Fertility regulation or limitation will not seem a reasonable option until refugee women are confident that most of the children they bear will survive. The question is whether rapid (but not necessarily lasting) improvements in child survival rates in refugee settings change women's views about the need to have a lot of children. And if so, how long does it take for the changed mortality conditions to influence childbearing aspirations? This is an important area to study. It also has important programmatic implications. In fact, simple discussions about the relationship between child survival levels and family size aspirations could form the basis for initiating family planning information programs in refugee settings. Such group or family discussions would make it possible for women and their husbands to talk and learn about the links that exist between family size, child spacing and the health of women and children.

The authors of *The Lancet* editorial address this concern that family planning programs are "insensitive" to refugee suffering and to the refugees' understandable fears of extinction. The editorialists acknowledge that "some western aid agencies equate offers of family planning to refugees with genocide, even though it is intuitively likely that many people will not wish to conceive while in . . . a refugee camp." But they insist that "none of us has to try and decide how people uprooted from their homes will behave in another setting; all that is needed is to offer refugees contraceptive choices and let them decide whether to adopt a method or not. It is *not* offering choices that is reprehensible."³⁰

Whatever the strength of the case for downplaying fertility regulation during a refugee camp's emergency stage, in many cases, after a year or so—thanks to the impact of high-quality public health, sanitation and MCH programs provided by the relief agencies—the number of severely malnourished children falls dramatically, child survival rates improve, and birth rates soar. And after a decade or so, average numbers of surviving children per family start to reach unprecedentedly high levels. Why are family planning services not introduced as soon as the high-fertility patterns begin to be established? One reason may be that the staff of many health agencies have been trained to focus on "emergency" and curative health services rather than on preventive activities. In fact, some health agencies prefer to leave the field once health standards have been stabilized, and the emergency situation is over. They may be right in that decision, since many professionals working in agencies with an exclusively emergency care mandate often prefer to go into a new situation to set up efficient life-saving systems, rather than to undertake the organization and provision of long-term, patient-oriented services, or the introduction of patient and community health education programs. In any case, such activities are better left to the refugees themselves, with assistance from the international NGOs, rather than to expatriate workers. In addition, prescribing contraceptive techniques such as the IUD or NORPLANT requires the type of training that emergency care doctors and nurses are unlikely to have received.

The obverse side of the genocidal argument against introducing family planning programs in refugee settings is the pronatalist position, which argues that family planning is undesirable because large numbers of children are a positive good for a particular refugee society. In particular, the Afghan religious and political clan leaders in the camps along the Pakistan border told women very clearly that their major contribution to the "jihad" or holy war against

the enemy would be measured in terms of the number of children they bore, especially boy children. Cambodian and Burmese women in the Thai camps, and Somali women on the Kenyan border, were subject to similar pressures to have a lot of children.

In certain refugee settings, the absence of family planning education and services can be accounted for by the values and mandate of the implementing health agency in a given site. The unwillingness of some religiously-based NGOs to recommend or offer modern contraceptive services to women at high risk of repeat pregnancies probably has no precedent in any other area of medical protocols. If a religious group that was implementing primary health care services in a refugee camp were to claim that the denomination's religious beliefs prohibited their nurses and doctors from immunizing babies, or from giving a blood transfusion to a hemorrhaging patient, it is highly unlikely that these views would be tolerated. It is surprising, therefore, that the relief authorities turn a blind eye to the refusal of some health agencies to provide modern contraceptive methods.

Whatever the logistical, attitudinal or cultural barriers to making contraceptive services a routine part of health programs in refugee settings, and despite the existence of UNHCR's detailed guidelines, the quality and the content of health care services in refugee settings is ultimately determined by the visibility of the refugee population in question, the political importance given to a particular refugee population or to a particular kind of assistance, decisions made by the refugees themselves as to which group within the culture has priority (men vs. women, or the old vs. the young), and the monetary and human resources available to support the services. For example, funding was easily obtained to help Afghan refugees in the early and mid-1980s, because their cause was highly popular in the context of the Cold War. Now that foreign troops have withdrawn from Afghanistan and many other areas of conflict have erupted in the world, funding levels for the Afghan refugees have dropped dramatically. Today, refugees in the former Yugoslavia are probably the most familiar refugee population in the public eye, attracting similar levels of international sympathy and support as the Afghan and Cambodian refugees did in the 1980s.

It is perhaps no coincidence that in 1993, the reproductive health needs of rape victims in the former Yugoslavia quickly became a *cause célèbre*. So effective was the publicity around their reproductive health needs that it did not take long for an international effort to be launched to bring these problems to the attention of international

agencies at the policy and program level.³¹ Is it simply then that policy and program planners in the international relief and family planning communities are unaware that rape is a common reality in many refugee settings and has been for generations of women, or that birth-spacing services are largely unavailable? If they learned that this was the case, would they be ready to support and help pay the costs of including rape counseling and contraceptive services in all relief efforts?

Discussion

The major conclusions of this assessment are that women in refugee sites throughout the world—many of them in questionable health and with few or no material resources—are having large numbers of pregnancies at closely spaced intervals, and that, by and large, birth-spacing information and services are not available as a part of the primary health care programs that exist in most camps. The high fertility level has many convincing explanations: women's spontaneous desires for children (perhaps to prove their continuing fecundity), a response to former well-founded fears that large numbers of children would not survive into adulthood, the frankly pro-natalist influences exerted by the cultural, political and religious leaders in certain refugee settings, the fact that food allocations are often made in direct proportion to a family's size, the general absence of contraceptive information or birth-spacing services, and the survival-enhancing effects of highly effective public health and basic health care measures all combine to produce high pregnancy rates in many long-term refugee settings, especially during the period following the emergency phase.

Given the absence of effective contraceptive practice, what other countervailing influences exist that might modify the high fertility patterns observed in many refugee settings? In some refugee sites, health workers believe that an unknown number of women resort to unsafe clandestine abortions to terminate unwanted pregnancies (itself a strong expression of an unmet need for contraception). In addition, families seeking resettlement in a third country might believe, rightly or wrongly, that their chances of being considered for resettlement will be greater if they do not have a lot of children. And finally, it is likely that for many women struggling to adapt to conditions of severe physical deprivation and psychological uncertainty, the prospect of having to cope with the additional stress of pregnancy, labor, breastfeeding and the care of small children would be quite overwhelming. But to the degree that we were unable to probe refugee

women's true attitudes to childbearing more systematically, the study must be judged sadly incomplete.

The second important finding is that comprehensive reproductive health services designed to serve the broader needs of a wider refugee population—not just pregnant women or mothers—are completely absent from the health care systems and services normally provided in refugee settings. This should not be surprising. In places where humanitarian agencies and courageous, dedicated individuals are struggling against almost insurmountable odds to save the lives and protect the human dignity of refugees and displaced persons, it is understandable that many needs are not addressed in the emergency phase (primary school facilities, for example) and that many needs (higher education, for example) are never addressed. However, such services as the identification and treatment of sexually transmitted diseases (especially AIDS), rape prevention, clandestine abortion monitoring, treatment for septic or incomplete abortions, or even abortion or morning-after services for rape victims, are intimately related to the physical and psychological health of a refugee population, particularly one of its most vulnerable groups—women. But these problems do not just touch women; they often affect the very survival of children and women's male partners. On the other hand, they are not services that can easily be introduced into refugee-like settings. Many of them require well trained and sensitive counselors. They also deal with issues that many societies—and many men—do not want raised.

In the light of these difficulties, what is the next step? The real dilemma facing the international relief agencies is that in the face of dwindling resources for refugee programs, even though the numbers of refugees are not declining, recommendations by special interest groups of any kind to do more for refugees—more education, more development activities, more projects involving women—are neither realistic nor very feasible. In addition, it does not seem reasonable to judge the reproductive health services available to refugee women by a higher standard than is used to assess the quality of such programs for all women in developing countries. There is little reason to expect that refugee women should be the beneficiaries of programs that are still unavailable to many millions of poor and rural women throughout the world.

For these and other reasons, some hard decisions will have to be made and some priorities set. What is most important, and what would be most cost-effective in the area of reproductive health care? Should the major emphasis be to expand and improve existing MCH programs so that

they include birth-spacing information and techniques? Or, given the multiple responsibilities already assumed by these programs, should alternative delivery systems be considered to provide a package of services that could truly go by the name of "comprehensive" reproductive health care? There are already NGOs in countries of first asylum that have a great deal of expertise at planning and offering this broader type of service. Many affiliates of the IPPF worldwide have been working for years in such areas as sex education, special adolescent programs, and abortion prevention. Indeed, many of these agencies might welcome the opportunity to extend their programs into refugee-like settings. In fact, many family planning program planners in developing countries might find the provision of services to a "captive" refugee population in a well defined geographic area supplied with most of the basic services needed for survival to be a comparatively modest challenge, after facing the logistical, technical and financial problems associated with delivering family planning services in far-flung and isolated rural areas of the world with no existing health infrastructure.

Finally, the whole issue of the effectiveness of maternal and child health programs in refugee settings has been insufficiently addressed. It is important for the international refugee agencies to try to foster a stronger sense of the need for self-evaluation and self-criticism among the health organizations that they fund. The dedication and energy of these NGOs are not in question. However, many NGOs work in complete isolation from the larger international health community. This is largely understandable, given the realities of working under often intense and draining emergency conditions. But the initial emergency situation is usually brought under control, and the more experience the agencies acquire in emergency medical and public health measures, the briefer the true "emergency" phase. Primary health care agencies must start thinking beyond the emergency phase to consideration of new health approaches that might be more successful in the long term in saving lives and in maintaining a healthy population and, very importantly, more respectful of the dignity and status of women.

Some Suggested Future Activities

The following recommendations are offered in the hope that some of the issues raised in this report (and their implications for women's reproductive health) might be more widely addressed by the expert community of health planners and professionals working in and for international refugee organizations:

1. In camp settings in which men or women have come to rely on the use of modern contraceptive methods, supplies allowing these women and men to continue to practice effective methods of family planning should always be available. Unfortunately, this best-case scenario is not the situation that exists in many of the world's major refugee settings. Efforts should be made, at the least, to suggest or ensure that the emergency health kits provided by various international agencies contain some contraceptive supplies.
2. In emergency refugee settings in which the overall health conditions of women are poor, where many women are infecund as a result of menstrual irregularities or severe malnutrition, and in which infant mortality rates are high, it is appropriate for health agencies first to pay attention to improving those conditions. However, even at that early stage in the life-cycle of a refugee camp, community leaders, public health workers, medics, TBAs, and para-professionals in every area of health care should start to promote the concept of STD prevention, screening and referral, as well as birth spacing to improve the future survival rates of women and infants.
3. Representatives of the UNHCR and of relevant international and health agencies responsible for providing refugee assistance programs should discuss the possible development of health indicators to mark progress along the emergency relief cycle that would help indicate the need to shift the focus from curative to preventive health services. For example, in the Rwandan and Kenyan camps, it took two years for the nutritional status of under-5-year-olds to improve to the level at which the relevant health agency thought that supplemental feeding programs for this group could be ended. What might be some other pertinent indicators? Once the type of assessment has been agreed upon, UNHCR and individual NGO health service guidelines should be revised to spell out in detail the important health rationale for making broader reproductive health and birth-spacing services an integral part of continuing health programs in refugee settings.
4. Consideration should be given to research on:
 - ◆ testing the notion that a free-standing system of reproductive and family planning services in refugee settings might attract a broader population group than is currently brought into the health care system through MCH programs that serve only pregnant women and mothers;
 - ◆ the special role of TBAs and other types of community health workers in refugee settings in encouraging and supporting the prevention of and screening for sexually transmitted diseases and birth-spacing information and services; and
 - ◆ ways of evaluating the impact of MCH programs in refugee settings on levels of maternal health. The aim of such research would be a systematic independent review of MCH programs in refugee settings, leading to some conclusions about the best ways to deliver safe motherhood services and to improve women's reproductive health conditions in refugee settings.
5. In view of the importance of high-quality services, representatives from international health and family planning agencies such as PATH/PIACT, Johns Hopkins/PIEGO, IPAS, INTRAH, IPPF, FPIA, Pathfinder, CARE, Marie Stopes International, Management Sciences for Health, and CEDPA should be invited to produce a set of clinical protocols and management guidelines for the management and treatment of STDs and incomplete abortions, and for the provision of contraceptive services and counseling in refugee settings.
6. Because every refugee setting is unique, and there is no such thing as a "typical" refugee or refugee woman, no new reproductive health projects of any dimension or scope should be considered without first asking the target population of women what they themselves want in this area. Such discussions would have to be very carefully conducted by women interviewers whom the refugee population has elected, or trusts, to make such a needs assessment.
7. An international agency such as UNHCR, UNFPA, or WHO should consider selecting or adapting, and then translating into a number of necessary languages, a standard TBA training manual that would stress, among other aspects of maternal health, the importance of child-spacing information, training and practice. Such a manual could then be routinely made available to all health agencies working in the refugee field.

8. A policy-making meeting should be held to discuss whether health agencies opposed to the use of modern contraceptive methods should be given responsibility for MCH services in refugee sites.
9. Consideration should be given to some broad epidemiological research on a number of maternal and child health issues, using the special databases created by the larger health service agencies that have a long history of working in refugee settings.
10. Consideration might also be given to studies of possible changes in the reproductive health attitudes and practices of returnee populations, when compared with those of rural populations in the home country, to determine the impact, if any, of the MCH/FP programs offered in the refugee setting from which the returnees came.

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Liberian Refugees in *Côte d'Ivoire*

September 23-30, 1993

Why Are the Refugees There?

Liberia has been in the midst of a violent civil war since 1989, when Charles Taylor led a group of several hundred rebel soldiers, armed with knives and machetes, in an attack on a village in Nimba County, killing a number of government soldiers and officials. The government's army, the Armed Forces of Liberia (AFL), responded by killing a large number of civilians from the Mano and Gio ethnic groups who were supporting Taylor. Taylor's forces, The National Patriotic Front of Liberia (NPFL) retaliated by torturing and killing Krahn and Mandingo civilians. The strife continued, and more than 120,000 Liberians initially escaped into the neighboring countries of Guinea, Sierra Leone, and Côte d'Ivoire. As the war intensified throughout 1990, Liberians continued to seek refuge in neighboring countries, resulting in an official estimate of over 700,000 refugees. The Economic Community of West African States (ECOWAS) established a peacekeeping force in Monrovia in 1990. A cease-fire was signed in November, 1990 and the ECOWAS-supported party was established, with Dr. Amos Sawyer as President. Several of the warring factions supported this interim government. Charles Taylor refuses to recognize it and has created his own government in Nimba County. He controls all of Liberia except Monrovia. Since the country's income from iron ore, timber, and rubber is controlled by Charles Taylor's government, Monrovia, its own population and its thousands of internally displaced people, must depend almost entirely on international relief.

The refugees in Côte d'Ivoire still do not feel that it is safe or wise to return home until a date for a new election has been set.

Which Agencies Are Assisting the Refugees?

When refugees first came to Côte d'Ivoire in 1989, the Ivoirian government was unwilling to call them "refugees" and spoke of them as relatives, since many of the Liberians were from ethnic groups similar to those of their Ivoirian neighbor. The United Nations High Commissioner for Refugees did establish an office and worked closely with the Ivoirian Ministry of the Interior. Médecins San Frontières was the first medical group assisting refugees in Côte d'Ivoire. Because of the initial attitude of the Ivoirian government and the fact that the refugees are spread out in villages and "cohabiting" with the local people, there are not as many international agencies working in the country as there are in other places.

In Guiglo, only the International Rescue Committee (IRC) has expatriate staff working with refugees in 1993-1994. The Adventist Development and Relief Agency (ADRA) is providing elementary education for all refugees in the form of buildings and supplies, but the program is staffed by Liberians.

General Conditions: How Do the Refugees Live?

Other than at the transit center in Danane, where refugees were first registered when they came to Côte d'Ivoire, all Liberian refugees live in villages within several hours of the Liberian border.

Sometimes, Liberians are given land to farm so that they can feed their families. Sometimes, they work for Ivoirian land-owners and are paid either in supplies or small

salaries. Liberians came with only the clothes they were wearing and little in the way of supplies. They are, however, an energetic group, and after four years, they have started to make lives for themselves and are trying to forget the trauma they have suffered during the civil war and while they were trying to escape. For the first year and a half in Côte d'Ivoire, the Ivoirian government did not provide education for Liberian children unless they wanted to go into the Ivoirian schools. As the Liberians speak English and the Ivoirians French, this presented real difficulties for the population. The refugees now have their own schools, and Liberians are allowed to work if they can find jobs. At this point, there is no serious malnutrition among the refugees, nor have there recently been any wide outbreaks of diseases.

Reproductive Health Care and Services

Liberian refugees have continually complained about not having access to proper health care and services. Because they came with nothing, they did not even have money for aspirin and cough syrup. That has now changed, and funding is available for supplies if they are not able to provide for themselves, as is also the case for their Ivoirian hosts.

Guiglo is the village chosen by IRC staff members, Amy and Patrick Poulin, to start the International Rescue Committee/UNIFEM Family Planning Program. Under the auspices of the United Nations Development Program (UNDP), a Women's Center is functioning on the main street of the town. We spent four days visiting Guiglo and the Center and attended family planning classes and talked with many of the refugee and the local women about the program. The first family planning class that I visited was number six out of a series of seven classes, and was attended by six men, all of whom seemed to know the material and to be very interested in spacing their children. As the coordinator for the family planning program is an educator and not a medical person, all medical problems are referred to a local Ivoirian physician. The Center does stock contraceptives in the form of pills, spermicides, and condoms. Spermicides and condoms may be sold by the Center at a subsidized rate (because Ivoirians must purchase these, the Center cannot give them free to refugees but it is allowed to loan the refugees the money to purchase them)—and women are sold the pill after a doctor has examined them.

An evaluation of the IRC/UNIFEM project has just been completed, and the findings are presented in a detailed report. Quoting from the report, "the results of the survey

indicate that the family planning program has led to behavior change among most of the survey respondents. Prior to the program, only 18 percent of the respondents had been using some form of medically approved birth control (condoms, natural birth control, spermicide, birth control pills, IUD's or injections). After participating in the program, 76 percent reported using some form of birth control. Among the 22 percent who were not using birth control, the most common reasons were sexual inactivity and lack of money."

The curriculum was devised by the coordinator, and classes are conducted by four health workers in the town. There are a series of seven half-hour sessions. Information is provided on all forms of contraception available in Guiglo, the prevention of sexually transmitted diseases, and how to communicate effectively with partners. Sessions are held both at the Center and the participants' homes in the community. Over 300 men and women participated in the program from July, 1993 to March, 1994. Briefer workshops have also been offered in the community, but those participants were not included in the survey.

Most respondents were between the ages of 16 and 30. Men and women participated—Ivoirians and Liberians. Many Liberian women left their country having been raped or having witnessed the rape and torture of family members. Many young women are widows or do not know where their husbands are and if they are still alive. Some women are unable to function because of what they have witnessed. These classes and individual counselling have helped many of them.

The other part of the IRC/UNIFEM program at the Center is a loan program supporting income-generating projects for women. Many people had told us prior to the setting up of this program that Liberian women were lazy, that they would not take advantage of either classes or projects, and questioned the use of the Center. In both cases, they have been proven wrong. Liberian women want, as do most women, to take charge of their lives, including their reproductive lives, and they certainly want access to income. Men have been more than willing to come to the classes and to share the information they have received with their partners. If refugees are given opportunities, they will take advantage of them. Many refugees are frightened about AIDS. This program, by offering information about and access to condoms, has given them hope that they can be spared this disease.

Mary Anne Schwalbe

The Camps for the Displaced Population in *Rwanda*

October 11-18, 1993

Why Are the Camps There?

During much of the second half of 1993, an estimated one million Rwandans, some 12 percent of the country's population, were displaced persons. The immediate strife that drove them from their homes was more complex than it appears at first glance, but to a significant extent it was the latest round of conflicts between the Hutu and Tutsi ethnic groups that together make up virtually the entire population. The current political situation in Rwanda stems from age-old political and ethnic conflicts that in more recent history culminated in a Hutu uprising against the ruling Tutsi aristocracy in 1959, when the Hutu overthrew the Tutsi ruler. At the time of the 1959 uprising and on a number of subsequent occasions, violent confrontations have resulted in thousands of deaths and in hundreds of thousands of people—mostly Tutsi—fleeing the country. This created a substantial population of Rwandan refugees living in neighboring countries and even further abroad, most of whom were forbidden to return to Rwanda.

In 1961, when a national referendum for the first time brought into power a Hutu-dominated government, the Tutsi monarchy was abolished and thousands of Tutsi refugees fled to Uganda and formed the rebel army, the Rwandan Patriotic Front (RPF). After independence from Belgium in 1963, the RPF attempted a comeback, but the government fought back once again, killing thousands. Ever since, the RPF has fought to allow its people (numbering up to 500,000) to return to Rwanda. With each attempt, civilian Tutsis have been drawn into the conflict and many have been killed by government forces, accused of being supporters of the RPF. In 1973, Major General Juvénal Habyarimana became President and in 1975 made

the National Revolutionary Movement for Development the only recognized political party. Throughout the 1980s, the Hutu-dominated government made sure that the refugees could not return, partly trying to justify this position by saying that Rwanda already had too large a population. Perpetuated by an increasing competition for land and other resources, and a growing population (Rwanda is the most densely populated country in Africa), the political conflict has continued.

In October 1990, in a move to depose the 17 year-old, single-party government of President Habyarimana, the RPF sent a military force across the Uganda-Rwanda border into the northern provinces of Ruhengeri and Byumba. At the time of this first incursion, an estimated 40,000 people were displaced from their land. A year later, in October 1991, the intensity of the fighting between the RPF and Rwandan army had increased and the number of displaced had doubled to about 80,000. By March 1992, UNICEF, Médecins Sans Frontières/France (MSF) and CARE International had made plans to provide services for as many as 120,000 displaced Rwandans. A few months later, in June 1992, a major RPF offensive pushed the front lines and entire communities even further south. The number of displaced was then put at approximately 350,000.

In July 1992, the government and the RPF signed a ceasefire agreement and agreed to share power, combine armies, repatriate all Rwandans who wanted to return, and abolish ethnic-based identity cards. But peace negotiations broke down again in January 1993, and on February 8, 1993, another major offensive took place, forcing the dislocation for yet a third time of large numbers of Rwanda's rural population in the north. At that point, the displaced

population swelled to one million, and because of the dangerous situation, MSF, one of the few relief agencies in the field at that time, was forced to withdraw its staff. So vast were the numbers that encampments of the displaced appeared near the outskirts of Kigali, the capital.

Another cease-fire was agreed to, followed by long months of negotiations in Arusha, Tanzania. An agreement was signed on August 4, 1993. It set forth details for, among other things, a new transitional government to include the RPF, a calendar for elections at all levels of government, and a merging and reduction in the size of the armed forces. (At the time of our visit in October 1994, the cease-fire generally seemed to be holding.) Separate from the civil war, and resulting from pressure for democratization, a new constitution had been written in June 1991 that established a multi-party transitional government, which was being readied to prepare for multi-party elections in 1993. The transitional government was in place, and negotiations were taking place to decide how the ministries would be distributed among the many political parties that had been formed.

In the months preceding our visit, some of the displaced had begun to go back home, some assisted by the government, others making their own way. The encampments closer to Kigali had considerably decreased in size (going from about 90,000 at the height of the last rebel offensive to 40,000 at the time of our visit), while camps in the more northern areas of the country were still holding large numbers of people fearful of returning to their still war-torn communities. In camps further north, in the demilitarized zone, relief services had only recently resumed, since the cease-fire in August 1993.

[As this report was being finalized, Rwanda was again devastated by civil strife. On April 6, 1994, Rwanda's president was killed in a suspicious attack on his plane, and the country immediately erupted into a full-scale civil war with widespread killing. Already, up to 500,000 people have been killed, an estimated 1.5 million refugees have fled to neighboring countries, and hundreds of thousands are homeless inside Rwanda. These numbers continue to grow.]

Which Relief Agencies Were Assisting the Displaced in October 1993?

About 10 major relief agencies were providing relief services at the time of our visit:

- ◆ CARE International was responsible for drinking water, sanitation, MCH/FP services in the Byumba region, reforestation, and other non-food aid.
- ◆ MSF/Holland was responsible also for water and sanitation in some Byumba camps.
- ◆ MSF/Belgium was responsible for health care, water and sanitation in the northernmost Kirambo region.
- ◆ Croix Rouge/Belgium was responsible for health, humanitarian assistance, education, a school for orphans in Kigali, and non-food aid (soap, blankets, cooking pots, clothing, plastic sheeting for roofing).
- ◆ World Food Programme—under UNDP—organized the acquisition and arrival of food from international donor countries. The WFP, however, was responsible only for getting the food to Rwanda; responsibility for its distribution fell to other agencies.
- ◆ The International Committee of the Red Cross (ICRC) was responsible for the war-displaced, and coordinated with EEC in food assistance, family reunification, and missing persons. It oversaw and coordinated with the Rwandan Red Cross in ensuring food distribution.
- ◆ Croix Rouge/Rwanda distributed food supplies (corn, sorghum flour, oil, and salt), supervised by ICRC.
- ◆ Catholic Relief Services also received food and transported it to several food distribution points.
- ◆ GTZ (the German government international aid and development organization) carried out water projects with the displaced populations, as well as ongoing MCH/FP projects in Butare, Gikongoro and Cyangugu provinces, among non-displaced populations, in collaboration with ONAPO, the government office of the national family planning program.

Other agencies, including Caritas, Médecins Du Monde, Oxfam, and Aide et Action (a French PVO) were involved in a variety of medical, food, and water and sanitation projects in Byumba province and in other parts of the

country that had no displaced persons at the time of our visit. However, just after we left Rwanda, a bloody civil war between the Tutsi and Hutu ethnic groups in Burundi forced half-a million Burundi refugees into Rwanda. The NGOs involved in general development work in Rwanda at the time of our visit will clearly now have other demands made on them to try and respond to the new refugee tragedies.

The emergency relief plan for displaced Rwandans was coordinated by a Comité de Crise, which was made up of representatives from all the relief organizations. Its primary function was to coordinate the work of the government and the international donors, and to share information and logistics through bi-weekly meetings held in Kigali. Coordination meetings also took place in each préfecture.

General Camp Conditions: How Do the Displaced Live?

Conditions in the displaced persons' camps differ dramatically, depending on how close they are to the DMZ, where most relief agencies are still fearful of working. In Kirambo camp (with about 20,000 displaced) on the northern edge of the DMZ, for example, MSF had returned to the site only within the last three months of our visit, and was able to provide only the most rudimentary type of primary health care. There was no evidence of any other relief organizations in that location, apart from the Croix Rouge/Belge (Belgian Red Cross), who were involved in food distribution.

On our drive to Kirambo, located about three hours by road from Kigali, we passed a huge ICRC truck that had smashed into the mountainside at the bottom of a particularly dangerous curve on the treacherous mountain road. The truck had been loaded with U.S.-donated corn being taken to a distribution point somewhere in the area. The driver, who could not have survived the crash, was still trapped inside his cab, and rescuers had not yet arrived on the scene. As we neared the DMZ, we saw endless forest fires in the near and distant hills. Sometimes the thick smoke swirling across the mountain roads impeded our driver's view. These fires, we were later told, were either set by the army of the RPF to destabilize the population while political negotiations were still going on, or by the government to hold back the RPF forces.

All government services had been withdrawn from this area because of the heavy fighting in 1992. They had not yet returned by the time of our visit, so any rural health

services or schools that had been operating before the war were all closed down. The only signs of any functioning administrative structure were the ubiquitous food distribution points along the roadsides. Rwandans are too poor to have any powered means of transport. They do not even have oxen carts or motor scooters hooked up to flat beds, as one sees throughout south-east Asia. As a result, every sack of food, and every can of oil has to be carried bodily into the camps. The roads are crowded with long, long lines of men, women and children with heavily loaded sacks, baskets and containers on their heads. The sight is depressing and sobering.

The food distribution points are deliberately located some kilometers away from the camp sites to forestall riots and to enable the agencies to monitor the lines and check eligibility cards. The allotted World Food Programme ration is based on a diet that affords 2,000 calories a day to the displaced, and 1,100 calories a day to the rural population that is not technically displaced, but whose farming output has been affected by the war.

There has been a considerable "diversion" of the food supplies and forging of food cards. Apparently, large numbers of the population are involved in this, from the commune leaders down to the camp level, and from the commune leaders up to the higher provincial levels of government. Our hosts in Rwanda told us that this type of widespread corruption, often with the complicity of the local and even central leadership, is reflective of the wider breakdown in social structure that has occurred in the wake of the civil war. Rwanda's population (which is 95 percent rural and food-producing) had recently become self-sufficient in food, despite enormous population pressures on the land, but the civil war had completely disrupted production cycles in the northern areas of the country, and malnutrition and hunger were becoming widespread, not just among the displaced populations. The diversion and misuse of food is particularly troubling to officials who know that malnutrition levels among children in the camps are very high.

Since our visit, we have learned, ICRC officials have computerized the lists of food beneficiaries to eliminate about 450,000 false name cards that were in circulation. The quantity of food distributed has also been reduced, as more and more people have returned to the demilitarized zone. As a result, malnutrition levels among children under age five in the camps are now no higher than they are in the country at large.

The camps for the displaced are wide open, with no set boundaries, and often there is very little to distinguish a camp site from a nearby settlement. The only real difference is the type and the proximity of the huts that are built out of tree branches and thatch by the displaced population. The French word for these huts is "blindé", which means a tank. Indeed, from afar, the igloo-shaped huts resemble an army of grey tanks strung out over the hillsides. They are built very close to one another, which creates a good deal of stress and friction among the camp residents. Apparently, Rwandans are not normally a very gregarious people. They like their privacy within the nuclear family, and do not have or crave close contact with their neighbors or the wider society. Somebody explained this characteristic to us as evolving out of the geographic terrain. There is not a flat or straight road in northern Rwanda. The land is made up of deep, once wooded, but now mostly denuded, valleys, each one quite cut off from the next, or reachable only after many strenuous hours of climbing. As a result of this topography, we were told, each family behind its compound walls lives separated from a wider community, and each community is socially estranged from the next. The prevailing sense of isolation and pride is not conducive to the kind of neighborly trust and friendship that might help people survive a civil war. In fact, we were told, the Rwandan's natural suspicion of any outsider has only been exacerbated by the war.

Once we reached the center of Kirambo camp, we had the clear sense that this was a site in chaos. Two very young and very recently arrived nurses working with MSF/Belgium were struggling to provide health care services to a desperate population that had access only to water and some very limited food supplies. In a deep valley below the steep hillside camp, an elaborate residential and working compound of large white tents had been erected by ICRC. However, the agency had pulled out its staff at the peak of the fighting, so the entire compound was a small ghost town. In fact, MSF—in the form of these two dedicated but inexperienced young women—was the only relief agency present in the camp.

Health conditions were dire, from what we could observe in the course of a brief afternoon visit. The young nurses showed us their clinic. It was virtually bare of any equipment, but with a few drugs, their stethoscopes, the help of three Rwandan paramedics, and on a wing and a prayer, these two young women were tending to about 300 patients each morning. A large group of women holding their newborns and young infants sat patiently waiting to be seen outside the clinic entrance, even though

there was to be no afternoon session, since the MSF nurses were planning to drive two hours into Ruhengeri, the nearest provincial capital, to take four seriously sick people to the hospital.

There were young children everywhere, barely clad in dusty ragged garments, but energetic, smiling, and happy to pose for photographs. The children's apparent oblivion to their grim condition was in striking contrast to the mood of their mothers who, we were told, were bored, anxious and depressed in their exile. Many children appeared to have runny noses, distended bellies, skin infections, and fungal infections on their heads which were overtaking any hair growth. The nurse told us that intestinal parasites, respiratory infections, diarrheal infections, and ringworm were rampant throughout the camp. The overall level of malnutrition in this camp is obviously high, and the nurses told us that lactating women complained about their shortage of breast milk. There is also a lot of mastitis among breastfeeding women. The children's scabies are due to a lack of vitamin A, and the chronic anemia is due to the lack of meat and dark green vegetables in the diet.

We followed the nurses' truck for a two-hour spine-wrenching drive into Ruhengeri. The nurses had explained to us that that was the route that would have to be taken if a pregnant woman with serious complications at the time of delivery had to be transferred to the hospital. But the MSF truck would not always be available for an emergency, and the usual means of transportation for such a woman would be a specially made woven straw hammock carried on poles at each corner by four bearers. The trip, which took two hours by truck, on rutted, rocky, sometimes destroyed dirt roads, would take six hours or longer if the patient had to be carried in a hammock.

The nurses arrived at the hospital just in time to have the battery for the clinic refrigerator recharged, but not in time for the hospital administration to agree to accept the camp patients. After an hour or so of negotiation with the hospital administration, it was agreed that the patients would be admitted the following morning, when some beds might become free, but that they would have to fend for themselves overnight. The nurses had to return to the camp with the precious re-charged battery, and the patients left behind in Ruhengeri would have to get back to the camp under their own steam, after they had been treated in the hospital. One had a suspicious tumor on the tongue, another, a broken foot, and a third was in serious pain from a grave eye wound. How would these "blessés" possibly walk back the 25-30 miles to the camp on their

own? Each patient was accompanied by a frightened family member, carrying a small amount of food that would have to see them and the sick family member through the remaining days, since none of them had any money to buy anything more to eat in the town.

General and Reproductive Health Conditions and Services in the CARE/MSF-Assisted Camps

Conditions in the three camps in which CARE International is providing water and MCH/FP services—Bidudu (with an approximate population of 20,000), Gikoma (12,000), and Bugarura (26,000)—are in very much better shape, although of course, that assessment is only relative to the sheer desperation and need we had seen in Kirambo. The fact that CARE is involved in these three locations has an interesting history, which illustrates some of the cross-cutting aspects that now make development and refugee work often intersecting fields.

In 1981, the Office National de Population (ONAPO) was created to help implement appropriate solutions to the country's problem of over-population. The country has a population of only 7.4 million, but it is Africa's most densely populated country, with about 777 people per square mile (as compared, say, with 126 in Kenya, 81 in Tanzania, and 270 in Nigeria). According to the as yet unpublished Demographic and Health Survey of 1992, the total fertility rate has fallen dramatically, from about eight to 6.2 children per woman. Rwanda is also one of the region's poorest countries, with an average per capita income of about \$200. The economy is based almost exclusively on agriculture, and the cash-economy has not yet reached much beyond the country's few cities and towns. The cash crops are coffee, tea and sugar cane. The staple crops are red beans, sweet potatoes, green beans, corn, sorghum, papaya and mangoes. Most families raise goats and chickens, but few have cows. In 1989, according to a UNICEF report, 30 percent of Rwandan children under four were severely or moderately malnourished. This was a year in which about 500,000 Rwandans suffered a serious famine from which many died. With a population doubling time of only 31 years, the government quickly understood that reducing or slowing its rapid rate of population growth was an important priority if the population was not to completely outstrip the country's resources.

ONAPO is a parastatal organization under the oversight of the Ministry of Health. ONAPO's program includes the support for the introduction of family planning ser-

vices as an integral part of the government's maternal and child health (MCH) program. This program receives technical and financial assistance from a number of foreign and international agencies. USAID supports the program through a "Mother-Child Health/Family Planning" project with ONAPO that is not limited to any one part of the country. UNFPA does the same for particular aspects of the program. German assistance has been provided by GTZ, through a program focusing on three southern provinces (of Rwanda's ten provinces). CARE operates several programs in a part of Byumba province. In 1991, CARE added MCH and family planning services to its program in Byumba province that already included reforestation and sanitation projects.

A vital part of ONAPO's MCH/FP program has been to train over 17,000 community-based volunteers (with the Kinyarwandan name of abakangurambaga, which means "wakers-up of the people"), whose role it is to inform their communities about the benefits of family planning and the contraceptive methods available, and to refer them to the government medical centers that supply those services. While their numbers have dropped to less than half of the 17,000 who were operational in 1991, these community-based volunteers continue to play an important role in the national program. At the time of our visit, approximately 9,000 volunteers were registered and 5,000 had been known to have recruited clients during 1993.

In 1991, CARE International in Byumba province began assisting ONAPO in providing MCH and family planning services. This was just when the civil war began to create problems for the population. As the numbers of displaced peoples grew, CARE moved with them, following or accompanying the population as it moved south to seek asylum from the fighting. CARE then became involved in helping to make firewood and clean water sources available to the displaced populations, and now works to establishing water supply systems from streams and rivers, and to bring those systems within the reach of the camp populations. It also continues to operate the reforestation and sanitation projects throughout Byumba province. In one CARE system, water was pumped from a stream into tanks, from where it is transferred to cleaned out petrol trucks that transport the water to smaller tanks in the camps. There is enough drinking water most of the time. The displaced collect their own wood for cooking, but this is only adding to the deforestation that is one of Rwanda's most pressing environmental problems. In general, the local population has been accommodating to the displaced, even though the encampments are sprawled out over land that would normally be cultivated. Their accep-

tance may partly be due to the fact that the entire population in these areas (whether in a camp or not) is eligible for food rations.

The MCH program in the CARE-assisted camps is typical of services provided in refugee settings throughout the world. But in the camps of Bidudu, Gikoma and Bugarura, the services are reinforced by the involvement of a group of unpaid male and female community volunteers (or *abakangurambaga*), each of whom has been trained by CARE and assigned responsibility for working with 200 families. This program is similar to that of the community-based volunteers who work throughout the country, but it benefits from increased training and supervision from CARE, and the volunteers provide a wider range of services, including referrals and follow-up services. We met 15-20 of these volunteers. Each of them carries an attaché case containing: a spiral-bound illustrated book that describes the various contraceptive methods and how to use them; a pack of small wallet-sized cards to leave with the families the volunteers visit (these also describe how each method is used, in Kinyarwanda); a supply of appointment cards, which are given to pill and injectable users to tell them when to return for resupply or for the next injection; and a record book to report the results of each household visit.

The volunteers receive a four-day training on the various contraceptive methods, how these are used, their potential side-effects, contraindications to their use by certain women, and the best way to approach potential family planning users. All the family planning promoters can read and write, and their record ledgers were neatly maintained in French, and very legible. The volunteers meet with a supervisor every two weeks to discuss the results of their work and any problems they might be having.

As well as pills and condoms, the CARE health staff give Depo Provera injections—a three-month hormonal contraceptive. The client receives a card with an appointment date reminding her when to return to the clinic for another injection. NORPLANT can be inserted in the nearby district hospital. The CARE midwife we met has herself inserted 80 NORPLANT systems, and has removed six. She was trained by Rwandan doctors through ONAPO.

The volunteers complained to us that because their clothes were so shabby and worn, the families they visited did not treat them with any respect. The *abakangurambaga* said they would have felt much more confident talking about family planning and its benefits if they had been better dressed when they made their household visits. In

Gikoma camp, we visited one of the small rural health posts that offer first-aid care. The health post is housed in tiny quarters—a thatch hut with two rooms, each about four by six feet. The clinic has general, but scant, first aid equipment. Several patients were waiting to be seen by a young Rwandan male nurse who has been trained to treat minor ailments, such as headaches, colds, and cuts. More complicated health problems are referred to the nearby camp, where MSF/Belgium runs a well equipped hospital.

In fact, the following day, we visited that camp—Bugarura, with a population of 26,000—and were given a tour of the MSF hospital. The waiting area had about 100 people waiting to be seen. The main hospital area is set up with five consultation rooms, one delivery room, and a pharmacy. The equipment in the delivery room was minimal: rubber gloves (reusable after washing), an autoclave, water, and scissors. The pharmacy keeps a supply of basic drugs, and it also had a kerosene-powered refrigerator.

Another male Rwandan nurse is employed by MSF for general health consultations and by CARE International for MCH/FP consultations. He sees approximately 30 family planning clients in a two-week period, or 60 a month. He has been trained to provide pills, injectables (both Noristerat [a two-monthly injectable] and Depo Provera), and condoms. Again, women wanting to use NORPLANT are referred to the district hospital. While we were in the family planning clinic, a 22-year-old woman with her first child was asking for a contraceptive method. The morning of our visit, the medic had enrolled three new pill users and given two injections. In the family planning record book we saw that a 30-year-old woman who had just had her 14th child (a premature birth, and the child had died) had also attended the clinic. The family planning reporting system is consistent with the national one used by ONAPO, since in times of peace the workers would normally all be government employees. Since CARE is operating the program in the camp, these volunteers report to CARE International.

Most of the women in the camps do not give birth in the camp hospital, but rather in their hut assisted by a traditional birth attendant (TBA). In talking with Rwandan women, we learned that this is because Rwandan women prefer the squatting position, and in the hospital not only must they lie down but their family members are not allowed to be present. While many of the births take place in their huts, the mothers usually bring the babies into the health facility the next day for a check-up. There is an incentive for them to do this because they can then obtain another food ration card.

The supplemental feeding center for children in the MSF hospital is highly organized. Children are enrolled if they are found to be less than 70 percent of the accepted weight-for-height measure. The center has an intake section, a medical examination room, two day centers—one for serious cases, the other for recovering cases—a 24-hour care center, a kitchen, a laundry, and latrines. The whole center is extraordinarily clean, but lifeless. There is great efficiency and briskness on the part of the staff, but little warmth. The children are fed five times a day, with various mixtures of milk, rice, beans, soups and biscuits. Some infants are also being breastfed, in which case lactating women also receives extra food at the center, although there does not seem to be a special diet for pregnant or lactating women. The MSF worker in charge of the feeding center told us that when the camp had opened six months earlier, children were dying every day, but there had been no deaths in recent weeks. However, the children in the center continue to suffer from pneumonia, mumps, diarrhea, vomiting and listlessness. If an infant is too weak to eat, naso-gastric feeding is introduced for the first 24 hours.

Some Other Aspects of the Lives of Rwandan Women

In rural areas, women do most of the work, and this is also true in the camps. However, because the heavy food sacks have to be hauled long distances into the camps, men have had to become more involved than would have been normal outside the camp setting. Traditionally, women leave school much earlier than boys because agricultural, domestic, family, childrearing, and marketing and bartering duties are so onerous that women need their daughters' help as early as possible.

The most important requirement for social mobility is to be able to understand, speak, read and write French, one of the country's two official languages. French is only taught at the secondary school level, so most girls seldom learn any language but Kinyarwanda, which leaves their opportunities for advancement even more restricted. The CARE employees we met in Byumba province were mostly men. They were all enlightened, educated people, but in a self-criticizing and light-hearted way told us that in Rwanda, "l'homme, c'est le roi."

We were told by various Rwandans themselves that the lack of trust among individual members of the community particularly does not help women's efforts for advancement, because there are few natural structures through

which they can work with each other to improve their situation. The UNICEF officer in Kigali told us that day-care centers have never been successful for working women in Rwanda because they do not trust another person taking care of their children. The same type of distrust among neighbors has impeded many efforts to develop income-generating projects at the community level, the UNICEF official told us. This insistence on privacy and independence probably means that development will be extremely slow, because even if a woman learns a new skill or a new piece of information (about the benefits of family planning, for example) she may not share her knowledge with a neighbor or friend.

The AIDS problem in Rwanda is horrific. Recent estimates suggest that one-third of all adults in Kigali, the capital, are HIV-positive, and a recent study of truck drivers coming from Mombasa and Nairobi, found that half were HIV-positive. However, unlike in developed countries, but typical of all developing countries, new AIDS cases in Rwanda are made up equally of women and men. Many married men in towns resort to prostitutes, but condoms are unpopular for a number of reasons, they are largely unavailable, and even if offered, the population is largely too poor to be able to afford them. For pregnant women and their infants, the implications of the spread of this disease are grim, to say the least.

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Somali Refugees in *Kenya*

October 19-25, 1993

Why Are the Refugees There?

A deadly combination of drought and violent civil war devastated much of the Horn of Africa in 1991 and 1992, leaving many millions of the population homeless within Ethiopia, Somalia and the Sudan, and many others forced to flee their war- and famine-stricken countries. The height of the refugee crisis was in 1992, by the end of which, almost half-a-million refugees had reached asylum in 12 camps and four border sites, most of these in Kenya's north-east province. In 1993, about 110,000 Somali and Ethiopian refugee repatriated, leaving about 370,000 still in those 16 sites by the end of the year.

A cross-border operation along the River Juba valley, 300 miles inside Somalia, has been in operation since the end of 1992. The operation—which concentrates on the repatriation of Somali refugees, the rebuilding or rehabilitation of schools, clinics, hospitals and water systems, and the provision of supplies of seeds tools and water pumps to farmers—is designed to help Somalis begin to reclaim their ravaged country. The total cost of the cross-border project in 1993 was estimated to be \$58 million, of which \$18 million was for transporting the refugees back across the border. About 30 international and African relief agencies are involved in the cross-border project.

The four Kenyan sites selected for the project visit—Liboi (which is technically a transit camp but where all services are available), Ifo, Dagahaley and Hagadera—held about 170,000 refugees, mainly Somalis, at the time of the project visit in October, 1993. Liboi, a former British police outpost before independence, is the site nearest the

Somali border; the other three camps are located around Dadaab, a small northern Kenyan settlement.

Which Relief Agencies Are Assisting the Refugees?

In cooperation with the mandated agency, the United Nations High Commissioner for Refugees (UNHCR), a consortium of international agencies and non-governmental organizations provides legal, medical, subsistence and social services to the refugees. The relief agencies are: UNICEF; Redd Barna (Norway's Save the Children Fund); the World Food Programme; the International Federation of the Red Cross and the Kenya Red Cross; the International Rescue Committee; CARE; Médecins Sans Frontières/France, Netherlands, and Belgium; Pharmaciens Sans Frontières; the YMCA; the Ibrahim al Ibrahim Foundation; the International Relief and Rehabilitation Service; the Islamic African Relief Agency; Jesuit Refugee Services; the Kenya Catholic Secretariat; the African Refugee Education Programme; the African Refugee Training Programme; Appropriate Technology for Enterprise Creation; the Baptist Mission of Kenya; the Canadian Baptist Overseas Mission; CARITAS; Christoffel Blindenmission (which works to prevent blindness and to do cataract training and surgery); the Lutheran World Federation; the Mandera Educational Development Society; Concern; the Deutsche Gesellschaft für Technische Zusammenarbeit; and the National Council of Churches of Kenya. Some of these agencies receive funding from UNHCR; others come with their own funding support.

General Camp Conditions: How Do the Refugees Live?

According to UNHCR, in June 1993, there were 49,337 refugees in Ifo camp, 48,485 in Liboi, 43,696 in Hagadera, and 39,500 in Dagahaley. There were 13,592 women in Ifo, 11,534 in Hagadera, and 12,260 in Dagahaley, for a total of 37,386. Because Liboi is so near the Somali border and subject to frequent refugee movement in and out of the camp, a specific count of women there was unavailable. Women and children account for 79 percent of the Ifo camp population, 76 percent of the Hagadera camp population, and 74 percent of the population of Dagahaley.

Although the four camps are located in a remote area of the desert (or bush), far from any developed area or town, the sites sit on top of a huge aquifer, covering an area about 60 miles by 35 miles in size. This means that water, obtained through deep-bore wells, is plentiful. In Liboi, Hagadera and Dagahaley camps, the refugees live in huts, or tougals, built out of the tough prickly thorn and acacia trees that grow in the bush surrounding the camps. Some huts have the ubiquitous UNHCR-supplied blue plastic sheeting over them. The dwellings in Ifo camp, built by a German government relief agency, have wood frames and a thatch roof. This camp is well planned and the shelters were ready when the refugees arrived, but the whole terrain was clear cut, so it has a more desolate, unshaded appearance. The sites for Hagadera and Dagahaley were not clear cut, so the huts are a little more protected by some tree and shrub growth. Inside the windowless tougals the space is usually divided into a living and a sleeping area. Cooking is done outside. By the time of the visit, almost every extended family compound (up to 1-4 family huts) had its own pit latrine. Each compound is usually surrounded by a high thorn bush fence that has been erected to keep out marauders and to provide some privacy.

Services in the camps are in four main areas: the distribution of food (sorghum, maize, wheat and oil), and non-food items (such as blankets, cooking utensils, plastic sheeting, and cooking charcoal); sanitation (including wells and latrine building and maintenance); shelter; and social services and education. Food distribution is the responsibility of CARE. UNICEF and CARE are responsible for sanitation. MSF/France provide clinic-based health services and run camp hospitals, as well as the training of community health workers, and supplemental feeding programs for the under-fives in the Dagahaley and Ifo camps. MSF/Belgium has similar responsibilities in Hagadera camp. Schools and language and literacy classes for adults

are also the responsibility of CARE and CARITAS, and some Muslim NGOs run Arab-language schools to teach the Koran. There is a Repatriation Officer for the whole site, and the U.S. Joint Volunteer Agency, under contract, assists refugees applying for resettlement in the United States. In 1993, 6,338 refugees were accepted for resettlement. The majority of these (78 percent) were accepted by the United States, which gives priority to people at medical risk, women at risk, and families being reunited (tracing and reunification are coordinated by the International Committee for the Red Cross).

Garden projects to produce maize, beans, onions tomatoes, cabbages, melons, okra and groundnuts, some income-generating projects, and special programs for the disabled, are organized by a variety of agencies, predominantly CARE and CARITAS. Participation in the agricultural projects is very low. The Somali population of these camps are basically nomadic tribes with little past experience or interest in farming. A small proportion of the refugees are from a Bantu tribe that originated in Tanzania and found its way to Somalia in the early part of the century to provide farm labor. The Bantus are not nomadic, are considered more industrious than the nomads, and show more interest in growing foods to re-sell and to feed their families. The income-generating projects attract much greater interest—especially the projects to teach women tailoring and how to make mosquito nets, but at the time of the visit, only 300 women in Hagadera, Ifo and Dagahaley were enrolled in the project. In addition, tailoring is traditionally a male occupation in Somali culture, so there is some resistance to women acquiring those skills. There is also a women's mat and basket-weaving project in the camps.

The overall conditions of the camps are generally good, but the heat, the dust, the flies, and the ugly scavenging maribous picking through the refuse piles, reinforce an overwhelming and unrelenting impression of hardship, especially in the hot dry season. All the camps are divided into sections, with appointed leaders who meet with UNHCR officials on a regular basis to discuss any problems that arise, such as a shortage of materials to repair the huts or fix the fences, poor garbage collection, or family- and clan-based disputes. The sections are organized along clan lines. The majority clan are Ogaden, Bantus and Hartis make up the two minority clan groups. Hostilities between the rival clans persist, as they do in Somalia.

Each section appoints a male community health workers (CHW) whose main responsibility is to instruct residents how to maintain good standards of hygiene and sanita-

tion. The CHW also tells the residents about the health services that are available, and promotes their proper use. In every second or third section, the CHW operates a small primary health post that provides anti-malarial drugs, antibiotics, aspirins and first-aid care.

UNHCR is also training a new category of refugee worker—community development workers (CDW)—some of whom are women. These volunteers do outreach into the camps, carry out simple demographic surveys, and help initiate special projects. These might include community clean-ups, cooking demonstrations, activities to reinforce protection of the elderly, or baby washing campaigns. The CDWs have just completed a survey of over 60,000 households. The information is being computerized to provide an ongoing data base for evaluation and planning.

Every camp has a market area, and these are the major centers of activity. From small makeshift trestles and stalls, merchants sell second-hand clothes, fresh camel meat, soap, laundry detergents, matches and a kind of melted pink bubble gum that is used to sweeten the sharp flavor of Khaat, the dried green leaf that older members of the clans chew all day as an analgesic and tranquilizer.

General and Reproductive Health Conditions and Services

The most serious general health problems in the camps are malaria, diarrheal diseases, and upper and lower respiratory infections. For example, in the month of September, of 8,190 new cases in the outpatient clinic of Ifo hospital, 2,070 were malaria cases, 1,344 were lower respiratory infections, 828 were for diarrheal conditions, 657 for the treatment of upper respiratory problems, and the remainder for anemia, skin and eye infections, trauma (mostly burns caused by the outdoor cooking stoves) and some few cases of jaundice. However, serious malnutrition has almost been eliminated, and the supplementary feeding centers in the camps are being phased out because the general nutritional status of children is reaching "acceptable" levels. The primary causes of death in the camp are diarrheal disease (46 percent of the total), malaria (25 percent) and respiratory diseases (12.5 percent).

In the Ifo hospital, which is managed by MSF/France, two expatriate doctors oversee the activities of six other expatriate staff (one midwife, one sanitarian, two nurses and two nutritionists), 13 Kenyan health workers (including four doctors and five trained nurses), and 147 refugee workers, mostly community health workers, or hospital

cleaners. The hospital has 200 beds, and a pharmacy that is open two days a week. Every MSF hospital is run along the same general lines, with a general ward, an adult ward, a pediatric ward, maternity, ante-natal and post-natal rooms, an isolation ward for severe infections and contagious diseases, a lab (without electricity, but performing routine testing of stools and blood for possible anemia, white blood cells, TB, hepatitis, syphilis, amoebas and worms), a drug stock room and pharmacy, a sterilization room, a dressing room, and a newly constructed isolation wing ready for when the predictable seasonal cholera season begins.

In the out-patient department of Hagadera hospital, about 140 patients are seen each day. The MSF nurse specializing in TB says there about 700 TB cases in the three camp sites, but that because the treatment protocol requires patients to come to OPD every day for drugs and check-ups over a period of seven months, very few patients complete the full course. In the pediatric ward, which has 25 beds, the cases include burn victims, children with head fungus, malaria cases, an epileptic with a bullet lodged in the head, and a premature baby with pneumonia being fed intravenously.

After diarrhea and malarial and respiratory infections, the next most serious health problem in the camp, according to UNHCR, is a "noted increase in pregnancies. This has become inevitable because of the mental and emotional stability of both men and women as a result of the restoration of normalcy within the camps," a report states. It is difficult to know what the actual pregnancy rates are. In Dagahaley, there were about 12,000 female adults of all ages, but some older women would no longer be fecund, and some would be unmarried, widowed or infertile. There were 893 pregnant women in June 1993—apparently a 40 percent increase over the average for the previous three months. Assuming that about 15 percent of the 12,000 women are not at risk of pregnancy for various reasons, 893 pregnant women would mean that one in every 11 fertile women of reproductive age was pregnant. The age-distribution of adult women is unknown, so if an even larger proportion were beyond their childbearing years or not exposed to sexual intercourse, the proportion pregnant is likely to be even higher.

If we made a rough calculation of the crude birth rate (CBR) using the total population and the number of monthly reported births, the results varied from camp to camp. In Dagahaley camp, for example, 155 births were reported in a recent month. If it is assumed that the monthly number of births is the same for most of the

other months of the year, the estimated annual CBR would be about 47 per 1,000 population. However, the comparable estimate for Ifo camp, where there were 127 births in one month, would be much lower—31 per 1,000.

These, of course, are highly unsatisfactory guesses, for many reasons: Reliable statistics on the number of sexually active fecund women aged 15-44 cannot be obtained, the number of births may actually differ widely from month to month, the total population base may not be constant over a given year, and births are likely to be underreported. The most recent CBR estimate for Somalia is 50 births per 1,000 population, and rates among Somali women in the Kenyan camps are likely not to be much different, since they have not been outside their country for very long, and are unlikely to have changed their reproductive patterns very radically.

Although many of the refugee women are pregnant at any given moment, that fact would not be obvious from visiting the hospital maternity section. On a bed in the maternity ward there was only one woman, surrounded by her five small children. An aged man—apparently a neighbor—has brought her some food. She has serious hypertension (pre-eclampsia), and the nurses are monitoring her progress carefully. The woman has no husband, and she is pregnant as a result of rape. In the post-natal ward there is also only one patient—an elderly Somali woman who is taking care of the premature twins born to her daughter the previous day. The daughter died soon after delivery. The grandmother recently lost another daughter in childbirth, so she now has six grandchildren to take care of at home. Discharging the woman is a problem, however, because MSF protocol says that low-birthweight infants should not be released until they weigh 2.5 kilos. There is some fear for the infants' well-being because there is a high risk of cross-infection in the hospital, and the babies cannot be breastfed.

The delivery room, which was empty, has only a crudely constructed wooden bed, an emergency medical box, and a few basic instruments. Instructions for their sterilization in the autoclave are taped to the wall. A new skylight was recently made in the ceiling because the delivery space had been too dark for the staff to see the woman while she was in labor. If an obstetric case develops serious complications, the woman has to be airlifted to Garissa General Hospital—about 30 miles away. After delivery, women stay 24 hours in the post-natal area, which has two beds with malaria nets, unless further complications develop. The recuperation period is used by the TBAs to talk to the women about nutrition, breastfeeding and

hygiene. Birth spacing is "sometimes" discussed, but the MSF doctors and nurses insist that this is not a traditional part of Somali culture, and that their responsibility is not to "change or influence" that culture. Anyhow, there are few contraceptives in the pharmacies or drug stock rooms, and no women in any of the sites are using a method to space their next pregnancy.

Most women prefer to give birth in their tougals, assisted by a traditional birth attendant. Twice a week, the MSF midwife meets with about 30 community TBAs to discuss hygiene and improved delivery practices, and any problems the TBAs might be having in their work. The official training of TBAs is carried out by a Kenyan NGO—Life Ministries. The course lasts three weeks, and the curriculum covers broad public health and sanitation measures, how to make medical referrals, and safe delivery practices. At the end of the course, CARE administers an oral test to the TBAs. UNHCR requires that TBAs work both in the camps and in the hospitals (dividing their time between the pre-natal and post-natal wards). UNHCR's long-term goal is for enough TBAs to have been trained for there to be one TBA serving a population of 2,500 (or about 400 women). TBAs now deliver about 15-20 babies a month in each camp site.

The MSF nurse responsible for the TBA training sessions told us that there are very few 2-3-year-olds in the camp. She attributes this to the war in Somalia in 1990 and 1991. But she says she does not know whether the small number of children in that age-group is due to a low pregnancy rate during those difficult years, to a high rate of spontaneous abortions, or to high infant mortality rates at that time. Now, she says, there has been a very dramatic and noticeable boom in the birth rate. But if there are infant or maternal deaths occurring in the women's huts, these might go unrecorded, so current maternal and infant mortality estimates would be difficult to make.

Some Other Aspects of the Lives of Women Refugees

The UNHCR social services coordinator arranged for us to meet the MSF staff from the three camps in the Dadaab area, so that we could obtain their impressions of reproductive health conditions among the refugee women. At the meeting, the MSF doctors and midwives discovered for the first time that in all three camps there was a sudden very pronounced rise in the incidence of pre-eclampsia among the pregnant women. This was developing at about the sixth month of pregnancy, when

it is far too early to induce labor. One MSF nurse had been so concerned that she had cabled the MSF office in Nairobi for advice. The staff speculated that changed diets with an excess of salt might be causing the problem. (The nomadic tribes in the Somali desert subsist largely on camel meat and goat milk. They very much dislike the diet of grains that they receive in the camps.) If the meeting had not been called, the pre-eclampsia problem might not have surfaced, because apparently the MSF staff from each camp do not usually meet to share information.

In subsequent discussions with the MSF/France nurses we gained the impression that the guiding philosophy of this relief agency is that western-trained health providers should not introduce to the Somali refugee population any health standards or medical practices that they won't be able to maintain once they go home. Yet a typical MSF/France professional seems to have little interest in the traditional health practices for which they claim to have so much respect. When we asked why so few refugee women choose to deliver in the hospital, they would answer with a shrug. However, in later talks with TBAs, we learned that nomadic Somali women prefer to deliver at home, in a squatting position, where they can hang on a rope to help them bear down. And in a later discussion with a group of community development workers, we learned about some other interesting aspects of reproductive behavior among nomadic Somali women.

One aspect had to do with traditional breastfeeding practices. Apparently, in the desert, a new-born is not put to the breast for the first 10-15 days of life, and is fed water or goat milk from a cloth until lactation is started. From that point on, many women only feed the infant from one breast. The explanation given was that traditional Somali dress makes it difficult for a woman to expose both breasts. However, it seems clear that the practice has some underlying purpose suited to the harsh conditions of nomadic desert life, to ensure the survival of the fittest. We also learned that nomadic women continue to work and do not always bind themselves when they are menstruating. Their long skirts hide the blood, which they simply let flow down their legs. It is possible of course that because their traditional diet is so limited, these women have very light periods. The MSF professionals did not seem to be interested in making any of these conditions easier for the women to deal with. The community health workers are working to change the way the refugees breastfeed in the camps, even though their in-camp training emphasizes that they should maintain respect for the women's traditional values.

We spent about two hours talking to this same group of TBAs and community health workers about women's lives in the camp. They told us that family reunification, inadequate camp security, and uncertainty about when they will be able to go home dominate women's concerns. This is followed by complaints about the diet of vegetable protein. The MSF trainer believes that the food rations are quite inadequate. While a diet that provides 1,800 calories a day might be sufficient for a non-working woman, it is grossly inadequate for women who spend long hours of the day planting live thorn fences around their compounds, cooking, taking care of their children, and walking miles to collect firewood, carrying water, or to obtain daily TB treatment.

The CHWs we talked to know that there is such a thing as birth control; some even have relatives living in cities who have told them about the pill. But in the camps, as in the desert, one pregnancy rapidly follows another, and sometimes no more than nine months separates a woman's births. The women told us that it is good to make children, and that if it was Allah's will for them to have three or 20 children, he would provide. And if some babies died, that would be Allah's will too. The women said they appreciated the opportunity the camp gave them to receive some health training, and for their children to go to school to learn English. But their only real desire was to return home.

There are other serious problems for some Somali women in the camp sites. The first of these—a growing problem of rape—was getting a lot of media attention at the time of the visit. Camera crews from Japanese, U.S. and British television companies had flown into the camps to report on a problem that had acquired prominence through an inflammatory report produced by a London-based Somali human rights organization. The report blamed UNHCR and the Kenyan authorities for ignoring the growing incidence of rape in the Somali camps, and for failing to provide women with adequate protection.

The rapes are mainly taking place outside the camps, among women who go out into the bush to collect cooking firewood. As the bush is increasingly being stripped bare by earlier scavenging, the women have to walk longer and longer distances to find the firewood they need. Far from any protection, they then became easy prey to roving bands of bandits, young men from the camps, or even, it is alleged, members of the Kenyan army and police force assigned to protect the camps. Other rapes occur at night inside the camp, when the women are attacked by "unknown" assailants.

The UNHCR is aware of the problem and has tried a number of approaches to reduce and prevent it. They had already made charcoal available for cooking, but Somali women are not used to this kind of fuel and do not like to use it. They also met with the camp elders to try and work out a way of involving the men in providing protection to their daughters and wives who were going out into the bush. This approach met with little success. The elders maintained that it would be unacceptable for men to be seen collecting wood or even accompanying the women. They also argued that if men were to go out into the bush, the bandits would in all probability kill them, whereas they only raped and assaulted the women. Tragically, Somali women who are raped, especially if they become pregnant as a result, are often abandoned by their husbands and their husbands' families. To scare off would-be rapists at night in the camps, the CDWs are encouraging the community to create a lot of noise by banging on pots and kettles, when they are alerted to the presence of possible intruders.

The UNHCR has recruited a Somali rape consultant who is training community workers and agency staff to help identify rape victims. The UNHCR Social Services, Protection and Field Officers, medical teams in the camps, the local police and other agencies have all helped in documenting rape cases and providing the women with counseling. However, according to a UNHCR report, when the Somali consultant recommended special assistance for certain rape victims, requests for "such assistance in the Somali context were seen as clan favouritism." The consultant has drafted guidelines designed to promote inter-agency coordination and cooperation in assisting sexually abused victims. She has also outlined a number of steps to be taken to improve the situation in the Dadaab camps. These include: the fencing of the camps with barbed wire or thorn bushes; the organization of community patrols; the hiring of two additional female protection officers; the recruitment of a female gynecologist for each camp; and further consideration of making it possible for raped women who become pregnant to obtain an abortion, even though neither Kenyan civil law nor Somali traditional values would support such a response.¹

Another problem affecting a small group of women is the lack of support and protection for women arriving in the camp with no family members. Some of these women with children to support have turned to prostitution. The UNHCR social services coordinator is beginning to make contact with a number of these women. She has befriended a young English-speaking Ethiopian prostitute whom the other prostitutes trust. This young woman has begun

to hold meetings in her hut, at which the social services coordinator talks to the women about their personal, social and financial problems. In particular, she wants to warn them about the dangers of AIDS and will try to obtain condoms for them. However, she doubts whether they would have the confidence to insist that the clients use a condom.

The final problem that touches on the life of every woman in the camp is the widespread practice of female genital mutilation. Ceremonies are still held every month to celebrate the circumcision ritual performed on young girls by traditional women practitioners. Apparently the older women look forward to these occasions, because they see this ritual as an affirmation of their link with past and future generations of women, and as a poignant reminder of the rich cultural life they have left behind. However, the aid workers also told us horrifying stories of young girls running away from their husbands during the first year or so of married life because intercourse was so painful, and it was so difficult for the man to achieve penetration.

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Reference

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Afghan Refugees in *Pakistan*

November 9-23, 1993

Why Are the Refugees There?

This is perhaps the most pertinent and certainly the most poignant question. Why, after 14 long years of exile, danger, deprivation and suffering, are there still a million-and-a-half Afghan refugees living in camps along the Pakistan border? Afghan refugees began fleeing to Pakistan shortly after an April 1978 coup d'état brought a Communist regime to power in Afghanistan. In November, 1993, some 15 years later, there were still approximately 1.6 million Afghan refugees in Pakistan. Why is this so?

The history of the Afghan war goes back some years, but the basic facts are familiar. In December, 1979, the Soviet Union invaded Afghanistan to provide support for a failing Communist government that did not have the support of the vast majority of the population. That date marked the beginning of a bloody 10-year guerrilla war waged against the occupying Soviet army by various mujahedin (or holy warrior) groups—resistance armies fighting under the banners of the various mujahedin groups. The mujahedin were able to fight against the might of the Soviet military because they received massive levels of military support from the western powers—predominantly the United States—who believed that the Afghan rebels' cause was an important part of the larger Cold War struggle to defeat communism worldwide.

To escape life under Soviet rule and the devastation of the country brought about by the war, an estimated five million Afghans, out of a total population of 16 million, fled the country—about two million going to Iran and an estimated three million ending up on the northern border of Pakistan. In February 1989, almost 10 years after they

had invaded the country, the last Soviet troops withdrew from Afghanistan. That date—December 1989—was supposed to mark the beginning of the return of the refugees to their homes. Tragically, for the refugees, for the Afghans inside the country, and for the world as a whole, there has been no resolution to the Afghan war. After the Soviet withdrawal, a communist regime continued in power in Kabul until May 1992, when the leader, Najibullah, was toppled. The various mujahedin groups vying to take over the country then turned against each other in what has turned out to be possibly as bloody a civil war as the war waged against the common enemy that had invaded 14 years earlier. An already devastated, war-torn country is now being reduced to ashes at the hands of its own people.

Between 1989 and December 1992, about 1.5 million refugees repatriated under a formal UNHCR repatriation scheme. Some unknown numbers of other refugees returned spontaneously. But the number of refugees remaining in Pakistan still represents the world's largest refugee population and for these people (estimated to be about 1.6 million), repatriation has become an elusive and dreaded prospect. By February 1993, the United States Committee for Refugees reported that repatriation from Pakistan to Afghanistan had come to a standstill, and that more Afghans were again entering Pakistan than were repatriating. In fact, in recent months the flow of Afghans back into Pakistan has accelerated, in the wake of even bloodier fighting around Kabul. As a result, nobody knows when and if the remaining refugees will ever be able to go home. If they do eventually return, it will be to a country that in many regions has been reduced to an environmental and human nightmare, after 15 cruel years

of bloodshed and hate. Meanwhile, the Pakistan government is putting increasing pressure on the remaining 1.6 million Afghan refugees to leave, and there are rumors that in addition to a sharp reduction in social services inside the camps, food distribution is being severely reduced, or drying up altogether.

Which Relief Agencies Are Assisting the Refugees?

This question cannot easily be answered today. It can be stated that there is probably not a single international relief agency that at some point during the 1980s did not work with Afghan refugees. The relief agencies were mostly based in Peshawar, in Pakistan's Northwest Frontier Province, 50 miles from the Afghan border across from the famed Khyber Pass. A formal body designed to facilitate the sharing of information among the huge number of international agencies working with the Afghan refugees—the Afghan Coordination Body for Afghan Relief (ACBAR)—publishes a regular list of the agencies working in the camps. By 1992, this directory contained the names of about 60 organizations, including the International Committee of the Red Cross and Red Crescent Societies, the World Food Programme, the Salvation Army, the International Rescue Committee, Catholic Relief Services, Church World Service, and Save the Children Fund. At the height of support for the cause of the Afghan refugees, there were apparently 200 organizations working with refugees, and as many as 265 organizations had been counted over the years.¹

A policy analyst for the U.S. Committee for Refugees estimates that between 1984 and 1990, "assisting the refugees in Pakistan alone cost the international community an average of \$64 million a year, not counting the substantial sums that the United States, Pakistan and Saudi Arabia and other countries spent on military aid and other assistance to the mujahedin."² However, since 1989, the number of relief agencies working with the Afghan refugees who did not or could not go home has declined precipitously. Many organizations left the field after the Soviet troop withdrawal, confident that the refugees would be returning home and that there would no longer be a need for aid. Tragically that has not proved to be the case. The need is still vast, but refugee crises have erupted in other parts of the world, there are other pressing demands on the international relief network, and the number of agencies remaining to work with the Afghan population is dwindling. Some agencies have moved inside Afghanistan to carry out development projects to try and help rebuild the devastated war-torn country.³ But others

remain in Pakistan, among them the International Rescue Committee, CARE, and Save the Children. The United Nations High Commissioner for Refugees (UNHCR) functions in Peshawar in support of offices in Mazar-i-Sharif and Hera inside Afghanistan. Like most of the NGOs, the UNHCR now maintains a presence on both sides of the border, for both logistical and security reasons.

A recent editorial in *Le Figaro* sums up the perceptions of many observers: "Afghanistan is a forgotten war. . . . With the Soviet Union gone, Afghanistan is off the game board. The war there is seen only as an affair between tribes from the Middle Ages. Moreover, the good guys became the bad guys."⁴ Representatives of the few remaining relief agencies in Peshawar think that this sentiment pretty much reflects what the larger world now believes about the Afghan refugee situation. In Peshawar and in the camps, there is a perception that the Afghan refugees have been forgotten, as the fickle international community turns its attention and its relief resources to new causes and new danger spots in the world, such as ex-Yugoslavia.

General Camp Conditions: How Do the Refugees Live?

Most refugees live in *katcha* housing that they have constructed themselves. *Katcha* houses are built with bricks that are made of dung, grass and wheat stalks mixed with mud and water. An extended family household would typically consist of 2-3 family houses or family rooms (if the members are less affluent) and a shared male guest room (*mebmankhana*) in a single compound, surrounded by high mud brick walls to conceal the women inside from the eyes of passers-by. Each family has its own cooking facility and each married woman with her children has her own oven. Since women move into their husband's family's house when they marry, one household would normally be made up of 8-9 persons, including 2-3 adults, so that a normal compound would house 20-25 persons spread over three generations. Inside the *katcha* houses, the furnishings are simple: traditional wool rugs cover the mud floors, flat cushions provide simple floor seating, and perhaps some embroidered panels hang on the white-washed or terracotta-colored walls.

In her detailed description of the life of Afghan women in the camps, Hanne Christensen provides a vivid description of a typical Afghan refugee camp setting. Her work, and that of renowned Afghan scholar Nancy H. Dupree, is cited extensively in the following pages because of the authoritative and intimate knowledge of Afghan life

shared by these two experts. In 1986, Christensen conducted a survey of 2,300 households in 58 refugee villages in Pakistan, then in 1989, she spent about three months in the Akora Khatak refugee camps in the North West Frontier Province, 50 miles west of Peshawar. At the time of Christensen's research, about 50,000 refugees in 8,700 households were living in these camps. Although four years have elapsed since her last research visit, the breadth and depth of Christensen's understanding of and insights into Afghan refugee life are far more valid than the brief impressions that could be gained in the course of a 10-day visit to the camps made by the project consultants.

Christensen writes:

Compared with earlier periods of the settlement process, the camps now give the impression of being habitable. . . . There is a distinctly human look about them. The compounds are built as small-scale farm houses or urban terraced housing, and there are people in every corner of the camps. The compound walls echo to the sounds of yelling and joy, the ringing of school bells or announcements from loud speakers in the mosques. The presence of domestic animals is notable. The refugees keep dogs to watch their compounds, donkeys to carry ration supplies from the distribution centers to the homes, and cows, goats, sheep and poultry in and outside their compound yards. A refugee [volunteer] collects the waste from the compounds and tracts in between, and both camp and compound areas on the whole are kept nice and clean. But mice, on a constant hunt for grain rations or sugar bits are observed both in the compound yards and inside the houses, and are obviously a daily nuisance, especially to the women and children. . . . Housing and vegetation are intermixed. Trees, bushes and flowers grow in and outside the accommodation areas. Streets and lanes of the main concentrations wind their way around the hills and neighbourhoods. Bazaars mushroom everywhere, offering a wide assortment of foods and commodities. Wood sellers put up sheds in many lanes, providing the refugees with access to firewood. . . . The camps are divided into large areas of cramped habitation and small-scale settlements around the periphery. Farmers and urbanites live in the concentrations, nomads . . . on the outskirts. Usually the two groups belong to the same tribes, but the latter have deliberately chosen to live in small groups away

from the mainstream areas because they find cramped living claustrophobic. Most of the refugees live among their close relatives.

The resistance parties run the schools in the camps and health facilities in Peshawar. They recruit and train mujahids from the camps and organize the mujahiddin service inside Afghanistan. All seven parties of the Alliance are represented in the camps, and the entire adult male refugee population seems to be enrolled. . . . The two strongest ones were Hizb-e-Islami (the Islamic Party led by Gulbadin Hekmatyar) and Jamiat-e-Islami (the Islamic Society led by Burhannudin Rabbani). All parties have their own perceptions of the woman's role in society but these two are at the extremes of the scale. . . . However, both parties support the purdah institution and believe that the woman's place is primarily in the home. . . .⁵

Dupree views conditions in the camps with a more critical eye. She writes that:

the overcrowded, closely built dwellings afford no private space, inside or out, for women who were accustomed to work and relax in large courtyards or secluded walled orchards. For many, this lack of private space produced acute psychological distress far outweighing physical discomforts.

The outward semblance of solidity masks an existence that continues to be tenuous and disrupted. Life is in many ways artificial, although the struggle for survival is very real. There are plenty of routine chores to be done but the daily life of a refugee is devoid of the meaningful activities that once contributed to a woman's sense of accomplishment and well-being. There are no crops to harvest for the women to process, no sheep to shear for wool which the women will spin and weave, no orchard fruits to pick for women to prepare and preserve.⁶

Christensen discusses the meaning and practical consequences for refugee women of the more rigidly imposed practice of purdah. She writes:

Purdah is a strong social institution which is differently applied by various age-groups. Adolescent girls from puberty to marriage are

allowed to leave the compound on their own to collect water. From marriage until the birth of a second child, a young woman is restricted to the compound and dwelling and allowed to visit the father's and brothers' compounds, and those belonging to her sisters' husbands only when escorted by her husband. Likewise, she may not attend the dispensary unless her husband accompanies her. Women with more than two children may make unescorted trips to visit family members or neighbours, or to attend the health facility. After the age of menopause, women are again granted the liberty to move around the area unaccompanied. Thus, purdah in its strictest form applies to young married women.

Contrary to most observers, who think the purdah system has been reinforced in Pakistan, refugee women have different perceptions. On the one hand, purdah is reported to have been strictly observed by people who live in small enclaves among multiple unrelated groups in the camps, including by highly educated women and nomadic women, neither of whom were subjected to purdah in Afghanistan. Anxiety about exposure to strangers practicing different customs and tradition was reported to have caused the reinforcement. On the other hand, purdah is reported to have been relaxed by newly arrived refugees who live in tents and move in open areas where women's activities can be seen by crowds of neighbours.

Purdah is deeply ingrained in Afghan life, and to observe purdah has a positive connotation for Afghan women in the camps. . . . Afghan women . . . practicing purdah are unanimously in favour of it. They feel protected by it and find that it ensures them privacy and the right to withdraw from unpleasantness. . . . None of the women found that purdah restricted their work and, contrary to what an outside observer might think, the women do not believe that purdah locks them up in their own separate universe; it merely keeps out men.⁷

Nancy Dupree points out that the rigid imposition of purdah is "based on the utterances and action of various grades of religious spokesmen scattered throughout the refugee communities, many of whom are barely literate. Some are genuine in their convictions, but others merely follow the dictates of party leaders and foreign missionar-

ies (mostly Arab) with bountiful largesse at their disposal." She believes that these extreme, conservative values imposed by "ignorant mullahism" in the Afghan camps have had a more profound influence on Afghan women in Pakistan, particularly on "educated urban women who have, by necessity, set aside the Western styles which before 1978 had symbolized modernity and emancipation." But Dupree believes that Afghan women remain "firm in their conviction that they can successfully contend with [religious extremism] by being true to their society's values, which they do not wish to deny, and that they can, even should, play an active part in the reconstruction of war-torn Afghanistan."⁸

General and Reproductive Health Conditions and Services

At the time of the project visit, the Afghan refugee population had been in camps for a very long time. The first camps were set up in Pakistan in 1980. One of the benefits of this long-term stability is that health conditions among the refugees are now very similar to those of the local population. One of the most serious disadvantages is a certain amount of irreducible psychological depression, especially among the women. These refugee women had been living in the close confines of purdah for a long time, without access to outside physical work on the land, which is what they were used to. In addition, many of them had been left with the responsibility of taking care of their large families while the men were away in Afghanistan fighting in the "jihad" or "holy war." There had also been a sharp reduction in services (particularly, income-generating and educational programs) and food supplies since the withdrawal of many of the NGOs across the border, to start helping some of the 1.2 million refugees who repatriated in 1992. Now, after prospects for peace had been finally within sight of the population, after years of patient waiting and anticipation, it looked as though these hopes were being cruelly dashed. This was not a happy time in the Afghan refugee camps.

We spent three days visiting the 12 camps around the northern town of Hangu, close to the Afghan border, about 50 miles south of Peshawar, with a total population of about 172,000 refugees. The primary health clinics in the Afghan camps are called basic health units (BHU). Each camp has its own BHU, but the professional medical staff circulate among them. The only fixed staff are the paramedics.

Each camp has volunteer Community Health Workers

(CHW) and Community Health Supervisors (CHS). These are all men, and they concentrate on sanitation and on public health education and activities. Volunteer Female Health Workers (FHW, or dais), and Female Health Supervisors (FHS) are the linchpin of maternal health activities in this high-fertility society. The FHWs and FHS are Afghan women who have been recruited and trained by the BHU staff to provide pre-natal monitoring and advice to pregnant women, and to assist them during their home deliveries. Because of the practice of purdah, these volunteer workers play a particularly important role in the context of the maternal health of Afghan refugee women. When the BHUs were first established, most Afghan women refugees were not permitted by their husbands or brothers to leave the compounds to come to the health facilities for medical care. In response to this problem of women being denied access to much-needed care, a health delivery system in use in the Northwest Frontier Province of Pakistan—also a strict Muslim society—was introduced in the camps. Instead of women coming to the BHUs, the health workers go to the women in their homes. At the time of our visit, there were 1,096 trained FHWs in the Hangu camps, but only 717 of these were currently active. Sixty-four FHWs had just completed a refresher course. The number is relatively large because FHWs may only enter the compounds of families with whom they have some kind of family kinship, and so do not reach the community as a whole. This approach has problems, both because the practice of the FHWs is limited, but also because their work within the family cannot be monitored.

The BHUs in the Hangu camps are administered by the International Rescue Committee (IRC), and the program is carried out with the help of a largely Pakistan and Afghan professional and paramedical staff. An Afghan medical director coordinates the activities of all the BHUs in the Hangu camps. Under him is one male and one female doctor, an MCH supervisor, two Lady Health Visitors (LHV), and a number of Afghan paramedics who staff the labs and stock rooms attached to each BHU, dispense drugs, weigh and measure children, and maintain patient records and clinic files. The LHVs provide maternal and child health services in the BHUs, and they also oversee the work of the FHWs who are providing maternal health services in women's homes. The LHVs are mainly Pakistani nurses or social workers who have received two years of basic nursing or social work training. However, most of them are of the same ethnic group as the refugees (Pushtun), and speak their language.

The visiting system has been so successful in per-

suading Afghan men of the benefits of health care for their wives and children, that many of them changed their minds, and have begun to allow the women to attend the center. So now, 10 years later, the BHUs are flooded with patients, most of them women and children. The expatriate staff say that attendance at the BHUs is now so high that they fear that the facilities are being overused by refugees who do not really have serious health problems but who have come to expect to be given drugs and treatment for every slightest ailment. However, another observer pointed out that the BHUs also function as a community center and contact point for many women, offering emotional and psychological support, as well as health care. This is all rather different from seven years ago. A survey of women in the Hangu camps carried out in 1987 found that one-third of all married women of reproductive age had never visited the BHU,⁹ and that 11 percent of all women were not permitted to go the BHUs because of the purdah requirements. Others said they did not go because the staff did not give them enough medicine, or because the BHU was too far from their homes, or because the staff treated them rudely.

Outside the BHU of Kai camp a large crowd of refugee women, children and men wait to be seen. We were told that coming to the clinic provides women with a much welcomed break from the cloistered routines of their daily life. It allows them to see other women and to take a look at the world beyond their four walls. A paramedic first casts an expert eye over the waiting crowd, carrying out a sort of informal triage—sending patients with high fevers or who seem to be in obvious distress to be treated first. The clinic building houses a general male clinic (staffed by men), a pre-natal and post-natal clinic, a pediatric clinic, including a nutrition education program, a vaccination room, a room where simple bandaging or skin treatments are given, a pharmacy, a laboratory, and various rooms set aside for dai or community health worker training sessions, or for staff meetings. This particular clinic—obviously the camp show case—also has a small early childhood development program—also run by IRC—for children living in the close neighborhood.

The child health center is the busiest section on the day we are visiting. Most of the care involves routine services—immunization, the weighing and measurement of children, post-natal visits. The children are not all clean, but they all look lively. We are shown the service statistics for the previous month: 720 children from the camp came in for routine weight and height checks; of these, 43 were first visits by newborns. A further 310 children were seen but not weighed, making a total of 1,030 visits by under

five-year-olds. In that month (October), 15 children were phased out of the MCH program because their growth chart was completed at age five, and they were judged to be in satisfactory health. Of the 467 pediatric visits for curative care in Kai camp in October, 78 percent were for common colds, 15 percent for diarrhea, and seven percent for skin infections. The FHWs in Kai camp (42 had been trained but only 32 were currently active) had referred 56 children to the BHU in the month of October. (Statistics show that in the whole camp, in the first 10 months of 1993 there had been 61 deaths of babies under a year old, and 26 among children one to five).

Thirty children were enrolled in the nutrition program, and there had been two new enrollees since the previous month. Of those, 29 had gained weight since the last clinic attendance and one had lost weight. We watched a full nutrition education session, in which a group of women were taught ORT and food preparation by an LHV. All the children in this session also receive food supplements (special high-protein biscuits, which the women are shown how to mix with water into a light gruel). The women in the nutrition group were shy and seemed slow to learn. We were told that constant repetition and reinforcement are needed before they feel comfortable in learning how to prepare and use the ORT therapy.

A day later, we observed the pre-natal clinic and were provided with a printout of recent service statistics. About 240 pregnant women were registered in the Kai BHU, 118 new enrollees in the past month. However, registration does not mean attendance, and of the total number of registered women, 91 were not coming for regular check-ups during pregnancy. By the end of October, a total of 2,054 pregnant women had been registered at the pre-natal clinic, of whom 1,264 were coming for care. We asked why there were so many absentees, and were told that the BHU is a long way for many women to walk; that women having a sixth or seventh child already "know the ropes" so feel they do not have to relearn what they think they already know; and some women are still forbidden from attending the BHU. Another revealing statistic is that of a total of 365 women who came to report a recent birth between January and the end of October, only 277 had previously attended for pre-natal care. There are no deliveries taking place in the BHU, all births occur in the home.

The birth statistics from all the BHUs in Hangu (12 centers) tell us a great deal about how difficult it is to monitor births among Afghan refugee women. In October, there were a reported 729 births in the Hangu camps.

However, only five were delivered at home with an LHV (a woman with at least two years of nursing training) attending; 413 were born at home with an FHW or dai (an untrained TBA) present; and the remainder (311) were born at home with no health worker present at all. That means that of the 729 births, 62 percent were not formally registered, and there is no information about the condition of the mother or the infant. Of the reported births, 35 women were referred to the Hangu hospital for complicated deliveries. If an average of 729 live births occur every month in these camps, the estimated crude birth rate would be about 51 per 1,000.

In 1987, the International Rescue Committee commissioned a fertility survey among married women in those same camps. The survey produced the following age-specific fertility rates among married women:

Age	Annual number of births per 100 married women
15-19	60
20-24	50
25-29	42
30-34	39
35-39	30
40-44	38
45-49	15

The results showed that if marital age-specific fertility rates reported at that time continued unabated, by the end of her childbearing life the average married woman would have 13.6 children. This total marital fertility rate (TMFR) is extraordinarily high, for any society, at any point in history. The pattern in the age-specific rates is hard to interpret. It shows that about 60 percent of married 15-19 have a child each year, but that marital fertility declines somewhat after that age. In most developing societies, the highest age-specific rates are among women 20-30, so this pattern is difficult to explain. Similarly, in most developing societies, marital fertility usually declines rapidly among women over 40, whereas in this camp sample, the marital age-specific fertility rate among women 40-44 is still 0.38 (that is, 38 percent of women 40-44 have a birth each year).¹⁰

While the survey sample is clearly not representative of all Afghan women refugees, and while the pattern of age-specific fertility may be quite skewed, the survey presents a convincing picture of a society in which practically all

women marry at a very early age, and no women practice fertility regulation. The author of the report provides some additional explanations. She notes that the "Afghan refugee population can be described as having all the characteristics to support high fertility levels: women have virtually no education; the majority . . . have come from very rural areas in Afghanistan; Afghan culture dictates a preference for marriage at a very early age; and marriages are very stable. Furthermore, social and religious pressures have imprinted the role of motherhood on women. With the adherence to strict purdah, women are constantly within the compound, as contrasted to their previous . . . activity in the agricultural sector in Afghanistan. Finally, it may be mentioned that increased access to antibiotics reduces infertility traditionally caused by infection."

This high birth rate does not necessarily mean that the final family size is large as might be anticipated. This is because infant and child mortality rates among Afghan women are extraordinarily high, even though it is impossible to monitor the rates accurately in the camp setting. The 1990 infant mortality rate inside Afghanistan was estimated to be 167 per 1,000 live births (the fourth highest in the world), and the under-five death rate, 292 per 1,000 live births—the second highest in the world.¹¹

In her studies of refugee life, Dupree made some estimates of infant and child mortality rates in the Afghan camps. She believes that:

although data collection is admittedly weak, there is no doubt that the infant and child mortality rates, which average 185 and 329 per 1,000 live births, respectively, are strikingly high. Sadly, these figures reflect the situation in pre-war Afghanistan, where children under the age of five accounted for over 50 percent of all deaths. . . . Predominant causes of mortality for all ages, but particularly among children under five, include acute respiratory infections, water-borne infections such as diarrhea and dysentery, and other gastro-intestinal problems. Malaria, skin and eye diseases and birthing complications due to inadequate techniques and lack of ante-natal and post-natal care are also prevalent." She concludes that "the crowds thronging the health units represented an unprecedented gathering of women, a concentrated audience never attainable in Afghanistan, where small remote villages located far from any traffic routes were often many days' walk from centers supplying even rudimentary health services. Tens of thousands of women have

now heard the health improvement messages put forward by medical teams working with numerous assistance agencies. Indications are that many of the refugees now appreciate the benefits of ante-natal care, immunization, the early introduction of infants to health care, oral rehydration therapy and even, in some cases, better weaning practices. As successful as these have been, it must be noted that by 1991, over a decade after the exodus [from Afghanistan] began, up to 50 percent of the refugee women are still underserved or unserved. It is likely that more than 85 percent of the women living in the refugee villages continue traditional birthing practices at home without the benefit of trained assistance.¹²

We talked to a young 16-year-old who was pregnant for the first time. She lives in her uncle's house because she married a cousin. Her husband is good to her, but she says she wishes her mother could be present when she gives birth, but this won't happen because her mother is in a camp in Peshawar. We also talked to a much older pregnant woman, who was almost toothless. She lifted her blouse and showed us a huge black and blue bruise just under her left breast. Almost with pride, she told us that her husband had beaten her. The other women giggled nervously at her boldness. An FHW told us that many Afghan men feel under a great deal of pressure these days, as the economic situation deteriorates, and that family violence is increasing.

In the 12 camps, 10 new users of birth control were reported in the previous month, and there were 19 continuing users. Seven of the camps reported no new users during October, and six camps had only one continuing user or none at all. A camp with one continuing user and no new user in October treated two women for induced abortion complications in that month. There was no indication as to what contraceptive methods these women were practicing, and it was not clear how the women came to be using contraceptives at all, or where they obtained their supplies, since we saw no evidence of any in the drug stock room.

We spent a couple of hours talking to a group of FHWs. When we asked them what were women's major problems in the refugee camps, the only constantly mentioned items were the need for vitamins, better food supplies for everybody, and supplemental foods for pregnant women. The Afghan women miss the milk products, daily vegetables and bread that make up their standard diet in Afghanistan. They said that only a few women had chick-

ens or cows, so eggs and meat are hardly ever eaten. The discussion about family size preferences was not very enlightening. Women say they want as many children as Allah sends, but, under pressure from both their husbands and their mothers-in-law, they want boys rather than girls.

A rapid assessment of the male and female health workers in the Afghan camps, commissioned by Save the Children Fund (U.K.), was carried out just before our visit. The author found that almost all the FHWs understood the dangers of bleeding during labor, but they had a less good understanding of abnormal presentations. The FHWs said they would try to change the baby's position themselves, and in the case of a hand or foot presentation, they would attempt to push it back. Only if these measure failed would they consider referring the woman to the BHU. The author suggested that the male workers should also be trained in the danger signs of pregnancy, because they are the decision-makers and family members who can authorize their wives to be taken to the BHU if a delivery becomes difficult. The assessor also pointed out that a man can talk to the male members of the family and thus is more influential than an FHW.¹³ Another observer has commented in a similar vein that since men do all the shopping, they also should be targeted for nutrition education courses.

The medical director and the supervisor of the LHWs told us what they thought were the weaknesses and strengths of the BHU program. The supervisor said there was a great need for more outreach to the women living in remote areas of the camps "over the mountains." She said these women never came for pre-natal care because the BHU was simply too far away. The medical director thought the health program over the years had achieved improved levels of personal and household hygiene, that far more women were coming in to the BHU than in earlier years, and that the Expanded Program for Immunization (EPI) had been the most successful aspect of the entire program. But he admitted that this might be because it is both the easiest to carry out and the easiest to report on.

Filling the Gap

One Afghan woman is aware of the problems refugees face in trying to space or limit the children they have. Her name is Fatanah Gailani, and she has family connections to one of the leading mujahedin parties that make up the Alliance whose unity made defeat of the communists possible and whose current rivalry is destroying Afghanistan from within. The Gailani party is one of the

moderate political parties. Fatanah's husband is currently living in Kabul (and commuting occasionally to Peshawar to be with his family), which is under constant shell fire. He is trying to keep open the only two hospitals in the region that are still standing. Fatanah and their only daughter spent most of the war in exile in Europe. She is now back in Peshawar with that daughter, and she has opened a woman and child health clinic in a suburb of the city—Hyaterabad. Attached to the clinic is a school for girls and boys up to the age of 17.

The medical director of Fatanah's Peshawar clinic is a sophisticated and highly intelligent Afghan woman obstetrician-gynecologist, with six years previous experience in a well known Kabul maternity hospital. Two other doctors, one female nurse, one educator and a pharmacist work with her. The clinic, which consists of an emergency room (with two beds), an examination room, a room for educational sessions where the women are also weighed, a pharmacy, and a lab, sees up to 100 women a day. It is open from eight in the morning till two in the afternoon. A long line of women sit in the alley beside the house, waiting to be served on a first-come first-served basis. Fatanah tells us that refugee women travel all day from some of the distant camps to find the type of women's services there that are unavailable to them elsewhere. A small sign on the side of the house announces it as a clinic belonging to the Assistance Committee for Afghan Refugees, and in her more optimistic moods, Fatanah fantasizes replicas of the clinic being opened in other locations throughout the Northwest Frontier Province. Her mission is to deliver high-quality reproductive health services that are given in an atmosphere that is respectful and supportive of Afghan women, who, she claims, are the true martyrs and victims of the "jihad."

The clinic provides pre-natal care, all women are given Pap smears, and the medical director is particularly interested in the treatment of PID (pelvic inflammatory disease). However, there is no delivery room, and women are referred to a local Afghan hospital in Peshawar to give birth. The clinic also prescribes pills, the IUD, and has a large supply of condoms, but the nurses told us that women do not like this method at all, even though the director thinks it is the best and safest method for couples in a refugee setting. In the pediatric service, children are treated for malnutrition, and their mothers are taught hygiene and such basic health concepts as proper diet, correct weaning, and the importance of sufficient sleep for both children and pregnant women, but it is clearly a less important aspect of the program.

The future of both the clinic and the school are uncertain. Fatanah begs and borrows drugs and equipment from any source available. NGO officials in Peshawar expect Fatanah to call or visit them at least once a month with a list of supplies that she needs for the clinic. MSF contributes the contraceptive supplies. Because the financial basis of the service is so precarious, a small charge is now being asked. Women pay 10 rupees (33 cents) for a visit, and 500 rupees (\$16.50) for an operation (such as surgical sterilization). The clinic will survive as long as Fatanah keeps its going on the strength of her own drive, warmth and charisma, but unless she can obtain some long-term funding, the future looks bleak.

Past and Present Conditions of Women in Afghanistan

It is interesting to note that most historians writing about the attempted communist revolution in Afghanistan confirm that one of the aspects of the communist regime's modernization program that was least acceptable to large numbers of the predominantly Muslim population was its efforts to improve the status of women. In the capital, Kabul, under the communist-led Afghan government of the late 1970s, and later under Soviet rule, young women were throwing off *purdah*, were going to school in large numbers, and were joining the labor force in unprecedented numbers. The communist rulers of the late 1970s had introduced laws to raise the minimum age at marriage for girls to 16, had put limits on the traditional "bride price" system, and had allegedly forced women to take part in literacy programs.¹⁴ In addition, many people we talked to who had lived or worked in Afghanistan before the war said that contraceptive practice had been quite widespread among urban and more educated women, and that services had not been difficult to obtain.

In fact, it is possible that couples inside Afghanistan, even today, have better access to family planning services, and are using them in higher proportions than are couples in the Northwest Frontier Province of Pakistan. A cross-border health services project carried out by Management Sciences for Health (MSH) inside Afghanistan between 1986 and 1994 began to incorporate family planning into its activities in the early 1990s. The authors of a study evaluating the MSH cross-border project write:

In the first major planning workshop with the Area Health Service Administrations (ASHA) in 1990, the key message to impart to the policy makers was this association between maternal

deaths and family planning. Surprisingly, with no resistance, the ASHAs immediately began requesting contraceptives. . . . [I]n 1991, the first shipments [of a 28-day pill and of condoms] were sent cross-border. The primary distribution point would be MCH clinics. Where there were none, one committee decided to distribute contraceptives through its basic health center. The rapid acceptance of contraceptives among the medical professionals was encouraging, and family planning services became a demand from the Afghan side rather than a push from the technical assistance team. However, in Peshawar, the Ministry of Public Health moved much more gradually. They accepted including child spacing as a topic in certain training programs, but due to the political risks of Peshawar, the MoPH chose not to supply contraceptives to any of its facilities across the border. By 1992, however, they were reconsidering this policy.¹⁵

Nancy Dupree, reflecting on the future role of Afghan women says that in the past, "women acquired self-esteem primarily through their own female networks forged by links with kin, place of origin, client/patron relationships and religious community organizations. Most importantly, through maintaining family solidarity, arranging marriages, mediating personal and family disputes, supplying healing and economic support, organizing religious gatherings and providing communications links throughout their networks, women exerted considerable influence within the home and the community." She feels confident that "although these networks have been damaged by the experience of exile, most women will undoubtedly repair them once repatriation takes place."¹⁶

An Afghan expert wrote in 1960: "It is not an exaggeration to say that the essential problem of Afghanistan is that of women. And it is from that problem that all others are derived because the situation of women influences all aspects of Afghan life. Consequently, a reform of their status would necessarily herald a real change in the country."¹⁷

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Central American Asylum Seekers in *Belize*

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Why Are the Asylum Seekers There?

Throughout the 1980s, Central America was torn apart by war, oppression, revolution and counter-insurgency. During that decade, a large number of the civilian population from El Salvador, Guatemala, Honduras and Nicaragua fled in search of asylum in neighboring Mexico, Costa Rica and Belize, as well as to the United States. According to the UNHCR, between 1979 and 1994, the Central American wars claimed the lives of more than 150,000 persons, and 1.8 millions were forced to flee their homes. The asylum seekers currently in Belize are predominantly from El Salvador and Guatemala. At one point, there were also a large number of Nicaraguans in Belize, but the vast majority went home once a fragile peace returned to that country. Despite a generally hospitable attitude toward the asylum seekers, public opinion is shifting slightly, and there is a sense that the country now feels a greater reluctance to continue the "open-door" asylum policies that previous governments had pursued.

Which Relief Agencies are Assisting the Asylum Seekers?

In 1990, the Conferencia Internacional sobre Refugiados Centro-Americanos (CIREFCA) was set up to coordinate a wide range of protection and development activities in support of returning refugees that were being undertaken and planned by the UNHCR, by governments in the Central America region and by non-governmental organizations in the area. Under that mandate a series of Quick Impact Projects (QIP) or small-scale, short-term projects designed to assist the insertion back into their communi-

ties of returning refugees were implemented throughout many Central American countries, particularly, Nicaragua, El Salvador, and Guatemala. In Belize, however, the QIPs are aimed at assisting the integration of asylum-seekers into the ongoing social and economic life of that country. The "underlying objective of the QIPs in Belize is to promote economic development in various communities with refugee populations, and alleviate the stress placed on local services by the presence of large numbers of refugees and displaced persons."¹ Apart from the UNHCR, a number of indigenous non-governmental organizations are now involved in development projects for asylum seekers in Belize. These include the Belize Family Life Association, the Red Cross, an agency called Breast Is Best, the National Development Foundation of Belize, and Help for Progress. However, only one international NGO, the International Rescue Committee, is currently involved in refugee work in Belize.

How Are the Asylum Seekers Living?

The situation of the refugees in Belize is quite unique, for a number of reasons. In the first place, even before the arrival of the displaced persons and refugees from neighboring countries, Belize itself, though small in size, has always been a multi-racial country. Secondly, a large percentage of the population in this officially English-speaking country also speaks Spanish, which is the mother-tongue of the refugees. Thirdly, the government owns vast tracts of land, and has made portions of this available to documented refugees for cultivation and housing. Finally, the border between Belize and Guatemala (and hence between Belize and Guatemala's neighbors) is only

lightly controlled, which makes it possible for refugees to go back and forth between the countries without much difficulty. As a result, there are fewer physical, linguistic or cultural barriers than would normally exist in a refugee setting to make the refugee population feel like an alien or alienated group within the country.

The population of Belize is small—a total of no more than 200,000 people. Another 100,000 Belizeans are living in the United States. The 1991 Census showed that 30 percent of the resident population are of Creole origin (the original slaves brought by the British as cheap labor in the logging industry), 44 percent are Mestizos (of Hispanic origin, for the most part Spanish-speaking), and 11 percent are Garifunas (also slaves who were first settled in the Caribbean islands before reaching Belize in the 19th century). This group inter-married with Caribs from South America, and has a somewhat different appearance from the black Creole population. The remaining 15 percent of the population is made up of Maya/Ketchis, East-Indians, a small settlement of German-Dutch Mennonites, and a small Chinese group. Now added to the resident population, there are 9,000 official Central American refugees (four percent of the population), and an additional unreported 19,500 refugees (10 percent). Of that total of 28,500, 13,800 are from Guatemala, 10,500 from El Salvador, and 4,200 from Honduras. Since all of this new population is Spanish-speaking, they are virtually indistinguishable from the existing Mestizo population. The main language of the Creole population is English, whereas the main household languages of Garifunas are, in equal proportions, Garifuna or English. The Maya/Ketchi mostly speak Mayan or Spanish. Most Garifunas are Catholic, as are two-thirds of Mestizos. Only four in 10 Creoles and five in 10 Maya/Ketchis are Catholic.

Apart from one refugee village (the Valley of Peace), the refugees have become absorbed into rural and urban Belizean life, and live alongside Belizean nationals in eight out of every 10 of the country's 200 rural villages. One-third of the total refugee population (and one-half of all the Guatemalan refugees in Belize) live in Cayo district, and one-fifth in Belize City, on the coast. In fact, the "refugee" village within the city of Belmopan in Cayo province (which is also the seat of the national government) is called Salvapan—a clear allusion to the country of origin of most of its residents.

The integration of the refugee population into Belizean society is unlikely to be reversed. Consequently, in order to prevent this group from becoming an onerous burden on the Belizean state and to address the growing resent-

ment toward refugees felt by some Belize residents, under an agreement with the government of Belize any development projects designed to help the refugee population must also benefit Belizeans. However, no development projects are undertaken unless the target community includes major concentrations of displaced or refugee Central Americans. The projects, which are purely development rather than relief activities, cover a range of needs: health, water and sanitation; agriculture; income generation; the creation of a market structure through the building or repair of roads and bridges; vocational schooling and education; and social development.

There have never been any refugee camps in Belize. The asylum seekers automatically gravitate toward areas of the country in which they have family or friends from their own country. There they initially settle, sharing houses, shacks or other accommodations until they can find the land and the money to build their own homes. Consequently, some villages have a decidedly large concentration of refugee residents. The official refugee population is registered, and all registered asylum seekers are entitled to receive all the social services (education and health especially) available to the resident population. However, since the country is extremely poor, the health and education services are neither of high quality nor universally available. Large proportions of the refugee population live without adequate health, sanitation or housing. However, the resident population is not much better off, so the development projects aimed at the refugee population are also a highly important part of Belize's overall development process. In fact, the total UNHCR-funded budget for development projects in 1993 represented about one-eighth of the country's entire gross national product in that year. Future projects are planned to include the improvement and extension of health facilities in remote rural areas, the building of new health posts, and the upgrading of the equipment in the only hospital in the new central capital, Belmopan.

Most of the refugees both come from rural areas of their countries of origin and now live in rural areas of Belize. As small landowners and tenant farmers in their countries of origin, they are therefore used to living on and from the land. In fact, it appears that they are more experienced farmers than the Belizean rural population, who rarely cultivated anything other than bananas and such food staples as manioc. Now the market places are busy with stall holders selling a wide range of fruits, vegetables and lettuces that were previously unavailable in the country. One of IRC's Quick Impact Projects in Belize City is designed to renovate the central market square, and other projects

are designed to make it easier for the refugees to get their produce to market by the improvement of the country's sparse road and bridge system.

General and Reproductive Health Conditions

A family health survey carried out in 1991 indicates that general health conditions in Belize are relatively good. The infant mortality rate is estimated at 42 deaths per 1,000 live births, 75 percent of children aged between nine months and five years have completed their immunization schedule (higher than the United States!), 76 percent of births at the national level take place in a government or private hospital (only 57 percent in rural areas, however), 95 percent of pregnant women receive some kind of pre-natal care, 84 percent are vaccinated against tetanus during pregnancy, and 84 percent have heard of AIDS.² Nine out of 10 women who know about AIDS also know that it can be transmitted through blood transfusions, by sharing needles, and through both homosexual and heterosexual intercourse. Few of these health indicators vary greatly with the family's racial or ethnic background. However, 40 percent of children under five had had a bout of acute respiratory infection in the two weeks prior to the survey, and 11 percent had had diarrhea.

The 1991 survey found that the Mestizo population of Belize (and presumably the Central American asylum-seekers) have had less schooling than the Creole or Garifuna populations. They are also more likely to live in rural areas, and much less likely to have paid employment. The survey also revealed that 31 percent of the Mestizo population had been born outside of Belize. On the other hand, Mestizo women aged 15-44 are more likely than women in the other major ethnic groups to be married or in a consensual union (67 percent, as compared with 44 percent of Creoles and 52 percent of Garifunas).

The overall total fertility rate (TFR) is 4.5 in Belize, a level very similar to that of neighboring El Salvador and Nicaragua (4.6), but lower than that of Guatemala (5.6). The TFR of the Creole population is lower (3.6) than that of Garifunas and Mayans (5.4), and the Mestizo population has a TFR of 4.8. However, in rural areas, where many of the asylum-seekers are currently living, the TFR is 5.8 children per woman. Finally, the survey shows, 47 percent of all married women aged 15-44 in Belize are currently practicing family planning. The leading method is female sterilization (19 percent), followed by the pill (15 percent). This contraceptive prevalence rate (CPR) is higher than that of Guatemala in 1987 (23 percent), very

similar to that of Honduras and Nicaragua, and slightly lower than that of El Salvador in 1993, where the CPR was 53 percent, and 32 percent of all women 15-44 had had a tubal ligation for contraceptive reasons. These comparisons suggest that asylum seekers from El Salvador are more likely to be controlling their fertility than those from Guatemala.³

A study carried out in 1989 to compare the fertility patterns of Central American refugees with that of resident Belizeans found that after controlling for a woman's age and parity, and the amount of land the family had available for cultivation, legally registered refugees said they wanted twice as many additional children as both permanent residents of Belize and those without legal residency. The study included Guatemalan, Salvadoran and Belizean women with children under six years of age who were living in three settlements that had a high proportion of refugees and economic migrants.⁴

There are some interesting differences in the CPR within Belize. Creole women are slightly more likely than Mestizo women to be using a contraceptive method (53 percent, compared with 46 percent), but slightly less likely to have resorted to sterilization and much more likely to be using the pill (21 vs. 13 percent). However, the major predictor of high contraceptive use is not ethnic group but the main language spoken in the home. Sixty-two percent of English-speaking married women, compared with 43 percent of those whose major language is Spanish, are currently using a contraceptive method, and that method is much more likely to be sterilization or the pill (48 percent vs. 30 percent).

It is clear then that the Mestizo population (and by inference, the asylum-seeking population) of Belize has somewhat less effective control over childbearing than does the Creole population, but this may simply be due to the fact that they want more children. It is also interesting that the CPR and the type of method used are almost identical for Catholic and for Protestant women. The unmet need for contraception in Belize is estimated to be 17 percent of all women aged 15-44. It is lowest among the Creole population (13 percent), highest among the Mayan population (25 percent) and similar among Mestizo and Garifuna women (18-19 percent). Almost four in 10 women using a contraceptive method obtain it from a government clinic, three in 10 go to pharmacies, and 10 percent (13 percent in rural areas) obtain the service from the Belize Family Life Association (BFLA), which is an affiliate of the International Planned Parenthood Federation. However, in 1991, the survey showed that

Mestizo women were much less likely than women from any other ethnic group to use the BFLA as a source of contraception (only four percent) and somewhat more likely to use a government facility.

The fact that there are no really large differences in the general contraceptive and reproductive patterns of Mestizos and the Creole and Garifuna populations seems to be added evidence of the degree to which the asylum-seeking population has become, and is increasingly becoming, integrated into Belize society. The reported differences in access to contraceptive services for Mestizo and other groups are difficult to interpret. A project currently being funded by UNHCR (as part of its ongoing CIREFCA program) might help change that situation. This project, which is being implemented by the BFLA, carries out community-based education and training of women in matters of family planning and reproductive health care. It is specifically designed to operate in areas of the country with large proportions of Spanish-speaking asylum seekers. A companion project being carried out by Breast Is Best targets these same population groups as potential recipients of information about post-natal care and child nutrition.

We spent a day with the staff of the BFLA who were working out of a one-room family planning clinic in the Belmopan hospital (in Cayo province). Both the nurse in charge and her clerical assistant were themselves Mestizo, Spanish-speaking Belizeans, and at least half of all the clients attending the clinic were also Spanish-speaking. The BFLA also runs a family planning clinic for Salvapan residents one morning a week (for three hours) in the Red Cross Center of Belmopan, which also doubles as a day care center for the pre-school-age children of working mothers (who pay one dollar a day), as a primary health care center (open three mornings a weeks), and as a heavily used, subsidized lunch center for secondary school students who have to travel a long way to school in Belmopan, and who have no possibility of returning to their rural homes for lunch. All the women involved in the Red Cross day care and health center activities are Spanish-speaking, and all the clients are refugee women—predominantly from El Salvador. The lunch group is predominantly made up of Creole and Garifuna students. BFLA is thinking of ending weekly family planning sessions in the Red Cross Center because attendance has dropped off, and most women from Salvapan now feel confident enough to attend the sessions held in the Belmopan hospital.

The room in the Belmopan hospital given to BFLA to hold family planning sessions is only about 15 feet square and is only just large enough to hold a desk, three chairs (one for the client and two for the nurses), a filing cabinet and an examination bed. Contraceptive supplies are kept in a box on top of the file cabinet. There is no running water or refrigerator in the room. Fees for service have recently been introduced. As each client comes for interview, the nurse explains to them the change in policy and asks whether paying the fee (a flat fee of about \$10.00 for contraceptive services, excluding female sterilization) is a problem. Some women are hesitant and explain that they cannot pay the full amount, but that they will make a down payment and bring the rest in on their next visit. The nurse must also explain that pregnancy or STD testing will cost an additional amount. None of the women attending the clinic that day are requesting these services. Most of the women are using the pill or the injectable, which is apparently becoming increasingly popular in the BFLA clinics. The completely trilingual (Spanish, Creole and English) nurse is kind and relaxed, but she chews gum throughout the afternoon session, and gossips with the clerical worker seated across the desk from her, even while the clients are present, and her counseling is minimal. When one woman says she would like to change from use of the injectable to another method, she is simply told that this would be unwise and that this is the "best" method for her.

The following day, we accompany the same good-natured BFLA nurse to a refugee village called Armenia, located about 20 miles outside of Belmopan. There she talks to a group of roughly 10 refugee women about the various contraceptive methods and shows them two dramatic soap-opera-type video films (made in Guatemala) about the perils of repeat childbearing and of teenage pregnancy. They watch the films with great fascination (the poor multiparous woman dies in childbirth!) but the nurse does not initiate a discussion of either topic, and appears anxious to get home. When she demonstrates the use of the condom by rolling it over two fingers, there is a lot of embarrassed giggling among the women, even though most of them are married and already have children. However, a Creole woman teacher who works but does not live in the village is attracted by the giggling, and stands in the back of the community center listening to the nurse's Spanish presentation. Afterwards, she comes up to the nurse and asks her in English for some more detailed information about the IUD, saying she has never heard of this method and would be interested to learn more about it.

Some Problems Specific to Central American Women

In 1991, UNHCR's Senior Coordinator for Refugee Women visited a number of countries in Central America to assess the degree to which assistance projects aimed at helping both returnees and refugees were sensitive to, and addressing, the special needs of women. In the course of a discussion with a group of Salvadoran women who were recent returnees from years of exile in Mexico, she heard from them about many of the types of problems they were encountering. Since it is likely that returnee women in El Salvador are experiencing many of the same conditions confronting Salvadoran asylum-seekers who are becoming integrated into life in Belize, it might be enlightening to report what these women described as some of their major problems:

- ◆ "[The women] expressed the importance of taking a more active role in the community, but explained the difficulties of trying to combine this with childcare. Many become mothers at 14, and by age 17 have three children.
- ◆ They were concerned about the future of their children, particularly girls, and saw their responsibility as mothers in ending the cycle of illiteracy, early marriage and childbearing in order that girls and women could contribute actively to the development of the community in partnership with men.
- ◆ They discussed family violence and the need for the community to condemn the practice.
- ◆ They then outlined how women were discriminated against from birth and how their exile had resulted in them becoming aware of this and how it was violating their human rights. Birth attendants are given extra money when a male is born, girls are fed last when there is not enough food, girls are expected to work around the house from an early age and wait on their brothers, who are encouraged to play and go to school. The women expressed repeatedly that they had an opportunity to change this pattern and were anxious to do so."⁵

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Refugees on the Laos and the Burma Borders of *Thailand*

February 1-11, 1994

Lowland and Hill Tribe Laotians on Thailand's North-East Border

Why Are the Refugees There?

The causes of refugee flight among the various populations of Laos go back into the mid-1970s, when the Communist Pathet Lao ruled the country and brutally oppressed many of its ethnic minorities—especially the highland Hmong, Mien and Htin, and the lowland Lao groups—the major group to engage in guerrilla warfare (with the help of the United States) to oppose the régime. Since that time, the refugees have lived in a number of camp sites along the Thai border, the largest of which, Ban Vinai, was closed down at the end of 1992. In June 1991, the UNHCR had launched a \$3.6 million program to encourage the Laotian refugees in Thailand to return home. A settlement was agreed upon among the UNHCR, the Lao People's Democratic Republic and the Thai government. Since 1975, as many as 320,000 Lao refugees fled to Thailand. The number still remaining along the border is now down to about 25,000, as a result of the spontaneous and assisted repatriation of about 13,500 and the resettlement in a third country (mostly the United States, Canada and France) of about 300,000. Of the 25,000 Laotian refugees remaining in Thailand, 14,000 are in Ban Napho camp (awaiting repatriation), and 11,000 are in Phanat Nikhom (ostensibly awaiting resettlement).

Which Relief Agencies Are Assisting the Refugees?

Ban Napho is still organized under the joint control of the United Nations High Commissioner for Refugees (UNHCR) and the Ministry of the Interior of Thailand. The situation is very different today, however, when compared with that period. Now only a handful of NGOs remain providing services to these 14,000 remaining refugees, as compared with 10-20 groups when the population of the camp was as large as 40,000: the International Rescue Committee (IRC); the Catholic Organization for Emergency Relief and Refugees (COERR); Ecoles Sans Frontières (ESF); the Dutch Redemptorist Church (ZOA); the Christian and Missionary Alliance (CAMA); the Thai-Chinese Refugee Service (TCRS); and the Planned Parenthood Association of Thailand (PPAT).

General Camp Conditions: How Do the Refugees Live?

There are approximately five thousand men and four thousand women over the age of nine in Ban Napho. And there are 2,400 boys and 2,300 girls nine years of age or less. Nobody was able to explain to us why adult males outnumbered adult females. Approximately 12,000 belong to the Hmong hill tribes, and 2,000 are Lowland Lao. Everybody agrees that the Lowland Lao are the more "developed" group. They came from less remote parts of Laos and had adopted a more modernized way of life (including some contraceptive practice).

Before Ban Vinai and Chiang Kham camps were closed down, the refugees living there were given the option to

seek resettlement or repatriation. Those who would not decide between these two options were moved to Ban Napho, and it was explained to them that there would be absolutely no more options available for resettlement in a third country. As a result of a recent policy to persuade all these refugees to repatriate, there are now two distinct groups within the camp: those who have agreed to go home if and when the Lao government finds them land, and the "undecideds," who are still holding out for a different resolution to their long years of exile. That other hoped-for outcome is resettlement in a third country—presumably the United States—which so far has accepted more Hmong than any other country. However, although the leaders understand that the chances for resettlement are nonexistent, many Hmong refuse to accept their fate. Because of this stand-off, even greater pressure is being put on the undecideds, and they are now made to live inside a closed-off area within the larger camp. They can only leave this guarded area at particular times of day and for a small number of reasons (to fetch water, to go to the market). The adults are not permitted to attend any of the vocational training classes available in the camp. These classes include sewing, cooking, construction, agriculture, sanitation and water training and bicycle repairs. The vast majority of the "undecideds" are from the Hmong hill tribes.

While this policy of isolating the Hmong seems to be punitive in the extreme (and somewhat self-defeating if the objective of the policy is to prepare the refugees for their eventual return), there is some desperation on the part of the UNHCR and Thai government to arrive at a solution that will allow them to close down the camp by the end of 1994 (although most of the Hmong still believe this will not happen). The reasons for the reluctance to go home on the part of the Hmong are complicated and varied, depending upon whose interpretation is to be believed. Many of the Hmong women we spoke to said they were afraid to go home because one of their most respected leaders, Vue Mai, had returned to Laos in September 1993, and had then disappeared, presumably killed by the Laotian government. However, some knowledgeable observers believe that Vue Mai was not a victim of the government, but rather, of even darker forces from within the Hmong leadership based in the United States. This group apparently wanted to stir up exactly the kind of fear of return that has resulted from the disappearance of Vue Mai, because so long as there are Hmong still in refugee camps in Thailand, their presence provides an excuse and pretext for fund-raising in the United States, funds which are then diverted by the leadership into unknown pockets. This, of course, is all supposition. It has

important consequences, however, because so long as the majority of hill tribe Hmong believe that their lives will be in jeopardy if they return to Laos, the longer Ban Napho will have to stay open, unless forced repatriation is resorted to. But nobody wants to see that happen, least of all the UNHCR, for whom such an eventuality would create bad publicity, as it did when 700 Cambodian "refuseniks" had to be forcibly repatriated in 1993.

In the meantime, there is some kind of stalemate in Ban Napho. The 2,000 refugees who have agreed to go home are still there because the Laotian government has not been able to find land for them. And the other 12,000 or so remain in a limbo that is partly of their own creation. They receive standard food rations, water, and basic health care, and the children are still permitted to attend primary school. Morale is very bad among this group. There is increasing resort to opium-taking and family violence, and despair, boredom and hopelessness are widespread. The UNHCR official in charge of Ban Napho told us that she thinks continued stay in the camp can only contribute further to the destruction of the soul of the people that has taken place since the mid-1980s. She believes that the body can be rebuilt, but not the spirit. We were unable to visit any of the undecideds because they are housed behind high fences in areas of the camp that are off limits to all visitors. Any impressions of camp life are, therefore, based on the experience of the 2,000 or so refugees awaiting repatriation.

The decideds live in much the same way as they have for years. Accommodation mostly consists of long wooden barrack-like huts that house between five and 10 family groups, each separated from the next by interior partitions. Many families have built bamboo fences in front of their huts in an attempt to gain some privacy, but the result is an increased sense of confinement, even though the dirt roads dividing the constellations of huts are broad and well maintained. Many refugees have grown small gardens behind their huts, and around each water pump, the drain-off is used for productive vegetable allotments, usually cared for by women. Outside every hut, groups of men, women and children of all ages sit on low stools, busily engaged in the ubiquitous Hmong embroidery and quilt-making that has become their main source of income over the years. Long lines wait at the water pumps to carry in wooden carts balanced on bicycle wheels the family's allotted daily ration of 12 or so plastic containers of water. Children play in the dirt, old people sit under shade trees observing the passing scene, groups of volunteers sweep and tidy the public spaces, and garbage removal teams cross the camps each morning.

General and Reproductive Health Conditions

The health services in Ban Napho were set up by Save the Children Fund/UK, but this group has now handed the responsibility over to the Dutch NGO, ZOA. The main hospital facility is staffed by two doctors, one dentist, four registered nurses, one lab technician and one pharmacist. At night, these staff leave the camp, and are replaced by a skeleton emergency staff of professionals belonging to the Thai Ministry of Public Health. The service is divided into an outpatient department, an emergency room, a delivery room, a dental service, a pediatric ward, a maternity ward, and MCH area (divided into well-baby, sick-baby and at-risk departments), and a room set aside for minor surgery (such as lancing boils and administering dressings).

As in every camp we visited, the major health problems are related to acute respiratory infections (ARI) and diarrheal diseases. Among the Hmong, these problems are compounded by their general unwillingness to allow their children to be immunized, or to resist immunization as long as possible. The main reason given for the resistance to immunization is that the Hmong cannot be persuaded to see that there is a link between preventive health practices and improved health in the long term. For example, since the Hmong have never seen diphtheria or whooping cough, they can see no reason to expose their children to the high fever and discomfort that often accompany these shots. Similarly, so long as the family's food ration is based on the number of children, it is hard for health educators to persuade women that there is any link between their economic well-being and family planning. Other problems mentioned were child epilepsy (as a result of birth complications) and cardiac problems.

The MCH service statistics for December-January 1993/1994 show that there were 68 births in that month. Of these, 50 took place at home, 15, in the camp hospital, and three outside the camp (referred to a Thai hospital for delivery complications that ZOA staff do not have the equipment to treat). If this average number prevails throughout the year, there would be about 816 births annually, for a crude birth rate per 1,000 population of 58. In that same month, 230 women were registered in the pre-natal clinic, which suggests that about 10 percent of all women of fertile age were pregnant in that month. If one assumes that some women were still in early pregnancy and as yet unregistered, the proportion pregnant would be even higher. No estimates of maternal or infant mortality were available, and none could be made. We were told that using clinic attendance to make any generalizations

about overall health conditions would be misleading. The bias would go in either direction, apparently, since clinic patients represent both the more educated refugee population, and the sickest.

In the well-baby section of the clinic, mothers and fathers arrive bringing with them a bright yellow Road to Health card which shows the child's weight gain, some demographic information and immunization status. Each card is numbered to correspond with a file maintained in the clinic by year of the baby's birth and ethnic background (Hmong or lowland Lao). A surprising number of Hmong children were brought to the clinic by their fathers. We were told that many Hmong men did not trust their wives to understand the instructions they were given at the clinic, or to obtain the correct drugs at the pharmacy.

When we met a group of Hmong women who were attending a training course that was open to both traditional birth attendants and young literate girls, we learned that they are happy to be pregnant if they "need" more children, but unhappy, if they do not. However, they do not have in mind an "ideal" family size. When we asked about methods they might use to delay or prevent conception, we were told that having sexual intercourse 10-14 days after the menstrual period (their understanding of the "safe" period) would probably have the desired effect. It is of some interest that the rhythm method (or the "safe" period), which would be the only birth-spacing technique acceptable to ZOA—a fundamentalist religious sect from the Netherlands that is opposed to the use of modern contraceptive methods—was so poorly understood by the women in the camp.

The young Thai woman giving the course on pre-natal and delivery care is herself from a Hmong background, so speaks the language. She has devised a very beautiful teaching guide, with the help of IRC, Dr. Win (see the next section on the Burma border camps), and a handful of refugee volunteers. It is based on color photographs of pregnant women and a woman in labor, accompanied by carefully typed instructions about the need for good diet, adequate rest, and safe delivery practices. Her rapport with and obvious understanding of the Hmong women were quite exceptional. She told us that few Hmong women choose to have their babies in the camp hospital because they prefer the squatting position (which is discouraged by the ZOA midwives), and because they are constrained by a profound sense of physical modesty from allowing anybody (even their mothers, daughters or sisters) to be present when they deliver.

We also visited one of the family planning sessions held three times week and staffed by the Planned Parenthood Association of Thailand (PPAT). During one three-hour morning session, 10 women—all of them lowland Lao—had come for pill refills. There had been a total of 776 family planning and gynecological visits in 1993. The very young and seemingly very inexperienced Thai PPAT nurse said that there were now very few patients for the service because most of the Hmong were restricted to the off-limits section of the camp, and in any case, the Hmong women had never practiced family planning in any large numbers. She said that when the lowland Lao made up the bulk of the camp residents, in the late 1980s, use of the service had been somewhat greater. Even then the pill was always the most popular method. She said that because of poor standards of hygiene, there were an increasing number of women suffering from genital warts (condylomas). Men shunned using condoms, because women tend to believe that if a man wears a condom, he does not love her. The clinic room assigned to the family planning session looked bleak and unoccupied, and there was no sense of interest on the part of the bored PPAT workers in their camp assignment. There were no longer any IEC or promotional activities being carried out in Ban Napho, and a pervasive sense of futility dominated this particular health activity.

A 1983 study of contraceptive practices in Ban Vinai (then with a mainly Hmong population) and Ban Napho (a mainly lowland Lao population at the time) camps found that the crude birth rate in Ban Vinai was 54.8 per 1,000 population in 1982, compared with 37.9 in Ban Napho, and that the mean age at marriage was 17.7 years in Ban Vinai and 20.0 in Ban Napho. At the time of the 1983 survey, Hmong women said that their ideal family size was 6.2 children, compared with an average ideal of 3.4 children among the lowland Lao. Knowledge of contraceptive methods was very different between the two ethnic subgroups. Only six percent of Hmong women, compared with 65 percent of lowland Lao women, had ever heard of the pill, and levels of knowledge about other methods also differed widely (one and 40 percent, respectively, for the IUD; and two and 36 percent, respectively, for the condom). However, the vast majority of women in both camps who knew about any method of contraception said they had learned about it while they were in the Thai camps. The investigators found that only three percent of Hmong couples, compared with 42 percent of lowland Lao couples were using a contraceptive method at the time of the survey. Some of the differences in contraceptive knowledge and use between lowland and highland Lao women can be explained in terms of educational

levels: only 12 percent of the Hmong women surveyed, compared with 65 percent of lowland Lao women, had had any schooling at all. However, the researchers pointed out that the administrative environment of the camp played a role as well. Women from both cultural groups were largely unaware of contraception before coming to the camps. However, "once in the camps, the Laotian women learned and rapidly adopted contraceptive methods, while the Hmong did not."¹ At that time, the Planned Parenthood Association of Thailand (PPAT) was responsible for family planning services in both camps. The PPAT trained family planning "motivators" to visit households and inform families about contraceptive methods. A PPAT worker reported as early as 1982 that "the Hmong were not open to family planning, and that the family planning motivators [in Ban Vinai] themselves lacked motivation."

Six years later, a study of family planning in Ban Vinai found that by the end of their childbearing years, ever-married Laotian women had had 6.75 children, on average, 67 percent of ever-married women wanted more children, and 24 percent of currently married women were practicing family planning (using mainly the pill or injectables).² In 1987, the estimated crude birth rate in Ban Vinai was 54.4 per 1,000 population. By that time, 72 percent of the women had been in the camp for seven years or longer. These studies appear to show that there has been relatively little change in attitudes toward, and the practice of, family planning among the Hmong population in the past 12 years, and that their fertility levels have not declined greatly as a result of their long-term stay in the camps.

What Would Reproductive Health Conditions Be Like for Returning Lao Women?

In 1992, UNICEF produced a report on social and health conditions among women and children in the Lao People's Democratic Republic.³ The analysis was carried out by UNICEF and the government, with assistance from UNDP, WHO and the World Bank. The picture is a brutal one. The analysis finds that the maternal mortality rate in Laos is 545 per 100,000 live births (compared with 140 in neighboring Vietnam, and 135 in Myanmar). This rate ranges from a low of 150 per 100,000 in the capital, Vientiane, to as high as 900 per 100,000 in the provinces. The report finds that 90 percent of births in rural areas take place at home without the assistance of a trained birth attendant. Only one in five rural women receive any pre-natal care during pregnancy, and only four percent of

pregnant women have had the double tetanus toxoid vaccination. Discussions with Lao doctors suggest to the authors of the report that complicated pregnancies are mainly the result of women's high levels of malnutrition and anemia, as well as the fact that Lao women continue to engage in back-breaking physical work throughout their pregnancies.

A demographic study carried out in 1984 found that women over 50 had had an average of 8.8 children. The authors conclude that "early and late pregnancies, short birth intervals and high parity, combined with hard physical work and limited food availability lead to the progressive deterioration of a woman's health and nutritional status. The women of rural areas, particularly those living in mountainous areas, appear more at risk." Despite these grim maternal health conditions, birth-spacing services are almost non-existent. The country's population policy was, up until quite recently, strongly pronatalist, and women can only obtain sterilization for contraceptive purposes after authorization is granted by the council of ministers, through a local authority. A recent pilot project funded by UNFPA and WHO is designed to promote birth-spacing activities in two government hospitals in Vientiane. "The project will promote birth spacing on a trial basis, identify training needs, and develop relevant teaching programs and learning aids, establish technical guidelines, and assess public response and demand for birth-spacing services in relation to different recommended methods (Depo-Provera injections, contraceptive pills, condoms and IUDs)."

A survey of women in 25 villages in two rural provinces found that although women expressed interest in controlling their pregnancies, most knew nothing about any modern methods of birth control. However, there was some use of traditional methods, and women also resorted to induced abortion. In 1989, one district hospital reported 60 cases of septic abortion.

Ethnic Minority and Political Dissident Refugees on Thailand's North-West Border with Burma/Myanmar

Why Are the Refugees There?

The refugee situation on Thailand's western border is complex and at times confusing. Approximately 73,000 Burmese (now officially Myanmar) ethnic minorities displaced by civil war, independence fighters and dissidents

are living precariously in small, impermanent but highly organized villages strung along the Thai border. The total number of refugees is frequently shifting, but the most recent Burmese Border Consortium estimates suggest that current population is made up of 11,000 Mon, 55,000 Karen, 6,000 Karenni, and 1,100 Tavoyan Burmese. None of these groups have been officially recognized as refugees by the Thai Ministry of the Interior, and thus, by UNHCR.

Various ethnic minority groups have been fighting the authoritarian socialist leadership of the Burmese state. The ethnic Karenni have been struggling for independence for almost 50 years, ever since the British left Burma, and the ethnic Karen are seeking independence within a federal system of government. The conflict moved across the Burmese border into Thailand when the first ethnic minorities fled in the early 1980s, in response to increased military pressure from the Burma military. Both the Karen and the Karenni were converted to Christianity by western missionaries at the end of the 19th century. The majority of the Burmese are Buddhists and Muslims (in 1992 about a quarter of a million Burmese Muslims fled into Bangladesh to escape Burma's reign of terror), despite 20 or so years of totalitarian rule. Because the Karen and Karenni adopted more western values, and because many of them learn to speak English (some starting with bible-reading and singing old-fashioned English-language hymns), they became the favorites of the British colonial rulers, made up a large part of the lower echelons of the civil service, and ultimately came to be seen as traitors to the patriotic cause of the Burmese who were struggling for independence from the British.

There are differing interpretations of why these tribes fled to Thailand, and why the Burmese government refuses to concede to their demands. It is generally agreed that there was a complete breakdown in the negotiations as to how the ethnic groups could maintain some degree of autonomy within their own land areas. There were also human rights abuses (the forced relocation of ethnic villages and the insertion of Burmese populations into these evacuated areas), heavy taxes imposed on rice crops, gross corruption on the part of Burmese officials, and even some destruction of villages suspected of supporting the ethnic insurgents.

The eastern highlands of Burma are rich in gems and teak. They also border the infamous Golden Triangle with Thailand and Laos, a region rich in opium-producing poppies. The Burmese government would not tolerate the loss of these potentially rich territories.

The population of asylum seekers was swelled in 1988 by the addition of some 2,500 Burmese "students" who had publicly demonstrated against the imposition of military rule by the State Law and Order Restoration Committee (SLORC) and who were cruelly and viciously attacked by government forces. These student representatives of the pro-democracy movement—the All Burma Students Democratic Front—fled Burma and have settled in the headquarters of the ethnic Karen people, where they have formed a broad alliance with the Karen and other ethnic armies, known as the Democratic Alliance of Burma. The anti-government coalition has set conditions for an end to the civil war. These include abolition of Burma's military government, the release of all political prisoners (including Nobel Peace prize winner Aung San Suu Kyi, who has been under house arrest in Rangoon for over five years), and the restoration of democracy inside the country.

Although they are always referred to as students (this group is mostly made up of younger, unmarried men), it is generally acknowledged that many of them are part-time or revolving members of the resistance army, waiting out their time in the jungle camps located just inside the Burmese border. The numbers of student dissidents are constantly being added to, as new arrivals from Burma join their ranks. Many of these new arrivals are refugees from the border areas who were forced to relocate by the SLORC to create free-fire zones. Another estimated 10,000 new arrivals in 1992 are refugees from deep inside Burma, fleeing economic difficulties, village destructions, destroyed paddy fields, and forced portage to carry ammunition to the line of fire. Many of these newly displaced persons are also single men without families.

Which Relief Agencies Are Assisting the Refugees?

The refugee groups receive assistance from five NGOs operating under the aegis of the Burmese Border Consortium (BBC): the International Rescue Committee (IRC), the American Refugee Committee (ARC), ZOA Refugee Care/Netherlands, the Jesuit Refugee Service, and the Thailand Baptist Missionary Fellowship. The BBC agencies are authorized by the Royal Thai Government to provide emergency relief in the form of food, blankets, mosquito nets and mats. In addition, the members of BBC initially cooperated with Médecins Sans Frontières (MSF), and the Catholic Office for Emergency Relief and Refugees (COERR) under an umbrella group accountable to the Thai Ministry of the Interior—the Coordinating Committee for Services to Displaced Persons in Thailand (CCSDPT). While food and relief supplies are the respon-

sibility of the BBC and COERR, MSF was made responsible for health care. Because MSF became increasingly over-burdened by having to provide health services to growing and widely displaced camps strung along the Thai border, under membership in the CCSDPT, ARC has now assumed these responsibilities in the southern Karen camps, and IRC is now responsible for health services in the northern Karenni camps. Each of the three major ethnic groups has its own appointed Refugee Committee for the coordination of assistance, and a separate political organization. Spending by the BBC came to about \$3.6 million in 1993.

General Camp Conditions: How Do the Refugees Live?

Under a clearly defined leadership structure, the Karen and the Karenni ethnic minorities have created highly organized communities, with schools, churches, and some health clinics served by paramedics trained by MSF. The refugee villages along the Burmese border consist of clusters of houses, usually built on either side of winding dirt roads. The bamboo houses, built on stilts, are of varying sizes, but all contain separate sleeping and eating areas and an inside cooking area. Animals are kept underneath many houses, and some dwellings even have small flower or vegetable gardens around them. This familiar type of all-bamboo housing can apparently be quickly dismantled and rebuilt in another location. This is important because the local authorities (the army, the border police, the forestry police or other provincial authorities) frequently tell the camp leaders at short notice to relocate. These instructions to move camp are sometimes given for genuine security reasons (the SLORC army launches sporadic offenses against the camps, or retaliates for military initiatives taken by the hill tribe armies inside Burma), but sometimes to meet some economic agenda, or in the interest of maintaining a relationship with the nearby SLORC groups.

The early mornings in the camps are periods of intense activity, followed by periods of quiet relaxation in the heat of the afternoon. Men and women spend long hours chopping, splitting and weaving the bamboo into building parts, mats and baskets, or attaching large dried leaves on to bamboo poles for roofing. Huge stacks of new or replacement roofing are piled outside every house. The roofing is also one of the camp residents' few sources of income, because it can be sold to neighboring Thai villagers, who also build their houses in the same way. Conditions seem to be most tolerable in the most remote camp sites, those located far up in the jungle covered

hills, right against the Burmese border, about a two-to-four-hour drive from Mae Hong Son, the nearest town. The hot mid-day air is somewhat cooled by the dense jungle foliage, and shallow streams and rivers flow through many of these refugee communities, providing washing facilities for families and play areas for children. The camps located in the flat valleys nearer Thailand's north-western border towns are less bucolic. The heat is intense, there are no trees, and the refugee houses stretch out unendingly across the dry mud plains.

Every camp has a school and several simply constructed churches, and most have clinics. Children start school at age six and continue through 10 grades. Upon graduation, the boys leave the camp to enlist in the guerilla army, or leave the camp every day to look for low-paying jobs in the surrounding communities. In the rainy season the young men can find work in the rice paddies. The rest of the year, they offer their services on construction sites or helping Thai tradespeople in the towns. A camp "immigration" pass costs about fifty cents a day, and permission must be given by the camp leader and countersigned by a representative of the Thai Ministry of the Interior (MOI), who sits in a guard post at the camp exit. Girl school-leavers have fewer choices. A few are trained as teachers' adjuncts, most have little to do other than helping their mothers with domestic chores, caring for the smaller children in the family (of whom there are many), or marrying and starting their own families at an early age. Life holds few prospects for these young women.

Women spend their days in household activities, tending to their small children, washing clothes in the river or under well pumps, cleaning, cooking and taking care of their domestic animals. The rhythm of life is similar to what it would have been in the Karen and Karenni villages on the Burmese side of the border. The important difference is that the hill tribes have no land on which to grow rice and vegetables—the two basic staples of their traditional diet. To compensate for this lack of basic food, and under closely monitored agreements with the Thai Ministry of the Interior, the refugees receive rice, fish paste, salt and chilies from the BBC. They are also given one blanket a year per two family members, sleeping mats, and mosquito nets (malaria is endemic throughout the whole area), and school supplies donated by ZOA (notebooks, pencils, pens and chalk) are also distributed by the BBC to the children. Assistance is restricted by the MOI to a bare minimum on the theory that more generous aid would create dependency among the population and might serve as a magnet, attracting economic refugees from inside Burma into the camps.

In the open-sided crowded classrooms, the school children, using much-thumbed notebooks and lead pencils, sit on benches in front of a teacher, whose only supply is likely to be a blackboard and some chalk. Many of the teachers are from among the educated student group that fled the Burmese junta's crackdown on the pro-democracy movement they represented. The subjects taught in the schools are the Karen language, English, mathematics, some geography and some basic sciences in the upper grades. In the lower grades, rote learning and chanting is the pedagogical method of choice, but the children are attentive and obedient, despite the lack of textbooks, other reading books or exercise books. The students go home for lunch and return for two more hours of lessons in the afternoon. During the short breaks between classes, they play inventive games in the dust, using flip-flops for goal posts, or skillfully spinning hand-hewn wooden tops.

Overall and Reproductive Health Conditions

Malaria is endemic in the camps, as are intestinal parasites, upper respiratory diseases (especially in the colder season from October to April), other infectious diseases and poor nutritional standards. None of the children have received any but measles vaccinations, and pregnant women have not been immunized against tetanus infection. Birth rates are high, and standards of maternal health are extremely low. Family planning is unknown and unpracticed. None of these conditions are surprising. While somewhat better than that of the general population inside Burma, they are not greatly different. The UN Population Division in New York estimates that the 1988 infant mortality rate inside Burma was 70 per 1,000 live births, the contraceptive prevalence level was five percent, and life expectancy was 57 years.⁴ A US government assessment of conditions inside Burma drew an even less favorable picture, claiming that the IMR was 96 per 1,000 live births,⁵ while a Population Reference Bureau factsheet from that same year cited a level of 103 infant deaths per 1,000 live births.⁶

The IRC health services in the area around Mae Hong Son are run by a team of health professionals led by a Burmese woman doctor—Dr. Win, previously a high-level health administrator and government official in Burma—who also left the country in 1988 in protest against the SLORC disregard of human and political rights. She is now IRC's medical administrator in Mae Hong Son, Thailand. From a simple office in that town the team runs IRC's primary health care program serving Karenni refugees in camps along the Burmese border. The team,

which consists of a community health sanitarian, a health educator and a primary health care nurse, works long, arduous hours planning and delivering basic health care services in the seven or so major Karenni camps. Dr. Win is disturbed by the gross inadequacy of maternal and child health conditions among the Karenni women, and is proposing a special effort to alleviate high maternal and infant morbidity and mortality rates amongst this population. She insists that Karenni women must be taught about the health benefits of spacing their births more widely, and must be offered the means to achieve this. Funding for an amplified MCH/family planning project in this area has not yet materialized. The population is small (involving roughly 1,000 women of reproductive age), and rumors of impending settlements between the Karenni leadership and the SLORC make it doubtful whether the refugees will remain for very much longer on the border.

The clinic services offered by MSF focused mainly on the supervision of local medics, nurses, lab technicians and sanitation workers, supplementary feeding for low-weight infants and pregnant mothers, the diagnosis and treatment of malaria and tuberculosis, the treatment of acute respiratory infections, the control of diarrheal diseases, and maternal and child health. Emergency cases and patients needing complex medical treatment are referred to the nearest Thai government hospitals. MSF trained ethnic minority paramedics to assume responsibility for day-to-day clinic sessions, to do basic first aid (bandaging wounds, treating burns, taking blood samples), and to give out routine drugs. The previous MSF staff used to travel in teams to each of the camps. In recent months MSF decided that this is not an efficient use of their resources so handed supervision of the clinics in the Karenni camps over to IRC. This relief agency works in a similar fashion, sending health teams (consisting of a doctor, a nurse and a sanitation worker) out from its main offices to make monthly or bi-monthly visits to as many camps as can be covered. Family planning is not offered, and there is still no immunization program, except for measles, because of the problems involved in establishing a cold chain to these remote areas.

Filling the Gap

In addition to Dr. Win, there is another remarkable woman doctor working on the Thai border on behalf of the Burmese—Dr. Cynthia, a Burmese doctor working in one of the few clinics serving the displaced populations from Burma who are living in the areas surrounding

Mae Sot. Dr. Cynthia has presented a grim assessment of maternal and child health conditions among women living in villages just inside the Burma border. According to Dr. Cynthia:

- ◆ 90 percent of Karen women become pregnant under the age of 18, and the same proportion continue to become pregnant until they reach their menopause.
- ◆ 90 percent of women who survive until the age of 30 have had 10 pregnancies by that age.
- ◆ 90 percent of all women have more than 10 pregnancies, and the average is 15 among women whose childbearing years are complete.
- ◆ 80 percent of all women deliver with untrained birth attendants.
- ◆ 10 percent of all infants die during delivery or before their first year.
- ◆ 50 percent of children die before their fifth birthday. The major causes of death are miscarriage, birth injuries, malnutrition and infections.⁷

Dr. Cynthia, a woman of Karen descent herself, trained to be a doctor at Rangoon University. Along with the other students and dissidents, she fled the country after the junta's brutal killing of thousands of demonstrating pro-democracy participants who took to the streets to oppose government resistance to political reforms. Since then, she has lived in and worked out of a ramshackle building on the outskirts of Mae Sot that serves as both her home and a hospital. Her work is supported by a number of NGO and international agencies, but particularly by the Rural Deanery of Christ Church in Bangkok, which raises funding for her program among church groups in Australia.

In addition to Dr. Cynthia and the paraprofessional Burmese students she has trained, a continually changing roster of visiting volunteer western doctors and nurses assist the hospital and clinic services. About 100 patients and health workers live in and around Dr. Cynthia's under-equipped, makeshift hospital. One of the newest members of the community is Dr. Cynthia's 11-month-old son. The patients include mine victims, amputees being prepared for prostheses, illegal clandestine abortion cases

with life-threatening complications, women suffering psychotic disorders, malaria and TB patients, and women from the refugee camps up and down the border who have been referred to the hospital for complicated or dangerous deliveries. Many women patients have been carried by family members from inside Burma to receive obstetric and gynecologic care at the hospital, since this is the only facility for many miles around to provide such services to the Burmese inside the country. Dr. Cynthia's hospital stocks a small supply of contraceptives, including pills and IUDs, and she herself performs IUD insertions. Because of the good relationship she has developed with the local Thai authorities, Dr. Cynthia is also able to refer some women to the local Thai government hospital to obtain female sterilization.

Dr. Cynthia is a quiet, modest woman. She tends to the clinic patients, holds case conferences with her visiting or resident staff, does hospital rounds, delivers babies, performs minor surgery, raises funds, takes care of her baby (who is still breastfeeding), and if time is available, tries to make frequent visits inside Burma to provide mobile health services across the border to address the desperate health care needs of the population groups in those areas. She also cooks Burmese meals that she serves simply to visitors and her family.

This Burmese woman doctor also worries about the reproductive health status of the refugee women she sees, and she is trying to raise funds to set up a maternal and child health project that would serve their needs. Dr. Cynthia knows that the untrained birth attendants now working in the Karen camps and villages are ill equipped to deal with any but uncomplicated deliveries. They do not recognize the signs of normal labor correctly, so often begin to massage the stomach of a woman having abdominal pains in the final trimester who is not yet ready to deliver, thereby inducing painful and dangerous early labor. They have no awareness of the need to keep the baby and the mother clean to reduce the risk of infection, or how to cut the umbilical cord safely. If a woman is having a difficult delivery, the traditional birth attendants often wait too long before they refer her to a health center or call for help. Finally, she stresses, these village health workers and their clients have no knowledge of or access to family planning or birth-spacing methods.

If sufficient funds are obtained, the MCH project will employ two or three nursing care educators who would run training courses for village midwives, birth attendants and paramedics working on the border. In addition to safe birth practices, these nurses would introduce the concept

of birth spacing and family planning to the traditional birth attendants they train. It is clear that this modest project could only have a minor impact on maternal health conditions among the Karen women. A 1994 monthly report from the Karen Refugee Committee estimates that in January, there were a total of 18,500 women over 12 years of age living in the large number of Karen refugee camps along the Burmese border.⁸

Deirdre Wulf

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Vietnamese Refugees in Detention Centers in *Hong Kong*

February 14-16, 1994

Why Are the Refugees There?

Since 1975, hundreds of thousands of Vietnamese have escaped from their country, choosing to risk their lives and their life savings. Until 1988, when screening procedures were introduced, Hong Kong provided automatic asylum for Vietnamese boat people. In 1988, however, in response to burgeoning numbers, Hong Kong introduced new measures to deter new arrivals. Vietnamese who arrived in Hong Kong prior to June, 1988 were declared to be refugees. Those arriving in Hong Kong after June 16, 1988 were held in closed detention centers and screened to determine whether they met the UNHCR definition of refugee. Those found ineligible would remain in these closed detention centers until they could be returned to Vietnam. Although returns to Vietnam were supposed to be voluntary, the government has, from time to time, chosen to repatriate some detainees against their will.

Which Agencies Are Assisting the Refugees?

The detention centers are run by the Correctional Services Department of Hong Kong. *Médecins Sans Frontières* provides medical services in the centers, along with Save the Children Fund/UK and British Red Cross. The Family Planning Association of Hong Kong takes care of family planning education programs and services for the refugees in all of the centers. UNHCR has overall responsibility for the coordination of these services.

General Conditions: How Do the Refugees Live?

The detention centers in Hong Kong are surrounded by barbed wire and high fences. Since they are operated by the Correctional Department as prisons, the guards are armed and act like police. The detention centers are overcrowded, dangerous and unhealthy. Most camps have barracks with rows of triple decker platforms that serve as living quarters. A family lives in an area that is around four feet by eight feet. This area is not only a sleeping space for the entire family but is also the storage area for the family's belongings.

During our visit in February, 1994, there was some lessening in the overcrowding as many families have been resettled or repatriated and no new refugees are arriving. Even so, minimal privacy is missing, and there is still fear of violence and of gangs.

Few outsiders are permitted to visit the centers. On this visit, we were encouraged to talk with medical and family planning personnel only. In Whitehead Detention Center, all one can see is concrete, barbed wire, and the barracks. The outside world is blocked off.

Most of the inhabitants of the center are women and children. We were told that the "big brother" and extortion rackets were more prevalent than ever, and that many people in the centers were often frightened, not only by the correctional officers supervising them, but also by the gangs in the centers.

Food is distributed, there are schools for the young children, and health services are being provided. But the day we were visiting, it was announced that the detention centers would close by the end of 1995 and that everyone would have to go home. In one section, a hunger strike was starting. Where we were, there was simply a feeling of hopelessness and despair.

General and Reproductive Health Care and Services

Though deprived of so many basic services and rights, men and women in the detention centers in Hong Kong have access to MCH programs provided by Save the Children/UK and full family planning services under the auspices of the Family Planning Association (FPA) of Hong Kong.

As of the end of December, 1993, the total population of Vietnamese in centers in Hong Kong was 32,270. The total number of births for 1993 was 1,249. These figures do not give an accurate ratio because many Vietnamese were both resettled and repatriated in 1993, and a number of those babies may have been born to the larger population. One of the paradoxical aspects of the situation is that even though there is a real emphasis on choice and family planning, families who know that they will have to go back to Vietnam are given a stipend based on the size of their families, so an extra baby means extra money.

Maternal and child health and Well Baby Services are provided in every center by MSF and Save the Children Fund/ UK. The FPA of Hong Kong has an education program which includes family planning, healthy pregnancy, happy marriage, sexually transmitted diseases, physical growth, pre-marital sex, women's health, birth control methods and termination of pregnancy. In December, 1993, total clinic attendance was 1,551, with 59 new cases, 87 old cases, and 1,405 revisits. Since December, 1979, total clinic attendance has been 148,202, and there have been 23,643 new cases. Methods of contraception prescribed include the pill, condoms, IUDs, injectables and sterilization.

In Hong Kong, for the refugees as well as the residents, a pregnancy may be terminated if two registered medical practitioners agree that:

1. Continuance of the pregnancy would involve greater risk to the women than termination of the pregnancy.

2. Continuance of the pregnancy would involve greater injury to physical or mental health of the woman than if the pregnancy were terminated.
3. There is a serious risk that if the child were to be born it would suffer from such physical or mental abnormality as to be handicapped.

We were told by the MSF midwife and by FPA staff that all methods of contraception are offered. Most women consult with their husbands before accepting family planning. Most unexpected pregnancies result from failed IUDs and failed condoms. A British doctor we spoke with wonders about this and feels that either the IUDs are not being properly inserted or that perhaps the IUDs that were being used were the wrong shape for Asian women.

One-third of the women are using the IUD. The rest are using the pill, the minipill, Depo-Provera, and diaphragms. A yearly Pap smear is given at the clinic. There are very few cases of cancer and very few detainees with STDs. During pregnancy, 50 percent of the women are given food supplements. Most pregnancies go well. The FPA doctors who work in the centers are not certified in Hong Kong but were certified in China. There was some feeling that, although they were doing a very competent job, there are communication problems.

The main reason for worry, however, was that any choices for women in the centers were extremely difficult. People cannot decide where they live, what they eat, what clothing they are to have, where their children are to go to school and for how long—all choice has been taken from them. How are they then to make choices about family planning? They are incapable of making decisions, having been dependent for so long. Also, prior to the classes that they are attending, Vietnamese women know very little about their bodies. If they don't know how conception occurs, how can they know how to prevent it?

In Hong Kong, as in other refugee sites, one of the reasons for having a baby is that both men and women want and need something to love when they have nothing else that gives them pleasure or happiness.

Mary Anne Schwalbe

Conditions Among Returning Refugees and the General Population Inside Cambodia

February 13-23, 1994

History of the Cambodian Refugee Situation

Cambodia was brought into the Vietnam war in the early 1970's when the United States began bombing raids inside Cambodia in an effort to prevent North Vietnamese troops from passing through Cambodia into South Vietnam. Prince Norodom Sihanouk, then head of state of Cambodia, attempted to secure Cambodia as a neutral country during the Vietnam war. But, in 1970 in a bloodless coup, Prince Sihanouk was overthrown and General Lon Nol was designated head of state. During the next few years the U.S. military effort against the North Vietnamese waged inside Cambodia increased and spread even deeper within the country. Millions of Cambodians fled to the capital, Phnom Penh, to seek safety.

On April 17, 1975 the communist Khmer Rouge, a guerilla army made up of young peasants and led by Pol Pot, took control of Phnom Penh and systematically emptied the city, marching the population to the countryside to work in the fields. Thus began a three-and-a-half-year rule by the Khmer Rouge. The country's borders were closed to all outside influence while the Khmer Rouge attempted to completely restructure the country into a perfect communist state. During this time the majority of Cambodia's educated people were killed and the entire country was essentially turned into a forced labor camp. People were forced to work in the fields from dawn to dark, and beyond, and family structure was completely destroyed, as parents, children, husbands, and wives were placed in separate work camps. Religious life was forbidden, and monks were either killed or forced to join in slave labor. Food was scarce, basic health services were not available, and thousands died of disease, malnutrition, and starvation. By

the end of the three-and-a-half years, more than one million people had died at the hands of the Khmer Rouge.

In late 1978, having been rejected by the Khmer Rouge in all attempts at political resolution to the war, and with increasing attacks against Vietnamese at the border with Cambodia, Vietnam invaded Cambodia, pushing the Khmer Rouge to the mountains and jungles in the North and Southwest areas of the country. By January, 1979, the Vietnamese had taken over Phnom Penh. During the next few months, millions of Cambodians returned to their home villages to search for their family members. By late 1979, Cambodia was again engulfed in war as the Khmer Rouge unsuccessfully fought to regain control from the Vietnamese. In the meantime, hundreds of thousands of Cambodians fled to neighboring Thailand seeking refuge. By late 1979, approximately 500,000 refugees were sheltered in the border encampments. A massive relief effort followed in which the United States and other Western governments initially provided food and medicine in an attempt to save Cambodian lives. For the next 13 years Cambodian refugees lived in Thai-administered refugee camps or in border encampments on the Thai/Cambodian border. Initially, few services were available in these sites, but later the refugees were to receive more and better medical, income-generating and educational services than would have been available to them inside Cambodia. In an attempt to stem the flow of refugees to Thailand, the Thai government officially closed its borders to new arrivals in 1980. The military maintained strict control of refugee and "displaced persons" camps and effectively restricted the eligibility of refugees attempting to seek resettlement in a third country.

Inside Cambodia, the Vietnamese-backed Hun Sen/Heng Samrin regime continued to battle against resistance groups, the communist Khmer Rouge and two non-communist groups—the Khmer Peoples National Liberation Front (KPNLF) led by Son Sann a former minister under Prince Sihanouk, and a group led by Prince Sihanouk, the National United Front for an Independent, Peaceful and Cooperative Cambodia (FUNCINPEC). Later these three guerrilla groups joined forces to form the Coalition Government of Democratic Kampuchea (CGDK) in an effort to gain international support for the resistance. The CGDK became recognized by the United Nations as the legal government of Cambodia and received military and other support from the United States and other western nations. The border camps became staging areas for the continuing fighting between the CGDK and the Vietnamese inside Cambodia and along the border areas, drawing many men from the border camps into the ongoing war.¹ Inside Cambodia, the population of about seven million people who had survived the Khmer Rouge genocide then struggled to survive an ongoing civil war as well as a cruel economic embargo led by the West.

In the mid-1980s Vietnam conditionally announced that it would withdraw its forces from Cambodia by 1990. For the next several years, as fighting continued, negotiations were underway to create a political settlement and the conditions under which the Vietnamese would withdraw. By September 1989 Vietnamese troops had pulled out. These events led up to the negotiations between the four major factions—the two non-communist resistance groups (KPNLF and FUNCINPEC), the Khmer Rouge, and the Hun Sen/Heng Samrin government—culminating in the signing of the Paris Peace Accords in October 1991. Under these agreements the four factions were to demobilize a significant portion of their armies and end the civil war. With the assistance of a large U.N. peacekeeping force numbering over 22,000, the U.N. Transitional Authority in Cambodia (UNTAC) had the responsibility of overseeing the demobilization process and preparing the country for democratic elections in May 1993.²

The Paris Peace Accords also set the stage for the repatriation of the more than 350,000 Cambodians still living in refugee camps in Thailand. The UNHCR developed a repatriation plan that provided for the voluntary and safe return of refugees to Cambodia in time for the May elections. To fulfill its mission, the UNHCR organized a massive repatriation effort that by all accounts was a logistical success. Beginning in March 1992, refugees began returning by the bus load to Cambodia, first to reception centers set up by the UNHCR and then on to district-level

distribution points from which they would find their own way to their new homes. At the height of the repatriation process refugees were returning at the rate of 40,000 per month. By May 1993, 362,209 Cambodians had repatriated.³

At the time of registration for repatriation in Thailand each family was to sign up for one of three plans. Option A provided 2 hectares of land (though productive mine-free land was scarce which later resulted in canceling out this option), wood for a house and \$25 to purchase thatch, bamboo, and household and farming tools. Option B offered a plot of land to build a house but no farm land, as well as the house kit and \$25 for tools. Option C provided only money, \$50 per adult and \$25 per child under the age of 12. All three options provided for 400-day ration of rice, cooking oil, and canned fish.⁴ As it turned out Option C was the most popular, largely because the UN was unable to secure free land in the returnees' province of choice. Under Option C, families could choose whether to live with relatives or go to a new location, and they could choose to go to the countryside or to the city. Unfortunately, as this and other Women's Commission delegations have observed,⁵ the money disappeared quickly, relatives were often unable to take in their returnee relatives for more than a short period of time, and a means for earning income was hard to find—particularly for women. As of May 1994, the last of the 400-day food rations will be delivered yet many returnees do not have a means for earning money, are often in settlement sites without land to farm, or are living in houses they have built for themselves on the edges of fertile but mined fields. Some returnees are making the transition to "food for work" support from the World Food Programme—a difficult solution for women-headed households.

In May 1993, the FUNCINPEC party headed by Prince Norodom Ranariddh (Sihanouk's son) won the election, followed closely by Hun Sen's Cambodian People's Party. They later decided to share power, while a constitutional monarchy was established that placed Sihanouk as King and Head of State, Ranariddh as first Prime Minister, and Hun Sen as second Prime Minister.

During the years in which refugees were given safe haven in camps on the Thai border, and many Cambodians resettled in third countries, an "invisible" group of more than 200,000 displaced persons inside Cambodia survived by living in informal encampments alongside the country's roadways. They received only minimal emergency relief assistance. Today this population of the displaced and homeless still numbers more than 100,000 persons.

Today the fighting continues in the north and west, where Khmer Rouge forces are still in control. The UNTAC forces have left, leaving the new government to resolve the conflict with the Khmer Rouge on their own. Since repatriation, significant battles have been fought that continue to displace Cambodians, some of whom have repatriated only to have to flee renewed fighting.⁶ While officially there are no more refugees in Thailand, and the camps have been burned to make sure that Cambodians do not return, news reports indicate that where there is fighting near the border, Cambodians continue to flee to safe areas inside Thailand. It is clear then that after as many as 13 long years on the Thai border for some Cambodian exiles, their return has not and will not be an easy one. In addition to the harsh socioeconomic conditions facing the returnees, many aid officials were worried that many of them might have lost the kind of self-reliance that would help them to overcome the huge obstacles confronting their reintegration into Cambodian society. Another question was how well had the experiences in the camps equipped them for life back inside Cambodia.

Along these lines, of particular interest to the Women's Commission on this visit was to observe the extent to which the returnee population had successfully reintegrated with the Cambodian population that had stayed in Cambodia, the conditions under which the returnees were living, and most importantly, whether any overall health, reproductive health, or birth-spacing practices that had been practiced in the camps in Thailand had been retained or in any way influenced their attitudes or behavior once they had returned home. What were these practices in the camps?

Fertility and Family Planning in the Cambodian Refugee Camps in the 1980s

A great deal has been written about conditions in the Cambodian refugee and displaced persons' camps on the Thai border. Possibly among the best descriptions are those found in Judy Mayotte's 1992 book on refugees.⁷ In addition, several landmark studies of fertility and family planning practices were carried out among the Khmer refugees. The first was a study of fertility and population dynamics in Khao I Dang and Sakaeo holding centers carried out only months after the refugees had arrived in late 1979.⁸ This study found a crude birth rate (CBR) in Khao I Dang of 55 births per 1,000 population. The population of this camp were from mainly urban areas of Cambodia, and were of higher socioeconomic status and

in better nutritional condition than the refugees in Sakaeo. In Sakaeo, only 17 percent of women interviewed within three weeks of their arrival were having regular menstrual periods, 63 percent were having periods every 2-3 months, and 20 percent were having them even less frequently. In addition, 15 percent of married women in Sakaeo were not accompanied by their husbands, and 53 percent were not married. As a result of these circumstances the CBR in Sakaeo was only 13 per 1,000 population. The authors commented that in Sakaeo, "in the initial weeks after the refugees arrived, acute care and treatment of the most critically ill required almost all of the available health care resources. As morbidity and mortality declined, services were expanded for prenatal care and began to include birth planning services, immunizations, more comprehensive health screening, and health education. The shift in health and fertility is predictable, and health care providers can plan accordingly for their changing use of available resources."

Six years later, a family planning survey was carried out in one of the same camps—Khao I Dang (as well as in Ban Vinai, with its largely highland Laotians (Hmong) population). The 1988 survey found that, indeed, the population of Khao I Dang was relatively well educated—79 percent of ever-married women could read and write.⁹ The average number of children among ever-married women 15-49 was 3.04. By the time women were in their mid-40s, they had given birth to 5.0 children, on average, and had 4.29 living children.

By 1988, contraceptive services were well established in Khao I Dang. In February 1980, the UNHCR and the Thai government had invited the Community-Based Emergency Relief Services program of the Population and Development Association (PDA—a Thai non-governmental organization) to provide family planning in the camp. In 1984, the program was being financed by USAID, under a grant to Family Planning International Assistance (FPIA). The reversible methods offered were the pill, injectables, the IUD and the condom.¹⁰ By 1988, the program was being run by two Thai personnel and 67 Khmer volunteers, who worked out of three family planning clinics and also in a community-based distribution project. The contraceptive prevalence rate in 1988 was 49.9 percent among married women. Of those practicing family planning, 49 percent were using the pill, 24 percent, injectables, 12 percent, periodic abstinence, and four percent, the IUD. Seven percent of couples relied on female or male sterilization. The remaining married women who were not pregnant at the time of the survey (15 percent) were asked why they did not use a contraceptive method.

Twenty percent said they wanted to have another child, 25 percent had just given birth, 18 percent were fearful of the side effects of contraceptives, and 13 percent said that contraceptives had made them ill during or after use. A 1988 CPR of 49 percent among currently married Cambodian refugee women is not as high as that found among married Thai women in 1987, when the Demographic and Health Survey found that 68 percent of married women were using a contraceptive method, but it is very similar to that of Indonesian women in 1987 (51 percent) and Vietnamese women in 1988 (53 percent).¹¹

However, the 1988 fertility and contraceptive patterns found in Khao I Dang, which was an official detention and holding center supported by the UNHCR, and run under authorization from the Thai government (Ministry of the Interior), are not necessarily typical of those found among the entire Cambodian refugee population. In 1988, over 267,000 displaced persons—a group who were not recognized as refugees by the Thai government—lived in encampments on the Thai-Cambodia border. These camps were the responsibility of the United Nations Border Relief Operation (UNBRO), and their services were much more limited. An annual epidemiological report issued by UNBRO shows that in 1989, 25 percent of the total population of the border encampments were under five years of age, and 47 percent were under 15. In 1989, 16 percent of women of reproductive age were pregnant at any given point in the year, down from 22 percent in 1987. The crude birth rate in the border camps was 53 per 1,000, the population's natural growth rate (births minus deaths) was four percent a year, and the number of years estimated for the camp population to double in size was a very brief 15 years. The infant mortality rate was 25 per 1,000 live births (far lower than the equivalent rate of 208 in Cambodia and 51 per 1,000 in Thailand), and the estimated maternal mortality rate was 140 per 100,000 live births, again, a far lower rate than that found in many developing countries of the world. Finally, because this was the only contraceptive method officially made available as part of the camps' maternal and child health programs, for every 1,000 women of reproductive age, 125 (or 12.5 percent) were using an injectable contraceptive in 1989. The report has no information on the use of any other kind of contraceptive method.¹² However, the former medical director for UNBRO told us that the use of Depo Provera in the border camps had risen to 30 percent by 1991.

General Conditions Inside Cambodia

Most refugees returning to Cambodia have settled either in existing villages, with family members, or in new "settlement sites" prepared by the UNHCR. These "sites" are largely separate from established villages and as such have a feeling of impermanence to them, even though they are not intended to be temporary. The settlement sites we visited were located in open, treeless field areas set well away from any existing village. While rainwater collection pots provided water, and latrines were being built, the surrounding land did not belong to the people living there, so the returnees had no land to farm on and in some cases no reliable transportation to get to a town to find work. These conditions, combined with those of other returnees who have not found permanent housing or are temporarily living with their relatives in crowded conditions, place returnees in a tenuous position. In many areas, living conditions are as bad as, if not worse than, the conditions the Cambodians were living under in the Thai border camps. On the other hand, some observers believe that apart from the shortage of arable land, their conditions are the same as, or sometimes better than, those of the local villagers.

Despite poor conditions everywhere, relief and development workers told us that the general acceptance of returnees by the local population was better than had been expected. But we were told of some returnees who had built or bought a house in a settlement site and who were later robbed of all their cash, which left them with nothing but a few articles of clothing and a food ration card. One settlement site was built in an area that floods during the rainy season. Massive efforts were being undertaken to build up the land in this community to prevent the serious health effects that would result from flooding (cholera, hook worm, malaria, and diarrhea).

The degree to which returnees had found some kind of solidarity with the population who had remained behind varied from location to location. Some aid workers lamented that the Khmer Rouge régime had so devastated any sense of family and community that Cambodians no longer trusted one another. They suggested that cooperative rebuilding efforts were hard to establish because, for many Cambodians, their memory of community/cooperative work was that of the forced labor that they had to endure during the Khmer Rouge days. These observers thought that any simple community self-assistance projects would be time-consuming and would require substantial support from the international NGOs over a period of time before any real change in community cooperation could be expected.

Health services in Cambodia are provided through seven national hospitals (three general, two pediatric, one ob/gyn, and one military), and through provincial hospitals and district and municipal clinics. All hospitals run out-patient facilities as well. There is an acute shortage of trained medical staff throughout the country, but we were told that health workers who were trained as para-professionals in the refugee and border camps have to go through a recertification process in order to be hired by the government. Since the government doesn't have enough money to pay salaries, most doctors (who would only earn the equivalent of \$10.00 a month even if they were paid), nurses and teachers work short shifts and then operate a private practice on the side. Because of a serious lack of drugs within the government health system, most clinic patients often have to buy their medical prescriptions on the open market. The country has no drug management system, many of the drugs being prescribed or purchased have expired, and we were told that some unscrupulous merchants and para-professionals charge for a full dose of antibiotic, injectable contraceptive, or pills, etc., but then only give the client a half dose, or give them something entirely different from what they think that they are buying. We were also told that the steroid Prednisone is taken for many ailments, with instructions to "take it until you feel better."

Which Development Agencies Are Providing Assistance?

Currently there are over 125 international agencies providing relief and development assistance in Cambodia, about 20 of which are involved in supporting health training and the delivery of health services. These include Médecins Sans Frontières/Holland, Belgium and France, Redd Barna, World Vision International, UNICEF, UNFPA, the International Federation of the Red Cross and Red Crescent Societies, CARE, Save the Children Fund/U.K. and Save the Children Fund/Australia, American Refugee Committee, Cambodian Women's Development Association, Action Nord Sud, Catholic Relief Services, the International Rescue Committee (IRC), and others. The World Food Programme (WFP), was in the final stages of its food distribution program for returnees. Each returnee family was entitled to food rations for 400 days after returning to Cambodia. In addition WFP, in collaboration with the Cambodian Red Cross, provides food to the 180,000 displaced persons inside Cambodia.

Kompong Chhnang Province

Staff members of the IRC, which is carrying out water, sanitation and health activities in Kompong Chhnang province, took us on a visit of their health projects in Kompong Leng district. The district clinic is located approximately one hour away from the provincial capital (40 minutes by boat and 15 minutes by motor cycle). This small district hospital had been built by the government. It is was clean and orderly, and provides beds for approximately 25 patients, although at the time of our visit only one bed was occupied by a TB patient. The patient's husband, who did not appear at all to be in good health himself, had set up a small area under a nearby tree where he slept and cooked food for her. The hospital is surrounded by bunkers that were used by the government military guard to protect the hospital at night, since a small mountain and several small surrounding villages several miles away were still controlled by the Khmer Rouge. Although there were several consultation rooms, a surgery room (only used when the Medical Assistant is on site), and medical, malaria, and leprosy wards, these were all empty. The reasons given were several: people tended to prefer to use local medicine first before coming to a hospital; it was difficult for families to come to the hospital due to the distance, the lack of transportation, and the need to care for the family at home as well as for the family member in the hospital. Further, there was still a great deal of fear of the Khmer Rouge and of possible attacks on the hospital at night. Such attacks had happened in the past, generally so that the soldiers could steal medical supplies.

We attended a lively training session for 12 traditional birth attendants from three nearby villages. The training, supported by IRC, is provided by a provincial midwife and by a medical assistant who had been previously trained in Site 2—one of the large border camps. The curriculum followed the national curriculum, and covered pre-natal care, delivery, and post-natal care. As part of a six-day training program, the session we watched covered safe birthing practices. With the use of a model and a cloth baby, the TBAs were asked to rehearse safe delivery procedures. The women were clearly very motivated, eagerly asked questions and were anxious to practice in front of the group during the session. At the end of the complete training program, each TBA is provided with a kit, which includes nylon string, soap, a brush, nail clippers, a towel, and a razor blade. In our discussions with some of the TBAs, who ranged in age from the mid-30s to the late 50s, we found that many of the women already had 7-10 children. They said they did not want any more children, and some of them did not know how to achieve

this. Some of them had heard about contraception but either did not have a prescription to get it or did not have access to the provincial hospital where contraceptives were available. Two of the younger TBAs had two children and neither they or their husbands wanted to have any more, yet they had no access to birth control methods and believed that they would not be able to afford them. They also told us of their traditional labor, delivery, and nutrition beliefs and practices, and the reasons that many women prefer to give birth at home.

In the nearby villages, IRC is conducting an extensive water and sanitation project that included assistance to communities in building their own wells, rainwater catchment pots, and family latrines. Although the content of the water pots was supposed to last until the rainy season, many villagers had used up their supply and had resorted to their earlier practices of transporting small pots of river water back to the house for cooking. It was evident that much health education had yet to be done in order for more healthy practices to take hold.

We were also taken on a tour of the provincial MCH clinic in Kompong Chhnang town. This active provincial MCH clinic is one of five MCH pilot projects receiving support from the International Federation of the Red Cross and Red Crescent Societies. Staffed by one medical doctor, one medical assistant, six secondary midwives, four primary midwives, one secondary nurse, and three primary nurses, the clinic provides services in pre- and post-natal care, birth spacing, immunizations, as well as information and education about oral rehydration therapy, nutrition, immunization and birth spacing. A schedule of these brief morning training sessions was posted for anyone who wanted to attend. In general, before receiving services, all clients attend whatever IEC session is scheduled for that day. In addition to pre- and post-natal care, many clients and their small children come to the clinic for treatment of anemia, parasites, toxemia, and malnutrition. In January, a total of 530 births had been reported for the whole province. Of these, 59 had been delivered in the provincial hospital, one in a district hospital, 250 at home (attended by a TBA), and 210 at home (attended by a midwife).

The birth-spacing program offers pills, injectables, condoms, and IUDs. Clients for tubal ligation and vasectomy are referred to the provincial hospital next door. The birth-spacing program had begun in mid-November, 1993. During the first one-and-a-half months, 51 clients had been served (nine clients for pills, two for injectables, 34 for condoms, and six for IUDs). The clients receiving IUDs tend to come from more distant villages and have

been advised to use a method that would not require frequent visits to the clinic for resupply. The director told us that a community volunteer program was to begin soon, and that as soon as the government had enough funds, birth-spacing services would be provided through the district hospitals as well.

The Director of Health of Kompong Chhnang province spoke to us of his ambitious plans for improving the health status of women. His goals are: 1) to increase the number of mothers giving birth at the hospital, 2) to increase immunizations, and 3) to increase the level of community participation in the province. It was evident to us that without external funding support and assistance it would be difficult to implement these plans.

Battambang Province

There are approximately 25 international NGOs and UN organizations, as well as a similar number of Cambodian organizations, currently working in Battambang province, which has received the largest number of returnees (approximately 90,000). Battambang City is the second largest in Cambodia. The broad range of living conditions we observed included squatter areas in and around the city, UN settlement sites, both near the city and in outlying districts, Bang Ampil—a displaced persons' camp with a population of approximately 14,000, located not far from the Khmer Rouge controlled area of Pailin, and an area that was soon to become a new settlement site just beyond the Bang Ampil camp.

Our visits began with a visit to the Battambang Woman's AIDS Project. This small organization, founded in 1993 and funded in part by the UNDP, works primarily to create AIDS awareness in the schools and among prostitutes. Run by five energetic Cambodians (four of whom had been trained in Site 2 and worked on an AIDS Team there) the organization provides teacher training, in-school information programs (including condom distribution when approved by the principal), and trains and distributes condoms to prostitutes in Battambang city. Sadly the staff reported that they were only able to buy a limited number of condoms and had been providing only three condoms per month to each prostitute with whom they were in touch. Condoms were for sale in many of the brothels for about 500 riels—approximately 20 cents a piece—but neither the prostitutes nor their clients tend to purchase them. They noted that in Site 2, prostitutes had access to a Prostitute Center where they could go for health services, but there is no such program in

Battambang. These ambitious and dedicated people clearly did not have even the minimum necessary resources to effectively carry out their mission.

We were taken on a visit to Moug Russey district hospital, south of Battambang City—a very active hospital supported by the French organization, Action Nord Sud (ANS). Staffed by three expatriate doctors and five Cambodian doctors, the hospital serves a population of 100,000—20,000 of whom are returnees. There are an average of 30 births per month in the hospital and 250 in the district (attended and reported home births). There is a charge of 1000 riels per month (30 cents) as a flat fee for staying at the hospital, and a charge of 500 riels for all outpatient services. Approximately one in three patients is a returnee, a disproportionate number in terms of the overall population. We were told that this is because returnees tend to use health services more than the local population. Client health and background data recorded in the family planning clinic include a brief medical history, blood pressure level, an anemia check (hematocrit), number of births, number of infant deaths, and number of abortions. The client keeps a booklet containing all this information, and returns for contraceptive resupply on the date indicated.

We also visited the district hospital in Ratanak Mondol, which lies south-west of Battambang City. Even though this is a very poor district, land in the area is very fertile (though much of it has still not been de-mined) so the returnees think it is a desirable area to move to. The district hospital is located not far from a newly developed village, Kilo 38, which is the last safe point beyond which Khmer Rouge forces are in control. Supported by World Vision, this well-run hospital has 22 beds, all of which were full at the time of our visit. There were also patients lying on the floor just outside the ward. Because shelling and other fighting frequently occur, a newly constructed bunker, requested by hospital staff, filled the interior hospital compound. A new TB ward was currently under construction. [We later heard from sources inside Cambodia that this hospital continued to be shelled by the Khmer Rouge forces, and that it was finally destroyed when the Khmer Rouge overran the area.]

On the day of our visit a mother had brought in a sick child who later died of malaria, her second to die this way. She knew the symptoms but didn't come to the hospital in time. Other patients in the hospital included people suffering from land mine injuries, malaria, diarrhea, respiratory tract infection, and tuberculosis. Malaria and TB account for the majority of cases. We were told that Cambodia has the highest TB rate in the world. The high

rate of mine injuries in the area is apparently because of the urgency the population feels to farm the fertile but as yet not demined fields.

Catholic Relief Services (CRS) carried out a survey of 16 villages (including Beng Ampil and Kilo 38) in Rattanak Mondol district in January 1994, and found that out of a total population of 23,000, approximately 4,500 were returnees. There had been 517 reported births in the district in 1993 (giving a crude birth rate of 22.5 per 1,000 population—far lower than in the refugee and border camps), of which 59 percent took place at home, attended by a TBA, 34 percent were attended by a clinic midwife in the woman's home, and seven percent took place in the district hospital.

Reproductive Health Services

In 1991, a birth-spacing program was integrated into the national MCH program (Protection Maternelle et Infantile—PMI), and the government began to urge NGOs to start birth-spacing programs. PMI is to take the lead role in developing the birth-spacing program, with support from the UNFPA. The project proposal outlined by UNFPA is very small, costing less than \$1.5 million for a three-year period starting in January 1994. The proposal documentation claims that Cambodia has a maternal mortality rate of 1,000-2,000 deaths per 100,000 live births, a total fertility rate of 6.4 children per woman, an infant mortality rate of 120 per 1,000 live births, an average life expectancy of only 50 years, a contraceptive prevalence rate of only three percent among women using provincial health services, and that only 7-10 percent of deliveries are assisted by trained health personnel. The UNFPA project aims at establishing birth-spacing services in four hospitals in the Phnom Penh area, in six provincial hospitals, and in 25 district clinics. The UNFPA project strategy focuses on institutional strengthening, increasing political awareness on population-related problems, the production and dissemination of IEC materials, the expansion of services, and improvements in the quality of care, through increased cooperation between the PMI and NGOs working in the country.¹³

The official birth-spacing policy, developed with the help of a WHO consultant, includes the following statements:

- ◆ A priority of the Ministry of Health is to reduce maternal and child mortality, and to improve the quality of life.

- ◆ Spacing of births is encouraged as a means of improving the health and well-being of women, and consequently the better nutrition and health of their children.
- ◆ The termination of pregnancy by induced abortion as a means of contraception is not acceptable.
- ◆ To implement the birth-spacing strategy, parents and health staff will be educated about contraceptive methods, and the availability of reversible and affordable contraceptives will be increased. Young adults will be educated in sexual and reproductive health matters.
- ◆ The national birth-spacing policy and programme will be developed for commencement as soon as possible.
- ◆ The Royal Cambodian Government affirms its mission to improve the health and well-being of all Cambodian people by interrupting the spread of sexually transmitted diseases, especially HIV/AIDS.¹⁴

Save the Children Fund/Australia is now providing assistance to the National MCH Centre in the form of training, equipment, medicine, salaries, and physical facilities. Statistics on maternal and child health conditions in 1993, collected by this Australian NGO in all 16 provinces of Cambodia, show a reported maternal mortality rate of 192 deaths per 100,000 live births. However, the researchers claim that maternal deaths are seriously under-reported, and that a rate of 800 per 100,000 is far more likely. The major causes of maternal death were hypertension, infection, malaria and post-partum hemorrhage. On the assumption that the population of the country was 7,916,876 in 1993, the crude birth for the whole country was an estimated 40 per 1,000. Of about 316,000 births in 1993, 53 percent of pregnant women had had at least one pre-natal care visit, although only 10 percent had had at least three pre-natal contacts with trained personnel, only 37 percent had received two tetanus shots, and 29 percent of deliveries had been attended by trained personnel.¹⁵

In a UNICEF-sponsored analysis of the situation of women in Cambodia, carried out in early 1992, the author pointed out that as a result of the history of the country over the past 20 years, during which time one-and-a-half

to two million Cambodians were killed or died, there is an excess of widows and of older women in the population. The most commonly cited figure is that 64 percent of the adult population is female, and 35 percent of all households are headed by women. Because of the severe shortage of a male labor force, women must take on many tasks that were previously performed only by men, which makes child care, especially in the cities, a huge problem for women. Given these developments, and the dire economic condition of most families, the author finds that there is a "great desire on the part of Khmer women for information on birth spacing. Women . . . in the countryside said that they knew nothing about birth control methods. They had heard that there was 'medicine' that city women used, but they did not know anything about how to obtain or use it. They asked for information. During the interviews in the city, I was asked for information on two occasions, without my raising the topic. One colleague who had worked with factory women also reported being asked to provide information on family planning."¹⁶

A 1992 survey in Kon Dieng district in Pursat province carried out by the American Refugee Committee found that only seven percent of women said they had received one tetanus shot during their most recent pregnancy. In that province, only five percent of births took place in a district hospital, and six percent of women said they had had a serious problem (including bleeding, toxemia, retained placenta or still birth) during their last pregnancy. The author of the survey concluded that the identification of high-risk pregnancies and their referral to a district or the provincial hospital should be improved.¹⁷

In 1993, Médecins Sans Frontières/Holland-Belgium examined maternal and child health conditions in Svay Rieng province. They surveyed 348 currently pregnant women as well as women who had delivered or had an abortion in the previous year. Of these, only 22 percent had had any contact with a health service during pregnancy, whereas 51 percent reported having had a health problem during that period (including edema, severe headaches, blurred vision and high blood pressure). Of women experiencing the typical symptoms of pre-eclampsia (facial swelling, blurred vision and high blood pressure), two-thirds had not sought medical help. This group of women had had a total of 1,316 births, 103 spontaneous, and 27 induced abortions in the course of their reproductive lives.¹⁸

In addition to the programs already mentioned, some other small-scale MCH projects being conducted by various NGOs include the following:

- ◆ Médecins Sans Frontières (MSF)/Belgium-Holland is working in Svay Rieng provincial hospital. MSF began offering birth-spacing services in Svay Rieng provincial hospital in 1992 and found that word spread quickly (without any organized IEC effort) and that the demand for contraceptives was high. The health agency began offering pills (at \$.50 per pack), injectables (\$1.00 per 3-month dose), and IUDs. Most of the users were women 35 years of age or older who had more than four children. The agency workers found that many Cambodian men tend to be very supportive of family planning, mainly for economic reasons.
- ◆ The International Medical Corps (IMC) had a project in Svay Rieng province to deliver primary health care in 11 villages in three districts. Birth-spacing activities were coordinated with those of the MSF group working in the provincial hospital. Both IMC and MSF reported a great demand for contraceptives. In a pattern that is quite the reverse from that of many other parts of the developing world, they found that women first come in for family planning services and then, when they learn that other MCH services are also available, they begin to seek those services. The staff learned that not just women but men too say they want fewer children. The project has now been handed over to its Cambodian staff, since IMC has left the country.
- ◆ The Cambodian Women's Development Association is involved in health education and family planning programs, as well as projects to offer health education to prostitutes, income-generation projects, and day care centers.
- ◆ World Vision runs five rural health projects, two in Battambang, one in Phnom Penh, one in Kompong Speu, and one in Kandal province. They reported to us that there was a very great interest in birth-spacing services on the part of couples in all these areas of the country. On the other hand, a member of one Australian NGO noted that when Cambodian women are asked to identify their immediate and most pressing needs,

they consistently say that their priority need is for water and food provisions, their second is for productive land, and their third is for a way to stop their babies from dying.

Coordinating Government and NGO Health Services

The government ministries and the NGOs coordinate all health programs through a group called MEDICAM, which is the coordinating committee for all medical service activities in the country. In addition, the government MCH division—called Protection Maternelle et Infantile (PMI) in French—has formed a coordinating sub-group that is made up only of agencies working in MCH/birth-spacing programs. During our visit, we were able to attend the monthly meetings for both these coordinating groups. These are held to discuss health issues, share information about new and ongoing programs, and to coordinate the overall and the MCH/birth-spacing activities of the NGOs and the Ministry of Health.

At the PMI coordination meeting, there was an animated discussion among the participants (representatives of most of the NGOs working in the areas of MCH and family planning) about a project that Family Planning International Assistance (FPIA)—the international arm of the Planned Parenthood Federation of America—was going to implement. Under this five-million dollar, three-year project, FPIA would start a number of free-standing family planning clinics throughout Cambodia. The plan involved the establishment of "model clinics" that would parallel government MCH centers. However, these would be facilities with no direct links to the government birth-spacing program. Some NGO representatives did not think this was a good idea, and that the funding agency for the project—USAID—should not be supporting a family planning system designed to work outside the government birth-spacing program, which needed all the training and logistical help it could get. In addition, others suggested that the existence of an independent, private-sector family planning service would confuse potential users, and that if FPIA did not coordinate with the government birth-spacing activities, the U.S.-based agency might be disseminating different information and health messages, and might apply different standards and protocols than those used by the government. One participant said that FPIA was used to working in developing countries with a poor existing health structure and where the main program objective was population control, but this was not the case in Cambodia, where a strong MCH

program existed and where the program's main goal was an improvement in the level of maternal health, not a change in the demographic growth rate.

A representative of Population Services International (PSI), a U.S.-based NGO, made a presentation in which he described his agency's proposed activity—a massive plan to distribute low-cost condoms and oral contraceptives through a social marketing program. Some participants warned him that given Cambodia's depressed economic situation, the pills and condoms would have to be priced very low indeed if there was to be any substantial demand for these products.

The general conclusion at the meeting was that UNFPA/WHO and FPIA/PSI were each taking very different and possibly conflicting approaches to strengthening family planning services in Cambodia, and that there was a danger to this. The existence of independent private-sector and commercial structures, without consistent guidelines, would encourage the growth of uncontrolled and unmonitored service activities that might slow down the development of the government program, and might also undermine any prospects for quality control.

Other topics discussed at the meeting included: ways to discourage multi-national corporations from flooding Cambodia with milk products; how to involve private practitioners in providing high-quality MCH/birth-spacing services; how to carry out refresher courses for government personnel when the government cannot afford to give the participants or the trainers per diems; and how to address the long-term problem of sustainability for government health services, in light of the fact that overall international NGO spending on health programs in 1994 is 10 times greater than it was in 1993.

Some Traditional Health Practices

We were told a number of facts or impressions about women's traditional health practices that have an impact on their health and the health of their children:

- ◆ It is generally considered advisable for women to eat papaya and rice soup before and during labor.
- ◆ Most infants are breastfed for 1-2 years, or until the next pregnancy. However, they start solid food at 3-5 months (fish and rice soup).

- ◆ Women like to give birth at home with the family nearby, or with the assistance of a TBA. Hospital delivery costs money and disrupts family life.
- ◆ Post-partum, lactating mothers do not eat eggs, vegetables, or meat because they believe that these foods make them sick, but they do eat rice soup with sugar and salt, which is the same basic food used to begin to feed babies at 5-6 months of age.
- ◆ Clandestine abortion is mostly performed by a technique involving hard abdominal massage.

Some Issues That Need to Be Addressed by Health, Population, and Development Agencies

- ◆ With almost 50 percent of the current population between 5-15 years of age, in the next 5-10 years a large proportion of the population will be women in their childbearing years. Substantial assistance should be provided to the MCH program to make reproductive health services available (including a basic package of contraceptives—injectables, pills, condoms, (IUD) in all provincial hospitals, MCH centers, and district-level clinics.
- ◆ Funding assistance and support is needed for developing a drug management program, to ensure that sufficient quantities of unexpired drugs and medical supplies are available in government pharmacies and clinics, and that these can be sold at affordable prices or provided free of charge to clients who are unable to pay.
- ◆ The training of TBAs in delivering birth-spacing information is much needed.
- ◆ The training of community workers and development of a community-based distribution (CBD) birth-spacing program is also a priority.
- ◆ Assistance should be given at the provincial level to train medical staff to perform voluntary surgical contraception and to insert Norplant implants.

- ◆ An updating of school text books and curricula should be considered, to include reproductive health, nutrition, and birth-spacing education beginning at the primary school level.
- ◆ Assistance should be offered to help pay the salaries of government health workers, nurses, doctors, and teachers so that they can work full time to serve the people, and to ensure that critical health services and education are provided at a cost affordable to all Cambodians.
- ◆ Consistent and reliable efforts should be made to rebuild community participation and trust within and among Cambodian communities so that they may begin to rely on one another.
- ◆ An evaluation might be carried out among the returnees and the local population to compare the knowledge, attitudes, and practices concerning current reproductive health and birth-spacing practices of these two groups.

Janice Miller
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Annex: Travel Schedule

Schedule of site visits made as part of the assessment of reproductive health needs among refugee women

DATE	LOCATION	PARTICIPANTS
September 23-30	Côte d'Ivoire	Mary Anne Schwalbe
October 11-18	Rwanda	Janice Miller Deirdre Wulf
October 19-25	Kenya	Janice Miller Deirdre Wulf
November 9-23	Pakistan	Mary Anne Schwalbe Deirdre Wulf
January 10-13	Belize	Deirdre Wulf
January 29- February 11	Thailand	Mary Anne Schwalbe Deirdre Wulf
February 13-24	Cambodia	Janice Miller Deirdre Wulf
February 14-16	Hong Kong	Mary Anne Schwalbe

The visit to Côte d'Ivoire focused on refugee women from Liberia; the trip to Rwanda involved women who were internally displaced as a result of civil war; the trip to Kenya looked at Somali women in refugee camps on the eastern border with Kenya; the visit to Pakistan involved Afghan women refugees living on the border of Pakistan's North West Frontier province; the brief trip to Belize was made to assess conditions among Salvadoran and Guatemalan refugees who are becoming absorbed into that small Central American country; the trip to Thailand involved multiple population groups: the Lowland Lao and the Hmong hill tribes remaining in camps along Thailand's eastern border with Laos, and the Burmese Karen and Karenni hill tribes on Thailand's western border; and the visit to the detention centers in Hong Kong centered on Vietnamese women waiting for repatriation or for resettlement in a third country. Finally, the trip to Cambodia was designed to try and assess reproductive health conditions among the populations recently returned from the Thai border camps, and general conditions among the wider Cambodian population.

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