Women Refugees

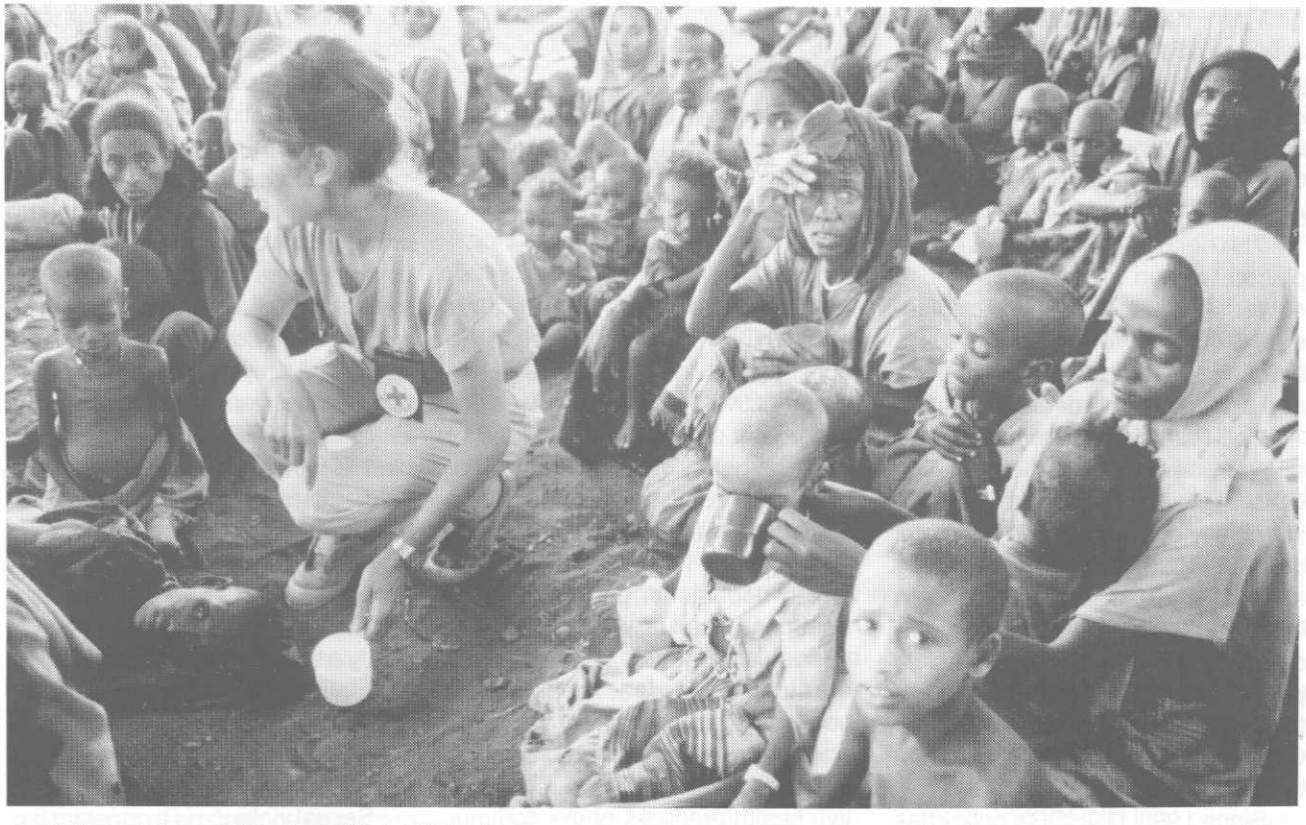
Some Aspects of Medical and Social Care

*by Daniel Pierotti**

Women with dependants make up the greater part of refugee or displaced communities. More than 80 per cent of them receive assistance under programmes of the United Nations specialized agencies. Refugee and displaced women are among the most vulnerable groups.

The refugee situation upsets culturally-based traditional roles; women suddenly become heads of families and, besides their traditional motherly duties, have to provide food and protection and look after the state of health of all members of their families. This new role, moreover, has to be assumed in difficult circumstances, without the traditional protection of the father, the family, or the community.

It is only in the last decade that the specific problems of women refugees have been taken into account and identified as such. In this paper, we shall be considering only two aspects: reproductive health and sexual violence.



UN/J. Isaac

Assisting victims of the drought in Ethiopia.

In its 1985 conclusions, the Executive Committee of the United Nations High Commissioner for Refugees (UNHCR) noted that women and girl refugees made up the majority of the refugee population and needed particular attention from UNHCR and host countries, especially with regard to protection.

In 1988, a steering committee was set up in UNHCR specifically to deal with the special problems confronting refugee women. Later, a Special Coordinator for Refugee Women was appointed.

In another sphere, it was only in 1994 at the third Conference on Population and Development in Cairo that the problem of refugee and displaced women was addressed for the first time Specific objectives were put forward in the plan of action to ensure that effective protective measures were introduced, that appropriate basic health services were provided and that women were involved in development and rehabilitation projects which concerned them

Then, in June 1995, the specialized agencies of the United Nations and the main non-governmental organizations met in Geneva to decide what basic reproductive health services were required for women refugees.

The needs of refugee and/or displaced women are similar to those of women affected by conflicts. Responses, however, should be adapted to each particular situation and preferably coordinated

Until recently, requirements in the area of women's reproductive health were somewhat neglected, consisting chiefly of prenatal and postnatal care with medical assistance during childbirth and assistance for newborn infants and young children. In the circumstances, only the mother-child pair were paid any particular attention. One positive effect of the Cairo Conference was to refocus reproductive health services on women.

Since 1995, UNHCR's policy has been to introduce reproductive health

Reproductive health is an overall approach covering:

- Prenatal and postnatal care,
- Reduced childbirth risk;
- Screening and prevention of sexually transmitted diseases;
- Appropriate family planning methods;
- Responsible sexual behaviour among adolescents;
- Prevention and treatment of sexual violence,
- Treatment of abortion complications.

as part of the basic health services for refugee or displaced women. These activities will be facilitated by the agreement signed with the United Nations Population Fund (UNFPA).

Reproductive health services can be provided following a period of emergency, entailing responses to vital needs (protection, clean water, sufficient food, sanitation and control of epidemics).

Sexual violence is a constant factor in a refugee situation

During the recent Great Lakes crisis in Central Africa, however, the concept of a "minimum emergency reproductive health service" was applied. This consisted at the time of the emergency in supplying a set of minimum basic services for the use of field personnel, in the form of different types of childbirth kits for different occasions, prevention and treatment of sexually transmitted diseases, emergency contraception, surgical equipment to deal with complications arising from abortions and staff information brochures. A suitable knowledge of the reproductive health practices of the communities in need of assistance can help personalize these minimum services

In the introduction of reproductive health services, due account must be taken of individual circumstances, of the laws and regulations of the host country, as well as the characteristics of the refugees' country of origin. As far as possible, basic information concerning the history and reproductive environment of refugee and displaced women prior to the conflict needs to be gathered and disseminated among humanitarian organizations in the field.

Account should also be taken of the new situation which arises when people are uprooted (refugee or displaced), when the most extreme attitudes are liable to be freely expressed, all too often with the result that the women involved are no longer able to decide freely how to manage their personal lives.

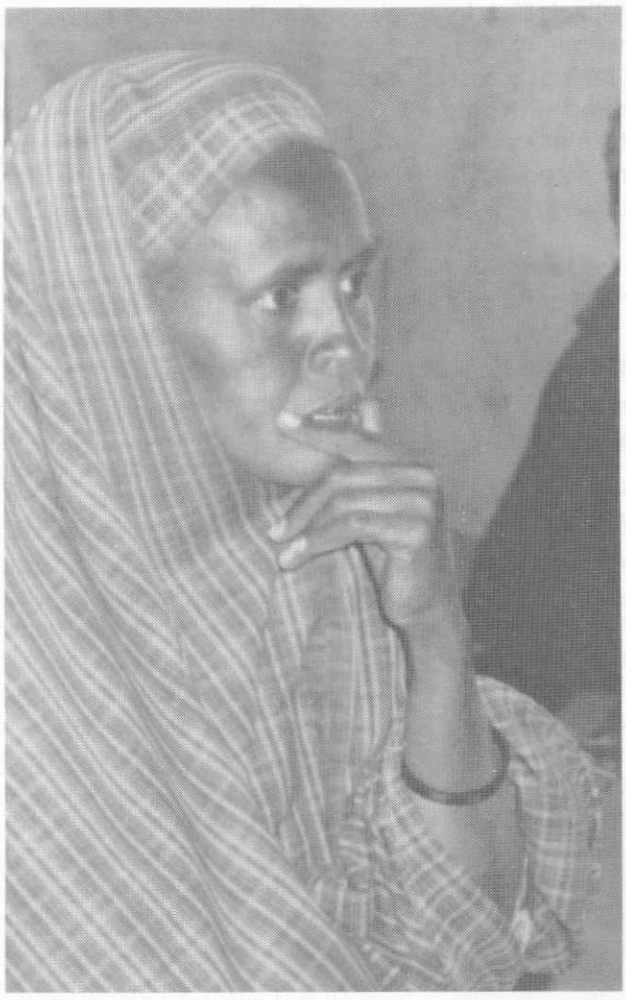
When new projects are introduced, the natural political and religious leaders of the community of displaced refugees must of course be consulted, but it should be ensured that women are also allowed to be part of the decision-making process, by encouraging the participation of organized groups of women in the preparation of projects which concern them.

Sexual violence is unfortunately inherent in any situation of warfare or conflict Women are its prime victims and rape is the most atrocious form of sexual violence.

Sexual violence has always existed (one only needs to remember the war between Bangladesh and Pakistan in 1971, 25 years ago, when over 100,000 women were raped by soldiers according to plan, following the precept: "Kill the men and rape the women.").

The occurrence of organized rape appears to have increased recently, partly as a result of the proliferation of conflicts, but also owing to the speed of communication media, which report such atrocities worldwide practically as they occur

Sexual violence is a constant factor in a refugee situation, during the



UNFPA/D. Pierotti

Dadaab Camp, Kenya, September 1996

conflict itself, at the time of the exodus, during the establishment of camps, and within the family and community. Violence may be brutal and direct, or it may take the more insidious form of forced prostitution, of "sex for services", or be hidden under different forms of intimidation. Rapists may be soldiers, vagrants, members of the community or family, or even the persons in charge of protecting the refugees.

In some situations, the problem has become so serious that a special programme has had to be set up for the protection and defence of raped women. Such was the case in the Somalian refugee camps in northern Kenya (Dadaab), where since 1992, UNHCR has set up a programme of assistance to women who are the victims of violence.

In 1995, UNHCR published a guide on the prevention of and responses to sexual violence. The various aspects of this approach are now well known and include a variety of means of protecting women, guaranteeing their rights, defending them in court and offering them appropriate medical responses. One of the most promising advances was made with a 1993 report by the United Nations Secretary-General to the Security Council, which extended crimes against humanity to include systematic rape against civilian populations. It may be remembered that planned, systematic rape is recognized as such by the International War Tribunals for the former Yugoslavia and Rwanda.

The World Health Organization (WHO) has just published a manual on the mental health of refugees, which in chapter 9 deals with responses to rape victims.

It is worth looking in more detail at the medical and surgical response to rape in refugee situations.

One of the major problems for a woman who has been raped is to establish a personal contact with a health professional who can help her.

This is a difficult step to take, requiring a great deal of courage and the active support of relatives and women's groups before the woman concerned will accept to be identified as a rape victim.

Thus in the most recent conflict in the former Yugoslavia, one NGO, Marie Stopes International, having difficulty identifying raped women, came to the conclusion that rape, however dramatic and degrading, represented only one trauma amongst many others, such as the death of the husband, dispersed children, sons at the front, departure from the country, destruction of the home, loss of a job and resources, all of these factors creating a series of traumas, in which rape was only one element among many others. One response consisted in opening special homes for refugee women and the host community, which gave these women an opportunity, in a place designed by them and for them, to start to recover by helping each other.

As an accompanying measure, specialized medical and psychological assistance was available for those who needed it.

While rape is always a tragic event, in some cultures the psychic trauma of rape may be aggravated by rejection on the part of the husband or father, and by exclusion by the family and by the community. Sometimes suicide may appear as the only way out.

Medical consultations should be treated confidentially, and a relationship of mutual trust must be established between the woman concerned and the medical personnel. It is essential to recruit female staff