

Displacement and Women's Health

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Abstract

With a record-breaking number of people displaced worldwide, 2015 saw more than one million refugees entering Europe, causing a crisis at European borders. Refugees face a host of different health problems, especially infection and malnutrition, but women's health is an area that receives less attention. This review of women's health problems during displacement shows that there are health issues especially in two main areas: sexual and gender-based violence (SGBV), and reproductive health. Conditions in refugee camps and conflict situations cause the breakdown of social structures which exist to protect women. Reproductive health is a major issue for refugees because of the risks of SGBV, and the lack of reproductive healthcare in refugee camps. There is a high risk of maternal death; unwanted pregnancy, unsafe abortions and spread of sexually transmitted infections (STIs) and HIV/AIDS are also significant problems.

These problems require serious attention from the international humanitarian aid organisations which help refugees. The United Nations High Commissioner for Refugees (UNHCR) outlines five key objectives to prevent SGBV, while the 2010 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* outlines eight main aspects which must be addressed to improve reproductive health. Although progress has been made in tackling refugee women's health issues, much work remains to be done, and the severe risks to refugee women's health must be addressed immediately.

Introduction

By the end of 2014, there were about 19.5 million refugees, 38.2 million internally displaced persons, and 1.66 million asylum seekers – a record-breaking number¹. In 2015, more than 1 million refugees entered Europe, though only about 942,000 claimed asylum². This has caused a crisis in the EU, leading to anti-immigrant protests and violence in host countries³. Figure 1 shows the numbers of refugees arriving in 2015, as well as some common entry routes.

A refugee is someone who flees his country of origin “for reasons of race, religion, nationality, membership of a particular social group or political opinion”, while asylum seekers are “person[s] who [have] left their country of origin and formally applied for asylum in another country”⁴. Neither of these definitions include internally displaced persons (IDPs), who are “people who are displaced within their own country

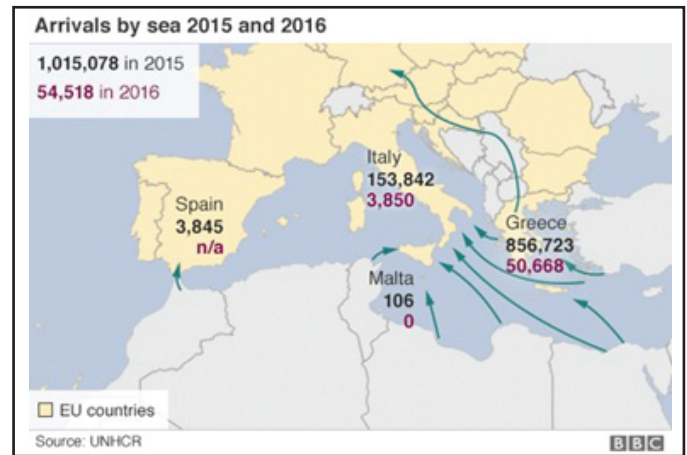


Figure 1

Refugees entering Europe in 2015 and 2016 (BBC, 2016)²

and to whom the UNHCR extends protection or assistance, or both”⁵. However, they share many of the same health problems and so have also been considered here; for brevity, they will only be referred to as “refugees” from this point.

There has been much work by international organisations, such as the UNHCR, to support refugees. However, refugee women's health is less often considered: “the greater the humanitarian crisis, usually the less concerned [the media is] with delving into the information from a gender perspective.” This is increasingly important as women made up 49% of UNHCR-protected refugees in 2014⁶.

For this reason, this report will focus on the effect of displacement on women's health, considering two main areas: What are the specific issues in women's health caused by displacement? How can they be improved?

Women's Health Problems caused by Displacement

2.1. Sexual and Gender-Based Violence

Sexual and gender-based violence (SGBV) can happen to any gender; however, women and girls are affected disproportionately. SGBV includes rape, physical assault, forced marriage, domestic violence, sexual harassment⁷, or forced prostitution⁸, among others. Figure 2 shows the magnitude of the problem.

SGBV can occur during displacement, in refugee camps, or during resettlement after leaving camps. Causes of SGBV can be related to the conflict that women are fleeing from, which may lead to abuse by armed soldiers or border guards for example; however, the most important causes of SGBV are the disruption of social structures which may otherwise protect women¹⁰.

Displacement and Women's Health *continued*

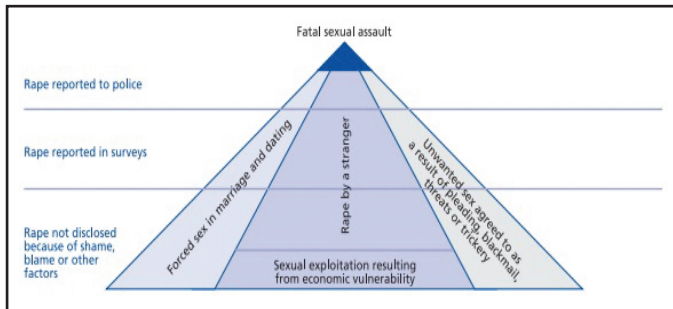


Figure 2

Magnitude of the problem of sexual violence (WHO 2002)⁹

In refugee camps, overcrowding, poor lighting, lack of segregated toilets and hygiene facilities, and unsafe shelters all contribute to an increased risk of SGBV¹¹. Very often, the need to accommodate increasing numbers of refugees leads to multi-household dwellings and communal shelters. Domestic violence is a particular problem; this includes marital rape, which may be increased by husbands' demands to "replace dying children"¹².

Camp leadership is often predominantly male – this leads to gender-biased decisions, such as placing distribution points in isolated areas, which can be dangerous for women to enter alone (as a consequence, women often struggle to gain enough resources in refugee camps – this is explored further in section 2.3.)

SGBV causes many health problems for the women who experience it, ranging from acute physical problems to long-term fatal outcomes. Examples of these are traumatic genital or anal injuries, unwanted pregnancies and psychosocial problems, such as anxiety and depression⁵. Other consequences of SGBV are shown in Table 1.

As can be seen from Table 1, SGBV causes many reproductive health problems; these will be discussed further in section 2.2: Reproductive Health.

There are also many social consequences of SGBV: considerable social stigma placed on the woman leads to rejection or isolation, which may cause further psychological problems, and results in under reporting of SGBV and an inability of women to access community services¹⁰.

2.2. Reproductive Health

Women of reproductive age make up a significant proportion of refugees; in 2015, among all women of reproductive age who attended Doctors Without Borders (MSF) clinics in Europe, 13% were pregnant¹³.

Fatal outcomes	• Homicide • Suicide • Maternal mortality • Infant mortality • AIDS-related mortality		
Non-fatal outcomes	Acute physical problems • Injury • Shock • Disease • Infection	Chronic physical problems • Disability • Somatic complaints • Chronic infections • Chronic pain • GI problems • Eating disorders • Sleep disorders • Alcohol/drug abuse	Reproductive problems • Miscarriage • Unwanted pregnancy • Unsafe abortion • STIs, including HIV • Menstrual disorders • Pregnancy complications • Gynaecological disorders • Sexual disorders
Emotional and psychological outcomes	• Post-traumatic stress disorder • Depression • Anxiety/fear • Anger • Shame/insecurity/self-hate/self-blame • Mental illness • Suicidal thoughts/behaviour		

Table 1

Different consequences of SGBV on the health of women. (Adapted from Sexual and Gender-Based Violence Against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response, UNHCR, 2003)¹⁰

Pregnancy is the most significant risk to women's health: each year, 529,000 women die from pregnancy related causes, and 99% of these deaths occur in developing countries¹⁴. Morbidity and mortality both increase in refugee situations, often due to insufficient healthcare services. Refugee camps often have no emergency obstetric services, and few deliveries are attended by trained health professionals; even when healthcare services are in place, they are often inaccessible.

Refugee camps also have few contraceptives available, leading to more unwanted pregnancies⁵: while 90% of refugee camps have at least one contraceptive method available, there are few trained staff members available to discuss contraception¹². Often, it is unaffordable. There is little antenatal care, and presentation to health services is often late and complicated¹⁵, while many women do not attend healthcare services at all¹².

Maternal deaths can occur during, or up to 42 days after pregnancy, and can be caused by different pathologies, most of which are preventable. Postpartum haemorrhage is a major cause of maternal mortality, preventable if treated rapidly by trained healthcare workers. Other causes include reproductive tract infections; eclampsia; complications from delivery, such as obstructed or prolonged labour; and unsafe abortions¹⁵. Malnourishment and a very young maternal age are both risk factors for obstructed labour, and are

problems which are greater in refugee camps.

Unsafe abortion is defined as any abortion “performed by someone lacking the necessary skills or one which is done in an unhygienic environment, or both”¹⁵, and often leads to infection or haemorrhage. Worldwide, 20 million unsafe abortions are carried out annually, resulting in 80,000 maternal deaths and a significantly higher number of disabilities¹⁴.

All women of reproductive age are exposed to these risks; however, adolescent girls are particularly vulnerable. Girls aged 15-19 years old are twice as likely to die during childbirth, and girls under 15 five times as likely, compared to women in their twenties¹⁴.

There is also a significant risk of sexually transmitted infections (STIs), including HIV/AIDS. Increased risk of STIs is associated with military operations⁵, economic disruption which forces women into sex work, and increased SGBV¹⁰. There are several long-term consequences such as stillbirth, low birth weight and premature babies, cervical cancer, pelvic inflammatory disease (PID) and infertility, and increased risk of HIV acquisition¹⁶. Other risk factors for acquiring HIV are poverty, powerlessness, social instability and disrupted protection systems¹⁷; all of these problems affect women disproportionately in refugee situations.

Many refugee women are also affected by traditional practices such as female genital mutilation (FGM), which is becoming increasingly common within Europe, with 180,000 women and girls at risk of FGM each year¹⁸. There are different types of FGM, ranging from a clitoridectomy (type 1) to complete closure of the vaginal opening (type 3). There are many long-term health consequences such as recurrent UTIs, vaginismus, cysts, neuroma or calculus formation in the vagina, and psychological problems such as anxiety and depression; it can also cause many problems for prenatal care and childbirth⁵.

2.3. Lack of Nutrition, Healthcare & Other Resources

In refugee camps, food and non-food resources are provided by international humanitarian aid organisations, such as UNHCR. However, malnutrition is still a leading cause of all mortality in refugee camps, especially for vulnerable population groups such as pregnant or breast-feeding women¹⁷.

Women's access to more general resources can often

be poor when they are given primarily to men due to the belief in traditional gender roles stating that men should provide for the family, while the women should look after the children. However, many women in refugee camps do not have men to rely on – perhaps killed in conflict, or separated along the way. Many women are thus forced to turn to sex work in order to obtain necessary resources, increasing the risk of unwanted pregnancy and STI's⁵.

Water, sanitation and hygiene resources are special concerns: the lack of hygiene products may lead to an increased risk of infection. Menstrual hygiene products in particular have been shown to be lacking throughout refugee camps¹⁹.

All refugees must be registered in camps to obtain food and resources; many women struggle with this, including transgender women, who often lack the necessary identification documents needed in order to obtain aid¹¹. Cisgender women are often registered under their husband's name¹², preventing them from obtaining their own resources.

Compounding these problems, the lack of adequate healthcare services is a significant issue in refugee camps. As asylum seekers, women are often entitled to the host country's health services; despite this, they are often unable to access them. This may be due to language barriers; the predominant presence of male doctors, which many women would not attend due to cultural beliefs; religious taboos, often regarding nudity necessary for proper examination; and general attitudes towards disease. Physical exams in particular stop many women utilising reproductive health services. Lack of knowledge and familiarity with such procedures play a role in this, made worse by many of these women having a history of sexual violence: the consequent trauma prevents them from seeing doctors⁵.

2.4. Trafficking and Exploitation

Four million people are trafficked into exploitation and prostitution each year, most of whom are women and children⁵. Trafficking is defined as “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion [or] of abduction... to achieve the consent of a person having control over another person for the purpose of exploitation”; exploitation, by contrast, is “at a minimum, the exploitation of the prostitution of others... forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs”¹⁰.

Displacement and Women's Health *continued*

There are many health consequences of trafficking; significantly, trafficking is always associated with increased SGBV. In one study, all trafficked women had been subjected to sexual abuse; consequently, gynaecological complications were the most commonly reported health problem. There are many other risks associated with trafficking, such as social restrictions, economic exploitation or legal insecurity, and mental health consequences such as depression and post-traumatic stress disorder (PTSD)²⁰.

3. Strategies to improve women's health during displacement

It is extremely important to find sustainable and effective interventions to respond to these problems and prevent them from occurring. Any intervention must be multi-sectoral and involve all key actors, including the healthcare system, psychosocial services, security services and the justice system. However, central to any intervention should be the refugee community itself; including a more gender-balanced leadership in refugee camps¹⁰. Furthermore, interventions should always be developed on the basis that prevention is always better than treatment²¹.

3.1. Preventing Sexual and Gender-based Violence

Despite many existing SGBV interventions, response is often inadequate; partly due to the perception that SGBV is not a significant problem in Europe (this is created in part by under-reporting). The focus is often on response to SGBV rather than prevention, which often lacks government support. Moreover, safe spaces for women, psychosocial guidance and translators are all lacking. Access is also hindered by lack of awareness of existing facilities⁷.

It is imperative to work on the assumption that SGBV is occurring, and to "treat it as a serious and life threatening problem; [taking] action... regardless of the presence or absence of concrete evidence".⁷ There are many guidelines which have been created to prevent SGBV, such as the Valetta Conference on Migration (11th-12th November 2015) aimed to prevent trafficking¹³.

The UNHCR outlines five key objectives in order to prevent SGBV: the transformation of sociocultural norms which are the root cause of SGBV; the development of community and cultural support structures; the provision of effective services; the regulation of legal systems to help target SGBV; and effectively monitoring and documenting SGBV incidents¹⁰. Table 2 shows some examples of how this

can be achieved.

Objective	Strategy	Methods
Transforming sociocultural norms	Developing information, education and communication (IEC) campaigns	Raise awareness of issues such as gender roles, human rights, SGBV, available support services
	Developing stronger community networks	- Women's groups - Youth groups - Volunteer work with refugees - Separate spaces for discussion
	Creating a gender-balanced leadership structure in refugee committees	
	Empowering women	- Equal access to education - Promotion of economic independence - Development of leadership skills for women
	Involving men	- Work with influential men in leadership positions - Gender equality training
	Engaging children	- Youth groups - Age appropriate health services
Developing community and cultural support structures	Using local NGOs with relevant SGBV expertise	Sustainable strategies
	Developing social programmes	- Sports and other recreational programmes - Equal access to education
	Encouraging resumption of religious and spiritual activities	- Churches, mosques and other places of worship - Work with religious leaders
Providing effective services	Addressing protection risks in the planning of refugee camps	- Safe location of distribution points - Adequate lighting - Avoid overcrowding, multi-household tents
		- Security presence - Distributing resources directly to women
	Creating safe spaces for women	- Housing for female households without males - Safe spaces for confidential consultation
	Developing referral pathways for incidents of SGBV	Cross-border protection systems
	Providing accessible SGBV response services at all entry and exit points along refugee routes	- Psychosocial first aid - Clinical management of rape (CMR) - Female interpreters
	Developing healthcare services for SGBV survivors	- Clinical management of rape (CMR) - Post-rape kits
Regulating legal systems	Providing legal assistance	Working with national justice systems
Monitoring incidents of SGBV	Creating a standard set of vulnerability criteria	International guidelines
	Enforcing compliance with accountability standards	Confidential methods of reporting humanitarian staff

Table 2

Strategies to prevent SGBV^{7, 10}

Raising awareness of SGBV and other issues in women's health is important; however, care must be taken to overcome language barriers or poor literacy levels.

3.2. Improving Reproductive Health

The most comprehensive and up-to-date set of guidelines concerning this is the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. Set out in 2010, it outlines 8 main areas of action, outlined in Table 3.

Implementing the Minimum Initial Services Package described above could vastly improve quality of care. This is aimed at preventing maternal and infant mortality, spread of STIs and HIV, pregnancy-associated

Area for Action	Methods
Coordination	Dedication of lead agency or lead officer to oversee reproductive health services
Quality of care	- Use of standard clinical protocols and treatment guidelines - Provide sufficient facilities and staff for SRH services - Provide female healthcare workers - Provide sufficient supplies - Monitor and evaluate healthcare services - Follow the IAFM framework for quality reproductive healthcare
Communication	- Spread key messages to improve reproductive health, e.g. - Risks of childbirth - Benefits of spacing pregnancies - Community wide IEC campaigns
Community participation	Encourage refugees to take active roles in managing the project
Technical and managerial capacity-building	Assess current health services and identify areas for improvement
Accountability	- Join the Humanitarian Accountability Partnership (HAP) - Communicate with refugees at all times - Create systems within organisations to respond to refugee complaints
Human rights	Follow international human rights treaties
Advocacy	"Strategic action to ensure that laws, policies, practices and social norms enable people to enjoy their right to reproductive health."

Table 3

Key areas for action in improving reproductive health, IAFM, 2010¹⁴

complications and consequences of SGBV, while also providing family planning services⁷. There are several ways this might be achieved.

For example, providing emergency obstetric services and recruiting traditional birth attendants appropriate for the population involved can prevent maternal mortality¹⁰. This would drastically decrease the risk of postpartum haemorrhage or complications such as obstructed labour, and decrease the amount of unsafe abortions. Improving abortion outcomes, through counselling and support, clean water and better hygiene practices, and preventing unwanted pregnancies in the first place by providing free condoms are all cost-effective way of doing this⁷. This would also prevent the spread of STIs and HIV.

Health education is extremely important; this may be done via various outreach programmes⁷. Specifically targeting adolescents is crucial, and must provide age appropriate information while at the same time involving parents and other peer groups¹⁹.

4. Conclusion

There are two main problems in refugee women's health: sexual and gender-based violence and reproductive health. Other issues include trafficking, exploitation, and lack of access to resources and healthcare.

To prevent SGBV, there are five main areas of work: transforming sociocultural norms, developing community and cultural support structures, providing effective services, regulating legal systems and monitoring incidents of SGBV.

To improve reproductive health, adequate healthcare services must be provided, for example through implementation of the minimum initial services package.

How, then, has this been implemented in Europe? According to the MSF, "[2015] will be remembered as the year in which Europe catastrophically failed in its responsibility to respond to the urgent needs... of hundreds of thousands of vulnerable people."¹³ Anti-immigration policies make it difficult for refugees to enter Europe, pushing them towards traffickers and smugglers.

However, there have been many efforts to improve women's health: in 2014, the MSF conducted more than 665,400 antenatal consultations, and a survey of Syrian refugee camps in Jordan⁸ showed that there is some progress towards enforcing the MISP, though this remains limited.

Despite this positive beginning, it is vital that work must continue – the problems facing women's health are significant and severe, and must be addressed as soon as possible.

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Displacement and Women's Health *continued*

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