A Balanced Response to Basic Human Rights Needs in Crisis Settings

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Overview

The screams emanating from the delivery room did not beckon me to enter, but such was my introduction to reproductive health in refugee settings. Like 51 million people around the world (“UNHCR,” 2014), the Palestinian woman in labor was forcibly displaced. As in any population, about half of refugees are women and girls, and pregnant women account for 20% of women of reproductive age (UNHCR and “Women Are,” 2012). As can be imagined, some of the women do not wish to be, or become, pregnant. Sadly, as has been the case through much of human history, rape is often used as a strategy of war, and violence in refugee camps can be frequent due to decreased stability and security. In addition, “desperate conditions may force unaccompanied women and adolescents to exchange sex for food, shelter or protection” (“Women Are”). The sexual activities – whether consensual or not – bring risk of sexually transmitted infections (including HIV) as well as unwanted pregnancies.

Owing to man-made and natural disasters, the need for reproductive health care and services for women and girls continues to grow, and these factors are increasingly converging (Harris, Keen, and Mitchell, 2013). As the world focuses on actions to meet the Millennium Development Goals, we are reminded that access to maternal and reproductive health care is an essential human right.

Despite this urgent need, in disaster situations, water, food, shelter, and sanitation are usually addressed first. However, progress is being made to focus attention on sexual and reproductive health needs, including unintended pregnancy and sexually transmitted infections.

Thanks to the work of UNFPA, RAISE, DFID, and other organizations, sexual and reproductive health care and education are increasingly offered within humanitarian settings to enable safe pregnancy and birth (including caesarian sections), post-birth care, post-abortion and post-rape care, as well as the provision of contraceptives (including emergency contraception). By providing assistance for these needs, maternal deaths, unintended pregnancies, and the risk of acquiring sexually transmitted infections can be reduced – thus allowing the women and families affected by disasters to overcome the inherent challenges associated with residing in a crisis setting and continue living healthy and productive lives. Nonetheless, humanitarian health care provides a range of challenges including obtaining reliable data, working collaboratively, and facing economic, political, military, and ethical barriers amidst the growing and complex needs (Leaning and Guha-Sapir, 2013).
Background

During World War II, psychologist Abraham Maslow posited his “Theory of Human Motivation” (Maslow, 1943), which included “hunger, sex, and thirst” as the most basic of physiological human needs – prioritized even above shelter and security.

Humanitarian responsiveness has been strongly focused on providing water, food, shelter, and sanitation – regardless of the duration of the disaster or conflict and its recovery. A trend has begun to address the needs related to pregnancy (and its prevention), birth, and other needs related to sexual and reproductive health and education. Demands to address sexual and reproductive health needs compete for scarce financial resources amidst escalating humanitarian situations.

Some Things Can’t Wait

News headlines highlight tsunamis, earthquakes, and bombings; but the one pregnant woman in five facing those situations, a host of personal thoughts and complications outweigh media sound bites. Labor will not wait until a woman reaches a hospital (if there is a hospital) – and indeed labor’s onset can be triggered by stress from the disaster (“Women Are,” 2012). Caesarian sections are three to five times more common in conflict settings – due to complications from pregnancy and women’s desires for proactive scheduling to pre-empt any further danger or stress (“Born Into,” 2013). As a result, at least 15% of such pregnancies will result in a life-threatening complication (“Mama,” 2013). In addition, about 40% of the pregnancies are unintended – of which, half will result in abortion – presenting additional complications (“Mama”). Making matters worse, where medical facilities were sufficient before the crisis, structures, staff, and supply chains are often destroyed in post-disaster and conflict settings.

RAISE (Reproductive Health Access, Information and Services in Emergencies) is one initiative working to bring the need for reproductive health care to the fore. “In humanitarian emergencies, [reproductive health] services are often limited and, in some cases, non-existent…. Such services have not traditionally been an element of humanitarian response programmes, and most programmes for [reproductive health] service provision have not included protocols for refugees and IDPs” (“Comprehensive Reproductive,” n.d.).

RAISE and other organizations are highlighting the need for delivery care and services (including caesarian sections) in such situations. “Skilled and timely interventions can mean the difference
between life and death for pregnant women and their newborns, and for other children and relatives who depend on them. A ‘clean delivery packet’ for a pregnant woman comprises a clean piece of plastic sheet, a razor blade and string to cut and tie the umbilical cord, soap, a diaper cloth to dry the baby, and gloves (“Women Are,” 2012).

Such kits are essential for pregnant women on the run and in the early phases of refugee camp setups. The United Nations Population Fund (UNFPA) alone has provided such kits for nearly one million women over the past two years.

In the longer term, a group of 33 United Nations and other aid agencies provides extensive guidance in the "Reproductive Health in Refugee Situations: An Inter-agency Field Manual" (Inter-agency, 2010). This manual describes the range of reproductive health goods and services, and how they should be provided in consideration of cultural and religious needs (in conjunction with the community in which they operate) alongside “protection, health, nutrition, education and community” services. With proper planning, problems during pregnancy and childbirth can be mitigated following crises. Addressing the needs of women and their families who have undergone loss and stress is critical to re-building life incorporating a new baby, who may be all that is retained from before the crisis.

Contraception in Crisis Situations

For women who have delivered – and those who do not wish to – family planning education and supplies are essential provisions in humanitarian settings. Given around 40% of pregnancies in crisis settings are unintended (“Mama,” 2013), an unwanted child adds pressure to a woman who may already be living in desperation. In South Sudan, a third of teenage girls are pregnant, and “a 15-year-old girl in South Sudan is more likely to die in childbirth than to complete her education” (Odiwuor, 2014). Provision of education along with a range of contraceptives can improve contraceptive prevalence rates while empowering women and averting 72,000 maternal deaths annually (“Comprehensive Reproductive,” n.d.).

The on-going crisis caused by the Syrian Civil War highlights issues for 40% of the country’s population. Nine million Syrians are displaced within the country or in refugee camps in neighboring Turkey, Jordan, and Lebanon (“Syrian Refugees,” 2014). Many Syrian women “say they would rather do anything than get pregnant”; however, “while they may not want to have children, displaced married couples do still want to have sex” (“Born Into,” 2013). “A Syrian women’s group, Refugees not Captives, calls on refugee women to postpone pregnancies until they return to Syria,” while others desire pregnancy to
replace those lost in the war (“Born Into”). In either case, the need for education about family planning is an essential accompaniment to pregnancy and childbirth care to ensure women and their partners are aware of their choices and have a range of short- and long-term contraceptive methods available.

Not only is access to health and family planning a fundamental human right, but it also “offers a wise, public health intervention in these resource poor settings” (“Family Planning in Crisis,” 2013). Education and advice must also include adolescents, who may reside in situations long enough to transition into adulthood. Adolescent reproductive health services offer a unique and growing chasm within the humanitarian response abyss. As in non-crisis settings, contraceptives have shown a positive return on investment by the reduction of maternal and child deaths and the avoidance of unintended pregnancies – along with “demonstrated social and economic returns in all sectors – food, water, health, economic development” and environmental improvements of up to a 400% return (“Family Planning in Crisis”). Renewed global efforts towards meeting the Millennium Development Goals, including FP2020, highlight the 220 million women worldwide with an unmet need for contraceptives – and the funding, advocacy, and other work needed to bridge the gap. As in the developed world, contraception can be a controversial and emotional topic requiring a range of stakeholders to work within a complex community. Humanitarian settings can further increase these complexities and controversies.

Weapons of War: Violence and Rape
An even more taboo topic in humanitarian settings is gender-based violence – particularly rape. Sadly, women and girls are raped with “profound brutality” (“Comprehensive Reproductive,” n.d.) as a strategy of warfare and domination in conflicts. At least 20% of women in crisis settings have experienced sexual violence (“Global Summit,” 2014); however, due to under-reporting due to shame, fear of retribution, and other factors, the occurrence is actually much higher. A shocking statistic: “two women every hour will suffer sexual violence in the Democratic Republic of the Congo this year” (“Global Summit”). In addition, refugee settings exacerbate pre-existing familial and societal tensions, and lawlessness and insecurity further enable violence and rape (Ferris, 2012; “Global Summit”).

\[\text{\textsuperscript{Statistics from Global Summit (2014)}}\]
Rape survivors need medical care, including emergency contraceptives, post-rape kits with HIV tests and pharmaceuticals, and surgical intervention to repair physical injuries caused by rape. However, the emotional trauma requires counseling and psychosocial support. Fortuitously, education about the topics of rape and gender-based violence can reduce its preponderance (Ferris, 2012), and organizations including UNFPA support gender-based violence prevention initiatives. Increasing attention is being focused on this topic as well as serving justice for its survivors.

Difficult to prosecute even in developed countries, rape is also “a weapon of war aimed at civilians. It has nothing to do with sex, everything to do with power” according to Angelina Jolie, Special Envoy for the United Nations High Commissioner for Refugees (Smith-Spark, 2014). At the June 2014 Global Summit to End Sexual Violence in Conflict hosted by the United Kingdom government, Jolie added, “The number of convictions for warzone sexual rape is pitifully small” (Remarks, 2014). Foreign Secretary William Hague added “impunity is a major factor in why these crimes continue… One of the primary reasons for the lack of prosecutions for sexual violence in conflict is the difficulty of gathering evidence that can stand up in court, and the trauma and the stigma faced by survivors in the process (Remarks”). Included with the “#TimeToAct” social media campaign, the government of the United Kingdom is leading global efforts to introduce a protocol, which assists authorities and practitioners with documenting and investigating rape in ways that both protect the survivor and encourage successful prosecution to serve justice for the women, men, girls, and boys involved in these crimes. Such efforts may help reduce the frequency of rape, whether committed in a conflict setting or following a natural disaster – both of which are bearing down on our world.

Trends and Needs

Over half a billion people – more than 7% of our planet’s population – are affected by both natural disasters (floods, droughts, earthquakes, storms, etc.) and short- and long-term armed conflicts (Leaning and Guha-Sapir, 2013). Data indicate that natural disasters have increased and will continue to do so (diagram below from Leaning and Guha-Sapir) – exacerbating armed conflicts (Harris, et al., 2013; Theisen, Gleditsch, and Buhaug, 2013). In addition, “organized deadly onslaughts against civilian populations will continue, fueled by the availability of small arms, persistent social and political inequities, and, increasingly, by a struggle for natural resources” (Leaning & Guha-Sapir).

Data also point to increasing financial and human losses related to natural disasters and human conflict; yet past activity prioritized responsiveness far above preparation or prevention. Indeed, only about 1% of the $1 billion of
costs incurred during the current century related to risk reduction (“Disaster Losses,” 2012). Among the responses, focus has been on water, sanitation, shelter, and food. Organizations have improved in rapid response to initial needs following disasters (Ferris, 2012). However, ongoing conflicts and post-disaster settings tend to be politically-charged and/or involve a range of disparate players. Not only do organizations need to better prepare, but humanitarian work must also provide for needs related to reproductive health as a human right and work in conjunction with a range of stakeholders. Such is difficult work, but necessary.

Organizations such as the United Kingdom’s Department for International Development (DFID) (Harris, et al., 2013) and UNFPA increasingly recognize the needs humanitarian settings demand – in particular relation to women – as highlighted in this UNFPA video.

With humanitarian response, it is not merely goods that are needed, but also medical services, counseling, and education on topics such as pregnancy, childbirth, contraception, and violence.

Positive Results in the Philippines

Amidst the doom and gloom, it is good to provide a hopeful example, where preparation and a range of actors came together to meet reproductive health-related needs. Last year, super typhoon Haiyan affected over 10% of the Philippines’ 92 million population. “ Possibly the most powerful storm ever recorded,” category 5 Haiyan combined wind gusts of up to 275 kilometers per hour (170 miles per hour) with rainfall of up to 30mm (over an inch) per hour and a storm surge of up to six meters (nearly 20 feet) – destroying infrastructure, power, and communications (“Philippines,” 2013). Working in “clusters” centered on topics such as emergency shelter, food security, education, and health, a range of over 20 organizations coordinated with a supportive Philippines government to assess needs for over $300 million of assistance (“Philippines”). These organizations were able to rapidly deploy ‘surge’ staff, knowledgeable in disaster recovery, who supplemented people already working in the Philippines, a country that is no stranger to humanitarian needs.

The humanitarian community’s Strategic Response Plan included the typical water, sanitation, and shelter, food, and health supplies. In addition, the coordination among the various organizations included a strong reproductive health component, estimated at over $16 million. Reproductive health kits that had been stocked in preparation were deployed along with medicines, medical equipment, ambulances and unique shipments to address the total devastation of some areas. Pre-fabricated delivery rooms constructed inside shipping containers provided rapid response to maternal health care needs, and motorcycle ambulances were able to transit health workers to emergency obstetric cases (and

Because of the leveraged impact between natural disasters and human conflict – and the established dichotomy of approaches to each, there is need for a holistic framework including:

- Risk prevention and management;
- Collaboration with a range of actors towards peace- and state-building; and
- Willingness to fund, provide, and accept assistance is required (Harris, et al., 2013).
vice versa) (“Support for,” n.d.). Dignity kits provided goods for safety and hygiene including items for pregnant, lactating, and menstruating women. Addressing gender-based violence, plans included shelter facilities with better lighting and gender-segregated toilets (with locking doors). “Safe spaces” were also provided, for women to meet on a range of issues – from education about family planning and human trafficking to psychosocial support and job assistance (“Support for”).

Visiting one of these safe spaces, UNFPA’s Executive Director Babatunde Osotimehin offered, “providing reproductive health care, including family planning, is essential to help women stay healthy and make informed choices while they rebuild their lives.... We are here to help you restore hope and dignity to the people of the Philippines” (“Women’s Health,” 2013). In the longer term, funds were requested for the re-building of facilities lost in the super typhoon, and this work has gained ground. In the six months since Haiyan struck, $6 million has been provided of the $16 million requested for sexual and reproductive health (“Typhoon Haiyan,” 2014). The humanitarian response to Haiyan provides an example of comprehensive preparation and responsiveness that includes reproductive health. It is in the re-building and preparation of the Philippines and other settings that the true test of our willingness to assist remains to be experienced.

Summary

The urgency to set aside financial resources both before and after a humanitarian crisis – as well as integrating all aspects of health care into relief efforts (including sexual and reproductive health) – will continue to grow as we face the increasing impact of human conflict and natural disasters across the globe. Likewise, human resources and goods to assist with humanitarian needs must be prepared in advance in order to be deployed when disaster strikes. Conducting advocacy about the needs and building relationships with a range of disparate and even conflicting stakeholders is difficult work requiring many resources. Balancing the immediate needs of the present against the possibility of future needs are issues for policy makers, governments, and donors. Their – our – decisions have immeasurable impact on those who bear the brunt of difficult labor, unintended pregnancies, and survivors of rape. Without careful balance of these conflicting needs, millions more like the Palestinian woman screaming in labor will face unnecessary hardship in an already dire situation.

References


