International Women's Day 2014: Briefing paper

FORCED TO FLEE

MEDECINS SANS FRONTIERES

Women's health and displacement

An MSF fieldworker assists a refugee in South Sudan. © Shannon Jensen

On International Women's Day 2014, as on every day, thousands of women will be forced to flee their homes. They will join the 45 million other people worldwide who are displaced, whether due to conflict, persecution, or natural disasters. More than half of all those displaced are women and children.

Médecins Sans Frontières/ Doctors Without Borders (MSF) has a long history of providing emergency medical aid to displaced populations, including refugees and internally displaced people (IDPs). One of our first large-scale interventions in a refugee crisis was in 1975 as hundreds of thousands of Cambodians fled the Khmer Rouge. Today, MSF runs projects for IDPs and refugees in more than 30 countries, from the Philippines to South Sudan.

While the provision of medical care to displaced people is at the forefront of MSF's work around the globe, so too is women's health. Displaced women face particular health risks as societal support structures break down and access to healthcare becomes difficult.

This briefing paper focuses on the key medical issues facing displaced women and girls, particularly **obstetric emergencies** and **sexual violence.** MSF makes it a priority to provide services that address these two critical medical issues in any situation of displacement. Emergency obstetric care and response to sexual violence are both part of the Minimum Initial Service Package for Reproductive Health in Crises – a set of priority activities defined by international agencies, designed to minimise mortality and morbidity.

Once these key medical services are assured, Médecins Sans Frontières can work to respond to other medical issues facing displaced women, such as access to family planning and newborn care.

DISPLACEMENT: CURRENT CRISES

1. MALI

70,000 refugees in Mauritania

Since 2012, the war in Mali has pushed thousands across the borders into neighbouring countries, including Mauritania. MSF supports primary healthcare centres in Mbera camp and at the Fassala border crossing, and an operating theatre in the town of Bassikounou.

2. SYRIA

6.5 million IDPs

2.4 million Syrian refugees in neighbouring countries

As the Syrian conflict continues into its fourth year, MSF is providing emergency medical aid to Syrian refugees in Jordan, Lebanon and Iraq, as well as the displaced population within Syria, including several reproductive health projects.

3. PAKISTAN

975,000 IDPs

1.6 million Afghan refugees

MSF has worked in Pakistan since the early 1980s and today provides obstetric and emergency healthcare to refugees and IDPs. Maternal, infant and child mortality rates remain high. Each day, more than 80 women die from preventable complications during pregnancy and childbirth.

4. MYANMAR

630,000 IDPs

200,000 Burmese refugees in Bangladesh

MSF has 20 years' experience working in Myanmar's troubled Rakhine state. Since an outbreak of violence in June 2012, MSF has provided essential health care services in Rakhine State to around 140,000 displaced people. MSF also works in Bangladesh, providing maternal care, mental healthcare and other services to refugees.

5. PHILIPPINES

4 million homeless

In November 2013, Typhoon Haiyan killed around 6,000 people and left millions without a home. MSF intervened to provide emergency relief to the victims and re-establish hospital facilities for the population, especially pregnant women, newborns and young children.

6. SOMALIA

1.1 million IDPs

1 million refugees in Kenya and Ethiopia

Since 1991, successive crises in Somalia have triggered several waves of displacement. In Kenya, MSF provides medical care to 125,000 people in Dagahaley camp, which is part of the Dadaab complex that hosts more than 350,000 Somali refugees. MSF also runs several medical projects in eastern Ethiopia where more than 235,000 Somali refugees are living.

10. HAITI

145,000 homeless

Four years after the earthquake, tens of thousands of Haitians continue to live in makeshift camps in and around Port-au-Prince, where access to health care remain insufficient. Among other projects, MSF runs a 130-bed obstetric and neonatal emergency hospital in Port-au-Prince, where nearly 15,000 babies were born in 2012.

9. DEMOCRATIC REPUBLIC OF CONGO

2.6 million IDPs

490,000 refugees in neighbouring countries

Recurrent violence in the Democratic Republic of Congo has caused large population movements, with millions displaced. MSF has worked in the country since 1981. MSF treats more than 4,000 incidents of sexual violence and provides more than 1.6 million outpatient consultations each year (2012 figures).

8. CENTRAL AFRICAN REPUBLIC

698,000 IDPs

250,000 refugees in neighbouring countries

The humanitarian crisis in Central African Republic has worsened since the level of violence escalated in early December. Targeted massacres provoked massive population displacement. MSF is running fifteen projects within the capital Bangui and across the country, including a maternal health and surgical project. More MSF teams are also present in neighbouring countries (Chad, Cameroon).

A PATIENT STORY

Fatimatou's baby is three days old. She delivered at home in Bangui. The rest of her family had already fled to Cameroon.

"My mother told me to go to Cameroon to have the baby, but I was already too pregnant to travel. I decided to stay here with my husband and give birth here. The baby is in good health and we have decided to stay for the moment. I hope that my family will be able to return soon. We are afraid. Our neighbours are all gone. We are practically the only ones left in our area."

7. SOUTH SUDAN

700,000 IDPs

165,000 refugees in neighbouring countries

South Sudan has faced a political crisis and an outbreak of violence since mid-December 2013, displacing hundreds of thousands of people. MSF has worked in South Sudan for 30 years, and currently runs 16 projects throughout the country plus more in neighbouring states (Kenya, Uganda, and Ethiopia). These include maternal and neonatal units and inpatient and outpatient care.

A MIDWIFE'S STORY

Mary was working as a midwife in Bor when the fighting escalated. She is now seeking safety in Minkaman, Lakes State, South Sudan.

"We first heard about the war in Juba, and slowly it reached Bor. Gunshots got so close to the hospital, and everyone started running away. Even the patients fled. We went to the river banks looking for boats to cross over. We heard the other side was calm. We saw bodies floating in the river, some of them were children. When we arrived in Minkaman, there were so many people, mostly women and children, who had fled too. I met a woman who was in labour under a tree with her three young children crying next to her. We had to look for a private area where she could deliver with some sort of privacy. This was not just one case; there are many women out there like this."

KEY MEDICAL RISKS FACING DISPLACED WOMEN

A nurse assists a critically unwell woman in Yida refugee camp, South Sudan. © Yann Libessart.

Obstetric emergencies

"A retrospective review of surgical services of Médecins Sans Frontières in six conflict settings found that only 22% of 4,630 surgical interventions were due to violent injury. At almost all sites, obstetric emergencies vastly outnumbered the war-wounded, accounting for 30% of all interventions." – Kathryn Chu, MSF[1]

The conflict or natural disasters that often precede displacement can have a devastating effect on health infrastructure, whether incrementally or immediately. Facilities can be destroyed and health workers killed, injured or displaced, leaving those that remain under-resourced and over-burdened. Then, if people are displaced they may find it harder to access care due to complete lack of services, distance, transport barriers, lack of finances and uncertainty about available services and their quality. Prevailing insecurity will only exacerbate the situation.

Pregnant women will be a part of any displaced population. Lack of access to routine care puts pregnant women and their babies at risk, but lack of emergency care can be life-threatening. In any population, up to 15 per cent of deliveries will develop a life-threatening complication needing urgent medical care. In fact, experience and research has shown that caesarean section is the most common major surgery undertaken following conflict and natural disasters, surpassing emergency surgery for the war wounded.

MSF teams strive to address the four greatest causes of maternal mortality: post-partum haemorrhage (severe bleeding), pre-eclampsia/eclampsia (hypertensive disorder), sepsis (generalised infection) and unsafe abortion. Without a skilled and timely response, the mother's life can be in danger, and so too that of her baby. Children whose mothers die are more likely to die within 1-2 years of their mothers' death[2].

To ensure displaced women have access to the obstetric care they need, MSF provides a range of services up to comprehensive emergency obstetric care centres with capacity for blood transfusions and caesarean sections. MSF promotes these services as widely as possible to ensure their acceptance and use, so that women do not give birth without skilled care, which is in itself the biggest risk factor for their survival.

1. Kathryn Chu, Miguel Trelles, Nathan Ford. Re-thinking surgical care in conflict. *Lancet* 2010. 375 (9711): 262-263.
2. WHO data, available at: http://www.who.int/features/qa/12/en/

Sexual violence

"Sadly, sexual violence has been used as a weapon of war in almost every conflict. It can be used as a deliberate tactic to destabilise populations, destroy community bonds, or humiliate victims and their families." – Dr Tane Luna, obstetrician and gynaecologist, MSF women's health advisor.

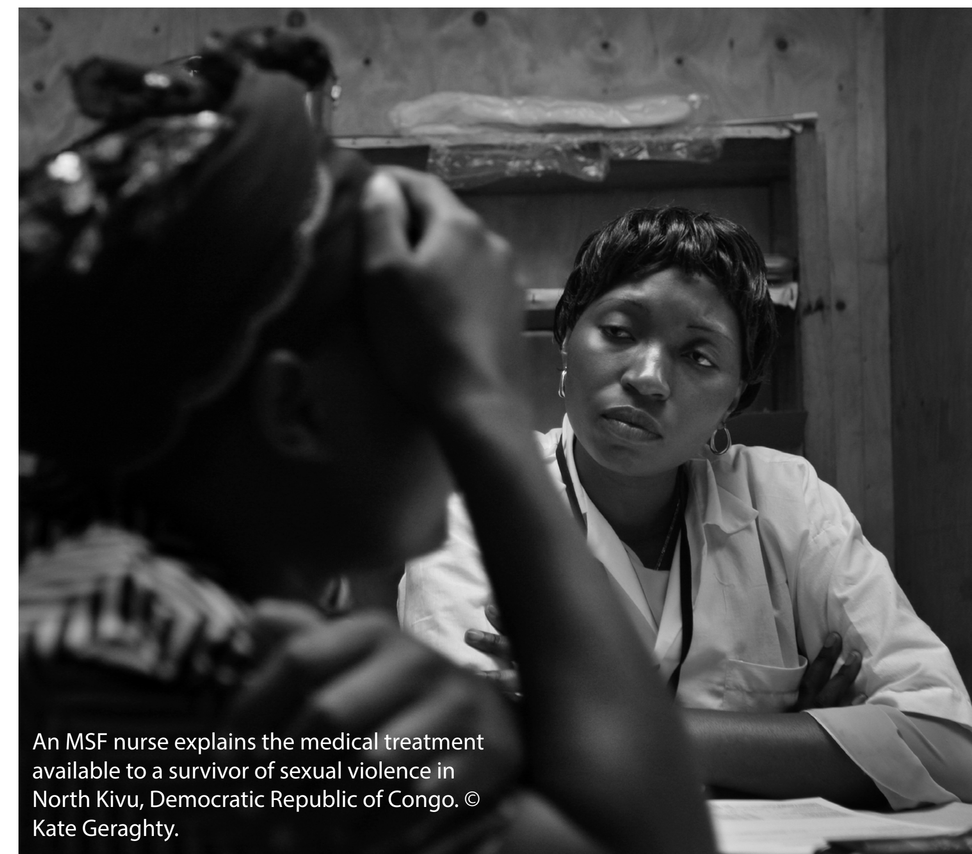
Sexual violence is a global problem, with an average of one in three women experiencing some form of sexual violence or intimate partner violence during her lifetime. However, women are at an even higher risk of sexual violence in situations of displacement.

During conflict, sexual violence including rape can be used as a weapon, to humiliate or terrorize communities. The breakdown of law and order that often accompanies conflict increases the risk of impunity.

When crossing borders, women can face assault from bandits or border guards abusing their power, or abduction by traffickers. Families are often separated during conflict, leaving solo women or children vulnerable to assault. In the insecure environment of a refugee or an IDP camp, women may be forced into prostitution to support their families, sexually exploited by those in power or sexually assaulted when collecting water or wood. Women need safe access to services through measures such as gender-separated latrines and direct distribution of relief items.

Sexual violence is a medical emergency, with consequences for physical and mental health. MSF offers:

- **Medical first aid.** Treatment of wounds, such as cuts or lacerations.
- **STI prevention.** Medicine to prevent HIV and other sexually transmitted infections.
- **Emergency contraception.** Women who present within five days of being raped can receive emergency contraception to prevent unwanted pregnancies.
- **Vaccinations.** Hepatitis B and tetanus vaccination.
- **Psychological care.**
- **Legal advice including provision of medical certificate.**


An MSF nurse explains the medical treatment available to a survivor of sexual violence in North Kivu, Democratic Republic of Congo. © Kate Geraghty.

HAITI: A PATIENT STORY

Manise, aged 19, has lived in a displaced person's camp in Haiti since the earthquake in 2010. A rape survivor, she gave birth in February this year at MSF's obstetric emergency referral centre, by caesarean.

"I find myself in a situation where I always feel ashamed. I have a child whose father I do not know. I am both mum and dad. My child was conceived in a rape.

I lived in Canaan camp with my cousin since the earthquake, trying to make ends meet. I would stay in the tent and prepare food while she was out working. One evening I went to fetch some water. Two men came and dragged me into a tent that was not in use. I shouted so loudly that one of them left. But the other held me tight and hit me repeatedly. It was after 8pm but the shops were still open and people were passing by. No one came to my rescue.

The pregnancy went well until my feet started to swell badly. My condition kept getting worse. One day I fell down and I lost consciousness. I woke up in a hospital. A doctor told me I had to be taken to the MSF hospital. I don't remember giving birth, I just saw the baby next to me.

Now I will go to live with my mum, my four siblings and my stepfather in Cinéas camp. They do not want me to go home because of what happened. I worry how I am going to feed my baby once he is too old for breastfeeding. I think I will offer to do laundry for people."

Family planning

"Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths." – Professor John Cleland et al[1]

Family planning typically lacks in an emergency setting and is often only introduced once a situation has stabilised. Displaced women including adolescents may not be able to continue their contraceptive method because they have simply lost it in the process of being displaced, or due to disruption of health services.

Family planning plays a critical role in improving maternal and child survival. It reduces the likelihood of unintended pregnancies, and of consequent unsafe abortion, which is the third biggest cause of maternal mortality worldwide. It also gives women the capacity to space and time births, which improves pregnancy outcomes. Family planning can also help women avoid the high risks associated with having large numbers of pregnancies and births.

Family planning is an ongoing need for women in any situation, but is often even more crucial when women are forced to flee due to conflict or natural disaster. In these situations, families may want to delay childbearing until their security and livelihoods are assured. MSF provides a range of family planning methods to ensure that displaced women and their families are able to make more informed choices about their sexual and reproductive health.

1. Prof John Cleland, Stan Bernstein, Prof Anibal Faundes et al. Family planning: the unfinished agenda. *Lancet* [online] 2006. 368 (9549): 1810-1827.

Other health issues

Implications of single parenting:
In many refugee situations, men may have been killed or remain in their home country to look after property or participate in the conflict. This leaves women with sole childcare responsibilities for often multiple children. Single parenting can make it difficult for women to seek healthcare, particularly for inpatient care, and to ensure their children receive the treatment they need.

Outbreaks of diseases:
In the often overcrowded and unsanitary setting of a refugee or IDP camp, there is an increased risk of epidemics such as cholera, malaria or hepatitis. While these diseases affect everyone, the outcomes are often much worse for pregnant women.

Chronic diseases:
A lack of access to routine care means displaced people, particularly the elderly, can suffer the complications of unmanaged chronic diseases such as hypertension or diabetes.

Mental health:
Women who have experienced conflict and displacement have often been exposed to a range of traumas, from losing loved ones to witnessing or experiencing extreme violence. The uncertainty of life in a refugee settlement is another stressor. Mental health conditions such as depression, anxiety or post-traumatic stress disorder can manifest in a variety of ways, from generalised body pains to non-responsiveness.

Corinne Torre in South Sudan. © Yann Libessart

A FIELDWORKER STORY

Corinne Torre is an MSF project coordinator.

"Displaced women not only face problems accessing medical care. Without sanitation, without food, without a roof, people keep getting sick. Men are often absent and women are left in charge of the kids, the housing and everything that is needed. If their husband comes back injured from the war, they will have to take care of him too.

They have to be incredibly strong. Many of these women are seeking medical care only so they can stay strong and work even more. Mothers just can't afford being sick. If they are ill, they will no longer be able to look after their children. MSF medical structures treat many consequences of domestic accidents, especially severe burns due to poor housing and young children left unattended. Beyond health care, one big humanitarian challenge is to help mothers take care of their family. Do they also need shelter, protection, kindergarten for their children, a job?"

FIELDWORKER STORY

"She was very sick, had been displaced by Typhoon Haiyan and was living in a tent."

Midwife Margie Barclay (left), after delivering the first baby in MSF's hospital in Tacloban, The Philippines. © Yann Libessart.

Margie Barclay is a nurse-midwife who has cared for displaced women in MSF projects in countries including Pakistan, the Philippines, Syria and Uganda.

"Safety and security issues affect displaced women deeply. When I was in the north of Uganda, women had been living for many years in camps established by the government to provide security from the Lord's Resistance Army. Often there were no males around and women were torn facing many responsibilities: how to provide food and water for their families, how to find fuel, yet how to look after themselves. The women had to take great risks going outside the boundaries of their camp, and maybe they wouldn't be killed, but they were very susceptible to abduction or abuse.

A woman may be alone because her husband has been killed, or is away at war, or she has been separated from her family for other reasons. So she's carrying the burden of trying to provide for her family, and her personal needs usually come second. Women are often only able to seek healthcare when they're desperate, or things have progressed, or it's last-minute. In some situations women may not be allowed to seek care without permission of males. So if women are alone they can't seek that care. Cost can also be a hurdle and people may not seek care if they can't afford what still exists.

Access is also a big challenge for women when they're displaced. In the Philippines, although access to healthcare was uneven, many people were used to good quality healthcare. But in a disaster that's all destroyed and people don't know whether healthcare is accessible.

> **"Women are often only able to seek healthcare when they're desperate, or things have progressed."**

The first woman who delivered with us in Tacloban, the Philippines, would have died if she had not received care. She was very sick, had been displaced by Typhoon Haiyan and was living in a tent. She hadn't had proper access to healthcare even during her pregnancy. She'd been in labour for quite some time and her labour was obstructed. She had also developed pre-eclampsia, which is a severe complication of pregnancy. When we delivered the baby it was 4.1 kilos, bigger than average, and we discovered that the mother had actually developed diabetes, for which she'd had no management or treatment. That made for a very vulnerable baby, needing its own specialised care as well. What was difficult was that the parents wanted to take their baby home, up north, even though he was unwell, because they had two other children who no-one was looking after.

The quality and appropriateness of healthcare for women is crucial. Women may not receive the care they need if they don't feel there's an environment which is culturally sensitive and confidential. This may often mean having female-only care providers. Women may be particularly reluctant to access care when it comes to things like miscarriage. Sometimes women try to terminate an unwanted pregnancy without proper medical supervision because they are desperate. This can put them at risk and cause severe complications. They then need management for safe abortion and follow-up care, inside a health facility.

There can also be different issues for younger and older women. Certainly in a lot of situations young women in their first pregnancy are very vulnerable. In Darfur, another displaced situation, a 14-year-old girl arrived from a remote area to our health facility and had been in labour for three days; in fact the baby had already died inside of her and she had a huge fistula. There were very few possibilities of access to the specialised care she needed. Although she was married her future was uncertain: if she didn't get the fistula repaired she would be living with it all her life, probably with no chance of future children, and the likelihood of being outcast.

For older women who have had multiple pregnancies, there's often more risk in subsequent pregnancies, so delivering without specialised care can be dangerous. Post-partum haemorrhage is still the leading cause of obstetric mortality worldwide and that's one of the big risks of multiple pregnancies. This is where emergency obstetric care has a big role to play along with family planning."

PATIENT STORIES

"When we had to flee the area, I ran for my life but, being eight months pregnant, it was not easy."

Refugees arrive in Minkaman, Lakes State, South Sudan in January 2014. © Judy Waguma/MSF.

Rhoda, aged 24, delivered her first child in a displaced person's camp in Minkaman, Lakes State, South Sudan.

"I was always attending the health clinic in Bor town during my pregnancy. When we had to flee the area, I ran for my life but, being eight months pregnant, it was not easy. Fortunately my mother was staying with me at the time. She is the one who heard things were getting bad and quickly packed a few belongings before we all rushed into the bush for a few days. This was the toughest moment in my life. My husband was stuck in Juba. I was here in the bush convinced I was going to lose our child.

One night, we got into one big boat with 100 others to cross to Awerial County because the security was not getting better. People travelled with very basic things, although some came with their animals. The journey was awful, lying in dirty water mixed with animal faeces.

When we arrived in Minkaman, my mother found a small area with a few trees, big enough for the two of us to settle. Soon I started having some persistent pains and my mother helped me deliver a baby boy in our small shelter. Two days later he started having high fever and convulsions. My mother went to look for help and by chance met some of the Médecins Sans Frontières staff who referred us to the clinic. The baby had an infection of the umbilical cord that had spread to his whole body. He is fine now."

ABOUT MÉDECINS SANS FRONTIÈRES

Médecins Sans Frontières/ Doctors Without Borders (MSF) is an international, independent, medical humanitarian organisation that was founded in France in 1971. The organisation delivers emergency medical aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters in more than 60 countries. Assistance is provided based on need and irrespective of race, religion, gender or political affiliation.

VOICES FROM MYANMAR

"Before the conflict, pregnant women used to deliver at home too, but there was always the option of having a midwife coming home, or going to the hospital. But now, we live in the IDP camp, and there is no more midwife, no more hospital we can go to if things go wrong," **23-year-old woman from an IDP camp in Rakhine State.**

"Several women died in the last months due to heavy bleeding after delivery, two of them were my nieces. One was 20 and the other 25 years old. They died a few hours after giving birth. If this had happened before the conflict, perhaps they would not have died as we would have been able to go to the hospital. But since the conflict, we have been displaced from homes and are not allowed into the nearest hospital anymore," **45-year-old female IDP from Rakhine State.**

"People, especially pregnant women, sometimes have to leave this camp to move to another IDP camp, further away, where they can have better access to health care, and where there are doctors they can see in case of complications, even though it means they will be even further away from their place of origin, and also from their families, and may never return," **60-year-old female IDP from Rakhine State.**

All testimonies from January 2014.