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Reproductive Health Matters 2008;16(31):4–9
0968-8080/08 $ – see front matter
PII: S0968-8080(08)31380-9

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

EDITORIAL

Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights

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"The camp is the space that is opened when the state of exception begins to become the rule... Insofar as its inhabitants [are] stripped of every political status and wholly reduced to bare life, the camp [is] also the most absolute biopolitical space ever to have been realized, in which power confronts nothing but pure life, without any mediation."[1]

IN Italian philosopher Giorgio Agamben's concept of the "state of exception", human beings are reduced to a condition of "bare life", banished from the dignities of citizenship and the protections of ordinary rights. While Agamben considers the Nazi concentration camps as the paradigm case, he warns that under conditions of global economic and ecological crisis and rampant militarism, growing numbers of people find themselves stripped of ordinary rights or even "the right to have rights".[2] These include not only the detainees in militarised sites of the US-led war on terror, but also the millions of internally displaced and transnational migrants and refugees fleeing war, ethnic and armed conflict, *tsunami*, hurricanes, floods and other disasters.

By the end of 2006, according to estimates by the United Nations High Commission on Refugees (UNHCR), nearly 33 million men, women and children worldwide qualified for humanitarian assistance: refugees, asylum-seekers, internally displaced persons (IDPs), returnees, and stateless persons. This was an increase of 56% over the available statistics for 2005, reflecting escalating armed conflicts, e.g. in Iraq, Lebanon, Sri Lanka and Timor-Leste.[3] The immediate – and in many cases long-term – result has been the wholesale concentration of "forced migrants" in camps and other displacement centres.

It is hardly surprising that the face of disaster – whether natural or conflict-induced – is highly gendered, as well as marked by divisions of class, race, ethnicity and age. Confronting this reality, increasing numbers of researchers, advocates and agencies have begun to address the gender dimensions of disaster, particularly those related to sexual and reproductive health and sexual and other forms of violence. Moreover, as articles in this volume by Judy Austin et al and Audrey Macklin examine, beginning in the mid-1990s with the International Conference on Population and Development (ICPD) in Cairo* and reactions to the crises in Bosnia and Rwanda, a series of international and intergovernmental initiatives have attempted to secure the access of both refugees and internally displaced persons to basic health care services, including reproductive health services and family planning. These efforts have included the work of the Inter-Agency Working Group on Reproductive Health in Crises and its *Field Manual on Reproductive Health in Refugee Situations*; the Reproductive Health Response in Conflict Consortium; the Minimum Initial Service Package that became part of the 2004 revised Sphere Minimum Standards for response to disaster; and UNHCR documents, including most recently, its 2008 *Handbook for the Protection of Women and Girls*.

*The ICPD Programme of Action adopted as an objective, in paragraph 9.20(b): "To put an end to all forms of forced migration."

While these developments are encouraging, nearly every article in this journal issue attests to the great distance that still remains between verbal recognition of sexual and reproductive rights for IDPs and refugees and their implementation on the ground. The challenge runs deeper than that of filling the enormous gaps in services that unquestionably exist. It also calls for better analysis and understanding of the ways in which sexuality and sexual violence, pregnancy, childbirth, HIV and AIDS, and racialised and gendered power relations take on whole new meanings – and help give meaning to – situations of armed conflict and disaster. A sense of urgency about this task of understanding prompted RHM to publish a set of papers on this topic that foregrounds the range of problems and contexts regarding sexual and reproductive rights – or their absence – in sites of political exclusion across the globe.

Complicating the good intentions of international NGOs and agencies in this troubled arena are the severe political, ethical and practical limitations of humanitarian regimes. Fifty years ago, Hannah Arendt observed that it is exactly in cases where inalienable human rights should operate with the clearest immediacy – for those who are stateless and/or survivors of disaster – that they become most impotent. Paradoxically, she said, human rights "show themselves to lack every protection and reality at the moment in which they can no longer take the form of rights belonging to citizens of a state".[2,4] The millions who languish in refugee and IDP camps, detention centres or rescue points are dependent either on agencies whose mission is only to provide minimal shelter and food, or on the states whose agents may have been responsible for their persecution, or abandonment, to begin with.

Many contradictions characterise this situation. Relief agencies are reluctant to tread on the prerogatives of local government officials, and field guidelines have an advisory rather than a mandatory legal status. Thus, UNHCR, whose original mandate was to serve those with "designated refugee status", provides humanitarian assistance to only half the current number of IDPs.[3] This is especially problematic given the dramatic reversal in the ratio of refugees to IDPs in the past 25 years; today, IDPs are two and a half times more numerous than cross-border refugees.[5] This change is due to the prevalence of local ethnic and communal conflicts and imperial policing operations in Iraq and Afghanistan, but also from the rising backlash in many countries against the waves of cross-border refugees fleeing economic as well as military crises. Despite the widely hailed open borders of globalisation, fences and walls are hardening into militarised fortresses everywhere. This is particularly troubling for women and children, who are not only a majority of all refugees but also constitute an estimated 70–80% of all IDPs.[3,6]

A second set of contradictions arises from the conventional definition of refugee and IDP camps as emergency or temporary way-stations en route to someplace else, whether return, repatriation or permanent asylum. In reality, given the long-term duration of armed conflict in places such as Sudan, Eastern Congo, Sri Lanka, Israel–Palestine, Northern Uganda, Colombia, Afghanistan and Iraq, IDPs and refugees may find themselves displaced for years or even decades, with serious implications for health care delivery. Moreover, the emergency or crisis management mentality among camp personnel may treat refugees and IDPs as passive victims, thereby undermining their autonomy and even their humanity.[7]

Looking at issues of reproductive health and maternal mortality outcomes and their relevance to factors such as the intensity of and proximity to conflict, or location relative to obstetric services, Therese McGinn et al found that fertility rates declined and rates of unsafe abortion and maternal mortality ratios (already quite high in the countries affected) went up during the most intense phases of conflict.[8] In high intensity situations, health care workers may be forced to abandon affected sites (as Médécins sans Frontières had to do in Iraq in 2004). Although some evidence suggests that women living in stable refugee camps may actually benefit from better access to reproductive health and family planning services than women in the host country or in their country of origin,[9] the risks faced by pregnant women in much more volatile and dangerous situations paint a much bleaker picture (for example, see papers by Bosmans et al, Chynoweth and Kottegoda et al in this journal issue).

Pregnancy and childbearing, and the presence or absence of access to maternity services, are obvious examples of experiences that affect

women refugees and IDPs directly. However, many other aspects of displacement also reveal differential impacts on women and girls. Armed conflict today overwhelmingly kills and maims civilians, and kills men and boys even more than women and girls, but when it comes to many other costs of war, women and girls suffer particular and often very great burdens. Audrey Macklin points out that in conflict situations, women are less mobile then men, due to responsibility for children, elderly or disabled kin, and obstacles to travel without male accompaniment. Likewise, although the lack of adequate sanitation and clean water in so many camp situations creates misery for everyone, women and girls suffer very specific reproductive and urinary tract infections, discomfort and shame – too often invisibly – from the absence of sanitary supplies and private toilet facilities that typically accompanies disaster.

Clearly the most devastating effects on sexual and reproductive health and rights from the upheavals of conflict and crisis come in the form of constant danger and vulnerability to sexual abuse and gender-based violence. Writing earlier of conditions of human (in)security in Southern Sudan, Audrey Macklin describes dilemmas that confront displaced women in armed conflict zones and refugee and IDP camps in many places today:

"Men worry about being killed by the GoS [Government of Sudan] or its allies, whether as civilians or as combatants in rebel forces. Women worry that they and their children will be abducted and enslaved by government-sponsored militia—if they are not killed outright. They also dread the moment when their boy children will be turned into child soldiers to fight in rebel armies against the GoS. Women fear rape by militia, rape by men who distribute aid in exchange for sex, and rape by husbands who demand that they replace dying children by producing still more children who will grow up to wage the national struggle—that is, if the women survive their pregnancies and the children survive to adolescence."[10]

Many of the papers in this issue describe widespread acts of rape and gender-based violence that seem endemic in camps and situations of ethnic conflict (for example, see papers in this issue by Khanna, Kottegoda, Al-Adili et al, Henttonen, and Longombe et al). They describe how camps and shelters that are supposed to provide refuge often become places of blatant violence and mutilation, demoralisation and dehumanisation, especially for women and girls. Not only do conditions of unequal power, dependency, crowding, sub-standard housing and lack of privacy make rape and abuse a constant threat. Beyond this are the demeaning images projected by local residents, media and policy-makers of refugees and IDPs as economically burdensome and morally threatening – if not potential terrorists. Such stereotypes are often deeply racist as well as gender-biased. Women refugees, who are often abandoned or widowed and forced to trade sex for survival, may be characterised as bad women and mothers, while men may be emasculated or treated as sexual predators.

What this set of papers in this issue of the journal suggest is the impossibility of isolating sexual and reproductive health and rights from a complex web of circumstances often hidden in more "normal" settings. Situations of extreme crisis expose a much larger weave of socio-economic conditions, all of which must change in order for human rights to be fulfilled. They cast new light on what humanitarian and disaster specialists have come to call "complex emergencies", i.e. that combine the multiple and highly combustible effects of poverty, racism, gender discrimination, economic crisis, armed violence, environmental devastation, social and political disarray, and massive displacement. Civilian exposure to death and morbidity from armed attacks, absence of clean water and adequate sanitation, loss of arable land and shelter, severe nutritional deficits, and lack of access to health care, along with drastic human insecurity of every kind and the banishment of those considered less than human, all form part of a single catastrophic web.

As activist women of color in New Orleans, USA, working to restore community health care after Hurricane Katrina in 2005, have shown, the most destructive dimensions of disaster are never entirely "natural" but in large part man-made.

"Cramped living conditions (with families housed in small travel trailers or in overcrowded homes and shelters) and high stress situations increase the prevalence of domestic violence. The lack of affordable housing in New Orleans, which contributes to domestic and sexual violence, will not

improve for low-income people anytime soon due to the decision of federal housing officials to raze 5,000 public housing units in an effort to drive poor people permanently out of the city. With the breakdown of communities. . .community accountability for rape and abuse becomes even harder to implement. . . These policies create a forced migration and displacement of people of African descent and other people of color from New Orleans. . . a city renowned for its African traditions and rich multicultural legacy, radically transforming and whitening [it]. Furthermore. . . the Institute for Women's Policy Research notes that 'more women than men left the region after the storm'. . . that low-income women of color in particular are having a difficult time coming back home. . .[and] that before Katrina, women made up 56% of the local workforce, but only 46% today; the number of families headed by single mothers in the metropolitan area has dropped from 51,000 to less than 17,000. . .

". . .If we were to re-center women of color in the work of organizing in the context of Hurricane Katrina, we would recognize that sexual violence is a serious political issue, both as it relates to community violence and safety in notoriously unsafe spaces such as the Superdome and as it relates to the military occupation that took place in the name of 'restoring order' to New Orleans. We would realize how critical it is to develop our own community-based resources and responses to violence within our communities, as well as to violence targeting our communities, such as police violence and environmental racism. Centering the lives of women of color – because they are often the primary caregivers for both children and elders – might have helped us anticipate the way that children would be targeted in chaos and the way in which people with disabilities and elders might be trapped in nursing homes and hospitals. Centering undocumented immigrant women, recognizing that often when they experience domestic or sexual violence they do not call the police for fear of deportation, we might have anticipated the dangers faced by undocumented people during and after the hurricane – in which they risked deportation if they asked for help and risked drowning if they didn't."[11]

Here, we return full circle to the most vexing contradiction in the states of exception defining refugees, IDPs and the victims of disaster: that international organisations as currently structured lack either the enforcement power or the political will to translate human rights principles for the excluded into lived reality. Humanitarian relief as a model of intervention tends to be disempowering and paternalistic, treating displaced people like passive victims. Standard human rights mechanisms, on the other hand, are formalistic and legalistic, requiring complaints procedures and follow-up beyond the capacity of uprooted populations in the constrained conditions of camps. Indeed, some have questioned the need for camps altogether, marshalling evidence that, where IDPs and refugees who cannot return home have been settled among the local population and provided free health care and other services, not only they but also local residents experience improved health outcomes and greater autonomy. Thus, Van Damme contrasts the massive cholera and other epidemics, causing some 50,000 deaths, among Rwandan Tutsi refugees sheltered in camps in Goma, Zaire, with the far better outcomes for refugees in Guinea who were settled among the residential population.[12] But the reality is that millions of people do live in camps and have no safe or welcoming place to go, which has prompted calls for renewed international, multisectoral efforts to fortify their health, housing, economic, physical, sexual and reproductive rights – including participation in all key areas of decision-making for women and girls.[13]

While these proposals, aimed primarily at national and international agencies and NGOs, all have merits and are by no means mutually exclusive, they still tend to imagine the inhabitants of states of exception as passive and silent. A more feminist approach would call attention to the extraordinary energy and resilience of displaced communities – often under the leadership of women – to survive, negotiate and rebuild. In northwest Sri Lanka, for example, displaced Muslim women actively rejected the female-unfriendly spatial arrangement in which latrines were located at opposite ends of the camp from wells and living areas (thus necessitating long and dangerous walks in the dark), and instead devised their own outdoor toilet area near the wells.[14] Under conditions of the worst imaginable devastation and near total abandonment by state and federal governments – including the continued closure of the local Charity Hospital

system and out-migration of many private physicians – the organisation Incite! Women of Color Against Violence opened a women's health clinic to serve low-income and uninsured women of color in New Orleans.[15] In Darfur, where the traditional gender division of labour famously assigns women and girls the task of roaming to collect firewood, resulting in a very high incidence of rapes and assaults, committees of women leaders have organised "firewood patrols" which have, in turn, become a forum for discussing and resolving common concerns.[16]

In these pages, too, there are examples of women's groups coming together in the face of horrific violence and disaster to demand investigations, accountability and gender-specific political and social action, particularly in Gujarat following the commuunal violence in 2002, in the wake of the 2004 Indian Ocean *tsunami* and the 2005 earthquake in Pakistan (see the paper by Khanna and review by Silverstein). These initiatives by feminist advocates to act on women's own behalf to pursue sexual and reproductive rights within a larger framework of social justice reaffirm the need for a new paradigm among humanitarian and public health workers that will allow the people directly affected "to define their needs and to find the appropriate solutions during disasters, rather than having external organizations impose solutions on them".[17] On many levels, these examples and the papers themselves attest to the power of Izugbara and Undie's call for a perspective on sexual rights that links bodies to communities.

Acknowledgments

Many thanks to Marge Berer, for unflagging support throughout the guest-editing process; Melissa Laurie, for her invaluable collaboration in earlier versions of this work; Leni Silverstein, for superb back-up in numerous ways; and all the excellent reviewers of manuscripts for this issue.

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Searching for baby clothes at Astrodome stadium after Hurricane Katrina, Houston, USA, 2005

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