



# Safe Motherhood in refugee settings

“Whatever a woman’s choice in terms of the number and timing of her children, childbirth must no longer carry with it the risk of death or disability for her and her newborn which it has held for far too long.”

World Health Organisation, Safe Motherhood Progress Report 1993-1995

Safe Motherhood is a critical part of saving lives in refugee situations. This approach seeks to ensure that women receive appropriate attention throughout their pregnancy and childbirth, providing pre and post-natal care including care of the baby and breastfeeding support, and delivery care, with referral for women with obstetric complications.

Pregnancy and childbirth are recognised health risks for women in developing countries. UNICEF estimates that 15 million women a year suffer long-term, chronic illness and disability because they do not receive the care they need during their pregnancy.

These risks are magnified for women living in refugee settings, where the majority give birth in temporary shelters where conditions are hazardous both for themselves and their children. Many refugee women are already seriously physically weakened as a result of the trauma and deprivation associated with their flight. The poor nutrition and stressful living conditions often associated with camp settings only compound this problem.

Without Safe Motherhood interventions, many refugee women and their newborns will die needlessly. The consequences of inaction affect the entire refugee community and exacerbate the difficulties and instabilities of refugee life. In refugee settings, a woman is often the main provider for her family, if she dies her family is left without her care, support and protection.

## Case study

In 1997, when members of the Reproductive Health for Refugees Consortium visited Somali refugee camps in eastern Ethiopia the need for emergency obstetric care was clear. 90% of births took place in traditional *tukuls* (traditional spherical-shaped huts with wooden frames covered with woven grass and UNHCR blue plastic sheeting or wattle), in poor conditions. Most refugee women were unaware of risk signs during their pregnancies and so were not referred in good time to Karamara hospital in Jijiga.

The hospital was at least one hour's drive away from the camps and in addition, ambulance services were controlled not by medical staff but by camp administrators and were not available 24 hours a day. Because of the lack of ambulances or alternative transport, it was often impossible to hospitalise cases of obstetric emergency.

Initiatives to improve the general health of refugee populations must seek to:

- reduce the numbers of high risk and unwanted pregnancies
- reduce the number of obstetric complications and
- reduce the number of women dying from obstetric complications.



## Key facts

- 585,000 women in developing countries die every year as a result of pregnancy, and many times that number of women suffer infection or injury<sup>1</sup>
- life-threatening complications of pregnancy (prenatal and postpartum haemorrhage, infection, eclampsia, obstructed labour, and complications of abortion) are responsible for nearly three-quarters of maternal deaths<sup>2</sup>
- 50% of all perinatal deaths are due primarily to inadequate maternal care during pregnancy and delivery.<sup>3</sup>

## What can be done?

### In emergency situations

At a minimum, in the initial phase of a new refugee situation, the following must be provided:

- clean delivery kits for self-use by women
- UNICEF mid-wife kits
- post-coital contraception on request
- facilities to provide essential obstetric care.

These are all elements within the Minimum Initial Services Package (MISP), developed by the Inter-Agency Working Group, for the introduction of vital services without further needs assessment.

Breastfeeding is particularly important in emergency situations. The risks associated with bottle feeding and breast milk substitutes are dramatically increased in refugee settings due to poor hygiene, crowding and limited water and fuel.

### In stabilised situations

Comprehensive services for antenatal, delivery and post-partum care must be organised as soon as feasible, including:

- risk screening
- detection and management of complications
- observation and recording of clinical signs such as height, blood pressure, oedemas, uterine growth, foetal heart rate and presentation
- maintenance of maternal nutrition
- health education
- preventive medication such as iron folate, tetanus toxoid immunisations, antimalarials and antihelminthics
- provision of skilled assistance
- clean and safe delivery
- recognition, early detection and management of complications
- 24 hour referrals and transportation to emergency obstetrics facilities
- attention to the health of the new born
- recognition, early detection and management of complications in new mothers
- information and services for family planning
- promotion and support for breastfeeding within the first hour.



## References

<sup>1</sup> The State of World Population, UNFPA, 1999

<sup>2</sup> Safe Motherhood and the World Bank, The World Bank, 1999

<sup>3</sup> Progress on maternal mortality, UNICEF, 1996

**Note:** The term 'refugee' officially describes a person who has crossed an international border, while an 'internally displaced person' (IDP) has had to leave her home but has remained in her own country. For the purposes of this factsheet, 'refugee' is used here to refer to both groups.

Produced by Marie Stopes International for the Reproductive Health for Refugees Consortium. For further information contact:

Samantha Guy, Marie Stopes International,  
153-157 Cleveland Street, London W1T 6QW, England.  
Tel: + 44 (20) 7574 7346, Fax: + 44 (20) 7574 7418

or

Rachel Jones, Women's Commission for Refugee Women and Children, 122 East 42nd St, New York NY 10168, USA.  
Tel: + 1 (212) 551 3112, Fax: + 1 (212) 551 3180.

## Technical resources

Contraceptive Guidelines for Refugee Settings, John Snow International, 1996

Five Day Training Program for Health Personnel, Reproductive Health Programming in Refugee Settings, CARE on behalf of the RHR Consortium, April 1998

One Day Awareness Building Module Intro to Reproductive Health for Refugee Settings, CARE on behalf of the RHR Consortium, April 1998

Refugee Reproductive Health: Needs Assessment Field Tools, RHR Consortium, 1997

The Reproductive Health Kit for Emergency Situations, UNFPA, 1998

Reproductive Health in Refugee Settings: An Inter-Agency Field Manual, UNHCR/UNFPA, 1999

Setting Priorities in International Reproductive Health Programmes: A Practical Framework, Columbia School of Public Health, 1996

## Further reading

Safe Motherhood Issue 23, WHO, 1997

Mother-Baby Package: A Guide to Saving the Lives and Improving the Health of Mothers and New-borns, WHO/FHE/MSM/94.11

Safe Maternal and Newborn Care: A Reference Manual for Program Managers, Susan Rae Ross, CARE, 1998