Chapter Five

RWANDA

Are They "Refugees"? Why Are Relief Agencies There?

No discussion of reproductive health for refugees would be complete without first considering the international community's experiences in the Great Lakes region of Central Africa. The 1994 genocide and subsequent mass displacement of people in Rwanda was one of this century's worst humanitarian crises. These tragic events presented seemingly intractable moral and ethical dilemmas to the international community and redefined the term "complex emergency". Relief agencies have been deeply affected by the crisis, both because of the extraordinary effort required to meet the needs of those in the Great Lakes region and because of the many lessons learned over the past four years. We know now how critical RH services are, and how important it is to involve refugees in addressing their own needs as early as possible to begin planning for longer-term development.

The RH status of women in Rwanda may be worse now than before the war. According to a 1996 socio-demographic survey, maternal mortality is as high as 810 per 100,000, HIV seroprevalence rates in semi-rural settings have increased dramatically, and use of modern contraceptives has dropped by 50 percent.

The RHR Consortium team visited Rwanda twice, in July and November 1997. This report focuses primarily on Rwanda because many of those affected by the emergency now reside there. The current government asserts that there are no refugees in Rwanda, with the exception of a small number of people who fled the Democratic Republic of the Congo (DRC) and Burundi. Since most Rwandans who have repatriated were required to return to their original village, genocide victims and perpetrators now live side by side. This tense situation has already resulted in land disputes and homelessness, and the potential for renewed violence is great. About 700,000 Tutsis who fled to Uganda in the 1950s have also recently returned to Rwanda. These refugees, referred to as "old caseload" refugees, have been relocated in what were formerly national game parks in the northeast part of the country. They are living in refugee-like situations, in camps, and are still largely dependent on outside assistance for basic provisions, including food, water and medical care.

It is likely that in the coming years, ethnic violence will continue to erupt periodically throughout the Great Lakes region. The crisis in Rwanda clearly demonstrated that preparedness and planning could significantly mitigate suffering–or perhaps even prevent similar large-scale tragedies. The international

community should, therefore, honestly acknowledge its shortcomings and failures during the Great Lakes emergency and, more important, work to ensure that they will not be repeated in the future.

Background

In April 1994, a plane carrying Rwanda's President Juvenal Habyarimana was shot down, igniting a bloody civil war. From April until June, a well-orchestrated campaign of mass murder was staged in Rwanda. An estimated one million people, nearly all of them Tutsis and moderate Hutus, were massacred by military personnel and civilians. The ensuing counter-offensive, led by the Tutsi-dominated Rwandan Patriotic Front, sparked one of the largest and fastest refugee flows in modern history. Nearly two million people fled the country into neighboring Zaire, Tanzania and Burundi. Because Burundi also teetered on the brink of a large ethnic conflict between its Tutsi and Hutu populations, there were often two-way refugee flows in the area.

Ethnic relations in Rwanda and the Great Lakes Region are volatile and complex. Although Hutu and Tutsi groups share a common language and many cultural traits, history has placed the two ethnic groups in competition for power. During the 19th century, colonial Belgians exacerbated the already-precarious situation by favoring Tutsis with jobs and educational opportunities. Over the second half of this century, the Hutu majority assumed political control of Rwanda. This power shift further polarized the two communities and led to the formation of radically nationalistic political and military groups. In the months before civil war broke out, extremist Hutu politicians waged a hate campaign against Tutsis and moderate Hutus. Many observers argue that the genocide could have been predicted and prevented, or at least stopped, by more timely intervention.

Courtesy of IRC/Lorelei Goodyear

A refugee woman takes a stand on violence against women.

For more than two and a half years, the international community, led by UNHCR, supported almost two million Rwandans in exile. The cost was staggering, and UNHCR made little headway in its efforts to repatriate refugees. As it turned out, the repatriation to Rwanda was nearly as dramatic and unexpected as the original flight. From the beginning, the refugee camps held mixed populations of civilians and armed members of the former Rwandan army and militia. In late 1996, Tutsi-sponsored military strikes were

launched against several of the largest camps in the former Zaire. Alleged Hutu insurgents were either killed or driven deeper into the forest, while approximately 1.3 million Rwandan refugees flooded home. The repatriation was so sudden and so massive that it overwhelmed both the government of Rwanda and the international community. Refugees crossed the border at a rate of twelve thousand per hour; approximately half a million refugees returned home during one four-day period. Most made the trek on foot, forming a river of humanity stretching nearly 100 miles. But their journey back to their former lives was far from over.

Reproductive Health in the Tanzanian Refugee Camps

During the initial crisis, international response focused on basic needs: providing food, water, shelter and basic medical care. Major public health priorities included preventing and controlling communicable diseases, such as cholera. During this time, little attention was given to reproductive health. Once the refugee situation stabilized, which happened rapidly, it seemed as if many factors favored early and vigorous implementation of RH activities. At the time of the crisis, policy pressure for RH services was growing from NGOs and advocacy groups. Since refugees came from and fled to areas of high HIV seroprevalence, there were clear epidemiological reasons to increase prevention efforts in order to stem a predictable epidemic. Soon after the initial refugee flow, a knowledge, attitudes and practices (KAP) survey was conducted in the Tanzanian camps by JSI Research and Training Institute. The study documented a breakdown of social norms among young people and behavior patterns that would put refugee communities at high risk for HIV and other STDs. At the time, few condoms were available in camps, and there was little motivation among the refugees to take preventive measures.

"Reproductive health services are a basic right of any couple or person. There is no reason to deny them in any situation."

Former director of CARE Rwanda's Byumba Maternal Health Project

Ironically, before the war Rwanda had one of Africa's better family planning programs. Contraceptive prevalence was as high as 13 percent, which is considered excellent for francophone Africa. This is particularly notable given that 90 percent of the Rwanda's population lives in remote, hilly areas. Anecdotal reports from women and men in the camps confirmed that the population needed and wanted RH services. Even though camp health workers reported that maternal mortality rates decreased while women were in the camps, greater emphasis could have been placed on educating the refugees about potential emergency obstetrics complications and on providing family planning services.

One of the lessons learned from working in the Tanzanian camps was the importance of planning for RH services as early as possible in the crisis. Even though many refugees had been trained as health workers, their expertise and assistance was often overlooked. Those who did help proved invaluable. In Rwanda, for example, CARE had coordinated community-based RH programs in the Byumba region and followed displaced communities as the situation in Rwanda deteriorated. When refugees crossed the Rwandan border, many CARE health workers fled

Barbara Monahan/CARE

Women gathered to discuss their RH concerns through participatory exercises..

with them, bringing along their experience in community education and community-based distribution in addition to supplies and materials.

Eventually AIDSCAP funded CARE, Population Services International and others to initiate HIV/AIDS prevention programs (see box). While distributing condoms and raising awareness were central elements of the programs, no significant funding materialized for family planning or contraceptive procurement.

In the early stages of the emergency, UNHCR placed a Reproductive Health Coordinator in Goma, Zaire. Because of high demand, her domain soon expanded to include Bukavu. She received support from local UNHCR medical coordinators and NGOs, and local refugee committees were willing to initiate RH programs. But a lack of materials and training as well as insufficient coordination hampered their efficiency. Condoms and other contraceptives remained mostly unavailable six months into the crisis. In the future, responsibility for logistics and supplies must be clearly defined and mobilization of resources must be coordinated to ensure a unified response.

Still, there were some notable program successes. UNHCR and UNFPA funded pilot testing of the Minimum Initial Service Package (MISP), a basic set of life-saving RH interventions for implementation at the earliest stages of an emergency, in the Tanzanian camps. Other successful activities were characterized by a heavy reliance on local and regional professionals and NGOs, such as the African Medical Research Foundation and UMATI, the local International Planned Parenthood Federation affiliate. Collaboration with local personnel was especially effective when using previously-developed materials and training curricula in education and communication programs.

Over time, many women in the camps became victims of sexual violence. Women had to walk long distances alone to collect firewood and so were often preyed upon by attackers. Men guarding the water taps made sexual demands on women in exchange for access to potable water. UNHCR produced guidelines on how to prevent sexual violence and respond to victims. The guidelines were distributed to relief personnel, peacekeeping forces and local health personnel. Relief agencies were sensitized to the importance of improved lighting, security patrols and careful placement of latrines within the camp to help

decrease the likelihood of rape. Still, sexual violence continues to be a major problem in refugee settings (see box on page 55), resulting in a cycle of emotional and physical devastation.

General Health Care in Rwanda Today

Rwanda is a small country, with a population of 7.7 million people. The genocide decimated Rwanda's health infrastructure, particularly its ranks of trained personnel. During the crisis, many doctors and nurses either disappeared, were killed or fled to other countries. UNICEF reports that only 20 percent of the prewar health center positions are now staffed by qualified personnel. Though most health facilities have been rebuilt, there are too few trained personnel to handle the enormous demand for health care.

After repatriation, international donors pledged $500 million for housing, justice programs, agriculture, social services and other development projects. The

In 1992, more than 30 percent of Rwanda's urban population was infected with the virus that causes AIDS. When hundreds of thousands fled genocide two years later, HIV followed them into the hastily-constructed refugee camps in neighboring Tanzania and the former Zaire. With their overcrowded conditions, splintered families, risks of rape and other forms of violence, the camps were prime breeding ground for a potential AIDS epidemic.

The Benaco camp in Tanzania, which housed nearly a quarter of a million people, was the site for the first early HIV/AIDS intervention for refugees. In August 1994, AIDSCAP and CARE launched a program of prevention activities that included training community health educators, distributing condoms and encouraging camp residents to seek treatment for STDs. Later, more specifically-targeted projects where launched, such as "Adolescent Health Days," in which teens were acquainted with the health services available to them; a women's crisis team, which gave social, legal and medical support to victims of sexual violence; and half-time shows at weekly sporting events, in which performers conveyed HIV/AIDS messages through traditional dance and music while condoms were distributed throughout the sports complex.

By the end of the first year, some 80,000 people had sought counseling and treatment for STDs as a direct result of the project. The program was gradually expanded to three other refugee camps; 2,173 peer educators were trained and more than 700,000 people were reached.

Collaboration was key to the success of this project. CARE trained counselors to conduct health education sessions about HIV/AIDS and STDs for patients awaiting treatment at outpatient clinics run by the African Medical Research and Education Foundation (AMREF); PSI managed condom distribution and trained special condom-promotion teams and peer educators; and other organizations working in the camps offered support and assistance wherever possible. The project's impact on the refugee community was nearly immediate and extremely encouraging. Even more auspicious is the tangible proof that, with understanding and cooperation, we *can* help refugees prevent HIV transmission.

Steve Dupont/CARE

government of Rwanda made a conscious effort to maintain control over NGOs by directing the nature, scope and breadth of their work. Like their neighbors in countries such as Eritrea, Rwanda's young, militant leaders want to see their country develop with nationals, not foreigners, assuming leadership roles. According to the Ministry of Health's NGO Coordinator, Rwanda's leaders want to create a health care program with a sustainable primary health infrastructure. They also insist that NGOs help advance national goals and make lasting contributions in both infrastructure and personnel development. While this is a laudable aim that should be supported, Rwanda lacks the human and financial resources to coordinate this effort.

The government stresses that paraprofessionals be trained uniformly on MCH/FP protocols. Yet, at the time of the Consortium team's visit, these protocols did not exist at the national level. This leaves NGOs that want to provide MCH/FP services in a quandary. The Ministry of Health is making an effort to coordinate NGO health programs, and NGOs routinely keep the government informed of their activities. However, the RHR Consortium team observed some tension between NGOs and the government as they learn how to work together.

The new leadership acknowledges the fact that, during the crisis, nearly all foreign aid was funneled to assist the refugees living in neighboring countries while there was still immense unmet need at home. At the time of repatriation, the number of international NGOs in Rwanda skyrocketed to around 200. The lack of coordination among them and competition for international donor funding led to some questionable uses of resources. By the time of our visit, government pressure and attrition had reduced

the number of NGOs to about 55. Fewer than a dozen of these agencies are involved in health, and fewer, still, in reproductive health. (The most visibly active NGOs working in reproductive health during our visit included the American Refugee Committee, the Belgian Cooperative, International Rescue Committee, Norwegian People's Aid, Population Services International and CARE.)

Most major international development organizations, including UNHCR and many bilateral donors, have established offices in Rwanda; and there has been some effort to address the needs of vulnerable groups, particularly widows and women-headed households. But need still overwhelms available resources. Local NGOs, such as the Barakabaho Foundation, struggle to obtain funding for their self-help programs including their micro-enterprise project for widows. On the individual level, many women and men are still trying to cope with the emotional trauma they experienced and, as a result, are having difficulty supporting their families consistently.

"Although women have very little to do in generating conflict, they suffer and carry the heaviest burden as a result of it."

Former Director of CARE Rwanda's Byumba Maternal Health Project

Reproductive Health Care in Rwanda Today

Rwanda is one of Africa's most densely-populated countries with nearly 270 people per square mile. Almost half the population is under 15, and the estimated growth rate is 3.1 percent. Before the genocide, Rwanda ran a large population program through the National Office of Population (ONAPO). Because many of its leaders were implicated in the genocide, ONAPO lost credibility, and only now under new leadership is it beginning to reassert its role in policy debate.

Fertility is rising dramatically in Rwanda. The Rwandan government maintains that population growth and fertility rates are too high and supports reproductive health as an essential component of primary health care services. Politics and ethnic tensions, and the desire to replace those lost, clearly play a role in family planning decisions. At every MCH center that the Consortium team visited, we observed pregnant mothers with small toddlers strapped to their backs and often a second child under five years old clinging to their dress. Maternal and infant mortality rates have risen dramatically to 810 per 100,000 live births and 117 per 1,000 births, respectively. According to an obstetrician interviewed by the Consortium team, most of these deaths are attributed to complications of pregnancy and delivery, such as hemorrhage, obstructed labor, eclampsia, abortion and sepsis, and are exacerbated by frequent childbearing, malaria, anemia and nutritional deficiencies and by poor management of complications.

In focus group discussions in the Gitarama prefecture, women cited irregular menstruation, closely-spaced births, delays in attending prenatal clinic and delays in seeking qualified assistance during a crisis delivery as their most pressing RH problems. Some of these problems resulted from an inability to cover the cost of delivery, the perceived poor quality of care at health centers due to a lack of technical skill and discretion, lack of security at night and lack of trust in their neighbors. Time and again, community mem-

Wendy Driscoll/CARE

bers spoke openly about continued politico-ethnic tensions in the community, including their mistrust of neighbors and their fear of vengeance and banditry. These concerns were directly linked to the low utilization of existing RH services.

Community members also spoke of how the genocide had adversely affected the local demographic profile. In one commune in the Gitarama prefecture, the male to female ratio was estimated to be 8.8:10 by community members. Not only were hundreds of thousands of men lost to the genocide, but thousands of others–in some areas, as much as 30 percent of the adult male population–are now in prison awaiting trial. As a result, many families have lost their primary income providers. One consequence of the gender imbalance and shortage of adult men is a desire within communities to replace family members lost during war.

One of the clearest rationales for encouraging child spacing is that it reduces maternal mortality. Yet, closely-spaced births featured prominently among the primary RH problems of women in Rwanda. Some of the negative effects of closely-spaced births as mentioned by women and men include family anguish, despair, premature aging, overpopulation, famine and malnutrition and an inability to care for their children.

The Ministry of Health is trying to improve the quality and coverage of prenatal and postnatal care, the conditions associated with home delivery and the access to and quality of family planning services. Its multi-pronged strategy includes training RH health personnel, providing clinical equipment and supplies, and expanding information, education and communication programs. Contraceptive prevalence rates are less than five percent, down from a pre-war high of 13 percent. Some factors that may account for the decline are a lack of available contraceptives, the cost-recovery systems introduced by the Government, and the great distances men and women must travel to reach health facilities. Abortion is illegal in Rwanda, but according to two obstetricians there, women do request these services.

Rwanda has done much to improve secondary and tertiary obstetrical facilities. For example, the dedicated staff of the national hospital in Kigali provides impressive emergency obstetric services. Still, most women must walk hours to reach health facilities. Approximately 80 percent of women deliver their children at home, unassisted by trained medical personnel. Although 8 in 10 women attend prenatal

Those who have experienced pain will understand.

Most of these women came to us and, in front of us, showed the pain they felt. Tears welled up in their eyes, but tears never fell. Tears just stayed in their eyes because the pain they felt was just too deep to be expressed by shedding tears. We could feel and see that they mourned; but they mourned with their souls. When pain has gone beyond your body, beyond your mind, and beyond your heart to your gut, it touches your soul; it touches you. The pain is just too great and tears from the heart do not carry it away.

Sexual violence touches the innermost privacy, and goes further to make that privacy public. Most of us want to keep something about ourselves private; and it is from those things that our identity springs. Sexual violence affects a woman's sense of identity; and the strong reproach from society and close relations does not make it easier for women to deal with this. It becomes very important for a woman to feel safe and trusting of the person with whom she will share her experience.

Women come to you and first they just look at you. They see deep into your eyes, into your heart and they understand what you feel and think of and about them. And then, from all they see and feel, they decide whether to trust you. As they narrate their ordeal, they do not look at you. One hand continuously covers one eye. When it moves, it is to squeeze the nose so as to stop the mucus from running down.

After you part, their faces stay with you; you hear their voices speak with difficulty of their experiences. They tell of the lack of animalism in the men who commit such atrocities. Animals have feelings for each other, especially for their own kind. Science has shown that lions care for each other and they mourn when one of their number dies. The men in these experiences have made women almost lose trust in humanity. They have proven that they do not have any animal feelings.

- Sydia Nduna, IRC Tanzania Sexual and Gender Violence Project Manager

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A 1997 survey conducted by IRC in the refugee camps in Tanzania found that 27 percent of females age 12-49 had been targets of sexual violence since becoming refugees. Fortunately, sexual and gender violence received significant attention by the agencies working with those refugees. In 1995, UNHCR and CARE organized Crisis Intervention Teams to offer support to Rwandan refugee survivors of sexual violence in the Ngara camps. A year later, IRC started a program to counter the effects of sexual and gender violence suffered by the Burundian refugees in Kibondo camps in Tanzania. The sensitive approach to developing the IRC project and conducting the assessment is described in the report, *Pain Too Deep for Tears: Assessing the Prevalence of Sexual and Gender Violence Against Burundian Refugee Women in Tanzania.* Today, IRC, male and female refugees and relief agencies are working together to reduce the incidence of violence against refugee women and children.

clinic during pregnancy, they often wait until the last trimester. Communication with health facilities is poor; and mothers in labor must often travel on foot to reach referral facilities. Such delays in reaching services could prove fatal in the case of an obstetric complication. Although much more work needs to be done in the field of emergency obstetrics and antenatal care in Rwanda, the reality is that the necessary infrastructure does not yet exist. As the Ministry of Health strives to make RH services more accessible to local communities, family planning services provided through community outreach can serve as a link to the health centers.

The traumatic events of the last four years have profoundly affected social norms and attitudes regarding the value of life in Rwanda. After surviving a genocide, rape, the loss of family members and displacement, many people have little incentive to protect themselves from a fatal disease like HIV/AIDS. As one woman in Gitarama said, "AIDS kills in ten years; maybe we'll die from war or insecurity before that." Still, HIV/AIDS is taking a tremendous toll on both urban and rural communities. Rates of seroprevalence in urban centers have reached nearly 30 percent, among the highest in Africa. These rates are holding constant in cities, but semi-rural populations have experienced a dramatic rise in HIV. A 1996 study conducted by the National AIDS Control Program reports that HIV prevalence rates in semi-rural areas increased from 0.2 percent prior to the genocide to 8.2 percent in the aftermath. More recently, the Rwandan government said that migration and rape linked to the genocide led to a six-fold increase HIV cases. According to a Ministry of Health study, released in May 1998, more than 11 percent of adult Rwandans are infected with HIV, compared to less than two percent in 1986, the last year for which such figures were available. More than two percent of respondents said they had been raped during or after the 1994 genocide; and 15 percent of them have since tested positive for HIV. Alarmingly, four percent of 12- to 14-year-olds tested positive for the virus.

As in other war-torn countries, all Rwandan citizens bear the burden of past violence, especially women who have suffered sexual violence. Although a number of programs are attempting to help Rwandan women cope with the psycho-social effects of sexual violence, these efforts are usually inadequate to the task. The best programs combine sensitive counseling with measures to improve women's health status and provide opportunities for employment. Many of the women interviewed face, with great bravery, a life fraught with inconceivable sadness. These women speak of the ever-present stress and anxiety they feel in being without male company and support. Although the Rwandan genocide has officially ended and refugees have repatriated, many women and men will be haunted by the pain of this tragedy for years to come. Meanwhile, international and local organizations still have much work to do to meet the RH needs of the Rwandan people.

The Next Step

Tragedies of the magnitude seen in the Great Lakes must, of course, be prevented. We must incorporate lessons learned during this crisis in planning for future large-scale refugee emergencies. Preparedness, as we have learned, can save many lives. Early on, sources of supplies and logistical assistance must be identified and mobilization of resources must be coordinated. Refugees should be involved as quickly as possible in determining their own needs. After large numbers of refugees have repatriated, NGOs

working with returnees should cooperate closely with each other and coordinate their activities to ensure efficacy and efficiency. Where health infrastructures have been damaged or destroyed, community outreach services should be quickly established. Information campaigns targeting HIV/AIDS awareness and prevention should be launched both in the camps and in return communities. In a refugee emergency, it is never too early to start providing RH services.

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