



# Reproductive Health Response in Conflict Consortium



## Conference 2003: Reproductive Health From Disaster to Development



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# PROCEEDINGS



*Conference 2003 was organized by the  
Reproductive Health Response in Conflict Consortium  
and co-sponsored by UNFPA and UNHCR.*



The International Centre for Reproductive Health  
at Ghent University was a collaborating partner.



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RHRC Consortium  
c/o Women's Commission  
for Refugee Women & Children  
122 East 42nd Street  
New York, NY 10168-1289

tel: 212.551.3112  
fax: 212.551.3180  
info@rhrc.org  
www.rhrc.org

This document was prepared by Julia Matthews, Sandra Krause and Sarah Chynoweth of the Women's Commission for Refugee Women and Children and edited by Diana Quick of the Women's Commission for Refugee Women and Children.  
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## Foreword

The Reproductive Health Response in Conflict (RHRC) Consortium is pleased to present the proceedings of *Conference 2003: Reproductive Health From Disaster to Development*, the second international research conference on reproductive health for conflict-affected populations.

Significant progress has been made in raising awareness and advancing reproductive health for conflict-affected populations since the mid-90's with the publication of the Women's Commission for Refugee Women and Children's report, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, which documented the severe deficits in reproductive health services for refugees and internally displaced populations and the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, which set the standard for reproductive health care and services in conflict settings. In the ensuing decade, data collection has increased substantially in these settings to inform programming and stimulate advocacy efforts. This conference provided an opportunity to support these endeavors with informative research, successful program models, innovative strategies and practical tools and guidelines. The RHRC Consortium hopes that these findings will be useful to agencies working in conflict settings to improve the quantity and quality of reproductive health programs and for development agencies to further extend their activities to include refugee and other displaced populations. It is essential that the link is made between the humanitarian and development agencies to better serve populations in a more holistic and sustainable manner.

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## Executive Summary

The Reproductive Health Response in Conflict Consortium *Conference 2003: Reproductive Health From Disaster to Development* provided an opportunity for sharing research, model programs, innovative strategies and practical tools and guidelines among a wide range of participants representing governmental and nongovernmental agencies, academic institutions, foundations and policy-making bodies from numerous countries. The conference also highlighted the importance of using research as an advocacy tool to positively impact reproductive health program funding and development and advance the cause of reproductive health for conflict-affected populations.

The Inter-agency Working Group on Reproductive Health for Refugees presented preliminary results on its effort to document the extent of reproductive health services for refugees and internally displaced persons globally. Early findings suggest reproductive health services for internally displaced persons are severely lacking and obtaining data from these settings is difficult but urgently needed. However, in stable settings, although gaps in services persist, preliminary results reveal that the availability of reproductive health services is improving. Emergency obstetric care continues to need attention to reduce maternal death and disability. Family planning availability has improved since the early 1990s, although the quality of services and community usage still vary. Services for the other two components of reproductive health, sexually transmitted infections including HIV/AIDS and gender-based violence, were found to be less comprehensive and in some cases quite limited.

A review of the implementation of the Minimum Initial Services Package noted the value of this set of priority activities for providing reproductive health services in the earliest days of an emergency to reduce maternal and infant mortality, prevent and manage gender-based violence and reduce the transmission of HIV. Unfortunately, the implementation of the Minimum Initial Services Package in the emergency phase is too often delayed. However, using few resources and collaborating with essential local partners, successful collaborations and linkages for emergency reproductive health preparedness have been undertaken in preparation for anticipated crises.

A range of studies presented findings on the four technical areas of reproductive health. Although safe motherhood services are available and are being accessed, there is a critical need to ensure conflict-affected women's access to emergency obstetric care to prevent excess maternal death and disability. Adequate standards for best practices in emergency obstetric care are needed in the current humanitarian relief protocols at the international level to ensure good quality basic and comprehensive emergency obstetric care is available to all conflict-affected women. Assessments of post-abortion care needs and program responses revealed significant unmet need for family planning, resulting in high numbers of women desperately terminating their own pregnancy or requesting assistance to do so. Conflict-affected populations' attitudes toward family planning remain widely variable; however, there is extensive evidence of unmet demand for family planning that should be addressed. More efforts also are required to increase awareness, communication and comfort level in discussing sexuality and human reproduction.

Over the past several years, many gains have been made in the depth and breadth of the HIV/AIDS prevention and response activities, yet many of the basics are still lacking. It is apparent now that prevalence surveys, behavior change communication strategies, voluntary counseling and testing and prevention of mother-to-child transmission interventions can be implemented in conflict-affected settings and, although a challenge, sex partner involvement in these interventions is vital. The assumption that HIV risk is higher in conflict settings has been challenged by new evidence and demands further investigation.

Gender-based violence exists in conflict settings globally, sometimes seen as an increase in incidents of domestic violence or evidenced by rape being used as a weapon of war. Female genital cutting, another form of gender-based violence, is still practiced widely in many places around the world. Although there is a burgeoning of programs and tools to address gender-based violence, more efforts are needed to raise awareness, standardize practice and adopt a multi-sectoral response in the field.

More attention must be directed toward integrating youth and men into reproductive health programming. Adolescents face numerous reproductive health risks in conflict settings; however, services targeting young people are scarce and youth are rarely involved in the design and implementation of programming that affects them. Integrating males into reproductive health programs is critical in getting men to engage in positive reproductive health behaviors as well as to support their partners' efforts toward improved reproductive health.

Implementing quality reproductive health programs depends upon the effective use of monitoring and evaluation tools. Monitoring and evaluation are essential to improving the quality of care provided and can help identify priority interventions such as the need to improve facilities and equipment or increase the number and technical capacity of staff. Monitoring and evaluation indicators for logistics system performance can be used to identify strengths and weaknesses in the supply chain, collect routine data and monitor stock levels—key in refugee settings where programs are faced with sometimes unpredictable fluctuations in population movement. Monitoring and evaluating indicators must measure not only the increase in use of services but also the improvement in reproductive health outcomes.

*Conference 2003* provided an opportunity to learn about and provide feedback on numerous new tools to advance data collection and quality programming in conflict settings. A draft rapid reproductive health assessment questionnaire has been produced that will assist field staff who have minimal epidemiological training to generate and analyze reproductive health data for advocacy, program design and fundraising purposes. A new screening guide to facilitate comprehensive sexual and reproductive health program development is now available. A pioneering standardized survey tool was recently developed, field tested and proven effective in determining the prevalence of gender-based violence in several settings. The survey instrument will assist humanitarian actors to collect data, inform advocacy efforts and design programs to prevent and respond to gender-based violence. New guidelines for developing and maintaining inter-organizational partnerships for humanitarian aid and transition settings were introduced. The Reproductive Health Response in Conflict Consortium launched two new reports, one an evaluation of the Consortium's activities and another documenting progress on reproductive health in conflict settings. The Consortium also released new versions of important field-based training and awareness-building modules and a field-friendly monitoring and evaluation tool kit on CD. The proliferation of these useful tools is excellent and valuable; however, it is now essential to ensure that these tools are used in the field.

Overall, participants rated almost all aspects of the conference highly. They were pleased to engage with colleagues from the South and attend a variety of high-quality presentations. Suggestions for future panels included more attention to peace building and conflict resolution, cost-sharing by host governments and analysis of integrating long-term refugees into host countries' national health plans.

It is critical for the reproductive health in conflict field to make the link to sustainable and long-term programming for populations that are in prolonged situations of displacement. Although many interventions become easier to implement once a situation stabilizes, it is essential to initiate these as early as possible. For example, literacy training has been used successfully in conflict settings

to improve reproductive health seeking behavior. Bridging the gap between the emergency and development settings demands the establishment of diverse networks and partnerships to facilitate the sharing of research, tools and lessons learned necessary for increased collaboration in the field. Linking humanitarian aid with longer-term development assistance is another avenue to maximize resources and seek new funding sources to expand the base of support for reproductive health in conflict settings.

The current challenging political and economic climate threatens the gains achieved in reproductive health for conflict-affected populations over the past decade. It is clear that data—as well as case studies that personalize the issue—are essential not only to inform and improve programming but also to drive advocacy and fundraising efforts. This conference was an occasion to come together to review lessons learned and share experiences, as well as revitalize and strategize for the road ahead.



*Roundtables provided participants an opportunity to discuss issues in depth.*

# Highlights

## 1. Introduction

The Reproductive Health Response in Conflict (RHRC) Consortium (formerly the Reproductive Health for Refugees Consortium) hosted its second international research conference, *Conference 2003: Reproductive Health From Disaster to Development*, on October 7 and 8, 2003 in Brussels, Belgium with co-sponsors UNFPA and UNHCR, and collaborating partner, International Centre for Reproductive Health at Ghent University. More than 150 people from 36 countries representing 70 organizations participated in the conference, bringing together people from Asia, Africa, Australia, Europe, and North and South America to share program findings and research on conflict-affected populations around the world. The first conference of this kind was held in December 2000 in Washington, D.C. Hosting this year's conference in Brussels allowed for greater participation by partners from around the world.

"Great conference and really inspiring to see the work that is being done. Learned a lot!  
Thanks!"

- Conference participant

## 2. Conference organizing

### Abstract Review

More than 100 abstracts were received on a wide range of topics related to reproductive health for conflict-affected populations. A panel of reviewers was organized, which included 32 people from academic, governmental, nongovernmental and international agencies. The panel appraised the abstracts and selected 47 for panel, 28 for roundtable and 16 for poster presentations. Presenters working in low resource countries were eligible for travel scholarships to attend the conference.

### Participation of Field-based Colleagues

Conference organizers spent a great deal of time working to facilitate the attendance of scholarship participants as well as other participants from the South whose participation was challenged by the effects of September 11, 2001 which have resulted in increased travel restrictions worldwide. Thanks to donor support more than 31 presenters received travel support, providing for a valuable exchange of ideas between colleagues from the North and South.

"Great to get so many presenters from the field."

- Conference participant



*Presenters had an opportunity to practice the day before the conference.*

### **Practice, Practice, Practice**

The RHRC Consortium offered presenters an opportunity to attend a practice day before the conference which provided helpful tips when preparing PowerPoint presentations, suggestions for public speaking and hands-on assistance in revising and improving presentations. Thirty-two people from 17 countries participated in the practice day. Audience comments indicate that this day made a positive difference in communicating the important information brought by partners in the field.

“What I preferred most was that the RHRC did bring Africans [to the conference] and helped them to present their work with ease, pride and conviction—congratulations!”

- Conference participant

### **3. Opening**

#### **European Parliament Members Call for More Support from EU**

Members of the European parliament (MEP) Ulla Sandbaek and Anne Van Lancker opened the conference calling for the European Union (EU) to strengthen its commitment to reproductive health for conflict-affected populations, particularly in the current challenging political environment. Ms. Sandbaek stated that the EU has already stepped up its commitments to reproductive health in response to the opposition by conservative forces. She also explained various mechanisms through which funding can be solicited for reproductive health activities within the EU and specifically noted the *Aid for Uprooted People* as a flexible funding instrument which supports populations from the time of displacement through to reconstruction and development phases. Ms. Van Lancker noted the EU's role in introducing a gender dimension into asylum policy and pointed to the EU's asylum and immigration policy area as an avenue for further development. She also described a number of Belgian initiatives, including the International Centre for Reproductive Health's research and advocacy efforts to reduce maternal death and illness in conflict settings and Belgian women's organizations that have been fighting for the reproductive rights of asylum seekers. Both MEPs noted the importance of providing themselves and other policy makers with the evidence necessary to advocate for progressive reproductive health policies and the value of linking humanitarian aid and longer-term development cooperation to maximize the efficiency of the European Commission's development assistance.

#### **Conference Agenda**

Following the plenary session, three panel presentations were held concurrently. Lunch was provided in the meeting site which allowed participants to network and share some relaxed time together. Two more concurrent sessions were held in the afternoon, the first with three concurrent panel presentations and the second with one panel presentation concurrent with two sequential

sets of roundtables. The RHRC Consortium hosted a reception in the evening. The final day of the conference opened with two concurrent sessions of three panel presentations each, which was followed by another networking lunch. Presenters discussed their posters with attendees. A final concurrent panel session ended the formal conference presentations. The closing session provided the perspective of two field practitioners and a final wrap-up by the RHRC Consortium.

“So many interesting panels making it difficult to choose.”

- Conference participant

#### 4. Sessions

##### **Global Evaluation of Reproductive Health in Conflict Settings**

The Inter-agency Working Group (IAWG) on Reproductive Health for Refugees presented preliminary results of its effort to document the extent of reproductive health programming for refugees and internally displaced persons globally using literature review, a coverage survey and key stakeholder interviews to assess quality and quantity of services, internal agency changes and funding trends. An important finding of the literature review was that reproductive health services for internally displaced persons were severely lacking and in need of urgent attention. However, in stable settings, although gaps in services persist, early findings reveal that the availability of reproductive health services is improving. For example, the literature review confirmed a range of safe motherhood services was available at most refugee sites and generally well used and that reproductive health indicators and outcomes for the refugee population were often better than in the host or home countries of the refugees. However, emergency obstetric care still demanded attention to reduce maternal death and disability. The study also suggested that although family planning has improved since the early 1990s, services still vary in regard to availability of methods, the abilities and skills of service providers and the level of usage by the community. The other two components of reproductive health, sexually transmitted infections (STI)/HIV/AIDS and gender-based violence (GBV), were found to be less comprehensive and in some case quite limited. STI/HIV/AIDS services varied based on availability of drugs, skills of service providers, partner notification and treatment, condom distribution and supplies for adherence to universal precautions. Although a number of efforts had been made to establish clear systems, roles and responsibilities for GBV prevention and response, services were often unavailable, lacked defined protocols, practices and procedures and tended to focus on rape survivors.

The IAWG evaluation also included a coverage survey sent to key informants in 73 countries with 10,000 or more refugees or internally displaced persons. Responses were received from 33 countries representing approximately 8.5 million displaced people, three-quarters of whom were refugees living in camp settings. The survey confirmed much of the findings of the literature review in that GBV programming is weak and areas such as HIV/AIDS and emergency obstetric care need more attention. Essentially, coverage was found to decrease with the newness of the technical area. Thus, GBV and HIV/AIDS, newer and less familiar and therefore more difficult programmatic areas, showed the lowest coverage, while antenatal care, the most common and straightforward to provide, had the highest coverage. In addition, the lack of information gathered from internally displaced settings again illustrates the challenge of obtaining data from such settings in the earliest days of an emergency and reinforces the necessity of intensifying efforts in these areas.

Another component of the evaluation reviewed the implementation of the Minimum Initial Services Package (MISP)<sup>1</sup> of reproductive health services and corroborated the other findings of the IAWG

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<sup>1</sup> The MISP is a series of actions needed to respond to the reproductive health needs of populations in the early phase of a refugee situation (which may or may not be an emergency). The MISP is not only kits of equipment and supplies; it is a



evaluation, noting the need to strengthen obstetric emergency referral systems and reinforce HIV prevention through safe blood supplies and universal precautions. In addition, it was clear that the MISIP provides a useful set of priority activities for providing reproductive health services in the earliest days of an emergency to reduce maternal and infant mortality, prevent and manage GBV and reduce the transmission of HIV. Although the reproductive health kits—an essential part of MISIP implementation—provide many necessary resources, there is a need to continually modify the kits' contents to respond to the needs identified in the field, and training is required on the correct use of the kits. Preliminary results from a review of funding trends for reproductive health over the past decade revealed that the major sources of funding remain unchanged and that funding has declined since 2000, pointing to the need for continued advocacy around these issues.

Evaluation activities will also extend to the field with study trips planned to evaluate the quality of and identify factors that facilitate or hinder access to, use of and satisfaction with reproductive health services. Interviews will be conducted with service providers, policy makers and administrators, users and non-users of reproductive health services and women's groups. Opinions of women, men and young people will be solicited in focus groups and health facilities will be assessed through observation visits. Finally, a survey will be administered to a range of agencies and institutions involved in reproductive health services for refugees and internally displaced persons to assess the changes over time within these organizations. Final results of the IAWG global evaluation will be available in 2004 and widely disseminated so that programs may build on the lessons identified to expand reproductive health services in emergency settings worldwide.

#### **Reproductive Health Clinical Care through the Phases of Conflict**

The United Nations Population Fund (UNFPA) reported on contingency planning conducted for the provision of emergency reproductive health services in situations of military and ethnic conflicts. Typically, life-saving reproductive health services included in the MISIP of priority reproductive health activities in the emergency phase are slow to be implemented. However, with minimal resources and essential local partners, successful collaborations and linkages for emergency reproductive health preparedness, have been undertaken in preparation for the Iraq crisis and in West Africa. Strategies, responding to signals of a potential crisis, involve the development of regional action plans, strengthening of cross-border initiatives and MISIP training for regional development and humanitarian relief actors, as well as the deployment of MISIP supplies during the pre-crisis phase. The presentation made a clear call to donors to support reproductive health emergency preparedness and contingency planning in anticipation of a crisis and the implementation of critical reproductive health services in the earliest days and weeks of emergencies.

One panel highlighted situations where refugees are dispersed in development settings, including urban areas, noting that their specific and significant reproductive health needs could remain unknown unless targeted efforts to identify them were undertaken. Establishing effective programs must include ensuring adequate services at stationary clinics where the reproductive health knowledge and attitude of service providers, including displaced or refugee service providers, must not be overlooked. In addition, comprehensive programs should include outreach to communities using, for example, community mobilizers or mobile clinics. Marie Stopes Mexico used this approach successfully to reach recently returned Guatemalan refugees who did not have access to health services due to their remote location. Identifying key reproductive health focal points,

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set of activities that must be implemented in a coordinated manner by appropriately trained staff. It can be implemented without any new needs assessment since documented evidence already justifies its use. The MISIP prevents excess neonatal and maternal morbidity and mortality, reduces HIV transmission, prevents and manages the consequences of sexual violence and includes identifying a focal point and planning for the provision of comprehensive reproductive health services integrated into the primary health program in place.

including male focal points from the community, has proven successful in the use of reproductive health services by conflict-affected populations.

Working through development agencies experienced in reproductive health programming with a cost recovery objective and planning from the start for long-term project continuation were presented by Population Services Lanka as ways to increase sustainable reproductive health programming in conflict-affected settings. Financial management success was shown through a mix of service fees: sliding scale based on a client's ability to pay, cross-subsidization and an endowment fund. A key component of the strategy is to involve the community and work closely with the government and other agencies. Marie Stopes Kenya found it was able to improve maternal health among urban refugees in Nairobi by increasing access to emergency obstetric care facilities through involving the community in its efforts and providing appropriate information, education and communication (IEC) materials and quality service delivery. Development agencies are well positioned to facilitate collaboration among other local and international development agencies to achieve project objectives.

Where international support services include both the host community and the local population, host communities may become more invested in responding to the needs of the displaced population to improve the overall health of the community and tension between the two groups may be prevented or mitigated.

#### **Reproductive Health Risk and Response**

The conference provided an opportunity to highlight the importance of research and how data can positively impact reproductive health program funding and development. CARE International reported that the widely publicized 2001 report by the International Rescue Committee (IRC) on war-related mortality in the Democratic Republic of Congo (DRC) influenced their decision to establish a country office in the DRC in 2002 where they subsequently implemented health programs including reproductive health projects. A baseline reproductive health survey was later conducted and funding was secured from the European Commission on Humanitarian Operations (ECHO) for program implementation. CARE's presentation demonstrated the challenges to conducting research in unstable settings and also stressed the critical role data play in guiding programming and supporting advocacy efforts. In addition, the findings of the study illustrate that unstable areas where data cannot be collected for security reasons are most likely in greater need of services. For example, the findings from participants in the CARE study—which could only reach 50 percent to 80 percent of villages in the unstable health zones of Kisongo and Kibongo—revealed high infant, maternal and fertility rates with a great unmet need for reproductive health services. The unmet need for family planning was high at 67 percent, women had no access to any modern contraceptives; and more than two-thirds of deliveries occurred at home with untrained traditional birth attendants (TBAs). Finally, the presentation relayed a message to donors: the short duration (often only six months of funding) of relief projects makes research and reproductive health programming a challenge.

Post-abortion care (PAC) needs and program response revealed a significant unmet need for family planning, resulting in high numbers of women desperately terminating their own pregnancies or requesting assistance from traditional birth attendants to do so. Women suffer significant morbidity and mortality as a consequence of unsafe abortions. One study of 43 women admitted to hospitals for PAC complications found that nearly one-third of women had five or more pregnancies and a third had had a previous abortion. Methods for self-inducing abortions include the insertion of bamboo and other sticks in the uterus, uterine pummeling, oral medicines sold over the counter and local herbal remedies. Studies show that health care workers are often not trained in PAC and do not follow standard protocols for treatment of life-threatening abortion complications. While manual vacuum aspiration—recommended best practice for first trimester incomplete abortion—has recently been initiated following collaborative partnerships for technical

training and assistance in some settings, less effective and more dangerous sharp curettage is still used in other settings. In addition, PAC frequently does not include timely family planning counseling, essential to preventing additional unwanted pregnancies. The establishment of standard protocols for PAC is urgently needed in all conflict-affected settings. Training and technical assistance for health providers in the use of standard PAC protocols must be undertaken to increase conflict-affected women's access to good quality PAC to prevent maternal deaths.



*Participants asked questions during panel presentations.*

### **Saving Mothers' Lives**

There is a critical need to ensure conflict-affected women's access to emergency obstetric care (EmOC) to prevent excess maternal death and disability. Respondents to the IAWG global study of reproductive health services coverage revealed that life-saving emergency obstetric care is available in less than 45 percent of the refugee and IDP settings where responses were obtained (not reflecting the quality or use by women in need of these limited services). Other studies show a lack of protocols and guidelines for the provision of EmOC at the field level and inadequate referral systems. In addition, a Ugandan study revealed how a parallel model of health services resulted in significant disparities in access to health care and health status between the refugee and host populations, reflecting the need to include host country populations affected by conflict.

One presentation highlighted the need for adequate standards in best practices in EmOC in humanitarian relief protocols at the international level. The United Nations Process Indicators developed by UNICEF, WHO and UNFPA in 1997 to assess and monitor the availability, use and quality of EmOC services should be integrated into humanitarian relief standards, protocols and guidelines. The

UN Process Indicators should be widely distributed and training and technical assistance should be provided to health workers in humanitarian settings on the UN Process Indicators to systematically ensure good quality basic and comprehensive EmOC are available to all conflict-affected women.

In Afghanistan, increasing remoteness of a community is associated with a lack of access to health care and increased risk of maternal death. A study by the Centers for Disease Control (CDC) found a maternal mortality ratio of 6,500/100,000 live births in its most remote study site in Ragh, Badakshan province—the highest ever recorded anywhere in the world. Most deaths were due to obstructed labor, a condition which can be remedied by Caesarian section, a procedure that should be available in a local referral hospital. The CDC noted that potential contributors to higher mortality in rural areas include lack of other basic health services such as vaccine, nutrition and sanitation services. The CDC concludes that evaluating the most important components of health care to reduce maternal mortality may help to guide resource allocation and service implementation to conflict-affected settings.

Maternal mortality is now used as an indicator for human rights abuse. A study by Physicians for Human Rights identified lack of access to quality health services, inadequate food, shelter and clean water, and denial of personal freedoms as factors contributing to the high maternal mortality ratio (593/100,000 live births) found in 13 districts of Herat province, Afghanistan. This study highlights the lack of attention to maternal health and that maternal health services must be integrated into an overall public health plan. The experience in Afghanistan also calls for guidelines for field staff and donors on obtaining information in a crisis situation.

In many cultures, women must gain approval from their husbands or mothers-in-law to seek health care, reflecting the importance of involving them in safe motherhood IEC campaigns. A study in the urban area of Afghanistan also noted the importance of looking at reproductive health outside of the health context to consider the impact that education and women's social position exert on their reproductive health status. Finally, these studies also underline the importance of data to inform and support advocacy efforts and that stories illustrating the personal impact of maternal mortality are essential to personify statistics.

#### **New Learning on and Challenges to Addressing HIV/AIDS**

Over the past several years, many gains have been made in the depth and breadth of HIV/AIDS prevention and response activities, yet many of the basics are still lacking. It is apparent now that prevalence surveys, behavior change communication (BCC) strategies, voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) interventions can be implemented in conflict-affected settings and, although a challenge, sex partner involvement in VCT and PMTCT is vital.

More efforts are required to increase awareness, communication and comfort level in discussing sexuality and human reproduction. There are alarmingly low levels of knowledge about basic sexuality among youth, particularly girls, putting them at increased risk when they do initiate sexual activity. In order to increase individual and community involvement in the prevention and management of HIV/AIDS, people must understand their degree of personal risk as well as how people living with HIV/AIDS are coping in their society. Moreover, integrated programming is required to address HIV/AIDS and the physical, social and psychological realities of conflict-affected populations' survival needs. While HIV/AIDS IEC campaigns can make a difference, it is clear that well-designed BCC strategies—targeted to high-risk groups such as commercial sex workers, military groups and youth—reflect significant improvement in HIV/AIDS prevention.

UNHCR provided evidence that populations in conflict settings—typically thought to be at higher risk of contracting HIV—in some circumstances, such as Angola, where people have been isolated and less mobile, may keep their prevalence rate lower than that of neighboring countries. More trend data are needed to continue to monitor how HIV prevalence among refugee and local populations changes over time. UNHCR called for increased advocacy to ensure that refugee populations are included in national strategic plans and for donors to target their funding to comprehensive programs that include all relevant groups in a country.

Many countries affected by conflict and refugee movements are also battling an HIV/AIDS epidemic; for example, Sierra Leone is a nation struggling to rebuild after a decade of civil war. The American Refugee Committee (ARC) shared results of its intervention to improve knowledge, attitudes and behavior regarding HIV among core transmitter groups—military, sex workers, youth and ex-combatants—in Port Loko. Significant increases in knowledge and reported use of condoms were shown; however, negative attitudes toward people living with HIV (PLWA) persisted at a high rate. Perception that personal risk is low points to the need to increase efforts to change personal attitudes. CARE's project in a rural area of Sierra Leone highlighted the lack of condoms in the country and noted family communication and economic recovery as key to addressing HIV. The question remains as to how areas of intervention are selected and the ethical dilemma of choosing to intervene in one province and not another. The International Rescue Committee's (IRC) program in Kenema district showed an increase in HIV knowledge but did not result in behavior change, i.e., people did not increase their use of condoms nor did they feel more comfortable discussing sex. IRC plans to focus on increasing male involvement and developing new strategies to improve condom use.

### **Preventing Gender-based Violence and Assisting Survivors**

Gender-based violence exists in conflict settings around the world, sometimes seen as an increase in incidence of domestic violence or evidenced by rape being used as a weapon of war. The IAWG coverage survey, although it does not report on the quality of programs, reflects that just over half of survey respondents implement GBV prevention and/or response programs with up to 60 percent of those providing emergency contraception for survivors of rape. Documenting these programs is important to add to the little information currently available about programs addressing GBV in conflict-affected settings. For example, domestic violence is a clear problem in many conflict-affected settings, yet there is little information about programs to address it. One flagship domestic violence project designed by a local NGO among Palestinian refugees in Lebanon resulted in increased reporting of incidents and use of counseling services. In one study nearly 25 percent of respondents in a survey of women aged 18-49 years in East Timor reported physical assault by an intimate partner during the crisis. In another study of conflict-affected populations in northeastern Uganda, all respondents, 70 percent of whom were women, reported torture experiences with medical and psychological problems 11 years after the war trauma. This study indicates the need to address the larger psychosocial issues related to conflict and sounds yet another call for multidisciplinary holistic trauma care for torture survivors. A program undertaken in northern Uganda underlined the importance of addressing the causes of GBV through continual community participation in psychosocial help workshops as well as improving access to alcohol abuse prevention and treatment programs and economic opportunities.

Female genital cutting (FGC), another form of GBV, is still practiced widely in many places around the world, including in the Somali community. Operations research carried out by CARE found that new groups of Somali refugees in Dadaab refugee camp in Kenya, which had not engaged in the practice previously, were taking up FGC due to the influence of settled groups in the camp. In addition, it was found that mothers were very influential in decisions and that religious leaders had varying opinions on the topic. The study found that addressing FGC through social change can lead to positive outcomes and that it is critical to attempt change only in a long-term setting, as support must be continued to prevent negative outcomes. ARC Thailand also found that attitudinal change takes long-term intervention and that community change is not a linear process, suggesting that policies must be supported by community will and must recognize key stakeholders and community leaders.

### **Involving Men and the Community in Family Planning Efforts**

Conflict-affected populations' attitudes toward family planning remain widely variable. However, there is evidence of unmet demand for family planning that could be addressed with more community-based outreach and education on contraceptive methods and by ensuring the availability of contraceptive commodities. The IAWG coverage survey suggested that although family planning availability has improved in the last decade, service provision and usage is far from uniform.

Fear of harmful effects of family planning identified in some studies reflects the importance of community education about contraceptive methods as well as clear counseling for family planning clients and diligent follow-up of defaulters. Integrating male involvement in both community and couples education about family planning is also critical. A study in Tanzania found that women discontinued their use of family planning primarily because their partners forbade them, while men reported the feeling that family planning programs were excluding them. Frequent meetings with men helped to ensure continuation of family planning services and men even began escorting their wives to the clinic.

### **Reproductive Health of Adolescents Affected by Conflict**

Adolescents face numerous reproductive health risks in conflict settings; however, as the IAWG evaluation study demonstrates, services targeting young people are scarce and they are rarely

involved in the design and implementation of programming that affects them. Nevertheless, a number of studies were presented focusing on the needs and concerns of refugee and internally displaced adolescents. A knowledge, attitude, practice (KAP) survey conducted among Bhutanese youth in Nepal provided rich information to design an appropriate curriculum for awareness education and follow-up programming using the peer sharing approach. Two projects in Tanzania and Colombia demonstrated the importance of integrating monitoring and evaluation methods into program activities to determine the impact of the project on increasing knowledge of participants to promote positive behavior change. A study in Kakuma refugee camp in Kenya looked specifically at the socio-cultural factors that influence the delivery and use of reproductive health services and emphasized the importance of providing social support to improving adolescents' access to services. A program in western Tanzania underscored the importance of involving adolescents in designing youth-friendly services and explained how the program was modified to meet the needs of girls and reached out to parents and the community to overcome initial disapproval. Finally, the Women's Commission for Refugee Women and Children described a variety of capacity building models targeting local organizations addressing adolescent reproductive health issues. One model designated an international agency to facilitate a network of community-based groups as a way of reaching more stakeholders, thus multiplying overall impact. It is essential that adolescents are involved from the initiation of programming through implementation and evaluation of programs that target their reproductive health needs.

#### **Raising Literacy to Improve Reproductive Health Status**

JSI Research and Training Institute, Columbia University and ARC undertook a study on the effect of literacy training among Sierra Leonean and Liberian women in refugee camps in Guinea. For six months, women attended classes, which used reproductive health topics as the primary educational material. Women increased their use of modern contraceptives to 48 percent and condoms to 51 percent, many of whom were first-time users. Although literacy skills improved only marginally, a dramatic increase in women's self-confidence termed "boldness" was demonstrated. Another study among recently returned Guatemalan refugees also found a minimal increase in Spanish literacy with a more significant increase in knowledge and use of family planning methods after a community education campaign aimed at reducing maternal mortality. It was also shown that a gap exists between acceptance and use of contraceptives, and women's empowerment was noted as a critical area to address.

#### **Implementing Quality Programs**

The continuous availability of reproductive health commodities is a key element in the delivery of quality health services in refugee settings. DELIVER, a USAID-funded project implemented by John Snow, Inc., has developed monitoring and evaluation indicators for logistics system performance useful in assessing reproductive commodity availability, identifying strengths, weaknesses and needs, designing programs, collecting baseline data and implementing programs. The project has also developed tools and standards to facilitate routine data collection. The tools have been applied in various refugee settings, including northern Uganda, where a study in June 2002 found that over half of government facilities had experienced a stockout of a number of critical medications during the six-month period preceding the survey. These logistics tools facilitate careful monitoring of stock levels which is important in refugee settings because of the sometimes unpredictable fluctuations in the size and movement of refugee populations.

The Mae Tao Clinic in Thailand demonstrated how the quality of the clinic's services to forced Burmese migrants was improved through the implementation of a monitoring and evaluation project. A baseline assessment, including a facility audit, observation checklists and a client exit interview, provided the evidence to initiate a number of interventions. The facility infrastructure and equipment for maternal care were improved, clinic hours were increased, more staff were hired, staff technical capacity was improved through targeted trainings, medical records were revised and staff job descriptions were developed. Finally, at follow-up, the clinic was able to demonstrate an

improvement in client knowledge of STI/HIV symptoms and prevention, an increase in ante-natal care visits and a slow decrease in patients seeking post-abortion care attributed to the increased use of family planning methods.

#### **Practical Tools for Programming in Refugee and IDP Settings**

Conference roundtable sessions created an opportunity for participants to learn about and provide input on new and emerging resources for use in conflict-affected settings. A draft rapid reproductive health assessment questionnaire for field staff, developed by the Centers for Disease Control and Prevention, was presented for participants' feedback. The planned toolkit will include software to assist field staff who have minimal epidemiological training to generate and analyze reproductive health data for advocacy, program design and fundraising purposes.

"The roundtable presented an excellent opportunity to get into in-depth discussions and go beyond the surface of important issues."

- Conference participant

The International Centre for Reproductive Health at Ghent University presented a new screening checklist guide, comprised of a series of technical topics as well as political, legal, economic, social and cultural issues, to facilitate comprehensive sexual and reproductive health program development.

The RHRC Consortium introduced a groundbreaking standardized GBV survey tool that was recently developed, field tested and proven effective in determining the prevalence of GBV in several settings. The toolkit consists of approximately 20 assessment tools including a GBV prevalence survey questionnaire to collect quantitative and qualitative GBV information for program design, monitoring and evaluation. The survey instrument will assist humanitarian actors to collect data, provide evidence to inform advocacy efforts and design programs to prevent and respond to GBV. The survey tool will also facilitate standardized data collection to compare GBV prevalence in conflict-affected settings globally. Authors of the GBV toolkit cautioned about important ethical and safety issues related to GBV research and advised that GBV research be carried out in close collaboration with local organizations to promote ownership of the research, and timely, effective use of data for advocacy, fundraising and program development.

CARE presented new guidelines for developing and maintaining inter-organizational partnerships for humanitarian aid and transition settings. The lessons learned and guidelines show methods for building strong partnerships to facilitate more effective and sustainable programs. UNICEF described how its partnership with UNHCR and implementing partners in western Tanzania refugee programs allowed for successful integration of a prevention of mother-to-child transmission (PMTCT) of HIV program which overcame numerous barriers including stigma, lack of partner involvement, losing clients to follow-up due to repatriation and lack of privacy and confidentiality.

All conference participants received the RHRC Consortium's Monitoring and Evaluation Toolkit CD. This toolkit contains protocols and sample materials for conducting assessments, designing projects, evaluating programs and preparing reports, presentations and publications.

## **5. Reception**

#### **RHRC Consortium Launches New Name and Publications**

At the conference reception, the Reproductive Health Response in Conflict (RHRC) Consortium announced its new name, reflecting the scope of its activities, which extends to all conflict-affected populations and is not limited to refugees. The Consortium also launched two new reports, *The Global Decade Report*, the third in a series of reports documenting the progress of providing

reproductive health to conflict-affected populations, and *Renewing International Commitment to Reproductive Health for Conflict-Affected Populations*, a review of the Consortium's work over the last eight years of collaboration and a description of the group's focus for the future. In addition, the Consortium released new versions of important field-based training and awareness-building modules, including *Raising Awareness for Reproductive Health in Complex Emergencies: A Training Manual* and *Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series*.



*Participants attended a reception at which the Consortium announced its new name and launched new publications.*

## 6. Closing

### Field Perspectives

Representatives of two organizations from the field, Marie Stopes International Yemen and UMATI in Tanzania, offered their personal perspectives on how learning from the conference could be applied to future efforts. The representative of MSI Yemen discussed the importance of taking a more holistic approach to reproductive health and increasing coordination and collaboration among partners. She also emphasized the need for capacity building and illustrated her point by reiterating the age-old adage (updated to today's language), "Give a person a fish; you have fed that person for today. Teach a person to fish; and you have fed that person for a lifetime." She also talked about her

work with Somali refugees in Yemen and how many of the mothers tell her that they are delivering their babies to send them back home to fight the war. She hoped that in the future, "Somali mothers will deliver babies not to send them back for war but to have better futures and better lives." The representative of UMATI noted four areas that need attention: programming to prevent and reduce tension that may exist between refugee and host populations; improving implementation of the MISRP of reproductive health so it is implemented in the earliest days of an emergency—"just like food and shelter"; addressing unsafe abortions resulting from unplanned and forced sex; and increasing male involvement in all program activities. He took time to acknowledge the success of increasing access of reproductive health services in conflict settings and also was encouraged by the words of the Members of European Parliament and hoped that the European Union would increase its support for reproductive health for conflict-affected populations. He ended by saying, "The time for action is now and we must pledge ourselves to action!"

### Conference Summary

A member of the RHRC Consortium, recapped the highlights of the conference in the final session. The RHRC Consortium noted that resources and health data have improved the reproductive health of refugees in stable settings; however, attention to internally displaced populations—as well as populations that stay in the conflict zone—is sorely lacking. There is an urgent need to collect data in these areas and increase services to these populations. It also is critical to work with local health departments, development agencies, donors and research organizations. New data made available at the conference questioned the assumption that HIV spreads more quickly in conflict settings, demonstrating that conflict in some situations might act protectively against the proliferation of HIV. It is clear that data—as well as case studies that personalize the issue—are essential to programming, advocacy and fundraising efforts. In regard to reproductive health services, some sites have improved access to emergency obstetric care and post-abortion care, and family planning services are available in most settings. There are some pilot projects for VCT and PMTCT, and GBV programming is expanding. However, HIV programming needs to be expanded beyond pilot projects, family planning usage is low, sexually transmitted infections are



neglected, adolescent-friendly services are rare and men are typically marginalized by reproductive health programs. In addition, efforts in GBV are puny given the scope of the problem and GBV programs must address cultural norms, economics, politics and power relations. In conclusion, the conference was an excellent opportunity for learning from others' experiences, exchanging ideas, acknowledging some of leaders in the field, such as Mary Anne Schwalbe and Carolyn Makinson, and celebrating the successes that have brought us to this point. Moreover, it also served to encourage greater advocacy and collaboration to increase funding and services for conflict-affected populations globally.

## 7. Evaluations

### What Participants Said

"The whole conference was really great. The mix of people, the commitment I felt among all the participants was almost magical for a lack of a better word. In this current political environment I think we all needed this kind of a forum all the more to encourage us to keep pushing! Thank you. Thank you! "

- Conference participant

Conference participants were pleased to see numerous colleagues from the South and field settings but noted the lack of young people and refugee presenters and participants. Others remarked on the diversity of topics that were addressed and the high quality of presentations. However, many conference attendees wanted extra time during panel sessions to hear more in-depth analysis, to delve deeper into the details of findings and to explore further the policy implications of program findings. Also, some found it difficult to choose among topics during concurrent sessions and would prefer an extra day. Some felt there needed to be a greater link between the presentations to the overall theme of the conference. Participants also requested a panel with representatives from funding organizations, ministries of health and other government agencies. Suggestions for future panels included more attention to peace building and conflict resolution, cost-sharing by host government and analysis of integrating long-term refugees into host countries' national health plans. Many conference attendees appreciated the roundtable sessions for their informal nature and opportunity to have greater interaction and to make contacts with colleagues with similar interests. Poster presentations needed a separate time and space for full understanding of information. Attendees also appreciated the numerous publications and other resources available at the conference space. Overall, evaluations of the conference rated all aspects of the conference, except posters, more than a 4 on a scale of 1 to 5.

"Very well organized, from content to logistics."

- Conference participant

## 8. Next Steps

### Challenges to Reproductive Health Globally

The gains achieved in reproductive health for conflict-affected populations are threatened by a particularly difficult political and economic climate. Clinics have been closed in Kenya, HIV/AIDS services to youth in Angola have been curtailed, and promising VCT programs in the Democratic Republic of Congo have ended. These are just a few examples of the impact reduced funding and detrimental policies have on the provision of reproductive health services around the world. The recent expansion of the Mexico City Policy to the U.S. State Department's Bureau of Population, Refugees and Migration is also of concern. At this juncture, it is critical to reach out to allies. The

conference keynote speakers, members of the European Parliament, have confirmed that providing data and evidence to policy makers gives them the tools they need to advocate for strong health policies. Linking humanitarian aid with longer-term development assistance is another avenue to maximize resources and seek additional resources to expand the base of support for reproductive health in conflict settings.

As the conference title suggests, it is essential to move toward making the link to sustainable and long-term programming for populations that are in prolonged situations of displacement. It is also crucial to improve the capacity of populations to return to their countries of origin and obtain the services they have become accustomed to in their refugee circumstances. This step will require relief organizations to extend their programming to sustain longer-term community rebuilding and development agencies to improve their capacity to expand services in emergency settings. Building the bridge between these communities demands the establishment of diverse networks and partnerships to facilitate the sharing of research, tools and lessons learned necessary for increased collaboration in the field.

Communities affected by conflict have a fundamental human right to good quality, integrated reproductive health services at all stages of crisis, from the emergency to reconstruction and development phase. Ensuring this right will require more advocacy, resources and collaboration from all involved to ensure that reproductive health is an integral component of every humanitarian response. Policy makers, donors, managers and implementers are called upon to heighten their resolve and come to grips with reproductive health concerns in conflict settings. Renewed leadership at all organizational levels must address the demand for sufficient human and financial resources to prevent and respond to HIV/AIDS and gender-based violence, while improving emergency obstetric care, family planning and reproductive health programs with special attention to the unique needs of youth and strategies for increasing male involvement.

## 9. Final Thoughts

The conference was a great success in sharing information, strategies and ideas among practitioners from North and South, demonstrating the essential nature of this event in moving forward the research and development activities necessary to improve the reproductive health of conflict-affected populations.

To review selected PowerPoint presentations and photos from the conference and access new RHRC Consortium publications, please visit the RHRC Consortium website at [www.rhrc.org](http://www.rhrc.org).



*The conference provided good opportunities for networking.*





RHRC Consortium  
**CONFERENCE 2003: REPRODUCTIVE HEALTH  
FROM DISASTER TO DEVELOPMENT**

Brussels, Belgium

7-8 October 2003

## Tuesday, 7 October

**8:30** Registration

**9:00** Morning tea and coffee - Foyer

### 10:00 Opening Session

Salle des Nations I

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**Moderator:** Patricia Hindmarsh, Marie Stopes International

**Keynote Address:**

Anne Van Lancker MEP      Reproductive health for refugees within Belgian development co-operation

Ulla Sandbaek MEP      Reproductive health for refugees within European development co-operation

**11:15—12:30**

### Concurrent Sessions

#### **Panel 1 : Reproductive health risks and response in conflict settings**

Salle des Nations I

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**Moderator:** Nicole Renner-Gaertner,  
Bureau for Population, Refugees and Migration, US Department of State

\*Biessé Diakaridja Soura  
(*not presented*)      Risks of HIV infection among women affected by the conflict in Ivory Coast  
(*Risques d'infection au VIH/SIDA chez les femmes liés à la situation de conflit en Côte d'Ivoire*)

Susan Igras      RH-related morbidity and mortality in eastern Congo: Findings from research in Maniema Province

Pamela Delargy      Contingency planning for emergency RH services in the context of military and ethnic conflicts

#### **Panel 2 : Topical trends and issues**

Salle des Nations II

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**Moderator:** Maggie Usher-Patel, WHO

Tezra Masini      UNICEF PMTCT interventions in the Western Tanzania refugee program: Opportunities and challenges

Christopher Orach      Post emergency health services for refugee and host populations in Uganda: The case for integration of health services?

Paul Spiegel      HIV prevalence among refugees: dispelling the myth

12:30

Lunch—Foyer

2:00—3:30

Concurrent Sessions

**Panel 3 : Post-Abortion care: Needs and programme response**

Salle des Nations I

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**Moderator:** Tamara Fetters, IPAS

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Suzanne Belton	Kathy Pan, sticks and pummelling: Burmese women's methods of fertility management
Hailu Yeneneh	Post-abortion care for refugee women in western Ethiopia
Joan Venghaus	Post-abortion care training for informally trained health workers in a refugee setting: Lessons learned

**Panel 4 : Where tradition, culture, and violence meet: Addressing GBV in camp settings**

Salle des Nations II

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**Moderator:** Lydia Leon, UNFPA

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Edna Jurugo	Gender-based violence amongst a displaced population
Susan Igras	Working with refugee communities to change the harmful practice of female genital cutting (FGC): Findings from operations research on FGC abandonment activities in Dadaab, Kenya
Penny Haora	The "success" of SGBV prevention and response initiatives—Does 'diffusion of innovations' merit consideration?

**Panel 5 : Understanding, involving and serving adolescents**

Watteau I & II

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**Moderator:** Alexandra Todd, USAID

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Julia Matthews	Improving reproductive health of adolescent refugees
Edmond Nkam Tadiesse	Socio-cultural determinants of pregnancy and the spread of sexually transmitted infections among adolescent residents of Kakuma Refugee Camp, Northern Kenya
*Roselidah Ondeko (presented by Naomi Nyitambe)	Adolescent sexual and reproductive health in refugee settings: Experiences from Western Tanzania refugee programme

3:30

Tea and Coffee Break

4:00—5:30

## Concurrent Panel and Roundtables

### Panel 6 : Measuring maternal mortality in Afghanistan

Salle des Nations I

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**Moderator:** Therese McGinn, Heilbrunn Department of Population and Family Health  
Mailman School of Public Health, Columbia University

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Leila Bisharat	Maternal mortality in Afghanistan: An index of the status of women's rights
Linda Bartlett	Maternal mortality and health care access in conflict settings: Case studies from maternal mortality studies among Afghan women in refugee camps in Pakistan and in Afghanistan.
Leila Bisharat	The measurement of maternal mortality during humanitarian response: Recent lessons from Afghanistan

### Round tables

Watteau I & II

#### Round 1: 4:00-4:50

1	Sheena Currie Basia Tomczyk	Cost-sharing: A barrier to gender equality in Afghanistan A report on the RH services available for IDPs in the southern region of Afghanistan
2	Helen Liebling Zeinab Abdi-Ahmed	Ugandan women's experiences of sexualised violence and torture during civil war years in Luwero District, Uganda: Implications for health policy, welfare and human rights Poverty and violence against women
3	Jeanne Ward Marqueline Zulu	Gender-based violence data collection: New tools for the field Setting up an SGBV prevention programme
4	Susan Purdin Salwa Najjab Khatib	Preparing reflective practitioners From emergency to development: Maternity homes in Palestine
5	Elizabeth Rowley Parviz Piran	RH literacy in Guinea Socio-cultural and religious concerns versus harsh realities of life: The case of Afghan refugees in Iran
6	Mary Kay Larson Antenane Korra	Toolkit for the rapid assessment of RH in refugee and IDP settings Knowledge, attitude, practice and behavior study in respect of HIV/AIDS amongst youth and adolescents in western refugee camps in Ethiopia: A qualitative study
7	Jessika Deblonde Susan Igras	Towards a comprehensive approach of sexual and reproductive needs and rights of women displaced by war and armed conflict: A practical guide for programme officers Building partnerships for reproductive health in conflict-affected settings

## **Round 2: 5:00—5:50**

### **Roundtables:**

- |   |  |   |
|---|--|---|
| 1 | Khatuna Katamadze<br>Evelyn Aguti                          | We will improve our health ourselves<br>Participation of young people in HIV/AIDS and SGBV prevention and response activities: A successful strategy in behaviour change and care among young people in the refugee settlements of Uganda |
| 2 | Rachel Partridge<br><br>*Desire Timngum<br>(not presented) | A qualitative study of the barriers to sexual health for internally displaced young people in Freetown<br>Refugee RH in Africa: Dilemmas of Central African accompanied refugee children in South Africa                                  |
| 3 | Monica Onyango,<br>Catherine Rielly<br><br>Doris Bartel    | HIV/AIDS, gender and conflict nexus: The case of Sierra Leone, the commoditization of girls and women<br>Strengthening protection mechanisms in conflict and post-conflict settings   |
| 4 | Laura Moch<br><br>Bérengère de Negri                       | Behavior change communication strategies for HIV prevention in a post-conflict setting<br>Adapting <i>Advance Africa's</i> strategic mapping approach to a post-conflict setting: The case of Angola                                      |
| 5 | Sandra Krause<br><br>Carlos Iván Pacheco                   | Displaced and desperate: Assessment of reproductive health for Colombia's internally displaced persons<br>The population affected by the humanitarian crisis in Colombia: A response with a development perspective                       |
| 6 | Stany Niyonzima  | Implementing community-based YRH projects in Burundi  |

6:30

Reception

Horizon Room, 30<sup>th</sup> Floor



## Wednesday, October 8

8:30—10:30 Forum: Early results from the Inter-Agency global evaluation of reproductive health services for refugees and internally displaced persons

Watteau I & II

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**Moderator:** Judith O’Heir, UNHCR

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Judith O’Heir	Review of literature: Evaluation of reproductive health services for refugees and internally displaced persons
Sara Casey	Evaluation of coverage of reproductive health services for refugees and internally displaced persons
Anna Whelan	Evaluation of quality, access to and use of reproductive health services for refugees and internally displaced persons
Wilma Doedens	Evaluation of the use of the Minimum Initial Services Package (MISP) and RH kits
Ali Buzurukov	Review of global trends in resources for reproductive health services for refugees and IDPs

9:00—10:30

### Concurrent Sessions

#### Panel 7 : Involving young people for programme success

Salle des Nations I

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**Moderator:** Tamar Renaud, UNICEF

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Nirmal Rimal	A study of the knowledge, attitude and practices (KAP) related to RH/STI/HIV in youths residing in Bhutanese refugee camps of eastern Nepal
Rester Boniface	Using indirect approaches to regulate youth and adolescent sexuality
Patricia Ospina	Findings from the project: “Sexual and reproductive health services and training for displaced and host adolescents in municipalities of Cartagena and Barranquilla, Colombia

#### Panel 8 : How do you know your services are good?

Salle des Nations II

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**Moderator:** Deborah Baglole, Merlin

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Paula Nersesian	Standardized measures for ensuring reproductive health commodity availability in refugee settings
Henia Dakkak	The need for the UN process indicators in the humanitarian context
*Sophia (presented by Tara Sullivan)	Using evidence to improve quality along the Thailand-Burma border

10:30

Tea and Coffee Break

11:00—12:30

Concurrent Sessions

**Panel 9 : Involving the community to ensure success**

Salle des Nations I

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**Moderator:** Olga Bornemisza, London School of Hygiene and Tropical Medicine

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| Maria Roble       | Improving family planning services in Huambo, Angola            |
| Elisa Muhingo     | Involving men to increase family planning acceptance            |
| Kathia van Egmond | Reproductive health KAP survey among Afghan women in Kabul city |

**Panel 10 : Using local resources in programmes to meet identified needs**

Salle des Nations II

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**Moderator:** Mary Kay Larson, Centers for Disease Control and Prevention

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| Jeannot<br>Wabulakombe                             | Using data to develop a reproductive health program in Goma, DRC   |
| Amani Badwan and<br>*Asa'ad Ramlawi                | Use of PRA and HFA data for emergency mother and newborn care program development in 9 Palestinian communities |
| *Neelofar Zahid<br>(presented by Connie<br>Kamara) | The role of a field labour room as a reproductive health unit in a refugee situation (A model)                 |

**Panel 11 : Reproductive health clinical care through the phases of conflict**

Watteau I & II

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**Moderator:** Wilma Doedens, UNFPA

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| Farhad Javid       | Increasing access to reproductive health care in post-conflict Afghanistan  |
| Fowzia Jaffer      | Improving the quality of reproductive health services for Somali refugees through needs assessment in Sana'a, Yemen |
| Atula Nanayakkarra | Ensuring sustainability of a reproductive and mother and child health care project in a conflict setting            |

12:30

Lunch—Foyer

1:00

## Posters and Lunch (continues)—Foyer

### **Posters:**

1. Naomi Nyitambe UNHCR/UNICEF/IP's ASRH intervention in the Western Tanzania Refugee Operation
2. Therese McGinn The effects of war on reproductive intentions and behavior: The case of Rwanda
3. Yayoi Takei The cases of adolescent pregnancy and its impact in the Congolese Refugee Camps, Kigoma Region, in Tanzania
4. Athanase Nzokirishaka A census of displaced populations in Burundi (Le recensement des populations déplacées au Burundi)
5. Sara Casey and S Suriyamurthy Reproductive health needs assessment in Northern Sri Lanka
6. \*Grace Odion  
(not presented) Needs assessments for the delivery of family planning services in Oru refugee camp, Nigeria

2:00—3:30

## Concurrent Sessions

### **Panel 12 : Gender-based violence: New findings from the field**

Salle des Nations I

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**Moderator:** Jeanne Ward, Reproductive Health Response in Conflict Consortium

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| Michelle Hynes  | Field test of a gender-based violence (GBV) survey in East Timor and Kosovo: Lessons learned |
| Eugene Kinyanda | War traumatisation in North-Eastern Uganda: The need for a holistic medical intervention     |
| Aziza Khalidi   | Association Najdeh domestic violence project: Baseline and follow-up KAP surveys             |

### **Panel 13 : Stopping the spread of HIV in Sierra Leone**

Salle des Nations II

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**Moderator:** Manuel Carballo, International Centre for Migration and Health

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| *Moi Tenga Sartie<br>(presented by Connie Kamara) | Strengthening AIDS prevention among commercial sex workers and military forces in Port Loko, Sierra Leone |
| *Vandy Kamara<br>(presented by Doris Bartel)      | Talking HIV in post-conflict Sierra Leone   |
| *Boima Kpuagor<br>(presented by Sonia Navani)     | HIV/AIDS KAP and community outreach in a post-conflict setting in Kenema District, Sierra Leone           |

## Panel 14 : Making motherhood safer

Watteau I & II

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**Moderator:** Leslie Davidson, Heilbrunn Department of Population and Family Health  
Mailman School of Public Health, Columbia University

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| Drileba Paul Bishop | Safe motherhood facility assessment of two health facilities in Kiryandongo Sub-county, Masindi District, Uganda              |
| Laura Miranda       | Findings from the project: <i>Reducing maternal mortality among repatriated populations along the Guatemala-Mexico border</i> |
| Cyprian Awiti       | Improving access to emergency obstetric care for non-camp refugees, Nairobi, Kenya  |

3:30

Tea and Coffee Break

4:00—5:00

Closing Session

Salle des Nations I

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**Moderator:** Connie Kamara, ARC International

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|---------------|---|
| Fowzia Jaffer | Personal perspective on taking the conference into the future |
| Elisa Muhingo | Personal perspective on taking the conference into the future |
| Susan Purdin  | Where do we go from here?                                     |

\*unable to attend

*Conference 2003: Reproductive Health from Disaster to Development could not have taken place without the support of many organizations, especially those who made it possible for their staff to attend. We would particularly like to thank UNFPA, the Ford Foundation, USAID, UNHCR and the David and Lucile Packard Foundation for their support.*

*NOTE: Many of the Conference 2003 panel presenters have offered to share their PowerPoint presentations. They are available online at <http://www.rhrc.org>.*

## **Reproductive health risk and response in emergencies**

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**Moderator:** Nicole Renner-Gaertner, Bureau of Population, Refugees and Migration, US Department of State

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| Biessé Diakaridja Soura | Risks of HIV infection among women affected by the conflict in Ivory Coast ( <i>Risques d'infection au VIH/SIDA chez les femmes liés à la situation de conflit en Côte d'Ivoire</i> ) |
| Susan Igras             | RH-related morbidity and mortality in eastern Congo: Findings from research in Maniema Province   |
| Pamela Delargy          | Contingency planning for emergency RH services in the context of military and ethnic conflicts  |

## **Risques d'Infection au VIH/SIDA chez les Femmes liés à la Situation de Conflit en Côte d'Ivoire**

**Authors** Soura Biessé Diakaridja, Enseignant—Formateur, Institut National de Formation Sociale  
**Presenter** Soura Biessé Diakaridja

### **Background**

L'infection à VIH/SIDA constitue une préoccupation majeure pour l'ensemble de la population ivoirienne. Avec plus de 10% d'infection, la Côte d'Ivoire est en effet le pays le plus touché de l'Afrique de l'Ouest. Pire, on note une grande progression de cette infection chez les jeunes et les femmes depuis quelques années. Le taux de seroprévalence chez ces dernières atteint parfois 15% dans certaines formations sanitaires du pays. 80% des voies de transmission sont d'ordre sexuel. La situation de conflit que connaît la Côte d'Ivoire, suite aux événements du 19 septembre 2002 et qui a occasionné le déplacement massif de populations estimées à 1 500 000 personnes ne manquera pas d'avoir une incidence sur le taux déjà élevé de seroprévalence chez les femmes compte tenu de la précarité dans laquelle elle les met.

### **Purpose of study or programme**

Cette étude voudrait permettre :

- d'identifier les facteurs de risque d'infection à VIH/SIDA chez les femmes déplacées fuyants les zones de conflit ;
- de mesurer l'influence de la situation de crise sur la vulnérabilité des femmes face au VIH/SIDA.

### **Data collection or programme methods**

Nous avons combiné la technique de l'échantillonnage aléatoire simple à celle dite de quota. La première nous a permis de tirer au sort 4 sites d'accueil des personnes déplacées ; et avec la seconde, nous avons pu sélectionner 225 femmes (15-34 ans) en âge de procréer venues des zones occupées par la rébellion. Les données ont été recueillies à l'aide d'un questionnaire et d'un entretien de type semi-directif. Leur traitement a permis d'obtenir les résultats suivants.

### **Study or programme findings**

Toutes les 225 femmes interrogées ont une connaissance moyenne du VIH/SIDA (modes de transmission, moyens de prévention, ...). Près de la moitié de notre échantillon (46%) avait passé plus de 2 semaines à trouver un refuge sauf (familles, centres d'accueil). Cette durée de parcours était un motif d'exposition de ces femmes à des violences et avances d'ordre sexuel. En effet, les femmes de ce groupe (90%) avaient reçu, tout au long de leur parcours, plus de 5 avances sexuelles de la part d'hommes se proposant de leur offrir leur service. De plus, les 10% des cas de violences sexuelles enregistrés étaient corrélés à cette durée de parcours. Le type de milieu d'accueil a une influence sur la « sécurité » de ces femmes. On note en effet, chez celles issues de centres d'accueil, plus de cas d'avances et de violences sexuelles (30%) que chez celles vivant dans une famille d'accueil (5%). Les femmes jeunes (15-24 ans) sont plus exposées (45%) à ces situations de risque que les femmes plus âgées (25-34 ans). Malgré cette situation, aucune d'elles n'a participé à une séance de sensibilisation sur le VIH/SIDA depuis leur départ de leur zone d'origine.

### **Conclusion and programme implications**

Les périodes de crises occasionnant des déplacements massifs de populations constituent des moments favorables à l'exposition des femmes à des situations de risque d'infection au VIH/SIDA. Les avances et violences sexuelles dont elles sont victimes s'opèrent, aussi bien, tout au long de leur parcours pour fuir les zones de combat que dans certains centres d'accueil. Il importe donc de veiller à une plus grande sécurité de ceux-ci, d'organiser avec régularité des campagnes de sensibilisation des populations sur le VIH/SIDA et de doter ces structures de kits chimioprophylaxiques ARV afin de pallier le cas échéant.

### **For further information:**

SOURA Biessé Diakaridja, 01 B.P. 2625 Abidjan 01, Cote d'Ivoire  
Tel: 225 07 92 91 50 or 225 22 44 16 72/73  
Fax: 225 20 21 56 19,  
E-mail: [souradiak@yahoo.fr](mailto:souradiak@yahoo.fr)

## **RH-Related Morbidity and Mortality in Eastern Congo: Findings from Research in Maniema Province**

**Authors** Dr Modibo Traore, Project Manager, Maniema Health Rehabilitation Project, Fred Grant, PHC Nurse, Maniema Health Rehabilitation Project, CARE International in the Democratic Republic of Congo

**Presenter** Susan Igras

### **Purpose of study or programme**

Working to rehabilitate two health zones (HZs) in an area that is still insecure in eastern Congo, CARE staff conducted a population-based study of mothers in Kisongo and Kibongo HZs to gain information to develop its health program.

### **Data collection or programme methods**

In November and December 2002, a population-based survey using cluster sample methodology was conducted, covering 80% of villages in the HZ of Kisongo and 50% of villages in the HZ of Kibongo (ie, was done in areas where it was safe enough to conduct the study). The study sought to gain information (from women who had at least one child) on infant and maternal mortality rates as well as knowledge, practices, and use of health services for maternal health and family planning.

### **Study or programme findings**

Because of the security situation, the survey could not be carried out in all parts of the health catchment area and therefore findings could not be generalized to the population. Still, findings are indicative of a grave RH situation. Infant mortality rates were high in both HZs: 3% of and 13% of households in Kasongo and Kibombo respectively had lost a child less than 7 days old in the past year. A correlation of number of ever births and neo-natal mortality rates was observed. Estimated maternal mortality rates were equally high. High fertility rates were recorded, with ever-births ranging from 1 to 17 births and an average 4.16 births of women interviewed. Knowledge of and use of modern FP methods was very low (10% could name one or more modern FP methods and 28% were using a traditional method. No modern FP methods were yet available). The desire to use modern methods to space births (unmet need) was high at 67%. Over 2/3 of deliveries occurred at home with untrained TBAs in attendance. TBA practices were very likely to lead to infection and other maternal and newborn health problems. Women were interested in using maternity and other health center services. Reasons for not using health center services for deliveries and other RH services included cost and distance.

### **Conclusion and programme implications**

The findings corroborate the need to provide RH services in unstable situations to reduce RH-related morbidity and mortality as well as to address unmet needs of the displaced population in Maniema Province. Research is important to guide programs and to advocate for donor support for RH services, but security situations and the length of relief projects (12 months or less) make research a challenge.

### **For further information:**

Susan Igras, CARE, 151 Ellis Street, Atlanta, GA 30306.  
Telephone: 1 404-979-9158  
Email: [igras@care.org](mailto:igras@care.org)

## **Contingency Planning for Emergency RH Services in the Context of Military and Ethnic Conflicts**

**Authors** Pamela DeLargy et al, Humanitarian Response Unit UNFPA

**Presenter** Pamela DeLargy

### **Background**

In complex emergencies, especially during armed conflicts, RH issues continue to be addressed after priority is given to food, shelter and other aspects of medical service. Early planning for provision of RH services in anticipation of an emergency may greatly reduce the conflict's impact on women and girls.

### **Purpose of study or programme**

This paper presents a critical analysis of the mechanisms and efficiency of contingency planning and response for RH and gender needs in Iraq and Liberia. It reviews the steps undertaken, partnership mechanisms in UNFPA and the larger Inter-Agency Working Group on RH in Refugee (IAWG) context, and preliminary results.

### **Data collection or programme methods**

This paper is based on a desk review of contingency plans, appeals, implementation reports, procurement and training records, donor response and resource allocation information, and results of field level assessments and field missions.

In June 2003, UNFPA organized a sub-regional workshop in Ghana to design a comprehensive humanitarian strategy for the West Africa sub-region, focusing on Liberia. UNFPA, UNHCR and the Ministry of Health carried out assessments in neighbouring countries and, with partner agencies and NGOs, UNFPA positioned equipment and supplies to meet Liberian refugees' RH needs.

For the Iraq crisis, UNFPA pre-positioned basic RH supplies inside Iraq, and deployed a Chief of Operations to Cyprus. In neighboring countries, UNFPA's efforts to meet the anticipated influxes of Iraqi refugees included coordination with national authorities, international agencies and NGOs to ensure inclusion of RH concerns in emergency response operations. In Jordan, UNFPA provided the government with safe delivery supplies and trained staff on the MISP, and undertook similar activities in other neighboring countries.

### **Study or programme findings**

Interest in RH issues in emergency settings continues to increase. Effective mechanisms for coordination between RHRC Consortium, UNFPA and other partners make possible the implementation of flexible and targeted training programmes to better equip potential partners at the country and regional levels to implement the MISP.

However, numerous obstacles still exist. Visibility given to RH in interagency appeals is still overshadowed by the larger needs in the shelter, food and sanitation sectors. Attempts to leverage support for RH as part of the larger health sector have been largely unsuccessful. Agencies implementing RH programmes are often excluded from consultative mechanisms. The proportional response to the RH sector in the Consolidated Appeals Process is substantially lower than for any other sector.

Multi-million dollar contingency planning exercises in Iraq and a much more limited but focused effort for Liberia have not gained much attention in the donor community.

### **Conclusion and programme implications**

Stronger collaboration between UNFPA, WHO, WFP, UNICEF, UNHCR and OCHA is the most promising way to leverage sufficient support for RH in emergency settings. Such collaboration should be further advanced through mechanisms of the RH IAWG. Innovative experiences in pooling resources and expertise to build the capacity of partners working to respond to RH needs in emergency settings may be seen as "good practice."

### **For further information:**

Pamela DeLargy, Humanitarian Response Unit, UNFPA, 220 East 42<sup>nd</sup> Street, New York, NY 10017

Telephone: 212-297-5247 Fax: 212-297-4946

Email: [delargy@unfpa.org](mailto:delargy@unfpa.org)



## Topical trends and issues

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**Moderator:** Maggie Usher-Patel, WHO

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|-------------------|---|
| Tezra Masini      | UNICEF PMTCT interventions in the Western Tanzania Refugee Program: Opportunities and Challenges                        |
| Christopher Orach | Post emergency health services for refugee and host populations in Uganda: The case for integration of health services? |
| Paul Spiegel      | HIV prevalence among refugees: dispelling the myth  |

## **UNICEF PMTCT Interventions in the Western Tanzania Refugee Program: Opportunities and Challenges**

**Authors** Tezra Masini, Assistant Project Officer PHC/PMTCT Focal person (Refugee program), UNICEF Tanzania  
**Presenter** Tezra Masini

### **Background**

Tanzania hosts more than half a million refugees from Burundi and DRC, whose disrupted social structure put them at risk of HIV/AIDS. UNICEF initiated a prevention of mother to child transmission (PMTCT) program in 2000. Since then, many activities have been implemented with marked success.

### **Purpose of study or programme**

To reduce mother to child transmission by 50% within 3 years; increase antenatal uptake to 100%; provide counseling to 100% of antenatal women and offer Voluntary Counseling and Testing (VCT) to 80% of these women and to 50% of their partners; improve general quality of care to pregnant women in health facilities.

### **Data collection or programme methods**

- Assessed present reproductive health services for possible PMTCT interventions
- Identified Lukole refugee camp in Western Tanzania as a pilot site
- Strengthened VCT and other existing HIV/AIDS related activities linked to PMTCT
- Developed and used integrated PMTCT training manual developed for national pilot program for training service providers with technical support from the national PMTCT program
- Integrated PMTCT into other existing reproductive health services
- Supported effective social mobilization and advocacy
- Developed capacity of service providers and community based workers
- Strengthened and established quality assurance monitoring and evaluation

### **Study or programme findings**

- 7393 pregnant women attended antenatal care in 6 months period. (Oct. 2002-March 2003)
- 97.6% of the above accepted counseling
- 90.1% of those counseled were tested for HIV
- 3.5% of those tested were found to be HIV positive
- Of those tested positive who reached 34 weeks of gestation, 93.3% took Niverapine
- 35 women delivered in the period mentioned above
- Of those who delivered, (28) 80% were hospital deliveries; all swallowed Niverapine during labor
- (7) 20% delivered at home where (5) 71% swallowed Niverapine during labor
- 32 deliveries were by vaginal delivery, 3 by cesarean section (all emergency)
- 100% of babies delivered at the hospital received Niverapine
- 71% of babies delivered at home received Niverapine within 72 hours of delivery
- One intra-uterine fetal death was reported (gestational age 32/40, Bwt 1.9kg)
- One abortion was reported during that period at 26/40
- Of those delivered only one opted for replacement feeding, the rest opted for exclusive breastfeeding up to 4 months, then replacement feeding
- 9.3% (288) partners were counseled; of those 93.6% (244) were tested, with 2.3% testing positive
- By 1<sup>st</sup> April, all camps in Western Tanzania had started a full PMTCT package

### **Conclusion and programme implications**

The collaborative effort between UNICEF/UNHCR/implementing partners made this project successful. Despite a low prevalence rate of HIV among pregnant women, bearing in mind the presence of geographical, economical, socio-cultural factors that could favor transmission, PMTCT is recommended in all refugee environments. An existing full package of reproductive health services makes integration easier.

### **For further information:**

Tezra Masini, UNICEF Kasulu, PO Box 81, Kasulu-Tanzania Tel: 255282810431 Email: [tmasini@unicef.org](mailto:tmasini@unicef.org)

## **Post Emergency Health Services for Refugee and Host Populations in Uganda: The Case for Integration of Health Services?**

**Authors** Dr Christopher Garimoi Orach, Makerere University Institute of Public Health Kampala and Institute of Tropical Medicine (ITM) Antwerp; Vincent De Brouwere, ITM Antwerp  
**Presenter** Christopher Garimoi Orach

### **Background**

Since 1990, Uganda has hosted an estimated 200,000 refugees. The majority, 71% (142,646), come from southern Sudan, and live in settlements in West Nile region, northern Uganda.

### **Purpose of study or programme**

Although the policy of the Government of Uganda allows refugees to live in settlements interspersed within local host communities, refugee and host health services run in parallel. We assessed maternal health conditions and services for refugee and host populations in the three refugee-affected districts of northern Uganda during 1999-2001.

### **Data collection or programme methods**

We collected data on major obstetrical interventions (MOI) for absolute maternal indication (AMI) for refugee and host populations retrospectively between September 2000 and December 2000; and prospectively between January 1<sup>st</sup> 2001 and December 31<sup>st</sup> 2001, from 5 hospitals covering three years, 1999-2001. We estimated the expected number of births and calculated rates of MOI for AMI in refugee and host populations for 1999, 2000 and 2001. These data were collected in the districts of Adjumani, Arua and Moyo in urban and rural areas with different numbers of refugee and host populations. We carried out a community-based maternal mortality survey between 1<sup>st</sup> to 30<sup>th</sup> November 2002 on refugee and host populations in Adjumani district and calculated the maternal mortality ratio (MMR) for the refugee and host populations.

### **Study or programme findings**

Rates of major obstetrical intervention for refugees were statistically significantly higher than for the rural host population who lives in the same rural areas as the refugees: 1.01% (95% CI 0.78-1.29) versus 0.45% (0.39-0.53)  $p < 0.001$ . MOI rates were also statistically significantly higher for refugees than for the host population who stays in rural areas without refugees: 1.01% (0.78-1.29) compared to 0.40% (0.37-0.44)  $p < 0.001$ . However rates of MOI for refugees were similar to those for the urban host population: 1.01% (0.78-1.29) versus 1.03% (0.91-1.15). The MMR was 2.5 times higher in the host population, 321.5 (95% CI 247-396) compared to 130 (95% CI 81-179) per 100,000 births in refugees in Adjumani district.

### **Conclusion and programme implications**

The parallel model of health services organisation is associated with significant disparities in access to health care and health status between refugee and host populations. The establishment of health and social services in refugee settings should be guided by policies that promote equitable access for host populations in refugee settings.

### **For further information:**

Dr Christopher Garimoi Orach  
Email: [cgorach@hotmail.com](mailto:cgorach@hotmail.com)

## **HIV Prevalence among Refugees: Dispelling the Myth**

**Authors** Paul B. Spiegel, MD, MPH, Senior HIV/AIDS Technical Officer, UNHCR Geneva  
**Presenter** Paul B. Spiegel

### **Background**

There is an unfortunate overlap between countries affected by HIV/AIDS and situations of conflict and refugee movements. Refugees are at higher risk for contracting HIV/AIDS; especially vulnerable are women and adolescents because of poverty, powerlessness, social instability and sexual abuse. Refugees suffer from discrimination and there is a common perception that refugees bring HIV/AIDS with them into countries of asylum and then transmit the infection to the host populations. Until now, little data have been available to examine this hypothesis.

### **Purpose of study or programme**

To estimate HIV prevalence rates in refugee camps using sentinel surveillance and to compare to the surrounding populations.

### **Data collection or programme methods**

The United Nations High Commissioner for Refugees, together with its partners, undertook antenatal HIV sentinel surveillance in over 20 camps representing approximately 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania. The refugee populations in three of the countries had significantly lower HIV prevalence rates than the surrounding host communities while the other had similar rates. The refugees' HIV prevalence was the same as or higher than in their respective countries of origin.

### **Study or programme findings**

Antenatal sentinel surveillance among refugee and surrounding host populations is feasible to implement and provides useful information to direct and monitor programmes, and to aid in the understanding of how conflict and refugees affect the AIDS pandemic.

HIV prevalence of refugee populations depends upon numerous factors including: 1) country of origin prevalence; 2) surrounding population prevalence; 3) interaction between refugee and host populations; 4) length of time camp established; 5) quality and comprehensive of HIV/AIDS programmes in both populations; and 6) number of refugees with HIV/AIDS who died during conflict or emergency phase when crossed over the border.

### **Conclusion and programme implications**

HIV sentinel surveillance among antenatal women should be conducted among refugees and the surrounding populations. Reduced access and mobility of refugees in camps may keep the HIV prevalence lower than the surrounding communities. Trend data are needed to examine how HIV prevalence among the refugees and the local surrounding populations changes over time.

### **For further information:**

Paul Spiegel, Senior HIV/AIDS Technical Officer  
UNHCR, Case Postale 2500, 1211 Geneva, Switzerland, 2 Depot  
Telephone: 41 22 739 8289  
Fax: 41 22 739 7366  
Email: [spiegel@unhcr.ch](mailto:spiegel@unhcr.ch)

## Post-abortion care: Needs and programme response

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**Moderator:** Tamara Feters, IPAS

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Suzanne Belton	Kathy Pan, sticks and pummelling: Burmese women's methods of fertility management
Hailu Yeneneh	Post-abortion care for refugee women in western Ethiopia
Joan Venghaus	Post-abortion care training for informally trained health workers in a refugee setting: Lessons learned

## **Kathy Pan, Sticks and Pummelling: Burmese Women's Methods of Fertility Management**

**Authors** Suzanne Belton, PhD Scholar, B. Soc. Sc. (Hons) Registered Midwife, Key Centre for Women's Health in Society, University of Melbourne  
**Presenter** Suzanne Belton

### **Background**

Burmese women living in Thailand outside of the UNHCR system of camps have a variety of ways of controlling their fertility. Few have regular and reliable access to modern methods of contraception due to language and cultural barriers, issues of citizenship in a foreign country and lack of access to culturally appropriate and qualified reproductive health information or services, despite Thailand's advanced public health system and infrastructure. This socio-political context leads to high rates of unwanted pregnancy, reproductive morbidity and mortality.

### **Purpose of study or programme**

This presentation will give an overview of the local situation and the impact on Burmese women's reproductive health rights while they live in Thailand. It is significant in that it tracked women who were experiencing a pregnancy loss who were referred between the Thai public hospital and Burmese-refugee-run health services. It documented women and lay midwives' views and experiences of pregnancy loss and fertility management.

Dr Cynthia Maung, a Burmese doctor and winner of the Magsaysay Award (2002), herself a refugee, requested the research in response to the high rates of unwanted pregnancy that she and her staff are seeing on the Thai-Burma border.

### **Data collection or programme methods**

Quantitative and qualitative data were collected. 400 medical records held by Thai and Burmese led health facilities were reviewed and demographic and bio-medical information were collected. 43 women who were admitted to hospitals for post abortion complications were interviewed and Burmese health workers, husbands, lay midwives and local community leaders also participated in interviews and focus groups.

### **Study or programme findings**

The demographic data showed that most women were married, 28% had a previous abortion experience and ten percent were under 20 years of age, 28% had five or more pregnancies, 34% of women accepted a modern method of contraception after the abortion experience. The Thai public hospital only offered sterilisation to women and expected them to return at 6 weeks after the pregnancy loss to get contraceptive supplies. Most of the women who were interviewed during the course of this study worked as undocumented workers in garment factories, on farms or as housemaids. Two thirds of the women interviewed disclosed inducing their own abortions with Kathy Pan, herbal medicines, sticks and pummelling the pelvic area which often resulted in gynaecological morbidity. Ten women died due to maternal causes. Traditional lay midwives shared their views on fertility and some shared their abortion techniques. The majority of lay midwives had very limited knowledge concerning modern methods of contraception.

### **Conclusion and programme implications**

Unsafe abortion is common inside Burma as well in this area of the Thai-Burma border. Women use multiple methods with increasing danger in their desperation to end the pregnancy. Outreach sexual health education and contraception programmes should be supported in factories, farms and community meeting places. Bi-cultural workers should be placed inside Thai public health facilities.

### **For further information:**

Suzanne Belton, Key Centre for Women's Health in Society  
University of Melbourne, Victoria, 3010, Australia  
Telephone: 61 3 83444333  
Fax: 61 3 93479824  
Email: [s.belton@pgrad.unimelb.edu.au](mailto:s.belton@pgrad.unimelb.edu.au)

## **Postabortion Care for Refugee Women in Western Ethiopia**

**Authors** Hailu Yeneneh, Research Associate, Ipas Ethiopia; Solomon Kumbi, Associate Prof., Addis Ababa University; Hailemichael Gebreselassie, Regional Research Advisor, Ipas; Takele Geressu, Program Associate, Ipas Ethiopia

**Presenter** Hailu Yeneneh

### **Background**

In August 2001, Ipas signed an agreement with the Ethiopian Administration for Refugee and Returnee Affairs (ARRA) and UNHCR. The aim was to improve the quality of post-abortion care (PAC) to refugee women in western Ethiopia camps.

### **Purpose of study or programme**

This baseline survey was carried out in order to make a situation assessment of PAC in refugee camp health facilities and their referral hospitals. Findings would guide action towards the improvement of services and also help in measuring impact of interventions.

### **Data collection or programme methods**

All four refugee health centers (HCs) and their 3 referral hospitals were included in the assessment. Questionnaires were employed to interview refugee camp officials on general issues including the flow and characteristics of the refugee population; health workers in the camps and referral hospitals on the status of their health services; and women refugee groups about their observations on the service provision as well as their knowledge, attitudes and practices with respect to reproductive health. A checklist was also used to guide walkthrough observation of the health facilities. We looked at such items like equipment, supplies, techniques of management, space, and records.

### **Study or programme findings**

There were a total of 73,177 refugees, more than 98% of whom were Sudanese. About 20% (14,566) were women in the reproductive age. All four HCs were staffed almost exclusively by Ethiopians. The HCs are directed by general practitioners and all have nurses/midwives among a variety of other health professionals. Male translators were used in the clinics even for women's reproductive health problems because females had little or no education. However, all community-based health workers were refugees. The staff turnover, especially of medical doctors, was very high. There was no one trained in PAC and none of the HCs or the referral hospitals had a standard protocol. Recording and reporting were poor. None of the HCs had manual vacuum aspiration equipment which has proved to be more effective and safer than sharp curettage for treating first trimester incomplete abortion. Organization of services and availability of drugs and supplies were good. There were 75 cases of abortion during the previous one year. All were treated by sharp curettage and only 13% received a post-abortion family planning (PAFP) method. Linkage with other reproductive health services within each facility was rather weak.

### **Conclusion and programme implications**

The refugee health service in western Ethiopia is well organized. However, post-abortion care requires improvement. Training and equipping should preferably include doctors and mid-level providers to make up for the high turnover. Women should get a post-abortion family planning method before leaving the clinic. Female translators need to replace the males!

### **For further information:**

Hailu Yeneneh, P.O. Box 63001, Addis Ababa, Ethiopia  
Telephone: 251-1-633379  
Fax: 251-1-626310  
Email: [hailuy55@hotmail.com](mailto:hailuy55@hotmail.com)

## **Post-Abortion Care Training for Informally Trained Health Workers in a Refugee Setting: Lessons Learned**

**Authors** Ms. Joan Venghaus, PAC Coordinator Asia Region, EngenderHealth. Dr. Cynthia Maung, Executive Director, Burmese Refugee Care Project. Ms. Evelyn Landry, Regional Director, Asia, EngenderHealth

**Presenter** Ms. Joan Venghaus

### **Background**

The Women's Commission requested EngenderHealth, on behalf of the Reproductive Health for Refugees Consortium (RHRC) and Columbia University - Heilbrunn Department of Population and Family Health, to provide Post-Abortion Care training for the staff from the Mae Tao Clinic, American Refugee Committee, International Rescue Committee, and Aide Medicale Internationale working on the Thai/Burmese border.

### **Purpose of study or programme**

To introduce systematic training on the management of abortion complications, use of Manual Vacuum Aspiration (MVA) equipment, provision of quality comprehensive post-abortion care (PAC) services, including counseling and referral to other reproductive health services and addressing other problems at the site using Quality Improvement tools such as COPE and whole-site training.

### **Data collection or programme methods**

The team used an approach to training that meet the learning needs of all the staff at the site, viewing the service site as a system and treating staff as members of the team which made the system work. The training did not put a burden on the site and ensured that the site was set up to give services. The training was flexible and required less logistic and financial support than the traditional training.

### **Study or programme findings**

Training informally trained health workers in PAC can prevent the maternal death and disability that often accompany incomplete abortion. Other areas of care can be improved using quality assurance tools. The following need to be taken into consideration when organizing trainings: flexibility, comprehensiveness, sustainability, language and counseling.

### **Conclusion and programme implications**

Conducting on-site training ensures that the services are implemented immediately. Using quality assurance tools focuses on problem-solving and facilitates teamwork and support to empower the trainees to improve their own overall quality performance.

### **For further information:**

Joan Venghaus, EngenderHealth India Country Office, IFPS Liaison Office, 50-M Shanti Path, Gate No.3, Niti Marg, Chanakyapuri, New Delhi-110021-India  
Email: [jvenghaus@engenderhealth.org](mailto:jvenghaus@engenderhealth.org)



## Where tradition, culture and violence meet: Addressing GBV in refugee settings

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**Moderator:** Lydia Leon, UNFPA

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Edna Jurugo	Gender-based violence amongst a displaced population
Susan Igras	Working with refugee communities to change the harmful practice of female genital cutting (FGC): Findings from operations research on FGC abandonment activities in Dadaab, Kenya
Penny Haora	The “success” of SGBV prevention and response initiatives—Does ‘diffusion of innovations’ merit consideration?

## **Gender-Based Violence amongst a Displaced Population**

**Authors** Edna C Jurugo, Transcultural Psycho-social Organization—Uganda  
**Presenter** Edna C Jurugo

### **Background**

Gender-based violence is a universal phenomenon, which in displacement could be exacerbated by the numerous stressors resulting from the destruction of familiar social and economic structures plus changes in the modes of settling family disputes.

### **Purpose of study or programme**

The study is aimed at identifying the causes of domestic violence, its manifestation, consequences and intervention-effects for program policy, evaluation and documentation.

It is one of the areas handled by the Transcultural Psycho-social Organization (TPO) which offers counseling and mental health services to both refugees and members of the indigenous population.

### **Data collection or programme methods**

The study was done in TPO operation areas in Northern Uganda: Adjumani, Moyo, Yumbe and Arua Districts, hosting thousands of Sudanese refugees since the early 1990s.

Data was collected from monthly and yearly reports, a baseline survey in refugee settlements, focus group discussions and in-depth interviews with key-informants. Discussions were also held with counselors on their modes of intervention and experience in handling domestic cases.

### **Study or programme findings**

Causative factors in gender-based violence are alcohol abuse, poverty, early marriages, forced marriages, infidelity and polygamy. Violence is expressed through physical abuse and psychological torture. The latter includes verbal insults and withdrawal/neglect of family obligations. Dire consequences, e.g. suicide, are part of gender-based violence, with the most common being family separation, increase in the number of single parents and female-headed households. Power imbalances compound the problem as a large percentage of women rely on their spouses for social and economic support. Societal perceptions of single women also favor men, making it difficult for women to leave abusive spouses, hence perpetuating the practice.

### **Conclusion and programme implications**

Despite on-going intervention, gender-based violence continues among refugees in the study area. Emphasis should be on addressing the causes through continual Community Participation in Psycho-social Help (CPPH) work-shops, empowerment of women and counseling at individual, family and group level. Alcohol abuse and alcoholism should also be addressed socially and legally in the areas.

### **For further information:**

Edna Jurugo, TPO - Uganda, P.O. Box 21646, Kampala, Uganda  
Telephone: 256-41-510256 or 077550104  
Fax: 256-41-510436  
E-mail: [tpouga@imul.com](mailto:tpouga@imul.com), [ednajurugo@hotmail.com](mailto:ednajurugo@hotmail.com)

## **Working with Refugee Communities to Change the Harmful Practice of Female Genital Cutting (FGC): Findings from Operations Research on FGC Abandonment Activities in Dadaab, Kenya**

**Authors** Susan Igras, MPH, Sr Program Advisor, CARE, Jacinta Muteshi, PhD, Multi-Country FGC Abandonment Project Coordinator, Jane Chege, PhD, Program Associate, Population Council

**Presenter** Susan Igras

### **Background**

Infibulation, the most severe form of female genital cutting (FGC), remains a universal practice in most Somali communities. Many consider it a form of gender violence. Because the practice is part of the social norm of communities, behavior change approaches are ineffective and social change approaches are needed. This study contributes to the small but growing body of operations research on FGC.

### **Purpose of study or programme**

Operations research was conducted in the Dadaab Refugee Camp in Northeastern Kenya to measure the effectiveness of community-based strategies (information and education, advocacy) in changing knowledge, beliefs, and intentions to continue the practice of FGC.

### **Data collection or programme methods**

Qualitative (focus group discussions) and quantitative (population-based surveys) research of men and women was conducted at baseline and endline in two camps, with one camp serving as the intervention site (using education and advocacy approaches), the other camp serving as the comparison site (using education approaches only). The intervention period was 15 months.

### **Study or programme findings**

About half-way through the intervention period, observable changes of a community debate were being seen in the two camps, with some individuals stating publicly that they would not be circumcised or not circumcise their daughters, and others taking the opposing position. Knowledge/awareness levels of negative health, social, and rights consequences increased significantly ( $p < .001$ ) in both camps between baseline and endline studies. Interestingly, negative beliefs increased in both intervention and comparison sites. It was less clear how much effect advocacy activities had on the camp community's knowledge and beliefs around FGC. Focus group discussions corroborated the many changes seen and the continuing debate in the camps as the intervention period ended.

### **Conclusion and programme implications**

Because social change is a long-term process, if the intervention had been for a longer period, we might have seen more change. (Abandonment activities will continue in Dadaab although the study will not.) Addressing harmful traditional practices such as FGC in community-based health project settings can lead to positive outcomes. We believe that it is better to engage in social change processes with displaced populations only in stable, long-term settings, as not supporting the change process over time could lead to more harm than benefits.

### **For further information:**

Susan Igras, Senior Program Advisor, CARE, 151 Ellis Street, Atlanta, GA 30306  
Telephone: 1 404-979-9158  
Email: [igras@care.org](mailto:igras@care.org)

## **The “Success” of SGBV Prevention and Response Initiatives—Does ‘Diffusion of Innovations’ Merit Consideration?**

**Authors** Penny Haora RN CM MPH, Reproductive and Child Health/Community Health Education Coordinator, Jarawan Abella RN MPH, Community Health Education Coordinator; American Refugee Committee (ARC) International—Thailand

**Presenter** Penny Haora

### **Background**

In recent years, non-governmental organizations (NGOs) engaged in the field have been encouraged to work towards improving the SGBV prevention and response “systems” within the communities where they operate. ARC coordinators in three camps on the Thai/Burmese border have responded.

### **Purpose of study or programme**

This paper asserts that the introduction of SGBV initiatives and the subsequent “success” of programs are based on an assumption of community attitude and cultural behavior change. The processes occurring in specified camps are considered in light of a community change theory - Diffusion of Innovations (Rogers, 1995).

### **Data collection or programme methods**

In aspiring to facilitate change ARC has undertaken a number of initiatives, including the preparation of an SGBV action plan and protocol. Coordinators have held workshops, and established and supported SGBV committees within the camps. Consultants conducted training for program coordinators, and camp groups. In consideration of the above assumption and in application of the theory, individual, group, organizational, and societal level characteristics are examined. Characteristics of the “innovation” are also analyzed, whereby the rate and extent of “adoption” has been predicted, or retrospectively examined. Case studies are presented for illustrative purposes, and an applied conceptual model is proposed.

### **Study or programme findings**

Published research on SGBV in refugee settings is scarce, with limited work reflecting on the processes of prevention and response initiatives found (Medline, 1966—2003). For “progress” to occur in SGBV prevention and response, UNHCR documents recommend broad collaborative approaches including that of NGOs from different sectors and UNHCR. But can changes in community level attitudes and dynamics also indicate progress?

There must be a realization of the many community stakeholders; the cultural gender roles predominating; the community power structure; decision-making and communication systems. Key stakeholders’ willingness to undertake and accept change can be assessed and understood with the use of change theory. Awareness and application of organizational development theory can also assist agencies in the process of fostering change. An assessment of the strengths, weaknesses, opportunities and threats involved for communities and individuals adopting an innovation can be useful for astute planning. A community development, social planning and social action approach can bring about sustainable progress.

Furthermore, there are important implications for evaluating the “success” of SGBV initiatives, since the diffusion is determined eventually “by the social group”. It may be unwise and inappropriate to impose traditional program timeframes and success indicators without an awareness of the diffusion phenomenon.

### **Conclusion and programme implications**

Effective and sustained change requires efforts from NGOs, UNHCR, and most importantly many community bodies and individuals. An analysis of key community stakeholders’ “readiness to change”, as well as the “stages of change” in light of the diffusion of innovations theory can assist change agents throughout the process.

### **For further information:**

Penny Haora, ARC International, PO Box 6, Sangklaburi, Kanchanaburi 71240, Thailand

Telephone: +66 34 595 177/560

Fax: +66 34 595 177

Email: [arcsang@loxinfo.co.th](mailto:arcsang@loxinfo.co.th) or [pennyhaora@yahoo.com](mailto:pennyhaora@yahoo.com)

## Understanding, involving and serving adolescents

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**Moderator:** Alexandra Todd, USAID

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|-------------------------|--|
| Julia Matthews          | Improving reproductive health of adolescent refugees   |
| Edmond Nkam<br>Tadiesse | Socio-cultural determinants of pregnancy and the spread of sexually transmitted infections among adolescent residents of Kakuma Refugee Camp, Northern Kenya |
| Tsegereda Assebe        | Adolescent sexual and reproductive health in refugee settings: Experiences from Western Tanzania refugee programme   |

## **Improving Reproductive Health of Adolescent Refugees**

**Authors** Julia Matthews, Reproductive Health Project Manager, Sandra Krause, Reproductive Health Project Director, Women's Commission for Refugee Women and Children  
**Presenter** Julia Matthews

### **Background**

Approximately 20 million young people are displaced due to armed conflict. These conditions affect adolescents' reproductive health by limiting their access to information; exacerbating unsafe sexual practices, unwanted pregnancies and unsafe abortions; and increasing exposure to sexually transmitted infections (STIs), including HIV/AIDS.

### **Purpose of study or programme**

The Women's Commission for Refugee Women and Children recognized supporting local organizations as an effective way to address the reproductive health (RH) needs of refugee and internally displaced adolescents. Through the Eleanor Bellows Pillsbury (EBP) Fund, the Women's Commission has supported 26 local organizations in 16 countries.

### **Data collection or programme methods**

Local partners use a variety of strategies to reach out to the adolescent population such as peer education, youth-friendly centers and dance. For example, Gulu Youth for Action (GYFA) in Northern Uganda—which is an organization run by adolescents for adolescents—is involving youth through education meetings, radio presentations and drama to teach them how to prevent sexually transmitted infections, including HIV/AIDS. The EBP Fund is supporting Shuhada in Afghanistan to provide basic literacy classes to young women using reproductive health as a main theme. The Women's Commission provides technical assistance, resource materials and advice for continued funding and networking.

### **Study or programme findings**

Through the EBP Fund, the Women's Commission has supported programs in 16 countries including Colombia, Gaza Strip/West Bank, Liberia, Nepal, Sierra Leone, Somalia, Tanzania, Thailand, and Zambia, reaching some 36,000 displaced adolescents. Some main themes addressed by the project are: raising awareness about STI/HIV/AIDS prevention, formulating a community response to gender-based violence and increasing awareness and access to family planning services. Many projects initiate workshops with the theme of general health to make the introduction of reproductive health more acceptable to the community. Other projects have used literacy classes as a way to integrate reproductive health into daily learning.

The EBP Fund is an established and growing area of the Women's Commission. Initially, the fund limited its support to local nongovernmental organizations (NGOs) but assistance has been expanded to international NGOs partnering with local agencies to bolster INGOs attention to the adolescent population and provide local NGOs with hands-on technical advice from experienced organizations. After three years of activity, the fund is evaluating new systems of increasing efficiency and coordination. For example, in Thailand there is interest in establishing a regional coordinator through which funds would be disbursed to facilitate planning and partnerships among groups doing adolescent reproductive health programming.

### **Conclusion and programme implications**

Supporting local community-based organizations (CBOs) is a valuable way to increase RH awareness and services to adolescents who have been displaced by conflict. Minimal external support and technical assistance to CBOs for adolescent RH builds their technical capacity for sustainable outreach to refugee and internally displaced youth.

### **For further information:**

Julia Matthews, Reproductive Health Project Manager, Women's Commission for Refugee Women and Children, 122 E. 42<sup>nd</sup>, 12<sup>th</sup> Floor, New York, NY 10168  
Telephone: 1 212 551 3112  
Fax: 1 212 551 3180  
Email: [juliam@womenscommission.org](mailto:juliam@womenscommission.org)

## **Socio-Cultural Determinants of Pregnancy and the Spread of Sexually Transmitted Infections among Adolescent Residents of Kakuma Refugee Camp, Northern Kenya**

**Authors** Mr Edmond Nkam Tadiesse, Tutorial Fellowship Centre for Complementary Medicine and Biotechnology, Prof Alloys. S.S Orago, Director Centre for Complementary Medicine and Biotechnology, Dr Regina Karega, Director Bureau of Educational Research, Kenyatta University; Dr Roger Vivarie, Senior Health Co-ordinator, UNHCR Branch Office, Kenya

**Presenter** Edmond Nkam Tadiesse

### **Background**

Teenage pregnancy and the spread of STIs are quite rampant in Kakuma camp. Despite free reproductive health services and intensive sex education campaigns, there was very low use of condoms, high spread of STIs and high rate of teenage pregnancy.

### **Purpose of study or programme**

This study was conducted to provide guidelines for health policy makers with regard to the mode of providing effective RH geared towards the special needs of adolescents in refugee camp as well as to motivate adolescents' acceptance and consumption of RH services by providing ways of increasing efficiency and effective delivery.

### **Data collection or programme methods**

This was a descriptive and cross-sectional study. Both quantitative and qualitative data collection techniques were used. In 2001, the camp had 64,000 refugees, out of which 40% were adolescents. The research instruments administered in collecting data included

*Questionnaires:* 575 boys and girls aged between 12-19 from 8 different nationalities participated.

*Key informant interviews :* 18 leaders were interviewed.

*Focus group discussions:* 5 different series were held.

*Participatory observations:* we had 45 day and night observations in all social, cultural and household activities of the refugees.

SPSS was used to analyze the data.

### **Study or programme findings**

- 70% of the respondents were sexually active and engaged in unplanned sexual intercourse.
- Boys did not use condoms and girls did not use contraceptives because of ignorance and incorrect marketing strategies.
- Religious teachings and cultural exclusion attached to marriage, premarital sex and FGM supported by elders created a barrier in addressing adolescent sexuality and utilization of RH services.
- Religious leaders, the formal school system and social services played an insignificant role in creating awareness on sexuality and related matters among the respondents.
- Teenage pregnancy was linked to adolescent rebellion against cultural norms, early marriages, forced marriages and to the situation of resettlement.
- Abortion was widely practiced among the adolescents.
- FGM did not enable girls to remain virgin until marriage as claimed by the communities that practiced it.
- Some male adolescents appeared to have been involved in sex with female adults in exchange for food or money. These adult females engaged the adolescents in sex because they had to fill the gap left by their adults male partners who are either nonexistent or always under the influence of drugs.

### **Conclusion and programme implications**

The socio-cultural factors that influence the delivery and use of RH, with specific reference to STIs and pregnancy, among adolescents were established. By identifying the barriers of addressing adolescent sexuality, this study has determined the social support necessary for the delivery of RH services to the adolescents.

### **For further information:**

Edmond N. Tadiesse, P.O. Box 61402, Nairobi/Kenya

Telephone: +254 2 713908

Fax: +254 2 574752

Email: [Tadiesse@yahoo.com](mailto:Tadiesse@yahoo.com)

## **Adolescent Sexual and Reproductive Health (ASRH) in Refugee Settings: Experiences from Western Tanzania Refugee Programme**

**Authors** Marian Schilperoord, RH Officer, Mohamed Qassim, Snr. Health Coordinator, Naomi Nyitambe, ASRH focal point, UNHCR Tanzania; Tsegereda Assebe, RH Officer, Kate Burns, Snr Public Health Officer, UNHCR Geneva; Edmund Rutta, Health Coordinator, NPA Tanzania; Beryl Hutchison, Health Coordinator, CORD Tanzania; Athanas Ngambakubi, UMATI Tanzania; Msafiri Swai, Marwa Mtalai, Tanzanian Red Cross, Tanzania

**Presenter** Tsegereda Assebe

### **Background**

A previous study in Western Tanzania refugee camps showed four major causes for sub-optimal accessibility and acceptability of reproductive health (RH) services for young people: 1) Lack of confidentiality; 2) Reduced utilisation of RH services due to lack of confidentiality; 3) Communication problems with service providers; 4) Lack of sensitivity by older service providers.

### **Purpose of study or programme**

Adolescent sexual and reproductive health (ASRH) services were established as pilot projects in two Tanzanian refugee camps in 2000, with expansion in 2001/2002 to other camps. The purpose was to provide a place for youth to congregate, to improve RH knowledge, behaviours and practices, and to provide basic RH services in a confidential and accessible manner.

### **Data collection or programme methods**

The ASRH programmes covered the following activities:

1. Establishment or rehabilitation of youth centres;
2. Continued health education and awareness;
3. Training of peer educators;
4. Establishment of vocational and skills training activities;
5. Provision of basic RH services including treatment of sexually transmitted infections (STIs), family planning, HIV/AIDS prevention education, condom promotion and distribution, and referral services; HIV voluntary testing and counselling was offered in some centres.

### **Study or programme findings**

After the training of health care providers and sensitisation of the community, more young people made use of the centres and the various services offered. The layout of the centres, developed with input from the users, appeared to be particularly important in sustaining confidentiality and improving accessibility. Attendance at the STI clinic increased over time as documented by reported cases. Messages developed by young people appeared to be a successful method to tackle sensitive RH issues including HIV/AIDS. The centres proved an ideal place to involve disabled young people.

Female involvement was a problem. Often girls were not allowed to attend due to domestic activities, parental disapproval, and cultural attitudes. To overcome this barrier, plans were made to have special opening hours for girls only, to develop targeted education and vocational and skills training for girls, and to sensitise parents and community leaders.

### **Conclusion and programme implications**

ASRH centres can provide a place for youth to congregate and take advantage of RH services in a confidential and accessible manner not available at traditional health centres. Different experiences and levels of involvement of the clients in the various camps showed that the involvement of young people themselves in the management and decision-making is important to the success of ASRH centres. Sensitisation of the community to improve female access is needed.

### **For further information:**

Marian Schilperoord, RH Officer, UNHCR, Tanzania Case Postale 2500, 1211 Geneva, Switzerland, 2 Depot  
Telephone: 41 22 739 8315 Fax: 41 22 739 7366 Email: [schilpem@unhcr.ch](mailto:schilpem@unhcr.ch)



## Measuring maternal mortality in Afghanistan

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**Moderator:** Therese McGinn  
Heilbrunn Department of Population and Family Health  
Mailman School of Public Health, Columbia University

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| Lynn Amowitz   | Maternal mortality in Afghanistan: An index of the status of women's rights  |
| Linda Bartlett | Maternal mortality and health care access in conflict settings: case studies from maternal mortality studies among Afghan women in refugee camps in Pakistan and in Afghanistan. |
| Leila Bisharat | The measurement of maternal mortality during humanitarian response: Recent lessons from Afghanistan  |

## **Maternal Mortality in Afghanistan: An Index of the Status of Women's Rights**

**Authors** Lynn L. Amowitz MD, MSPH, MSc, Chen Reis, JD, MPH, Vincent Iacopino, MD, PhD; Physicians for Human Rights, Boston, MA (Drs. Amowitz and Iacopino, Ms. Reis); Brigham and Women's Hospital and Harvard Medical School, Boston, MA (Dr. Amowitz)

**Presenter** Lynn Amowitz

### **Background**

Maternal mortality rates in Afghanistan are among the highest in the world. These preventable maternal deaths may be an important indicator of the health and human rights status of women, their access to health care, and the adequacy and ability of the health care system to respond to their needs.

### **Purpose of study or programme**

The purpose of this study was to 1) provide a rapid and accurate estimate of maternal mortality in Herat, Afghanistan, 2) assess women's human rights issues that may contribute to maternal mortality, and 3) assess maternal health services in the region.

### **Data collection or programme methods**

The study was a cross-sectional, randomized survey of Afghan women, using structured interviews/questionnaires. A total of 4486 women participated and provided maternal mortality information on 14,085 sisters. At the time of the study, approximately 500,000 women were living in the 13 districts of Herat province, Afghanistan. To obtain a representative sample of women, we selected randomly from 7 districts, villages that had populations greater than 200 households and were within a 4-hour drive from Herat City. A total of 34 villages from 7 of 13 districts in the province of Herat were included in the study. The 7 districts from which villages were sampled represented 72% (793,214/1,094,377) of the population in Herat.

### **Study or programme findings**

There were 276 maternal deaths among 14,085 sisters of the survey respondents (593 maternal deaths/100,000 live births; confidence interval [CI] 557-630). Of the 276 deaths, 254 (92%) were reported from rural areas. The respondents reported the following primary problems: lack of food (41%), shelter (18%) and clean water (14%). Eighty-six percent (4065/4748) of women thought they should have the right to choose a husband and enter into marriage. Of 4721 respondents, 4008 (85%) wanted to marry at the time of their wedding, but 957 (20%) felt pressured by the family. Of 4073 women, 4117 (87%) had to obtain permission from their husband or male relative to seek health care; however, only 54 (1%) were not permitted to obtain prenatal care. Only 519 (11%) women obtained prenatal care and 40 (0.83%) women reported a trained health care worker attended births. Ninety-seven percent (4473/4612) of women had an untrained traditional birth attendant at the birth. Birth control methods were used by 12% (597/4881) of women, whereas 23% (1013/4294) of women indicated they wanted birth control. Seventy-four percent (3189/4306) of women stated that the husband and wife made decisions about the number and spacing of children equally.

### **Conclusion and programme implications**

This study indicates that women in Herat province have an extraordinarily high risk of maternal mortality. The study also identifies human rights factors that may contribute to preventable maternal deaths in the region. These include access to and quality of health services, adequate food, shelter, and clean water, and denial of personal freedoms.

### **For further information:**

Lynn L Amowitz MD, MSPH, MSc, Senior Medical Researcher  
Physicians for Human Rights, 100 Boylston Street, Suite 702, Boston, MA 02116 USA

## **Maternal Mortality and Health Care Access in Conflict Settings: Case Studies from Maternal Mortality Studies among Afghan Women in Refugee Camps in Pakistan and in Afghanistan**

**Authors** Linda A. Bartlett, Shairose Mawji, Sara Whitehead, Chadd Crouse, Denisa Ionete, Peter Salama, the Afghan Maternal Mortality Study Group and the Afghan Refugee Study Group  
**Presenter** Linda A. Bartlett

### **Background**

To examine maternal mortality and health care access among populations affected by conflict, we compare results of mortality studies conducted among Afghan women in Pakistani refugee camps and in Afghanistan

### **Data collection or programme methods**

In Pakistan, data were collected in 12 refugee camps in the Northwest Frontier Province whose health care and hygiene services were delivered by the International Rescue Committee (IRC). In Afghanistan, we collected data in four districts selected to represent urban to rural settings (urban: Kabul City, Kabul Province; semi-rural: Alisheng district, Laghman province; rural: Maywand, Kandahar Province and Ragh, Badakshan Province). Total deaths among women of reproductive age (WRA; 15-49 years) during the study periods (Pakistan 1999-2000 [n=66]; Afghanistan 1999-2002 [n=357]) were identified during household surveys. Verbal autopsy interviews were then conducted among the family members of deceased women to identify deaths due to maternal causes and assess risk factors for death including health care access. Maternal mortality ratios (MMR) were estimated as the number of maternal deaths per 100,000 live births. The Fisher exact test was used to determine whether differences in prevalence of use of selected indicators of reproductive health care use between the five regions were statistically significant.

### **Study or programme findings**

Among refugees in Pakistan, the MMR was 300 deaths/100,000 live births (95%CI: 200-400). In Afghanistan, the MMRs were: 400 (200-600) in Kabul, 800 (400-1100) in Alisheng, 2200 (1500-2900) in Maywand, and 6500 (5000-8000) in Ragh (our most remote study site). Health care access decreased with increasing remoteness of study sites. Among the reproductive health care access indicators measured among the deceased women—ever use of family planning was 15% in Pakistan, 11% in Kabul, 6% in Laghman, 7% in Kandahar and 0% in Badakshan ( $p < 0.01$ ); prenatal care use was 68% in Pakistan, 56% in Kabul, 6% in Laghman, 14% in Kandahar and 3% in Badakshan ( $p < 0.01$ ); and delivery with skilled attendant was 46% in Pakistan, 47% in Kabul, 12% in Laghman, and 0% in Kandahar and Badakshan ( $p < 0.01$ ).

### **Conclusion and programme implications**

Our health care access data are limited to deceased women. However, assuming that access among women who died did not differ substantially from women who did not die, increasing remoteness of our study sites was significantly associated both with lower prevalence of health care access among the deceased woman and with increasing risk of maternal death. Potential contributors to higher mortality in rural areas include lack of other basic health services such as vaccine, nutrition and sanitation services such as those available in the refugee settlements. Evaluating the most important components of health care to reduce maternal mortality may help to guide resource allocation and service implementation to refugees and others in conflict-affected settings.

### **For further information:**

L. A. Bartlett MD, MHSc, Division of Reproductive Health  
Centers for Disease Control and Prevention (CDC) MS-K-23  
4770 Buford Highway N.E., Atlanta, Georgia, USA, 30341  
Telephone: (770) 488-6250  
Fax: (770) 488-6283  
Email: [LTB7@cdc.gov](mailto:LTB7@cdc.gov)

## **The Measurement of Maternal Mortality during Humanitarian Response: Recent Lessons from Afghanistan**

**Authors** Leila Bisharat, Director Center for Reproductive and Women's Health, JSI  
Patricia David, Director Center for Health Information Monitoring and Evaluation, JSI  
Laura Reichenbach, Research Scientist, Harvard Center for Population and Development Studies

**Presenter** Leila Bisharat

### **Background**

In late 2002, Physicians for Human Rights requested John Snow Research and Training Institute to bring together a consultation on the measurement of maternal mortality during humanitarian response, looking specifically at the recent experience in Afghanistan.

### **Purpose of study or programme**

This presentation shares the findings of this consultation on the measurement of maternal mortality during humanitarian response in Afghanistan.

### **Data collection or programme methods**

The questions posed for the consultation were:

- What were the challenges faced in two studies of maternal mortality in post-conflict Afghanistan, one undertaken by the CDC (Bartlett et al) and one undertaken by PHR (Amowitz)?
- What have we learned from the experience?
- What are the recommendations for assessing maternal mortality in complex humanitarian emergencies?
- How can these studies be most effectively implemented under the conditions of humanitarian crises?

Both principal investigators participated, as did specialists in MM who had contributed to developing the methods used in the Afghanistan surveys (Graham—sisterhood method and Fortney—RAMOS method).

### **Study or programme findings**

#### *Design and Measurement Issues*

The information needs and the realities of the local situation must drive the design of data collection and choice of methods to measure maternal mortality and other indicators. What we know about the upper limits of the MMR in post-conflict situations is very limited, if non-existent and further research to greater understand the burden of maternal mortality in extremely poor resource settings is needed. However, depending on the immediate needs of the program, participants suggested the following timeframe for research in emergency settings: first, rapid qualitative methods may be appropriate to plan immediate humanitarian response; and second, larger quantitative and qualitative data collection efforts to inform and stimulate the policy community.

### **Conclusion and programme implications**

The survey work of both PHR and CDC in Afghanistan has brought a heightened awareness of death in childbirth as a human rights issue that must and can be addressed. All estimates in Afghanistan indicate unacceptably high levels of maternal mortality. There is a need to build on this experience so that maternal health stays high on the humanitarian response agendas. The participants saw a need for a handbook that brings together guidance for field staff and donors on obtaining information on maternal health in crisis situations. Guidance should be aligned with the realities faced in humanitarian crises, both in terms of logistics and resources, as well as programmatic and advocacy needs.

### **For further information:**

Leila T. Bisharat, JSI, 1616 N. Fort Myer Drive, 11th Floor Arlington, Virginia 22209  
Telephone: 703-528-7474 ext. 5245  
Fax: 703-528-7480  
Email: lbisharat@jsi.com

## Forum: Early results from the Inter-Agency global evaluation of reproductive health services for refugees and internally displaced persons

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**Moderator:** Judith O’Heir, Consultant, UNHCR

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Judith O’Heir	Review of Literature: Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons
Sara Casey	Evaluation of Coverage of Reproductive Health Services for Refugees and Internally Displaced Persons
Anna Whelan	Evaluation of Quality, Access to and Use of Reproductive Health Services for Refugees and Internally Displaced Persons
Wilma Doedens	Evaluation of the Use of the Minimum Initial Services Package (MISP) and RH Kits
Sandra Krause	Review of Changes Over Time within Agencies/Institutions Involved in Reproductive Health Services for Refugees and Internally Displaced Persons
Ali Buzurukov	Review of Global Trends in Resources for Reproductive Health Services for Refugees and IDPs

# INTER-AGENCY GLOBAL EVALUATION OF REPRODUCTIVE HEALTH SERVICES FOR REFUGEES AND INTERNALLY DISPLACED PERSONS

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## - BACKGROUND -

In a bid to promote the introduction and strengthening of appropriate reproductive health (RH) services for refugees and internally displaced persons (IDPs), UNHCR, UNFPA, and WHO together with a number of other key actors organised, in June 1995, an inter-agency symposium on Reproductive Health in Refugee Situations. The symposium was held in Geneva and more than 50 governments, non-governmental organizations (NGOs) and UN agencies participated. The major accomplishments of the symposium were:

- The establishment of an Inter-agency Working Group on Reproductive Health (IAWG) to facilitate the objective of strengthening RH programming in refugee situations.
- The outlining of a set of RH services for implementation in refugee situations, including a minimum package of services to be provided at the outset of an emergency.
- The publication of the Inter-agency Field Manual: Reproductive Health in Refugee Situations. This manual was first issued in 1995, then field-tested, revised and reissued in 1999. It is now available in English, French, Portuguese, Russian and Spanish.
- The recognition of RH as an essential part of primary health care and assistance to refugees. Continued advocacy, funding and technical assistance were agreed upon as key factors in the implementation of adequate RH programmes in refugee situations.

It has been seven years since the symposium took place and the IAWG established. It is now time to review what has been achieved in pursuit of the overall objective of strengthening RH programmes for refugees. At its April 2002 meeting, the IAWG endorsed a plan put forth by UNHCR to evaluate efforts to institutionalize RH care in programmes serving refugees and IDPs. To guide the evaluation process the IAWG established an Inter-agency Steering Committee consisting of CDC, ICMH, IFRC, IMC, UNFPA, UNHCR (EPAU/HCDS), WHO, the Population Council, the Women's Commission for Refugee Women and Children, and Columbia University.

## - OVERALL OBJECTIVE -

- The overall objective is to evaluate the provision of RH services to refugees and IDPs, based on the framework for implementation outlined in the Interagency Field Manual: Reproductive Health in Refugee Situations.<sup>2</sup> The evaluation process will involve a variety of methods, including self-assessment, external evaluation, and selected participatory techniques.

## - SPECIFIC OBJECTIVES -

- To take stock of the range and quality of the RH services provided to refugees and IDPs and identify factors that facilitate or hinder the provision of these services.
- To identify factors that facilitate or hinder access to, use of, and satisfaction with the RH services, from the perspective of the beneficiaries of these services.
- To explicate the lessons-learned over the last seven years and recommend ways in which RH services for refugees and IDPs can be strengthened and/or expanded.

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<sup>2</sup> Minimum Initial Service Package, Safe Motherhood, Sexual and Gender-Based Violence, Sexually Transmitted Infections, including HIV/AIDS, Family Planning, other Reproductive Health Concerns, and Reproductive Health of Young People.

- EVALUATION FRAMEWORK -

	<b>What</b>	<b>How</b>
FIELD	1. Analyze available literature relevant to past evaluations of RH services for refugees and IDPs	<ul style="list-style-type: none"> <li>- Access, review and analyse relevant reports/documents</li> <li>- Write up results (including bibliography) and use these to guide evaluation activities</li> </ul>
	2. Determine AVAILABILITY of RH services— evaluate coverage of services available at camp/urban/IDP sites	<ul style="list-style-type: none"> <li>- Questionnaire listing services outlined in RH Field Manual</li> <li>- “Key informants” in countries to arrange completion of questionnaires</li> </ul>
	3. Determine QUALITY, ACCESS to and USE of RH services - more in-depth evaluation of services at sample of camp/urban/IDP sites where coverage evaluated	<ul style="list-style-type: none"> <li>- Sample sites where coverage evaluated</li> <li>- Questionnaire/checklists with details of services (staff, planning, organization, supervision, training, recording and reporting, facilities, supplies, equipment, referral)</li> <li>- Focus group discussions with beneficiaries (access to, use of, satisfaction with RH services; knowledge of RH and related behaviour change)</li> <li>- Other participatory techniques</li> </ul>
	4. Determine AVAILABILITY and QUALITY of emergency response (MISP) to RH needs	<ul style="list-style-type: none"> <li>- Retrospective study of distribution and use of MISP/RH kits</li> <li>- Revise/expand UNFPA questionnaire used for previous study of RH kit distribution</li> <li>- Evaluate MISP during an emergency</li> </ul>
AGENCY	5. Review changes over time relevant to the following: <ul style="list-style-type: none"> <li>- Programming</li> <li>- Policies/protocols/guidelines</li> <li>- Budget/financing</li> <li>- Staffing</li> <li>- Programme components</li> <li>- Technical assistance and the impact thereof</li> <li>- RH training</li> <li>- Technical resources (e.g. practice guidelines)</li> <li>- Collaboration/coordination within and between agencies</li> <li>- Future priorities</li> </ul>	<ul style="list-style-type: none"> <li>- Questionnaire administered electronically to IAWG members and other agencies working with refugees (including “faith based” agencies), followed by phone call/IV</li> <li>- Questionnaire design to ensure the input of multiple staff per agency</li> <li>- Agency specific internal evaluations</li> </ul>
	6. Review resources: <ul style="list-style-type: none"> <li>- Origins (ICPD/Beijing)</li> <li>- Trends in funding (donors; global appeal)</li> <li>- IAWG/IASC</li> <li>- Training courses</li> <li>- Advocacy</li> <li>- Changes in policies and practices</li> </ul>	<ul style="list-style-type: none"> <li>- Desk review</li> <li>- Key informants</li> </ul>
GLOBAL	7. Prepare evaluation report and plan for dissemination of results	<ul style="list-style-type: none"> <li>- IAWG Conference on Lessons Learned</li> <li>- Webcast launch</li> </ul>
	<b>Funding Sources</b> <ul style="list-style-type: none"> <li>- UNHCR (EPAU/HCDs)</li> <li>- Participating agencies (e.g. earmarked funds and “in-kind” contributions)</li> <li>- Additional funds may be requested as appropriate</li> </ul>	

## **Review of Literature: Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons**

**Authors** Judith O'Heir, Consultant, UNHCR  
**Presenter** Judith O'Heir

### **Background**

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan, presented by UNHCR at the annual IAWG meeting in 2002, to conduct an interagency global evaluation of reproductive health services for refugees and internally displaced persons, based on the framework for implementation outlined in the *Inter-agency Field Manual*. The literature review is the first of seven components outlined in the evaluation framework.

### **Purpose of study or programme**

The purpose of the literature review was to provide background information for the subsequent components of the evaluation.

### **Data collection or programme methods**

The literature review focuses primarily on a relatively small number of assessment and/or evaluation reports related to reproductive health services for refugees and internally displaced persons. The fact that these services had not been assessed and/or evaluated extensively supported the need for an interagency global evaluation. Considerably more literature was found, however, which describes the reproductive health needs of refugees and war-affected populations. A brief review of this literature is presented as background to the review of the assessment and/or evaluation reports on reproductive health services. Several assessment reports on the quality of refugee health services as a whole are also included, as the results of these assessments are relevant to reproductive health services for refugees.

### **Study or programme findings**

The reproductive health needs of refugees and IDPs are, on the whole, the same as for people living in settled populations. The services required to meet these needs include those for family planning, safe motherhood, the prevention and management of STDs/HIV/AIDS, and the prevention and response to gender-based violence (GBV). The assessments and/or evaluations reviewed provide a generally favourable impression of reproductive health services for refugees. Some gaps were noted, however, in family planning services, particularly with respect to the availability of methods and the skills and abilities of service providers. With respect to safe motherhood, although the services at most sites for refugees were comprehensive, with better indicators and outcomes than in the host or home countries of the refugees, improvements were needed with respect to, for example, antenatal care and emergency obstetric care. Notwithstanding these positive findings, services for STDs/HIV/AIDS and, to an even greater extent, those for GBV in refugee settings, were found to be generally less comprehensive and in some instances considerably limited. However, in contrast to the reproductive health services provided for refugees, those for IDPs appeared, in general, to be severely lacking.

### **Conclusion and programme implications**

While the impression of reproductive health services for refugees is generally favourable, there is a need still to fill gaps in family planning services, improve some aspects of the services provided for safe motherhood, and generally strengthen services for STDs/HIV/AIDS and GBV. Moreover, in contrast to the services for refugees, those for internally displaced persons require a great deal more attention if the reproductive health needs of these persons are to be met.

### **For further information:**

Judith O'Heir, Consultant, UNHCR  
4/119 Oaks Avenue, Dee Why, N.S.W. Australia 2099  
Telephone/Fax: 61-2-99823090  
E-mail: [joheir@bigpond.com](mailto:joheir@bigpond.com)



## Evaluation of Coverage of Reproductive Health Services for Refugees and Internally Displaced Persons

**Authors** Sara Casey, Susan Purdin, Therese McGinn, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University  
**Presenter** Sara Casey

### Background

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan, presented by UNHCR at the annual IAWG meeting in 2002, to conduct an interagency global evaluation of reproductive health services for refugees and internally displaced persons, based on the framework for implementation outlined in the *Inter-agency Field Manual*. The study described here is the second of seven components outlined in the evaluation framework.

### Purpose of study or programme

The purpose of the coverage study was to establish a baseline of which RH services are available to conflict-affected populations and to identify the gaps in service provision.

### Data collection or programme methods

Countries with a minimum of 10,000 refugees or IDPs were identified. A questionnaire posing questions about the RH services available to the refugee or IDP population in a single settlement was emailed to key informants in these countries. Respondents were asked to include all RH services available to the population. Questions referred only to the availability of services; quality of care and usage were beyond the scope of the study. Data were collected March - May 2003.

### Study or programme findings

188 questionnaires were received from refugee and IDP settings in 33 countries, covering approximately 8.5 million displaced people (82% refugees, 18% IDPs). 76% lived in camps, 6% lived in urban areas, and the rest lived in non-camp settings.

68% had 2-4 elements of antenatal care (ANC), while 32% offered comprehensive ANC. Basic emergency obstetric care (EmOC) was available in 45% of the sites, while comprehensive EmOC was available directly or through referral in 39% of sites.

Nearly all sites reported offering at least one method of family planning with oral contraceptive pills (96%), condoms (95%) and injectable hormones (89%) the most commonly available methods.

Some aspects of HIV prevention were reported to be widely available, such as condoms (94%), the correct practice of universal precautions (90%) and community-based AIDS education (89%). Diagnosis and treatment of STIs were available in 84% of sites.

In over half of sites, programs for the prevention (57%) and the response (59%) to gender-based violence were in place. Community education and awareness-raising took place in 79% of sites, while psychosocial support and counseling were available in 64%. In 60% of sites, emergency contraception was available to survivors of rape. Two in three (66%) sites had guidelines for medical personnel's response to incidents of sexual violence, while one in three (33%) had such protocols for security personnel and protection officers (39%).

### Conclusion and programme implications

Looking at the results by technical area, coverage of RH services appears to be fairly good. GBV is weak however, and other areas such as HIV/AIDS prevention and EmOC could (and should) be stronger. Coverage decreases with the newness of the technical area. GBV, the newest, least familiar and most difficult area, has the lowest coverage, while antenatal care, the most familiar, most standard and easiest to provide, has the highest coverage.

### For further information:

Sara Casey, Center for Global Health and Economic Development, Columbia University  
215 W. 125<sup>th</sup> Street, 3<sup>rd</sup> floor, New York, New York 10027 USA  
Tel: 1 646-284-9675 Fax: 1 646-284-9684  
Email: [sec42@columbia.edu](mailto:sec42@columbia.edu)

## Evaluation of Quality, Access to and Use of Reproductive Health Services for Refugees and Internally Displaced Persons

**Authors** Anna Whelan, Anthony Zwi, Leissa Pitts, James Blogg, School of Public Health and Community Medicine, University of New South Wales

**Presenter** Anna Whelan

### Background

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan, presented by UNHCR at the annual IAWG meeting in 2002, to conduct an interagency global evaluation of reproductive health services for refugees and internally displaced persons, based on the framework for implementation outlined in the *Inter-agency Field Manual*. The study described here is the third of seven components outlined in the evaluation framework.

### Purpose of study or programme

The purpose of the study is to identify factors that facilitate or hinder access to, use of, and satisfaction with reproductive health services, from the perspective of the beneficiaries of these services.

### Data collection or programme methods

The evaluation will be conducted in four countries (Uganda, Nepal, Yemen, and Congo) that provide geographic, cultural and statistical representation, have significant refugee and/or IDP populations, multiple sites, and a range of contexts and providers in each country. Three approaches to data collection will be used, as follows: interviews with field-based service providers, including clinicians, reproductive health service users and non-users, policy makers and key administrators, and representatives of women's health advocacy groups; focus groups discussions with women, men, and young people; and observation of health facilities to assess the process and observable quality of service delivery, the availability of equipment, drugs and consumable supplies, and physical infrastructure.

### Study or programme findings

The field visits are scheduled to begin in October 2003 and be completed by April 2004

### Conclusion and programme implications

Not available at the time of printing.

### For further information:

Deborah Raphael, School of Public Health and Community Medicine  
University of New South Wales, Sydney 2052, Australia  
Telephone: 61 2 9385 2510  
Fax: 61 2 9385 1036  
Email: [D.Raphael@unsw.edu.au](mailto:D.Raphael@unsw.edu.au)

## Evaluation of the Use of the Minimum Initial Services Package (MISP) and RH Kits

**Authors** Nelly Comon, Consultant, UNFPA  
**Presenter** Wilma Doedens, UNFPA Geneva

### Background

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan, presented by UNHCR at the annual IAWG meeting in 2002, to conduct an interagency global evaluation of reproductive health services for refugees and internally displaced persons, based on the framework for implementation outlined in the *Inter-agency Field Manual*. The study described here is the fourth of seven components outlined in the evaluation framework.

### Purpose of study or programme

The purpose of the study was to conduct a retrospective evaluation of the use of the Minimum Initial Services Package (MISP) and the distribution and use of RH kits in post emergency situations.

### Data collection or programme methods

An evaluation questionnaire was developed containing two parts. Part I was designed to collect information on general issues including implementation of the MISP components, logistics for ordering, packaging, storage, distribution of the kits, and usefulness of the IEC materials distributed with the kits. Part II was designed to collect feedback on the contents of the RH kits. Forty-eight questionnaires were distributed via e-mail, with a letter of explanation, to UNFPA, UNICEF and WHO field offices and to IRC and IFRC, in 39 countries. In the case of non-responses, a first reminder was sent two weeks following distribution of the questionnaire and a second reminder two weeks after the first.

### Study or programme findings

Thirty-three (68%) of the 48 questionnaires were received, 28 of which were completed fully. With respect to implementation of the MISP, 68% of respondents had implemented all of the MISP components at some point during an emergency, whereas 78% indicated that they had implemented at least one component. Of these, 81% had appointed an RH coordinator; 90% implemented prevention and medical management of the consequences of sexual and gender violence; 90% addressed reduction of HIV transmission by distributing condoms (90%) and introducing universal precautions (65%); 100% implemented the prevention of neonatal and maternal mortality and morbidity through clean delivery kits and/or clean and safe deliveries; 72% planned for the provision of comprehensive RH services; and 72% established a data collection system for monitoring RH services.

Of the total number of RH kits ordered in 2000, 2001 and 2002, Kits 2 (clean delivery kit), 6 (professional midwifery delivery kit) and 5 (STI kit) were the most frequently ordered. Most of the organizations that completed a questionnaire indicated that they were satisfied with the usefulness of the RH kits and with the materials included in the kits, although suggestions were made to add and/or change some items. In addition, the need for training on the correct use of the contents of the kits was identified.

### Conclusion and programme implications

The MISP provides a useful set of activities relevant to providing RH services for refugees in emergency situations. Additionally, the RH kits provide many of the resources required to implement RH services for refugees and, where necessary, should be revised based on the outcome of the evaluation.

### For further information:

Wilma Doedens, UNFPA Geneva  
Email: [Wilma.doedens@undp.org](mailto:Wilma.doedens@undp.org)

## **Review Changes Over Time Within Agencies/Institutions Involved in RH Services for Refugees and IDPs**

**Authors / Presenter** Sandra Krause, Women's Commission for Refugee Women and Children

### **Background**

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan to conduct an interagency global evaluation of reproductive health services for refugees and internally displaced persons. The study described here is the fifth of seven components outlined in the evaluation framework.

### **Purpose of study or programme**

The purpose of this review was to identify changes over time within agencies/institutions involved in RH services for refugees and IDPs.

### **Data collection or programme methods**

A questionnaire will be administered electronically to selected staff at key agencies/institutions involved in reproductive health services for refugees and IDPs. Questions will be directed toward obtaining information about changes over time (i.e. 1995 to present) relevant to reproductive health.

### **Study or programme findings**

The interviews will be conducted in December 2003/January 2004 with final results available in early 2004.

### **Conclusion and programme implications**

Results will be available in 2004.

### **For further information:**

Sandra Krause, Women's Commission for Refugee Women and Children.  
Email: [sandra@womenscommission.org](mailto:sandra@womenscommission.org)

## **Review of Global Trends in Resources for Reproductive Health Services for Refugees and IDPs**

**Author/Presenter** Ali Buzurukov, JPO, UNFPA

### **Background**

The Interagency Working Group on Reproductive Health (IAWG), formed in 1995, endorsed a plan to conduct an interagency global evaluation of RH services for refugees and internally displaced persons. The study described here is the sixth of seven components outlined in the evaluation framework.

### **Purpose of study or programme**

The purpose of this review was to identify changes over time in resources for reproductive health services for refugees and IDPs and the factors contributing to these changes.

### **Data collection or programme methods**

An interview agenda was developed containing questions related to trends in funding for RH for refugees and IDPs at the global level; advocacy activities and/or strategies at the global level; changes in policies and practices at the global level affecting the availability of resources; and resources provided through the IAWG. Phone interviews were conducted with 10 senior key informants from a range of international agencies and/or organizations, selected on the basis of their knowledge of resource availability.

### **Study or programme findings**

Interviews were conducted in August / September 2003; a preliminary report will be available October 2003.

### **Conclusion and programme implications**

Not available at the time of printing. Preliminary results will be shared at the Conference 2003.

### **For further information:**

Ali Buzurukov, JPO, UNFPA  
Email: [buzurukov@unfpa.org](mailto:buzurukov@unfpa.org)

## Involving young people for programme success

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**Moderator:** Tamar Renaud, UNICEF

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|-----------------|---|
| Nirmal Rimal    | A study of the knowledge, attitude and practices (KAP) related to RH/STI/HIV/AIDS in 10-24 years youths residing in Bhutanese Refugee Camps of eastern Nepal                  |
| Rester Boniface | Using indirect approaches to regulate youth and adolescent sexuality  |
| Patricia Ospina | Findings from the project: "Sexual and reproductive health services and training for displaced and host adolescents in municipalities of Cartagena and Barranquilla, Colombia |

## **A Study of the Knowledge, Attitude and Practices (KAP) Related to RH/STI/HIV in Youths Residing in Bhutanese Refugee Camps of Eastern Nepal**

**Authors** Dr. Nirmal Rimal, Project Director, Dr. D.P. Bhandari, Health Coordinator, Dr. H.C. Upreti, Project Coordinator, Mr. Sudesh Regmi, Senior Administrator, Association of Medical Doctors of Asia (AMDA)—Nepal, Primary Health Care Program for Bhutanese Refugees (PHCP for BR), Jhapa, Nepal

**Presenter** Dr. Nirmal Rimal, Project Director, AMDA—Nepal PHCP for BR, Jhapa, Nepal

### **Background**

AMDA-Nepal is providing primary health care services to 100,000 Bhutanese refugees residing in eastern Nepal since 2001. A baseline study related to RH/STI/HIV/AIDS was undertaken in April 2002 before starting a reproductive health care program for refugees.

### **Purpose of study or programme**

To know the baseline KAP regarding reproductive health in the Bhutanese refugee youths and use survey results to design appropriate curriculum for awareness education and to design appropriate RH services targeting youths in refugee settings.

### **Data collection or programme methods**

A standard KAP questionnaire was adopted from the UNHCR KAP survey guidelines. These questions were modified according to the field situation after consulting refugee representatives and field-testing. A stratified systematic random sampling method was used for data collection. The total population of youths, age 10-24 years, as of 31 December 2001, in the refugee camps was 38,234 and the desired sample size for the study was determined at 362. The collected sample size was 371. The data was analyzed using EPI INFO.

### **Study or programme findings**

There were 49% male and 51% female respondents. Among them, 22% male and 46% female respondents didn't know anything about sexual contact. Only 17% of the respondents reported having sexual contact; and, among them, 57% had their first contact at the age of 15-16 years. 21% youths learned about sex from friends, 27% from radio, and only 2% from their guardians. Among the sexually active, 32% were unmarried.

34% of the respondents could not define rape, while 84% of the respondents were aware of rape incidents in the community. 2% of the respondents were found to have been sexually assaulted. 18% thought that rape cases should be kept secret.

Regarding STIs, 83% were aware that diseases could be transmitted by sexual contact; 47% thought that STIs are acquired after sexual contact with multiple partners; 20% think that sexual contact without using condoms is the main reason for transmission; and 46% didn't have any idea about the symptoms of STI. Only 41% know that the use of condoms is the method of prevention.

Regarding HIV/AIDS, 89% have heard about it; 46% were afraid of getting it; and only 8% were able to specify three ways of prevention. If a family member is found to be HIV positive, only 57% of the respondents were positive about providing support.

### **Conclusion and programme implications**

This KAP survey revealed important information on RH among the youth, including gaps and emphasized the necessity of conducting appropriate programs on reproductive health including STI/HIV/AIDS. It also provided rich information to design appropriate curriculum for awareness education, to use as a tool for future comparison and to assess the success of program implementation. A RH program based on the peer sharing approach was subsequently implemented which resulted in positive changes in KAP relating to RH among the Bhutanese refugee youths.

### **For further information:**

Dr. Nirmal Rimal, Project Director, AMDA-Nepal, Primary Health Care Services for Bhutanese Refugees, Birtamod, Jhapa, Nepal  
Telephone: 977-23-540232 Fax: 977-23-540031  
E-mail: [n.rimal@amda.org.np](mailto:n.rimal@amda.org.np)

## **Using Indirect Approaches to Regulate Youth and Adolescent Sexuality**

**Authors** Elisa Muhingo, Project Coordinator, Umati Refugee Project  
Rester Boniface, Family Planning Project Supervisor, Umati Refugee Project

**Presenter** Rester Boniface

### **Background**

About 477,000 refugees from neighboring countries currently reside in eleven camps in western Tanzania. Twenty-five percent are youth and adolescents of 10 to 24 years. UMATI has a project that aims at improving the reproductive health of refugee youth in Karago, Kanembwa and Mkugwa camps.

### **Purpose of study or programme**

The program was established in 2000 to address the youth reproductive health problems by providing related services in the youth centers and in the community.

### **Data collection or programme methods**

During the baseline survey conducted in November 2000, youth said two of the major causes of early pregnancies and marriages were idleness and poverty.

The project was designed to provide SRH services in the youth centre and community. They include counseling, family planning, STD treatment, voluntary counseling and HIV testing.

A simple mid-term evaluation that was conducted in late 2002 did not show very significant changes in sexual behavior.

Activities that address idleness and poverty were introduced/strengthened as skills training, income generation, sports and cultural activities. They were aimed at involving youth and indirectly assisting them to decide/regulate their sexual behavior. Within these activities/groupings, various educational materials i.e. posters, leaflets, playing cards with educative message were provided. Youth were encouraged to discuss the messages while working and Peer Health Educators continued to visit the places for education.

### **Study or programme findings**

After introduction of the mentioned activities, the number of youths using condoms has increased, youths are freer in discussing sexual related matters and the number of early marriages were reduced. (Survey results will provide figures).

### **Conclusion and programme implications**

Addressing the facilitating factors of Youth/Adolescent reproductive health problems has contributed/ resulted in regulating their sexuality.

### **For further information:**

Rester Boniface, UMATI Refugee Project, Box 123, Kibondo, Tanzania  
Telephone/fax: 255 28 2820208  
Email [umatikib@africaonline.co.tz](mailto:umatikib@africaonline.co.tz)

## **Findings from the Project: “Sexual and Reproductive Health Services and Training for Displaced and Host Adolescents in Municipalities of Cartagena and Barranquilla, Colombia”**

**Authors** Patricia Ospina, Project Coordinator, Ana Vega, Project Evaluator, PROFAMILIA

**Presenter** Patricia Ospina

### **Background**

PROFAMILIA'S youth programmes have extensive experience in the necessary approaches to motivate the participation of young people in sexual and reproductive health initiatives. These methodologies have now been applied in a pilot project to reach vulnerable young people displaced by Colombia's violent 40-year internal conflict.

### **Purpose of study or programme**

The purpose of the project is to increase the level of knowledge and use of reproductive health services and raise awareness of sexual and reproductive rights. The project has been monitored and evaluated in order to gauge the impact of the intervention and the replicability of the model.

### **Data collection or programme methods**

1. Program method:

Educational activities include workshops for displaced and host adolescents, training workshops for youth promoters, awareness and sensitization talks for adults in the community. Services include family planning counselling, sale of family planning methods, general medicine, gynaecology, antenatal care, STI diagnosis and management.

2. Data Collection:

- Information on service provision and educational activities is routinely collected.
- Pre and post evaluations of training workshops have been carried out to assess quickly and consistently if the adolescents are understanding and learning.
- Baseline and final surveys were conducted to assess impact of the intervention.

### **Study or programme findings**

During the first two years of the project (June 2001 to June 2003), the following were held: 24 workshops - subsequently reinforced and replicated- with 583 peer educators, 227 workshops with 5,602 participating adolescents, 25 workshops with 512 parents, and 142 community talks with an overall assistance of 3,411. The project has provided 1,076 family planning consultations, 413 gynaecological consultations, 295 antenatal care consultations and 979 general medicine services. The project has also sold 3,180 condoms to adolescents as well as 831 cycles of pills, 1,419 injectables and 203 doses of emergency contraception.

Study findings:

- *Workshops.* Peer educators have increased their knowledge of family planning methods from 94% to 100%. Generalised knowledge of HIV has increased from 49% to 85%. Knowledge of sexual and reproductive rights has increased from 80% to 98%.
- *Baseline and final survey.* Knowledge of family planning methods has increased from 92% to 95%. Condom use has increased from 3.7% to 4.1% while the use of injectables has increased from 1.3% to 3.6%. 60% of adolescents declare a change in sexual conduct to avoid HIV infection compared with 42% in the baseline survey; 73% recognise that HIV infection can be avoided by using a condom, compared to an initial figure of 59%; and 74% recognise that condoms prevent the spread of STIs, compared to an initial figure of 53%.

### **Conclusion and programme implications**

- Methodologies used with static adolescent populations are transferable to displaced populations.
- Educational methodologies have to be dynamic, interactive and flexible.
- Support of key gatekeepers promotes positive and responsible attitudes to reproductive health.
- This is a model that will be replicated by PROFAMILIA in Colombia.

### **For further information:**

Patricia Ospina, Profamilia, Calle 34 No. 14-52, Bogotá, Colombia

Telephone: 57 3 39 09 00 Fax: 57 2 87 55 30

Email: [pospina@profamilia.org.co](mailto:pospina@profamilia.org.co)



## How do you know your services are good?

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**Moderator:** Deborah Baglole, Merlin

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Paula Nersesian	Standardized measures for ensuring reproductive health commodity availability in refugee settings
Henia Dakkak	The need for the UN process indicators in the humanitarian context
Sophia	Using evidence to improve quality along the Thailand-Burma border

## **Standardized Measures for Ensuring Reproductive Health Commodity Availability in Refugee Settings**

**Authors** Dana Aronovich, Research and Evaluation Advisor, John Snow, Inc./DELIVER  
**Presenter** Paula Nersesian

### **Background**

A critical component in delivering health services in refugee settings is the continuous availability of high-quality reproductive health (RH) commodities. The absence of these commodities will leave refugee groups without the health care services they need.

### **Purpose of study or programme**

Careful monitoring of commodity availability and logistics system performance can help managers ensure the effectiveness and efficiency of a supply chain. This paper describes a methodology for monitoring and evaluating logistics systems, along with core indicators and tools for data collection.

### **Data collection or programme methods**

DELIVER, a USAID-funded project implemented by John Snow, Inc., has developed a set of logistics indicators for monitoring and evaluating logistics system performance. Program managers in refugee settings can use these indicators to assess RH commodity availability and to determine existing strengths, weaknesses, and needs. These indicators can be used for program design, baseline data collection, and program implementation. To collect data to measure these indicators, DELIVER has developed a data collection tool that can be applied to RH programs, as well as standards for developing logistics management information systems to collect these types of logistics data routinely.

### **Study or programme findings**

Routine monitoring of commodity management is imperative for managers to track supply requirements to ensure continuous availability and quality. These indicators have been applied to national public sector supply chains in many countries around the world. In refugee settings, they have been applied in limited areas, including northern Uganda, northern Kenya, and southern Sudan. Baseline data have been collected in the field and analyzed to assess the status and performance of supply chains in these countries. Changes in the indicators will be monitored over time to encourage continuous system improvements and to adjust strategies and interventions, as required.

This paper presents results from several of these surveys, including certain indicators that would be most appropriate for use in refugee settings. For example, stockout frequency is a useful measure that represents clients who will not receive the treatment they were seeking at the health care facility. In a survey conducted in June 2002 in Uganda, over 50% of government facilities experienced a stockout during the six-month period preceding the survey of co-trimoxazole, 29% of chloroquine, 46% of benzathine penicillin, and 50% of the TB blister pack. These commodities are critical for the management of significant public health threats in Uganda.

In addition, stock levels should be carefully monitored because of the often unpredictable fluctuations in the size and movement of a refugee population. From the same survey in Uganda, the results showed that, for most of the commodities studied, the stock levels were low at the higher levels of the system and higher at the lower levels of the system, which is where they need to be to serve clients. Nonetheless, low stock levels leave facilities at risk of stockouts and overstocks leave facilities at risk of losing products to expiration. The supply chain must be flexible enough to move supplies between facilities to ensure that they can meet client needs while preventing stockouts or significant overstocks.

### **Conclusion and programme implications**

These findings demonstrate how the data collected through the application of standardized measures can be presented to provide a picture of logistics system performance and of a health facility's ability to meet its clients' health care needs. These standard measures are also useful in refugee settings to measure the overall health program's ability to provide high-quality health services to its target population, ultimately leading to better health outcomes.

### **For further information:**

Dana Aronovich, John Snow, Inc./DELIVER, 1616 N. Fort Myer Drive, 11<sup>th</sup> floor, Arlington, VA 22209  
Telephone: 703-528-7474 Fax: 703-528-7480  
Email: [dana\\_aronovich@jsi.com](mailto:dana_aronovich@jsi.com)

## The Need for the UN Process Indicators in the Humanitarian Context

**Authors** Henia Dakkak, International Medical Corps (former EmOC Technical Advisor, Reproductive Health for Refugees Consortium); Samantha Lobis, Monitoring & Evaluation Officer, Averting Maternal Death and Disability Program, Heilbrunn Dept. of Population and Family Health, Mailman School of Public Health, Columbia University

**Presenter** Henia Dakkak

### Background

The evidence shows that to prevent maternal deaths, women with life-threatening obstetric complications need access to good-quality emergency obstetric care (EmOC). In 1997, UNICEF, WHO and UNFPA issued a set of indicators, called the 'UN Process Indicators,' to assess and monitor the availability, utilization and quality of these EmOC services.

### Purpose of study or programme

This study's objective is to demonstrate the need for and utility of the UN Process Indicators in the humanitarian context. The overall goal will be to systematically help improve EmOC for war-affected women.

### Data collection or programme methods

An extensive review of major health-related guidelines, policies and service packages was conducted to identify deficits in EmOC. The materials reviewed include:

- The Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response (2000),
- Inter-agency Field Manual on Reproductive Health in Refugee Situations (1999),
- Médecins Sans Frontières' Refugee Health: An Approach to Emergency Situations (1997),
- WHO's Reproductive Health Services During Conflict and Displacement: A Guide for Program Managers (2000),
- UNHCR's Guidelines on the Protection of Refugee Women (1991).

### Study or programme findings

In recent years, a variety of tools, service packages and policies have been developed to standardize humanitarian health services, establish systems of accountability and to protect and promote the human rights of war-affected populations. Unfortunately, EmOC has not been adequately addressed in most of the documents reviewed.

War-affected populations have access to EmOC through the Minimum Initial Services Package (MISP). However, MISP was designed and developed to prevent excess neonatal and maternal morbidity and mortality in the **early phase** of complex emergencies. Since most war-affected populations remain in camps for extended periods of time, efforts establishing permanent access to EmOC need to be made.

The Sphere Project recommends establishing systems for referral to facilities offering EmOC. However, they do not specifically state which EmOC services must be in place to avert maternal deaths and disabilities nor do they include appropriate indicators to monitor their progress in improving access to EmOC.

The Inter-Agency Field Manual does address EmOC in more extensive detail. However, many of its guidelines and standards related to EmOC are different from what is published in guidelines accompanying the UN Process Indicators. For example, the Inter-Agency Field Manual defines Basic Essential Obstetric Care (EOC) as providing five services while the UN Guidelines define Basic EOC as a minimum of six services (including assisted vaginal delivery).

### Conclusion and programme implications

To help ensure women's access to EmOC, the UN Guidelines should be distributed to all agencies and NGOs working with war-affected populations. In addition, the UN Process Indicators should be incorporated and harmonized with all existing service packages, guidelines, sets of minimum standards and policies pertaining to war-affected populations' health care and protection.

### For further information:

Samantha Lobis  
Telephone: 1 212-304-5631  
Email: [SJL54@columbia.edu](mailto:SJL54@columbia.edu)

## **Using Evidence to Improve Quality along the Thailand-Burma Border**

**Authors** Cynthia Maung, Director, Sophia, Program Manager, Mae Tao Clinic  
**Presenter** Sophia

### **Background**

The Mae Tao Clinic is an unregistered clinic located in Mae Sot, Thailand along the Thailand-Burma border. Established in 1989, it provides services for illegal migrant workers in Thailand and Internally Displaced People (IDP) from Burma.

### **Purpose of study or programme**

In 2001, the clinic initiated a monitoring and evaluation project to improve the quality of reproductive health services.

### **Data collection or programme methods**

A baseline assessment was conducted using a facility audit, observation checklists, and a client exit interview. Using evidence from the assessment, the RH team initiated a number of interventions.

First, the RH team purchased basic delivery and emergency obstetric care equipment and improved the facility infrastructure.

Second, outside organizations conducted training activities to strengthen staff capacity in weak areas identified through the assessment. The IPPF affiliate in Thailand (Planned Parenthood Association of Thailand) conducted training on stock and inventory management. EngenderHealth conducted training on post-abortion care (including family planning counseling) and infection prevention. This training also introduced COPE (Client Oriented, Provider Efficient), a methodology used for quality improvement.

Third, the team, with the assistance of several technical consultants, reviewed and revised patient charts, registries, and other medical records. The new records will assist health workers to administer complete health examinations (including counseling) and will also ensure consistent data collection.

Finally, the team (with technical assistance) developed job descriptions and an organizational chart to clarify staff roles and expectations.

### **Study or programme findings**

The findings of the facility audit showed that we increased clinic hours and the number of the staff. We developed a job description for each position and improved our method of collecting data and recording information.

### **Conclusion and programme implications**

The M&E project has helped the health workers to gain knowledge and skills in how to measure the effectiveness of the health services. The project identified weak areas and prioritized program interventions.

### **For further information:**

Dr. Cynthia Maung, Director,  
Mae Tao Clinic, P.O. Box 67, Mae Sot, Tak Province 63110 Thailand  
Telephone: 66-55-563-644  
Fax: 66-55-544-655  
Email: [win7@loxinfo.co.th](mailto:win7@loxinfo.co.th)

## Involving the community to ensure success

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**Moderator:** Olga Bornemisza, London School of Hygiene and Tropical Medicine

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|-------------------|---|
| Maria Roble       | Improving family planning services in Huambo, Angola            |
| Elisa Muhingo     | Involving men to increase family planning acceptance            |
| Kathia van Egmond | Reproductive health KAP survey among Afghan women in Kabul city |

## **Improving Family Planning Services, Huambo, Angola**

**Authors** Maria Nanette Roble, IMC Consultant; Bob Lueth, IMC Angola Country Director  
**Presenter** Maria Nanette Roble

### **Background**

In 2001, International Medical Corps in Angola initiated a 2.5 year project in Communa Xavier Samacao, Huambo Province, serving a population of 35,000. Project activities include clinic-based and community-based services and community education.

### **Purpose of study or programme**

The objectives of the project were to improve family planning service delivery and increase knowledge and use of family planning and other reproductive health services among men and women in the commune.

### **Data collection or programme methods**

The project obtained data from baseline and post-intervention surveys and monthly clinic, TBA and supervision reports. In the baseline survey, a random sample of 483 women and 374 men was interviewed; in the post-intervention survey, a random sample of 472 women and 379 men was interviewed. The questionnaires contained sections on socio-demographic background characteristics, knowledge, attitudes and use of prenatal and family planning services and awareness of HIV/AIDS. Clinic, TBA reports and supervision information for 24 months between June 2001 and June 2003 provided data on utilization trends and service operations.

### **Study or programme findings**

Knowledge of family planning among women and men was extremely low at baseline, only 5% of women and 8% of men could name at least 2 modern methods. At post intervention, knowledge increased substantially to 21.6% women and 11.6% men who named at least 2 modern forms. Current use of modern contraceptives among women increased from a very low 2.5% to 10.6%. This increase was seen mainly in use of condoms and this finding should be interpreted carefully. Interest in spacing or limiting births remained high: 41.4% of women and 50% of men expressed interest during the baseline and 73.3% of women and 72.3% of men did so post-intervention. Awareness of HIV/AIDS was low at baseline (only 43% of women and 70% of men cited sex as a means of HIV transmission); by post-intervention, this increased to 57% of women and 83% of men. Only 1% of baseline respondents reported using a condom at last sex; this increased to 12% at post-intervention.

Clinical records show a steady increase in the number of family planning acceptors, from a mean of 33.5 in the first 6 months of the project to a mean of 230.8 in the last 6 months.

### **Conclusion and programme implications**

Though there was an increase in knowledge of contraceptives and interest in family planning, use remains low. Among non-users of family planning, the main reason cited for non-use was lack of information on available contraceptives and where to find them. Programs to provide for this unmet need in Angola are essential to lower maternal mortality and infant mortality due to increasingly high birth rates.

### **For further information:**

Maria Nanette Roble: [mr538@columbia.edu](mailto:mr538@columbia.edu)  
IMC Angola Country Director: [imc.ang.cd@ebonet.net](mailto:imc.ang.cd@ebonet.net)

## **Involving Men to Increase Family Planning Acceptance**

**Authors** Elisa Muhingo, Project Coordinator, Umati Refugee Project  
Rester Boniface, Family Planning Project Supervisor, Umati Refugee Project

**Presenter** Elisa Muhingo

### **Background**

UMATI implements a Monitoring and Evaluation Project in Kagera and Kigoma Refugee camps. The total population is about 477,000 settled in 11 camps. The project covers family planning and youth and adolescent reproductive health projects.

### **Purpose of study or programme**

In family planning, the project aims at (1) increasing family planning acceptance to 20% and (2) ensuring that 90% of FP acceptors continue using their method of choice.

### **Data collection or programme methods**

In order to achieve objective #2 above, a pilot project was designed to monitor the number of accepting clients who do not come for follow-up visits, and reasons for not returning for contraception. This was done in one camp (Kanembwa) and later extended in all camps

It was revealed that 39% were not continuing because of husbands' decisions.

A Pilot project was established/designed (implemented in two camps of Mtabila II —Kasulu and Kanembwa (Kibondo) to involve men in deciding for Family Planning.

Meetings with leaders (religious, community and traditional) were conducted to gather views and ascertain their knowledge and attitudes. Focus group discussions, simulations and drama were used in the meetings with men to educate them on the benefits of Family Planning.

### **Study or programme findings**

Men's attitudes changed; they started supporting family planning services. Some have started encouraging their wives to attend family planning clinics. Some are coming with them to clinics or collecting contraceptives on their behalf. This has increased acceptance to about 23% in Kanembwa and 15% in Mtabila II.

### **Conclusion and programme implications**

In communities where decision-making depends on men, their involvement in family planning programs is crucial.

### **For further information:**

Elisa Muhingo, UMATI Refugee Project, Box 123, Kibondo, Tanzania  
Telephone/fax: 255 28 2820208  
Email [umatikib@africaonline.co.tz](mailto:umatikib@africaonline.co.tz)

## **Reproductive Health KAP Survey among Afghan Women in Kabul City**

**Authors** Dr. Kathia van Egmond, ICRH (International Centre for Reproductive Health) - Ghent University, Dr. Ahmad Jan Naeem, director of IbnSina, Prof. Marleen Temmerman, Ghent University  
**Presenter** Dr. Kathia van Egmond

### **Background**

The reproductive health (RH) situation in Afghanistan is known to be extremely poor. Improving reproductive health in Afghan women is an enormous challenge to the international community and requires a good understanding of the Afghan context.

### **Purpose of study or programme**

The main objective of this KAP survey consists in contributing to a better understanding of the way Afghan women perceive RH. More specifically, this survey explores their knowledge, attitudes and practices in relation to antenatal care, obstetrical care, family planning, STIs (Sexually Transmitted Infections) and gender issues.

### **Data collection or programme methods**

The survey was carried out in October 2002 in Kabul city. 468 women of reproductive age (15 to 49 years) were interviewed, using a questionnaire translated into Dari. Women were selected through systematic sampling at the outpatient departments of four health care facilities (2 MCH clinics and 2 polyclinics) in Kabul city.

### **Study or programme findings**

- Antenatal care (ANC): 79% of the women attended ANC during their last pregnancy. 90% expressed the desire to attend ANC in the future.
- Obstetrical care: 67% delivered their first child between 13 and 19 years. 59% delivered at home, of whom 1/3 preferred another home delivery. Caesarean section rate was low (1,6%).
- Family planning (FP): 23% were using a FP method (16% a modern and 7% a natural method). Lack of knowledge of FP methods (40%) was the most important obstacle to FP, followed by women's unwillingness to limit their number of pregnancies.
- STIs: Only 24% had knowledge of any STI. Knowledge regarding transmission or prevention of STIs was extremely poor.
- Gender: 93% of the women needed authorization from their husband or a male relative before seeking health care.
- Multivariate analysis: Schooling of the women and ANC attendance were positively associated with an increased use of RH services.

### **Conclusion and programme implications**

Even within this privileged group of Afghan women, RH parameters were poor. Socio-cultural factors play an important role in RH in Afghanistan. Therefore RH should be seen in a broader perspective than only from a "health care" point of view. Education as well as the improvement of women's social position are equally important.

A multi-sectoral approach and long-term commitment is needed in order to improve the RH situation in Afghanistan.

### **For further information:**

Dr. Kathia van Egmond, ICRH - University Ghent  
University Hospital, De Pintelaan 185 P3, B-9000 Ghent, Belgium  
Telephone: 32 9 240 35 64  
Fax: 32 9 240 38 67  
E-mail: [kathia.vanegmond@ugent.be](mailto:kathia.vanegmond@ugent.be)



## Using local resources in programmes to meet identified needs

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**Moderator:** Mary Kay Larson, Centers for Disease Control and Prevention

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Jeannot Wabulakombe	Using data to develop a reproductive health program in Goma, DRC
Asa'ad Ramlawi Amani Badwan	Use of PRA and HFA data for emergency mother and newborn care program development in nine Palestinian communities
Neelofar Zahid	The role of a field labour room as a reproductive health unit in a refugee situation (A model)

## Using Data to Develop a Reproductive Health Programme in Goma, DRC

**Authors** Jeannot Wabulakombe, Goma programme medical co-ordinator, Merlin Eastern DRC  
**Presenter** Jeannot Wabulakombe

### Background

Since 1998, war has raged in DRC involving 6 foreign armies and several rebel groups. The conflict has had severe repercussions for the health of the Congolese population, including high maternal and infant mortality; poor reproductive health services utilization; lack of community awareness and trained personnel; low capacity of the district health team for management, coordination, equipment, data collection; and taboos, religious obstacles and cultural impediments.

### Purpose of study or programme

Merlin conducted a survey of people's knowledge, attitudes and behaviors regarding safe motherhood and family planning. Based on the results of the survey, Merlin implemented a safe motherhood and family planning (FP) program to reduce maternal and infant mortality.

### Data collection or programme methods

The community survey and assessment activities included individual interviews with community members and key informants, visits to health facilities, focus groups discussions and home visits.

Program activities include: Raise community awareness, make the health facilities operational, transfer skills to the district health team, change the health-related behaviour of the population, provide drugs and equipment to health facilities, guarantee supervision, overcome religious and cultural obstacles, provide motivation, establish data collection system, follow-up issues raised.

### Study or programme findings

Although the incidence of HIV infection is not known, a random screening of donated blood in the blood bank showed that 3.9% of the blood bags were HIV positive. A survey on HIV and sexually transmitted infections revealed that the situation is alarming: out of 322 people screened for HIV prior to their wedding, 64 (20%), tested positive. Between 25—30% of the total number of patients admitted to the Hospital were HIV positive. Blood screened from 100 soldiers returned a positive test on 60 of them.

The prevalence rate of malaria (with all consequences) is 30% and has decreased to 9% for pregnant women. Antenatal consultation rate has increased from 55% to 88%. The proportion of safe deliveries conducted by the trained staff has increased from 37% to 60% since the beginning of the reproductive health program. Maternal mortality has decreased from 0.22% to 0.15%.

Survey results revealed that some households have up to 13 children. Most people cited high infant mortality rate as a reason for wanting large families (to replace the dead). 36.8% said simply that they would welcome whatever number of children "God gave" them. 13.7% had their first child before the age of 15; 56.6% were aged between 15 and 20. The interval between 2 previous births is less than a year for 28.6% of the women, and between 1 to 2 years for 35.7%. It is difficult to implement family planning because people want large families and because men don't allow their wives to use FP.

### Conclusion and programme implications

Reproductive health services are very important and feasible in complex emergencies. The infant and maternal mortality rate is too high in such situations. The proper use of protocols for pregnant women, community mobilisation against taboos and cultural impediments, and trainings contribute to a reduction in mortality.

### For further information:

Jeannot Wabulakombe  
Telephone: 250 084 23 981 E-mail: [sarelgod@yahoo.fr](mailto:sarelgod@yahoo.fr)

Bernard Leflaive  
Telephone: 250 083 034 28 E-mail: [bernard@merlin.org.uk](mailto:bernard@merlin.org.uk)

## **Use of PRA and HFA Data for Emergency Mother and Newborn Care Program Development in Nine Palestinian Communities**

**Authors** Ali N. Shaar, MD.,MSc, Randa Bani Odeh; Amani Joudeh; Tahani Madhoun; Khitam Awad; Jamalata Ali; Kanar Qadi; Hanan Halaweh

**Presenter** Dr. Asa'ad Ramlawi, Ministry of Health, and Amani Badwan, SCF

### **Background**

Infant and maternal mortality among Palestinians have shown a steady increase in the last 2.5 years. Most of the mortality was attributed to a lack of access to appropriate care during pregnancy and/or labor.

### **Purpose of study or programme**

This project aims to enhance the capacity of marginalized and isolated communities to meet the basic health needs of women and children, and in particular to enable safe pregnancies and childbirths at the community level. The program seeks to reduce dependence on secondary hospital facilities for deliveries through better management of normal deliveries, and through improved routine delivery and life saving skills at the Primary Health Center (PHC) or community level, thereby reducing the need for referrals.

This was designed through assessments conducted at the healthcare facility level and at the community level. The program is being implemented in 9 isolated clusters in the West Bank and Gaza strip.

### **Data collection or programme methods**

Program design aimed to ensure the availability of the Safe Motherhood Package within target communities. In 9 target communities, a PRA was conducted to explore the community structures, resources, cultural contexts which influence pregnancy, labor and newborn care, with a focus on the decision-making processes and contexts concerning home-care and care-seeking practices. In addition, a comprehensive Health Facility Assessment (HFA) was conducted to assess the availability, capacity and quality of services available within target clusters.

### **Study or programme findings**

Access to antenatal care, delivery and postnatal care was compromised by recurrent curfews and long-lasting closures due to restrictions on the movement of people to clinics and of health care workers to community health facilities. Cost of care was another factor limiting access, due to the deteriorating socio-economic conditions where the un-employment rate reached 70% of the labor force.

HFA findings reflected a severe shortage in staffing, hours of service provision and infrastructure. These findings also reflected the lack of training in the field of emergency obstetric care (EmOC) and the absence of a clear referral system. Although the MOH has protocols for antenatal and postnatal care, protocols for EmOC and essential newborn care do not exist.

The assessments reflected that knowledge about danger signs, appropriate home care and timely care-seeking practices remains fairly good, but identified a need for further awareness-raising targeting husbands and mothers-in-law, the primary decision makers. Knowledge must be increased about available sources of care and/or alternatives, which need to be specified and widely disseminated. Community-oriented health education programs were paralyzed throughout the last two years and there were no systematic alternatives for message dissemination concerning RH issues.

### **Conclusion and programme implications**

1. Access: Improve infrastructure and equipment for antenatal, EmOC and essential newborn care.
2. Quality: Develop and train healthcare providers on protocol-based case management and behavior-centered communication
3. Demand: Improve community members' ability to recognize danger signs, provide appropriate home care and timely care-seeking practices.
4. Policy change: Advocate at different levels for free access of pregnant women and women with children to health care services, and for the introduction of the program model into the formal Palestinian healthcare system.

### **For further information:**

Ali N. Shaar, MD., MSc., P.O. Box 25042, Shufat 97300, Jerusalem  
Telephone: +972 2 5833683/5836302 Fax: +972 2 5835771  
E-mail: [ashaar@scuspalestine.org](mailto:ashaar@scuspalestine.org)

## **The Role of a Field Labour Room as a Reproductive Health Unit in a Refugee Situation (A Model)**

**Authors** Dr. Neelofar Zahid, Health Coordinator, American Refugee Committee (ARC), Quetta, Pakistan  
**Presenter** Neelofar Zahid

### **Background**

The instability in Afghanistan post-September 11th led to an influx of 60,000 refugees to Mohammed Khail Camp, Baluchistan, Pakistan. This camp is 250km from any specialised medical services and therefore a Labour Room and comprehensive RH unit were established on site.

### **Purpose of study or programme**

The lack of culturally suitable RH facilities lead women to continue with traditional, mostly unhealthy practices, resulting in increased maternal and infant mortality. In such situations, a Labour Room can play a role as part of a comprehensive RH unit rather than merely a delivery room.

### **Data collection or programme methods**

The need for change was obvious. After 20 years of camp health programmes, the maternal mortality rate amongst Afghans was rated the highest worldwide. ARC established a model Labour Unit where all RH needs were taken care of under one roof. Coordination with health agencies, UN agencies and an inter-sectoral approach were the main features of the activity. Extensive staff training, health education sessions in the community and the provision of a complete RH package were the main features of this model.

### **Study or programme findings**

ARC conducted a needs assessment survey and established a Labour room with the full RH package:

- Gynaecology out-patient department
- Delivery room
- Arrangements for handling obstetrical emergencies
- Child spacing program
- Treatment of sexually transmitted infections (STIs)
- Antenatal clinic (ANC)
- Health education and counselling unit
- Awareness-raising regarding the prevention of HIV / AIDS and other STIs
- Sexual and gender-based violence: recording of cases and counselling
- Diagnostic facilities (lab and ultrasound facilities).
- Vaccination against Tetanus.

Use of the labour room as an RH unit ensured women would benefit from a complete RH package under one roof in a culturally suitable environment. Use of community health workers and educators helped raise awareness and remove myths and taboos that were a great hindrance to the program acceptability. Greater acceptance by the community made it possible to talk about HIV / AIDS and child spacing in a community where previously sex could not even be discussed.

The impact was a decreased in unregistered deliveries from 17% to 8%, increased ANC coverage from 55% to 78%, increased contraceptive prevalence rate from 1.4% to 3.5%, decreased still birth ratio and decreased maternal mortality rate from over 350 to 197.

### **Conclusion and programme implications**

Given the limited available resources within refugee camps and the restricted movement of many refugee women within the community, a comprehensive RH unit that is socially and culturally sensitive is lifesaving. A multi-sectoral approach involving all the health actors is the corner stone of a successful RH unit.

### **For further information:**

Dr. Neelofar Zahid, Health Coordinator ARC Quetta, House No. 71 AB, Chaman Housing Colony Quetta, Pakistan  
Telephone: 081-830762  
Email: [drneelofarZahid@yahoo.com](mailto:drneelofarZahid@yahoo.com)

## Reproductive health clinical care through the phases of conflict

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**Moderator:** Wilma Doedens, UNFPA

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|--------------------|---|
| Farhad Javid       | Increasing access to reproductive health care in post-conflict Afghanistan  |
| Fowzia Jaffer      | Improving the quality of reproductive health services for Somali refugees through needs assessment in Sana'a, Yemen |
| Atula Nanayakkarra | Ensuring sustainability of a reproductive and mother and child health care project in a conflict setting            |

## **Increasing Access to Reproductive Health Care in Post-Conflict Afghanistan**

**Authors** Farhad Javid, Marie Stopes Afghanistan; Bayard Roberts, Julie Porkeson, Marie Stopes International  
**Presenter** Farhad Javid

### **Background**

Access (in terms of physical, economic, social, and cultural access) to reproductive health (RH) information and services in Afghanistan remains extremely low, resulting in high fertility rates and maternal mortality rates ranging between 500 to over 6,000 per 100,000 live births.

### **Purpose of study or programme**

Project purpose: to increase access (physical, knowledge, economic, social, and cultural) to RH care in Afghanistan through the provision of RH information, services and social marketing.

Study purpose: to assess barriers to reproductive health care

### **Data collection or programme methods**

Project methods:

- Provision of clinic and outreach information and services (in association with UN Habitat).
- Establishment of a contraceptive social marketing programme
- Sourcing and development of appropriate RH IEC materials

Data collection:

- Quantitative and qualitative research of attitudes and perceived barriers to RH care amongst women and men through the network of UN Habitat community forums (mainly urban-based).
- Interviews with community leaders to establish prevailing attitudes to RH care within communities.
- Client exit interviews; client focus group discussions.

### **Study or programme findings**

Early data suggest the following:

- General knowledge and use of family planning is low, particularly amongst men, despite the fact that there is a high interest and demand for family planning amongst both women and men
- Poor knowledge, lack of locally-based RH services, and the attitudes of men all significantly influence women's access to RH information and services. Young married women, in particular, are less able to access RH services
- Widely variable attitudes towards family planning exist amongst community and religious leaders
- Knowledge and treatment of STIs is low, and knowledge of HIV/AIDS is extremely low/negligible
- Access to emergency obstetrics care is extremely low, with transportation a significant problem
- The attitude of information and service providers is a significant determinant in the initial uptake and continuation of RH services
- Appropriate RH IEC methodology and materials are critical in increasing understanding and support for RH

### **Conclusion and programme implications**

Initial analysis indicates the importance of reducing physical and knowledge-based barriers to RH care through community-based RH promotion and service provision. Additionally, the varied attitude towards RH amongst men and community and religious leaders suggest potential for reducing social and cultural barriers to accessing RH care through community-based information and advocacy initiatives.

### **For further information:**

Lucy Palmer, Programme Support Manager  
Marie Stopes International, 153-157 Cleveland St, London, W1T 6QW  
Telephone: 44 20 7574 7368  
Email: [Lucy.Palmer@stopes.org.uk](mailto:Lucy.Palmer@stopes.org.uk)

## Improving the Quality of Reproductive Health Services for Somali Refugees through Needs Assessment in Sana'a, Yemen

**Authors** Ms Fairoza Shams Aldeen, researcher, Dr. Fowzia Hamed Jaffer, Country Director, Marie Stopes International Yemen  
**Presenter** Dr. Fowzia Hamed Jaffer

### Background

In 2002 Yemen hosted over 67,000 Somali refugees. Marie Stopes International Yemen (MSIY) runs a clinic, outreach service and social marketing programme. In 2001 the programme was extended to Somali refugees.

### Purpose of study or programme

- To identify unmet need for reproductive health services among Somali refugees in urban Sana'a
- To improve the quality of reproductive health services available to Somali refugees.

### Data collection or programme methods

MSIY's programme began in 1998 with two reproductive health clinics and outreach services in Sana'a and Sayoun. MSIY became concerned about the reproductive health services available to refugees and undertook an assessment to guide future service development:

- Literature review of available government and other studies
- Interviews with government and other providers
- Interviews and focus group discussions with male and female refugees: 11 female groups and 4 male groups in February 2001
- Client feedback surveys
- Project records

### Study or programme findings

*Study findings:*

- Refugees experience poor access to general and reproductive health care services
- Transportation is a major barrier to accessing services
- Refugees lack basic reproductive health information
- Ante-natal care and immunisation is very low
- Knowledge and use of family planning is low

As a result of these findings, MSIY implemented an integrated training, information and service delivery project.

*Project findings:*

- Training refugees as RH focal points increases accessibility and affordability of information and services
- Men have played a key role in the uptake of services
- Integrating local and refugee populations at clinic locations requires intensive advocacy work with all stakeholders especially when a high proportion of clients are refugees
- The MSIY Sana'a centre provides RH services to an average of 1500 refugee women per month, this comprises approximately 60% of total clients
- In 2002, over 6000 people took part in health awareness sessions

### Conclusion and programme implications

Increased health information and training for focal points as well as working with men is essential to ensure acceptability of services and to improve the reproductive health of Somali refugees in Yemen.

This project demonstrates the longer-term benefits of such an approach and provides a model for reaching dispersed groups in other stable settings.

### For further information:

Dr. Fowzia Hamed Jaffer, Marie Stopes International Yemen, B.P. 16160, Sana'a, Yemen  
Telephone: 967 124 1494  
Fax: 967 150 0268  
Email: [msfowzia@y.net.ye](mailto:msfowzia@y.net.ye)

## Ensuring Sustainability of a Reproductive and Mother and Child Health Care Project in a Conflict Setting

**Authors** Atula Nanayakkara , Executive Director, S. Suriyamurthy, Project Manager, Population Services Lanka; Jill Brennick, Program Manager, Marie Stopes International  
**Presenter** Atula Nanayakkara

### Background

Civil war in Sri Lanka resulted in immense damage to the infrastructure in the North and East of the country and displaced over a million people. Damage to the health systems led to a shortage of facilities, equipment, and medical personnel especially at the reproductive and mother and child health care levels.

### Purpose of study or programme

To establish a sustainable and accessible model of reproductive and mother and child health (RH/MCH) care services for internally displaced persons (IDP) and their host communities through static clinics, mobile outreach facilities, and a network of community health promoters (CHPs).

### Data collection or programme methods

- Establishment of RH/MCH sustainable static clinics in central locations
- Establishment of mobile clinics, outreach activities, and a network of community health promoters
- Recruitment of local staff from both the IDP and host communities
- Provision of RH/MCH services and primary health care services for both the IDP and host communities
- Provision of IEC materials and activities
- Close cooperation with the government and other NGOs
- Charging appropriate service fees
- Establishment of an endowment fund
- Ongoing monitoring and evaluation, including client exit interviews and focus group discussions
- Carrying out Annual Impact Analyses (AIA) which assess RH/MCH indicators and the coverage of care in the IDP areas

### Study or programme findings

PSL has established a financially, socially, and culturally sustainable program through the following efforts:

- Regular mobile clinics, outreach activities, and centrally located static clinics have contributed to increased accessibility and utilization of RH/MCH services.
- Employing staff, particularly CHPs, from the IDP community has improved the health seeking behavior of the IDPs, especially in the area of RH/MCH.
- Provision of RH services in a polyclinic setting allows clients to seek out FP services in a confidential setting. Impact Analysis results have shown improvement in FP spacing methods since 1998.
- Provision of services for both the IDP and host communities contributes to the host community's acceptance of the IDP programs, and improves the overall health status of both populations.
- Efforts to increase RH knowledge and awareness contributes to improved RH outcomes as reflected in evaluations showing a near zero maternal mortality rate, low infant mortality rate, and an increase in hospital deliveries.
- Close collaboration and coordination with both government and non-government organizations prevent gaps in services and avoid duplication.
- Charging appropriate service fees can be implemented in a low-resource setting and contributes to the sustainability of service provision.
- Provision of subsidized fees increases affordability and accessibility of services.
- Establishment of an endowment fund can sustain a program beyond a donor funding period.

### Conclusion and programme implications

Placing emphasis on sustainability from the beginning of the project, working closely with both the IDP and host community, and collaborating with the government and other NGOs, can lead to a sustainable and lasting program in an unstable, low resource setting.

### For further information:

Atula Nanayakkara, Executive Director,  
Population Services Lanka, 155, Kirula Road, Narahenpita, Colombo 5, Sri Lanka  
Telephone: 941 500824/581035 Fax: 941 500 544 E-mail: [poplanka@pslk.ccom.lk](mailto:poplanka@pslk.ccom.lk)



## Gender-based Violence: New findings from the field

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**Moderator:** Jeanne Ward, Reproductive Health Response in Conflict Consortium

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| Michelle Hynes  | Field test of a gender-based violence (GBV) survey in East Timor and Kosovo: Lessons Learned |
| Eugene Kinyanda | War traumatisation in North-Eastern Uganda: The need for a holistic medical intervention     |
| Aziza Khalidi   | Association Najdeh domestic violence project: Baseline and follow-up KAP surveys             |

## **Field Test of a Gender-Based Violence (GBV) Survey in East Timor and Kosovo: Lessons Learned**

**Authors** Michelle Hynes, Epidemiologist, Centers for Disease Control and Prevention (CDC); Jeanne Ward, Gender-based Violence (GBV) Research Officer, Reproductive Health Response in Conflict Consortium, Kathryn Robertson, GBV Program Manager, International Rescue Committee (IRC) East Timor Office; Lumnije Decani, Director, Women's Wellness Center Kosovo; Victor Balaban, Orise Fellow, CDC; Chadd Crouse, Statistician, CDC; Mary Koss, Professor of Public Health, Mel and Enid Zuckerman Arizona College of Public Health; University of Arizona; Mary Kay Larson, Refugee Reproductive Health Coordinator, CDC

**Presenter** Michelle Hynes

### **Background**

The Reproductive Health for Refugees Consortium (RHRC), a group of 7 international NGOs, has designed a standardized GBV survey instrument to measure prevalence in conflict and post-conflict settings. Field tests were undertaken in East Timor and Kosovo, where prevalence of GBV is not known, and where data is critical to improve existing GBV prevention and care strategies.

### **Purpose of study or programme**

The principal aim of this study was to assess the prevalence of GBV among women 18-49 years of age during conflict and post-conflict. Additional gains of the research project included: field testing a survey tool in a post-conflict setting; identifying the barriers to and preferences for GBV prevention and treatment services; improving the field's ability to conduct and disseminate GBV research; and providing data necessary to conduct advocacy on GBV issues.

### **Data collection or programme methods**

This was a cross-sectional survey design with a two-stage random selection process. In the 1<sup>st</sup> stage, we selected an unclustered, equal probability sample of households from population lists. In the 2<sup>nd</sup> stage, we randomly selected 1 woman of reproductive age from each household. A survey was administered orally to the women at a central location outside of the home to protect confidentiality. The survey was administered in 1 urban and 1 rural district of East Timor in July/August 2002 and in 6 villages in the western region of Kosovo in August 2002. Final samples totaled 283 women in East Timor and 329 in Kosovo.

### **Study or programme findings**

Types of GBV investigated in the survey included rape and sexual coercion, physical assault, RH outcomes of violence, family/intimate partner violence, and mental health. In East Timor, rates of intimate partner violence reported during the year preceding the crisis and the past year were not significantly different. During the year preceding the crisis, 23.8% of respondents reported physical assault by an intimate partner, and 24.8% reported physical assault by a partner in the past year. Reported rates of sexual coercion by intimate partners decreased 4.0% (P=0.65) from 16.4% in the year preceding the crisis to 15.7% in the past year. Sexual coercion was defined as partner using threats of physical harm or using force to obtain sex, or forcing the woman to have sex with other people. Violence by perpetrators outside the family was significantly lower post-crisis with a 75.8% decrease (P<0.001) in physical assault from 24.2% during the crisis to 5.8% reported post-crisis. There was a 57.1% decrease (P=0.046) in sexual assault with 22.7% during the crisis to 9.7% post-crisis. Physical assault by outsiders included threats with a weapon, slapped/hit, choked, beaten/kicked, tied up/blindfolded, shot at/stabbed, physical disfigurement, or abduction. Sexual assault included improper sexual comments, stripped of clothing, internal body cavity searches, unnecessary medical exam of private areas, unwanted kissing, touched on sexual parts of body, beaten on sexual parts of body, forced to give/receive oral/vaginal/anal sex, or rape. Similar findings will be presented from Kosovo based on preliminary analysis.

### **Conclusion and programme implications**

The survey tool proved effective in measuring prevalence of GBV and will be a useful instrument in future surveys. The data will inform how to more effectively target local GBV programming in East Timor and Kosovo, such as creating community-based initiatives to facilitate reporting, improving service delivery, and addressing socioeconomic variables associated with GBV. The research will also be compared to research in other sites in order to draw conclusions about the nature of GBV among conflict-affected populations.

### **For further information:**

Michelle Hynes, Division of Reproductive Health, Centers for Disease Control and Prevention, 2900 Woodcock Blvd., Mail stop K-22. Atlanta, GA 30041-3724.  
Telephone: (770) 488-6406 Fax: (770) 488-6291 E-mail: [mhynes@cdc.gov](mailto:mhynes@cdc.gov)

## **War Traumatism in North-Eastern Uganda: The Need for a Holistic Medical Intervention**

**Authors** Dr Kinyanda Eugene, Consultant Psychiatrist and Musisi Seggane, Senior Consultant Psychiatrist, African PsyCare Research Organisation (APRO); Dr Otim Tom, Gynaecologist, Association of Obstetricians and Gynaecologists of Uganda; Dr Kirya George, Surgeon, Soroti Hospital, Uganda

**Presenter** Dr Kinyanda Eugene

### **Background**

The North-Eastern region of Uganda (approximate population: 930,702) has suffered from war traumatisation since historical times to the present. This war traumatisation has been due to cattle raids from neighbouring tribes and a devastating uprising in 1987-92. This has resulted in: loss of lives, more than 80,000 people displaced in internally displaced persons (IDP) camps and a multitude of psychological, gynaecological and surgical problems.

### **Purpose of study or programme**

A study was undertaken by Isis-WICCE (an international women's organisation) to document the medical consequences of the conflict on the women in this region in partnership with a number of medical professional organisations including the African PsyCare Research Organisation.

### **Data collection or programme methods**

A cross-sectional descriptive study was carried out at 4 health centres in the region. The study was carried out in two stages, with an initial screening interview using a questionnaire that contained: socio-demographics, a psychological screening tool (SRQ-25), questions on gynaecological and surgical problems and previous health-seeking behaviour. During the second stage diagnostic interviews, referred patients were assessed for psychiatric, gynaecological and surgical disorders using structured questionnaires. The program offered limited emergency treatment including surgery. We present the findings of the initial screening interviews.

### **Study or programme findings**

During the initial screening interviews, 826 respondents were seen of which 582 (70.8%) were female. Most of respondents were peasant farmers of low educational attainment. A wide range of torture experiences were reported including: beatings and kickings 491 (59.4%), gunshot injuries 60 (7.3%), panga/spear injuries 112 (13.6%), having close relations killed 458 (55.4%), of whom 105 (12.7%) lost a spouse. Among the females, heterosexual rape—single incidence, was reported by 56 (9.6%), while gang rape was reported by 36 (6.2%). The reported perpetrators of torture included police/prison officers, army personnel, rebel soldiers and cattle raiders. Six hundred (72.6%) respondents had significant psychological distress (SRQ-25 scores of 6 and above) while 188 (22.8%) had suicidal thoughts and 113 (13.7%) homicidal thoughts. Among the females, 299 (51.4%) reported having a gynaecological problem which included: chronic pelvic pain 138 (75%), abnormal vaginal discharge 37 (6.4%), infertility 31 (5.3%), vaginal/perineal tears 16 (2.7%), and urinary/rectal fistulae 5 (0.9%). Surgical complaints were reported by 626 (75.8%), which included: recurrent back pain 626 (75.8%), discharging wounds on limbs 29 (3.5%), broken limbs 43 (5.2%) and gunshot injuries 26 (3.1%).

### **Conclusion and programme implications**

The communities of the Teso region have undergone prolonged suffering due to the chronic insecurity that has characterised this region. As a result this region suffers from a heavy burden of medical and psychological illnesses that are currently going untreated. There is therefore a pointed need to institute a holistic trauma treatment programme in the region.

### **For further information:**

Dr. Kinyanda Eugene, P.O. Box 5183, Kampala, Uganda  
Telephone: 256-77-410285  
Fax: 256-41-543954  
Email: [ekinyanda@hotmail.com](mailto:ekinyanda@hotmail.com)

## Association Najdeh Domestic Violence Project: Baseline and Follow-up KAP Surveys

**Authors** Aziza Khalidi, Fatima Chahine, Haifa Jammal, Susan Purdin, Sandra Krause  
**Presenter** Aziza Khalidi

### Background

Association Najdeh is an NGO providing social services to Palestinian refugees in Lebanon. Increasing awareness of domestic violence and field observations led to a study on perceptions of domestic violence (DV) among mothers of students in Najdeh's kindergartens (1999). Subsequently, Najdeh launched a DV program that involved a series of workshops on DV in Najdeh's target communities and the establishment of listening centers. The project started with a baseline survey in 2001. A follow-up survey at the end of the project was conducted in 2003.

### Purpose of study or programme

- Evaluate program effectiveness by comparing the baseline with the followup KAP surveys.
- Use the above findings to guide future programming decisions.

### Data collection or programme methods

The same methodology was used for the baseline and follow-up studies in terms of sampling frame and methods of data collection and analysis. A sample of 301 families was drawn from 2025 families who participated in Najdeh's programs in 2000. Interviews were conducted with all women and men age 15 years and above with mental capacity. Baseline survey data were collected in May 2001; follow-up data were collected in May 2003. Frequency distributions were used to describe the population and Pearson's Chi-square testing was conducted to assess the relationship between KAPs and socio demographic variables.

### Study or programme findings

The study population is young; almost half are under 20 years. Families are relatively large, almost half have more than five individuals. Household income remains mostly below 400 USD per month in both surveys. In the baseline survey, physical interpersonal violence in neighborhoods is mentioned by 59.7% of respondents. A higher percentage (67.8%) report DV is revealed in the second survey. The most popular means of managing disputes is dialogue in both surveys (70.2% at baseline and 78.3% at follow-up). However, the percentage of respondents who report "hitting" as a way of managing disputes decreased by 2% in the follow-up (10.6% to 8.9%). Help is sought mostly within the home (51.2% in the baseline and 59% in the follow-up), followed by approaching relatives 47.5% at baseline and 41.9% in the follow-up. In the follow-up, 12.7% report seeking help from the Najdeh listening centers and one-third (36.3%) place it as an option in case they need help. There is a sizable reduction in the proportion opposing the statement on the right of women not to be harmed from 10% in the baseline to 5.4% in the follow-up survey. A similar pattern is shown in an increase in the proportion who oppose hitting women and girls from 59.8% to 70.5%.

### Conclusion and programme implications

A comparison of the baseline and follow-up surveys shows that the program was effective in contributing to increased knowledge about domestic violence in view of the increased reporting and the inclusion of listening centers in options for help. To achieve the purpose of reducing the practice of domestic violence in the community, a longer time span is needed as with any other form of cultural change.

### For further information:

Fatima Chahine, Association Najdeh, P.O.Box 113-6099, Beirut, Lebanon  
Telephone: (961) 1 302 079, (961) 1 703 357  
Fax: (961) 1 703 358  
E-mail: [association@najdeh.org.lb](mailto:association@najdeh.org.lb)

## Stopping the spread of HIV in Sierra Leone

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**Moderator:** Manuel Carballo, International Centre for Migration and Health

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|------------------|---|
| Moi Tenga Sartie | Strengthening AIDS prevention among commercial sex workers and military forces in Port Loko, Sierra Leone |
| Vandy Kamara     | Talking HIV in post-conflict Sierra Leone   |
| Boima Kpuagor    | HIV/AIDS KAP and community outreach in a post-conflict setting in Kenema District, Sierra Leone           |

## **Strengthening AIDS Prevention Among Commercial Sex Workers and Military Forces in Port Loko, Sierra Leone**

**Authors:** Moi-Tenga Sartie, AIDS Prevention Team Manager, Dr. Mary Gutmann, Country Director, Martha Saldinger, Former Country Director, ARC International—Sierra Leone; Mandi Larsen, MPH candidate, Heilbrunn Department of Population and Family Health, Columbia University

**Presenter** Moi-Tenga Sartie

### **Background**

In January 2001 American Refugee Committee International (ARC) launched an HIV/AIDS/STI prevention pilot project in Port Loko, Sierra Leone. ARC chose to target its intervention towards four populations identified as “core transmitters” in Port Loko: commercial sex workers, military, youth, and ex-combatants.

### **Purpose of study or programme**

The project’s causal hypothesis posits the following: “Skilled community health promoters, conducting effective information, education and communication activities where condoms and STI treatment are readily accessible, will facilitate community members using effective treatment for STIs and practicing safer sex, and will also contribute to a reduction in the HIV/AIDS prevalence in Port Loko/Maforki Chiefdom.”

### **Data collection or programme methods**

In March 2001, a baseline survey was performed to assess knowledge, attitudes, and practices regarding HIV/AIDS and STIs among the project’s target populations. In June 2003, a post-intervention survey was performed to assess changes following ARC’s interventions. Both surveys used a purposive quota sampling technique, with interviewers approaching respondents among 30 cluster sites in Port Loko. At baseline 940 respondents were interviewed (202 military, 201 CSWs, 293 male youth, and 244 female youth), and at post-intervention 956 respondents were interviewed (205 military, 202 CSWs, 299 male youth, and 250 female youth). Epi Info 2002 was used for data entry and data analysis, and chi-square analyses were performed to assess differences between baseline and post-intervention data.

### **Study or programme findings**

Survey results for CSW and military respondents, in particular, showed remarkable changes.

Those who could spontaneously name 3 or more...

*Correct routes of AIDS transmission* increased from 9% to 69% of CSWs, and from 23% to 75% of military;

*Effective means of avoiding AIDS:* increased from 5% to 70% of CSWs, and from 11% to 75% of military;

*Sources of condoms:* increased from 13% to 81% of CSWs, and from 19% to 71% of military.

Reported *condom use at last sexual intercourse* increased from 38% to 68% of CSWs, and from 39% to 68% of military.

The proportion of respondents *successful in attaining partner agreement when negotiating condom use* increased from 63% to 83% of CSWs and from 64% to 93% of military.

The proportion who are *not worried about AIDS* did not change from 53% of CSWs, and decreased from 38% to 18% of military respondents.

Those who reported believing *people living with AIDS should be treated or counseled* increased from 49% to 64% of CSWs, and from 62% to 90% of military.

### **Conclusion and programme implications**

Widespread information, education, and communication activities, combined with condom promotion, have been effective in helping to raise the levels of HIV/AIDS knowledge and condom use in the CSW and military populations of Port Loko. These efforts should be continued, with an additional emphasis on increasing personal concern about HIV-infection and decreasing negative attitudes towards people living with HIV/AIDS.

### **For further information:**

Dr. Mary Gutmann, Country Director

ARC International, 16 Riverside Drive, Off King Harman Road, Brookfields, Freetown, Sierra Leone

Telephone: (232) 22-234-464/(232) 22-235-884/(232) 22-235-463

E-mail: [arcsi@sierratel.sl](mailto:arcsi@sierratel.sl)

## Talking HIV in Post-Conflict Sierra Leone

**Authors** Diane Lindsey, Health Advisor, Vandy Kamara, Health information officer, CARE International in Sierra Leone  
**Presenter** Vandy Kamara

### Background

Rates of HIV infection have been shown to increase dramatically during and following situations of forced migration and civil conflict. In Sierra Leone, HIV rates were documented to be 4.9% in April 2002. Sierra Leone's debilitating civil war, with the war-generalised violence, rape, sexual coercion, highly mobile populations of multi-national armed forces and refugees, has created a potentially explosive HIV/AIDS epidemic.

### Purpose of study or programme

Data were gathered prior to the start of a behaviour change program in order to:

- Document level of awareness and understanding of HIV/AIDS and other reproductive health issues among rural conflict-affected populations in Sierra Leone.
- Understand the potential societal factors that influence behaviour change or high risk behaviour in post-conflict Sierra Leone.
- Adapt the Stepping Stones personal awareness and change HIV/AIDS training materials to be appropriate for the post-conflict situation in Sierra Leone.

### Data collection or programme methods

Characteristics of communities in 2 sections of Tonkolili district were compared using surveys and focus group discussions in an operations research design. Descriptive data about the communities and data on knowledge and attitudes was collected through a random sample survey of 20% of the population over 15 years (n=240). Qualitative data was gathered through focus group discussions representing peer groups of old men, women and young men and women, in all villages.

### Study or programme findings

Initial findings indicate that low levels of knowledge exist around HIV/AIDS, although symptoms of STIs were generally known. Poverty, religion and gender were found to play major roles in the knowledge level of the population. Further analysis is currently underway to better understand the major influential factors in societal norms and personal risk behaviour. With regard to adaptation of Stepping Stones, it was found that discussing death as a result of AIDS was found to be premature in this setting.

### Conclusion and programme implications

HIV personal change awareness program materials that focus on the impact of the epidemic, such as the death of a family breadwinner, may not be appropriate in a post-conflict setting where many family deaths are related to the recent conflict. Adaptations of the Stepping Stones materials in post-conflict settings should be adapted to be more sensitive to war-related issues.

### For further information:

Kelland Stevenson, CARE, 35 Wilkinson Rd, Freetown, Sierra Leone  
Telephone: 232-22-234263  
Email: [Kelland@sierratel.sl](mailto:Kelland@sierratel.sl) or [Kstevenson@sl.care.org](mailto:Kstevenson@sl.care.org)

## **HIV/AIDS KAP and Community Outreach in a Post-Conflict Setting in Kenema District, Sierra Leone**

**Authors** Boima Kpuagor- IEC Supervisor, Josephine Jamiru, RH/Nursing Supervisor, Dr. Abdulqadir Omar, Health Manager, IRC Sierra Leone; Sara Casey, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University

**Presenter** Boima Kpuagor

### **Background**

Kenema District was severely impacted by ten years of civil war. It was a place of refuge for those living in rebel-held areas and faced significant population movement during the conflict. IRC conducted a baseline survey of RH knowledge, attitudes and behaviors in Kenema district in March 2001. Following a community outreach program for RH promotion, IRC conducted a follow-up study in November/December 2002. This presentation will focus on the HIV/AIDS KAP in the villages of Kenema District

### **Purpose of study or programme**

Determine knowledge, attitudes and behaviors regarding RH in the villages in Kenema district. The project aims to increase community awareness and understanding of reproductive health issues, including HIV/AIDS/STIs, and promote access and correct use of condoms through education, training, sensitization campaigns and the use of media advocacy.

### **Data collection or programme methods**

The same study method was used for both baseline and follow-up surveys. Probability proportional to size (PPS) sampling was used to select 30 clusters. 911 individuals (548 women, 363 men) were interviewed in the baseline, and 983 (490 women, 493 men) in the follow-up survey. The questionnaire included close-ended questions that were translated into the local languages.

### **Study or programme findings**

- AIDS transmission: knowledge of 2 correct routes increased from 96% to 99% (women) and from 98% to 100% (men).
- AIDS prevention: knowledge of 2 correct means of avoiding AIDS increased from 44% to 61% (women) and 61% to 69% (men).
- Condoms: Knowledge of what is a condom increased from 62% to 85% (women) and 80% to 87% (men). Use of condom at last sexual intercourse remained the same for women (6%), but increased slightly for men (18% to 21%).

### **Conclusion and programme implications**

Following the baseline survey, outreach sensitization campaigns were conducted in the communities. Knowledge about AIDS has increased, although behavior has not changed much (unsurprising given the short program implementation time). With increased sensitization and media advocacy, demand for condoms increased steadily from very low demand at the beginning; however participants remain very uncomfortable discussing sexual issues, including condom use. The data from the surveys do not show a marked increase in condom use at last sexual intercourse. Our future plans include critically reviewing the condom distribution process to establish a strategy that will help us to track effective beneficiary use. IRC will also explore other effective discussion approaches to break the culture of silence and shyness regarding reproductive and sexual health.

### **For further information:**

Boima Kpuagor, IRC Sierra Leone

Email: [irc@sierratel.sl](mailto:irc@sierratel.sl)



## Making motherhood safer

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**Moderator:** Leslie Davidson

Heilbrunn Department of Population and Family Health  
Mailman School of Public Health, Columbia University

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- Drileba Paul Bishop    Safe motherhood facility assessment of two health facilities in Kiryandongo Sub-county, Masindi District, Uganda
- Laura Miranda        Findings from the project: *Reducing maternal mortality among repatriated populations along the Guatemala-Mexico border*
- Cyprian Awiti         Improving access to emergency obstetric care for non-camp refugees, Nairobi, Kenya

## **Safe Motherhood Facility Assessment of Two Health Facilities in Kiryandongo Sub-county, Masindi District Uganda**

**Authors** Drileba Paul Bishop, Ann Burton, and Roselidah Ondeko, International Rescue Committee Uganda  
**Presenter** Drileba Paul Bishop

### **Background**

Kiryandongo Hospital serves approximately 200,000 people in Masindi District, Northern Uganda. The hospital is the referral facility for Panyadoli health centre, which serves a nearby Sudanese refugee camp. Both facilities have suffered from years of civil war and low government expenditure on health.

### **Purpose of study or programme**

In this population, an alarming number of women are dying from pregnancy-related complications. A needs assessment was undertaken to:

- Identify gaps in scope and quality of safe motherhood services, particularly emergency obstetrics.
- Develop interventions that will increase the capacity of both facilities to manage obstetrical emergencies.

### **Data collection or programme methods**

Both quantitative and qualitative data were collected through the following activities:

- Observation of the organization and delivery of services, including the physical facilities, equipment and drug availability.
- Interviews with key staff members in both outpatient and inpatient facilities.
- Review of client records and registers pertaining to safe motherhood services.
- Review of data collected and compiled (RH related) in the outpatient and inpatient services.
- Administration of a facility checklist.

### **Study or programme findings**

Deficiencies in the scope and quality of services were noted in both facilities. Firstly, essential medical supplies were inadequate. As a result, key elements of antenatal care, such as malaria prophylaxis and syphilis testing, were frequently unavailable and women often had to be further referred for blood transfusion. Neither facility had magnesium sulphate and the hospital had frequent shortages of antibiotics, severely compromising their ability to manage a range of obstetric complications.

Significant gaps in staff knowledge were identified. For example, partographs were available but were often filled incorrectly or not at all. Care of preterm and very low birth weight babies was inadequate with little attention to key elements, such as thermal protection. Both facilities lacked basic newborn resuscitation equipment. Neither facility had written guidelines to support care of the mother or the newborn. Women with complications were not accessing services. For example, in the preceding twelve months, 73 caesarean sections had been performed, representing less than 1% of the expected deliveries in the catchment population. Furthermore, 9 maternal deaths had been recorded in the preceding twelve months, but there was no maternal death review mechanism in place.

Exacerbating the above deficiencies, physical facilities in both sites were poor with a lack of running water, hand washing facilities and appropriate lighting.

### **Conclusion and programme implications**

The quality and accessibility of safe motherhood services in this population were poor, placing women at risk of adverse obstetric outcomes. In addition to addressing problems relating to staff capacity, infrastructure and the lack of essential supplies and equipment, there is a need to further explore the reasons women are not accessing services when needed.

### **For further information:**

Ann Burton  
International Rescue Committee, Plot 7, Lower Naguru East Road, P.O.Box 24672, Kampala, Uganda.  
Telephone: +256-41-286212/ 77-734928/29 Fax: +256-41-286219

## **Findings from the Project: Reducing Maternal Mortality Among Repatriated Populations Along the Guatemala-Mexico Border**

**Authors** Laura Miranda, Programme Director—Marie Stopes Mexico; Cristina Alonso, External Project Evaluator  
**Presenter** Laura Miranda

### **Background**

The project targets recently returned Guatemalan refugees living in isolated areas lacking health services. Guatemala, a country with tremendous social inequalities, experiences one of the highest maternal mortality rates in Latin America at 270 per 100,000 live births in 2002.

### **Purpose of study or programme**

The project seeks to address safe motherhood through training of community health workers, community education and the provision of services via a mobile team. The project has been monitored and evaluated in order to gauge the impact of the intervention and the lessons learnt for similar and future projects.

### **Data collection or programme methods**

Marie Stopes Mexico coordinates a mobile unit in 23 rural frontier communities in the Department of Huehuetenango, providing non-surgical family planning and maternal and child health (MCH) services and information, education and communication (IEC) activities including the training of health promoters and traditional midwives.

Evaluation of the intervention was conducted using pre and post KAP surveys in 12 selected communities using a representative sample. Interviews were conducted with 388 indigenous men and women of reproductive age in the baseline survey in June 2001, and with 398 in the post-intervention survey in June 2003. Data were analyzed using EpiInfo 2000.

### **Study or programme findings**

- Literacy level among women was 34% in baseline and 37% in follow up. Literacy levels among men were higher, with 71% at baseline and 61% at follow up.
- 44% of women in baseline and 52% in follow up could speak Spanish.
- Pre-natal and childbirth care by midwives increased significantly from 71% to 89% ( $p=0.00$ ) as well as knowledge of problems which can occur during childbirth.
- Knowledge of problems during pregnancy and childbirth were inversely related to literacy in women and improved with increased age group among men.
- Knowledge of all modern family planning methods increased significantly ( $p=0.00$ ) in the overall population and use increased from 9% to 30% ( $p=0.00$ ).
- Desire to use contraceptives increased from 36% to 68% ( $p=0.00$ ).
- Contraceptive knowledge and use was associated with knowledge of Spanish and literacy in women and with increased age group among men.
- A gap exists between acceptance and use of contraceptives.

### **Conclusion and programme implications**

Provision of reproductive health services and training of local agents has a positive effect on knowledge, and use of services among repatriated Guatemalans.

Women's empowerment, and other variables, such as transportation to hospital in emergencies remain problematic. These should be addressed in order to decrease maternal mortality rates.

### **For further information:**

Laura Miranda, Marie Stopes Mexico, Calle Comitán 13, Barrio el Cerrillo, San Cristobal de las Casas, Chiapas, Mexico  
Telephone: 52 967 67 45812  
Email: [lmirandaa@yahoo.com.mx](mailto:lmirandaa@yahoo.com.mx)

## Improving Access to Emergency Obstetric Care for Non-Camp Refugees, Nairobi, Kenya

**Authors** Cyprian Awiti, Director, Marie Stopes Kenya; Dr F.O. Akonde Obstetrician gynaecologist; Martha Warratho, National Clinical Services Manager; B.O. Alutsachi, Regional Manager—Eastern Region

**Presenter** Cyprian Awiti

### Background

A needs assessment in 2000 highlighted a lack of access to emergency obstetric care for the non-camp refugee community in Nairobi. In response, Marie Stopes Kenya (MSK) implemented a project under the Columbia University Averting Maternal Death and Disability Programme.

### Purpose of study or programme

*Project purpose:* to extend access to emergency obstetric services to non-camp refugee communities through improved emergency transport and community outreach education.

*Study purpose:* to measure the impact of the project on utilisation of the MSK obstetrics unit by refugee communities.

### Data collection or programme methods

Project methods:

- Provision of 24-hour transport to target night shortages of transport for emergency obstetric cases particularly for the refugee community and slum areas.
- Recruitment and training of culturally and linguistically appropriate service providers, including community health educators who take the services closer to the refugees.
- Development of appropriate IEC materials in Somali, Ethiopian and Sudanese languages to facilitate provision of services to the target communities and promote client centred health education for women, adolescent and communities.
- Improved medical record system to facilitate organisation of patient records and management of information.

Data collection includes:

- Ongoing monitoring and evaluation
- Qualitative and quantitative study (March—May 2003)

### Study or programme findings

The percentage of clients from the non-camp refugee communities has increased since the outset of the project. Study and project findings indicate the following:

- Improved transport is critical to the utilisation of obstetric services by the refugee community.
- Development of IEC materials in collaboration with the refugee community has improved health education.
- The recruitment of appropriate service providers has been a major factor in uptake of services.
- Refugee community participation in planning and implementation of activities has been key to the success in reducing barriers to services.
- Dedicated technical assistance has increased the capacity of MSK to serve non-camp refugee communities.
- Community collaboration particularly with informal youth and women groups from among the refugee community has enhanced the accessibility of services by marginalised groups.
- Quality, client-friendly facilities contribute to uptake of services by refugee communities.
- Refugees are able to contribute towards healthcare costs with only 10% of clients requiring completely subsidised services.

### Conclusion and programme implications

Improved maternal health among dispersed refugee communities, through increased access to emergency obstetric care facilities, can be achieved with small-scale, focused interventions which integrate community participation, appropriate IEC materials, and quality service delivery. This project serves as a model for similar project interventions in other settings and will be replicated in other sites in Kenya.

### For further information:

Cyprian Awiti, Marie Stopes Kenya, Kindaruma Road, P.O. Box 59328, Nairobi, Kenya  
Telephone: + 25 42 570139 Fax: + 25 42 570280  
Email: [sss@net2000.co.ke](mailto:sss@net2000.co.ke)

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Mary Kay Larson	Toolkit for the Rapid Assessment of Reproductive Health in Refugee and Internally Displaced Persons (IDP) Settings
Antenane Korra	Knowledge, Attitude, Practice and Behavior Study in Respect of HIV/AIDS amongst Youth and Adolescents in Western Refugee Camps, in Ethiopia: A Qualitative Study
Jessika Deblonde	Towards a Comprehensive Approach of Sexual and Reproductive Needs and Rights of Women Displaced by War and Armed Conflict: A Practical Guide for Programme Officers
Susan Igras	Building Partnerships for Reproductive Health in Conflict-Affected Settings
Khatuna Katamadze	We Will Improve our Health Ourselves
Evelyn Aguti	Participation of Young People in HIV/AIDS and SGBV Prevention and Response Activities: A Successful Strategy in BCC among Young People in the Refugee Settlements of Uganda
Rachel Partridge	A Qualitative Study of the Barriers to Sexual Health for Internally Displaced Young People in Freetown, Sierra Leone
Desire Timngum	Refugee Reproductive Health in Africa: Dilemmas of Central African Accompanied Urban Refugee Children in South Africa
Monica Onyango and Catherine Rielly	HIV/AIDS, Gender and Conflict Nexus: The Case of Sierra Leone
Doris Bartel	Strengthening Protection Mechanisms in Conflict and Post-Conflict Settings
Laura Moch	Behavior Change Communication (BCC) Strategies for HIV Prevention in a Post-Conflict Setting
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Sandra Krause	Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Persons
Carlos Iván Pacheco	The Population Affected by the Humanitarian Crisis in Colombia: A Response with a Development Perspective
Stany Niyonzima	Implementing Community-Based YRH Projects in Burundi

## **Cost Sharing: A Barrier to Gender Equality in Afghanistan?**

**Authors** Sheena Currie, HealthNet International

**Presenter** Sheena Currie

### **Background**

Reducing the high maternal and infant mortality rates in Afghanistan has been identified as two of the five key priorities of the interim government. Various NGOs are offering support to maternal child health programs to improve quality of health service delivery.

### **Purpose of study or programme**

A key component of this support is the concept of capacity building which involves human resources, organizational and institutional development. Cost sharing is one element of capacity building which aims to contribute to sustainable service delivery amongst resource-poor populations. Cost sharing has advantages and disadvantages and will be considered within a gender context.

### **Data collection or programme methods**

HealthNet International (HNI) is well established in the Eastern region and the Health Care Support Project (HSCP) of which maternal child health is a component has been in place since 1995. Approaches to ensure the sustainability of the services were introduced shortly thereafter. Paying for health care was an existing cultural reality in Afghanistan; therefore, cost sharing was commenced and endorsed by the MOH and local community. Within reproductive health, examples include payment for inpatient/outpatient care, drugs and operations. Certain groups qualify for exemptions through a 'red card' system. The purpose of the recovered funds varies however; within HNI, uses include funding staff incentives and expansion of services.

### **Study or programme findings**

Paying for a service should enhance accountability to the consumer and improve the quality of care. A review in 2001 identified that expenditure and cost sharing revenues per capita per health facility vary and the analysis of these differences may identify best or poor practices. Shortages of drugs are regularly reported. Accounting systems are primitive and despite control systems aimed at minimizing risks of error and fraud, there is a covert but probably extensive system of 'under the table' money. The red card system is open to misuse with evidence of cards being signed for friends and relatives leading to the organization losing income and the really vulnerable not being helped. Cost sharing is considered to be widely accepted by the community.

Capacity building should recognize and support women's rights and remove barriers which might hinder the move towards Safe Motherhood. There is evidence within the current system of the gendered nature of health care as all services are charged for, even blood transfusions and family planning. Estimates suggest over 50% of the population live in absolute poverty, of whom women and girls are especially vulnerable due to the cultural context and other factors contributing to gender inequality. The aim of equity as a goal for cost sharing is questionable.

### **Conclusion and programme implications**

Donors require a credible plan to phase out or devolve activity to local partners; thus financial sustainability through cost sharing is seen as good practice but should there be gender specific exemptions? It is recommended that specific interventions related to reproductive health are not included in cost recovery, including emergency operations and family planning.

### **For further information:**

Sheena Currie, HealthNet International, PO BOX 889, University Town, Peshawar, Pakistan

Telephone (SAT): 00882 1689802927

Email: [sheena@mara2.freemove.co.uk](mailto:sheena@mara2.freemove.co.uk)

## **An Assessment of Reproductive Health Services for Internally Displaced Persons in the Southern Region of Afghanistan**

**Authors** Basia Tomczyk RN, MS, Dr.PH. International Emergency and Refugee Health Branch/Centers for Disease Control and Prevention  
**Presenter** Basia Tomczyk

### **Background**

In complex emergencies the heaviest burden of disease is on women and children whose vulnerabilities are usually underestimated.

### **Purpose of study or programme**

The purpose of this investigation was to assess the availability and accessibility of reproductive health services in five camps for internally displaced persons (IDPs) in the southern part of Afghanistan and to address gaps in services.

### **Data collection or programme methods**

This study was conducted during the period November 2002 to January 2003 in five IDP camps, four in Kandahar and one in Helmand Provinces. The total population was approximately 110,000 and ranged from 12,000 to 37,000 IDPs per camp. Data collection techniques included face-to-face interviews with local providers and IDP community leaders, and review of reproductive health indicators.

### **Study or programme findings**

There were four agencies providing health services in four of the five camps. Looking at the main activities related to reproductive health showed that one health center referred complicated deliveries to the hospital. Home births were the norm and male providers were not allowed to examine female patients. Only one camp had female midwives. Four camps did support traditional birth attendants.

In one camp there were 6 neonatal deaths in a 24-hour period. Interviews with the mothers showed that five of the six mothers did not have prenatal care since they could not attend the health clinic unescorted.

Contraception was available in one camp but there was no evidence of distribution. For a one month period one agency recorded that there were 819 pregnant women but only 66 of them came to the health center for natal care. Another agency reported a total of 201 antenatal visits, 166 postpartum visits, 6 referrals made for emergency obstetric care, and 48 deliveries occurred at home and 1 occurred in the health center.

Another agency presented summary data and one agency did not record any activity. Some providers believed that the lack of data was due to security issues and absence of female health providers.

### **Conclusion and programme implications**

One finding suggests that a gap in service seemed to occur due to lack of female providers. A major effort needs to be made to build capacity among female health professionals and enhance their ability to address reproductive health. Another finding shows the unequal distribution of reproductive health services in the camps, highlighting the need for a coordination role to be assumed by the Ministry of Health with support by the United Nations. Constraints on health care delivery due to security issues will continue to challenge the aide community. Therefore, training IDP leaders in basic public health measures should be a standard component of the health program in these settings.

### **For further information:**

Basia Tomczyk, International Emergency and Refugee Health Branch, Centers for Disease Control and Prevention, 4770 Buford Hwy. MS F-48 CDC, Atlanta, GA 30341 USA  
Telephone: 770-488-3136  
Fax: 770-488-7829  
Email [bet8@cdc.gov](mailto:bet8@cdc.gov)

## **Ugandan Women's Experiences of Sexualised Violence and Torture During Civil War Years in Luwero District, Uganda: Implications for Health Policy, Welfare and Human Rights**

**Authors** Helen Liebling, Chartered Clinical Psychologist and Ph.D. Researcher, Centre for the Study of Women and Gender, The University of Warwick, UK, African Psycare Research Organisation, APRO, Uganda

**Presenter** Helen Liebling

### **Background**

A multidisciplinary project was carried out with women war survivors in Luwero District, Uganda by Isis-WICCE, a women's international non-government organisation (NGO) (Musisi et al, 1999; Liebling and Kiziri-Mayengo, 2002). I was a member of this team that provided psychological and gynaecological services for women who suffered sexualised violence and torture during the 1981-1986 civil war years.

### **Purpose of study or programme**

This project recommended that gender-sensitive services be urgently established. Hence, my Ph.D. research study focused on determining in greater detail the experiences, views and ongoing needs for services of the women survivors of rape, violence and torture in this war-affected region of Uganda.

### **Data collection or programme methods**

I carried out seven months of fieldwork in Kikamulo Sub-County, Luwero District in 2001. Focus group discussions were held with women volunteers in 5 of the 7 parishes and individual interviews were carried out. Three parishes were concentrated on in greater detail. The main emphasis was for women to talk about their war experiences, the effects on their lives and their views about current needs and services still required. Men's groups were also held, as well as individual interviews, for comparative purposes. Key informants, including health workers, human rights activists' local leaders and NGOs, were interviewed. Data analysis was informed by a combination of qualitative methods and assisted by the use of a computer programme, Atlas Ti.

### **Study or programme findings**

During the Luwero civil war years, women experienced gender-specific violations including gang rape and genital mutilation. They suffered extreme psychological, social, and physical effects. The stigma associated with sexual violence during war within Ugandan culture is immense and many women still suffer in silence. Women were infected with sexually transmitted diseases, including HIV/AIDS. Genital mutilation and rape caused considerable damage to their reproductive organs (Isis-WICCE, 1998; AGOU, 1999). I view their very serious resulting gynaecological and reproductive health needs, in this context, as a human rights issue (see Cunningham et al, 1999; AGOU, 1999). Men were also subjected to extreme physical torture, and changes in gender roles since the war were evident and have resulted in women gaining new identities and power whilst men appear to have lost their traditional roles (Sideris, 2003; El-Bushra, 2000).

In spite of their experiences, these women were not silent victims. In contrast, they demonstrated great agency and survival skills. Since Museveni came to power, there has been a greater focus on women's empowerment politically and economically (Museveni, 1997:90-92). However, despite this 'apparent' political progress for women, legal redress for the violations they suffered during the war has been rare and usually unsuccessful. Compensation provided by the government and non-government organisations has often failed to reach war-affected women (Lubanga, 1999).

### **Conclusion and programme implications**

Urgent priority should be given to establishing specialist gynaecological and reproductive health services for women war survivors in Luwero District. Women's specific health needs should be incorporated into current health policy (AGOU, 1999). There is also a pressing need for gender-sensitive health, welfare, and legal services for women war survivors and their families utilising collective empowerment principles and enhancing local initiatives, skills and knowledge (Musisi et al, 1999; Liebling and Kiziri-Mayengo, 2002).

### **For further information:**

Ms. Helen Liebling, Chartered Clinical Psychologist/Ph.D. student  
Centre for the Study of Women and Gender, Department of Sociology, The University of Warwick  
Coventry CV4 7AL, United Kingdom  
Telephone: 44 (0) 2476 52 3600 Fax: 44 (0) 2476 52 3497  
E-mail: [helenliebling@hotmail.com](mailto:helenliebling@hotmail.com)



## Poverty and Violence Against Women

**Authors** Zeinab A. Ahmed, Programme Officer, Women & Children, CARE Kenya, Refugee Assistance Project  
**Presenter** Zeinab A. Ahmed

### Background

Women with little economic security are vulnerable to many forms of gender-based violence. Sexual violence is considered to be a significant problem among Somali refugee women living in the Dadaab camps in northeastern Kenya, where security conditions are poor for women who leave their homes to conduct routine activities such as collecting firewood. Programs addressing the prevention and response to sexual and gender-based violence (SGBV) have been ongoing in the Dadaab camps since 1993, including legal assistance, security/protection actions, health services for survivors, community services and refugee-led awareness programs.

When consulted on potential solutions for reducing vulnerability to gender-based violence, Somali refugee women strongly recommended economic recovery programs targeting vulnerable women as a means of diminishing their risks for sexual and gender based violence.

### Purpose of study or programme

In October 1999, CARE initiated income generation activities (IGA) as part of an integrated program addressing prevention and response to gender based violence. Based on the recommendations from the refugee women, the income-generation program was designed to target vulnerable women: widows, SGBV survivors, divorcees, disabled, single unwed mothers and women in special circumstances. The program was designed to address the link between poverty and SGBV.

### Data collection or programme methods

- In the SGBV case documentation forms, there is a column for writing the occupation of the survivor. On analyzing the case documentations, it was revealed that most of the women and girls who were sexually assaulted in the bushes while collecting firewood, grass or building materials were of low economic status.
- When appraising women loan applicants, they were asked to state their savings so that we could know whether a woman's income/savings has increased from \$20 to \$200.
- The loan program distributed \$96,215 over 3.5 years to 379 vulnerable women groups (1,895 women).
- We have used qualitative methods to document the results of the project: formal interviews with beneficiaries.

### Study or programme findings

Micro-credit programs targeting vulnerable refugee women can be successful both in terms of loan repayment and improving women's economic and physical security from sexual assault. The repayment rate of the loans averaged 90%. Women who have benefited from the IGA project are now more economically secure, and are able to buy basic necessities like sugar, milk, meat and clothes for their dependants. In addition, they are more physically secure and less fatigued, since they are engaging in petty trading in secure areas of the camps and no longer travel long distances in insecure areas. In addition, IGA were found to improve women's confidence and morale.

### Conclusion and programme implications

Economic empowerment of women should be included as an important aspect of addressing SGBV. IGA projects for women should be prioritized when funding decisions are made by managers.

### For further information:

Zeinab A. Ahmed, CARE RAP, P.O. Box 43864, Nairobi, Kenya  
Tel: 254-046-2060/2529  
Fax: 254-046-3242  
Email: [Zeddie@ddb.care.or.ke](mailto:Zeddie@ddb.care.or.ke)

## **Gender-based Violence Data Collection: New Tools for the Field**

**Authors** Jeanne Ward, Gender-based Violence Research Officer, Reproductive Health for Refugees Consortium; Michelle Hynes, Epidemiologist, Centers for Disease Control and Prevention (CDC); Kathryn Robertson, Gender-Based Violence Program Manager, International Rescue Committee (IRC) East Timor Office; Lumnije Decani, Director, Women's Wellness Center Kosovo; Victor Balaban, Orise Fellow, CDC; Chadd Crouse, Statistician, CDC; Mary Koss, Professor of Public Health, Mel and Enid Zuckerman Arizona College of Public Health, University of Arizona; Mary Otieno, Senior Technical Advisor for Reproductive Health, IRC; Mary Kay Larson, Refugee Reproductive Health Team Coordinator, CDC

**Presenter** Jeanne Ward

### **Background**

In 2002, the Reproductive Health for Refugees Consortium (RHRC) concluded a global review of issues and programming related to addressing gender-based violence (GBV) among conflict-affected populations. Consistent gaps identified by the RHRC were scant prevalence data and lack of best practices for quantitatively and qualitatively describing the nature and scope of GBV in humanitarian settings.

### **Purpose of study or programme**

In response to the lack of data on GBV, the RHRC has developed a series of tools to enhance field-based GBV data collection. Recently field-tested and published in a comprehensive manual, the tools include focus group and situational analysis guidelines, a draft prevalence survey questionnaire, and standards for monitoring and evaluation that support the documentation of service statistics. This presentation will briefly review the tools, focusing primarily on the methods for field-testing the GBV prevalence survey.

### **Data collection or programme methods**

Sites were selected in East Timor and Kosovo, where the research was conducted in collaboration with international and local organizations experienced in GBV programming. A training tool was developed and field-tested for local interviewers, as were methods for training "locaters" responsible for randomly selecting participants at the household level. To ensure safety of all research participants, interviews were conducted outside of the household, and supervisors were assigned to all sites to review individual questionnaires and respond to any safety concerns.

### **Study or programme findings**

The training process, survey instrument, and research methods were revised during and following the field-tests to address lessons learned during the respective research projects. Adjustments included extending the length of training for interviewers in order to more comprehensively review the rationale for each item in the questionnaire; inserting additional questions in order to capture GBV over the lifespan of the participant; creating internal validation methods within the instrument to address the lack of baseline data on GBV; and sampling sites in one day in order to minimize risks and refusals resulting from community awareness about the research. The field-tests and related adjustments to the research methodology and instrument confirmed the feasibility of the research design and process.

### **Conclusion and programme implications**

Conducting research on GBV in conflict-affected settings raises many important ethical and safety considerations. It is crucial that the research be strongly linked with local organizations so that these organizations have a sense of owning the research. Action plans should be developed with local collaborators so that data are used in an effective and timely manner and strategies devised for using the data most effectively for fund-raising for programmatic response.

### **For further information:**

Jeanne Ward, c/o International Rescue Committee, 122 East 42<sup>nd</sup> Street, New York, NY 10168 USA  
Tel: (212) 551-3000  
Fax: (212) 551-3185  
E-mail: [Jeanne@theIRC.org](mailto:Jeanne@theIRC.org)

## **SGBV Prevention in Kala Refugee Camp in Zambia**

**Authors** Joseph Musonda, Refugee Officer, Ministry of Home affairs, Zambia; Marcqueline C Zulu, Community Counsellor, HODI, Zambia.

**Presenter** Marcqueline C Zulu

### **Background**

Kala refugee camp is located in Northern Zambia, housing approximately 21,600 refugees who have fled the conflict in the Democratic Republic Congo (DRC). Sexual and gender-based violence (SGBV) is a serious problem in the camp. An estimated 12 incidents of sexual violence and wife battering were recorded each month. Girls as young as 12 years of age are subjected to early marriages by their parents/guardians in exchange for gifts or favours.

### **Purpose of study or programme**

The programme aims to prevent and manage the rampant cases of defilement of children and abuse of women. The programme also helps both men and women of the refugee community and all the stakeholders, including the Zambia community, understand their roles in addressing SGBV issues.

### **Data collection or programme methods**

Hodi, in conjunction with other stakeholders, established an SGBV committee that receives and follows up on SGBV cases in the camp. This committee is composed of 12 volunteers of whom 6 are women and 6 men who review cases and arbitrate matters. Cases not solved by the committee are referred to another committee made up of the host government, UNHCR and implementing partners. One of the two committees reports cases to the law enforcement agency for prosecution with the consent of the victim or victim's family. This programme is supported by the formation of support groups that help to raise awareness of human rights and SGBV prevention in the community. The group goes into the community to sensitise people through drummer and drama skits. Referral to the health centre for examination and treatment to prevent pregnancies and STI's were evident. Counselling is offered immediately and emotional support is on going.

### **Study or programme findings**

- At least 4 cases of teenage pregnancy were reported each month within the camp
- Some of the young girls could experience sexual violence during their flight to the country of asylum.
- Many families prefer to settle the SGBV cases with payments of goats, bicycles and money/pieces of cloth.
- Three cases of SGBV taken to the courts of law were successfully prosecuted. For example two men ages 29 and 31 who had impregnated 2 girls of 13 years of age were jailed for 2 years. A 26 year-old man who raped a 4 year-old child was jailed for four years.

*Main factors contributing to the acts of GBV:*

- Ignorance of human rights. About 95% of Kala community came from the rural part of the DRC. Thus the community is unaware of human rights principles
- Religious beliefs. Some churches believe that the religious leaders can have sex with any member of the church and adolescents are the most common targets.
- Cultural beliefs. Most of the tribes do not favour a girl child to go to school but promote early marriage. Some tribes practice female genital mutilation.
- Low level of education. The low level in the community is a barrier to the understanding of these issues.

### **Conclusion and programme implications**

Women and children, especially the unaccompanied girls, are the most in danger of being targets of this insidious form of human rights violation and those displaced or caught up in conflicts are often at the greatest risk.

Hodi's programme provides a means of education to the refugee community on the need to prevent child rape and early marriage through reproductive health awareness and the importance of allowing girls to remain in school and complete their education. The program also offers the community the opportunity to address SGBV cases by means of legal action as well as provides SGBV survivors the proper care to address their health needs.

### **For further information:**

Chileshe Chilangwa Collins, HODI, BOX 36548, Lusaka, Zambia

Tel: 260-1-290455

E-Mail: [director@hodi.org.zm](mailto:director@hodi.org.zm)

## Preparing Reflective Practitioners

**Authors** Susan Purdin, Therese McGinn, Sara Casey, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University

**Presenter** Susan Purdin

### Background

Shocking descriptions of excess mortality as a result of the mismanagement of the humanitarian response to the 1994 Rwandan refugee crisis in Goma, Zaire, led to a call for professionalization of humanitarian relief. This presentation describes a program responding to the call.

### Purpose of study or programme

The Program on Forced Migration and Health at Columbia University's Mailman School of Public Health prepares reflective practitioners—humanitarian workers with the capacity to understand the origin and consequences of forced migration, to design and implement health programs that improve the well-being of refugees and internally displaced people and to recommend effective public policies.

### Data collection or programme methods

Characteristics of the program that contribute to the development of reflective humanitarian practitioners include:

- Selection criteria requiring that all students admitted into the program have demonstrated prior experience relevant to the humanitarian field.
- Skills and content coursework that build one's capacity to assess health needs and to design and evaluate health programs in the various phases of disasters.
- A supervised internship in a relevant international program.
- A capstone exercise applying theory and principles acquired in course work, integrated with knowledge gleaned from field experiences, to synthesize an analysis of professional practice.

### Study or programme findings

Program faculty participate in the three primary activities to which the Mailman School is dedicated: research, practice and training. Each of these informs and improves the other. For example, reflection on field practice of faculty and students provides case studies for classroom learning which, in turn, prepare the next generation of humanitarian practitioners for improved practice.

Reflective practitioners prepared by this program are able to:

- Analyze the context of a forced migration setting, including: local culture, nature of the emergency, impact of societal disruption on social roles, impact of external intervention (military, humanitarian) on social roles, roles and responsibilities of agencies (intergovernmental, governmental, non governmental).
- Utilize an evidence-based public health approach in humanitarian response:
  - Assessing health needs; engaging a community to look at human suffering beyond nutrition, water and sanitation; analyzing trans-boundary issues, determining a framework for effective protection.
  - Designing effective programs, meeting standards, synthesizing and coordinating, promoting healthy practices, problem solving given situational constraints.
  - Using good scientific techniques to monitor and evaluate programs.
- Use evidence to improve policy at every level:
  - Presenting scientific findings at local, regional and international meetings
  - Publishing relevant literature.

### Conclusion and programme implications

Graduates of the program hold responsible headquarters and field positions in intergovernmental, governmental, non governmental humanitarian organizations globally. Preparing reflective public health practitioners facilitates the professionalization of humanitarian responses and contributes to improved well-being of persons affected by disaster.

### For further information:

Susan Purdin, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, Center for Global Health and Economic Development  
215 West 125th Street, 3rd Floor, New York, New York 10027, USA  
Telephone: 1 646 284 9659 Fax: 1 646 284 9684  
Email: [sjp98@columbia.edu](mailto:sjp98@columbia.edu)

## **From Emergency to Development “Maternity Homes in Palestine”**

**Authors** Salwa Najjab Khatib OBGyn, Dina Nasser, MPH  
**Presenter** Salwa Najjab Khatib

### **Background**

The Total Fertility Rate in Palestine is high. It is calculated to be 3.87 (Gaza 4.6 and West Bank 3.5). According to the information centre of the Ministry of Health of the Palestinian Authority and before the Intifadah in Palestine - which started in September 2000-, access to health services used to be fairly easy. Almost 90% of the deliveries in WB and 60% in Gaza, a total of 77.5%, of reported deliveries occurred in hospitals. The policy had been to encourage women to deliver in hospitals. Currently, closures, curfews and checkpoints are major obstacles to accessing health care services and have contributed towards an increase in morbidity and mortality, especially in maternity care. Reports state that 33 women delivered at checkpoints and more than 27 newborns died at checkpoints. Seventy-two patients died at checkpoints during evacuation, 22 of them were women, and some were pregnant. Currently at least one-third of deliveries, especially in the West Bank, are occurring outside hospital settings; at homes and private clinics

### **Purpose of study or programme**

To establish maternity homes, not only as a response to the emergency situation in Palestine, but also as a long term developmental step to increase access to quality maternity care, where hospital maternity wards were overcrowded, and cases that required special care had to compete with normal delivery cases for limited resources

### **Data collection or programme methods**

To establish the maternity home, the method included starting with a community that serves a cluster of surrounding villages and already has a primary health care facility, which provides some form of women's health services. The project decided to build upon these services to provide comprehensive services, including prenatal, delivery and postnatal care to pregnant women. Delivery services were offered to women with low risk, who do not require hospitalization, and who remain less than 24 hours at the facility. The facility must be supported by a hospital that can manage obstetric-neonatal emergencies (EOC Essential Obstetric Care), and act as a referral and support center.

### **Study or programme findings**

The case of the Birzeit Women's Society was one such example. They operated a health center that provided antenatal, post natal and infant care. In the emergency situation where along with surrounding villages they became isolated and had no access to secondary health services, they mobilized their resources. One Gynae/Ob and two health workers, with the assistance of a back up hospital giving technical support by phone around the clock, they were able to deliver 80 women and deal with two missed abortions effectively. Within the concept of a maternity home, they are trying to systematize their efforts. Realistically this requires developing community support for the concept both at a national level and at a local level. At the national level, support is being generated through discussions with all stakeholders as well as through national mass media campaigns to disseminate health messages related to pregnancy, delivery and postnatal care for mothers and infants. At the community level, the society is encouraged to form a committee that includes figures from the local authority as well as lay people from the community to act as support agents for this effort. Also at the community level, mother-to-mother groups can complement national mass media campaigns on newborn and maternal postpartum care, and on breast-feeding practices. Lack of knowledge and lack of simple skills in these areas are contributing to the current nutritional crisis, and to both maternal and newborn morbidity and mortality.

### **Conclusion and programme implications**

Such efforts along with commitment of policy makers will help Palestine move from models that served its needs in the emergency situation to structured models where a maternity home can be regarded as a “mother and newborn friendly” primary health care facility which provides safe delivery, counseling, health promotion, shared pre and post natal care, family planning and other services related to women's reproductive health.

### **For further information:**

Dina Nasser, PO Box 17333, East Jerusalem, Occupied Palestinian Territories  
Tel: +972 2 2344677/8 Fax: +972 2 2344676  
Email: [Juzoor@planet.com](mailto:Juzoor@planet.com)

## **Improving Refugees' Reproductive Health through Literacy in Guinea**

**Authors** Therese McGinn, Katherine Allen, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University; Meriwether Beatty, JSI Research and Training Institute  
**Presenter** Meriwether Beatty

### **Background**

This paper presents the results from a study of the Reproductive Health Literacy (RHL) Project among Sierra Leonean and Liberian women in refugee camps in Guinea. Literacy classes met for two hours twice a week for six months, with content focused on safe motherhood, family planning, STIs/HIV/AIDS and gender-based violence.

### **Purpose of study or programme**

A follow-up study was undertaken in 2002 to understand the short and medium term health effects of the project on the women who participated in RHL courses in 1999, 2000 and 2001.

### **Data collection or programme methods**

A closed-ended interview and a written test of literacy skills were administered to 549 women who had taken the RHL course. The instrument included questions on respondents' socio-demographic characteristics; fertility; child deaths; knowledge of specific reproductive health information; attitudes towards reproductive health topics; and behaviors related to reproductive health, prior to and since their RHL class. In addition, 22 survey respondents were interviewed in-depth about their views on RHL before, during and since their participation.

### **Study or programme findings**

The findings suggest that retention of specific factual material taught in RHL classes was high (mean knowledge score: 16.1 out of 20). Women's communication with their partners on reproductive health topics increased since RHL (more than 4 in 5 respondents reported such communication). RH behavior also showed a marked change: current use of modern contraceptives was 48%. Moreover, 38% of these users were first-time users since RHL. The same pattern holds for condom use: 51% of women who used a condom at last sex had used condoms for the first time since RHL. Literacy test results suggest improvements in these skills were only marginal. The women's sense of 'boldness' showed a dramatic increase from the pre-RHL period. Respondents clearly identified RHL as key to their new-found confidence, in part because of what they learned but perhaps in larger part simply out of a sense of belonging. RHL participation appears to have influenced its participants, whether or not they had had previous schooling.

### **Conclusion and programme implications**

The results of the RHL follow-up study in Guinea in 2002 suggest that the RHL model is worth replicating—in Guinea's refugee camps; in Sierra Leone; in Liberia, as the ongoing conflict there permits; and elsewhere. Implementing the model in villages and towns, rather than in refugee camps, may require adaptation to the different daily demands that women face in those settings.

### **For further information:**

Meriwether Beatty  
JSI Research and Training Institute, 1616 North Fort Myer Blvd, 11th floor, Arlington VA 22209, USA  
Telephone: 1 703 528-7474  
Fax: 1 703 528-7480  
Email: [meriwether\\_beatty@jsi.com](mailto:meriwether_beatty@jsi.com)

## **Socio-Cultural & Religious Concerns Versus Harsh Realities of Life: The Case of Afghan Refugees In Iran**

**Authors** Parviz Piran, Ph.D, Allameh Tabatabaiee University; Ali Shirazi, MD, UNFPA Iran  
**Presenter** Parviz Piran

### **Background**

In the past five years, the authors have been engaged in two distinct researches concerning Afghan refugees in Iran. The first research on RH was carried out in Golshahr, a poverty stricken neighborhood located on the outskirts of Mashad, Iran's second largest city with over two million inhabitants. The second research was related to poverty alleviation in Shirabad, an informal settlement now a part of Zahedan, capital of Sistan & Baluchestan, the poorest province in Iran bordering both with Pakistan & Afghanistan. In the course of both researches an interesting issue became apparent. Afghan refugees are faced with a painful struggle: on one hand they have very strong concern for their socio-cultural and religious reservations, but on the other hand are faced with harsh economic conditions and the struggle to meet the basic needs of very large families.

### **Purpose of study or programme**

The main purpose of the study is to show how Afghan refugees solved the above-mentioned dilemma. In light of the harsh realities of life and the observation of Iranian Muslims who have been able to use birth control and access RH services, some Afghans gradually developed a system of justification in accordance with their beliefs which allowed them to use contraceptives. Such a system is reviewed and analysed.

### **Data collection or programme methods**

The main techniques of data collection were focus group discussions and in-depth interviews. In each community, 50 heads of Afghan families were interviewed. Later a number of focus group discussions were held in which Afghan females freely discussed their approaches to very sensitive issues. The harsh realities of life due to having very large families were the centre of those discussions. After comparing the data collected in each community, a number of conclusions were reported.

### **Study or programme findings**

1. Contrary to what appears on the surface, Afghan women played a decisive role in changing their husbands' attitude towards family planning and RH in general.
2. Despite the visible change in attitudes, many Afghan families still kept their concerns and reservations, not paying any attention to the grave situation they were experiencing.
3. Those who adapted to the realities of life are gradually gaining some power and acting as the community leaders. However, a power struggle still exists.

### **Conclusion and programme implications**

These two researches can teach valuable lessons in terms of public awareness concerning family planning and RH in general

### **For further information:**

Pirouz Piran, [pooria@mavara.com](mailto:pooria@mavara.com)  
Ali Shirazi, [ashirazi@unfpa.un.or.ir](mailto:ashirazi@unfpa.un.or.ir)

## **Toolkit for the Rapid Assessment of Reproductive Health in Refugee and Internally Displaced Persons (IDP) Settings**

**Authors** Mary Kay Larson, Lead Health Scientist, Centers for Disease Control and Prevention (CDC); Michelle Hynes, Epidemiologist, CDC; Martha F. Rogers, MD, Task Force for Child Survival and Development; Lenette Golding, Task Force for Child Survival and Development; Chad Crouse, Statistician, CDC, and Jason Hsia, Statistician, CDC

**Presenter** Mary Kay Larson

### **Background**

Rapid health assessments are crucial to organizing appropriate and effective responses in complex emergencies. It has been increasingly recognized that reproductive health is an important component of health needs of displaced populations, both in the emergency and post-emergency phase of complex emergencies. While several rapid health assessment tools have been developed, a population based scientifically rigorous tool for the assessment of reproductive health is still needed. In collaboration with humanitarian organizations, the Centers for Disease Control and Prevention has developed a prototype rapid assessment toolkit for use in refugee and IDP settings.

### **Purpose of study or programme**

To develop a rapid health assessment toolkit for reproductive health, including software that allows field staff with minimal epidemiological training to conduct rapid reproductive health assessments and generate data needed for designing service programs.

### **Data collection or programme methods**

Participants for the roundtable will come from a wide variety of disciplinary, organizational, experiential and geographic perspectives. Through the roundtable format, comments will be solicited on:

- additional indicators required for the IDP/refugee setting or indicators that can be omitted in the prototype rapid assessment questionnaire
- desirability and feasibility of sampling using geographical positioning systems
- format of the questionnaire with core, standard and country specific questions
- useful additional analysis tables
- additional tools needed for a complete assessment

### **Study or programme findings**

The session is meant to provide a variety of perspectives and spark discussion on the specific format and use of the toolkit. Formal presentation of the prototype toolkit will be brief so as to allow time for group interaction and expression.

### **Conclusion and programme implications**

The rapid assessment toolkit will be used to identify health needs, provide information for designing appropriate interventions, and prioritize competing needs in a resource poor situation. This session is meant to contribute to discussion of development of such a tool.

### **For further information:**

Mary Kay Larson, Coordinator, Reproductive Health for Refugees, Division of Reproductive Health  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE MS K-22, Atlanta, GA 30341, USA  
Email: [marykaylarson@cdc.gov](mailto:marykaylarson@cdc.gov)



## **Knowledge, Attitude, Practice and Behavior Study in Respect of HIV/AIDS amongst Youth and Adolescents in Western Refugee Camps, in Ethiopia: A Qualitative Study**

**Authors** Antenane Korra, M&E Advisor for the Health Sector, CARE-Ethiopia  
**Presenter** Antenane Korra

### **Background**

HIV/AIDS spreads fastest in conditions of poverty, powerlessness and social instability like displacement. Displaced women are subjected to sexual abuse at every stage of their flight and they are also pushed into sex to gain access to basic needs.

### **Purpose of study or programme**

This study was intended to assess HIV/AIDS and STI situation in the Western Refugee camps in Ethiopia, and identify the best means to improve access to information and services on HIV/AIDS for young people. Existing activities on HIV/AIDS and STI prevention and care in the camps were also examined.

### **Data collection or programme methods**

The study has been carried out in the three refugee Camps of Western Ethiopia. The main method of data collection technique employed for this study was Focus Group Discussion (FGD). The prime target of the study was youth (both in and out-of school) in the refugee camps between the ages of 10 and 24 years. A total of 18 focus group discussions were conducted in the study sites with 123 participants, yielding about 7 people per session. The size of the groups ranged from 5 to 11 participants.

### **Study or programme findings**

It was discovered that young men focus group participants have a better level of awareness about STIs compared to young women. Most of the FGD participants identified Gonorrhoea and Syphilis as important STIs.

With regard to HIV/AIDS, the results of FGDs revealed that there is high level of awareness among all groups, except for a few out-of-school youth, concerning its modes of transmission and prevention. Furthermore, pockets of ignorance and misinformation about the nature of the diseases and its modes of transmission were identified.

There are some limited awareness-raising activities underway to address the issue of HIV/AIDS in the refugee communities. Health centers provide information and STI diagnosis and treatment services. Trained community health agents (CHAs) educate people on health and related issues.

The majority of FGD participants considered themselves among the lowest risk group with regard to HIV/AIDS. This is a misconception that necessitates a more focused educational intervention.

Knowledge about condoms appeared to be high among young refugees, while its utilization is generally low. According to young FGD participants, access to condoms is a problem. There also appeared to be rampant misconceptions about condoms among the focus group discussants.

### **Conclusion and programme implications**

Increasing knowledge and the perception of risk associated with STIs and HIV/AIDS among young refugees should receive due attention. The inadequacy of health services delivery in the refugee camps to address the problem of STI and HIV/AIDS is also a great concern and calls for an aggressive program of intervention.

### **For further information:**

Antenane Korra, P.O.Box 4710, Addis Ababa, Ethiopia  
Telephone. 251-1-534080  
Email: [antenanek@yahoo.com](mailto:antenanek@yahoo.com)

## **Towards a Comprehensive Approach of Sexual and Reproductive Needs and Rights of Women Displaced by War and Armed Conflict: A Practical Guide for Programme Officers**

**Authors** Marleen Bosmans, Prof.Dr. Marleen Temmerman, International Centre for Reproductive Health, Ghent University

**Presenter** Jessika Deblonde

### **Background**

Although humanitarian aid programmes are paying more and more attention to the provision of sexual and reproductive health (SRH) services, the development of a comprehensive approach of SRH still constitutes a real challenge for donors, international humanitarian agencies, national authorities and national and international non-governmental organizations.

### **Purpose of study or programme**

The guide is meant as a tool for programme officers in humanitarian aid programmes in SRH to support the development of a comprehensive approach to sexual and reproductive needs and rights of women displaced by war and armed conflict.

### **Data collection or programme methods**

1. Literature review on sexual and reproductive needs and rights of women in conflict situations, and more particularly of refugee and internally displaced women in developing countries.
2. Development of a draft checklist based on the findings of the literature review.
3. Field testing of the checklist in the Occupied Palestinian Territory:
  - literature review
  - identification of key stakeholders in SRH programmes for Palestinian refugee women
  - identification of key-informants
  - semi-structured interviews and focus group discussions
  - formulation of preliminary conclusions and recommendations
  - feed-back to the main stakeholders in the case study.
4. Peer review of the checklist at several workshops and meetings.
5. Finalization of the checklist.

### **Study or programme findings**

The development of comprehensive SRH services in conflict situations should be seen as a process evolving from the delivery of emergency aid in SRH to the planning of more sustainable SRH programmes as the situation stabilizes.

Obviously specific SRH projects may focus on only one or just a few aspects of SRH but they should always be embedded in a coordinated effort to achieve a more comprehensive approach. The guide is meant to be used as a tool for screening humanitarian aid programmes in SRH within the context of a given setting in order to identify the needs and gaps for reaching a more comprehensive approach, as well as for assessing the contribution of specific SRH projects to coordinated efforts for reaching such an approach.

The guide is divided into different chapters comprising a series of topics to be considered when developing comprehensive SRH programmes. It not only includes medical aspects, but equally emphasizes the need for support for the development of an enabling political, legal, economical, social and cultural environment.

The conclusions of this screening process can be translated into recommendations which may contribute to the development of strategies to achieve a more comprehensive approach to SRH needs and rights of the displaced women.

### **Conclusion and programme implications**

The basic assumption of the guide is that sexual and reproductive rights are human rights, and more specifically women's human rights which are universal, integrated and indivisible. Taking this rights-based approach as a starting point, the promotion and protection of women's sexual and reproductive rights should be encouraged in all humanitarian relief operations.

### **For further information:**

Marleen Bosmans, ICRH, De Pintelaan 185 P3, B-9000 Gent, Belgium

Telephone: +32 (0) 9 240.35.64./52.82 Fax: +32 (0)9 240.38.67 E-mail: [marleen.bosmans@ugent.be](mailto:marleen.bosmans@ugent.be)

## **Building Partnerships for Reproductive Health in Conflict-Affected Settings**

**Authors** Doris Bartel, Technical Advisor, Health & Conflict, Susan Igras, Senior Advisor, Reproductive Health, CARE

**Presenter** Susan Igras

### **Background**

In post-conflict settings, reproductive health programs may include rebuilding the infrastructure and human resource components of the health sector. To maximize impact and sustainability, non-government agencies addressing reproductive health may choose to work in partnership with other civil society or government agencies to improve the impact and sustainability of the programs. Strategies for building strong organizational partnerships in transition settings are not well documented.

### **Purpose of study or programme**

CARE has undertaken a systematic review to identify program examples and lessons learned on health-related inter-agency partnerships in relief and transition settings. Improved understanding of methods of building successful partnerships in relief and transition settings can contribute to both effective and sustainable reproductive health programs.

### **Data collection or programme methods**

CARE undertook a review of the gray literature regarding partnerships in relief settings and collected qualitative data on "lessons learned" on partnerships in relief settings from a sample of relief agencies. Ten humanitarian agencies were interviewed for descriptions of health-related partnership strategies, tools, and better practices in relief and transition settings.

### **Study or programme findings**

Little documentation exists on the methods and strategies for inter-organizational partnerships in relief and transition settings. While many agencies are already working in partnerships, many report problems with these partnerships. Challenges cited by agencies include lack of adequate time to build and maintain trust, particularly at the onset of a crisis. When programming time-frames are short, joint understanding and agreement for clearly defined objectives, roles and responsibilities are difficult to obtain, yet critical for success. Local agencies may have strong political or ethnic affiliations that could make partner agencies vulnerable, or potentially worsen the social, economic, environmental, and human rights situation of a complex emergency. Tools for developing and assessing partnership capacity and guidelines for inter-organizational partnerships in humanitarian aid and transition settings have been developed as a result of these findings.

### **Conclusion and programme implications**

Lessons learned and draft guidelines for developing and maintaining inter-organizational partnerships for humanitarian aid and transition settings should be disseminated, as they may improve sustainability and effectiveness of reproductive health programs. Draft guidelines developed by CARE will be available for conference attendees.

### **For further information:**

Susan Igras, CARE, 155 Ellis Street NE, Atlanta, GA 30303, USA

Telephone: 1 404-979-9158

Email: [igras@care.org](mailto:igras@care.org)

## **We Will Improve our Health Ourselves**

**Authors** Khatuna Katamadze, Leader of the health care center of the Women's Charity Fund, Gynecologist; N. Merabishvili, Professor of Medical Science, Head of Medical Cathedra of Tbilisi State Medical University; Irakli Arshilava, Gynecologist.

**Presenter** Khatuna Katamadze

### **Background**

Adolescents, especially young refugee women, don't have autonomy, decision-making skills and access to information and services. They are vulnerable to a host of RH problems. For adolescent refugees, this vulnerability is compounded by violence, separation from family and poor living conditions. In this situation are adolescents from Abkhazia and Ossetia who now live in Batumi, Ajara Region, Georgia. The Women's Charity Fund has worked with refugee adolescents for 5 years. They attend health care seminars regularly. Many participants didn't have any knowledge about RH and rights because their parents don't have time for their children. Also it is important that nearly all adolescents had menstrual disorders, reported during a medical exam, and they didn't know whom to ask about it. In Georgia, parents think visiting a doctor before the wedding is shameful.

### **Purpose of study or programme**

To address the unique health needs of adolescent refugees, Women's Charity Fund "Favorite" developed a comprehensive training and peer education project. The Health of Adolescent Refugees Project (HARP) allows young women to earn a merit badge by completing a series of activities that includes teaching others about RH. Project participants receive hope for the future. Families are also able to learn from their daughters. So it increases access to quality RH services in refugee settings in Ajara Region.

### **Data collection or programme methods**

Different activities were conducted at the fund:

? April 2001 - The Forum "The harms of HIV and prevention" was attended by 60 refugee adolescents (ages 14-18) who received booklets "How to prevent HIV" and were also given the opportunity to discuss interesting questions and recommendations.

? September 2002 - The workshop "Girls' Reproductive Health" was conducted with 25 refugee girls ages 7-10 which taught about physical and emotional changes during adolescence.

? December 2002 -The workshop "Adolescents' Reproductive Health" taught 25 refugee girls ages 14 to 16 about STIs, pregnancy prevention, healthy pregnancies and baby care. Afterwards, the girls served as peer educators in their communities, working with other girls through informal group discussions, one-on-one visits, distribution of educational materials or formal talks.

? August 2003 -The seminar "Women's Reproductive Rights" included 3 one-day seminars for parents, teachers and representatives of Health Care Departments and provided information on HIV-AIDS including news, research, statistics, medical information and prevention guidelines.

### **Study or programme findings**

During the April 2001 forum, refugee adolescents heard important information about HIV infection. They worked out future plans which included working with important groups who needed help. After the forum, they also conducted small seminars in their hotels for adolescents who didn't attend the forum and gave them the booklets.

The September 2002 workshop was conducted on the adolescents' initiative and was financed by the Love Fund, which was created by the refugee adolescents and existed through the contributions of kind people. Their desire was to inform young girls about important questions of reproductive health. They knew how important it was for them, because the lack of education was very difficult for them. They prepared materials with the help of a Gynecologist, printed and distributed them to participants after the workshop.

### **Conclusion and programme implications**

The girls who participated in educational activities and attended sessions where they discussed health topics, including the female reproductive system, physical and emotional changes during puberty, relationships, the human body, nutrition, hygiene and disease prevention. This program improved young girls' use of health-care services and their self-esteem. Using local funding, they continued to work with others who were in need.

### **For further information:**

Maya Katamadze, President of Women's Charity Fund "Favorite"  
49, M. Abashidze Str., Batumi, 384515, Georgia

Telephone: +99577440646 Fax: +99522272217 Email: [favorite@posta.ge](mailto:favorite@posta.ge), [maikokatamadze@yahoo.com](mailto:maikokatamadze@yahoo.com)

## **Participation of Young People in HIV/AIDS and SGBV Prevention and Response Activities, A Successful Strategy in Behaviour Change and Care among Young People in the Refugee Settlements of Uganda**

**Authors** Evelyn Aguti, HIV/AIDS Focal Person [UNV], Tibyampasha Dominic, Health Coordinator, Linnie Kesselly, Senior Community Services Officer, UNHCR Uganda

**Presenter** Evelyn Aguti

### **Background**

Adolescent refugees are vulnerable to HIV and SGBV because of the situations they experience during flight, in the refugee settlements and during repatriation. The breakdown of social structures like family, clan, tribe, idleness and poverty increases their vulnerability

### **Purpose of study or programme**

To empower adolescents with life skills, improved knowledge, changed attitudes and practices that prevent SGBV, HIV/STIs and care for adolescents living with HIV/AIDS and survivors of SGBV. To provide social support services that are community-based, adolescent-friendly and conveniently accessible to adolescents.

### **Data collection or programme methods**

Raising awareness through adolescent peer educators who are trained and equipped with knowledge on HIV/AIDS and SGBV prevention and response. Peer educators use music, dance, drama, sports competitions, home visits, group discussions, HIV/AIDS and SGBV club activities, shared experiences and video shows.

Adolescents collectively identify what makes them vulnerable to SGBV and exposes them to risks of HIV/STI and identify strategies to address them.

It is essential to train community service providers on the provision of adolescent-friendly services, ensuring convenient and easy access.

Income generation activities for out of school youth.

### **Study or programme findings**

Young people are resourceful. Programs designed to help them grow up and lead meaningful healthy lifestyles should involve them. Participatory methods to change behavior and address adolescents' problems are effective. In the refugee settlements of Uganda, adolescent involvement in HIV/AIDS and SGBV prevention and response in the program cycle has been interesting and effective. The strategy helps managers of the programs learn more about adolescents' problems, and therefore helps them address these problems from the perspective of young people.

The empowerment of adolescents has led them to become role models, creative, mobilize their community and voluntarily give life testimonies. Parents and adults have been sensitized by adolescents on their problems in the refugee settlements. HIV/AIDS and SGBV clubs in schools and the community aimed at educating their peers and adults have been formed and managed by them with the support of trained adolescent-friendly focal persons in the refugee community.

Adolescents have not only been seen but also have been heard through regular consultations. They know their rights. Systems are in place in case of abuse or violence to encourage them to be reported to the law enforcement system. The police report that they have seen an increase in cases reported.

### **Conclusion and programme implications**

Adolescent participation in the program makes them feel a sense of ownership and responsibility for changing behavior and addressing the risks. They have proved to be the best channel for information and support in response. Adult support and adolescent-friendly services that are conveniently accessible to them is imperative.

### **For further information:**

Evelyn Frances Aguti, UNHCR Representation in Uganda  
Plot 4B Accacia Avenue, Kololo Kampala, P.O BOX 3813, Kampala, Uganda.  
Telephone: 256 041 231229 or 256 077424788 Fax: 256 41 256989 Email: [aguti@unhcr.ch](mailto:aguti@unhcr.ch)

## **A Qualitative Study of the Barriers to Sexual Health for Internally Displaced Young People in Freetown, Sierra Leone**

**Authors** R Partridge, R Ingham, P. Greene

**Presenter** Rachel Partridge

### **Background**

The West African region, including Sierra Leone, has been affected by massive population movements triggered by years of civil unrest. As a consequence, many thousands of people are living in temporary Internally Displaced People (IDP) and refugee camps in difficult conditions. Research has highlighted that refugee and displaced populations face disproportionately greater sexual and reproductive health (SRH) risks, often with limited access to services - this is particularly true for young people.

### **Purpose of study or programme**

The aim of this collaborative study between the University of Southampton and Marie Stopes International was to gain an understanding of the sexual and reproductive health service needs of the young people in the IDP camps of Freetown, Sierra Leone.

### **Data collection or programme methods**

This study used qualitative methods to gain information from both the young internally displaced people and key "gatekeepers" in the camps in Freetown. Twenty Focus Group Discussions (FGDs) were carried out in five separate camps amongst 10-14 and 15-20 years old young men and women. In addition, 24 in-depth interviews (IDIs) were conducted with camp leaders, teachers and health service providers. The transcripts of both the FGDs and IDIs were translated from Krio into English and analysed using horizontal and vertical thematic analysis.

### **Study or programme findings**

The results show that barriers to young people accessing good SRH information and services in the IDP camps operate at a variety of levels, ranging from the individual, such as lack of awareness of health services or understanding of sexual health issues, to the structural, such as inconvenient opening times, location of services and attitudes of staff. The data also reveal that social and contextual factors such as poverty and community values, lead many young people to compromise their sexual and reproductive health.

Poverty, lack of security, gender norms and lack of information about HIV and sexual health issues all lead to a situation where young people are engaging in risky sexual behaviours and not accessing SRH services, thereby exposing themselves to negative sexual and reproductive health outcomes including HIV and unwanted pregnancy.

### **Conclusion and programme implications**

It is clear that there are a complex range of factors which impact the SRH of young displaced people in Freetown; these operate at all levels, from the individual through to structural and include contextual issues such as poverty and gender roles. The improvement of the SRH of young people will only be achieved if there is collaboration between a wide range of actors in the IDP camps. It is not only necessary to include young people in the design and organisation of improved youth-friendly SRH services and education campaigns, but also involve the government, NGOs and the community leaders to improve the general context in which young people live their lives, including the provision of basic necessities such as food, clothing, accommodation and education, poverty alleviation strategies and skills training.

### **For further information:**

Rachel Partridge, Research Fellow, Safe Passages to Adulthood, Centre for Sexual Health Research  
University of Southampton, Highfield, Southampton, UK SO17 1BJ  
Telephone: +44 (0) 2380 597770 Fax: +44 (0) 2380 59 3846  
Email: [rachelp@socsci.soton.ac.uk](mailto:rachelp@socsci.soton.ac.uk)

## **Refugee Reproductive Health in Africa: Dilemmas of Central African Accompanied Urban Refugee Children in South Africa**

**Authors** Desire Timngum, Graduate School for the Humanities, Wits University

**Presenter** Desire Timngum

### **Background**

Recent statistics show that from 1994—2003, when South Africa began formally recognising refugees, about 129,132 refugees or asylum seekers lodged applications for refugee status at the Department of Home Affairs. Of this number, 5,005 are children, both accompanied and unaccompanied. Central African refugee children (from Cameroon, Democratic Republic of Congo and Rwanda), who are the focus of this research, number about 1,299 in total. Though refugee children may flee conflict situations in Central Africa, seeking asylum in another territory, and especially in urban settings, presents challenges to their social and economic development or well-being.

### **Purpose of study or programme**

The aim of the study was to investigate and develop an understanding of the experiences and lives of Central African urban accompanied refugee children when it comes to accessing available medical services in South African health institutions.

### **Data collection or programme methods**

Data gathering involved the following methods:

- The research focused on urban Johannesburg involving 100 accompanied refugee children who were identified through snowball sampling techniques.
- The research design included a review and analysis of international, regional and national literature and documentation on refugee children and refugees in general.
- Quantitative and qualitative methods included personal interviews using semi-structured questions, focus group discussions and questionnaires containing open-ended and close-ended questions.
- Ethical considerations included issues surrounding privacy, confidentiality of information, informed consent, risk and benefit analysis as well as right to participate or not in the study.

### **Study or programme findings**

Findings from the study indicate that:

- 60% of refugee children were found to have limited information on HIV/AIDS, its transmission and prevention.
- Despite guarantees of access to primary medical care without discrimination as specified under international and national legal frameworks, 50% of interviewees reported being refused medical treatment in South African hospitals because their parents could not afford to pay for medication or consultation fees.
- 50% expressed that xenophobic tendencies by nurses and doctors were scaring them away from seeking medication in South African hospitals.
- 80% of interviewees mentioned mental and stress-related problems as major health issues that were confronting their lives in South Africa.
- 20% of refugee girls faced sexual violence and exploitation.
- Refugee girls were found to be unable to deal with family planning issues and more particularly pregnancy.
- Access to food items was seen to be a major health problem to refugee children under study.

### **Conclusion and programme implications**

The study concludes that Central African accompanied refugee children in South Africa face numerous health problems accessing health institutions. It suggests that unless existing health policies are reviewed to ensure access to health facilities their health situation may continue and result in premature deaths.

### **For further information:**

Desire Timngum, Graduate School for the Humanities, Wits University, Private Bag 3, Wits 2050, Johannesburg, South Africa

Telephone: +27826256400 Fax: +27117174040 Email: [Timngum142@yahoo.com](mailto:Timngum142@yahoo.com)

## HIV/AIDS, Gender and Conflict Nexus: The Case of Sierra Leone The Commoditization of Girls and Women

**Authors** Dr. Angela M. Wakhweya, Principal Investigator, Center for International Health, Boston University School of Public Health; Dr. Catherine A. Rielly, Co-Principal Investigator, School of Community Economic Development, Southern New Hampshire University; Monica Onyango, Co-Investigator, Department of International Health, Boston University School of Public Health; Gail Helmer, Co-Investigator, Vermont Department of Public Health.

**Presenter** Monica Onyango and Catherine Rielly

### Background

The HIV/AIDS situation in Sierra Leone, and other countries emerging from decades of conflict, requires a gender analytical framework that seeks to identify the pertinent risks that seriously compound the situation of girls and women.

### Purpose of study or programme

UNIFEM and UNFPA commissioned a case study on the HIV/AIDS, gender and conflict nexus in Sierra Leone to contribute to Progress of the World's Women 2002 Biennial Flagship Report. The aim of the study was to assess the intersection of HIV/AIDS, gender and conflict using a gender analytical framework.

### Data collection or programme methods

The research team designed a semi-structured questionnaire to serve as a guide for field data collection in Sierra Leone. Questions were open-ended and qualitative in nature. The team selected a non-random sample of approximately 30 service providers and key informants and interviewed them with the assistance of the UNFPA office in Freetown. The field survey involved secondary data sources such as key informants and service providers. The BU research team also interviewed other resource persons in the United States who are involved in HIV/AIDS policy in the military, health sector, international organizations and agencies.

### Study or programme findings

Post-war Sierra Leone is a situation with all the key ingredients for spreading HIV infection from high-risk groups into the general population. The first ingredient on the supply side of the equation is desperately poor girls and women, many of whom have lost their families and are struggling for their own survival and that of their children. The second ingredient on the demand side of the equation is approximately 17,000 well-paid expatriate United Nations (UN) peacekeepers, who are young, sexually active and separated from their spouses and families.

The study's central finding is that the convergence of an increase in the *supply* of girls and women willing to engage in survival and commercial sex in post-conflict Sierra Leone, coupled with an unusually large presence of international peacekeepers, increases the *demand* for sex, thereby heightening the risk of HIV/AIDS transmission for both population groups. The result is the commoditization of girls and women in Sierra Leone. The trading of women's bodies for cash, barter or for free threatens to accelerate the HIV/AIDS epidemic among the general population of Sierra Leone in the post conflict period.

### Conclusion and program implications

To reduce women's vulnerability to HIV/AIDS in post-conflict settings, the United Nations is urged to support:

- Women's economic empowerment through poverty reduction strategies,
- Mandatory HIV counseling and testing of peacekeepers.
- A vigorous education, behavioral change and 100% condom use campaign for both girls and women.

### For further information:

Dr. Angela M. Wakhweya, Principal Investigator, Center for International Health and Development, Boston University School of Public Health, 715 Albany Street, T4W, Boston, MA 02118, USA  
Tel: 617-414-1264 Fax: 617-414-1261  
Email: [wakhweya@bu.edu](mailto:wakhweya@bu.edu)

Monica Onyango, Department of International Health, Boston University School of Public Health, 715 Albany St. T4W, Boston, MA 02118, USA  
Telephone: 617-414-1403 Fax: 617-638-4476  
Email: [monyango@bu.edu](mailto:monyango@bu.edu)



## **Strengthening Protection Mechanisms in Conflict and Post-Conflict Settings**

**Authors** Doris Bartel, Technical Advisor, Health & Conflict, Susan Igras, Senior Advisor,  
Reproductive Health, CARE

**Presenter** Doris Bartel

### **Background**

Refugees have the right to "international protection" from UNHCR, which focuses on the legal rights of refugees to safety, access to procedures to determine refugee status, the principle of *non-refoulement*; and humane standards of treatment. Many international agencies are working to expand the definition of protection, and articulate the ways that protection against gender based violence and exploitation can be incorporated into multi-sectoral programs, particularly for internally displaced persons and "internally stuck" persons, who may not be afforded the same international protection by international law.

### **Purpose of study or programme**

To document current and better practices for integrating protection mechanisms against gender-based violence and exploitation into multi-sectoral programs targeting populations affected by conflict.

### **Data collection or programme methods**

CARE undertook a review of mechanisms that could be used in programming targeting populations affected by conflict. This included a survey of five country-office experiences and qualitative data collection of current and "better practices" for protection mechanisms.

### **Study or programme findings**

Agencies are looking at the following mechanisms for improving protection mechanisms into their operations:

- Codes and standards of staff conduct that reflect standard components of action
- International witnessing of human rights abuses
- Operationalizing definitions, attributes, and degrees of harm
- Integrated systems for assessing, monitoring and evaluating protection mechanisms into programming, including the following components:
  - Sensitizing both staff and program participants to the rights and responsibilities of all parties to ensure distribution systems free of discrimination, harassment and exploitation;
  - Ensure gender balance in field staff, especially in activities related to distribution of goods and services;
  - Rotate distribution teams, so no one team returns regularly to the same community/camp;
  - Incorporate surprise inspections by administration staff in program monitoring activities;
  - Female "safe reporting" teams, perhaps made up of older trusted women;
  - An ombudsman with no other implementing role.

Such protection efforts need to be framed in the context of culturally-defined definitions of exploitation in order to be relevant and understood by those involved in programs and those who receive services.

### **Conclusion and programme implications**

All humanitarian agencies can and should contribute to implementing protection mechanisms for vulnerable groups affected by conflict. Codes of conduct are not sufficient for ensuring protection of women, children and other vulnerable groups against gender based violence and exploitation.

### **For further information:**

Susan Igras, CARE, 155 Ellis Street NE, Atlanta, GA 30303, USA

Telephone: 1 404-979-9158

Email: [igras@care.org](mailto:igras@care.org)

## **Behavior Change Communication (BCC) Strategies for HIV Prevention in a Post-Conflict Setting**

**Authors** Tekleab Kedamo MD, American Refugee Committee (ARC); Laura Moch MPH, ARC; Philip Sedlak PhD, FHI; Basilica Keji MD, International Rescue Committee (IRC)

**Presenter** Laura Moch

### **Background**

Decades of civil war in southern Sudan has led to the destruction of community and family structures, resulting in societal changes and increased risks and vulnerability of the population to HIV. Reproductive Health (RH) knowledge and condom use is low, coupled with lack of appropriate RH services and low media availability. ARC International, along with IRC and the New Sudan National AIDS Council, implemented an HIV prevention pilot project in Yei and Rumbek Counties, Southern Sudan.

### **Purpose of study or programme**

The goal of the project was to develop appropriate strategies for reducing the transmission of HIV and improving related reproductive health services in the project locations.

### **Data collection or programme methods**

The project developed a behavior change communication (BCC) strategy based on formative research in order to create awareness, improve knowledge, create demand for and improve access to products and services. With technical assistance from Family Health International (FHI), a BCC formative assessment was conducted using qualitative methods (key informant interviews, in-depth interviews and focus group discussions) to establish the knowledge, attitudes and behaviors of target populations. The audience was segmented into women, youth in school, youth out of school and military. A BCC strategy development workshop presented the results of the formative assessment to the key stakeholders and members of the target audiences. Participants identified behaviors to change, such as increase condom use, go for voluntary counseling and testing (VCT), treat STIs and reduce partners, and drafted key messages for each target audience. Peer Educators (PEs) were trained for each target audience in HIV/AIDS prevention, condom distribution and referrals to services including VCT and STI treatment. Posters were developed for each target audience. Qualitative research was used to select and fine-tune messages. Messages included "Be at Peace, Use Condoms", "Avoid Problems, Use Condoms", "Protect your family, go for VCT", and "Use condoms today, have a healthy family tomorrow". A simple monitoring system was set up to track PE monthly activities, condom distribution, materials distribution and referrals.

### **Study or programme findings**

RH services are limited and HIV awareness is very low, coupled with many social and cultural activities that place people at risk for HIV such as polygamy, drinking, smoking of marijuana and opium, traditional healing practices (scarification, etc.), and women and girls engaging in sex for money or favors. Sex with multiple partners is very common. Condom use is very low, and condoms were not readily available at the start of the project. A BCC Strategy was developed with the theme "New Weapons for a New Enemy." Demand was created for services (weapons) such as STI syndromic treatment, VCT and condoms through PEs, flyers, brochures, and posters. PEs were trained from both locations to educate peers on HIV/AIDS, refer peers to services and promote and distribute condoms. PEs were provided with flipcharts, education materials, condoms and bicycles to facilitate their movement. Each PE received monthly incentives such as soap, dictionaries, t-shirts, hats and notebooks. Posters were developed based on messages identified during the BCC strategy Development Workshop, and pre-tested for both the message and picture content. Posters were distributed to create demand for services and included messages on condom use and VCT.

### **Conclusion and programme implications**

Southern Sudan is a resource-poor setting with little media available. Use of qualitative research ensured that messages and channels were tailored to each audience. Peer Educators must be carefully selected by their communities and be semi-literate in English in order to complete monitoring forms. PEs were in high demand and were thus seen by the community as full-time educators. Programs should plan accordingly when providing incentives for PEs. Print messages took into account the low-literacy of the audience, and used pictures that show behavior change in action, coupled with messages in several local languages. It is imperative to ensure that supply can meet demand (VCT, Condoms) before initiating BCC activities.

### **For further information:**

Laura Moch, ARC International, Box 7868, Kampala, Uganda  
Telephone: (256) 41 349091/4/5/6 or (256) 77932053 Fax: (256) 41 349147 Email: [arc4@africaonline.co.ug](mailto:arc4@africaonline.co.ug)

## **Adapting *Advance Africa's* Strategic Mapping Approach To A Post-Conflict Setting: The Case Of Angola**

**Authors** Issakha Diallo and Bérengère de Negri, Advance Africa  
**Presenter** Bérengère de Negri

### **Background**

Angola is emerging from 40 years of war. This has negatively affected the health status of the population with an infant mortality rate of 195 per 1000 live births and a maternal mortality rate of 1,854 per 100,000 live births. Ante-natal care is not widely available; the use of family planning is low. The overall contraceptive prevalence rate varies from 0.5% to 8% depending on the geographical area.

### **Purpose of study or program**

The Ministry of Health asked Advance Africa for technical assistance to undertake a qualitative participatory assessment to determine people's ideas, perception and beliefs regarding the current status of family planning (FP) in the country. The research team focused its efforts in three provinces: Luanda, Benguela and Huambo.

### **Data collection or program methods**

Advance Africa applied its strategic mapping exercise, using its triangulation approach: (1) consensus between decision-makers and stakeholders; (2) focus groups and interviews; and (3) site observations. A total of 30 taped focus groups of adolescents, men, women, nurses, traditional birth attendants, along with more than fifteen semi-structured individual interviews of key informants (religious and communities leaders, political decision makers, heads of NGOs and international communities), and more than ten health centers - site observations allowed the pointing out of key factors of the low utilization and conditions of the existing FP services. The qualitative data collection, management and analysis were quite participatory, preceded by a hands-on-training.

### **Study or program findings**

Women blame men for preventing them from using FP by saying that if not pregnant, their husband will find another woman. Men say that it is women's matters to use FP and that Angolans like large families. Women working at the market place realize that having children will put them on the street, as they have to work. Pregnancy also prohibits them from carrying on business. They ask for FP, advice and counseling, as they want a better future for these children and for themselves.

Overall key factors of the low utilization of the existing FP services are:

- Poverty, perceived as a major issue of access to services
- Low status of women and low power
- Huge unmet FP needs
- Strong influence by the church against modern contraceptive methods
- Cultural tendency to want large families
- Little responsibility by men on FP
- Men have little respect for women's [FP] decision
- Youth have little access to RH/FP services

Quality of RH/FP services is poor. Nurses do not have basic means to deliver good services; traditional birth attendants do not receive support/training to respond more efficiently to their responsibility. The youth are begging for information, counseling and RH/FP services.

### **Conclusion and program implications**

The quality of health services is poor; FP demand is limited. Access to health services is problematic and sustainability is hypothetical. The Advance Africa team will work closely with the MOH in 13 health centers in Huambo and their communities through (a) integration of FP services in HIV/AIDS and MCH services; (b) decentralization of FP services; (c) community development and partnership, and (d) multi-sectoral collaboration with agencies.

### **For further information:**

Bérengère de Negri, Advance Africa, 4301 N Fairfax Drive, Suite 400, Arlington VA 22203, USA  
Email: [bdenegri@advanceafrica.org](mailto:bdenegri@advanceafrica.org)

## **Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Persons**

**Authors** Sandra K. Krause, Reproductive Health Project Director, Women's Commission for Refugee Women and Children; Claire Morris, Regional Director-Latin American Programmes, Marie Stopes International; Therese McGinn, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University

**Presenter** Sandra Krause

### **Background**

Representatives from the Women's Commission for Refugee Women and Children, Marie Stopes International, Columbia University Heilbrunn Department of Population and Family Health with support from the local nongovernmental organization, Profamilia, conducted a reproductive health assessment in Colombia in November 2001.

### **Purpose of study or programme**

To identify reproductive health needs among the internally displaced persons (IDP) in Colombia and to advocate their access to comprehensive good quality, voluntary reproductive health services.

### **Data collection or programme methods**

The assessment was initiated with desk-top research to determine the existing reproductive health status of Colombians and IDPs. The assessment team then traveled to Barranquilla, Bogotá, Cartagena, Quibdó and Putamayo and obtained information through observation, interviews, meetings and focus groups with IDPs, host-country and international relief representatives and donors.

### **Study or programme findings**

The Minimum Initial Services Package (MISP) of reproductive health services, a standard of care for the early phase of an emergency, is not available to IDPs in Colombia. Representatives of UN agencies, human rights groups and IDP women themselves described numerous incidents of gender-based violence, including sexual exploitation, sex to meet survival needs, rape often followed by murder by armed actors. Free services, including emergency contraception, are not available to manage and support survivors of violence. Currently there is no distribution of MISP kits, including clean delivery supplies to pregnant women. A number of women told assessment team members stories of being turned away from hospitals for childbirth, including for emergency services.

The circumstances for adolescent IDPs is dire, and very little is being done to recognize their specific needs and capacities. Some adolescent girls seek solace and comfort from motherhood, while others would prefer to avoid or delay pregnancy suggesting a need, currently unmet, for family planning. A study conducted by Profamilia in 2000 indicated that 30% of adolescent IDPs were already mothers or pregnant with their first child, a percentage nearly twice that of adolescents in Colombia's general population.

### **Conclusion and programme implications**

The assessment team findings indicate significant reproductive health needs among the IDP population with an alarming dearth of services available to them. The Colombian Ministry of Health, United Nations agencies, international organizations such as the International Committee of the Red Cross and others should provide significantly more financial and technical support for reproductive health care to IDPs.

### **For further information:**

Sandra K. Krause, Director, Reproductive Health Project  
Women's Commission for Refugee Women and Children  
122 E. 42<sup>nd</sup>, 12<sup>th</sup> Floor, New York, NY 10168, USA  
Telephone: 1 212.551.3110  
Fax: 1 212.551.3180  
Email: [sandra@womenscommission.org](mailto:sandra@womenscommission.org)

## **The Population Affected by the Humanitarian Crisis in Colombia: A Response with a Development Perspective**

**Authors** Carlos Iván Pacheco & Mercedes Borrero, UNFPA

**Presenter** Carlos Iván Pacheco

### **Background**

In peri-urban zones of Colombian cities, hundreds of thousands of internally displaced persons (IDPs) live in extreme poverty, unable to access government-supported RH services. In remote rural areas, many people's access to RH services is restricted by ongoing fighting, similarly putting them at risk for unwanted pregnancies, HIV/AIDS/STIs and other RH-related conditions.

### **Purpose of study or programme**

Evidence shows that IDPs are at greater risk of suffering violations of their sexual and reproductive rights. Within a human rights framework, and working with the strengths of the existing health system, UNFPA has initiated a project in Colombia to address the sexual and reproductive health (SRH) needs of IDPs, with a focus on adolescents.

### **Data collection or programme methods**

The project entails the collection of baseline data to design response interventions and evaluate progress towards objectives. It also includes a set of activities that have been underway for 18 months, though these will no doubt be modified based on what is learned through the baseline data.

Data is being collected on health institutions and the RH status of IDP communities in 4 cities: Barranquilla, Cartagena, Sincelejo, and Villavicencio. The institutional data is being collected with local health teams, while the community research involves structured in-depth interviews on aspects of SRH in squatter settlements.

### **Study or programme findings**

Analysis of baseline data for Barranquilla, Cartagena and Sincelejo is being completed and will be presented in the conference. Some preliminary activities have been initiated, based on the findings. The 2 main areas of project activities include 1) institutional strengthening, and 2) actions to more directly improve the status of IDPs.

1. Institutional strengthening involves providing technical assistance so that public sector institutions in health, education and justice in receiving communities are better prepared for IDPs' arrival. It has included training in technical areas, norms, and guidelines for providing services in SRH and in prevention and management of gender-based violence.

At this time, the local health teams in the 4 cities now understand the phenomenon of displacement and the differential impacts this has on IDPs' SRH. They have developed and begun carrying out activities to improve services for IDPs.

2. In the area of improving the situation of IDPs, UNFPA has developed alliances with local NGOs, the Church and other UN agencies (especially WFP and UNHCR) to achieve the integration of emergency needs for food, housing and basic sanitation services with needs for SRH. [For adolescents, it means ensuring that they have access not only to SRH services but also to education, cultural activities, income generation and leisure activities.]

### **Conclusion and programme implications**

Interventions in the area of SRH for IDPs in Colombia require institutional development so that the State will assume its responsibility for providing the MISAP in emergency situations and integrated RH services in periods of stability.

Meeting the needs of especially vulnerable adolescent IDPs in the area of SRH requires providing services and helping ensure their access through capacity building among local health institutions. These interventions are most effective when integrated with others for education, housing and basic sanitation services.

### **For further information:**

Mercedes Borrero, Assistant Representative UNFPA Colombia, Apartado Aéreo No. 091369, Bogotá  
Telephone: 57-1-488-9012 Fax: 57-1-376-0166 Email: [mercedes.borrero@undp.org](mailto:mercedes.borrero@undp.org)

## Implementing Community-Based YRH Projects in Burundi

**Authors** Mr Stany Niyonzima, Project Officer, CARE International in Burundi

**Presenter** Stany Niyonzima

### Background

CARE intervient au Burundi depuis 1994 dans plusieurs secteurs, y compris dans l'humanitaire et la relance des activités économiques et sociales. C'est dans ce cadre qu'un programme pilote d'éducation sexuelle et reproductive, adressé particulièrement à la jeunesse victime des conflits socio-politiques que ce pays vit depuis 1993, a été initié. La situation d'instabilité sociale est aggravée par le VIH/SIDA qui, selon l'étude la plus récente, atteint actuellement une séroprévalence de 9.4% en zone urbaine, 10.5% en zone semi-urbaine et de 2.5% en zone rurale.

L'étude montre une évolution croissante de la séroprévalence selon l'âge. Elle est faible entre 12 et 14 ans avec des taux de 1.5%, 4.2% et 0.0% respectivement en milieu urbain, en milieu semi-urbain et en milieu rural. La séroprévalence augmente dès l'âge de 15 à 24 ans avec respectivement 4.0%, 6.6% et 2.2% en zone urbaine, semi-urbaine et rurale. Elle est maximale dans la tranche d'âge entre 25-34 ans en zone semi-urbaine et dans celle entre 34-44 ans en zone urbaine et rurale avec respectivement 15.9%, 16.1% et 4.0 %.

### Purpose of study or programme

Intégrer dans les interventions de Care Burundi un programme d'éducation sexuelle et reproductive en faveur des jeunes (14-28 ans), en vue de renforcer sa capacité de se prémunir (a) des rapports sexuels précoces, (b) des grossesses non désirées, (c) des MST/VIH/SIDA, et (d) d'adopter un comportement sexuel responsable. Le programme vise également la conscientisation des adultes sur leur rôle de respecter et protéger la santé sexuelle des plus jeunes et/ou des plus vulnérables

### Data collection or programme methods

Trois approches méthodologiques ont été privilégiées.

1-La formation des formateurs choisis parmi les encadreurs des centres d'accueil des enfants de la rue, des orphelins, des handicapés et des incarcérés. Ces formateurs ont pour mission la formation et la conscientisation des jeunes sur le comportement sexuel responsable.

2-Les pairs éducateurs qui sont les membres du groupe, volontaires ou choisis par les autres membres de leurs groupes selon les critères de popularité, de respect et leadership dans leur groupe, et qui ont pour mission l'éducation et la communication liée à une confiance réciproque.

3-Le renforcement des capacités organisationnelles et opérationnelles qui s'applique aux organisations qui s'occupent de l'éducation à la santé sexuelle et reproductive qui ont été choisies selon leur accessibilité pour la jeunesse en difficulté. Certaines organisations des adultes sont également ciblées pour conscientiser les adultes sur le respect et la protection des droits des jeunes.

### Study or programme findings

Ces approches ont permis d'atteindre 1000 jeunes garçons et filles, de former :

- 70 formateurs issus de 10 centres d'accueils des enfants en difficultés, de 14 associations féminines et de 6 collectifs d'associations.
- 90 pairs éducateurs sont à l'œuvre dans les centres d'accueils et dans les écoles
- 3 organisations de prise en charge des victimes du SIDA ou des violences sexuelles ont été renforcées pour pérenniser les acquis.
- 4 organisations des adultes à savoir : Le corps de police, le syndicat des enseignants, la Ligue des Droits de l'homme et le Conseil des parents des élèves ont été conscientisées pour intégrer dans leurs programmes le respect et la protection des droits jeunes et des pauvres en ce qui concerne l'exploitation sexuelle. Un programme de plaidoirie a été établi auprès du Ministère de l'Education en vue de décourager l'exploitation sexuelle des élèves.

Quelques actions concrètes ont pu être menées par les communautés :

- L'implication des comités des parents dans l'évaluation des examens des élèves pour contrecarrer les enseignants qui exploitent sexuellement les filles contre une bonne note
- Suite à la sensibilisation des comités de parents, deux clubs d'exploitation sexuelle des jeunes en Mairie de Bujumbura ont été dissous
- Les enfants qui habitent les centres d'accueil se sont mieux ouverts à leurs pairs éducateurs et à leurs

encadreur pour exprimer leurs problèmes liés au sexe

#### **Conclusion and programme implications**

C'est possible d'intégrer des activités de santé reproductive de jeunes dans les programmes disant 'non-santé.' Le projet a permis au staff et aux autres adultes de mettre au découvert les comportements des adultes qui influencent négativement celui des jeunes et vice versa. Le projet a ouvert les esprits sur les problèmes qu'affrontent la jeunesse Burundaise qui sont notamment :

- Les grossesses précoces et non désirées ;
- Les violences sexuelles de plusieurs natures, particulièrement dans les zones de conflits ;
- L'exploitation des jeunes par les adultes par multiples voies ;
- La prostitution due à la pauvreté.

Parmi les causes principales qui ont été identifiées il y a :

- L'absence de l'éducation familiale ;
- Le conflit persistant au Burundi qui occasionne beaucoup de violences ;
- La dégradation des mœurs, particulièrement dans le milieu scolaire ;
- La tolérance de la société face aux auteurs des abus sexuels.

#### **For further information:**

Stany Niyonzima, CARE-Burundi, c/o CARE, 151 Ellis Street, Atlanta, GA 30306, USA  
Email: [sniyonzima@careburundi.org](mailto:sniyonzima@careburundi.org)

## Posters

<b>Presenter</b>	<b>Title of Presentation</b>
Naomi A. Nyitambe	UNHCR/UNICEF/IP's ASRH intervention in the Western Tanzania Refugee Operation
Therese McGinn	The Effects of War on Reproductive Intentions and Behavior: The Case of Rwanda
Yayoi Takei	The Cases of Adolescent Pregnancy and its Impact in the Congolese Refugee Camps in Kigoma Region, Tanzania
Sara Casey and S. Suriyamurthy	Reproductive Health Needs Assessment in Northern Sri Lanka
Grace Odion	Needs Assessment for the Delivery of Family Planning Services in Oru Refugee Camp - Nigeria
Athanase Nzokirishaka	Le recensement des populations déplacées au Burundi



## **UNHCR/UNICEF/IP's ASRH intervention in the Western Tanzania Refugee Operation**

**Authors** Naomi A. Nyitambe: Reproductive Health Assistant (Refugee Operation) UNHCR Tanzania  
**Presenter** Naomi A. Nyitambe

### **Background**

Tanzania is home to 509,751 refugees from DRC and Burundi (June, 2003 HIS), a situation that exposes youths/adolescents to sexual and reproductive health risks. UNHCR piloted Adolescent Sexual Reproductive Health (ASRH) programs in two camps in the year 2000. With UNICEF support, activities were expanded to the remaining 10 camps.

### **Purpose of study or programme**

To create a positive environment for 95% of adolescents/youth to have correct ASRH information, increase number of youth/adolescents freely accessing services at multi-purpose, youth-friendly centers by providing recreation activities, family planning, treatment of STIs, counseling and voluntary counseling and testing (VCT).

### **Data collection or programme methods**

- UNHCR hired a consultant for the initial assessment for pilot sites.
- The pilot sites identified were Nyarugusu for the DRC and Lukole for Burundian refugees
- Multi-sectoral approach by training staff to provide youth-friendly services
- Youth/adolescents participated holistically in developing ASRH PHE/Life Skills TOT training manual including IEC materials and script for puppet/drama show
- UNICEF, in collaboration with UNHCR, expanded the ASRH intervention to the remaining 10 camps, including the construction of multi-purpose, youth-friendly centers
- Linkage with HIV/AIDS prevention
- Strategies to strengthen girls' participation

### **Study or programme findings**

- 5,182 youth out of 40,152 from 5 camps used VCT services, and 88 (1.5%) were found to be HIV positive
- Use of PHE has contributed to the wide sharing of ASRH information. Each camp has youth leadership
- Effective use of the manual developed by youth/adolescents with community help has shown sense of ownership
- 186 youth were treated for STIs in July 2002 while 239 were treated in July 2003, representing an increase of 28%
- In July 2002, 121 youth used VCT as compared to 367 in July 2003, an increase of 67%
- Increased girls' participation over time

### **Conclusion and programme implications**

The partnership with youth/refugee CORP's, IP's and the collaborative efforts between UNHCR/UNICEF outcome are felt. This model of assisting youth considers them potential resources and not problems. The intervention has been found to be of paramount importance, and it is advocated to continue so as to have responsible youth.

### **For further information:**

Naomi Nyitambe, UNHCR KIBONDO, P.O. Box 13, Kibondo, Tanzania  
Telephone: 255 28 2820217  
Fax: 255 28 2820223  
Email: [nyitambe@unhcr.ch](mailto:nyitambe@unhcr.ch)

## **The Effects of War on Reproductive Intentions and Behavior: The Case of Rwanda**

**Authors** Therese McGinn, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University  
**Presenter** Therese McGinn

### **Background**

Data on the effects of war on fertility have been limited and somewhat contradictory. Understanding is limited by the overall lack of data as well as the difficulty of isolating the effects of war on health service delivery, its effects on individuals' reproduction-related attitudes and behaviors, themselves influenced by war, and the more familiar socio-demographic variations normally found among and between population groups.

Rwanda's pre-war national family planning program began in the early to mid-1980s and was relatively strong. The contraceptive prevalence rate was lower in the post-war (2000) than in the pre-war period (1992) as measured by DHS.

### **Purpose of study or programme**

The current study was an attempt to understand the factors influencing the change in prevalence.

### **Data collection or programme methods**

Secondary analysis of the 2000 DHS cross-sectional health and demographic survey and a 2001 DHS service availability survey in Rwanda was the principal method used. Additional data on the degree to which specific prefectures and communes were affected were culled from refugee movement and repatriation data and included in the analysis.

### **Study or programme findings**

The analysis suggested that several factors have influenced post-war reproductive behavior in Rwanda. These include the degree to which individuals' area of current residence (in 2000) was affected by the war (as measured by the level of population movement); health service availability and quality; and the familiar socio-demographic characteristics such as age, parity, education and prior contraceptive use. The relative contribution of these factors to the prevalence decline are discussed.

### **Conclusion and programme implications**

The analysis suggested that despite the national and individual trauma suffered in the war and in the post-war period, there is a demand for family planning services in Rwanda that is not fully met by existing services.

### **For further information:**

Therese McGinn, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, Center for Global Health and Economic Development  
215 West 125th Street, 3rd Floor, New York, NY 10027, USA  
Telephone: 1 646 284 9668  
Fax: 1 646 284 9684  
Email: [tjm22@columbia.edu](mailto:tjm22@columbia.edu)

## **The Cases of Adolescent Pregnancy and its Impact in the Congolese Refugee Camps in Kigoma Region, Tanzania**

**Authors** Yayoi Takei MD, Health Delegate Lugufu, International Federation Red Cross and Red Crescent; Marwa Mtalai, RN, Reproductive Health Manager Lugufu, Tanzanian Red Cross and Red Crescent Society (TRCS); Justin Lugoi, MD, MPH, Health coordinator Lugufu, TRCS

**Presenter** Yayoi Takei

### **Background**

Adolescent pregnancy is regarded as a risk for both mother and foetus. Recently we had an 18 year old Congolese girl having the second Caesarean Section (CS) due to Cephalo Pelvic Disproportion (CPD) one and half years after the previous CS in the dispensary in Lugufu I refugee camp, Kigoma, northwest of Tanzania. If a woman has more than one CS in her teenage years, she will only be able to conceive one or more pregnancies for her rest of her life, and may develop the risk of rupture of the uterus during the next pregnancy or gross adhesion during laparotomy.

### **Purpose of study or programme**

To know the incidence and circumstances of young refugee girls becoming pregnant and having a CS operation at a young age, even for a second time within a short interval. Does their situation as refugees influence adolescent pregnancy? How can we prevent this high risk pregnancy occurring among young Congolese girls?

### **Data collection or programme methods**

A preliminary retrospective study was done to look at all deliveries of both Congolese and Tanzanian women in the registration book and patient charts in Dispensary 1 at Lugufu camp in February 2003. Tanzanian women come from villages outside the camps. The information collected consisted of name, date, delivery time, age, address, gravidity, parity, mode of delivery and placenta, amount of blood loss, situation of peritoneum, postpartum blood pressure, treatment given and duration of hospitalization of mother, body weight, sex, Apgar score and condition of newborn babies.

### **Study or programme findings**

The total number of Congolese deliveries in Dispensary 1 was 142, of which 21 deliveries were by CS (CS ratio: 14.8%). The numbers of Congolese deliveries to women under 18 years, 19-24 years and older than 25 years are 42 (29%), 43 (31%), and 57 (40%) respectively, and CS was done in 6 women (CS ratio: 14.3%), 7 (16.2%) and 8 (14.0%) respectively. The youngest primigravidae was 14 year old. Of six CS under 18 years old, four CS were done in primigravidae due to CPD and foetal distress. Two second CS were done in gravidae 2 and 3 in Congolese women under 18 years old. The total number of Tanzanian women delivered was 14 (9.7% of whole deliveries), of which CS was done in 2 women at the age of 18 and 28. Although the number of Tanzanians was small, compared with Congolese refugee women there is a tendency of older age and less gravidae.

### **Conclusion and programme implications**

The lowest rates of maternal and perinatal morbidity and mortality occur at maternal age of 20-29 years. Thus younger women are at greater risk. We found from our small preliminary survey that almost 30% of deliveries were done in women between 14 and 18 years old, an age when they still need to develop and grow physically and mentally. What is worse, in spite of health education about contraception for a certain period after CS, given at their discharge from the Dispensary, an immediate next pregnancy is often observed.

We are conducting a survey on a larger scale to gain more accurate data, compare it with the Tanzanian population outside the camps, do statistical work with the literature, and consider what is needed to prevent this high risk adolescent pregnancy.

### **For further information:**

Yayoi Takei, c/o Tanzanian Red Cross and Red Crescent Society, PO Box 101, Kigoma, Tanzania  
Email: [ifrcz05@ifrc.org](mailto:ifrcz05@ifrc.org) and [myayoi@yahoo.com](mailto:myayoi@yahoo.com)

## **Reproductive Health Needs Assessment in Northern Sri Lanka**

**Authors** Sara Casey, Heilbrunn Department of Population and Family Health, Columbia University; S. Suriyamurthy, Population Services Lanka

**Presenter** Sara Casey and S. Suriyamurthy

### **Background**

For the past 20 years, the Liberation Tigers of Tamil Eelam (LTTE) fought a brutal civil war against the majority Sinhalese government. A Memorandum of Understanding, signed in February 2002, and subsequent peace talks led to increased access to areas under LTTE control in the North and East.

### **Purpose of study or programme**

The purpose was to undertake an assessment of the current reproductive health situation in the LTTE-controlled areas of Sri Lanka in the light of the recent peace process.

### **Data collection or program methods**

Sites were visited in Mannar, Vavuniya and Kilinochichi districts. Assessment activities included health facility visits, focus groups with women and discussions with service providers.

### **Study or programme findings**

Health services, including for reproductive health, and health facilities are not adequately available in the North and East.

**Safe Motherhood:** Women have good knowledge and health-seeking behavior. A severe shortage of midwives and doctors combined with the destruction of many health facilities leaves women without access to necessary services.

**Family Planning:** Many women use family planning and expect it to be available. Access must be improved in many areas. Some women expressed fear of an earlier LTTE ban on the use of FP.

**HIV/AIDS/STIs:** Knowledge is very low. Condoms are not common. Few AIDS awareness programs are being implemented. STI treatment is rarely available.

**Gender-based violence (GBV):** Some women reported that rape was common in areas under army control. Domestic violence is reportedly a widespread problem. No formal services are available for survivors of GBV.

**Adolescent RH:** Little attention is focused on adolescents who, according to social mores, are not supposed to be sexually active.

### **Conclusion and programme implications**

Health services, including RH, are sorely lacking in the North and East of Sri Lanka. This must be addressed as the pace of returning internally displaced persons and refugees accelerates. Positive health behaviors may be discouraged if the services people seek are not available. RH services should be integrated into the primary health care system, and provided with adequate resources.

### **For further information:**

Sara Casey, Center for Global Health and Economic Development, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University  
215 W. 125<sup>th</sup> Street, 3<sup>rd</sup> floor, New York, NY 10027 USA  
Tel: 1 646-284-9675  
Fax: 1 646-284-9684  
Email: [sec42@columbia.edu](mailto:sec42@columbia.edu)

## **Needs Assessment for the Delivery of Family Planning Services in Oru Refugee Camp - Nigeria**

**Authors** Grace Odion, Peace Foundation International  
**Presenter** Grace Odion

### **Background**

The Oru refugee camp is home to over 10,000 refugees from different parts of Africa, and an unverifiable number of internally displaced people in Nigeria. The available services such as housing, health, water, etc. are overwhelmed by the sheer number of persons to be served. Consequently, their needs and preferences are hardly considered when planning delivery. In Oru Camp, there is a very low level of family planning acceptance while failure rates are high.

### **Purpose of study or programme**

If a family planning service provider is to achieve its set goal in Oru refugee camp, it must undertake an assessment of the situation of family planning and the needs and preferences of refugees. The goal of this study is to document the specific family planning services available, the preferred choices of refugees and displaced people from the perspective of a more people relevant and effective family planning delivery programme.

### **Data collection or programme methods**

The data for this paper were obtained by the utilization of 3 main research methods/data collection instruments. This analysis is based on interviews with over 1,500 refugees and internally displaced people. In addition, 20 in-depth interviews were held with the service providers. Finally, focus group discussion held with refugees provided sharper insights into their particular family planning problems and preferences that were hitherto unattended to by the service provider. They were asked questions relating to their access to family planning services, availability of method choices, effectiveness of the services and most preferred means of obtaining information on family planning.

### **Study or programme findings**

The results of these analyses should be of value for upgrading the services offered by the Family Planning Programme.

The types of family planning services available were chosen by the service providers. The social and health workers at present are less successful in promoting family planning services with the refugees, especially with women. This is a sensitive issue, although some women are secretly receptive of its adoption if they have access to family planning services.

There is a statistically significant difference between the type of family planning services available and the preferred family planning choices by the refugees.

Gender, education and age proved to be significant factors in the level of family planning acceptance among the refugees. There is a very low level of family planning acceptance while failure rates are particularly high amongst female pill users.

The most preferred means for disseminating family planning information and materials is person to person contact via the use of peer group. Although there is apparent awareness of the family planning services, the level of ignorance is quite severe.

### **Conclusion and programme implications**

The current analysis shows that refugees' needs for family planning can no longer be taken for granted, as they vary by age and gender and are affected by the peculiar circumstances that made them refugees. The need for family planning service providers to plan with the beneficiary refugee community is very crucial for programme success in Oru.

### **For further information:**

Grace Odion, Peace Foundation International, AREF Complex, Old Secretariat, GRA. Ikeja, Nigeria; P.O. Box 1006, Festac Town, Lagos, Nigeria  
Email: [peacenet3@yahoo.com](mailto:peacenet3@yahoo.com)

## **Le recensement des populations déplacées au Burundi**

**Authors** Mr Athanase Nzokirishaka, Assistant Representative, UNFPA/Burundi  
**Presenter** Athanase Nzokirishaka

### **Background**

Le recensement des personnes déplacées réalisé au Burundi en juillet - août 2003 s'inscrivait dans le cadre des travaux préparatoires d'une enquête nationale socio-démographique et de santé de la reproduction exécutée avec l'appui financier et sous la coordination de l'UNFPA. Cette enquête, qui a touché 7.500 ménages, était organisée selon trois strates : « urbain », « rural » et « population déplacée ». Pour pouvoir tirer un échantillon représentatif de la population déplacée, il a été décidé de procéder d'abord au recensement exhaustif des personnes déplacées, puisqu'avant cette opération, les données sur ces personnes étaient disparates et différaient selon les sources.

### **Purpose of study or programme**

Le recensement des déplacés avait le double objectif de fournir une liste exhaustive des camps de déplacés dans le pays, et donc une base de sondage pour le sous-échantillon « population déplacée » de l'enquête d'une part et, d'autre part, mettre à la disposition de l'administration et de la communauté humanitaire des données élémentaires mais fiables sur cette catégorie de la population.

### **Data collection or programme methods**

Un questionnaire léger a été utilisé pour collecter des informations sur la population déplacée, concernant les 7 variables suivantes : nom, prénom, sexe, âge, année de naissance, lieu de naissance, date d'arrivée dans le site. L'identification des sites de déplacés a été faite à partir d'une liste de déplacés publiée récemment par OCHA, UNICEF et PCAC/PNUD. Le département de la population, qui exécutait le projet, a alors réuni les antennes provinciales de l'état civil pour compléter cette liste. Au cours de cette réunion, on a pointé sur chaque carte administrative provinciale les sites de déplacés qui s'y trouvaient. Il s'en est suivi la numérotation de tous les sites de déplacés alors identifiés dans l'ordre alphabétique des provinces. Des corrections ont encore été apportées à la liste au cours du travail de terrain, de sorte qu'au total, 230 sites de déplacés ont été recensés. Chaque agent recenseur devait numérotter et recenser les ménages un par un, ensuite les personnes y résidant, en prenant soin de n'oublier personne et d'éviter les doubles comptes.

### **Study or programme findings**

Le dépouillement exhaustif des déclarations au recensement réalisé en juillet—août 2002 a permis de dénombrier 281.628 personnes déplacées dans 230 sites situés sur 213 collines dans 78 communes et dans 3 zones de la mairie de Bujumbura. La répartition spatiale des personnes déplacées montre que seule une province sur 17 n'a pas de site de déplacés, que 2 provinces regroupent à elles seules la moitié des personnes déplacées et que seulement 7 communes sur les 129 que comptent le pays concentrent la moitié des déplacés. La population déplacée est à dominante nettement féminine avec un sexe ratio de 89 hommes pour 100 femmes contre 94 hommes sur 100 femmes au dernier recensement national de la population. Ce déficit d'hommes est le plus important dans les tranches d'âge 20-24 ans (79.7%) et 25-29 ans (76.4%) La pyramide des âges fait apparaître un déficit d'enfants au sein de la population déplacée, aux jeunes âges (0-4 ans et 5-9ans). Ce déficit serait expliqué à la fois par une surmortalité infantile et juvénile due aux mauvaises conditions d'hygiène d'une part et d'autre part par un recul de la fécondité parmi les populations déplacées suite à la déstructuration des familles et à une forte mortalité intra-utérine. L'enquête proprement dite, dont l'exploitation est en cours, pourra confirmer ou infirmer ces hypothèses de même qu'elle fournira davantage d'informations sur les caractéristiques socio-démographiques et de la santé de la reproduction de ces populations.

### **Conclusion and programme implications**

Ce recensement a permis de fournir des informations simples mais très utiles, directement utilisables par les différents intervenants dans l'action humanitaire et la reconstruction. Ainsi, l'UNFPA est entrain de finaliser un document de projet visant la fourniture de services de santé de la reproduction, qui couvrira les 7 communes regroupant la moitié des populations déplacées du Burundi. Ces données, qui seront complétées par celles de l'enquête, sont essentiellement quantitatives. Couplées avec d'autres informations provenant d'enquêtes qualitatives, tel l'évaluation des besoins en santé de la reproduction des personnes sinistrées menée en province de Makamba en 2001, elles permettent de mieux connaître les populations déplacées, leurs caractéristiques socio-démographiques ainsi que leurs besoins dans le domaine spécifique de la santé de la reproduction.

### **For further information:**

Athanase Nzokirishaka, UNFPA, P.O. Box 1490, Bujumbura, Burundi  
Telephone: 257-223098 Fax: 257-229581 Email: [nzokirishaka@unfpa.org](mailto:nzokirishaka@unfpa.org)

## Participant List

Name	Organization	Email	Work Phone
Aguti, Evelyn	UNHCR Kampala	aguti@unhcr.ch	256-41-23-229
Ahmed, Zeinab	CARE Kenya	zeddie@ddb.care.or.ke	254-46-2060/2529
Alli, Lookman	Nigerian Ministry of Health	lookman_alli@yahoo.com	
Assefi, Nassim	University of Washington School of Medicine	nassefi@u.washington.edu	1-206-731-4029
Awiti, Cyprian	Marie Stopes Kenya	sss@africaonline.co.ke	25-42-570-139
Badwan, Amani	Save the Children, West Bank/Gaza	ashaar@scuspalestine.org	972-2-583-5771
Baglole, Deborah	Merlin	debbie@merlin.org.uk	0207-378-4849
Bartel, Doris	CARE	dbartel@dc.care.org	1-202-595-2804
Bartlett, Linda	Centers for Disease Control and Prevention	ltb7@cdc.gov	1-770-488-6278
Belton, Suzanne	University of Melbourne	s.belton@pgrad.unimelb.edu.au	
Betukumeso, Jean-Marie	SCEV		
Bigirimana, Pierre-Claver	Canadian International Development Agency	pierre_bigirimana@acdi-cida.gc.ca	819-994-2634
Billings, Deborah	Ipas	dbillings@webtelmex.net.mx	1-919-967-7052
Bisharat, Leila	JSI	lbisharat@jsi.com	1-202-543-5915
Bishop, Paul	IRC Uganda	annb@theirc.org	256-41-349-21718
Bonds, Sera	Boston University School of Public Health	serabonds@hotmail.com	1-512-479-8886
Boniface, Rester	UMATI Refugee Projects	umatikib@africaonline.co.tz	255-28-282-0208
Borchert, Matthias	London School of Hygiene & Tropical Medicine	matthias.borchert@lshtm.ac.uk	44-20-7299-4679
Bornemisza, Olga	London School of Hygiene & Tropical Medicine	olga.bornemisza@lshtm.ac.uk	44-20-7927-2006
Boutros, Mark	Columbia University, Mailman School of Public Health	mnb2001@columbia.edu	
Buzurukov, Ali	UNFPA - HRU	buzurukov@unfpa.org	41-22-917-8440
Calain-Watanabe, Tomo		pomo_cw@yahoo.co.jp	
Campbell-Reidhead, Lindsay	US Mission to the European Union	lcampbellr@hotmail.com	26-723-870
Carballo, Manuel	International Centre for Migration and Health	mcarballo@icmh.ch	41-22-783-1081
Casey, Sara	Columbia University, Mailman School of Public Health	sec42@columbia.edu	1-646-284-9675
Chahine, Fatima	Association Najdeh	association@najdeh.org.lb	961-1-302-079
Chynoweth, Sarah	Women's Commission for Refugee Women and Children	sarahc@womenscommission.org	1-212-551-3113
Cisse, Cheikh Tidiane	UNFPA	cisse@unfpa.org	
Coates, Rosemary	Australian Reproductive Health Alliance	dianne@arha.org.au	61-2-6287-4422
Collingwood, Clare	Marie Stopes International	clare.collingwood@mariestopes.org.uk	44-207-574-7346
Colombini, Manuela	WHO	colombinim@who.int	412-2-791-4281
Currie, Sheena	Healthnet International	sheena@mara2.freemove.co.uk	882-168-980-2927
Dakkak, Henia	International Medical Corps	hdakkak@imcworldwide.org	1-917-650-3345
Davidson, Leslie	Columbia University, Mailman School of Public Health	ld1@columbia.edu	1-212-304-5201
de Becker, Leen	Belgian Ministry of Foreign Affairs	leen.debecker@diplobel.fed.be	
de la Fuente, Martha	Columbia University, AMDD Program	mdelafuente@chello.nl	31-20-638-4932
de Negri, Berengere	AED Advance AFRICA	bdenegri@advanceafrica.org	703-310-3538
Deblonde, Jessika	International Centre for Reproductive Health	jessika.deblonde@ugent.be	32-9-240-3564
Del Vecchio, David	UNFPA - HRU	delvecchio@unfpa.org	1-212-287-5254
DeLargy, Pamela	UNFPA - HRU	delargy@unfpa.org	1-212-287-5254
Delstanche, Laurie	UNFPA	delstanche@rocketmail.com	

<b>Name</b>	<b>Organization</b>	<b>Email</b>	<b>Work Phone</b>
DeVriese, Machtelt	UNHCR	devriese@unhcr.ch	
Diallo, Mamadou	UNFPA	mdiallo@unfpa.org	
Doedens, Wilma	UNFPA - HRU	wilma.doedens@undp.org	41-22-917-8315
Elema, Riekje	Medecins Sans Frontieres	riekje_elema@amsterdam.msf.org	
Fauveau, Lucy	Marie Stopes International	lucy.faveau@mariestopes.org.uk	44-207-274-7346
Feather, Jo	Interact Worldwide	jof@populationconcern.org.uk	44-20-7241-8500
Fetters, Tamara	Ipas	fetterst@ipas.org	1-919-960-5629
Frost, Nicholas	Marie Stopes International	nicholas.frost@mariestopes.org.uk	
Gakire, Aimable	GVT - MINALOC		
Goodyear, Lorelei	Program for Appropriate Technology in Health	lgoodyear@path.org	1-206-285-3500
Gray, Nicole	William and Flora Hewlett Foundation	ngray@hewlett.org	1-650-234-4500
Guy, Samantha	Marie Stopes International	sam.guy@mariestopes.org.uk	44-207-574-7346
Haora, Penny	ARC Thailand	arcsang@loxinfo.co.th	66-34-595-177/560
Harmen, Adele	Humanitarian Policy Group		
Hawkins, Steve	USAID	shawkins@usaid.gov	202-712-4739
Heisecke, Karen	UNFPA	heisecke@unfpa.org	32-2-550-1832
Hepworth, Sarah	Interact WorldWide	sarahh@populationconcern.org.uk	44-20-7241-8500
Hindmarsh, Patricia	Marie Stopes International	patricia.hindmarsh@stopes.org.uk	44-20-7574-7346
House, Krista	Andrew W. Mellon Foundation	klh@mellon.org	1-212-838-8400 x 2207
Hynes, Michelle	Centers for Disease Control and Prevention	mhynes@cdc.gov	1-770-488-6406
Igras, Susan	CARE	igras@care.org	1-404-979-9158
Jacobs, Jean-Marc	JSI UK	jjacobs@jsiuk.com	44-20-7241-8599
Jaffer, Fowzia	Marie Stopes Yemen	msfowzia@y.net.ye	967-124-1494
Javid, Farhad	Marie Stopes Afghanistan	msafghan@uku.co.uk	
Jess, Mathiolice	Commission of DG Development		
Jurugo, Edna	Transcultural Psycho-Social Organization	tpouga@imul.com	256-41-510256
Kamara, Connie	American Refugee Committee	conniek@archq.org	1-612-872-7060
Katamadze, Khatuna	Women's Charity Fund	khatuna_k@hotmail.com	995-7744-0646
Khalidi, Aziza	Association Najdeh	association@najdeh.org.lb	961-130-2079
Kinyanda, Eugene	African Psycare Research Organisation	ekinyanda@hotmail.com	256-77-410285
Korra, Antenane	CARE Ethiopia	antenane@yahoo.com	251-1-534080
Krause, Sandra	Women's Commission for Refugee Women and Children	sandra@womenscommission.org	1-212-551-3110
Larson, Mary Kay	Centers for Disease Control and Prevention	marykylarson@cdc.gov	1-770-488-5227
Leon, Lydia	UNFPA - HRU	leon@unfpa.org	1-212-297-5000
Liebling, Helen	University of Warwick, Centre for the Study of Women and Gender	helenliebling@hotmail.com	
Maeriën, Jozef	UNFPA - HRU	maerien@unfpa.org	
Maes, Sophie	Medecins Sans Frontieres	sophie.maes@msf.be	32-2-474-7474
Masini, Tezra	UNICEF Tanzania, Ngara Field Office	tmasini@unicef.org	255-28-2223741
Matthews, Julia	Women's Commission for Refugee Women and Children	juliam@womenscommission.org	1-212-551-3112
McGinn, Therese	Columbia University, Mailman School of Public Health	tjm22@columbia.edu	1-212-304-5224
Mejia, Maryluz	UNFPA	maryluz.mejia@undp.org	
Meyers, Janet	Reproductive Health Response in Conflict	janetm@womenscommission.org	1-212-551-3113
Miranda, Laura	Marie Stopes Mexico	lmirandaa@yahoo.com.mx	52-967-67-45812



<b>Name</b>	<b>Organization</b>	<b>Email</b>	<b>Work Phone</b>
Moch, Laura	ARC International - Uganda	lauramoch@hotmail.com	256-41-349091
Morris, Tim	Oxford University, Forced Migration Review	fmr@qeh.ox.ac.uk	44-1865-280-700
Morris, Claire	Marie Stopes International	claire.morris@mariestopes.org.uk	44-207-574-7346
Muhingo, Elisa	UMATI Refugee Projects	umatikib@africaonline.co.tz	255-28-282-0208
Mujawayezu, Agnès	UNFPA	mujawayezu@unfpa.co.rw	
Mwindilila, Lizzy	World Vision Zambia	lizzy_mwindilila@wvi.org	260-1-2219-50/55
Najjab Khatib, Salwa	Juzoor	Juzoor@palnet.com	972-2-234-4677/8
Nanayakkara, Atula	Population Services Lanka	poplanka@lanka.ccom.lk	941-500-824
Navani, Sonia	IRC Headquarters	sonian@their.org	1-212-551-3006
Nersesian, Paula	JSI	paula_nersesian@jsi.com	1-703-528-7474
Niewczasinski, Jane	Marie Stopes International	jane.niewczasinski@mariestopes.org.uk	44-207-574-7346
Niyonzima, Stany	CARE Burundi	sniyonzima@careburundi.org	257-241-662
Nkuzimana, Canut	CORDAID		
Nyitambe, Naomi	UNHCR Kibondo	nyitambe@unhcr.ch	255-28-282-0217
Nzokirishaka, Athanase	UNFPA	athanase@usan-bu.net	257-223-098
O'Heir, Judith	UNHCR	joheir@bigpond.com	61-2-998-23090
Ondeko, Roselidah	UNHCR	ondeko@unhcr.ch	41-22-739-8382
Onyango, Monica	Boston University School of Public Health	monyango@bu.edu	1-617-414-1403
Orach, Christopher	Makerere University, Institute of Public Health	cgorach@hotmail.com	256-77-511-444
Ospina, Patricia	Profamilia	pospina@profamilia.org.co	571-338-3160
Pacheco, Carlos	UNFPA	carlos.pacheco@undp.org	488-9000 x 241
Palmer, Lucy	Marie Stopes International	lucy.palmer@mariestopes.org.uk	44-207-574-7346
Partridge, Rachel	Univeristy of South Hampton, Department of Social Statistics	rl@socsci.soton.ac.uk	44-23-8059-5763
Paulette, Gina	ARC - Guinea	brianguinea@yahoo.co.uk	224 -13-409338
Pett, Celia	Refuge Egypt	ianpett@compuserve.com	77-92-744-976
Pillsbury, Henry	EBP Fund	kingsfountain@siteparc.fr	
Pillsbury, Barbara	EBP Fund	kingsfountain@siteparc.fr	
Piran, Parviz	Allameh Tabatabaiee University	pooria@mavara.com	98-21-8302485
Pitner, Jess	American Refugee Committee	jessp@archq.org	1-612-872-7060
Pitts, Leissa	FPA Health	leissa@ozemail.com.au	02-9327-2864
Popoola, Deji	UNFPA	popoola@unfpa.org	31-20-540-7121-6
Pörksen, Julie	Marie Stopes International	julie.porksen@mariestopes.org.uk	44-207-574-7346
Purdin, Susan	Columbia University, Mailman School of Public Health	sjp98@columbia.edu	1-646-284-9659
Ramchandran, Deepa	Johns Hopkins University, Bloomberg School of Public Health	dramchan@jhuccp.org	1-410-659-6372
Rebold, Andrew	UNFPA - HRU	rebold@unfpa.org	
Renaud, Tamar	UNICEF	trenaud@unicef.org	1-212-326-7003
Renner-Gaertner, Nicole	Bureau of Population, Refugees and Migration	gaertnernr@state.gov	1-202-663-1481
Rielly, Catherine	Southern New Hampshire University	c.rielly@snhu.edu	1-603-644-3156
Rimal, Nirmal	Association of Medical Doctors of Asia - Nepal	n.rimal@amda.org.np	977-23-540232
Roble, Maria	IMC Angola	imc.ang.md@ebonet.net	244-2-392-174
Rowley, Elizabeth	JSI	erowley@jhsph.edu	1-703-528-7474 x 5080
Sandbaek, Ulla	Member of European Parliament	usandbaek@europarl.eu.int	

<b>Name</b>	<b>Organization</b>	<b>Email</b>	<b>Work Phone</b>
Sansour, Nadira	World Education	nsansour@worlded.org	1-617-482-2110 x 555
Schwalbe, Mary Anne	Women's Commission for Refugee Women and Children	mas@theirc.org	1-212-551-3090
Shadid, Sana Kanaa	UNFPA	shadid@unfpa.org	
Shah, J. Jina	Centers for Disease Control and Prevention	zat5@cdc.gov	1-770-488-6280
Soura, Biesse Diakaridja	National Institute for Social Welfare	souradiak@yahoo.fr	07-92-9150
Spiegel, Paul	UNHCR	spiegel@unhcr.ch	41-22-739-8289
Sullivan, Tara	Johns Hopkins University, Bloomberg School of Public Health	tsulliva@jhucpp.org	1-410-659-6254
Suriyamurthy, S.	Population Services Lanka	poplanka@lanka.ccom.lk	941-500-824
Tadiesse, Edmond	Kenyatta University	tadiesse@hayoo.com	254-73-379-7440
Takei, Yayoi	International Federation of Red Cross	ifrctz05@ifrc.org	
Tavazde, Lia	International Medical Corps	lika_md@yahoo.com	7-95-241-7449
Thapa, Poonam	IPPF European Network	pthapa@ippfen.org	32-2-250-09-50/58
Thomas, Marleen	Belgian Ministry of Foreign Affairs	marleen.thomas@dipobel.fed.be	
Timngum, Desire	Wits University, Graduate School for the Humanities	timngum142@yahoo.com	
Todd-Lippock, Alexandra	USAID	atodd@usaid.gov	1-202-483-3234
Tomczyk, Basia	Centers for Disease Control and Prevention	bet8@cdc.gov	1-770-488-3136
Törnqvist, Caroline	Marie Stopes International	caroline.törnqvist@mariestopes.org.uk	44-207-574-7346
Tucker, Kelly	US Department of State	tuckerkj@state.gov	1-301-920-1991
Usher-Patel, Maggie	WHO	usherpatelm@who.int	412-27-911-4370
van Egmond, Kathia	International Centre for Reproductive Health	kathia.vanegmond@ugent.be	32-9-240-3564
Van Lancker, Anne	Member of European Parliament	avanlancker@europarl.eu.int	
Vega, Ana	Profamilia	avega@profamilia.org.co	1-571-339-0900 x 238
Venghaus, Joan	EngenderHealth India Country Office	jvenghaus@engenderhealth.org	
Venter, Wendy	Reproductive Health Response in Conflict	allison@womenscommission.org	1-212-551-3107
Vinh-Thomas, Elmar	Packard Foundation	e.vinhthomas@packard.org	
Wabulakombe, Jeannot	Merlin	sarelgod@yahoo.ft	
Ward, Jeanne	Reproductive Health Response in Conflict	jeanne@theirc.org	1-212-551-2734
Webb, Douglas	Save the Children UK	d.webb@scfuk.org.uk	
Whelan, Anna	University of New South Wales	a.whelan@unsw.edu.au	61-2-9385-3593
White, Carol	Center for Victims of Torture	cwhite@cvt.org	1-612-436-4847
Wood, Caroline	World Association of Girl Guides and Girl Scouts	caroline@wagggsworld.org	44-20-7433-6443
Woodward, Shirley	ARC Guinea		224-13-409338
Yamamoto, Aiichiro	JICA UK Office	aiichiroy@jica.co.uk	
Yeneneh, Hailu	Ipas Ethiopia	hailuy55@hotmail.com	
Zazay, Maima	Family Planning Association of Liberia		
Zulu, Marqueline	HODI	director@hodi.org.zm	260-1-290455

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