Summary, conclusions and future directions

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1. The findings presented for Components 1 through 6 of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs attest to the progress made since 1995 with respect to the institutionalization of reproductive health programmes. The evaluation findings also indicate particular aspects of reproductive health services that need to be strengthened and/or expanded, as outlined in the following. It should be noted here, however, that the findings from the field (with the exception of the MISP evaluation in Chad) relate primarily to stable camp settings and therefore do not necessarily reflect the situation in acute complex emergency settings where information is particularly difficult to collect due to security constraints.

2. At the field level, Components 1 through 4 of the evaluation indicate that the services being provided are consistent with those outlined in the *Inter-agency Field Manual*. For example, past assessments and/or evaluations, such as those included in the literature review (Component 1), report the availability of services for safe motherhood, sexual and gender-based violence (SGBV), sexually transmitted infections (STIs), including HIV/AIDS, and family planning. These services were found to be generally favourable for refugees living in stable settings, although there were gaps noted in most areas. For example, while services for safe motherhood were generally good, there is still a need to ensure that antenatal care includes all of the recommended elements, particularly syphilis screening and treatment and intermittent preventive treatment for malaria, where indicated. In addition, access to EmOC for all pregnant women needs to be ensured. Although family planning services were widely available, there were gaps related to the availability of methods and the skills and abilities of service providers. Services for STI/HIV/AIDS and, to an even greater extent, those for GBV in refugee settings, were less comprehensive and in greater need of strengthening. However, it is imperative to note that, in contrast to the services for refugees, those for internally displaced populations appeared to be severely lacking and in need of urgent attention if the reproductive health needs of these populations are to be met.

3. The findings from the coverage study (Component 2) reinforce those from previous assessments and/or evaluations. For example, the findings by technical area suggest that coverage is fairly good. However, services for the prevention and response to GBV were weak and other services such as those for HIV/AIDS prevention and obstetric emergencies could (and should) be stronger. Coverage was found to decrease with the newness of the technical area; GBV is the newest, least familiar and most difficult area and has the lowest coverage, whereas antenatal care, the most familiar, most standard and easiest to provide, has the highest coverage. These findings relate primarily to refugee populations, as although attempts were made to gather information on IDPs too, information about them was more difficult to access. However, despite this, given the status of reproductive health for populations affected by armed conflict in the mid-1990s, the results of the coverage

study are promising. Even if the availability of services has been overestimated, it is clear that a wide range of services and a meaningful absolute number of sites provide services, which is impressive given that ten years ago there were few services available for refugees and IDPs.

4. The findings from the evaluations conducted in Uganda, RoC and Yemen (Component 3) were variable, although similar gaps were identified to those outlined above. Services for safe motherhood were, for example, reasonably good, with the exception of those for obstetric emergencies, which need strengthening in the three study countries. Referral for the management of obstetric complications was difficult due to issues with transport, communication, and personnel. In addition, some referral centres were unable to provide the services needed. Family planning services at the evaluation sites in Uganda and Yemen were found to be of good quality in terms of commodities and trained staff, but there was cultural resistance to the use of these services. In contrast, in RoC, health care providers were found to have limited expertise in family planning and there were inadequate supplies. The supply of drugs for treating STIs was described as variable in Uganda, poor in RoC, and limited in Yemen. In addition, the use of syndromic case management was problematic at some sites. While GBV was prevalent in the three study countries, there appeared to be very little available in terms of programming to address this problem. Although the evaluation was to cover services for both refugees and IDPs, the study team appears to have had limited access to the latter. Hence the evaluation findings apply primarily to refugee populations.

5. The general recommendations, applicable to the three study countries, included, but were not limited to, formalizing referral networks and strengthening referral systems through strategic planning; ensuring the availability of essential drugs for treating STIs and obstetric emergencies; ensuring the availability of the equipment needed for post-abortion care; providing GBV awareness raising activities in all refugee camps and with all staff working in the camps; building on the capacity of TBAs; and improving data collection methods relevant to reproductive health.

6. The findings from the evaluation of the use of the MISP and RH Kits in post-emergency situations (Component 4 Part A), suggest that, based on retrospective data from more than 40 countries covering the years 2000-2002, the MISP was better used than in the past and the RH sub-kits were found to be generally useful. Suggestions were made, however, to add and / or change some of the items in the kits and to provide more training on the correct use of the kits. In addition, many of the survey respondents indicated that they had encountered problems with in-country transport and storage of the kits. In relation to this, it was concluded that, in some countries, poor road conditions, irregular flights, extreme heat and humidity, and other factors might continue to pose a serious challenge to the distribution and storage of the kits and, therefore, delay or prevent their use.

7. In contrast to these findings, those from the assessment of the MISP during the Sudanese refugee emergency in Chad (Component 4 Part B) indicate that most of the humanitarian actors in Chad were not familiar with the MISP and did not know its overall goal, key objectives and priority activities. There was no overall reproductive health coordinator and only one agency had a designated reproductive health focal point. While several protection activities supporting the prevention of sexual violence had been implemented in some camps, the protection needs of the majority

of refugees in spontaneous refugee sites on the dangerous border area were unmet. With the possible exception of one agency, humanitarian actors in Chad were not prepared to address the clinical management of rape survivors. Although the assessment team heard widespread reports of women and girls abducted and raped in Darfur, Sudan, there was no initiative to provide the necessary health services to women and girls who had survived sexual violence and escaped to Chad.

8. There were significant problems related to the prevention of transmission of HIV / AIDS, including inconsistent practise of universal precautions and no provision of free condoms. None of the three priority interventions to prevent excess maternal and neonatal mortality and morbidity — provision of clean delivery kits for mothers and TBAs, midwifery delivery kits for health facilities, and establishment of a referral system for obstetric emergencies — were fully established.

9. The final MISP objective — to begin planning for comprehensive reproductive health services integrated with primary health care as the situation stabilizes — was not evident. Other factors that hindered timely implementation were lack of awareness on the part of donors and UN agencies, and delays in funding.

10. These findings point to the need for increased awareness and understanding of the MISP amongst donors and humanitarian actors; the need for better health coordination and the appointment of a reproductive health coordinator early in an emergency; the allocation of funds to support the use of the MISP; and the need for a network of experienced reproductive health coordinators.

11. At the agency / institutional level, the findings of the assessment of changes over time within agencies / institutions involved with reproductive health services for refugees and IDPs (Component 5) were generally positive. For example, since 1995, improvements were noted in all areas of RHR, technical support, and reproductive health strategy. Moreover, there was overwhelming evidence that collaboration and exchange amongst organisations involved in RHR had increased since 1995, due in large part to the vital roles played by the IAWG and the RHRC Consortium, as well as other key groups. While these achievements are impressive, the majority of organizations involved in RHR also feel that inadequate funding and, frequently, too few technical staff to support all of their functions hampers their work.

12. Notwithstanding these concerns, the growth in collaboration through a variety of exchange mechanisms among RHR organizations over the past decade was seen to provide momentum for extensive activities to promote future connections. It was suggested that encouraging new partnerships that draw on the increasing interest and expertise of development organizations would expand the base of support for RHR and facilitate smoother transition from emergency situations to longer-term development assistance. In addition, it was suggested that the various academic centres and institutes throughout the world, some of which already have programmatic involvement related to refugees and health, should also be actively engaged.

13. To facilitate this goal, it is suggested that IAWG consider developing an outreach committee to take responsibility for seeking out and engaging peripherally involved organizations, and raise awareness throughout the larger community, especially toward potential new entrants in the field. In addition, IAWG might also establish and oversee a central repository / database to contain membership, reports,

documents, and other information relevant to the operation of the IAWG and the field of RHR.

14. At the global level, the review of resource availability over time in support of reproductive health services for refugees and IDPs (Component 6) raises important questions regarding reproductive health programmes in conflict situations and suggests some useful lessons for the future. While the funding sources for these programmes remain unchanged, funding has actually declined since 2000 and seems unlikely to increase in the near future. The major reasons suggested for this are weakening political support for reproductive health programmes in general, the continuing perception at some levels that reproductive health is not an essential part of emergency response, and the absence of a strategic advocacy plan on behalf of the IAWG. It was further suggested that the IAWG's advocacy strategy should focus on providing evidence to donors and the public of reproductive health needs in conflict settings; integrating reproductive health into the UN system's humanitarian response mechanism; involving senior staff in advocacy and fundraising; and working with media to increase the visibility of the problem. The review concluded that better coordination, exchange of information and experience and joint operational planning are required if the IAWG is to impact on resource mobilization in a competitive humanitarian environment.

15. The summary of findings presented above provides a comprehensive picture at field, agency/institution, and global levels with respect to providing reproductive health services for refugees and IDPs, highlighting the progress made since 1995 and emphasizing the gaps that need to be filled. Based on the findings, the main challenges for the future include: implementing the MISP in new emergencies; establishing GBV programming in all situations where it is required; ensuring access for IDPs to the full range of reproductive health services; and improving access to and quality of EmOC, family planning services, and services for the prevention and management of STIs, including HIV/AIDS, for refugee and other displaced populations, male and female adolescents included. Additional challenges include improving the collection and appropriate use of data, nurturing the growth of inter-agency collaboration, and the development of an advocacy strategy aimed at ensuring that reproductive health for refugees and IDPs remains securely on the agendas of donors and relevant international agencies and organizations. Collectively, these challenges will provide direction for the future work of the IAWG.